Staffordshire and Stoke-on-Trent
Adult Safeguarding Partnership Board

Abuse must stop

Annual Report 2022 to 2023

NHS

Staffordshire County Council

City of Stoke-on-Trent

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

1. Independent Chair Foreword

This Annual Report is longer than previously for good reason. Once again it illustrates the enormous amount and range of safeguarding activity done in partnership, much of which builds on learning from good practice as well as where things have gone wrong. The constant challenge – it is a big one - is to demonstrate and evidence that the necessary changes in practice needed in response to the learning have been implemented by safeguarding partners to mitigate the potential for future recurrences.

Accordingly, the SSASPB has adapted its approaches to seeking assurances and these are reflected in the revisions to the Strategic Plan to include a new strategic priority of Effective Practice. As you will read there are five themes to Effective Practice and the updates of actions and, where available, their positive impacts have lengthened this report. A key element in responding to the challenge of breaking the cycle of recurring themes and issues is to continuously raise awareness of the learning points from adults who have had adverse experiences.

A significant theme has been identified in relation to adults who self-neglect and the practical difficulties that this sometimes presents for practitioners. This was illustrated with the 'Andrew' SAR in last year's Annual Report. Over a period of 18 months Andrew was seen on 308 occasions by 11 organisations but sadly died at the age of 37 years. This was a 'watershed' moment for safeguarding partners locally and in the last 12 months a total of 1,193 practitioners have attended training or learning events emanating from the learning from 'Andrew'.

The case studies in this report illustrate the positive differences being made and what can and is being achieved by reflective practice and determination to go the extra mile. What is still missing, however, is a greater sense of safeguarding partners being able to better evidence what local communities and people who have experiences of using the multi agency safeguarding services say.

I again take this opportunity to acknowledge the commitment and enthusiasm of all our partners and supporters including the statutory, independent, and voluntary community sector who consistently demonstrate a strong clear focus on doing their best for those adults we are here to protect. Through the extension of an inclusive approach to safeguarding I extend a welcome to new partners who have recently joined the Board and bring a particular focus and a wider perspective to the work on recurring themes.

As always, I am immensely grateful to all who chair the Board Sub-Groups as well as the Board Manager Helen Jones who works so hard behind the scenes to ensure that our business programme works efficiently. On behalf of the Board, I record here thanks and good wishes to Rosie Simpson who, after 4 years, left her valuable role of Board Administrator in November 2022 to re-locate to another area. We look forward to working with Lorraine Hudson in the Administrator role.

John Wood QPM

2. About the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board

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:

1. It must publish a Strategic Plan that sets out its objectives and how these will be achieved.
2. 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.
3. 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:

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 center of planning to meet support needs to ensure they are safe in their homes and communities.

[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

3. 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 on page 5 of the SSASPB Adult Safeguarding Enquiry Procedures.

4. What have we 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.

The Board

Independent Chair:	John Wood
Vice Chair:	Lisa Bates, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent 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 every quarterly Board meeting the Chair reminds 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 and assurances that agencies are working together effectively. The Chair goes on to say that constructive challenge, as always, is welcomed and encouraged.

During 2022/23 the Board has:

- Approved the 2022/2025 SSASPB Strategic Plan with Effective Practice, focusing on 5 key themes, and Engagement as its two Strategic Priorities.
- Held a Development Day Workshop in June 2022 at which pledges were made by Board partner organisations in support of the 5 themes within the Effective Practice Strategic Priority. The Board has received reports on the progress of priorities at each of its quarterly meetings.

- Approved Safeguarding Adult Reviews 'Heather' (April 2023) and 'Frank & Elsie' (January 2023), Safeguarding Adult Reviews (SARs) (ssaspb.org.uk).

- Received a presentation from the chair of the Staffordshire and Stoke-on-Trent Quality, Safeguarding and Information Sharing Meeting. QSISM examines quality and safeguarding matters in care settings and aims to support providers through challenges aiming to prevent escalation. Themes and trends from the meetings in 2022/23 were discussed. The Board sought assurances on recurring themes and reaffirmed alignment on mutually relevant work.

- Examined annual assurance reports regarding Large Scale Enquiries and constructively challenging reasons for recurring themes.

- Examined annual assurance reports regarding Deprivation of Liberty Safeguards including reasons for and responses to the increasing number of DoLS applied for.

- Received a presentation on the refocus of the LeDeR (Life and Death Mortality Review) programme noting the changes to the programme which now includes 'autistic people' in its remit. The presentation included the main themes and trends outlined in the LeDeR Annual Report. Reaffirmed alignment on work on mutually relevant themes.

- Continued to contribute to the review of the arrangements and working of the Multi-Agency Safeguarding Hub (MASH) and received updates on the review.

- Received a presentation by Dr Laura Pritchard-Jones, Keele University, on the key findings from the Insight research into the impact of COVID on Adult Safeguarding. One area of focus was the reduction of Mental Capacity Assessments undertaken during the pandemic. The SSASPB hosted a learning event presented by Dr Laura Pritchard-Jones, covering Mental Capacity and Adult Safeguarding in response to this.

- Received an update on the progress of the Stoke-on-Trent City Council Multi-agency Resolution Group (MaRG) and the Changing Futures programme. The chair of the MaRG, a lead officer from Changing Futures, and one of the Expert Citizens attended the Board meeting to discuss strategic and operational links on matters of mutual relevance and the key contribution of Expert Citizens. The discussions helped to further strengthen the links between the work of the Changing Futures programme and the SSASPB Effective Practice priority.

- Received a presentation from the Staffordshire County Council lead officer for the Integrated Co-occurring Needs (ICON) project. The project is about the response to adults with vulnerabilities and multiple needs whose personal circumstances don't meet the eligibility criteria for support through the Care Act 2014 or other eligibility. The plan is for the project work to result in a forum similar to the MaRG in Stoke-on-Trent but bespoke to the needs of a multi-tiered Local Authority.

- Promoted and supported the Ann Craft Safeguarding Adult week, hosting multi-agency awareness raising and learning events and encouraging partners to run events within their own organisation. One example was the 'Safeguarding's Got Talent' event arranged by the Integrated Care Board. Several connected partners showcased multi-agency adult safeguarding work. Congratulations to North Staffordshire Combined Healthcare Trust for receiving the highest scores in a very closely contested event. The practitioner networking was also appreciated by those attending.

- Received and considered the publication of a report 'Addressing Violence against Older Women; Learning from practice' sponsored by Comic Relief. Staffordshire Women's Aid were one of 7 areas contributing to the research. An update on actions arising was received from the Chief Executive, Stafford Women's Aid.

- Considered the impact that the 'Cost of Living crisis' and other winter pressures was having on Adult Safeguarding and sought and received assurances that risks were being mitigated as far as possible and that partners were ready to respond to increases in demands upon resources.

- Contributed to the funding and supported the Alcohol Change led research into 'Cognitive Impairment in Dependent Drinkers'. One of the key reasons for participation in this research was as a response to the findings of the Safeguarding Adult Review of 'Andrew'.

- Discussed the impact of the increase of 'quality' concerns currently being reported into Safeguarding and actions needed to help practitioners to identify which process should be used.

- A standing agenda item on matters arising from links with others partnership boards and fora enables visibility and alignment on matters of safeguarding relevance.

- Cross partnership working is being strengthened through the development of a protocol with Safeguarding Children Board, Health and Wellbeing Board, Integrated Care Board and the Police and Crime Commissioner.

- A standing agenda item for inspection, organisational review and peer review updates from partners that facilitates constructive discussion about areas of good practice and offers of support to meet organisational challenges. Subjects have included CQC readiness assessments in preparation for the forthcoming Adult Social Care inspections, this included participation in a peer assessment of Staffordshire County Council and focus groups (both tactical and strategic) with Stoke-on-Trent City Council.

Internal Audit of the SSASPB

In August 2022 Staffordshire County Council and Stoke-on-Trent City Council jointly commissioned an internal audit of the SSASPB to seek assurance that the Board was fulfilling its role as outlined in the Care Act 2014.

The aim of the audit was to provide assurance on the governance and performance of the SSASPB to ensure that the Adults Safeguarding Partnership Board continues to operate in accordance with its terms of reference and statutory requirements of the Care Act 2014 including roles and responsibilities of the Board and representation by partner organisations.

The terms of reference for the audit were to ensure that:

- adequate governance arrangements are in place, which are robust and effective;

- a performance management framework has been established, against which performance is reviewed and reported routinely;

- SSASPB members are trained appropriately to ensure that they can carry out their membership duties;

- financial support is provided to assist with achieving the aims and objectives of adult safeguarding and to ensure that strategic risks have been identified and are being monitored periodically.

The auditors spoke to the Independent Chair and Board Manager and scrutinised key SSASPB documents. The overall findings were that Internal Auditors were able to offer adequate assurance as most areas reviewed were found to be adequately controlled.

The following control weaknesses were identified with 3 medium risks and 1 low risk resulting in associated recommendations:

Medium priority

1. Officers should ensure that Terms of Reference and business plans are approved/ratified within the required timescales.

2. Budget information should include complete information to show a clear picture of the account of the Board.

3. The SSASPB should produce a statement to record the Board's new approach in respect of how risk is going to be managed.

Low priority

1. The Board should ensure that sub-group meetings are held in accordance with their frequency stipulated within their corresponding Terms of Reference.

Actions in response

All recommendations were completed and finalised by Internal Audit by 31 July 2023.

Executive Sub-Group

Chair:	Lisa Bates, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent Clinical Commissioning Groups August 2020 to present.
Vice Chair:	Sharon Conlon, Head of Strategic Safeguarding, Midlands Partnership Foundation Trust.

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;
- ensuring 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 Integrated Care Board); the Midlands Partnership Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT).

During 2023/23 the sub-group has:

- Co-ordinated the work undertaken to review the strategic priorities in preparation for the Board approval of the 2022/2025 Strategic Plan. Monitored progress against the SSASPB strategic priorities (Engagement and Effective Practice).

- Monitored the progress of all Safeguarding Adult Reviews raising constructive challenges around practice where appropriate. Used several of the challenges to inform the new Strategic Plan 2022/25 – these have formed the basis of the Effective Practice Strategic Priority.

