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

Safe and Strong Communities Select Committee

Wednesday, 9 November 2016
2.00 pm
Oak Room, County Buildings, Stafford

John Tradewell
Director of Strategy, Governance and Change
1 November 2016

A G E N D A

1. **Apologies**

2. **Declarations of Interest**

3. **Minutes of the Safe & Strong Communities Select Committee held on 5 September 2016** (Pages 1 - 6)

4. **Deprivation of Liberty Safeguards** (Pages 7 - 14)

   Report of the Cabinet Member for Health, Care and Wellbeing

5. **Customer Feedback & Complaints Adult Social Care Annual Report 15/16** (Pages 15 - 48)

   Report of the Cabinet Member for Health, Care and Wellbeing

6. **Customer Feedback & Complaints - Children's Social Care Annual Report 15/16** (Pages 49 - 76)

   Report of the Cabinet Member for Children & Young People

7. **Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2015/2016** (Pages 77 - 124)

   Report of the Cabinet Member for Health, Care and Wellbeing

8. **Work Programme** (Pages 125 - 134)

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

Committee Membership

Margaret Astle	Bob Fraser
Maureen Compton	Robert Marshall
Mike Davies	Christine Mitchell
Terry Finn	Mark Olszewski
John Francis (Chairman)	David Williams (Vice-Chairman)

Note for Members of the Press and Public

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Scrutiny and Support Manager: Tina Randall Tel: (01785) 276148

Minutes of the Safe and Strong Communities Select Committee Meeting held on 5 September 2016

Present: John Francis (Chairman)

Attendance	
Margaret Astle	Robert Marshall
Mike Davies	Christine Mitchell
Terry Finn	Mark Olszewski

Also in attendance: Matthew Ellis, Staffordshire PCC and Glynn Dixon, Chief of Staff to the PCC.

Apologies: Maureen Compton, Gill Heath and David Williams

PART ONE

17. Declarations of Interest

In connection with minute no. 19:

- Mr M Olszewski declared an interest in relation to questions that may be considered about Stafford Prison in his capacity working for the National Offenders Rehabilitation Service; and
- Mr T Finn, Mrs C Mitchell, Mr M Davies and Mr R Marshall declared an interest as members of the Staffordshire Fire Authority.

18. Minutes of the previous meeting held on 8 July 2016

RESOLVED – That, subject to reference to “Lichfield” skate park being amended to “Burntwood” skate park at minute 12, the minutes of the 8 July 2016 Safe and Strong Communities Select Committee be confirmed and signed by the Chairman.

19. Community Safety

Staffordshire’s Police and Crime Commissioner (PCC), Mr Matthew Ellis, attended the meeting for Select Committee Members to scrutinise his work on community safety. The PCC informed Members that the key challenges faced when he first became Commissioner were predominantly financial challenges and around poor technology and multiple IT systems. Changes in the types of crime, including the rise of internet crime, also required changes in approach from the more traditional image of policing. The PCC explained the work he had undertaken to address the lack of investment and the use of improved mobile technology allowing more visible policing. A wider approach to policing was being developed as part of the National Transformation of Policing to ensure the service was fit for the future. The pace of change was growing with a move to preventative rather than reactive policing.

The Select Committee had a number of questions they then put to the PCC.

How are you ensuring visible policing?
Members felt there were less police officers, Police Community Support Officers (PCSOs), and police vehicles visible in communities. The PCC informed Members that visibility was a top priority. Replacing outdated technology systems allowed significantly less time spent in police stations filling out forms and enabled better and more visible use of police officers. Approximately one third of the new technology had been rolled out to date, with the final two thirds rolled out in November 2016 and January 2017. The Force had a new Assistant Chief Constable (ACC) for territorial policing who was looking at the impact of visibility on community policing and how this could be improved. It was anticipated that there could be a possible 200,000 extra hours of police time to be gained from using the new technology, as whilst the necessary administration would continue, this could be undertaken out in communities rather than the need to return to police stations.

The PCC expressed disappointment that Members felt police vehicle visibility had not improved. He informed Members that at least 80% of police vehicles were now marked. The PCC also informed them of the Central Motorways Policing Group (CMPG), made up of officers from the West Midland, West Mercia and Staffordshire Police Forces. This allowed more regional ways of working which was encouraged by HMIC. The OPCC Chief of Staff, Mr Glynn Dixon, was currently looking at whether the CMPG could absorb more substantial road network policing in Staffordshire. This would give the advantage of a less fragmented service.

The PCC agreed there was an urgent need to review the Staffordshire Road Safety Partnership, feeling this was too detached from day to day business. Following a review six months earlier there had been a move away from placing cameras in areas most likely to catch and fine drivers to those areas with genuine safety concerns.

Members welcomed these initiatives but felt there had been little effect on improved visibility. They remained concerned at difficulties in getting police officers and/or PCSOs to attend local residential meetings and felt there was a general lack of engagement. They also expressed concern at response times and difficulties with 101 calls. Members gave examples of poor visibility in community policing in Kidsgrove and shared concerns that the general public were loosing faith in the police service.

The PCC informed Members that Staffordshire had not lost the number of police officers that other forces had. Across the Country there had been a reduction of 17% whilst Staffordshire had increased by 1%. However if the resources were not used effectively then visibility would not improve and there was a need for a cultural change to ensure mobile technology was used effectively and police officers remained within the community rather than in police stations. Local Commanders needed to embrace this cultural change. He also informed the Select Committee that police officers should not in general be spending more than ten minutes at a meeting as the more time they spent in meetings the less they had on the streets and there was a need for a balanced approach.

The PCC accepted that there had been difficulties with 101 calls but felt that they were now performing well.

The Select Committee noted that the police workforce had reduced by 18% since 2010, whereas the reduction had been 15% nationally. There was less police officers per 1000 people in Staffordshire than nationally. The PCC informed Members that he stopped the reduction in staff once he came to office. Since 2012 Staffordshire numbers had reduced less that in other areas of the country.

What are the causes of rising violent crime figures locally and how is this being addressed, particularly in respect of managing hate crimes since Brexit and the increase in knife crime?
The PCC informed Members that the biggest increase was due to what now constituted violent crime, with an example given of offensive tweets now being considered as a violent crime. He felt that the media were largely responsible for rousing concerns around Brexit. Distinguishing whether a hate crime resulted from Brexit was not possible and he felt this was an artificial media engineered issue.

What has and is changing to ensure the protection of the most vulnerable?
The work undertaken by Staffordshire Police around people with mental health issues being placed in police cells had been successful, with a 53% reduction. Vulnerability covered many variations and therefore policing was much more complex. Training of police officers had been developed to increase awareness around vulnerability.

Work was underway to jointly commission domestic abuse services across Stoke on Trent and Staffordshire to ensure services were not based on postcode and to have a one Staffordshire approach. There was a need for information to be managed properly and the PCC shared concerns around the information flow with the NHS which was poor.

Members asked whether the PCC had been surprised by the recent damming report around domestic abuse and whether he had been aware of the failings. The PCC informed Members that since the report was published the HMIC had pulled back from some of their criticism and had now given a clean bill of health. The PCC had some criticism of HMIC feeling that they measured quantitative detail that in many instances added no value rather than the more difficult qualitative performance. The reason for the concerns in Staffordshire's domestic abuse figures was due to Domestic Abuse Incident Log (DAIL) reporting. The PCC wanted his officers to make a judgement as to whether there was a need to create a paper chase on what may be unsubstantiated reports. He did accept that at an extreme level there was some justification for the criticism and that his officers were now beginning to use DIAL more robustly, however he felt that in many ways it was bureaucracy for bureaucracy's sake and made little difference to frontline outcomes.

Members informed the PCC of a meeting in Burntwood with a group of vulnerable adults and agreed to forward the outcome of the meeting to the OPCC for information.

What is the effect of Policing Hubs?
Investigation services were to be centralised in the north and south of the county. This initiative had been something the Police Force had been requesting for some time as it enabled expertise for investigations to work more effectively together.

How often are police cells being used as places of safety? What has/will be done to address this?
The PCC informed Members that he had raised this issue nationally and the concerns raised had led to the Concordat national initiative. There had been a significant reduction since the PCC initiative to include a mental health specialist working with the Police Force. The PCC had funded this initially and more recently the NHS had agreed to provide this service. The PCC informed Members that there had been some differences in the level of service since the NHS took over funding this initiative however he intended to look at this again to see whether there was a need for further funding from the OPCC. The PCC recounted a recent example of an individual with mental health issues who had been in a police cell for 64 hours until appropriate care was found. The PCC explained that this had largely been due to an inability for each of the NHS trusts the individual had moved through wanting to take responsibility for his care. The PCC had since received an apology from the NHS for their shortcoming in this instance.

What work is being undertaken to minimise any potential risk posed from sex offenders who are released from Stafford Prison?
Centralising this type of offender in specific prisons allowed specialist support and rehabilitation work to be undertaken. In this way offenders were more likely to receive the type of support that would prevent re-offending than if there were fewer numbers spread across the more of the prison service. The PCC had sought assurances for the safety of Staffordshire residents when the proposed specialism was suggested and he in turn assured Members that the right processes were in place. The Probation and Police Service were aware of where an individual was release to and the requirements placed on them. A detailed briefing note had been produced by the OPCC on the resettlement service and this would be forwarded to the Select Committee.

Members asked what the current situation was in Staffordshire in respect of Child Sexual Exploitation (CSE). Much work had been done in this area with the OPCC leading on a strategy to join the various pieces of information onto one system. It was a very comprehensive jigsaw of information which would be linked primarily through the Multi Agency Safeguarding Hub (MASH). There were clear expectations on each organisation performing their part in this process. A copy of the CSE Framework would be forwarded to Select Committee Members.

The PCC also informed Members that he wanted to instigate a route and branch audit of democratic service governance issues to help rationalise community safety governance. The PCC said he would welcome the Select Committees help with this rationalisation process.

What is your current and future envisaged relationship with the Fire and rescue Service in Staffordshire?
An independent report had identified opportunities and synergies between the Police and Fire Service. The Fire Service had been successful in reducing the impact of fires and had improved fire safety. The demands on the Fire Service had reduced dramatically. Broadly speaking the PCC felt the Police and Fire Services worked towards the same aim, i.e. to keep people safe. The number of calls to the Fire Service averaged 23 per day compared with 550 to the Police Service. He felt there was the potential for significant savings to be made, particularly when considering back office

services and avoiding inefficiencies around deployment. There was also efficiencies to be made within leadership with the Fire Service having significantly larger leadership roles than the Police despite being one fifth its size.

Legislation now enabled PCCs to make a determination to the Secretary of State on the future of these arrangements. Staffordshire's PCC explained that he would rather find an agreed way forward than needing a determination. The outcome of the independent review was expected in early October, with discussions expected to be held with the Fire Service at the end of October.

Members suggested there may be better synergies in joining the Ambulance and Fire Services rather than the Fire and Police Services. The PCC felt the closer synergy was between Police and Fire Services with a greater prospect of a successful marriage between these services. He informed Members that he had been under some pressure to include the Ambulance Service as well but that he had ruled this out.

How local crime statistics are made available to Members?
These were available on line for Members to access themselves. A new Dashboard website had been developed and gave Members the ability to compare crime figures across areas as well as across the County. Members requested that the link to this Dashboard be forwarded to them.

How can the use of drones be monitored?
The Civil Aviation Authority was the lead authority on this issue. Only where an issue impacted on common law would the police be involved.

RESOLVED – That the following documents be forwarded to Select Committee Members:

- briefing report on re-settlement service for sex offenders at Stafford Prison
- CSE comprehensive framework
- link to the dashboard enabling Members to access local crime figures

20. Work Programme

The Scrutiny Manager informed Members that the Chairman and Vice Chairman had a Triangulation meeting arranged shortly where consideration would be given to timing of the current work programme items. The following items had been requested for the future meetings:

- Customer feedback on complaints,
- Update on modern day slavery, and
- Deprivation of Liberty Safeguards (DoLS).

RESOLVED – That the amendments to the work programme be noted.

Chairman

Local Members' Interest
N/A

Safe and Strong Communities Select Committee – 9th November 2016

Deprivation of Liberty Safeguards

Recommendation

1. The Select Committee to consider and provide their views on the Deprivation of Liberty Safeguards: update on the impact of central government cuts on assessments.

Report of Cllr Alan White, Cabinet Member for Health, Care and Wellbeing

Summary

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

2. The Safe and Strong Communities Select Committee is being updated on the progress relating to the Deprivation of Liberty Safeguards.

Report

Background

3. The Deprivation of Liberty Safeguards (DoLS) provide protection for the most vulnerable people living in residential homes, nursing homes or hospital environments; they enshrine in law the requirement that care will always be provided in a way that is consistent with the human rights of people lacking capacity, who are not otherwise protected or safeguarded through the use of the Mental Health Act or Court of Protection powers.

4. DoLS apply to anyone:

   a. aged 18 and over

   b. who suffers from a mental disorder or disability of the mind – such as dementia or a profound learning disability

   c. who lacks the capacity to give informed consent to the arrangements made for their care and / or treatment and

   d. for whom deprivation of liberty is considered, after an independent assessment, to be necessary in their best interests to protect them from harm.

5. The safeguards cover patients in hospitals and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements.

6. The safeguards are designed to protect the interests of an extremely vulnerable group of service users and to:

    a. ensure people are given the care they need in the least restrictive way
    b. prevent arbitrary decisions that deprive vulnerable people of their liberty
    c. provide safeguards for vulnerable people
    d. provide them with reviews and rights of challenge against unlawful detention
    e. avoid unnecessary bureaucracy

7. If there is no alternative but to deprive such a person of their liberty, the Safeguards say that a hospital or care home (the Managing Authority) must apply to the local authority (the Supervisory Body) for authorisation.

8. Good practice dictates that DoLS should only be put in place where it is absolutely necessary and for the shortest period of time, with a maximum authorisation of 12 months.

9. On 19th March 2014 the Supreme Court delivered its judgment on P v Cheshire West and Chester Council and P & Q v Surrey County Council in which it considered Deprivation of Liberty. The ruling means that substantial numbers of people who lack the capacity to make a decision about their admission to hospital or placement in a care home will now be considered to be deprived of their liberty.

10. It is clear that the intention of the Court was to extend the safeguard of independent scrutiny. They said that “a gilded cage is still a cage” and that “we should err on the side of caution in deciding what constitutes a deprivation of liberty”.

11. The Court has now confirmed that there are two key questions to ask, which they describe as the ‘acid test’:

    a. Is the person subject to continuous supervision and control? and
    b. Is the person free to leave? (This is no longer just about a person saying they want to leave or attempting to leave and now includes if they would be stopped if they did try to leave).

12. This means that if a person lacks capacity, is subject to both continuous supervision and control and not free to leave they are deprived of their liberty and an authorisation from the local authority should be sought.

13. The Court also indicated that the following are no longer relevant when deciding if a person is deprived of their liberty:

    a. The person’s compliance or lack of objection;
    b. The reason or purpose for the placement / admission or restriction
    c. Comparison with what you would expect for someone in a similar situation.

14. Referrals for DoLS up until March 2014 had been steadily increasing; this increase was met by training additional assessors across all the partner agencies.

15. **DoLS application data**

2009-2010	69
2010-2011	123
2011-2012	168
2012-2013	208
2013-2014	289
2014/2015	2213
2015/2016	3341

Additional DoLS grant

16. As a response to the surge in DoLS referrals (nationwide) the Department of Health provided a grant in 2015/2016 in Staffordshire this amounted to £377,000 this allowed Staffordshire to commission assessments through a social work agency and the backlog on outstanding assessment was kept to a minimum

National Picture

17. Nationally in 2015/2016 **195,840** DoLS applications were received by Local Authorities this compares to the national data from 2013/2014 with **13,715** DoLS applications. Regionally the data varies with the lowest level of DoLS applications in London with the highest in the North East. In the west midlands this amounted to 450 applications per 100,000 adult population 105,055 applications were completed by Local Authorities of which 73% were granted leaving 90,785 not assessed.

Current situation

18. *As of* 30th September 2016

Referrals	1817
Overall backlog	2687

Prioritisation tool

19. ADASS issued a note in November 2014 regarding DoLS and gave guidance on using a prioritisation process in order to identify the risk and complexity of DoLS applications. Staffordshire use a prioritisation tool which classifies applications into three groups high, medium and low priority. This is completed by examining the application data and matching this information to the prioritisation tool.

Current Situation in Staffordshire

20. A report was presented to SLT on the 25th April 2016 and pre cabinet on the 4th May 2016 with an options appraisal the decision taken by SLT and pre cabinet was to focus resource on those individuals who meet the criteria to be considered high priority applications all other applications are unlikely to be assessed.

Applications	1817
High priority	488 (26%)
Medium priority	399 (22%)
Low priority	905 (52%)
Assessments completed (high priority)	268
Backlog high priority	193

Assessments completed

21. 268 assessments have been completed in 2016/2017 at an average of 44 assessments per month however demand based on high priority assessments has continued to increase and on average is approximately 81 per month this leaves a short fall of 37 assessments per month. The backlog of high priority applications has subsequently increased to 193.

22. Plan:

    a. Recruitment of substantive Best Interests Assessor (BIA) roles (3 posts) – on going

    b. Increase performance of BIA rota from current 20 assessments to 27 a month from April 2017, 35 a month from April 2017 and 44 a month from April 2018 in partnership with SSOTP, both Mental Health Trusts and Independent Futures

    c. Increase the numbers and capacity of independent BIA contractors

23. The plan will increase capacity to complete assessments over a period of time and it is anticipated that current monthly demand of 81 high priority assessments should be reached by the end of January 2017 at which point the high priority backlog will have increased to an estimated 300 assessments. By continuing to use the BIA rota, employing substantive BIA's and using independent BIA contractors the backlog of high priority applications will be eliminated by June/July 2018 (anticipating the current rate of applications).

24. **Budget Projections**

Budget	Budget	Planned Spend	Overspend
2016/2017	£128,000	£130,700	£2,700
2017/2018	£128,000	£154,800	£31,996
2018/2019	£128,000	£130,800	£2,800

S21A appeals

25. Anyone deprived of their liberty has a statutory right to appeal against the deprivation of Liberty. Staffordshire currently has 18 ongoing and expected cases and a further 9 completed appeals.

Deprivation of Liberty (outside of care home/hospital)

26. DoLS applies to care home and hospitals only. To authorise a Deprivation of Liberty in other accommodation settings an application is required to the Court of Protection Staffordshire have made 5 applications to the court.

Future changes to the law

27. The law Commission are publishing a white paper in December 2016 which will put forward proposals to change the legal framework for Deprivation of Liberty. It is anticipated that any change would not be introduced for at least 2/3 years.

Link to Strategic Plan

28. The Deprivation of Liberty Safeguards supports the County Councils vision for a connected Staffordshire by ensuring that appropriate prevention and assessment mechanisms are in place to support people's health, wellbeing and independence.

Contact Officer

Name and Job Title: Peter Hampton, Adult Safeguarding Manager
Telephone No.: 01785 895676
Address/e-mail: peter.hampton@staffordshire.gov.uk

Appendices/Background papers

Appendix A - Prioritisation Tool

High Priority	Priority	Lower priority
• Continuous 1:1 care throughout the day and night • Sedation/medication used frequently to control behaviour • Physical restraint used regularly equipment or persons • Restrictions on family/friend contact (or other Article 8 issue) • Objections from relevant person • Objections from family /friends • Meaningful attempts to leave • Confinement to a particular part of the establishment for considerable period of time • Unstable placement • Possible challenge to Court of Protection, or Complaint	• Already subject to DoLS about to expire • Psychiatric or acute Hospital and not free to leave	• Minimal evidence of control/ supervision • No specific restraints or restrictions being used. E.g. in a care home not objecting, no additional restrictions in place. • Has been living in the care home for some time (at least a year) • Settled placement in care home/hospital placement, no evidence of objection etc. but may meet the requirements of the acid test. • End of life situations, intensive care situations which may meet the acid test but there will be no benefit to the person from the Safeguards

Local Members' Interest
N/A

Safe and Strong Communities Select Committee – 9th November 2016

Customer Feedback and Complaints Service Adults Social Services Annual Report 2015/16

Recommendation/s

1. That the Committee consider the Annual Report of the Customer Feedback and Complaints Service, Adults Social Services 2015/16, taking the opportunity for any comments on the content of the report.

Report of the Cabinet Member for Health, Care and Wellbeing

Summary

What is the select Committee being asked to do and why?

2. That the Committee consider the Annual Report of the Customer Feedback and Complaints Service, Adults Social Services 2015/16 taking the opportunity for any comments on the content of the report.

Report

Background

3. The appended report fulfils the Council's duty to publish an Annual Report on the activity of the Statutory Complaints and Representation Service on behalf of the Council. The operation of the Statutory Complaints Procedure was established under the NHS and Community Care Act 1990 and the Local Authority Act 1970. The report provides information about activity during twelve months between April 2015 and March 2016 in respect of statutory complaints relating to Adult Social Care.

4. The Annual Report, Customer Feedback and Complaints Services, Adults Social Services 2015/2016 is being submitted for scrutiny and endorsement.

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

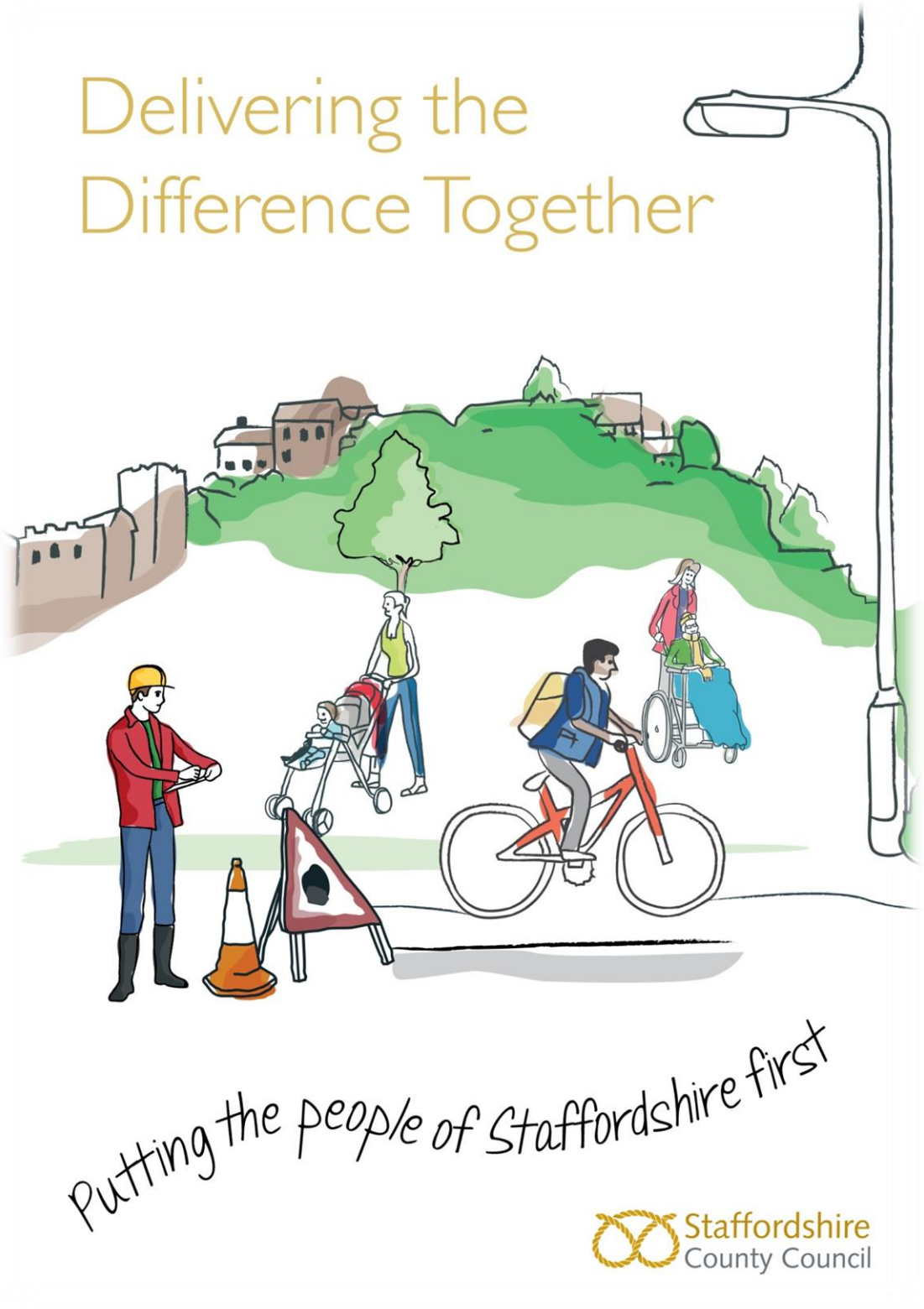
6. Organisational Learning remains at the heart of the legislation. This is reflected in the function of the Responsible Person and Actions Plans that ensure steps are taken to improve, where services may have failed to deliver to an acceptable standard.

Contact Officer

Name and Job Title: Kate Bullivant, Customer Feedback and Complaints Manager
Telephone No.: 01785 277407
Address/e-mail: kate.bullivant@staffordshire.gov.uk

Appendices/Background papers

Appendix A - Customer Feedback and Complaints Service, Adult Social Services, Annual Report 2015/16



CUSTOMER FEEDBACK AND COMPLAINTS TEAM
STATUTORY ANNUAL REPORT 2015-16
ADULTS SOCIAL SERVICES

CONTENTS

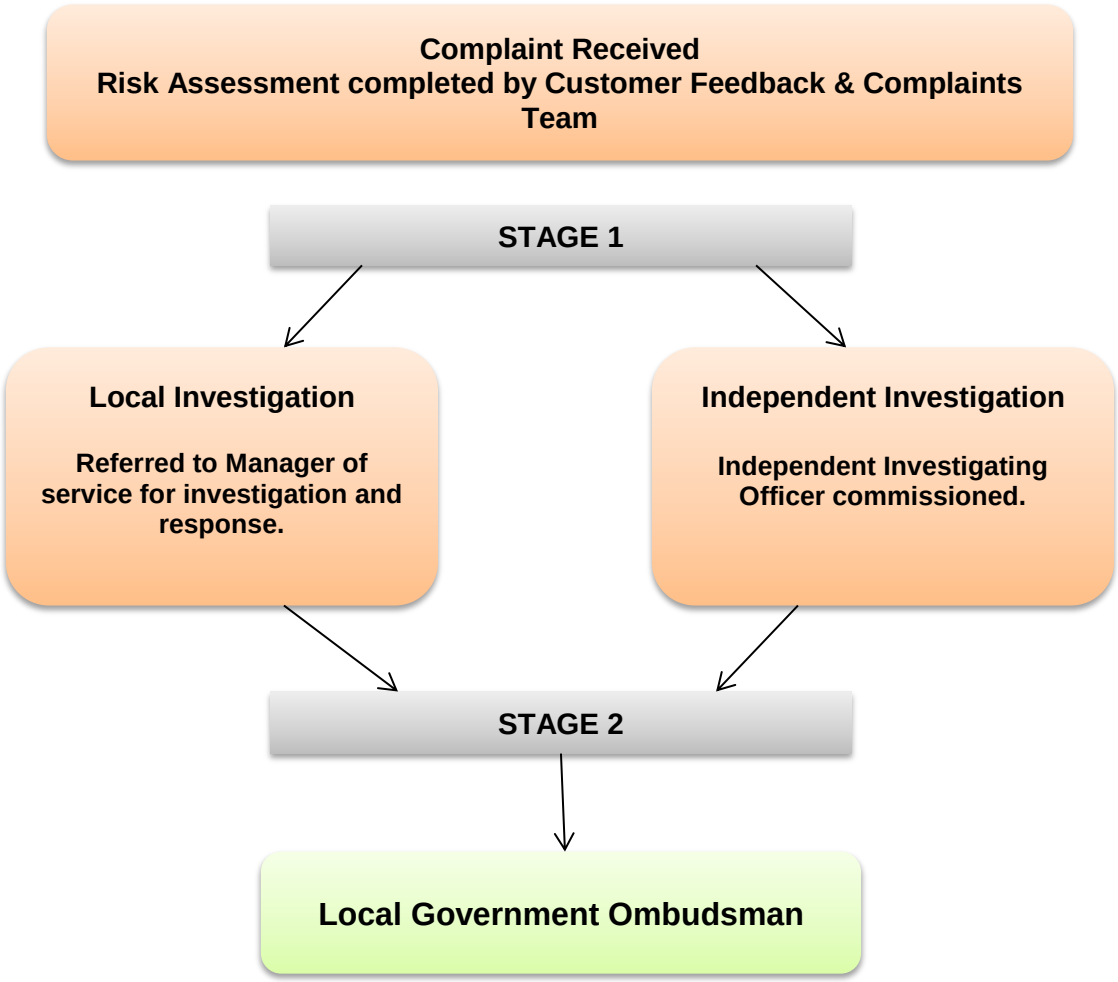
Introduction

This report provides information about complaints made during the twelve months between the 1 April 2015 and the 31 March 2016 under the complaints and representations procedures established under the NHS and Community Care Act 1990 and the Local Authority Act 1970.

From April 2012 Adult Social Care services were transferred over to Staffordshire and Stoke-on-Trent NHS Partnership Trust. As commissioner, the Local Authority co-ordinates all statutory complaints which relate to Adult Social Care services, on behalf of the Partnership Trust. Statistical complaint data has also been provided to the Partnership Trust to be included in their Annual Complaint Report for 2015/16.

The Statutory Complaints Procedure

The Council has a statutory obligation to operate a complaints procedure concerning statutory provision for adults. This is in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. These regulations set expectations for the handling of complaints by Councils, NHS bodies, Primary Care providers and independent sector providers responsible for the provision of NHS and Social Care.



Criteria for Accessing the Statutory Complaints Procedure

Who can complain?
The NHS and Community Care Act 1990 and the Local Authority Act 1970 places the following restrictions on who can access this procedure:

- Complaints under these procedures must be made by or on behalf of an eligible person and must be in respect of that person
- An eligible person is anyone for whom the Council has a power or duty to provide, or secure the provision of a service, and this need or possible need has come to the attention of the Council
- Complaints can be made on behalf of an eligible person where the eligible person lacks capacity to make the complaint themselves (In accordance with the Mental Capacity Act 2008 or has given explicit and verified consent for the Complainant to act on their behalf

Time Limit:

Section 12 of the statutory regulations advise that the complaint must be made no later than 12 months after the date in which the matter which is the subject of the complaint came to the notice of the complainant, unless the complainant has good reason for not making the complaint within this time limit.

Overview

Careful consideration is given in the operation of the Complaints Procedure to ensure an appropriate and proportionate response is provided. Communication, coordination and information sharing are critical and ensure that safeguarding measures are applied where necessary. In addition, liaison with the Council's Delivery Commissioning Hub and the Care Quality Commission ensures a coordinated response to concerns about commissioned services. Similarly, dialogue with the office of the Local Government Ombudsman ensures that the Local Authority is able to take steps to resolve complaints locally where possible.

It is pleasing to note that the number of complaints investigated locally has decreased this year by 24% for Adult Social Care, including services provided by Staffordshire & Stoke-on-Trent Partnership Trust. There has been an increase by 60% of complaints investigated at the 'Independent Investigation' stage, with 1 concerning Independent Futures, 3 regarding the care provided by Residential / Nursing Care homes and 1 regarding a domiciliary home care agency. The number of complaints investigated by the Local Government Ombudsman remain consistent with the previous year. The total amount of monies paid to complainants as an outcome of an Ombudsman investigation is £10,400 in recognition for the time and trouble in raising the complaint and any distress caused. 3 complainants received a waiver or refund of care fees as a result of the Ombudsman's investigation.

There has been a 45% reduction in complaints received for Independent Futures this reporting year. This is the result of staff swiftly resolving any concerns at the point of contact thus reducing service users and / or their families escalating matters through the formal complaints procedure.

The key themes investigated under Stage 1 of the complaints procedure this reporting year is regarding the delays in sending invoices for home care and residential care due to information not being inputted onto Care Director in a timely manner by adult social care staff. This had resulted in service user's receiving large bill's which were often over 12 months old. This remains a consistent theme with the last reporting year. **7%** of complaints received were regarding inaccurate financial information (including third party top-ups) provided by adult social care staff which resulted in service users and / or their families receiving bills for the care that they were not aware was chargeable. A recent change to the forms used when referring a service user for a financial assessment has reduced the amount of information required by adult social care staff and therefore reducing confusion is respect of service user contributions.

'Lessons Learnt' from complaint investigation's remain a key feature for the service and are always fed back to services and performance groups for action.

