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Safe and Strong Communities Select Committee

Monday, 15 January 2018
10.00 am
Oak Room, County Buildings, Stafford

NB. Members are requested to ensure that their Laptops/Tablets are fully charged before the meeting

John Tradewell
Director of Strategy, Governance and Change
5 January 2018

A G E N D A

1. **Apologies**

2. **Declarations of Interest**

3. **Minutes of the previous meeting held on 9 November 2017** (Pages 1 - 6)

4. **Domestic Abuse** (Pages 7 - 14)

   Report of the Cabinet Member for Communities

5. **SSCB Annual Report 2016-17** (Pages 15 - 98)

   Report of the Cabinet Member for Children and Young People

6. **Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board - Annual Report 2016/17** (Pages 99 - 160)

   Report of the Deputy Leader and Cabinet Member for Health, Care and Wellbeing

7. **Work Programme** (Pages 161 - 168)

8. **Exclusion of the Public**

   The Chairman to move:-

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

Part Two
(All reports in this section are exempt)

9. **Home Care** (Pages 169 - 176)

Report of the Deputy Leader and Cabinet Member for Health, Care and Wellbeing
(exemption paragraph 3)

Committee Membership

John Francis (Chairman)	Kyle Robinson
Syed Hussain	Paul Snape
Trevor Johnson	Conor Wileman (Vice-Chairman)
Jason Jones	Victoria Wilson
Natasha Pullen	Mike Worthington

Note for Members of the Press and Public

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

Minutes of the Safe and Strong Communities Select Committee Meeting held on 9 November 2017

Present: John Francis (Chairman)

Attendance	
Trevor Johnson	Paul Snape
Jason Jones	Conor Wileman (Vice-Chairman)
Kyle Robinson	Victoria Wilson

Also in attendance: Gill Burnett

Apologies: Syed Hussain, Natasha Pullen and Mike Worthington

PART ONE

6. Declarations of Interest

There were none at this meeting.

7. Mr Robert Marshall

A minutes silence was held in memorial of Mr Robert Marshall, County Councillor for Codsall (South Staffordshire) who had died on 2 November. He will be sadly missed.

8. Minutes of the previous meeting held on 26 September 2017

RESOLVED- That the minutes of the Safe and Strong Communities Select Committee held on 26 September 2017 be confirmed and signed by the Chairman.

9. West Midlands Peer Review of Adult Safeguarding

In February 2017 the County Council participated in a peer review of adult social services focusing on safeguarding for vulnerable adults and market management for commissioned services. At their 13 June 2017 meeting Select Committee Members received feedback on the Review and requested a report on progress implementing identified actions to address the areas highlighted for development.

The Peer Review had provided a helpful snapshot assessment of key challenges and areas of strength within the change programme for Health and Care. The findings provided confidence in the direction that was currently being taken, assured the organisation that the work to protect the most vulnerable was safe and well-structured whilst highlighting challenges around scale and capacity. The Review also identified operational enhancements required to the assessment and case management arrangements delivered through partners, which had been addressed as part of on-going work to renegotiate and reshape S75 agreements. Members received a full update of progress in respect of the identified actions.

Members were aware of the changes within home care following the recent tendering process, with new arrangements designed to address the chronic shortages of home care and give providers a guaranteed number of hours in defined geographical areas, allowing them to offer permanent contracts to staff and organise their operations more efficiently. Whilst Members understood the rationale behind this process they had concerns over the way this had been communicated to service users and providers, with some Select Committee Members having a number of complaints and/or concerns raised with them.

As part of the new home care arrangements some service users care would be transferred to new providers. Whilst their care package would remain unchanged, the individual providing that care may change, although an assurance was given that where ever possible continuity would be retained. Members were aware that some staff were being TUPEd over to the new providers, however they were also aware that others had chosen to remain with the smaller providers and asked for an update on this process. The retendering had been led by the Care Commissioning Team, working with new and previous providers to ensure all TUPE information was shared effectively and no significant issues had been highlighted during this process. It was recognised that people would make personal choices and may wish to remain receiving their care from their original provider. In such cases individual's would be able to use the direct payments system.

Members were informed that as part of the TUPE process there was an expectation that continuity of staff to service user would be sustained as far as possible, where appropriate.

Members asked whether any of those care companies that had been successful in the tendering process had previously operated under a different name and/or previously been judged as failing by the Care Quality Commission (CQC). Due diligence would have been undertaken as part of the tendering process. The CQC regulate the market and all providers needed to meet their standards and contractual requirements. As part of the procurement process the Commissioning Team would be aware of any company changes. Changes may happen where a company has failed and subsequently had a change of directors or where a company has been taken over. In either case the new company was still required to meet the CQC standards.

Poor communication was a factor in the home care changes, with unhelpful correspondence being sent to service users and with some service providers indicating they had not been consulted about the changes. Members sought reassurance that steps had been taken to mitigate the problems this had created and to ensure adequate advice was given around the option of direct payments. There was a particular concern shared that the correspondence had implied choosing to use direct payments and receiving care from a smaller provider may result in greater costs to the service user over bank holiday periods. There had been some issues with the initial letter to service users which had subsequently been addressed. The care package of individuals would not change irrespective of the change of provider and therefore there had been no requirement to undertake consultation. The County Council had provided guidance on the use of direct payments with 140 service users transitioning to direct payments so far.

Members noted that communications had been an issue highlighted within the Peer Review. Communicating with such a wide range of individuals with very different expectations and needs was recognised as challenging. However there was also a recognition that the initial correspondence had resulted in uncertainty and concern which had been addressed as soon as the issue had been identified. The Cabinet Support Member for Adult Safeguarding assured the Select Committee that this would not happen again.

Members asked for clarification of the measures in place to safeguard care home residents in scenarios where the home fails in its care and has to close. The County Council has a provider failure protocol which would be followed to ensure the safety and continued care of service users.

The Cabinet Support Member distributed leaflets produced by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership entitled “What do I do if I have a safeguarding concern”. She urged Members to encourage individuals to report any concerns so that possible safeguarding issues could be addressed at the earliest opportunity.

The Select Committee noted the progress made with the Peer Review recommendations. They noted delays in implementing part of recommendation 3 and asked for an explanation for this delay. This related to delays in work with trade unions, however the second phase of this work was due to start shortly.

Members commended officers on the significant progress made in implementing the recommendations.

RESOLVED- That:

a) the Officers be commended on the significant progress made so far in implementing the recommendations made; and
b) a progress report on the action plan and implementation of the recommendations be brought to a future meeting.

10. Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards (DoLS) provide protection for the most vulnerable people living in residential homes, nursing homes or hospital environments. The safeguards enshrined in law gave the requirement that care would always be provided in a way that was consistent with the human rights of people lacking capacity, who were otherwise protected or safeguarded through the use of the Mental Health Act or Court of Protection powers.

The Select Committee received details of the differentiation between high, medium and low priority DoLS. They were aware that the backlog of high priority cases had been reduced this year. Members asked whether low and medium priority cases were likely to escalate if no DoLS assessment was undertaken for these cases. This could happen, however providers could request a review of the assessment if they had concerns over escalation.

As a result of the dramatic increase in referrals following the 2014 Supreme Court Judgement and the subsequent decision taken by the Senior Leadership Team (SLT) and Cabinet to focus on high priority cases only, there was no likelihood of assessments being completed on medium or low priority cases with the current resource available. However it was possible to manage the high level assessment and address the backlog with the 9 Best Interest Assessors now in post.

Mental health assessments are a key element to the best interest decision of a DoLS assessment. In Staffordshire this had historically been funded by Health, however this was not the case across the Country, with local authorities funding mental health assessment in many cases. Whilst every attempt was being made to maintain this funding arrangement, residential care act money is being set aside to cover this assessment cost within the MTFS in the coming year. The Clinical Commissioning Groups (CCG) had agreed to provide the County Council with details of the costs involved with these assessments. They had also agreed to continue funding these assessments at present. If these assessments were funded by the County Council there would be a need to consider both cost and quality of any commissioned service as well as to modify the administrative process and finance structure.

Anyone deprived of their liberty had a statutory right to appeal against this deprivation. Members heard that Staffordshire currently had 14 ongoing or expected appeal cases. Staffordshire had not received any malicious appeals, with appeals most often being made by independent professionals through the Asist contract.

The Select Committee asked whether, in not addressing the low or medium priority DoLS, Staffordshire was in breech of the law and asked whether other authorities were in a similar position. Whilst the London Boroughs and some smaller urban councils such as Sandwell were able to keep abreast of their DoLS assessments, most Shire Counties were in a similar position to Staffordshire. Birmingham had spent millions on trying to meet demand but had recently accepted that for the resource required this was not sustainable and were now looking at addressing high priority cases only.

Members asked whether there was a risk of the Council being taken to court because of their breech over medium and low priority assessments. This had been part of the risk matrix considered by Cabinet when taking their decision to focus on high priority cases only. The Council had received no claims for compensation and any financial burden would more likely be in legal costs rather than compensation, as compensation would be minimal. The Council had received no criticism from the Court of Protection from any appeal case. DoLS was a safeguarding measure rather than an intervention, with any care package in the best interests of the individual.

The Law Commission published a report and draft bill in March 2017 which put forward proposals to change the legal framework for DoLS. The proposals intended to streamline the process for assessing whether a DoL was necessary and was planned to ensure that those deprived of their liberty in settings outside care homes and hospitals were covered by the new scheme. It was anticipated that this would have no additional cost to the Authority as assessment would be undertaken through the case management structure already in place. However it was unclear at present how this would affect those who were self-funding. Responses to the report had to be made by March 2018.

RESOLVED – That the difficulties with addressing the number of DoLS assessments, and the decision to focus on high priority cases be noted.

11. Work Programme

The Scrutiny Manager informed Members of the following changes to their work programme:

- A paper had been produced around the work already undertaken by the County Council on hard to reach communities. This would be circulated to Members after the meeting ,with Members then deciding if they wished to consider any element in more detail;
- 30 January Inquiry Day on Edge of Care. The Vice Chairman would be chairing this event and Members would be asked whether they wish to take part in the session, with approximately 4 members ideally needed;
- Following a referral from the Corporate Parenting Panel around elective home education, a joint working group will be set up between this Select Committee and the Prosperous Staffordshire Select Committee to consider the issues around EHE and the significant increase in numbers; and
- Home Care had been added to the work programme for the December meeting. Members requested that the report specifically address the lessons learnt around communication.

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

Chairman

Local Members' Interest
N/A

Safe and Strong Communities Select Committee – 15th January 2018

Domestic Abuse

Recommendation

1. That the Select Committee scrutinises the content of this report concerning Domestic Abuse.

Report of Cllr Gill Heath, Cabinet Member for Communities

Summary

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

2. This report provides an update on the re-commissioning of Domestic Abuse services across Staffordshire and Stoke-on-Trent and on other key pieces of work associated with Domestic Abuse. The Select Committee is being asked to note the progress made.

Report

Background

3. The Select Committee previously received an update on the commissioning of Domestic Abuse services across Staffordshire and Stoke-on-Trent at its meeting on 16 January 2016. This report provides a further update along with information on other key areas of work related to Domestic Abuse across Staffordshire.

Commissioning of Domestic Abuse Services

4. Staffordshire County Council, Stoke-on-Trent City Council and the Office of the Police & Crime Commissioner (OPCC) are jointly commissioning Domestic Abuse (DA) services across Staffordshire and Stoke-on-Trent, with the OPCC acting as lead commissioner. Services will include provision for victims, perpetrators, children and young people.

5. DA services were tendered earlier this year in January 2017 but a contract was not awarded as the bids received did not fully meet the service specification. DA services will be re-tendered again in December 2017 with new services to be in place in October 2018. This timeframe allows for at least 12 weeks for interested organisations to return their bids and also allows for a three-month mobilisation period following award of contract in summer 2018.

6. Commissioners met with organisations that did and that did not bid when services were tendered earlier this year in order to take feedback on the process. Two

further market engagement events, with those organisations interested in bidding, took place in October 2017 and these were very well received.

7. Funding Agreements are being extended with the three commissioned Staffordshire DA Support Services providers (Arch, Pathway and Staffordshire Women's Aid), to continue with existing provision until the new services are in place in 2018. In October 2017, Pathway took over the operation of the East Staffs DA service as Home Group, the previous provider, did not wish to extend their Agreement with the County Council.

8. A Staffordshire DA Perpetrator Programme provided by Core Assets is underway and will run until the end of 2017. This is a voluntary programme for males across Staffordshire aged 16 and above. It was commissioned as a result of demand from Children's Social Care.

9. At the time of writing, the annual value of the new commissioned DA services for victims and perpetrators (from October 2018) is to be confirmed but is likely to be at least £1,836,000 per annum of which there will be a minimum spend of £600,000 per annum (ie the County Council's annual financial contribution towards DA services) in Staffordshire and a minimum spend of £421,000 per annum in Stoke-on-Trent.

10. There will be robust governance and performance management of the new contracts so that the County Council can be assured that its money is being spent to best effect and that progress against outcomes and outputs is being recorded. All of the commissioning organisations will receive regular performance management reports and be actively involved in the performance management arrangements.

Information and Advice on Domestic Abuse

11. The organisations listed below are the current commissioned providers of Domestic Abuse Services across Staffordshire and can provide information, advice and guidance to victims of domestic abuse or to those who are concerned on their behalf.

    a. **Arch North Staffs** (Newcastle and Staffordshire Moorlands)
    Helpline Tel: 01782 205500
    Enquiry Line Tel: 01782 222421

    b. **Pathway Project** (East Staffs, Lichfield and Tamworth)
    Helpline Tel: 01543 676800
    Helpline e-mail address: talktoeve@pathway-project.co.uk

    c. **Staffordshire Women's Aid** (Cannock, South Staffordshire and Stafford)
    Helpline 0300 330 5959

    Additional sources of help are:

    d. **Staffordshire Victim Gateway** - provides information, advice and support to all

victims of crime across Staffordshire even if they have not reported it to the police.

Tel: 0330 0881 339 (charged at a local rate) help@staffsvictimsgateway.org.uk

e. **National Domestic Violence Helpline** This is a Freephone 24 Hour National Domestic Violence Helpline, run in partnership between Women's Aid and Refuge, and is a national service for women experiencing domestic violence, their family, friends, colleagues and others calling on their behalf.

Tel: 0808 2000 247

f. Where someone is in immediate danger, always dial 999.

Staffordshire and Stoke-on-Trent Domestic Abuse Strategy

12. As part of the re-commissioning process, a comprehensive Needs Assessment was undertaken and used to inform the joint commissioning activity. It has also been used to develop the first pan-Staffordshire and Stoke-on-Trent Domestic Abuse strategy. The strategy was consulted upon widely and drew upon feedback from engagement activities, evidence from the Needs Assessment as well as the national Violence Against Women & Girls Strategy. Joint governance arrangements have been established to oversee the delivery of the strategy and a shared multi-agency action plan is being developed.

13. The Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board is holding a workshop to develop the action plan in early December 2017.

Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board

14. A pan Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board has been established as part of new governance arrangements around domestic abuse and has met three times in March, July and October 2017. The Board will be responsible for the delivery of the pan Staffordshire Domestic Abuse Strategy 2017-20. It is jointly chaired by the County Council's Commissioner for Safety, Children and Families and Stoke-on-Trent City Council's Strategic Manager - Safe and Healthy Communities. The Board has a broad membership from a wide variety of agencies including (but not limited to) Police, District and Borough Councils, Probation, Health agencies, the Safeguarding Adults Partnership Board and Safeguarding Children Boards for Staffordshire and Stoke-on-Trent and commissioned Domestic Abuse providers.

Staffordshire Domestic Abuse Steering Group

15. Staffordshire's multi-agency Domestic Abuse Steering Group will continue to meet until such time as the Domestic Abuse Commissioning and Development Board (referred to above) is firmly established. It is anticipated that organisations currently represented on the DA Steering Group will be represented either on the

DA Commissioning Board itself or one of its sub-groups.

Domestic Homicide Reviews (DHRs)

16. A Domestic Homicide Review (DHR) is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

    a. A person to whom they were related or with whom they were or had been in an intimate personal relationship (an 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality), or
    b. A member of the same household as themselves, held with a view to identifying the lessons to be learnt from the death.

17. Copies of the Overview Reports and Executive Summaries resulting from completed DHRs undertaken in Staffordshire can be found on the Staffordshire website at: Published Staffordshire Domestic Homicide Reviews

18. As at November 2017, there are two DHRs underway in Staffordshire.

19. A piece of work is being carried out by the Domestic Abuse Commissioning and Delivery Board to look at the key themes arising from DHRs undertaken to date across Staffordshire and Stoke-on-Trent.

Multi Agency Safeguarding Hub (MASH)

20. MASH reporting continues to be routinely shared via the Joint Local Safeguarding Children Board Performance function and to provide data to inform the position concerning Domestic Abuse as part of the assurance process. Information is provided on the throughput and outcomes as well as risks and issues.

21. 'Project Doing More' moved to an implementation phase on 1st February 2016; this effectively improved the MASH model and significantly reduced the challenge of case backlogs compared to what partners have previously experienced. A three month review was undertaken in May 2016 where improvements were made to the MASH Police triage process; this effectively concluded on 4th November 2016 and was followed by a 'bedding in' period up to and including the 2016 Christmas public holidays where traditionally most demand is seen.

22. The new model improved the throughput of cases across MASH and reduced process duplication for the MASH Police Team. All MASH agencies have benefitted from this as the majority of referrals processed within MASH originate from police incidents. The police triage process, introduced through MASH Doing More, provides a consistent and structured mechanism for pre-referral information sharing. This also contributes towards maximising the value of MASH by ensuring all children, known to partners, in a household are identified at the earliest opportunity thereby enabling practitioners to make better informed decisions around the management of risk at the referral stage of the safeguarding process.

23. In addition to this, MASH health colleagues are sharing outcomes documents, produced from this process that are contributing towards prevention within the community. A case study early this year supported a hypothesis that the sharing of outcomes documents contributes towards prevention.

24. Compliance with timely referrals has improved and this was reported on at the Joint Local Safeguarding Children Board Performance Subgroup.

25. There have been some delays in getting domestic abuse referrals to partners brought about by serious Police technology challenges that have led to backlogs and then a very significant deficit in police resources in MASH has compounded this problem. Things are slowly improving with a high organisational level of intervention providing the necessary support to re-establishing the infrastructure.

Multi-Agency Risk Assessment Conference (MARAC)

26. The Multi-Agency Risk Assessment Conference (MARAC) review (2016) was originally commissioned by the Multi-Agency Safeguarding Hub (MASH) Strategic Management Board to provide them with assurance in their role that MARAC was delivering effectively for vulnerable people in Staffordshire and Stoke-on-Trent. Circumstances around MARAC changed in January 2016 and beyond following the Staffordshire Police response to their inadequate rating by Her Majesty's Inspectorate of Constabulary. This therefore significantly changed the original remit of the review to propose a fundamental new model for MARAC that is able to support the significant increase in demand and deliver the best possible outcomes from the process for those involved in serious Domestic Violence situations.

27. On 1 December 2016 the review report that discussed issues with the current model and included an options appraisal of four potential future models was published for consultation. This consultation process concluded on 15 January 2017 and the conclusion report was considered and a decision made to implement the recommended model by the MASH Strategic Management Board on 26 January 2017. A sub group was established, led by C/Supt Jeff Moore to oversee the delivery of a conceptual model that could be adopted across the Staffordshire and Stoke-on-Trent area.

28. The group is made up of professionals from many statutory agencies involved in dealing with domestic abuse and also the commissioners of services that cover the same area. John Maddox, MASH Principal Officer, is leading the review into its second stage.

Method:

29. In order to ensure that a model appropriate to the need and demand is achieved it has been decided to adopt a pilot site development so that lessons and changes can be derived in an agile development method. This should provide the environment to understand whether there is a commitment from agencies to work differently in order to ensure that cases are managed in a timelier manner but whilst retaining the principles of the Safelives effective MARAC process.

Governance:

30. At present the partnership governance has sat with MASH strategic management group and as outlined the project board is a sub group of this. It is however envisaged that the Commissioning Development Board will in time adopt this work within its remit once it has matured. Currently the project reports into the County and City Domestic Abuse forums.

Demand:

31. The total MARAC demand for April 2016-March 2017 was 2247 and there have been 447 MARAC cases within the first quarter of this 2017-2018. Data indicates an upward trend in respect of repeat cases; this is an issue that will be being explored further as part of the current MARAC review and the development of an outcome framework.

32. Mental Health services are continuing to support MASH arrangements with relevant information in respect of domestic abuse. Further discussions are taking place around the substance misuse information in support of the toxic trio risk (ie domestic abuse, substance misuse and mental ill-health) in MASH.

33. Consultation in relation to this project has been undertaken on an individual agency basis to establish the statutory strategic support that will be required to deliver any change.

Next steps:

34. In October 2017 a Pilot was launched in Tamworth, Staffordshire adopting the principles set out in the MARAC review as to a different way of working. This in essence will mean that domestic abuse cases will be discussed daily in the Multi-Agency team (MAT) meetings and that MARAC cases will be initially actioned on a daily basis but reviewed against additional information from MASH on a weekly basis to ensure that a multi-agency plan is effective and delivering appropriate safety for victims and their family. This plan will also consider opportunities for perpetrators.

35. The method and outcomes will be evaluated with a view to formulating a business case for further adoption and roll out. In the meantime MARAC in its traditional form will continue elsewhere.

36. The anticipated benefits are that earlier identification of issues owned locally could provide a wealth of existing knowledge and agency contribution that delivers outcomes at the time and not weeks after the event. Joined up thinking delivers joined up outcomes and taking a whole family approach means that local agencies can be alerted such as schools which is currently a gap, thus providing that additional safety for children. This is in line with the Place Based Approach for the children's and families system and provides an opportunity for the earliest help.

37. The project board will next review the position in November 2017 to ensure that

service delivery meets the assumptions of the project. Close liaison is being maintained with the Office of the Police and Crime Commissioner (OPCC) in relation to the commissioning of services from summer 2018. A full business case will be provided by April 2018.

Staffordshire Police

38. A formal PEEL (Police Efficiency, Effectiveness and Leadership) Effectiveness inspection was conducted during October 2017 by HMIC. The inspection covered vulnerability including Domestic Abuse.

39. HMIC are currently conducting another online survey with domestic abuse practitioners about their experiences of the service provided by police over the previous 12 months to inform this PEEL Effectiveness inspection.

40. Staffordshire Police Domestic Abuse Procedure has been reviewed and subject to internal consultation. The procedure is subject to ratification prior to publication.

41. Supt Jav Oomer is leading a piece of work to review the effectiveness of the DIAL risk assessment for domestic abuse incidents. This is being undertaken in conjunction with the College of Policing and academic partners. This work includes the examination of data to assess the weighting of the risk assessment questions to accurately assess risk.

42. Staffordshire Police will sign up to the OPCC Supporting Domestic Abuse Victims at Work initiative. Internal Domestic Abuse Champions have been identified and will receive specialist training in order to support colleagues subject to domestic abuse. An internal Domestic Abuse Policy has been drafted to support this.

43. HMIC have conducted a recent inspection into Stalking nationally titled “Living in Fear” this produced a number of findings and recommendations for all Police forces.

44. Staffordshire Police have conducted an internal scrutiny and support review of Stalking cases. An action plan has been developed with key themes of training, identification and risk assessment. A series of five Public Protection Development Days commenced in September 2017 with the delivery of specialist training by Paladin to officers and staff regarding the identification, investigation and risk assessment of Stalking cases (including DA). This will be further supported by additional enhanced training for 25 single points of contact (SPOCs) across the service to implement the learning and ensure the Police are responding effectively to victims.

45. Improvement activity within the Force continues to be monitored and delivered through robust and established Senior Officer led governance arrangements.

Learning from Inspections

46. Staffordshire County Council Children’s Social Care Service was inspected by Ofsted between 31st July and 4th August 2017 under the new Pilot Inspection of

Local Authority Children's Services (ILACS) Inspection process. The final Ofsted report (paragraph 3) identified that:

"The local authority has worked well with the police and partners to strengthen the response to domestic abuse, following concerns identified in Her Majesty's Inspectorate of Constabulary's inspection of Staffordshire police in 2016. The multi-agency safeguarding hub completes checks on all police domestic abuse notifications, and a triage system helps to identify children in need of an urgent response. However, the police do not consistently notify the local authority of all domestic abuse incidents in a timely manner. Further work is needed to ensure a systematic and timely response to all notifications".

47. This is an issue that the Staffordshire Safeguarding Children Board will want to scrutinise and seek assurances about going forward.

Link to Strategic Plan

48. The work undertaken in relation to domestic abuse links with the third of the three priorities within the County Council's Strategic Plan 2014-18, ie that the people of Staffordshire will feel safer, happier and more supported in and by their community.

Link to Other Overview and Scrutiny Activity

49. The Select Committee previously received an update on the commissioning of Domestic Abuse services across Staffordshire and Stoke-on-Trent at its meeting on 16 January 2016.

Community Impact

50. The joint recommissioning of domestic abuse services across Staffordshire and Stoke-on-Trent, and all the other key areas of work outlined in this report, should benefit those members of the community who are victims, or at risk of being victims, of domestic abuse.

Contact Officer

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Appendices/Background papers

None

Local Members' Interest
N/A

Safe and Strong Communities Select Committee – 15th January 2018

Staffordshire Safeguarding Children Board Annual Report 2016 - 2017

Recommendation

1. Members are asked to receive the report to understand the role and function of Staffordshire Safeguarding Children Board (hereafter referred to as the SSCB). Members are asked to consider or comment on the progress that the Board has made since the last annual report was presented to the committee on 6 March 2017. This SSCB Annual Report sets out the progress made by the partnership during 1st April 2016 and 31st March 2017.

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

Summary

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

2. The SSCB should report annually on the progress made by the Board to the Safeguarding Scrutiny Committee to enable robust Member scrutiny of its statutory functions. SSCB Annual Reports provide a transparent, public account of the work of the partnership during 2016-2017 and includes key messages for local commissioners to consider how to help strengthen local safeguarding children arrangements.

Report

Background:

3. The SSCB is the key statutory mechanism that brings together representatives of each of the main agencies and professionals responsible for promoting the welfare and safety of children and young people. It is an inter-agency forum for agreeing how the different services and professional groups should cooperate to safeguard children throughout Staffordshire (except Stoke-on-Trent which has its own Local Safeguarding Children Board) and for making sure that arrangements work effectively to help to promote better outcomes for children.

4. The SSCB works together in partnership to safeguard and promote the welfare of children across three broad areas of activity all of which take into account the need to promote equality of opportunity and to meet the diverse needs of all children living in our communities. Specifically:

a. Engage partner agencies to set the strategic direction for safeguarding all children;
b. Identify and prevent harm and impairment of health or development and help ensure that all children are provided with safe and effective care as they are growing up;
c. Lead and coordinate on proactive work to target vulnerable groups;
d. Lead and coordinate on responsive work to protect children suffering, or at risk of suffering, significant harm; and
e. Lead and coordinate the development and delivery of multi-agency safeguarding training.

5. The objectives of the Board are pursued through core statutory functions which are set out within the Children Act 2004 and the statutory guidance Working Together to Safeguard Children 2015. These core functions are achieved through the work of the Board's subgroups which are chaired by a Board member or representative of one of the partner agencies. Each subgroup is responsible for measuring its performance against an annual work plan, which is derived from the SSCB Business Plan. Members of the Executive Group and the Board monitor the effectiveness of the work completed.

Membership

6. Membership of the SSCB is set out in section 13(3) of the Children Act 2004 and has been updated in Working Together to Safeguard Children 2015 (page 68/69). Organisations that include local authority, police and health are required to cooperate with the local authority in the establishment and operation of the Board and have shared responsibility for the effective discharge of its functions. The Staffordshire County Council Cabinet Member for Children and Young People also attends the Board as a participating observer.

7. The SSCB Independent Chair is continuing to steer the strategic direction of the Board and provides an opportunity to promote improved synergy within safeguarding children arrangements across the whole of Staffordshire and Stoke-on-Trent.

Budget

8. The SSCB is reliant on the contributions it receives from statutory member agencies and the SSCB is funded through a multi-agency budget. The agreed budget allocation for 2016-2017 was £283,065.

Governance

9. The governance arrangements of the SSCB have been the subject of significant review since 2014 and are in line with the statutory guidance 'Working Together to Safeguard Children 2015. The Board is confident that it is fully compliant with the statutory function requirements for local safeguarding children boards.

SSCB Activity and challenges

10. Since the last report to the Safe and Strong Communities Select Committee the SSCB has made considerable progress on a wide range of objectives through effective local partnership working, despite the challenges presented by the current economic climate and agency restructures. This includes engaging in activity which is targeted at groups of children and young people who have been identified as being vulnerable due to sexual abuse and exploitation, or neglect as a result of parental alcohol use, substance misuse, parental mental health and / or domestic abuse (known as the 'toxic trio'). The information provided in the annual report highlights some of the most noticeable achievements.

11. However, in light of the current challenges to both services and families in Staffordshire below are the key priorities and actions that will drive the Board activity in the coming twelve months:

Early Help

a. Review the Early Help Strategy for formal approval of the Family Strategic Partnership Board.
b. Develop, implement and embed a solution focused methodology for all Early Help Professionals.
c. Develop specific forums for children and young people and parents and carers to seek feedback on their experiences and effectiveness of the services and support they have received.
d. Improve the analysis of data to measure the effectiveness of Early Help on statutory services particularly referrals to the Safeguarding Referral Team, Children in Need plans and Child Protection Plans.

Neglect

a. To refresh the SSCB Neglect strategy to ensure that smart outcomes are clear and that partner agencies can continue to maintain the focus on delivering assurances to the Board. It has been identified that the above assurances should be sought in relation to Third Sector parental mental health provision. The extent to which this already takes place is not known and needs to be examined.
b. To ensure that that the current activity by Staffordshire County Council, Stoke-on-Trent City Council and the Staffordshire Police and Crime Commissioner who are jointly commissioning domestic abuse services across the City Council and County Council areas under joint contracts are designed to provide a consistently high quality service that will:-

i. be more responsive to the needs of victims and their children
ii. promote early identification and referral
iii. have a greater focus on prevention
iv. address perpetrator behaviours

Child Sexual Abuse

a. To continue with the rigour and focus on this priority to maintain its significant importance with partner agencies whilst being cognisant that this is the second year of a three year strategic plan and encourage the further embedding of activity which demonstrates evidence of improved outcomes.
b. The continued focus for the strategic alignment with other related activity discussions have taken place and continue with the Safer Staffordshire Strategic Board where there is overlapping activity.
c. Strategic partnerships without clear co-ordination can cause governance and leadership confusion in respect of local priorities. Therefore it is paramount that all partner agencies are fully sighted on individual areas of strength and areas for development relating to those key strategic priorities in order to achieve the best possible outcomes for children, young people and families.

12. To fully utilize the enhanced Joint Strategic Needs Assessment (JSNA) for safeguarding children with key partner agencies who work with children and their families. This would create the potential for a shared vision about working together to help keep children safer, smarter multi-agency prioritisation and cohesive strategically aligned planning and delivery that could be more innovative. This multi-agency approach would complement the national drive towards integrated inspection, joint accountability frameworks, stronger local multi-agency governance and scrutiny arrangements.

13. The national consultation of the formal Working Together legislation and arrangements concludes in December 2017 with an amended framework proposed for April 2018. The proposed vision is for a framework where there would be the local freedom to recognise geographical and political differences. This provides an opportunity to reduce system bureaucracy, to work more efficiently as an inter-agency partnership and refocus partner agency resources back onto the coordination and effectiveness of child protection arrangements.

14. All children and young people should have equal access to information about how to keep themselves safer regardless of where they live in the county and what education provision they are accessing. Parents and carers should also receive consistent messages about how to help keep their children safe and education staff should know about local multi-agency arrangements or learning that helps them to fulfil their critical safeguarding role. Whilst some good work has been undertaken, further action is required to help to build on this to ensure that there is a consistent approach across the county; this is particularly pertinent given the change in local authority roles and responsibilities. This includes communication to all early years providers, schools, colleges and alternative education provision.

Link to Strategic Plan:

15. The work of the SSCB contributes to and supports the values and principles detailed in the Staffordshire County Council's Strategic plan for 2014-2018, particularly in relation to the priority outcome for the people of Staffordshire to, *'Feel safer, happier and more supported in and by their community'.*

Link to Other Overview and Scrutiny Activity:

16. The work of the SSCB links to Committee's overview of the local authority's Children's Social Care arrangements, domestic abuse and child sexual exploitation.

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Appendices/Background papers:

Appendix A - Staffordshire Safeguarding Children Board Annual Report: 2016-2017.

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STAFFORDSHIRE SAFEGUARDING CHILDREN BOARD

Annual Report on the Effectiveness of Safeguarding Children in Staffordshire

1st April 2016 - 31st March 2017

Contents Page

INTRODUCTION AND WELCOME

Purpose of this Report

It is a statutory requirement under Section 14A of the Children Act 2004 for the Chair of a Local Safeguarding Children Board (LSCB), in this case Staffordshire, to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.

This annual report provides a rigorous assessment of the performance and effectiveness of local services that have responsibilities to safeguard children and accordingly it:

- Provides evidence of progress and achievements
- Identifies areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action
- Demonstrates the extent to which the functions of the LSCB are being effectively discharged
- Includes an account of progress made in implementing actions from Serious Case Reviews (SCR) and Learning Reviews
- Provides an outline of the assurances sought about the work of the Staffordshire Family Strategic Partnership Board

Who should read this report?

In accordance with statutory requirements and best practice this annual report has been sent to the Staffordshire Deputy Chief Executive and Director of Families and Communities, Deputy Director of Children's Services, the Lead Member for Children's Services, the Police and Crime Commissioner, Chair of the Staffordshire Health and Wellbeing Board and the Chief Officers of all partner organisations represented on the Safeguarding Children Board.

The report is presented to the Staffordshire County Council Overview and Scrutiny Committee demonstrating transparency and enabling further scrutiny and challenge.

Operational managers and frontline practitioners should be provided with a copy of the report to enable awareness of the work undertaken through the Board during 2016-2017 to help our wider workforce to understand what they have helped to achieve during the year and the plans for working together to achieve the desired safeguarding children outcomes for 2017-2018.

This report is published on the Staffordshire Safeguarding Children Board website SSCB Annual Reports to provide a visible public account of the work of the Board and its connected partners.

Foreword

It is my privilege as Independent Chair to write the Foreword to this Annual Report of the Staffordshire Safeguarding Children Board.

The current economic and social climate continues to be very challenging for families and for those professionals working with children who are at risk of neglect and abuse. Statutory services are working to capacity as a result of increasing numbers of referrals over recent years and at the same time partner agencies are facing pressures from a significant reduction in public funding and increased levels of poverty and deprivation within communities. This combination of socio-economic factors can result in extremely vulnerable families and the potential for increases in the numbers of cases of neglect and abuse of children and young people.

It is against this background that this annual report provides an overview of the work of the Board and how, despite operating in austere times with the reality of having to do more with less that, safeguarding partners are making a positive difference to ensuring that children and young people who may be at risk of or experiencing abuse or neglect are protected. As you will read the Board has actively sought assurances as to the effectiveness of the local arrangements to protect children and young people by commissioning audits of the quality of case work practice in joint working between adult mental health services, drug and alcohol services and children's services and used the findings to drive improvements.

In my role as Independent Chair I have been able to see and continue to be impressed and encouraged by the energy, commitment and enthusiasm of Board members as well as the many front line practitioners that I have met and their clear focus on doing their very best for the children and young people 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 Business teams 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 QPM

ABOUT THE BOARD

Statutory context

The Children Act 2004 (sections 13 and 14) requires each Local Authority to establish a Local Safeguarding Children Board (LSCB) to co-ordinate the actions of partner agencies and ensure the effectiveness of the local arrangements to safeguard children.

The statutory guidance, "Working Together to Safeguard Children" (Department for Education 2015) provides the framework informing how agencies should work together to help to safeguard and promote the welfare of children and young people.

The Staffordshire Safeguarding Children Board has a range of roles, responsibilities and statutory functions as set out in the Children Act and Regulations 5 and 6 of the Local Safeguarding Children Board Regulations 2006 that are summarised below:

- Participating in the planning of services for children in the area of the local authority
- Developing policies and procedures for safeguarding and promoting the welfare of children
- Monitoring the effectiveness of what is done to safeguard and promote the welfare of children
- Delivering effective multi-agency safeguarding training
- Undertaking serious case reviews
- Communicating the need to safeguard and promote the welfare of children
- Publishing an Annual Report on the effectiveness of local arrangements to safeguard and promote the welfare of children

Composition and governance arrangements

The Board has a broad membership of statutory partners and others connected with safeguarding children and is chaired by an Independent Chair appointed by Staffordshire County Council in conjunction with Board members. The Board membership is shown at **Appendix 1** on page 73.

The existing contract of the Independent Chair is reviewed on an annual basis in the form of a review with the Staffordshire Chief Executive and Deputy Chief Executive/Director of Families and Communities informed by reflections and formal appraisal from members of the Board.

The Board met four times during 2016/17. In relation to attendance at SCB meetings, a named deputy is accepted and through this arrangement the vast majority of members attended all meetings. The Chair communicates directly with the Chief Officer of partners not maintaining regular attendance to understand the reasons and to ensure active engagement.

An annual review of roles and responsibilities of Board members, the sub-groups chairs and Terms of Reference of each sub-group was undertaken in September 2016. Each SCB member is required to sign a copy of a Memorandum of Agreement which asks for confirmation that requirements of Board membership are met. This document is countersigned by the Chief

Officer of each individual agency. The SCB Constitution is next due to be reviewed in November 2017 to ensure that it remains fit for purpose.

Relationship with other forums

The Board is dependent on the performance of agencies with a safeguarding remit for meeting its objectives. The Organisation Structure at **Appendix 2** on page 75 shows the sub-groups and the strategic partnerships with which the Board is required to agree responsibilities and reporting relationships to ensure collaborative action and mutual accountabilities.

A Memorandum of Understanding is in place between the Staffordshire Families Strategic Partnership Board (FSPB), the Health and Wellbeing Board (HWB) and Staffordshire Safeguarding Children Board.

Through the attendance of the Independent Chair and several members of the Safeguarding Children Board, links are maintained with the Staffordshire Families Strategic Partnership Board (FSPB), which is accountable in Staffordshire for overseeing the development and delivery of the Staffordshire's Children, Young People and Families Strategy 2016 – 2026 that has a specific focus on ensuring the welfare and safety of children and young people. The FSPB considers the annual report of the Safeguarding Children Board in preparing and refreshing the Children, Young People and Families Strategy. The Health and Wellbeing Board is required to consider the annual report in completing the Joint Strategic Needs Assessment. The Safeguarding Children Board holds both those bodies accountable for their delivery of good safeguarding practice.

During 2016/17 the Independent Chair has met regularly with the:

- Councillors with lead responsibilities for children and young people
- Deputy Chief Executive and Director of Families and Communities
- Head of Families First and Deputy Director for Children's Social Care (who is also Chair of Safeguarding Children Board Executive Group)

He attends the quarterly meeting of the Safer Staffordshire Strategic Board chaired by the Police and Crime Commissioner.

The Safeguarding Children Board managers for Staffordshire and Stoke-on-Trent meet on a regular basis with the Board manager of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board to ensure effective joint working and appropriate information

sharing. There have been benefits, particularly in relation to consistency of practice, from the three Boards having the same Independent Chair.