- Heard a case study of Predatory Marriage and as a consequence sought and received assurances that Registrars in Stoke-on-Trent and Staffordshire receive adult safeguarding training.

- Received a presentation on the main themes arising from the Learning from Lives and Deaths Programme (LeDeR).

- Examined assurance updates from both Local Authorities regarding Large Scale Enquiries (LSEs) and Deprivation of Liberty Safeguards (DoLS) authorisation backlogs, linked to Effective Practice Theme 2.

- Discussed the work of the Stoke-on-Trent Multi-Agency Resolution Group which is a multi-agency forum to discuss adults who have multiple needs and at risk of abuse or neglect, particularly self- neglect linked to Effective Practice Themes 3 and 5.

- Received an update on the work which is looking at the response to 'vulnerable adults with multiple, complex and co-occurring needs' in Staffordshire. In particular, those who are not in safeguarding processes. This has links with Theme 5 of the Effective Practice Strategic Priority.

- Received the feedback from the Joint Local Authority Internal Audit of the SSASPB and initiated actions to respond to the 4 recommendations.

- In response to challenge raised at SSASPB meeting received assurance from SCC that there were no instances of safeguarding concerns connected to prison releases (medication prescription).

- Agreed support for the National Ann Craft Adult Safeguarding week. The SSASPB hosted 3 learning events covering Mental Capacity, Adult Safeguarding Awareness and the Role of Advocacy in Adult Safeguarding. From the subsequent local evaluation acknowledged the excellent work done by many partners to support the awareness raising initiative.

- Considered several Board membership requests in accordance with the SSASPB Board membership procedure.

- Continued to strengthen alignment of working on mutually relevant themes working with leads/chairs of Safeguarding Children Boards and Health and Wellbeing Boards in accordance with the Staffordshire Strategic Partnership Protocol.

- Confirmed that links with the MAPPA governance and procedure were in place. Several Board members sit on both MAPPA and SSASPB meetings and can share learning from reviews through standing agenda item on links with other fora.

- Made links to two new Independent Domestic Violence Advocate roles specialising in Older People and Disability facilitating information sharing on matters of relevance.

- Considered the Whorlton Hall findings (SAR) the seeking of assurances locally.

- Received assurances from partners that there had been individual agency activity in response to the SAR Andrew action plan.

- Tasked the Audit and Assurance sub-group to consider Discriminatory Abuse as a theme for a Tier 3 audit arising from the finding of extremely low numbers in the annual data capture (it was noted that this finding was replicated nationally).

- Received updates from Regional and National Adult Safeguarding fora through membership at various meetings.

- Sought assurances that any safeguarding issues from the welcoming of Ukrainians to the Stoke-on- Trent and Staffordshire area are recognised and addressed.

- Received updates from the links with the Domestic Abuse Commissioning Board with shared partners reporting matters of relevance to each Board.

Safeguarding Adult Review Sub-Group

Chairs:	Staffordshire Police Superintendents Nicky Furlong to March 2023. Victoria Lee from March 2023.
Vice Chair:	Lisa Bates, Designated Nurse Adult Safeguarding Stoke-on-Trent and Staffordshire Integrated Care Board (ICB).

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 learned from any reviews conducted by other SABs.

During 2022/23 a total of five SAR referrals were received. Following assessment, two met the criteria for a SAR, two did not meet the criteria and one is being considered as a Domestic Homicide Review. Information is provided on the referrals meeting the criteria.

'Frank and Elsie': A SAR conducted under Section 44(1) Care Act 2014 – Mandatory Review (Staffordshire)

Brief overview of the circumstances and how the criteria for a SAR was met:

A referral was received in July 2022 and involved a white British male (81yrs) and a white British female 72yrs, neither of whom had capacity and resided in a nursing home in Staffordshire. The names Frank and Elsie are not their actual names have been used to protect their identities.

There were concerns that there was insufficient focus and multi-agency working with regards to the risks presented by Frank to Elsie and others. There were numerous incidents of both physical and sexual violence to other residents and physical assaults/sexualised behavior to staff. There were concerns about the lack of clarity on the funding for the extra supervision of Elsie via one-to-one support. Frank was a Stoke on Trent resident (initially funded by Stoke) who then was assessed as having eligibility for NHS funded care (Funded Nursing Care). Staffordshire County Council were involved in a Section 42 safeguarding enquiry into one of the sexual assaults and it is believed that a more proactive stance to prevent re-occurrence may have been required.

This SAR was conducted by an Independent Reviewer supervised by the Social Care Institute for Excellence (SCIE) using their Review in Rapid Time model. The review commenced on 25 October 2022 and the final draft was presented to the SSASPB where it was approved on 26 January 2023. This model focuses on systems findings and seeks to identify the key barriers and/or enablers that make it harder/easier for good practice to flourish and that need to be tackled to see improvements.

Systems Finding 1:
Staffordshire safeguarding policies and procedures recognise sexual abuse as a category however there is no local policy or procedure about how sexual safety can be maintained specifically in residential care settings, including how to respond to incidents, assess and manage risk. This is despite recognition of the extreme vulnerability of residents and problematic sexualised behaviour of some residents being acknowledged as common. This leaves disparate and sometimes contradictory efforts by different agencies to support the individual and protect others, with no effective multi-agency working or effective oversight of risk management within a home, or of placement decision making, whether routine or in emergencies following evictions.

Systems Finding 2:
Staff in residential care are not adequately equipped to distinguish consensual sexual activity from sexual assault, based on an assessment of an individual's capacity to consent. This is reflected in unclear language to describe sexual activities and increases the chances of downplaying both the risks an individual may pose, and the needs of others for protection.

What the SSASPB has done in response to the findings

The Board responded by developing an action plan to address the above findings. It was agreed that a practical toolkit or resource pack would be produced making use of guidance and help available from National bodies including the Local Government Association (LGA), SCIE and the Care Quality Commission (CQC).

In response to Finding 2 the SSASPB will be facilitating a learning event 'Mental Capacity and Sexual Safety' with a presentation and workshop to be delivered by Doctor Laura Pritchard-Jones, Senior Law Lecturer, Keele University, timed to contribute to associated learning events during the Ann Craft Adult Safeguarding Week.

Clive Treacey: A SAR conducted under Section 44(4) Care Act 2014 – Discretionary Review (Staffordshire)

Brief overview of the circumstances and how the criteria for a SAR was met:

A referral was received on 8 November 2022 about Clive Treacey a 47-year-old white British man

from Staffordshire who died in January2017. Ordinarily, the identity of a person subject of a review would be anonymised but his family wish the circumstances of his lived experiences to be widely known and communicated.

Clive had a learning disability and diagnosis of autism and epilepsy. He grew up within a loving and supportive family. At the age of 18 years he attended a residential college and went on to reside in a variety of residential settings as an adult. It was alleged by Clive that he was sexually abused whilst in one of the placements in Cheshire. It is then reported that the source of risk followed Clive into subsequent placements.

Clive had been detained under the Mental Health Act 2005 (MHA) for a decade. He gained an unwarranted reputation for being complex and challenging, and someone for whom a community setting was only properly considered during the later years of his life. A LeDeR (Learning from Life and Death review - formerly known as a Learning Disability and Mortality Review) was conducted on behalf of NHS England which identified that there were financial and systemic barriers that thwarted Clive residing in community settings and remained in settings that were poorly equipped to meet his needs.

Concerns have been raised that the safeguarding alerts that Clive's family and professionals raised over the course of his life through community and specialist hospital settings were not adequately responded to. It has been raised that these were missed opportunities to intervene and had these matters been responded to more effectively, this may have altered the course of events that followed.

Clive was not kept safe from harm, and it is believed that he experienced sexual abuse whilst in the care of some providers. Questions have been raised regarding the effectiveness of his safeguarding and the police response to this. The reviews by NHS England and LeDeR were not able to ascertain what safeguarding and police actions followed these serious incidents.

It was decided that a Safeguarding Adult Review would be conducted jointly by Staffordshire County Council and Cheshire East Council. The focus of the SAR is to be how policies, procedures and practice have changed since the early 1990s when the abuse is alleged to have taken place and to seek assurances that future risks for others can be mitigated. The review is ongoing at the time of writing and will be authored by Professor Michael Preston-Shoot. An update will be provided in the 2023/24 Annual Report.

Update on the 'Andrew' SAR from the 2021/22 Annual Report

The SSASPB approved the final report of 'Andrew' in April 2022. Briefly, the SAR was about the learning from the death of a 37 years old white British man who was living in social housing in Stoke-on-Trent. Andrew had multiple needs arising from mental ill health, substance misuse, grief following the death of his mother, poor health generally and indifference to whether he lived or died and fluctuating engagement with service providers.

Over the last 18 months of his life Andrew was seen on 307 occasions by 11 service providers. Andrew died from gastrointestinal bleeding with self-neglect as one of the key contributory factors. There were concerns as to how agencies worked together.

The published report can be accessed from the link to the SSASPB website Safeguarding Adult Reviews (SARs) (ssaspb.org.uk).

What the SSASPB has done in response to the findings

The Andrew SAR has provided significant and extensive learning that is continuing. The findings and lessons learned are a regular focus of discussion.

During the review of the SSASPB Strategic Plan 2022-25 the themes from the SAR of self-neglect and adults with multiple needs who don't meet the eligibility criteria under the Care Act 2014 were specifically included within the themes of a new strategic priority to seek assurances of Effective Practice.

The SSASPB has initiated and facilitated several events focusing on themes from the learning attended by a total of 659 practitioners. These include:

- Three interactive learning events (facilitated through Microsoft Teams) presented by the Independent Reviewer, Patrick Hopkinson, which focused on the findings from the review attended by 336 practitioners and supervisors/managers.

- An interactive learning event presented by Patrick Hopkinson on the theme 'Trauma Informed Practice'. A total of 169 practitioners attended this event which was open to anyone whose work includes engagement with adults with needs for care and support.

- An interactive learning event presented by the Prevention and Engagement sub-group on 'Self Neglect'. This was attended by 134 practitioners.

- A learning event to focus on 'Mental Capacity and Self-Neglect' has been planned to take place in the autumn of 2023.