The Customer Feedback and Complaints Team continue to promote the early and effective resolution of complaints together with providing advice and support to those wishing to complain.

Local Investigation
Between 1st April 2015 and 31st March 2016, the Customer Feedback and Complaints Team received 186 complaints that have been directed for Local Investigation (54 County Council and 132 Partnership Trust).

Independent Investigations
Between 1st April 2015 and 31st March 2016 the Customer Feedback and Complaints Team undertook 5 Independent Investigations of complaints. All 5 were undertaken by Staffordshire County Council.

Local Government Ombudsman Complaints
Between 1st April 2015 and 31st March 2016, the Local Government Ombudsman received 20 complaints which related to a service provided by Adult Social Care.

Comparison with Preceding Year

This year's figures indicate a 43% decrease in the Local Investigation of complaints relating to Adult Social Care services provided by County Council compared to the previous year. There is also a 12% decrease in the Local Investigation of complaints regarding services provided by Staffordshire and Stoke on Trent Partnership Trust.

There is a 60% increase in the number of complaints investigated under the 'Independent Investigation' stage of the Statutory Complaints Procedure when compared to the previous year and the number of Local Government Ombudsman investigations remain consistent.

SCC Adult Social Care Services		
	2014/15	**2015/16**
Local Investigation	95	54
Independent Investigation	0	5
Local Government Ombudsman	9	10

Partnership Trust Adult Social Care Services		
	2014/15	**2015/16**
Local Investigation	150	132
Independent Investigation	2	0
Local Government Ombudsman	10	10

Staffordshire County Council Adult Social Care Services

Stage 1 – Local Investigation – Breakdown

The complaints procedure aims to resolve complaints at a local level within 10 days (with an extension to a further ten days where necessary). This is not a statutory time limit but a goal for effective complaints management. According to the complexity and needs for an effective investigation, this time scale can be extended by agreement with the complainant.

The current guidance suggests that the majority of complaints should be resolved locally and frontline managers are encouraged to meet with complainants and attempt to address complaints in a swift and effective manner.

54 complaints were recorded under Stage 1 – Local Investigation during 2015/16 53% of the complaints received were for Independent Futures.

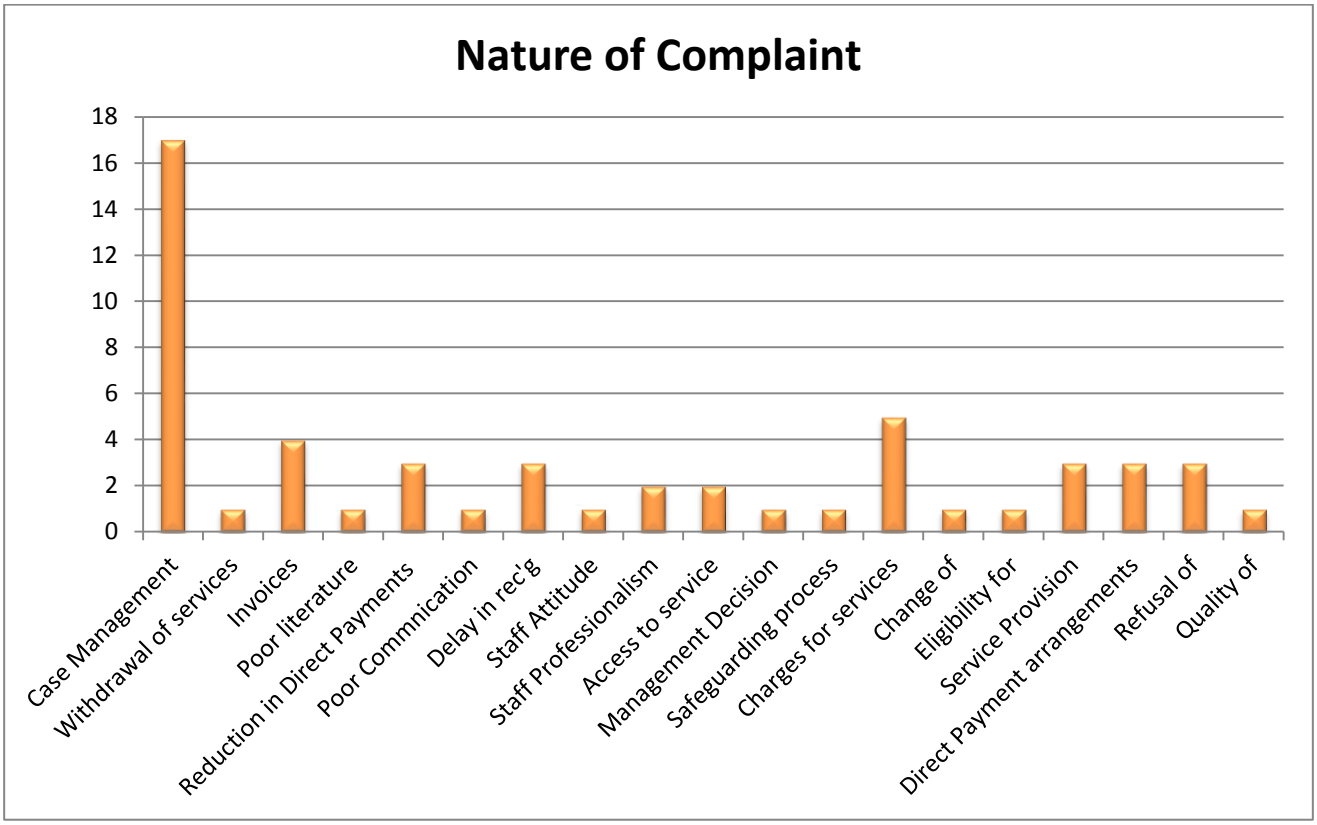
Service	District (if applicable)	Number
Independent Futures		
	Lichfield	*1*
	Stafford	*6*
	Cannock	*1*
	Moorlands	*4*
	Newcastle	*5*
	East Staffs	*3*
	Tamworth	*2*
	South Staffs	*7*
	Total	**29**
Welfare Benefits		**1**
Self Directed Support Team		**2**
Commissioning Hub		**2**
Public Health		**1**
Residential Home *(Provider Services)*		**1**
Deputyship and Deprivation of Liberty Safeguards		**2**
Fairer Charging Team **Joint Finance Unit**		**6** **6**
Mental Health (Advanced Mental Health Practitioner)		**1**
Emergency Duty Service		**1**
Adult Care Team (pre 2012 – transfer to Staffordshire and Stoke on Trent NHS Partnership Trust		**1**
Total		**54**

53% of complaints received were for Independent Futures with 24% regarding services provided by the South Staffs District. It is pleasing to note that overall there has been a 45% reduction in complaints received for Independent Futures

The Fairer Charging Team received 24% of complaints investigated**.** Consistent with last year, the complaints received were regarding the timeliness of invoices being raised.

Summary of Complaints Received – Adult Social Care (Council)

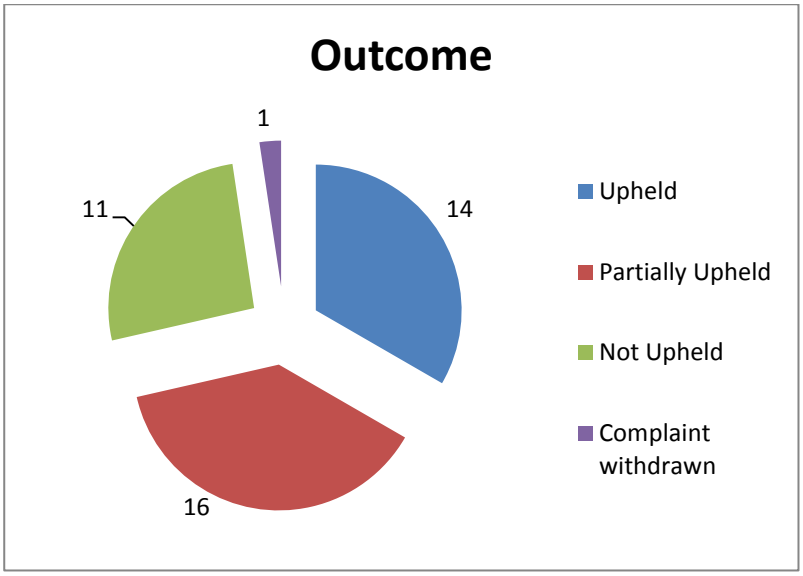
A total of 54 complaints were received concerning Adult Social Care services provided by the Council during the period 2015/16. The chart below provides an overview of the nature of the complaints received.



31% of complaints received related to Case Management (complaints which involve more than one concern and generally poor management of the service user's case. **9%** of complaints were concerning charges for services (home care and residential) **7%** of complaints were regarding direct payment arrangements

Stage 1 – Local Investigation Adults Social Care (Council) – Outcomes and Response Timescales

The chart below provides an overview of the outcome of the complaints investigated.

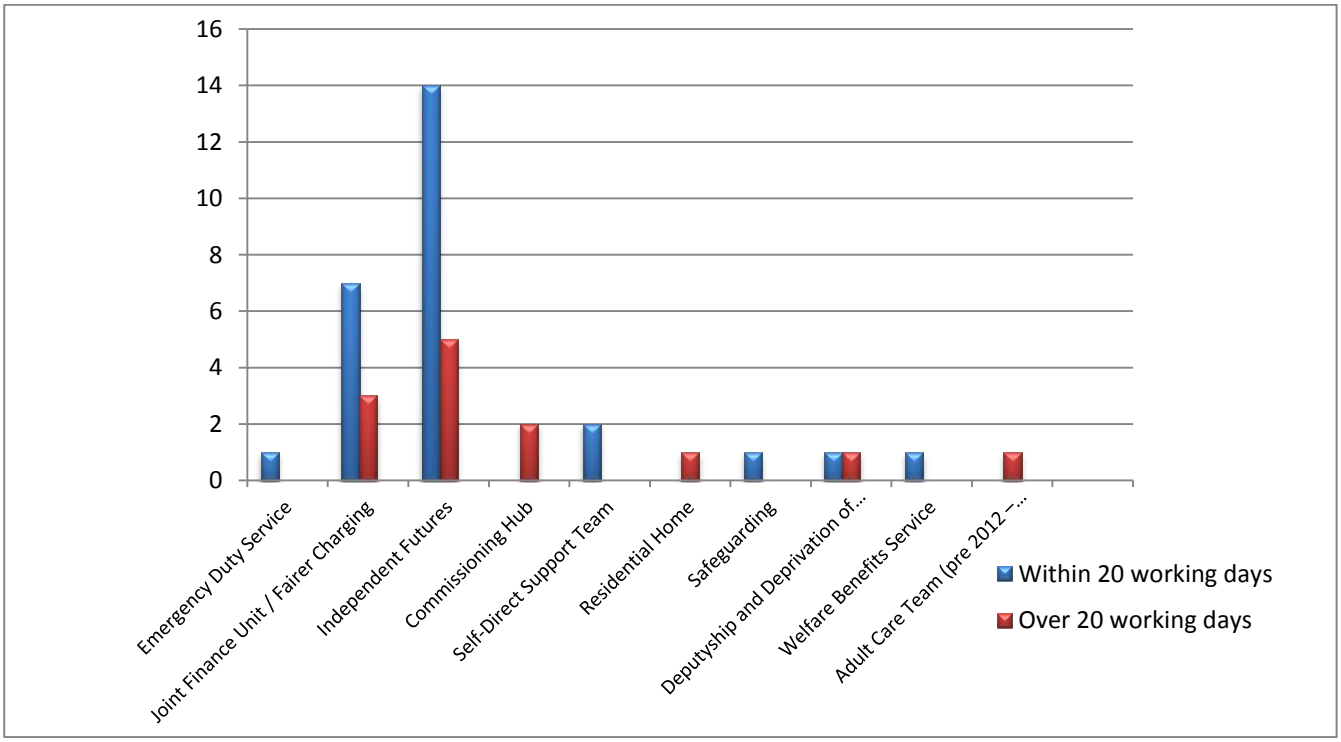


Complaint closure information was not shared for 12 complaints; therefore outcomes have not been recorded.

39% of complaints closed were Partially Upheld and 34% was Upheld.

The timescale for responding to Stage 1 – Local investigation complaints is 20 working days. A total of 67% of complaints were responded to within timescale and 33% were closed out of timescale. In comparison to last financial year the response timescale has improved, 44% of complaints were responded to within timescale in the previous year.

The chart below provides information on the response timescales for Local Investigations during 2015/16

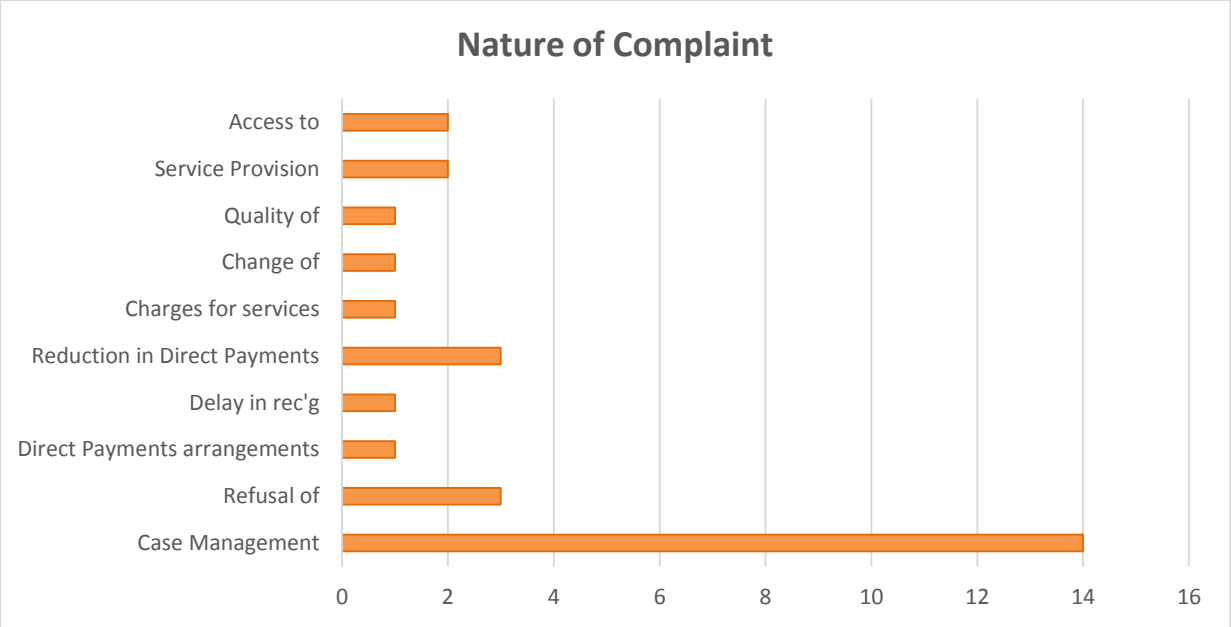


Stage 1 – Local Investigation Adult Social Care (Council) – Breakdown of Nature of Complaint and Outcomes by service

The charts below show the nature of complaint and outcome for services areas within Staffordshire County Council during 2015/16.

Independent Futures

There has been a 45% reduction in complaints received for Independent Futures this reporting year. This could be the result of staff swiftly resolving any concerns at the point of contact thus reducing service users and / or their families escalating matters through the formal complaints procedure.

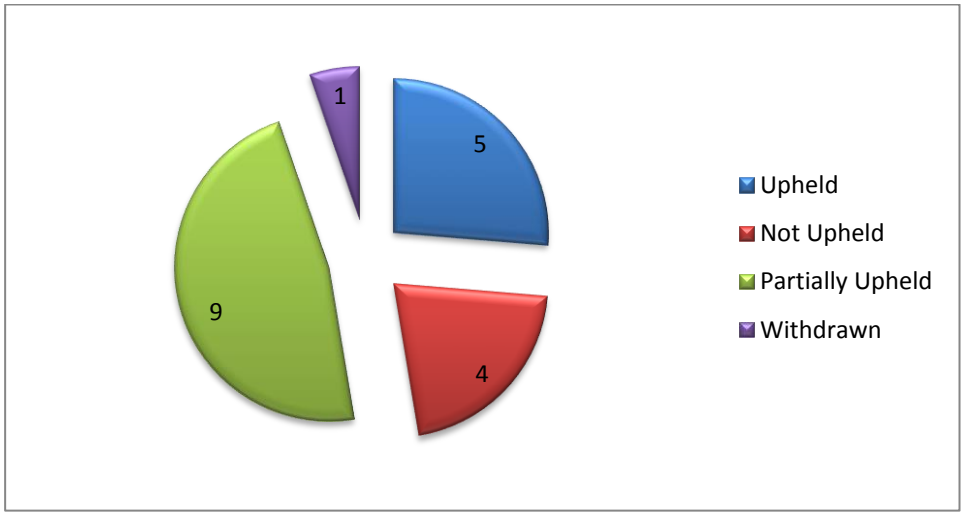


48% of complaints received for Independent Futures were regarding Case Management* and 10% of complaints were in respect of the reduction of Direct Payments.

*Case Management category is used when the complaint refers to more than one concern and general management of the a case e.g. poor communication, delays in receiving a service, telephone calls not returned etc.

In comparison with last year (3 received), there were no complaints received about the transition from Children's to Adult Social Care.

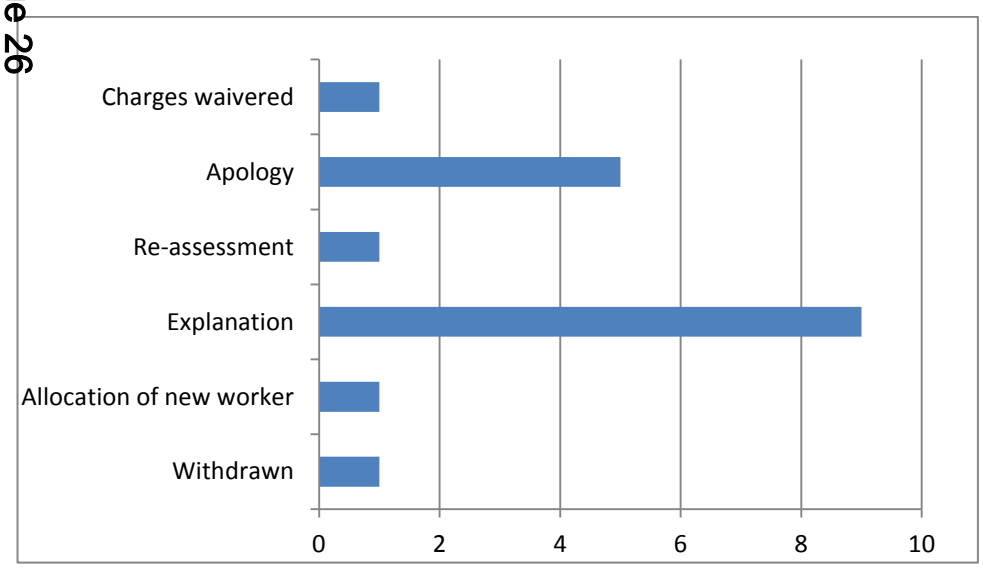
Outcome of complaint



47% of complaints were Partially Upheld and **21%** of complaints closed were Not Upheld. **10** complaints have been investigated however closure information has not been provided by the team. This is due to the team manager being off sick

74% of complainants were offered an apology / explanation as a result of the complaint investigation

Recommendation / Learning Action

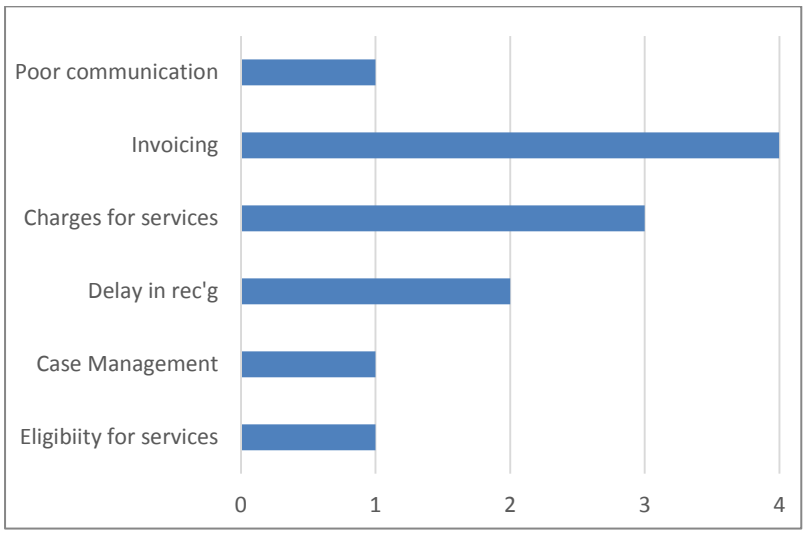


Organisational Learning;

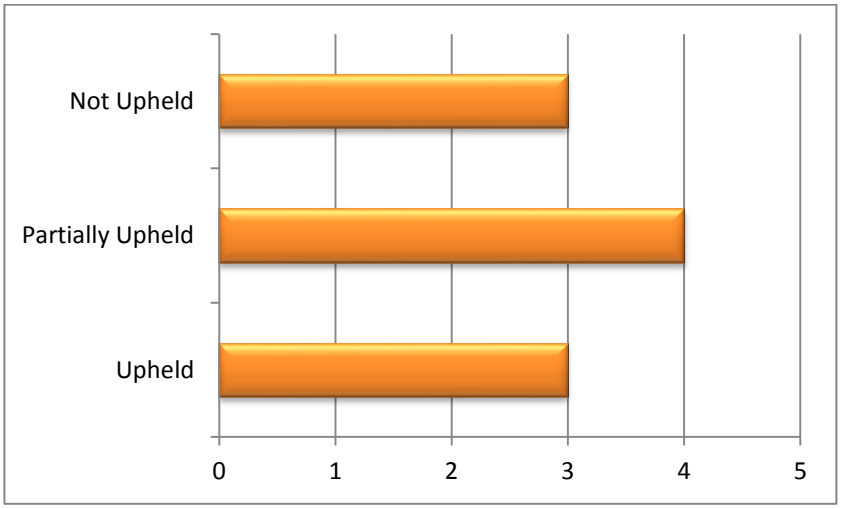
- Address complaint with staff member during supervision session;
- Guidance on charging has been shared with all staff within the Independent Futures service within the Newcastle and Moorlands area

Joint Finance Unit (including Fairer Charging)

Nature of Complaint Outcome



58% of complaints received were regarding invoicing and charges for services. This includes service user's being charged for services that they have not received e.g. home care visits missed.



Resolutions and Organisation Learning

- Apology provided where complaints were Upheld
- Explanation of events provided to complainant
- Payment Plan offered to service user in order to pay a large invoice
- 2 complaint resulted in charges being reduced
- 1 complaint resulted in no interested being charged due to the delays incurred.

Other services

Commissioning Hub	
Nature of Complaint	**Outcome/Remedy**
2 complaints received; • Withdrawal of service • Management decision	X2 Not Upheld – Explanation provided

Emergency Duty Services (EDS)	
Nature of Complaint	**Outcome/Remedy**
X1 – Staff Professionalism during by Advanced Mental Health Practitioner out of	Not Upheld - Explanation provided

Mental Health (Advanced Mental Health Practitioner)	
Nature of Complaint	**Outcome/Remedy**
X1 – Staff conduct	Outcome not known

Provider Services - Residential Home	
Nature of Complaint	**Outcome/Remedy**
x1 – Service provision	Complaint Not Upheld Explanation provided.

Self-Directed Support Team	
Nature of Complaint	**Outcome/Remedy**
2 received; Both related to Direct Payment arrangements	1 complaint was Partially upheld - £500 time and trouble payment. 1 complaint not upheld.

Welfare Benefits Service	
Nature of Complaint	**Outcome/Remedy**
X1 - Complaint received regarding the charges for services	Complaint was Upheld and an apology was provided.

Deputyship and Deprivation of Liberty Safeguards	
Nature of Complaint	**Outcome/Remedy**
X2 – • Staff professionalism. • Poor literature.	Both complaints were Upheld and an apology was provided.

Safeguarding	
Nature of Complaint	**Outcome / Remedy**
1 complaint concerning the safeguarding process.	Complaint Upheld Safeguarding process and documentation to be reviewed following the implementation of the Care Act.

Adult Care Team (pre 2012 – transfer to Staffordshire and Stoke on Trent NHS Partnership Trust	
Nature of Complaint	**Nature of Complaint**
1 complaint concerning the hospital Social Work Team, Stafford, - pre April 2012. Continuing Healthcare Assessment not initiated.	Complaint Not Upheld Explanation provided

Stage 1 – Independent Investigation Adults Social Care (Council)

An independent investigation is initiated in circumstances where a complaint is complex and / or a level of seriousness is identified. This is often in circumstances of multi-agency involvement. The independent investigation is conducted by commissioned external Investigating Officer.

A report of investigation is produced that details conclusions reached and recommends action to both resolve the complaint and make improvements for the organisation. The relevant Senior Officer adjudicates the report and provides the Council's formal response to the complainant.

The timescale under this part of the procedure is 25 days, although there is facility to agree with the complainant an extension up to 65 days. (Again this is not a statutory requirement but an operational goal that may be subject to negotiation)

There have been 5 complaints independently investigated during 2015-2016.

Details of the complaint investigations and outcomes are detailed below.

Service	Nature of Complaints	Outcome	Recommendations
Domiciliary Home Care Agency – Home Instead (Stone)	Home Instead failed to undertake a robust investigation into the complaints raised and to address the desired outcomes	Upheld	• An apology from Home Instead to acknowledge the distress caused by the withdrawal of the service. • The management of Home Instead need to ensure prior to commencement of a care package they have staff with the appropriate skill set to meet the needs of the service user. • The management of Home Instead need to review the standard of record keeping within the organisation and provide training as required. • The purpose of the service level agreement needs to be explained fully with the service user and their family prior to completion. • For the complainants to be made aware of how the County Council will hold Home Instead accountable in light of the complaints being upheld.
Independent Futures - Stafford	Complaints raised regarding the assessment undertaken by independent futures.	Upheld	• That Independent Futures specify in advance of assessments of need how long they will take in each case, or the date upon which they will be completed. In the event of an overrun, the person whose needs are being assessed should receive a written

			explanation and details of the new target. • That the standard response and acknowledgement times which are detailed on the Council's website should be relaunched and re-emphasised for staff, in order to provide customers with reasonable expectations of their communications with staff. • That a greater level of definition and specification should be applied to the Quality Assurance process, in order to deliver consistency. This should not result in a tick-box approach, but in a critical and accountable sign-off to the work undertaken. • That all assessments are subjected to specific scrutiny (whether as part of the Quality Assurance process or otherwise) to ensure that the proposed final outcome and budget makes sense and is capable of meeting the relevant need. • That, in the context of the Care Act, there should be a renewed focus on Well-Being, what it means and its underlying implications for assessment and service delivery.
Residential Home – Tall Oaks Care Home	Concerns raised regarding the action of staff at Tall Oakes when a resident was found unresponsive.	Partially Upheld	• An apology from the management of Four Seasons Health Care for the stress caused by the delay in responding to the complainants requests for information. • The management of the Four Seasons to address the competency of the nurse in charge in light of her failure to make comprehensive notes of both the incident and the subsequent conversation with the medical staff at the hospital. • The management of Four Seasons Health Care need to review the standard of record keeping within Tall Oaks and provide training as required. • For the Home to introduce communication systems which ensure relatives requests for

			information are acted upon in a timely manner.
Residential Home – Beechcroft Residential Care Home	Complaint about care provided during respite stay.	Partially Upheld	• An apology to the complainant by the management of Beechcroft House for the distress caused whilst a resident at the home. • The management of Beechcroft House need to review the standard of record keeping and provide training as required. • The management of Beechcroft House need to adopt a listening and learning culture in relation to complaints. • The Registered Manager and staff of the Home need to respect individual's preferences and implement a person centred approach to service delivery. • The Quality Monitoring Team of Staffordshire County Council need to be proactive in addressing matters raised by Staffordshire and Stoke on Trent Adult Safeguarding Team
Residential Home – Shenstone Hall Nursing Home	Complaint about the delivery of care provided by Shenstone Hall	Partially upheld	• An apology should be made to the complainant by the management of Wright Care Homes for the stress caused by the failure to implement fully the details of the care plan and failure to provide information regarding the injuries as requested. • The management of Wright Care Homes to review the standard of record keeping within Shenstone Hall Nursing Home and provide training as required. • The management of the Wright Care Homes to address the competency of staff in respect of recording information.

All actions are shared with the residential care home and home care agency via the Contract Monitoring Officer's, Staffordshire Council Council.

Adult Social Care Services Provided by Staffordshire and Stoke-on-Trent Partnership Trust

From April 2012, Adult Social Care services were transferred over to the new Staffordshire and Stoke-on-Trent NHS Partnership Trust. As the commissioner of these services, the Local Authority co-ordinates all statutory complaints, which relate to Adult Social Care services on behalf of the Partnership Trust.

A total of 132 complaints were investigated under Stage 1 - Local Investigation of the Statutory Complaints Procedure for Adult Social Care services. This is a 14% reduction in comparison to the number of complaints received in previous year.

Service	**North**		**South**						**Total**
	Moorlands	Newcastle	Stafford	Cannock	Lichfield	Siesdon	Tamworth	East Staffs	
Integrated Locality Care Team	7	18	12	11	9	9	5	8	**79**
Community Intervention Service	0	3	6	0	1	2	1	4	**17**
- **Community Hospital**	0	3	0	0	0	0	0	0	**3**
- **Discharge Team**	0	3	8	1	1	1	4	2	**20**
Intermediate Care & Enablement	0	0	0	1	0	0	0	0	**1**
Integrated Therapy Team	0	0	2	3	2	0	3	1	**11**
Able 2 (commissioned Occupational Therapy Service)	0	0	1	0	0	0	0	0	**1**
Total	**7**	**27**	**29**	**17**	**13**	**12**	**13**	**15**	**132**

59% of complaints investigated were regarding services provided by the Integrated Locality Care Team with 23% relating to the Newcastle District and 15% for Stafford. This is consistent with the previous year

Stafford District have received the highest proportion of complaints in the South with 29%. This is consistent with the previous two year's

Newcastle District have received the highest proportion of complaints in the North with 79%, again this is consistent with the previous two year's

Stage 1 Local Investigation (NHS Partnership Trust) – Nature of Complaints and Outcomes – North Division

The tables below provide information on the nature and outcome of complaints for the North Division for 2015/16.

Nature - North	Integrated Locality Care Team	Community Intervention Service	Community Hospital	Hospital Discharge Team	Total
Care provision	1	0	0	0	**1**
Case Management	7	1	1	1	**10**
Clarity of	1	0	1	0	**2**
Unsafe discharge	0	0	0	1	**1**
Staff Attitude	0	1	0	0	**1**
Staff conduct	1	0	0	0	**1**
Safeguarding investigation	1	0	0	0	**1**
Poor communication	4	0	1	0	**5**
Professionalism	4	0	0	0	**4**
Information provided	1	1	1	0	**3**
Reduction of	1	0	0	0	**1**
Management decision	2	0	0	0	**2**
Access to	1	0	0	1	**2**
Total	**24**	**3**	**4**	**3**	**34**

24 complaints were received for the Integrated Locality Care Team in the North with 7 for the Moorlands area and 17 for Newcastle. 29% of the complaints received for the Integrated Locality Care Team were regarding 'case management'. The Community Intervention Service, including Community Hospital's and Hospital Discharge Team, received 10 complaints and all concerned the Newcastle District.

Outcome - North	Integrated Locality Care Team	Community Intervention Service	Community Hospital	Hospital Discharge Team	TOTAL
Upheld	6	1	1	1	**9**
Not Upheld	8		0	0	**8**
Partially Upheld	8	1	1	2	**11**
Inconclusive	1	0	0	0	**1**
Withdrawn	1	0	0	0	**0**
Total	**24**	**2**	**2**	**3**	***31**

*Please note that 3 complaints remain open.

Stage 1 Local Investigation (NHS Partnership Trust) – Recommendations and Learning Actions – North Division

The information below illustrates the types of recommendations and learning actions that have arisen from complaints during 2015/16.

	Integrated Locality Care Team	Community Intervention Service	Community Hospital	Hospital Discharge Team	TOTAL
Explanation	6	1	0	1	**8**
Apology	12	0	0	2	**14**
Allocation of new Social Worker	3	0	0	0	**3**
Charges waivered	2	1	2	0	**5**
Total	**23**	**2**	**2**	**3**	***30**

***Please note that 3 complaints remains open and 1 complaints was withdrawn and therefore there were no recommendations recorded.**

As a result of making a complaint 17% of service users had charges waivered for residential care home fees and home care charges due to the delays in receiving invoices, service user not being informed of the charges incurred by the allocated worker and being charged for an enablement package following discharge from hospital.

