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

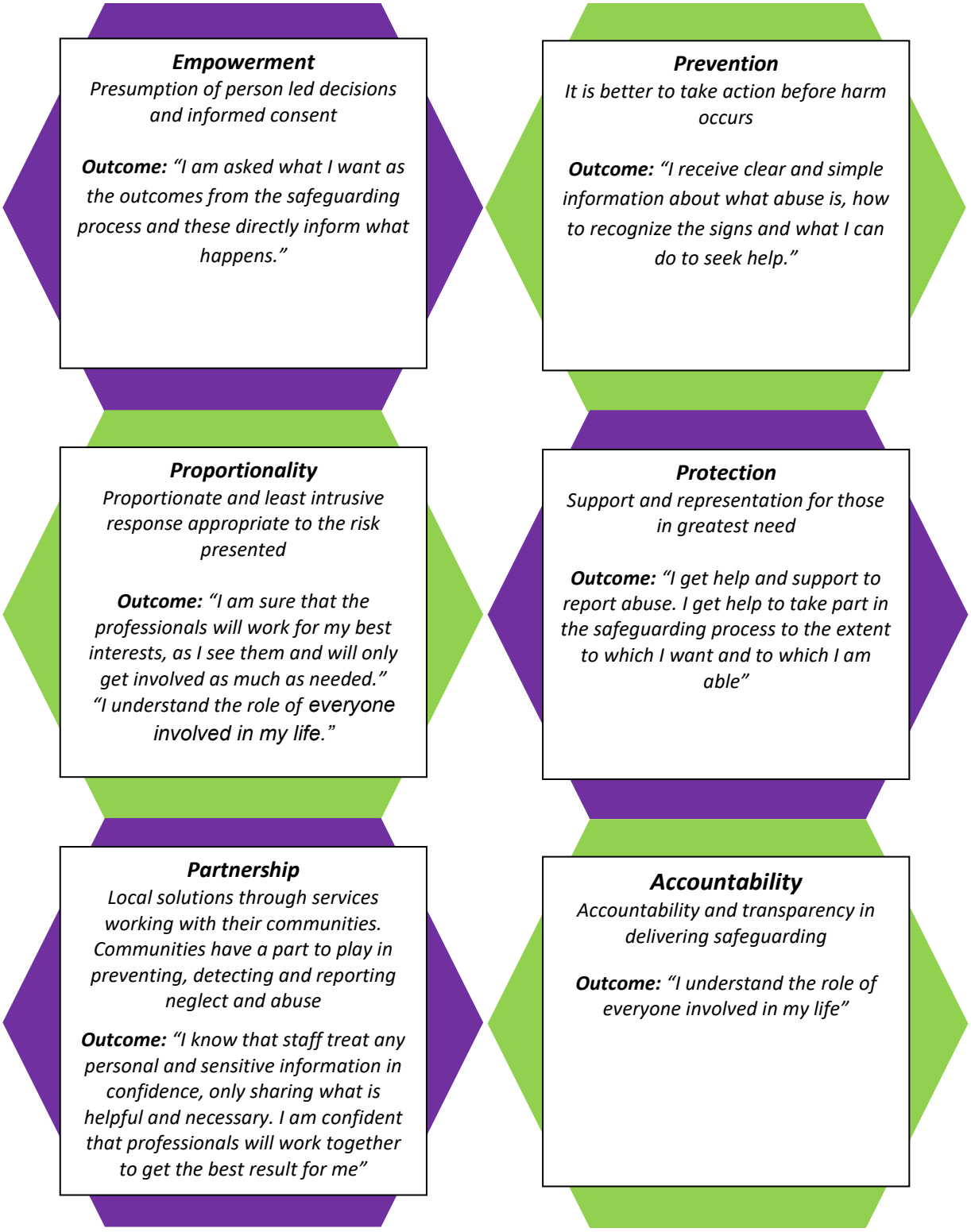
'Adults with care and support needs are supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse and neglect.'

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:

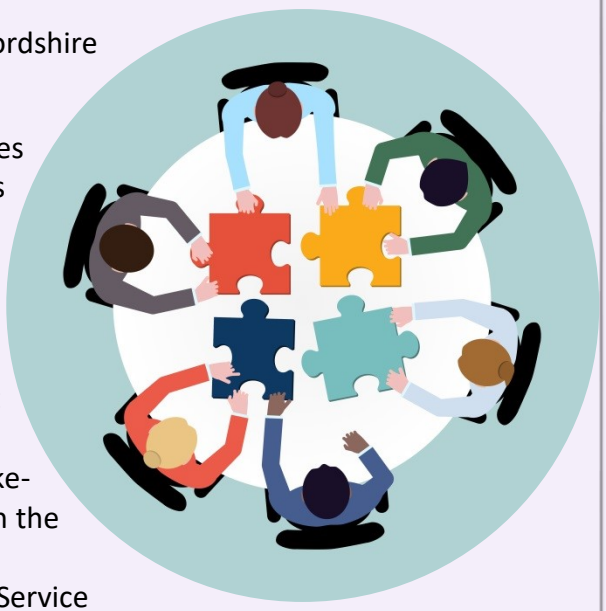
To maintain momentum towards the achievement of ambitious Strategic Priorities. Despite the best efforts progress may not be as rapid as envisaged.

