SSASPB Annual Report 2021 to 2022

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

2. Independent Chair Foreword

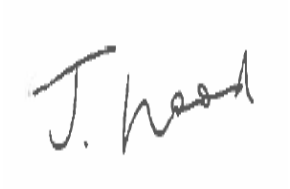
It is my privilege as Independent Chair to write the foreword to this Annual Report of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board. This report provides a look back at the work by the partners of the Board and its sub-groups over the year 1st April 2021 to 31 March 2022. It illustrates the enormous range and amount of safeguarding activity done in partnership, much of which builds on learning from good practice as well as where things have gone wrong.

This has been a second consecutive year where the COVID-19 pandemic has provided a dominant context adversely impacting on the health and wellbeing of millions of people both here in the United Kingdom and throughout the world. I again take this opportunity to offer, on behalf of the Board partners, our condolences to all those who lost loved ones in social care settings, hospitals, secure institutions, or in their own homes during the pandemic. I also acknowledge the enormous role of all professionals who delivered services to adults with care and support needs, often at considerable personal cost.

In the last 12 months the strength and maturity of local partnership working has been demonstrated in the constructive way that connected partners have shown a willingness to challenge each other and be challenged as to the effectiveness of safeguarding arrangements. Consequently, the Board has adapted its approaches to seeking assurances and these are reflected in the revisions to the Strategic Plan that was being reviewed at the time of writing this Foreword. The Annual Report next year will provide details on how the Strategic Plan has been implemented and what has been achieved.

I again 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 in these most challenging of times and consistently demonstrate a strong commitment to do that.

I am immensely grateful to all who chair the Board Sub-Groups as well as the Board Manager Helen Jones and the Board Co-ordinator Rosie Simpson who work so hard behind the scenes to ensure that our business programme works efficiently.



John Wood QPM

3. About the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB)

The Care Act 2014[1] provides the statutory requirements for adult safeguarding. It places a duty on each Local Authority to establish a Safeguarding Adult Board (SAB) and specifies the responsibilities of the Local Authority and connected partners with whom they work, to protect adults at risk of abuse or neglect.

The main objective of a Safeguarding Adult Board, in this case the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB), is to help and protect adults in its area by co-ordinating and ensuring the effectiveness of what each of its members does. The Board's role is to assure itself that safeguarding partners act to help and protect adults who:

- have needs for care and support
- are experiencing or at risk of abuse or neglect; and
- as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect

A Safeguarding Adult Board has three primary functions:

- 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
- It must conduct a Safeguarding Adult Review where the threshold criteria have been met and share the detailed findings and on-going reviews within the annual report

Composition of the Board

The Board has a broad membership of partners in Staffordshire and Stoke on Trent and is Chaired by an Independent Chair appointed by Staffordshire County Council and Stoke on Trent City Council in conjunction with Board members. The Board membership can be found here.

The Board is dependent on the performance of agencies with a safeguarding remit for meeting its objectives. The strategic partnerships with which the Board is required to agree responsibilities and reporting relationships to ensure collaborative action are shown in the Governance Structure and can be found here.

Safeguarding Adults – A Description of What It Is

The statutory guidance[2] for the Care Act 2014 describes adult safeguarding as:

"Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time, making sure that the adult's wellbeing is promoted including where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances".

Abuse and neglect can take many forms. The various categories as described in the Care Act are shown here. The Board has taken account of the statutory guidance in determining the following vision.

[1] Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/contents
[2] Care and support statutory guidance: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

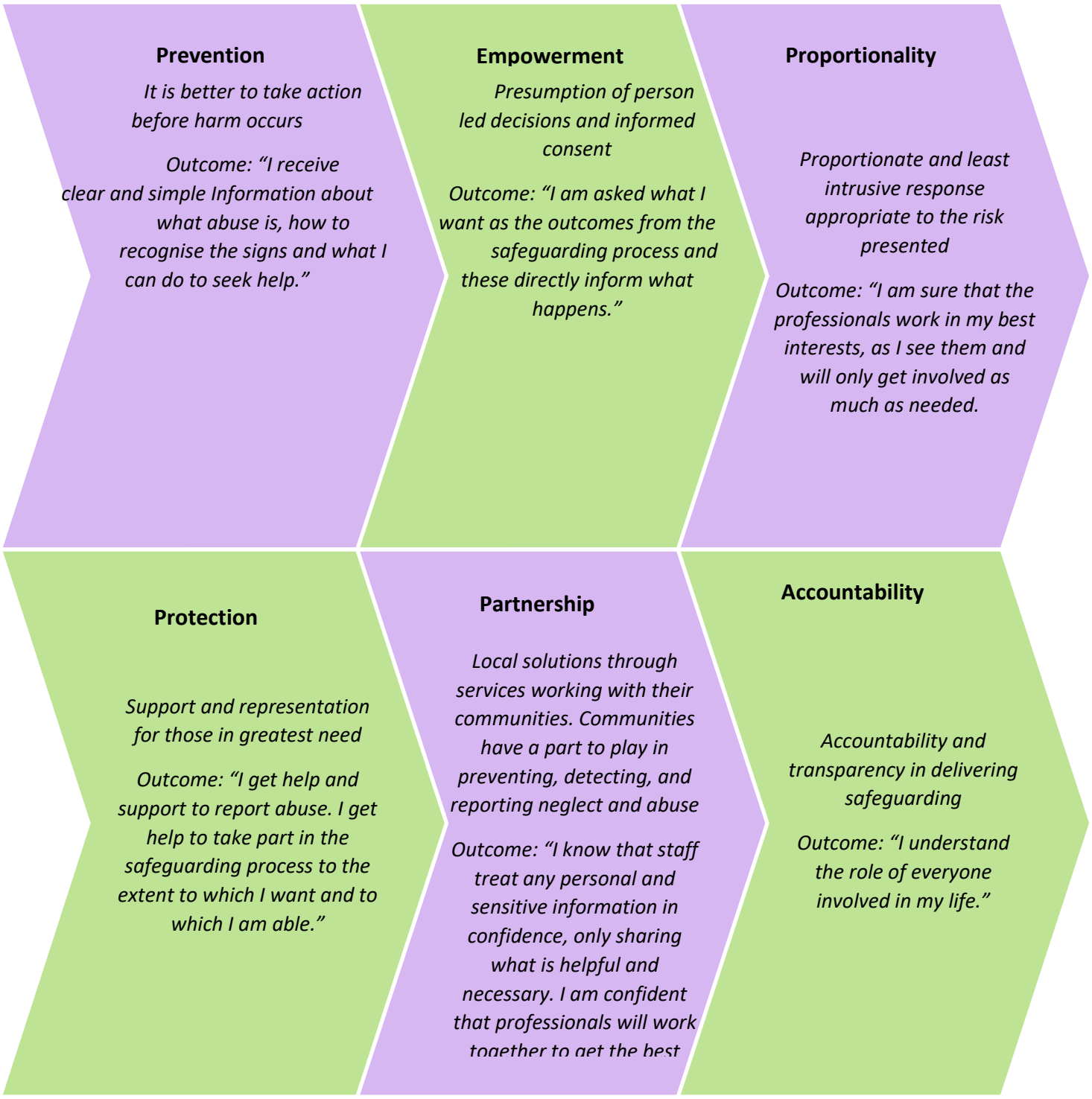
Vision for Safeguarding in Staffordshire and Stoke on Trent

'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 2011 (DoH) set out the Government's statement of principles for developing and assessing the effectiveness of their local adult safeguarding arrangements and in broad terms, the desired outcomes for adult safeguarding for both individuals and agencies. These principles are used by the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board and partner agencies with safeguarding responsibilities to benchmark their adult safeguarding arrangements. The principles can be found here.



5. What we have done

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.

Board

Independent Chair: John Wood

Vice Chair: Lisa Bates, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (now Integrated Care Board – ICB)

The Board oversees and leads adult safeguarding across our area and is interested in a range of matters that contribute to the prevention of abuse and neglect. These include the safety of patients in the local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders.

At each quarterly meeting the Chair sets the tone reminding Board members of their statutory responsibility to seek assurances that there are effective arrangements in place to protect adults with care and support needs who are at risk of abuse and neglect and unable to protect themselves. The Chair helps to create an environment where constructive discussion and mutual challenge is welcomed and encouraged.

During 2022/22 the Board has:

- Consulted a wide range of connected partners and practitioners to review, revise and approve the Board Strategic Plan. The Plan has a new priority that seeks assurances from partners that there is Effective Practice around mutually agreed key safeguarding themes.
- Sought and received assurances from partners that risks of abuse and neglect were being identified and addressed where there is the potential for adults with care and support needs in a variety of situations to be subject to 'hidden harm'. On this theme there have been discussions with members of the Domestic Abuse Commissioning and Development Board and an action agreed to improve partner recording systems to better identify adults with care and support needs who are subject to Domestic Abuse.
- Received a presentation about the Serious Violence strategy from Jon Rouse City Director, Stoke-on-Trent City Council and Naomi Smith Office of the Staffordshire Police and Crime Commissioners Office, Programme Lead for Serious Violence Strategy to discuss and agree responses on matters of relevance.
- Considered, approved and published on the SSASPB website three Safeguarding Adult Reviews (SARs) which were finalised in 2022. (Andrew, Anne and Heather)
- Tasked the chair of the Practitioners' Forum with ensuring that the lessons to learn from all 3 published SARs are included in the practitioners' development programme
- Received two detailed presentations from Care Quality Commission (CQC) Inspectors:
  - Safeguarding adults within regulated independent hospital settings
  - The CQC perspective on safeguarding adults within regulated care settings

  The CQC inspectors are regular presenters to the Board. The CQC input helps to confirm the current themes and trends to help facilitate learning and to help inform a preventative approach to learning events, publications and themed audits.

- Sought and received assurances from the local Clinical Commissioning Groups on their response to safeguarding concerns arising from significant events at Independent and Private Hospitals within Staffordshire and Stoke-on-Trent
- Received detailed presentations on the learning from the lives and deaths of adults with a learning disability and autistic people (LeDeR) programme and strengthened alignment of working on mutually relevant themes. On a related theme, considered the recommendations from the Norfolk Safeguarding Adult Review into the deaths of three young adults with learning disabilities which was published in September 2021, and subsequently seeking assurances from relevant agencies locally in relation to the recommendations.
- Participated in two national research projects:
  - Strengthening Adult Safeguarding response to homelessness and self-neglect, by Jess Harris, Research Fellow, King's College London
  - COVID-19 and Adult Social Care and Safeguarding, by Dr Laura Pritchard-Jones, Director of Taught Post-Graduate Programmes Keele University, Staffs.
- Received the findings from the research projects at Board meetings. The relevant local themes have subsequently been incorporated into the Board work programme, for example, the Engagement Strategic priority and the 'Andrew' SAR action plan
- Sought and received assurances that operational demands caused by COVID-19 and other winter pressures were identified and risks mitigated as far as possible in the context of significant operational challenges.
- Considered and contributed to the review of the arrangements and working of the Multi-Agency Safeguarding Hub (MASH)
- Through constructive links developed with National and Regional Safeguarding networks contributed to the development of a variety of work. Examples include the production of a National Data Toolkit, the consultation on the revision of the Safeguarding Adult Review Quality Markers, membership of the reference group for the national Safeguarding Adult Review improvement plan, production of regional policies and guidance and the production of guidance on how to better engage adults who are often referred to as 'non-engaging'
- Attended various national webinars, many of which involving lessons learned from important national research, with learning shared amongst local partners.
- A standing agenda item for inspection, organisational review and peer review updates from partners that facilitates open discussion about areas of good practice and offers of support to meet organisational challenges.
- A standing agenda item on matters arising from links with others partnership boards and fora enables visibility and alignment on matters of safeguarding relevance.

Executive sub-group

C hair: Lisa Bates, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent Clinical Commissioning Groups August 2020 to present

Vice Chair: Carl Ratcliffe Staffordshire Police Superintendent June 2021 to July 2021, Sharon Conlon, Head of Strategic Safeguarding, Midlands Partnership Foundation Trust August 2021 to present

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. Organisations represented include the Statutory partners (which are Stoke-on-Trent City Council, Staffordshire County Council, Staffordshire Police and the local Clinical Commissioning Groups); also the Midlands Partnership Foundation Trust (MPFT).

During 2021/22 the sub-group has:

- Monitored progress against the SSASPB strategic priorities (Engagement and Financial and Material Abuse)
- Co-ordinated the work undertaken to review the strategic priorities in preparation for the Board approval of the 2022/2025 Strategic Plan
- Sought and received assurances that partner responses to the COVID-19 pandemic and associated pressures on front line services were being monitored and mitigated on matters relating to adult safeguarding
- Checked local activity against the National COVID Assurance framework that had been distributed through the National Board Business Manager network
- Monitored the progress of all Safeguarding Adult Reviews raising constructive challenges around practice where appropriate
- Approved funding to participate in the Alcohol Change project 'Cognitive Impairment in Dependent drinkers' to support the delivery of the improvement plans following the publication of the Safeguarding Adult Review 'Andrew'
- Received updates on local matters of concern in connection to Independent Hospitals and changes to oversight arrangements arising from learning from hospital closure
- Strengthened links with the Learning from Lives and Deaths Programme (LeDeR) through the attendance of and discussion with the Chair of the Strategic Group. Discussions followed up with further updates and discussions at SSASPB
- Examined assurance updates from both Local Authorities regarding Large Scale Enquiries (LSEs) and Deprivation of Liberty Safeguards (DoLS) authorisation backlogs
- Monitored the activity towards mitigation of risk using the SSASPB Risk Register. Approach to the management of risk has been revised within a new strategic priority (2022-2025) seeking assurances around Effective Practice in 5 key risk areas
- Received regular updates on the progress of the transformation from Clinical Commissioning Groups to the Integrated Care Board and developing early links to the planned arrangements
- Received updates on the progress of the Stoke on Trent Multi-Agency Resolution Group which is a multi-agency forum to discuss adults who have multiple needs and advocated for a similar forum in Staffordshire, whilst acknowledging the complexities of a layered and geographically large authority
- Worked with leads/chairs of Safeguarding Children Boards and Health and Wellbeing Boards to plan for a Staffordshire Strategic Partnership Protocol. The aim is to strengthen alignment of working on mutually relevant themes
- Received updates from Regional and National Adult Safeguarding fora through membership at various meetings
- Planned the partnership contributions to the Ann Craft National Adult Safeguarding week (15 to 19 November 2021). From the subsequent local evaluation acknowledged the excellent work done by many partners to support the awareness raising initiative

- Strengthened links with the Domestic Abuse Commissioning Board with shared partners reporting matters of relevance to each Board
- Monitored progress of the forthcoming Liberty Protection Safeguards and its interface with Safeguarding
- Reviewed the membership of the Board and managed the Board membership process
- Managed and monitored the SSASPB budget
- Reviewed the SSASPB Constitution
- Approved the Information Retention and Disposal Policy for the Board
- Considered the position of the Board against the NICE Guidance: 'Safeguarding in Care Homes'
- Considered the local requirements of work nationally to produce a joint Protocol between Her Majesty's Coroners and SABs with reference to co-operative working in SARs and Coronial processes
- Overseen the development of the SSASPB Annual Report

Safeguarding Adult Reviews sub-group:

Chairs: Staffordshire Police Superintendents Carl Ratcliffe to September 2021, and Jason Nadin to April 2022

Vice Chair: Lisa Bates, Designated Nurse Adult Safeguarding South Staffordshire Clinical Commissioning Groups

The Safeguarding Adult Reviews (SAR) sub-group has responsibility for management of SAR referrals from the point of receipt to the approval of the final report and delivery of the improvements action plan. The sub-group also has responsibility for identifying and cascading the lessons learnt from any reviews conducted by other SABs.