Learning Actions

The following Learning Actions have been identified for the North Districts; (Please note that this is a selection of learning actions as each complaint can receive several actions)

- For the process of referrals to community hospitals to be clearly defined and communicated with patients and their families. Within this the status of 'medically fit' and its relevance to be shared. – To be addressed within team meetings and staff training.
- Discussion with social work staff and ward staff regarding 'Risk Management' measures in order to achieve a greater professional understanding of the status.
- All assessors to receive regular training and refresher training on direct payments.
- Partnership Trust to update the 'Consent Policy' dated May 2013 to include a consent form for social care staff to obtain service user's medical information from a GP.
- To ensure 'high risk' cases are allocated with a 24 hour timeframe, especially for referrals not already known to adult social care.
- A process to be put into place to ensure all service provisions inputted on Care Director are authorised in a timely manner.
- To discuss with staff the importance of maintain regular contact with service users / relatives to provide reassurance and guidance.
- Team Leader to reflect on the issues raised within the complaint with the allocated worker during supervision session.
- For clearer protocols to put on place around whose responsibility it is to recognise when food parcels should be provided for service users who have been in hospital for some time prior to discharge.
- All social care staff that are part of the Community Intervention Service in Moorlands area will be reminded to record all discussions relevant to the decision making as part of the case management.
- All Community Intervention Service staff in Moorlands will be reminded to complete Information Governance training. The managers of the service will monitor compliance through supervision and local management and team meetings including the Adult Service Committee

Stage 1 Local Investigation (NHS Partnership Trust) – Nature of Complaint's and Outcomes – South Division

The tables below provide information on the nature and outcome of complaints for the South Division for 2015/16.

Nature - South	Integrated Locality Care Team	Community Intervention Service	Hospital Discharge Team	Integrated Therapy Service	Intermediate Care & Enablement	*Able 2	Total
Delay in receiving	1	3	0	3	0	0	**7**
Top-up issues	1	1	1	0	0	0	**3**
Case Management	25	2	6	4	0	0	**37**
Access to service	2	0	0	1	0	0	**3**
Care Provision	2	1	0	0	1	0	**4**
Inaccurate financial info provided	1	2	3	0	0	0	**6**
Reduction of service	1	0	0	0	0	1	**2**
Staff Attitude	2	2	0	0	0	0	**4**
Quality of	1	0	0	1	0	0	**2**
Withdrawal of direct payment	1	0	0	0	0	0	**1**
Eligibility for	0	0	1	1	0	0	**2**
Staff Professionalism	1	0	1	0	0	0	**2**
Poor communication	5	2	1	0	0	0	**8**
Allocation timescale	0	0	1	1	0	0	**2**
Information provided	2	0	1	0	0	0	**3**
Clarity of	1	0	1	0	0	0	**2**
Standard of	1	0	0	0	0	0	**1**
Social Worker decision	2	0	1	0	0	0	**3**
Management decision	3	0	0	0	0	0	**3**
Safeguarding	3	0	0	0	0	0	**3**

*Able 2 is a Occupational Therapy Service commissioned by the Partnership Trust

investigation / Process							
Total	**55**	**13**	**17**	**11**	**1**	**1**	**98**

37% of complaints received were regarding 'case management'. The category 'case management' is used when a complaint relates to the general management of a case, this can include poor communication, delay in receiving a service.
6% of complaints received were regarding 'poor communication' from a staff member, this included telephone calls not returned and services users not being kept up-to-date with their case.
7% of complaints were regarding 'inaccurate financial information provided' and 'third party top ups'. These complaints were regarding the information provided by adult social care staff regarding funding / contributions for care provisions and information provided third party top-up payments and who should pay this cost.

Outcomes	Integrated Locality Care Team	Community Intervention Service	Integrated Therapy Service	Hospital Discharge Team	Intermediate Care & Enablement	Able 2	Total
Upheld	17	4	6	6	0	0	**33**
Not Upheld	7	2	1	3	0	0	**13**
Partially Upheld	23	6	4	7	0	0	**40**
Complaint withdrawn	3	1	0	1	1	0	**6**
Inconclusive	0	0	0	0	0	1	**1**
Total	**50**	**13**	**11**	**17**	**1**	**1**	**93**

*Please note that 5 complaints remain open.

The table below provides information on recommendations and learning actions that have arisen from complaints during 2015/16

	Integrated Locality Care Team	Community Intervention Service	Integrated Therapy Service	Hospital Discharge Team	Intermediate Care & Enablement	Able 2	Total
Explanation	12	5	4	5	0	0	**26**
Apology	24	4	6	7	0	1	**42**
Records updated	0	1	0	0	0	0	**1**
Reimbursement of monies	1	0	0	1	0	0	**2**
Meeting / Review	2	0	1	0	0	0	**3**
Complaint withdrawn	3	1	0	1	1	0	**6**
Charges Waivered	8	2	0	3	0	0	**13**
Total	**50**	**13**	**11**	**17**	**1**	**1**	**93**

16% of complainants had charges waivered or received reimbursement of monies as a result of making their complaint. It was found that there was a delay in service users receiving invoices due to the length of time taken for adult social care staff to action service provision's on Care Director

Learning Actions

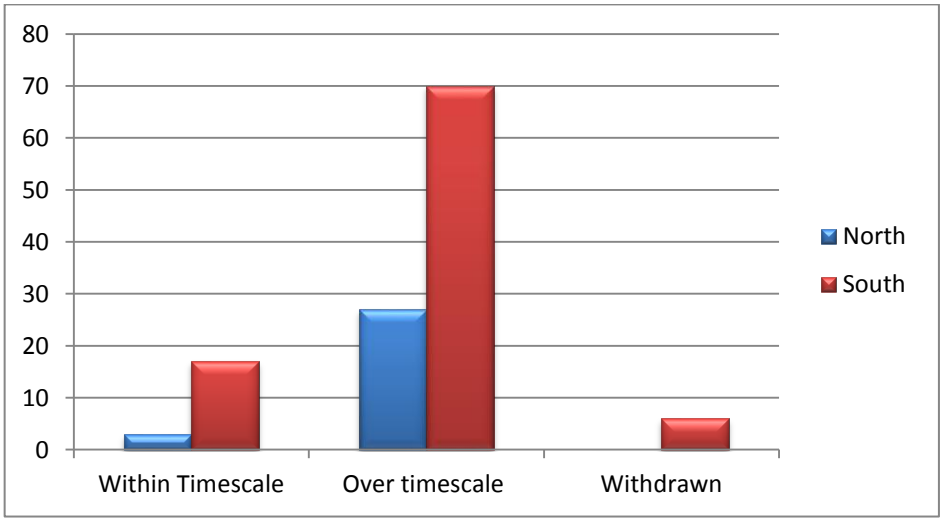
The following Learning Actions have been identified for the South Districts: (Please note that this is a selection of learning actions as each complaint can receive several actions)

- Provide further training and learning opportunities to staff in relation to effective communication skills.
- Staff training – provide up-to-date training on direct payments.
- To ensure formal training around safeguarding procedures are up-to-date.
- To address complaint details with staff member during formal supervision.
- To develop a short induction file for all new starters with standard processes.
- A leaflet / flyer to be developed detailing the Disability Facilitates Grant process and which organisation is responsible for each part of the process.
- Reminder to be sent to all staff to ensure that families are advised that provisional charges are implemented whilst full financial assessments are being undertaken.
- Letters to be sent to service users awaiting an occupational therapy assessment in order to provide an update on allocation.
- A discussion to take place with staff in regards to inputting periods of care onto care Director to ensure financial assessments are completed in a timely manner.
- A 'Standing Operating Procedure for Waiting List Management' has been introduced fir use by social care staff which will ensure assessments are undertaken within the designated time frame.
- To clearly document and evidence on the case file that other care homes have been approached to establish vacancies and to establish if they could meet the service user's needs. To distinguish between servicer user / family choice and availability.

Stage 1 Local Investigation (NHS Partnership Trust) –Response Timescales

The internal timescale for Adult Social Care complaints is 35 working days, with a 25 working day deadline for the investigation officer to conclude the investigation and complete the report. Each investigation is allocated to an 'investigating officer' who is not part of the service subject to the complaint. The investigating officer is required to meet with the complainant, interview all staff members involved and produce am investigation report.

The graph below shows the numbers of complaints responded to within and outside timescales for North and South districts.



Overall 79% of complainants did not receive a formal outcome (investigation report and cover letter) to their complaint within the agreed timescale.

The Customer Feedback and Complaints Team are required to quality assure the investigation report and draft a summary letter based on the information contained within the report for each complaint investigation. The Partnership Trust operates a Quality Assurance process for all complaint responses and reports prior to them being sent out. Often the Investigation report and response letter have been drafted within timescale, however the Quality Assurance process can take the complaint over timescale.

Stage 1 Independent Investigation (NHS Partnership Trust)

An independent investigation is initiated in circumstances whereby a complaint is identified to be particularly complex and/or involves multi-agency involvement.

There has been no independent investigation's undertaken during 2015/16

Stage 2 - Local Government Ombudsman Complaints (to include Staffordshire County Council and Staffordshire and Stoke-on-Trent NHS Partnership Trust)

The Local Government Ombudsman (LGO) is empowered to investigate where it appears that a Council's own investigations have not resolved the complaint. Whilst anyone can approach the Ombudsman at any time, the Complainant is usually required to first take up their complaint with the relevant Council to allow a local response. However, if the Complainant remains dissatisfied following local or independent investigation by the council they then have the right to pursue the matter with the Local Government Ombudsman.

The Local Authority has received **10** complaints which have been referred to the Local Government Ombudsman regarding County Council services and **10** complaints regarding services provided by Adult Social Care Teams, Staffordshire and Stoke on Trent NHS Partnership Trust. The Local Government Ombudsman still investigate complaints about Adult Social Care Team's (SSOTP) and therefore outcomes are reported to the Local Authority via the Monitoring Officer. I have therefore included the figures in the tables below.

Compared to last financial year there has been a 5% increase in complaints received by the Ombudsman.

Staffordshire County Council Services			
Service	**Nature**	**Outcome**	**Recommendation**
Independent Futures - Tamworth	Council has not provided family with any support in relation to their son's transition to independent living. They are also dissatisfied with the Council's decision to withdraw the day service provision currently in place	Upheld – injustice caused	Council to apologise and pay £100 to family and apologise and pay £100 to service user. Council to put in place formal procedures to ensure appropriate support is provided to those transitioning into independent living.
Independent Futures- Stafford	Council should not have decided to move service user into a flat that is on the first floor and which he has to share with a service user who the	Not upheld	No recommendations

	Council knew he does not get along with		
Independent Futures – Newcastle	The Council and the Health Authority failed to provide service user with day services when he left school in 2009. Failure to properly assess service user's needs and day services were not provided until 2011 but this was not enough. The Council and the Health Authority failed to provide written communication about funding when changes were made.	Upheld – maladministration and injustice	Apologise to service user for failing to provide him with the day services he was entitled to access over a six year period. Pay service user £4,200 to acknowledge the two years of day services he lost out on which then had an adverse effect on his wellbeing. The recommended payment also acknowledges the four years when the CCG and the Council failed to provide service user with enough day care services to meet his assessed eligible needs. Apologise to service user's parents for failing to provide them with carer's support. Pay service user's parents £2,000 each to acknowledge the prolonged distress, anxiety and inconvenience they experienced over six years. The Council should review service user's parents needs as carer's to see if they need any additional breaks from their caring role.
Independent Futures – Stafford	Council and CCG failed to follow a clear decision-making process in relation to service user's attendance at Chase Day Services. As a result, service user was left without appropriate support.	Not Upheld – no injustice.	No recommendations
Emergency Duty Service	Actions of a social worker in assessing service user under the Mental Health Act and forcibly taking him to hospital.	Not Upheld – no injustice	No recommendations
Welfare Benefits Service	Council has provided incorrect information regarding occupational pension.	Decision not to investigate	n/a
Redwood Care Homes	The care home is failing to honour its contract with family by pursuing for top up fees from the time before the service user became a self funder.	Upheld – Injustice caused	The Care Home has agreed to; • stop pursuing family for the difference between the rate paid by the Council and its self-funding rate from 6 March to 2 June 2015; • apologise in writing for pursuing this; • audit residents' records to ensure it has an inventory of belongings; and • review its procedures to ensure an inventory is made of resident's belongings when they move in.
Finance Services / Debt Recovery	Complaint that service user, now deceased, was removed from hospital	Decision not to investigate	n/a

	and placed in Foxwalls Home without families consent and wishes. A complaint was made at the time, in 2012. 4 years after the service users death family member has received a demand for £500+ for respite care.		
Legal Services	The Council delayed until December 2015 in dealing with matters concerning the calculation of the late service users' capital and did not properly reach its decision about the value of the property	Complaint still open	Complaint still open
Legal Services	The Council has refused to include the standing charge of complainant's mothers utility bills as a housing cost in her financial assessment.	Decision not to investigate – not enough evidence of fault in the way the Council exercised its discretion in the matter to warrant an investigation.	n/a

Staffordshire and Stoke on Trent Partnership Trust			
Service	**Nature of Complaint**	**Outcome**	**Recommendations**
Integrated Locality Care Team – Tamworth	The Council has fettered its discretion by following its Direct Payment policy, which states hotel expenses should be funded from the person's own income, without properly considering her personal circumstances	Upheld	As it has now reviewed matters and changed its decision the Ombudsman will not pursue the complaint any further
Community Intervention Service – Newcastle	The Council failed to adequately assess service users social care needs particularly in respect of the placement at Alder Grange Care Home. The Council failed to put an inadequate care package in place when service user returned home from hospital. The Council did not consider the service users needs in respect of care and help to attend medical appointments. The Council placed the service users in an unsuitable care home (Samuel Hobson House) which failed to provide	Upheld – however no injustice caused	No recommendations

	adequate care and put them at unnecessary risk.		
Community Intervention Service – East Staffs	The Council misled about top up charges for husband's care. The Council failed to follow proper procedures in setting up her husband's care package including not providing correspondence to support care costs, copies of contracts or invoices showing care costs.	Upheld There is evidence of fault by the Council in its failure to apply the Charging for Residential Accommodation Guidance, Local Authority Circular LAC (2004)20 and the Care and Support Statutory Guidance.	Apologise for failing to put in writing the 'top up' arrangement and provide service users wife with clear information showing her 'top up' contributions; To re-calculate the contribution for roughly 20.85 weeks the service user was in the residential home to the £97 per week his wife expected was her 'top up' contribution; To refund the difference between the figure above and the £6,593.36 she paid in 'top up' fees. To pay £250 for the distress suffered including the time and trouble in bringing this complaint; To pay the service user £100 for the avoidable distress caused by moving him from home Z to home V; Provide evidence within three months of the date of the final decision the Council has put in place a process ensuring written agreements/support plans, detailing clearly the financial responsibilities of all parties, are available before any 'top up' arrangement is signed
Integrated Locality Care Team – Tamworth	The Council failed in its duties towards service user, resulting in the accrual of a debt for his care with the Council of over £13,000. The Council has not made a proper decision about the service users eligibility for a hospital bariatric bed.	Investigation discontinued	Complainant has withdrawn the complaint following the Trust's decision to waiver the outstanding debt.
Integrated Locality care Team – Stafford	Council and the Health Trust have failed to assess the service users needs properly which means he does not have enough support to meet his needs. Delays with assessments resulted in the service user remaining in a residential placement for too long had to pay residential care charges when he did not want to be in the residential home. The Council failed to properly consider service users outgoings in its financial assessment.	Upheld – maladministration and injustice	Within six weeks of the Ombudsmen's final decision the Council, the Trust and the CCG have agreed to: • collectively apologise in writing to the service user for the delays in the CHC assessment process which led to him remaining in a residential care home for longer than should reasonably have been expected; • waive the charges the Council says the service user owes for residential care home fees, agree which body is responsible for the charges and confirm the outcome

			• each pay the service user £350 to acknowledge the impact the delays in the CHC process had on his independence and wish to return home; • collectively apologise in writing to the complainant for the failure to continue and provide interim services which then impacted on his caring role; and • each pay the complainant £150 to acknowledge his distress, increased carer's strain and time and trouble. Within three months of the Ombudsmen's final decision the CCG should review the local arrangements it has in place for NHS CHC eligibility processes. It should then consider whether it needs to provide any training to practitioners working within the community to ensure quality standards are met and good practice maintained.
Integrated Locality Care Team (Moorlands) and Finance Team	Council should not charge service user for domiciliary care it failed to invoice for. The Council should only charge from the date the invoice was received	Decision not to investigation	Council / Trust agreed to pay £150 compensation for the delay in sending invoice.
Integrated Locality Care Team – Stafford	Complaint about the charges the Council has levied for service users residential care	Complaint still open	Complaint still open
Integrated Locality Care Team – Moorlands	Complainant received an invoice for an emergency placement of his farther that was arranged by the Trust	Complaint withdrawn	Complaint withdrawn as Trust have agreed to waiver outstanding invoice
Integrated Locality Care Team – Moorlands	Complaint about the Trust's assessment and support for the complainant. Complaints raised previously	Closed after initial enquiries – out of jurisdiction	n/a
Integrated Locality Care Team – Newcastle	Complaint that service user was placed in a care home against her will and charged the family a top-up fee for her care charges.	Decision not to investigate	Recommendations from Stage 1 Complaint are in the process of being completed

Summary of Local Government Ombudsman Complaints

Out of the 20 complaints which were received by the LGO, the Council received 11 outcomes where there was no maladministration and the Council was not at fault or a decision was made not to continue the investigation due to insufficient evidence. A total of £10,400 'time, trouble and distress caused' payments were awarded to complainants following referral to the Ombudsman. 3 complainants received a waiver or refund of care fees as a result of the Ombudsman's investigation.

Compliments

During 2015/16 a total of 108 compliments were recorded with the Customer Feedback and Complaints Team which related to Adults Social Care.

Services provided by Staffordshire County Council and Staffordshire and Stoke-on-Trent Partnership Trust	No. Rec'd
Living Independently Staffordshire;	
East Staffs	34
Cannock	11
Seisdon	14
Newcastle	1
Integrated Therapy Service;	
Lichfield	4
East Staffs	1
Seisdon	1
Cannock	2
Tamworth	2
Integrated Locality Care Team;	
Cannock	1
Lichfield	1
Stafford	1
East Staffs	1
Newcastle	3
Hospital Discharge Team;	
Seisdon	1
Community Intervention Service	
Stafford	1
Hawthorn House Residential Home – Lichfield	1
Intermediate Care & Enablement;	
Moorlands	1
Independent Futures;	
Stafford / South Staffs	8
Lichfield	2
Newcastle Moorlands	7
Tamworth	5
East Staffs	2
Adult Safeguarding Enquiry Team	2
Moorlands Day Service	1
Total	**108**

Received a visit from IF social worker in regard to our daughter's assessment. We register our appreciation for her efficient and courtesy during visit

Occupational Therapist has visited by home 3 times, always with a smile, always professional and sensitive to me disabilities and appeared eager to help me remain independent and safe in my home.

We were delighted with the help and care of the many charming ladies given to my husband. The ladies were all so patient with a very difficult patient

Although we had to wait from November 2014 until July 2015the service and advice was excellent resulting in Midland Heat agreeing to fit a wet room in our flat

Other Activity

In addition to the recording and administering of Statutory Complaints, the Customer Feedback and Complaint Service have formally acknowledged and monitored an additional 260 enquiries each requiring redirection to other organisations/authorities or action into other procedures.

Dealt with by Complaints Team*	96
Complaint refused**	4
Joint Statutory Stage 1 response with other organisation / NHS	4
Referral to another Organisation for action / investigation	11
MP Enquires (Adult Social Care)	114
Councillor enquiries (Adult Social Care)	7
Public Enquiries	10
Comments	3
Public Health Complaint	1
Safeguarding referral initiated	2
Corporate Complaints Procedure	8
Total	**260**

*Complaints / enquiries which are handled by the Complaints Team consist of liaising with the service team in order to resolve the complainants concerns or the Complaints Team solely investigating the complaint and providing a response to the complainant. Depending on the nature and complexity of the concern raised this can take 24 hours to complete or several weeks of investigative work in order to fully conclude.

** A complaint is refused if the complainant does not meet the criteria to register a statutory complaint. In the four cases refused, this was due to the complaint already being investigated in line with the complaints procedure or the complaint is over 12 months old.

Commissioned Services

Domiciliary Care Agencies

A total of 7 complaints about private sector domiciliary care agencies were received directly by the Complaints Service during 2015/2016. All complaints were acknowledged and passed to the agency for consideration and response under their own complaints procedure in the first instance. Commissioning Delivery Hub, Care Quality Commission and Adult Social Work Teams are alerted to the complaint to ensure appropriate action can be taken if necessary.

Service Approach for 2016/2017

- Continue greater emphasis on quality of Stage 1 responses to complainants and the importance of discussing the complaint details with the complaint during each investigation.
- Continue to work with Staffordshire & Stoke-on-Trent NHS Partnership Trust in order to administer complaints for adult social care.

- Continue to provide complaint data to Staffordshire & Stoke-on-Trent NHS Partnership Trust on a weekly, monthly basis and quarterly basis.
- Continue to review, develop and streamline all complaint processes within the Customer Feedback and Complaints Team;
- Compliance with the new Care Act which came into force in April 2015 and any future changes to the complaints process.
- To develop and enhance reporting processes and requirements with colleagues within Staffordshire County Council in order to provide complaint data regularly to senior management.

Author; Natalie Smith
Customer Feedback and Complaints Officer
Customer Feedback and Complaints Team

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Local Members' Interest
N/A

Safe and Strong Communities Select Committee - 9th November 2016

Customer Feedback and Complaints – Children's Social Care Annual Report 2015/16

Recommendation

1. That the Committee considers the Annual Report of the Customer Feedback and Complaints Service, Children Social Services 2015/16, taking the opportunity to comment on the content of the report.

Report of the Cabinet Member for Children and Young People

Summary

What is the select Committee being asked to do and why?

2. That the Committee considers the Annual Report of the Customer Feedback and Complaints Service, Children's Social Services 2015/16 taking the opportunity to comment on the content of the report.

Report

Background

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

4. The Annual Report, Customer Feedback and Complaints Services, Children's Social Services 2015/2016 is being submitted for scrutiny and endorsement.

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

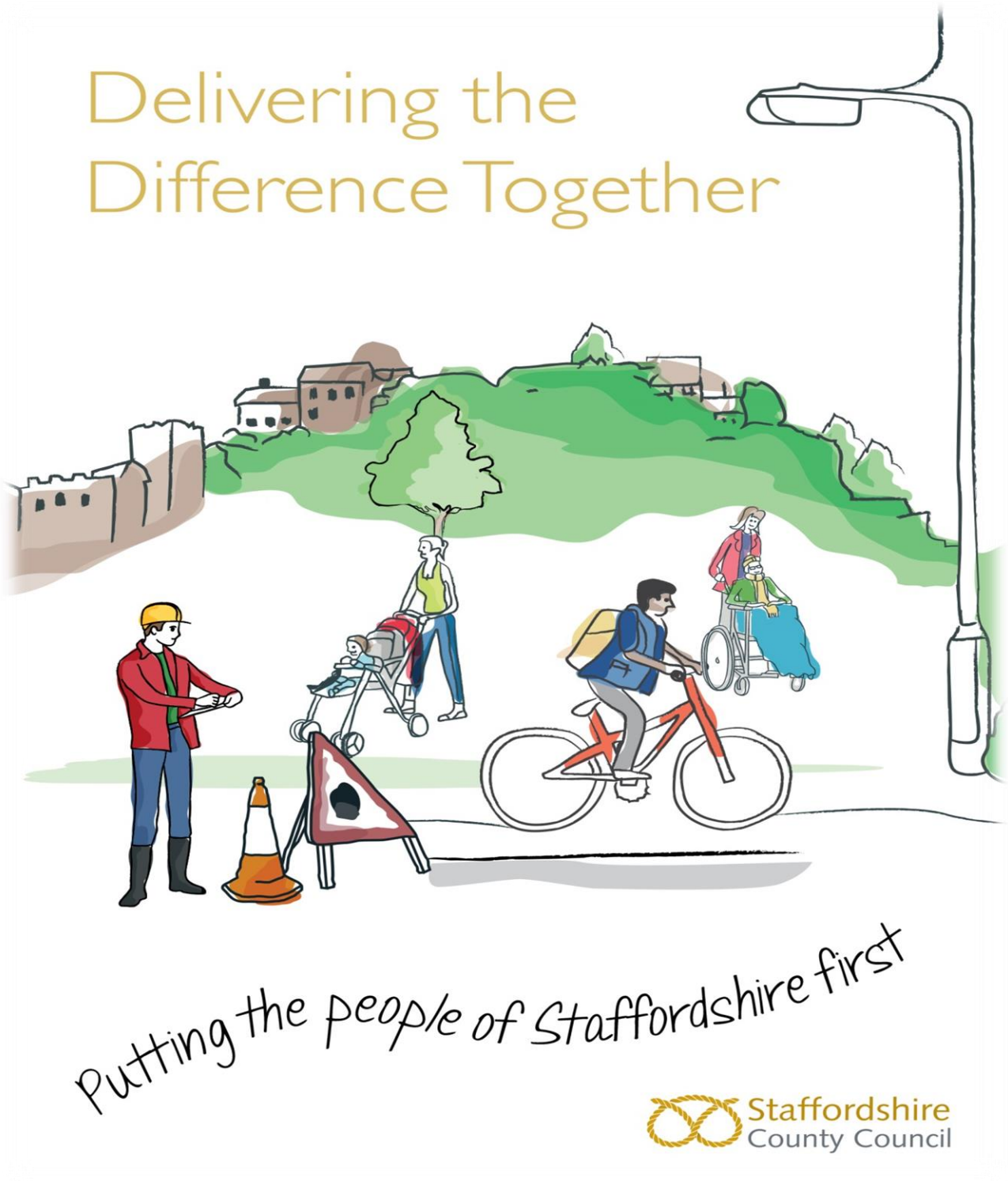
6. It is important that the Local Authority uses the evidence available from Complaints and Representations to inform service improvements. The report provides information about how complaints investigations are used to identify specific themes, where service improvement can be addressed and highlights where the County Council is providing quality services to customers which may be identified from compliments received. This is in line with the Council's Strategic Plan, to use Customer Insight to develop high quality services which meet customer needs.

Contact Officer

Name and Job Title: Kate Bullivant, Customer Feedback and Complaints Manager
Telephone No.: 01785 277407
Address/e-mail: kate.bullivant@staffordshire.gov.uk

Appendices/Background papers

Appendix A: - Customer Feedback and Complaints Service, Children's Social Services, Annual Report 2015/16



CUSTOMER FEEDBACK AND COMPLAINTS TEAM
STATUTORY ANNUAL REPORT 2015-2016
CHILDREN AND FAMILIES SERVICES

CONTENTS

Introduction

This report provides information for the Statutory Children's Complaints and Representations Service and the Corporate Feedback Procedure for Children and Families services, for the period 1 April 2015 to 31 March 2016. The report and service is provided in accordance with the Complaints and Representations Procedures established under the Children Act 1989 and the Local Authority Act 1970.

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

The Statutory Complaints Procedure

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

There are three stages to the Statutory Complaints Procedure:

Stage 1 - Local Resolution
Stage 1 Statutory Complaints are investigated and responded to by a Team Manager or a County Manager, depending on what the complaint concerns. In accordance with the guidance the expectation is that the majority of complaints should be resolved at this stage. The Customer Feedback and Complaints Team place emphasis on resolving complaints at this stage, as local resolution allows the Team Manager to provide the most thorough and detailed response to a complaint, with it being their service. Effective handling at Stage 1 can prevent the complainant escalating to further levels of the procedure, or in the event that further investigation was requested a robust Stage 1 response can support a decision to decline some requests, or support any decisions challenged by the Local Government Ombudsman. There is a timescale to respond to Stage 1 complaints, of up to 20 working days.

Stage 2 – Independent Investigation
If a complainant remains dissatisfied with the outcome following Stage 1 of the procedure, they have a right to request a Stage 2 Independent Complaint Investigation. Stage 2 investigations are carried out by external Investigating Officers. An Independent Person is appointed for all Stage 2 complaint investigations as required by the regulations.
At the conclusion of an investigation, a report is produced with findings, conclusions and recommendations. The relevant Strategic Lead acts as the Adjudicating Officer on behalf of the Local Authority and provides the Local Authority's formal response to the complainant along with an action plan to implement the recommendations. The timescale for completion of a Stage 2 investigation is up to 25 working days, although this can be extended to 65 working days with the complainant's agreement.

Stage 3 – Complaint Review Panel
Where a complainant remains unhappy with the outcome of the Stage 2 investigation they may request a Complaints Review Panel. The Panel is made up of 3 independent people and is clerked by the Local Authority Legal Services. The timescale for setting up the panel is 30 working days.
The Panel's remit is to review the investigation; it cannot re-investigate a complaint. The Panel provide their findings in writing within 5 working days to the complainant and the Local Authority. The Local Authority will consider the panel's findings and produce the Local Authority's response to the Panel's findings within 15 working days.

Local Government Ombudsman (LGO)
In the event that a complainant remains dissatisfied following exhaustion of all three stages of the complaints procedure they can take their complaint to the LGO. A complainant can access the LGO at any point but the LGO normally provides the Local Authority with the opportunity to process through all stages of the complaints procedure unless they decide otherwise. Complaints referred back to the Local Authority to process are classed as 'premature referral' complaints. If the Local Authority take the decision to refuse to investigate a complaint or refuse to escalate the complaints to the next stage of the procedure, a complainant may then also approach the LGO.

Criteria for Accessing the Statutory Complaints Procedure

Who can complain?
The Children Act 1989 advises that the Statutory Complaints Procedure can only be utilised by the following persons:

- Any child or young person (or a parent of his or someone who has Parental Responsibility for him) who is being looked after by the Local Authority or is not looked after by them but is in need;
- Any Local Authority foster carer (including placements through independent fostering agencies);
- Children leaving care;
- Special guardians;
- A child or young person (or parent of his) to whom a Special Guardianship order is in force;
- Any person who has applied for an assessment under section 14F(3) or (4);
- Any child or young person who may be adopted, their parents and guardians;
- Persons wishing to adopt a child;
- Any other person for whom arrangements for the provision of adoption services extend;
- Adopted persons, their parents, natural parents and former guardians; such other person as the Local Authority consider has sufficient interest in the child or young persons' welfare to warrant his representations being considered by them.

Time Limit:
In addition to the above, there is a time limit on making a complaint to the Local Authority. Regulation 9 (1) states that 'a complainant must make their representations to the Local Authority no later than one year after the grounds to make the complaint arose'. However the Local Authority may consider complaints outside the specified time limit if it would not be reasonable to expect the complainant to have made the complaint within the time limit and that it is still possible to consider the complaint effectively and fairly. Matters such as these would be considered on a case by case basis.

Re-occurring Issues:
Complaints will not be accepted if they are the same or substantially the same as complaints that have already been investigated and responded to previously.

Complaints Made on Behalf of a Child:
The Local Authority has the discretion to decide whether or not the representative is suitable to make a complaint on behalf of a child or young person. The Customer Feedback and Complaints Team will confirm with the service user that the complaints raised accurately reflect their views. This is subject to the child's age and understanding and is a matter which is given careful consideration on a case by case basis.

Complaints Relating to a Child:
A number of complaints received are from adults that relate to a child or young person but are not made on that child's behalf. The Children Act 1989 gives the Local Authority discretion to decide in cases where eligibility is not automatic and whether or not an individual has sufficient interest in the child's welfare to justify his own complaints being considered.

In order to establish 'sufficient interest' the Customer Feedback and Complaints Team will review the Social Work records and liaise with the Social Work Team to ascertain the following:

- Is the complainant party to any Court proceedings?
- Does the complainant attend Child Protection Conferences, Family Group Conferences or Core Groups?
- Is there evidence on the case file of frequent communication between the complainant and the Social Worker?
- Is there evidence on the case file that information regarding the plans for the child or young person is shared with the complainant?
- Has the complainant, at any time, had care of the child or young person?
- Have the issues that are being complained about matters that have directly involved or been relayed to the complainant or are they issues that have been passed to the complainant by another party?

Once the above has been taken into account, the Customer Feedback and Complaints Team will then make an informed decision as to the sufficient interest of the complainant.