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

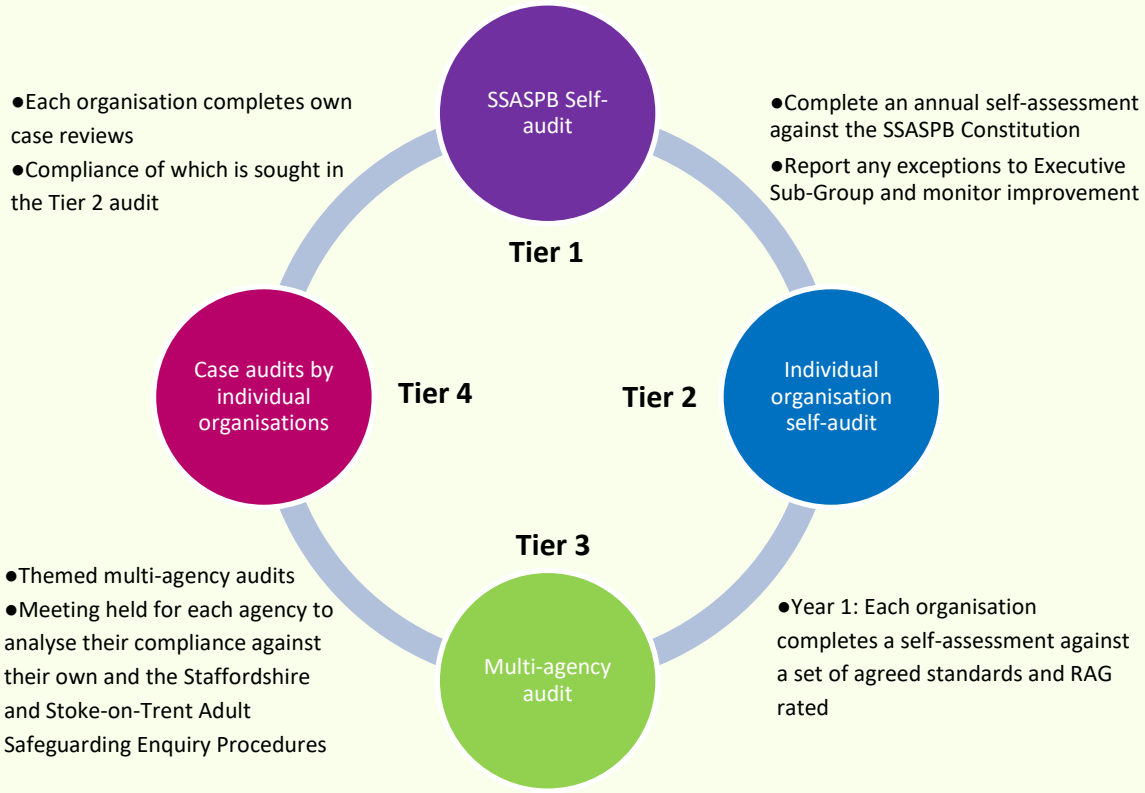
Chair: Sharon Conlon; Safeguarding Lead (South Staffordshire & Shropshire Healthcare NHS Foundation Trust)

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

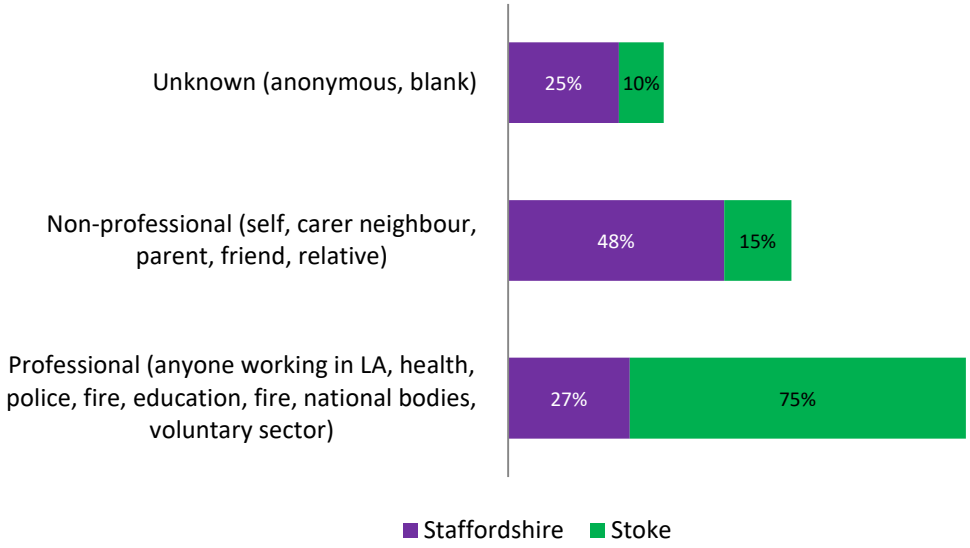
There are three parts to this Priority:

(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

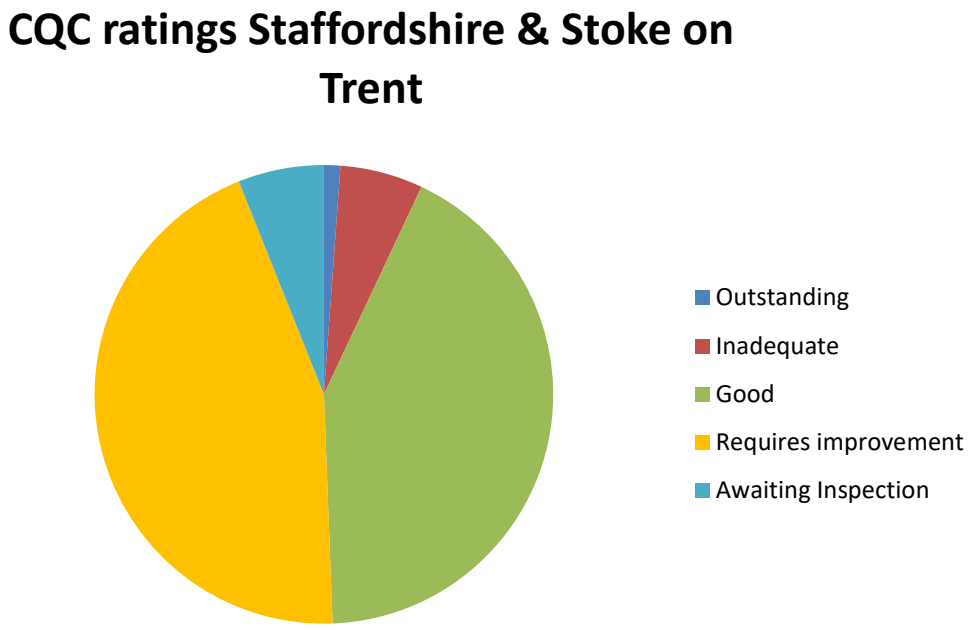
Strategic Lead: Lisa Bates; Lead Nurse of Adult Safeguarding (South Staffordshire Clinical Commissioning Groups)