During 2021/22 a total of 4 SAR referrals were received. None of these met the criteria for a Safeguarding Adult Review.

It was concluded that one of the referrals would be dealt with through a single agency learning review. In one of the referrals Her Majesty's Coroner had issued a 'Prevent Future Deaths Report' under Regulation 28 of The Coroners (Investigations) Regulations 2013. The SAR sub-group was satisfied that there would be lessons learned in response to HM Coroner's request without a requirement to duplicate the review and learning process.

In response to the referrals not meeting the SAR criteria the SSASPB has further raised awareness of the criteria for SARs through the SSASPB newsletter and Practitioners' Forum.

During the year the following SAR was approved by the Board and published on the SSASPB website.

Heather – A SAR conducted under S44(4) Care Act 2014 – Discretionary Review (Stoke-on-Trent)

Brief overview of the circumstances of death and why a Discretionary SAR was undertaken:

Heather had been in hospital for a short period in the autumn of 2019. She was subsequently transferred to a 'discharge to assess' unit where it was determined that she was able to be cared for at home.

Prior to going home her capacity had deteriorated so a Best Interests meeting was held on 13th February 2020. The outcome of the meeting was that the Multi-Disciplinary Team agreed that they needed to honour

Heather's previous wishes that she did not want to go into a residential care setting, and she did not want to receive intensive treatment for her cancer diagnosis. An advocate was present at this meeting.

Heather returned home on 16th March 2020 with a self-funded care package which provided for a carer to live full-time at Heather's home address.

The allocated social worker mistakenly identified the care broker as a care provider. A broker is not a registered care provider. This meant that on discharge the responsibility to manage the care provided lay with the social worker. It was subsequently recognised that the social worker, carer, and broker were not sure of each other's roles and responsibilities.

The timing coincided with the early days of the COVID 19 pandemic and shortly before the first national lockdown. There was uncertainty about how the virus would impact on the population and the accordingly the carer lived with Heather for 7 weeks without a break to minimise the risk of COVID infection.

Heather had leg ulcers which were attended to frequently by District Nurses. On 28th April 2020 Heather was seen to have a low body temperature and was shivering. On 29th April 2020, the carer called Heather's GP as she identified that Heather may have sepsis. An ambulance and paramedics attended. Sepsis was suspected and she was taken to hospital but sadly died the following day.

Following investigation by the Police it was determined that there was no evidence of abuse or neglect of Heather, but there may be learning for the organisations involved. The published report and recommendations illustrated the learning that:

- It would have provided better continuity for Heather's care if someone from the District Team where she lived had attended the Best Interest meeting.
- There should be better awareness across SAB partner organisations concerning the symptoms of sepsis and the importance of early medical intervention.
- More detailed and more timely information sharing may have negated the need to detain the carer on suspicion of causing neglect.
- More detail should be included in records demonstrating clear rationale for decision-making.
- Where there is a multi-agency approach to the care and support needs of an adult, professionals and other frontline staff/volunteers should make sure that others understand their individual roles and responsibilities to negate assumptions.

Update on the Anne SAR from the 2020/21 Annual Report

The action plan to implement the learning for this review was completed and signed off by the Executive sub-group in March 2022. The action plan included:

- The SSASPB is to seek assurance that Commissioners, care agencies and Hospitals agree and document their role in ensuring that there is continuance of care in circumstances where an adult with care and support needs is discharged from A&E particularly as an out of area patient (i.e. not admitted to hospital).
- The SSASPB is to reinforce the need for clear documentation and record-keeping, particularly where more than one organisation may need to respond to or act upon the comments. Decision-making is to be supported by clear rationale and acronyms explained on first use.
- The SSASPB is to seek an insertion in the West Midlands Regional Self-Neglect guidance to address the following finding 'Where adults with capacity are living at home in unsafe conditions that could put

the adult's health at significant risk, steps should be taken to explain the potential risk to support the adult in making their own decision'

- The SSASPB is to task Commissioners with ascertaining the feasibility of adults (with care and support needs who appear unkempt, are assessed as frail and are living in isolation without a package of support) having an Occupational Therapy home assessment prior to discharge
- A briefing note has been produced by the Board to give an overview of the circumstances leading to the SAR and the recommendations which is posted on the SSASPB website.

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

- Engaged with the Safeguarding Adult Board Managers National and Regional Networks to share good practice developed by other SABs
- Reviewed the SAR protocol to ensure continuous improvement and consistency with Regional SAR procedures
- Maintained links and reporting relationships with Community Safety Partnerships that are managing Domestic Homicide Reviews (where they involve adults with care and support needs)
- Oversaw the progress of ongoing SARs.
- The SSASPB Business Manager was a member of a national working group which acted as a reference group for the Social Care Institute for Excellence (SCIE) Quality Markers for SARs which will ensure that there is a consistent approach to SARs nationally. These were launched in March 2022. She also volunteered to represent the West Midlands Region as a SAR Champion, this entails regional representation at national meetings where SAR matters are discussed and key points widely communicated.
- Provided detailed assurance against the 29 Improvements recommended by Professor Michael Preston-Shoot in his academic analysis of SARs (2020)
- Actively raised awareness of the previously identified recurring lessons to learn from SARs, which are:
  - Better recording of the rationale for decision-making to be made in case files
  - Use of the SSASPB escalation policy to resolve professional disagreements as soon as possible
  - Appointment of a lead professional to drive multi-agency resolution in complex cases
- Promoted webinars made available nationally that are relevant to SARs
- Trialled then adopted a revised SAR 'triage' process using 3 or 4 experienced SAR members to assess the referral shortly after receipt. This was introduced to try to minimise the resource put into scoping SAR referrals that were highly unlikely to meet the criteria. The approach is regarded as helpful to the referral process.
- Produced an Independent Reviewer contract with which to commission review authors. This allowed for consistency in approach and clarity of expectations
- Promoted the finding from the National Review of SARs (Professor Michael Preston-Shoot 2020) which highlights the importance of identifying and appointing a lead practitioner in circumstances where there are several partners involved with adults having multiple needs. This was included in the SSASPB newsletter, reinforced in the Multi-agency S42 Procedures, and delivered in several learning lessons from SARS presentations

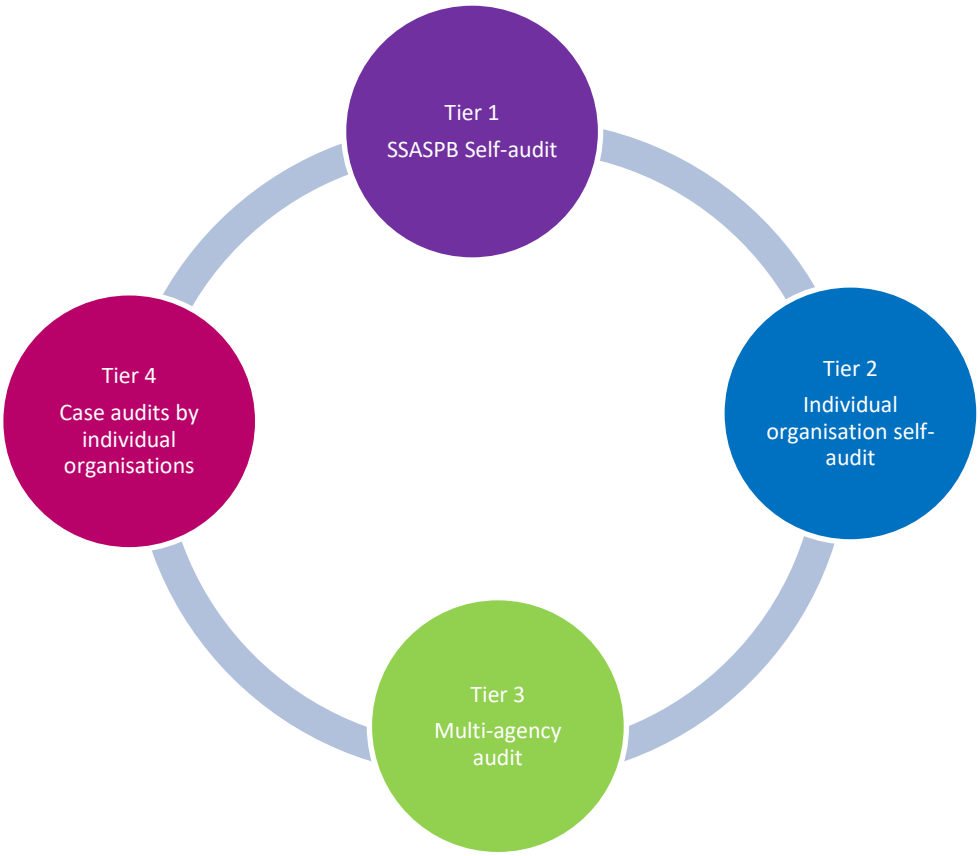
- The Board Business manager is a member of a national task to finish group which will engage with the Chief Coroner to seek the feasibility of guidance as to how Coronial and SAR processes best work together in support of their individual objectives

Audit and Assurance 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;



Tier 1 SSASPB self-audit is an annual self-assessment against the SSASPB constitution

Tier 2 Individual Organisational audit: in year 1 each organisation completes a self-assessment against a set of agreed standards, in year 2 there is a peer review of evidence put forward against specific standards

Tier 3 Multi-Agency Audits are themed multi-agency audits, the themes come from questions raised following receipt of the annual data report

Tier 4 Individual Agency audits which can be requested by the Board or one of the sub-groups with the purpose of seeking more detailed information about a trend or theme which becomes apparent

During this year the Audit and Assurance sub-group has:

- Completed the annual Tier 1 audit. This helps the Board to understand where its challenges are and where it can evidence that it is meeting the requirements set out in the Board's Constitution.
- Initiated the Tier 2 audit (year 1). All Board partners were asked to complete a comprehensive self-audit evidencing how they deliver their responsibilities both to the Care Act 2014 and as a SSASPB partner. A total of 28 responses were received and the follow up work which includes scrutiny of the evidence submitted against the self-awarded rating of Red, Amber and Green (RAG) continues at the time of this Annual Report. The outcomes will be reported on in the Annual Report for 2022/23
- Conducted a Tier 3 Multi-agency Case File Audit on the theme of Persons in a Position of Trust (PiPoT) on 11th May 2021. This audit revealed that several of the cases which were considered evidenced matters better routed through quality assurance processes this led to a Tier 4 individual agency audit where those partners who receive concerns audited what happened to referrals that did not result in a Section 42 enquiry.
- Conducted a Tier 3 Multi-agency Case File Audit on the theme of Organisational Abuse held on 1st October 2021. This audit identified that it would be helpful to raise practitioner awareness of what constitutes Organisational Abuse. The findings and learning from the audit were subsequently communicated amongst connected partners at the Practitioners Forum, through the SSASPB Newsletter, and related learning events.
- Initiated a Tier 4 audit relating to the reporting, progression and outcome of safeguarding concerns. This audit identified that often there are safeguarding concerns submitted to the local authority which would be more appropriately referred elsewhere, for example, through Quality Assurance processes. The consequence is that there are safeguarding concerns awaiting a response from 'front end' processes which are better responded to elsewhere.
- Initiated a Tier 4 audit with the question - What happens to the reported concerns which do not result in a Section 42 Care Act Enquiry? This audit arises from the findings of the 'Andrew' Safeguarding Adult Review. The audit commenced in early 2022 and is not complete at the time of this Annual Report.
- Contributed to the review of the SSASPB Strategic Plan by considering the focus for proposed strategic priorities for 2022-25. The recommendations for a focus on Self-neglect and considerations around the application of the Mental Capacity Act 2005 were accepted by the Board.
- Provided the detailed information from relevant partners to explain the data and illustrations of investigation work contained in the Annual Report.
- Completed all elements of the sub-group business cycle including the review of the Audit and Assurance Business Plan and Terms of Reference
- Sought assurances that, despite the inability to accurately determine the number of situations where Domestic Abuse is a factor the domestic abuse element is recognised and actioned including consideration for MARAC referrals. Assurances were also sought that outcomes which had been determined by the adult at the centre of the process were being met.
- Sought assurances that connected partner agencies have mechanisms to identify repeat concerns and able to have an informed picture of risk rather than consideration of immediate presenting factors.
- Revised the SSASPB Performance and Quality Framework

Policies and Procedures sub-group

Chair: Ruth Martin, Principal Social Worker and Safeguarding Lead, Staffordshire County Council

Vice Chair: Jackie Bloxham, Adult Safeguarding Team Manager, Stoke-on-Trent City Council

A contact list is held of partner agency staff who assist with the production and review of policies, procedures, promotional material and guidance. The work is ongoing throughout the year and a record is kept of the documents which need to be reviewed together with the date this took place.

Although this group works virtually most of the time there is no less importance to its status within the structure of the SSASPB and it plays a vital role in ensuring that the Board documents are up to date and support interagency working.

The Policies and Procedures sub-group has reviewed the below documents;

- Mental Capacity Act Guidance
- Financial Abuse Guidance
- Mental Capacity Act Package and Trainer Notes
- Adult Safeguarding Awareness Package and Trainer Notes
- Decision making guidance
- Adult Sexual Exploitation guidance
- Retention and destruction policy (new Policy for 2021/22)
- Board Membership Process and Guidance
- Risk Register Guidance
- Information Sharing Guidance
- Board Membership application

All public-facing documents can be found on the SSASPB website.