The Corporate Services Feedback Procedure

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

The Children and Families section of the Customer Feedback and Complaints Team began to facilitate the Corporate Services Feedback Procedure, for the People Directorate in September 2014. This was previously facilitated by the Corporate Section of the Customer Feedback and Complaints Team, however due to the high level of service areas which this section covered, it was felt beneficial for all complaints in relation to Children and Families services to be facilitated and maintained by one section of the Team. Therefore, the monitoring and administration transferred over in September 2014; as such this report will only make reference to Corporate Complaints from this date.

Stage 1: Local Resolution
The first stage of the process is when a senior member of staff or manager of the service being complained about, is given the opportunity to investigate and respond to the complaint. The timescale for a response is 15 working days.

The complainant is advised in the response letter that they can request a review of the complaint on the basis that they can provide the Council with additional relevant information that was not considered as part of the investigation.

Corporate Complaint – Stage 2: Internal Review
On receipt of a request for further consideration of the complaint, the Customer Feedback and Complaints Team will screen the request to ascertain if the complainant has provided sufficient evidence to support a further review. If the request is accepted, the Internal Review will be allocated to a Senior Manager for investigation and response. The timescale for a review is 25 working days.
If the screening process identifies that no evidence has been provided by the complainant to support the carrying out of further investigation, the Customer feedback and Complaints Team will inform the complainant of this decision. The complainant will be advised why this decision has been made and that they can refer their concerns to the Local Government Ombudsman.

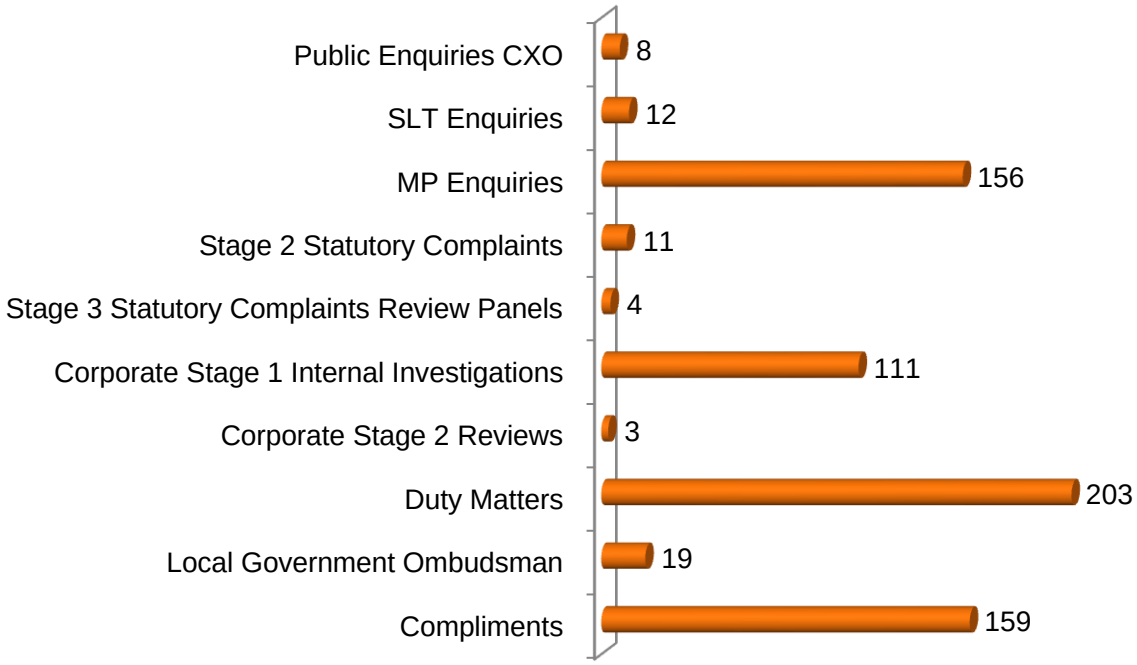
Corporate Complaint – Stage 2: Independent Review
Depending on the complexity and severity of the complaint, it may be necessary for the Customer Feedback and Complaints Manager to appoint an approved Independent Investigating Officer to

investigate a complaint and then report on their findings. The findings are then summarised in a review response by a designated senior member of staff within the service area.

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

Total Feedback Received

The chart below provides a general overview of the total amount of feedback which has been recorded by the Customer Feedback and Complaints Team. For the purpose of the below chart feedback has been categorised as 'duty matters' in general; however this figure shall be further broken down as the report progresses.



Screening System

In order to ensure that either Complaints Procedure is used correctly, a detailed screening process is applied to all feedback which is received. This process allows the Customer Feedback and Complaints Team to gain essential background information on the case and consider information submitted by the complainant together with the criteria previously detailed and any legal implications before making a final decision for sign off, as to how the feedback can be dealt with.

If, following completion of the screening process it is found that a representation is not eligible to enter the Statutory or Corporate Feedback Complaints Procedure then the complainant must be informed and provided with the reason why this decision has been made. If the Customer Feedback and Complaints Team take the decision to refuse to investigate, the complainant is routinely directed to the Local Government Ombudsman which places great importance on the decision making process by the Customer Feedback and Complaints Team.

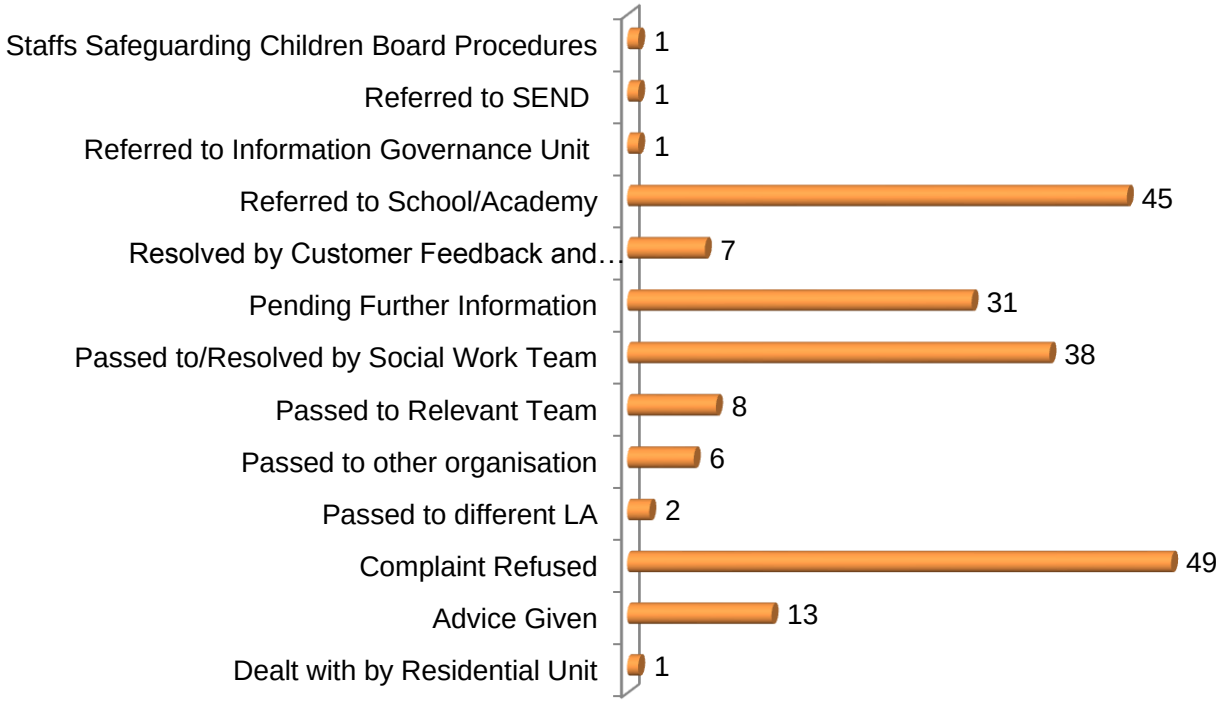
In addition to the above, there may be occasion when an individual approaches the Customer Feedback and Complaints Team with issues that fall outside of the jurisdiction of the Complaints Procedure. When this arises the Team provide advice and assistance to ensure the individual is appropriately signposted.

Duty Matters

The below table shows a comparison against the previous year's data for matters categorised as 'duty', an increase of 4% compared to the last reporting year should be noted.

Year	Number of 'Duty Matters'
2013 – 2014	118
2014 – 2015	201
2015 – 2016	203

The following chart provides a breakdown of how duty matters have been categorised. Specific detail on duty matters is provided to Senior Management via routine monthly and quarterly management reports or via request.



The Customer Feedback and Complaints Team place great significance on duty issues and matters of this nature can often be the most time consuming. The Team have to be certain that the complaints do not meet the criteria for either complaints procedure or are issues which are for investigation via a separate procedure. Through careful consideration and liaison with the relevant practitioners and officers, the Team will then prepare correspondence to advise the complainant of this decision. Due to the fact that the complainant can approach the Local Government Ombudsman at any point, the Team have to be safe in the knowledge that they have provided the correct information. It is pleasing to note that this reporting year the Local Government Ombudsman have not found fault with any of our decisions in terms of refusing complainants access to either complaints procedure.

Statutory Stage 1 Investigations

The Customer Feedback and Complaints Team believe that providing a robust response at Stage 1 of the procedure, this can prevent the complaint progressing to Stage 2 or can support the Local Authority's decision if the matter was referred to the Local Government Ombudsman.

The Customer Feedback and Complaints Team have assessed how it can support both the complainant and the responding officer during Stage 1 and has built in the following steps into the process:

- Specific complaints are defined by the Customer Feedback and Complaints Team from the information submitted by the complainant. This is to ensure that the scope of the investigation is clear from the beginning. It also serves to ensure that each complaint is considered separately and for a clear outcome to be determined and is also in line with how the Local Government Ombudsman investigates.
- The complainant is advised in an acknowledgement letter from the Customer Feedback and Complaints Team, to make contact if they feel their complaints have been defined incorrectly. This provides assurance that the complainant is happy with the complaints being investigated and prevents any challenge on the defined complaints once the investigation has concluded.
- A pre-populated Stage 1 response letter template is created in order to provide a framework for the responding officer to use when dealing with complaints. This is to promote consistency in responding to the complaints and to ensure that the response letter clearly lays out the investigation findings in relation to each defined complaint. The standard paragraphs within the template contain information which must be provided to the complainant in order to comply with our statutory obligations.
- This reporting year the Customer Feedback and Complaints Team have made it mandatory for responding officers to submit their draft responses to the Team for statutory investigations for a quality assurance check to be carried out.

The Customer Feedback and Complaints Team processed a total of 70 complaints through the Statutory Complaints Procedure at Stage 1. The chart below provides a breakdown by quarter together with a comparison for previous years.

Reporting Period	Q1	Q2	Q3	Q4	TOTAL
2013/14	22	32	26	33	**113**
2014/15	47	61	51	34	**193**
2015/16	15	11	31	14	**70**

The data above reports a decrease of 64% in comparison with the preceding year. The Customer Feedback and Complaints Team cannot report a trend in terms of numbers of complaints or provide future forecast, as it is clear to see that these fluctuate on a year to year basis. It is also worthy of note that representation received for this reporting year may have fallen into a different category such as a duty matter or the Corporate Services Feedback Procedure. With this information in mind, the Customer Feedback and Complaints Team place more importance on the findings of complaints for performance indication, rather than simply the number of complaints received.

Breakdown

The following tables provide a further breakdown of the 70 complaints investigated at Stage 1 of the Statutory Complaints Procedure.

Specialist Safeguarding Delivery	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
Specialist Safeguarding Units	4	7	25	6	**42**
TOTAL	**4**	**7**	**25**	**6**	**42**
LAC and Disability	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
Care Planning and Court Teams	4	-	1	1	**6**
Through Care Teams	2	-	1	1	**4**
Adoption Service	-	-	-	1	**1**
Fostering Service	-	-	1	1	**2**
TOTAL	**6**	**0**	**3**	**4**	**13**
Independent Futures	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
Children with Disability Teams	3	4	2	2	**11**
Occupational Therapy Team	2	-	-	1	**3**
TOTAL	**5**	**4**	**2**	**3**	**14**
Partnership and Development	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
Independent Case Conference Chair	-	-	1	-	**1**
TOTAL	**-**	**-**	**1**	**-**	**1**

Nature of Stage 1 Statutory Complaints

The table below shows the nature of complaints dealt with under Stage 1 of the Statutory Complaints Procedure during 2015/16, broken down by service areas, also detailing a percentage format specific to each service area:

Nature of Complaint	Figure	Percentage
Specialist Safeguarding		
Inaccurate Information Provided	1	3%
Case Management	29	69%
Staff Conduct	7	16%
Standard of Service	5	12%
TOTAL	**42**	**100%**
LAC and Disability		
Lack of Funding	1	8%
Access to Information	1	8%
Case Management	6	46%
Refusal of Service	1	8%
Standard of Service	4	30%
TOTAL	**13**	**100%**
Independent Futures		

Case Management	8	54%
Delay in Service	1	9%
Level of Care Provided	1	9%
Staff Conduct	1	9%
Standard of Service	3	19%
TOTAL	**14**	**100%**
Partnership and Development		
Standard of Service	1	100%
TOTAL	**1**	**100%**

The figures above show the main theme for nature of complaint to be Case Management with an overall 62% of Stage 1 Statutory Complaints being recorded in this category. It should be noted that complaints are defined from written or verbal communication, where there may be a number of concerns raised; therefore the nature of is recorded as a general term for the complaints as a whole, rather than for each specific complaint.

Outcomes of Stage 1 Statutory Complaints

The table below illustrates the outcome of complaints dealt with under Stage 1 of the Statutory Complaints Procedure during 2015/16, including a comparison for preceding years:

Reporting Period	Upheld	Partially Upheld	Not Upheld	Complainant not Engaging	Closed: Sensitive Matter	Complaint Withdrawn
2013/14	11%	41%	43%	-	-	-
2014/15	17%	48%	40%	1%	1%	2%
2015/16	10%	63%	18%	2%	-	7%

The data above has shown a slight fluctuation in complaints being found to be partially upheld and not upheld. It should however be noted that the figures for Statutory Complaints as a whole are much lower than previous reporting years which would have an effect on these figures. Complaints at Stage 1 of the Statutory Complaints Procedure are classed as Local Resolution, where the Team Manager will investigate and respond. Based on this, it is therefore commendable that Managers are able to identify and accept any faults and areas for improvement within their respective teams.

Timescales for Responding to Stage 1 Statutory Complaints

The following chart shows a comparison of the response timescales for Stage 1 Statutory Complaints for 2015/16 against previous reporting years.

Reporting Period	Within 10 Working Days	Within 20 Working Days	Over 20 Working Days	Complainant not Engaging	Closed: Sensitive Matter	Complaint Withdrawn
2013/14	27%	37%	30%	-	-	-
2014/15	18%	51%	27%	1%	1%	2%

2015/16	11%	47%	35%	2%	-	5%

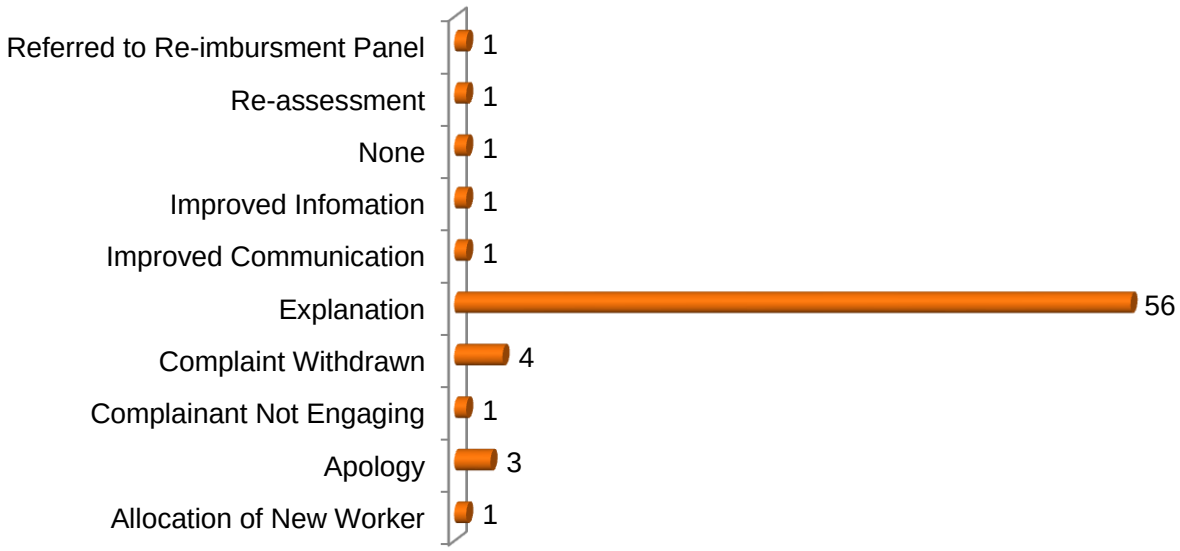
The above figures show that 58% of complaints have been responded to within the prescribed timescales, supporting the services willingness to meet these targets together with the ongoing pressures of the day to day work they are faced with.

It is of course preferable for these timescales to be adhered to, however in some cases this is simply not possible. There can be a number of reasons why a complaint can fall outside of the timescales such as staff members who need to be spoken to are away from the office, the complainant is unable to meet/discuss with the responding officer until outside of timescales or the complainant does not attend a planned appointment to discuss the complaint. When instances of this nature occur, it is the view of the Customer Feedback and Complaints Team that the responding officer make contact with the complainant to agree a suitable timescale for completion. Emphasis is placed upon the complainant receiving a robust and detailed response to their complaints, which may require a slightly longer timescale to complete. The Customer Feedback and Complaints Team will closely monitor any extensions to timescales and inform the complainant that they are in agreement with this.

Any instances of exceeding timescales are reported on within monthly and quarterly management reports sent to Strategic Leads and County Managers.

Remedies for Stage 1 Statutory Complaints

The chart below provides an overview of the remedies that have been provided to the complainant following the outcome of the complaint.



The above chart shows that 80% of Statutory Stage 1 Complaints are recorded as having an explanation provided as a remedy. It is a frequent theme that an explanation is the most common remedy, as in many cases complainants are unsure of why certain decisions have been made and can usually be resolved by the responding officer providing a written response explaining this.

Stage 2 Statutory Independent Investigations

As detailed within the preceding years Annual Report, 2014/15 bought a change in the way Stage 2 Statutory Independent Investigations were managed by the Customer Feedback and Complaints Team. Following communication with the Local Government Ombudsman, the current stance is that requests for a Stage 2 Independent Investigation are accepted.

This reporting year, the Customer Feedback and Complaints Team have placed emphasis on the standard of the response at Stage 1 of the procedure, and offered a quality assurance check on all draft response letters. The aim of this is to ensure the response is robust, identifies fault where evident and provides a suitable and proportionate remedy; and that it supports any action taken in line with the correct legislation or procedures.

The process at Stage 2 of the Statutory Complaints Procedure can be lengthy and as such the Customer Feedback and Complaints Team will, where appropriate, discuss any requests with the relevant Senior Managers to ascertain if there is a quicker resolution which could be agreed upon, without the need for the complainant to access the Stage 2 Process. In instances of this nature, the Customer Feedback and Complaints Team will closely liaise with the complainant to ascertain if they are happy with this course of action or if they wish to proceed with the Stage 2 Investigation.

The below table shows the number of Stage 2 Investigations commissioned this reporting year, with a comparison for previous years:

Reporting Period	Number of Stage 2 Independent Investigations
2013/14	8
2014/15	13
2015/16	11

The figures above show a decrease in the amount of Stage 2 Independent Investigations upon comparison; however it should be noted that there is a high decrease in the amount of Stage 1 Statutory Complaints investigated during this reporting year. The below table provides a comparison for the preceding year, in a percentage format:

Reporting Period	Number of Stage 1 Statutory Complaints	Number of Stage 2 Independent Investigations	Percentage of Stage 1 Complaints Progressing to Stage 2 Investigation
2014/15	193	13	7%
2015/16	70	11	16%

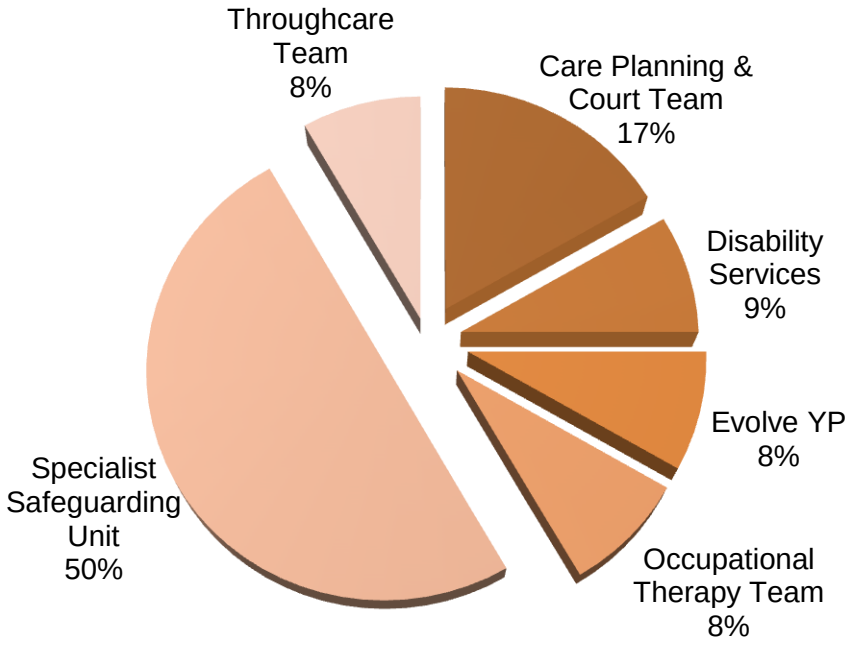
Whilst there is an overall increase in complaints progressing to the next stage of the Statutory Complaints Procedure, the Customer Feedback and Complaints Team feel strongly that this isn't an indication of poor performance or inadequate response letters. As with all complaints, the focus should remain on the finding of the complaint rather than the numbers received.

The table below shows the Stage 2 Investigations that took place in respect of the services within Families First and Independent Futures:

Service	Number of Stage 2 Independent Investigations
LAC and Disability	4*
Independent Futures	2
Specialist Safeguarding	6

*LAC and Disability had one investigation which covered two separate Teams and as such the above figures are higher than reported above.

The chart below provides a further breakdown into teams:



Findings from Stage 2 Independent Investigations

Investigations carried out at Stage 2 of the Statutory Complaints Procedure usually contain a number of defined complaints, which the Independent Investigating Officer will make a finding on following their Investigation. The number of complaints within each Investigation will depend on the complainant and would be informed from the initial interview. For this year's Annual Report, it was felt that some additional data would be helpful in terms of the findings from the Investigations.

From the 11 Stage 2 Independent Investigations commissioned during 2015/16, 10 have concluded while one remains ongoing. From the investigations concluded, there were 60 complaints contained within.

The below table provides data in terms of the findings of those 60 complaints:

Findings	Figure	Percentage
Upheld	33	54%
Not Upheld	20	35%

Partially Upheld	3	5%
No Finding	4	6%

The above data shows that just over half of the total amount of complaints investigated at Stage 2 of the Statutory Complaints Procedure have been found to be upheld. The Local Authority place great significance on the outcomes from complaints, and where these are found to be upheld robust actions are put into place, monitored by Senior Managers to ensure completion. The findings from complaints can also inform various other aspects of practice such as staff development, communication and policy developments.

Recommendations from Stage 2 Investigations

The tables below offer a small selection of some of the complaints that escalated to Stage 2 and the actions which the services have taken to complete the recommendations made by the Investigating Officer.

Service : Specialist Safeguarding Service
Action taken by the service following recommendations:
• Senior Managers within Children and Family Services are reminded of the need to include an apology in their correspondence to complainants when it has been found that their complaints have been upheld.
• Senior Managers within Children and Families First review the standards to be applied for the distribution of Core Group Meetings, etc. and determine a challenging but realistic standard that members of staff will be expected to achieve.

Service : LAC and Disability Service
Action taken by the service following recommendations:
• Procedural clarity is given to the arrangements for sharing of the Social Work Report ('LAC Care Plan incorporating Social Work Report to Review') to review participants.
• Officers are reminded of the importance of using 'Out of Office' to indicate their availability and alternative contact arrangements.
• Council procedures are reviewed to ensure compliance with guidance and regulations - Volume 2: care planning, placement and case review June 2015 and takes into consideration the following: ○ Provision of written policy information to involved parties ○ Written information about the Statutory Review process and the expectations of all involved. ○ Explanation about the function of Pathway Plans and their relationship with Care Plans.

Service : Independent Futures

Action taken by the service following recommendations:
• Gaps in knowledge to be identified in supervision and appraisals with individual staff and appropriate training, learning and development needs to be part of the ongoing performance conversation and fed into training matrix and workforce development plan.
• The Commercial Unit, Commissioners and Independent Futures will work jointly to consider current non-contracted provisions and identify appropriate options available to the Council to progress any such arrangements onto more fit for purpose, formalised agreements.
• Outcomes from complaint to be shared with Localities to ensure understanding around issues of procurement and support plans.

Stage 3 Complaint Review Panels

The below table provides an overview of any Stage 3 Complaints Review Panels for 2015/16 and the respective services involved:

Service	Number of Stage 3 Complaints Review Panels
LAC and Disability	3
Independent Futures	1
TOTAL	4

The above figures show that from the 11 complaints investigated at Stage 2 of the Statutory Complaints Procedure, only 4 progressed to a Stage 3 Complaints Review Panel. From this data, it can be taken that the majority of complainants were satisfied with the outcome and recommendations made through the Stage 2 Process.

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

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

Service : LAC and Disability
Action taken by the service following recommendations:
• Adoption Support Team to review and where required revise and develop the information provided to ensure that there is clear and age appropriate information for the siblings of children being adopted.
• Training and information to be delivered across the relevant workforce relating to adoption and post adoption.
• Staff undertake training in relation to Cultural awareness to have a focus on working with Eastern European Families.

Service : Independent Futures
Action taken by the service following recommendations:
• Literature to be completed and implemented regarding the DFG process to provide additional information to service users.
• The Local Authority to continue to develop and strengthen the relationship with District Councils, to ensure actions are monitored and coordinated.

Comparative Figures for Other Authorities

It was requested during the presentation of last year's Annual Report that the following year comparative data be provided for other Authorities. The below table provides data which has been collated from other Authorities, it should be noted this is for Statutory Complaints only:

Authority	Statutory Stage 1	Statutory Stage 2	Statutory Stage 3
Wolverhampton	128	3	0
Dudley	97	4	1
Shropshire	62	5	0
Telford and Wrekin	109	2	0
Coventry	120	8	0
Staffordshire	**70**	**11**	**4**

The Customer Feedback and Complaints Team would wish to note that the difference in size of these Authorities should be noted and the potential difference between the number of young people in receipt of a service for each Authority.

Corporate Stage 1 Investigations

As detailed within the preceding years Annual Report; the Children and Families section of the Customer Feedback and Complaints Team did not facilitate the Corporate Feedback Procedure for the full reporting year in 2014/15. With this in mind, there would be no benefit in providing comparative year on year data as this would not be representative of a full reporting year for 2014/15.

Reporting Period	Q1	Q2	Q3	Q4	TOTAL
2015/16	35	29	19	28	**111**

Breakdown

The following tables provide a further breakdown of the 111 complaints investigated at Stage 1 of the Corporate Feedback Procedure:

Education and Skills	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
SEND Teams	2	4	4	3	**13**
School Admission and Transport	3	-	-	1	**4**
Elective Home Education	1	-	-	-	**1**
TOTAL	**6**	**4**	**4**	**4**	**18**
Targeted Services	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
Early Years Forum	-	1	-	-	**1**
Educational Psychology	-	1	-	-	**1**
Hearing Impairment Team	1	-	-	-	**1**
Local Support Teams	3	2	2	2	**9**
TOTAL	**4**	**4**	**2**	**2**	**12**
Partnership and Development	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
Independent Review Officer	-	1	1	-	**2**
Children's Wellbeing	1	-	-	-	**1**
TOTAL	**1**	**1**	**1**	**-**	**3**
Independent Futures	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
Children with Disability Teams	2	-	1	3	**6**
Occupational Therapy Team	-	1	-	-	**1**
TOTAL	**2**	**1**	**1**	**3**	**7**
LAC and Disability	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
Care Planning and Court Team	3	4	1	2	**10**
Fostering Support Team	-	3	1	-	**4**
Intensive Intervention Fostering	1	-	1	-	**2**
Throughcare Team	1	-	1	-	**2**
Virtual Head teacher	-	-	2	-	**2**
TOTAL	**5**	**7**	**6**	**2**	**20**
Specialist Safeguarding	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
Emergency Duty Team	-	2	-	-	**2**
Specialist Safeguarding Units	17	10	5	17	**49**
TOTAL	**17**	**12**	**5**	**17**	**51**

Nature of Stage 1 Corporate Complaints

The table below shows the nature of complaints dealt with under Stage 1 of the Corporate Feedback Procedure since the period where these were absorbed by this section of the Customer Feedback and Complaints Team, broken down by service areas, also detailing a percentage format specific to each service area:

Nature of Complaint	Figure	Percentage
Education and Skills		

Access to Service	2	11%
Case Management	7	40%
Delay in Service	2	11%
Reduction of Service	1	5%
Refusal of Service	1	5%
Staff Conduct	1	5%
Standard of Service	4	23%
TOTAL	**18**	**100%**
Independent Futures		
Access to Service	1	14%
Case Management	2	30%
Delay in Service	1	14%
Eligibility	1	14%
Level of Care Provided	1	14%
Standard of Service	1	14%
TOTAL	**7**	**100%**
LAC and Disability		
Access to Service	2	10%
Case Management	12	60%
Communication	3	15%
Staff Conduct	1	5%
Standard of Service	2	10%
TOTAL	**20**	**100%**
Partnership and Development		
Withdrawal of Service	1	33.3%
Staff Conduct	1	33.3%
Communication	1	33.3%
TOTAL	**3**	**100%**
Specialist Safeguarding		
Information	1	2%
Disclosure of Information	2	4%
Inaccurate Information Recorded	3	6%
Case Management	20	40%
Communication	3	6%
Delay in Service	1	2%
Level of Care Provided	1	2%
Staff Conduct	10	19%
Standard of Service	10	19%
TOTAL	**51**	**100%**
Targeted Services		
Access to Service	1	9%
Case Management	4	33%
Refusal of Service	1	9%
Staff Conduct	2	16%
Standard of Service	4	33%

TOTAL	**12**	**100%**

Outcomes of Stage 1 Corporate Complaints

The table below illustrates the outcome of complaints dealt with under Stage 1 of the Corporate Feedback Procedure during 2015/16:

Reporting Period	Upheld	Partially Upheld	Not Upheld	Complainant not Engaging	Remains Ongoing	Unable to make a Finding
2015/16	9%	42%	40%	2%	4%	1%

The data above shows a very small amount of complaints investigated under the Corporate Feedback Procedure have been found to be wholly substantiated. The figures for partially and not upheld are fairly consistent with each other; a partially upheld finding indicates services being open and honest to accepting fault, assisting the valuable learning which complaints do provide.

Timescales for Responding to Stage 1 Corporate Complaints

The table below illustrates the timescales for responding to Stage 1 Complaints via the Corporate Complaints Procedure, during 2015/16:

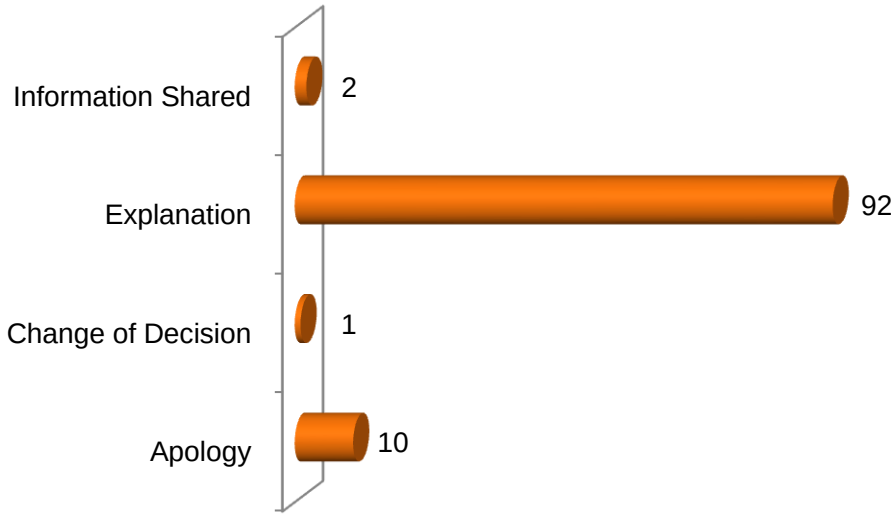
Reporting Period	Within 10 Working Days	Within 15 Working Days	Over 15 Working Days	Complainant Withdrawn
2015/16	15%	44%	36%	5%

These figures show that 59% of complaints are responded to within the prescribed timescale set out within the Corporate Feedback Procedure.