ANALYSIS OF EFFECTIVENESS IN SAFEGUARDING CHILDREN

Analysis of Effectiveness in Safeguarding Children

This section of the report provides an assessment of the effectiveness and performance of local services. The categories and themes do not cover all the factors influencing the risk to children and young people within Staffordshire. The focus is on key local vulnerabilities and related themes which the Board needs to have scrutiny and seek assurances about in order to help ensure the effectiveness of local inter-agency arrangements to protect children and young people.

About Staffordshire's Children

Approximately 168,824 children and young people under the age of 18 years live in Staffordshire. This is approximately 20% of the total population in the area.

Approximately 15% of the local authority's children are living in poverty.

The proportion of children entitled to free school meals:

- in primary schools is 9.4% (the national average is 14.1%)
- in secondary schools is 8.7% (the national average is 12.9%)

There are 490 children and young people with a disability who are supported by the Children with Disabilities Team.

Based on the Index of Multiple Deprivation 2015, Staffordshire is a relatively affluent area but has notable pockets of high deprivation in some of its urban areas with 9% of its population living in the fifth most deprived areas nationally. In addition some of the remote rural areas in Staffordshire have issues with hidden deprivation, particularly around access to services.

Children and young people from minority ethnic groups account for 8.5% of all children living in the area, compared with 25.1% in the country as a whole.

The largest minority ethnic groups of children and young people in the area are Asian British 4% and mixed 3%. The proportion of children and young people with English as an additional language:

- in primary schools is 7.5% (the national average is 20.6%)
- in secondary schools is 5% (the national average is 16.2%)

Contacts and Referrals to Children's Social Care

During 2016-2017 there were a total of 11,585 contacts to the Staffordshire Children's Social Care First Response Team (FRT), an increase of 3% from the previous year (11,253). This equates to an average of 223 contacts per week that cover a range of issues concerning the welfare of children and young people. The FRT is based within our local Multi-agency Safeguarding Hub (MASH) where a highly trained team of workers, including social workers and senior practitioners consider every contact received.

Of the 11,585 contacts made to the FRT 10,034 (86.6%) had an outcome of advice and information, 1240 (10.7%) were referred to Local Support Teams, the remaining 211 (2.7%) were no further action.

Following contact, the FRT aims to ensure that those children meeting thresholds for statutory assessments are progressed as referrals to Children's Social Care (CSC) social work teams. Local Authorities have a duty to undertake these assessments to determine what services to a child may need and any action required.

Staffordshire Children's Social Care received 9142 referrals in 2016-17. Referrals have increased from the previous year (8469) by 7.9%. The proportion of referrals resulting in no further action (NFA) has decreased, from 9.6% to 8.8%. Staffordshire's Social Care Services continue to work with partners to ensure that threshold and referral criteria are clearly understood by referring agencies and professionals.

The proportion of re-referrals within one year (21.0%) has increased slightly from last year (18.8%) though is below the statistical neighbours' (22.1%) and national (22.3%) averages. Staffordshire's re-referral rates over the last five years have been below the national and statistical neighbouring authorities' averages.

Children's Social Care Assessments

During 2016-2017, 10,489 social work assessments were completed; an increase of 7% from the previous year (9,792). 1,086 assessments were in progress as at 31/03/17.

The timeliness of child social work assessments completed in 45 days has remained stable at 84.4% (85.3% in 2015-2016). This performance is just above the national (83.4%) and statistical neighbouring authorities' (84.2%) rates. Staffordshire monitors assessment timeliness very closely every month to ensure continuous improvement and reduce the potential stress involved for families during the assessment process. Staffordshire continues to promote the use of an interactive safeguarding dashboard by managers which aims to avoid delays in families having a specialist assessment.

As at the end of March, the total number of cases open cross all Children's Social Care Families First service areas was 5054, a 10% decrease from the same period 12 months earlier (5620); this follows a focused drive to close cases promptly and avoid drift. The numbers of cases closing in 2016-2017 has increased by 19% from 2015-2016.

Children in Need (CiN)

Section 17 of the Children Act 1989 defines a child in need as 'a child who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services'.

At the end of March 2017, Staffordshire had 2906 child in need cases open (including those in assessment), compared to 3323 at the end of March 2016, a decrease of 417; this is mainly due to improved recording processes, robust case management oversight ensuring that cases are assessed more promptly and case closures are being appropriately closed in a more timely way.

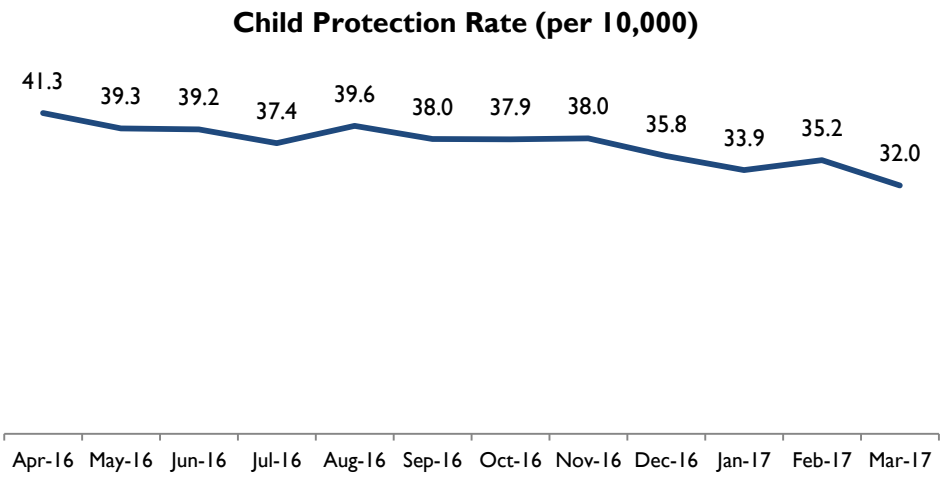
The national rate of Children in Need (includes CiN cases, CP and LAC) rate was 288.9 for Staffordshire, a decrease from the previous year (343.8); due to the CP population decreasing. This rate is below both the national (337.7) and statistical neighbouring authorities' (309.9) average for 2015-16.

One third (33.1%) of Staffordshire's children in need cases open as at March 2017 had been open more than two years, similar to last year's figure (32.9%) and in line with the national (30.9%) and statistical neighbours' (30.3%) average for 2015-16.

Child Protection

Child protection is the process of protecting individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect. It involves measures and structures designed to prevent and respond to abuse and neglect. A child protection plan is drawn up by the local authority. It sets out how the child can be kept safe, how things can be made better for the family and what support they will need. Parents are informed of the reason for the plan.

Child Protection Rate Diagram:



Between April 2016 and March 2017, the Child Protection population has been declining. This can be partially explained by the cyclic nature of children subject of a Child Protection Plan and proactive management of children subject of Child Protection Plans for 15 months or over by County Managers and the Independent Chairs Service. The proportion of children subject of a Child Protection Plan for greater than 15 months has reduced from 11% in April 2016 to 9% at the end of March 2017. Staffordshire's rate at the end of March 2017 (32.0) is below the statistical neighbours' (45.7) and the national (43.1) average (2015-2016).

706 children and young people in total became the subject of a child protection plan over the annual period (-13% from 2015-2016) and 871 ceased to be the subject of a plan (+21% from 2015-16). For the latter group of children this was a result of positive outcomes such as improved parenting capacity that led to a return home, living with other family and friends, special guardianships or adoption.

Staffordshire's proportion of Initial Child Protection Conferences held within the required timescale of fifteen days from the start of the section 47 enquiries has increased this year, from 86.6% to 89.6%. This is higher than the national (76.7%), regional (76.5%) and statistical neighbours' (77.1%) averages (2015-2016). Improvements have been made to data quality and

this is being monitored by Safeguarding Review Managers on a regular basis to ensure that timescales are being met.

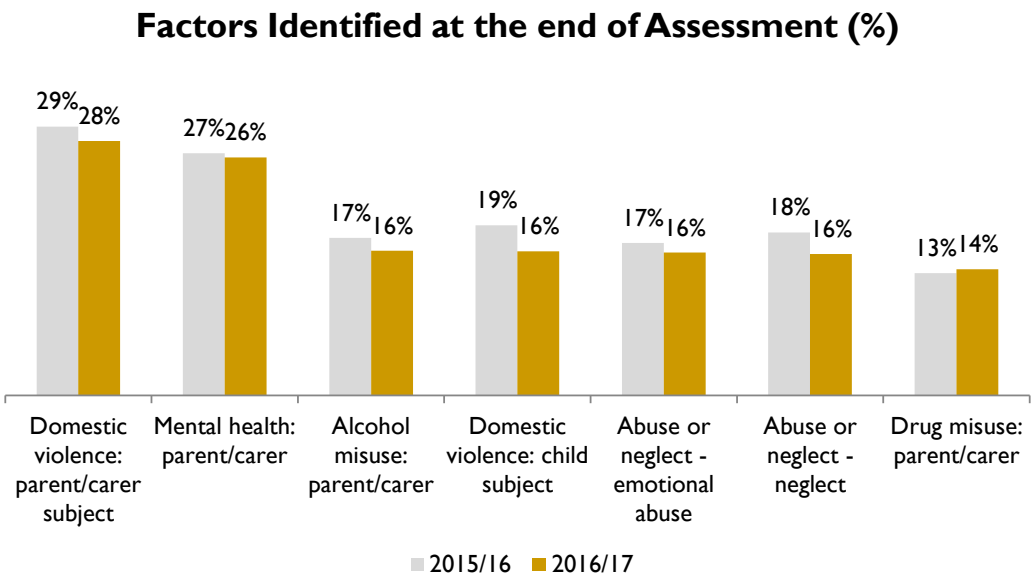
There has been a decrease in the proportion of children subject of a child protection plan for a second or subsequent time this year, from 18.8% in April 2016 to 16.4% in March 2017. This proportion is just below the national (17.9%) and statistical neighbours' (16.6%) averages for 2015-2016.

An improved reporting process has been introduced to provide managers with a bi-monthly report that identifies children that have been subject of a child protection plan for 15 months. This enables managers to rigorously review cases to reduce drift and help ensure that planned work is focused to reduce risk factors and identify appropriate exit strategies. Staffordshire CSC will monitor the impact of this revised process and will be required provide an assurance report to the SSCB Performance Management Subgroup.

Staffordshire's proportion of child protection reviews in timescale has remained high this year at 97.9% (99.1% in 2015-2016); this is higher than the national (93.7%) and statistical neighbours (94.6%) level.

Risk Factors

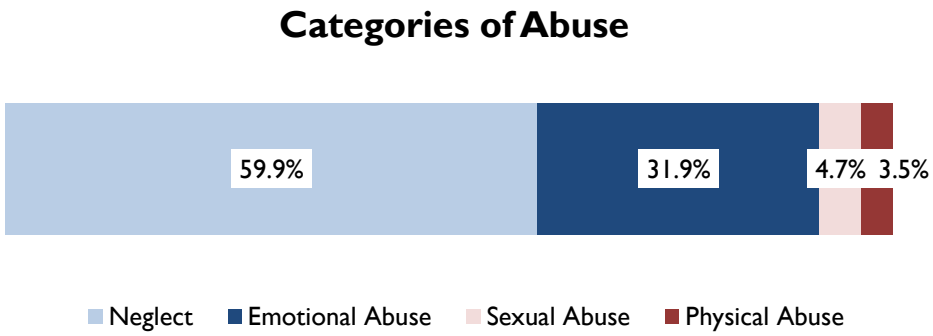
Risk Factors Graph:



The risk factors identified at the end of the single assessment process are submitted by all local authorities for the annual Child in Need Census. The above chart identifies the most frequent factors in Staffordshire over the past two years (national data for 2016-2017 has not yet been published); there has been no significant change since 2015-2016. As a proportion of all assessments completed in the period, the risk factors identified as being the most prevalent related to domestic violence (parent/carer is subject to) - 28%, followed by mental health (parent/carer is subject to) - 26%, alcohol misuse (parent/carer is subject to) – 16%, domestic violence (child subject) – 16%, emotional abuse – 16%, neglect – 16%, and drug misuse (parent/carer is subject to) – 14%. Toxic trio, where domestic abuse, substance misuse and mental health issues are identified makes up 8% of assessments.

Categories of Abuse

Child Protection – Categories of Abuse Diagram:

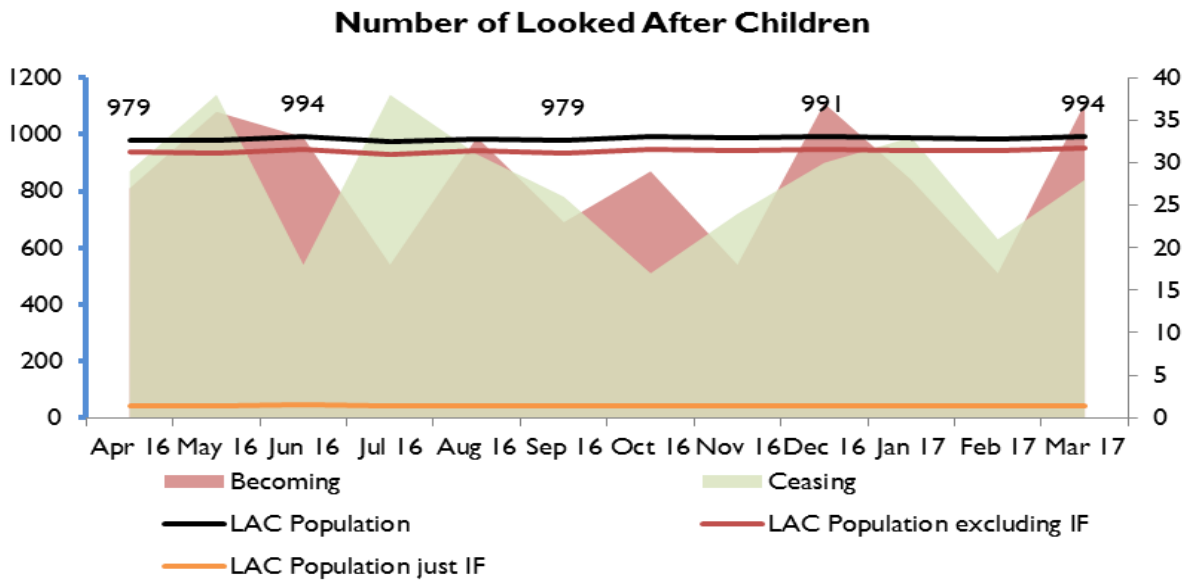


Of the 706 local children and young people becoming subject of a child protection plan in the year, neglect continues to represent the largest category (59.9%); proportions of all categories remain similar to last years' figures. This forms the rationale for neglect being a joint strategic safeguarding children priority for Staffordshire and Stoke-on-Trent LSCBs.

Looked after Children in Staffordshire

'Looked after Children' is the term for children and young people who are in the care of the local authority. They can be placed in care voluntarily by parents /carers who are struggling to cope; they can be unaccompanied asylum seeking children; or children and young people in other circumstances. The local authority and partner agencies will also intervene when a child or young person is at risk of significant harm. Children and young people who come into the care system at a younger age are more likely to go on to be adopted or be made subject of Special Guardianship Orders. In such instances children and young people are able to leave the care system at an early stage; however older children and young people are more likely to remain longer term in the care of the local authority.

Number of Looked After Children Diagram:



The number of children and young people looked after in Staffordshire at 31st March 2017 was 994; an increase of 11 (1.1%) children and young people from the previous year. According to the latest data, the national figures for looked after children have increased by 1.4% but decreased by 1.3% across the West Midlands region. The looked after children population figure for Staffordshire is higher than the average population across our statistical neighbours of 761.

Latest statistics state that the rate of looked after children has risen to 58 per 10,000 from 55 the previous year. This is lower than the national rate of 60. During 2016 – 2017 there were 346 children starting to be looked after, 27 less in comparison to last year's figure of 373. Families First are analysing vulnerable children populations to look at reasons for changes and any pressure points in the system to support strategies to reduce the looked after population when it is safe and appropriate to do so.

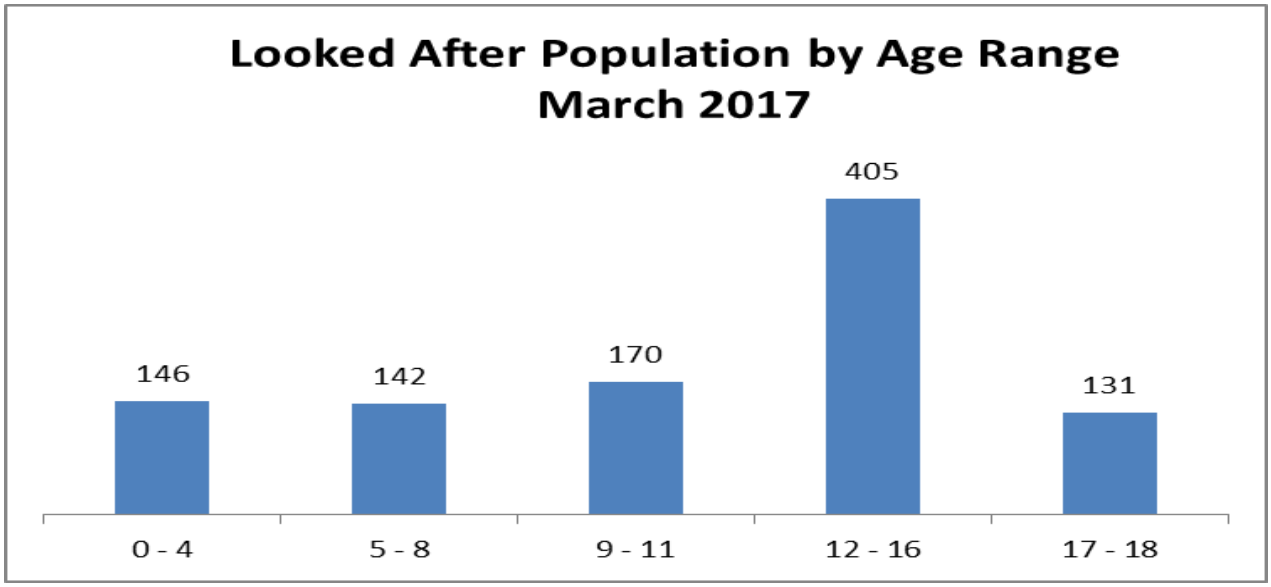
There were 338 children ceasing to be looked after (an increase of 38) compared to the previous year of 331. The main reasons for ceasing are returning home to their parents or guardians (27% which is a 4% increase than last year (23%); adoption (at 12% which is nearly half of last years (22%); and special guardianship (at 13% which is 15% less than last year (28%). Staffordshire's Intensive Prevention Service (IPS) has continued to have a major impact in reducing the number of teenagers coming into care by offering intensive support in their home environment.

The stability of those children in a long term placement of two years or more has increased to 70.5% from 64.8 in the previous year. The CSC short term stability indicator (of three plus placements in twelve months) has decreased to 9.7% (from 12.4% in 2015-2016) – last year's increase was partly due to a number of planned placement moves occurring during this time. A new auditing process has been designed and introduced to monitor placement stability more

closely and help reduce the number of any unplanned placement moves children and young people experience.

Children and young people in care are subject to Statutory Reviews in a prescribed timescale. The first review must be undertaken within twenty days, followed by a subsequent review at three months and every six months thereafter. Keeping Staffordshire's looked after children safe and achieving their potential is a key part of the local authority's corporate parenting responsibilities, with the Independent Chairs service having a pivotal role in supporting this. The majority of looked after child reviews during 2016-2017 (94.8%) were held on time and in accordance with national guidance; this figure is an increase from last year (90.4%).

Looked After Children by Age Range:



From an age perspective the largest increase in looked after children was in the 12 - 16 year age cohort which has risen from 386 children and young people in 2016 to 405 children in 2017**.** Whilst there was an increase in the 9 – 11 year age cohort (10) a fall was recorded in the numbers of Looked After Children aged 0 - 4 and 5 - 8 (10 and 18 less respectively), as well as those aged 17 - 18 (10).

Placement type and location

The vast majority of looked after children 604 (60.8%) are in foster placements, which is a slight increase on last year's figure of 592 (60.2%). Staffordshire has 91 (9.2%) children and young people in residential placements, a decrease of 14 in comparison to figures as at March 2016.

At the end of March 2017, 320 looked after children were in placements outside the Local Authority area (32.2%) which is a 2.4% increase from figures obtained at March 2016 (274).

When a decision is made by the local authority to place a looked after child outside of its area high priority must be given to the child's needs. During the year CSC services has continued to lead work on supporting this group of looked after children across multi-agency partners and to resolve any common issues, for example around accessing mental health support for young people placed in other areas.

Unaccompanied Asylum Seeking Children (UASC)

The numbers of UASC in Staffordshire has risen from 75 in March 2016 and 86 in March 2017.

The latest figures show that Staffordshire has a higher average than our statistical neighbours (58). Work has been undertaken to review this increase and this has identified a link with the county's proximity to the motorway network.

Children subject to Care Proceedings

The Government implemented the Family Justice Review (FJR) in an attempt to significantly reduce delay in care proceedings concerning children and young people considered to be at serious risk of significant harm. As a result of the FJR, the expectation is that all care proceedings should be completed within twenty-six weeks. In exceptional circumstances, cases can be extended for a further eight weeks.

The number of orders granted in Staffordshire has increased from 347 in 2015-2016 to 402 between April 2016 to March 2017, a rise of 52 (15.9%). Of these 402 orders, over half (55%) were for Interim Care Orders, which is a small increase from last year's where it was 51% of the total orders granted. 31% of orders granted in the year were Full Care orders whilst 14% of them were Placement Orders.

Figures available from the Children and Family Court Advisory and Support Service (CAFCASS) on the timeliness of care proceedings reveal that at the end of March 2017, the average duration of care applications in Staffordshire was 31 weeks, an increase of 4 weeks in comparison to last years (27). Nonetheless, Staffordshire's figure for 2016 – 2017 was equal to that of the national average.

Links between the Local Family Justice Board (LFJB) and the Safeguarding Children Board are ensured through our Chair of the Executive Group and other Board partners attending the LFJB.

Adoption

During 2016-2017 the number of children adopted decreased in Staffordshire from 74 to 42.

Nationally the percentage of children leaving care due to adoption has remained the same (16%), however Staffordshire's figure (21%) is higher than average in comparison to our statistical neighbours (19.2%). Staffordshire also recorded the seconded highest increase in comparison to the previous years (an increase of 2%). It is important to note that these figures are run on a three year basis, with the latest figures from 2013 – 2016.

In addition, figures released by the Adoption Leadership Board suggests that the average length of time spent waiting since entering care at the end of March 2017 was 385 days in Staffordshire. According to the latest figures, this is less than the national average (543), the West Midlands average (530) and the average for our statistical neighbours (496) which demonstrates the speed and effectiveness of our adoption system in Staffordshire.

Children with Disabilities

The Children with Disabilities Team (CWD) was working with 490 children and young people at the end of March 2017 who had been assessed as having a social care need linked to their disability. 43 of the disabled children were looked after by the local authority. Where there are

increased concerns or it becomes evident that a parent is unable to safeguard their child from harm Staffordshire's CSC services will investigate the concerns. The child's CWD worker also remains involved throughout.

Staffordshire's Care Leavers

Some of our most vulnerable young people are care leavers who are in need of safeguarding and support as they transition into adulthood. In Staffordshire care leavers are well supported by their personal advisors with the implementation of the 'staying put' policy helping care leavers feel safe where they are living.

From recent analysis undertaken, information indicates that between April 2015 - July 2017, just over half of the children ceasing care in a fostering placement went on to Staying Put (42)

Staffordshire's looked after children service has been working in partnership with 'Sustain' in a new contract, which commenced in April 2015 to focus on extending the age of engagement with young people up to 25 years. This is a very significant development as the previous service end date of 18 years has left some young people vulnerable. A Multi-Agency Complex Cases Panel has been established to look at those cases which don't meet adult safeguarding/ protection criteria. A structured programme of preparation for independence is undertaken with young people through the National Youth Advisory Service (NYAS)[1] CD Rom which provides a series of 'Getting Ready for Life' modules.

There is evidence of progress with care leavers in education, training and employment with increasing levels of care leavers going to university; joint work with the Virtual Head teacher and Entrust around post 16 years opportunities and Staffordshire's Foundation to Employment scheme which has received a quality mark. There is still work to do in ensuring that the local authority is investing in care leavers so they can live independent safe lives.

Missing Children

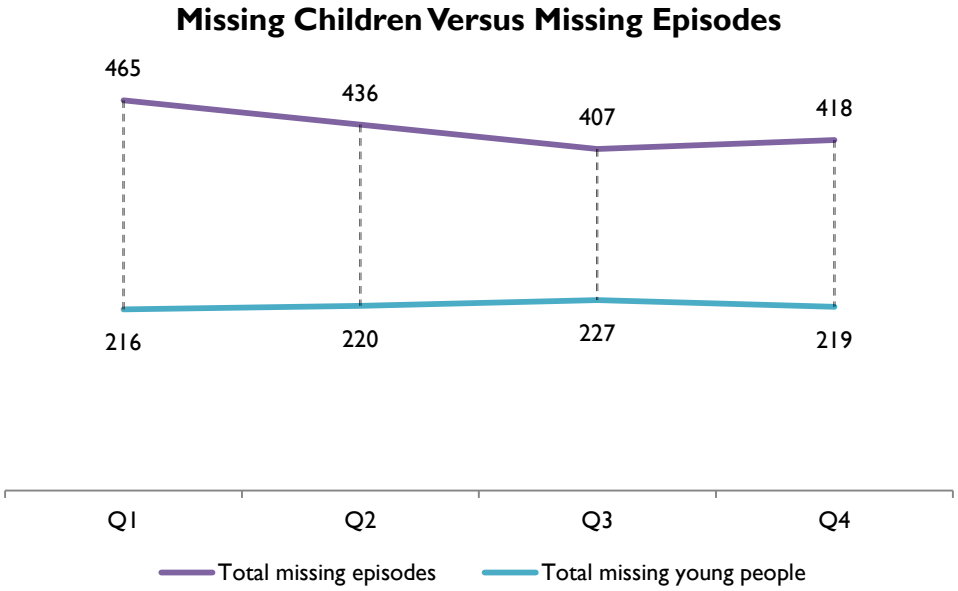
Under section 13 of the Children Act 2004, Staffordshire CSC services along with its statutory partners (such as health, police and education services) are required to have in place arrangements to ensure that our statutory functions are discharged to safeguard and promote the welfare of children. This includes planning to prevent children from going missing; including assessing any risks, analysing data for patterns and trends associated with particular concerns and risks and taking a proactive approach to reduce missing episodes or to protect children when they do go missing.

As part of the framework to safeguard children, a joint protocol between Staffordshire and Stoke on Trent Local Authorities and Staffordshire Police is in place for those children who go missing from home or care.

The Strategic Lead for Looked after Children continues to chair the Strategic Missing Children Board that works to a clear action plan. A Missing Children Operational Group also focuses on learning and trends across the county in respect of for example the child / young person, their placement, locations, the reason for the missing episode and any associated risk factors.

[1] [1] The NYAS CD rom is a series of modules which young people work through with their foster / residential carers on issues such as budgeting, being a good tenant etc. in preparation for when they have to live on their own.

These multi-agency meetings help to ensure a focus on these vulnerable groups of children and young people. In addition strong information sharing links have been established between CSE and children missing from education.



During 2016/2017, 882 young people went missing from home and care, with a total of 1726 missing episodes. Numbers of young people going missing have remained stable over the period, however the number of missing episodes has reduced by 47 from quarter one to year end. The majority of young people going missing (74%) have had previous missing episodes.

Young people going missing have increased by 37% compared to last year, however, missing episodes have only increased by 15 episodes since 2015/2016. This increase may be explained as more cases are actually being reported, rather than an actual increase in children gong missing.

The average number of children and young people missing per quarter is 220, with just over a third being other local authority looked after children placed in Staffordshire. 41% (707) of missing episodes are from Independent Care Homes, of those episodes from these homes, 68% are from Other Local Authorities. Another 40% (695) missing episodes are from Home and 10% of missing episodes were from Foster Care provision.

The children and young people repeatedly missing are all known to CSC services and for this particular cohort, there is a high correlation between their missing episodes and vulnerabilities associated with child sexual exploitation, youth offending, learning difficulties or disabilities and problems within the school environment.

There is a continuing trend of females that go missing more than once compared to males and the 15-16 year old age range is the highest cohort.

Most young people went missing from Stafford (17%) with 287 episodes; however in Staffordshire Moorland there were more missing episodes (323), but slightly less young people. This is in line with last year's reporting, where the number of missing episodes in Staffordshire

Moorlands was highest. South Staffordshire and Lichfield remain the areas where young people and episodes reporting have been the lowest.

The local authority is continuing to work in partnership with Staffordshire Police to target hot spot locations, particular children's homes and foster carers experiencing high levels of call-out incidents. A Care Pack has been circulated to Independent Care Homes and Foster Carers to support them with managing children going missing who are in their care.

There is also an improved recording process on CSC ICT systems around the missing episode and return interview; this helps to ensure that the local authority and social workers have the relevant information needed to safeguard children and young people. Monthly and quarterly performance reporting systems are in place to monitor demand, manage risk, timescale compliance and to provide general insight into local themes.

Brighter Futures were commissioned for a twelve month pilot in Staffordshire Moorlands, Newcastle and Stafford up to the end of August 2017. Families First employed dedicated Return Interview Workers to target the remaining District/Borough areas. Improvements have been made in relation to notifications from other local authorities placing children and young people in Staffordshire; a revised notification form and letters setting out expectations has been implemented.

Over the last twelve months the local authority has strengthened the focus around missing children from care and home, particularly around the return interview process and performance management arrangements. On average, over the year, a total of 80% of return interviews are undertaken for children that go missing; 57% are held within 72 hours. It is often difficult to conduct the interview meeting within the 72 hour guideline when young people have gone missing from home and therefore, having to rely on the cooperation of the family/young person making themselves available.

The reasons given for young people going missing are consistent with reasons reported in previous years; 'to be with friend' was the most common reason given, followed by 'no apparent reason'. Other reasons provided include coping mechanism, unsettled at home, substance misuse, boredom, confrontation and family ties.

Three cohorts of the most prolific missing young people have been reviewed by the Operational Missing Group. Findings reveal that, although risks, push and pull factors have remained static across the three cohorts, there have been changes in the characteristics of the young people.

The proportions of young people with a current Youth Justice Order at the time of their missing episodes has increased over the three cohorts. Whilst there were changes in the seriousness of offences and orders, violent offences were the most prevalent across all cohorts. Proportions of young people with fixed term exclusions in the previous 12 months have increased over the cohorts, however, this was not seen for permanent exclusions. Levels of special educational need were much higher in the second cohort than the other two. Across the three cohorts, most young people with identified special educational needs were being supported below the level of an Education Health and Care Plan. In the second cohort there were a number of young people who self-harmed and/or had been detailed under the Mental Health Act. Similar levels were not seen in the other two cohorts.

The Staffordshire Voice Project undertook some consultation with young people. The session covered what support information could be offered to young people who go missing, reasons why young people might go missing, what makes young people feel safe and what traits a support worker should have to work with young people who go missing. Young people suggested that having a list of contact numbers when they feel like running away again (including ChildLine) ,a top tips information sheet, including reasons or misunderstandings that are the cause of running away may prove useful. Having a buddy, mentor or advocate who has been through the same or similar situation who could empathise with their situation could also help. The information provided will be used by the local authority when commissioning new Missing Services/Workers.

Young people reported feeling safe when they knew someone cared about them, that they have a good relationship with their carer/s and time is taken to make a bond so they can talk openly about any worries. Ensuring that placement matching is right and that where possible children are placed with siblings or that good contact is maintained when they're not.

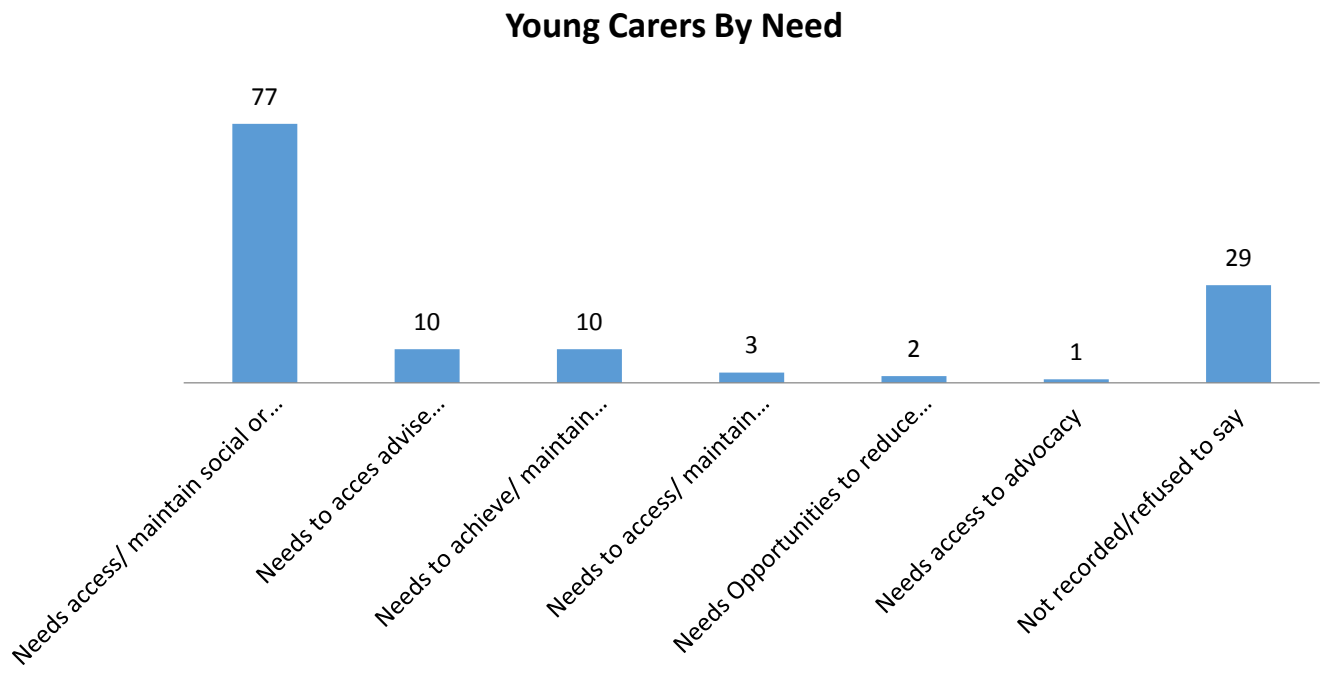
The main focus for the coming year will be to embed the arrangements for the newly commissioned Service for Missing Children and Child Sexual Exploitation Service to ensure consistent quality provision across the County for supporting children and young people.

Young Carers

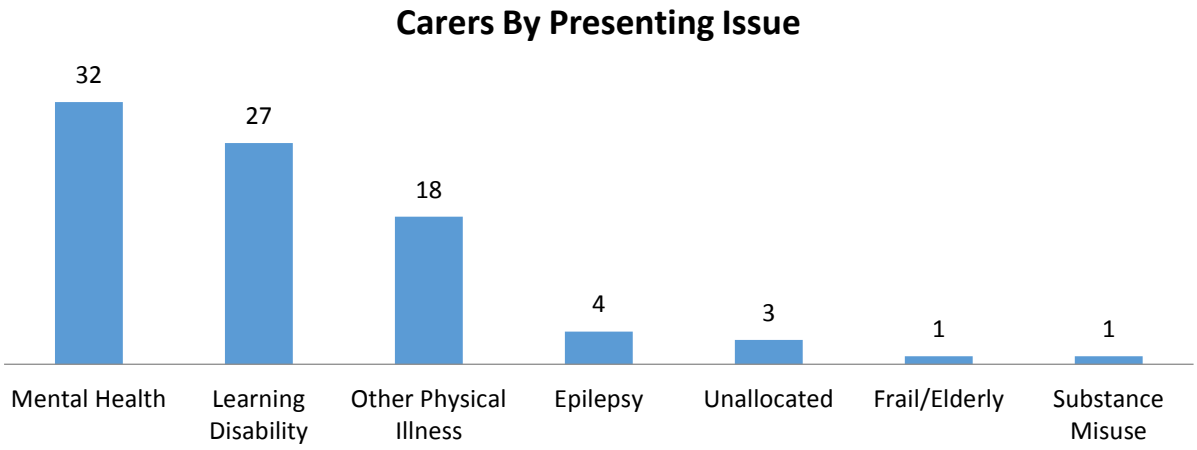
Young carers are children and young people aged from 5 to 18 years who provide regular or on-going care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances. A young carer becomes vulnerable when the level of care given and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical well-being or educational achievement and life chances.

New legislation under the Care Act 2014 and the Children and Families Act 2014 came into force in April 2015 where all young carers are entitled to an assessment of their needs from the local authority. From October 1st 2015 Staffordshire County Council has a commissioned and appointed a service to manage, co-ordinate and provide an integrated Carers Hub.

The Hub received 132 referrals during 2016/2017, 18 are 5-10 years old, 101 are 10-15 years old and 13 that are 15-18 years old. The majority of the young carers were female.



The majority of young carers were supported to access and maintain social or leisure activities.



The above information shows the number of carers by presenting issue, showing that for the majority this was caring for someone with a physical illness, with another 45% due to either mental health issues or learning disabilities.

Private Fostering

A child under the age of 16 (under 18, if disabled) who is cared for and provided with accommodation by someone other than a parent, a person with parental responsibility or a close relative for twenty-eight days or more is privately fostered.

At the end of March 2017, there were 15 children and young people who were reported to be living in private fostering arrangements. This is a decrease in the previous year (when 20 children and young people were identified.

The main age range for those children living in private fostering arrangements was between 12-15 years and the majority gender of the children referred was predominantly males. In respect of the ethnicity of the children it is evidenced that half of the children privately fostered in Staffordshire during this annual period were from the UK, with the rest of the children originating from Asia, Europe, Caribbean and Africa.

It is evident that private fostering arrangements continue to be a grey area, due to individuals and other agencies outside of the local authority remaining unclear about what constitutes as a `private fostering arrangement` and not making a referral to CSC services. It is recognised that this is an area that will continue to require ongoing improvements if we are to increase the number of notifications received.

Whilst Staffordshire has met the minimum requirement for responding to notifications, there are areas that require improvement, particularly in respect of the timeliness of initial actions, visits and ongoing statutory visits in accordance with DfE minimum standards. This is a key area for continued improvement during 2017-2018.

Raising awareness

Staffordshire's Private Fostering Communication Strategy was initiated in 2012 following additional direction from the Department for Education. The Communication action plan was reviewed in June 2016 and February 2017. The following actions were completed between April 2016 – March 2017:

- Internal campaign undertaken to key stakeholders via increased activity on the website including links to the new leaflets for Private Fostering.
- Private Fostering posters were devised for schools and other agencies.
- Private Fostering leaflets, posters and explanatory letters were sent to an extensive list of schools (Inc.; private and language schools), guardianship agencies, AEGIS whom many guardianship agencies are a member of, faith groups and GP surgeries.
- Information about Private Fostering was published in the Staffordshire Safeguarding Children's Newsletter.
- A day in the life of a social worker managing Private Fostering cases is posted on Staffordshire's webpage for Private Fostering.
- Feedback from a private foster carer was uploaded onto the website to evidence `what Private Fostering has meant for them` and the support they received from Staffordshire County Council, which supported the placement to be successful.
- SSCB continue to raise awareness with social workers, health and education professionals. Leaflets are also provided and a power point presentation devised to enable all professionals to understand their roles/responsibilities regarding notifying the First Response Team of Private Fostering arrangements.
- The Family & Friends Team continue to attend area social work team meetings across the county, to raise awareness of private fostering and the requirements.
- A schools mailshot was also undertaken whereby information about Private Fostering was sent via the e-bag to all schools, nurseries, colleges and academies within Staffordshire totalling approximately 400 schools.
- An article about Private Fostering was put on Staffordshire's website to signpost people to the relevant contact points.
- Messages were put on Facebook/Twitter to promote Private Fostering.
- The Private Fostering webpage was updated on the Care4child website

- Partnership work continues with bordering Local Authorities, their education admissions department and schools in respect of identifying children who may be living in Private Fostering arrangements and who cross borders.
- Close joined up working has been undertaken with Immigration, Border Agency, Health, Education and HM Revenue and Customs in respect of specific cases whereby trafficking was of concern (discussed in further detail below).
- Data collection continues to be maintained through updating and maintaining an internal spreadsheet and through the implementation of the IT system (Care Director), which captures all private fostering arrangements and key data.