6. Performance against 2019/22 Strategic Priorities

Strategic Priority: Engagement

A sub-group has been formed to drive the work of the Engagement Strategic Priority. The activity around this priority is managed and co-ordinated by the Prevention and Engagement sub-group which meets bi-monthly.

Chair: Sarah Totten, Strategic Manager – Early Intervention, Contact and Hospital Adult Social Care, Health Integration and Well Being, Stoke-on-Trent City Council. Covered by Helen Jones, SSASPB Business Manager between November 2020 and April 2021.

Vice Chair: Helen Jones, SSASPB Business Manager

Engagement is a broad term, for the purposes of the work of the Board during 2021/22 engagement refers to raising awareness of adult abuse and neglect and how to respond with several key groups of people including:

- Adults with care and support needs

- Carers and advocates
- Professionals and Volunteers
- Members of the public
- Board partners

From the onset of the COVID-19 pandemic the approach to engagement changed from predominantly face to face communications through diverse networks to making extensive use of a variety of electronic methods using telecommunications and the internet. This approach has continued.

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

- Hosted 4 Financial and Material Abuse events via Microsoft Teams
- Held event 1 on 20th April 2021; 58 front line practitioners logged in to the first SSASPB webinar in support of the strategic priority Financial and Material Abuse. Presentations were delivered by Jackie Bloxham (SoTCC) Ruth Martin (SCC) and Claire Histead (MPFT). The topic for this presentation, the first of three, was financial and material abuse in the context of Section 42 Enquiries. This included case studies and legislative framework which were well received. The feedback following the event was extremely positive
- Held event 2 on 19th July 2021; this one was from the perspective of the Trading Standards work in both Stoke-on-Trent and Staffordshire. It was attended by 55 people, mostly from the front line within partner organisations
- Held event 3 on 15th September 2021: this one was focused on Domestic Abuse with reference to Financial and Material Abuse incorporating Coercion and Control or Psychological Abuse. A total of 28 front line practitioners or volunteers logged in to the event. The attendance was adversely affected due to competing operational demands at the time. The presenters were New Era which is commissioned to provide Domestic Abuse services in Stoke-on-Trent and Staffordshire
- Held event 4 on 29th September 2021: this was a repeat of event 3 to maximise the possibility of attendance and another 3 practitioners attended.
- Produced short video briefings on key topics including Advocacy in Financial Abuse Enquiries and Cuckooing. The videos have been placed on the SSASPB website.
- Participated in important national research projects conducted by Dr Laura Pritchard-Jones from Keele University and Research Fellow Jess Harris from Kings College London
- Refreshed the SSASPB website to make it more compliant with accessibility legislation and to refresh the content. Since the refresh there has been an increase in the use of the website.
- Commissioned Board partner Rockspur to produce a more accessible version of the 2020/21 Annual Report. This was produced by adults with autism or a learning disability and has been posted on the SSASPB website. The report was very well received and will be repeated for 2022/23.
- Supported Ann Craft Adult Safeguarding week (between 15th and 19th November 2021) with several events arranged by connected partners. Subjects covered included raising awareness of adult abuse (including specific types of abuse and neglect), how to report concerns, and an explanation and illustration of Safeguarding Adult Reviews.
- Used Twitter to support Adult Safeguarding week, raising awareness of local activity as well as retweeting relevant information produced by other SABs within the UK.
- In response to a need identified by practitioners hosted a webinar for practitioners on the subject of stalking and harassment that was delivered by members of the Prevention and Engagement sub-

group from North Staffordshire Combined Healthcare Trust (NSCHT) and Midlands Partnership Foundation Trust (MPFT), this was attended by 44 front line practitioners

- Produced two newsletters (June and November 2021) which were distributed widely and covering a variety of topics including:
  - learning from Safeguarding Adult Reviews
  -- how to make a referral to Stoke-on-Trent Multi-Agency Resolution Group (in response to SAR 'Andrew')
  - Sepsis awareness (in response to SAR 'Heather')
  - What is adult safeguarding?
- How to make a good SAR referral
  - spotlight on Rockspur – producer of the more easily accessible Annual Report
  - Lasting Powers of Attorney (link to Financial and Material Abuse)
  - links provided to both versions of the SSASPB Annual Report
- The Board has agreed to continue with Engagement as a Strategic Priority for 2022/25 and will focus in particular on how to better engage with adults with needs for care and support who have experienced abuse or neglect.

The following case studies exemplify the approach to Making Safeguarding Personal and cross-partner collaboration.

Case Study: Midlands Partnership Foundation Trust

The Safeguarding named nurse at Midlands Partnership Foundation Trust (MPFT) was contacted by the clinical lead of District Nursing service asking for advice regarding 'Grace' a female patient with whom the vascular team was finding difficulties in engaging and concerns about safeguarding. Grace was an intravenous drug user with a below knee amputation on one leg. Her remaining leg was in a poor state and in need of dressings.

The Tissue Viability team wanted to continue with dressings however the team were struggling with compliance – either Grace was not at home at the time of a visit, or she refuses treatment.

The District Nurses had concerns as they had not assessed the wound for some time. The consultant has been contacted and advised that nothing more could be done with the remaining leg, the options were either conservative treatment or amputation. Grace was at risk of Sepsis.

From a previous safeguarding concern an assessment concluded that the woman did not have care and support needs and she reported that she did not require any help from social care.

The clinical lead for Grace's care convened a Multi-Disciplinary Team (MDT) meeting which was attended by the named nurse for safeguarding, social work team, substance misuse worker, consultant, and Tissue Viability Lead. The consultant explained to those present the risk that Grace may lose her remaining leg and that she would not be able to walk again. The wounds are not going to heal, and it is important to ensure that they stay infection free. The risks had been explained to the patient.

It was decided at the MDT meeting that Grace's social worker and the district nurse would make a joint visit to establish if the patient met the self-neglect criteria under safeguarding. The decision was also made that Grace would only be given a script covering 7 days for her drug use and would then need to see the substance misuse worker at the clinic. As part of a coordinated approach the District Nurses would see Grace when she attended for her substance misuse appointment at the clinic.

The MDT approach to supporting and working with the patient lead to better engagement. The patient was being seen and had been doing well in self managing the necessary dressings to keep herself safe. This is a good illustration of the mutual benefits of team working with the clinical lead happy to support self- care model with supervision.

Case Study: Stoke on Trent City Council Adult Social Care

Michael and Freya had lived together as the only tenants in a Group Support Living house for several years. Both adults had diagnosed moderate learning disabilities. The accommodation was a two-storey house with each adult having their own bedroom whilst sharing the kitchen and living room areas. Individual and core support was provided twenty-four hours per day based on a strength-based approach to maximise independent living.

There was a significant age difference between the two adults - Michael was 82 years of age and Freya was 46. Their compatibility was becoming negatively affected by changes in their needs and this became more apparent during an imposed lockdown due to the pandemic. Both were forced to spend more time together in the house, at the same time, Michael was experiencing a deterioration in his mobility and mental health.

This situation led to a Section 42 Enquiry as both adults were becoming verbally and physically abusive towards each other on a regular basis and it became apparent that their living arrangements were becoming unsustainable.

Separate Social Workers were allocated to work with Michael and Freya to consider appropriate safeguards and explore solutions in the best interests of both. This involved working closely with the adults themselves, family members, the advocacy service, the Community Learning Disability Team, and the care providers, utilising a multi-disciplinary strengths-based approach.

It quickly became apparent that the relationship between both adults had broken down to the point that they were at risk of harm from each other, and it was identified that a positive solution could involve both adults moving to new accommodation with other adults of a similar age, interests, and compatibility. As part of the safeguarding and assessment process, Mental Capacity Act (2005) assessments were completed with both adults with contributions from the multi-disciplinary team. These concluded that both adults lacked the mental capacity to choose their care and support accommodation, and this would need to be done in their best interests.

The Section 42 enquiry involved working with the care provider to ensure there was sufficient staff on duty to minimise the risk of further incidents, whilst still allowing both adults to safely move freely around the house. The accommodation identified for Michael was another Group Supported Living accommodation within the same local area, with the current support team in place. It was felt that this provision would provide Michael with consistency of support, familiarity of local community services and shops. There were two other men living in this property of a similar age with similar interests and support needs. The property was a single storey bungalow which was suitable for Michael's increased mobility needs.

The accommodation identified for Freya was a tenancy-based apartment with twenty fours a day support to meet her individual needs. This provides Freya with the opportunity to increase her social and independent living skills and have more choice in her daily living and community activities.

The safeguarding enquiry was concluded with an outcome that was mutually agreed to be in the best interests of both adults in improving their quality of life and manage the risks to each other from the breakdown in their living arrangements.

Case Study: Staffordshire County Council, Adult Safeguarding Enquiry Team

'Alice' is a 31-year-old woman with learning disabilities who lives in supported accommodation.

Alice was referred to adult safeguarding by the manager of her supported living scheme following an allegation of sexual abuse by another adult with care and support needs living at the service address. The concern was graded as high risk and sent to the Adult Safeguarding Enquiry Team for further enquiry. The enquiry was joint with Staffordshire Police.

The source of risk to Alice was subsequently arrested by Police and bailed with conditions to prevent contact. This became difficult to manage when both adults lived within the same service. The source of risk breached the bail conditions on multiple occasions.

The allocated Safeguarding Practitioner and Police had gained an understanding from Alice as to how she could best be supported and the outcomes she wanted to achieve from the safeguarding process. Alice was clear that she wanted the other adult to leave the service.

The service provider had put measures in place to support Alice. Whilst the source of risk remained within the same supported living scheme the provider in conjunction with the professionals supporting Alice also considered the potential transferrable risks to other adults within the accommodation.

The source of risk presented with behaviours which were challenging for the service to manage. Due to previous concerns the provider had already given notice to the source of risk. However, the new concerns escalated the need for an alternative placement to be identified.

The Safeguarding Practitioner was in contact with professionals involved with both Alice and the source of risk. An urgent meeting was held to discuss the risks and the measures that could be put in place to mitigate these. This provided an opportunity for information to be shared in a timely way and actions set to ensure both adults received the necessary support for their assessed needs. A multi-agency approach ensured that the needs of both adults were considered and that appropriate steps were taken to manage the identified risks.

The source of risk did subsequently move to alternative accommodation which was better suited to meet his needs and the risks he presented to others. The risk of harm to Alice was removed and her anxieties reduced following his departure.

Case Study: University Hospital North Midlands Trust

'Gary' a 28 years old man was found lying outside the Accident and Emergency department of University Hospital of North Midlands, Stoke-on-Trent. He presented as unresponsive and physically unstable with respiratory and cardiac health problems. It was noted that Gary had physical injuries including facial and limb bruising and appeared malnourished and unkempt.

When Gary was transferred into the Accident and Emergency department he was reviewed and assessed. Physical health assessments determined that he was critically unwell and required admittance to the intensive care unit for life saving treatment. Gary's presentation highlighted safeguarding concerns for frontline staff as it was noted that he had a complex social history including alcohol and drug dependency with mental health and social problems. Gary explained that he had been brought to the hospital by a friend and left outside Accident and Emergency department.

Staff in the department escalated their safeguarding concerns highlighting his physical presentation, concerns for his on-going safety and welfare, as well as concerns regarding his relationship with his 'friend'.

When the patient made clinical improvement, it became apparent that there was a network of friends who were trying to obtain information about him and to contact him. Gary's friends wanted him to take his own discharge and return to a shared residence.

As Gary's condition further improved the patient began to engage with services. Social Care and the Nursing team on the ward worked together and helped the patient to talk about his personal circumstances. Gary disclosed that he had been the subject of sexual assaults. The Health and Social Care staff suspected that he may have been a victim of human trafficking. Further disclosures by the patient highlighted that his finances and accommodation were controlled by 'the friend'. The patient did not acknowledge that he had been subject to abuse or criminal activity.

The allocated social worker and ward manager worked with Gary to develop trust and offer support to mitigate on-going risk, develop safety plans and promote a safe discharge.

When further information was disclosed by the patient it became apparent that there may be wider concerns with other people at risk of human trafficking. These concerns were reported to Staffordshire Police.

When the patient was medically fit to be discharged, he was offered safe accommodation and the offer of ongoing support from Social Care, Mental Health, and Staffordshire Police. This case illustrates the prompt and positive action of the staff at University Hospital North Midlands to respond positively and sensitively to serious abuse of a patient and work with connected partners and the patient to mitigate his health risks.

Case Study: Midlands Partnership Foundation Trust

'Carol' had been experiencing domestic abuse for the duration of her 30 years of marriage which had negatively impacted her anxiety and self-esteem. In recent years Carol had been accessing mental health services to address her anxiety which, coupled with other health complaints, led to her being unable to leave her home.

As a consequence of Carol accessing more support services several professionals had raised safeguarding referrals, however Carol had not felt able to engage with immediate safeguarding measures as she did not want to leave her home.

A subsequent escalation in concern about domestic abuse led to a Multi-Agency Risk Assessment Conference (MARAC) referral. A further adult safeguarding concern led to a Section 42 enquiry. It was agreed by the professionals supporting Carol, and subsequently with Carol herself, that the only way to address this situation and remove the ongoing risk and experience of abuse was for Carol to live in her own accommodation.

Carol worked with the social worker, domestic abuse support worker and housing officer to overcome the challenges associated with moving away from her partner. Carol was required to provide medical evidence of domestic abuse to support her housing application, however, to obtain this from her GP there would be a cost of £50 that would show on her bank statement and therefore alert her abuser. Carol had also been deterred from moving home as she was not sure how to obtain the required legal advice regarding ending her tenancy.

With the support of the safeguarding social worker and domestic abuse support service, medical evidence was provided, and Carol has now been offered appropriate accommodation which she was delighted with.

A combination of joint working, appropriate sharing of information and knowledge of how to navigate agency processes and legislation helped to produce this resolution. As well as a successful outcome for Carol which was in line with her wishes there was learning for the organisations involved around domestic abuse and adult safeguarding which can be used to help others in similar situations of abuse.