As stated within the data for Statutory Complaints, it is sometimes necessary for responses to run outside of timescales for a number of reasons outside of the responding officer's control. The Customer Feedback and Complaints Team will continue to work closely with staff members to ensure that communication is kept open with the complainant and a revised completion date agreed.

Remedies for Stage 1 Corporate Complaints

The chart below provides an overview of the remedies that have been provided to the complainant following the outcome of the complaint.



The data evidences that the majority of Corporate Complaints have been provided with an explanation as the remedy. As with Statutory Complaints, many complainants simply require an explanation as to why certain decisions have been made and in the majority of cases, this enables the complainant to move on and accept the explanation as some form of resolution to their complaint.

Corporate Stage 2 Complaints – Internal Review

During this reporting year, three complaints were accepted for an internal review at Stage 2 of the Corporate Complaints Procedure. The Customer Feedback and Complaints Team have discretion over the Corporate Feedback Procedure and complainants are requested to provide further detail if they require an internal review. The below chart provides further detail in respect of these:

Service	Number of Stage 2 Reviews	Summary of Findings
Specialist Safeguarding	1	Partially Upheld. Apology provided to complainant.
Special Educational Needs and Disability (SEND)	1	Partially Upheld. Apology provided to complainant.
Independent Futures	1	Upheld. Apology provided. Agreement for Education Health and Care Plan to be revisited and meeting arranged with Senior Manager.

Contact Submitting Complaints

This reporting year has seen 73% of the total feedback received has been from Parents of Service Users with 4% being received directly from Service Users. It is a regular trend that Parents provide the majority of complaints for Children and Families Services. The Customer Feedback and Complaints

Team will, where it is suitable, contact the Service User to ascertain if they are happy for the complaint to be made on their behalf. This is a difficult decision as a number of factors need to be taken into account such as the age and understanding of the young person and whether or not the complaints being made would cause any animosity between themselves and the family member. This also needs to be carefully balanced against the issue of the young person's information being released through a complaints response and whether or not they are old enough to dispute this. Liaison will take place with the relevant practitioners in these instances to inform the overall decision.

In terms of young people being able to access the procedures, there are currently a number of ways which this can be done:

- The Local Authority's Website provides clear information on how a complaint can be submitted, with the inclusion of an online feedback form
- Leaflets are provided to all premises receptions, which include a freepost complaints form
- Leaflets are handed out following the completion of assessments
- Parents/Service Users are made aware of the Complaints Procedure in Statutory Reviews
- Leaflets are included in U-Packs for children/young people who are in the care of the Local Authority
- Advocacy services are promoted and provided to young people should they request them

Local Government Ombudsman (LGO)

The Local Government Ombudsman received 18 complaints for Children's Services in this reporting period. The LGO will make a judgement on whether or not they chose to investigate the complaint themselves, or make enquiries with the Local Authority before making a decision. The below table provides further detail, the LGO finding is reported below how it is stated from the LGO:

Service	LGO Status	LGO Finding	LGO Proposed Remedy
Care Planning and Court Team	LGO Enquiry	LGO Investigation Commenced	Not Applicable
Care Planning and Court Team	LGO Investigation	No Fault	Not Applicable
Care Planning and Court Team	LGO Enquiry	Refusal to Investigate	Not Applicable
Specialist Safeguarding Unit	LGO Enquiry	Premature Complaint	Complaints Procedure implemented.
Specialist Safeguarding Unit	LGO Enquiry	No Fault	Not Applicable
Specialist Safeguarding Unit	LGO Enquiry	Refusal to Investigate	Not Applicable
Specialist Safeguarding Unit	LGO Enquiry	No Fault	Not Applicable
First Response Team	LGO Enquiry	No Fault	Not Applicable
School Transport Team	LGO Enquiry	Refusal to Investigate	Not Applicable
School Transport Team	LGO Investigation	No Fault	Not Applicable
School Admissions	LGO Investigation	No Fault	Not Applicable
School Admissions	LGO	No Fault	Not Applicable

	Investigation		
School Admissions	LGO Investigation	No Fault	Not Applicable
Special Educational Needs and Disability	LGO Enquiry	LGO Investigation Commenced	Not Applicable
Special Educational Needs and Disability	LGO Investigation	No Fault	Not Applicable
Special Educational Needs and Disability	LGO Enquiry	LGO Investigation Commenced	Not Applicable
Special Educational Needs and Disability	LGO Investigation	Injustice Caused	Apology provided to complainant as requested by LGO.
TOTAL			**18**

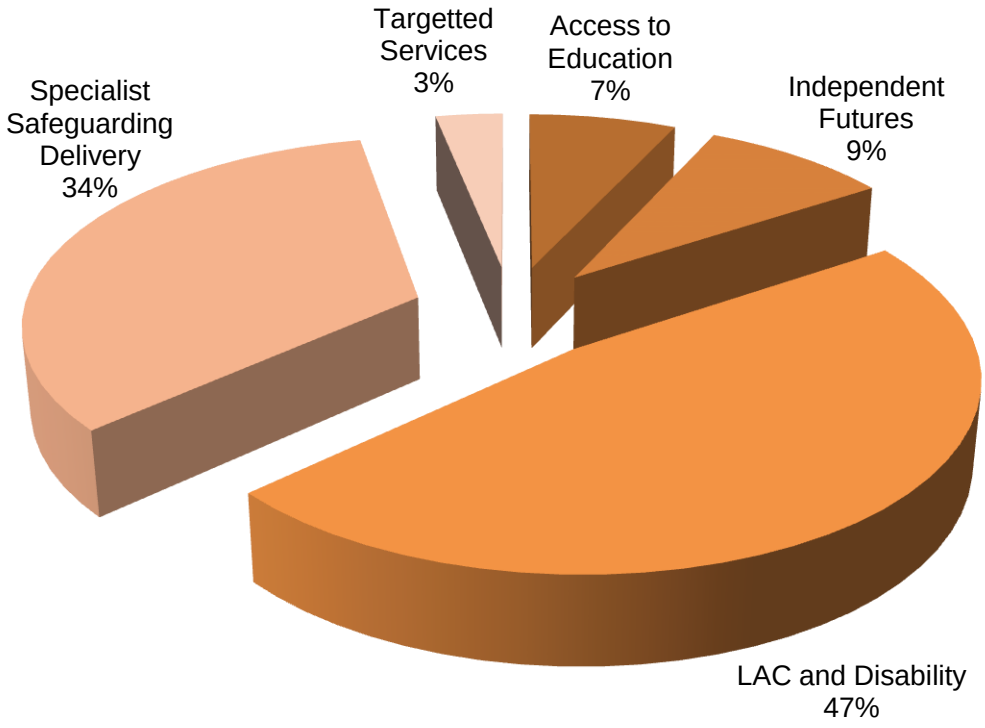
It is pleasing to see that from the above data there was only one matter which following investigation, injustice was found to have been caused. The LGO found there was fault from the Local Authority in terms of a delay in issuing an Education Health and Care Plan (EHCP) which caused the complainant an injustice. The recommended remedy was an apology which the Local Authority complied with and the LGO were satisfied with those actions.

The findings from the LGO are testament to the hard work of the professionals within the Local Authority as the Customer Feedback and Complaints Team rely on these individuals to provide them with the data which is being requested from the LGO. It also reinforces the need to provide a clear, concise and robust response at Stage 1 of either complaints procedure; as the LGO will take these into account when making a finding.

Compliments

A total of 159 compliments have been received for the reporting year 2015/16. This is an increase of 9% on comparison to the previous year's figures. Compliments should always be significantly recognised and held in the highest regard as appreciation of the work being undertaken by staff within the Children and Families service. Data regarding compliments is routinely shared with management through monthly and quarterly reporting.

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



Examples of Compliments

Targeted Services

- He is always highly professional and has been an asset to our team. He is one of the best I have worked with in my career and having come through a route of Pastoral Management I have worked with a range of staff over the years. His focus is always on the pupils and getting the best for them which in the current climate is something which I feel is often sadly missing. As with all within Education at the moment I am certain that you have significant numbers of emails to complain but when praise is due I feel that we should speak out as loudly.
- I just want to send a quick email to say how supportive the LST have been when we have required cover for a contact and if social workers have required additional support when working step up step down cases.
- During her time in the post she has worked closely and positively with us to ensure our staff teams work in partnership for the benefit of local families. In fact, she has undoubtedly improved the way the Voluntary sector and LSTs week at many levels she is industrious, creative and dedicated in her work with a 'can do' attitude. She always brings a positive approach to meetings and is always available with advice, support and practical help.

LAC and Disability

- Stated in his Pathway Plan that "Social Worker will always be in my heart she has been such a good person for me. I will always remember her even if I am 90 years old, I will remember. Thank you for all the help you have given me, my life is good now".
- I found you and your staff very knowledgeable and accommodating, and wanted to thank you all for taking time out of your day to fulfil my request and allowing me to contribute to the amazing work that you and your team undertake.
- I wanted to say a huge thank you for the training we facilitated today. Your knowledge and understanding of radicalisation was great, you both conveyed this with confidence and certainly shared this with the group.

- I couldn't fault the care plan and it was lovely to be able to give a grade descriptor of outstanding.
- Thank you card from a care leaver (case was due to close aged 21 years), who advised that the Social Worker had helped her tremendously throughout her leaving care experience.

Specialist Safeguarding

- During the advocates meeting, a solicitor who you will know is held in high regard, was very complementary about the Social Workers practice and this was echoed by the Guardian, the solicitor for the children and the solicitor for mother. They were 'staggered' by her knowledge and how well she just 'knows children.' They were very clear that the way this case has been social worked has hugely impacted on the outcome for these children. In addition they confirmed her evidence is excellent and her updates very, very thorough.
- Social Worker was, throughout, extremely professional and knowledgeable whilst at the same time being friendly and approachable. She was extremely quick to sort out any queries we had and came back to us straight away with anything we needed to know.
- We were give the most background information on placement that we have ever been given and we were kept informed throughout on what was happening with court etc. Meetings and visits were well planned and we were informed in a very timely manner.
- Throughout she has been professional, punctual, organised and helpful. She has had her best interests at the heart of everything that she has done.
- He has specifically commented to me on how well informed the Social Workers have been throughout the case and more generally seemed impressed that we didn't simply try to take the easy option. He doesn't strike me as the type to give our praise loosely so I'd take the comments as a compliment.

Access to Education

- Thank you ever so much for your help this morning it really has helped me & what you have sent me will help us to understand what needs to be done when we return this summer. Thank you.
- I just wanted to thank you for your help and support through the appeal process for my daughter, to attend Moorside High School. She was successful in gaining a place through the appeal and I believe that it would not have been possible without your time and patience.
- Brilliant thanks ever so much for your help! You have no idea how worried I've been and how much calmer I feel now.

Independent Futures

- Despite our 3 girls being young and having a disability, she dealt with the situation calmly, respectfully, professionally and with the most lovely smile and gentle aura. The Social Worker was calm and professional with myself and incredibly discreet. On Friday, we had a great meeting and I left feeling honoured to be supported by the services who I had never really thought of as 'my friend'. I opened up hugely to her, more than any of your colleagues and this I believe is as a result of her coming into our home with a nurturing & warm nature and a non-judgemental approach.
- I want to take the opportunity to thank you for being so reasonable and patient. The transition period has been extremely fraught but I can whole heartedly say that Staffordshire Social Services were the only ones to not put additional obstacles in my way and were supportive.
- I can only compliment the Social Worker and the excellent service and support which we have been given. We have a greater feeling of being worked with as people and individually in our own rights as opposed to figures on documents.
- She was more than fantastic in her support and had to deal with me at my weakest, I was finding it hard to talk past my tears on several occasions yet she used such great skills to be able to ensure she was fully supporting of not just me but my husband and my other children at

a vulnerable time. To be honest as a student nurse, (very many years ago) I had worked within learning disability care and I had a real fear that any respite meant I had failed in my job as a mother. I was also reluctant as I thought places or people may not be as kind to him as he would need. The Social Worker was able to use her interpersonal skills to make me talk -and then see sense - she was brilliant !! I honestly feel she is a credit to her profession and I feel so supported and I'm so appreciative of her on-going care.

Commentary from the Customer Feedback and Complaints Team

This reporting year sees a further increase in the amount of duty matters which have been facilitated by the Customer Feedback and Complaints Team. The Customer Feedback and Complaints Team believe that this is testament to the strong working partnership which we have with the various services within the Local Authority. It is this positive working relationship which allows us to communicate effectively and access any required information in a timely manner, before making an informed decision on the piece of feedback in hand. Matters recorded as duty can be overlooked as they do not fall into a specific procedure. The Customer Feedback and Complaints Team would ask readers to note that duty matters require carefully balanced decisions to be made in line with the appropriate legislation and can often be time consuming. Reports prepared for management will continue to detail duty work to ensure staff are aware of the different types of feedback received.

A decrease in Stage 1 Statutory Complaints can be seen within this year's Annual Report however as it is routinely stated throughout all reports from this Team, numbers of complaints received will always fluctuate and for that reason a far better performance indication should always be taken by the outcome found, following an investigation.

This reporting year also provides the first full year of data for Corporate Complaints, since this section of the Customer Feedback and Complaints Team began to facilitate the Corporate Complaints Process for Children and Families Services. It can be seen that the figures for this data are high in comparison to Statutory Complaints, supporting the Customer Feedback and Complaints Team's management decision to facilitate these through the Children's section of this team. All services within Children and Families Services can now access their respective complaints and feedback data through one report.

Figures for complaints found to be wholly substantiated continue to be a minority, even with the Corporate Complaints data included. The Customer Feedback and Complaints Team believe this to be the main focus of any reports created, as ultimately the numbers of complaints received becomes irrelevant if the findings do not support the concerns being raised. This is not to say that there are not certain areas within various Teams, where there has been fault found, the willingness of the different teams to accept responsibility for any fault and put relevant steps into place to remedy these shows motivation to make changes in order to achieve positive outcomes in the future.

It is of high importance to the Customer Feedback and Complaints Team that any agreed actions arising from complaints are implemented and monitored. Learning from complaints is an important and valuable exercise which is reiterated throughout training provided to staff members from the Customer Feedback and Complaints Team. By providing the complainant with a clear message that concerns have been addressed, it can prevent the matter from further escalating.

Reporting shall continue to be a key aspect of the Customer Feedback and Complaints Teams work, to ensure management are kept informed with any potential trends in terms of complaints and feedback.

Whilst compliments have slightly decreased these should still be held in the highest regard as each compliment provides encouragement and positive messages for those staff involved. The Customer Feedback and Complaints Team will continue to regularly report on compliments and encourage all staff to forward these on once received.

Whilst it is acknowledged that the number of complaints received is unpredictable, the Customer Feedback and Complaints Team will continue to support its customers and work with the Social Work Teams to resolve complaints. In a service which is continually adapting and striving to meet targets, complaints can be best used to assist in the design and delivery of services and as an important learning mechanism to highlight any areas where improvement can be made.

The Customer Feedback and Complaints Team wish to continue the message that the Local Authority operate accessible complaints procedures where individuals can be assured their concerns will be given full consideration and carried through the appropriate procedure wherever possible.

Report Author:
Elaine Cox - Customer Feedback and Complaints Officer Children's Services
01785 278601
elaine.cox@staffordshire.gov.uk

Local Members' Interest
N/A

Safe and Strong Communities Select Committee – 9th November 2016

Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2015/2016

Recommendation:

1. To scrutinise the role and function of 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. The progress made between April 2015 and March 2016 is detailed within the SSASPB Annual Report attached (Appendix A).

Report of the Cabinet Member for Health, Care and Wellbeing

Summary

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

2. The Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board should report annually on the progress made by the Board to the Safe and Strong Communities Select Committee to enable robust member scrutiny of its functions. The Care Act 2014 made this a statutory requirement. The last report was presented to members of the Safe and Strong Committee on 5th November 2015.

Report

Background

3. In April 2015 the Care Act gave Safeguarding Adult Boards (SABs) statutory footing. There are three main statutory functions of the Board i) To publish an Annual Report ii) to produce a strategic plan and iii) to undertake Safeguarding Adult Reviews. This Annual Report of the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB) covers the period from 1st April 2015 to 31st March 2016. Mr John Wood was the Independent Chair of the Board throughout this period. He also chairs both Staffordshire and Stoke on Trent Safeguarding Children Boards.

4. Role and function of the SSASPB: The Care Act 2014 states that the '*objective of a SAB is to help and protect adults in its area by coordinating and ensuring the effectiveness of what each of its members does'.*

5. Key duties as outlined in the Board's constitution include:

a. Play a strategic role in holding organisations to account where practice leads to abuse;

b. Ensure policies and procedures promote engagement with adults throughout the enquiry process;

c. Ensure staff are competent in working with people and have the authority, skills and

d. knowledge to use the full range of interventions/legal powers;

e. Ensure lessons are learnt to improve practice;

f. Communicate the importance of adult safeguarding widely to communities and all those delivering services with guidance on how to seek help and support;

g. Collect hard data (statistics), qualitative data (audits) and the views of service users, carers' and family members to inform commissioners of service requirements and to improve practice.

6. **Structure:** The core functions of the SSASPB are to be delivered through seven sub-groups (District sub-group, Learning and Development sub-group, Policies and Procedures sub-group, Performance, Monitoring and Evaluation sub-group, Mental Capacity sub-group, Safeguarding Adult Review sub-group and an Executive Sub-group. Each sub-group produces its own business plan which is monitored and driven through the Executive Sub-group and overseen by the Board itself whose responsibility it is to monitor progress and unblock inhibitors.

7. **Strategic Priorities:** The 2015/16 Strategic priorities of the SSASPB were i) to embed the requirements of the Care Act 2014 (in relation to Safeguarding Adult Boards), ii) to review the Transition process between Children and Adult Services and iii) to understand what issues exist with regard to Leadership in the Independent Care Sector.

8. **Terms of reference and membership**: During the reporting period the Board and its sub-groups have developed agreed terms of reference and a consistent membership which reflects the broadness of the partner agencies. Together with the statutory partners (Local Authorities, Health and Police) there are representatives from Healthwatch, Staffordshire Fire and Rescue Service, West Midlands Ambulance Service, Staffordshire and West Midlands Probation Trust, Her Majesty's Prison Service, District Councils, VAST, Staffordshire Association of Registered Care Providers, Domestic Abuse and Hate Crime partnerships.

9. **Budget:** The SSASPB is reliant on the contributions it receives from member agencies and the SSASPB is funded through a multi-agency budget. The partnership funding for 2015/16 was £112,500.

Current challenges:

10. The challenges facing the SSASPB are made out in the attached Annual Report between pages 7 and 14. In brief:-

    a. The speed of progress with the 'Transition' and' Leadership in Care Home' Strategic Priorities was slower than expected. Following the Board Development Day held on 8th January 2016 the Board agreed to move to a three year strategy to allow further scoping and making delivery much more realistic.

    b. Prior to the January 2016 Board meeting the Executive Sub-Group had considered progress towards delivery of the Care Act 2014 requirements and found that all were delivered except for those requiring community engagement. This is an area of challenge for the Board and it was agreed that 'Engagement' would become one of its Strategic Priorities from April 2016.

    c. The Board acknowledged the challenge in the cultural change required to consistently ensure a Making Safeguarding Personal (MSP) approach within agencies and have been seeking assurances and evidence from partners which demonstrates commitment to it.

    d. The Care Act 2014 compliant 'Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry Procedures' are to be distributed in an electronic version only for the first time. The Board will be seeking assurance that these are readily accessible and promoted within partner organisations for use by front line practitioners.

    e. The extension of the definition of Domestic Abuse into wider family relationships has led to a number of referrals for Domestic Homicide Reviews (DHRs) where there may be a safeguarding element. The Board has worked with connected partners to ensure that the Safeguarding Adult Review (SAR) sub group is notified of potential DHRs and has the opportunity to consider whether a safeguarding element exists and ensure that it is considered throughout the review process. This approach will need to be formally ratified in the SAR Protocol during 2016/17.

    f. The provision of a Board approved E-Learning Adult Safeguarding Awareness training package had limited uptake and has therefore not been cost-effective. A decision has been taken not to continue to offer this methodology and instead make the Board approved packages more widely available for delivery within individual organisations.

    g. During the early stages of the formation of the Mental Capacity Sub-Group there was some uncertainty as to what was required from the Board. The Group has worked through the challenge and is now clearly focused on its important work.

    h. Due to the different partner organisational structures and data collation processes it was difficult to develop a universal performance data set that all

partners could regularly contribute to. Working with partners the Board has been able to identify the information that is available from each agency and has developed a range of tools and guidance to help gather the relevant data to inform safeguarding work

Adult Safeguarding data: A brief overview.

11. There was a decrease in the total number of concerns (previously called referrals) reported; from 4789 in 2014/15 to 4457 in 2015/16 (7%). This has been attributed to the introduction of the Care Act in April 2015 and the revised criteria for safeguarding enquires. The percentage of concerns assessed as meeting the threshold for a Section 42 Care Act Safeguarding Enquiry dropped from 80.4% in 2014/15 to 71.7% in 2015/16. This is considered to be as a result of increased awareness by the Contact Centre who are now more confident to signpost concerns to other, more suitable, routes. Such outcomes include an assessment of need rather than a safeguarding enquiry.

12. There continues to be unavailable data with regard to the source of concerns this is owing to limitations in the data capture of the Care Director IT system. A service-wide upgrade is scheduled for 2016/17 and it is believed that this information will be available in the future with the potential for historical data to be included.

13. The Care Act 2014 introduced new categories of abuse: Modern Day Slavery, Self-Neglect, and Domestic Abuse. IT systems are to be updated to capture these new categories, but it comes with a challenge as Domestic Abuse may also be sexual or physical abuse. The matter is being discussed nationally as it would be unhelpful to report figures where there is double-counting. The introduction of the new categories makes it difficult to make comparisons between pre-Care Act and post-Care Act data.

14. The main source of risk to adults with care and support needs continues to come from those known to them. This has been the trend for 6 years, and IT systems do not currently record the actual relationship to the adult.
With regard to location there are two categories where most reported abuse occurs with 47% occurring in the adult's home and 38% in a social care setting. In the past 3 years the percentage reported in a social care setting has reduced from 43% to 38%.

15. The vast majority of reported concerns are in relation to the adults over 64 with a physical primary support reason (2135), the second largest being adults under 64 with a learning disability (691).

16. **Link to Strategic Plan** – The core aims and strategic priorities support Staffordshire County Council's priority outcomes of people in Staffordshire being healthier and more independent also feeling safer, happier and more supported in and by their communities.

17. **Link to Other Overview and Scrutiny Activity** – The Healthy Staffordshire Select Committee has oversight of the health providers who make a contribution to the Adult Safeguarding Partnership.

18. **Community Impact** –There are clear links with Domestic Abuse, Hate Crime (particularly disability hate crime) and Community Safety. The local authority takes cases to the Court of Protection on a regular basis when it is believed that there is need to take action to protect adults with care and support needs who are at risk of abuse or neglect - and who lack capacity.

Contact Officers:

Stuart James, County Commissioner for Safeguarding, 01785 854805
stuart.james@staffordshire.gov.uk

John Wood, SSASPB Independent Chair, john.wood1@staffordshire.gov.uk

Helen Jones, SSASPB Manager, 07887 822003, helen.jones4@staffordshire.gov.uk

Appendices/Background papers:

Appendix A - Annual Report of the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB)

The Staffordshire and Stoke-on-Trent
Adult Safeguarding Partnership
Abuse must stop

Annual Report 2015- 2016

1. CONTENTS

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

If you suspect abuse or neglect

Phone 0845 604 2719 if the adult lives in Staffordshire

or

Phone 0800 5610015 if the adult lives in Stoke-on-Trent

Board contact details
Staffordshire Place 1
SSASPB (Adult Protection Team)
Stafford
ST16 2DH
SSASPB.admin@staffordshire.gov.uk

2. INDEPENDENT CHAIR FOREWORD

It is my privilege as Independent Chair to write the introduction to this Annual Report. This is my first year as Chair and I take this opportunity to acknowledge the significant contribution of my predecessor Jackie Carnell in building a sound foundation for our work.

The Annual Report provides an overview of the work of the Board and how it is making a positive difference to ensuring that adults with care and support needs who may be at risk of or experiencing abuse or neglect are protected.

Whilst there is a common commitment by safeguarding partners to improving outcomes, in practice this means understanding how to support and empower people at risk of harm to resolve the circumstances which put them at risk. We want to encourage and develop practice which puts the person with care and support needs in control and generates a more person-centered set of responses and outcomes. This means the Safeguarding Adults Board seeking assurances that all those who work with adults know when and how to act when they are concerned about a possible risk and the Board seeking assurances that effective advocacy services are in place for anyone who may need them at any point during a safeguarding episode.

Arising from our learning from the first year since the introduction of the Care Act 2014 there is an increased emphasis on making the actions within the Board Business Plans as specific as possible to ensure that we are clear about the outputs, outcomes and impact that the Board intends to be achieved. This will be an ongoing focus and will further strengthen our ability to quality assure and monitor performance against planned and intended actions.

In my first year as Independent Chair I have been impressed by the energy, commitment and enthusiasm of Board members and the many front line practitioners that I have met and their clear focus on doing their very best for those adults whom we are here to protect from harm.

I would like to take this opportunity to acknowledge the commitment of all of our partners and supporters including the statutory, independent and voluntary community sector who have contributed significantly to the work of the Board during the year. I am particularly grateful to all who chair the Board Sub-Groups and the Board Manager Helen Jones and the Board Administrator Stephanie Kincaid-Banks who work so hard behind the scenes to ensure that our business programme works efficiently.

I look forward to working with you again next year.
John Wood

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

The Care Act 2014 provides the statutory requirements for adult safeguarding. It places a duty on each Local Authority to establish a Safeguarding Adults 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 Adults Board (Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) in this case) is to help and protect adults in its local area by coordinating 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; and
- 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 Adults Board has three primary functions:

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

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 is shown at Appendix 1, at page 38.

The Board is dependent on the performance of agencies with a safeguarding remit for meeting its objectives. The strategic partnerships with which the Board is required to agree responsibilities and reporting relationships to ensure collaborative action are shown in the Governance Structure at Appendix 2, at page 39.

SAFEGUARDING ADULTS – A DESCRIPTION OF WHAT IT IS

The Statutory Guidance 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 at Appendix 3, at page 40. The Board has taken account of the Statutory Guidance in determining the following vision.

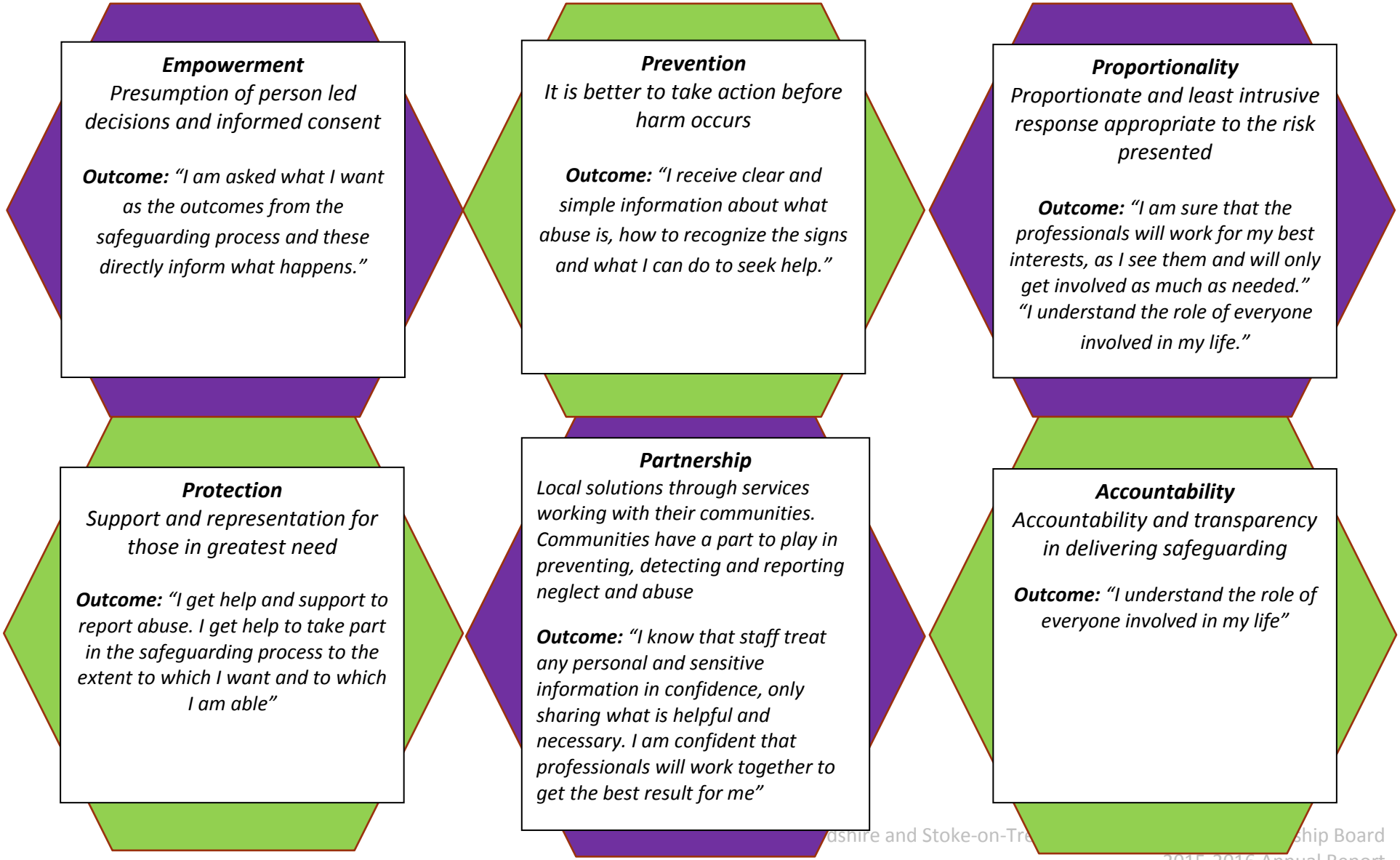
VISION FOR SAFEGUARDING IN STAFFORDSHIRE AND STOKE-ON-TRENT

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

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

4. SAFEGUARDING PRINCIPLES

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



5. KEY ACHIEVEMENTS AND FOCUS OF THE SUB-GROUPS

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

Executive Sub-Group

Chair: Kim Gunn; Lead Nurse Head of Adult Safeguarding (North Staffordshire and Stoke-on-Trent Clinical Commissioning Group)

The Executive Sub-Group has responsibility for monitoring the progress of all of the other Sub-Groups' Business Plans as well as its own work streams which include the development of a Communication Plan and Information Sharing Guidance for practitioners. It ensures that the core functions identified in the Board's Constitution are carried out and that the overarching Strategic Objectives of the Board and the Sub-Group Business Plans are delivered. The membership is made up from the Chairs of the six Sub-Groups, Officers to the Board, the Board Manager and the Board Independent Chair.

The Sub-Group has:

- Led on the delivery of the Strategic Priorities
- Monitored progress towards delivery of the Sub-Group Business Plans, receiving and examining exception reports and escalating matters where appropriate to the Board
- Strengthened links with the Staffordshire Safeguarding Children Board and Stoke-on-Trent Safeguarding Children Board in supporting our Strategic Priority of 'Transition' into adulthood
- Gained assurances from safeguarding partners regarding Care Act 2014 compliance
- Engaged with and received presentations from advocacy services and Public Health England, specifically regarding local issues for adults who use care and support services and carers, including consultation on Public Health's 'Suicide Strategy'
- Reviewed and revised the Communication Plan, Information Sharing Protocol and Escalation Policy
- Led on the consultation for and development of the Board Strategic Plan for 2016-18
- Sought assurance from the two Local Authorities in relation to the Deprivation of Liberty Safeguards (DoLS) backlog resulting from the Cheshire West Supreme Court judgement in May 2014.

