Staffordshire and Stoke-on-Trent
Adult Safeguarding Partnership Board

**Abuse must stop**

# SSASPB Annual report 2018-2019

NHS

City of Stoke-on-Trent

Staffordshire County Council

Staffordshire Police

## 1. CONTENTS



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

**Adult living in Stoke-on-Trent – Telephone: 0800 561 0015**

**Adult living in Staffordshire – Telephone: 0345 604 2719**

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

Front cover includes photographs of Staffordshire and Stoke-on-Trent, from top right to bottom left: Stafford Castle, Tamworth Castle, Lichfield Cathedral, Stoke-on-Trent Potteries, Mow Cop Castle.

## 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 (pages 20-23) 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, which is a fundamental right of every person.

As the Independent Chair my role is to provide leadership and constructive challenge to ensure that Board members work effectively together and make a positive difference to adult safeguarding. The Board collectively recognises that it is vitally important that our safeguarding adults services are as good as they can be to meet the needs of some very vulnerable adults who need support to help keep them safe from harm. It is also important that those providing services always recognise that each person's needs are different and respond accordingly.

As the Board has matured, the openness and willingness to both challenge and be challenged, to provide assurances as to the effectiveness or services or where improvements are required has developed and that culture is vital if we are to remain effective in meeting our statutory responsibilities. The changing demographics locally and nationally and the continued budgetary pressures on all agencies that have been widely publicised make joint working all the more important. In Staffordshire and Stoke-on-Trent there is evidence that collectively we have created the right environment for that work to take place and have strong levels of commitment from partners to make it happen.

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 and consistently demonstrate a strong commitment to do that.

I am again particularly grateful to all who chair the Board sub-groups as well as the Board Manager Helen Jones and the Board Administrator Rosie Simpson who work so hard behind the scenes to ensure that our business programme works efficiently.

I look forward to building on the work and achievements of the Board next year.

John Wood QPM

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

The Care Act 2014 provides the statutory requirements for adult safeguarding. It places a duty on each Local Authority to establish a Safeguarding 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 (SARs) 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 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 41.

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 42.

**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, page 43. The Board has taken account of the Statutory Guidance in determining the following vision.

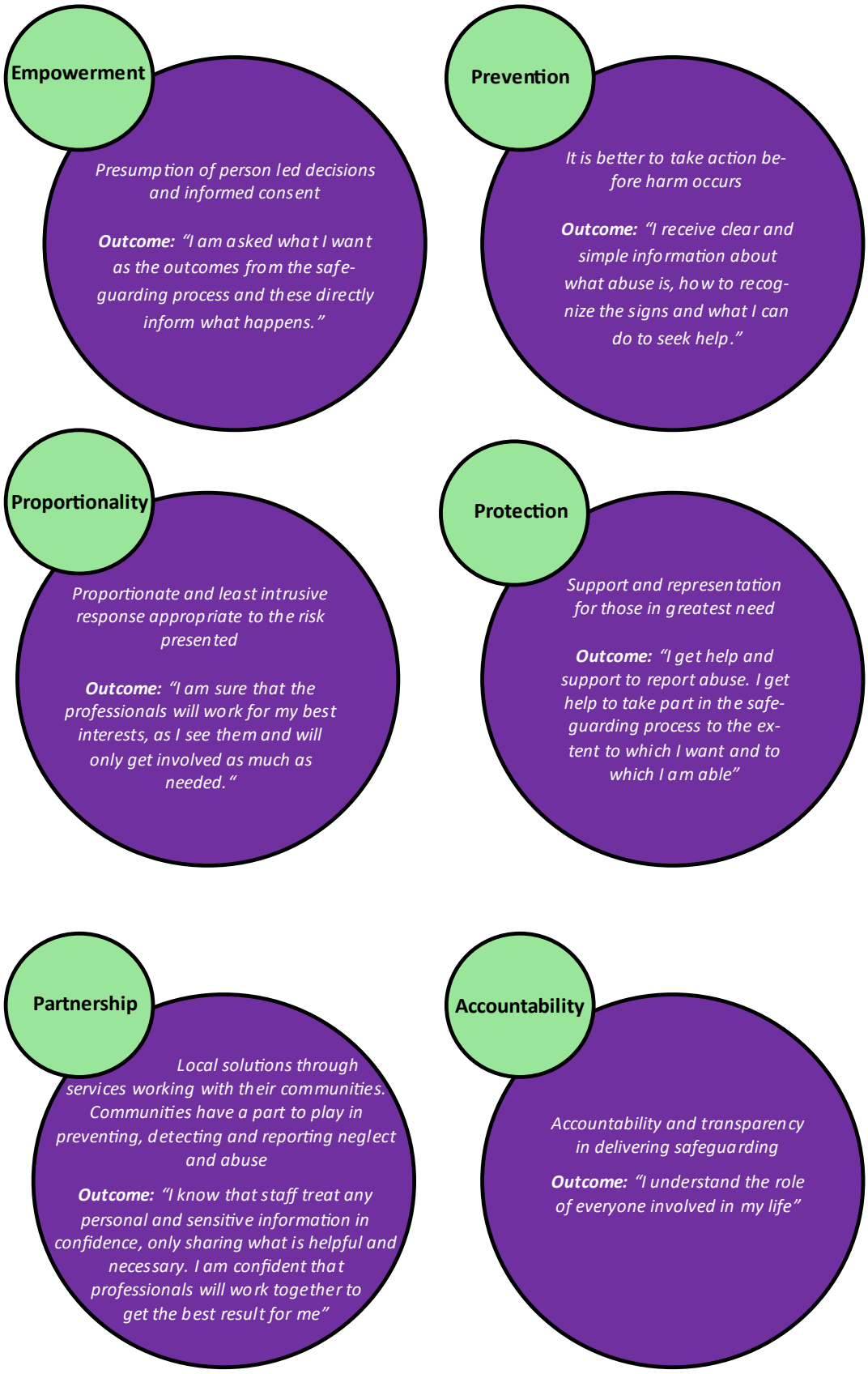
**Vision for Safeguarding in Staffordshire and Stoke-on-Trent**

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

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

## 4. SAFEGUARDING PRINCIPLES

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



## 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; Designated Nurse 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 are undertaken and that the Strategic Priorities of the Board are delivered. The Executive membership is made up of the Chairs of the sub-groups, Officers to the Board, the Board Manager and the Board Independent Chair.

**During 2018/19 the sub-group has:**

- Monitored the progress against the three Strategic Priorities (Leadership in the Independent Care Sector, Financial and Material Abuse and Engagement)
- Monitored the activity towards mitigation of risk using the SSASPB Risk Register
- Managed the membership of the Board and managed the Board membership process
- Managed and monitored the SSASPB budget
- Driven the review of the Strategic Plan which was discussed in detail at the SSASPB Development Day held on 18th May 2018 and consequently updated
- Delivered the structural changes that were proposed at the Development Day i.e. concluding the Mental Capacity Act sub-group, the Learning and Development sub-Group and the Policies and Procedures sub-group. Relevant activities have been merged with other work. Also, created the Prevention and Engagement sub-group and Practitioner forum
- Considered a suggestion to join with the Local Safeguarding Children Board and become a family Board. This was discussed at length and the result was that the Board would remain as it is for now. Further discussions could take place during 2019/20 once the new Childrens Board arrangements are embedded if requested
- Received updates and challenged both Local Authorities regarding Large Scale Enquiries (LSEs) and Deprivation of Liberty Safeguards (DoLS) authorisation backlogs
- Approved final drafts of SSASPB documents
- Reviewed the membership of the Executive sub-group and amended the Constitution to reflect this
- Overseen the introduction of the General Data Protection Regulations and how it has impacted upon the work of the Board and its sub-groups
- Supported the review of the performance of the Independent Chair
- Overseen a piece of work designed to improve the potential for successful Police prosecutions through improved evidence gathering processes
- Contributed to a National Review of the engagement of Prisons with Safeguarding Adult boards
- Considered the requirements of the NHS Intercollegiate document

- Considered the proposal by the District and Borough Council sub-group to change how they engage with strategic fora (Including the SSASPB)
- Driven the improvement plan that followed the Development Day held in May 2018
- Researched and planned the agenda for the Development Day held in June 2019
- Consulted upon and proposed that the SSASPB hosts a Safeguarding Conference in November 2019 and agreed speakers and content designed to enhance the skills of practitioners

## Safeguarding Adult Reviews sub-group

Chairs: Detective Superintendent Jennie Mattinson April 2018 to January 2019; Detective Superintendent Simon Brownsword January 2019 to present (Staffordshire Police)

The Safeguarding Adult Reviews (SAR) sub-group has responsibility for ensuring that the SAR protocol is revised at least annually and that any SAR referrals comply with the process. Since the conclusion of the Learning and Development sub-group it has also taken responsibility for identifying and cascading the lessons learnt from any reviews (SARs or Multi-Agency Learning Reviews or MALRs).

**Safeguarding Adult Review referrals:**

During 2018/19 there were 3 referrals for consideration of a Safeguarding Adult Review.

**Case 1:** This case was referred in early August 2018. It involved a man in his early 60s with Down's Syndrome who was placed in a nursing home for respite in October 2016 whilst there was an assessment of his elderly mother's care and support needs. Three weeks after placement he was found to have a fractured femur which was believed to be the result of an unwitnessed fall in the home. Sadly, he passed away in hospital in mid-December 2016. The circumstances had not initially been brought to the attention of the SAR sub-group, but it subsequently became aware following the inquest where the Coroner had raised concerns about the care provided. The Coroner had issued two Prevent Future Deaths notices and the scoping panel determined that, after considering the responses to these notices, the learning to be gained had been identified through this process. It was agreed that no further review was necessary.

**Case 2:** This case was referred in early August 2018 and involved a 29-year-old woman (R) with a mild learning disability. Her mother had formed a relationship with a sex offender (who had been convicted of sexually abusing R as a child) and there was concern about the risk posed to R. It was agreed by the SAR sub-group that the Section 42[i] enquiry had safeguarded the woman by supporting her to move into independent accommodation and that the criteria for a statutory SAR were not met.

The consideration of both cases above has led to the SAR sub-group considering how to raise awareness of the SSASPB SAR protocol so that appropriate cases are forwarded for consideration. The SAR protocol and lessons learned from SARs and MALRs are available on the SSASPB website www.SSASPB.org.uk

**Case 3:** This case was referred in March 2019 and a scoping panel meeting was held on the 5th June 2019. Further information will be provided in the 2019/20 Annual Report.

## Safeguarding Adult Reviews (SARs): Concluded in 2018/19

**Safeguarding Adult Review conducted under Section 44(1) Care Act 2014**

'John' was a 66-year-old male at the time of his death in 2016. He had a learning disability and a long diagnosed mental health condition together with other medical conditions which included difficulties with swallowing food. He was placed by one local authority into a care home situated in a neighbouring local authority where he lived for many years. John's health deteriorated, and he was observed to start unusual eating habits, including taking and eating frozen food during the night.

A Section 42 (Care Act 2014) enquiry was commenced in autumn 2015 in response to concerns about the risks of choking. A Care Plan was agreed. At a multi-disciplinary team meeting held in March 2016 it was agreed that he required a 'waking' night staff rather than the current 'sleep in' arrangements to monitor his nocturnal activity due to the heightened concerns of him taking food.

Before the staffing arrangements were put into place John took food which was not fork mashable from the kitchen during the night and was found deceased the following morning by care home staff. A post mortem examination recorded the cause of death as 'choking' with a secondary cause of cerebral vascular disease

**Lessons Learnt:**

- There was poor verbal and written communication. Better record keeping would have improved everyone's knowledge about John's care and support needs. The Care Home staff were in the best position to monitor John's well-being and information sharing with others engaged in meeting his needs could have been improved.
- There was a lack of a holistic and coordinated approach to the complex needs of adults with care and support needs. The care home staff could have co-ordinated activity.
- There is a disconnect between the information from quality inspections of care homes, individual safeguarding enquiries and wellbeing assessments meaning that all information needed to address the circumstances of adults with care and support needs is not available and not addressed.
- Confusion about roles and responsibilities undermined care planning and safeguarding planning. Where there are cross boundary matters it would be beneficial to clarify roles and responsibilities early on in any enquiry.
- The Lack of clarity regarding who should carry out a mental capacity assessment with John regarding food choices and actions left him at risk.

The full report can be found on the SSASPB website here.

The SSASPB has also undertaken two Multi-Agency Learning Reviews which have been concluded within the 2018/19 reporting period.

**Multi-Agency Learning Review 1**

In 2017 the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) received a Safeguarding Adult Review referral relating to 'David' aged 50 years who was a resident of Stoke-on-Trent who died with self-neglect contributing to his death. He had lived with his mother, but after her death he

moved from the home address. The loss of his mother had a significant emotional impact upon David and he became very lonely.

David appears to have been unable or unwilling to care for himself. He had a lengthy history of excessive alcohol use. Several agencies were involved in supporting him at home; his personal hygiene was extremely poor and his home was unclean most of the time. He had several mental health assessments. Agencies were involved in trying to support him to reduce and eventually stop his alcohol use however he declined offers of inpatient detoxification interventions.

Adult Social Care (Stoke-on-Trent) maintained appointeeship for David in an attempt to reduce his access to alcohol, they also arranged for him to receive care at home. This was initially two calls per day, but this changed to one longer call to support him more effectively with his personal care.

West Midlands Ambulance Service was repeatedly called by David, sometimes daily, and regular, inappropriate and unnecessary calls made to Staffordshire Police. It is believed that this was mainly because of boredom and loneliness. David's presentation caused unpopularity in his community as he was often soiled and unclean.

At the inquest the Coroner recorded that death was because of bronchopneumonia, chronic obstructive pulmonary disease, skin ulceration and chronic alcoholism. Whilst there were no concerns about the provision of care offered and sometimes agreed to by David, the SSASPB decided to conduct a multi-agency learning review to better understand the links between substance misuse, mental ill-health and self-neglect as many professionals were left wondering what they could have done to improve David's willingness to engage with them.

The review highlighted areas of good practice and those where improvements could be made.

**Lessons learned:**

**Areas of good practice:**

- GP was excellent at sharing their concerns with other agencies including ASC and WMAS
- Housing allowed David to remain in the home he shared with his mother over and above any usual timescale as the house met under-occupancy scheme.
- David's situation was referred to the Vulnerability Hubs for information sharing
- Excellent support provided over the phone at 2am by the Mental Health Access Team.