Case study: Clinical Commissioning Group

'Robert' had a diagnosis of a progressive neurological disorder. The disorder progressed quickly, and he required a 24-hour care package. His care had become very complex, and he had a range of professionals involved. Robert had very little support outside of the professionals involved, he had no family to support therefore heavily relied on carers and other professionals to provide social stimulation and advocate for him as he was beginning to lose his voice due to his diagnosis.

A safeguarding referral was made, as one of the professionals involved had become increasingly concerned about the care, he was receiving from his domiciliary care provider. The concerns raised ranged from a lack of training around machinery needed to support Robert's breathing, to a lack of personal care and issues around the language barrier between the carers and Robert.

When the Clinical Commissioning Group (CCG) Adult Safeguarding Nurse became involved, it became apparent Robert was not being provided with the care he needed. A multi-agency team meeting was arranged with the professionals involved. Robert's wants and wishes were identified and discussed along with the safeguarding concerns raised, and a plan was agreed.

From the plan, to help with Robert's deteriorating communication he was provided with assistive technology. A communication book was used for his carers to readily identify Robert's basic needs. An advocate was engaged to seek Robert's wants and wishes before he lost his speech.

A pain management plan was agreed to control Robert's pain, for him to use his wheelchair comfortably and access social activities held at his home and in the community. A new domiciliary care provider was sourced on Robert's request enabling him to build new relationships, develop trust with the care company and receive the care he needed.

The collaborative work undertaken by the various agencies enabled Robert to achieve his desired outcomes, enhancing his quality of life and ensuring that he was in receipt of safe and appropriate care.

Case Study: Stoke on Trent City Council Adult Social Care

'Amy' lives alone in a local authority property and is supported by a domiciliary care agency. Amy requires support with tasks of daily living to manage risks due to visual impairment and deterioration in physical health, she also relies on family support with practical tasks and management of finances. There are no concerns in relation to Amy's capacity in any of these decisions.

The care agency raised concerns with Adult Social Care as they were concerned regarding Amy's home environment, the lack of food in the property and that she had no money in her purse to buy items that were important to her such as cigarettes, which was leaving her in distress. The Social Worker gained further information from the referrer and visited Amy to discuss her views and wishes on the concerns raised.

The visit identified that Amy's distress came from not having access (as and when she needed) to cigarettes, relying on carers to purchase food and toiletries out of their own money and from Amy having her meal

delivered by family members too late at night when she was sleeping. Amy explained that her relationship with her family was important to her but did not want to continue to be reliant on them for support. Amy was aware that her family may have been using her finances for their own purposes, but she did not wish for the concerns to be considered within the safeguarding process nor did she want any police involvement. In line with Making Safeguarding Personal, options were explored outside of a formal safeguarding enquiry.

Amy decided to inform her family of her decisions and did not want Social Care to be part of this discussion. A Care Act review was commenced and from that Amy requested that the Local Authority manage her finances via an appointeeship arrangement. Locality Connectors provided support and made links with Amy into her local community and the housing team supported via tenancy support, to ensure that the home environment was safe.

Amy maintains a positive relationship with her family, however, is not reliant upon them to meet any care and support needs.

Case Study: Queens Hospital Burton

'Michelle' name anonymised is a middle-aged lady, who resided on her own and self-funded a package of care for her physical health for which she was nursed in bed. As well as her physical health needs Michelle has a psychiatric history. Michelle has a son who is her next of kin.

The Trust Safeguarding Team received an email from the District Nurse to advise of Michelle's admission to the Queen's Hospital Burton and concerns of self-neglect, being generally unwell, and having multiple pressure ulcers. Previous hospital admissions identified presenting concerns of anaemia, being malnourished and concerns around self-neglect.

In the follow up discussions it was discovered that

- Historical safeguarding referrals had been raised in relation to concerns of self-neglect, and there was an open safeguarding enquiry.
- Michelle's GP had referred Michelle to the District Nurse due to pressure ulcers. However, the District Nurses had difficulty attending to Michelle as she had declined their services.
- Two nurses had visited Michelle and found her to be cold and in pain. The ambulance service was contacted, and she was conveyed to hospital. At hospital Michelle presented with dehydration, she was emaciated, and had numerous pressure ulcers.

Arising from the discussion of the safeguarding concerns at the Emergency Department a request was made for a Tissue Viability Team review, and for medical photography to be undertaken. The Trust Safeguarding Team supported completion of the safeguarding adult referral. Michell did not give her consent to the safeguarding adult referral because she was deemed to lack capacity to make the decision taken in her best interests.

The safeguarding referral described the nature of the pressure ulcers of concern to inform the ongoing safeguarding enquiry. The safeguarding referral detailed the measures implemented to minimise the risks of further harm and deterioration of the pressure ulcers, including the use of relevant equipment, wound management, and repositioning. A referral was made to the Dietitian.

Arising from the multi-agency discussions involving professionals from various agencies Michelle's historical care issues and responses to those were identified and used to inform the options for a plan for her safe discharge from hospital.

When Michelle was medically stable for discharge, she was deemed to lack capacity for her care and treatment, and it was not safe for her to return home. A Deprivation of Liberty Safeguards (DoLS) referral was submitted to the Local Authority.

Michelle was subsequently transferred to Samuel Johnson Community Hospital, for further social care assessments, as it was deemed unsafe for her to return home.

There was regular liaison with Michelle's son whilst she was in hospital. It was agreed that an Independent Mental Capacity Advocate was appointed to represent her views and wishes. Following a Continuing Healthcare Assessment Michelle was subsequently discharged to a nursing home to provide her with the safe care to meet her needs.

Strategic priority: Financial and Material abuse

Lead: Ruth Martin, Principal Social Worker and Safeguarding Lead for Staffordshire County Council

Strategic Priority: Financial and Material Abuse

Financial and Material Abuse has been a strategic priority for the SSASPB between April 2019 and March 2022. It is strongly suspected that the number of victims of financial or material abuse who have care and support needs is likely to be enormously under reported. Nationally it is estimated that between 10 – 20% of incidents are ever reported but this is not widely recognised. Coupled with this, perpetrators exploit the vulnerabilities of the victims and perceive that the risk of detection is low which contributes to this offending being a significant problem.

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.

A task to finish group was formed, attended by a broad range of partners, which took responsibility for managing the actions to be taken through strategic priority. A total of 8 meetings were held, the number and frequency of the meetings were severely impacted by the COVID 19 pandemic.

What we did:

- Created a Financial and Material Abuse guidance document which has been added to the SSASPB website. This will continue to be reviewed annually to ensure that it remains up to date.
- Produced a questionnaire that was completed by connected partners that provided the Board with an overview of the actions taken by partners to raise awareness of financial and material abuse, the actions taken when financial and material abuse occurs and to gain assurances as to how partners assess the effectiveness of those actions.
- Awareness raising of Financial and Material Abuse at the SSASPB conference attended by around 200 people at Yarnfield in November 2019.
- Planned for learning events in April and June 2020 that had to be cancelled due to the COVID 19 pandemic. These were converted to webinar events consisting of three separate presentations. On 20th April 2021 presentations were given by Ruth Martin (Staffordshire County Council), Jackie Bloxham (Stoke-on-Trent City Council) and Claire Histead (Midlands Partnership Foundation Trust). On 19th July 2021 there was a presentation by Trading Standards. The final presentation was given twice, on 15th and 29th September 2021 by New Era which specifically referenced Financial Abuse as a type of Domestic Abuse. A total of 232 practitioners attended these events.

- Conducted two multi-agency case file audits on 28 January 2020 and 15 September 2020. (Findings previously reported in Annual Report 2020/21)
- In April 2020 there was a focus on raising awareness of Financial and Material Abuse and practical actions for practitioners in the SSASPB newsletter.
- Through the links with the Prevention and Engagement sub-group the ASIST and Voiceability advocacy agencies produced a short video which was widely distributed and posted on the SSASPB website in November 2021

The SSASPB has excellent links with the universities in our area. Staffordshire University (School of Law, Policing and Forensics) was invited to assist with research into doorstep crime. Five BSc Hons final year students produced dissertations connected to Financial and Material Abuse. The projects entailed the researchers' examining data from Staffordshire County Council and Stoke-on-Trent City Council safeguarding teams, Trading Standards for both local authorities and Staffordshire Police.

The projects highlighted that age was a significant factor in likelihood of being a victim of this type of crime, with the propensity increasing for people over the age of 50 years. The research indicated some geographical areas where there appeared to be a higher risk but, it was recognised, this could be related to better reporting. The reports highlighted that women were more likely to be targeted than men.

The research also highlighted the different ways that organisations categorise types of financial abuse and suggested that responses may be improved if there was collaboration and consistency between agencies particularly in recording arrangements.

The projects identified examples of good practice and awareness raising and that wider engagement in these would benefit communities. These practices included visibility of groups such as Neighbourhood Watch and local Police Community Support Officers. It was recommended that proactive awareness raising could be done in those areas that have been identified as having a greater prevalence of repeat victims.

Conclusions

Much of the work undertaken through the SSASPB has involved raising awareness about the potential for and impact of Financial and Material abuse.

It would be difficult and overly optimistic to rely upon data to identify the effectiveness of the actions taken as recording methods have to be considered. Raised awareness could increase reports of abuse which was a key focus of the priority and accordingly a good outcome.

The final report of the task and finish group was considered at the meeting of the Board on 21st July 2022 when it was agreed that the work of the task group has helped to ensure a focus on a category of abuse that is under reported. The work of the task group is complete and oversight by the Board will continue through business as usual.

Staffordshire and Stoke-on-Trent 2021/22 performance report overview

Number of safeguarding concerns received by the Local Authorities in 2021/22

13,227	4,590
Staffordshire	Stoke-on-Trent

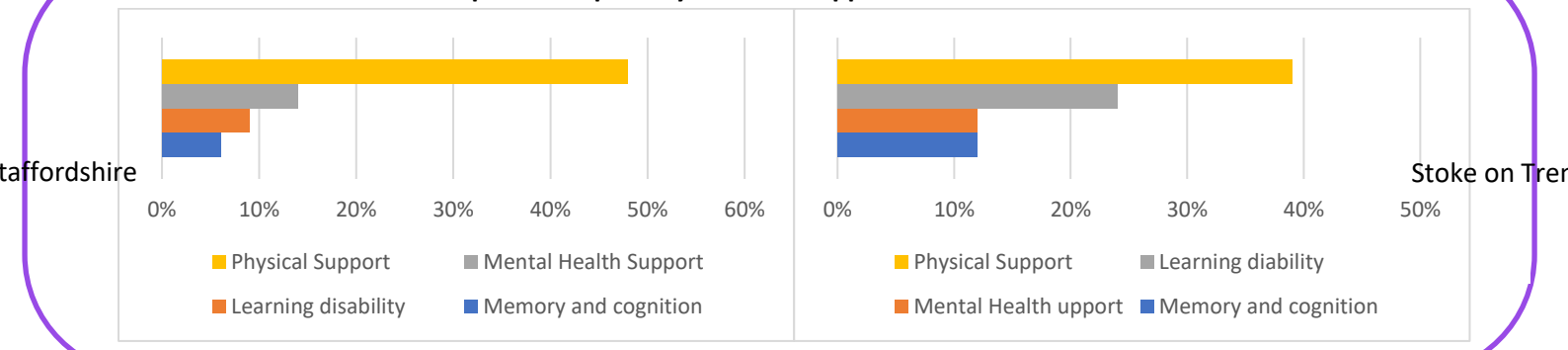
Staffordshire	Stoke-on-Trent
59%	54%

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

Most prevalent types of abuse 2021/22

Staffordshire		Stoke-on-Trent	
Neglect and acts of omission	37%	61%	Neglect and acts of omission
Financial Abuse	19%	21%	Physical Abuse
Physical abuse	17%	14%	Psychological Abuse
Psychological	12%	13%	Organisational

Most prevalent primary care and support need for the adult



Location of Abuse

	Own Home	Residential Home	Nursing Home	Hospital
Staffordshire	62%	11%	16%	1%
Stoke-on-Trent	26%	35%	12%	2%

8. ANALYSIS OF ADULT SAFEGUARDING PERFORMANCE DATA

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

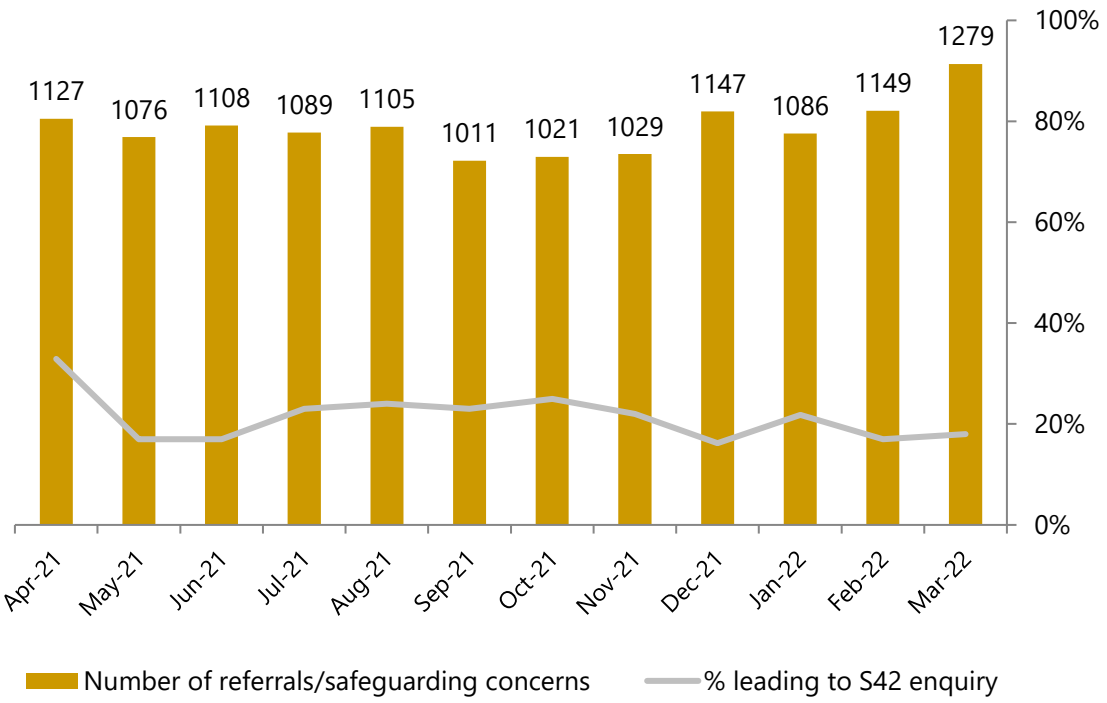
Number and proportion of referrals/safeguarding concerns

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

Reported concerns can progress to a formal enquiry under Section 42 of the Care Act 2014 if the criteria for the duty of enquiry requirement is met. 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.