The SSCB continues to play a vital role in helping protect children who are privately fostered, exercising leadership and raising awareness of the requirements and issues around private fostering. A full analysis of activity in Staffordshire during 2016-2017 is available in the Staffordshire CSC Private Fostering Annual Report 2016-2017.

Challenges

Despite the significant activities to identify children and young people living within private fostering the numbers identified remain low. It is widely believed that there is under reporting around this issue.

Allegations against a Person in a Position of Trust – Local Authority Designated Officer (LADO)

The SSCB has a duty to ensure that there are effective inter agency procedures in place for dealing with allegations against people who work with children and that all allegations are investigated in accordance with those procedures.

The Staffordshire LADO arrangements continue to be delivered via a generic duty desk based service, co-located with Staffordshire's FRT and embedded within the MASH environment. All referrals or requests for advice, irrespective of workforce sector, are routed initially via FRT which allows for the capture of basic information prior to passing directly to the duty LADO. The duty desk's embedded location within the MASH allows for real time conversations with Staffordshire Police and other MASH located agencies (eg DBS ; Adult Safeguarding Team) which greatly enhances the provision of well-informed advice and decision making.

Staffordshire LADO continues to benefit from a very effective working relationship with Staffordshire Police's 'Common Law Police Disclosure Unit' (previously known as the Notifiable Occupations Scheme) which is also located within the MASH environment. This provides for additional robustness in identifying adults potentially employed within the children's workforce who have been detained in Police custody on suspicion of offences which may (or may not) reflect possible risk to children. This working relationship assists greatly in tracking early activities with individuals who have chosen not to advise their employer of events which may requires an assessment of risk.

The LADO location within the MASH also allows checks to be made and information gathered in support of case management activities within the fostering service, for example, when risk features indicate the need for rapid assessment of peripheral adults.

The critical statistical data relevant for the 2016-2017 reporting period indicates a continuing trend of increasing referral activity. In terms of formally managed cases, 440 referrals (a 24%

increase on 2015-2016) were processed in addition to 367 enquiries for advice which fell short of the formal threshold criteria.

The majority of referrals (61%) emerge from three professional occupations which reflect the nature of the often intense daily interactions between children and adults. These are teachers and lecturers (91 referrals and 21% of total number of referrals received); foster carers (66 and 15% of all referrals received); and residential care workers (112 and 25% of the referrals).

Very effective working relationships continue to be maintained with regional Ofsted personnel. Frequent dialogue is undertaken between Staffordshire LADO and Ofsted regulatory inspectors in support of their inspection and monitoring activities, and there are a number of examples of robust joint working in dealing with organisations whose services and employees have caused concern. Staffordshire LADO was a founder member of the National LADO Network which was launched in June 2016 and continues to make active contribution within the West Midlands Regional LADO Network.

It is appropriate to acknowledge that a significant amount of work is undertaken by the LADO and Specialist Safeguarding Unit's in relation to allegations emerging form independent children's homes reflecting work around children who are placed in Staffordshire by other local authorities.

There are approximately 100 independent children's homes in our local authority area, predominantly providing care for 'out of area' children. There continues to be some frustration with the inconsistent approach taken by placing local authorities in terms of the wide variation in their commitment and support to the allegations management process. This seems to be related to a small number of local authorities who appear to have acute recruitment challenges which leads to lack of consistency and communication breakdowns between the placing authority and the host authority.

To help to address these issues the Staffordshire LADO meets with Ofsted on regular basis to raise local observations and concerns. The placing authorities are monitored to help to identify those who do not notify Staffordshire about a child or young person placed in our area and representations are made to escalate these concerns as required. Clear messages and information is also provided to all local children's homes managers and staff about their roles and responsibilities and the use of advocacy services is encouraged where needed to promote a child's best interests. Staffordshire CSC services are also clear within their looked after children documentation about the expectations they have on placing social workers and their responsibilities to support their children irrespective of geographical location.

During 2017-2018 the Staffordshire LADO service will continue to facilitate bespoke training events for the schools sector and providers of services to children workforce in respect of 'allegations management'. This is being offered within the SSCB's wider training catalogue and feedback from events continues to be overwhelmingly positive.

Independent Chairperson Annual Report

The Staffordshire CSC Independent Chairperson (IC) Service consists of 19 Independent Chairs and 2 Business Managers and the Principal Social Worker has operational lead for the IC service. The chairs undertake the dual function of chairing meetings for looked after children and those who are subject to child protection plans. All chairs are co-located within the social

work safeguarding teams and are well positioned to have an overview of both corporate parenting and child protection in Staffordshire. The following offers key messages from the IC Service for 2016-2017:

Key Messages about Looked After Children:

- The looked after children population for 2016/2017 has ranged from 979 to 994.
- 346 Children have entered the care system in the last 12 months, a decrease of 42 since 2015-2016.
- The majority of children and young people who started to be looked after were aged 0-4 years which equates to 31.1% of those children becoming looked after
- The majority of looked after children (86) achieved permanency through a return home to parents which is consistent with last year, with a marginal increase of 2.
- The number of children placed more than 20 miles from their home is 230 (23.1%) which is a decrease of 17 children from last year.

Key Messages about Child Protection:

- A total of 766 children were considered at Initial Child Protection Conference, a decrease of 86 children (-10.1%) compared with 2015-2016 (852 children)
- A total of 1251 children were considered at Child Protection Review Conference, a decrease of 182 children (-12.7%) compared with 2015-2016 (1433 children)
- 88.9% of children presented at Initial Child Protection Conference were within timescales, above the proportion in 2015-2016 (86.6%)
- 97.9% of children presented at Child Protection Review Conference were within timescales, just below the proportion in 2015-2016 (99.4%)
- Of the CP plans starting during 2016-2017; 59.9% had an initial category of neglect, 31.9% emotional, 4.7% sexual abuse, and 3.5% physical abuse.

Children with a Disability

Research and inspection indicate that nationally disabled children face an increased risk of abuse or neglect yet they are underrepresented in safeguarding systems. It is believed this is because there are greater barriers in identifying and responding to abused disabled children than for non-disabled children. During 2016-2017 Staffordshire had 24 children with a disability who were the subjects of Child Protection Plans, this is a decrease of 15 children from 2015-2016. At the end of March 2017, there were 490 children and young people being provided services by Staffordshire's Children's with Disabilities service.

To help with this, during 2016-2017, the IC Service has an identified practice champion for children with disabilities which is in addition to 4 IROs who specialise in chairing looked after statutory care plan reviews for children with disabilities. In light of national inspection process changes, there are plans for the 4 IROs to deliver a presentation to their IC colleagues regarding legislation, research and policy for children with disabilities. Furthermore the service has already started to build positive working relationships with the Children's with Disabilities service which will inform future practice regarding child protection and care planning.

Children and Young People's Involvement

Children and young people's participation in their review is a fundamental aspect of the review process and in Staffordshire a high percentage of children and young people continue to

participate by attending and/or actively contributing to their review. The IROs continue to use a number of different mediums to promote children's participation which includes the following:

- Viewpoint as a tool for promoting feedback and capturing children's wishes and feelings
- Meeting children and young people before/in between the reviews ensuring they have opportunities to talk to their IRO in private before the review meeting.
- Conducting the review in 2 or more parts
- Promoting the use of advocacy for every looked after child
- Ensuring reviews are child friendly with some IROs using a social pedagogic approach in the child's review
- A successful pilot of MOMO – Mind Of My Own
- The IROs create opportunities for children and young people to chair all or part of their reviews. This is really empowering and remains an ongoing area for improvement and development
- Feedback from each child or young person is also sought following their review by giving them a child friendly questionnaire. Of the 188 questionnaires completed this year **95% of children felt listened to and 95% of children reported everything was explained well.**
- The use of advocacy is the dominant method of participation for children and young people in their child protection conferences with 47.15% using this mode of participation. This demonstrates the Local Authority's commitment to promoting the use of advocacy for children who are subject to child protection planning.

During 2016-2017 the service has:

- Undertaken a full revision of the current dispute resolution policy to facilitate the implementation of a solution focused approach to resolution. This will increase the chair's 'footprint' on the child's file.

- Continued to work collaboratively with the Children's Voice Project and Children in Care Council in order to strengthen their voice within their meetings and increase their participation in the process.
- Launched an information pack for parents and carers of looked after children.
- Developed SMARTER child protection and dual process conference agendas in addition to developing specific agendas for statutory care plan reviews which focus on key priorities for looked after children.
- Completed planned audits.
- Held themed discussions in supervision to capture local trends in single agency and multi-agency practice.
- Helped to ensure that practitioner and children and young people feedback continues to inform and shape service development.

THE KEY STRATEGIC PRIORITIES

CHILD SEXUAL ABUSE

At a joint meeting of Staffordshire and Stoke-on-Trent Boards in September 2014 it was agreed that the strategic priorities for 2015-2018 would be common to and owned by both Boards. The development sessions held by the partnership Boards and the Executive Groups to examine and assess the national and local drivers set out within the Single Improvement Plan identified the need to tackle child sexual abuse as a priority.

The strategic priorities for 2015-2018 have been developed following self-assessments, external scrutiny and evaluation. High profile national serious case reviews have identified child sexual abuse as a significant risk factor for children regardless of where they live in the country. It is also known that children who are missing from home or from residential care settings are particularly vulnerable to the risk of internal trafficking and child sexual abuse.

The Safeguarding Children Boards have developed a cross agency approach to tackling child sexual abuse in all its forms and produced an overarching Child Sexual Abuse strategy. The strategy sets out the vision, commitment and approach of the Staffordshire and Stoke-on-Trent Safeguarding Children Boards.

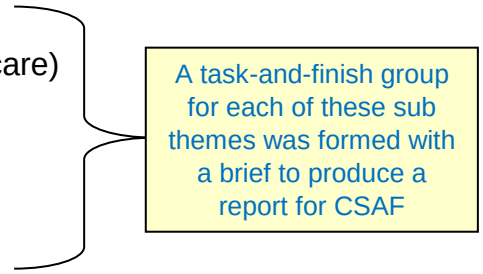
This strategy advocates that the best way to tackle the sexual abuse of children is through effective, co-ordinated, inter agency and partnership working to a clear and coherent plan, doing everything possible to prevent child sexual abuse and as well ensuring that there is a swift and proportionate response with practical and tailored support provided to children and young people unfortunate to become victims It has the following four key elements:

- **Prepare –** Provide strong leadership, effective systems and working with partners to tackle child sexual abuse
- **Prevention** – Raising awareness of child sexual abuse amongst young people, parents, carers, the community and potential perpetrators and provide help at the earliest opportunity. This includes building resilience with families and partners to understand and act together in preventing this form of abuse.
- **Protect** - Safeguard young people by providing targeted support in order to achieve good outcomes for those who are at risk of or already victims of exploitation and support professionals to do so
- **Pursue** – Disrupt, arrest and prosecute offenders wherever possible and appropriate

The Staffordshire and Stoke-on-Trent Safeguarding Children Boards have formed a Child Sexual Abuse Forum (CSAF) the key purpose of which is to share information; initiate action to implement the above mentioned Child Sexual Abuse strategy; provide mutual challenge to connected partners and to ensure that work towards implementation is given continual priority. The CSAF reports to the respective Safeguarding Children Boards. The governance structure showing links to connected partnership groups is at **Appendix 2** on page 75.

Whilst CSAF was established largely in response to the emerging national and local profile of CSE, triggered by a series of high profile cases being highlighted in the media, local safeguarding partners wanted to ensure that there were robust safeguarding arrangements in place for all children and young people at risk of sexual abuse in whatever form the abuse may be. The Safeguarding Children Boards decided that CSAF would have a remit to consider all forms of sexual abuse and determined the following themes for specific focus:

- Child Sexual Exploitation –
- Children Missing (from home, education and care)
- Child Trafficking – Modern Day Slavery
- Intra Familial Abuse
- Youth Violence
- Forced Marriage
- Female Genital Mutilation (FGM)
- Honour Based Abuse (HBA)



Progress and Achievements

Throughout the year the SSCB has monitored and sought assurances from connected partners as to the actions being taken on a single agency and multi-agency basis to tackle child sexual abuse and the effectiveness of arrangements. The following sections provide an outline of what has been done and achieved during the year in relation to each of the elements of the Child Sexual Abuse Strategy.

PREPARE

- Multi agency work to tackle child sexual abuse is well established across Staffordshire and Stoke-on-Trent with a network of engaged partners.
- Each of the strategic leads from the above themed task groups attend the quarterly CSAF meetings to update on progress and to respond to questions seeking assurances as to the existence of and effectiveness of safeguarding arrangements. It is not the purpose of this annual report to list all of the progress made through this activity but it is documented as part of CSAF meeting papers.
- The updates to CSAF cover what is currently in place structurally and operationally and the associated governance arrangements; cross-cutting equality and vulnerability issues; training needs in the form of an analysis; considerations for education; mental health; public health; local gaps and concerns; key messages for service commissioners; outcomes to be achieved
- The employment of the CSE Coordinator, who plays an important role in driving the CSE agenda across Staffordshire and Staffordshire, has been reviewed and extended to January 2018 with funding provided by the Staffordshire Police and Crime Commissioner (PCC).
- The revised CSE strategy was approved in June 2016 and the associated action plan has been reconfigured to align with the CSE outcomes framework.
- The CSE Risk Factor Matrix Tool used by practitioners to inform their assessment of children and young people where there is a concern about child sexual exploitation has been revised. The tool aims to assist professionals in determining the right help at the right time for children at risk.

- A peer review process for the child sexual abuse cases referred through the Sexual Assault Referral Centre provides assurance on the quality of medical examinations and opinions of paediatricians. This approach supports succession planning through the training of doctors. (UHNM)
- The Chair of the CSE Commissioning Group attends CSAF to update on needs-led service-wide commissioning priorities. Updates from the specialist provider delivering service to children at risk of or being sexually exploited are also provided to the SSCB.
- Quarterly reporting arrangements have been established for the mutual sharing and scrutiny of performance reports between the SSCB and the Safe and Strong Select Committee.
- The NSPCC has a Service Centre in Staffordshire offering post-abuse therapeutic work, harmful sexualised behaviour and work with mothers who are linked to sexual offenders. The NSPCC has reviewed its approach to service delivery and has undertaken to work with four local authorities nationally, on the delivery of services based around child sexual abuse or multiple deprivation (mental health, substance misuse, domestic abuse). Staffordshire was identified as a partner of choice with a focus on child sexual abuse.

PREVENTION

There has been a major focus by safeguarding partners on raising awareness of and preventing child sexual abuse. Below is a summary of some key developments and achievements:

- Staffordshire Police working together with the two local authorities has formed a multi-agency Preventing Child Sexual Exploitation Team. The Prevention Team has been delivering CSE awareness and internet safety advice to a range of diverse communities and local businesses. The team offers support and education to families, potential victims and their families and will also work with perpetrators and potential perpetrators.
- Through an Early Intervention approach, funding from the Police and Crime Commissioner and Home Office has provided over 2000 books on the theme of vulnerability that have been used alongside lesson plans in Staffordshire primary schools as part of a prevention strategy (Staffordshire Police)
- Early Help services are delivered through 11 Children Centres where supporting materials are available for children and young people, parents, professionals, and local communities. The services are helping to raise awareness of the risks, recognise the signs that a child may be vulnerable to, or subject to, abuse and to initiate appropriate interventions. Partners are encouraged to co-deliver from the sites to ensure parents and children receive holistic support within familiar settings that are easily accessible.
- Barnardo's has provided free factsheets for parents, carers, professionals and children and young people raising awareness of what it means, how to recognise it, what to do, how to ask for help.
- CSE Awareness training - A basic awareness course targets everyone employed and engaged in school settings including lunchtime supervisors, cleaners, site supervisors, governors etc. The training content includes: - what is Child Sexual Exploitation; the national and local picture; who is at risk; models of exploitation; recognising signs and indicators; why report it and who to. Members of staff that required more in-depth training were signposted to appropriate SCB courses.
- The Safeguarding Education Officer co-delivered training to specifically raise awareness across the education sector. Since January 2015, 433 schools have signed up to the SSCB Level 1 Licence agreement so they can deliver training which includes CSE

Awareness Training with a Train the Trainer programme to ensure quality and consistency.

- Level 1 safeguarding children training is delivered or accessed by all school staff and these training programmes contain an input on the signs and indicators of CSE along with local profile information.
- The new taxi and private hire licensing policy came into effect in September 2016 and requires all existing drivers to have attended a Level 1 safeguarding children course within six months of the new policy start date. All new drivers have to attend the safeguarding training before they can submit their application. The focus of the training is on recognising abuse and neglect, communication, disability, hate crime, how to report concerns, the law on consent, CSE with an underlying message that taxi drivers and passenger assistants are the 'eyes and ears of the community'.
- Local Authority Licensing Officers, working with Children's Social Care, have responded swiftly to allegations against individuals working with children and assisted the Local Authority Designated Officer. In some cases taxi drivers have appeared before the Licensing Committee and had their licences revoked due to safeguarding concerns.
- There is a designated YOS Manager who attends the CSE panel and receives referrals and co-ordinates information sharing
- There is an established multi agency management of risk forum which co-ordinates plans to reduce risks for all cases of children and young people where there are concerns for their vulnerability and welfare.
- If there are significant safeguarding incidents these are reported to the Youth Justice Board as required and overseen by the Safeguarding Serious Case Review sub group.

Awareness-raising campaigns

A local Child Sexual Exploitation Campaign was delivered from October 2015 to April 2016 that followed on from the nationally co-ordinated Safer Internet Day and CSE Awareness Day. There were three parts to the local campaign:

'**Professionals' campaign**- To raise awareness and understanding of CSE, the associated warning signs, sexting and associated risks among all relevant professions and partner agencies to support a proactive approach to identify CSE, safeguard the child and ensure all allegations are investigated.

'Say no to sexting' – A campaign developed as a result of internet safety research with young people. Sexting was discovered as the main digital and online risk factor. The campaign group worked with young people to design a simple solution to tackle perceptions and the likelihood of repeat sexting.

'Know About CSE' – A campaign to raise general public, parents and young persons' awareness of the signs of CSE, how to report concerns and to increase reporting. In addition, to support young people to know what is and what is not a safe and healthy relationship, and to recognise targeting and grooming.

A website www.knowaboutcse.co.uk was also developed to help young people, parents and carers, and practitioners to access information on being targeted and groomed, spotting the signs of CSE and reporting concerns. A particular emphasis was placed on challenging and changing

the mind set of young people with regards to sexting being 'Ok' through the 'Say No to Sexting' campaign.

The six month campaign used social media (Email; Facebook; Twitter) and had a significant reach across Staffordshire and Stoke-on-Trent. The campaign's partnership with schools across the city and county has enabled parents to be provided with information about resources related to CSE, including the website. The full evaluation report was reported to the Child Sexual Abuse Forum in July 2016. The key headlines identified that:

- 87% of professionals who had accessed training in Staffordshire were now confident about spotting the warning signs of a child being sexually exploited (an increase of over 27%)
- There was a 14% increase in the number of parents who feel confident in recognising the signs of CSE.
- There was a 17% increase in number of parents who feel confident about how to report CSE concerns.

In addition to the above the number of contacts made to the dedicated Staffordshire County Council telephone number recognised as being from members of the public showed a large increase when comparing the campaign period to the same month in the previous year with 74 calls compared to 36 calls in March 2015**.** Although there is a general upward trend this year, calls received in the campaign period were significantly higher when compared to the month before (54) and the month after (36). Staffordshire Police had a 12% increase in recorded CSE related sexual offences over the course of the campaign period.

It has been agreed that a further awareness raising campaign to build on the positive outcomes of the previous activity should be developed for 2017-18 to be arranged by the CSE co-ordinator.

PROTECT

- All Children's Social Care teams are responsible for working with children and young people at risk of being sexually exploited. Due to the demands associated with an increasing number of joint police investigations, additional resources have been deployed in the form of a team to work on these specific investigations.

- A senior practitioner with specialist skills in supporting young people who have experienced CSE is permanently in post with Families First and there is an agreement that they are based there Staffordshire Police Child Exploitation Team at Police Headquarters 1 day per week and supports practitioners across Families First, sometimes taking an active role supporting the safeguarding teams with complex abuse cases and more complicated high risk CSE cases.

- CSE Panel meetings are operational and are chaired by safeguarding County Managers held bi monthly.

- The Panels cover Staffordshire's eight districts and have been split into four separate panels as below:

    - Newcastle-Under-Lyme and Staffordshire Moorlands
    - East Staffordshire (Uttoxeter and Burton-On-Trent)
    - Cannock and South Staffordshire (inc Stafford)

- Tamworth and Lichfield (including Burntwood)

- For CSE Panels that took place between April 2016 – April 2017, 221 young people were identified as being victims of child sexual exploitation at low, medium and high level (as per the CSE Risk Factor Matrix), and have been discussed at County-wide multi-agency Panels. This is a 66% increase from the number that was discussed over the full year of 2015/2016 (133). This increase is expected given the increased awareness amongst children, parents and professionals and ongoing workforce development amongst professionals, care homes and foster carers.
- For those young persons discussed more than once at the panels strategic oversight is given by a social care senior manager

No. of young People	No. of Times discussed at Panel
54	1
61	2
49	3
26	4
18	5
8	6
5	7

- The majority (90%) of young people identified as being at risk from child sexual exploitation at the initial Panel were girls, with over half (56%) aged 14 and 15 years old. The majority (82%) of young people discussed at Panel are of White British background.
- The number of males discussed at last year's CSE panels was 12 equalling 9% and this year the number of males discussed this year was 23 or 10.4%.
- 38% of young people were identified as Children in Need and 33% had an Early Help Assessment, 20% were looked after children and 10% were subject to a child protection plan.
- The Staffordshire County Council Transport Safeguarding Policy, training and assessment now provides the framework to ensure Staffordshire's contracted services protect both passengers and contractors from any unknown risks and enable vulnerable persons who may be at risk to be identified. The policy and operational delivery is consistent with current legislative requirements, best practice and serious case review investigations in other local authority areas and were developed in partnership with licencing authorities, Staffordshire and Stoke on Trent CSE professionals and contractors to maintain safeguarding standards and achieve the best possible outcomes in delivering transport services for vulnerable young people.
- The assessment work on existing operators and contracted personnel is complete with attention now focused to evolve training and processes based on case studies, legislative changes and Staffordshire's experience. As of May 2017 the following work had been completed

- Number of Applicants 2618
- Number SCC trained 1878
- Applicants with DBS traces 467
- Refusals 71
- Appeals 23

- During 2016/17 Brighter Futures have worked on a commissioned basis to conduct return interviews with children and young people who go missing. When CSE is identified as linked to a missing episode, the young person is referred to Base 58 (this arrangement will be amended later in 2017 when revised commissioning arrangements will be introduced).

- The NSPCC has provided the 'Letting the Future In' service to help children who have been sexually abused. The impact of the service has been assessed. Almost three-quarters (73%) of children aged 8 and over who completed 6 months of 'Letting the Future In' had severe emotional difficulties at the start. After 6 months this dropped to less than half (46%). For those children remaining in the service after 1 year there was promising evidence of positive change. At the start 89% were experiencing severe levels of distress but after a year this had dropped to less than half (40%).

- Staffordshire Police has continued to use prevention orders where it is appropriate to do so. Between April 2016 and March 2017 a total of 16 Child Abduction Notices were served in Staffordshire in relation to CSE. Two CSE related Sexual Harm Prevention Orders' and one Sexual Risk Order have been granted in Staffordshire in the last 12 months.

PURSUE

- Staffordshire Police has three teams responding to the issue of CSE. These are the Preventing CSE Team; the 'On-street' Child Exploitation Team (CET) which is a team of officers and a social worker who work closely with partner agencies in tackling protracted investigations of Child Sexual Exploitation by groups or gangs as well as individual perpetrators; and the 'Online' Child Exploitation Team who work on Operation Safenet that tackles all aspects of online child sexual abuse.
- The officers on the Operation Safenet Team are both proactive and reactive in dealing with child sexual exploitation online. Proactive actions have included targeting groups or individuals who are seeking to distribute indecent images of children and young people online and those who are grooming children online with a view to meeting them to commit child sexual offences. The team works closely with regional, national and international law enforcement agencies sharing intelligence to safeguard victims and prosecute offenders.

In time since Operation Safenet was formed in July 2015 to March 2017 there has been significant enforcement activity in offences related to child sexual exploitation in Staffordshire and Stoke-on-Trent:

- 172 warrants have been issued
- 149 arrests have been made
- 122 people charged with 538 charges
- 41 voluntary interviews (where arrest was not required)
- 218 children safeguarded

Challenges

Whilst the Board is eager to make progress on this priority it is also cognisant that this is the second year of a three years strategic plan and it will take time for the work for the obvious activity to demonstrate evidence of improved outcomes.

There are some issues around strategic alignment with other related activity. Discussions have taken place and continue with the Safer Staffordshire Strategic Board where there is overlapping activity.

Strategic partnerships without clear co-ordination can cause governance and leadership confusion in respect of local priorities. Therefore it is paramount that all partner agencies are fully sighted on individual areas of strength and areas for development relating to those key strategic priorities in order to achieve the best possible outcomes for children, young people and families.

NEGLECT

The need for this priority was based on national learning and local evidence which highlighted neglect as a recurring theme in serious case reviews and is known to be the most prevalent form of abuse for children subject of a child protection plan in Stoke-on-Trent and Staffordshire.

Around half of all children looked after by the Local Authority are known to have experienced harm as a result of neglect. Arising from the knowledge of local factors the Safeguarding Children Boards have a particular focus on the impact of parental behaviours and influences that can often lead to neglect of the welfare and safety of children and young people specifically, domestic abuse, drug and alcohol misuse and parental mental ill-health. In combination these factors are known locally as the 'toxic trio'.

The Safeguarding Children Boards have resolved to develop and co-ordinate a multi-agency approach to improve partnership effectiveness in tackling neglect. This approach has a specific focus on the impact that parental behaviours have on the welfare and safety of children and young people. Working to the Safeguarding Children Boards strategy the aim is to ensure there is both early recognition of neglect and through strong multi-agency leadership and governance improve agency responses to children and young people affected by neglect.

The following sections illustrate the focus of the SCB on the toxic trio with an outline of what has been undertaken in partnership during the year to tackle neglect, the challenges that have been highlighted and are being addressed and concluding with a summary of further actions to be undertaken in 2017/18.

DOMESTIC ABUSE

There is extensive evidence illustrating the harm caused to children and young people who live with domestic abuse. The Adoption and Children Act 2002 extended the definition of harm to include 'impairment suffered from seeing or hearing the ill-treatment of another'. The term 'living with domestic abuse' includes:

- Children who are currently living where there are incidents of domestic abuse, or where there is risk of domestic abuse, taking place
- Children seeing or hearing domestic abuse outside of their home
- Children witnessing the effects of domestic abuse on others.

The reported number of Domestic Abuse crimes in Staffordshire follow:-

2015/16 = 7,141
2016/17 = 8,890

Number difference = 1,749
% change = 24% increase

The number of incidents for Domestic Abuse cases in Staffordshire are:-

2015/16 = 14,406
2016/17 = 14,997

Number difference = 591
% change = 4% increase

The risks of harm to children who are exposed either directly or indirectly to domestic abuse are known to be significant but the gathering of data in relation to the number of children affected by domestic abuse can in some instances be difficult to capture. The SCB has actively encouraged a focus on improving understanding of the associated issues.

In Staffordshire and Stoke-on-Trent the Multi Agency Safeguarding Hub (MASH) provides an integrated approach where a number of agencies work together in one place, sharing information and making collaborative decisions to promote the welfare and safety of vulnerable children and adults so that any required interventions can be put into place at the earliest opportunity.

Through this joint working a number of issues for improvement have been identified. From a toxic trio perspective there is currently no facility or ability in MASH to bring together a domestic incident with mental health and substance misuse information. Whilst there is ongoing work to bring mental health data into the MASH more work needs to be done to include substance misuse information.

On a more positive theme through the implementation of a new MASH operating model, the previous domestic abuse incident backlogs have been removed and there is timely assessment of risk and information sharing. There is evidence that the overall benefit is being felt at the front line with practitioner feedback suggesting that this information is leading to improved decision making.

It is also a benefit that the Multi Agency Risk Assessment Conference (MARAC) team are based within the MASH. Cases that are assessed in the MASH are often sent direct to MARAC enabling a swift response.

The MARAC caseload for Stoke-on-Trent and Staffordshire combined for the comparative periods April 2015 to March 2016 and April 2016 to March 2017 is shown below:-

	April 2015 – March 2016	April 2016 – March 2017
Total Number of Cases	539	920
Female Victims	512	859
Male Victims	27	61
Children Involved	609	1012

Throughout the year the focus of the SCB has been on seeking assurances from connected partner organisations that:

- domestic abuse cases are screened in a timely manner and children in these settings are identified and referred to statutory services
- children who live with domestic abuse experience a child-centred approach from all professionals and the risks to them and their needs are assessed effectively and responded to appropriately
- professionals and support staff see incidents through the eyes of the child and are trained, confident and knowledgeable to understand the impact of domestic abuse
- children living with domestic abuse receive the right help and protection because application of appropriate thresholds, effective information sharing and timely intervention take place
- the risk of harm to children is reduced through the identification and assessment of the risks that perpetrators and adult offenders pose
- Multi Agency Risk Assessment Conferences (MARACs) - support the protection of children through developing effective action plans, timely sharing of information, and assessment of risks to children
- the impact of domestic abuse on children is reduced because they, their families and perpetrators can access a sufficient range of commissioned local services

Activity and outcomes

More children and victims are being referred to the MARAC forum and whilst there is no hard evidence of improving outcomes there can be a conclusion drawn that such people are safer than they would have been using the previous operating model.

The SCB has sought and been given assurances from the Multi Agency Safeguarding Hub (MASH) that in all cases where children and young people were involved, either directly within the family, or as associated children to those families i.e. grandchildren, children with ex-partners etc. discussions have been held in the MASH; their information appropriately shared with Children's Social Care; and in the majority of cases, a formal assessment has resulted to ensure that the children are properly safeguarded.

ARCH received 62 referrals of male perpetrators within families in the Staffordshire area. The actual number of men who received a service was 83 (some men having support carried over from previous year). The support offered in this area includes first and second suitability assessments, the 30-week Domestic Violence Perpetrator Programme (DVPP) and post-group support for those men who completed the programme. During the year ARCH reported a 66% completion rate for those men who were assessed as being suitable for a behaviour-change programme.

A new 'child safe tool' has been produced for GP practices. This highlights domestic abuse between parents as a potential risk factor to trigger a risk analysis of potential children at risk. (Staffordshire Clinical Commissioning Group)

Each Local Policing Team has a Vulnerability Team with dedicated staff and officers who have received specific training to deal with the complexities around domestic abuse. The Vulnerability Teams have forged strong links with the MASH ensuring consistency and effectiveness in the practical application of policy and procedures.

As at 31 March 2017 the Troubled Families programme, (known in Staffordshire as Building Resilient Families and Communities- BRFC) had identified and supported 827 families with children experiencing, or at risk of experiencing domestic abuse.

During the year the Safeguarding Children Board multi-agency policy and procedure in relation to Domestic Abuse has been reviewed confirming alignment between the respective the Staffordshire and Stoke-on-Trent documents.

The Safeguarding Children Board E-learning Level 1 child protection training and the SCB multi-agency Level 2 Working Together Training both include awareness on domestic abuse and its impact on children who are either living with domestic abuse, see or hear domestic abuse outside of their home or who witness domestic abuse on others.

The Level 3 SCB multi agency training delivered by Staffordshire Women's Aid in relation to children and young people experiencing domestic abuse has been revised to be more targeted around referral pathways and assessment of risk and need.

Staffordshire Police continue to provide training and professional development around legislation for all staff and officers up to the rank of Chief Inspector. In addition to providing training on Coercion and Control there have been inputs from partner organisations about support and specific 'tools' that officers and police staff can use to help victims of domestic abuse. The training includes the "Voice of a Victim", whereby a victim of domestic abuse spoke of her personal experience in a way that conveyed the impact on her that provided a stimulus for professional reflection.

Over 120 dental practice staff attended domestic abuse awareness training, with follow up support to practices provided and a dedicated referral pathway put in place.

The learning from Domestic Homicide Reviews in Stoke-on-Trent and Staffordshire has been shared with practitioners through a series of briefings, the common themes of which are mental ill health, substance misuse and domestic abuse.

Routine Enquiry about Adversity in Childhood Experiences (REACh) Pilot

In recognition of the potential harm caused to children and young people who experience domestic abuse during the year Staffordshire has been piloting an initiative Routine Enquiry about Adversity in Childhood (REACh). The pilot involves 3 key organisations ARCH, Lifeline and Staffordshire and West Midlands Community Rehabilitation Company (CRC). The intention of the programme is during individual assessments to ask young people about any adverse experiences that they may have suffered and to respond appropriately with planned interventions which in the longer term will reduce the likelihood of adverse impact of domestic abuse on later health and wellbeing.

Implementing routine enquiry requires that each connected organisation has a commitment to understanding the impact of adversity on their client. Good systems and processes will ensure that routine enquiry becomes embedded in each organisation and becomes a part of everyday working practice. Good practice will ensure that professionals feel confident and supported in

enquiring which in the longer term will enable more focussed interventions and potentially reduce the number of repeated interventions required by many individuals.

Routine enquiry supports solution focussed approaches which incorporated with an emphasis on resilience can potentially increase the likelihood of successful longer term health and wellbeing outcomes. Funding for the entire project is supported by a number of partners. The Directorate of Public Health and Adult Social Care are funding the initial training and follow up support and the evaluation is funded by the Office of the Police and Crime Commissioner Staffordshire.

It is expected that the pilot will be delivered and evaluated during 2017/18, supported by wider awareness training around attachment, adversity and emotional wellbeing for 1,000 practitioners across Stoke-on-Trent and Staffordshire funded through the Violence and Vulnerability Working Group.

Challenges

- There remains a high prevalence of domestic abuse within Staffordshire and a significant proportion occurs in households with children. It is a challenge to meet the increasing demands on services.
- Breaking the cycle in families with a history of inter-generational domestic abuse through strengthened family relationships / approaches
- To strengthen capacity in support for young people who have been affected by domestic abuse.
- To ensure the joint commissioning of domestic abuse services across Stoke-on-Trent and Staffordshire is consistent, of high quality and meets the needs of victims, perpetrators and their children / families
- Partnership arrangements around domestic abuse have evolved and must be fully embedded
- To improve the existing information sharing process with schools to ensure that they are made aware of any of their children who are living in a household where a domestic incident has occurred
- Domestic abuse information in relation to people who are vulnerable is not routinely shared with GPs which is an identified risk. Through the 'Project Doing More' a universal health team is proposed but there are challenges for local Clinical Commissioning Groups in the delivery of this approach. Discussions are ongoing to find a way to cover the risk.
- More action is needed to bring about a wider understanding amongst professionals of the root causes / key determinants of domestic abuse and the impact on children and young people
- A coordinated approach to training for front-line professionals on identifying and referring domestic abuse

Priorities for Domestic Abuse 2017/18

Staffordshire County Council, Stoke-on-Trent City Council and the Staffordshire Police and Crime Commissioner are jointly commissioning domestic abuse services across the City Council and County Council areas under joint contracts that are designed to provide a consistent high quality service that will:

- be more responsive to the needs of victims and their children

- promote early identification and referral
- have a greater focus on prevention
- address perpetrator behaviours

It is intended that the new contracts will commence in autumn 2018.

A revision of the domestic abuse system, including the MARAC process, is underway, with 2 pilots due to commence in 2017 in Stoke-on-Trent and Staffordshire. The anticipated benefits include a more dynamic approach, fewer meetings for professionals and swifter activity arising from greater coordination of services and by reducing duplication.

SUBSTANCE MISUSE

Public Health England collects data nationally on the number of drug and alcohol service users who are parents. In 2011 it was estimated that around one third of people receiving treatment were parents and had children living with them.

Whilst the extent to which difficulties impact on parenting varies enormously, In terms of assessing the impact of problem drug and alcohol misuse on children and young people there is limited evidence. However, it is clear from a variety of sources that alcohol misuse by parents can result in violence and risks of physical harm to children and young people and as referenced in other parts of this strategy there are overlaps with the so called 'toxic trio' of Domestic Abuse and Parental Mental ill Health.

The focus of the Safeguarding Children Boards has been on seeking information from connected partners in relation to:

- Confirming with commissioners and providers what data and information should be received from children and drug and alcohol services for inclusion in the Safeguarding Board performance data set.
- Assurances that commissioners of drug and alcohol services have systems in place to monitor the extent to which providers of those services meet their responsibilities to safeguard and protect children
- The number of adults receiving specialised drug and alcohol services who are parents or carers; in order to develop an understanding of local needs relating to children affected by parental substance misuse and to seek assurances that children and young people are being supported.
- Assurances that senior managers from connected partners have arrangements in place for supervision and oversight and evaluate the quality of joint working through analysis of referrals and case file audits with findings reported to the LSCB
- Assurances that senior managers and practitioners across all connected partner agencies services are made aware of learning from Serious Case Reviews relevant to drug and alcohol misuse
- Assurances that all children's and adults services practitioners working with families affected by drug and alcohol problems have the competence and confidence in identifying the impact of these difficulties on the child or young person
- Assurances that commissioners of drug and alcohol services ensure that the role of adult drug and alcohol services in safeguarding is set out explicitly in all relevant tender

documents and in contracts.

Activity and progress

During the year the SCB has strengthened links with the Responsible Authorities Group. The SCB Independent Chair attended the Responsible Authorities Group to discuss mutual accountabilities and reporting arrangements in relation to tackling substance misuse by parents of children and young people at risk of harm. Agreements were made for the Commissioning Manager of the Safer City Partnership to provide quarterly updates to SCB meetings.

The Alcohol Harm Reduction Strategy 2016 – 2020 and action plan, that includes a focus on prevention and early intervention for children and young people at risk, was approved by connected partners at the Responsible Authorities Group and with lead member support was also approved by Staffordshire County Council Cabinet.

A Tier one and Tier two young people's drug and alcohol service has been developed which works specifically with young people vulnerable to hidden harm.

A Tier three young people's drug and alcohol service has been commissioned and is delivered by the same provider of the adult drug and alcohol treatment which brings the added benefits of enhanced information sharing and joint care-planning and is delivered from the intensive prevention service.

Safeguarding policy sets out the standards, strategies and approaches to safeguard vulnerable service users and their children and families.