Challenges: The speed of progress with the 'Transition' and' Leadership in the Independent Care Sector' Strategic Priorities was slower than expected. Following the Board Development Day held on 8th January 2016, the Board agreed to move to a three year strategy to allow further scoping and to make delivery much more realistic.

Prior to the January 2016 Board meeting the Executive Sub-Group had considered progress towards delivery of the Care Act 2014 requirements and found that all were delivered except for those requiring community engagement. This is an area of challenge for the Board and it was agreed that 'Engagement' would become one of its Strategic Priorities from April 2016.

Policies and Procedures (P&P) Sub-Group

Chair: Stephen Dale; Adult Safeguarding Team Leader (Staffordshire County Council)

The Policy and Procedures Sub-Group has been focused on a major project to ensure the effective implementation of the Care Act 2014 and the requirement to ensure that our local multi-agency policies and procedures reflect the new legislation.

The Sub-Group has:

- Actively engaged with practitioners and training staff in all safeguarding partner organisations to ensure that the needs and requirements of the new 'Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry Procedures' were understood and being complied with
- Organised a large scale post-implementation of procedures event, consulting and engaging with 150 practitioners to gain detailed feedback to identify where revisions were required
- Produced practical, easy to understand and fit for purpose inter-agency safeguarding enquiry procedures – as reflected in the positive feedback from practitioners using them.

Challenges:

The Board acknowledges the challenge in the cultural change required to consistently ensure a Making Safeguarding Personal (MSP) approach within agencies and have been seeking assurances and evidence from partners which demonstrates commitment to it.

The Care Act 2014 compliant 'Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry Procedures' are to be distributed in an electronic version only for the first time. The Board will be seeking assurance that these are readily accessible and promoted within partner organisations for use by front line practitioners.

Safeguarding Adult Review (SAR) Sub-Group

Chair: Mark Dean; Detective Superintendent – Safeguarding (Staffordshire Police)

The Sub-Group has:

- Reviewed and refreshed the Safeguarding Adult Review (SAR) Protocol to ensure it remains compliant with the legislative changes of the Care Act 2014 and refreshed Care Act Guidance. It has been further enhanced through learning from local review processes
- Undertaken/commissioned SARs and learning reviews in accordance with the statutory requirements and SSASPB Protocol to highlight good practice and areas in need of improvement
- Developed and utilised a suite of options to learn from cases, whether they meet the threshold for SAR or not
- Monitored the implementation of recommendations from reviews undertaken by the SSASPB and quality assured the evidence provided by agencies in relation to how actions have been progressed to improve local adult safeguarding arrangements
- Ensured that the SSASPB has an experienced and consistent Scoping Panel, drawn from the core membership of the SAR Sub-Group to enhance the experience and expertise of members
- Invited non-contributing agency SAR Sub-Group members to act as Critical Friends, providing independent scrutiny and challenge, enhancing their experience and ensuring the integrity of the process and its adherence to the SAR Protocol
- Arranged for SAR Sub-Group members to access local and national training and events relevant to their positions within the Sub-Group.

Challenges:

The extension of the definition of Domestic Abuse into wider family relationships has led to a number of referrals for Domestic Homicide Reviews (DHRs) where there may be a safeguarding element. The Board has worked with connected partners to ensure that the SAR Sub-Group is notified of potential DHRs and has the opportunity to consider whether a safeguarding element exists and ensure that it is considered throughout the review process. This approach will need to be formally ratified in the SAR Protocol during 2016/17.

Learning and Development (L&D) Sub-Group

Chair: Shirley Heath; Head of Adult Safeguarding (Staffordshire and Stoke-on - Trent Partnership NHS Trust)

The Sub-Group has:

- Sought assurance from partners through the submission of quarterly training figures which are reviewed by the Learning and Development Sub-Group
- Sought assurance of the quality of training delivery by undertaking a Peer Review process where partners observe each other's training sessions and learn from each other; identifying best practice and giving developmental feedback
- Developed and ratified Adult Safeguarding Awareness and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) packages in line with the Care Act 2014 and the Mental Capacity Act Code of Practice (2005)
- Purchased E-learning licenses for 200 users for use by Private/Independent care providers and District Councils
- Supported Staffordshire County Council in delivering lessons learnt from Safeguarding Adult Reviews (SAR) training
- Sent Board members to two of the Economic and Social Research Council (ESRC) and Safeguarding and Legal Literacy (SALLY) seminars
- Provided for the attendance of the SSASPB SAR Sub-Group Chair at a key national SAR Conference
- Regularly provided information to safeguarding partners on regional and national safeguarding conferences and developmental opportunities
- Developed a draft Training Strategy, which will be ratified beyond the date of this Annual Report in 2016/17.

Challenges:

The provision of a Board approved E-Learning Adult Safeguarding Awareness training package had limited uptake and has therefore not been cost-effective. A decision has been taken not to continue to offer this methodology and instead make the Board approved packages more widely available for delivery within individual organisations.

Burton Hospital NHS Foundation Trust (BHFT)

Safeguarding Adult Level one face to face training is mandatory for all clinical staff at Burton Hospitals (BHFT) with a 3 yearly update and is included in the induction programme for all new starters. Compliance for 2015/16 is 93%. Non-clinical staff receive a signposting session on induction, with a mandatory 3 yearly update through e learning, compliance is 97% for 2015/16.

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training is delivered at BHFT, with a mandatory requirement for clinical staff from April 2016 including 3 yearly update.

Lessons learnt and patient stories are a key part of all safeguarding training and safeguarding operational meetings, in order to cascade and share lessons learnt. This provides assurance and embedding of safeguarding into clinical practice.

Staffordshire Police's organisational training delivery plan includes training for operational officers and staff in relation to adults with needs for care and support. This is complemented by fortnightly themed Public Protection Development Days which enable the opportunity of face to face training for all officers and staff. Throughout 2015/16 themes have included Domestic Abuse and 'Hidden Harm' which has raised awareness of Adult Safeguarding, the Care Act 2014, Mental Health, Human Trafficking and Modern Slavery. This has supported officers and staff in recognising and responding to the signs of adult abuse and neglect.

Staffordshire Police are currently working with the SSASPB to update the Level 1 Adult Safeguarding Awareness training product and to develop the SSASPB endorsed Level 1 package into a 'Computer Based Training' product accessible to all officers and staff. This will complement the planned activity to deliver Adult Safeguarding themed Public Protection Development Days in 2016/17.

Staffordshire County Council (SCC)

The Council's Adult Safeguarding learning and development programme has prioritized equipping staff with the knowledge and skills needed to enable them to undertake their statutory safeguarding duties. Training events, underpinned by the new 'Adult Safeguarding Enquiry Procedures', have emphasised the duty of the Local Authority to consider the physical, mental and emotional wellbeing of people needing care and support. This includes having regard for the person's views, wishes, feelings and beliefs. An aim of training delivered has been to support the cultural change necessary for successful implementation of the Care Act; to encourage workers to adopt a more person centered approach, identifying outcomes that matter to the person and incorporating Making Safeguarding Personal (MSP) into practice.

Training events on Adult Safeguarding Awareness and Mental Capacity Act 2005, combining theory with practical application, have been widely accessed by Local Authority staff and partners; over 70% of attendees represented Partner organisations i.e. Health, Staffordshire Police, Staffordshire Fire and Rescue and workers in the Private, Independent and Voluntary (PIV) sectors.

At the beginning of the year, the Local Authority continued with the delivery of briefings about the Care Act; preparing workers and supporting the implementation of the Care Act 2014 in relation to Safeguarding duties. Following on from these workshops, an extensive programme of events on Adult Safeguarding and the Mental Capacity Act 2005 has been delivered. Training incorporated current legislation, Case Law updates and learning from practice. Awareness events have been supported by more detailed training for workers who may be required to undertake the Section 42 Enquiry and for those with managerial responsibility. There has been an increase in multi-disciplinary attendance at all events. In addition to the planned events, the Local Authority has delivered bespoke training; significantly supporting workers with their understanding of the Mental Capacity Act 2005 and its application to practice.

Stoke-on-Trent City Council (SoTCC)

Our Local Safeguarding Adults Workforce Development Plan is designed to deliver appropriate training for all levels of staff and volunteers commensurate with their responsibilities in the safeguarding processes. In addition:

- All Adult Social Care staff have Safeguarding Adults training that is appropriate to their experience and grade as part of their appraisal objectives.
- Full Care Act 2014 training was rolled out to staff and partners prior to April 2015. Safeguarding under the Care Act has been a key focus within the Adult Social Care service and has been identified in the Community Wellbeing Assessment Service Training Plan.
- Safeguarding training was provided in relation to the Care Act 2014 changes and Making Safeguarding Personal (MSP) principles and Mental Capacity Act 2005 training to staff and providers where appropriate.

South Staffordshire and Shropshire NHS Foundation Trust (SSSFT)

Adult Safeguarding Awareness and Mental Capacity Act (2005)/ DOLS training is a mandatory requirement for all frontline SSSFT Staff. The training is provided via an E-Learning platform making this easily accessible to our staff. This training includes a competency test which provides assurance around the knowledge and skills of our workforce in relation to safeguarding. Individual managers have oversight and responsibility for ensuring and supporting their staff complete this training as required. Regular reports are generated so that non-compliant staff can be identified and sufficient priority given to those individuals during professional supervision in order to ensure that they are practicing with up to date knowledge. In addition SSSFT provide safeguarding updates via the Trusts internal newsletter and discussion forum.

Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs) (South Staffordshire & Seisdon Peninsula CCG, Stafford & Surrounds CCG, East Staffordshire CCG, Cannock Chase CCG, North Staffordshire CCG and Stoke-on-Trent CCG)

Online Adult Safeguarding training level 1 is part of mandatory and statutory training and is provided for all staff when they commence employment with the CCGs. Staff then complete refresher training every three years which is monitored.

The Clinical Commissioning Groups represented by the Safeguarding Lead have maintained ongoing attendance to the Board. Throughout the period we have supported the Sub-Groups and the preparation for the increased challenges of the Care Act 2014. Safeguarding has been maintained as an important activity and we have continued to monitor and respond to clinical concerns raised. The Clinical Commissioning Groups hold safeguarding meetings where we review overall safeguarding activity and responsibilities.

Activity

- Ongoing interaction with the Commissioning Support Unit Safeguarding Nurses who also have oversight and support Adult Safeguarding Section 42 Enquiries within our local nursing homes.
- Ongoing provision of an Adult safeguarding lead, providing support and guidance to CCG staff and local GPs
- Successful joint bid with North Staffordshire and Stoke-on-Trent CCG to fund a Mental Capacity Act awareness raising project including development of a phone App
- Maintained awareness of NHS England updates through national webinars and study days

Key Developments

- Recognition of the need to recruit resource to support the growing adults safeguarding agenda within the multi-agency team
- A particular area of concern is the number of alerts relating to pressures ulcers; the focus has been aimed to increase awareness of correct reporting and investigation routes, reduce duplication and ensure learning is embedded within practice.

Training

- Safeguarding Clinical Lead attended educational and professional development sessions run through the Board for all partners. In addition, has attended NHSE Safeguarding development days.
- Local GPs have received Adult Safeguarding and Mental Capacity Act training provided by our Safeguarding Lead and MCA project Lead which were held across a number of dates to ensure good attendance.
- As commissioners, basic training is required for all Group staff at varying levels. Many of our staff have received basic level 1 training and this is under review to ensure all staff receive training in 2016-17 appropriate to their role.

Priorities and Plans for 2016/17

- A training needs analysis to be undertaken for Group staff to ensure appropriate levels of training are maintained and delivered
- To review of the current Adult Safeguarding Policy to ensure any required amendments are updated
- Provider contracts compliance – to undertake dashboard quarterly reviews and audits to ensure providers are adhering to their contractual obligations in respect to safeguarding
- Introduction of Mental Capacity Act audit for providers.

Staffordshire and Stoke on Trent Partnership Trust (SSOTP) is committed to ensuring that its workforce has the competencies and skills to apply adult safeguarding requirements and Mental Capacity Act 2005 principles. In doing so it has the following arrangements:-

- Adult Safeguarding level 1 training is a mandatory requirement for all staff within the Trust. Training is available via E-learning or taught sessions. Compliance rates are currently exceeding the 90% target set for achievement
- Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training is mandatory every 3 years for all staff who are responsible for care/support/management of patients/service users, via E-Learning. There is a competency framework in place and staff who lead best interest decision-making or complex decisions are required to achieve competency level 3 via taught sessions. E-learning is also available in between as a best practice option. The Trust has improved compliance with training in a short time frame.
- Staff who are required to make Deprivation of Liberty Safeguards referrals are required to attend bespoke training sessions
- Application of training to practice is ascertained via appraisals, supervision, quality visits and a range of audits. Training compliance is monitored regularly and reported via the Trust governance processes.

South Staffordshire and Shropshire NHS Foundation Trust (SSSFT)

Adult Safeguarding Awareness and combined Mental Capacity Act / DOLS training is a mandatory requirement for all SSSFT Staff. The training is provided via E-Learning packages making this easily accessible to our staff group in order to support their on-going development. E-Learning also ensures that compliance with these training requirements is easy to establish. Individual managers have oversight and responsibility for ensuring and supporting their staff group to complete this training as required. Regular reports are generated so that non-compliant staff can be identified and sufficient priority given to those individuals during professional supervision in order to ensure that they are practicing with up to date knowledge.

University Hospitals of North Midlands NHS Trust (UHNM)

All staff working within UHNM undertakes Adult Safeguarding Awareness / signposting training as part of the statutory and mandatory training programme for which we are currently 96% compliant. The training is delivered face to face to all new starters and thereafter staff have access to an E-learning package devised by the Adult Safeguarding Team. Within the training staff are also provided with an overview of the Prevent (Counter Terrorism) strategy and process to follow should they have any concerns.

In addition to the above it is mandatory for qualified front line practitioners to attend level 1 adult safeguarding training which again is provided in house; UHNM are working towards achieving 85% compliance. Adult safeguarding study days are run approximately six times per month and the agenda covers Adult Safeguarding Awareness level 1, WRAP (Workshop to Raise Awareness of Prevent), Dementia Awareness and Mental Capacity Act / Deprivation of Liberty Safeguards.

Mental Capacity Act (MCA) Sub-Group

Chair: Karen Capewell; Strategic Manager (Stoke-on-Trent City Council)

The MCA Sub-Group was formed to address some specific matters in relation to the application of the Mental Capacity Act 2005 and to assure the Board that this was consistent across partner agencies. The MCA Sub-Group has been tasked with raising awareness of the MCA across the partnership and measuring the effectiveness of its application.

The Sub-Group consists of a range of partners who are accountable for implementation and monitoring of the MCA in their respective organisations. Through this approach the membership of the group is able to identify and address the gaps in MCA awareness, application and practice across the partnership.

The Sub-Group has:

- Developed a complex case review process
- Identified MCA themes to audit for policy compliance during 2016/17
- Reviewed the structure and function of the Sub-Group to reinvigorate and refocus our work

Challenges: During the early stages of the formation of this Sub-Group there was some uncertainty as to what was required from the Board. The group has worked through the challenge and is now clearly focused on its important work.

District Council Sub-Group

Chair: David Smith; Principal Officer Communities and Partnerships (Staffordshire Moorlands District Council)

The District Councils Sub-Group serves both the SSASPB and the Staffordshire Safeguarding Children Board (SSCB). Its representatives are made up from Staffordshire District and Borough Councils. There are eight District or Borough Councils as follows: - Cannock Chase District Council, East Staffordshire Borough Council, Lichfield District Council, Newcastle Borough Council, Stafford Borough Council, Staffordshire Moorlands District Council, South Staffordshire Council, Tamworth Borough Council.

District Councils are statutory partners of the Local Children Safeguarding Boards, but they were not included in the Care Act 2014 as a statutory partner for Safeguarding Adult Boards. Nevertheless, the District Council Sub-Group has been a very well attended, enthusiastic and committed Sub-Group.

The Sub-Group has:

- Promoted delivery of level 1 Adult Safeguarding Awareness training to District and Borough Council staff members
- Reviewed and updated the District and Borough council policies to take account of the changes in the Care Act 2014
- Reviewed and updated District and Borough council websites to provide information on safeguarding, including promoting the work of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board.

Performance, Monitoring and Evaluation (PM&E) Sub-Group

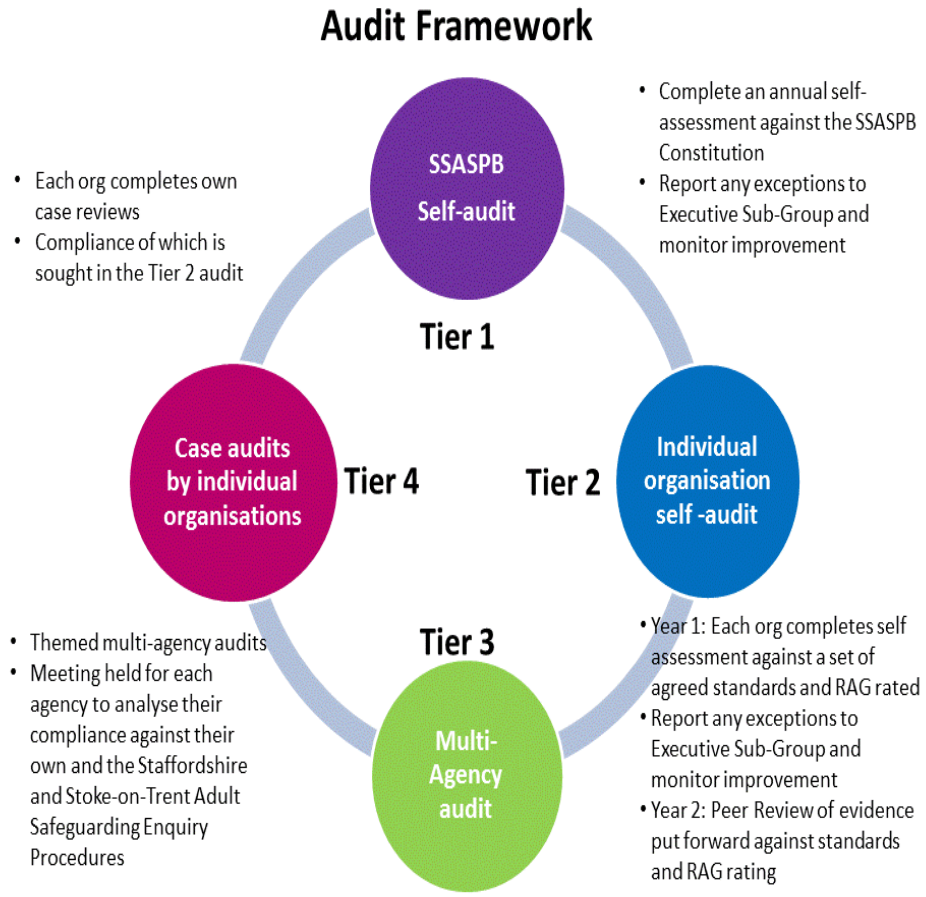
Chair: Sharon Conlon; Safeguarding Lead (South Staffordshire & Shropshire Healthcare NHS Foundation Trust)

It has been a challenging year for the Sub-Group, in part as a result of the implementation of the Care Act 2014 which has prompted the need for a revision of the performance indicators needed to support the assurance of functionality and success of safeguarding activity and also Staffordshire County Council's transition over to a new case management system which created some challenges for data collection.

During the course of the year the Board, through the Independent Chair, negotiated an arrangement for a Performance Manager to provide the performance requirements of the Board through a shared, collaborative Service Level Agreement with the two Local Safeguarding Children Boards in its area. There is more developmental work to be done in 2016/17 but the early indications are that this approach will deliver mutual benefits.

The Sub-Group has:

- Refined the tiered audit model (see Audit Framework diagram)
- Developed and negotiated approval for the introduction of an organisation audit tool to assess compliance with safeguarding requirements and an associated peer review process. Guidance notes have also been produced and approved by the Board.
- Overseen the gathering of the performance information for this annual report starting on page 17.



Challenges:

Due to the different partner organisational structures and data collation processes it was difficult to develop a universal performance data set that all partners could regularly contribute to. Working with partners the Board has been able to identify the information that is available from each agency and has developed a range of tools and guidance to help gather the relevant data to inform safeguarding work.

6. PERFORMANCE AGAINST 2015/16 STRATEGIC PRIORITIES

In the reporting period (April 2015 to end of March 2016) the three Strategic Priorities were:-

- Embedding the requirements of the Care Act (in relation to Safeguarding Adult Boards)
- Transition between Children and Adult Services
- Leadership in the Independent Care sector

Reports against Strategic Priorities have been a standing agenda item at the Executive Sub-Group and Board meetings with progress monitored against an action plan. A summary of progress and achievements is outlined below:

Care Act 2014

The SSASPB has worked to an Action Plan to prepare for the requirements of the Care Act 2014. This was a significant piece of work which was delivered using the Statutory Guidance. Progress was driven through the Executive Sub-Group and monitored by the Board.

At the January 2016 Board meeting it was reported that all standards were met other than those connected to community and service user engagement. The Board took the decision to have 'Engagement' as one of its Strategic Priorities for 2016-2018.

Transition

This Strategic Priority has a three year delivery timescale, led by the SSASPB and supported by both the Staffordshire Safeguarding Children Board and the Stoke on Trent Safeguarding Children Board.

In this first year the Board identified gaps in support and service for those young people who were in receipt as a child, but who did not meet the threshold for support by adult social care and health services.

Seven groups (or cohorts) of young people were proposed and for each one a focus group tasked to discuss where the gaps were. At the end of the reporting period work is continuing to identify the next steps the Board needs to take and will be reported upon in the 2016/17 Annual Report.

Leadership in the Independent Care Sector

This theme has a three year work programme and in the reporting period the Board has considered how this will be translated into meaningful and achievable local activity; and what the Board will focus on, as part of its assurance function. Through the Safeguarding Adult Review Sub-Group key themes which are considered to demonstrate examples of effective leadership - or lack of it - have been identified through scrutiny of Large Scale Enquiries (LSEs) led by Staffordshire County Council and Stoke-on-Trent City Council.

7. SAFEGUARDING ADULT REVIEWS

For the period April 2015 to March 2016 there is one Safeguarding Adult Review (SAR) to be reported upon.

Patient S was a 44 years old woman with known learning disabilities. She lived independently with a support plan and carers visiting. The woman was known to an acute provider's Safeguarding Adults team. She was admitted to hospital in July 2013 with a history of vomiting and weight loss.

Medical enquiries did not identify any organic cause of her symptoms. Whilst in hospital the woman refused all food, oral medication, and at times fluids. She was reviewed by liaison psychiatry, social services and dieticians at differing times during her stay in hospital and early in August 2013 was sectioned under Section 5.3 of the Mental Health Act 1983. She died five days later and her death was reported to the Coroner.

A Safeguarding Adult Review which involved two Health Trusts commenced in December 2013. Although the organisations shared their findings and learnt lessons in real time there has been some delay in the report publication due to protracted police investigations.

The **key learning points** from the Safeguarding Adult Review were the need for improved:

- ***Information sharing between multi-agency/multi-disciplinary Professionals***
- ***Understanding of the Mental Capacity Act 2005 and the Mental Health Act 1983 (as amended in 2007)***
- ***Pathways and policy regarding nutritional needs of patients***
- ***Recognition of the complex needs of S and referrals to specialist safeguarding teams***
- ***Recognition of malnutrition and***
- ***The consideration of specialist capability within the Trust for patients with a learning disability***

S had complex needs which required a coordinated and consistent approach. This consistency was compromised by the number of professionals who cared for her, all of whom saw S for small periods of time. Although they all contributed to the patient notes a joined up approach was lacking.

It is apparent that many professionals in their specialist fields endeavoured to follow best practice to care effectively for S but were hampered by their lack of collaboration and understanding of the Mental Capacity Act 2005 and Mental Health Act 1983.

For positive outcomes and the patient experience to be improved, clinicians at all levels need to have a requisite understanding of the Mental Capacity Act 2005 and the Mental Health Act 1983 and when each should be applied in practice. Progress against the multi-agency SAR Action Plan is monitored through the SSASPB SAR Sub-Group. The Group are also considering the roles of the Clinical Commissioning Group (CCG) led Clinical Quality Review Meetings (CQRM) to provide additional monitoring and scrutiny of this Action Plan.

8. ANALYSIS OF SAFEGUARDING DATA

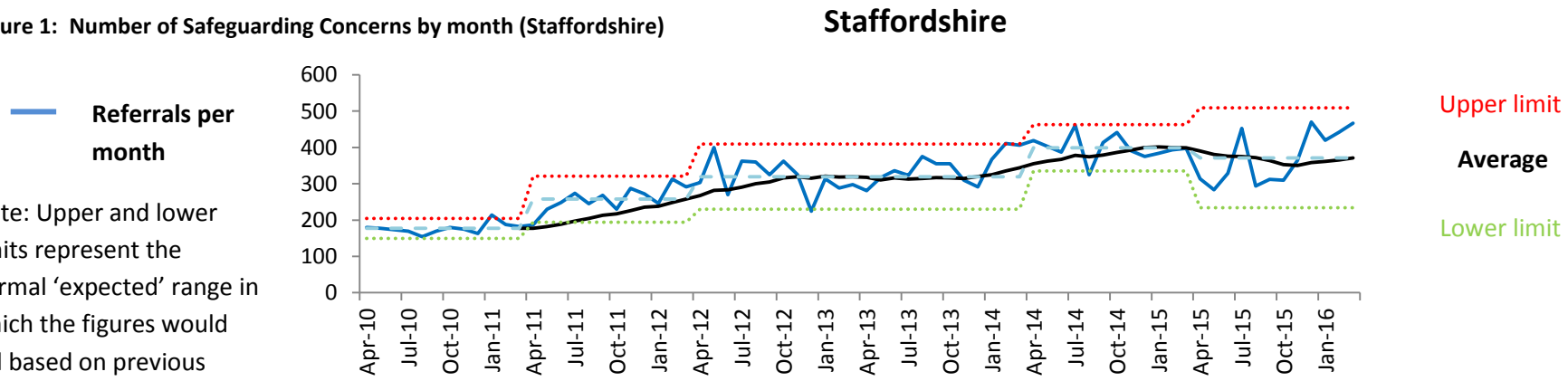
The introduction of The Care Act 2014 in April 2015 has resulted in a number of changes to safeguarding adults' terminology as listed below;

Previously under 'No Secrets Guidance'	Care Act 2014
Vulnerable adult	Adult at Risk
Alleged Perpetrator	Potential Source of Risk
Safeguarding Alert	Safeguarding Adult Concern
Safeguarding Referral	Section 42 Enquiry
Serious Case Reviews	Safeguarding Adult Reviews

This section provides a commentary and analysis of safeguarding data for 2015/16 from Staffordshire and Stoke-on-Trent with graphical illustrations of trends where appropriate.

i. Number of Safeguarding concerns received by month

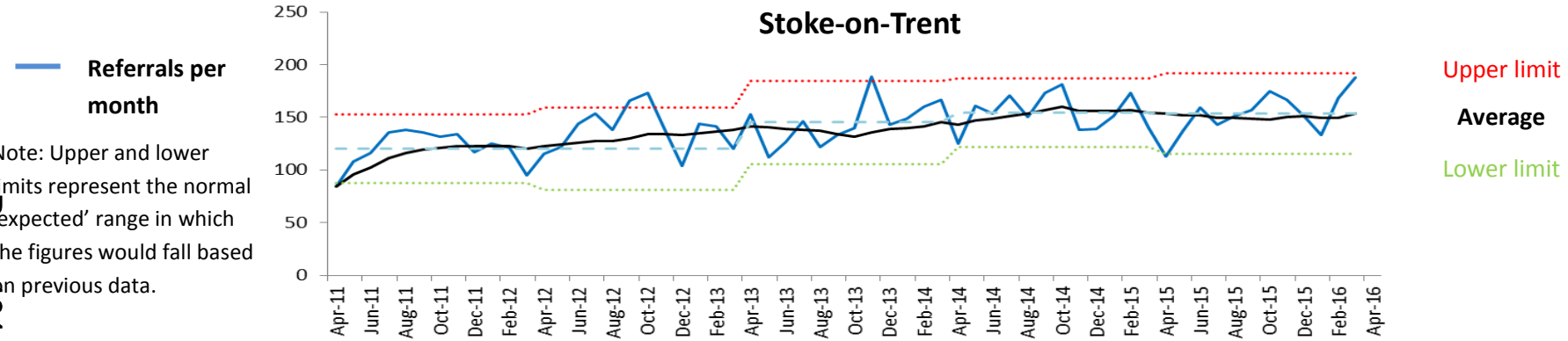
Figure 1: Number of Safeguarding Concerns by month (Staffordshire)



Note: Upper and lower limits represent the normal 'expected' range in which the figures would fall based on previous data.

Staffordshire: Figure 1 evidences the random distribution of the number of safeguarding concerns received in Staffordshire on a month by month basis. Whilst a comparison with previous years data does not identify seasonal trends, significant fluctuations can be partly explained either by periods of concentrated safeguarding awareness raising or when other processes highlight areas of concern for deeper investigation such as where there are clusters of concerns around Large Scale Enquiries (LSEs) where each person resident in a care home is recorded as a safeguarding concern.

Figure 2: Number of Safeguarding Concerns by month (Stoke-on-Trent)



Note: Upper and lower limits represent the normal 'expected' range in which the figures would fall based on previous data.

Stoke-on-Trent: Figure 2 shows that the average numbers of concerns in Stoke-on-Trent, around 155 per month, have been similar over the last 2 years. The upper and lower limits for 2015/16 are wider as the variation in monthly referrals is greater than in 2014/15. Some of the reasons for these variations include the commencement of Large Scale Enquiries where we see a spike in safeguarding activity, a change in internal organisation and management of workflow (initial dip in April 2014) and the implementation of the Care Act in April 2015 where the dip experienced is reflective of the national picture.

ii. Numbers of Safeguarding concerns meeting the threshold for a Section 42 Enquiry

Figure 3: Comparative of Number of concerns raised and numbers meeting the threshold for Section 42 Enquiry

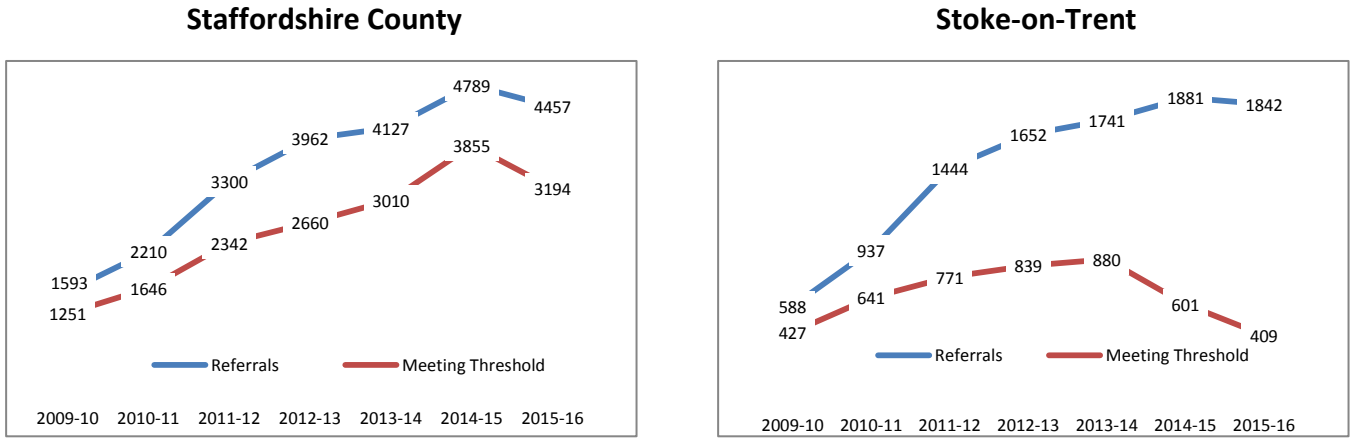


Figure 3 shows that during 2015/16 there was a reduction in the total number of recorded safeguarding concerns in both Staffordshire and Stoke-on-Trent which halts a trend in annual increases. This is in part explained by the introduction of the Care Act 2014 with the revised criteria for Safeguarding Section 42 Enquiries.

Staffordshire County

In Staffordshire the numbers of concerns meeting the threshold for Enquiry had increased annually between 2010 and 2014, but in 2015/16 the numbers fell markedly; at the end of 2015/16 the rate of the concerns reported meeting the threshold was 71.7% compared to 80.4% in the previous year. A key reason for this is the significant work undertaken within the Contact Centre where professionals determine if cases should be signposted to other more suitable routes, for example, where there is no concern regarding abuse but where there is a need for an assessment of need.