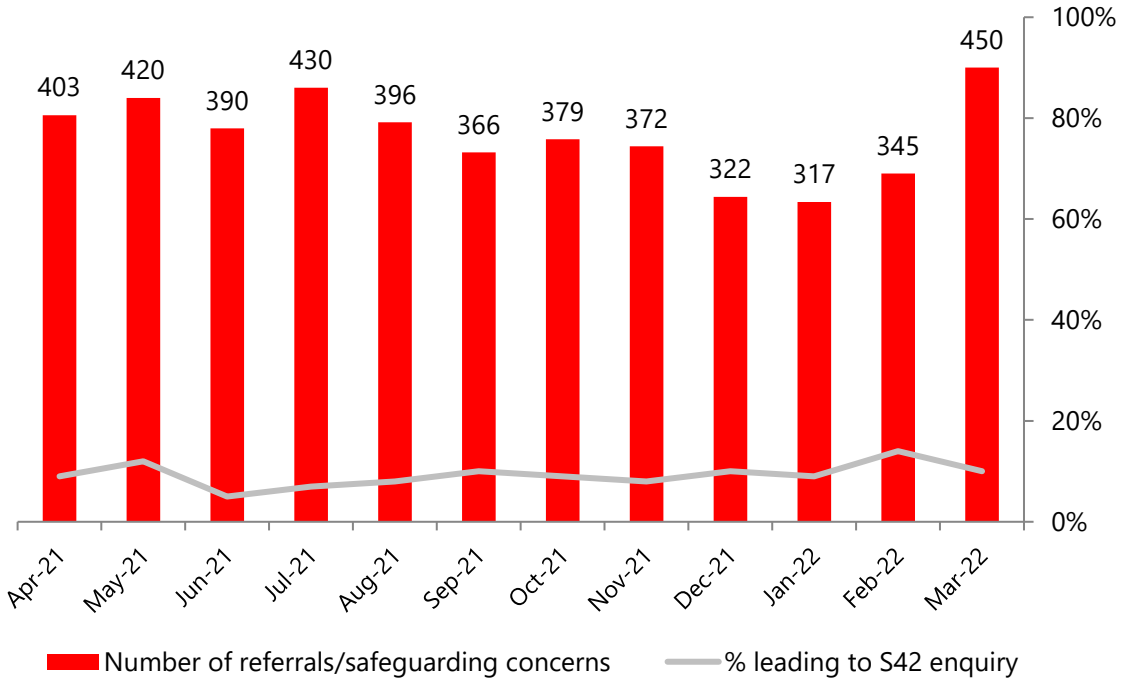
Fig.1 - Staffordshire: number and proportion of referrals/safeguarding concerns



During the course of the year 2021/22 in Staffordshire there have been 13,227 occasions when concerns have been reported that adults with care and support needs may be at risk of or are experiencing abuse or neglect. The total figure has increased by 1,051 occasions from 12,176 in 2020/21 which is an increase of 8.6%. This year the duty of enquiry requirement was met in 21% of reported concerns a decrease of 4% from 2020/21.

The reasons for the percentage decrease in concerns meeting the duty of enquiry threshold have been explored. The information gathered from audits, indicates that this could be related to the type of concerns raised, for example, there are more concerns relevant to quality issues and or requests for assessments. Monitoring of those concerns that do not meet threshold will continue over the next year to better understand this.

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



In Stoke on Trent there were 4590 reported safeguarding concerns in relation to adults with care and support needs during 2021/22. This is an increase of 395 from 4195 compared to 2020/21 which is an increase of 9.4%.

In Stoke on Trent the first contact workers carry out fact finding/information gathering on each safeguarding concern prior to being passed on to a manager who then makes the decision on whether or not the concern is moved onto a S42 enquiry or an alternative route to S42. Therefore, a lot of work is done at first contact stage which may be viewed as an enquiry albeit a telephone call or further discussions with the provider and or adult at risk in accordance with Making Safeguarding Personal. Following initial assessment, it was determined that the duty of enquiry requirement was met in 9% of occasions when a concern was raised.

The Board has requested an audit by both local authorities regarding what is done with concerns that do not meet the criteria for a section 42 enquiry. This will be reported on in the 2022/23 Annual Report.

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

- Both authorities review information on the initial safeguarding referral form
- Both make a decision at this point to determine if the three stage criteria is met
  a- does the adult have care and support needs,
  b- are they at risk or experiencing abuse
  c- and as a result of their care needs, are they unable to protect themselves
- If the three-stage test is met, then a decision is made by both authorities to gather further information (called a planning discussion).
- The planning discussion will involve information gathering from various sources, both professional and family and friends and the adults view where they have capacity to be involved.
- Following this information gathering both authorities make a decision if further enquiries and exploration of safeguards for the adult is required.

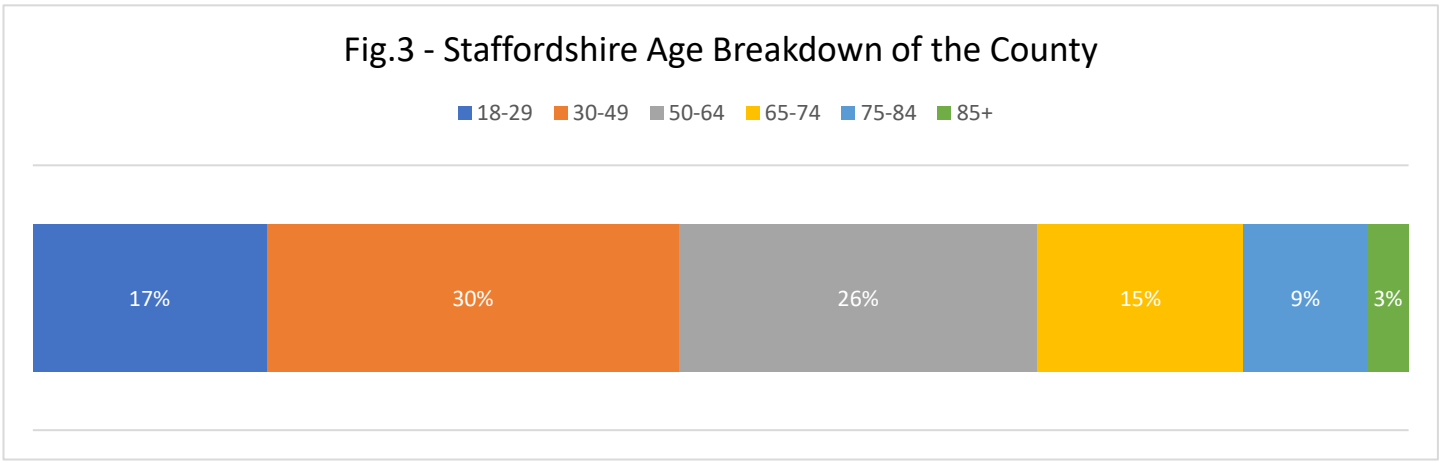
- If the decision is for no further enquiries, it is at this stage that Staffordshire and Stoke on Trent make a different recording decision –
- Stoke on Trent record this decision as – No Section 42 required (but also record what other actions either care assessment request, review etc. as a non-statutory Section 42)
- Staffordshire record this decision as – Section 42 enquiry completed (either no ongoing risk, closed at adult's request, concerns substantiated or unsubstantiated)

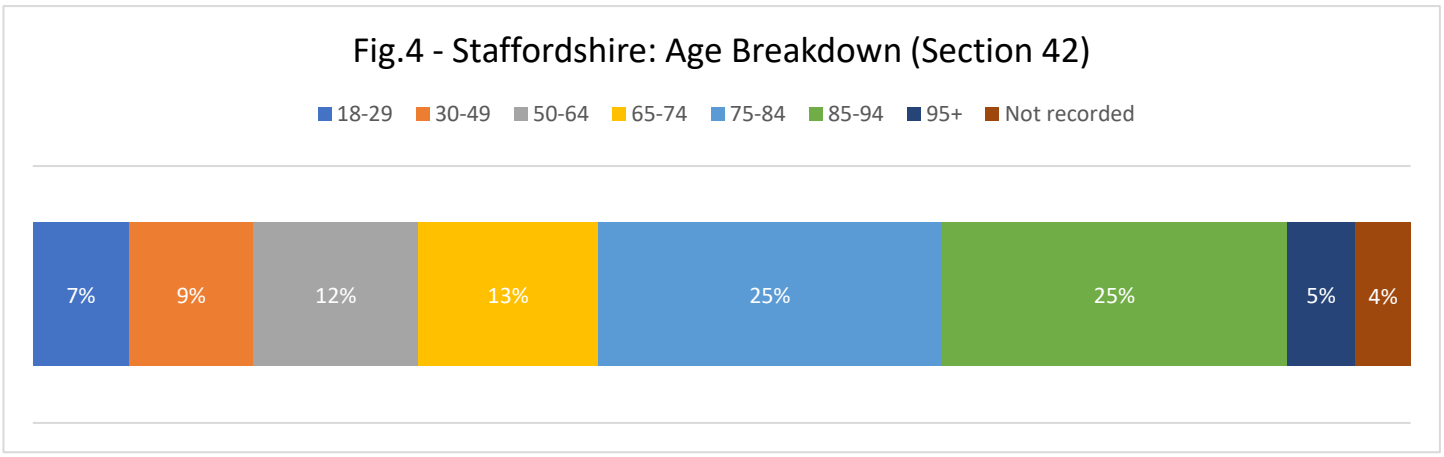
In essence Staffordshire and Stoke on Trent Local Authorities follow the same procedures but the recording on systems is an internal decision for each authority. This review has illustrated that both authorities are taking the same steps to ensure adults are safe and risks minimised. Both authorities have undertaken to re-examine their approaches to seek better alignment in recording practices and conversion to Section 42 enquiry rates.

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

About the Person

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





Staffordshire

Of the adults who have been the subject of a Section 42 enquiry, those aged 85-94 (25.2%) represent the largest cohort followed closely by 75-84 (24.9%), there has been very little change in age percentages this year compared to last year.

When comparing the age breakdown with general Staffordshire population statistics, it is evident that people in the 75+ age groupings are disproportionally overrepresented for Section 42 enquiries. Around 3% of the adult population in Staffordshire are aged 85 or over, however, 30% of safeguarding enquiries relate to this age group.

The average life expectancy for a man living in Staffordshire is 79.7 years and for a woman 83.5 which may explain why there are more enquiries for women than for men as there is an increased need as a population grows older for care and support. This seems consistent with the national picture over the last few years.

Note: the age bands given by the Office of National Statistics conclude at 85+ and do not match the age-related Section 42 enquiries above.

Fig.6 Stoke-on-Trent Age Breakdown (Section 42)

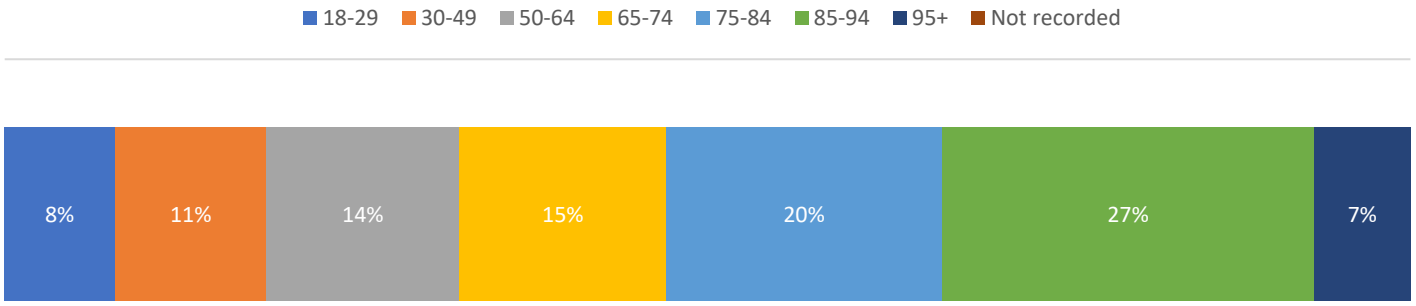
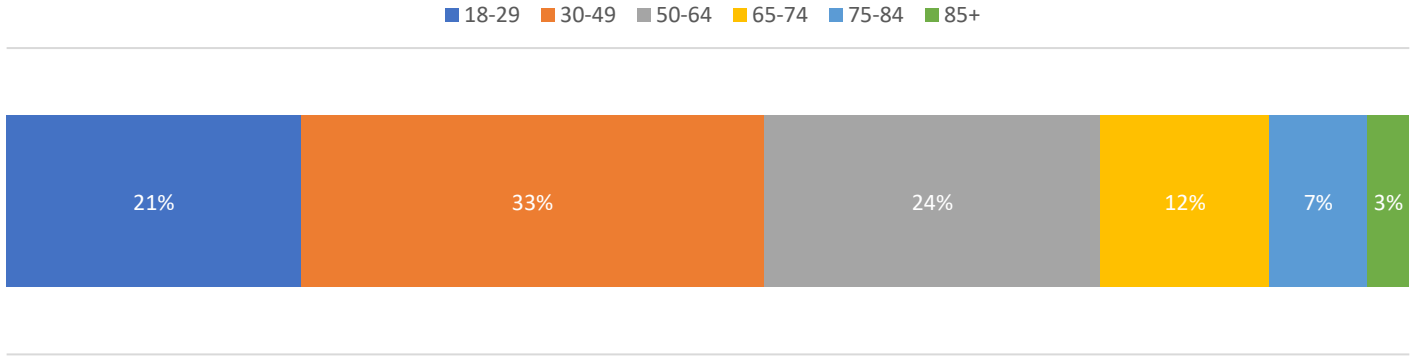


Fig.5 - Stoke-on-Trent age breakdown of the City



Stoke-on-Trent

For Stoke-on-Trent, the largest cohort is adults aged 85-94 years (27%) an increase of 7% from last year and 75-84 (20%) a decrease of 5% from last year. There has been a 5% increase on average for all adults over 75 who have been subject of a Section 42 enquiry.

When comparing the age breakdown with the general Stoke on Trent population figures, it is apparent that people over 65 are disproportionally overrepresented for Section 42 enquiries and that 34% of referrals are regarding 3% of the adult population in Stoke-on-Trent, those 85 or over.