It was confirmed to the SCB during the year that commissioned drugs and alcohol treatment services are compliant with local Safeguarding Children Board guidelines

The NSPCC interim evaluation report collates findings from questionnaires that children and parents completed at the beginning and end of a support programme. It also includes interviews with some of the children and parents who took part. The findings are used to enhance practice.

The GP child safeguarding audit has been reviewed and asks specifically about considering the impact of drug and alcohol abuse on children residing in the family. (North Staffordshire and Staffordshire Clinical Commissioning Group).

The Substance Misuse Prevention officers, within the Public Health team (who support schools in the delivery of drug and alcohol education to young people), have extended their offer and have delivered parenting sessions. A dedicated family team supports substance misusing adults with parental responsibilities, individuals affected by a family member, carers, young carers and families.

Challenges

It is estimated that a maximum of only 15% of dependent drinkers (national research) will ever engage in formal treatment. This illustrates to some extent the problems associated with identifying hidden harm.

There are a large number of parents in drug/alcohol treatment who do not have their children living with them (44% vs 27% nationally for drug treatment: 51% vs 33% nationally for alcohol) which can provide some barriers in terms of supporting whole families

A strategically and operationally aligned approach to prevention and early intervention is essential to avoid increased referrals into Children's Social Care and an increase in related overarching health and social problems, including poor wellbeing, poor physical health, antisocial behaviour and domestic abuse.

The Personal and Social Health and Education (PSHE) is fragmented and would benefit from a more structured and better co-ordinated approach

Significant cuts have been made to drug and alcohol treatment service budgets which will impact partner organisations being able to provide a consistent response to families at risk.

There is a need to better equip front line staff with the knowledge and skills to talk to people about drug and alcohol misuse to help them to access support

Plans for 2017/18

The way in which need is recorded by services, and reported by Public Health England is going to change which is anticipated will give a more accurate insight in to service user need, including e.g. mental health and parental status. At present, reports are fixed based on information gained at first assessment when a person may not feel as comfortable sharing accurate information

A pilot in Routine Enquiry in to Adverse Experiences in Childhood (REACh) is to be developed through a range of agencies, including the community drug and alcohol service and the Community Rehabilitation Company (CRC)

The integrated community drug and alcohol service is scheduled to attend each of the Safeguarding and Support Team meetings to provide a presentation on drug testing arrangements for parents of children open to social care. This will also provide an opportunity for further discussion around joint care-planning and enhanced information sharing.

The focus of the Responsible Authority Group is on enabling more people to become and remain abstinent from substance misuse by providing recovery-focussed treatment and support for dependent drug and alcohol users and increasing the visibility of recovery communities[2]

PARENTAL MENTAL ILL-HEALTH

Progress to date:

[2] Recovery communities are connected, cohesive communities of people who are in recovery from addiction to drugs and/or alcohol

In the 2015/16 annual report the Board acknowledged some of the challenges it faced with regards to progress against the requirements set out in the Joint SCB Neglect strategy. The following information provides an update on progress made against those challenges;

- Progress has been made in confirming with commissioners and providers what data and information is required to assist the Board in understanding the profile of parents with mental health needs. The majority of the LSCB data set has now been approved with agreements in place to seek the remaining elements.
- Internal documentation used by the two providers of adult mental health across the county records the details of any children, including names, DOB, other agencies involved and any risks (This includes first time entrants). Regular audit activity provides assurances to the Board that children, where relevant are appropriately safeguarded. NSCHT reported that the recently completed base line case file audit noted good practice in that the majority of details regarding children are being recorded during the assessment process. Care planning for adults continues to be strengthened in relation to including relevant children. To support this the safeguarding training includes a stronger focus on this aspect of care planning
- Those children who are caring for adults with mental health needs are identified and supported as both providers have ensured their staff have had training. Assessment documents include prompts and supervisions with clinical teams encourage discussion around young carers and any potential safeguarding issues.
- Serious case reviews and learning reviews locally have identified parents with mental health issues and as such the providers have included this within their training. This learning also forms part of trust wide internal 'Learning Lessons' programme where learning is shared across the organisation.
- Regular audit activity provides assurances that referral pathways are robust and highlights areas of good practice such as Think Family thus emphasising the golden thread that runs through all safeguarding training delivered.
- Safeguarding training is provided in line with the Intercollegiate document; it focusses on Think Family and considers the risk of compromised parenting if parents have a mental health problem. Training compliance is monitored centrally within the trust; this is reported on monthly through directorate performance reviews and bi-monthly to Quality Committee. NSCHT safeguarding team continue to be sighted on child safeguarding referrals that are made by staff for children living in a household with substance misuse.
- The head of safeguarding /named nurse provides specific safeguarding supervision to staff and in turn receives supervision from the CCG designated nurse.

Plans for 2017/18

To continue to maintain the focus on gathering information and assurances as outlined in the Board Neglect Strategy. It has been identified that the above assurances should be sought in relation to Third Sector mental health provision. The extent to which this already takes place is not known and needs to be examined.

Transition to Adult Care and Support

Young people with ongoing or long-term health or social care needs may be required to transition into adult services. Transition is defined as a purposeful and planned process of supporting young people to move from children's to adults' services.

In April 2015 the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board adopted Transition to Adult Care and Support and this remains a key strategic priority. In recognition of the areas of overlap the Adult Board is supported by both the Stoke-on-Trent and the Staffordshire SCBs in its activities.

Young people with ongoing or long-term health or social care needs may be required to transition into adult services. Transition takes place at a pivotal time in the life of a young person, part of wider cultural and developmental changes that lead them into adulthood; individuals may be experiencing several transitions simultaneously. There is evidence that transition services in health and social care are inconsistent, patchy and varied depending on the condition. A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at an enhanced risk of psychosocial problems.

The transition to adulthood covers every aspect on a young person's life. Supporting disabled young people in their transition to adulthood can be a challenge to service providers. This is because the process must be individual to the needs and aspirations of each young person and local options for disabled young people may vary geographically. Also, more recently, some services have been affected by funding reductions or decommissioning.

Progress and Achievements

Eight cohorts of young people were identified and between January and May 2016 focus groups were held each of which having representation from key connected agencies. These cohorts were:-

- Mental ill-health
- Autism
- Young carers
- Children who offend
- Physical and Learning Disability
- Substance misuse
- Looked after Children (LAC)
- Children in Need

The findings revealed some good practice, for example the Staffordshire multi-agency Transition panel where young people are considered on a case by case basis, and some areas for improvement. The two cohorts of young people for whom transition was likely to be the most challenging were those with lower level autism and those for whom child protection legislation had safeguarded them.

During the period that the focus groups were held the Department of Health (DoH) commissioned the National Institute for Health and Care Excellence (NICE) to develop an evidence-based guideline to improve practice and outcomes for young people using health and social care services and their families and carers. The guideline focuses on young people passing through transition to adult services with health and/or social care needs. The guideline covers young people up to the age of 25 who expect to go through a planned service transition, and proposes a set of high level principles which the Transition working Group considered.

Between January and March 2017 the following proposals were taken to the three Boards and approved:

- Ask Directors of relevant services to agree and sign-up to the high level principles produced at the working group
- Consider and adopt the NICE guidelines and relevant 'Preparing for Adulthood' (PfA) self-audit tools as examples of how to self-audit against good practice
- Ask the Directors of relevant services to arrange for the provision of evidence based assurance with which to demonstrate compliance with good practice and guidance and that the high level principles are being embedded into practice
- Assurance to be delivered to the three local Safeguarding Boards (adults and children) in the third and fourth quarter of 2017/18.

In January 2017 the SSASPB received a referral for consideration of a Safeguarding Adult Review following the death of a young person aged 18 years. In April 2017 it was decided that although the circumstances did not meet the threshold for a SAR, the SAR Sub-Group believed that there may be lessons to learn from reviewing the case. The SAR Sub-Group recommendation of a Multi-Agency Learning Review (MALR) was approved by the SSASPB Independent Chair and subsequently commissioned with transition forming part of the terms of reference. An update will be provided in next year's Annual Report.

The work towards the delivery of the Strategic Priority continues and will be reported upon further in the 2017/18 annual reports of all three safeguarding boards.

EARLY HELP

EARLY HELP

Early Help means: *'…providing support as soon as problems emerge, at any point in a child's life, from the foundation years through to the teenage years. Early help can also prevent further*

problems arising, for example, if it is provided as part of a support plan when a child has returned home to their family from care.'

(Working Together to Safeguard Children, 2015)

It is well recognised amongst safeguarding partners that Early Help is more effective in promoting the welfare of children than reacting later. Early Help services in Staffordshire are delivered by the Children and Family Service Directorate and a range of partners, including schools, children centres, through a range of Health settings and the community and voluntary sectors.

The vision for Early Help is that all children and young people in Staffordshire are happy, safe and healthy, inspired and enabled to succeed. For some children this can only be achieved with additional support. Our vision is to make Staffordshire an "Early Help" county by helping families at the earliest point, enabling them to access the right service, at the right time, from the right part of the system.

Governance Arrangements

The overarching governance arrangements for the co-ordination of Early Help in Staffordshire are under the Staffordshire Family Strategic Partnership Board (FSPB). The Safeguarding Children Board has established a scrutiny and challenge role and there is a standing agenda item at quarterly meetings to examine activity and progress and to seek assurances in relation to the quality of assessments and overall management of practice and performance in relation to Early Help.

Activity and progress

During the year April 2016 to March 2017, a total of 4,398 requests for support were received by Local Support Teams. At the end of March 2017 LSTs were actively supporting 2,825 families. There were an additional 946 cases being led by External Agencies and Family Intervention Workers.

The top 3 sources of requests for support were schools, Families First (SSU) and Health (combined total). These 3 sources accounted for 3,044 (69%) of all requests received. The highest number of requests for support came from schools, which were the source in 1,360 (31%) of cases during the year.

Families are assessed to ascertain what support is required to be clear about objectives and also provide the headlines for their action plan. The type of support is grouped into categories which reflect the outcome areas used in the Family Plus Outcomes Star. This tool is used across LSTs (and across all agencies for Building Resilient Families & Communities case work) with families to identify issues and track progress.

The main areas identified for support are:

- Boundaries and Behaviour, specifically the focus of child/young person being disruptive in school or at home

- Education and Learning, specifically Child is Persistently Absent from School

Analysis of the outcomes of the 4,006 cases closed during the year indicates that:

- 65% of cases LST or BRFC objectives were achieved
- 13% of cases were closed because families disengaged or consent was withdrawn
- 13% of cases closed because families engaged with or were referred to another service

Audit analysis was completed on a quarterly basis during the year, as well as a full audit analysis report, a one page summary of Learning from Audits was completed each quarter to provide feedback and focus to auditors and Local Support Team staff. The audit picture across the full year was one of improvements in the quality of assessments and action plans completed, and of improvements in the quality of interventions and timely management of cases. Areas for continued focus and development include ensuring that all professionals involved with children and families contribute to assessments, and ensuring that appropriate agencies are actively involved in the family plan.

Whilst good progress has been made with Early Help in many situations there have also been challenges, some of which are yet to be resolved, as summarised below.

Challenges

- Need to actively encourage the involvement of children, young people and their parents/carers to ensure their voice is captured and is used to influence and reshape service provision.
- Need to continue to improve partner engagement at the Early Help Strategy Meetings to strengthen the partnership approach to Early Help
- To understand and address the barriers preventing partner agencies initiating Early Helps.
- Raise confidence with partner agencies to lead Early Help Assessments.
- To establish robust processes which enable the sharing of partnership data and embed clear communication pathways to enable both the needs and strengths of families to be better understood by everyone.
- To strengthen the reporting of outcomes from the EHA and include the links to Domestic Abuse, substance misuse and parental mental ill health
- To understand why a relatively high number of school exclusions appear to have had no Early Help Intervention.
- There is a shortage of appropriate parenting support available, particularly for the 11-18 years age groups.
- To continue to improve the quality of Early Help Assessments so that they are more outcome-focused.

Actions for 2017/18

- Review the Early Help Strategy for formal approval of the Family Strategic Partnership Board
- Develop, implement and embed a solution focused methodology for all Early Help Professionals
- Develop specific forums for – children and young people and parents and carers to seek feedback on their experiences and effectiveness of the services and support they have received.
- Improve the analysis of data to measure the effectiveness of Early Help on statutory services particularly referrals to the Safeguarding Referral Team, Children in Need plans and Child Protection Plans.

THE WORK OF THE SUB-GROUPS

Communication

A key part of the Safeguarding Children Board functions is to communicate to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so.

During 2016-17 the following activity has been undertaken:

- Circulated extensively amongst the wider safeguarding partnership regular briefings informing of procedure/policy/strategies updates, changes within organisations and local safeguarding events.
- Circulated a quarterly newsletter across partnerships to raise practitioner awareness around safeguarding issues such as progress on SCB priorities, learning from case file reviews training opportunities, highlighting specific safeguarding issues and promoting local campaigns.
- Updated on a monthly basis, to ensure that it remains a useful resource, the Board website accessed through https://www.staffsscb.org.uk/Home.aspx which is the key electronic platform for the publicly accessible site that provides a substantial amount of information about safeguarding duties, good practice, and how to access help and support.
- Worked with young people from the Voice Project to improve the layout and content of the Children and Young People's section of the Board website.
- Updated information leaflets covering a wide range of topics. These have been widely distributed and are also available on the Board website.
- There have been a number of campaigns to raise the profile of safeguarding awareness in the community. The "Know about CSE" campaign continued into 2016-17 in partnership with Staffordshire Safeguarding Children Board, and the Staffordshire Police and Crime Commissioner. The Board website focuses on raising awareness amongst young people, their families and professionals around CSE. The website provides details of local and national helplines and support services. This campaign was evaluated during 2016 indicating that the communication objectives had been achieved.
- The SSCB supported Staffordshire County Council's Fostering Service with their campaign to promote awareness around private fostering. This was widely distributed to schools and included in the Section 175 audit process.

Policy and Procedures Sub-group

LSCBs have a statutory duty to develop policies and procedures for the safeguarding and protecting the welfare of children in the area of the authority. In recognition of the benefits of collaborating to share expertise to ensure consistency in approaches and efficient use of time the Staffordshire and Staffordshire Safeguarding Children Boards decided to form a shared Policies and Procedures Subgroup in 2014. The subgroup fulfils the following core functions:

- To produce and develop legislatively compliant inter-agency policies and procedures for safeguarding and promoting the welfare of children and young people which promote consistent and effective evidence based practice across organisations working with children; and

- Focus on meeting the needs of children and young people via multi-agency working in order to improve their outcomes.
- Policies and procedures are available to practitioners on the SCB website: https://www.staffsscb.org.uk/Professionals/Procedures/Procedures.aspx

Progress and Achievements

Where it has been possible, Staffordshire and Stoke-on-Trent's inter-agency policies and procedures have been aligned to provide synergy to those professionals who work across our borders. Listed below are the policies, procedures and guidance documents that have been formally reviewed, updated and ratified by the SCB during this year:

- The Framework for the Assessment of Children in Need and their Families
- Legal Framework
- Information Sharing Guidance
- Joint Glossary of Terms and Acronyms
- Organisational Whistle Blowing Policy to Safeguard and Promote the Welfare of Children
- Responding to concerns about unborn children
- Concealed Pregnancies
- Private Fostering
- Child Sexual Exploitation
- Children who display Sexually Harmful Behaviour
- Child Neglect
- Neglect Threshold Matrix Appendix 1
- Fabricated/Induced Illness
- Joint SCB learning and Development Framework

In order for all partner agencies to engage in the review of documentation, a decision was taken in January 2017 that future reviews would take place bi-annually unless there was a change in legislation or learning from serious case reviews or changes to local processes that required. In such situations those documents would be amended or revised prior to bi-annual.

Alongside the above activity the Safeguarding Board managers have been engaging with an innovation project that is examining the feasibility of a single set of policies for all safeguarding partners in the West Midlands region. Whilst there are clearly some advantages to such a collaborative approach there is also a need to consider the local procedures that are usually required to take account of the different geographical and political considerations associated with wider partnership arrangements.

At the time of compiling this report, the SCB is monitoring developments but has not made any formal commitments to become part of the arrangements as there are cost and procurement implications beyond the above considerations for the SCBs that participate.

Challenges

- The work of this particular group is demanding of time as all policies and procedures are compiled and revised by frontline staff from partner agencies. Whilst this work doesn't

impact directly on the SCB budget, clearly there is an expectation that all partner agencies will nominate staff to attend the bi-monthly meetings and undertake the required duties as required.
- To ensure policies and procedures are relevant and up to date through the most cost effective methods.

Serious Case Review Sub-group

The key focus of the sub- group is on the learning from national and local Serious Case Reviews (SCR) as well as local cases not reaching the criteria for a SCR but from which it is likely lessons can be learned.

All serious incidents are carefully considered and all key decisions as to whether a review should be initiated are ratified by the Independent Chair of the Safeguarding Children Board.

Activity and outcomes

- Two Scoping Panels were held in 2016-17. In one of the cases the criteria for a Serious Case Reviews was not met; however the panel recommended that there could be important learning from this case. The Independent Chair agreed that the case did not meet the threshold for a Serious Case Review but that a multi-agency learning review should be undertaken. The learning review will be completed in 2017-18. The second case did meet the criteria for a formal Serious Case Review. An Independent Reviewer was appointed and the Serious Case Review will be concluded during 2017-2018.
- One Serious Case Review was published in January 2017. The learning from this Serious Case Review was shared with partner agencies. The action plan is being monitored by the serious case review sub-group.
- The sub-group considers the progress of action plans at each meeting providing transparency and a focus on delivery.
- Lessons learned from the learning reviews have been cascaded to a wide circulation including through the SCB newsletter for a wider local circulation.
- Learning from the Staffordshire reviews has been shared with the Staffordshire SCB to identify common themes and consider any impact.

Challenges

Ensuring that the learning from Serious Case Reviews and learning reviews is meaningful and acted upon by frontline practitioners with evidence of improvement in practice.

Plans for 2017-18

The Wood Review on the role of functions of Local Safeguarding Children Boards has advocated the discontinuation of Serious Case Reviews in favour of an independent body at national level to oversee a new national learning framework for inquiries into child deaths and cases where children have experienced serious harm. The new arrangements will cover local child safeguarding practice reviews, to identify any improvements that should be made by persons in the area to safeguard and promote the welfare of children.

The anticipated changes in arrangements will be linked to the provisions of the Children and Social Work Bill that is to be enacted through legislation in 2017.

Performance Sub-group

Since April 2016 the Performance Sub-group has been joined with Stoke-on-Trent SCB reflecting the focus on a common performance framework and joint strategic priorities. The analysis of the effectiveness in safeguarding children produced in conjunction with the Performance sub-group is covered at pages 11 to 28 above. The key findings from the Section 11 conducted during the year are summarised below.

The Full Section 11 Audit was carried out with the Local Safeguarding Children Boards' partner agencies this year. The Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. Working Together to Safeguard Children 2015 sets out Section 11 standards that organisations need to comply with.

Partners participating in the Full Section 11 for 2016/2017 include Children's Social Care Services, Commissioning Services for both Local Authorities, Borough/District councils, NHS organisations, Staffordshire & Stoke National Probation Service, Werrington Young Offender Institution, Youth Offending Teams and other non-statutory organisations.

There was an excellent response from all Board partners contributing to the audit, with the majority of agencies assessing themselves as either meeting standards or meeting them with recommendations for improvement; no agency reported not meeting any of the standards. A wide range of supporting examples were given and evidence of partners identifying follow-up actions were given where judgements were **'**met with recommendations for improvement'.

There is clear evidence of a nominated lead representation from each agency, with evidence of designated professionals, attendance and contribution from the majority of partner agencies is good. Most partners are able to demonstrate ways in which information from the Boards is cascaded to staff across organisations via emails, on the intranet, included in training events and team meetings as standard agenda items.

Commissioners for Stoke-on-Trent and Staffordshire social care identified that there was a need to improve commissioning tendering and implementation of safeguarding standards with all commissioned services as well as better monitoring of contracts. The Police Service and Borough & District Councils have noted areas of further work to ensure that accountability structures and staff understanding met this standard fully.

Many areas of good practice were identified during the review of information for having a culture of listening to children and young people and using information to develop Services; especially by both social care providers and health partners, detailing various innovative ways of gaining service user feedback, using it to evaluate provision and incorporate into service development.

Information Sharing protocols were in place for all partners and there was good staff awareness of how to share information with partners to ensure that children and young people were kept safe and to allow a full account of circumstances to ensure the right provision and support was offered.

The majority of partners have Safer Recruitment, Allegations against Staff who work with children and Whistleblowing policies in place and the relevant officers have received appropriate training, DBS and other checks take place before staff are appointed. South and North CCG clusters are reviewing policies currently to ensure they are fit for purpose. Partners have appropriately qualified officers to manage and have oversight of allegations against people working with children and have good links with both Local Authorities' LADOs.

A comprehensive Training Strategy/Plan is in place for most agencies with evidence of appropriate staff accessing mandatory level 1 & 2 safeguarding training or there are plans in place to ensure that this is consistent throughout services with training refreshed every three years in most organisations. Partners identified multi-agency priority training for 2017/18 that reflect the LSCBs' priorities including CSE, Domestic Abuse, Substance Misuse, Early Help, Toxic Trio, Mental Health, Adolescence Health. This information will be useful in planning multi-agency training sessions and developing new resources.

There is reporting of auditing activity taking place that should reassure the Board that service areas are working towards safeguarding children and young people. Staff surveys, inspection findings, internal audit and staff feedback demonstrates a good understanding of awareness of safeguarding responsibilities and priority issues, who to contact in their organisations for advice and guidance and making appropriate referrals to Children's Social Care Services and Early Help is evident for most agencies. However, an improved understanding of safeguarding thresholds for some agencies to ensure all agencies are referring safeguarding concerns at the appropriate level is required as identified in Stoke-on-Trent Children's Social Care return.

The newly devised audit template has provided a more focused, streamlined response avoiding duplication of evidence and allowing partners more useful judgement criteria. Positive feedback about the S11 template and process has been received via the Performance Sub Group.

Actions for 2017/18

During the following year, actions provided for improvement where standards weren't fully met will be followed up to ascertain progress made to ensure full compliance. The Peer Review Section 11 will take place during 2017/18 and the findings from the full S11 and Board priorities will be used to select the focus of this review.

Child Death Overview Panel (CDOP)

It is the responsibility of Local Safeguarding Children Boards to ensure that a review of every death of a child normally resident in their area is undertaken by a Child Death Overview Panel (CDOP). In line with best practice that CDOPs responsible for reviewing deaths from larger populations are better able to identify significant recurrent contributory factors the Stoke-on-Trent and Staffordshire Safeguarding Children Boards decided to form a shared and jointly funded CDOP in 2008.

The overall purpose of the Staffordshire and Stoke-on-Trent Child Death Overview Panel is to undertake a multi-disciplinary review of child deaths, in order to understand how and why children die and use the findings to take action to prevent other deaths and improve the health, safety and wellbeing of our children.

- There have been 50 deaths of children and young people who lived in Staffordshire during 2016/17 which is a slight increase from the 48 children and young people who died in 2015/16.
- From the 50 deaths in 2016/17, 27 deaths were unexpected compared to 15 deaths in 2015/16. An increase in sudden and unexpected deaths was also seen in Stoke-on-Trent. National statistics for the period have yet to be released.

Reviewed Deaths during this period:

As part of its functions, the CDOP is required to categorise the preventability of a death by considering whether any factors may have contributed to the death of the child and if so, whether these could be "modified" to reduce the risk of future child deaths.

- The CDOP panel met 5 times during the period and 54 deaths were reviewed by the CDOP across Stoke-on-Trent and Staffordshire and of these 46 were local to Staffordshire.
- From the 54 deaths CDOP identified modifiable factors in 15. Of the 46 deaths in Staffordshire modifiable factors were recorded in 13.

7 of the 15 deaths with modifiable factors related to children under one year old. Of these 4 were associated with sleeping arrangements; 4 were associated with adult smoking. Within Staffordshire 10 children were male, and 38% of the population resided in North Staffordshire.

CDOP Activity and Achievements

Throughout 2016/17 CDOP has continued to work with partners locally and nationally to continue to improve child safety, child welfare and develop the functions and effectiveness of CDOP. The following is a summary of the key activity and achievements:

- Continued to promote the Safe Sleeping Campaign to raise awareness amongst parents, carers and practitioners of the importance of safe sleeping arrangements. Safe sleep workshops were held to continue to promote to staff the safe sleep assessment, more are organised for autumn 2017.

- The CDOP developed Safety Booklet entitled 'Protect Your Little Bundle… From Birth and Beyond' to raise awareness of potential hazards in and around the home and to prevent unintentional injuries to babies and children continues to be circulated and promoted Funding has been provided by Stoke-on-Trent and Staffordshire Public Health for the next 2-4 years, and supplies this year were bolstered by a private donation of booklets.

- The CDOP designed and circulated 14 issues of the CDOP newsletters – now entitled 'Child

Health and Safety Newsletter', to appeal to a wider audience. This is designed to raise awareness of key issues and campaigns including Drowning Prevention, Button Battery Awareness, Asthma and Immunisations and Breastfeeding.

- We continue to be members of the National Network of CDOPs to share best practice, exchange information and collectively support each other to prevent and reduce child deaths

- Re-invigoration of West Midlands Regional CDOP Network to share local best practice, collation of statistical information and regional working groups to look at shared procedures, learning development days.

- Local Sudden Unexplained Death in Infancy and Childhood guidance (SUDIC) has been updated and reviewed in line with the recent publication of the Royal College of Pathologist SUDIC Guidance

- Continued to work with regional colleagues in the palliative care network to improve the quality of Advanced Care Plans to support children and young people and their families in circumstances where there are life limiting conditions. The Staffordshire Child and Family Bereavement Alliance held a study day at Staffordshire Police Headquarters, support by the CDOP in November 2016.

Objectives for 2017/18

The 2017/18 objectives are contained in the CDOP Business Plan (2017/18). The Plan builds on the strong joint arrangements between the Staffordshire and Stoke-on-Trent Safeguarding Children Boards and the key areas of focus are summarised below.

- To conduct a formal evaluation of the CDOP Safety Booklet to include feedback from practitioners and service users
- To support another Staffordshire Child and Family Bereavement Alliance study day
- To respond to demand from professionals to continue to deliver Safer Sleep Awareness Workshops to support multi-agency practitioners in their role in preventing and reducing Sudden Infant Death Syndrome. To continue to promote safer sleeping and update and promote awareness material
- To build on the work undertaken with Staffordshire Police to enhance their response to investigating child deaths and use this learning to inform a refresh procedures.
- To monitor progress against the Asthma Thematic Review Action Plan to ensure that improvements in service delivery are operationalised and sustained
- To continue to develop the support available to bereaved families through working with local services to develop support networks (the 'Star Café') at venues across the county
- To respond to recommendations relevant to CDOP from the national review of Safeguarding Children Boards

The CDOP Annual Report 2016/17 is available from the respective Safeguarding Children Board websites using the following links:

- Stoke-on-Trent: www.safeguardingchildren.stoke.gov.uk
- Staffordshire: www.staffsscb.org.uk

The Wood Review on the role and functions of Local Safeguarding Children Boards has advocated changes in the arrangements pertaining to the Child Death Overview processes. The details will be available for consultation later in 2017.

Workforce Development and Training Sub-group:

Core Business Objectives 16-17 (within SSCB Training Strategy 16-19):

- Our role is to ensure strategic overview of the quality and provision of single and multi-agency training. We will ensure that training needs of all partner agencies are met within the context of local and national policy and procedural developments. Also training needs arising from SCR's, audit and Inspection.
- All SSCB training shall incorporate learning in respect of issues relating to equality and diversity.
- Support the management of the SSCB training pool through recruitments, training and monitoring.
- Evaluate the impact of training on practice, organisations procedures, and outcomes for children, young people and their families.

https://www.staffsscb.org.uk/Aboutus/Annual-Reports/Annual-Reports.aspx

Delivery in 16-17:

- 117 events in total
- 39 Working Together events
- 2377 participants
- 74% of participants rated their knowledge as good to excellent after attending one of the SSCB training courses and the same amount of people rated the course overall as good to excellent.
- 22 different training events
- 14 E-learning packages
- 12% courses cancelled
- New E-learning - FGM / Forced Marriage & CSE
- 5% did not attend
- Over 75% completed evaluations and these are demonstrating impact.

Outcomes as reported/evidenced by practitioners:

- The evaluations from practitioners highlight that they are more responsive to the needs of children and families in Staffordshire.
- Practitioners recognise the Safeguarding priorities and how they can respond to those needs.
- There is an increased understanding of multi-agency roles and communication between them.
- Practitioner evaluations denote a change in practise from lessons learnt within SCR's in Staffordshire.
- We have high numbers of practitioners that have completed initial (31%) and 3 month (31%) evaluations
- We have reduced numbers of 'Did Not Attends' down to 5% due to our charging policy and charging up front
- The multi-disciplinary training team remains sustained (see appendix 4)
- The new Child Protection Level 1 Core Slides have been utilised and there is a good response from a wide range of partners.

Challenges:

- The SSCB training manager post was recruited to following the retirement of the previous employee
- Training provided within the local and national priorities.
- Ensuring the quality assurance process is adhered to and robust.
- Continued confidence of practitioner's being familiar with the Learning Management System, Virtual College.

Acknowledgement of Training Team activity 2016-17

The training programme could not succeed without the positive input from those members of partner organisations who sit on the SCB Workforce Development and Training Sub-group.

The Safeguarding Children Board wishes to express its thanks and gratitude to those agencies and the individual members of staff whose commitment to SCB training has been so invaluable and we look forward to continuing our successful partnership. The successful delivery of the SCB Training Programme is highly dependent on the contributions of members of staff representing the range of SCB partner organisations. The names of the trainers to whom the SCB is most grateful are shown at Appendix 4 on page 77.

The contribution of those SCB staff who work so tirelessly behind the scenes to facilitate the staging of SCB training programmes is also recognised here and we would also wish to express our gratitude in for their excellent contributions.

Districts Sub-group

The District Safeguarding Subgroup is a formally constituted arm of Staffordshire Safeguarding Children Board (SSCB) and of Staffordshire & Stoke on Trent Adult Safeguarding Partnership (SSASP). It is responsible for helping to ensure that the safeguarding children and vulnerable adults' agenda is fully embedded and driven forward in district and borough councils across Staffordshire. The subgroup is responsible for progress such as:

- Promoting effective channels of engagement and communication between the district / borough councils and the safeguarding boards; between subgroup members; and with children and their parents/ carers;
- Promoting SSCB / SSASP priorities and campaigns with district and borough councils;
- Raising awareness in partner agencies of the contribution that District Councils make to safeguarding and promoting the welfare of all ages and advise Board partners on good practice and ways to improve;
- Establishing a shared understanding of safeguarding issues in district / borough councils, and develop common approaches across the eight district/borough councils towards discharging their responsibilities; and
- Promoting safeguarding workforce development and training opportunities to help to improve the recognition of and response to welfare and abuse concerns and safeguarding practice.

Progress and Achievements:

During 2016-2017 the subgroup has:

- The members of the District's Safeguarding Subgroup altered the wording / language to the Section 11 audit tool to make it more relevant for District Councils. The section 11 peer audit was completed as part of the workshop on the same date. The full section 11 audit tool is scheduled to be reviewed during next year, to make it more relevant to District Councils.
- District and Borough council policies have been updated to take account of legislative and other changes.
- Reviewed and updated District and Borough council websites to provide information on safeguarding, including promoting the work of the SSCB.
- Vulnerability hubs have been established in each district/borough to provide a local focus to safeguarding.
- Training of staff members and Councillors on safeguarding issues
- Awareness raising of key issues within organisations
- Raising awareness and commissioning services to respond to the issue of domestic abuse
- Development of a draft safeguarding policy for use by parish councils

Challenges

- Ensure that the work of the Districts is aligned to Board priorities
- Develop new, innovative ways to help keep safeguarding on local agendas
- Ensure that training for staff members is refreshed as appropriate

Review of Restraint Task Group

HMYOI Werrington falls within the SSCB locality of Staffordshire. It houses approximately one hundred and twenty children aged between fifteen and eighteen years of age. The SSCB has strong links with Werrington and robust systems and procedures. This relationship provides external partnership scrutiny and helps to ensure the effective use of Managing and Minimising Physical Restraint (MMPR) procedures, as well as to agree what action is required to remedy any identified non-compliance.

The SSCB Board Manager and other partner agency representatives are invited to quarterly Safeguarding Meetings at the establishment and an SSCB coordinated multi-agency Review of Restraint Task Group Meeting is convened on a quarterly basis.

This task group is chaired by the Local Authority's County Manager for Youth Offending Services and is attended by a range of other partners. Dip samples of restraint incidents and associated documentation which includes the views of the child / young person, are reviewed by partners to provide challenge and seek assurance that any use of force is being used appropriately in the establishment.

There are also daily checks and scrutiny feedback to the establishment's Safeguarding Team members via two local authority full time social workers who are located in HMYOI Werrington and are available for the children and young people to access; these workers help to contribute

to the establishment's welfare and safety multi-agency decision making processes. In addition there is a team of Barnardo's advocates within Werrington which see the children on request

The task group has been reviewing and monitoring the recommendations following an unannounced inspection of Werrington in February 2017 in which there were some recommendations on the use of restraint.

Key Progress on other Safeguarding Children Activity

Staffordshire Council of Voluntary Youth Services (SCVYS)

SCVYS was established in 1982 to meet the needs of young people by strengthening and supporting the work of local voluntary youth organisations. To the core infrastructure functions of influence, develop and connect, SCVYS adds a unique youth work specialism to providing information, advice and guidance, direct support, facilitated learning, networking, consultation and collaboration opportunities, as well as promoting Staffordshire's voluntary youth sector in various ways. SCVYS also represents the sector on a number of district, county and regional strategic partnership networks.

Current membership stands at over 150 organisations, reaching 33,000 local children and young people via programmes delivered by 8,300 volunteers and over 400 staff. SCVYS is continually working hard to interpret the high level complexities of the safeguarding arena into clear and simple key messages for the voluntary youth sector, as well as ensuring that people know where to go for help and advice as and when they need it. We do this through regular e-bulletins, newsletters, social media and direct support from development workers who have relationships with the member organisations.

SCVYS and SSCB refreshed various existing tools this year including volunteer safeguarding cards, flowchart posters and the template policy suggested for local voluntary and community groups. In addition, 672 DBS checks have been processed through SCVYS this year on behalf of the local sector.

SCVYS leads on Early Help and Children, Young People and Families Voice on behalf of local partners, and good progress has been made in both areas. Early Help, which is of particular interest to the SSCB, is taking an innovative approach locally including developing and strengthening an informal earliest help offer alongside the more formal early help approach. SCVYS has supported a Child Sexual Exploitation consultation around risky behaviour alongside the Voice Project, and continue to provide opportunities for young people to identify, debate and promote their priorities, including mental health and a curriculum for life.

The impact of all of this behind the scenes support is a safer sector where the workforce knows how to respond appropriately to concerns and disclosures, helping to keep children and young people participating in voluntary youth groups safe in Staffordshire and its surrounds.

Safeguarding in Education

The role of the Education Safeguarding Lead, Staffordshire County Council continues to develop to meet the needs of Staffordshire Education settings. The role was developed to be a

central expert and single point of contact in supporting schools and other agencies in the educational world. The role is now managed by Clive Cartman-Frost, County Manager Responsive Services, and is overseen by Vonni Gordon, Strategic Manager, Specialist Safeguarding Services. Some of the functions are:-

- Establishing direct contact and engagement routes with Heads and DSL (Designated Safeguarding Leads.
- To develop DSL termly briefings, to deliver key safeguarding messages and to foster sharing of good practice and DSL support networks in District bases
- The development of a dedicated email for communication as a vehicle to update DSL; efficiently and effectively and confidentially; this supports multi-agency information sharing partner agencies information and resources to enhance partnership working e.g. CSE, Gang Violence, Prevent.
- Central portal for Ofsted complaint with robust process of outcomes.
- Review and update Education Safeguarding website. To support and work closely with the ESAS (Education safeguarding advice support) telephone line
- Provide guidance for **all** schools on policy and process, guidance for Governors linked to their roles and responsibilities
- Support and promote campaigns e.g. CSE, prevent, gang violence.
- Audit safeguarding for individual schools and produce a working document for the schools to action.
- To be the author, on behalf of the SSCB, of the annual Sec 175/157 Safeguarding audit, and to analyse the data and produce the report for Board.
- To work alongside the SSCB to develop policies and to deliver appropriate training
- To review the SCC Education Safeguarding Policy and to disseminate it to Staffordshire schools.

During 2016/2017 all of the above functions were discharged, alongside a change in post holder in early 2017. This meant that there was a delay in producing the 2016/2017 Sec 175/157 audit report to Board but this was urgently addressed, as well as the 2017/2018 audit report being completed.

There continued to be a steady flow of Ofsted complaints, all of which were investigated and any Safeguarding concerns highlighted were addressed with the individual schools. Whether this be through identifying training needs or whistleblowing complaint procedures being implemented. Some of the complaints were identified as vexatious.

The Education Safeguarding Lead has continued to undertake audits in schools, either at the schools own request or that of Ofsted report outcomes, but the new post holder is also encouraging DSL's to support each other as a means of reflective practice. DSL's have been very vocal about the high level of support that they now feel they are receiving,

The role requires attendance and contribution at a number of strategic priority groups, eg. PREVENT, CSE outcome, SSCB, CME.

In September 2016, The Education safeguarding Lead developed the SCC Education safeguarding Policy, in line with the Keeping Children Safe in Education 2016 guidance, and shared it with schools who wanted to adopt the SCC policy.

The role continues to be key to sustaining and challenging robust Education Safeguarding practices in Staffordshire education settings, and to provide the evidence to that effect.

Multi-agency Public Protection Arrangements (MAPPA)

MAPPA is the mechanism whereby agencies within the 42 criminal justice areas across England and Wales work collaboratively to minimise the risks of serious harm posed to the public by sexual and violent offenders.

The Risk Management Co-ordinator, located within CSC services is the primary interface between the CSC and the MAPPA activity within Staffordshire and acts as a Single Point of Contact for all MAPPA related business. The Risk Management Coordinator also initiates any necessary referrals through to CSC services in respect of any assessment or activity required in response to information shared about a specific offender and/or as part of a multi-agency risk management plan. During 2016-2017, 224 individual discussions 42 panels were held in respect of 82 individual offenders and Staffordshire CSC services attended 100% of these panels.

Staffordshire's Families First continues to make a very significant and effective contribution to the MAPPA activities within Staffordshire. The provision of a core representative to all MAPPA panels helps to ensure that any potential risks to children can be identified and factored into offender risk assessments; and the early undertaking of appropriate social care interventions and safeguarding actions which are critical elements of individual Risk Management Plans. The function of the Risk Management Co-ordinator remains pivotal to the maintenance of effective working partnerships with those agencies whose contribution to the broader children's safeguarding agenda extends well beyond their specific MAPPA obligations. Much work also continues to be undertaken outside of the panels to understand and manage risk and this activity is an equally essential component to the protection of vulnerable children within Staffordshire.

Prevent

Staffordshire County Council, using a small grant allocated from the Home Office, has pooled funds with district and borough councils to commission the development of a curriculum resource pack for schools. The pack will include lessons plans and a DVD featuring scenarios based on issues which have been identified by young people themselves, which can be used by teachers as a stimulus for classroom discussion and other activities. The pack is intended to provide young people with a robust understanding of the risks and threats of radicalisation and extremism, equip practitioners with the confidence and skills required to address the issues in an age-appropriate way and provide an accessible way of engaging with local communities to promote resilience and cohesion. Work to develop the package commenced in the Summer Term, with the aim of launching it in the autumn of 2016.