**Areas for improvement:**

- Professionals should not make assumptions that alcohol misuse is a lifestyle choice but should explore underlying issues recognising that it could be triggered by more complex issues
- Professionals should explore how to support adults with extremely poor self-hygiene to access local facilities and community groups
- Full documentation on case files is essential, allows others to really understand why decisions were made and trends in well-being.

**Multi-Agency Learning Review 2:**

**Stoke-on-Trent: Closure of a Nursing unit of a care home**

In August 2017 there was serious professional concern about the nursing unit of a Care Home in Stoke-on-Trent. This led to the regulator, the Care Quality Commission (CQC,) arranging an urgent inspection which in turn led them to requiring the immediate closure of the nursing unit of the home. A combination of health and social care agencies worked with the owners and staff in the practical arrangements to achieve this. Nursing and social care staff were allocated to arrange urgent assessments of all residents while other staff were involved with informing relatives and staff at the home. The third element was identifying alternative and available placements that would meet the needs of each individual resident. The tasks were completed within less than a week. However, there were concerns from those involved that although the outcomes were largely positive the process adopted was confusing and at times chaotic. There was a view that, despite substantial goodwill and energy from staff from all agencies, the result was in part fortunate and there was little confidence that in a similar future event such a positive outcome could be guaranteed.

The Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board decided to commission an independently led Multi-Agency Learning Review from which to identify lessons to be learned and to improve future processes and practice.

**Areas of good practice:**

- Despite the at times chaotic response to a challenging situation there was excellent collaborative working by all involved agencies, including working with partners across geographical boundaries.
- The willingness of the care home owners to participate in the Multi-Agency Learning Review
- Acknowledgement by all that there are areas for improvement and a willingness to work together to achieve this for the benefit of future similar situations

**Areas for improvement:**

- The SSASPB partners are to consider how WMAS data about frequency of incidents at a care or a nursing home could be used to prevent incidents of abuse and neglect
- To seek assurance that Commissioners of care have appropriate mechanisms to share concerns about nursing and care homes that is informed by, and in turn informs, front line staff
- The local partnership of the Council, NHS agencies and the CQC should have an agreed written process to support the closure of homes at short notice and that staff are aware of this. The policies should reflect national good practice
- The guidance is to include how the Police may capture evidence with which to consider any potential criminal justice process.
- The local partnership should consider testing the procedures, for example by using simulated exercises, to further identify improvements.

**Other SAR sub-group activity -** In addition to the management of SAR and MALR processes the sub-group has:

- Worked closely with the Learning and Development sub-group in preparation for the handover of responsibilities to produce and cascade lessons learned from any reviews
- Used the Board Managers National Network to consider good practice developed by other SABs

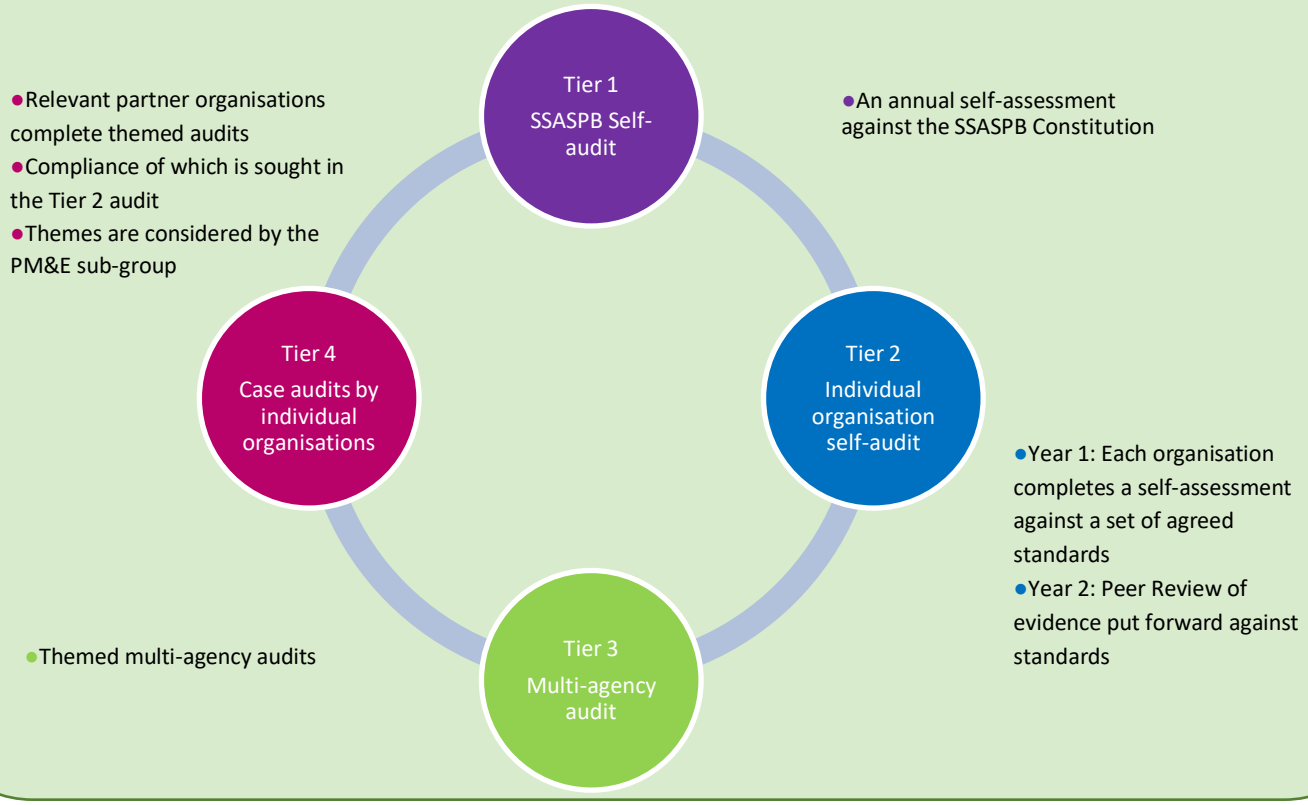
- Reviewed the SAR protocol to ensure continuous improvement
- Contributed to the West Midlands Region SAR Repository to share learning whilst the National SAR library is being developed
- Worked with Community Safety Partnerships managing current Domestic Homicide Reviews (where they involve adults with care and support needs)
- Considered a request made by the Stoke-on-Trent Community Safety Partnership to undertake a review under Section 44(4) Care Act 2014 – 'power to review' (the sub-group determined that there was no significant learning for partners and a review didn't take place)
- Used the above Domestic Homicide Review case to raise awareness that adults with care and support needs may be intentionally hidden from partner agencies and therefore inhibiting their ability to provide care and support
- Considered the impact of the General Data Protection Regulations (GDPR), May 2018, on information sharing and updated the SAR protocol
- Updated the items owned by the SAR sub-group on the SSASPB risk register
- Produced 3 lessons learned bulletins which are published on the SSASPB website
- Developed a letter to provide information to families who become involved in SARs
- Initiated a review of how agencies gather evidence and share information to support criminal proceedings to enable the best possible case to be presented to the Crown Prosecution Service (CPS)
- The Board Manager has represented the SAR sub-group at the newly formed Regional SAR group.

## Performance, Monitoring and Evaluation sub-group

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

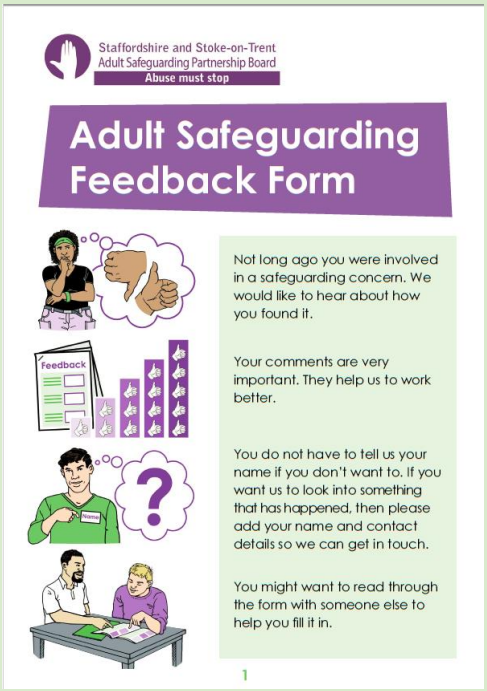
**The SSASPB 4-tiered audit framework:**

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



**The sub-group has:**

- Reviewed the SSASPB performance report and the various contributions from connected partners. More detail can be found on page 17 in the Board Development section
- Agreed the submission of the Performance section of the 2018/19 Annual Report
- Reinforced the need for detailed commentary from relevant partners to explain the performance data contained in the Annual Report
- Refreshed the Tier 1 audit (Compliance with the SSASPB Constitution)
- Determined which partners should be asked to complete the next Tier 2 audit (Organisational self-audit)
- Conducted the Tier 2 audit during March and April 2018 (findings to be included in the 2019/20 Annual Report)
- Received 27 responses to the non-statutory request to complete the Tier 2 audit – an excellent response
- Considered the impact of GDPR on Tier 3 Multi-agency Case File audits (MACFA)
- Conducted a Tier 3 Multi-agency Case File Audit without sharing personal data to assess how useful this would be (in consideration of GDPR). It was found to be of very little benefit.
- Agreed that the themes for Tier 3 audits should be informed by the annual data capture, SARs or the Practitioners Forum
- Received themes and trends from four single agency (Tier 4) audits by Health partners (University Hospitals of North Midlands (UHNM), University Hospital of Derby and Burton (UHDB), North Staffordshire Combined Healthcare Trust (NSCHT), Midlands Partnership Foundation Trust (MPFT).
- Received and responded to the analysis on the four Tier 4 audits
- Confirmed the assurance elements of Learning and & Development sub-group which will come within the remit of the Audit and Assurance sub-group
- Reviewed the list of partners from whom the Board seeks assurance about the compliance rate and quality of training provided
- Sought the support of the National SAB Managers network to identify a way of conducting MACFAs whilst remaining compliant with GDPR. One Board then shared their compliant gateway which has been adopted by the SSASPB
- Considered the case of R. v Kurtz heard in Court in December 2018 which highlights the importance of the Crown Prosecution Service (CPS) preferring the most suitable charge. In this case the appeal of conviction was upheld – we compared this result with the successful prosecution in a very similar Stoke-on-Trent case (the abuser was charged with manslaughter as opposed to wilful neglect as seen in the Kurtz case). The study of this case also led to a better understanding of the importance of good liaison with Community Safety Teams with particular reference to DHR and SAR discussions
- Reviewed the Section 42 post-enquiry questionnaire pilot. Unfortunately, despite good partner buy-in there was a very poor response with only two Stoke-on-Trent questionnaires returned. It was agreed not to pursue this methodology of feedback.


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

Adult Safeguarding Feedback Form

Not long ago you were involved in a safeguarding concern. We would like to hear about how you found it.

Your comments are very important. They help us to work better.

You do not have to tell us your name if you don't want to. If you want us to look into something that has happened, then please add your name and contact details so we can get in touch.

You might want to read through the form with someone else to help you fill it in.

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## Policies and Procedures sub-group

**Chair: Ruth Martin, Safeguarding Team Manager, Staffordshire County Council**

**The sub-group has:**

- Considered the learning from a 'Person Story' about a young woman with a learning disability and who became pregnant. Staffordshire County Council, North Staffordshire Combined Heath Trust and University Hospitals of North Midlands all worked together to support the young woman to ensure that she was able to be responsible for bringing up her child. It had been thought initially that the child may have been taken from her under legislation using the Children Act (1989). The case study was also presented to the October 2018 SSASPB meeting
- Continued to consider how SSASPB and prisons in Staffordshire can better engage with reference to their responsibilities for adult safeguarding
- Refreshed Section 9 of the Section 42 procedures (Large Scale Enquiries and Enhanced Provider Monitoring) on the basis of feedback
- Engaged with the West Midlands Regional Safeguarding Network and contributed to the Editorial Group which produces Regional Procedures
- Adopted the West Midlands Self-Neglect principles (with localised procedures)
- Adopted the West Midlands Persons in a Position of Trust Policy
- Reviewed the SSASPB Policy schedule with the outcome that products remain current in a prioritised order
- Considered the impact of GDPR on information sharing and revised the information sharing guidance to take account of changes
- Reviewed the risk register
- In April 2019, in response to the findings of the Development Day held on 18th May 2018, the formal sub-group was closed. Instead, an email group of former members has been retained to communicate on relevant matters. Task to Finish groups will be formed as and when the need arises.

## Learning and Development sub-group

**Chairs: Angela Jervis, (Head of Safeguarding Children) Staffordshire and Stoke-on-Trent Partnership Trust, (1st April 2018 to 4th October 2018) and Claire Histead, Adult Safeguarding Lead, Midlands Partnership Foundation Trust, (4th October 2018 to December 2018)**

**The sub-group has:**

- Identified the need and decided to develop a lessons learned poster/flyer for each SAR or MALR. These are to be found at the end of the Safeguarding Adult Review section.
- Reviewed the training presentations for the Mental Capacity Act and Adult Safeguarding which are freely available on the SSASPB website
- Planned for and hosted a Multi-agency event to share learning from the Safeguarding Adult Reviews, Multi-Agency Learning Reviews and Domestic Homicide Reviews conducted in Staffordshire and Stoke-on-Trent in the past 2 years. There were also presentations on Prevent, Domestic Abuse and Hoarding delivered by Staffordshire Police, ARCH (domestic abuse service) and Staffordshire Fire and Rescue Service.