Men in Stoke on Trent have a life expectancy of 76.5 years and for women 80.2 years, there are also more concerns raised for women this year which may be because there are more women who are older and the older the population the greater the need they may have for care and support.

Due to the relative low numbers that go to Section 42 Enquiry small changes in numbers can significantly change these percentages. The number of Section 42 enquiries for adults aged 85-94 increased by 10 in 2021-22 from 2020-21, whereas number of Section 42 Enquiries for adults 75-84 decreased by 13 in same period.

Gender

Fig.7 - Staffordshire: Gender breakdown (Section 42)

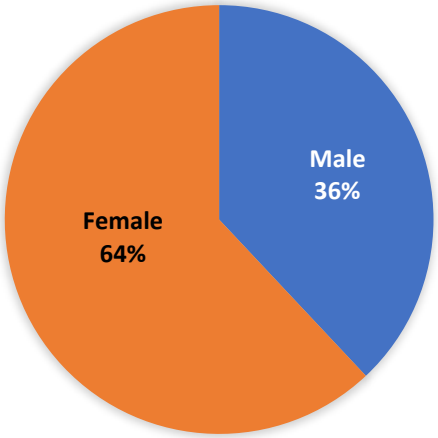
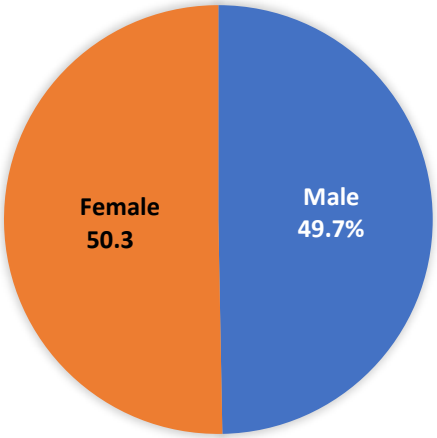


Fig.8 - Staffordshire: Gender breakdown of the County



Staffordshire

Females represent the majority of adults subject of a Section 42 enquiry with 64% over the year an increase of 2% with males having a corresponding decrease. Females are overrepresented (by 14%) when compared to the overall Staffordshire gender breakdown. This may be partially due to the fact that women have a higher life expectancy 4.8% (3.8 years) more than men and as a population is more elderly, they may have more needs for care and support.

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

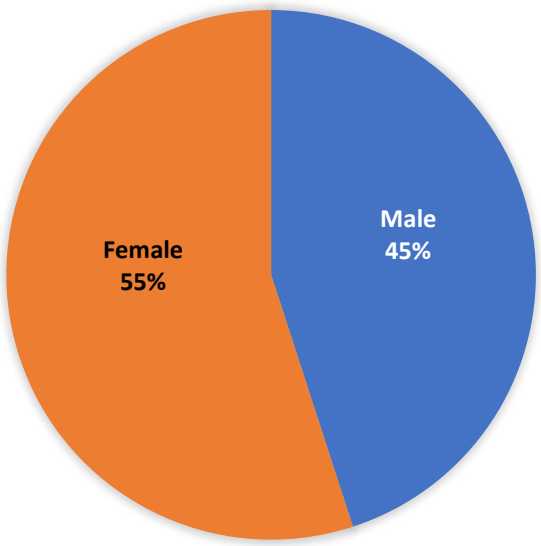
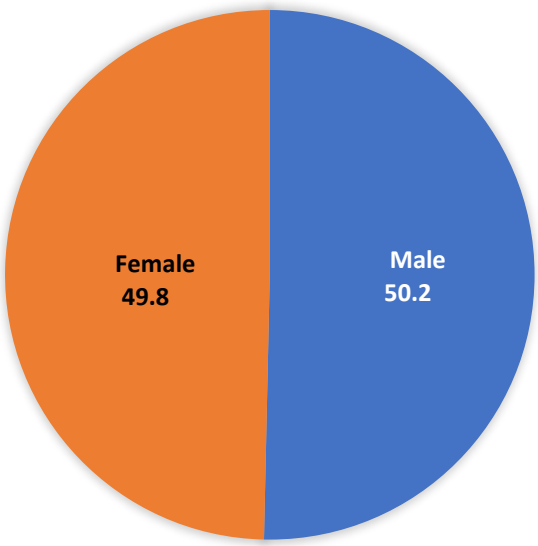


Fig.10 - Stoke-on-Trent: Gender breakdown of the City



Stoke on Trent

Stoke on Trent has remained the same for the number of males and female who were part of the Section 42 enquiry process. This may be partially due to the fact that women have a higher life expectancy by 4.8% (3.7 years) more than men and as a population is more elderly, they may have more needs for care and support.

Note: Recording systems are currently unable to break down data further to reflect broader gender categories to be fully inclusive. This has been raised with the Local Authorities with regards to their recording systems with requests that there be a greater range of gender options to reflect the local communities.

Ethnicity

Ethnicity	Stoke on Trent section 42 enquiries	Stoke on Trent overall population		Staffordshire S42 enquiries	Staffordshire overall population
White British	83.1	86.4		87.8	93.6
Not Known	9.8	-		6.2	-
Pakistani	1.3	4.2		0.5	0.8
Black Caribbean	1.3	0.3		0.4	0.3
Other White British	0.9	1.9		1.1	1.6
White Irish	0.9	0.3		0.3	0.5
Any other ethnic group	0.9	0.5		0.2	0.1
Indian	0.4	0.9		0.5	0.8
Not Stated	0.4	-		2.3	-
Any other mixed background	0.4	0.5		-	-
Mixed White/Caribbean	0.4	0.3		0.3	0.5
Any other Asian Background	0.4	1.4		0.2	0.4
Bangladeshi	0.0	0.4		0.0	0.1
Black African	0.0	1.0		0.1	0.2
Arabic	0.0	0.2		0.0	0.1
Gypsy /Roma	0.0	0.1		0.0	0.1
Any other Black Background	0.0	0.1		0.1	0.1

Note: the table is presented in order of the most prevalent based on the Stoke on Trent figures.

Staffordshire

The majority of individuals (Section 42) are 'White British' 87.8%, a very slight decrease from last year (87.9%), followed by 'Other White British at (1.1%). The Not Known category has decreased by 2.2% (from 8.4%) since a Not Stated category has been introduced this year. Following the upgrade to the Care Director recording system Staffordshire County Council has held practitioners' forums to raise staff awareness and understanding of the increased functionality.

Stoke-on-Trent

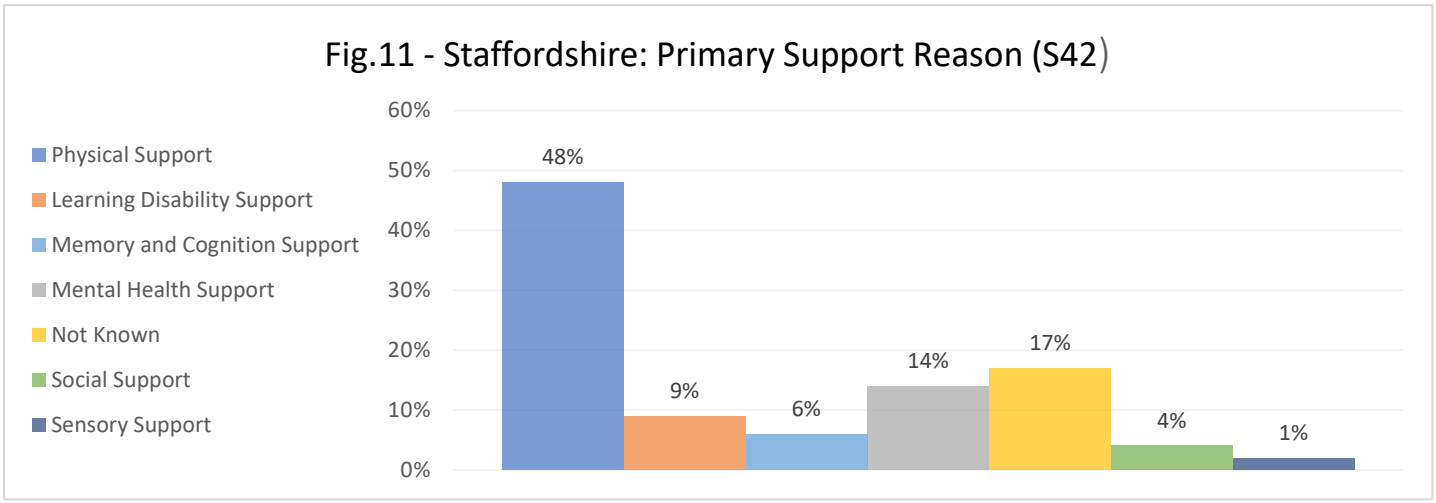
The pattern is similar in Stoke-on-Trent, the majority of declared ethnicities are 'White British' 83.1%, a decrease from 88.2% last year.

It is known that people from ethnic minority populations are disproportionally under-represented in Section 42 enquiries, however, for both local authorities Staffordshire 8.5% and Stoke on Trent 10.2%, there are

records where the adults do not have their ethnic background captured which limits the usefulness of any comparison to the wider population.

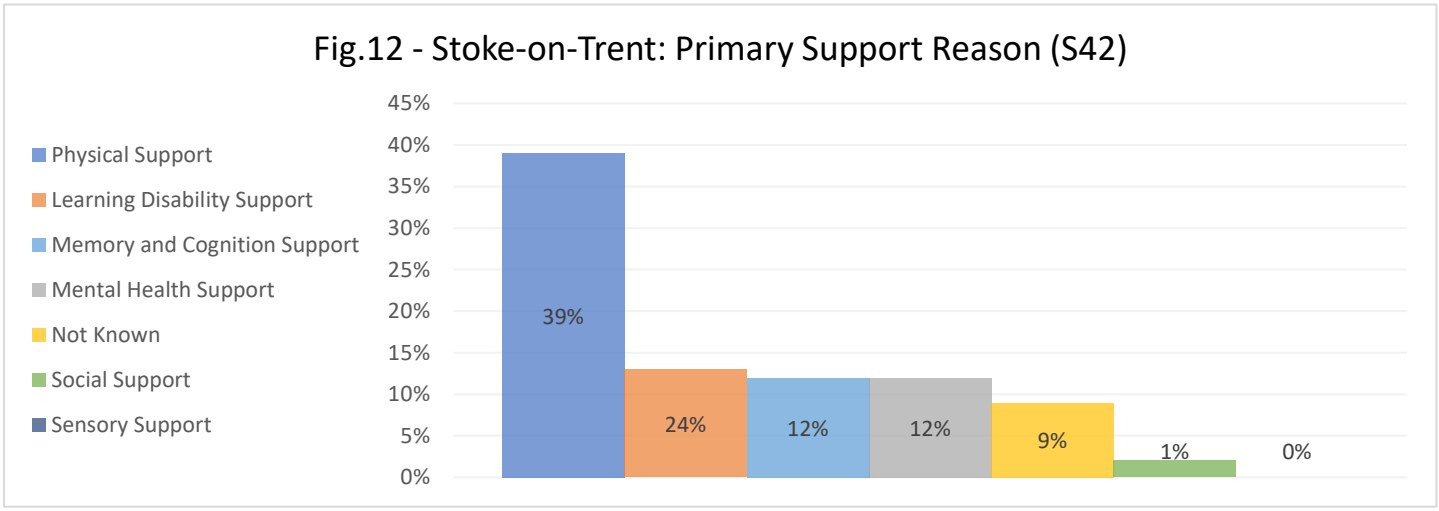
Primary Support Reason

The bar charts below illustrate the type of care and support need of the adult subject of abuse or neglect.



Staffordshire

Physical support continues to be the most common primary support reason in Staffordshire in 2021/22 (48%) an increase from 40% last year. This is followed by 'Not knowns' (17%) that is a decrease from 29% last year.



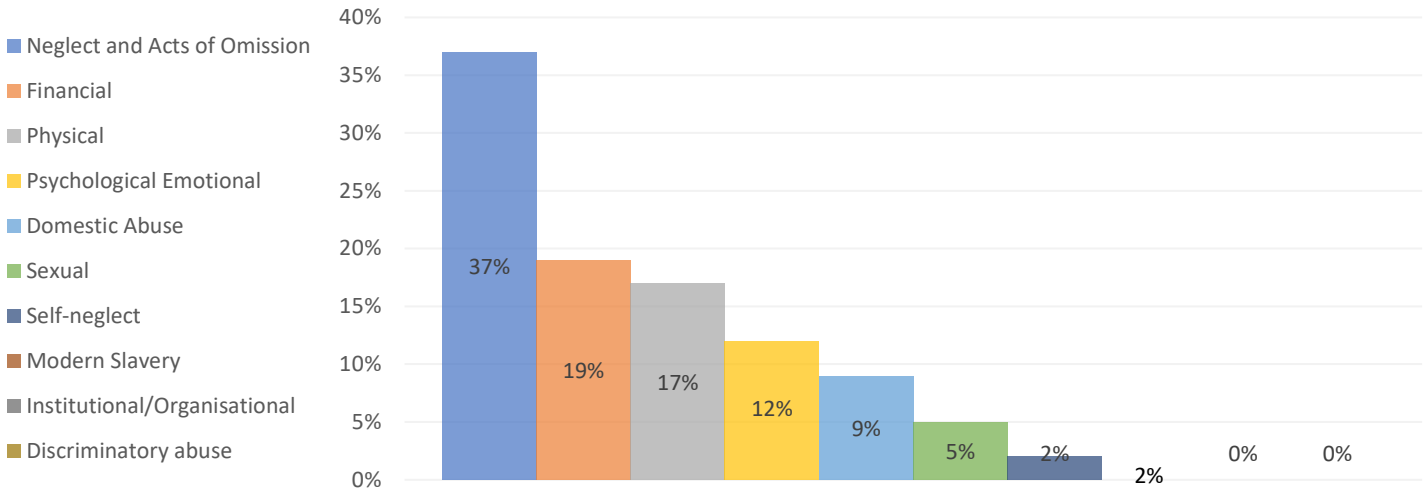
Stoke on Trent

Physical support similarly represents the largest proportion of primary support reasons recorded in Stoke on Trent at 39%, followed by learning disability support with 24%, which remains at the same percentage as last year. Mental health support accounts for 12% which remains at a similar level to last year.