The remaining County Council Home Office funding has been used to commission Staffordshire Observatory to undertake work in relation to enhancing our current understanding of communities in Staffordshire. This will look at the challenges and opportunities they face and the most effective ways of engaging with them. Information about risks and challenges faced by

communities will be used to enhance the Staffordshire Counter Terrorism Local Profile (which is a document produced by Staffordshire Police and which identifies the threat and vulnerability from terrorism and extremism relating to terrorism in local areas).

Prevent Referrals and Staffordshire Channel Panel

The Counter-Terrorism and Security Act 2015 required local authorities to establish a multi-agency panel (known as a 'Channel Panel') to identify and support those felt to be vulnerable to being drawn into terrorist activity. The Staffordshire Channel Panel has been in place since April 2015. It is made up of a small core group, which includes adult and child safeguarding, education, health (including mental health) and community safety, and a wider co-opted group of members, who can be called upon as necessary on a case-by-case basis.

In Staffordshire the approach to Prevent is being embedded as an integral part of the safeguarding agenda. Joint Staffordshire and Stoke-on-Trent Prevent Safeguarding Guidance has been produced which is intended to provide a clear framework for all professionals working with people (or those around them) for whom there are concerns that they are at risk of becoming involved in violent extremist activity. The guidance reinforces the link between safeguarding procedures and the Channel programme and the document has been developed and endorsed by Staffordshire and Stoke-on-Trent Adult and Children's Safeguarding Boards.

Between 1st January 2015 and March 2016, 60 referrals were made to the Police Prevent Team. Further information about the number of referrals and the impact of local activity will be more readily available in the next SSCB Annual Report.

There has been a considerable amount of work undertaken to effectively implement and embed a robust response to tackling extremism and radicalisation in Staffordshire. The partnership approach to Prevent will continue to be developed and will build upon the strong foundations which have been established. The focus over the next 12 months will include the implementation of the training plan across the partnership workforce; the SSCB continues to support this activity by helping to coordinate free Workshop to Raise Awareness of Prevent (WRAP) training across Staffordshire. Mechanisms will be developed to ensure that the impact of training can be measured and any gaps identified and addressed. Work will also be undertaken to develop tailored and proportionate communication material for use with various audiences, including partners from the SSCB.

PARTNER AGENCIES' FINANCIAL CONTRIBUTIONS

Partner agencies continued to make financial contributions to the work of the Board in addition to providing a variety of resources, such as staff time to help facilitate and deliver the multi-agency training and offer venues to hold both training sessions and workshops.

Income

The Board Training Team has again generated income from training that they have provided to private sector settings. This income contributes to the Board training budget. Total Income **£89,373**

Contributions

During the year the Partner Agency contributions received were £253,047.30

In addition to this £20,000 was received from the OPCC and a contribution of £9825.75 was received from Stoke-on-Trent SCB towards the CDOP Post. Total Contributions received **£283,065**.

Other Income

Included £19,540 Stoke's Contribution to IC Post, £17,860 Stokes Performance Post Contribution, £15,600 Adult Board Contribution to IC Post, £11,280 Adults Board Contribution to Performance Post. Total other Income **£64,280.**

Total Income

Total Contributions	£283,065	
Other Income	£64,280	
Training Income	£89,373	
CDOP Booklets	£ 1,650	
Total Income	£438,368	
Surplus Training Income	£ 49,152	Transferred to Reserves
Total Income 16/17	**£389,216**	

Expenditure

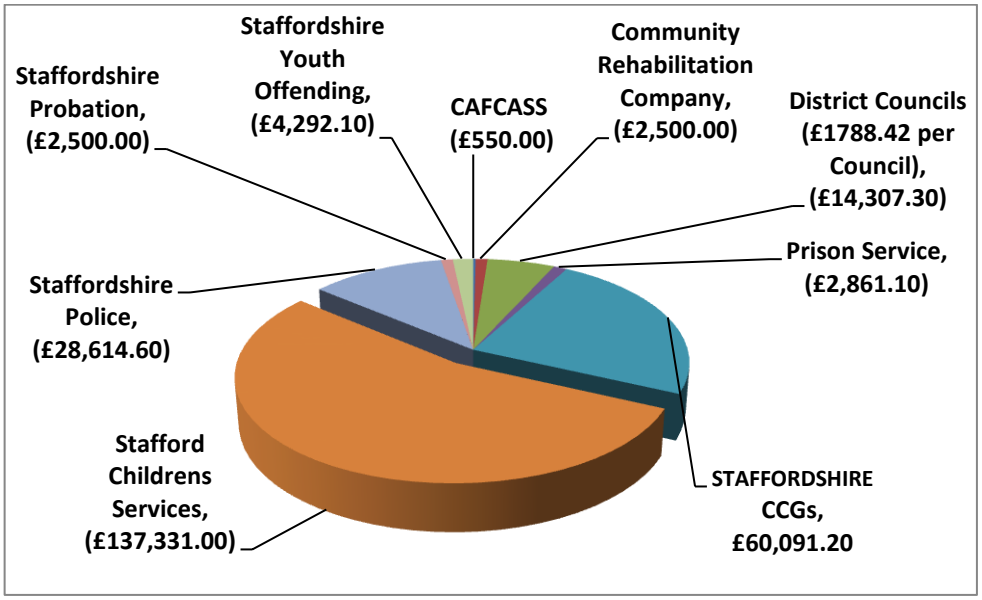
Whilst the SCB has a multi-agency training team of 47 professionals from a range of partner agencies who utilise their local knowledge and expertise, there are a small number of multi-agency training opportunities that are externally commissioned. Total Cost £18,137

Total Expenditure

Staffing costs for the SCB Core Team (including Training Team)	£186,605
Independent Chair	£ 57,169
SCB Trainer Costs	£ 18,137
Serious Case Reviews	£ 3,479
Contribution to the CDOP Administrator	£ 29,317
Supplies and Services	£ 36,925
Service development	£ 57,000
Transport	£ 584
Total Expenditure for 16/17	**£389,216**

The contribution to reserve was £49,152, making a total surplus as at 31 March 2017 of £142,009.

The pie-chart below provides a breakdown of partner agency contribution to the SCB budget:



APPENDICES

Appendix 1

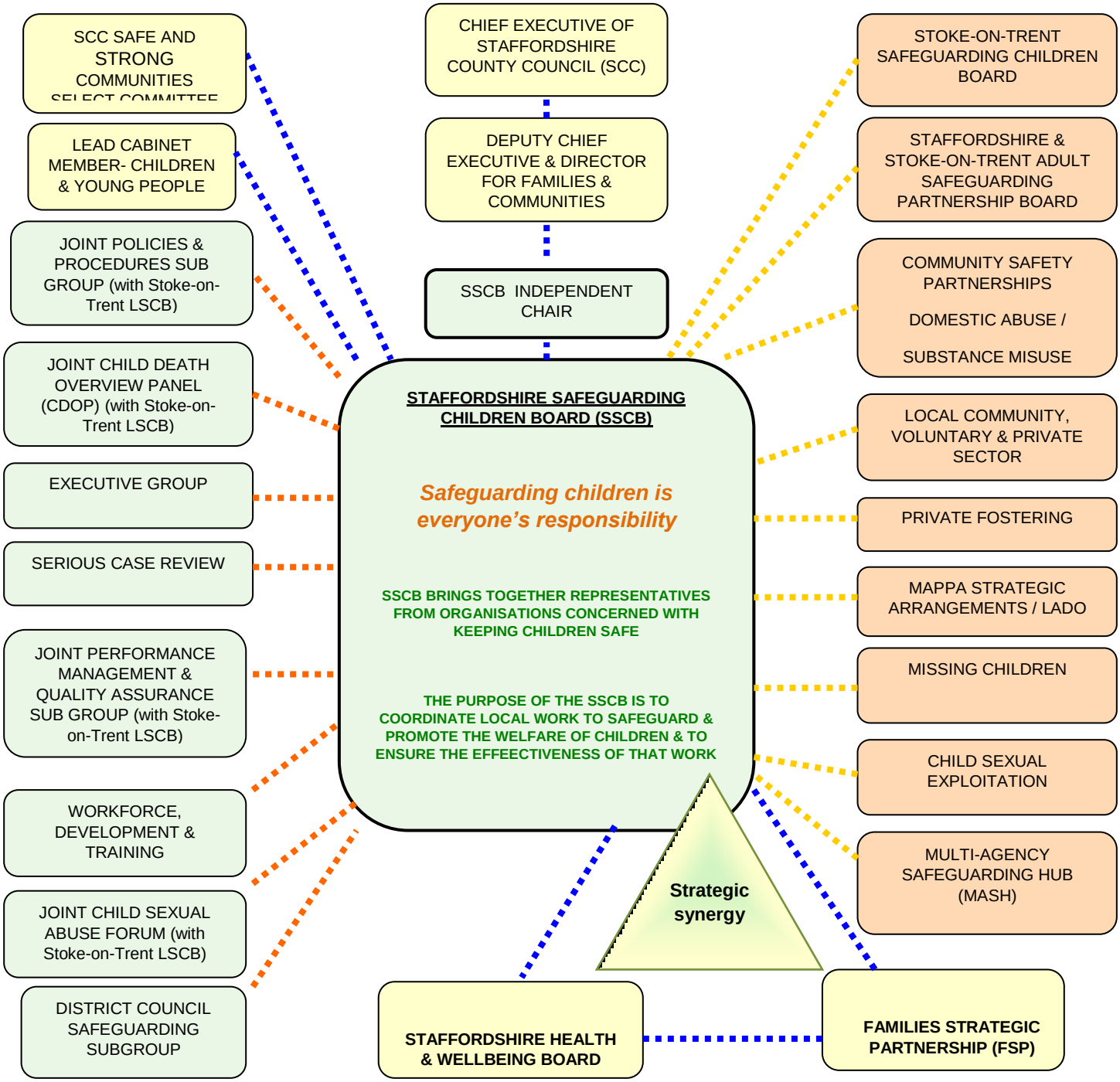
Agencies of the Board

Staffordshire County Council
CAFCASS
Community Rehabilitation Company (CRC)
Staffordshire Council of Voluntary Youth Services (SCVYS)
Burton and South Derbyshire College *(representing further education)*
Lay member
NHS England – North Midlands
North Staffordshire Combined Healthcare NHS Trust
North Staffordshire Clinical Commissioning Group
South Staffordshire Clinical Commissioning Group
NSPCC
Chasetown Community School *(representing special schools)*
St Dominic's Grammar School *(representing independent schools)*
Entrust
Staffordshire and Stoke-on-Trent Partnership NHS Trust
Staffordshire and Stoke-on-Trent Probation Trust
Staffordshire Fire and Rescue
Staffordshire Police
Army Welfare Service
Burton Hospitals NHS Foundation Trust
Birmingham Community Healthcare NHS Foundation Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
HMYOI Werrington
University Hospitals of North Midlands NHS Trust

West Midlands Ambulance Service
Barnardos
District Councils

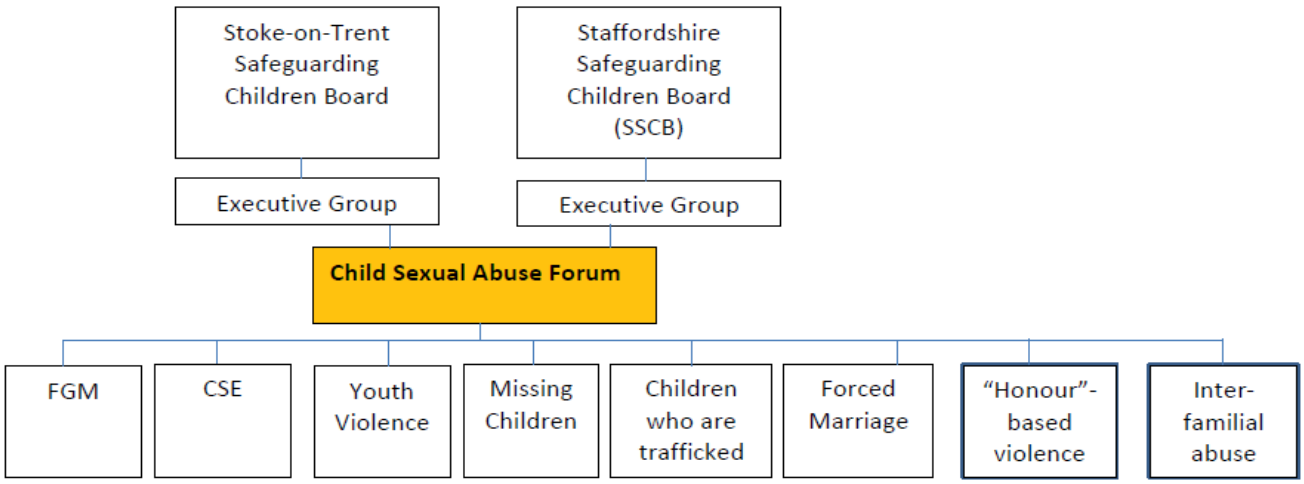
Appendix 2

Staffordshire Safeguarding Children Board Structure



Appendix 3

Child Sexual Abuse Forum – Structure Chart 2016



Acknowledgement of Training Team activity 2016-17 **Appendix 4**

Topics	Trainers	Agency
Level 2 Multi-Agency Working Together – The Staffordshire Way	Darren Maskill Dean Burrows Deb Barnes Dorothy Thomas Dr Jackie Kilding Dr Ros Negrycz Emma Blinkhorn Helen Kyle Helen Purshouse Jessica Hackett Joanna Holmes Josie Holloway Julie Burrows Lesley Frith Liz Ford Naomi Banks Narriman Crofts Penny Wilson Roz Randall Sheena Adams Shirley Archibald Simon Langford Victoria Baxendale Vikki Draper	SCC - Families First SCC - Families First SCC - Education Staffordshire & Stoke on Trent Partnership NHS Trust Royal Stoke University Hospital Royal Stoke University Hospital SCC - Families First Staffordshire & Stoke on Trent Partnership NHS Trust Staffordshire Police SCC - Families First SCC - Families First Independent Trainer Staffordshire Police SCC - Families First SCC - Families First SCC - Families First Staffordshire & Stoke on Trent Partnership NHS Trust Birmingham Community Healthcare NHS Trust SCC - Education SCC - Families First Staffordshire & Stoke on Trent Partnership NHS Trust South Staffordshire & Shropshire Healthcare NHS Foundation Trust North Staffordshire Combined Healthcare NHS Trust SCC - Families First
Level 3 Multi Agency Lessons Learnt from Serious Case Reviews	Lynne Milligan	Staffordshire Safeguarding Children Board – Development Officer
Level 3 Multi Agency Children and Domestic Violence	Alison George Beverley Davis Sandy Sykes	Staffordshire Police SCC - Families First Staffordshire Women's Aid
Level 2 Multi Agency Refresher in Child Protection	Dr Jackie Kilding Hazel Shaw Josie Holloway Roz Randall Vikki Draper	Royal Stoke University Hospital SCC - Families First Independent Trainer SCC - Education SCC - Families First
Level 4 Multi Agency Designated Lead Person Training	Kim Gristy Roz Randall Stephanie Ivey	SCC - Education SCC - Education Tamworth Borough Council
Level 4 Multi Agency Safer Recruitment	Alison George Gemma Derrick Roz Randall Sharon Davies	Staffordshire Police Staffordshire Police SCC - Education Staffordshire Police
Level 4 Multi Agency Refresher in Safer	Roz Randall	SCC - Education

Recruitment and an Ongoing Culture of Vigilance		
Level 4 Multi Agency Managing Allegations of Abuse Against a Person who Works with Children – Lite Bites	Lisa Dada	SCC - First Response
Level 3 Multi Agency Female Genital Mutilation	Jenny Blewitt Roz Randall	Staffordshire Police SCC – Education
Level 3 Multi Agency Information Sharing Workshop – Lite Bites	Narriman Croft Vikki Draper	Staffordshire & Stoke on Trent Partnership NHS Trust SCC – Families First Trainer
Level 3 Multi Agency Recognition of Neglect and Emotional Harm	Ruth Pearson	Independent Trainer
Level 3 Multi Agency Working with Hostile and Uncooperative Families	Ruth Pearson	Independent Trainer
Level 3 Multi Agency Child Sexual Exploitation (2 Day)	Suzi Moore	Independent Trainer
Level 3 Multi Agency Intra-familial Sexual Abuse	Suzi Moore	Independent Trainer
Level 3 Multi Agency Substance Misuse and Parenting Capacity	Danielle Ferrari David Sheffield	T3 Young Person's Substance Misuse Service
Level 3 Multi Agency Safeguarding Children with a Disability	Sarah Goff	Ann Craft Trust
Level 3 Multi Agency Forced Marriage and Honour Based Violence	Savana Trainer	Savana
Level 3 Multi Agency Getting to know the Child Sexual Exploitation unit and your role – incorporating missing children	Julie Burrows	Staffordshire Police
Level 3 Multi Agency Mental Health and Child Protection	Claire Histead Simon Langford Victoria Baxendale	South Staffordshire & Shropshire Foundation Trust South Staffordshire & Shropshire Foundation Trust North Staffs Combined Healthcare Trust
Level 3 Multi Agency Understanding Suicide and Self Harm	Beverley Roberts Narriman Croft	Birmingham Community Healthcare NHS Trust Staffordshire & Stoke on Trent Partnership NHS Trust
Level 3 Multi Agency Safeguarding Children & E Safety	Simon Street	Staffordshire Police

Local Members' Interest
N/A

Safe and Strong Communities Select Committee – 15th January 2018

Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board Annual Report 2016/17

Recommendation

1. The Safe and Strong Communities Select Committee are requested to scrutinise the work of the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB); and to consider or comment on the progress that the Board has made since the last report. The progress made between April 2016 and March 2017 is detailed within the SSASPB Annual Report attached (Appendix A).

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

Summary

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

2. **What?:** To scrutinise the work 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 2016 and March 2017 is detailed within the SSASPB Annual Report attached (Appendix A).

3. **Why?:** In order to comply with a requirement of the Care Act 2014 which states that the SSASPB must send its Annual Report to a number of bodies including the relevant overview and scrutiny committee meeting of the Local Authority. (Care Act Statutory guidance (August 2017): Chapter 14 para 160).

Report

Background

4. Safeguarding Adult Boards became statutory as a result of the Care Act 2014.

5. 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 2016 to 31st March 2017. Mr John Wood was the Independent Chair of the Board throughout this period.

6. 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'.

7. **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 knowledge to use the full range of interventions/legal powers;
    d. Ensure lessons are learnt to improve practice;
    e. Communicate the importance of adult safeguarding widely to communities and all those delivering services with guidance on how to seek help and support;
    f. Collect hard data (statistics), qualitative data (audits) and the views of service users, carers' and family members

8. **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.

9. **Strategic Priorities:** The 2015/16 Strategic priorities of the SSASPB were i) To improve Engagement with service users – their carers and families, members of the public and professionals, ii) to seek assurance that Transition processes between Children and Adult Services consider the NICE (National Institute for Health and Care Excellence) guidelines and iii) to understand what issues exist with regard to Leadership in the Independent Care Sector.

Adult Safeguarding Data: A brief overview.

10. The report highlights a 25% increase in reports of safeguarding concerns in Staffordshire; from 4393 to 5529. This is in part due to raised awareness of what constitutes abuse and neglect and how to report but it is widely believed that there is still under reporting and the likelihood is for reported concerns to further increase.

11. The majority of people that these concerns relate to are aged 65 years and older (66%) with physical support needs. 28% of concerns reported were in connection to those aged 85 and above.

12. When abuse or neglect occurs it most frequently takes place in the person's own home or a residential care home and is perpetrated by people that they know who should be protecting them.

13. Around one in four of the reported safeguarding concerns relate to People in Positions of Trust.

14. 26% of concerns were about neglect, 26% were physical abuse, 20% financial abuse, 14% psychological or emotional abuse, 8% domestic abuse and 3% sexual abuse. The other remaining 4 categories total 3%.

15. In an ageing society there are many challenges for adult social care and safeguarding and it is vital to continue to work in partnership on preventative strategies to prepare for this.

16. The Annual Report includes case studies forwarded by partner agencies through which they demonstrate their commitment to Making Safeguarding Personal (MSP).

Link to Strategic Plan – The assurance role of the Board supports the following Staffordshire County Council strategic priorities:

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

Link to other Overview and Scrutiny Activity – Deprivation of Liberty Safeguards.

Community Impact – There is no anticipated Community Impact.

Contact Officer

Name and Job Title: Jo Sutherland, Statutory Services Lead and Principal Social Worker
Telephone No.: 01785 277432
Address/e-mail: jo.sutherland@staffordshire.gov.uk

Also:

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

Appendices/Background papers

Appendix A - SSASPB Annual Report 2016/17
Appendix B - SSASPB Strategic Plan

Staffordshire and Stoke-on-Trent
Adult Safeguarding Partnership Board

Abuse must stop


Annual Report 2016- 2017


1. CONTENTS

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

Adult living in Stoke-on-Trent – Telephone: 0800 5610015

Adult living in Staffordshire – Telephone: 0345 604 2719

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

2. INDEPENDENT CHAIR FOREWORD

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

The Annual Report provides an overview of the work of the Board and its sub groups illustrated with case studies as to how the focus on Making Safeguarding Personal is making a positive difference to ensuring that adults with care and support needs are supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse and neglect.

Whilst this report illustrates a broad range of achievements during the year it also highlights an increase in reports of safeguarding concerns in both Staffordshire, up 25% and Stoke-on-Trent, up 6%. Some of the increases are due to raised awareness of what constitutes abuse and neglect and how to report but it is widely believed that there is still under reporting and the likelihood is for reported concerns to further increase.

When the reported concerns are analysed it will be seen that the majority of people that these relate to are aged 65 years and older predominantly with physical support needs. When abuse or neglect occurs it most frequently takes place in the person's own home or a residential care home and is perpetrated by people that they know who should be protecting them. Around one in four of the reported safeguarding concerns relate to People in Positions of Trust. In an ageing society there are many challenges for adult social care and safeguarding and it is vital to continue to work in partnership on preventative strategies to prepare for this.

It is against this background that I would again like to take this opportunity to acknowledge the commitment and enthusiasm of all of our partners and supporters including the statutory, independent and voluntary community sector who have a clear focus on doing their best for those adults whom we are here to protect from harm. This commitment is vital to sustaining the effectiveness of the partnership work.

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

The main objective of a Safeguarding Adult Board, in this case the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) is to help and protect adults in its area by 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
- are experiencing or at risk of abuse or neglect; and
- as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect.

A Safeguarding Adult Board has three primary functions:

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

Composition of the Board

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

The Board membership is shown at Appendix 1, page 39.

The Board is dependent on the performance of agencies with a safeguarding remit for meeting its objectives. The strategic partnerships with which the Board is required to agree responsibilities and reporting relationships to ensure collaborative action are shown in the Governance Structure at Appendix 2, page 40.

Safeguarding Adults – A Description of What It Is

The statutory guidance[iii] 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, page 41. The Board has taken account of the Statutory Guidance in determining the following vision.

Vision for Safeguarding in Staffordshire and Stoke-on-Trent

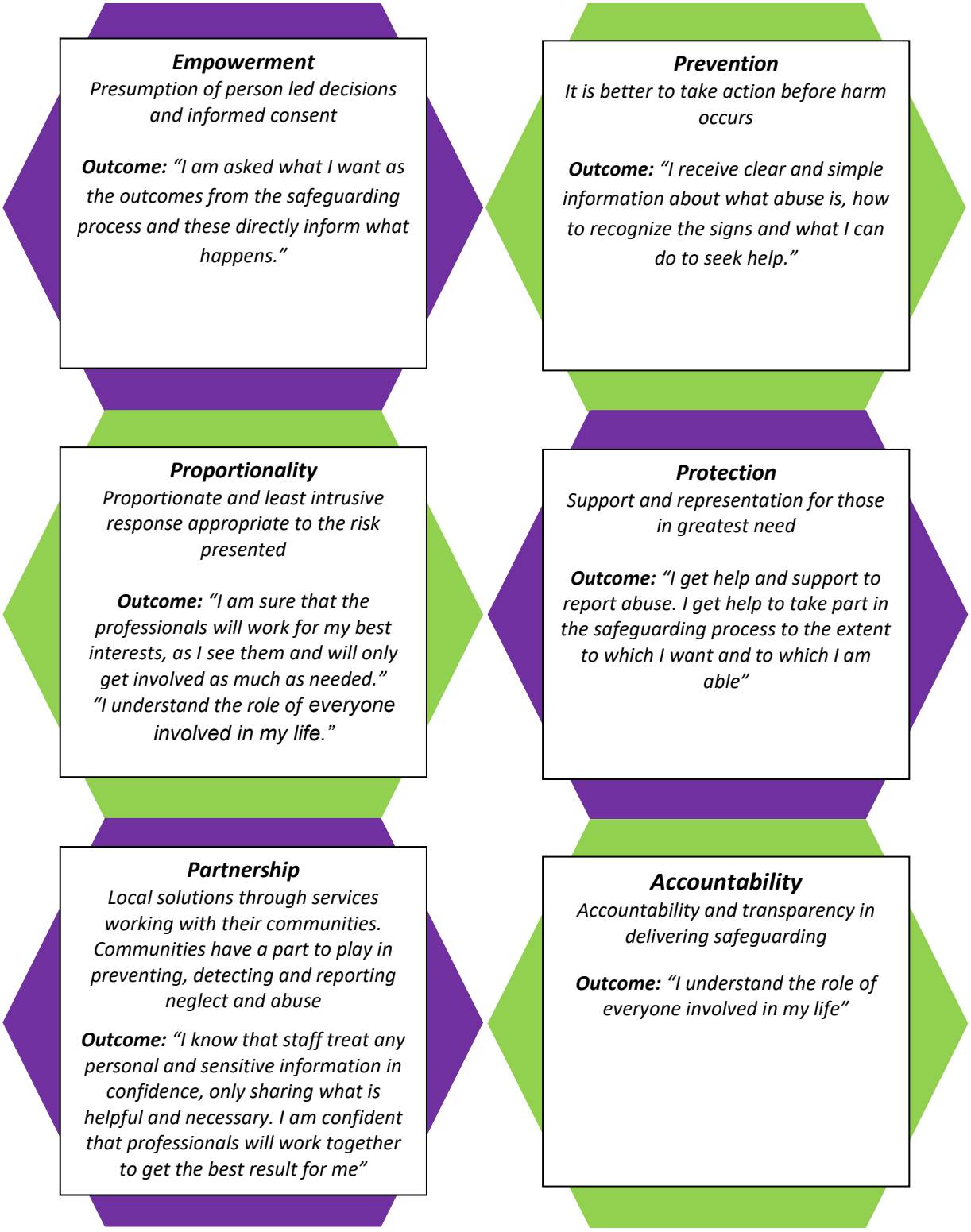
'Adults with care and support needs are supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse and neglect.'

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.

Promoting the work of the Board at the Managers Quality Networking Forum in 2017

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. WHAT WE HAVE DONE

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

Executive Sub-Group

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

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

During 2016/17 the Sub-Group has:

- Consulted upon and developed a two year Strategic Plan 2016-18[v] that was approved by the Board
- Monitored and driven progress against the Board's Strategic Priorities
- Monitored and driven progress on the action plan derived from the Staffordshire County Council commissioned audit of the SSASPB
- Developed a Safeguarding Board risk management framework and a Risk Register which is now used by all Sub-Groups. The Risk Register is a standing item at Executive Sub-Group meetings to ensure appropriate mitigating actions are taken and escalation to the Board as required
- Reviewed the Sub-Groups chairing arrangements
- Conducted performance appraisal of the Independent Chair of the Board
- Developed a proposal for SSASPB membership for Board approval
- Developed and proposed SSASPB training provision for Board approval
- Consulted upon and reached agreement for partner funding contributions covering 3 years (2017-2020)
- Monitored and driven progress against the action plan derived from the SSASPB development day that took place in January 2016; the majority of actions have been completed and others are on schedule for completion.
- Arranged and received presentations to seek safeguarding assurances from, for example, the national lead for safeguarding and community services from a large health service provider.

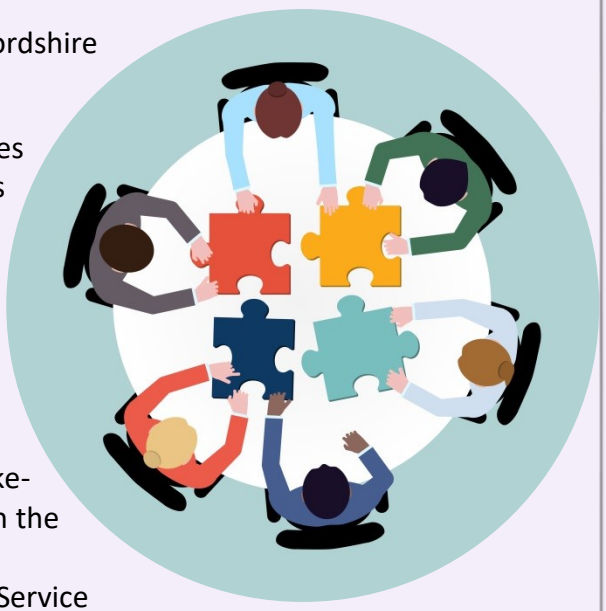
Challenges:

To maintain momentum towards the achievement of ambitious Strategic Priorities. Despite the best efforts progress may not be as rapid as envisaged.

Message to Stakeholders:

The continued active involvement of safeguarding partners in the work of the Board and its Sub-Groups is vital. Whilst the financial contributions mandated partners make are acknowledged, the protection of Sub-Group members' time to enable the Board's work to be delivered has been the key enabler of the progress made this year.

Policies and Procedures (P&P) Sub-Group



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

The Policies and Procedures Sub-Group has met four times during the year and been well attended by representatives from a broad range of connected partners.

Achievements:

- Oversaw the production of a range of refreshed publicity materials [vi] to raise awareness of adult safeguarding in a variety of formats
- Provided for the availability of Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry Procedures[vii] on the SSASPB website
- Facilitated the local adoption of the National Health Service (NHS) Safeguarding App[viii]
- Reviewed and approved internal policies including an Escalation Policy[ix] and Information Sharing Guidance for Practitioners[x]
- Revised the Adult Safeguarding Enquiry Procedures arising from a recommendation and learning from a Domestic Homicide Review (DHR)
- Reviewed and considered a national protocol regarding out of area arrangements for adult safeguarding. The document was changed significantly after feedback to the Regional Network and a combined response to Association of Directors of Adult Social Services (ADASS) from the region.
- Considered and adopted the revised West Midlands Adult Safeguarding Policy[xi] and the policy relating to People in Positions of Trust[xii] (PiPoT). This provides for consistency in approach throughout the West Midlands region.
- Considered the amendments to the Care Act 2014 statutory guidance. However after consideration there was no requirement to change to the local procedures.

Challenges:

- There is a continuing challenge in ensuring that current policies and procedures are disseminated to and readily available to practitioners within all agencies across both Local Authority areas
- Ensuring the general compliance with current procedures is a challenge in the face of increasing demand and depleted front-line resources.

Messages to Commissioners:

- The need for compliance with the local Adult Safeguarding Enquiry Procedures and arrangements for compliance checking should be embedded in all contractual arrangements
- Leadership in care services is a critical factor in delivering safety and protection from abuse. Commissioners should consider how contractual requirements around quality assurance can be used to promote positive management cultures and effective practice.
- The outcomes of personalisation of services must include aspects relating to safety and protection if they are to be lasting and effective. Commissioners should ensure that the consideration of safety and protection are integral to service development and delivery.

Safeguarding Adult Review (SAR) Sub-Group

Chair: Mark Dean; Detective Superintendent – Safeguarding (Staffordshire Police)
Javid Oomer; Detective Superintendent – Safeguarding & Protection (Staffordshire Police)

Javid Oomer became chair of the Sub-Group in February 2017 following the retirement of Detective Superintendent Mark Dean from Staffordshire Police. The Sub-Group acknowledge and thank Mark Dean for his outstanding and valued contribution as chair over many years.

Activity:

During 2016/2017 the circumstances surrounding four people were referred to the Sub-Group for consideration of a Safeguarding Adult Review (SAR). The details of the people are anonymised to protect confidentiality and accordingly are named as cases.

- Case 1: Did not meet the criteria for a SAR as there were no agencies supporting the adult and no agency held any relevant information. It is possible that the circumstances of this case may in due course be reviewed through an alternative statutory process.
- Case 2: Did not meet the criteria for a SAR as there was no apparent evidence of abuse or neglect. However, the circumstances raised concerns about the transition of the young person into adulthood and therefore an independently lead Multi-Agency Learning Review (MALR) will be commissioned. The findings of the learning review will be reported in the 2017/18 Annual Report.
- Case 3: Met the criteria for a SAR. An independently lead SAR in accordance with Section 44 Care Act 2014 has been commissioned. The findings will be included in a future Annual Report.
- Case 4: The circumstances were referred in this reporting year. Arrangements have been made for the case to be considered by a scoping panel in June 2017. The outcome will be reported upon in a future Annual Report.

Achievements:

In addition to considering the above cases the Sub-Group has:

- Reviewed the SAR Protocol[xiii] to include improvements arising from reflection and learning from SARs locally as well as from Safeguarding Adult Boards (SABs) in other areas. The Sub-Group will in future conduct an annual review of the Protocol for the purpose of continuous improvement. The Sub-Group reports to the West Midlands Regional SAR repository[xiv] to enable the sharing of good practice and lessons learnt
- Supported the Learning and Development Sub-Group in the development of a 'SAR lessons learnt' training programme
- Delivered a SARs lessons learnt presentation to 250 care providers at a Managers Quality Network Forum (MQNF) held in Stafford
- Provided content for a section on the SSASPB website dedicated to learning lessons from SARs
- Through attendance at review panel meetings evidenced achievement of a Business Plan objective to develop a knowledgeable and experienced SAR Sub-Group membership
- Continued to use 'Critical Friends' in the SAR reviews to positive effect. Critical Friends are Board partner representatives who have no involvement in the case and are appointed to make constructive challenges throughout the SAR process
- Strengthened links to both Stoke-on-Trent and Staffordshire Community Safety Partnerships (CSPs) in relation to Domestic Homicide Reviews (DHRs), thereby enabling early engagement of the SSASPB in cases where the parties involved have care and support needs to determine if there are safeguarding elements within the DHR
- Included lessons learnt from DHRs as a standing agenda item at SAR Sub-Group meetings

- Engaged with Clinical Quality Review Meetings (CQRM) within the local Clinical Commissioning Groups (CCGs) to ensure completion of actions from SARs where improved practice outcomes were required from provider agencies
- Identified and considered risks from the SAR Sub-Group perspective and recorded these together with mitigating actions taken in the SSASPB risk register.

Challenges:
The number of SAR referrals is increasing, resulting in increased demand for both the dedicated SSASPB staff and partner organisations. This demand is unpredictable, making resourcing and financial planning particularly challenging. The associated time commitment has on occasions impacted upon the progression of other work. The local experiences are consistent with experiences in other areas nationally and these in turn impact upon the availability and cost of experienced independent reviewers.

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 have met six times during the year and have been well attended by representatives from a broad range of connected partners.

During 2016/17 the sub-group has:

- Developed and quality assured training packages[xv] that have been posted on the SSASPB website; the training packages are easily accessible to visitors to the website
- Consulted upon and developed a Training Strategy that reflects the Board's responsibilities under the Care Act 2014 and processes for seeking assurances as to the effectiveness of training
- Developed a Peer Review process that enables colleagues to observe training delivery in a supportive and constructive capacity
- Developed a process to review staff training, measure effectiveness in practice and for the Board to be assured that staff are trained appropriately
- Received annual assurance statements from connected partners as to the arrangements for staff to receive mandatory training and as to the effectiveness of and compliance with those arrangements.

Plans for 2017/18 include:

- To continue to provide and update lessons learned briefings from Safeguarding Adult Reviews and safeguarding cases across Staffordshire and Stoke-on-Trent to connected partners.

Mental Capacity Act (MCA) Sub-Group

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

The Mental Capacity Act (MCA) Sub-Group is responsible for raising awareness of, and seeking assurances from safeguarding partners as to the effectiveness of their implementation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) legislation in Staffordshire and Stoke-on-Trent.

The Sub-Group is made up of representatives from partner organisations that have responsibility for the implementation and application of the legislation. Through the collective knowledge of its membership, the Sub-Group is able to identify and respond to any gaps in MCA awareness and practice amongst the partnership.

During 2016-17 the Sub-Group has:

- Completed the annual revision of its Terms of Reference to ensure these remain fit for purpose
- Broadened its membership to include advocacy organisations
- Monitored and driven progress to achieve the required actions in the Sub-Group's Business Plan
- Generally improved engagement and increased awareness of MCA and DoLS amongst practitioners
- Actively worked to improve awareness and use of Care Act advocacy to support people through safeguarding processes - safeguarding processes include referrals to Independent Mental Capacity Advocates (IMCAs) in the later stage of processes, however, through the Care Act 2014 this also includes the provision of advocacy which can be sought much earlier in the process to support the adult
- Received reports and presentations from partner agencies, gaining assurances in terms of staff awareness of MCA, examples of application of the legislation in practice including the use of advocacy
- Been a forum for discussion and review of cases, both local and national, where MCA/DoLS has been a key feature, the learning in terms of good practice and areas for improvement have been shared with front line practitioners
- Reviewed national MCA bulletins to provide learning and best practice examples
- Contributed to the national consultation of the Law Commission review of DoLS - currently awaiting the Government response
- Established a Task and Finish Group to develop guidance and working examples for practitioners to help better understand the practical application of undertaking assessments. Whilst there are significant resources that reference the Act, there are limited working examples of decision making that practitioners can refer to. This work is underway and will be disseminated to the partner organisations once complete.

Challenges:

Due to the different partner organisational structures and priorities it has been difficult to establish the assurance that MCA is embedded into frontline practice. The Sub-Group is currently working to develop tools and guidance to support this area of practice. At times it has also been difficult to maintain momentum of the Sub-Group but it is on track to deliver against its Business Plan.

Message to Commissioners:

Having sought assurances from the partners of their MCA practice the group was concerned that staff understanding and practical application of the legislation cannot always be evidenced.

Commissioners should actively monitor and seek assurances from provider organisations regarding compliance in relation to training and support for staff and the consequent impact on practice in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

District Sub-Group

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

The District Council sub-group reports into both the Staffordshire Safeguarding Children Board (SSCB) and the SSASPB, having a Business plan with both elements in it. The sub-group has met four times in 2016/17 as outlined in the SSASPB Constitution and has been well attended by representatives from District and Borough Councils across the County. The group has considered a wide variety of safeguarding issues including hoarding, links to housing providers, parish council safeguarding procedures, safeguarding on local authority land/buildings accessed by the public, training and awareness raising.

What we have done:

- District and Borough Councils provided strong levels of assurance in the SSASPB Tier 2 audit and have provided improvement plans ready for the Board partner agency peer review which is to be undertaken in 2018
- Vulnerability hubs with a multi-agency attendance have been established in each district/borough to provide a local focus and response to safeguarding
- Provided training for staff members and Councillors on safeguarding issues
- Required locally-commissioned, third-sector organisations to have safeguarding policies and procedures in place (and assisting to develop where required), which assists in raising awareness of safeguarding in the wider community
- Raised awareness of and shared effective practice within each district/borough
- Raised awareness of modern slavery
- Raised local awareness of scams and illegal money lending
- Developed a draft safeguarding policy for use by parish councils.