- Received detailed feedback (produced by Board partner Brighter Futures) from the 87 attendees at the event.
- Used this feedback to deliver 2 further events later in the year to a total of 74 partner agency staff.
- Sought assurance on the training delivered by statutory and provider partners through quarterly training returns
- In December 2018, in response to the findings of the Development Day held on 18th May 2018, the sub-group was closed with relevant areas from the business plan being allocated to other sub-groups. An email group of former members has been retained to communicate on relevant matters. Task to Finish groups will be formed as and when the need arises

## Mental Capacity Act sub-group

**Chair: Karen Capewell, Strategic Manager Safeguarding, Quality and Commissioning Adult Social Care, Health Integration and Wellbeing, Stoke-on-Trent City Council**

**The sub-group has:**

- Developed a practitioner's guide (3 separate documents) to the Mental Capacity Act which has been placed on the SSASPB website. This was done in response to a recurring theme from SARs and MALRs where frontline staff appeared to be unsure about the application of the Mental Capacity Act (2005)
- Supported Staffordshire Police with their introduction of the nationally acclaimed Herbert Protocol which assists them to more quickly locate adults with dementia who go missing from care homes
- Reflected on recent case law circulated via the Mental Capacity Act Case Law Bulletin
- Reviewed the DoLS reports which are submitted to the Board

- Monitored the progress of the replacement DoLS legislation and considered the various implications
- Considered the risk to the Board if it doesn't have sight of DoLS performance and updated the SSASPB risk register
- In December 2018, in response to the findings of the Development Day held on 18th May 2018, the sub-group was closed. Instead, an email group of former members has been retained to communicate on relevant matters. Task to Finish groups may be formed as and when the need arises

## District/Borough Council sub-group

**Chair: Michael Hovers, Communities, Open Spaces & Facilities Manager, East Staffordshire District Council**

This is a joint sub-group of the Staffordshire Safeguarding Children Board (SSCB) and the SSASPB. Although a Unitary Authority, and therefore not having District or Borough Councils, Stoke-on-Trent City Council was represented through a Housing Manager. This proved beneficial to both the sub-group and Stoke-on-Trent City Council and was brought about following attendance at an Overview and Scrutiny meeting at Stoke-on-Trent City Council where a member felt that Stoke-on-Trent ought to be in attendance. The Chair of the sub-group sits on both SSASPB and SSCB Executive sub-groups.

- Considered the revised Strategic Priorities for both the SSCB and SSASPB so that supporting work plans may be devised
- Considered how the priorities of the Boroughs/Districts and the Boards could better align
- Considered how best practice could be shared within this forum
- Reviewed the agenda to include presentations of relevant topics for example Modern Slavery, Domestic Abuse, Child Sexual Exploitation, Mental Capacity Act etc
- Considered Borough/District council responses to the recent Modern Slavery briefing
- Considered the new Domestic Abuse provision by New Era
- Received a presentation from Stafford and Rural Housing, following publication of their safeguarding Annual Report. This was really useful and generated much debate
- Added a representative from Stoke-on-Trent City Council Housing team as it was believed that there were benefits from their attendance
- Reviewed and approved the Parish Council generic safeguarding policy
- Considered a request from Boroughs/Districts to have one safeguarding training package covering adults and children – to be explored further
- Agreed to hold further events attended by Ruth Martin and Helen Jones to help nominated District and Borough staff better understand adult safeguarding and MCA implications.
- Received an update on the SSASPB SARs/MALRs and Community Safety Domestic Homicide Reviews
- Sought and received agreement for all District/Borough Councils to complete the SSASPB Tier 2 (Individual Organisation) audit.
- All Districts and Boroughs completed and returned the Tier 2 audit.
- Received an overview of the work of New Era, the countywide Domestic Abuse service provider.
- Considered the proposal put forward by this sub-group with regards to future engagement with multi-agency fora.
- This sub-group was closed in June 2019. An alternative means of engagement with the work of the Board is to be proposed. The emailing list will be maintained, and members will continue to be consulted upon and complete Tier 2 audits through which to provide assurance to the Board.

## 6. BOARD DEVELOPMENT AND IMPROVEMENT ACTIVITY

**Development day 18th May 2018**

The purpose of the day was to examine and confirm the aspirations of the Board and review its Strategic Plan and Strategic Priorities. There was agreement for the Board to work towards outstanding performance and to be consistently good at everything it does.

The Independent Chair welcomes challenge and some of the partners in attendance raised concerns about the amount of time committed by their staff in support of the work of the Board. In particular there was comment about the number of sub-groups in the Board's structure with specific reference to the frequency of meetings and the travelling time taken in order to attend. As a joint Local Authority Board, meetings are shared mainly between the locations in Stoke-on-Trent and Stafford.

At a subsequent Executive sub-group it was considered how to respond to these concerns resulting in a reduction in the number of sub-groups from 7 to 5. (This includes the District Council sub-group which ceased to exist in its current format in May 2019).

The new structure can be seen on page 42 of this annual report.

**Changes:**

The **Policies and Procedures sub-group** no longer meets on a routine basis. Board policies/procedures/guidance are reviewed through electronic communications. A task to finish group will be formed for more complex matters.

The **Performance, Monitoring and Evaluation** sub-group refocused its work and became the Audit and Assurance sub-group.

The Audit and Assurance sub-group reviewed how the Board seeks assurance through data reports. Consequently, from April 2019, rather than receiving quarterly performance reports there is now an annual data capture which is used to determine areas which need closer scrutiny and to request more detailed information or audit activity.

The work of the **Learning and Development** sub-group was shared between others:

- the Safeguarding Adult Reviews (SARs) sub-group took on responsibility for sharing lesson learned from SARs and Multi-Agency Learning Reviews (MALRs)
- the newly named Audit and Assurance sub-group now seeks assurance on the training provided by partner agencies in line with the Board's Care Act commitments
- the Executive sub-group has responsibility for overseeing the arrangements for key SSASPB events

The **Mental Capacity Act sub-group** ceased to exist once the Mental Capacity Guidance documents were produced and published. This is another group which remains virtually so that relevant matters can be forwarded to the previous membership for attention.

A new sub-group was formed: **Prevention and Engagement,** to reflect the commitment to the prevention of adult abuse and to provide support to the Engagement Strategic Priority of the Board.

This year the Board considered the impact of the General Data Protection Regulations (GDPR), which commenced on 25.05.18, on the sharing of data for safeguarding audit purposes. It was agreed that there is a legitimate reason to share data for the necessary activity of safeguarding service improvement through

the identification of good practice and areas for improvement. The information is shared confidentially and with only those who are engaged in the audit.

In the Spring of 2020, the Tier 2 audit (page 12) submissions from 27 connected partners will be revisited, and more detailed work undertaken on selected standards to ensure that there is a consistent approach to evidence submission by those engaged in the process.

In taking on responsibility for the training assurance from the Learning and Development sub-group, the Audit and Assurance sub-group proposed that from April 2019 all agencies participating in the Tier 2 process will also forward information to support training assurance requests.

## 7. PERFORMANCE AGAINST 2018/21 STRATEGIC PRIORITIES

In the reporting period (April 2018 to 31 March 2019) the three Strategic Priorities were:

- Engagement
- Leadership in the Independent Care sector
- Financial and Material Abuse

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: Engagement**

This year the Board reinforced its commitment to 'engagement' by forming a new sub-group 'Prevention and Engagement'. This was brought about following the SSASPB Development Day held on 18th May 2018 where Board members were invited to review the Strategic Priorities and structure of the SSASPB. The sub-group is chaired by the Statutory Service Lead and Principal Social Worker for Staffordshire County Council with the Strategic Manager Safeguarding, Quality and Commissioning Adult Social Care, Health Integration and Wellbeing for Stoke-on-Trent City Council as vice chair.

Engagement is a broad term and for the purposes of the work of the Board this means engagement with several key groups of people:

- Adults with care and support needs
- Their carers and advocates
- People who work or volunteer with them
- Members of the public

**What we have done to engage with the key groups:**

For the past two years the Board Manager has been visiting the Carers Hubs meeting in several locations in the City and County. This has enabled contact with friends and family of adults who have care and support needs and was invaluable when the Board was reviewing its Strategic Priorities. As a direct result of listening to the concerns of the carers the Board decided to focus on Financial and Material Abuse as a new Strategic Priority for 2019/22, further detail about this Strategic Priority can be found on page 27 of this Annual Report.

During October 2018 the Board Manager visited the North Staffordshire branch of the British Sight Loss Association held at Hanley Library to present on Adult Safeguarding and how to recognise and report abuse and neglect; together with an overview of lessons learned from Safeguarding Adult Review and Multi-Agency Learning Reviews. At the end of the discussion a woman with significant sight loss approached the Board

Manager and asked for help with making her less susceptible to financial abuse as she was receiving many 'cold callers' via the telephone. With her permission her details were passed to Staffordshire County Council Trading Standards department who helped her to adjust her telephone system and gave good advice. The woman was extremely grateful and thanked all concerned. A further visit to this group has been arranged for Autumn 2019.

The Performance, Monitoring and Evaluation sub-group consulted upon, developed and piloted a questionnaire with which to gain the views and experiences of those adults engaged in a Section 42 Enquiry. These were produced in easy-read format and handed out by Social Workers at the conclusion of the enquiry. Adults and/or their carers were invited to complete the questionnaire when it suited them and return it by post in a pre-paid envelope. Unfortunately, the return rate was so low that when the pilot concluded the process was discontinued. This methodology of seeking feedback has also been seen to have limited success in other areas of the Country.

The Board has been responsive to requests made by those who most need support to deliver improved practice in adult safeguarding. Through the work of the sub-groups, and as part of the Strategic Priorities work plans, the Board has done a significant amount of work this year to support those who work or volunteer with adults who have care and support needs. The need to deliver this work came from those who identified the benefits from having practical guidance. Two key pieces of work were guidance on:

- Supported Decision Making and Good Practice in Assessing Mental Capacity
- Financial and Material Abuse

Both are available on the SSASPB website under the SSASPB Policy, process and Guidance section which has been accessed on 818 occasions during the past year. The Mental Capacity guidance consists of 3 separate documents including an information leaflet which was printed and distributed to partner organisations and at multi-agency meetings/events.

The Board has refreshed its adult safeguarding awareness material which is also available to view and print on the website. Hard copies of wallet cards, posters and leaflets are available upon request to SSASPB.admin@staffordshire.gov.uk and all products cover information relevant to both Stoke-on-Trent and Staffordshire.

The SSASPB website was updated and contains much information about adult safeguarding in our area and the lessons we have learned from Safeguarding Adult Reviews and Multi-Agency Learning Reviews.

The following two training packages that are available on the SSASPB website are reviewed annually:

- Adult Safeguarding Awareness (ASA) - Level 1, and
- Mental Capacity / Deprivation of Liberty Safeguards (DoLS) Awareness – Level 1.

They are available without cost to anyone who wishes to use them.

A request was made via the District Council sub-group for the Adult Safeguarding Team Leader (Staffordshire County Council) and the SSASPB Manager to visit the District and Borough Councils to discuss examples of adult safeguarding concerns with key staff who come into contact with adults who have care and support needs in their communities. Seven District and Borough Councils were represented at 4 events at which they were able to openly discuss specific examples of scenarios with the Team Leader and Board Manager. They were attended by staff from teams including Community Safety, Environmental Health, Housing, Taxi Licensing, Late Night Refreshment Licensing and Enquiry Offices. This proved to be an excellent forum at which to clarify any misunderstandings of what adult safeguarding is and isn't and how to approach

situations which don't meet Section 42 criteria - self-neglect and hoarding being the most frequently put forward for discussion.

One of the Board's responsibilities from the Care Act 2014 is to learn lessons from Safeguarding Adult Reviews (also includes Multi-Agency Learning Reviews or MALRs). The Learning and Development sub-group led on the production and arrangements for a total of 7 half-day learning events which started in January 2019 and finished in August 2019. A total of 240 front line staff and supervisors from many agencies in Stoke-on-Trent and Staffordshire attended these events and received excellent evaluations. The events centred on the Multi-Agency Learning Review into the care and support provided to a 50-year-old Stoke-on-Trent man who self-neglected. More information on the circumstances and what the Multi-Agency Learning Review identified can be found on page 9 of this Annual Report.

The Board commissioned VOICES (Voices of Independence, Change and Empowerment in Stoke-on-Trent) and Expert Citizens to support the events. They gave a presentation on their work with those who are rough sleeping and an Expert Citizen openly talked about his experiences as someone who self-neglected and lived on the streets of Stoke-on-Trent. This was particularly impactive and was hugely appreciated by those who attended. Owing to the prevalence of queries about self-neglect and hoarding at the District Council events Staffordshire Fire and Rescue Service did a presentation on Fire Prevention and hoarding to further support the self-neglect theme. Finally, the Adult Safeguarding Team Leader from Staffordshire County Council, supported by the Adult Safeguarding Manager at Stoke-on-Trent City Council, presented on self-neglect and adult safeguarding.

Another series of learning and engagement events was funded by the local Clinical Commissioning Groups and aimed at GP Practice Managers. These were held in different locations in the City and County and a total of 48 attended. The presentations covered Domestic Abuse, Adult Safeguarding Awareness and the requirements of the NHSE Intercollegiate Document (Adult Safeguarding: Roles and Competencies for Health Care staff).

In May 2018, 87 front line staff and supervisors from many partner agencies attended a full day learning and engagement event. Presentations had a focus on adults with care and support needs in the areas of Hoarding, Domestic Abuse and the Prevent programme. There was also a presentation on Learning Lessons from Safeguarding Adult Reviews.

At every opportunity the lessons we learn from reviews are covered at Board events. This includes learning from Domestic Homicide Reviews involving adults with care and support needs.

**The following exemplify Making Safeguarding Personal and cross-partner collaboration;**

**Case Study: North Staffordshire Combined Health Trust (NSCHT)**

A staff member from the NSCHT Home Treatment Team had assessed a service user who had a physical disability. The service user was experiencing a decline in their mental health after becoming aware that a person who presented a risk to them had identified where they were living. The Police were contacted by the service user, however when the circumstances were explained there was no Police action as no crime had been committed. The staff member made an adult safeguarding referral, with the service user's consent, on the grounds that their ongoing care and support needs due to physical disability meant they were unable to protect themselves from potential abuse. This resulted in a multi-agency co-ordination of actions which were taken to safeguard the individual. This a good example of involving the service user in safeguarding plans, thinking holistically about potential risk, remaining focused on the outcomes the adult with care and support needs wants and working creatively with third sector agencies to find solutions.

**Case Study: University Hospitals North Midlands (UHNM)**

A consultant who works at the Royal Stoke Hospital, was walking outside the hospital premises and witnessed an elderly woman experiencing verbal abuse from a young male. The male was seen to pour a bottle of water over the elderly woman whilst repeatedly shouting and swearing at her. His behaviours escalated, and the elderly woman appeared very frightened and distressed. The consultant approached her to determine if she was okay and if she needed help. The woman said she would be fine and quickly left with the male but looked frightened.

The Consultant was very concerned for the woman and telephoned UHNM safeguarding team for advice. Hospital security located her using CCTV and the Safeguarding Team lead others to offer multi-agency support to her. The man who was with her was her son and the woman declined the offer of any help and support at this time saying that she was fine.

Noting that a clinic appointment had been scheduled in outpatients for the male the Safeguarding Team were able to discuss the concerns with the clinical nurse specialists about the witnessed abuse. The clinical nurse specialists advised that when the patient next attended clinic an opportunity would be created to talk alone with his mother and ask if she was okay. In addition, the information relating to the incident would also be passed onto the patient's GP for them to be aware and create the opportunity for further monitoring. The letter outlined the concerns for potential domestic abuse.