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:

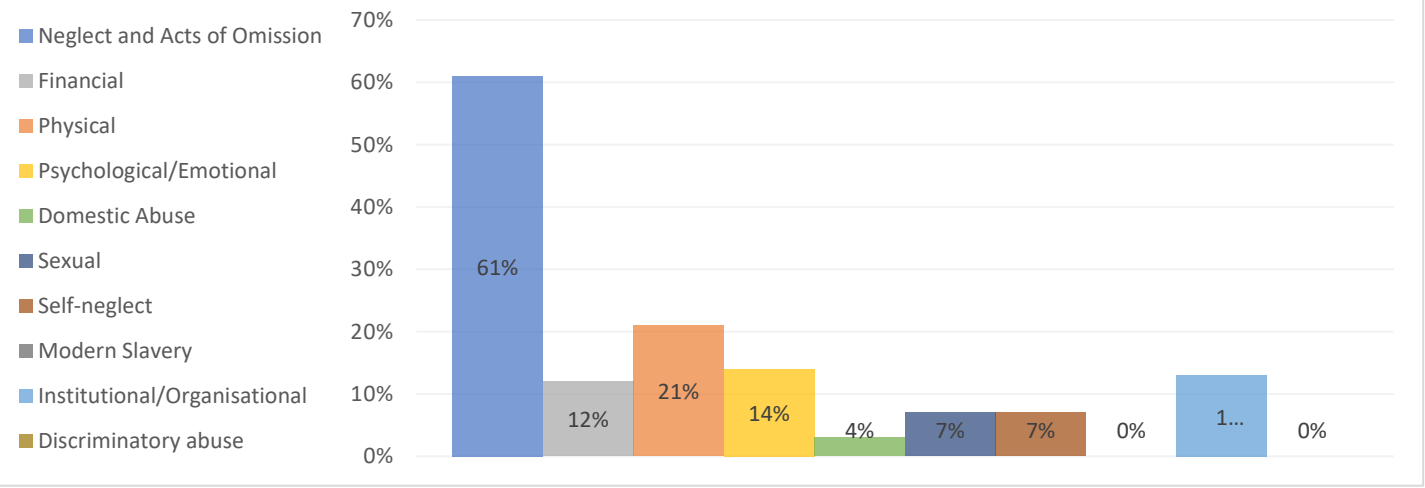
Fig. 13 -Staffordshire: Types of abuse or neglect identified at Section 42 safeguarding enquiry



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 73% of all harm/abuse recorded. Neglect and acts of omission show a slight increase from last year; whilst financial abuse has increased (by 4%) in 2021/22. There has been a significant decrease in recognition of Organisational abuse which has decreased from 7% to 0%. This may be related to the fact that there is only one type of abuse that can be recorded. Organisational abuse has been the subject of an audit by the Audit and Assurance subgroup. The Board has been given assurances that practitioners in contact centres know and recognise organisational abuse and are able to record this appropriately. The contact centre record what type of abuse the referrer believes the abuse to be. Practitioners have access to guidance as to what constitutes organisational abuse and this is confirmed at the decision making stage.

Fig. 14 - Stoke-on-Trent: Types of abuse or neglect identified at Section 42 safeguarding enquiry

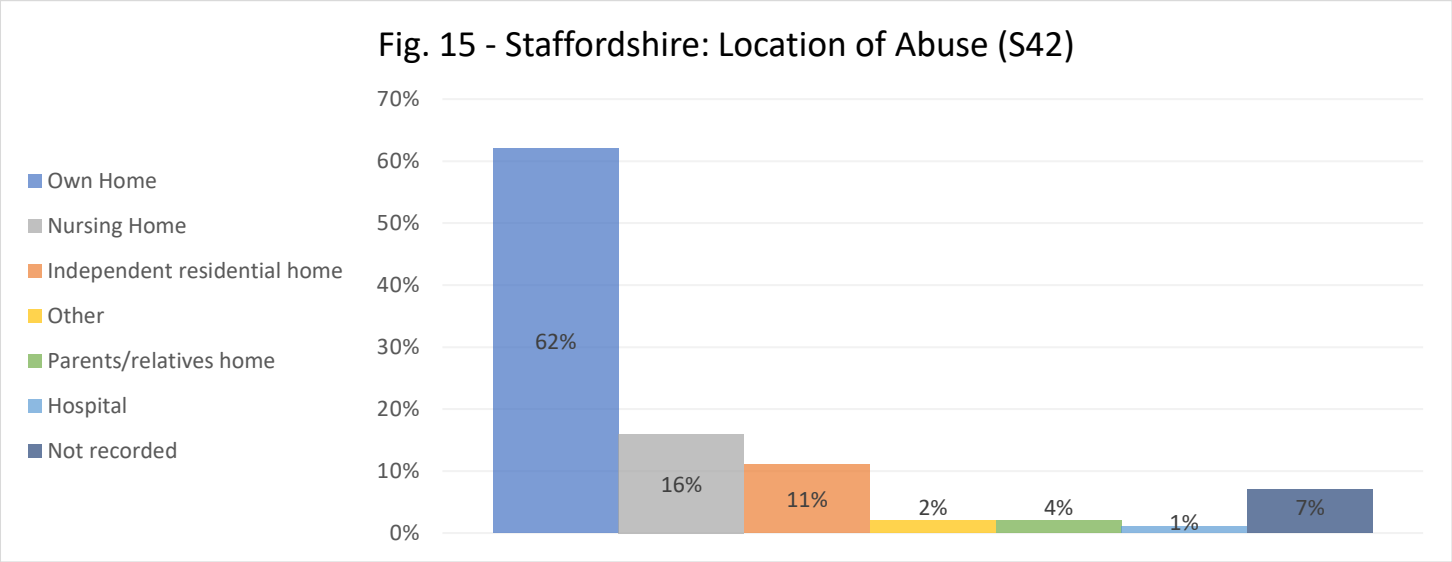


Stoke-on-Trent

The percentage of neglect and acts of omission cases has increased from 58% in 2020/21 to 61%. Physical abuse has increased by 7% (from 14% last year) and financial abuse has decreased by 14% (from 26% last year). Self-neglect has increased from 2% to 7% reflecting in part an increased awareness amongst practitioners arising from the learning from the 'Andrew' SAR.

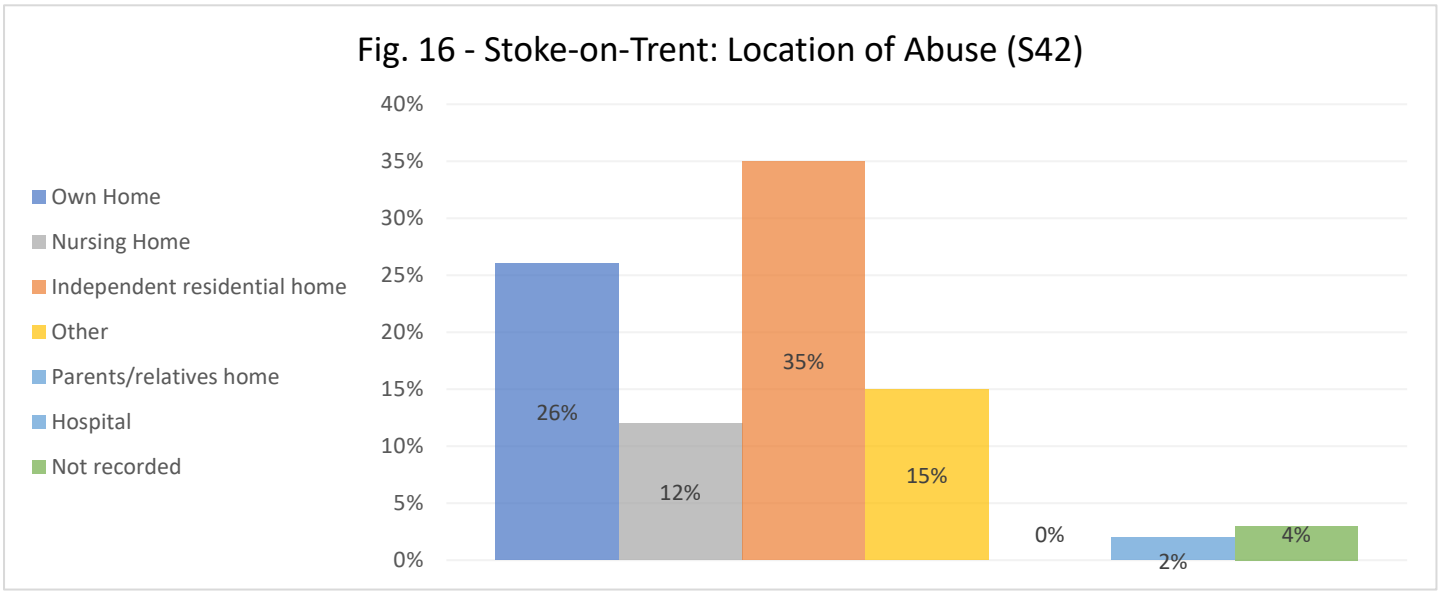
It should be noted that there can be relatively small numbers of adults in types of abuse which can cause a percentage change to appear more pronounced. In Stoke on Trent more than one type of abuse may be reported for a single case. The total cases are therefore more than 100%.

Location of abuse



Staffordshire

Of those people subject of Section 42 enquiries, the most common location of abuse or neglect was the person's own home (62%). The next most common locations in Staffordshire were nursing homes (16%) an increase of 5% from 2020/21 and independent residential homes (11%) which is similar to last year.



Stoke on Trent

The most prevalent location of abuse in Stoke on Trent is in an independent residential home (35%) followed by the person's own home (26%) and Nursing Home (12%). There has been a decrease in Abuse in the person's own home by 11% from last year and an increase of abuse reported in Independent Residential homes by 11%.

Through audit it has been identified that some practitioners record a care home as a person's own home

Findings of Concern Enquiries

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

Staffordshire: Repeat referrals have remained the same from last year at 19% and remained relatively stable for the past three years.

Stoke-on-Trent: The percentage of repeat referrals has decreased from 7% to 4% with similar rates for the past three years.

Note: There is an explanation for the reasons for variation in repeat referral recording between Staffordshire and Stoke on Trent on page 26.

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

Fig.17 - Staffordshire: Outcomes

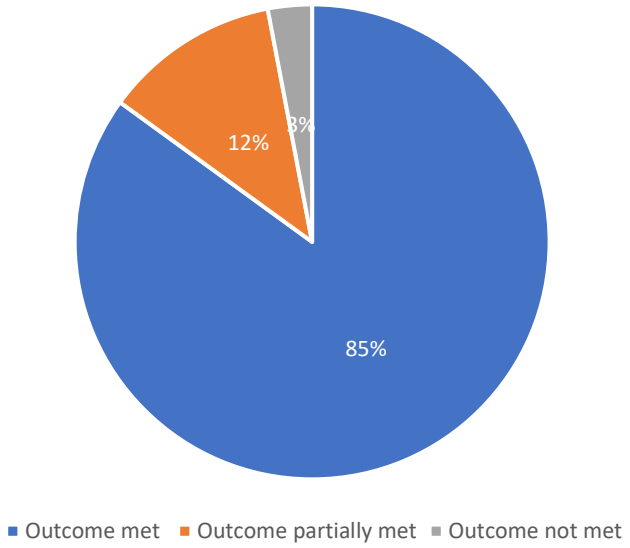
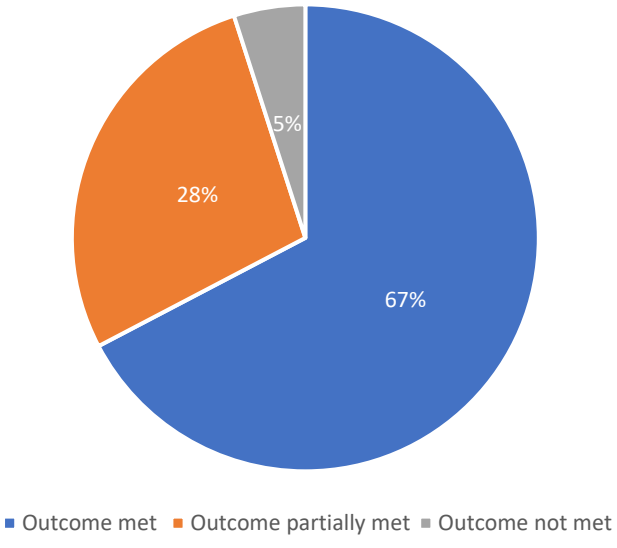


Fig.18 - Stoke-on-Trent: Outcomes



Staffordshire

The data is collected by the enquiry worker at the close of the case who will discuss with the adult or their representative their opinion on if the case has met, partially met, or not met their preferred outcome.

In Staffordshire 67% of adults subject of a Section 42 enquiry provided a response to the question of whether their desired outcomes from the enquiry were either met in full, partially met or were not met. A total of

97% of adults responding stated that their desired outcomes were fully met or partially met. This is a slight reduction from 98% last year.

Stoke on Trent

The data is collected by a social worker who has been working with the adult and able to obtain the adults opinion.

In Stoke on Trent 44% of adults subject of a Section 42 enquiry provided a response. A total of 96% responding stated that their desired outcomes were fully met or partially met. This is a slight decrease from 98% last year.