Stoke-on-Trent

In Stoke-on-Trent the rate of concerns meeting the threshold for investigation was 22.2%; processes in Stoke-on-Trent do not duplicate the additional stage of pre-social work involvement where contacts are triaged as seen in Staffordshire; rather all safeguarding calls are logged as concerns and passed on to a social worker for a threshold decision and therefore there are a lower number of concerns that meet threshold.

There were particularly marked changes during 2014 – 2015 and 2015 – 2016. In April 2014 the Local Authority reorganised the social care teams into a locality based structure in preparation for the Care Act 2014 which came into force in April 2015. Both of these changes to practice contributed to the reduction in the number of concerns that met the threshold for a section 42 enquiry. The conversion rate for Stoke-on-Trent is in line with the average for West Midlands Local Authorities (26%).

It is important to note that just because a concern does not lead to a Section 42 Enquiry it should not necessarily be considered as an 'inappropriate' social care referral as the number of concerns that are progressed to a Section 42 Enquiry are more indicative of the varying processes within Local Authorities, i.e. the managing of cases, variation in recording systems and appropriate signposting to alternative means of addressing concerns such as care assessment, review and complaint processes which are undertaken by Social Care staff.

iii. Number of Safeguarding Concerns received by Source of Referral

Figure 4: Source of concern over the past 3 years

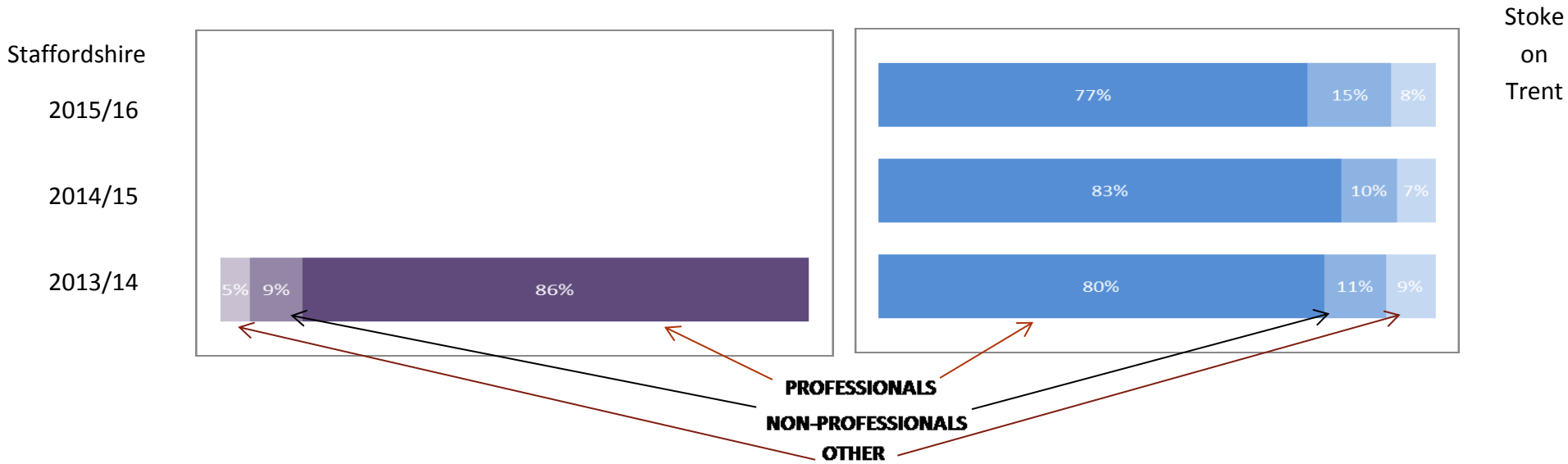


Figure 4 illustrates that concerns from both Staffordshire and Stoke-on-Trent have come predominantly from professionals. Due to the limitations of the Staffordshire County Council Adult Social Care case management system the referral source cannot currently be identified for individual safeguarding concerns and has not been collected since 2013/14. A service wide upgrade is scheduled in 2016-17 and Staffordshire County Council will refresh what data the revised management system is able to capture once this has been completed.

In Stoke-on-Trent the majority of concerns are referred by Health and Social Care professionals, mainly based in the community and many from within the private sector i.e. statutory social care staff, care homes, domiciliary care agencies etc. This seems to indicate a good level of education, awareness and reporting mechanisms across the social care sector.

However, in 2015/16 Stoke-on-Trent reported an increase in concerns recorded from non-professionals. The increasing contact from non-professionals coincides with the Board's engagement in a number of awareness raising events and the production and distribution of promotional material across the Staffordshire and Stoke-on-Trent area.

iv. Service user profile

Ethnicity

Where ethnicity had been stated, the majority of individuals for whom concerns had been made in 2015/16 were categorised as 'White British' 94% in Staffordshire and 92% in Stoke-on-Trent reflecting the populations in the latest census returns (March 2011).

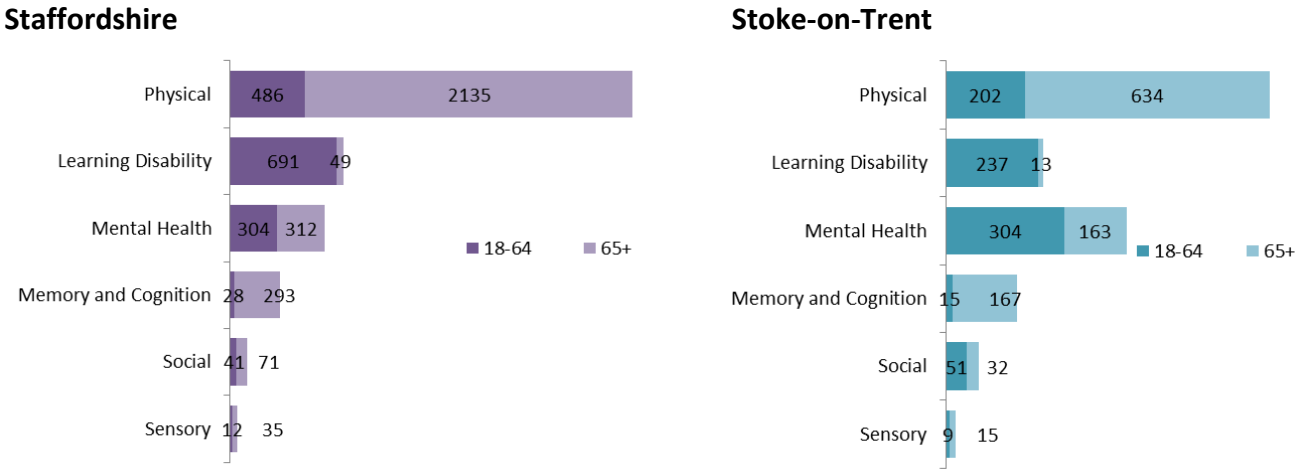
Stoke-on-Trent has seen an increase in safeguarding concerns for of adults of Pakistani origin over the last three years. Although still under represented Stoke-on-Trent has seen the proportion of Safeguarding Section 42 Enquires that are for adults of Asian ethnicity doubled, this was previously 1.9% and is now 3.7%. As there is a significant difference in the population of 'White British' and minority groups such as 'Pakistani' residents, any concerns could potentially appear to be a significant increase, particularly if multiple concerns are submitted for one or two individuals and should be taken in context. An increase in reporting would not be surprising in view of the general demography of the area. However, at this stage, on the basis of the information available any wider conclusions would be premature.

The Board needs to continue to improve engagement with black and minority ethnic groups. Work will be undertaken during 2016/17 through the implementation of the Communication and Engagement priority to raise awareness amongst diverse communities of the importance of safeguarding adults and to promote and encourage the recognition and reporting of abuse and neglect or potential abuse. The Board will continue to promote its key messages at awareness raising events, using a variety of communication methods and materials.

Primary Support Reason (PSR)

Figure 5 shows for 2015/16 all safeguarding concerns by age group and Primary Support Reason (PSR). Historically the largest number of concerns in Staffordshire and Stoke-on-Trent relate to people with physical support needs with the majority of those being aged 65 and over.

Figure 5: Number of referrals by primary support reason and age for 2015/16



In Staffordshire the second largest number of concerns continues to be received for adults aged 16 – 64 years with a learning disability as their primary need. People with a learning disability are more at risk in situations where they may be befriending strangers or misinterpreting social situations, which exposes them to abuse or potential abuse. In Stoke-on-Trent the second largest number of concerns continues to be received for adults aged 16 – 64 years who have a primary need related to Mental Health.

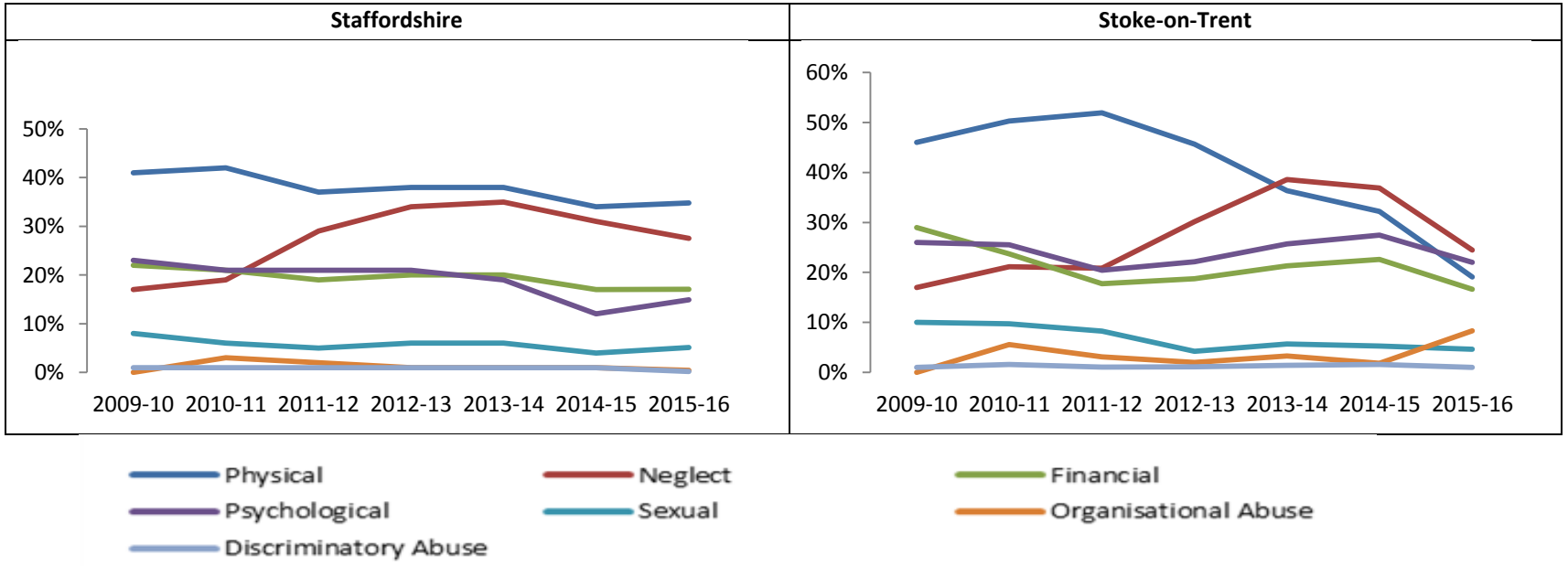
v. Categories of abuse; concerns by type of abuse

Figure 6 on the following page demonstrates how the **proportion of concerns** for each alleged type of abuse has changed over the last five years in Staffordshire and Stoke-on-Trent.

The Care Act 2014 Statutory Guidance identifies ten categories of abuse: **Physical, Sexual, Financial, Discriminatory, Neglect, Self-neglect, Emotional abuse, Organisational abuse, Domestic abuse and Modern slavery.** The addition of several new categories has been acknowledged

by Local Authorities and the collation of data is being revised in order to be able to provide assurance going forward.

Figure 6: Type of alleged abuse



The reason for the change in picture for Stoke-on-Trent is that they now only record the primary category of concern to each case whereas previously multiple categories could be selected; this has been implemented as choosing more than one category could affect data and give a false impression of caseloads and outcomes.

Allegations of physical abuse and neglect have remained the two most common reasons for referrals in both areas however, since 2012 Stoke-on-Trent has seen a continued reduction in concerns for physical abuse alongside an increase in concerns for neglect. Although neglect concerns appear to reduce in 2015/16, this was still the most common reason for referral last year and the reduction is largely attributed to the increase from seven to ten categories of abuse and neglect following the Care Act 2014, meaning alternative categories, such as organisational abuse may have been chosen as the primary concern.

The key trend continues to be the increase in the proportion of concerns that are raised in relation to neglect and this is directly connected to the numbers of allegations involving paid staff. The raised awareness of the need to challenge poor and unsafe care alongside better reporting of abuse and neglect is partly responsible for this continued trend, as is the perception of neglect as being something that goes beyond sub-

standard care and the failure to meet regulatory standards.

Caution should be exercised in over-interpreting the types of abuse, as these are subjectively defined and most abusive incidents involve more than one form of abuse. The data is mostly derived from that which is required for national statistics and this is essentially quantitative in nature and focuses on activity rather than outcomes; it is also heavily dependent on the client record systems for the Local Authorities and these can have an effect on the presenting amalgamated data when this is placed beside that of other authorities. This does lead to inconsistencies, even in neighbouring council areas, and this is also reflected regionally and nationally.

The new recording systems may partially explain why there has been a change in the profile as concerns are recorded differently e.g. recording 'domestic abuse' may lead to a reduction in concerns recorded as 'physical' or 'psychological'. The Board will seek to work with Local Authorities to gain a better understanding of local trends to ensure declines are reviewed in context and do not provide false positives.

The inclusion of new categories of abuse in the national reporting system will mean that it will be difficult to compare pre Care Act and post Care Act classifications. Additionally, the drive for a more personalised response to abuse may lead to even greater difficulties in interpretation in the medium term as the Board and the Local Authorities seek to clarify the key indicators and performance measures. Additionally, the inclusion of new categories of abuse in the national reporting system based on the revised statutory guidance to the Care Act 2014 will mean that it will be difficult to make meaningful comparisons with past data.

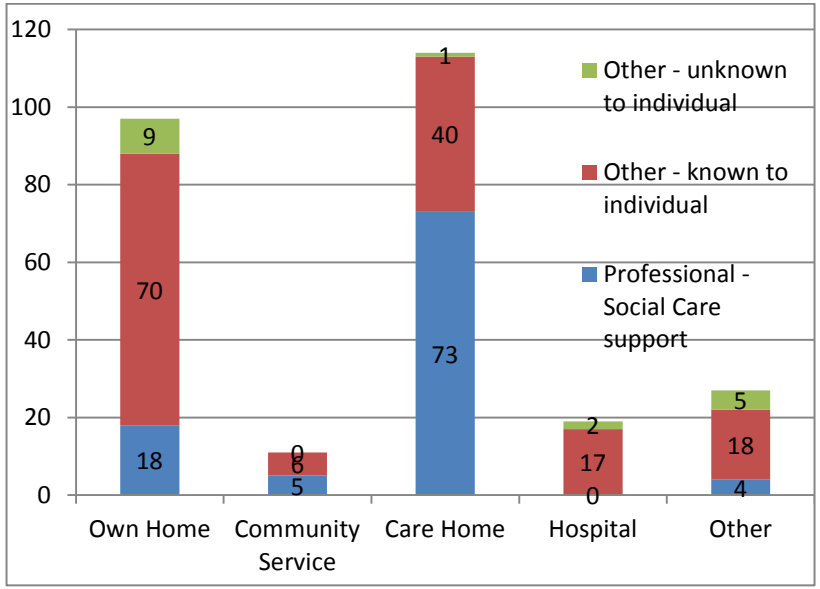
vi. Concerns by source of risk and location

Source of risk

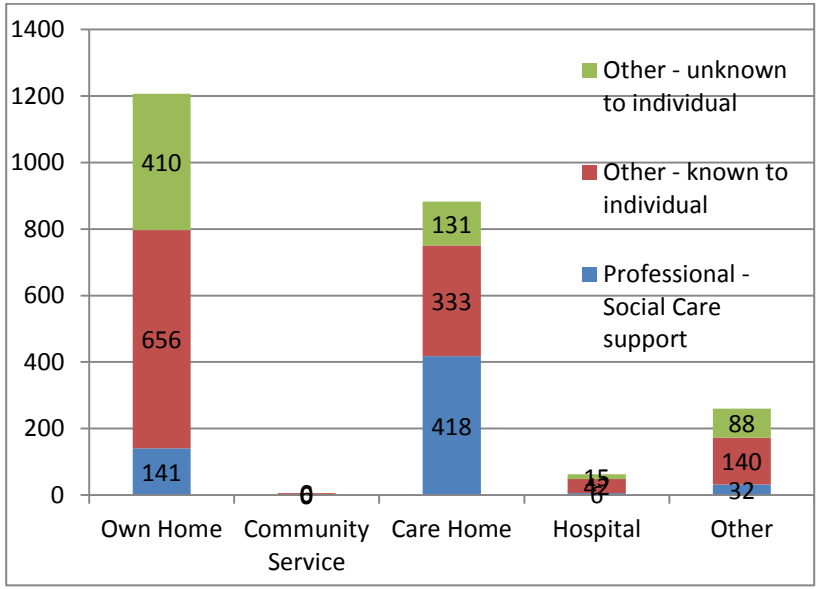
Figure 7 illustrates the proportion of alleged perpetrators of abuse categorised into three groups. *Professionals* e.g. Health care or social care workers for both local authority and the private, independent and voluntary sector, *Other – known to individual* such as family or friends and *Other* – not known to individual e.g. where the source of risk is not known or a stranger.

Figure 7: Sources and location of harm

Stoke-on-Trent



Staffordshire

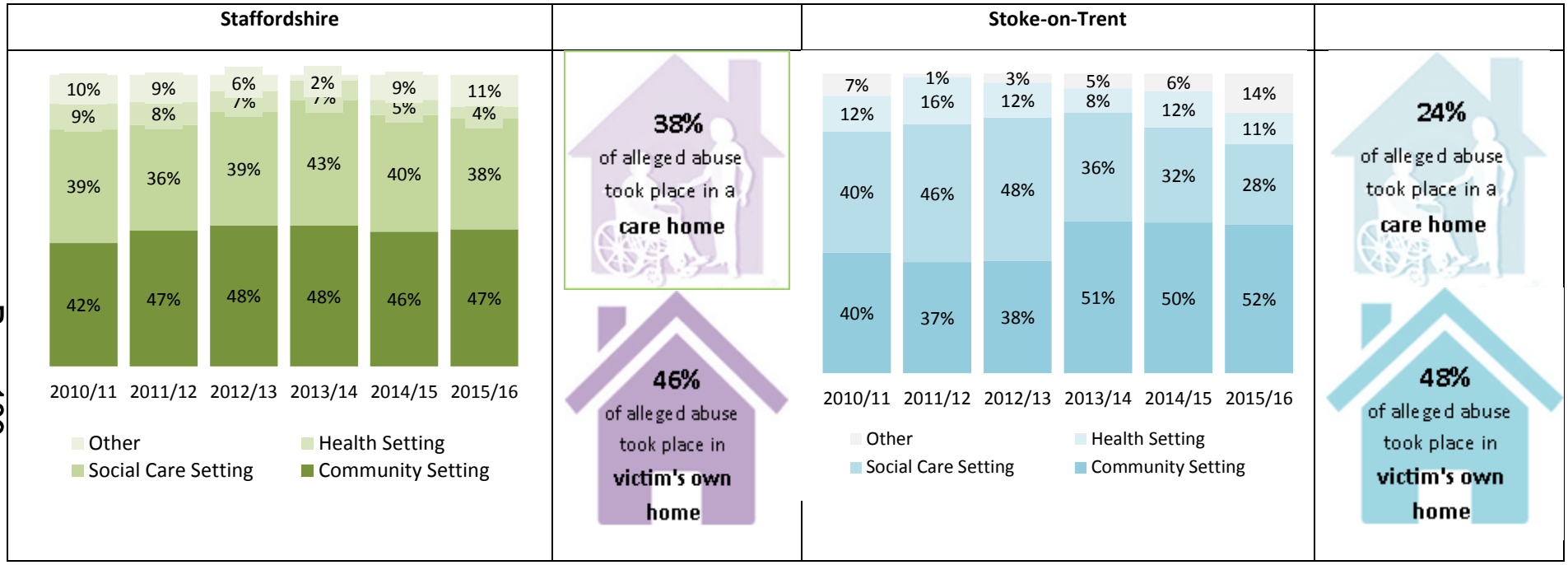


Individuals that are known to the adult remain the most common source of risk across both areas, a trend that has continued over the last six years. Staffordshire and Stoke-on-Trent Adult Social Care case management systems do not currently record the specific relationship between the source of risk and the service user.

Location of alleged abuse

Figures 7 above and 8 below provide an overview of the location of alleged abuse over the last six years.

Figure 8: Location of abuse



Since 2013/14 Stoke-on-Trent has seen an increase in the number of cases occurring within a community setting, more specifically this relates to an increase in cases within the adult's own home. There have also been notable reductions in the number of cases within social care and health settings.

In Staffordshire, proportions have remained relatively similar to those seen over the previous two years, although it must be noted that the increase in cases within a social care setting, which relate specifically to incidents in care homes, have reduced during 2015/16.

The location of alleged abuse or neglect is monitored to identify areas for further investigation, however there is limited value in collating data around the location of 'substantiated abuse' as abuse is naturally more apparent and observed in some settings; for example, there are more

often than not multiple witnesses to a service user's abuse of another service user but it is more difficult to substantiate allegations of abuse in an adult's own home.

vii. Outcomes of concerns

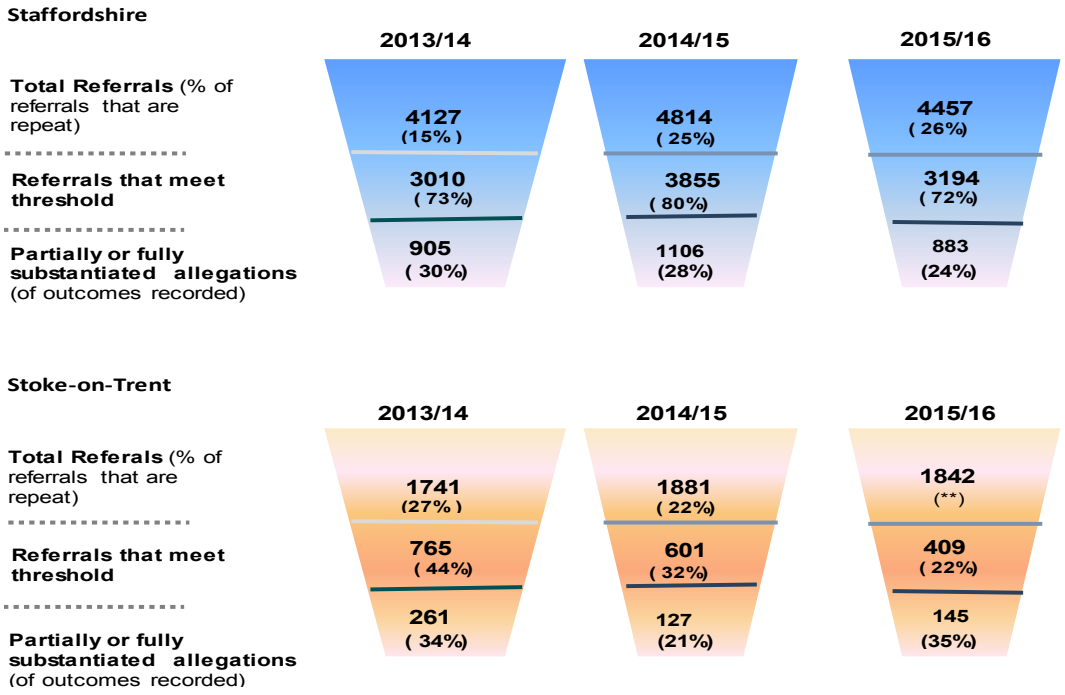
In view of the introduction of statutory criteria last year it may not be possible to directly compare 2015/16 outcomes data with previous years even though the data looks broadly similar. Figure 9 shows the proportions of concerns that met threshold for a Section 42 Enquiry and those partially or fully substantiated, and illustrate how trends have changed over the last three years in Stoke-on-Trent and Staffordshire.

During 2015/16 Stoke-on-Trent received a similar volume of concerns yet a smaller percentage than in previous years hit the threshold for a Section 42 Enquiry. Of those that met the threshold, a higher percentage was found to be substantiated (35%) i.e. where an outcome had been recorded.

Staffordshire does not follow this pattern as the number of allegations that are substantiated is lower than in 2014/15. The lower threshold can be explained as the process for measuring threshold differs between the two Local Authorities. In Staffordshire there is an additional stage where contacts are triaged prior to social work involvement, whereas within Stoke-on-Trent all safeguarding calls are logged as concerns and passed on to a social worker for a threshold decision.

Further details about Section 42 Enquiry outcomes can also be found in Figure 10; Outcomes of investigation on page 28.

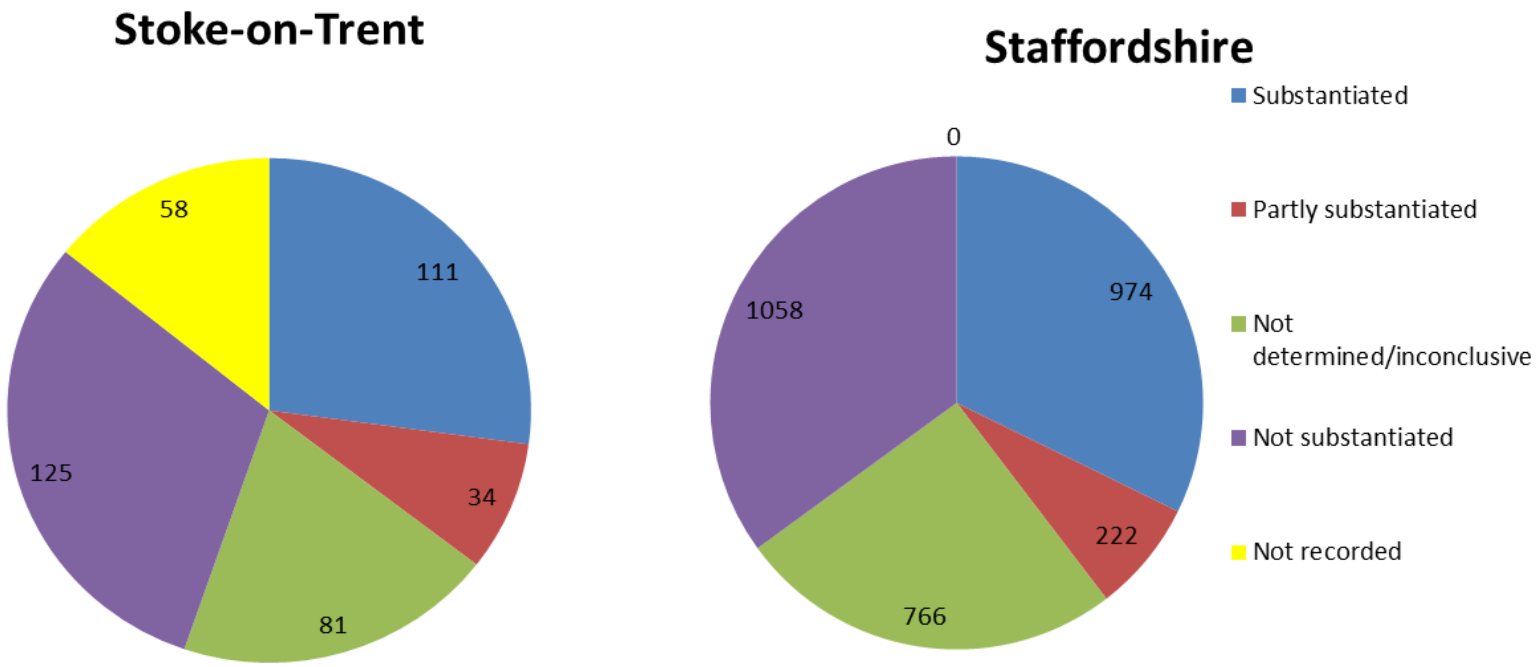
Figure9: Outcomes of concerns



** Stoke-on-Trent % Total Referrals not available for 2015/16

Capturing outcomes data has previously been an issue for Staffordshire County Council but has improved through careful monitoring of data quality. This issue is being continuously reviewed by the Information Technology and Performance Teams. Both Local Authorities provide a suite of data to the Performance, Monitoring and Evaluation Sub-Group of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board for scrutiny to identify risks, trends and identify relevant action for partners.

Figure 10: Outcomes of investigation



9. SAFEGUARDING IN PRACTICE

The following are examples from partner organisations of effective person centred safeguarding in practice; (*Names have been changed)

Burton Hospital NHS Foundation Trust (BHFT)

*Margaret is a lady in her eighties whose bi-polar diagnosis had meant that she had been struggling to live in her warden controlled accommodation. Her granddaughter, *Amanda, (who was named as her next of kin) moved Margaret into a residential home which was Amanda's choice and not Margaret's. While Margaret was in the residence a safeguarding concern was raised alleging that she had been physically and verbally abused. As a consequence she was admitted to an Acute Trust in order to enable her to be cared for until alternative accommodation could be found. She had no medical condition which warranted admission to the Acute Trust.

Whilst in hospital concerns were raised by the ward team caring for Margaret that she was constantly trying to call Amanda on the ward telephone and that Amanda had requested the ward staff prevent this from happening. The Adult Safeguarding team was contacted for advice and they attended the ward to speak to Margaret. It transpired that she was suffering financial abuse, with Amanda being identified as the source of risk, which was why she was making the repeated phone calls. Margaret also outlined that her granddaughter had power of attorney over her finances and health and she wished to revoke this.

The Adult Safeguarding team liaised with Margaret's social worker and Mental Health team and a mental capacity assessment was performed which determined that Margaret had capacity with regard to the decision to manage her own finances and the decision of placement on discharge.

The Office of the Public Guardian (OPG) was contacted to clarify the status of the power of attorney in order to take the relevant steps for revocation.

A multi-agency meeting was held at which Margaret was able to choose a care home to be discharged to. A visit to this home was arranged and the senior sister from the ward accompanied Margaret for support.

Once the Adult safeguarding team was involved a multidisciplinary approach lead to the positive outcome for Margaret. This involved collaboration between the Community Mental Health Team, the Trust Mental Health team, social workers, medical team, Office of the Public Guardian and the nursing home team.

Adult Safeguarding Enquiry Team (ASET)

In January 2015, Staffordshire Police and Staffordshire Adult Social Care formed the Adult Safeguarding Enquiry Team (ASET) with police officers working alongside, and co-located with Adult Social Care investigators. The team were created to deal with complex and high risk investigations where adults at risk who were victims of crime were able to be supported by a one touch service leading to positive safeguarding experiences and criminal justice outcomes that took account of their wishes and needs. Bespoke training was provided to the officers covering specialist interviewing and financial investigation followed up with regular multi-agency inputs.

During 2015/16 ASET have dealt with 268 referrals of which 21 have resulted in perpetrators of crime being charged or cautioned. 8 offenders have been convicted at court and a further 7 are awaiting trial. The incidents and offences ASET responded to cover a broad spectrum of offences including complex and protracted investigations.

Some examples of this multi-agency work are as follows:-

- Care worker charged with 8 counts of sexual assault, two on elderly residents (who lacked capacity) and six on fellow carers. He was employed at a large care home in Stoke-on-Trent where he committed all of the offences. He has been convicted at court and sentenced to 12 months imprisonment;
- Care worker at a residential home in Rugeley, ill-treated two residents (who lacked capacity and had complex care needs) whilst providing personal care despite being told to stop by fellow carers. He was subsequently charged and convicted with 3 offences of ill-treatment and sentenced to 26 weeks imprisonment;
- Care worker at a residential home in Lichfield, whilst providing personal care, physically ill-treated two residents by pinching the nose of one and kicking the other. He was convicted at court and sentenced to 12 weeks imprisonment.

The team has played a key role in raising awareness of colleagues to adult safeguarding concerns. They have delivered training to police colleagues and partners within the health and social care sector in relation to the Care Act 2014 and associated legislation. They have supported six Public Protection Development Days entitled ‘Hidden Harm’ delivered by the force to 300 officers and police staff to raise awareness of Adult Safeguarding, the Care Act 2014, Mental Health, Human Trafficking and Modern Slavery and help colleagues to recognise and respond to the signs of adult abuse.