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

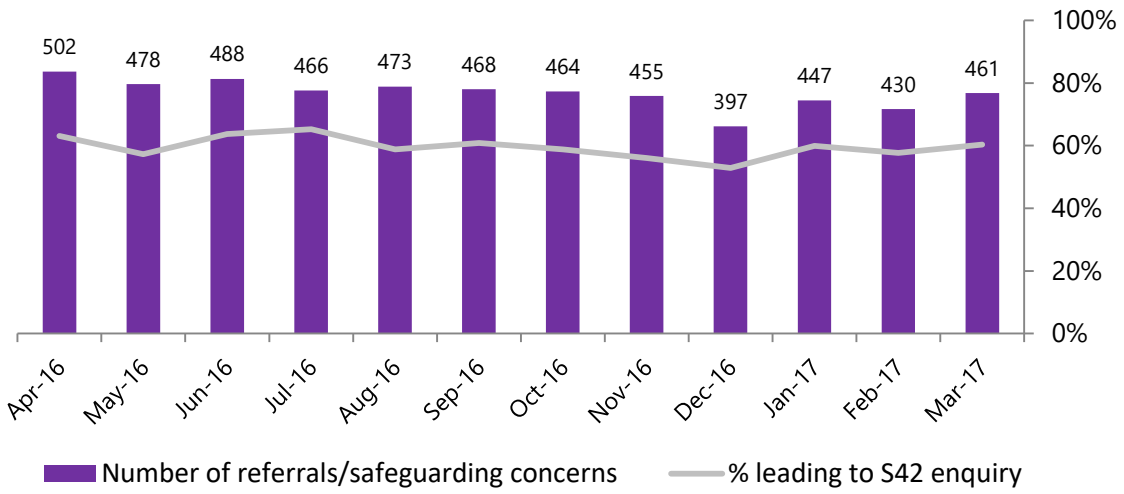
This section provides commentary and analysis of safeguarding data from Stoke-on-Trent and Staffordshire with associated graphical illustrations.

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.

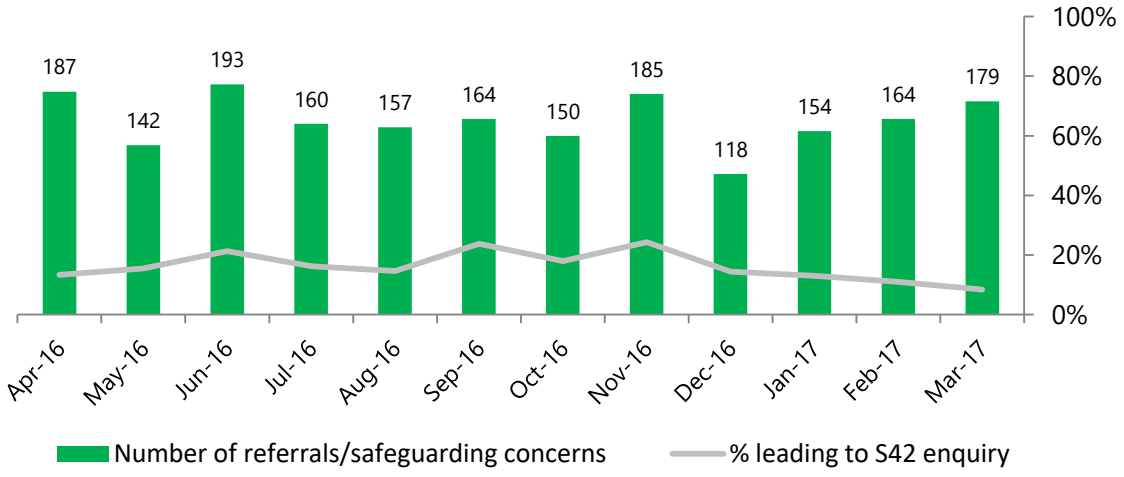
Figure 1: Number and proportion of referrals/safeguarding concerns – Staffordshire



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.

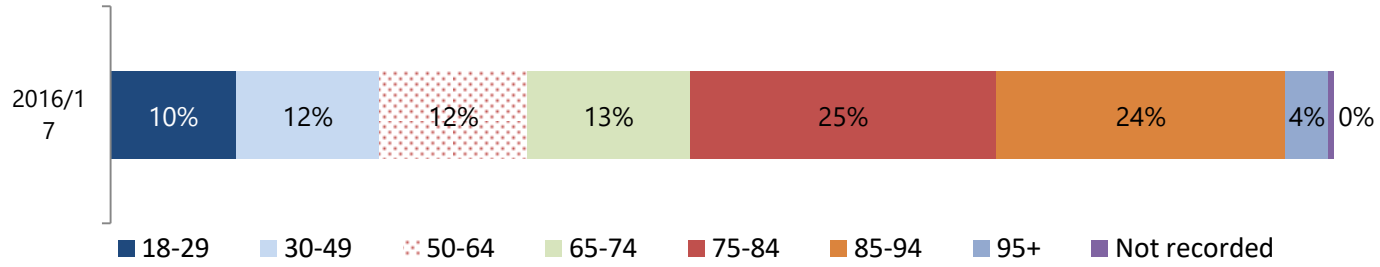
The following pages provide an analysis of the findings under various headings from the concerns that have resulted in a formal Section 42 enquiry.

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.

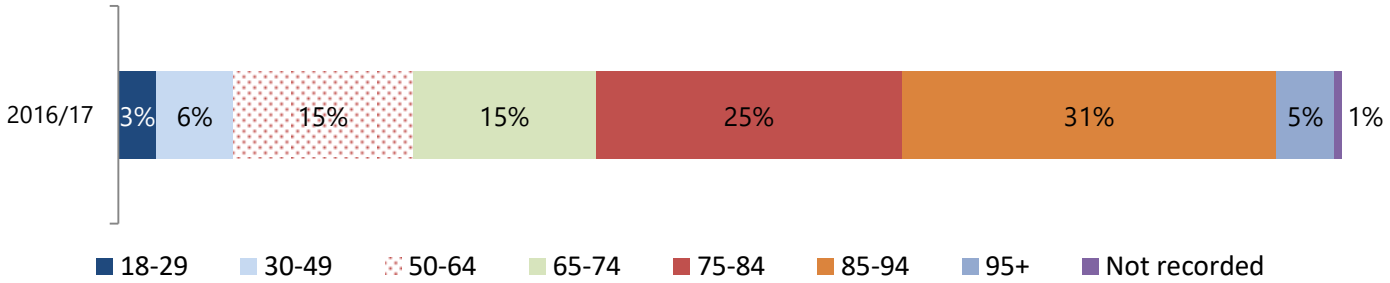
(i) Age breakdown

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.