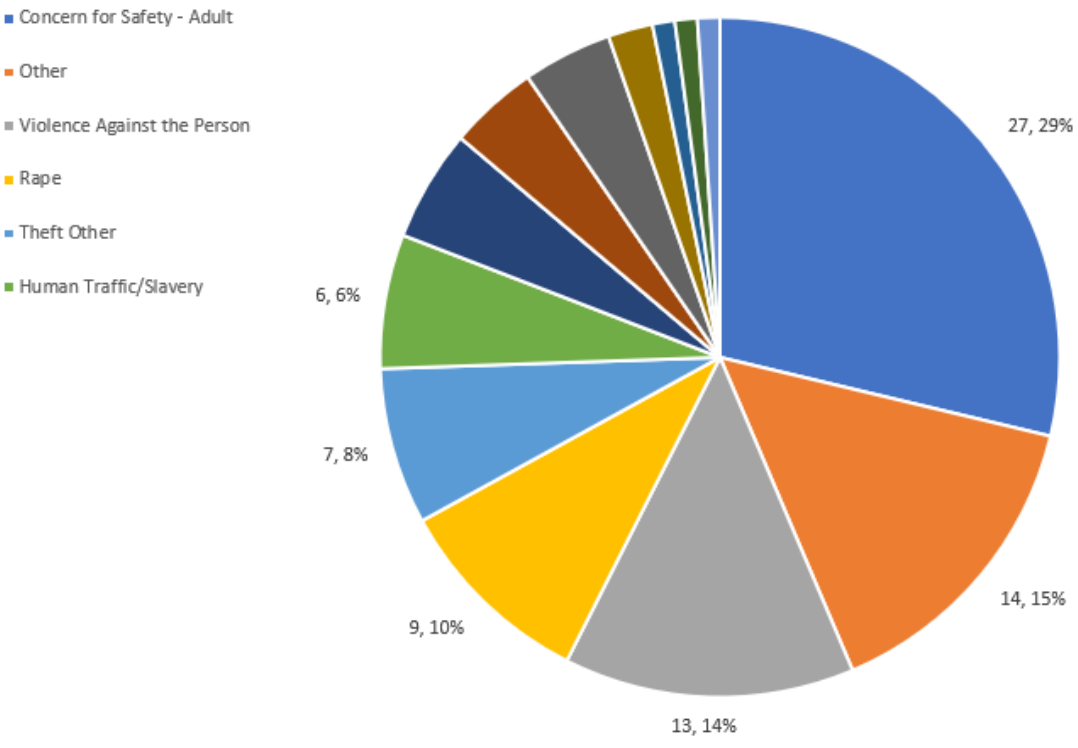
Report from Staffordshire Police and Adult Safeguarding Enquiry Team

The Adult Safeguarding Enquiry Team (ASET) is a multi-agency team comprising Police detectives and Adult Social Care with a remit to undertake investigations into reports of abuse and neglect of adults with care and support needs and associated investigations into persons in positions of trust. The team has wider links to safeguarding partners, the Care Quality Commission (CQC) and Her Majesty's Coroner.

Whilst a number of investigations involve a potential criminal act the team is also engaged in multi-agency investigations and early intervention in care settings that do not reach criminal thresholds, for the purpose of preventing harm to vulnerable adults. This approach can achieve better outcomes for adults than a response after harm has occurred.

The below table and chart indicate the types of incidents that the ASET investigate (1st April 2021 to 31st March 2022)

Fig. 19 - Incident types



Incident Type	
Concern for safety - Adult	27
Other	14
Violence against the person	13
Rape	9
Theft other	7
Human Trafficking /Slavery	6
Administration	5
Fraud - Action Fraud	4
Sexual offences - Not Rape	4
Sudden Death	2
Concern for safety - Child	1
Fraud - Other/Forgery	1
Harass/Stalking	1
Total	94

In the last 12 months ASET has dealt with a lower proportion of non- recordable crime compared to the previous year. The proportion of violent offences such as common assaults have reduced. Sexual offences make up a higher proportion of the identified crimes.

Examples of investigations include: -

A 97-year-old female who was moved to a care home due to her granddaughter spending her money under Power of Attorney. Following an investigation, the granddaughter was charged with offences of Fraud. During the granddaughter's trial at the Crown Court special measures were put in place to enable the grandmother to attend court via Video link from the care home where she was living. Despite their being a 5-year time gap in the matters being heard by the Crown Court and the grandmother having dementia, the grand daughter was found guilty of Fraud whilst being in a Position of Trust and was sentenced to imprisonment.

An investigation was conducted into a taxi driver and assistant following reported concerns of ill treatment of young adults with significant health and learning difficulties. The victims were not verbal and could not give any evidence for the offending. The main witness has severe learning difficulties but gave evidence by video interview. Special measures contained within Section 28 of the Youth Justice and Criminal Evidence Act 1999 enabled the witness to give evidence in the best possible way without the ordeal to attend court. The taxi driver and assistant pleaded guilty to the charges at court and await sentence.

Fig. 20 - Adult Safeguarding by Crime type

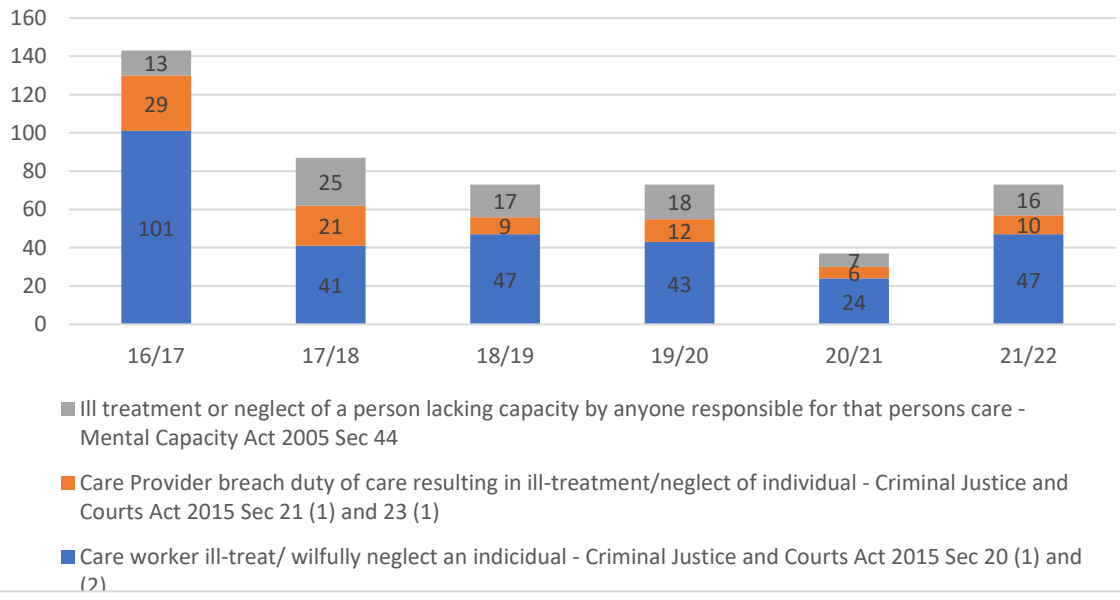


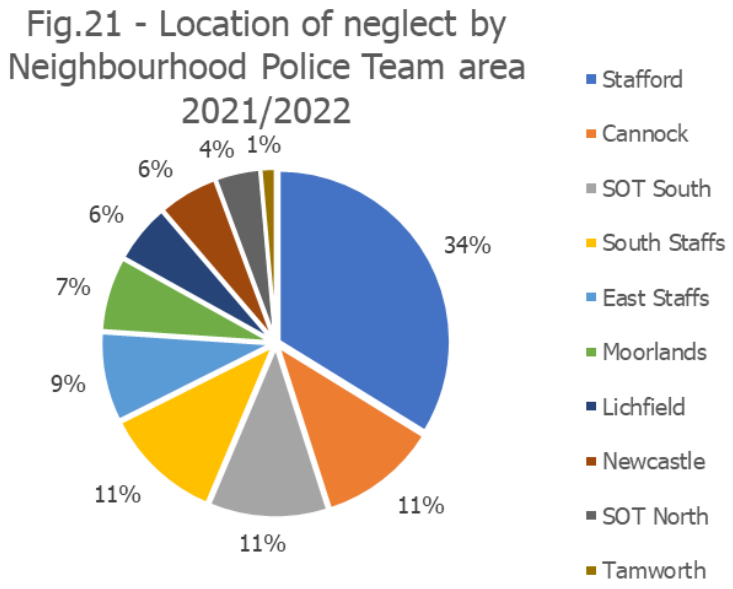
Figure 22 illustrates that there were a total of 73 offences reported for criminal investigation in the 12 months to 31 March 2022. The year is contrasted with previous years to indicate reporting rates over time.

From analysis of 2021/22 reports:

- Of the Neglect offences, there are 5 repeat victims in the last 12-months period; neither had been a victim in the previous 5 years.
- 4 out of the 5 offences against the repeat victims were committed at the same location.
- 2 repeat offenders are linked to the same 3 crimes.
- There are 5 repeat locations in the last 12-month period. These are at 4 care homes; 1 residential address.
- There are 9 locations that had 1 offence in the last 12-month period as well as other Adult Safeguarding offences in the previous 5 financial years.

The analysis is used operationally in conjunction with safeguarding partners to target preventative actions.

The below pie chart demonstrates the geographical locations of Neglect offences based on Neighbourhood Police Team (NPT) areas.



8. Financial report

The Board is supported by a part-time Independent Chair, a full-time Board Manager, and a full-time Administrator.

The Board wishes to acknowledge those partners who have offered to provide rooms without cost which includes Staffordshire County Council, Stoke on Trent City Council, Staffordshire Fire and Rescue Service, the Clinical Commissioning Groups and Staffordshire Police.

Income: This was year 2 of a 3-year budget agreement which was approved by the statutory partners in July 2019.

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/Employee costs	£120,034 *note (i)*
	Consultant fees	£5,750
	Training resources	£4,500
	Website costs	£2,500
	Insurance	£2,368
	TOTAL:	**£135,152**

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

9. APPENDICES

APPENDIX 1: BOARD PARTNERS

Statutory Partners as of 1st April 2021

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

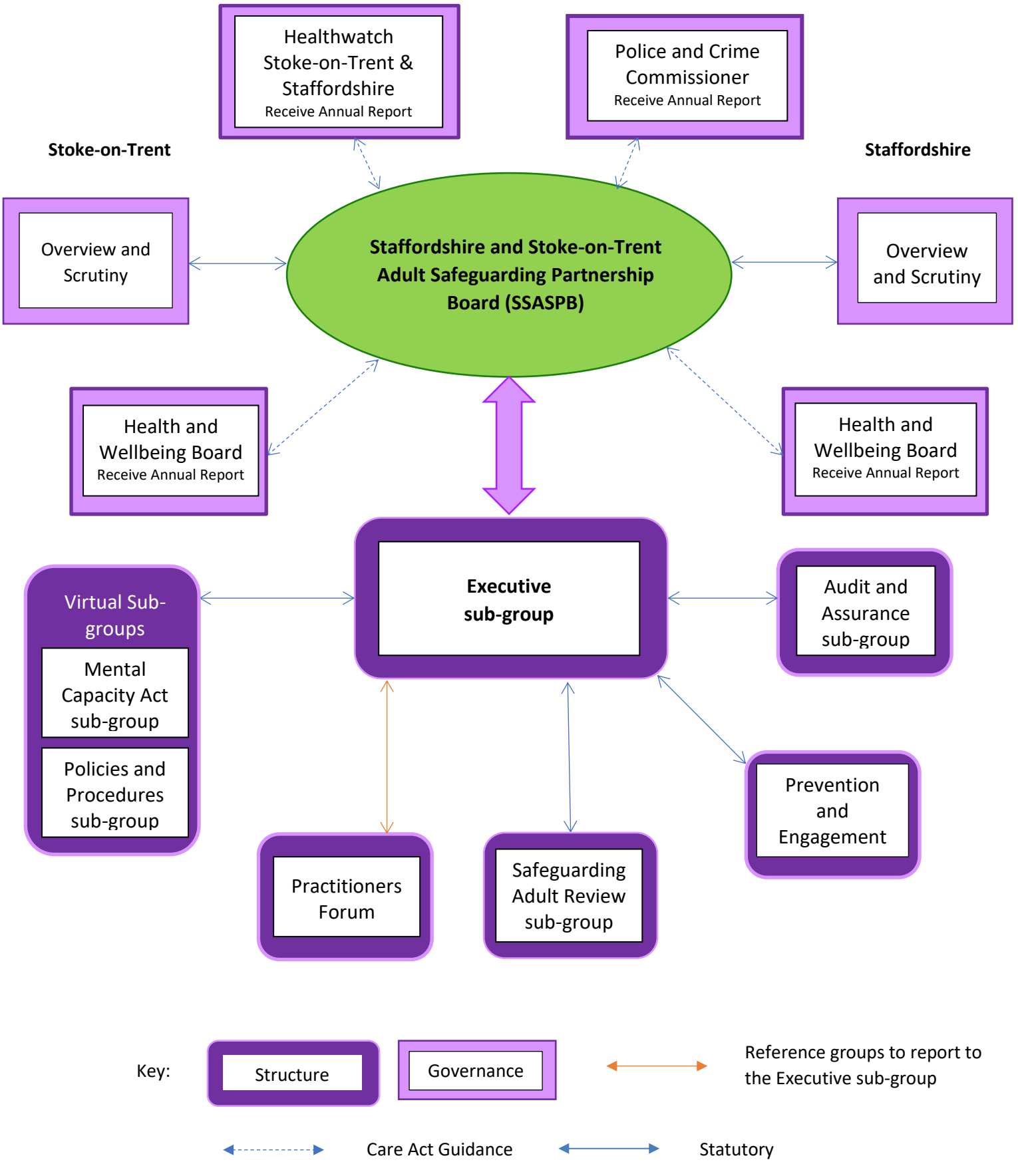
Extended Partnership as of 1st April 2021

- ASIST advocacy
- Brighter Futures
- Community Rehabilitation Company (CRCs) (Staffordshire and Stoke-on-Trent)
- Domestic Abuse Forum
- Domestic Abuse Providers Network (GLOW, Staffordshire Women's Aid)
- Healthwatch (Staffordshire and Stoke-on-Trent)
- Her Majesty's Prison Service (HMPS)
- Housing Plus
- Local Authority Lead members
- Midlands Partnership Foundation Trust (MPFT)
- Middleport Matters Community Trust
- National Probation Service (NPS) (Staffordshire and Stoke-on-Trent)
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- Representatives from the voluntary sector
- Rockspur
- Staffordshire Association of Registered Care Providers (SARCP)
- Staffordshire Fire and Rescue Service (SFARS)
- Support Staffordshire
- Trading Standards (Staffordshire and Stoke-on-Trent)
- University Hospitals of Derby and Burton (UHDB)
- University Hospitals of North Midlands (UHNM)
- Your Housing Group
- West Midlands Ambulance Service (WMAS)

APPENDIX 2: GOVERNANCE STRUCTURE

From 1st April 2021

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.

10. 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
DoLS	Deprivation of Liberty Safeguards
GDPR	General Data Protection Regulation
HMIC	Her Majesty's Inspectorate of Constabulary
HMIP	Her Majesty's Inspectorate of Prisons
ICB	Integrated Care Board
LD	Learning Disabilities
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
PiPoT	Persons in a 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
SFARS	Staffordshire Fire and Rescue Service
SSASPB	Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board
SSSCB	Stoke on Trent and Staffordshire Safeguarding Children's Board
SoTCC	Stoke on Trent City Council
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

‘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