The SSASPB contributed to the funding of a national project undertaken by Alcohol Change on the theme of 'Identifying and Addressing Cognitive Impairment in Dependent Drinkers'. The project included research using local case studies and a focus group with practitioners who work with dependent drinkers. The findings of the project were communicated through a multi-agency training event led by the clinical researchers which was offered to practitioners from the Board member organisations to whom the theme was relevant. Key learning points from the training and key messages for practitioners were subsequently included in the SSASPB Newsletter which prompted positive feedback.

The SSASPB has reviewed its representation and invited Humankind to become a member to meet a need for a perspective on substance misuse by adults with care and support needs to be better recognised.

Audits have been conducted to examine reported safeguarding concerns that were not considered to have met the requirement for a Section 42 enquiry. The audit in Stoke-on-Trent identified that two referrals should have been categorised as Section 42 enquiries because a significant amount of protective work was described in both. Three cases were closed without the person referred being seen in person and the inherent risks of managers agreeing closure without the referee being seen were followed up with managers by the auditors. In two cases seen, there appeared to be an absence of clear descriptions of actions undertaken and the rationale for closure. Auditors concluded that overall the adult had been seen, protective factors had been put in place and risks mitigated.

The SSASPB has actively promoted the benefits of the appointment of a Lead Professional for multi-agency responses, recognising that Andrew had been in contact with 11 different services but there was no effective co-ordination of intervention or support. Messages have been conveyed through a combination of Newsletter articles, Social Media messages, learning presentations as well as amendments to the Section 42 multi-agency procedures.

The SSASPB has received a presentation from the Independent Chair of the Multi Agency Resolution Group (MARG) in Stoke-on-Trent and the programme lead for Changing Futures to seek assurances on the effectiveness of the partnership work to help adults with multiple needs typically including homelessness, drug and alcohol misuse and self-neglect.

The Board has encouraged preventative work, especially with those adults who don't meet the Care Act 2014 criteria for 'care and support' and received a presentation from Staffordshire to seek assurances on the response to inadequate care for people with co-occurring needs (ICON).

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.
- Incorporated the National SAR Quality Markers into the local SAR Guidance.
- Promoted the Olive Branch training made available by Staffordshire Fire and Rescue Service, to support fire risk reduction at home.
- Engaged with Community Safety Partnerships that are managing Domestic Homicide Reviews (where they involve adults with care and support needs).
- Promoted the use of advocacy services in SARs to support the adult involved (where appropriate).
- Tasked the Audit and Assurance sub-group with auditing how lessons are being embedded in organisational practice from the recurring findings in SARs.
- Provided detailed assurance against the 29 improvements recommended by Professor Michael Preston-Shoot in his academic analysis of SARs nationally (2020)
- Continued to actively raise awareness amongst practitioners 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 as early as possible to resolve professional disagreements.

- Appointment of a lead professional to drive multi-agency resolution in complex cases.
- The need for better understanding of the application of the Mental Capacity Act 2005 particularly in relation to self-neglect.

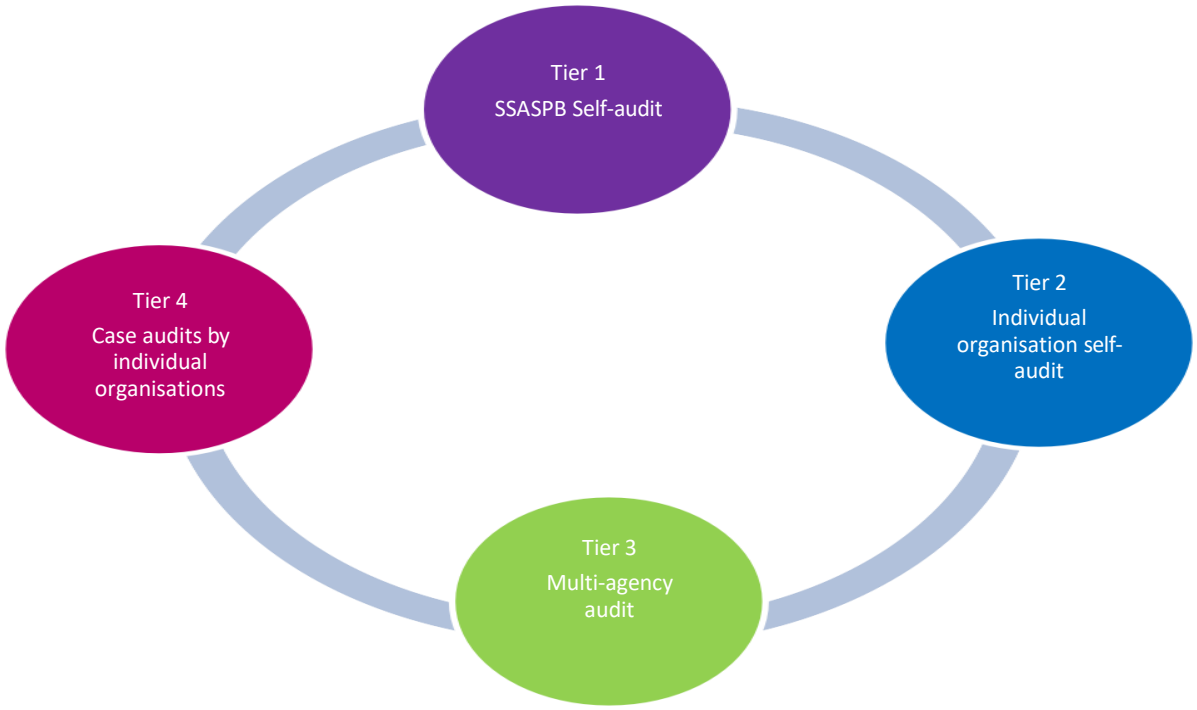
➢ Promoted to practitioners' webinars made available nationally that are relevant to SARs.

Audit and Assurance Sub-Group:

Chair:	Sharon Conlon, Head of Strategic Safeguarding, Midlands Partnership Foundation Trust
Vice chair:	Laura Collins, Named Nurse for Safeguarding, North Staffordshire Combined Healthcare NHS Trust

The SSASPB 4-tiered audit framework:

Overleaf 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.

- Selected specific standards from the Tier 2 audit data capture to request further assurances and evidence to support the self-awarded RAG (Red, Amber, Green) ratings. The standards chosen were bespoke to each partner's submission to provide detailed assurance on their Workforce Development section of the audit (Training).

- Conducted Tier 3 (Multi-agency) audit on the subject of 'Appointment of Lead Professionals in multi-agency responses to safeguarding activity'. Key findings and actions were:

  - There was evidence in some cases that a lead professional had been appointed but there were more cases where this would have been beneficial; there was often a perception that the appointment of a lead professional would impact on that person's capacity.

  - It was agreed that the benefits of appointment of a Lead Professional should be further promoted through the SSASPB Newsletter and Practitioner Forum.

- Conducted Tier 3 (Multi-agency) audit on the theme of Discriminatory Abuse. Key findings and actions were:

  - Where Discriminatory Abuse is recorded this was an accurate assessment of the abuse presented.

  - Limitations on recording systems mean that Discriminatory Abuse may be recorded as other categories of abuse leading to under representation in data; the Police often record discriminatory abuse as a Hate Crime and this type of crime is a rich source for further research (understanding that Care and Support needs is often difficult for Police to categorise separately); two partners who expected to find Discriminatory Abuse referrals had none recorded, a further check is to be done following this audit to examine if there is an increase.

  - Awareness of discriminatory abuse was included in the SSASPB newsletter and learning presentations.

- Conducted Tier 3 (Multi-agency) audit on the subject of online abuse. Key findings and actions from the Online Abuse Tier 3 audit: This audit was conducted following a query by Staffordshire County Council's Overview and Scrutiny of the SSASPB Annual Report 2021/22. This type of abuse isn't one of those identified in the Care Act 2014, consequently the research had to identify cases through free-text research where that was possible.

  The lack of a facility to identify the online abuse of adults with needs for care and support is a barrier to understanding this type of abuse; this type of abuse mostly affects adults under 60 years of age who have a learning disability or mental ill- health, most adults affected by online abuse don't have care and support needs as identified by the Care Act 2014; there was evidence of good awareness of this type of abuse and positive action to prevent impact, seen especially by banks when unusual activity on an account was identified; there were many links

to so-called 'romance-fraud' i.e. people from oversees approaching others using dating apps requesting money; many did not believe that they were being exploited and gave the money willingly.

Following the audit contact was made with both Local Authorities' Trading Standards teams and an article written for the SSASPB Newsletter which included links to more information and help available.

Prevention and Engagement

Interim Chair:	Helen Jones, SSASPB Business Manager.
Vice chair:	Laura Collins, Named Nurse for Safeguarding, North Staffordshire Combined Healthcare NHS Trust.

This sub-group was formed to drive the work of the Engagement Strategic Priority. For an update on progress please see the Strategic Priority section on page 32 of this report.

5. Performance against 2022/2025 Strategic Priorities

Strategic Priority 1: Effective Practice

This is a new priority arising from a revision of the SSASPB Strategic Plan. It was developed with the engagement of the Board and sub-groups in response to five themes of significant importance and recurring concern arising from a combination of learning events. At the SSASPB Development Day in June 2022 Board partners made a series of pledges and commitments to action. The updates are summarised below.

Theme 1:
That Making Safeguarding Personal (MSP) is meaningfully implemented and embedded in practice by all partners, (other than in exceptional circumstances when it may be less appropriate) and that its effectiveness is measured to give confidence.

The Board has sought assurances that adults are supported to make choices that balance risks with positive choice and control in their lives.

Stoke-on-Trent City Council

- Case file audits in relation to 57 safeguarding cases were undertaken during October and November 2022. Findings were that overall, there was good social work practice, however, the rationale for decision making was not always clear and therefore MSP is not always visible. Arising from the findings a series of workshops were convened with all qualified Social Workers, Senior Social Workers, Team Managers and Senior Managers to provide feedback and to improve recording and practice in line with MSP.

- Case note practice guidance was issued to staff to support person centered and consistent case note recording following the above audit and workshop.

- A new training package for practitioners has been developed which includes legal duties under the Care Act 2014 and responsibilities in relation to Making Safeguarding Personal.