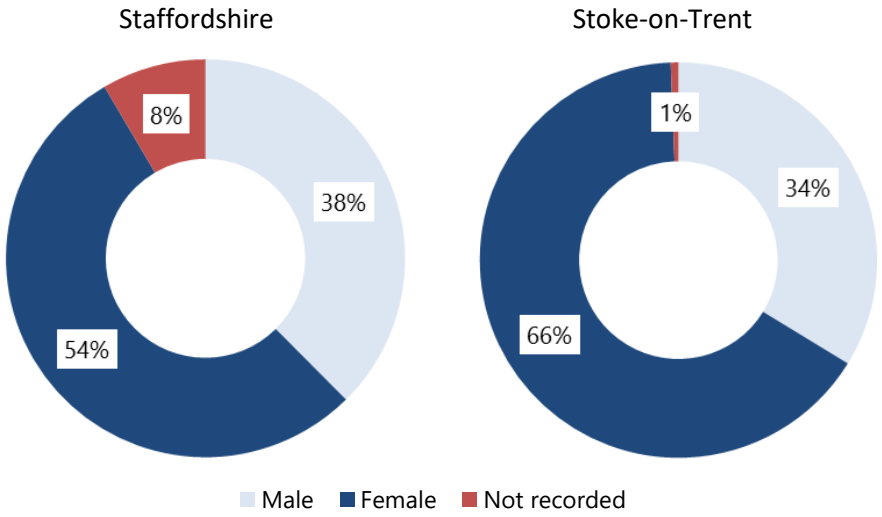
Figure 4: Age Breakdown (Section 42) – Stoke-on-Trent



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



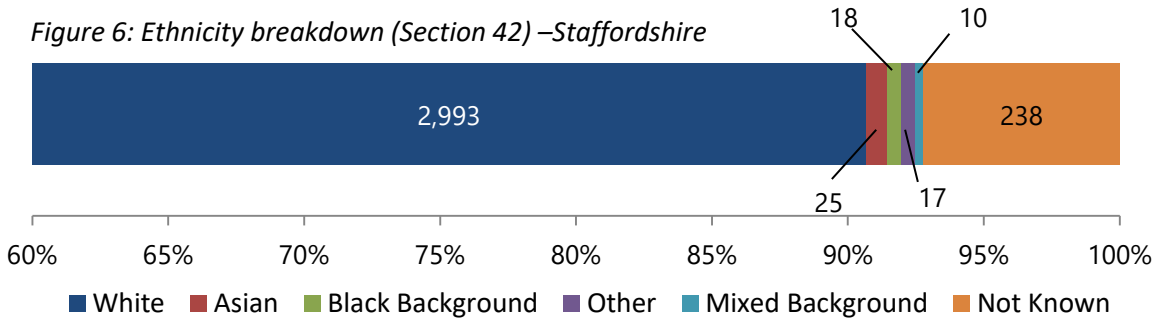
Staffordshire: Females represent the majority of adults' subject of a Section 42 enquiry (54% over the year), males representing 38%. For 8% the gender was not recorded.

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.

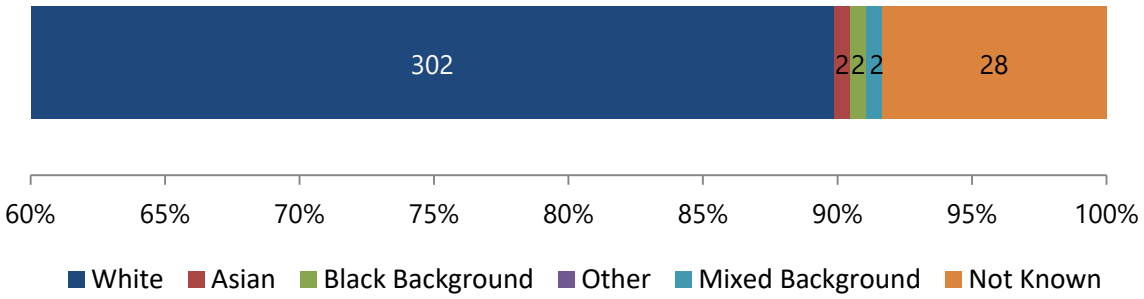
(iii) Ethnicity

Figure 6: Ethnicity breakdown (Section 42) –Staffordshire



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

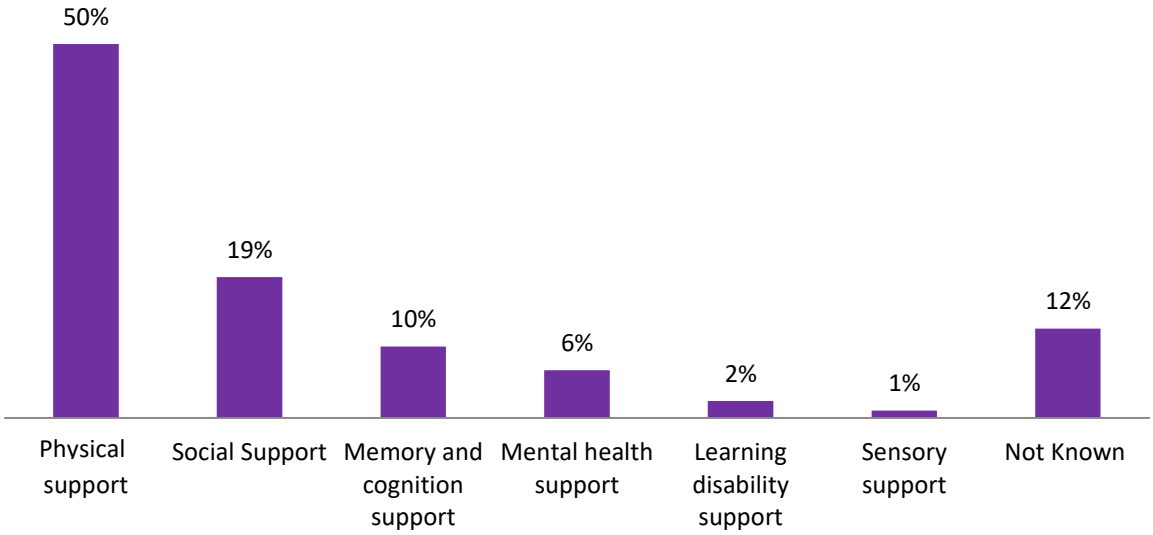
Figure 7: Ethnicity breakdown (Section 42) – Stoke-on-Trent