In addition to organisational development, the team also contributes to carrying out work to prevent the abuse of adults at risk. The team developed and delivered a campaign to coincide with national SCAMS awareness month to raise awareness of this type of abuse. A detailed and intensive strategy reached out to some 1.75 million users of Twitter and Facebook and highlighted the signs to practitioners across the organisation.

University Hospitals of North Midlands (UHNM)

A female adult presented to the pharmacy within the University Hospitals of North Midlands (UHNM) to collect her prescription following an out-patient appointment. During general conversation between the pharmacist and the patient it became apparent that she was anxious and distressed. The pharmacist had concerns and therefore tried to engage her further to establish if she could support her in any way. The patient disclosed that she felt suicidal and expressed that she wished to kill herself. The pharmacist tried to determine if she had any support at home for which she divulged that she was alone with an older child away at University. Sadly the patient became more agitated and left the department.

The pharmacist contacted the UHNM Adult Safeguarding Team for advice. The pharmacist was advised to urgently raise a safeguarding concern. The hospital based Social Care Team was contacted who advised that patient was not known to them. Given the nature of the concern raised, a decision was made to share information with Children's Safeguarding at UHNM who then undertook lateral checks.

It was established that the lady had two children one of which was under 18 years old. The Safeguarding Team alerted the Contact Centre that there was a minor living at the same address and that due to information known to the team, that her threats of suicide were valid. A home visit was carried out.

As a result, it was identified that the service user had a Community Psychiatric Nurse (CPN) who supported the multi-agency safeguarding response.

Staffordshire Fire and Rescue Service (SFARS)

In October 2014 the Staffordshire Fire and Rescue Service (SFARS) attended a house owned by an elderly lady named *Barbara. She had confused her alarm clock with the smoke alarm. Barbara was being looked after by her neighbour and her brother. Barbara was hard of hearing and her brother reported that she had early signs of dementia although this had not been diagnosed. Following consultation with the family, SFARS arranged for a specialist hearing alarm to be fitted along with a pendant system. A referral was made to Staffordshire Cares (Staffordshire County Council).

At the end of 2015 the SFARS staff attended a number of emergency calls at Barbara's home and a further referral to social services was made. Barbara was letting pans boil dry and putting toast under the grill and forgetting about them. SFARS were alerted each time by an alarm monitoring company. Barbara was very confused when SFARS staff arrived, constantly asking who we were and why they were there.

On a follow up visit there were further concerns that Barbara had let SFARS staff into the property without asking for identification. It was also noticed that there was personal paperwork (mainly bank statements) left on view. It was discovered that the battery in Barbara's hearing aid had

expired, this was replaced. A safeguarding concern was submitted and, after a joint visit with Social Services, Barbara went into supported living accommodation with the engagement and approval of both Barbara and her family.

Staffordshire and Stoke-on-Trent NHS Partnership Trust (SSOTP)

An elderly man, whist resident in a Staffordshire care home, contracted Methicillin-Resistant Staphylococcus Aureus (MRSA). The SSOTP Infection Control Team were able to determine that the gentlemen had been in the care home for over a fortnight without care plans and with no specific care plan for his urinary catheter. There had also been documented incidents of poor care and delays in getting the patient seen by a GP when he was showing signs of sepsis (severe infection).

The matter was subject to a Section 42 Enquiry (Care Act 2014), and the allegation of neglect around his catheter care was substantiated. The Infection Control Nurse met with staff at the care home and the safeguarding professionals involved and several improvements were put in place with immediate effect. These changes included improvements to record keeping and care planning, catheter care and infection control training sessions which were delivered by SSOTP at the home and well attended by care home staff. Re-audits of Infection Controls were arranged to monitor progress and to ensure that standards have been maintained and are benefitting all the residents in the home. The Local Authority Quality Team are also providing on-going support and monitoring.

10. BOARD DEVELOPMENT AND IMPROVEMENT ACTIVITY

Development Day

Since the Care Act 2014 and its Guidance the Board has taken the opportunity to ensure that it is meeting the new legislative requirements as well as the needs of our diverse communities. During the current reporting period the Board has been transitioning its role and becoming more strategic.

On 8th January 2016 the Board held a Development Day with the purpose to constructively challenge and reflect on what it is seeking to achieve, how this would be done, and to identify business areas that needed more focus and improvement. All partner organisations were well represented and actively engaged in themed workshop discussions. From the deliberations the Board affirmed its ambition to be 'consistently good' at what it does.

Arising from the discussions the following three key themes were identified for development and improvement:

1. **Engagement**

Whilst the Board membership includes representatives from a number of community and voluntary organisations it has not directly engaged with people who have used services in a formal safeguarding process at an individual or strategic level. The Board could obtain valuable input from engaging with those service users that had gone through the process but the current Business Plan actions focus on commissioners and providers. The importance of understanding the many and potentially different concerns of the various groups that make up our local communities was also recognised.

The Board concluded that engagement with service users, professionals, members of the public and its own members was an area for development.

Response: The Board needs to adopt a broad engagement strategy through which service users can shape and influence the Board's priorities, but it also needs to adopt a more targeted approach when seeking to address specific issues. It was decided that 'Engagement' with strands of service users; members of the public; carers' and professionals would be one of the SSASPB 2016/18 Strategic Priorities.

2. **Assurance**

The Statutory Guidance for the Care Act 2014 states at Para 14.133 'Each *local authority must set up a Safeguarding Adults Board (SAB). 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 meet the criteria'.*

The Board recognised that whilst there is evidence in the minutes of Board meetings that there is a healthy level of challenge it was important to be clear as to the areas where it seeks assurance from partner organisations and how that assurance will be obtained.

Response: The Board has embarked upon a programme of challenge and assurance, driven through the Board and the developing performance management and audit functions in all areas of business.

3. Risk Management

Prior to the Development Day the Independent Chair had expressed a desire to have a Board Risk Register. This was subject of a workshop discussion which recognised that strategic risks were not being monitored at Board level. Discussion resulted in a unanimous endorsement of the proposal.

Response: The Executive Sub-Group has developed a Risk Register template which was populated by each of the Sub-Groups and formally approved for use at the April 2016 Board meeting. The Risk Register will be refined according to the experiences from its use during 2016/17.

Internal Audit of SSASPB

In 2014/15 Staffordshire County Council commissioned an internal audit of SSASPB. The objective of the audit review was to assess whether the statutory requirement to establish a Safeguarding Adults Board had been complied with. The review covered the following areas:

- The SSASPB Constitution complies with statutory requirements;
- Board work fits in with strategic partnership working across the County Council;
- Governance arrangements are robust and effective;
- There are adequate business planning arrangements in place; and
- A performance management framework has been established against which performance is routinely reviewed.

The scope of the audit was limited to the systems and controls in place over the operation of the SSAASPB.

An overall audit opinion of 'Adequate' assurance was given with no significant issues for management or audit committee being raised. There were 5 medium risk and 4 low risk recommendations. Most of the recommendations had already been highlighted as matters for attention, arising from the discussions at the Development Day in the month prior to audit, and were being addressed.

11. MESSAGES TO COMMISSIONERS

Throughout the year Sub-Group Chairs have been asked to identify messages to convey to Commissioners as identified through their Sub-Group activity. The following were forwarded for inclusion in this Annual Report.

From the Learning and Development Sub-Group

Commissioners should monitor the compliance rates of their provider organisations in relation to training provided and the impact on practice in relation to Adult Safeguarding; Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

From the Mental Capacity Act (MCA) Sub-Group

Commissioners need to be assured that there is a sound understanding of Mental Capacity Act legislation and that it is applied in practice.

Policies and Procedures Sub-Group

The financial pressure on some local care providers is now extreme and this may not be conducive to positive and safe care for service users. This is demonstrated by the increased rate of service failure and the significant difficulties in identifying good leadership in some services. Quality monitoring in the independent care home sector is a powerful proxy in terms of safeguarding surveillance, harm reduction and prevention. Poor quality care has a substantial impact upon safeguarding practice. Commissioners of health and social care packages should ensure that adequate quality monitoring systems are in place to assist this.

Safeguarding Adult Review (SAR) Sub-Group

Commissioners should ensure that their providers are cognisant of lessons learnt, as identified through Safeguarding Adult Reviews and other learning review processes. Commissioners should seek assurance that learning is routinely used to improve practice.

12. FINANCIAL REPORT

Board resources include a dedicated core team who support and facilitate the work of the Board and Sub-Groups. Board members have the responsibility to deliver the Strategic Priorities, objectives and Sub-Group Business Plans with ownership retained at formal governance level.

This team and business activities were funded in 2014/15 through contributions from statutory partners and health providers as detailed in the financial report below.

Income

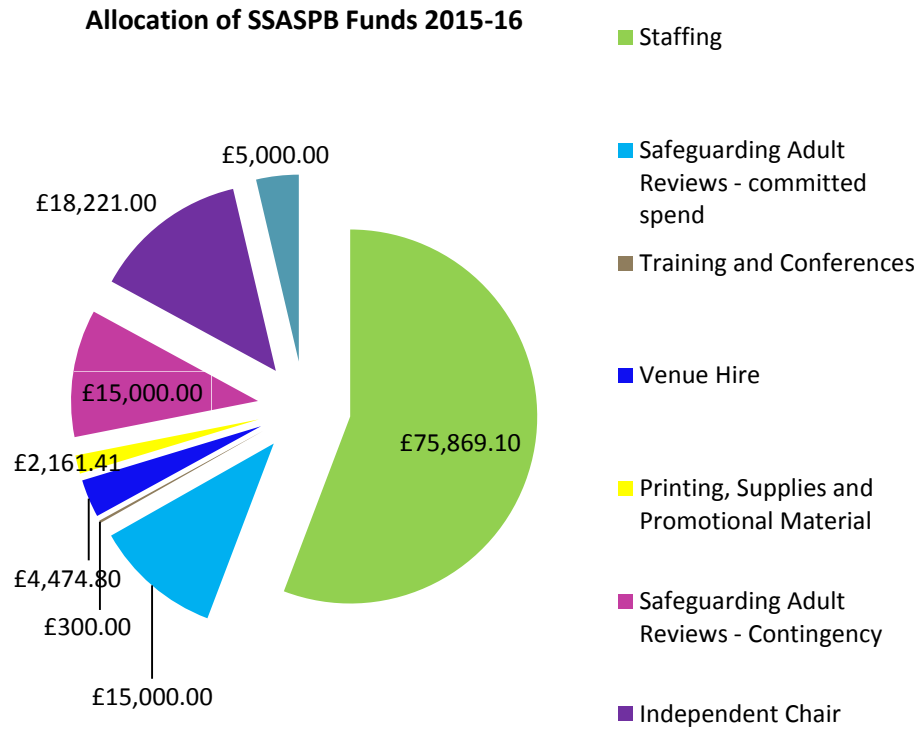
Organisation	Amount
Burton Hospital NHS Foundation Trust	£12,500
North Staffordshire Clinical Commissioning Group	£ 9,375
North Staffordshire Combined Healthcare Trust	£12,500
South Staffordshire Clinical Commissioning Group(s) (South Staffordshire & Seisdon Peninsula CCG, Stafford & Surrounds CCG, East Staffordshire CCG, Cannock Chase CCG)	£18,750
South Staffordshire & Shropshire NHS Foundation Trust	£12,500
Staffordshire and Stoke on Trent Partnership NHS Trust	£12,500
Staffordshire Police	£12,500
Stoke-on-Trent Clinical Commissioning Groups	£ 9,375
University Hospitals of North Midlands	£12,500
TOTAL	**£112,500**

Other income

The Board agreed that as in previous years the 2015/16 contributions from Staffordshire County Council and Stoke-on-Trent City Council would be provided through delivery of a training programme accessible to all partner agencies. The programme includes a range of level 3 training sessions around assessing capacity and making best interest decisions, the chairing and minuting of safeguarding meetings, completing and managing investigations and more.

The Board thanks the below agencies for their further 'in kind' contributions during 2015/16:

- Staffordshire Fire and Rescue Service for providing facilities for SAR scoping panels and Board meetings throughout the year.
- Other agencies providing meeting facilities without charge include Staffordshire Police, Staffordshire County Council and Stoke-on-Trent City Council.



During the year expenditure totalled more than the income received from partners. The Board had budgeted for this and decided before the start of the year to utilise part of the financial surplus from 2014/15.

13. APPENDICES

Appendix 1: Board Partners

Statutory Partners as of 31st March 2016

- Local Authorities
  - Staffordshire County Council
  - Stoke-on-Trent City Council
- Staffordshire Police
- NHS
  - Shropshire and Staffs Area Team NHS England
  - Stoke-on-Trent Clinical Commissioning Group
  - North Staffordshire Clinical Commissioning Group
  - South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
  - East Staffordshire Clinical Commissioning Group
  - Cannock Chase Clinical Commissioning Group
  - Stafford and Surrounds Clinical Commissioning Group
  - University Hospitals of North Midlands (UHNM)
  - Burton Hospital NHS Foundation Trust (BHFT)
  - Staffordshire and Stoke-on-Trent NHS Partnership Trust (SSOTP)
  - North Staffordshire Combined Healthcare NHS Trust(NSCHT)
  - South Staffordshire and Shropshire NHS Foundation Trust (SSSFT)

Extended Partnership as of 31st March 2016

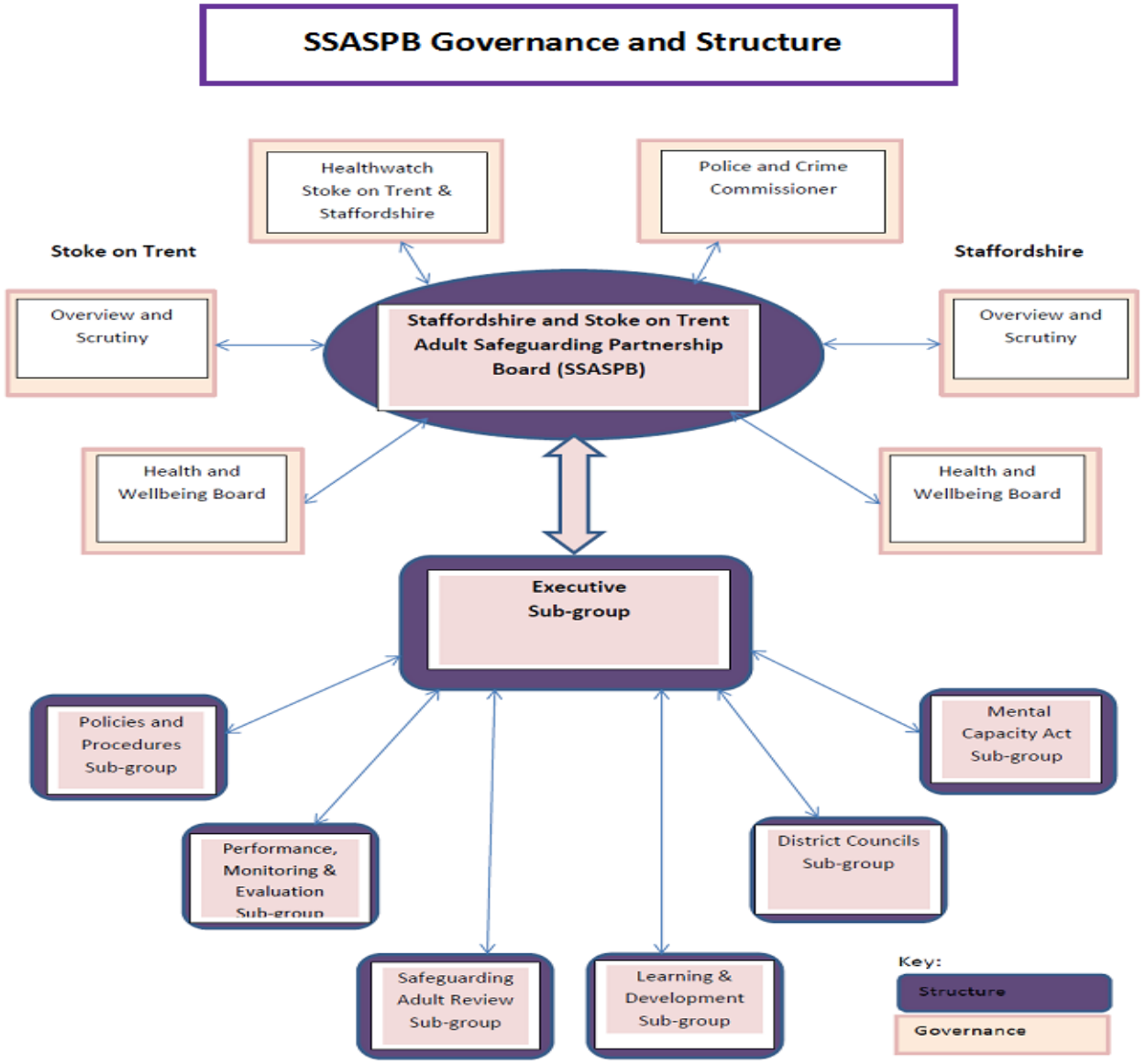
- National Probation Service (NPS) (Staffordshire and Stoke-on-Trent)
- Community Rehabilitation Company (CRCs) (Staffordshire and Stoke-on-Trent)
- West Midlands Ambulance Service (WMAS)
- Staffordshire Fire and Rescue Service (SFARS)
- Stoke-on-Trent City Council Housing
- Independent Futures (IF)
- Healthwatch (Staffordshire and Stoke-on-Trent)
- VAST (Voluntary Sector Representation)
- Staffordshire Association of Registered Care Providers (SARCP)
- Domestic Abuse Fora
- Hate Crime Fora
- Staffordshire District Councils Safeguarding Sub-Group
- Department of Work and Pensions (DWP) Job Centre Plus
- Her Majesty's Prison Service (HMPS)
- Trading Standards (Staffordshire and Stoke-on-Trent)

City of Stoke-on-Trent

NHS

Staffordshire County Council

Appendix 2: Governance arrangements



Appendix 3: Catergories of abuse and neglect

Categories of abuse and neglect - Section 14.17 of The Care Act Statutory Guidance describes the various categories of abuse and neglect:

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

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

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

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

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

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

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

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

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

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

15. REFERENCES

Care Act 2014 - http://www.legislation.gov.uk/ukpga/2014/23/contents

Care and support statutory guidance - https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Deprivation of Liberty Safeguards (DoLS) - https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance

Mental Capacity Act (MCA) 2005 - http://www.legislation.gov.uk/ukpga/2005/9/contents

Mental Health Act (MHA) 2007 - http://www.legislation.gov.uk/ukpga/2007/12/contents

A 'Glossary' of terms will be available on the SSASPB website, which will be available at www.SSASPB.org.uk from 1st November 2016.

Staffordshire County Council

WORK PROGRAMME –September 2016
Safe and Strong Communities Select Committee 2016/17

This document sets out the work programme for the Safe and Strong Communities Select Committee for 2016/17.
The Safe and Strong Communities Select Committee is responsible for scrutinising: Children and adults' safeguarding; Community safety and Localism. The Council has three priority outcomes. This Committee is aligned to the outcome: The people of Staffordshire will feel safer, happier and more supported in and by their community.

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

Councillor John Francis
Chairman of the Safe and Strong Communities Select Committee
If you would like to know more about our work programme, please get in touch with Tina Randall, Scrutiny and Support Manager on 01785 276148 or by emailing tina.randall@staffordshire.gov.uk

Membership – County Councillors 2016-17

John Francis (Chairman)
David Williams (Vice-Chairman)
Margaret Astle
Maureen Compton
Michael Davies
Bob Fraser
Terry Finn
Robert Marshall
Christine Mitchell
Mark Olszewski

Calendar of Committee Meetings 2016-2017

Wednesday 8 June – 2pm
Friday 8 July – 10am
Monday 5th September – 10am
Wednesday 9th November – 2pm
Monday 12th December– 10am
Monday 16th January 2017 – 10am
Monday 6th March 2017 – 10am

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

Work Programme 2016-17				
Date of meeting	**Item**	**Link to Council's Commissioning Plans**	**Details**	**Action/Outcome**
Wed 8 June 2pm	**Low Level Neglect Working Group Feedback** Councillor David Williams	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	This will be an opportunity for the Working Group to share their findings and recommendations with the Select Committee.	The report was endorsed by the Committee and submitted to the Cabinet Members for response.
	Children, Young People and Families Transformation Programme Cabinet Member: Mark Sutton Officer: Mick Harrison	**Resilient Communities** **Living Well** **Best Start** **Ready for Life** **Enjoying Life**	This report follows on from the information presented in October 2015 on Commissioning for better outcomes for children, young people and families.	The Children's Transformation Programme was discussed. More detail would be provided regarding the pilot programmes to the Committee in July 2016.
	Update on work to address child sexual exploitation (CSE) in Staffordshire, to include progress against the CSAF Action Plan and information regarding Revenge Porn & Sexting Cabinet Member: Mark Sutton Officer: Mick Harrison	**Resilient Communities** Build a joint approach to crime and addressing the causes of crime. Enable people to access appropriate intervention at the right time. Ensure effective safeguarding for the most vulnerable in our communities	This item is considered on a biannual basis. At the Triangulation meeting in May 2016 the work undertaken to address revenge porn and sexting was queried.	It was confirmed that Staffordshire Safeguarding Children Board was undertaking an audit of schools and that the findings of this audit could be shared with the Committee. The Vice Chairman had written to the Leader of the Council re Chelsea's Choice funding. The number of referrals to CSE Panels were increasing as they had shown to be useful. There had not been appropriate or sufficient interest from providers to commission bespoke support service. Members sought reassurances regarding licensing practices in the District and Boroughs and it was confirmed that South Staffordshire District Council had invited auditors in to assess the process.

Fri 8 July 10am	**Youth and Community Service update** Cabinet Member: Mark Sutton Officer: Paul Woodcock	**Living Well** **Enjoying Life** **Resilient Communities**	The Committee last considered this item in July 2015.	• The District Commissioning Leads share more information about local funding at Member Meetings. • More information about the Liberty Staffordshire Community Interest Company be shared with Councillor Finn.
	C,Y &Fs Transformation Programme – Overview of Programmes including the Vision Pilot Cabinet Member: Mark Sutton Officer: Janene Cox/ Barbara Hine	**Resilient Communities** Living Well Best Start Ready for Life Enjoying Life	This report will follow on from the Overview of the Children Young People and Families Transformation Programme presented in June 2016. There are a number of pilots that are being initiated by partners across Staffordshire to explore the delivery of different aspects of the Family System model.	The names of schools involved in the pilots will be circulated to the Committee and an update will be brought to in December 2016.
	New: Verbal Cabinet Response: Preventing the Low Level Neglect of Children in Staffordshire Cabinet Member: Mark Sutton Officer: Mick Harrison	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	The Working Group's report was endorsed by the Committee at the 8 June Committee meeting and an Executive Response to the recommendations requested in 3 months time. This verbal update will be followed by a formal response in September.	The Select Committee were informed that a full written response to the recommendations would be presented to the September Select Committee meeting.
Mon 5 Sept 10am	**Update from Staffordshire Police and Crime Commissioner** P&CC: Matthew Ellis	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities. Build a joint approach to addressing crime and the causes of crime.	The Committee has a responsibility to hold the Police and Crime Commissioner to account for safety issues. The Cabinet Member for Health, Care and Wellbeing had suggested that the Committee scrutinise how successful diversion schemes had been. Responses to modern slavery, honour crime and the protection of those who are vulnerable and supporting victims may also be of interest. At the December 2015 meeting it was agreed that the Police and Crime Commissioner be invited to attend a future meeting and that Members submit lines of inquiry in advance of this	Discussion centred around the PCC's safeguarding role. Key areas of inquiry being around: • Visible policing; • Rises in violent crime including hate crime since Brexit; • Protection of the most vulnerable within the community; • Investigative policing hubs; • The use of police cells as places of safety; • Potential risks around sex offenders released from Stafford Prison; • The current and future relationship between the Fire and Police Services; and • Access to local crime statistics

Wed 9 Nov 2pm	**Deprivation of Liberty Safeguards: update on the impact of central government cuts on assessments.** Cabinet Member: Alan White Officer: Peter Hampton	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities.	This item was suggested at the Triangulation Meeting in May 2016.	
	Customer Feedback &Complaints Adult Social Care Annual Report 15/16 Cabinet Member: Alan White Officer: Kate Bullivant	**Running the business well**	Adults' Services have a statutory obligation to submit the Annual Report on complaints and representations	
	Customer Feedback & Complaints - Children's Social Care Annual Report 15/16 Cabinet Members: Mark Sutton Officer: Kate Bullivant	**Running the business well**	Children's Services are required to submit an annual report on complaints and representations to the relevant County Council Committee.	
	Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board 2015-16 Annual Report Cabinet Member: Alan White Independent Chair: John Wood	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our		
Mon 12 Dec 10am	**Staffs Safeguarding Children Board (SSCB) Annual Report 15/16** Cabinet Member: Mark Sutton Independent Chair : John Wood	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities Build a joint approach to addressing crime and the causes of crime.	SSCB is a statutory inter-agency forum for agreeing how different services and professional groups should co-operate to safeguard children throughout Staffordshire and, for making sure that arrangements work effectively to promote better outcomes. The 2014/15 report was considered in December 2015.	
	Transforming Care Partnerships – Adults Safeguarding Implications	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our	This item was suggested at the Triangulation Meeting in May 2016.	

	(previously referred to as "Quality of Care in Adult Residential Care Homes") Cabinet Member :Mark Sutton Officer: Nichola Glover-Edge			
	Progress with the Children and Families Transformation Programme Pilot projects Cabinet Member: Mark Sutton Officer: Mick Harrison		This report will follow on from the information presented in June/July 2016.	
	Modern Slavery Officer: Mick Harrison Tim Martin and Lindon Evans, Staffordshire Police	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	It was agreed at the April 2016 meeting that update on Modern Day Slavery would be shared with the Committee in July 2016 however it was suggested in June 2016 that an update in December would be more timely.	
	C,Y &Fs Transformation Programme – Overview of Programmes including the Vision Pilot Cabinet Member: Mark Sutton Officer: Janene Cox/ Barbara Hine	**Resilient Communities** Living Well Best Start Ready for Life Enjoying Life	This follows on from the Overview of the Children Young People and Families Transformation Programme presented in June 2016. There are a number of pilots that are being initiated by partners across Staffordshire to explore the delivery of different aspects of the Family System model. At the July 2016 meeting Members requested an update to their December meeting.	
Mon 16 January 2017 10am	**Update on work to address child sexual exploitation (CSE) in Staffordshire, to include progress against the CSAF Action Plan** Cabinet Member: Mark Sutton Officer: Mick Harrison	**Resilient Communities** Build a joint approach to crime and addressing the causes of crime. Enable people to access appropriate intervention at the right time. Ensure effective safeguarding for the most vulnerable in our communities	This item is considered on a biannual basis and was considered in June 2016.	

	Cabinet Response: Preventing the Low Level Neglect of Children in Staffordshire Cabinet Member: Mark Sutton Officer: Mick Harrison	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	This item is the formal response to the Working Group's recommendations.	
Mon 6 March 2017 10am	**Places of Safety – the use of police cells as places of safety.** Cabinet Member :Mark Sutton Officer: Richard Hancock/Vonni Gordon/ CI Simon Tweats, Jeff Moore (OP&CC)	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities. Build a joint approach to addressing crime and the causes of crime.	This item was suggested at the Triangulation Meeting in May 2016.	
	Wood Report: review of the role and functions of local safeguarding children boards Cabinet Member: Mark Sutton Officer: Mick Harrison	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities Build a joint approach to addressing crime and the causes of crime.	Item requested at the 8 June meeting..	

Items carried over from the 2015/16 Work Programme

Safeguarding Vulnerable Children			
Item	***Link to the Council's Commissioning Plans***	***Background***	***Possible Option***
Social work staffing levels and caseloads Cabinet Member: Alan White Officer: Richard Hancock	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities.	Discussed at the March 15 meeting. Within the Specialist Safeguarding Units (SSUs) caseloads of between 17 and 23 were considered acceptable, but in Oct 13 and early summer 14 there was a significant increase in referrals. At the same time the 40 week legal process was reduced to 26 weeks and Court work had to be undertaken by the SSUs. Teams largely fully staffed and the	Briefing note by Richard Hancock before July meeting.

		referral rate stabilised but some staff having caseloads are over 23.	
Impact of the Staying Put Policy Cabinet Member: Mark Sutton Officer: Richard Hancock	**Resilient Communities** **Ready for Life** **Living Well**	Staying Put Policy arrangements are where young people aged eighteen and older who were previously looked after, remain living with their former foster carers. The broader policy issue was considered by the Corporate Parenting Panel on 16/06/16 and is discussed on a regular basis.	Briefing note by Richard Hancock before July meeting.
Fostering and adoption: availability of places Cabinet Member: Mark Sutton Officer: Richard Hancock	**Resilient Communities** Enable people to access the appropriate intervention at the right time Ensure effective safeguarding for the most vulnerable in our communities.	The MTFS report in Feb 15 identified concerns about the non delivery of savings in respect of foster care placements. Adoption support was considered by the Corporate Parenting Panel in March 2015.	Briefing note by Richard Hancock before July meeting.
Evolve YP Pilot Project Cabinet Member: Mark Sutton Officer: Richard Hancock	**Resilient Communities** **Ensure effective safeguarding for the most vulnerable in our communities**	The predecessor Committee evaluated the Social Work Practice (SWP) pilot: Evolve YP. The SWP contract was extended to April 16 to allow time for the commissioning for children's services to become clear and the future role of SWP contract to be considered.	Briefing note by Richard Hancock before July meeting.
Safeguarding Vulnerable Adults			
Item	***Link to the Council's Commissioning Plans***	***Background***	***Possible Option***
Protecting from harm those who are vulnerable and supporting victims. Cabinet Member; Alan White Officer: Mick Harrison	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities.	In December 2015 HMIC published PEEL: Police effectiveness 2015 (Vulnerability). An inspection of Staffordshire Police. This report considered how effective the force was in protecting from harm those who are vulnerable, and supporting victims. HMIC found serious weaknesses in the services Staffordshire Police provides to protect and support victims, most notably victims of domestic abuse. Some staff were focused on identifying and protecting vulnerable victims. Where vulnerability is identified and the risk to victims is assessed properly the force works well with partner agencies to safeguard and support victims. However, there are several areas where urgent improvement is needed to ensure that the force provides a consistent service, and that victims are kept safe. HMIC has particular concerns about Staffordshire Police's poor approach to formally assessing the risks	At the January 2016 Councillor Frank Chapman, Chairman of the Police and Crime Panel explained that Her Majesty's Inspection of Constabulary (HMIC) had undertaken an inspection of Staffordshire Police Force in December 2015 and that the Police and Crime Commissioner and Chief of Staff would be held account at a meeting of the Police and Crime Panel. It was agreed that a copy of the report would be shared with Members. A backlog in the MASH was referred to in January 2016, the Chairman of the Police and Crime Panel discussed with Suggested that this item be programmed as part of the 2016/17 Committee Work Programme.

		faced by domestic abuse victims. Given the scale of the challenge in this area and the significant risk that these weaknesses pose to some of the most vulnerable people, HMIC judges that overall, the force is inadequate. In many cases, Staffordshire Police responds well to victims but this standard is not achieved consistently.	
Honour Based Crime Cabinet Member; Alan White Officer: Mick Harrison	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities.	In December 2015 HMIC published a report entitled The depths of dishonour: Hidden voices and shameful crimes. An inspection of the police response to honour-based violence, forced marriage and female genital mutilation. Honour-based violence (HBV) is the term used to refer to a collection of practices used predominantly to control the behaviour of women and girls within families or other social groups in order to protect supposed cultural and religious beliefs, values and social norms in the name of 'honour'. HBV incidents and crimes include specific types of offence, such as forced marriage (FM) and female genital mutilation (FGM), and acts which have long been criminalised, such as assault, rape and murder. HMIC assessment of forces' own self-assessments identified that Staffordshire was 'Not Yet Prepared' in any of the inspected areas.	Suggested that this item be programmed as part of the 2016/17 Committee Work Programme.
Care Director Cabinet Member: Alan White Officer: Ian Benson	**Running the business well**	The Chair proposed an investigation into the implementation of Care Director across children and adults services, to compare and contrast the implementation.	A letter was sent to the Chairman from the Cabinet Member and circulated to the Committee 04/08/15. Information was included in the 07/09/15 Care Act report. At the Sept 2015 meeting the Cabinet Member discussed the work undertaken with the architects of Care Director to ensure that the system was Care Act compliant. At the Nov meeting it was suggested that the use of Care Director in adult services be added to the work programme. At the Triangulation meeting on the 9 December it was agreed that a briefing note would be provided giving an update on the current situation.