- A new feedback loop is under development. Each month safeguarding assistants contact people who have been involved in a Section 42 enquiry and seek information on their experiences, this helps to inform practice and development of communication/feedback methods.

- In complex cases where high risk individuals cannot access all mainstream services there is access to support and representation through Expert Citizens to enable the person's thoughts, feelings, goals, and strengths to be articulated at the meeting.

Staffordshire County Council

- Quality audits generally demonstrate that safeguarding is person centred and Making Safeguarding Personal can be demonstrated. The quality audit on safeguarding found that 69% of people subject of the enquiry agreed that it had been completed in a timely way and the good practice timelines had been met.
- Staff responses identified variances in terms of approach, but there was agreement about keeping the person at the centre through practice, personalisation, proportionality, and with sensitivity. One team identified this as one of their services strengths by supporting people to balance risk with positive choice and control.
- It is recognised that there is a need to further improve to ensure that MSP is consistently embedded in practice. The safeguarding training has been redesigned and with the principles of MSP at the centre of it.
- A feedback form has been produced for adults who have been subject to a safeguarding enquiry completed by the Adult Safeguarding Enquiry Team (ASET). A feedback form has also been produced for carers and providers. At the time of this Annual Report the arrangements are subject to an evaluation.

- A process to seek feedback from adults where a concern may not have progressed to a Section 42 enquiry is being developed.

- Health and Social Care are committed to co-production and have a co-production network to support colleagues with information and resources about doing it well.

Midlands Partnership Foundation Trust (MPFT)

- Produced a Making Safeguarding Personal information leaflet that is available to all staff and patients through MPFT intranet.

- Produced a seven-point briefing on MSP that is of helpful practical relevance during safeguarding supervision discussions.

- An audit to examine compliance with MSP guidance was completed. This will be repeated to take account of the updated guidance issued to practitioners.

Staffordshire Fire and Rescue Service (SFRS)

- A quarterly safeguarding report is produced that provides details on the number of staff who have completed mandatory training. In the report for the period January to March 2023, Adult Safeguarding Awareness Level 1 – 92% completed (7% increase from previous quarter).
- Different levels of safeguarding training commensurate with roles and responsibilities have been developed and are being rolled out across the service.
- Information is produced in the quarterly Safeguarding Report and shared at SFRS Safeguard Board and SFRS Prevent and Protect Board.

Trent and Dove Housing

- There is a reflective practice approach used in the supervision of staff involved in safeguarding settings.
- Enhanced reporting of relevant information to the quarterly meeting of Safeguarding Forum.

Healthwatch

- Healthwatch has reviewed the use of its approach to 'Enter and View' with partners to be more effective. Enter and View is now consistent with Making Safeguarding Personal. All staff have a focus on Safeguarding in their work. All safeguarding concerns are raised with relevant parties to ensure good practice.

Theme 2:

The assessment and reviews of mental capacity and Deprivation of Liberties Safeguards (DoLS) are of a good standard and includes the perspective of service users/carers, with appropriately skilled advocacy accessed where appropriate.

Stoke-on-Trent City Council

- The Advocacy contract has been renewed to support adults needing representation. Management information on Deprivation of Liberties Safeguards and safeguarding data is produced monthly. Team Managers and senior social workers meet to scrutinise it and respond to issues arising.
- Audit cycle to check quality of assessments is overseen by quality assurance officer.
- Group supervision is on a bi-monthly cycle to discuss new case law and any relevant cases that may require peer support.
- Work has been commissioned to tackle the backlog of assessments. At the time of this Annual Report working with three separate providers to complete assessments and quality assurance work.

- Options being examined to identify longer term plans to sustainably address the assessment backlog.
- DoLS authoriser training completed via 'Edge Legal' with four more training places on Best Interest.
- Assessor course being offered to current workforce to increase assessment capacity.
- Transitions team in discussions to have a multi-agency approach to assessing capacity where appropriate involving Adults, Children and Health services (at the time of this report going through governance processes).

Staffordshire County Council

- Monthly audits examine how the person's voice is heard and this includes the use of advocacy. It is recognised that this is an area that needs more attention. Strength based training will cover aspects of this.
- In practice it is not easy to distinguish between when independent advocacy has been used or when family members have been involved. This is currently being reviewed by performance and systems teams so that the data can be more easily collected.
- There is a need to develop a specific audit in relation to the application of the Mental Capacity Act that will better capture the use of advocacy. This will be done once the updated statutory guidance which is awaited has been produced.
- Practitioners have been provided with training in relation to advanced mental capacity as well as the overview of mental capacity that has been available previously. These resources are now part of the role related training programme.
- Part of the preparation for CQC assessment has included how adults are supported when they experience transitions/moves between settings. Guidance is being produced and will include the use of advocacy when a person lacks capacity.

MPFT

- MPFT has worked with the Trust's Mental Health Law Team to produce learning materials and prompts to help practitioners to adhere to the requirements of the Mental Capacity Act.
- Completed a safeguarding confidence and competency survey across the Trust with responses from over 700 practitioners.
- Plan is to include Mental Capacity Act considerations in the next Trust wide safeguarding survey of staff.

SFRS

- SFRS was a partner in the Fireside Study Project lead by Keele University resulting in the production of a paper: Optimising Fire and Rescue Service "Safe & Well" visits to support detection and signposting for mental health problems in older adults. This report was submitted to the National Institute for Health and Care Research.

- Further project work is to be carried out to develop this area further primarily researching if, by providing more training in this area, it will help staff to recognise the signs of early mental health concerns and equip the staff with the knowledge and understanding of how to access help and advice.

- As partnership working continues to expand, there is further work required regarding signposting to relevant partners regarding Mental Capacity and DoLS. It is expected that awareness will be raised through the work of the Fireside Project and the wider work in this area that is being conducted by the National Fire Chiefs Council.

Healthwatch

- Staff are being trained around DoLS to be actively looking out for patients and resident feedback on their experiences.

Theme 3:

Safeguarding partners commit to improve our response to self-neglect, including that we will explore what experiences led, and sustain, a person to live in this way rather than judge self-neglect and substance use to be a lifestyle choice and we will consider wider social, physical and mental health factors rather than over rely on substance use to explain a person's circumstances. We will recognise the impact of trauma, substance use, and the coercive and controlling effects of addiction, on a person's mental capacity to make decisions about their self-neglect and substance use.

Stoke-on-Trent County Council

- Changing Futures and Public Health have co-commissioned the enhancement of the services of the Multiple Disadvantage Team which is delivered by North Staffordshire Combined Healthcare Trust. The aim is to understand and address underlying trauma, whilst individuals may still be in active substance addiction. The approach of the service is to be flexible with outcomes that evidence the impact of addressing co-occurring needs.

- The Changing Futures programme is currently funded until 2025.

- Attendance at Trauma Informed training and Safeguarding training is mandatory for all social care practitioners who are engaged with making assessments. The training input is co-produced with Insight Academy and people with lived experiences.

- Safeguarding audits where self-neglect has been identified are scrutinised. Examples of trauma informed approaches being used in practice have been found in case file audits.

- Making Safeguarding Personal feedback arrangements are being developed to add value and understanding of people with lived experience.

- People with lived experience are increasingly engaged to inform commissioning strategies. Current engagement includes Learning Disability and Autism Panel and Direct Payments.

- Principal Social Worker, Adult Social Care practitioners and Expert Citizens are actively engaged in the Multi Agency Resolution Group where the circumstances of adults with multiple needs are examined with the aim of improving outcomes.

- Research into a practice model for self-neglect is being conducted from an academic and practitioner perspective in partnership with Keele University.

Staffordshire County Council

- The Integrated Co-Occurring Needs (ICON) and Bullseye projects are in place. The projects are a multi-agency approach currently involving Public Health, Commissioners, Midlands Partnership Foundation Trust and Humankind/STARS. There is an ongoing expansion of the projects to include Adult Social Care and Housing. The aim and approach is to provide: one team for people with drug/alcohol and mental health needs; preventing 'bounce' between services and long waits for trauma therapy; focusing on the client not their 'conditions' in isolation supported by psychologists and overcoming significant data-sharing and governance hurdles.
- The ICON and Bullseye projects have been independently reviewed with a positive endorsement of the approaches.
- Training in Trauma Informed Practice has been introduced and provided to practitioners conducting assessments. More training is to be provided in Autumn 2023.
- Training to respond to and help adults in situations of self-neglect has been provided as well as forums to support staff.
- It is recognised that there is a need to review the self-neglect pathways from a multi-agency perspective and arrangements are being made for this be done.

MPFT

- Safeguarding practitioners recognise the challenges when dealing with adults who self-neglect. A self-neglect tool kit is being produced to provide staff with practical support.
- Ambition is to recruit a self-neglect navigator who can support staff with complex cases and ensure that multi agency actions are overseen and completed.
- Training in Trauma Informed Practice is available for staff. This is not currently mandatory training.
- An audit into the practical application of the Mental Capacity Act has been undertaken. It had not been published at the time of this Annual Report.

Integrated Care Board (ICB)

- All ICB safeguarding staff completed the training arising from learning from 'Andrew' SAR.
- There is a plan to work on shared understanding of risk across partner agencies especially in relation to self-neglect.
- Work is underway on the Safeguarding Collaborative approach across the health system.
- Further work to done across the health system and with SSASPB partners to review the self-neglect pathway.

SFRS

- Improved the Olive Branch offer, making it more accessible, and users can do the training at a time that suits them. Olive Branch Training is aimed at people who visit vulnerable members of communities in their own homes within Staffordshire. It helps them to identify potential fire hazards, including self-neglect (hoarding) and other risks in the home. It will also advise how to refer vulnerable people for a Safe and Well Visit.

- The number of referrals that are made regarding self-neglect are recorded and examined to identify the outcomes arising from the referral. The number of referrals received from partners following Olive Branch training are also recorded to identify outcomes.

- SFRS Prevent Teams attend relevant meetings to discuss concerns raised by partners and our teams as required.

- Learning events are regularly shared with relevant staff who are encouraged to attend to help to enhance understanding.