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

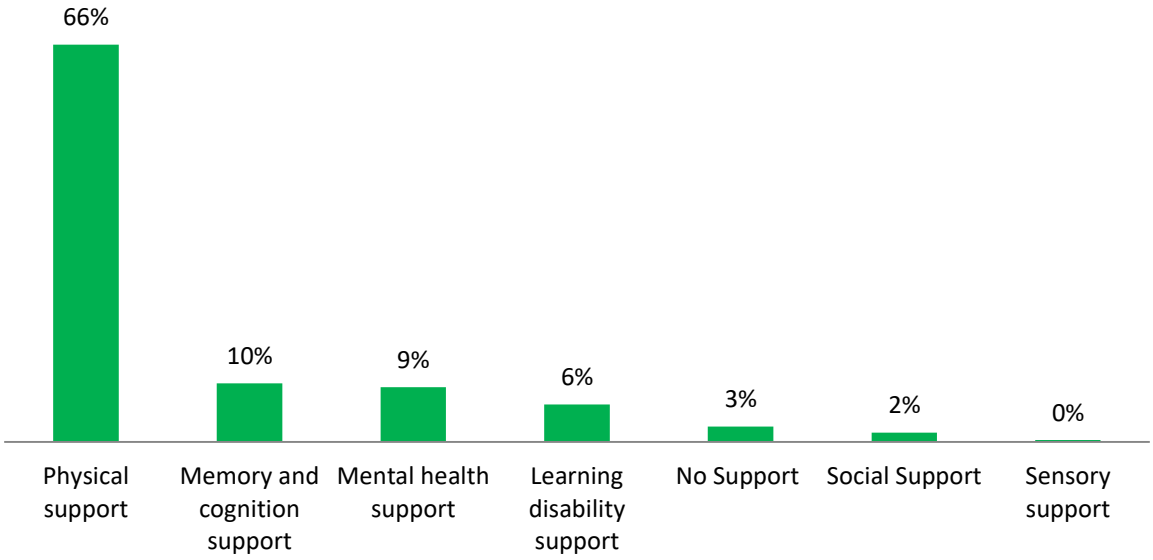
Primary Support Reason

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

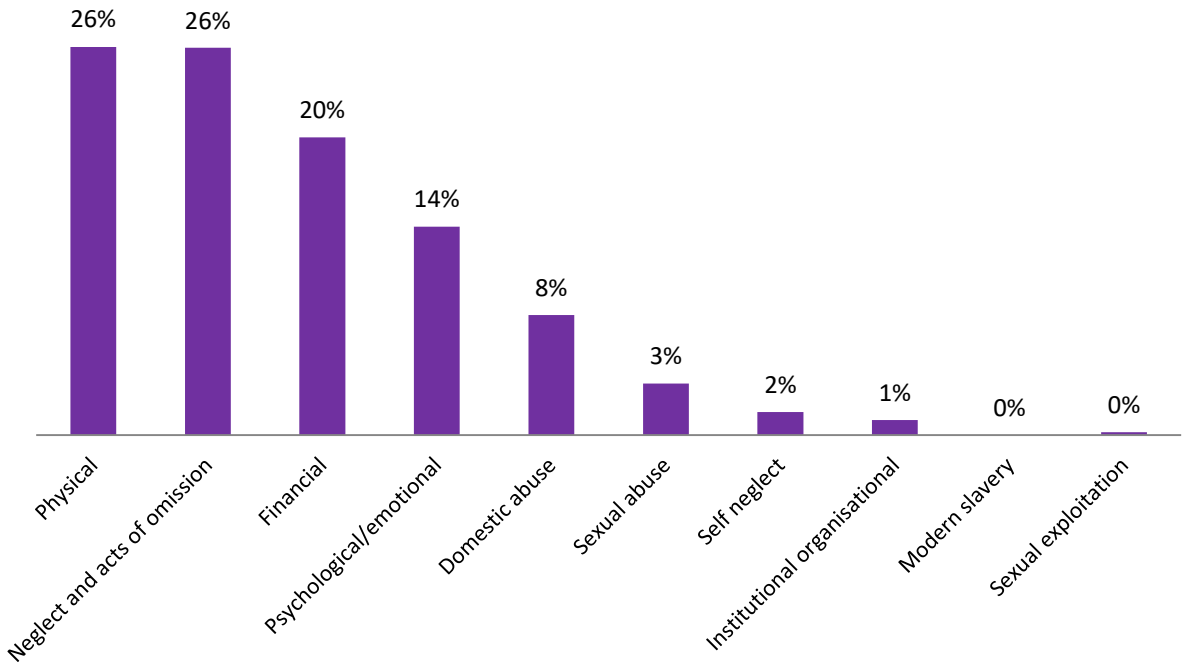


Physical support similarly represents the largest proportion of primary support reasons recorded in Stoke-on-Trent at 66%, followed by memory and cognition support (10%) and mental health support (9%).

Types of Harm or Abuse identified at Section 42 safeguarding enquiry

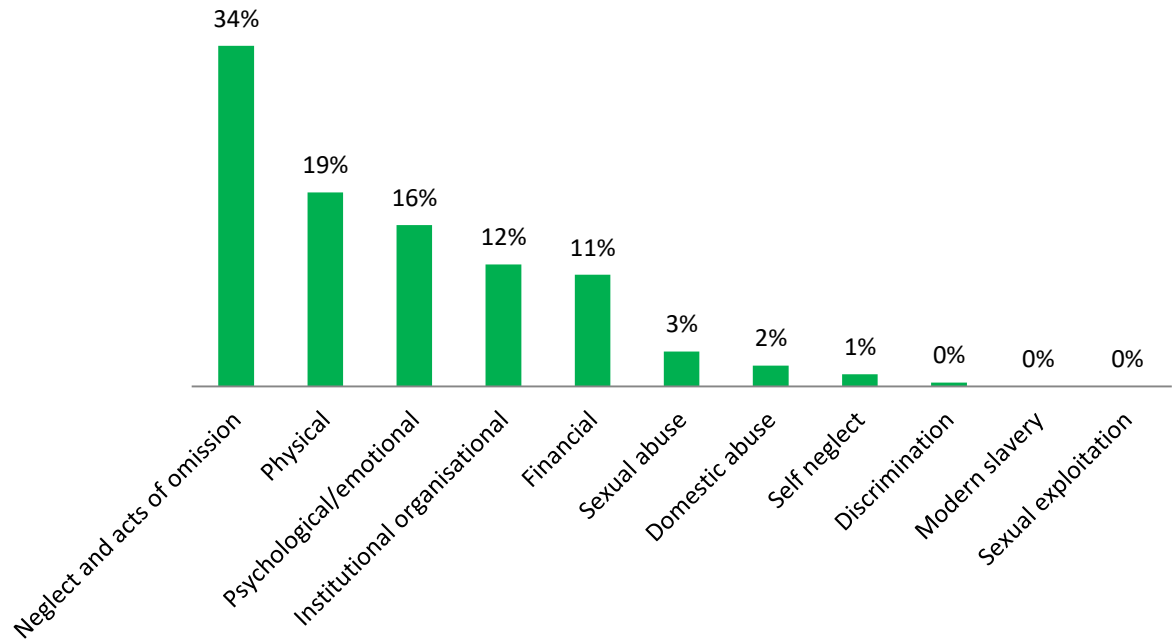
The below information shows the types of abuse and neglect reported in comparative proportions:

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

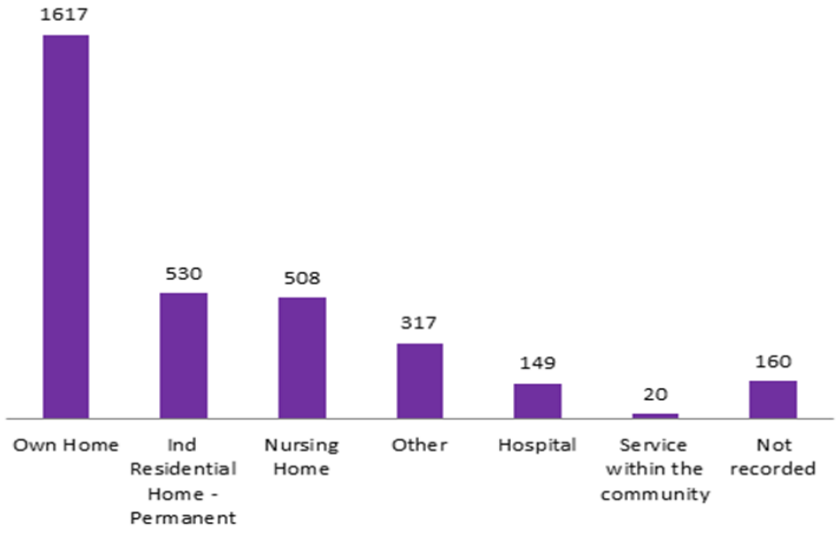
likely type of abuse/harm identified at Section 42 safeguarding enquiry. Other categories remained proportionally similar throughout the year.

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.

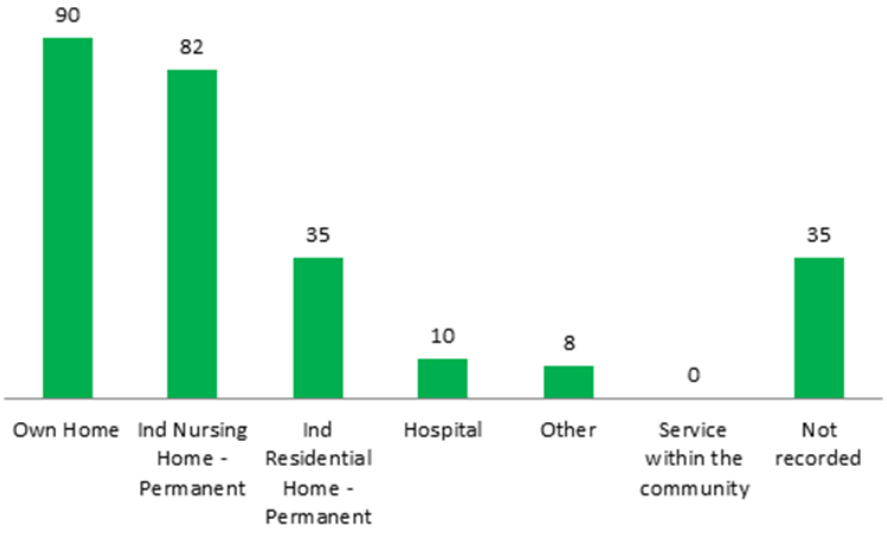
Location of abuse

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.

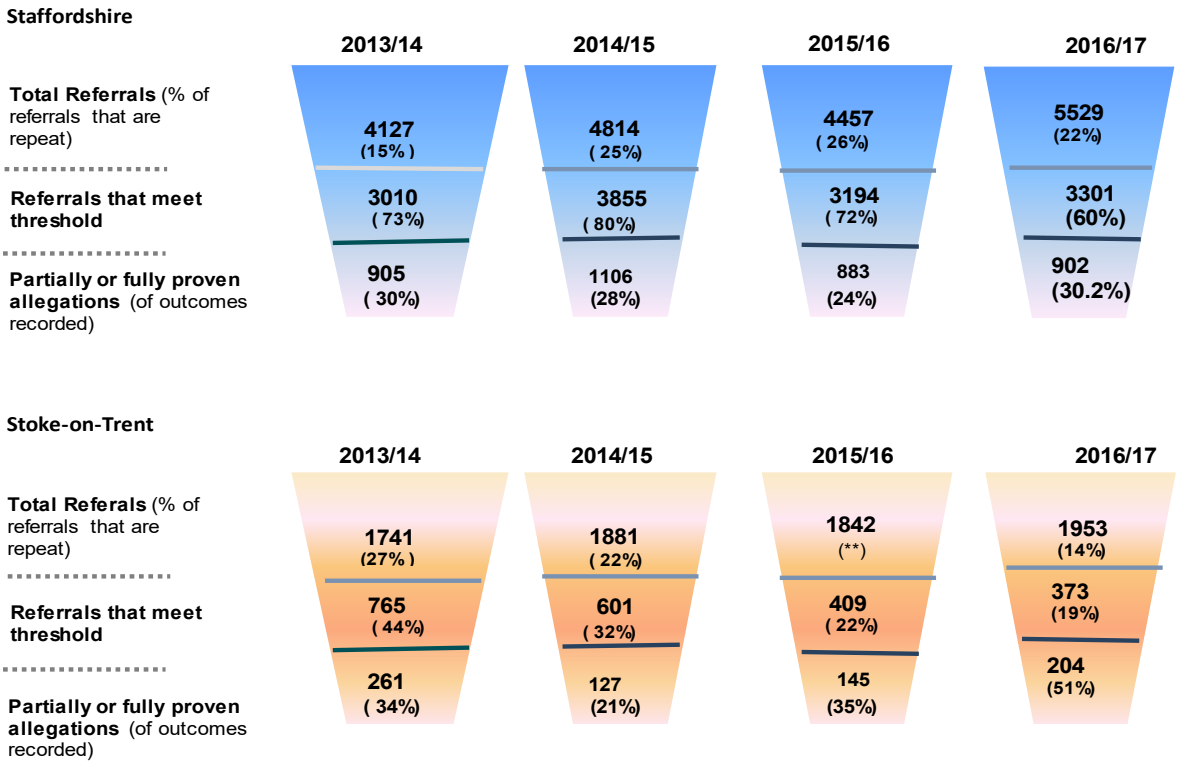
Large Scale Enquiries (LSE's) will impact on nursing home data due to other safeguarding concerns resulting from additional scrutiny of a service.