This case highlights the recognition of abuse together with a rapid response, good knowledge of who to go to for help, excellent communication and escalation. In addition, there was also evidence of effective networking between both UHNM Safeguarding Team and the specialist clinical areas and appropriate information sharing between UHNM and the GP.

**Case Study: University Hospital of Derby and Burton (UHDB)**

A 54-year-old female with a life limiting illness was being cared for in a side room in hospital. She had capacity to make small decisions at certain times of the day, but due to illness, became tired quickly and was unable to retain information, she was assessed as lacking capacity to make decisions for her care and treatment.

The female's ex-partner was observed by staff on the ward to physically assault her. He leaned on her chest with his arm, grabbed her face and forcefully made her look and listen to him. The ward contacted the Safeguarding Team for advice and support with a safety plan.

A meeting was held with the Safeguarding Team, ward staff and family members to discuss the concerns and share the safety plan that was to be implemented. The safety plan consisted of moving the patient out of the side room and into a bay to allow for better monitoring; increasing observations during visiting times and for a Deprivation of Liberty Safeguard (DoLS) to be applied for as the ex-partner had been threatening to remove her from hospital. Visiting times were also restricted for him. He was advised of the measures and why they had been put in place when he next visited. The senior ward staff were supported by the Safeguarding Team to have this difficult but necessary conversation. The Police were contacted; they attempted to speak to the patient but unfortunately, she was too ill to be interviewed.

Because of the action taken the patient was protected from further abuse and the ex-partner acknowledged that his behaviour was wrong, taking responsibility for his actions. The Safeguarding Team then supported the ward staff with a review of the situation to identify good practice and learning.

**Staffordshire Police: Case Study 1**

'J' was a frequent caller to the police. He would often call 999 requesting whisky and reporting that his fire had been left on by carers. 'J' was diagnosed with dementia and already had a social worker working with him. His local Police Community Support Officer (PCSO) visited 'J' frequently. She identified that the domiciliary care providers could improve the standard of their care for him as their lack of support was having a negative impact on 'J's' emotional wellbeing. The PCSO also identified that there was a lack of food being purchased for him and that he would only leave his bed to use his commode. With frequent communication between the PCSO, the mental health team and adult social care, the decision was made for a review of his care package and a best interest meeting took place. As a result of this meeting, 'J' agreed to move into a residential home whereby he receives around the clock care. This was a good outcome for 'J' who no longer felt that he had to ring the Police for help and which followed Making Safeguarding Personal and Best Interest Assessment principles. His wellbeing improved and he was able to take outside walks which he had been previously unable to do.

**Staffordshire Police: Case Study 2**

'K' was a woman who was repeatedly calling Staffordshire Police, sometimes up to 11 times per day. She had dementia and lived alone as her dog was removed from her care due to un-intentional neglect. She would phone the police daily to report the theft of her dog. Owing to her vulnerabilities, a safeguarding concern was forwarded, and 'K' was supported through the Police Early Help Project which aims to support people to keep themselves safe. 'K's' local Police Community Support Officer (PCSO) visited and while there checked her fridge which was full of out of date food. She had no support around her home or for personal care and she was extremely isolated. 'K's' neighbours were estranged from her and lacked awareness of her needs. The PCSO worked closely with 'K's' allocated Social Worker, and subsequently a care company became involved. The PCSO frequently provided 'K's' social worker with a list of calls that she would make to the police and these were used to identify when 'K' appeared to be most anxious. The care calls were then centred around these times which also ensured that 'K's' care needs would be sufficiently met.

As a result of frequent care package review meetings and communication between agencies, 'K' now receives a minimum of 9 hours of care each day, is taken out to her favourite places and has recently been to the theatre to watch her favourite stage show. 'K' has built a great rapport with the care givers and the calls to the Police have stopped completely. The PCSO organised a dementia awareness raising event for members of 'K's' immediate community so that they had a better understanding of her needs.

**Case Study: Midlands Partnership Foundation Trust (MPFT)**

'M' is a 59-year-old female who was living in conditions judged by others as unsuitable. 'M's' flat was described as unclean, cluttered and smelly. There were also reports of 'M' crying and screaming in her flat and struggling to look after her dog. Several safeguarding concerns for self-neglect had been made within a short timespan regarding the condition of the property from various sources however 'M' appeared to remain outside of the thresholds for adult safeguarding, as she appeared to have no eligible care and support needs.

'M' had a history of a mental health diagnosis however had no current or recent contact with secondary mental health services or physical health teams. 'M' had contacted her local Mental Health team and advised

the team not to accept any referrals from her housing provider as she was not struggling with her mental health. It was known that 'M' was frequently seeing her GP and able to access the community and shop for herself. There were no clear concerns that 'M' was self-neglecting.

The last referral advised that M had arranged for someone to walk her dog, however this person had taken payment but not provided the service. This final referral was raised as financial abuse. This referral raised questions about 'M's' ability to protect herself and met the threshold for further enquiries.

The enquiry was undertaken by a member of the adult safeguarding team, using relationship-based practice, 'M' agreed to allow her into her flat. The enquiry officer took account of all of the previous safeguarding concerns and discovered that 'M' had been initially allocated a ground floor flat, then given an upstairs flat. The majority of 'M's' difficulties stemmed from her inability to negotiate the stairs safely, this was the reason for rubbish backing up in the flat, the dog not going out and 'M's frustrations around her housing situation were the reason for her crying. The investigation also found that 'M' had, since childhood, been mistrustful of professionals and had an eccentric way of interacting with them.

Although the outcome of the financial abuse enquiry was 'no further action', it was a positive one as 'M' had taken appropriate steps to protect herself, there was no ongoing risk of abuse and the loss of a small sum of money was causing 'M' no issues. The investigating worker conducted an informal assessment, mindful that 'M' had declined social work involvement, and established no ongoing care and support needs other than a need for more suitable housing. There were no issues of self-neglect, 'M' was taking appropriate steps, albeit unconventional, to ensure she was clean, despite not having a washing machine. The enquiry officer ensured 'M' was receiving appropriate benefits and was accessing the correct medical interventions for her health concerns.

The enquiry officer however did work with the housing provider, addressing the concerns which ensured that 'M's' housing application was reprioritised to the highest priority. The housing providers were also informed of 'M's' strategies for managing her needs, which although unconventional, were working for 'M'. The enquiry officer was also able to reinforce that 'M's' history of interacting with people should not be perceived as someone with mental health issues, but as someone who had developed coping strategies over her lifetime and although these could be perceived as unusual to others, were not a cause of concern. As a result of the working relationship between 'M', the enquiry officer and the housing provider 'M' was to be allocated a more appropriate property as a matter of urgency. Since this intervention, there have been no further referrals from any agency raising concerns for 'M' which would suggest that this intervention through Section 42 was successful in resolving the issues leading to 'M's' difficulties. This case study exemplifies the Making Safeguarding Personal approach; demonstrating flexibility of decision making to support the adult's wishes.

**Strategic Priority: Leadership in the Independent Care Sector**

In 2015 the Board identified the lack of leadership skills in the independent care sector being a recurring trend locally in Large Scale Enquiries (LSE) and Safeguarding concerns. The priority was re-reviewed and allocated to the CCG Safeguarding Lead in August 2016 and this report sets out to evidence the achievements of the priority following the collaboration of work between health and social care to deliver on the agreed performance indicators with the recommendation to the Board to close this now as a priority.

**What we set out to do:**

- Monitor relevant CQC inspection reports and Enhanced Provider Monitoring 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 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 Large Scale Enquiries.
- Identify relevant matters for consideration of action by commissioners of services.

**The Key performance indicators were agreed as:**

- 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.

The CQC State of Care report https://www.cqc.org.uk/publications/major-report/state-cares indicates people's experience of care depends on how well local systems work together where they live. There have been improvements in regulatory ratings during the course of this priority and detailed below are some of the key factors which have impacted to deliver the objectives of the priority.

1) **Quarterly report to Safeguarding Board of Large Scale Enquiries led by both Local Authorities.**

The board agreed a standardised reporting template which is far more focused and aids the auditing of themes and trends to identify gaps in services or areas of concerns. The report focuses entirely on the services being supported through the LSE Process and provides assurance of the protection measures in place to ensure the health and welfare of the individuals in receipt of care affected.

2) **Escalation process and assurance of proportionate and timely agency responses through an annual update from Quality and Safeguarding Information Sharing Meeting (QSISM) chair to board.**

QSISM is attended by members of the Safeguarding Board and there is a clear escalation route embedded within the terms of reference. The QSISM chair presents an annual update to the safeguarding board of the themes and trends within the region supported by additional annual presentations and assurances from CQC, Health Watch and the Quality Assurance Teams from both local authorities. All agencies have reported notable improvements in services rated "Good" or "Outstanding" and continued decreases in regulatory enforcement actions.

3) **Joint working with both Local Authority and Clinical Commissioning Group Staff for Quality Assurance and shared reporting with CCG Safeguarding and Nursing Home Support Nurses working across both Safeguarding and Quality Assurance teams.**

The CCG Adult Safeguarding and Nursing Home Support Nurses are now working across two teams providing support to the Adult Safeguarding Enquiry Team and both Local Authority Quality Assurance Teams targeting the high risk services resulting in significantly improved information sharing and supported early warning identification of services requiring additional support.

4) **Inception of the Nursing Home Quality Assurance meeting within the CCG with attendance by LA with escalation to QSISM.**

The CCG has a new working group and this escalates issues into the Quality and Safeguarding Information Sharing Meeting (QSISM) and into the CCG Quality Committee. The focus of this monthly meeting is on quality improvement within the independent Care Home sector.

5) **Appointment of the named GP for Adult Safeguarding.**

The CCG secured half funding for 2 year pilot of a GP to support Adult Safeguarding who has been supporting the work with care homes in LSE and some of the significant safeguarding cases in addition to providing clinical guidance to the teams within the Adult Safeguarding Enquiry Teams of the Local Authority and the Police. There has also been additional training delivered within Primary Care to improve the early warning flagging of concerns by visiting professionals.

6) **Multi-Agency Learning Review funded by SSASPB to review urgent closure of a Nursing unit of a care home in Stoke-on-Trent.**

A Multi-Agency Learning Review was held on 3rd September 2018 to identify lessons to learn, among these was the identified need of an early alert to the Police to ensure that they are able to gather sufficient information to make prosecutions in the event of neglect reaching the criminal threshold. This work continues and there is currently work on-going to produce a defined closure policy which is aligned between Staffordshire and Stoke-on-Trent.

7) **Provider Improvement Response Team pilot housed by Staffordshire LA but covering 6 CCG geographical areas.**

A 12 month pilot has commenced to work with Care Home providers continually failing to achieve standards in addition to those in regulatory failure. The focus of this team was set up to support services continually failing to achieve regulatory standards. The team have effectively supported several services under enforcement action providing timely assurance of safety to those service users affected having a greater presence within the provision and ensuring external support systems are effectively linked.

8) **Trigger system implementation at contact centre for early identification/escalation of concerns within Staffordshire.**

A monitoring system has been set up to flag up to the Advanced Practitioners within the Staffordshire Adult Protection Investigation Team (SAPIT) when there are safeguarding concerns about a service provider outside of expected referrals. This escalation has allowed for early information gathering to determine the requirement for an Large Scale Enquiry Strategy discussion. Linked to this is the dynamic procurement systems which automatically suspends placements for providers rated inadequate by the Care Quality Commission.

9) **Twice yearly LSE thematic review and lessons learnt events to be managed by Quality Assurance Teams.**

Both local authority quality leads agreed to co-ordinate a thematic review of repeated concerns identified throughout the LSE process to ensure support services are effectively commissioned and used with engagement from the independent sector.

10) **Assurance from Disclosure and Barring Service (DBS) to board members due diligence with effective information sharing via assurance presentation to Board.**

The DBS provided a detailed update of their work within the region on 18th July 2019. They gave assurance around the operational work undertaken to monitor individuals identified through criminal and/or safeguarding route and how this is used effectively to respond to the issue of individuals moving from provision to provision.

Since the inception of the priority there has been a steady improvement across the patch of the improvement in regulatory standards and this is reflected in the reduced numbers of services subject to Large Scale Enquiries but an increase in enhanced provider monitoring which evidences the effectiveness of monitoring and early interventions being successful across Staffordshire and Stoke-on-Trent. The data below from CQC supports this improving picture.

**Data**

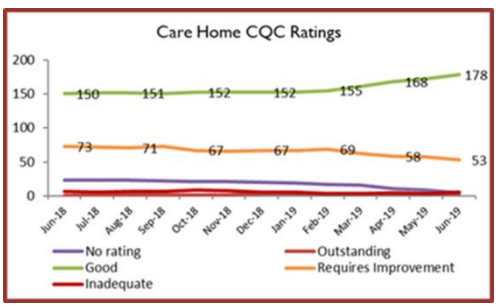
**April 2017**

| Nursing Home Area | No of Homes | No of beds | Awaiting Inspection | Outstanding | Good | Requires Improvement | Inadequate |
|---|---|---|---|---|---|---|---|
| Staffordshire | 85 | 4281 | 5 | 0 | 43 | 31 | 2 |
| Stoke-on-Trent | 19 | 1122 | 3 | 1 | 7 | 9 | 2 |
| **Totals:** | **104** | **5403** | **8** | **1** | **50** | **40** | **4** |

**April 2019**

| Nursing Home Area | No of Homes | No of beds | Awaiting Inspection | Outstanding | Good | Requires Improvement | Inadequate |
|---|---|---|---|---|---|---|---|
| Staffordshire | 78 | 4236 | 2 | 1 | 42 | 31 | 2 |
| Stoke-on-Trent | 19 | 1122 | 1 | 0 | 10 | 5 | 0 |
| **Totals:** | **97** | **5358** | **3** | **1** | **52** | **36** | **2** |

During the last 2 years, whilst there has been a loss of 7 care homes (45 beds) within the nursing home market, the data demonstrates a marked reduction in providers outside of regulatory standards with 55% of our market now rated Good or Outstanding and only 3% awaiting a rating which is further evidence of due diligence and oversight by CQC when compared to 8% waiting for inspection 2 years prior.




| Large Scale Enquiries | Staffordshire | Stoke-on-Trent |
|---|---|---|
| **April 2017** | **7** | **4** |
| **April 2019** | **3** | **1** |

Both local authorities have evidenced a reduction in the number of Large Scale Enquiries which have reduced to 75% in Stoke-on-Trent and 57% across Staffordshire in the last two years. This was one of the original objectives set within the priority. Staffordshire & Stoke-on-Trent LAs are working effectively supported by the CCG Quality and Safeguarding Teams enabling early identification of concerns through robust continuous

monitoring which has led to ensuring to providers struggling to achieve standards are assisted with the production of support plans and clearer access to resources. Care Homes that repeatedly fall into LSE are also identified through biannual thematic meetings by the Quality Assurance Teams. Leadership is measured by the regulator as "Well Led" and as at April 19 both Staffordshire and Stoke-on-Trent Local Authority data evidences an increasing trend of improvement. Stoke-on-Trent achieved an overall 75% in Good or Outstanding CQC ratings in Residential and Nursing Homes. Staffordshire achieved good or outstanding in 72% of Residential Homes and 59% of Nursing Homes. There has been a particularly noticeable upward trend from February 2019 to August 2019 as some of the interventions became more imbedded.