Healthwatch

- Working with commissioners around Drug and Alcohol contract designs to reflect the impact these are having on the users of the services. Constructive feedback provided that, from experience of users of services perspective, drug services need to be more person centred and not so data driven.

Case Study 1: North Staffordshire Combined Healthcare NHS Trust

A female patient 'Sarah' (name anonymised) was referred to North Staffordshire Combined Healthcare NHS Trust following repeated attendances at University Hospital of North Midlands Accident and Emergency Department related to alcohol misuse.

Sarah has been known to misuse alcohol since she was a child and lives with her elderly mother who also has care and support needs. The relationship between Sarah and her mother appears to be dysfunctional. Staff at the University Hospital of North Midlands experienced difficulties when trying to follow up the Sarah's non-attendance at outpatient appointments. Sarah's mother would inform staff that her daughter did not need services and that she did not need any follow-up care. It appeared that the mother was preventing her daughter from accessing services.

There were concerns for both the mother and daughter as they both had their own vulnerabilities and they lived at home together. North Staffordshire Combined Healthcare NHS Trust High Volume Users Team made a referral to the Olive Branch due to the risks presented around alcohol and smoking. Arising from a professionals meeting Sarah was referred to the Community Mental Health Team within North Staffordshire Combined Healthcare NHS Trust (NSCHT).

As there was a high risk for both women, who both appeared to be avoiding or unable to access support, further meetings of professionals were arranged by the High Volume Users Team to engage Staffordshire Police, University Hospital of North Midlands and NSCHT Safeguarding

Team to establish what additional help could be offered. A social worker was allocated to the case and a joint visit of partner agencies arranged.

This is an illustration of effective multi-agency working. Meetings were arranged quickly, with appropriate information sharing, safeguarding referrals and risk mitigation with all relevant agencies involved.

Case Study 2: Stoke-on-Trent City Council Adult Social Care

'Ken' is a 56-year-old white British man. He has had a variety of physical health issues and suspected cognitive impairment.

Ken was self-neglecting. He was not looking after his personal care; not meeting his nutritional needs; not taking prescribed medications; not maintaining his home environment and was experiencing significant deterioration in his physical and mental health. Adult Social Care was contacted arising from concerns that he was being subjected to physical and financial abuse, was alcohol dependent and was 'rough sleeping'.

Continuous communications between the Rough Sleepers Team and Adult Social Care resulted, after several attempts, a meeting between all relevant agencies which was the start of Ken receiving the support that he needed.

A Section 42 Safeguarding Enquiry was commenced in response to concerns for self-neglect. There were difficulties in engaging with Ken and his living environment was not conducive to completing an accurate assessment of need. A series of Multi-Disciplinary Team Meetings were convened to involve the relevant services including Housing, Health Services, Occupational Therapy, Memory Clinic, Police, Drug and Alcohol Services, Changing Futures and support workers through charities including Reaching North Staffordshire.

Ken's circumstances presented challenges to the safeguarding partners particularly in relation to the differences in value bases between professionals. Service gaps were also a challenge - the most notable of these between housing and the limited services that are willing to work with adults who are actively misusing alcohol.

The processes included completing mental capacity assessments, risk assessments and regular reviews of Ken's needs. A key aspect was managing the co-ordination of relevant services to address each specific area of need. These included completing health checks, supporting Ken to make, remember and attend appointments. Supported living was eventually sourced and implemented with an appropriate care package that promoted Ken's independence and sustains his safety. Police supported Ken to examine previous incidents of abuse through the appropriate channels. The Community Drugs and Alcohol Service (CDAS) completed ongoing work around Ken's misuse of alcohol and the trauma-based factors underlying this.

Six months after the referral to Adult Social Care Ken has stability in his life. He is thriving in supported accommodation; engaging well with support services for his mental health and alcohol dependence; receiving proportionate daily support; building social networks; establishing new relationships and is no longer self-neglecting.

Case Study 3: Staffordshire County Council, Adult Safeguarding Enquiry Team (ASET)

"Violet" is an 82 years old woman with a number of physical health needs. She lives in her own home with a care package in place. Violet is known to use alcohol to excess which resulted in recurrent falls.

Several safeguarding concerns about the risk of self-neglect were raised by Violet's domiciliary care provider and social worker. It was noted that Violet was choosing not to engage with the recommendations from professionals and it was considered that Violet was at high risk of harm due to self-neglect. It was agreed that a Multi-Agency Planning Meeting (MAPM) would be convened under the self-neglect protocol and chaired by one of the Practice Leads from the Adult Safeguarding Enquiry Team (ASET).

A MAPM was arranged with all involved agencies which included Violet's Social Worker, District Nursing Team, GP, Domiciliary Care Provider, Day Care Provider and the Fire and Rescue Service. Although Alcohol Services were not involved at the start of the process, and Violet had initially declined their support, it was recognised that their involvement was required in terms of sharing knowledge and they were invited to meetings. The meetings enabled consideration of the measures that could be put in place to reduce the risks.

Violet had clearly identified that she wanted to remain in her own home, but it was noted that her family felt that she would be safer in a residential setting. Given the differences of opinion it was agreed that a referral to advocacy services would be made to help Violet express her views and wishes throughout the process. Violet attended safeguarding meetings supported by her advocate.

A safeguarding plan was developed with input from all involved agencies and agreed by Violet. Following a hospital admission Violet returned to her home address with a new package of care in place. Violet continued to attend the day centre which she appeared to gain significant benefit from. Violet had also agreed to measures to reduce the risk of falls at home such as an additional handrail on her stairs and the removal of a rug identified as a trip hazard. Violet had also agreed to the gas cooker being disconnected and had purchased an electric hob.

Violet was involved with her needs and wishes being heard throughout this process. It was recognised that it would not be possible to remove all risks, but professionals were able to work with each other and Violet to reduce the risks. Violet was able to remain living in her own home in accordance with her wishes. At the time of writing the safeguarding plan remained in place and was being monitored by the local area team.

Theme 4:

There is awareness and understanding that there can be an increased risks in relation to safeguarding when a person moves between services, such as when a person is discharged from hospital to their home or other community settings

Stoke-on-Trent County Council

- Adults with Multiple Disadvantages are identified and provided with case co-ordination, aware that many self-neglect, with an approach to enable services to identify gaps and work effectively. Weekly Multiple Disadvantages Team meetings to review progress and address service barriers, so individuals do not 'slip through the net'.

- Social Care staff are based at the Acute Hospital to support discharge planning. Daily calls are undertaken with all partners across the system to facilitate safe planning. If required, a personal budget may be provided for quick solutions to mitigate risks following hospital discharge.
- Homeless Healthcare Service in the community enables treatment to continue post discharge (co- commissioned by Changing Futures and Housing Department in LA).
- Feedback from young people transitioning to adulthood and their carers/advocates is that transitioning requires further attention and resourcing capacity.

Staffordshire County Council

- Pathways have been reviewed and there is working towards a 'One Adult Social Care' approach.
- Training to staff around effective recording has been provided with guidance updated. The focus is on ensuring that a person's records are reflective of their current circumstances including where they live, if they are at a temporary address or in hospital.
- There is an ongoing project in relation to Preparation for Adulthood. This is focusing on meeting the needs of young people where multiple agencies are involved to ensure that agencies work better together at an early stage to prepare for the transition from children's services to adult services. It has been recognised that adult safeguarding had not been considered as part of this but is now to be included.
- Guidance to staff in relation to how to approach transitions between services and teams is being reviewed. This includes how people transfer between settings, such as leaving prison or hospital.

Integrated Care Board (ICB)

- The Safeguarding Team has contributed to the pan health digital design group and worked with IT providers to support the visibility of patient information pertinent to safeguarding and risk.
- Collaborative work will continue to promote the value, and use of, the Integrated Care Record (One Health and Care) across Health and Social Care.
- Multi-Disciplinary Team (MDT) risk assessment is completed before complex discharges from hospital/care setting.

MPFT

- One Health and Care record is now available across Staffordshire and Stoke-on-Trent and accessible by all NHS Trust primary care and social care staff. This innovation allows all those who have a legitimate purpose to access the information to have sight of a person's health journey, including discharge from hospital and community support.

UHNM

- The vulnerable patient team has been invited to become a member of the Trust's Patient Experience Group. This will provide a direct source of feedback from patients and carers experiences at the acute trust. Any learning pertaining to safeguarding will be then shared via the Safeguarding Working Group.

- The Head of Patient Experience and the Corporate Governance Team are now members of the Trust's Safeguarding Working Group and the Vulnerable Patient Steering Group. This will enable the team to triangulate information, reviewing themes and trends.

- Work has commenced on developing and implementing a carers strategy which the vulnerable patient team support and cross reference to safeguarding.

- The audit programme will identify good areas of practice and areas of learning in relation to discharge arrangements where there was an identified safeguarding concern.

Healthwatch

- Is involved in Integrated Care Board meetings to ensure processes are being followed with a focus on ensuring that the patient voice is being heard.

- Through attendance at meetings of the Health and Wellbeing Board reported the concerns around delays in hospital discharges and the impact of safeguarding when moving people at a later stage than is beneficial to the person which is leading on occasions to a greater need for care.

SFRS

- Arrangements have been agreed with the Hospital Discharge Teams throughout Stoke-on-Trent and Staffordshire to ensure there is a robust pathway in place for clinicians to sign post for a Home Fire Safety Visit for patients that pose a fire risk. This is on-going work and will be shared with the relevant Prevent Leads.

Trent & Dove Housing

- Person centred risk assessment is an operational focus for new applicants for social housing and where existing customers with an identified need wish to move to alternative accommodation.

Theme 5:

That amongst connected partners professionals and leaders are alert to the sources of risk of abuse and neglect for adults with care and support need in communities and residential settings particularly the hidden voices and people 'falling between the eligibility gaps'.

Stoke-on-Trent County Council

- Changing Futures programme provides a prevention strategy and practical support to people with multiple disadvantages.

- There are 15 Community Lounges in Stoke-on-Trent that provide a 'Front Door' to offer early help to prevent further need. These facilities are well used.

- Two new posts for Locality Connectors are at the recruitment stage. One of these is for hospital discharge planning based in Accident and Emergency and the other is to meet need for Ukraine/Asylum seekers working across the City at Community Lounges.