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

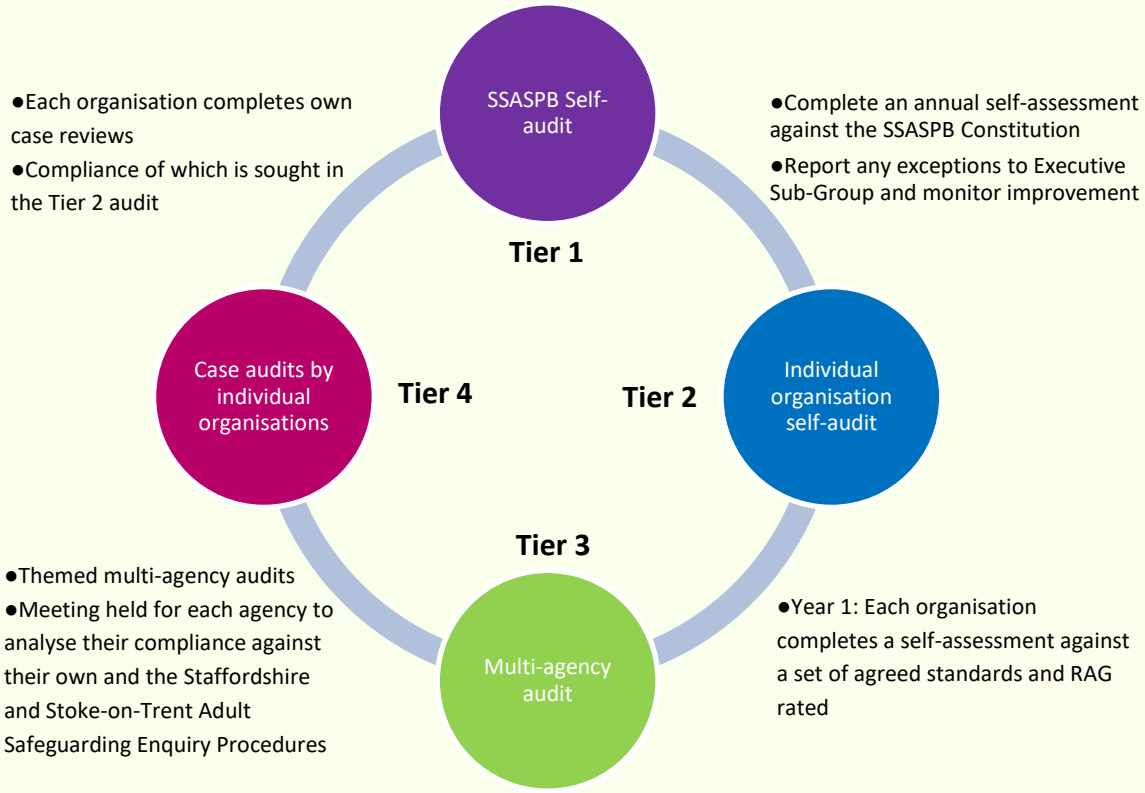
Chair: Sharon Conlon; Safeguarding Lead (South Staffordshire & Shropshire Healthcare NHS Foundation Trust)

It has been a busy and productive year for the Sub-Group with good progress made against its Business Plan. The key points are summarised below.

What we have done:

- The safeguarding partnership Performance Framework has been revised and data is now being collected against a range of relevant indicators
- The Sub-Group have overseen the gathering of the performance information for this Annual Report on pages 23 to 34. The analysis is helping to develop awareness of the themes around reported safeguarding concerns and prompts questions to enhance understanding of causes and what needs to be done around prevention. As a result of feedback from the formal scrutiny processes last year this year's performance data is broken down into narrower age bands providing a more meaningful analysis.
- The sub-group have implemented a 4 tier audit model which was developed last year and has completed audits for Tiers 2 and 3 and with a schedule of dates for the Sub-Group to seek assurances that partner agencies are conducting Tier 4 audits.

Audit Framework



Tier 1: The Tier 1 audit utilises the Board's Constitution in the form of a self-assessment. There was no audit in 2016/17 as there is a review of the Constitution. A Tier 1 audit will be undertaken following approval of the revised Constitution.

Tier 2: Following the Tier 2 audit that was completed in May/June 2016 an update has been provided by each participating organisation demonstrating how it is progressing with the Board's challenge to improve. The next steps are to understand what blockages, if any, there are to improvement and identify how the Board may help.

The Sub-Group will continue to monitor progress updates and in 2017/2018 the partner organisations will be paired to undertake detailed scrutiny of each other's evidence provided.

Tier 3: There were three Multi-Agency Case File Audits (MACFA) in 2016/17**.** The themes were Neglect (July 2016), Domestic Abuse (October 2016) and Mental Capacity (March 2017). On each occasion one or more cases were discussed in detail and the MACFA tool was used to understand where there was good practice, lessons learned and areas for improvement.

The MACFA process is particularly important to the SSASPB as it helps to mitigate the potential risk that the Board may not be sighted on front-line practice. Whilst small in number, the 'deep dive' audits were found to be informative in examining front-line practice. Although time consuming for partner agencies in the research and collation phase the benefits gained outweighed any concerns regarding this.

The tool was reviewed and refined following each audit to enhance the benefits from subsequent audits.

Tier 4: The Board seeks assurance that single agency audits are being undertaken through the Tier 2 audit. Each agency is allocated a date to present its audit findings to the Performance, Monitoring and Evaluation (PM&E) Sub-Group meetings which is then scrutinised by safeguarding partners.

Challenges:

The SSASPB covers two Local Authorities, each having different structures and processes in relation to how concerns are handled prior to undertaking a Section 42 Safeguarding Enquiry. The differences are not easy to reconcile but are explained where necessary in the narrative which accompanies each section in the performance report.

6. PERFORMANCE AGAINST 2016/17 STRATEGIC PRIORITIES

In the reporting period (April 2016 to 31 March 2017) the three Strategic Priorities were:

- Engagement
- Transition between Children and Adult Services
- Leadership in the Independent Care sector

Progress reporting towards Strategic Priorities has been a standing agenda item at Executive Sub-Group meetings. A summary of progress is outlined below.

Strategic Priority 1: Engagement

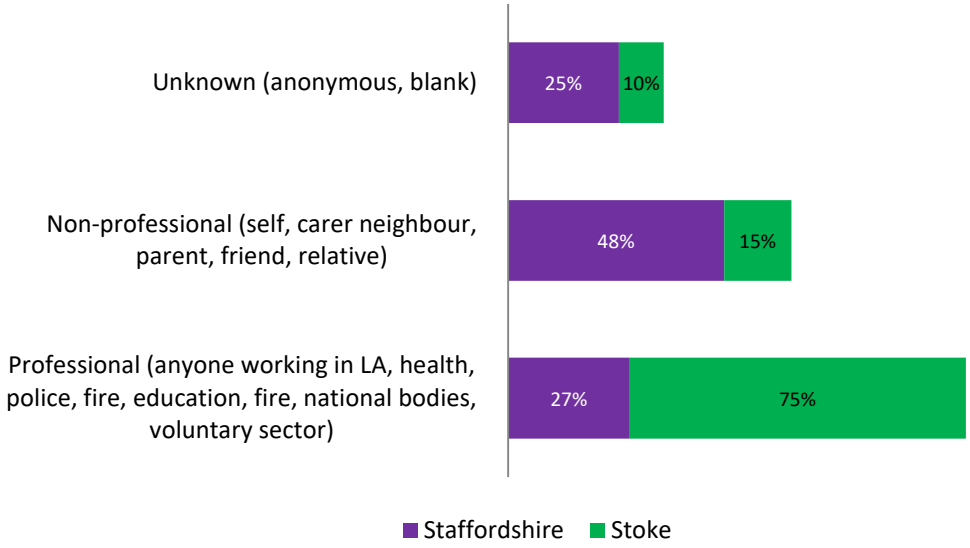
There are three parts to this Priority:

(i) Improve public awareness of adult safeguarding

Considerable progress has been made over recent years raising awareness of safeguarding. The Board and its connected partners have produced and distributed a wide range of information using a variety of methods that feedback suggests has been well received. These activities appear to have had the desired effect of contributing to an increase in safeguarding concerns and alerts. There is more to be done on raising awareness and it is important that there continues to be an emphasis on producing good quality and up to date information and publicity materials targeted to meet the needs of the diverse range of recipients.

The SSASPB has through campaigns and training been actively communicating messages about the importance of spotting the signs of abuse and neglect to a wide range of organisations and people in all walks of life, as well as raising awareness as to how to report any concerns. The following information illustrates the source of reported safeguarding concerns.

Figure 1: Number of adult safeguarding concerns received by referral source



Staffordshire: The majority of referrals come from non-professionals with nearly half (48%), just over a quarter (27%) come from professionals and 25% are either unknown/anonymous.

Stoke-on-Trent: In contrast, most referrals come from professionals, with three quarters received from this source, a further 15% come from non-professionals and 10% are either unknown/anonymous.

The following example illustrates the important role of family members in identifying when an adult with care and support needs is at risk.

South Staffordshire & Shropshire Healthcare NHS Foundation Trust (SSSFT)

Following Alan's admission into hospital, his brother Brian raised concerns to the ward detailing alleged financial abuse. The concern was followed up through an Adult Safeguarding Enquiry which was jointly conducted by the Mental Health Trust Safeguarding Team and the Police. During the enquiry Alan disclosed that his bank accounts were being accessed by his neighbour without his consent. It transpired that several bank accounts and loans had been taken out in Alan's name without his knowledge, with the financial abuse totalling over £80,000.

Feedback from Alan suggested he was relieved when he had the support and intervention from the safeguarding team. He stated that he was glad that he could finally open up and talk about what his neighbour had been doing to him. When Alan realised the extent of the financial abuse he stated that he'd been taken for a "fool" and believed he was to blame. However, with support he was able to retain control over the situation and he became determined to achieve resolution to prevent further financial abuse. Alan continued to thank the safeguarding team for their support and emphasised that he would not have been able to perform some of the tasks without this due to the deterioration in his mental health.

Brian subsequently became instrumental in Alan's recovery. He communicated his gratitude to the safeguarding team regarding their timely and effective intervention commenting that without support he believes that Alan would not have been able to make a complaint to the police. Brian believes that the situation would have undoubtedly got progressively worse and he "would not like to think about the outcome".

(ii) Making Safeguarding Personal (MSP)[xvi]

Making Safeguarding Personal (MSP) requires engagement with a person experiencing, or at risk of abuse or neglect, at an early stage to establish the person's desired outcomes. A person centred approach is then taken to make this happen. There is an emphasis in conversations about what would improve an individual's quality of life as well as their safety. Unless people's lives are improved, all the safeguarding work, systems, procedures and partnerships have limited value.

The Board has been actively advocating for the Making Safeguarding Personal approach to become a 'golden thread' that runs through strategic and operational adult safeguarding work in Staffordshire and Stoke-on-Trent and reflected prominently in connected agency work programmes.

The following are a sample of cases from partner organisations where Making Safeguarding Personal has been put into practice:

Staffordshire County Council (SCC)

Glenn is a 57 year old man with a learning disability residing in the community. He was the subject of a Safeguarding Plan regarding concerns including risks posed by Simon, a former work colleague, dating back to 2014. In 2016 he disclosed to his brother that he was being threatened and blackmailed by Simon. The blackmail involved a threat to tell local people that Glenn was a paedophile and requesting that Glenn shoot a third person, Peter. This had been happening for 9 years.

Glenn wished for the abuse to stop but was anxious about reporting the matter to the Police. The safeguarding practitioner was able to assist him to have confidence to report the matter and also made a referral to Chase Against Crimes of Hate (CACH), a local organisation that supports victims of hate crime.

After discussion with a Police Officer it was agreed that the Police would serve Simon with a Harassment Notice that would prevent him from approaching Glenn. The officer would also liaise with housing landlords to ensure that the threats were known and that if false stories were circulated locally, these could be challenged. Glenn was happy with this as he was anxious about the idea of going to court. CACH also provided Glenn with advice on personal safety and resilience in the community. The Harassment Notice was issued and the safeguarding plan was updated to ensure that Glenn and all other parties involved knew how to respond to any further threats.

This work evidences the dilemmas that people have when they wish to disclose abuse and decide what to do about it. The case highlighted excellent partnership working with a number of SSASPB partners. The approach taken clearly demonstrated that Glenn was at the centre of the activity taken to protect him and others. Glenn continues to live in a place where he feels secure and will receive ongoing support from a number of agencies for as long as it is necessary to keep him safe from abuse.

Staffordshire County Council (SCC)

Frances is a 76 year old widow. Her son separated from his wife and son four years ago and moved into Frances' shed in her garden. Her son is an alcoholic and also uses heroin.

Frances disclosed to her General Practitioner (GP) that she was thinking about throwing herself under a bus or hurting someone as she could no longer cope with the emotional abuse and threats from her son. He had also thrown heavy items at her grandson when he had visited.

A safeguarding concern was raised by the Mental Health team and a joint visit made by a social worker and a Police Officer. In the discussions that followed Frances felt able to ask her son to leave and she was assisted to then change the locks to prevent his return. Her son was assisted to find alternative accommodation and support for his substance misuse. There was follow up by both the social worker and by Police to ensure that the concerns had been addressed. Frances continued to have contact with her son but he no longer lived at her house; she no longer had thoughts of harming herself. Frances offered the following feedback: 'Thank you for being there when I needed help. I felt that I had been understood. I am much stronger now in making decisions, especially in regard to boundaries'.

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

Ronnie received support from the Staffordshire and Stoke-on-Trent Partnership Trust Community Nursing Team. They attended his home twice each week to attend to a wound to his leg. After he was assessed as having capacity to make decisions about his health and welfare needs his neighbour intervened and cited that she had Lasting Power of Attorney (LPA) for his care and welfare and trying to impose her views on the treatment and management of Ronnie, to a detrimental effect. The neighbour said that no decisions about his care could be made without her. She wrote all over the patient held records and was intimidating to staff. She was trying to bypass his input.

Checks were made by Social Care staff in relation to the claims of the neighbour. They found that she was not registered as next of kin and had no legal authority in place. This was confirmed by the Office of the Public Guardian (OPG) so an Enduring/Lasting Power of Attorney (LPA) would only be relevant if Ronnie lost capacity. The neighbour responded by taking the patient to see a solicitor and had a letter drawn up and signed on headed paper stating the neighbour had a 'general power of attorney'. This would not have legal status, could have involved coercion and illustrates the importance of checking the validity of LPAs.

The Community Nursing team managed the situation as and when incidents occurred and ensured that Ronnie's care was not compromised. The neighbour also behaved with a threatening manner towards the GP practice and expressed intentions to make official complaints. A Multi-Agency meeting was held at the GP's practice where Ronnie's case was discussed, including the challenges faced by the neighbours' involvement. The Trust contacted the Police and they visited the neighbour to address the concerns raised by Trust staff.

GPs, District Nurses, and Social Care staff continued to work together to manage the situation and to ensure the care delivered was effective and in agreement with Ronnie. The Trust Risk team and the Safeguarding team continued to monitor and support to ensure good outcomes for him.

South Staffordshire & Shropshire Healthcare NHS Foundation Trust (SSSFT)

Having taken a significant overdose, due to relationship discord, Caroline sought support from her Community Mental Health Trust (CMHT). Caroline disclosed to the CMHT that her partner was very controlling, emotionally abusive and pressurised her into having sexual intercourse; consequently the CMHT raised a Safeguarding concern. Upon initial enquiry Caroline elaborated on the domestic abuse detailing serious sexual assaults which had resulted in a significant amount of emotional distress. She expressed difficulties with maintaining her employment and managing her mental wellbeing as she no longer wished to continue a relationship with her partner.

Caroline also stated that she did not feel in immediate danger and minimised some of her partner's behaviours meaning she wanted to consider her options before leaving the home she shared with him. She was very accepting of all offers of support and stated "I can't leave on my own, I don't know how to and have nowhere to go". Similarly Caroline's mother, Diane, concurred with the safeguarding concerns and offered her support to her daughter. A referral to the Multi-Agency Risk Assessment Conference (MARAC) was made based on professional judgement by the safeguarding team. This initiated the involvement of an Independent Domestic Violence Advocate (IDVA). Following the continued support of the IDVA and successful information sharing between the agencies Caroline independently left her relationship and home which she shared with her partner and moved to a new flat that had been found by the IDVA after the MARAC meeting. The risk to her from her previous partner was significantly reduced.

(iii) Improve cross-partner collaboration

One of the main responsibilities of the Board is to make sure that it knows that the local adult safeguarding system is safe. This requires us to work effectively with other partnerships and organisations in areas of overlapping focus to ensure clarity of governance and purpose, minimise the risk of unnecessary duplication and confusion and to gain the assurances that we need.

The Board has been working to ensure the visibility and effectiveness of partnership agreements, illustrated as follows.

Northern Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs, NHS)

The Safeguarding Team in North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups work closely with both Local Authorities (Staffordshire County Council and Stoke-on-Trent City Council). This includes completing and jointly working on Section 42 (Care Act 2014) Safeguarding Enquiries. The Safeguarding Team have developed strong working relationships with the Local Authorities with regards to information sharing about issues in individual care homes. In Stoke-on-Trent the team supports the Local Authority on quality monitoring visits to care homes. This provides a clinical view on issues within a home and forms part of any action plan issued to a home to work to. This joint working provides a clear oversight of any issues and helps to drive up standards and quality where a provider needs support to improve: the main purpose being to ensure that residents have a good quality of life and are safe and well cared for.

Strong links have also been developed with the Care Quality Commission (CQC) with whom information is shared to help ensure that any homes requiring improvement are identified at an early stage and appropriate action can be taken to prevent a potential crisis occurring.

Southern Clinical Commissioning Groups

John was a resident in a nursing home as his family were struggling to manage his needs. John was suffering with Heart Failure, Parkinson's disease and had the onset of dementia. His mobility was poor and needed assistance with all of his activities of daily living. After 4 weeks at the home, a visiting family member made a complaint to the nursing home manager as John was losing weight and appeared unkempt; the family nor the home raised a safeguarding concern with the local authority and the family were advised his low mood and deterioration was due to his disease progression.

Another month on, John was admitted to hospital via accident and emergency due to him developing sepsis. The accident and emergency team raised a safeguarding concern due to him presenting in an unkempt state with multiple areas of skin breaks and with severe dehydration.

The Case did not meet the threshold for a Section 42 enquiry as the person was no longer at risk due to him no longer residing at the care home, however, the case was allocated to the CCG Adult Safeguarding Nurse to review with the Police team within ASET due to the extent of the concerns. Through liaison with the GP, Care Provider, the ambulance team and the admitting consultant, sufficient evidence gathered which enabled the case to meet the threshold for a criminal investigation and a file was submitted to the Crown Prosecution Service for a charge of neglectful care under the Mental Capacity Act (2005).

Following on from his acute admission, John is now residing at a care home closer to his family home, his care and support needs are being met effectively and he is enjoying daily meaningful activity which has improved his quality of life.

Stafford Prison

Gerry was an 86 year old man who entered custody (Prison) in June 2015. He had been diagnosed with vascular dementia and could be verbally and physical aggressive at times. He was doubly incontinent and had some mobility issues. He was unable to live independently without assistance.

Prison staff had little or no experience working with prisoners suffering from dementia or acute social care needs. The challenge for staff was in managing his care appropriately within a custodial setting.

Gerry was referred by staff for social care assessment. An appropriate social care package was identified and implemented and was reviewed frequently as his condition changed. In addition, he was supported on a daily bases by a team of trained prisoner carers who helped to clean his cell, collect food, drinks and provide social interaction.

In August 2016 Gerry was diagnosed with an inoperable cancer. As a result, he was placed on the prisons palliative care register with his ongoing care needs being discussed at the palliative multi-disciplinary monthly team meetings.

Assessment of capacity was undertaken by the prison GP and as part of the end of life care planning for Gerry, and with the involvement of an Independent Mental Capacity Advocate (IMCA), a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was obtained.

A number of training and education days to improve staff awareness on dementia and end of life care needs were facilitated. Feedback from staff who attended was very positive, and this equipped staff with the confidence to help deal with Gerry's daily needs. As his condition deteriorated he was initially transferred to a local hospital and then later to a local hospice provider where he passed away peacefully.

A death in custody review by Prison and Probation Office noted that the prison managed Gerry's vulnerability and care needs extremely well within a custodial setting.

West Midlands Ambulance Service (WMAS)

West Midlands Ambulance Service (WMAS) identified an adult, Sylvia, who makes regular calls to them which include requests such as wanting a cup of tea and the television putting on. There is a care package in place for Sylvia and her family are involved.

Following the care concern referrals made by WMAS to the local authority a number of agencies are now involved with Sylvia including the Older People's Mental Health and Dementia Team, GP, Social Care, Housing, Police (due to numerous calls to their service) and the Mental Health triage team which carries a Paramedic, Police Officer and Mental Health Nurse on board.

A multi-agency meeting has taken place and Sylvia has subsequently been diagnosed with a condition that may require surgery which they feel may contribute to the number of calls she is making. A formal Mental Capacity assessment has been considered and may be carried out after the surgery has taken place so then a full action plan can be decided upon which will include full partnership agreement.

Strategic Priority 2: Transition

This priority is led by the SSASPB with support from the Stoke-on-Trent Safeguarding Children Board (SoTSCB) and the Staffordshire Safeguarding Children Board (SSCB).

Young people with ongoing or long-term health or social care needs may be required to transition into adult services. Transition takes place at a pivotal time in the life of a young person, part of wider cultural and developmental changes that lead them into adulthood; individuals may be experiencing several transitions simultaneously. There is evidence that transition services in health and social care are inconsistent, patchy and varied depending on the condition. A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at an enhanced risk of psychosocial problems.

The transition to adulthood covers every aspect on a young person's life. Supporting disabled young people in their transition to adulthood can be a challenge to service providers. This is because the process must be individual to the needs and aspirations of each young person and local options for disabled young people may vary geographically. Also, more recently, some services have been affected by funding reductions or decommissioning.

Progress in 2016/17:

Eight cohorts of young people were identified and between January and May 2016 focus groups were held, each of which having representation from key connected agencies. These cohorts were:

- Mental ill-health
- Autism
- Young carers
- Children who offend
- Physical and Learning Disability
- Substance misuse
- Looked after Children (LAC)
- Children in Need

The findings revealed some good practice, for example the Stoke-on-Trent multi-agency Transition panel where young people are considered on a case by case basis, and some areas for improvement. The two cohorts of young people for whom transition was likely to be the most challenging were those with lower level autism and those for whom child protection legislation had safeguarded them e.g. Child Sexual Exploitation (CSE) and intra-familial abuse.

During the period that the focus groups were held the Department of Health (DoH) commissioned the National Institute for Health and Care Excellence (NICE) to develop an evidence-based guideline to improve practice and outcomes for young people using health and social care services and their families and carers. The guideline focuses on young people passing through transition to adult services with health and/or social care needs. The guideline covers young people up to the age of 25 who expect to go through a planned service transition, and proposes a set of high level principles which the Transition working Group considered.

Between January and March 2017 the following proposals were taken to the three Boards and approved:

- Ask Directors of relevant services to agree and sign-up to the high level principles produced at the working group

- Consider and adopt the NICE guidelines and relevant 'Preparing for Adulthood' (PfA) self-audit tools as examples of how to self-audit against good practice
- Ask the Directors of relevant services to arrange for the provision of evidence based assurance with which to demonstrate compliance with good practice and guidance and that the high level principles are being embedded into practice
- Assurance to be delivered to the three local Safeguarding Boards (adults and children) in the third and fourth quarter of 2017/18.

In January 2017 the SSASPB received a referral for consideration of a Safeguarding Adult Review following the death of a young person aged 18 years. In April 2017 it was decided that although the circumstances did not meet the threshold for a SAR, the SAR Sub-Group believed that there may be lessons to learn from reviewing the case. The SAR Sub-Group recommendation of a Multi-Agency Learning Review (MALR) was approved by the SSASPB Independent Chair and subsequently commissioned with transition forming part of the terms of reference.
An update will be provided in next year's Annual Report.

Strategic Priority 3: Leadership in the Independent care sector

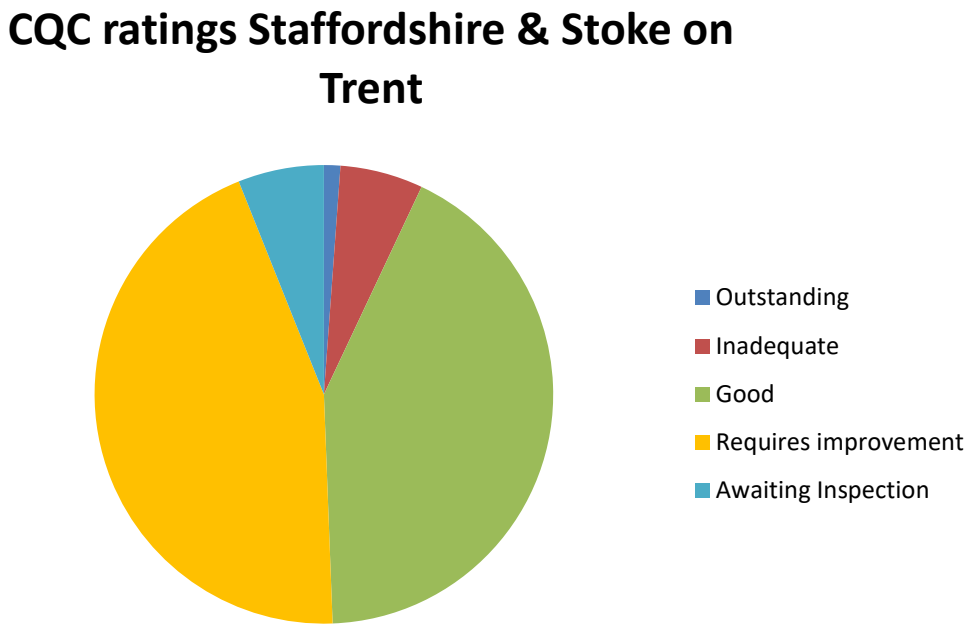
Strategic Lead: Lisa Bates; Lead Nurse of Adult Safeguarding (South Staffordshire Clinical Commissioning Groups)

Many people have been shocked by the revelations highlighted in national high profile cases of poor care and worse, outright abuse, in our health and care system. Such instances, whilst fairly rare, remind us that the way care and support is provided to individuals and their families can have a major effect on their whole quality of life. It is the leaders in the system – operating at all levels from the practice of individual staff members to the strategic planning of commissioners – that set the tone and culture of organisations. It is they who ensure that high quality care is provided day in and day out – or, sadly, that the opposite is sometimes the case.
The Adult Safeguarding Board has had an interest in the importance and significance of leadership in care homes after it was identified as a recurring theme locally in Large Scale Enquiries (LSE) and Safeguarding Adult Reviews (SAR).

The importance of leadership is also highlighted in inspections of commissioned care homes conducted by the Care Quality Commission (CQC). The table and pie chart give a summary of the ratings from the inspections of care homes in Stoke-on-Trent and Staffordshire, broken down by Clinical commissioning group area.

CQC ratings of commissioned Care homes with Nursing across Staffordshire & Stoke-on-Trent as at 31st March 2017

Nursing Home Area	No of Homes	No of beds	Awaiting Inspection		Outstanding		Good		Requires Improvement		Inadequate	
			Homes	Beds	Homes	Beds	Homes	Beds	Homes	Beds	Homes	Beds
Cannock CCG	15	800	0	0	0	0	7	262	8	538	0	0
East Staffs CCG	13	620	1	42	0	0	8	405	4	173	0	0
North Staffs CCG	16	1020	3	203	0	0	6	278	6	512	1	27
Staffs & Surrounds CCG	14	683	0	0	0	0	7	358	6	258	1	67
SES & SP CCG	23	1122	1	80	0	0	15	666	7	376	0	0
Stoke CCG	19	1122	0	0	1	62	7	306	9	534	2	220
Totals:	**100**	**5367**	**5**	**325**	**1**	**62**	**50**	**2275**	**40**	**2391**	**4**	**314**



It is of note that in homes where there is a rating of Inadequate and Requires Improvement there will be some concerns as to the safety of residents. The findings provide an important context to the work of the SSASPB in relation to this strategic
priority.

Progress in 2016/17

At its quarterly meetings the Board has sought assurances as to the effectiveness of the Local Authority oversight arrangements for care homes subject to Enhanced Provider Monitoring (this intervention commonly precedes Large Scale Enquiry process.

A task and finish group was formed to include all relevant partners including representation from the Independent Sector for the purpose of reviewing quality assurance processes and seeking wider assurances about the effectiveness of reporting and monitoring practices.

Engaged with partner organisations to consider the themes and trends identified and develop an action plan to reduce the duplication of audits by a number of commissioning and regulatory organisations.

Contributed to the revision of the terms of reference for the Quality and Safeguarding Information Sharing Meeting (QSISM), that has a key oversight function, to include a requirement to produce an annual report and to make clear the procedure for escalation to the Safeguarding Board where this is required.

Benchmarked local regulatory data, in the 'well-led' and 'safe' domains, and compared this against other regions with similar demographics.

Facilitated Clinical Commissioning Group (CCG) led Investigation training to the Independent Sector on lessons learned from Serious Incidents.

Challenges:

Care homes in Staffordshire and Stoke-on-Trent have a shortage of qualified nurses reflecting the national picture and illustrated in the CQC report "The State of Adult Social Care Services 2014 to 2017"[xvii].

The report warns of high staff turnover rates, heavy reliance on agency nurses and an inability to attract permanent nurses. There is a common feature in regulatory failure of the promotion of care staff into leadership positions who lack the knowledge and skills to deliver the standards and practice required. The CQC report links poor care standards with poor leadership and recognises the importance of a committed and consistent registered manager as the key influence on the quality of care people receive.

7. ANALYSIS OF ADULT SAFEGUARDING PERFORMANCE DATA

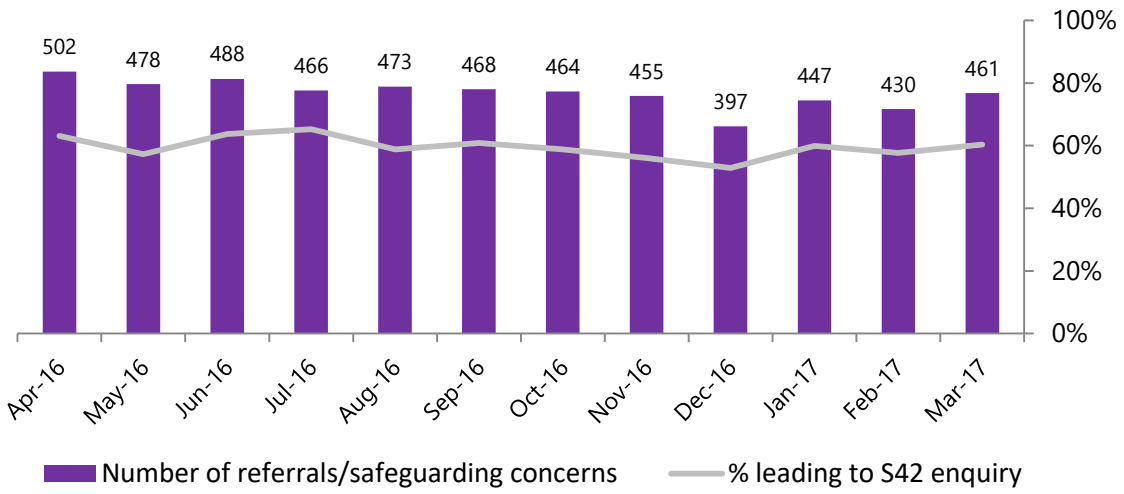
This section provides commentary and analysis of safeguarding data from Stoke-on-Trent and Staffordshire with associated graphical illustrations.

Number and proportion of referrals/safeguarding concerns

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

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

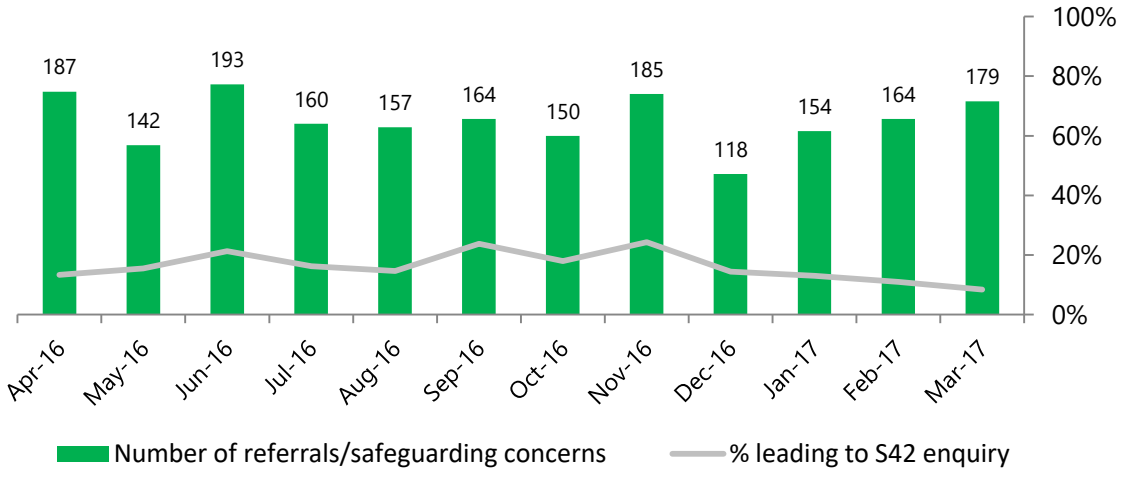
Figure 1: Number and proportion of referrals/safeguarding concerns – Staffordshire



During the course of the year in Staffordshire there have been 5,529 occasions when concerns have been reported that adults with care and support needs may be at risk of or are experiencing abuse or neglect. The total figure has increased by 1,136 occasions from 4,393 in the previous year 2015/16 which is an increase of 25%. The reported concerns averaged 461 per month.

Following initial assessment it was determined that the duty of enquiry requirement was met on 3301 of those occasions which is 60% of the total reported. This proportion is lower than the 71% in the previous year due in large part to the significant work in the Contact Centre where professionals determine if cases should be signposted to more suitable routes, for example, where there is no concern regarding abuse or neglect but there is a need for a formal assessment of need.

Figure 2: Number and proportion of referrals/safeguarding concerns – Stoke-on-Trent



In Stoke-on-Trent there were 1,957 reported safeguarding concerns in relation to adults with care and support needs. This is an increase of 111 from 1,846 in the previous year, an increase of 6%. The reported concerns averaged 163 per month.

Following initial assessment it was determined that the duty of enquiry requirement was met on 373 of those occasions which is 19% of the total reported. This proportion is lower than the 22.2% in the previous year.

The increases in the number of concerns in both Staffordshire and Stoke-on-Trent is most likely to be due to a combination of improved training and awareness raising leading to better recognition of abuse and

neglect amongst safeguarding partners and non-professionals as well as better understanding of referral routes and information sharing. Despite the increases this year it is believed that abuse and neglect is still under reported and is expected to rise. This has been acknowledged in national research, particularly for those adults with care and support needs aged over 65 years.

The wide variance in conversion rates for Section 42 enquiries between Staffordshire and Stoke-on-Trent is due to differing local approaches and practice. This is mirrored nationally where conversion rates vary between 12% and 69%. In Staffordshire, all concerns are recorded as Section 42 enquiries from the initial point of investigation. This is different to some other local authorities that make a decision about eligibility later in the process and do not consider the initial fact finding stages which sometimes may result in cases being directed to other appropriate pathways.

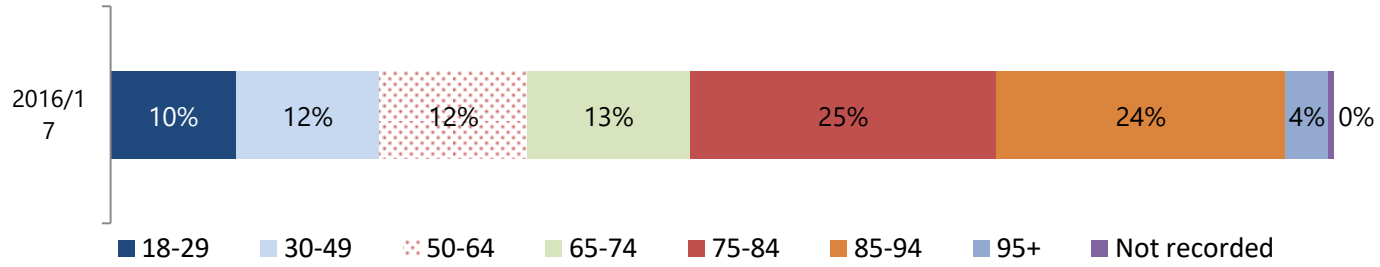
The following pages provide an analysis of the findings under various headings from the concerns that have resulted in a formal Section 42 enquiry.

About the Person

To build the picture of the personal circumstances of those at risk of abuse or neglect information is collected on the age, gender, ethnic origin and primary reason for the adult having need for care and support and this information is provided below.

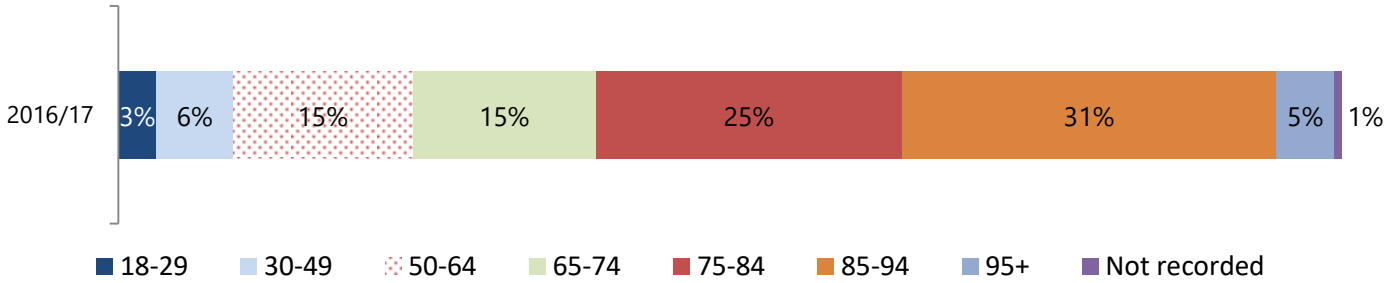
(i) Age breakdown

Figure 3: Age Breakdown (Section 42) – Staffordshire



Of the people subject of a Section 42 enquiry, those aged 75-84 (25%) represent the largest cohort at one quarter for the year, closely followed by 85-94 (24%), and then 65-74 (13%). All age bands have remained stable throughout 2016/17. In a proportion of cases no data has been recorded.