There are a number of factors outside of agencies control which was reflected within the CQC's annual report on their review of health and social care in England. https://www.cqc.org.uk/publications/major-report/state-care The State of Care report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve. The report shares national ratings and provides the assurance that most people in England receive a good quality of care. The evidence suggests quality overall has been largely maintained from the preceding year, and as in Staffordshire and Stoke-on-Trent there are some areas able to evidence improvements, despite the continuing challenges that Care providers face.

Workforce problems nationally have a direct impact on people's care. Getting the right workforce is crucial in ensuring services can improve and provide high-quality, person-centered care and this remains a focus locally with greater opportunities for accessing training and development opportunities within this sector. Recruitment and retention is an issue locally as is the demand for additional staff due to increased demands on services. Staffordshire has a higher than national rise within its ageing population with many people living with complex, chronic or multiple conditions, such as diabetes, cancer, heart disease and dementia.

**Conclusion**

Whilst Leadership in this sector remains a cause often cited when a service is failing, the board has received assurances that connected partners are responding in a timely and effective manner. Joint working, implementation of robust practices and processes is ensuring the safety of our individuals in receipt of support within the borough. Commissioners of both health and social care, through collaborative working continue to drive the necessary improvements and Staffordshire and Stoke-on-Trent have a greater alignment to the national CQC ratings reported within the State of Care report. It is recommended that the board continue to receive updates from agencies and the assurance that the quality and audit assurances are maintained and continue to be supported by board partners.

**Strategic Priority: Financial and Material Abuse**

Financial and Material Abuse was identified as a key strategic priority in July 2018. Financial and Material Abuse includes theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

It is strongly suspected that the number of victims of Financial or Material Abuse who have care and support needs is likely to be massively under reported. Nationally it is estimated that only between 10 – 20% of incidents are ever reported but this is not widely recognised. During 2016/17 the proportion of Section 42 enquiries where Financial and Material Abuse was identified was 20% in Staffordshire and 11% in Stoke-on-Trent. The national average was 18%.

Financial abuse can also be identified in other forms of abuse. Financial control is often found in domestic abuse and modern slavery. It is important that when completing enquiries consideration is given to safeguarding the adult's finances.

The consequences can be far more costly than just the financial loss and the impact can contribute to deteriorating health, loss of independence and loss of self-confidence. This can extend to additional resource demands on the health and social care sector to provide support - which could be prevented through earlier intervention and protection.

By making this a priority the Board aims to raise awareness of financial and material abuse, how to recognise it, report it, respond to it and take steps to prevent it from happening.

The sub-group has representatives from both Staffordshire and Stoke-on-Trent Trading Standards Team, Staffordshire Police fraud team, safeguarding leads from both Stoke-on-Trent and Staffordshire Adult Social care as well as input from the Community Safety Partnership. The focus of the sub-group has been to:

Seek assurances as to the effectiveness of safeguarding partner arrangements to widely communicate to communities the risk of financial abuse and scams, with a particular emphasis on people most vulnerable to risk

Seek assurances as to the effectiveness of the current arrangements for reporting concerns, by safeguarding partners and the wider public, that an adult with care and support needs is suspected of being subject to financial or material abuse

Seek assurances as to the effectiveness of the current arrangements of safeguarding partners to respond to concerns that an adult with care and support needs is suspected of being subject to financial or material abuse

Conduct an analysis of the reported cases of financial or material abuse involving adults with care and support needs to identify trends in abuse and opportunities for prevention actions

Respond to the findings of the review of reporting arrangements with actions that may be necessary to raise awareness. A consideration should be that the more complicated and time consuming the referral process is, the less likely it is that an individual will make a referral

Encourage and co-ordinate actions around workforce development, including signs to look for and how to respond

Update Financial Abuse Guidance through the policy and procedure sub-group and make this available through the SSASPB website

To date the sub-group has been comparing data and details of concerns of financial abuse to gain an understanding of the scale of the problem in Staffordshire and Stoke-on-Trent. This has led the sub-group to determine that a more in-depth study of the information is required. Links are being made with Staffordshire University to conduct research studies in to the data to better identify the most prevalent types of financial abuse in Staffordshire and Stoke-on-Trent and those people most at risk.

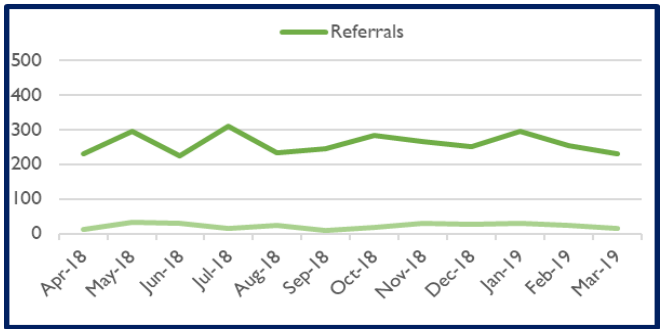
Training has been delivered to practitioners both from Trading Standards but also the Police and social care practitioners in the Multi-Agency Safeguarding Hub. The Financial and Material Abuse guidance to support all practitioners has been completed and is available on the board website.

The sub-group will continue to progress the work and research over the next year which will then enable preventative actions that shall seek to help empower adults who have care and support needs to protect themselves or be supported to reduce the risks of Financial and Material Abuse.

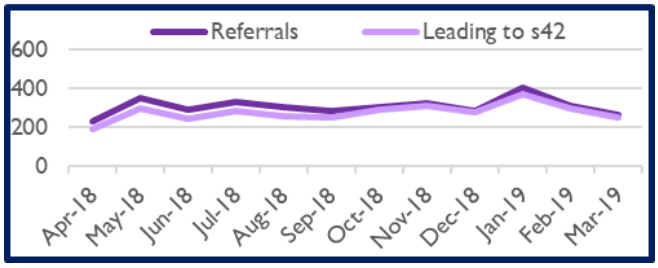
# 8. ANALYSIS OF ADULT SAFEGUARDING PERFORMANCE DATA

## Performance Summary

### Stoke on Trent




### Staffordshire




| Gender | |
|---|---|
| Staffordshire | Stoke on Trent |
| **61%** Female | **59%** Female |
| **39%** Male | **41%** Male |

| Age | |
|---|---|
| Staffordshire | Stoke on Trent |
| **8%** 18-29 | **7%** 18-29 |
| **10%** 30-49 | **14%** 30-49 |
| **12%** 50-64 | **20%** 50-64 |
| **24%** 65-74 | **15%** 65-74 |
| **26%** 75-84 | **19%** 75-84 |
| **26%** 85-94 | **21%** 85-94 |
| **4%** 95+ | **4%** 95+ |
| **1%** Unknown | |

| Primary Support Reason (Top 5) | |
|---|---|
| Staffordshire | Stoke on Trent |
| **61%** Physical | **51%** |
| **14%** Learning Disability | **21%** |
| **11%** Mental Health | **16%** |
| **7%** Memory | **8%** |
| **<3%** Social | **<1%** |

| Types of abuse (Top 5) | |
|---|---|
| Staffordshire | Stoke on Trent |
| **34%** Neglect | **45%** |
| **20%** Financial | **22%** |
| **21%** Physical | **21%** |
| **12%** Emotional | **20%** |
| **8%** Self Neglect | **6%** |

Note: Stoke on Trent LA record multiple types of abuse and therefore may not total 100%

| Location of abuse (Top 5) | |
|---|---|
| Staffordshire | Stoke on Trent |
| **49%** Home | **34%** |
| **20%** Residential Home | **19%** |
| **16%** Nursing Home | **19%** |
| **5%** Other | **14%** |
| **<5%** Hospital | **<5%** |

| Staffordshire | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|---|
| **Total Referrals** (% of referrals that are repeat) | 4814 (25%) | 4457 (26%) | 5529 (22%) | 4908 (23%) | 3711 (18%) |
| **Referrals that meet threshold** (% of total referrals) | 3855 (80%) | 3194 (72%) | 3301 (60%) | 3198 (65%) | 3342 (90%) |
| **Partially or fully proven allegations** (of outcomes recorded) | 905 (30%) | 1106 (28%) | 883 (24%) | 823 (26%) | 1405 (42%) |

| Stoke on Trent | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|---|
| **Total Referrals** (% of referrals that are repeat) | 1881 (22%) | 1842 (x) | 1953 (14%) | 2242 (14%) | 3034 (8%) |
| **Referrals that meet threshold** (% of total referrals) | 601 (32%) | 409 (22%) | 373 (19%) | 248 (11%) | 248 (9%) |
| **Partially or fully proven allegations** (of outcomes recorded) | 127 (21%) | 145 (35%) | 204 (51%) | 158* (64%) | Data no longer collected |

X- Data not available *Based on cases with a recorded outcome

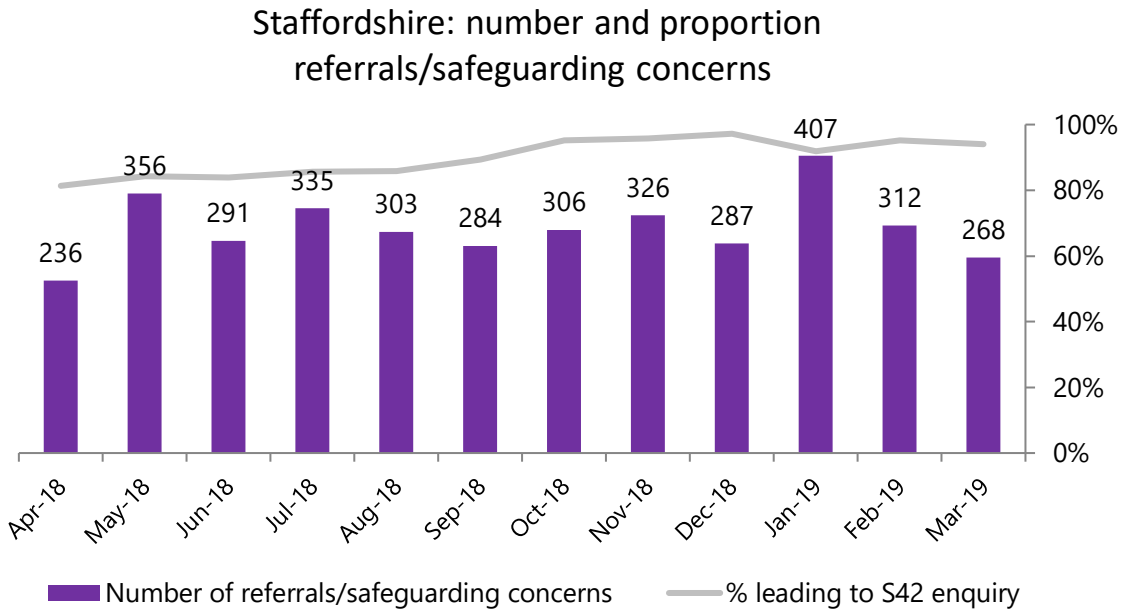
This section provides commentary and analysis of safeguarding data from Stoke-on-Trent and Staffordshire.

**Number and proportion of referrals/safeguarding concerns**

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

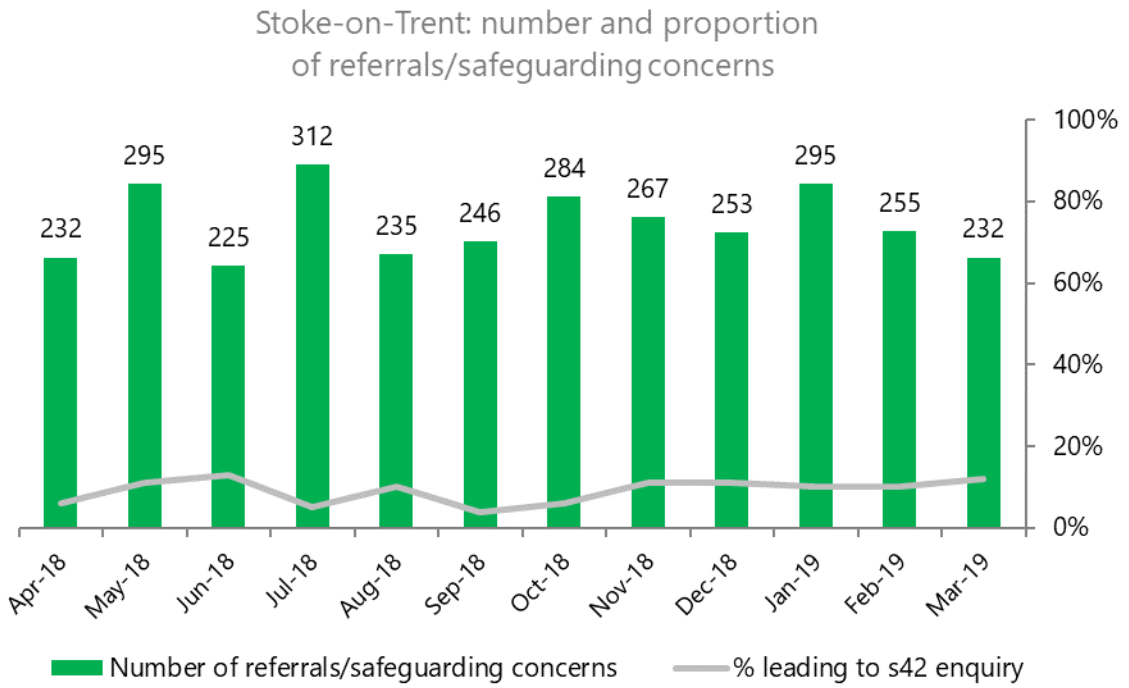
Reported concerns can progress to a formal enquiry under Section 42 of the Care Act 2014 if the criteria for the duty of enquiry requirement is met. In cases where a statutory response is not required the local arrangements ensure signposting and engagement as necessary with appropriate support services.