- Insight Academy is providing training on Care Act, Safeguarding and Trauma Informed Care.

- Case Managers provide bespoke support to social care staff. Multi-Disciplinary Team meetings are convened to provide bespoke solutions to prevent escalation to full care package requirements.
- Work is ongoing to upskill the workforce to professionally challenge and respond when people are deemed to be 'falling through the gap'.
- Social Worker in post to work with people on the Homes4Ukraine Scheme and other people seeking Asylum in Stoke-on-Trent.

Staffordshire County Council

- The developing work of the Multi Agency Risk Collaboration group will seek to address those who currently fall between the gaps of support services. There is a working group examining how to work differently and more effectively with people with multiple needs and complex personal circumstances. This work is still in its early stages but over the next 12 months will make progress.
- There is improved support from an administrative perspective in relation to our approach to People in Position of Trust risk so that we can monitor individuals and risk assess. This approach is being reviewed to seek further improvements.

MPFT

- The term professional curiosity has been used in relation to safeguarding for some time, however, the meaning and purpose of it does not seem generally to be well understood. MPFT safeguarding service has developed guidance on professional curiosity and this is included in staff briefings and forms part of the safeguarding supervision offer. Encouraging staff to think beyond the care and treatment being offered provides an opportunity to intervene and prevent adults at risk from falling between the gaps of service eligibility.

Integrated Care Board (ICB)

- The Safeguarding Team continuously monitor to ensure statutory reviews are completed.
- Plan to work on shared understanding of risk across partner agencies especially in relation to self- neglect.
- Multi-Disciplinary Team (MDT) risk assessment is completed before complex discharges from hospital/care setting.

Healthwatch

- Working more closely with Adult Social Care and ICB to discuss eligibility gaps and to ensure the voices of those who would otherwise be missed is being heard at all levels.

SFRS

- Through its activities within communities SFRS staff fulfil a valuable role as the 'eyes and ears' in identifying neglect and abuse. The Service has developed many single referral pathways with partners across the Stoke-on-Trent and Staffordshire.
- The SFRS safeguarding report provides a record of actions and outcomes. Referrals into Mental Health services is an area for further development and improvement.

Staffordshire Humankind

- Using links with the safeguarding board to identify shared learning and disseminate this learning across our Staffordshire services.
- We will ensure that all staff are trained to recognise and respond to abuse and will support this by developing safeguarding champions who will lead on a rolling programme of training which includes identifying risk factors for self-neglect and financial abuse.
- We will roll out a new programme to upskill staff to work in a trauma informed way from first point of contact.

Trent & Dove Housing

- Has completed a review of its approach to safeguarding and introduced a safeguarding forum that meets quarterly. From this an assurance statement is provided to Executive Management Team.
- Safeguarding is a mandatory training requirement for all staff.
- Safeguarding referenced in Strategic Risk Register.

VAST/Support Staffordshire

- Has disseminated safeguarding information through bulletins, social media and website in line with the pledge made by Support Staffordshire.
- Has supported its members by providing awareness events:

    - 4 Adult Safeguarding awareness training courses attended by 37 VCSE organisations.
    - 3 Bitesize Supportive Communities training sessions attended by 29 community-based staff/volunteers.
    - 1 - 1 information, advice and guidance on Adult Safeguarding policy and practice to 15 VCSE organisations.

Case Study 4: North Staffordshire Combined Healthcare NHS Trust

This case concerns 'Matthew' (name anonymised) a male who was referred to North Staffordshire Combined Healthcare NHS Trust Early Intervention Team with first episode psychosis. The approach of the team was to engage with and treat Matthew using the least restrictive approach in the community.

At the beginning Matthew was engaging well and his partner was fully involved and supportive. Over time Matthew developed and expressed fixed beliefs about his partner and he made persistent accusations about her which were unfounded. The couple separated and Matthew left the family home, but he continued to contact his ex-partner which became distressing. His ex-partner reported the matter to the Police.

Police concluded Matthew's illness was the reason behind his persistent harassment of his ex-partner. The ex-partner had contacted a range of services for advice and support and had been told by each organisation there was nothing that any of them could offer to help her. The situation was getting worse and risks to her were increasing.

The Early Intervention Team concluded that the risks to the ex-partner could not be ignored. Mental illness could not be an excuse for Matthew's behaviour. The Early Intervention Team escalated their concerns and contacted North Staffordshire Combined Healthcare NHS Trust Safeguarding Team for advice.

The Safeguarding Team arranged a meeting with the Stalking and Harassment Lead Officer for Staffordshire Police and the case was reviewed. Arising from the review Police confirmed that the case did meet the threshold for a Stalking Protection Order and the appropriate steps were taken to safeguard the ex-partner.

This case highlights the importance of escalation and professional challenge particularly in situations when people are adjudged not to meet the threshold for support services.

Case Study 5: Stoke-on-Trent City Council Adult Social Care

'Isaac' is a black man of Afro Caribbean heritage aged around 60 years. Adult Social Care was contacted by Isaac's tenancy support officer due to concerns about his deteriorating personal health and the increasing risks of physical, psychological and financial abuse that he was experiencing from 'cuckooing' at his home.

A Changing Futures worker and the local Police Community Support Officer (PCSO) would visit daily due to the significant risks identified with the aim of dispersing the people who were cuckooing Isaacs property. A deep clean was completed at his home but within a week it was back to the condition it was before the clean. At that time Isaac wanted to remain at his home to decorate and to make it a safe and nice environment to live but his living situation deteriorated and the risks to him escalated. A Section 42 safeguarding enquiry was subsequently commenced.

Changing Futures worked closely with the Police and the Local Authority Anti-Social Behaviour Officer. A warning marker was put on Isaac's home address, ensuring that in the event of any calls to the Police relating to him or his property a Police Officer would attend as a matter of urgency.

One day Isaac was assaulted whilst walking in the street near his home. Arising from this Isaac agreed that he was no longer safe and he wished to move home. However, none of the housing providers locally would rehouse Isaac. This was due to his previous criminal convictions and his reputation. All involved in offering support considered that he was being unjustly disadvantaged and this became a major difficulty.

Arising from the persistent approach of the Changing Futures team, the consistent approach of the local PCSO and a housing provider being prepared to give Isaac a chance where no one else would he moved into a supported tenancy.

The safeguarding risks to Isaac have been significantly reduced. He has maintained contact with his support team. He is happy, able to communicate effectively with his key worker and feels safe, eating regular meals and has plans to pursue his hobbies which include art and music. He now has access to benefits, he is registered with a GP, is engaging with Community Drug and Alcohol Service (CDAS) and attending appointments and his drug use has significantly reduced.

Case Study 6: Stoke-on-Trent Adult Social Care

Steven is a 35-year-old white British man living in council tenancy.

Adult Social Care was contacted due to concerns about significant self-neglect and substance misuse accompanied by Schizophrenia. His associates were financially and emotionally exploiting him, selling him substances at inflated rates, threatening violence to intimidate him and cuckooing his flat.

Following a Care Act Assessment, a Section 42 safeguarding process engaged agencies in developing a safeguarding strategy. Many attempts were made through multi-agency approached to support and engage Steven including providing regular food parcels, contacting utility providers as his services had been disconnected, frequent visits from Police Community Support Officers, support from the Community Mental Health Team and Housing Officers to alleviate the risks he was known to be subjected to. Steven did not sustain his engagement with services which diluted the impact of the support offered. During this time Steven had to move out of his home.

However, the allocated Changing Futures worker was able to offer the consistency of contact and approach that is the unique added value of Changing Futures workers. Through the repeat visits, perseverance and dedication of the Changing Futures worker, Steven began to engage.

Changing Futures was able to utilise a budget to safeguard Steven in bed and breakfast accommodation until a Social Worker eventually sourced a supported living flat. Steven began to access and sustain community support for his substance misuse addiction and remains substance free. He has been provided with new clothes and has regular meals. His relationships with his family have healed.

The willingness to 'go the extra mile' in multi-agency working coupled with Changing Futures working intensively beyond the usual challenging time constraints of Social Workers has helped Steven to work to his potential and shine. He is engaged with Expert Citizens and developing a peer mentor role for himself and currently working towards becoming a volunteer as a peer member with lived experience.

Strategic Priority 2: Engagement

Lead: Helen Jones, SSASPB Business Manager

The activity around this priority is managed and co-ordinated by the Prevention and Engagement sub- group which meets bi-monthly and is chaired by Laura Collins (North Staffordshire Combined Healthcare Trust). This is a sub-group with a broad membership and attended by partners with a good knowledge and insight into operational practice.

For the purposes of the work of the Board during 2022/23 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

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

- Hosted 3 events for the Independent Reviewer of the Safeguarding Adult Review of 'Andrew' to present the findings and learning. The three events were attended by 336 practitioners.

- Hosted a Trauma Informed Practice learning event in support of the findings of SAR 'Andrew' attended by 169 practitioners.

- Hosted Practitioner Forum events to discuss topics arising from audit findings, SARs, or at the request of practitioners. Topics have included cuckooing; hoarding; self-neglect; Advocacy in Adult Safeguarding and Mental Capacity.

- Supported the Ann Craft Trust National Safeguarding Adults Week in November 2023.

- Hosted a learning event covering Adult Safeguarding Awareness pitched at practitioners including District and Borough councils and housing groups for whom adult safeguarding is part of their work but not a full-time element.

- Supported the inclusion of Advocacy services and Drug and Alcohol Services to the SSASPB membership in recognition of the findings from SARs locally and nationally.

- Produced the autumn newsletter which was distributed widely. Topics included: contributions in support of the Adult Safeguarding Week; the work of the Board partner Asist who provide advocacy services; how to raise a safeguarding concern; key messages to practitioners from SARs and audits and introduction to new Strategic Priority 'Effective Practice.'

- Enhanced awareness raising of Adult Safeguarding Week by promoting partner organisations to host their own organisational events.

- Provided a variety of online learning events that were attended by a total of 1193 practitioners in 2022/23.

- Commissioned Board partner Rockspur to produce a more accessible version of the 2021/22 Annual Report. This was produced by adults with autism or a learning disability. It is the second to be produced and reflects the positive feedback from the report produced for 2020/21.