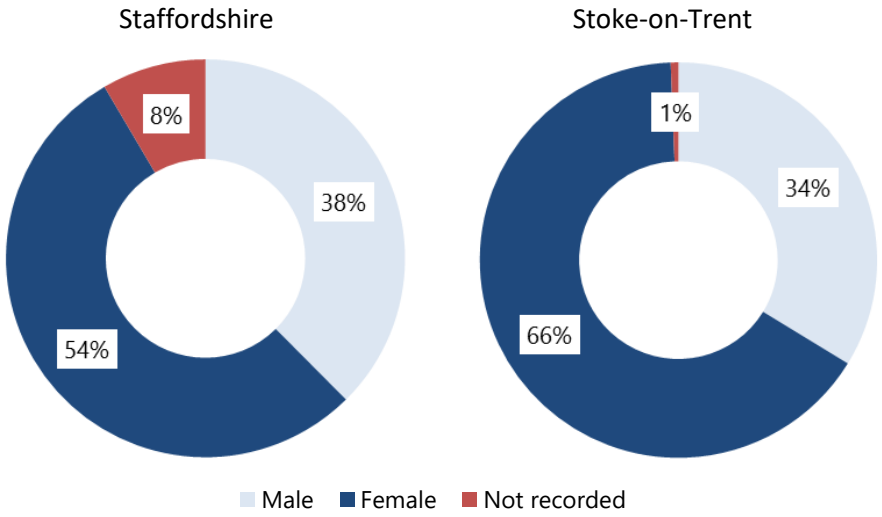
Figure 4: Age Breakdown (Section 42) – Stoke-on-Trent



For Stoke-on-Trent, the largest cohort represented is those aged 85-94 (31%), followed by 75-84 (25%), and then 50-64 and 65-74 (both 15%).

(ii) Gender

Figure 5: Gender breakdown – Staffordshire and Stoke-on-Trent



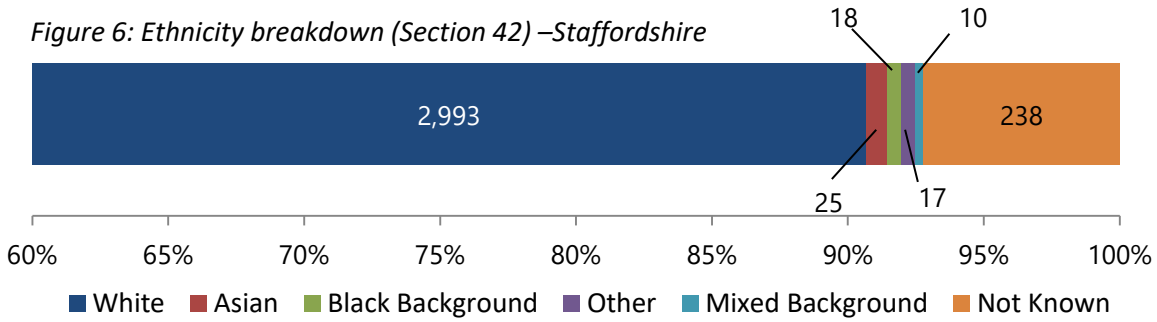
Staffordshire: Females represent the majority of adults' subject of a Section 42 enquiry (54% over the year), males representing 38%. For 8% the gender was not recorded.

Stoke-on-Trent: Stoke has a much higher proportion of females in their cohort compared to Staffordshire, with two thirds being female and one third being male.

Recording systems are being reviewed to reflect how gender categories can be broadened to be fully inclusive.

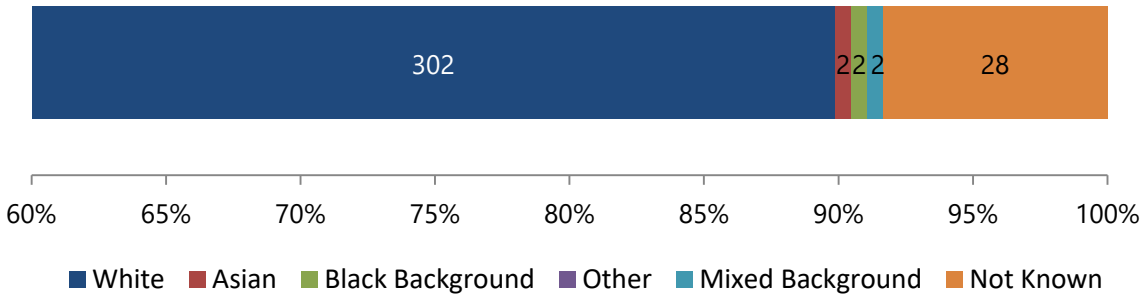
(iii) Ethnicity

Figure 6: Ethnicity breakdown (Section 42) –Staffordshire



The majority of individuals (Section 42) are 'White', reflecting the population in the latest census returns.

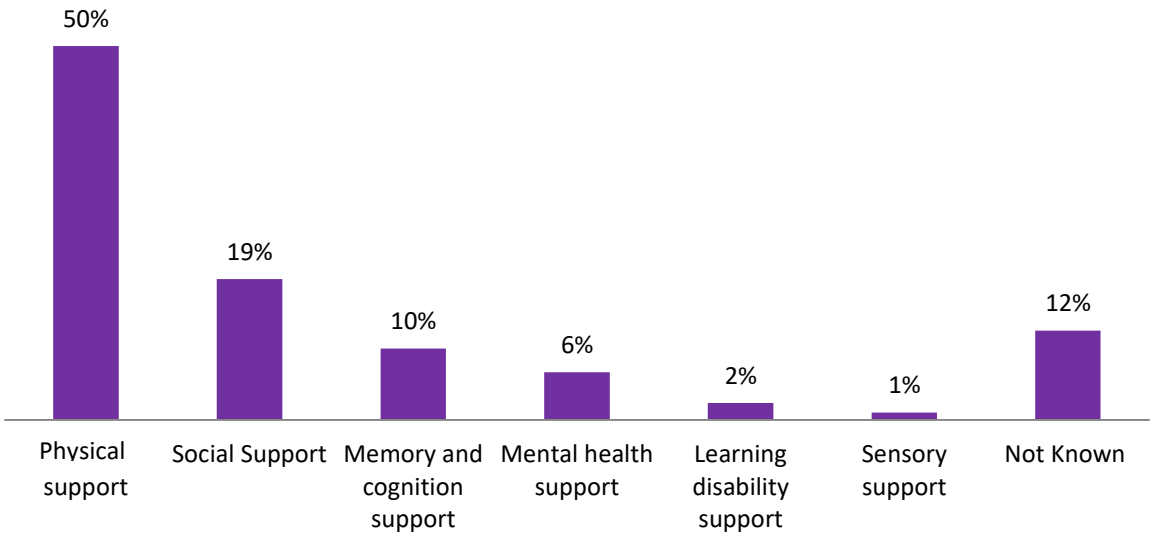
Figure 7: Ethnicity breakdown (Section 42) – Stoke-on-Trent



90% of all Section 42 enquiries are for people of 'White' ethnicity.

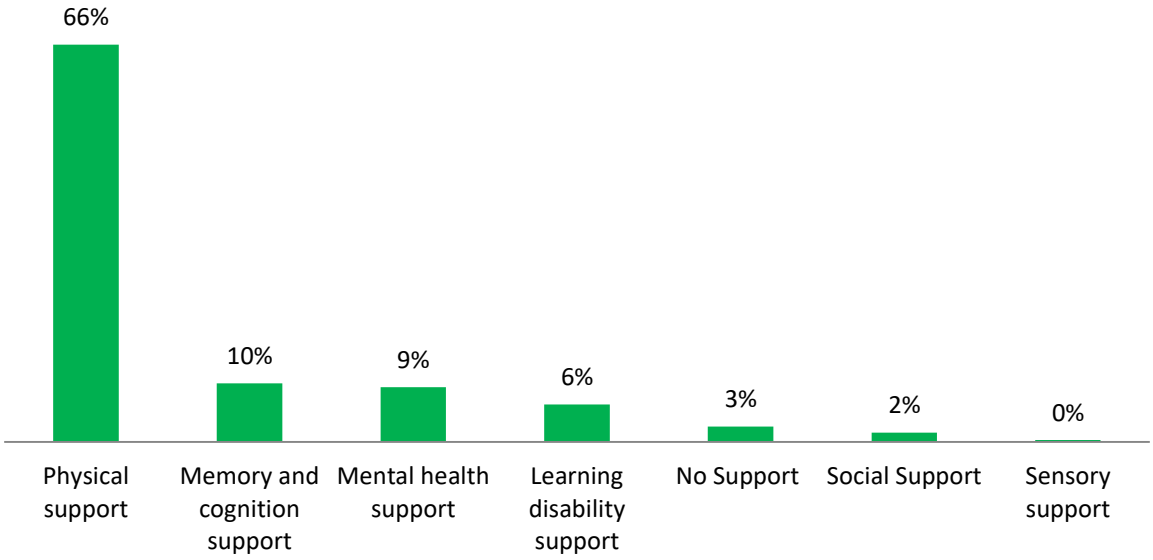
Primary Support Reason

Figure 8: Primary support reason (Section 42) – Staffordshire



Physical support was the most prevalent primary support reason in Staffordshire in 2016/17 (50%), especially for the older age groups, followed by learning disability support (19%), predominantly relating to younger adults, and then mental health support (10%) which was more of a factor for the older age groups.

Figure 9: Primary support reason (S42) – Stoke-on-Trent

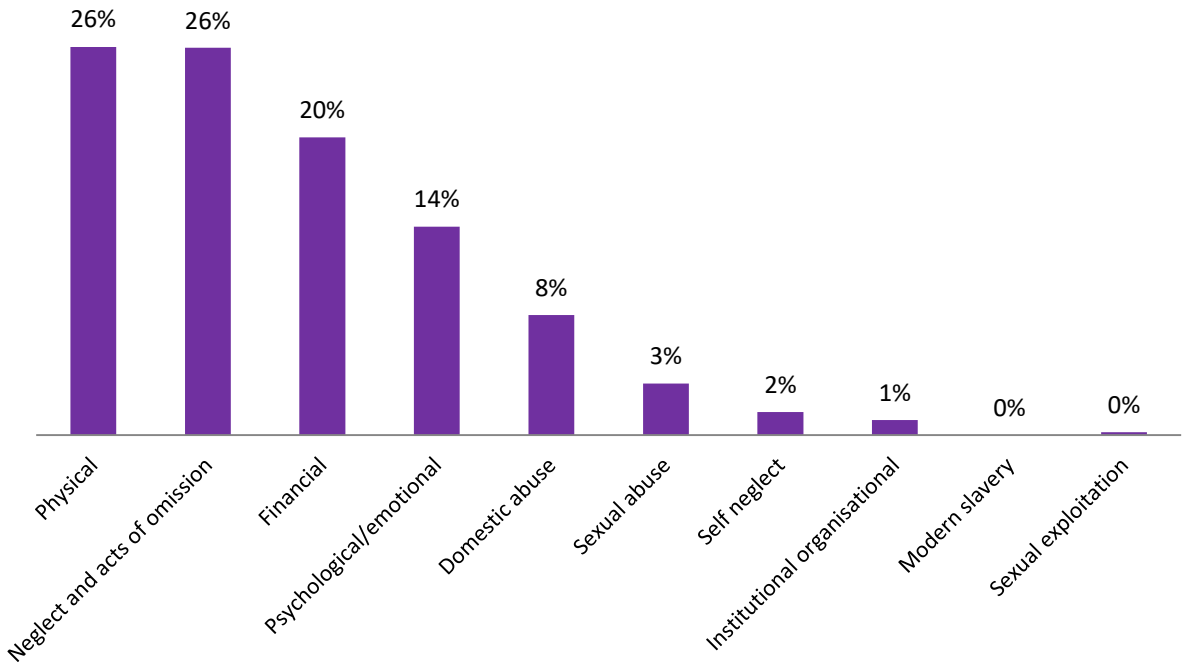


Physical support similarly represents the largest proportion of primary support reasons recorded in Stoke-on-Trent at 66%, followed by memory and cognition support (10%) and mental health support (9%).

Types of Harm or Abuse identified at Section 42 safeguarding enquiry

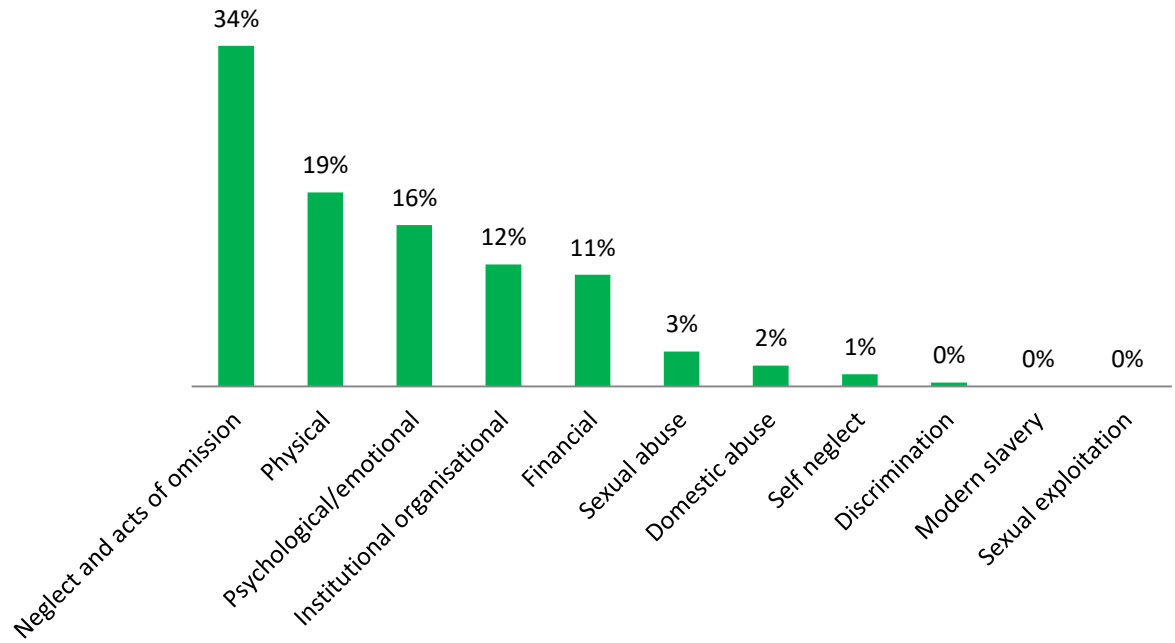
The below information shows the types of abuse and neglect reported in comparative proportions:

Figure 10: Types of harm or abuse identified at Section 42 safeguarding enquiry – Staffordshire



Physical harm/abuse and neglect/and acts of omission continue to be the most frequent types of harm and abuse identified at Section 42 safeguarding enquiry in Staffordshire, accounting for 26% each of all harm/abuse recorded. The numbers of reports of physical harm/abuse were high in Q1 (314) and Q2 (303), then declined during Q3 (125) and Q4 (151). Neglect and acts of omission, show a proportional increase during the course of the year. Financial abuse represents one fifth of all harm/abuse in 2016/17.

Figure 11: Types of harm or abuse identified at Section 42 safeguarding enquiry – Stoke-on-Trent



Whilst still significant there has been a continued trend from last year of a decrease of physical abuse alongside an increase in neglect up to 34%. Psychological/emotional harm/abuse (16%) is the third most

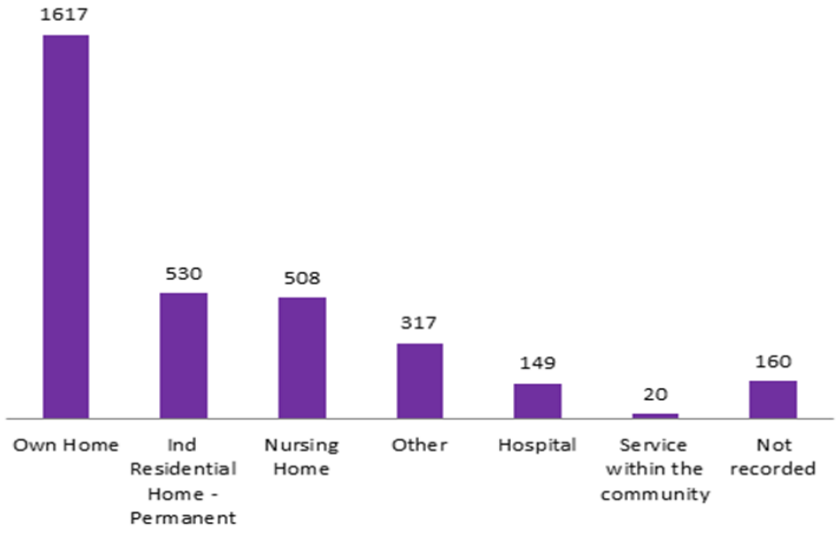
likely type of abuse/harm identified at Section 42 safeguarding enquiry. Other categories remained proportionally similar throughout the year.

Despite the low numbers of safeguarding concerns recorded under sexual abuse, there is a risk to adults with care and support needs and particular trends for adults with a learning disability. This trend is mirrored in the West Midlands region where there is consideration of developing a specific sexual abuse policy in acknowledgement of the significant impact this type of abuse has on service users.

A direct comparison and trend cannot be provided as types of abuse/harm for both LAs have changed and are broken down further this year to include domestic abuse, modern slavery and self-neglect as well as other changes to the categories of sexual exploitation/abuse; Stoke data provides an additional category of discrimination. Allegations of physical abuse and neglect remain the most common identified types of harm and abuse at Section 42 safeguarding enquiry. There have been no identified and recorded abuse/harm for Modern slavery, sexual exploitation or Discrimination for Section 42 enquiries for 2016/17 for either LA, perhaps because these are new categories and awareness raising/staff training may be required.

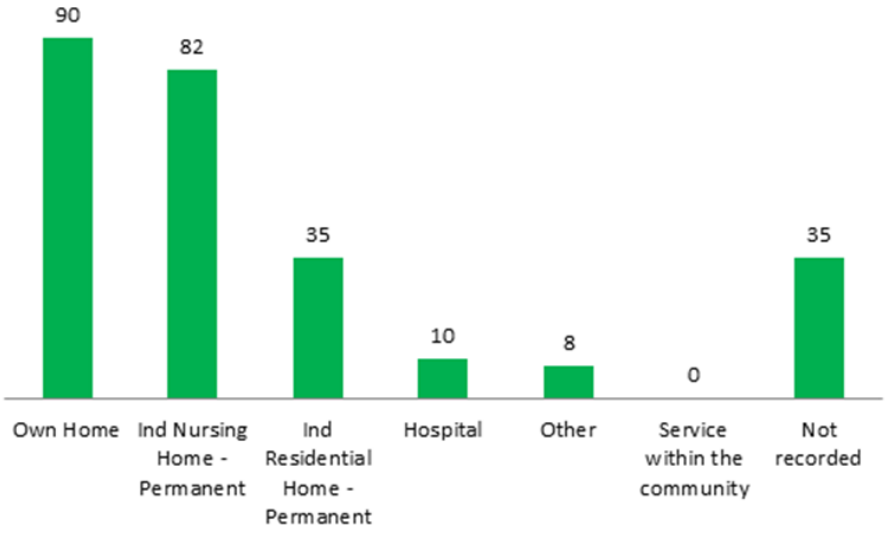
Location of abuse

Figure 12: Location of abuse/harm (Section 42) – Staffordshire



Of those people subject of Section 42 enquiries, the most prevalent location was the person's own home at nearly 50%. The next most common locations in Staffordshire were independent residential homes (16%) and nursing homes (15%).

Figure 13: Location of abuse/harm (Section 42) – Stoke-on-Trent



The most prevalent location was also the persons 'own home' in Stoke-on-Trent, though representing a smaller proportion at 28% which is in line with the national picture. Independent residential nursing homes was the next most prevalent location of abuse/harm (26%). As at the 31st March 2017, there were 448 people in nursing care and 945 in residential care. This indicates that only a small proportion of Section 42 enquiries take place compared to the overall population in nursing homes and residential care.

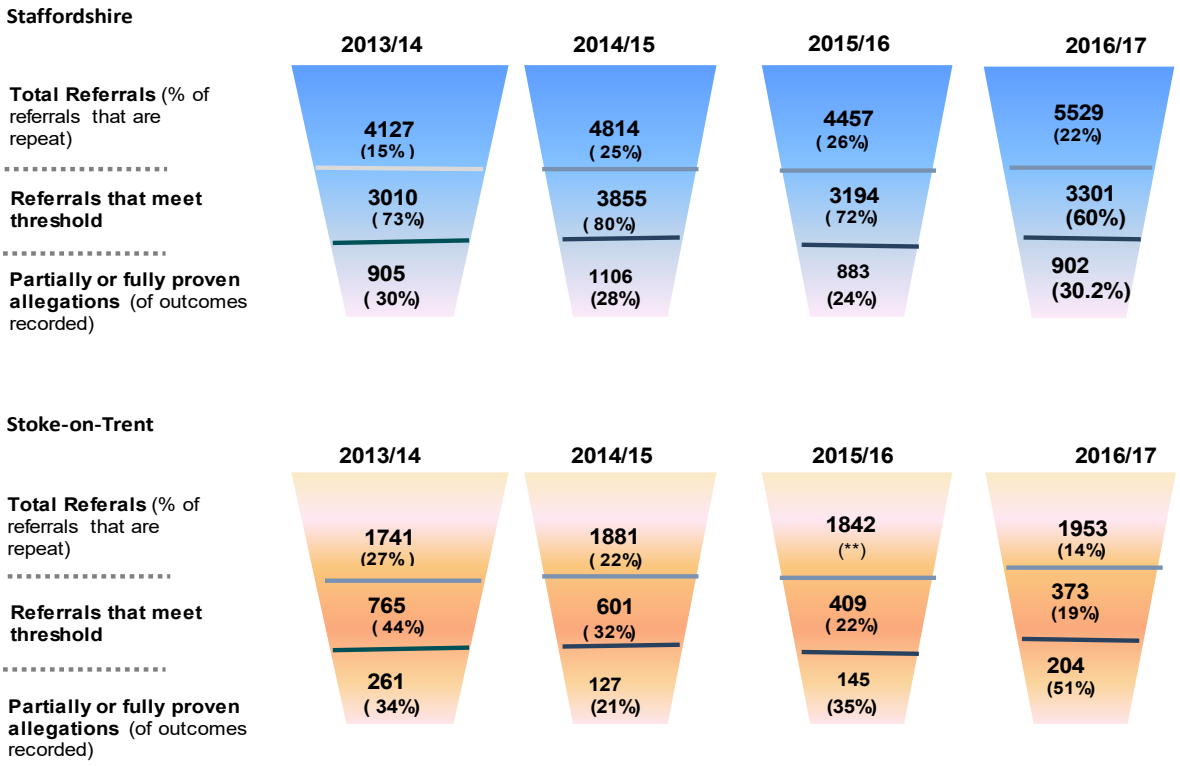
Large Scale Enquiries (LSE's) will impact on nursing home data due to other safeguarding concerns resulting from additional scrutiny of a service.

It is of note that in Staffordshire 1,639 of the reported safeguarding concerns related to an allegation against a Person in a Position of Trust (PiPoT)[xii] an increase of 27% compared to last year. In Stoke-on-Trent there were 453 reported safeguarding concerns related to a Person in a Position of Trust.

Outcomes of reported safeguarding concerns

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

Figure 14: Outcomes of concerns

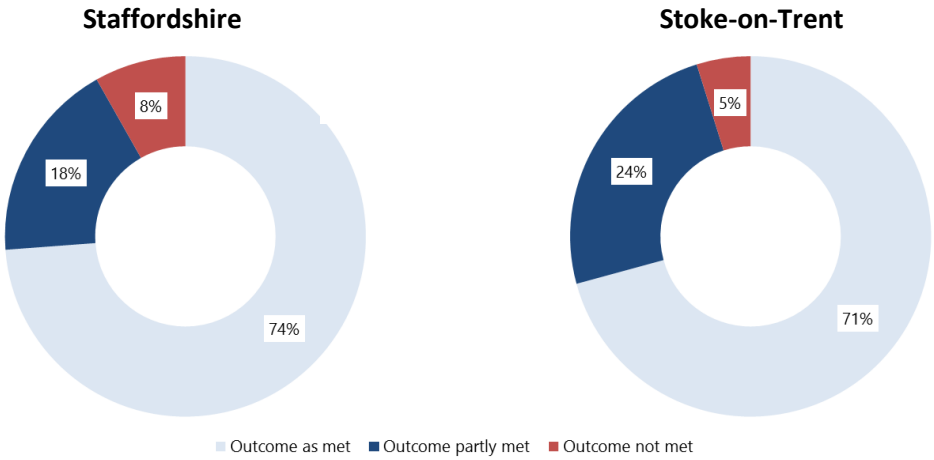


Staffordshire: The volume of referrals has increased steadily over the last four years, however the proportion of repeat referrals has decreased from last year (from 26% - 22%). Referrals that meet the threshold have decreased to a low of 60% this year compared to 72% last year. A higher proportion (30.2%) of allegations have been either partially or fully proven.

Stoke-on-Trent: During 2016/17 Stoke-on-Trent received a 6% increase in reported number of concerns yet a smaller percentage than in previous years hit the threshold for a Section 42 Enquiry. Of those that met the threshold, where an outcome had been recorded a higher percentage 51% compared to 35% the previous year was found to be substantiated.

Number and proportion of people who have a Section 42 enquiry whose expressed outcome was met

Figure 15: People who have a Section 42 enquiry whose expressed outcome was met



Staffordshire: In Staffordshire the proportion of people subject of a Section 42 enquiry whose expressed outcome was met has increased from last year with over 90% of people expressing their desired outcomes as either fully or partly met. However, 8% of people reported that their desired outcomes were not met.

Stoke-on-Trent: The proportion of people subject of a Section 42 enquiry whose expressed outcome was met increased to 71% from 64% in 2015/16. Some 24% of people reported that desired outcomes were partially met with 5% of people reporting that desired outcomes were not achieved.

It will be noted that there have been increases in the achievement of desired service user outcomes this year particularly when taking account of outcomes defined as 'partly met'. The increases are believed in large part to be attributed to the Making Safeguarding Personal (MSP) focus as well as improved recording the importance of which is widely recognised.

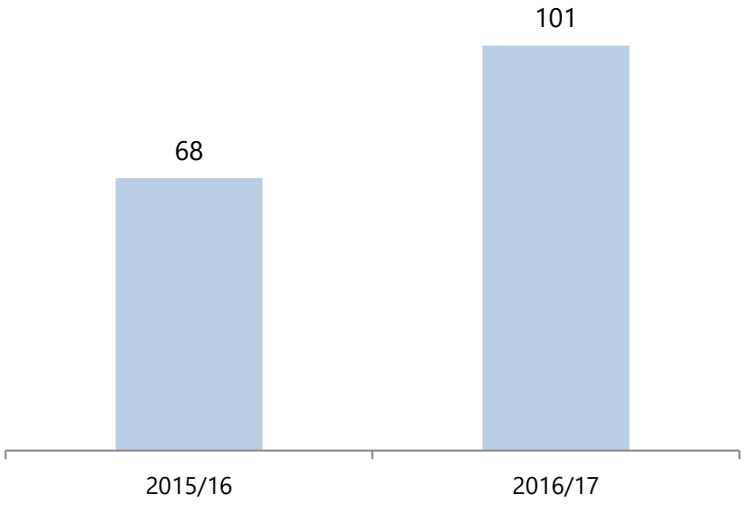
It is also of note that the high levels of service user satisfaction with outcomes is not necessarily linked to the proving of allegations following Section 42 enquiries which, as shown above, are well below satisfaction with outcome rates in Staffordshire and Stoke-on-Trent.

Staffordshire Police information

Care Worker ill treatment/wilful neglect of an individual

The annual report of the SSASPB for 2015/16 indicated an increasing number of concerns and criminal allegations involving paid care staff. The graph below illustrates further increases in 2016/17.

Figure 16: Care worker ill-treatment/wilful neglect of an individual

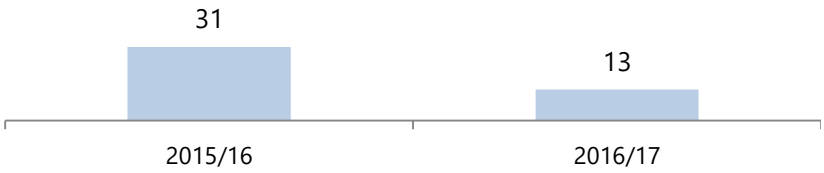


There has been an increase of 33 crimes alleging ill treatment or neglect by a care worker in 2016/17 compared to the previous year. The majority of the victims, 57, are female with 44 men. Three of the allegations were from repeat victims. The majority of offences were alleged to have been committed against people aged 65 years and older.

The majority of the recorded crimes, 75, are alleged to have occurred in care homes. The majority of these crimes have resulted in no suspect identified reflecting the difficulties associated with substantiating allegations to the required standard of proof.

There has been a reduction of 18 crimes compared to the previous year. There were no repeat victims. 8 are female victims, 5 are male victims and the majority are committed against 40-65 age group.

Figure 17: Ill treatment or wilful neglect of a person lacking capacity by anyone responsible for that person's care



The majority of these crimes have resulted in no suspect identified.

No suspect identified is due to a combination of third party reports of injuries to elderly victims unable to explain how the injury occurred or due to lack of capacity. Some of the injuries are later explained by medical reasons or accidents where no criminal intent can be shown.

8. BOARD DEVELOPMENT AND IMPROVEMENT ACTIVITY

At its Development Day in January 2016 the Board resolved to be consistently good at what it does.

Throughout the year the Board has worked to complete the actions in the plan arising from the Development Day which are summarised below:

- The Board produced its Strategic Plan for 2016/2018 which outlines the Strategic Priorities and how the aims are to be achieved
- In July 2016 the Board approved a new training strategy which reinforced the Board's responsibility to seek assurance that connected partners are providing quality assured adult safeguarding training for their staff. The Board also approved an awareness training package, together with detailed trainer notes, which is made freely available for anyone to access on the website. This initiative was an acknowledgement that some smaller organisations may not have access to a quality training package
- Having developed the SSASPB risk register during the previous year the Executive and other Sub-Groups have frequently scrutinised the risk register through a standing agenda item at meetings, adding updates from which to reassess and score the net risk. Many risks have been reduced following the mitigating evidence
- October 2016 - launch of the dedicated website www.SSASPB.org.uk. There has been a lot of positive comments and compliments about the website and the useful information contained there. There is still work to do and more information to be included. On a number of occasions there have been emails from members of the public sent to the Board administration in box which demonstrates the wider interest in the website
- New promotional material was designed and printed including a set of 5 posters depicting adults with a range of ages and care needs. There is also a wallet size card advising the numbers to contact if there is an adult safeguarding concern and a tri-fold leaflet called 'What to do if I have a safeguarding concern' which is easily understood and aimed at both the public and professionals. All of these can be seen and downloaded from the website https://www.SSASPB.org.uk/Guidance/Promotional-material.aspx.

In February 2016 Staffordshire County Council commissioned an external review of the Board to seek assurance that the Board was fulfilling the role as outlined in the Care Act 2014. The reviewer spoke to a broad range of Board members, the Independent Chair and Board manager and also scrutinised key Board documents.

All of the key areas identified for improvement had already been identified by the Board at its Development Day and in this reporting period there was much work undertaken resulting in the action plan being signed off as complete at the July 2017 Board. The main areas for improvement included:

Funding: *In developing its Strategic Plan the Board needs to be clear what it is going to do in the future and the level of support, and hence cost, of delivering its plans. This should form the budget for the Board which in turn should be fully funded, in cash terms, by the Partner organisations.*

Response: The Independent Chair negotiated a 3 year funding agreement with the statutory partners which will be refreshed in time for April 2020.

Risk Management: *The Board should seek to populate its recently produced risk template with its strategic risks, taking care not to replicate those risks that should be being managed by its Partner organisations. The risks included in the template should be based on the strategic risks arising from the Board's Strategic Plan and they should be reported regularly to the Board.*

Response: The Board has developed a risk register which is managed through the Executive sub-group and reports to the quarterly Board meetings.

Assurance: *In developing its strategic plan the Board should clarify the areas in which it needs assurance and how such assurance will be obtained.*

Response: The Board has a clear focus on its assurance role as evidenced by the Board meeting agendas through 2016/17. Board meetings have a standing agenda on seeking assurance providing the opportunity for discussion and challenge. In 2016/17 assurances have been sought through:

- An overview of the work towards reducing Care Review backlogs by both Local Authorities
- Presentations from each Local Authority on their response to the reduction in Better Care funding
- A presentation by the Care Quality Commission (CQC) 'Working with the CQC to prevent abuse and neglect'
- An assurance presentation by Continuing Health Care (CHC) covering the challenges they face and how they are responding
- A presentation from three Board partners (Police, Local Authority and Hate Crime groups) outlining the current picture in relation to Disability Hate Crime, trends in reporting, and the agency's response with particular focus on repeat victims
- Discussion on the proposed joint commissioning arrangements for Domestic Abuse services.
- A presentation from each Local Authority on their Transition arrangements from children to adult services
- Partners reported to the meeting on how the Annual Report, Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry Procedures and the newly launched SSASPB website have been promoted and received within partner organisations
- The Board continues to receive quarterly reports and seek assurances upon progress towards the reduction of the Deprivation of Liberty Safeguards applications
- Quarterly reports are received from both Local Authorities in relation to the number of new, open and closed Large Scale Enquiries (LSEs) and also the key concerns and themes from them.

Performance Management: *The Board should, in the development of its Strategic Plan, determine how the objectives in it are to be measured i.e. what specific indicators will demonstrate success or otherwise, and develop a performance reporting mechanism that facilitates the reporting of such data.*

Response: During 2016/17 the Performance, Monitoring and Evaluation sub-group developed a performance data set which was approved at the July 2017 Board meeting and is included on pages 23 to 34 of this Annual Report. The Board four tier audit framework is included at page 13 of this Report.

Service User Engagement: *The Board should develop a service user engagement strategy through which it can maximise service user input into its decision making process. This should identify how existing groups and forums can support the work of the Board as well as those areas in which there are gaps that need to be addressed to obtain the necessary representation.*

Response: Engagement is one of the three Board Strategic Priorities. The Strategic Plan 2016/18 outlines how the Board will deliver its aims and can be found on our website. In a key development the Strategic Priority leader and the Board Manager began a programme of visits to Carer's Hubs and other service user organisations/clubs to promote the work of the Board and find out what elements of adult safeguarding are important to them to assist in future priority setting. In this work the Board has strengthened its links with two Healthwatch teams on matters of overlapping interest.

9. FINANCIAL REPORT

Board members have the responsibility to deliver the Strategic Priorities, objectives and Sub-Group Business Plans with ownership retained at formal governance level.

Board resources include a dedicated core team who support and facilitate the work of the Board and Sub-Groups. This year the team has been supplemented by a dedicated performance support role to facilitate the Performance Framework and audit activity that informs SSASPB work-streams. This team and business activities were funded in 2016-2017 through contributions from statutory partners and health providers as detailed in the financial report below.

Income

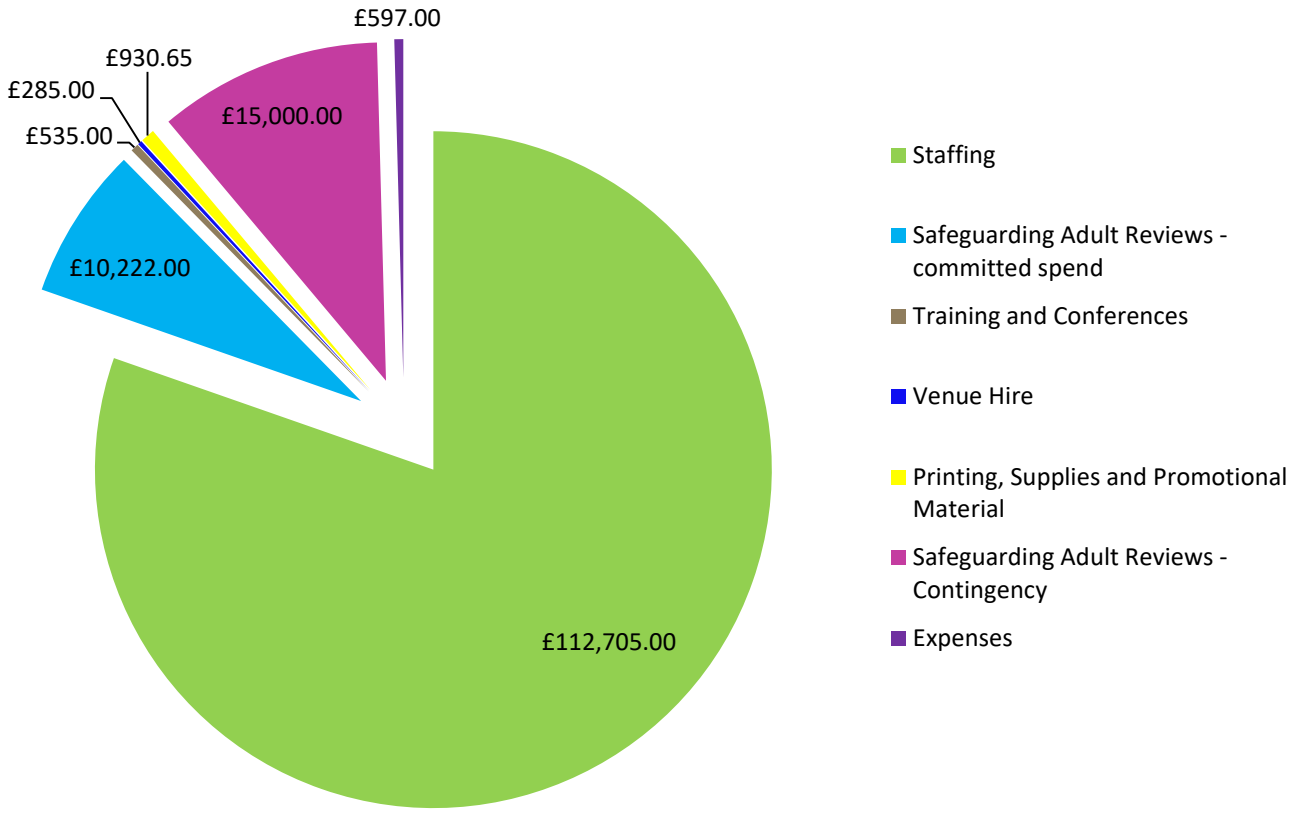
Organisation	Amount
Burton Hospital NHS Foundation Trust	£12,500
North Staffordshire Clinical Commissioning Group	£ 9,375
North Staffordshire Combined Healthcare Trust	£12,500
South Staffordshire Clinical Commissioning Group(s) (South Staffordshire & Seisdon Peninsula CCG, Stafford & Surrounds CCG, East 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 2016-2017 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 2016-2017:

- 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 2015-2016.