It should be noted that there is a difference between how both LAs capture and report this data. This accounts for similarities in the numbers between both LAs which could reasonably be assumed to vary more due to the difference overall population sizes.




During the course of the year, in Staffordshire, there have been 3711 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 decreased by 1197 (24%) occasions from 4908 in 2018/19. This is due to a change in the way this data is now captured by Staffordshire; only those that require a Section 42 enquiry (i.e. meet the threshold) are recorded as a safeguarding concern, and therefore the number of referrals will be lower and the proportion of referrals leading to Section 42 enquiries will be much higher.

Following an initial assessment, it was determined that the duty of enquiry requirement was met in 90% of concerns. This proportion is much higher than previous years, (65%) which is due to a change in the way of recording (see above). The expected trend is that all referrals will meet the threshold for a Section 42 enquiry over the next 12 months indicating better initial assessment.




In Stoke-on-Trent there were 3034 reported safeguarding concerns in relation to adults with care and support needs during 2018/19. This is an increase of 792 from 2242 compared to 2018/19 an increase of 35%. This can be partly explained by the Large-Scale Enquiries that have been undertaken causing an increase as more cases are identified through this process. As part of 'Making Safeguarding Personal' referrals will take other routes of support and avoid becoming a safeguarding concern.

Following initial assessment, it was determined that the duty of enquiry requirement was met on 9% of those occasions which has decreased from 11% in 2017/18.

The Board has asked for an explanation from the local authorities about the different methods of gathering and interpreting information in relation to safeguarding concerns. The responses are summarised below.

- Both authorities review information on the AS1 (initial safeguarding referral form)
- Both make a decision at this point to determine if the three stage criteria is met
  *a- does the adult have care an support needs,*
  *b- are they at risk or experiencing abuse*
  *c- and as a result of their care needs are they unable to protect themselves*
- If the three stage test is met then a decision is made by both authorities to gather further information (called a planning discussion).
- The planning discussion will involve information gathering from various sources, both professional and family and friends and the adults view where they have capacity to be involved.
- Following this information gathering both authorities make a decision if further enquiries and exploration of safeguards for the adult is required.
- If the decision is for no further enquiries, it is at this stage that Staffordshire and Stoke-on-Trent make a different recording decision –
- Stoke-on-Trent record this decision as – No Section 42 required (but also record what other actions either care assessment request, review etc. as a non-statutory Sec42)
- Staffordshire record this decision as – Section 42 enquiry completed (either no ongoing risk, closed at adult's request, concerns substantiated or unsubstantiated)

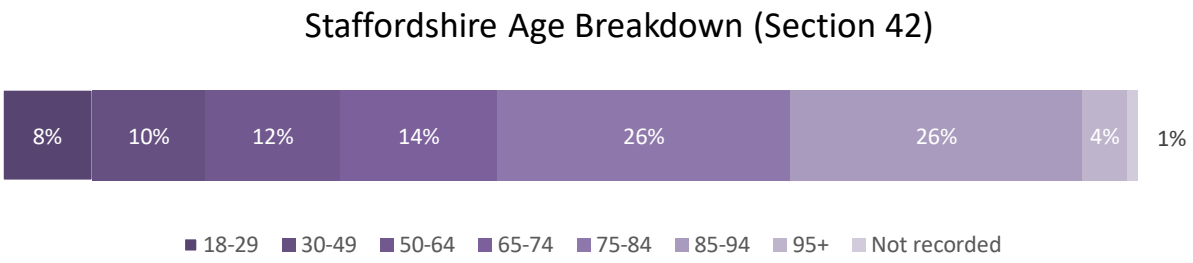
In essence Staffordshire and Stoke-on-Trent Local Authorities follow the same procedures but the recording on systems is an internal decision for each authority. This review has illustrated that both authorities are taking the same steps to ensure adults are safe and risks minimised.

This difference in recording is replicated throughout the country with a wide variation in conversion rates for Section 42 enquiries between 12% and 69%. Both authorities have been involved in the work of the Local Government Association in an attempt to reduce this variance. The Local Government Association has announced that it will produce further guidance to make the process for recording a Section 42 clearer.

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

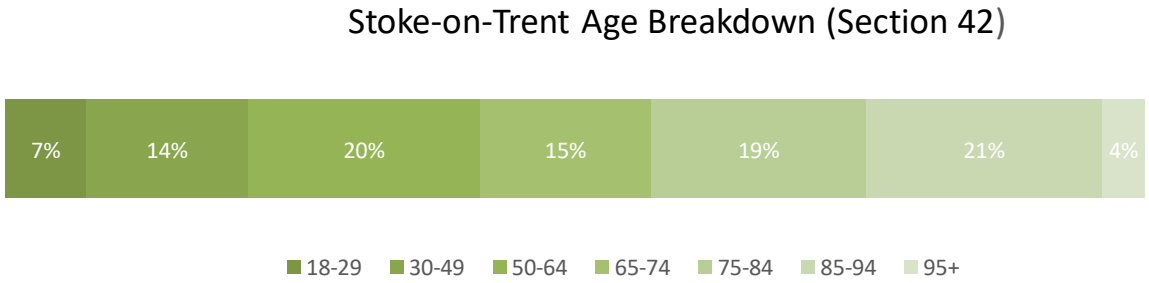
**About the Person**

To give a picture of the personal circumstances of those at risk of abuse or neglect information is collected on the age, gender, ethnic origin and primary reason for adults needing for care and support and this information is provided below.




**Staffordshire**

Of the people subject of a Section 42 enquiry, those aged 75-84 and 85-94 (both 26%) represent the largest cohort, followed by 65-74 (14%), and then 50-64 (12%). There has been very little change in the population this year compared to last year. Only in 1% of cases has no data been recorded. When comparing the age breakdown with general Staffordshire population statistics, it is evident that people in the 65+ age groupings are disproportionally over represented for Section 42 enquiries.



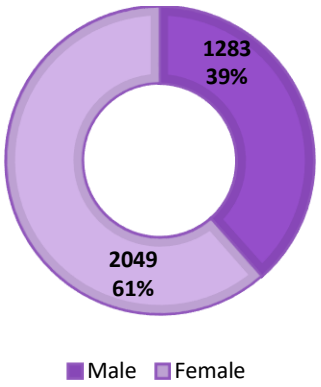

**Stoke-on-Trent**

For Stoke-on-Trent, the largest cohort represented is those aged 85-94 (21%), closely followed by 50-64 (20%), and then 75-84 (19%). The proportion of people over 75 has been decreasing (by 17%) over the last

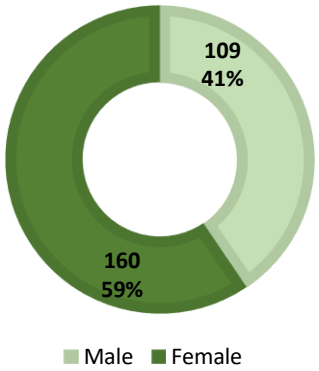
two years, whilst those under 50 have increased (by 11%) in the same period. This may be due to the increase in large scale enquiries in relation to people with learning disabilities being younger. When comparing the age breakdown with the general Stoke-on-Trent population figures, it is apparent that people over 65 are disproportionally over represented for Section 42 enquiries.

## Gender

Staffordshire: Gender Breakdown




Stoke-on-Trent: Gender Breakdown




**Staffordshire**

Females represent the majority of adults' subject of a Section 42 enquiry, with 61% over the year and males representing 39%; similar to last year. Females are over represented (by 12%) when compared to the overall Staffordshire gender breakdown.

**Stoke-on-Trent**

Stoke-on-Trent has a slightly lower proportion of females in their cohort compared to Staffordshire, but females have increased compared to 54% last year with a corresponding decrease for men.

Note: Recording systems are currently unable to break down data further to reflect broader gender categories to be fully inclusive.

## Ethnicity

| Ethnicity | Staffs | Stoke-on-Trent |
|---|---:|---:|
| White | 89.6% | 87.9% |
| Asian | 0.9% | 2.8% |
| Black | 0.4% | 0.4% |
| Mixed | 0.3% | 0.0% |
| Other | 0.3% | 1.2% |
| Refused | 0.0% | 0.0% |
| Undeclared / Not Known | 8.5% | 7.7% |

**Staffordshire**

The majority of individuals (Section 42) are 'White' (89.6%, a slight decrease from last year), followed by Asian (0.9%).

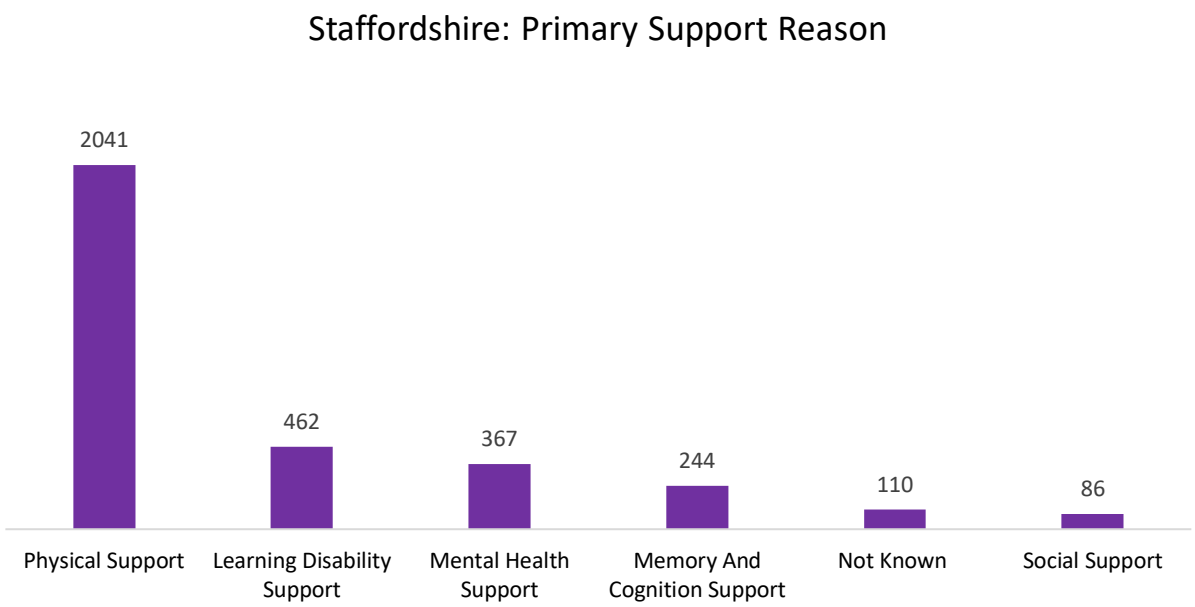
**Stoke-on-Trent**

The pattern is similar in Stoke-on-Trent, the majority of declared ethnicities are 'White' (87.9%, a slight decrease since last year), followed by Asian (2.8%, a slight increase since last year).

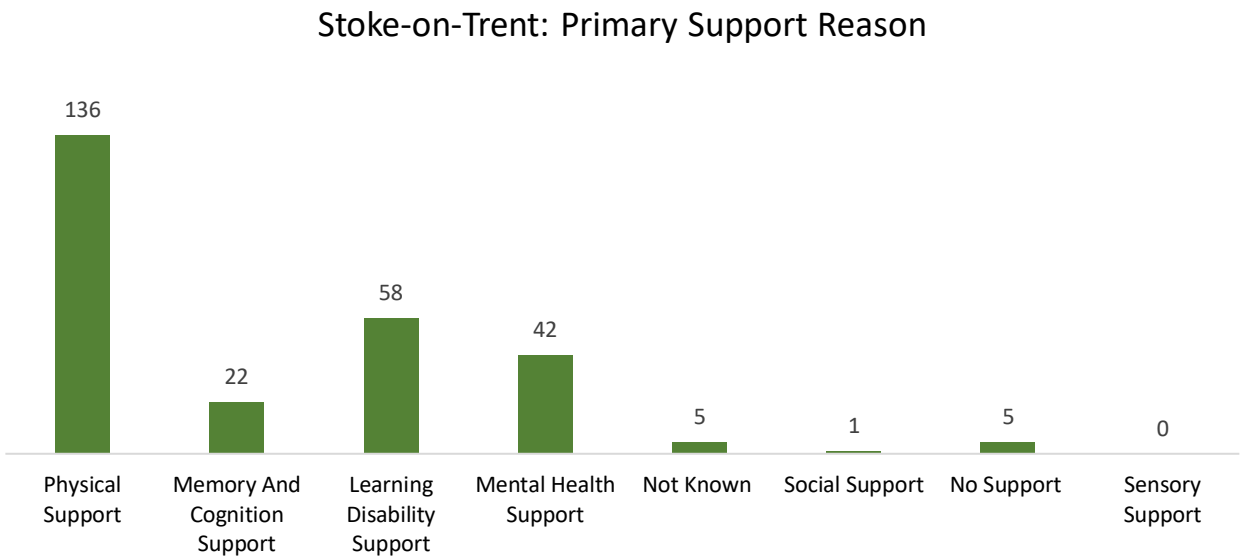
Anecdotally, it is known that people from ethnic minority populations are disproportionally under-represented for Section 42 enquiries; however, for both local authorities (Staffordshire 8.5% and Stoke-on-Trent 7.7%), records do not have their ethnic background captured which limits the usefulness of any comparison to the wider population.

**Primary Support Reason:** the bar charts below illustrate the type of care and support need of the adult subject to abuse or neglect

**Staffordshire**




Physical support continues to be the most common primary support reason in Staffordshire in 2018/19 (61%) an increase of what was reported last year (49%), followed by learning disability support (14%) and then mental health support (11%) which was more of a factor for the older age groups. 'Not knowns' have decreased from last year as updated data has been resubmitted by Staffordshire giving an opportunity for updated validated data.