- Facilitated the gathering of information for a refresh of the SSASPB website that is accessed on a monthly average of more than 3,000 occasions.

- Produced a power point presentation for partner organisations to use on the subject of 'Learning Lessons from SARs'. The presentation highlights the recurring themes and encourages effective practice.

- The Board has decided to continue with Engagement as a Strategic Priority for 2023/25 and will continue to focus on how to better engage with care and support needs who have experienced abuse or neglect.

6. Staffordshire and Stoke-on-Trent 2022/23 Performance Report Overview

Number of safeguarding concerns received by the

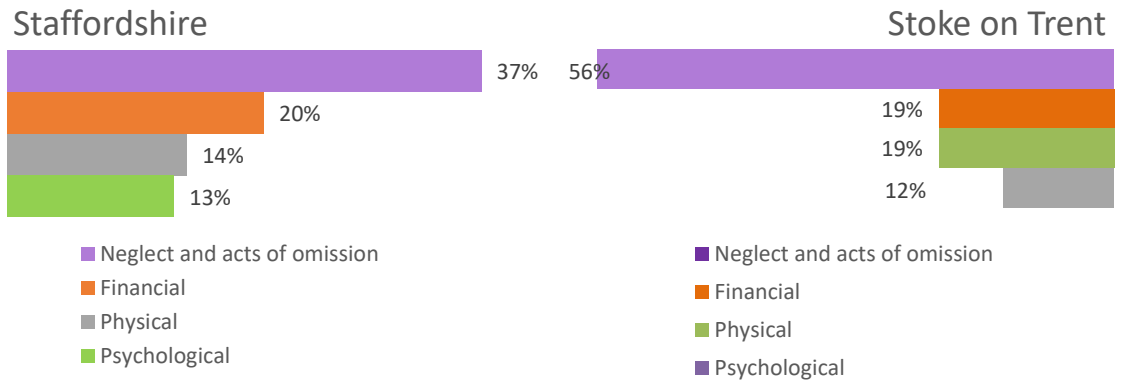
Staffordshire	Stoke-on-Trent
15,680	5,226

Staffordshire 57%

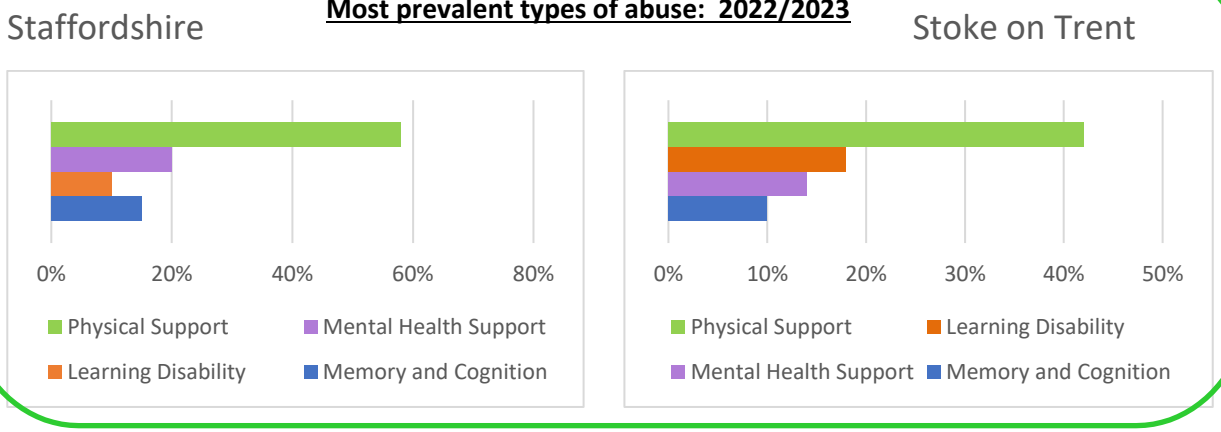
Stoke-on-Trent 42%

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

Most prevalent primary care and support need for the adult



Most prevalent types of abuse: 2022/2023



Top 4 Locations of Abuse

	Own Home	Residential Home	Nursing Home	Hospital
Staffordshire	70%	17%	12%	1%
Stoke on Trent	37%	22%	15%	4%

7. Analysis of Adult Safeguarding Performance Data

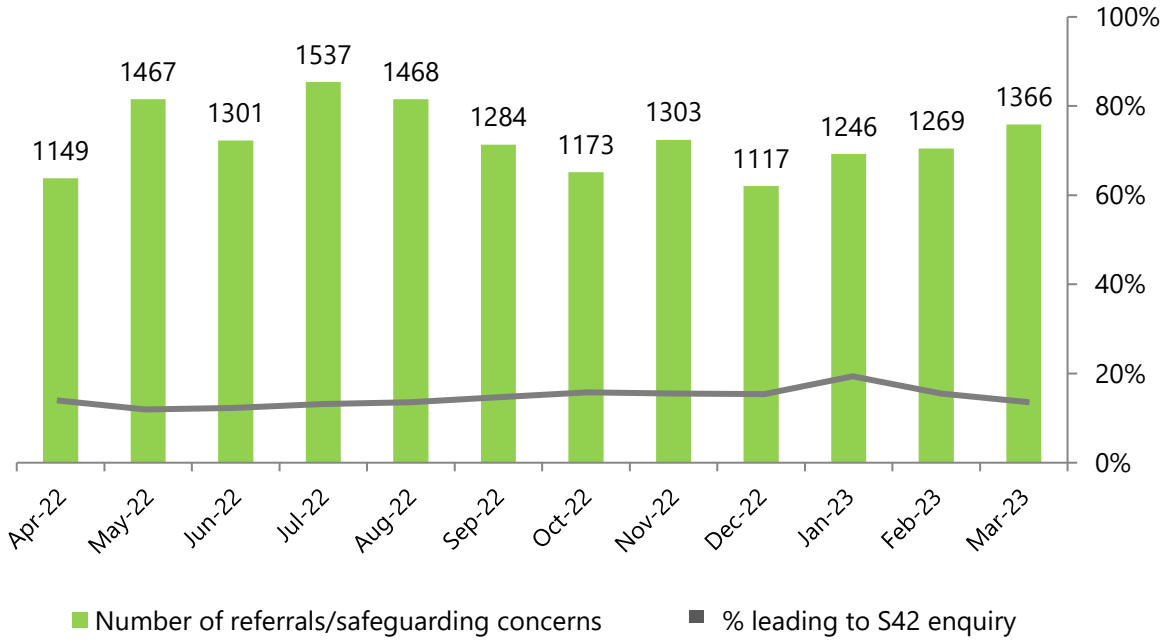
This section provides commentary and analysis of safeguarding data from Stoke on Trent and Staffordshire. Please note that in many sections the percentage has been rounded to the nearest whole number and therefore not all percentages will add up to 100%.

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. It should be noted that there is a difference between how both LAs capture and report this data. In cases where a statutory response is not required the SSASPB continues to seek assurances that local arrangements ensure signposting and engagement as necessary with appropriate support services.

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

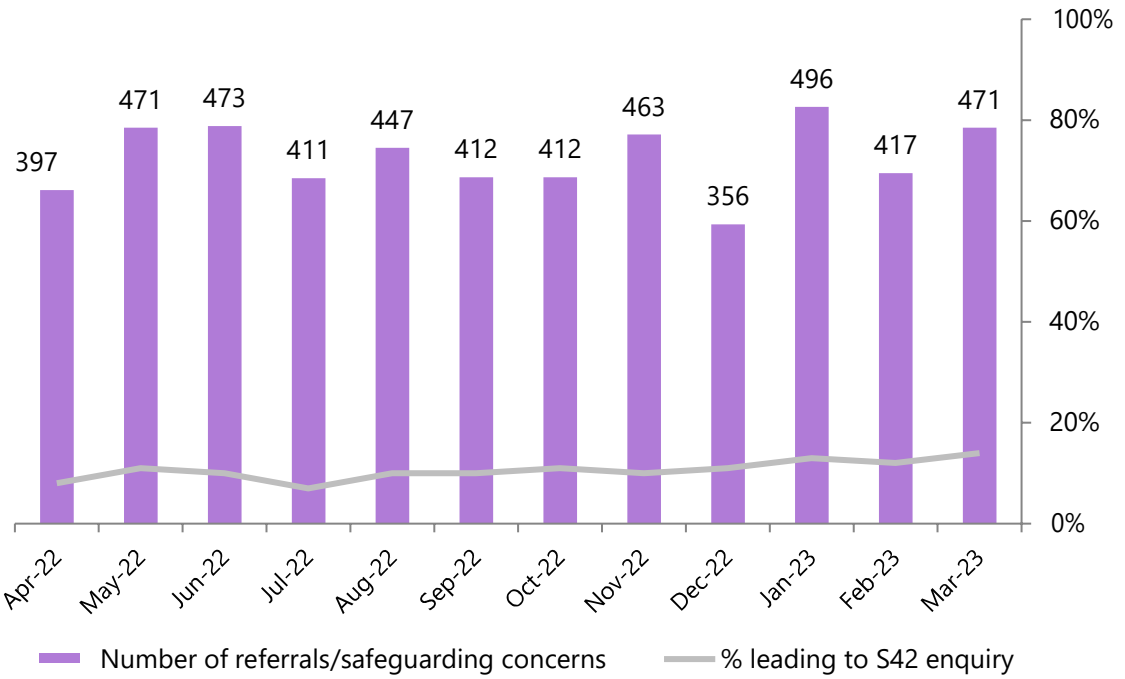


During 2022/23 in Staffordshire there have been 15,680 occasions when concerns have been reported that adults with care and support needs may be at risk of or are experiencing abuse or neglect. The total figure has increased by 2,543 occasions from 13,227 in 2021/22 which is an increase of 19.2%.

This year the duty of enquiry requirement was met in 17% of reported concerns, a decrease of 4% from 2021/22 (21%) reflecting a downward trend, a further 4% fewer than the figure of 25% in 2020/21. The reasons for the percentage decrease in concerns meeting the duty of enquiry threshold have been explored. The number of people who meet the threshold for a Section 42 enquiry is broadly unchanged. It is the increase in the total number of reported concerns that

has contributed to the reducing conversion rate. The information gathered from audits, indicates that the variance could be related to the type of concerns raised, for example, there are a significant number of concerns arising through quality or assessment processes. Audits indicate that there is rarely 'no activity' following the submission of a concern and whilst a formal enquiry may not commence there is a benefit to the person subject of concern. Staffordshire has been examining the reported concerns and is working with referring partners to ensure that thresholds are understood.