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

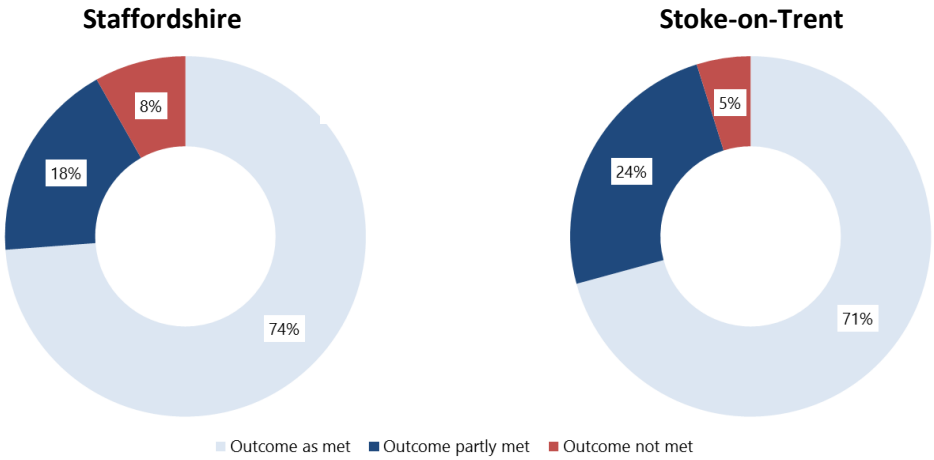


Staffordshire: The volume of referrals has increased steadily over the last four years, however the proportion of repeat referrals has decreased from last year (from 26% - 22%). Referrals that meet the threshold have decreased to a low of 60% this year compared to 72% last year. A higher proportion (30.2%)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

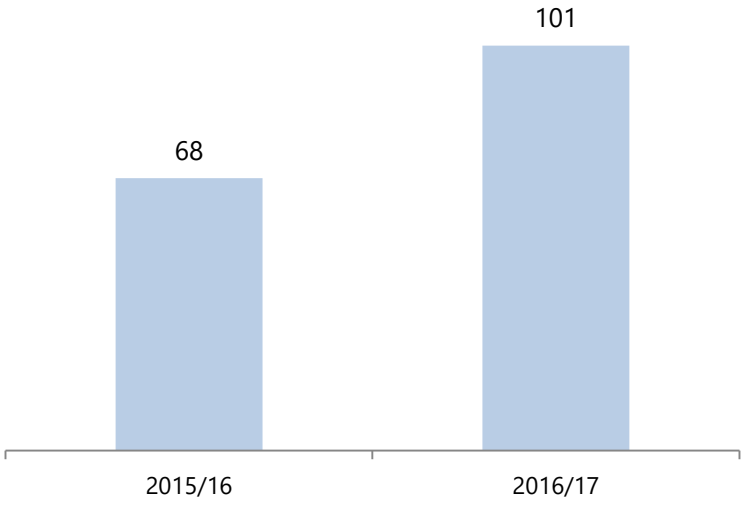
It is also of note that the high levels of service user satisfaction with outcomes is not necessarily linked to the proving of allegations following Section 42 enquiries which, as shown above, are well below satisfaction with outcome rates in Staffordshire and Stoke-on-Trent.

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

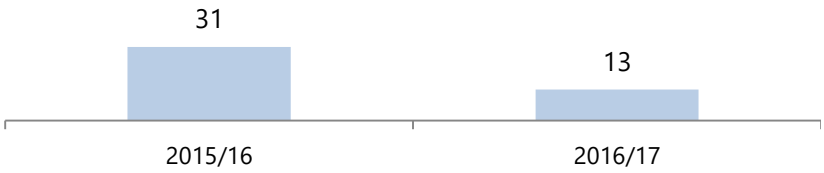


There has been an increase of 33 crimes alleging ill treatment or neglect by a care worker in 2016/17 compared to the previous year. The majority of the victims, 57, are female with 44 men. Three of the allegations were from repeat victims. The majority of offences were alleged to have been committed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