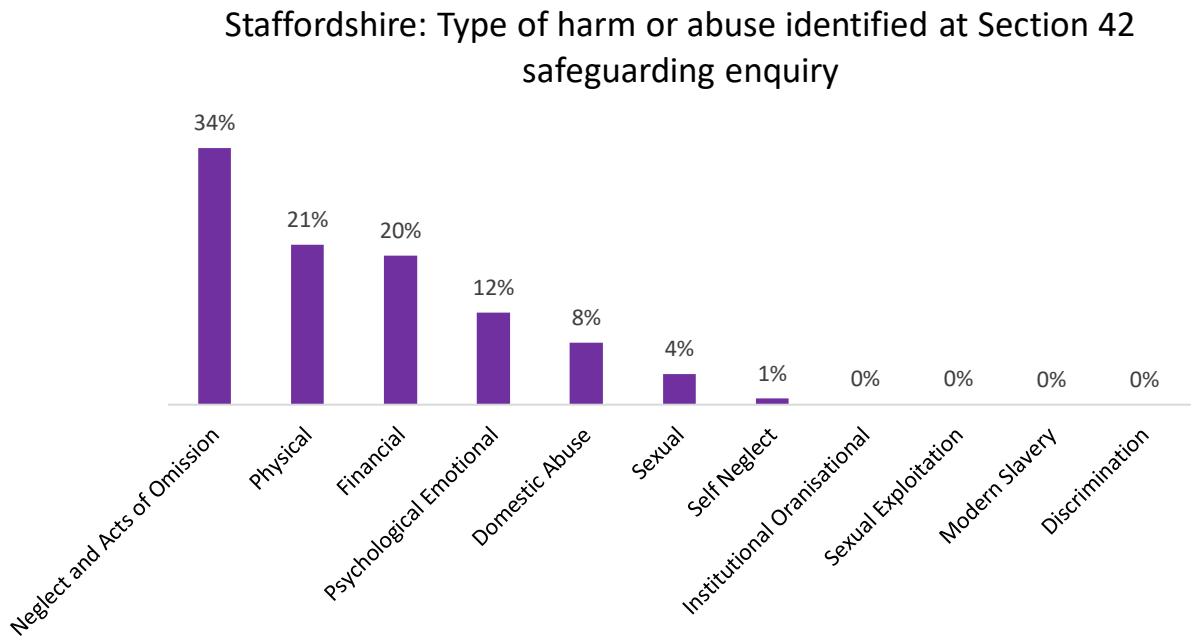

**Stoke-on-Trent**

Physical support similarly represents the largest proportion of primary support reasons recorded in Stoke-on-Trent at 51%, followed by learning disability support with 21%, an increase of 8% since last year, due to large scale enquiries that have uncovered abuse in this area; mental health support accounts for 16%.

**Types of Harm or Abuse identified at Section 42 safeguarding enquiry**

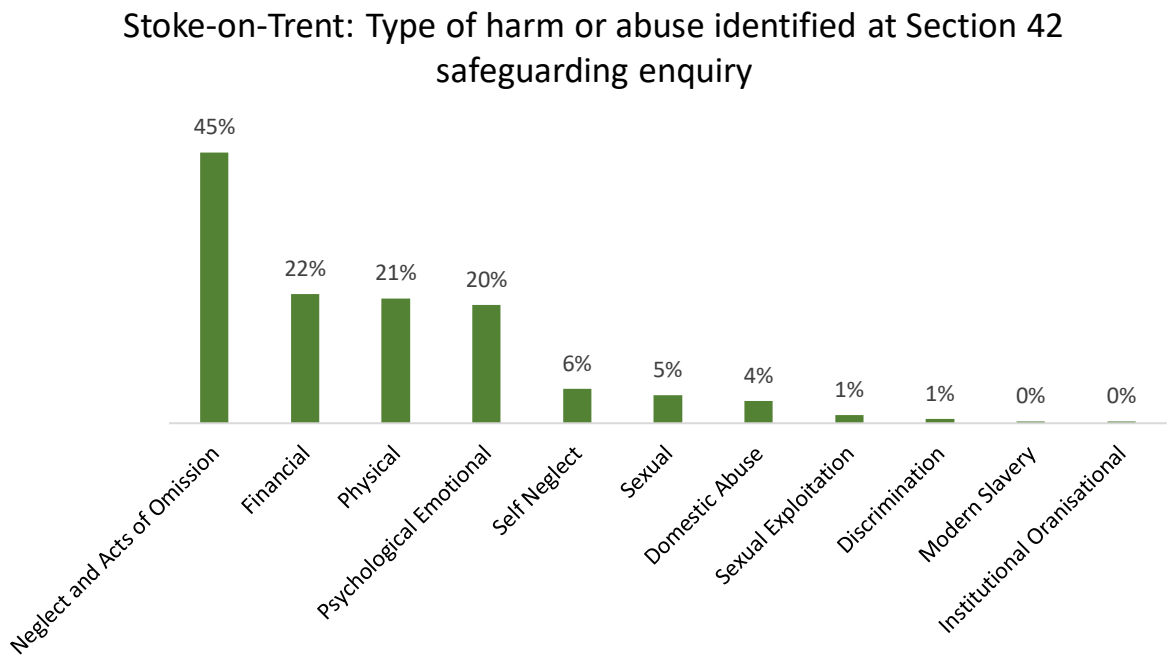
The below information shows the types of abuse and neglect reported in comparative proportions:

**Staffordshire**




Neglect and Acts of Omission/Physical harm/financial abuse continue to be the most frequent types of harm and abuse identified for Section 42 safeguarding enquiries in Staffordshire, together accounting for 75% of all harm/abuse recorded. Neglect and acts of omission, show a slight decrease during the course of the year; whilst financial abuse has increased (3%) in 2018/19.

**Stoke-on-Trent**

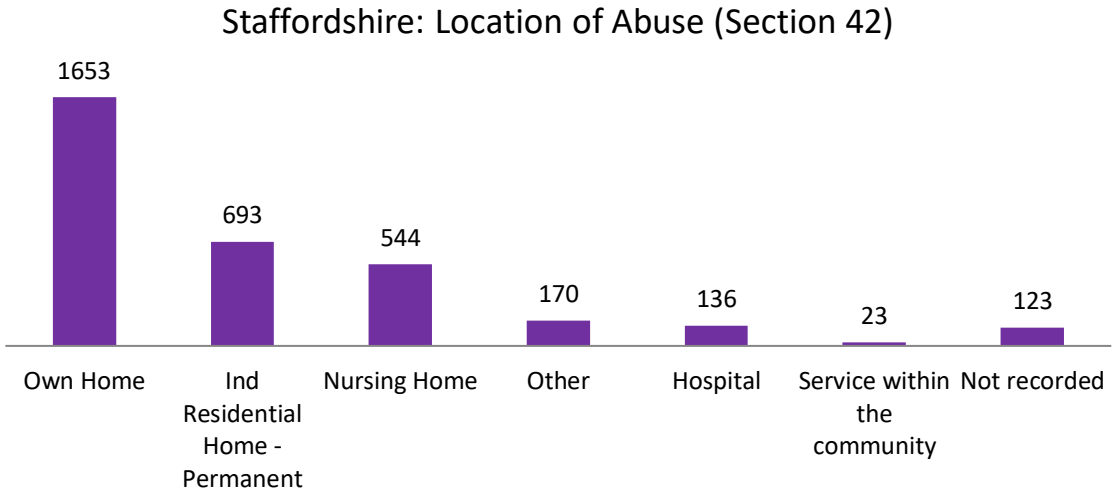



The trend of increasing neglect cases has continued in 2018/19 and is up to 45%, from 37% in 2017/18. The proportion of cases where financial abuse has been reported has increased significantly when compared to 2017/18, from 9% to 22% due to improved identification of this type of abuse. Psychological emotional abuse has also increased this year, from 14% last year to 20% this year, again most likely to be linked to better identification and awareness.

Despite the relatively 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.

Since 2016/17 new categories of Sexual Exploitation, Discrimination and Modern Slavery have been included. In Staffordshire, fewer than 10 cases were identified as involving sexual exploitation and fewer than 5 cases for discrimination and modern slavery. Stoke-on-Trent reported fewer than 5 cases in all of these categories. Figures may not reflect what is happening in communities and an awareness campaign and training for partner agencies may be required so that this type of abuse is recognised and supported appropriately.

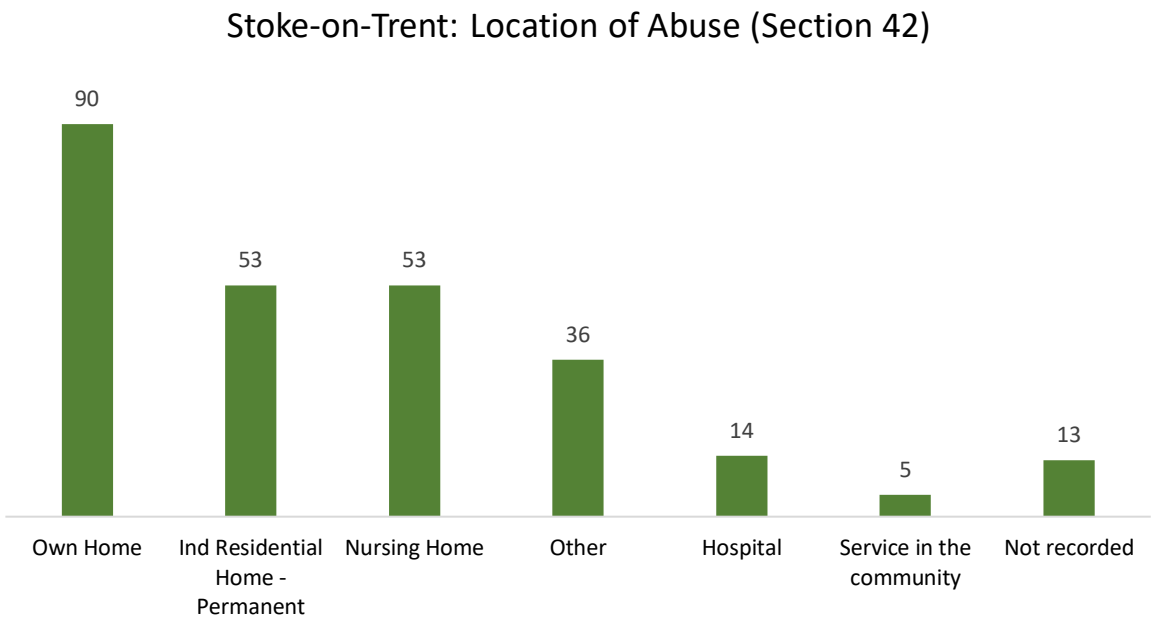
**Location of abuse**



**Staffordshire**

Of those people subject of Section 42 enquiries, the majority (1653) were in the person's own home with nearly 50%. The next most common locations in Staffordshire were residential homes (21%) and nursing homes (16%); similar to last year.

**Stoke-on-Trent**




The most prevalent location of abuse in Stoke-on-Trent are the person's own home (34%) and Independent Residential Home and Nursing Home (both 20%). This has changed from last year, when the majority of concerns were in nursing homes, identified in Large Scale Enquiries. Abuse in the person's own home has increased by 13% from last year. Other locations are similar to last year.

**Findings of Concern Enquiries**

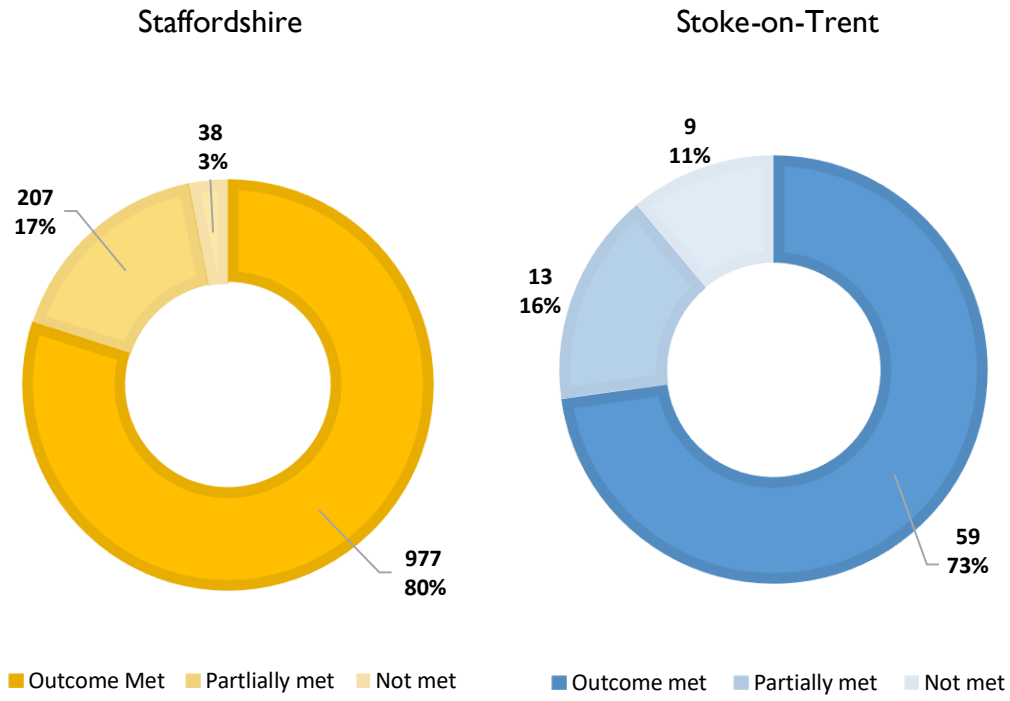
The following section provides an overview of the findings of Section 42 enquires showing what is happening to referrals through to whether allegations were proven with a comparison to previous years.

**Staffordshire:** Referrals have reduced again this year, but more meet the threshold; due to being captured differently as noted earlier. Repeat referrals have decreased by 5% from last year. Partially or fully proven allegations have increased from 26% last year to 42% this year.

**Stoke-on-Trent**: Demand has continued to increase during 2018/19 for Stoke-on-Trent with the reported number of concerns rising by 26%. The proportion of cases meeting the threshold has continued to reduce from 32% in 2014/15 and is now 9%. Partially or fully proven allegations data is no longer collected by Stoke-on-Trent.

**Note:** There is an explanation for the reasons for variation in recording between Staffordshire and Stoke-on-Trent on page 31.

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




**Staffordshire**

In Staffordshire the proportion of people subject to a Section 42 enquiry whose expressed outcome was met has decreased from 85% last year, 97% of people expressing their desired outcomes as either fully or partly met has remained the same as last year.