10. APPENDICES

APPENDIX 1: BOARD PARTNERS

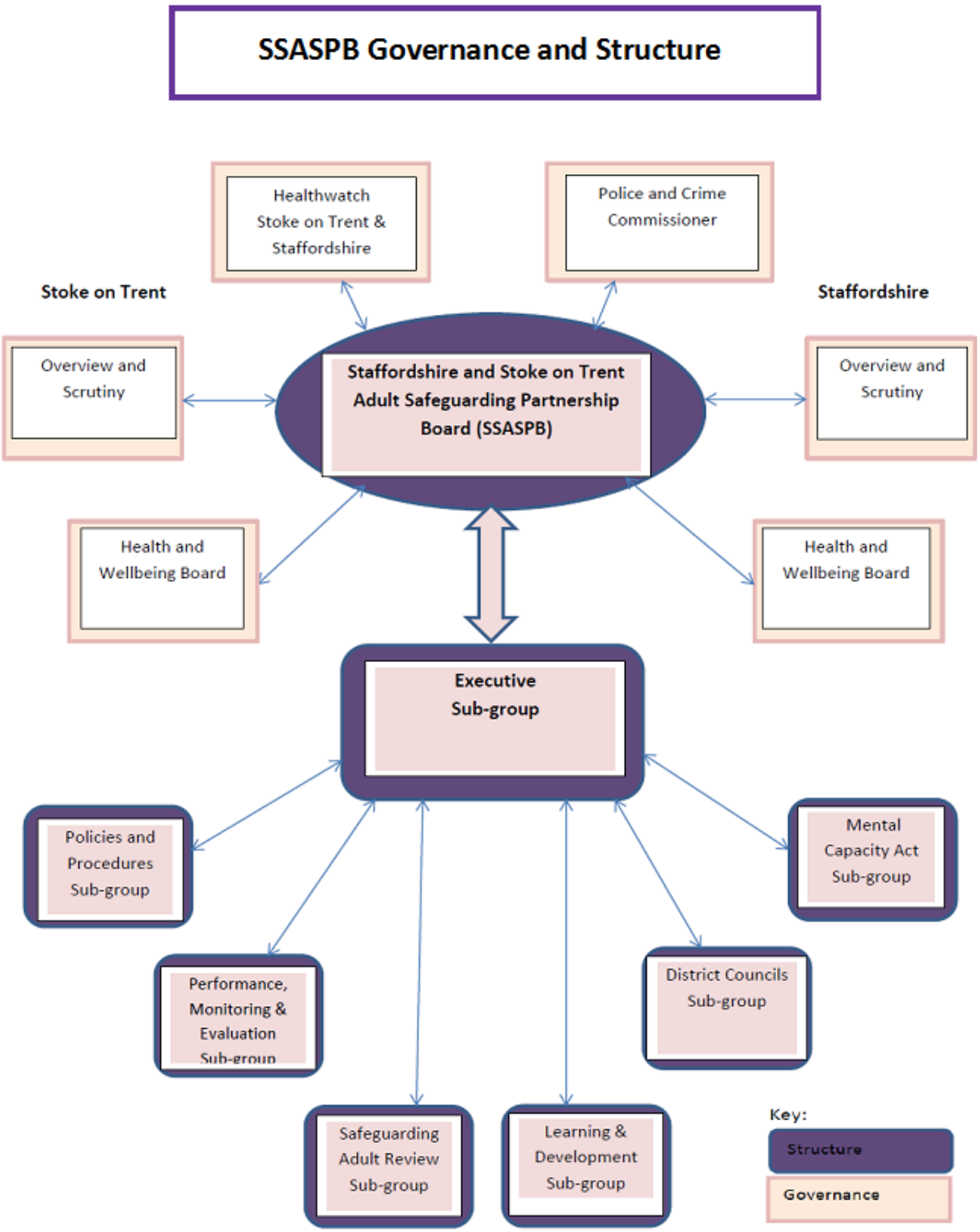
Statutory Partners as of 31st March 2017

- Local Authorities
  - Staffordshire County Council
  - Stoke-on-Trent City Council
- Staffordshire Police
- NHS
  - Cannock Chase Clinical Commissioning Group
  - East Staffordshire Clinical Commissioning Group
  - North Staffordshire Clinical Commissioning Group
  - Shropshire and Staffs Area Team NHS England
  - South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
  - Stafford and Surrounds Clinical Commissioning Group
  - Stoke-on-Trent Clinical Commissioning Group

Extended Partnership as of 31st March 2017

- Burton Hospital NHS Foundation Trust (BHFT)
- Community Rehabilitation Company (CRCs) (Staffordshire and Stoke-on-Trent)
- Department of Work and Pensions (DWP) Job Centre Plus
- Domestic Abuse For a
- Hate Crime Fora
- Healthwatch (Staffordshire and Stoke-on-Trent)
- Her Majesty's Prison Service (HMPS)
- Independent Futures (IF)
- National Probation Service (NPS) (Staffordshire and Stoke-on-Trent)
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- South Staffordshire and Shropshire NHS Foundation Trust (SSSFT)
- Staffordshire Association of Registered Care Providers (SARCP)
- Staffordshire and Stoke-on-Trent NHS Partnership Trust (SSOTP)
- Staffordshire District Councils Safeguarding Sub-Group
- Staffordshire Fire and Rescue Service (SFARS)
- Stoke-on-Trent City Council Housing
- Trading Standards (Staffordshire and Stoke-on-Trent)
- University Hospitals of North Midlands (UHNM)
- VAST (Voluntary Sector Representation)
- West Midlands Ambulance Service (WMAS)

APPENDIX 2: GOVERNANCE STRUCTURE



APPENDIX 3: CATEGORIES OF ABUSE AND NEGLECT

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

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

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

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

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

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

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

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

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

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

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

11. REFERENCES

[i] **Care Act 2014:** http://www.legislation.gov.uk/ukpga/2014/23/contents

[ii] **SSASPB Board membership list:** https://www.ssaspb.org.uk/About-us/Board-Agency-Membership.aspx

[iii] **Care and support statutory guidance:** https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

[iv] **SSASPB Constitution:** https://www.ssaspb.org.uk/About-us/SSASPB-Constitution-REVISED-2016-FINAL-APPROVED-v1.pdf

[v] **2016-18 Strategic Plan:** https://www.ssaspb.org.uk/About-us/SSASPB-strategic-plan.aspx

[vi] **SSASPB publicity materials:** https://www.SSASPB.org.uk/Guidance/Promotional-material.aspx

[vii] **Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry Procedures:** https://www.ssaspb.org.uk/Guidance/Section-42-Safeguarding-Adult-Enquiries.aspx

[viii] **National Health Service (NHS) Safeguarding App**: http://www.myguideapps.com/nhs_safeguarding/default/

[ix] **SSASPB Escalation Policy:** https://www.ssaspb.org.uk/Guidance/SSASPB-Escalation-Policy-July2015-FINAL-APPROVED-v1.pdf

[x] **SSASPB Information Sharing Guidance for Practitioners:** https://www.ssaspb.org.uk/Guidance/SSASPB-Information-Sharing-Guidance-for-Practitioners-June-15-FINAL-APPROVED-v1.pdf

[xi] **West Midlands Adult Safeguarding Policy:** https://www.ssaspb.org.uk/Guidance/Adults-Safeguarding-Multi-agency-policy-procedures-for-the-protection-of-adults-with-Care-Support-needs-in-the-West-Midlands.pdf

[xii] **West Midlands People in Positions of Trust:** https://www.ssaspb.org.uk/Professionals/WM-Adult-PoT-Framework-v1.0.pdf

[xiii] **Safeguarding Adult Review (SAR) Protocol:** https://www.ssaspb.org.uk/Guidance/Safeguarding-Adult-Reviews-SARs.aspx

[xiv] **West Midlands Regional SAR repository:** http://www.hampshiresab.org.uk/learning-from-experience-database/

[xv] **SSASPB Training packages:** https://www.ssaspb.org.uk/Professionals/Training.aspx

[xvi] **Making Safeguarding Personal (MSP):** https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal

[xvii] **The state of adult social care services 2014 to 2017:** http://www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf

A glossary of terms is available on the SSASPB website along with further useful contacts and publications.

Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB)

Strategic Plan

2016 - 2018

Team	SSASPB	**Author(s)**	Executive Sub-Group
Document	SSASPB Strategic Plan 2016-2018		
Date Created	August 2026	**Address**	SSASPB Team Wedgwood Building, Floor 3 Tipping Street, Stafford ST16 2DH
Version	Final approved V1 - March 2017 Revision		
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Review Date	April 2018		

Metadata for this document

Name	Content
Subject Category	Governance
Description	SSASPB Strategic Plan
Audience	Board Partners
Creator	Executive sub-group Members
Contributors	Consultation via SSASPB Board Members
Publisher	SSASPB
Protective Marking	Unclassified

Revision History

Revision Date	Revised by	Previous Version	Description of revision
March 2017	Executive SG	1	Revision to strengthen inclusion of prevention within the Strategic Plan (pg. 7) Update to membership (pg. 14)

Governance

This document requires the following approvals:

Approving Body/Group	Approved on	Chair signature
Executive sub-Group	29.03.2017	**Approved**
SSASPB	27.04.2017	

CONTENTS **Page**

LIST OF APPENDICES

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.

MESSAGE FROM THE CHAIR

It is my privilege to write the introduction to this Strategic Plan. The Plan has been developed with the engagement of members of the Board and Sub-groups and builds on the progress made in 2015/16 as well as the lessons learned from some of the more ambitious actions not being concluded as intended following a review of the previous year's performance.

The main purpose of this Plan is to set out the key outcomes and impact that the Board is aiming to achieve over the next two years that will make a positive difference in the collective efforts to tackle the agreed strategic objectives of:

- Engagement with service users, communities and safeguarding partners
- Transition arrangements from child to adult services
- Leadership in the independent care sector

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 Plan 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 further strengthen our ability to quality assure and monitor performance against planned and intended actions.

Another key focus of the Board through this plan is to continue to seek assurances that all those who work with adults know when and how to act when they are concerned about a possible risk.

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. It promises to be, as ever, another demanding year and I take this opportunity to thank the Board, Sub-group members, support team and the network of connected partners for the time and expertise that you willingly devote to this most important area of our work.

The Safeguarding Adults Board will be publishing an Annual Report next year that will provide the details of how this strategy has been implemented and what has been achieved. I look forward to reporting on the good work that has been done to protect the adults at risk in our communities from harm.

John Wood
Independent Chair, Staffordshire and Stoke-on-Trent Safeguarding Adults Board

STRATEGIC CONTEXT

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 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 in this case) is outlined in Schedule 1 of the Care Act 2014 as being to help and protect adults in its local area by co-ordinating and ensuring the effectiveness of what each of its members does. The Board 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 Board may do anything which appears to it to be necessary or desirable for the purpose of achieving its objective.

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 SAB 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 has been met.

COMPOSITION OF THE SAFEGUARDING ADULTS BOARD

The Board has a broad membership of key 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 14.

The Board is dependent on the performance of other 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 15.

PURPOSE OF THIS STRATEGIC PLAN

This strategy sets out the vision, commitment and approach of the Staffordshire and Stoke-on-Trent Safeguarding Adults Board to do everything possible to minimise the risk of adults with care and support needs suffering abuse and neglect. The plan will support our fundamental aim to work with local people and with partners to ensure that adults who may be at risk are:

- Able to live independently by being supported to manage risk;
- Able to protect themselves from abuse and neglect;
- Treated with dignity and respect;
- Properly supported by agencies when they need protection,

and delivery will be supported by the Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry Procedures.

The strategy recognises that adults with care and support needs and their carers must be at the heart of what safeguarding partners do. It is important that we not only listen, but that we strengthen our commitment to engage with adults with care and support needs at both a strategic and operational level in all aspects of our safeguarding work.

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 16. The Board has taken account of the Statutory Guidance in determining the following vision.

SAFEGUARDING PRINCIPLES

The Department of Health 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 Safeguarding Adult Board and partner agencies with safeguarding responsibilities to benchmark their adult safeguarding arrangements:

Principle	Description	Outcome for Adult at Risk
Empowerment	Presumption of person led decisions and informed consent.	*"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."*
Prevention	It is better to take action before harm occurs.	*"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."*
Proportionality	Proportionate and least intrusive response appropriate to the risk presented.	*"I am sure that the professionals will work for my best interests, as I see them and will only get involved as much as needed."* *"I understand the role of everyone involved in my life."*
Protection	Support and representation for those in greatest need.	*"I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able"*
Partnership	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.	*"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me."*
Accountability	Accountability and transparency in delivering safeguarding.	*"I understand the role of everyone involved in my life."*

OUR FOCUS

The main focus of the Board is to ensure that safeguarding is consistently understood by anyone engaging with adults with care and support needs who may be at risk of or experiencing abuse or neglect. Whilst there is a common commitment by safeguarding partners to improving outcomes, in practice by way of example, this means understanding how to support and empower people at risk of harm and anti-social behaviour 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-centred set of responses and outcomes. This means the Safeguarding Adults Board seeking assurances and being confident that effective advocacy services are in place for anyone who may need them at any point during a safeguarding episode.

When things go seriously wrong, we have a responsibility to look into this thoroughly with a Safeguarding Adults Review and report the findings and learning so that practice will improve. Equally important, is our role in promoting good practice and generating confidence within our communities that concerns about abuse and neglect can be expressed openly and are encouraged and will be responded to effectively when raised.

All working in adult safeguarding have the difficult task of understanding risk, assessing the level of this for the individual concerned and constructing a plan to manage it which works for the person and is understood by those around them. This requires practitioners to have a sound grasp of the legal basis for their work and to demonstrate effective listening and communication. This often presents a challenge in a society where there can be a tendency to avoid rather than to manage risk. It is a key task for the Board is to seek assurances as to effectiveness of risk management and oversight in safeguarding in Staffordshire and Stoke-on-Trent and seek assurances that the right balance is being struck.

Feedback from the external scrutiny of the Board Annual Report 2015/16 emphasised the importance of strategies for and operational practice in the prevention of abuse and neglect for adults with care and support needs. Accordingly, the Board will intensify its focus on understanding and ensuring the effectiveness of prevention activity how this ties in with the work of the Health and Wellbeing Boards (HWBs) and the Care Quality Commission's (CQC's) approach and practice.

OUR PRIORITIES

1. ENGAGEMENT

(i) Improve public awareness of adult safeguarding

Why it is important

Considerable progress has been made over recent years raising awareness of safeguarding. The Board and its connected partners have produced and distributed a wide range of information using a variety of methods that feedback suggests has been well received. These activities appear to have had the desired effect of contributing to an increase in safeguarding referrals and alerts. There is more to be done on raising awareness and it is important that there continues to be an emphasis on producing good quality and up to date information and publicity materials targeted to meet the needs of the diverse range of recipients.

What we will do

Continue to develop and enhance the Board communication plan to raise public awareness of:

- what constitutes abuse and neglect
- when and how to report it
- what happens after a report is made
- concerns that are not abuse or neglect and how these should be reported
- practical things that can be done to prevent or reduce the risk of abuse or neglect occurring.

The messages conveyed through the communication plan will be informed and updated by periodic feedback from service users, carers, the public and practitioners about what is working well, what needs to improve and what the plan should focus on.

How we will know that we have made a positive difference?

- raised public awareness of what constitutes abuse and neglect
- raised public awareness about how to prevent abuse and neglect
- raised public awareness of how to report concerns about abuse and neglect
- expected initial increase in reports of abuse and neglect
- increased proportion of concerns that go on to require a section 42 enquiry (appropriate referrals)
- increased public awareness of how to report concerns that do not amount to abuse and neglect

- raised public awareness of what happens after a report is made
- positive feedback on the effectiveness of the communication methods for target audiences

(ii) Making Safeguarding Personal

Why it is important

Making Safeguarding Personal is a significant shift in approach, that requires engagement with a person at an early stage to establish desired outcomes that are then supported by a person centred approach to make this happen. There is an emphasis in those conversations about what would improve an individual's quality of life as well as their safety. Unless people's lives are improved, all the safeguarding work, systems, procedures and partnerships have limited value.

What we will do

- For the Safeguarding Adults Board to comply fully with its statutory functions it must continuously seek to develop effective ways of engaging with people and communities, including in the production of this strategic plan.
- The Board will be actively advocating for the Making Safeguarding Personal approach to become a 'golden thread' that will run through strategic and operational adult safeguarding work in Staffordshire and Stoke-on-Trent and reflected prominently in connected agency work programmes.

How we will know that we have made a positive difference

As part of implementing 'Making Safeguarding Personal' the Board will want to see evidence of the following:

- Evaluation of the experiences of people using safeguarding services and how those experiences have been used to improve services. The extent to which service users have a sense of being in control and feeling that they sufficiently influence and determine outcomes.
- Effective support provided for carers
- Effective application of the Mental Capacity Act and appropriate use of advocacy
- That commissioners are developing procurement and contracting arrangements that ensure the provision of personalised services.
- An understanding of emerging trends in relation to safeguarding people with care and support needs and how this awareness informs practice development across connected agencies.

(iii) Improve cross-partner collaboration

Why it is important

One of the main responsibilities of the Board is to make sure that we know that the local adult safeguarding system is safe. This requires us to work effectively with other partnerships and organisations in areas of overlapping focus to ensure clarity of governance and purpose, minimise the risk of unnecessary duplication and confusion and to gain the assurances that we need.

What we will do

- The Board will formally agree responsibilities and reporting relationships, through protocols, with the following Strategic Partnerships to ensure effective collaborative action:
    - Clinical Commissioning Group Boards
    - Community Safety Partnerships
    - Domestic Abuse Partnerships
    - Hate Crime Partnerships
    - Health and Wellbeing Boards
    - Local Authorities Overview and Scrutiny Committees
- **Multi Agency Public Protection Arrangements (MAPPA)**
    - NHS England Quality Surveillance Groups
    - Safeguarding Children Boards
    - Stoke-on-Trent Adult Strategic Partnership Board
- Ensure that adult safeguarding policies and procedures clearly demonstrate how agencies will work together from the point that safeguarding concerns are raised, during all safeguarding enquiries and actions, and for any follow up action or review
- Ensure that the multi-agency safeguarding audits identify to what extent adults have been able to make choices and gain greater control over their lives as a result of safeguarding enquiries and actions
- Ensure that multi-agency safeguarding audits will identify to what extent that the voice of the adult is heard at the point of the safeguarding alert during all safeguarding enquiries and actions and in all safety plans
- Ensure that Information Sharing Agreements are up to date and that agencies are sharing information appropriately without undue delay.

How we will know that we have made a positive difference

- Annual business plan will identify how these actions will be implemented. The Board will monitor progress and will manage the risks in its delivery.
- Key to our approach will be how effectively the Board engages with local partners to ensure that we work together to reduce the incidence of abuse and neglect across Staffordshire and Stoke-on-Trent.
- Findings from the tiered audit processes contained within the Board assurance framework.

2. TRANSITION

Young people with ongoing or long-term health or social care needs may be required to transition into adult services where they are eligible under the Care Act 2014. Transition is defined as a purposeful and planned process of supporting young people to move from children's to adults' services.

Why it is important

The preparation and planning for moving into adult services can be an uncertain time for young people with health or social care needs. Transition takes place at a pivotal time in the life of a young person. There is a risk that there may be service gaps where there is a lack of appropriate services for young people to transition into and evidence that young people may fail to engage with services without proper support.

A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at an enhanced risk of psychosocial problems. Some groups are seen as at particular risk of falling into service gaps including: Young people with complex and multiple needs, child and adolescent mental health service users, young people with palliative care needs and life limiting conditions and young people leaving residential care.

What we will do

- Working with connected safeguarding partners scope the transition arrangements and identify gaps in the provision of support
- Seek assurance from connected partner organisations that the transition arrangements and outcomes are effective
- Engage with commissioners and providers to develop and implement an improvement plan to address areas of unmet need in transition arrangements
- Promote and advocate good practice and encourage application amongst connected partners
- Support young people with care and support needs.

How we will know that we have made a positive difference

- Positive survey/audit/inspection feedback on the experiences of young people transitioning to adult services
- Evidence that service gaps in transition arrangements (in relation to safeguarding) are identified and appropriate assurances sought

3. LEADERSHIP IN THE INDEPENDENT CARE SECTOR

Why it is important

Many people have been shocked by the revelations highlighted in national high profile cases of poor care and worse, outright abuse, in our health and care system. Such instances, whilst fairly rare, remind us that the way care and support is provided to individuals and their families can have a major effect on their whole quality of life.

It is the leaders in the system – operating at all levels from the practice of individual staff members to the strategic planning of commissioners – that set the tone and culture of organisations. It is they who ensure that high quality care is provided day in and day out – or, sadly, that the opposite is sometimes the case. The Board has had an interest in the importance and significance of leadership in care homes after it was identified as a recurring theme locally in Large Scale Investigations (LSI) and Safeguarding Adult Reviews (SAR).

What we will do

- Monitor relevant CQC inspection reports and Enhanced Provider Monitoring (EPM) reports
- Identify non-compliance with the 'well-led' and 'safe' domains through scrutiny of 'inadequate' and 'require improvement' ratings of care homes
- Monitor compliance with improvement actions arising from inspections and quality monitoring reports, seeking further assurances around leadership management interventions if required
- Seek assurances as to the effectiveness of the Local Authority oversight arrangements for care homes subject to Enhanced Provider Monitoring (this intervention commonly precedes Large Scale Enquiry process.
- Identify relevant matters for consideration of action by commissioners of services

How we will know that we have made a positive difference

- Reduction in Large Scale Enquiries where 'leadership of the care provision' is a factor
- Fewer care homes requiring compliance action from CQC
- More services being rated as good or outstanding in the 'well-led' and 'safe' domains

Membership

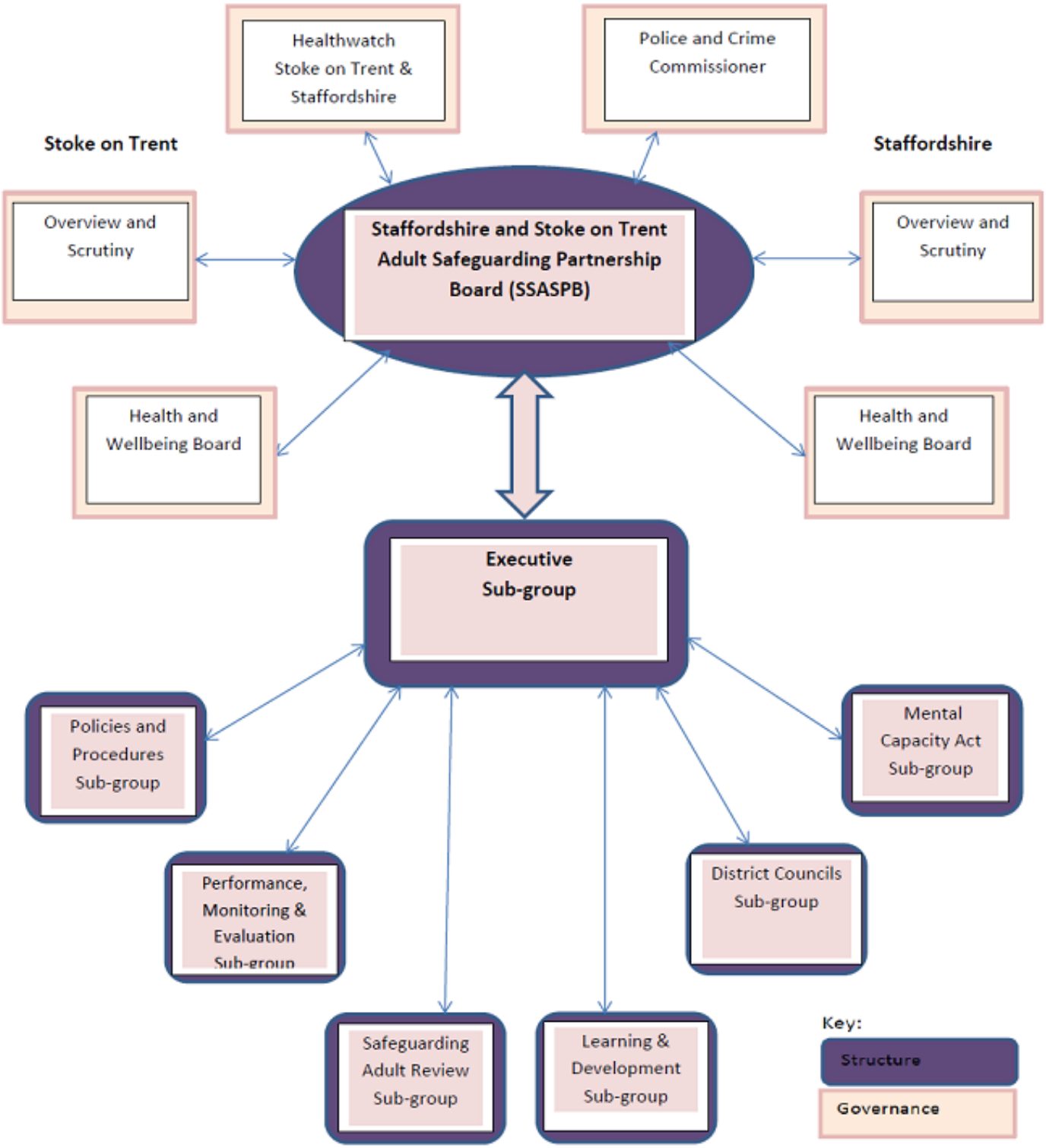
Through the requirements of the Care Act 2014 Staffordshire County Council, Stoke-on-Trent City Council, Staffordshire Police and the six Clinical Commissioning Groups in Stoke-on-Trent and Staffordshire are statutory partners of the SSASPB.

As part of its inclusive approach that recognises that safeguarding is everyone's responsibility the statutory partners have agreed to invite the following organisations or departments to become members of the SSASPB.

- Burton Hospitals NHS Foundation Trust (BHFT)
- South Staffordshire and Shropshire NHS Foundation Trust (SSSFT)
- NHS England - Shropshire and Staffordshire Local Area Team
- North Staffordshire Combined Healthcare NHS Trust (NSCHCT)
- Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP)
- University Hospitals of North Midlands including County Hospital in Stafford (UHNM)
- Representatives from the voluntary sector
- Staffordshire Association of Registered Care Providers (SARCP)
- Local Authority Lead members
- Healthwatch; Staffordshire and Stoke-on-Trent
- Hate Crime Forums
- Domestic Abuse Forum
- Trading Standards; Staffordshire and Stoke-on-Trent
- Staffordshire Fire & Rescue Service (SFARS)
- West Midlands Ambulance Service (WMAS)
- District Safeguarding Sub-Group
- Her Majesty's Prison Service; West Midlands (HMPS)
- National Probation Service; Staffordshire and Stoke-on-Trent (NPS)
- Community Rehabilitation Company; Staffordshire and Stoke-on-Trent (CRCs)
- Department of Work and Pensions (DWP)
- Housing; Stoke on Trent

Appendix 2

SSASPB Governance and Structure



Appendix 3

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.

Staffordshire County Council

WORK PROGRAMME
Safe and Strong Communities Select Committee 2017/18

This document sets out the work programme for the Safe and Strong Communities Select Committee for 2017/18.
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 Gould, Scrutiny and Support Manager on 01785 276148 or by emailing tina.gould@staffordshire.gov.uk

Membership – County Councillors 2017-18

John Francis (Chairman)
Conor Wileman (Vice Chairman)
Syed Hussain
Trevor Johnson
Jason Jones
Natasha Pullen
Kyle Robinson
Paul Snape
Victoria Wilson
Mike Worthington

Calendar of Committee Meetings 2017-2018

13 June 2017 at 2.00 p.m.
13 July 2017 at 10.00 a.m.
26 September 2017 at 2.00 p.m.
9 November 2017 at 10.00 a.m.
11 December 2017 at 2.00 p.m. Cancelled due to inclement weather
15 January 2018 at 10.00 a.m.
5 March 2018 at 10.00 a.m.

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

Work Programme 2017-18				
Date of meeting	**Item**	**Link to Council's Commissioning Plans**	**Details**	**Action/Outcome**
Tues 13 June 2017	**Introduction to S&SC SC**	Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	The Committee received a presentation which gave an overview of the remit of the Select Committee and highlighted some of the key issues going forward.	As a result of the presentation and subsequent discussion on developing the work programme Members requested the following items be included on their work programme: • The West Midlands Peer Review of Adult Safeguarding • How to engage with hard to reach communities • Modern day slavery and domestic violence • CSE
Thurs 13 July 2017	**Children's & Families System Transformation** Cabinet Member: Mark Sutton Officer: Mick Harrison/Helen Riley	Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	The Transformation programme for Children and Family Services has previously been considered by this Select Committee on 8 June, 8 July & 12 December 2016.	Due to meeting timings and restrictions during the recent elections it had not been possible on this occasion for the Select Committee to undertake pre-decision scrutiny, with this report being included on the 21 June 2017 Cabinet agenda. Comments and/or concerns raised were therefore reported to the 19 August Transformation Programme Board, with these then helping inform future working.
	Children, Young People & Families Pilots Cabinet Member: Mark Sutton Officer: Mick Harrison/Janene Cox	Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	The Pilots support the work of the Transformation Programme and were last considered by this Committee on 16 January 2017.	Progress on the Pilots varied and Members requested that in their next 6 monthly report they receive details of which pilots will cease and how the success of the others will inform best practise across the County.
	Public Analyst & Scientific Services Laboratory Cabinet Member: Gill Heath Officer: Trish Caldwell [exempt item]	Well Run Council Making the most of our Assets, Managing Change Well, Transforming Ourselves, Innovation in ICT, Continued Modernisation of HR, Outcome Based Performance Management	To inform the Select Committee of a review carried out into the operation of the in-house Public Analyst and Scientific Services laboratory.	The Select Committee did not endorse the recommendations but asked the Cabinet Member for Communities to take their concerns to the 19 July Cabinet and ask for a deferment on the decision to close the service pending consideration of their concerns/alternative suggestions.

Mon 26 Sept 2017	**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** Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	The Committee has requested a six monthly update on this issue. The Chair of the Children and Young People's Overview and Scrutiny Committee at Stoke City Council has been invited to attend this meeting and this arrangement is reciprocated.	The Select Committee want to encourage schools to make use of the DVD "For the Whole World to See" in their PHSE lessons and for this resource to be used as part of school governor training. Future reports are also asked to include consideration of LGBT as a potential vulnerable group within this context. Members also requested that they receive an update in 6 months time on the OPCC funded post to develop PHSE resources around safeguarding in its broadest sense and the take-up of schools.
	Cabinet Response: Preventing Low Level Neglect of Children in Staffordshire Cabinet Member: Mark Sutton	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities	The Committee received an initial response to the recommendations contained within its Working Group report on Low Level Neglect on 6 March 2017. It was agreed to follow up outstanding actions in 6 months' time.	Members thanked the Cabinet Member for Children and Young People for his progress in implementing the recommendations made by the Working Group. They also asked for an organogram showing the governance model and relationship between groups involved.
Thurs 9 Nov 2017	**West Midlands Peer Review of Adult Safeguarding** Cabinet Member: Alan White Officer: Andrew Sharp	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities	This review took place in February 2017. Councillors Francis and Olszewski participated in this review. At the June meeting Members requested feedback on the review to a future meeting.	The select Committee commended officers on the significant progress made in implementing the recommendations made by the Peer Review. They also requested a progress report on the action plan and implementation of recommendations to a future meeting.
	Deprivation of Liberty Safeguards Cabinet Member: Alan White Officer: Peter Hampton	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities.	At its meeting on 9 November 2016 Members were told that the anticipated backlog of referrals should be cleared by June/July 2017. The Committee should monitor and review this matter.	Members noted the difficulties with the number of referrals and the need to prioritise high priority assessments only. They have some concerns that this means the Council is effectively in breech of the law but within the resource available accept this is the only current solution.
Mon 11 Dec 2017 ***cancelled***	**Customer Feedback & Complaints, Adult Social Care Annual Report 16/17** Cabinet Member: Alan White Officer: Kate Bullivant	**Well run Council**	Adult's Services have a statutory obligation to submit an Annual Report on complaints and representations to the relevant County Council Committee.	The answers to the key lines of inquiry were forwarded to Members.

	Customer Feedback & Complaints, Children's Social Care Annual Report 16/17 Cabinet Member: Mark Sutton Officer: Kate Bullivant	**Well run Council**	Children's Services have a statutory obligation to submit an Annual Report on complaints and representations to the relevant County Council Committee.	The answers to the key lines of inquiry were forwarded to Members.
Mon 15 Jan 2018	**Staffordshire & Stoke-on-Trent Adult Safeguarding Partnership Board** Cabinet Member: Alan White Independent Chair: John Wood	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities	This report is presented to the Select Committee on an annual basis.	
	Staffs Safeguarding Children's Board (SSCB) Annual Report 2016/17 Cabinet Member: Mark Sutton Independent Chair: John Wood	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities	This report is presented to the Select Committee on an annual basis.	
	Home Care Cabinet Member: Alan White Officer: Richard Harling	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	Included on the work programme following the October Triangulation meeting. Consideration of Home Care from a safeguarding point of view and the lessons learnt around communication.	

	Domestic Abuse Cabinet Member: Gill Heath 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.	Select Committee Members requested an item on this issue at their meeting of 13 June.	
Mon 5 March 2018	**Child Sexual Exploitation (CSE) in Staffordshire, to include progress against the CSAF Action Plan** 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 Committee has requested a six monthly update on this issue. The Chair of the Children and Young People's Overview and Scrutiny Committee at Stoke City Council has been invited to attend this meeting and this arrangement is reciprocated.	
	Children's & Families System Transformation & update on Pilot Projects Cabinet Member: Mark Sutton Officer: Mick Harrison/Helen Riley/ Janene Cox	**Ensure effective** safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	The Transformation programme for Children and Family Services has previously been considered by this Select Committee on 8 June, 8 July & 12 December 2016 & 13 July 2017.	
	Youth Offending service Cabinet Member: Mark Sutton Officer: Vonni Gordon	**Well run Council**	Consideration of the YOS Review	

Briefing Notes/Updates/Visits 2017-18				
Date	**Item**	**Link to Council's Commissioning Plans**	**Details**	**Action/Outcome**
17 July, 10 August and 15 September 2017	**Visit to the MASH (Multi Agency Safeguarding Hub)**	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities	Select Committee Members requested a visit to the MASH to see first hand the multi agency partnership working and the rationale for creating this facility.	The main visit took place on 10 August jointly with members of the Corporate Parenting Panel, with those unable to make 10 August visiting separately.
December 2017	**Modern Slavery**	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our	At the 12 December meeting Members requested a further report giving progress on the Task and	Briefing note circulated and Members asked to highlight if they

		communities Enable people to access the appropriate intervention at the right time.	Finish action plan following their January meeting. Following this meeting there was no significant developments to report and this item has therefore been deferred for consideration in the new municipal year and due to be considered at the December meeting, which was cancelled. The report was therefore circulated to Members as a briefing note	wished to include any further investigation on the work programme.
January 2018	**Community Safety Agreement**	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities.	Select Committee response to the SCC Stronger Communities Strategy Group Draft Agreement and results of the Strategy Group's 13 September meeting had been requested by the Select Committee and at the 11 October Triangulation meeting it was agreed that this information should be brought to the Select Committee via a briefing note rather than be included on an agenda.	

Working Group and/or Inquiry Days 2017-18

Date	Item	Link to Council's Commissioning Plans	Details	Action/Outcome
Monday 31 July 2017 **9.30 – 11.00 am**	**Community Safety Agreement – shared priorities** Cabinet Member: Gill Heath Officer: Mick Harrison	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities.	The SCC Stronger Communities Strategy Group (chaired by Gill Heath and including representation from District and Borough Councils) has produced a draft Community Safety Agreement Safe which sets out shared priorities. This will be agreed at their meeting of 13 September. The Select Committee will consider the Draft Agreement at an informal review session, reporting their findings to both the Strategy Group on 13 September and the Select Committee on 26 September.	Findings from the informal meeting were agreed by Members and forwarded to Becky Murphy, Safer Communities Commissioning Officer, to share at the 13 September Strategy Group meeting. Feedback from the Strategy Group meeting will be shared with the Select Committee at their meeting of 26 September.
Monday 14 August	**Local Business Case for Joint governance of Police and Fire & Rescue in Staffordshire** PCC: Matthew Ellis	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	The Police and Crime Commissioner (PCC) has produced a business case proposing the joint governance of the Police and Fire and Rescue Services in Staffordshire. The consultation ends at the beginning of September. This informal session will be an opportunity for the Select Committee to consider the business case in detail and formally respond to the consultation.	The Select Committee's informal workshop session was held jointly with the Corporate Review Committee and the Police and Crime Panel. The findings from this scrutiny will be formally reported to a special meeting of the County Council on 31 August where they will agree the County Council's formal response to the PCC's consultation.

Thursday 9 November	**Customer Feedback and Complaint Annual Reports for adult and children's social care** Cabinet Member: Mark Sutton and Alan White Officer: Kate Bullivant	**Well run Council**	An informal session will be held to consider these annual reports in detail. From this informal session a list of questions and/or comments will be drawn together and forwarded to the Customer Feedback and Complaints Manager prior to the December meeting. This will enable the discussion at the December Select Committee meeting to concentrate on the key areas highlighted by Members.	Key lines of inquiry were forwarded to the Customer Feedback and Complaints Manager in readiness for the December meeting.
Inquiry Day 30 January 2018	**Preventing Children coming into Care- now called "Edge of Care"** Cabinet Member: Mark Sutton Officer: Richard Hancock	**Ensure effective** safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	This item was initially proposed by the Commissioner for Community Safety, Children and Families. The Chairman has met with the Head of Families First and a scoping report has been prepared for Members' consideration.	
tbc	**How to engage hard to reach communities** Cabinet Member: Gill Heath 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.	Possible Review to identify hard to reach communities within Staffordshire and the most effective way of addressing the issues identified.	A desk top exercise is underway to establish if, and in what ways, the County Council is currently addressing this issue.
tbc	**Children's Centres – 3 years on** 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.	Three years ago the Select Committee completed work to assess the role of the Children's Centre. Three years on the Select Committee will re-visit this work, visiting the Centres to assess the current situation in comparison with the findings of the original working group report.	At the Select Committee meeting of 26 November Members agreed to a request that this review be put back until the current significant changes within Children's Centres were completed.

Current & Related Work of Select Committees and/or All Party Member Groups 2017-18

Timescale	Area of Work	Link to Council's Commissioning Plans	Details	Action/Outcome
tbc – likely to be December or January	**All Age Disability Strategy** Cabinet Member: Alan White Officer: Martyn Baggaley	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	The **Healthy Staffordshire Select Committee** has the All Age Disability Strategy on their work programme. To avoid duplication this issue has not been included as a work programme item for this Select Committee, however the outcome of their scrutiny will be shared with Safe & Strong Communities Select Committee Members.	
September 2017 -	**Children's mental health & wellbeing** Cabinet Member: Alan White Officers: Tilly Flannigan & Divya Patel **APMG Membership**	**Resilient Communities** Ensure effective safeguarding for the most vulnerable in our communities Enable people to access the appropriate intervention at the right time.	**Innovation APMG:** Terms of Reference 'how to promote children's emotional and mental wellbeing to reduce referrals to specialist services across SCC and other partners, by intervening earlier to ensure better long-term outcomes'	End of September agree scope, lines of enquiry and membership of the APMG First full meeting of the APMG with specialist officers - October Development of the focus groups - October

	Keith Flunder (Chair) Johnny McMahon Bernard Peters Ron Clarke Bryan Jones Ann Edgeller			Submit initial progress to the Leaders report October / November
August 2017 -	**Increasing S3 Capacity** Cabinet Member: Gill Heath Officers: Angela Schulp & Adam Rooney **APMG Membership** Mike Davies (Chair) David Smith Kyle Robinson Maureen Compton Julia Jessel	**Well run Council**	**Community APMG:** How do we increase the capacity and utilise the services of S3 to deliver 'People helping people' and reduce the involvement of SCC?	Agree scope with Cabinet –end of August Meet with S3 to understand what they do – end of August / early September Look at 8 Community Members priorities and see if any cross over / themes – end of August / early September Meet with local agencies that are also building capacity – e.g. Fire service, bigger voluntary groups (Age UK, Alzheimer's Society etc) – September First meeting APMG to discuss scope and plan – September Meet with local community groups with DCLs and CPOs – September / October Submit early findings to Leaders report – October Second meeting of APMG to discuss findings – late October / early November

Referrals from other Select Committees 2017-18				
Timescale	**Area of Work**	**Link to Council's Commissioning Plans**	**Details**	**Action/Outcome**
tbc	Elective Home Education	Best Start	Referral from Corporate Parenting Panel – August 2017 (NB – also referred to Prosperous Staffordshire Select Committee)	

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