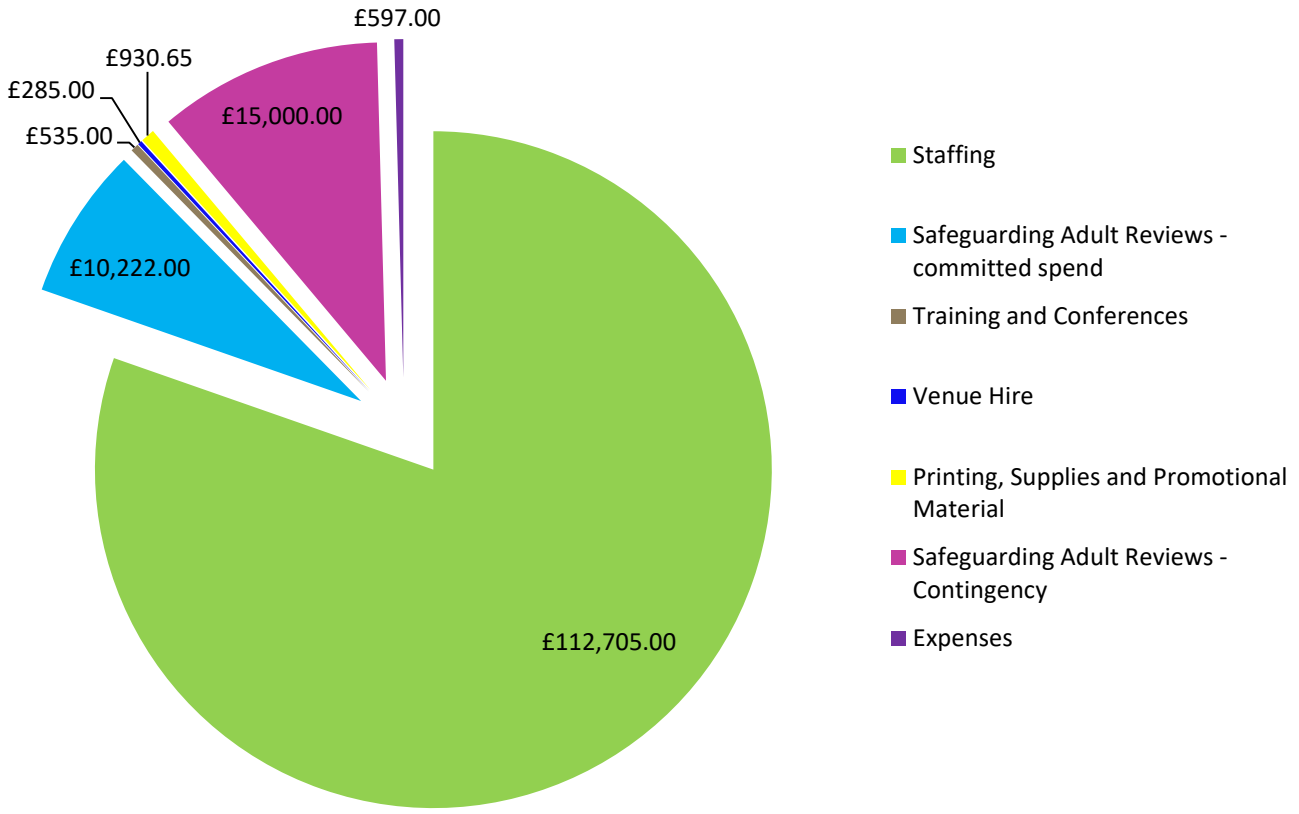
Organisation	Amount
Burton Hospital NHS Foundation Trust	£12,500
North Staffordshire Clinical Commissioning Group	£ 9,375
North Staffordshire Combined Healthcare Trust	£12,500
South Staffordshire Clinical Commissioning Group(s) (South Staffordshire & Seisdon Peninsula CCG, Stafford & Surrounds CCG, East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

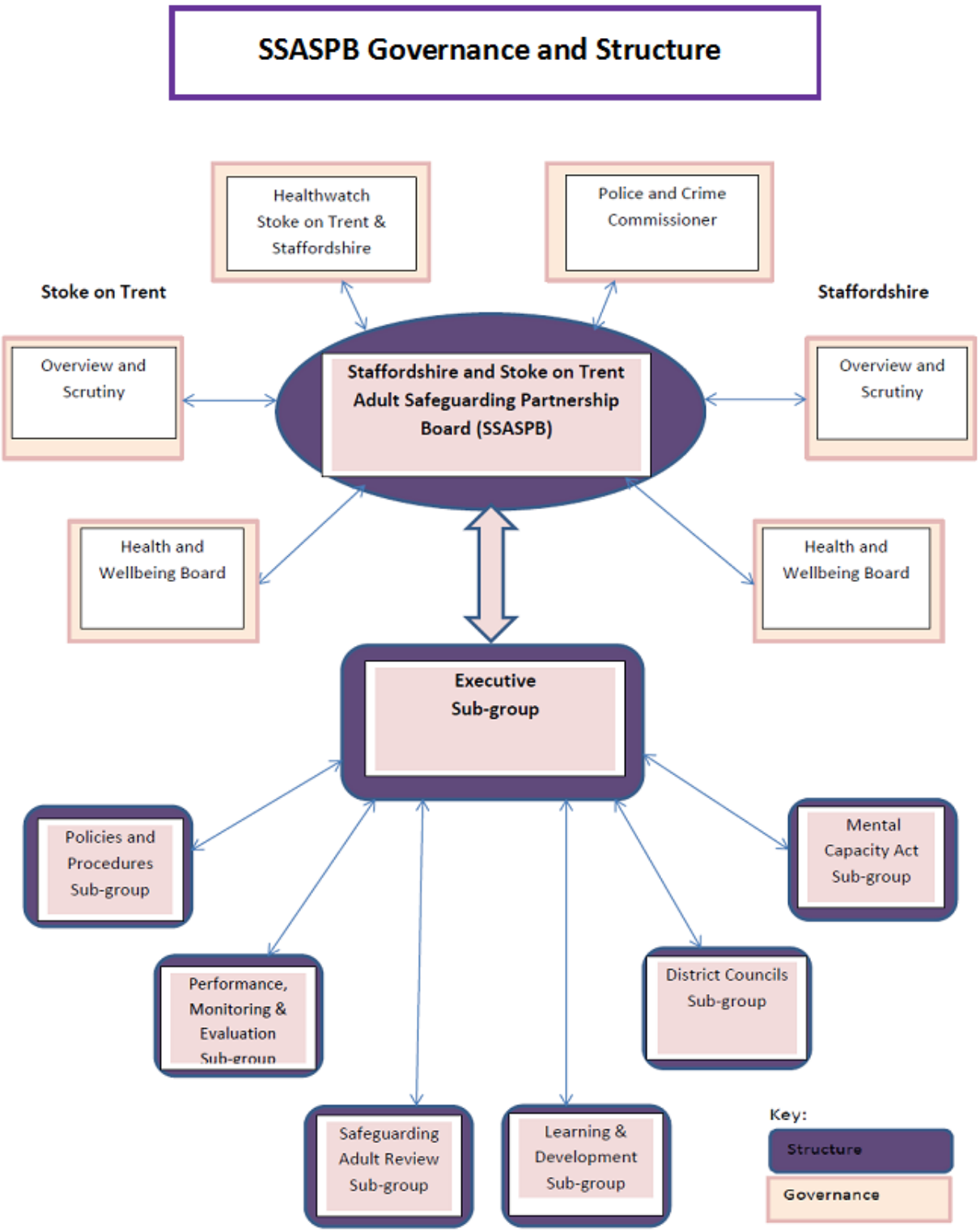
Statutory Partners as of 31st March 2017

- 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.