**Stoke-on-Trent**

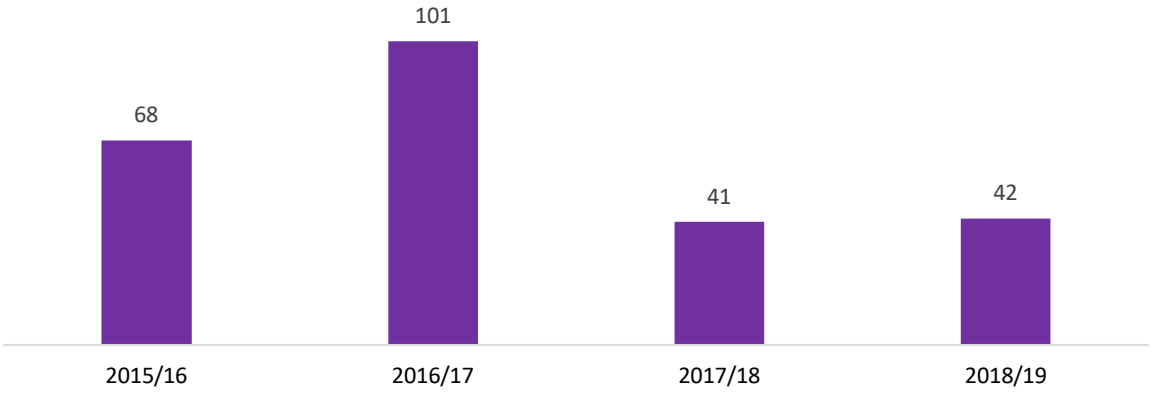
The proportion of people subject of a Section 42 enquiry whose expressed outcome was met or partially met decreased to 89% from 92% in 2017/18.

**Staffordshire Police information**

**Care Worker ill treatment/wilful neglect of an individual**

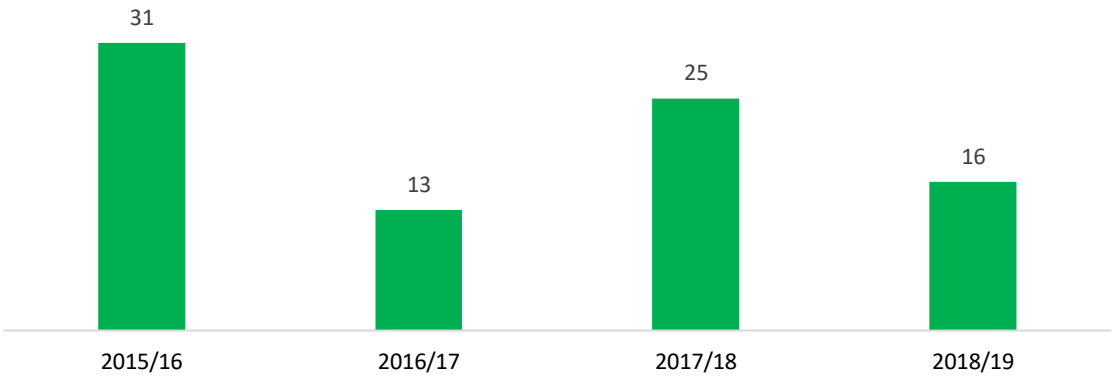
The 2016/17 SSASPB Annual Report indicated an increasing number of concerns and criminal investigations involving paid care staff. There were a large number of repeat locations, which had a large number of crimes linked to them. There were also a number of historic offences (committed prior to the date period) were only 1 historic offence has been recorded in the last 2 years. For the last two years the number of recorded crime offences has remained similar at 41 and 42 respectively.

Care Worker ill-treatment / Wilfully Neglect of an individual




The number of recorded crimes is spread over 9 locality policing teams. There have been no repeat victims, but there are 3 repeat offenders. There are also 7 locations with more than 1 crime recorded and the majority occurred in care/nursing homes.

Ill Treatment or Wilful Neglect of a Person lacking capacity by anyone responsible for that person's care




There has been a decrease of 9 crimes compared to the previous year. These are spread over 8 locality policing teams with only 1 area experiencing an increase. There are no repeat victims or offenders, but there is a repeat location. Almost half of crimes occurred in nursing/ care home settings.

## 9. FINANCIAL REPORT

**Budget Report 2018/19:**

The Board is supported by a part-time Independent Chair, a full-time Board Manager and a full-time Administrator. There was a change in Administrator in this period resulting in nine weeks without cover or cost.

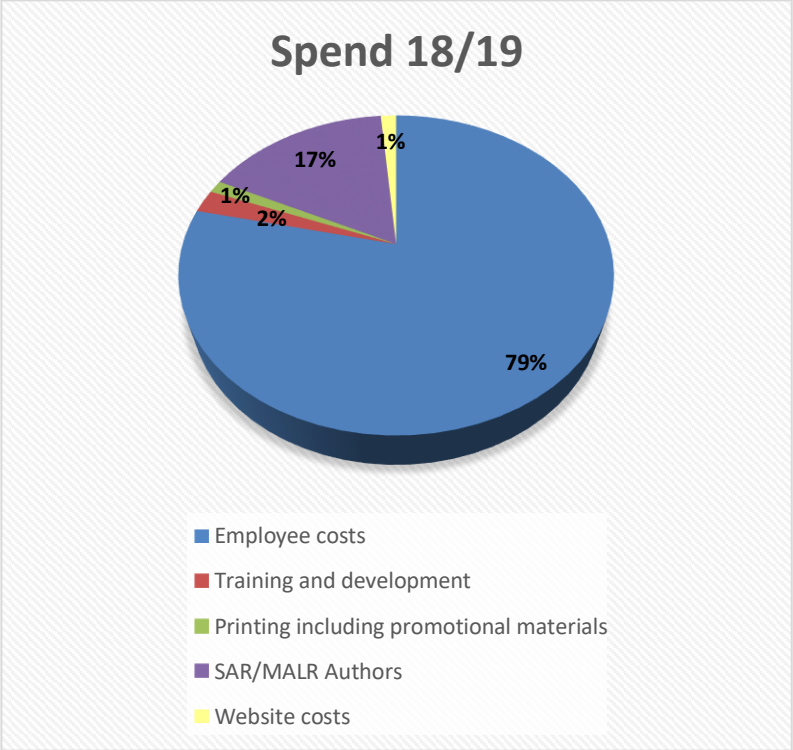
The Board wishes to acknowledge those partners who have provided rooms without cost which includes Staffordshire County Council, Stoke-on-Trent City Council, Staffordshire Fire and Rescue Service and Staffordshire Police.

**Income:** This was year 2 of a 3 year budget agreement which had been approved by the statutory partners in January 2017.

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

**Spend:**

| | |
|---|---|
| Staffing | £102,801 *note (i)* |
| Training and development | £3,056 |
| Catering | £55 |
| Printing/stationery | £1,688 *note (ii)* |
| SAR/ MALR Authors | £21,444 |
| Website costs | £1,800 |
| **TOTAL:** | **£131,982** |




*Notes (i) All staffing costs including employment costs, mobile phone and travelling*

*(ii) Including promotional leaflets*

## 10. APPENDICES

### APPENDIX 1: BOARD PARTNERS

**Statutory Partners as of 31st March 2019**

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

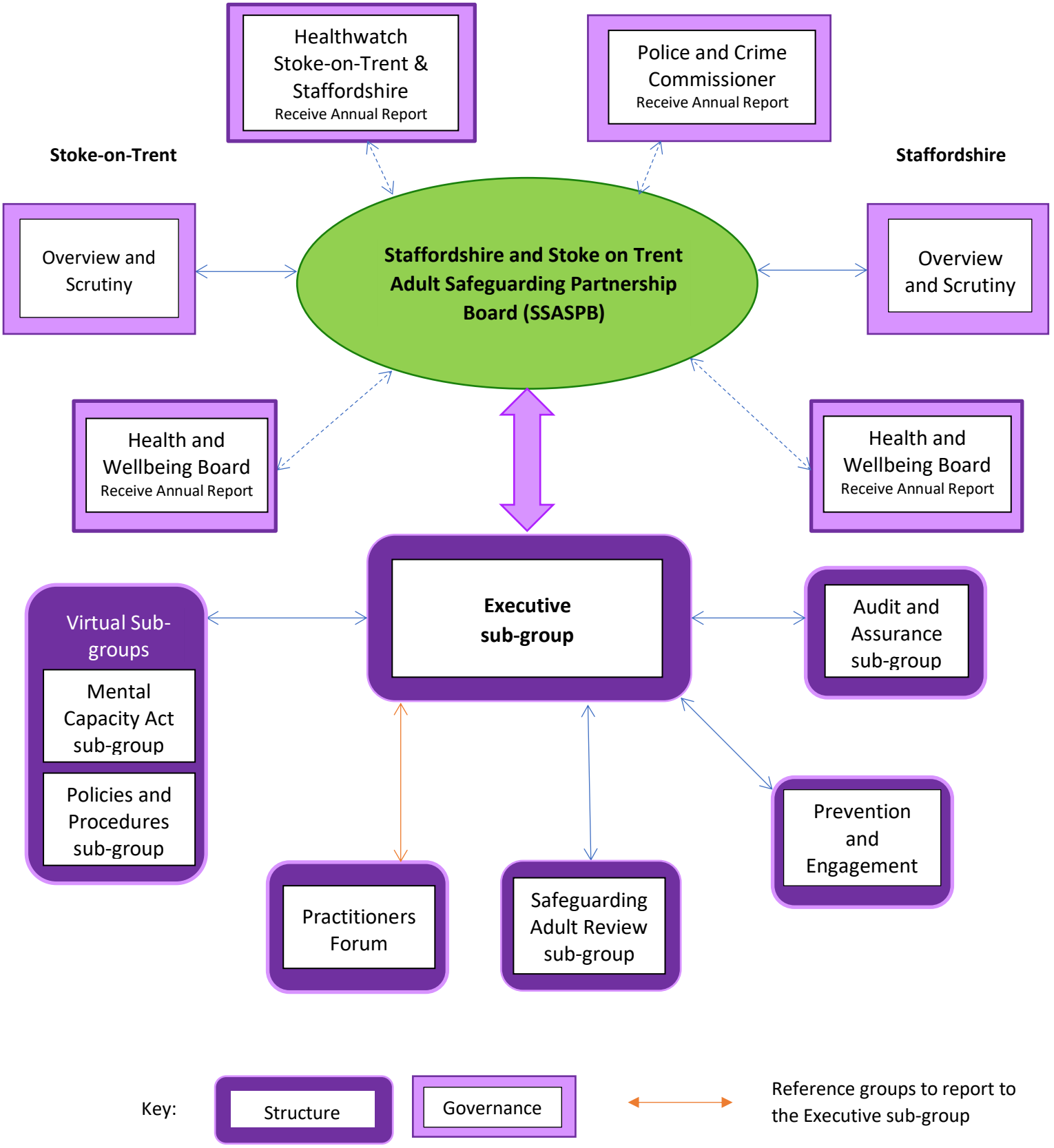
**Extended Partnership as of 31st March 2019**

- Community Rehabilitation Company (CRCs) (Staffordshire and Stoke-on-Trent)
- Domestic Abuse Forum
- Hate Crime Forum
- Healthwatch (Staffordshire and Stoke-on-Trent)
- Her Majesty's Prison Service (HMPS)
- Local Authority Lead members
- Midlands Partnership Foundation Trust (MPFT)
- National Probation Service (NPS) (Staffordshire and Stoke-on-Trent)
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- Representatives from the voluntary sector
- Staffordshire Association of Registered Care Providers (SARCP)
- Staffordshire District Councils Safeguarding sub-group
- Staffordshire Fire and Rescue Service (SFARS)
- Trading Standards (Staffordshire and Stoke-on-Trent)
- University Hospitals of Derby and Burton (UHDB)
- University Hospitals of North Midlands (UHNM)
- Virgin Care
- West Midlands Ambulance Service (WMAS)

**APPENDIX 2: GOVERNANCE STRUCTURE**

**From 1st April 2019**

## Governance and Structure



**APPENDIX 3: CATEGORIES OF ABUSE AND NEGLECT**

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

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

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

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

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

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

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

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

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

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

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

## 11. REFERENCES

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

## 12. GLOSSARY

| Glossary | |
|---|---|
| **CCG** | Clinical Commissioning Group |
| **CPS** | Crown Prosecution Service |
| **CQC** | Care Quality Commission |
| **CRC** | Community Rehabilitation Company |
| **DA** | Domestic Abuse |
| **DHR** | Domestic Homicide Review |
| **DBS** | Disclosure and Barring Service |
| **DoLS** | Deprivation of Liberty Safeguards |
| **GDPR** | General Data Protection Regulation |
| **HMIC** | Her Majesty's Inspectorate of Constabulary |
| **HMIP** | Her Majesty's Inspectorate of Prisons |
| **MAPPA** | Multi-Agency Public Protection Arrangements |
| **MARAC** | Multi-agency Risk Assessment Conference |
| **MASH** | Multi-agency Safeguarding Hub |
| **MCA** | Mental Capacity Act (2005) |
| **MPFT** | Midlands Partnership Foundation Trust |
| **NHSE** | National Health Service England |
| **NPS** | National Probation Service |
| **NSCHT** | North Staffordshire Combined Healthcare Trust |
| **OPG** | Office of the Public Guardian |
| **PiPoT** | Persons in Position of Trust |
| **QA** | Quality Assurance |
| **QAF** | Quality Assessment Form |
| **QSISM** | Quality Safeguarding and Information Sharing Meeting |
| **SAB** | Safeguarding Adults Board |
| **SAR** | Safeguarding Adults Review |
| **SARCP** | Staffordshire Association of Registered Care Providers |
| **SCC** | Staffordshire County Council |
| **SCR** | Serious Case Review |
| **SFARS** | Staffordshire Fire and Rescue Service |
| **SSASPB** | Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board |
| **SSSCB** | Stoke-on-Trent and Staffordshire Safeguarding Childrens Board |
| **SoTCC** | Stoke-on-Trent City Council |
| **TS** | Trading Standards |
| **UHDB** | University Hospital of Derby and Burton |
| **UHNM** | University Hospitals of North Midlands |
| **WMAS** | West Midlands Ambulance Service |

Please use the link below to the SSASPB website for more detailed descriptions and additional glossary items.

https://www.ssaspb.org.uk/Professionals/Glossary.aspx

# What do I do If I have an Adult Safeguarding concern?

## REPORT IT

If the adult lives in Stoke-on-Trent

**0800 561 0015**

Minicom: 01782 236037

If the Adult lives in Staffordshire

**0345 604 2719**

Please visit the SSASPB website for more ways to report a concern

www.ssaspb.org.uk/reporting-abuse

NHS

City of Stoke-on-Trent

Staffordshire County Council

Staffordshire Police