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



In Stoke on Trent there were 5226 reported safeguarding concerns in relation to adults with care and support needs during 2022/23. This is an increase of 636 (13.8%) from 4590 during 2021/22.

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 Section 42 enquiry or takes an alternative route. 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 11% of occasions when a concern was raised. This is an increase from 9% in 2021/22.

Stoke-on-Trent has been conducting audits to explore the outcomes for adults whose safeguarding concern does not progress to a Section 42 enquiry. This is part of a quality assurance process with the aim to examine decision making and rationale for the actions taken. Referrals made to the local authority are subjected to a scrutiny process to ensure that these meet threshold criteria. The findings of the audits provide assurances that it is rare that no action at all is taken following receipt of a safeguarding concern.

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).

At the request of the SSASPB both local authorities have re-examined their approaches to seek better alignment in recording practices. This review has illustrated that both authorities are following the same procedures to ensure adults are safe and risks minimised and both comply with the recording guidelines. In essence the preferred recording systems is an internal decision for each authority.

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.

Fig. 3 Staffordshire Age Breakdown of the County

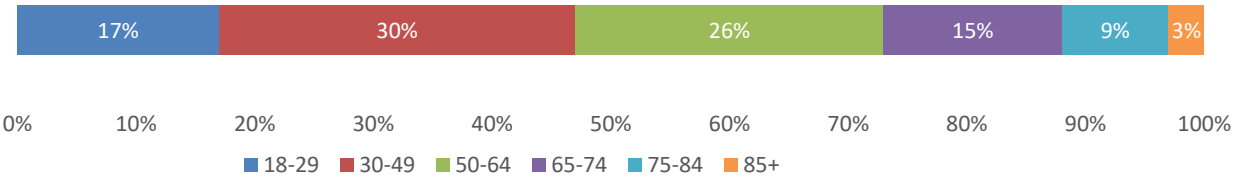
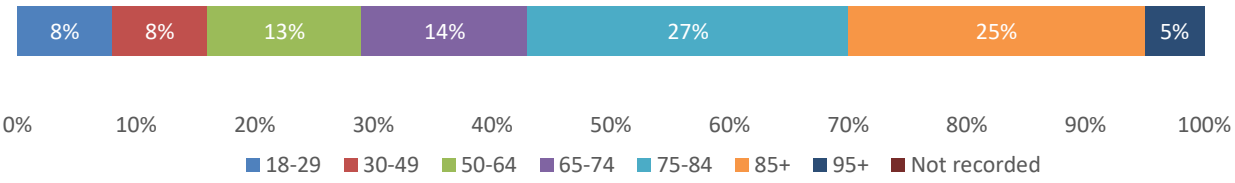


Fig. 4 Staffordshire Age Breakdown (Section 42)



<u>Staffordshire</u>**:**

Of the adults who have been the subject of a Section 42 enquiry, those aged 75–84 (26.9%) represent the largest cohort followed by 85-94 (25.1%). Last year, 2021/22, these age groups were reversed with 85–94 being the most prevalent at 25.2% compared to 24.9% for 75-84yrs.

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 12% of the adult population in Staffordshire are aged 75 or over, however, 56.8% 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. 5 Stoke-on-Trent Age Breakdown (Section 42)

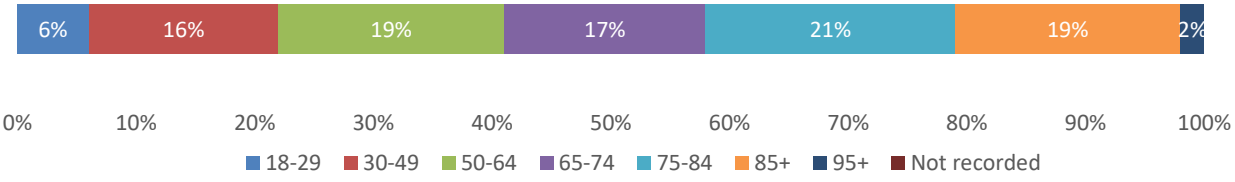
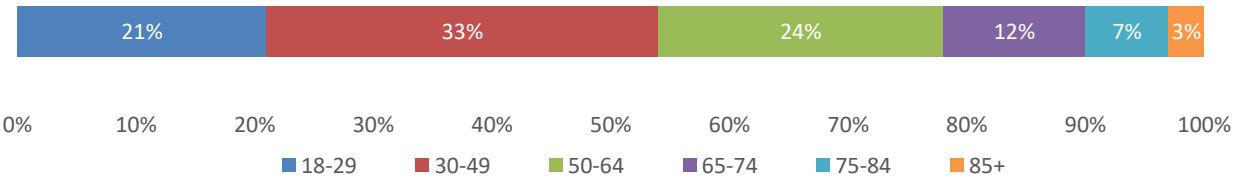


Fig. 6 Stoke-on-Trent Age Breakdown of the City



Stoke-on-Trent:

For Stoke-on-Trent there is a fairly even spread of ages of adults who have been involved in a Section 42 Enquiry. The largest cohort is adults aged 75-84 years (21%) an increase of 1% from last year. The second largest cohorts both represented 19% of Section 42 enquiries. These adults aged 85-94, a reduction of 8% compared to 27% in 2021/22 and adults aged 50-64 years. For the younger cohort this is an increase of 5% from last year. There was a decrease from 27% to 19% for those adults aged 85 to 94. Due to the relatively small number of Section 42 enquiries small changes in numbers can significantly change the percentages.

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, 22% of the population are over 65 but 59% of adults subject of a Section 42 enquiry are in this age category.

Men in Stoke on Trent have a life expectancy of 76.5 years and for women 80.2 years. There are again 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.

Gender

Fig. 7 Staffordshire: Gender Breakdown (Section 42)

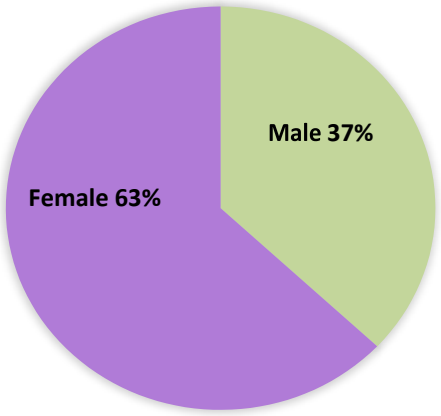
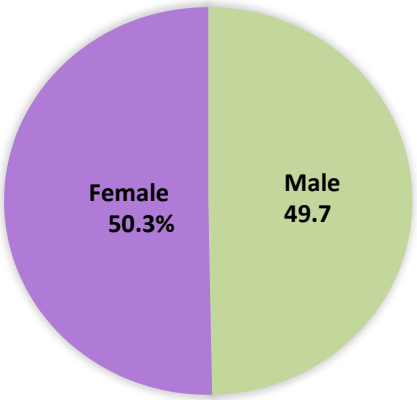


Fig. 8 Staffordshire: Gender Breakdown of the County



Staffordshire:

Females represent the majority of adults subject of a Section 42 enquiry with 63% over the year. This is in very similar proportions to those seen in previous years.

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

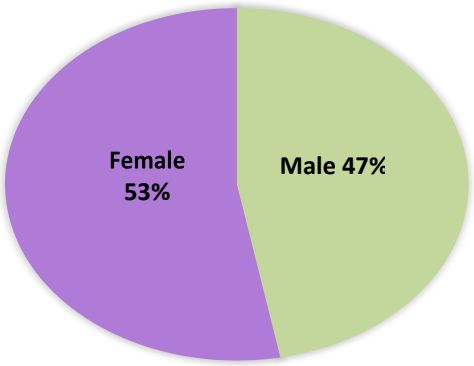
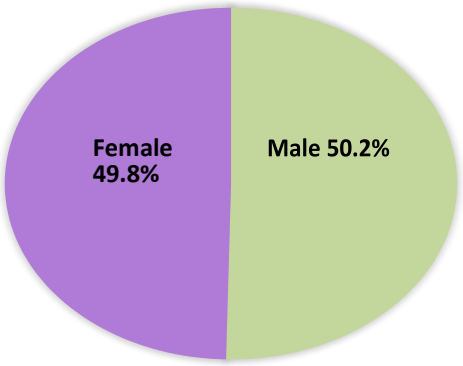


Fig. 10 - Stoke-on-Trent: Gender Breakdown of the City



Stoke on Trent:

Stoke on Trent has broadly remained the same for the number of males and female who were subject of the Section 42 enquiry process (last year females accounted for 55%). It is of note that women have a higher average life expectancy 3.7 years more than men and as a population is more elderly and accordingly 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 Local Authorities with a request that there is a 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	87.9	78.5	91.9	90.2
Not Recorded	4.5	-	2.2	-
Pakistani	1.9	6.0	0.4	1.3
Any other mixed background	1.6	1.5	0.2	0.0
Black Caribbean	1.0	0.4	0.5	0.3
Not Stated	1.0	-	2.3	-
Other White	0.6	4.5	0.8	2.9
Any other ethnic group	0.6	1.8	0.3	1.4
Any other Asian Background	0.3	1.8	0.4	0.8
Indian	0.3	1.1	0.3	1.1
Mixed White/Caribbean	0.3	0.8	0.2	0.8
Black African	0.0	2.0	0.1	0.4
Bangladeshi	0.0	0.6	0.0	0.1
Any other Black Background	0.0	0.4	0.0	0.1
Arabic	0.0	0.3	0.0	0.1
Gypsy /Roma	0.0	0.3	0.0	0.1
White Irish	0.0	0.2	0.4	0.4

Stoke-on-Trent:

The majority of individuals subject to a Section 42 enquiry are recorded as 'White British' at 87.9%, an increase from 83.1 % last year. There has been an improvement of 'Not Recorded' which has been reduced to 4.5% from 9.8% in 2021/22.

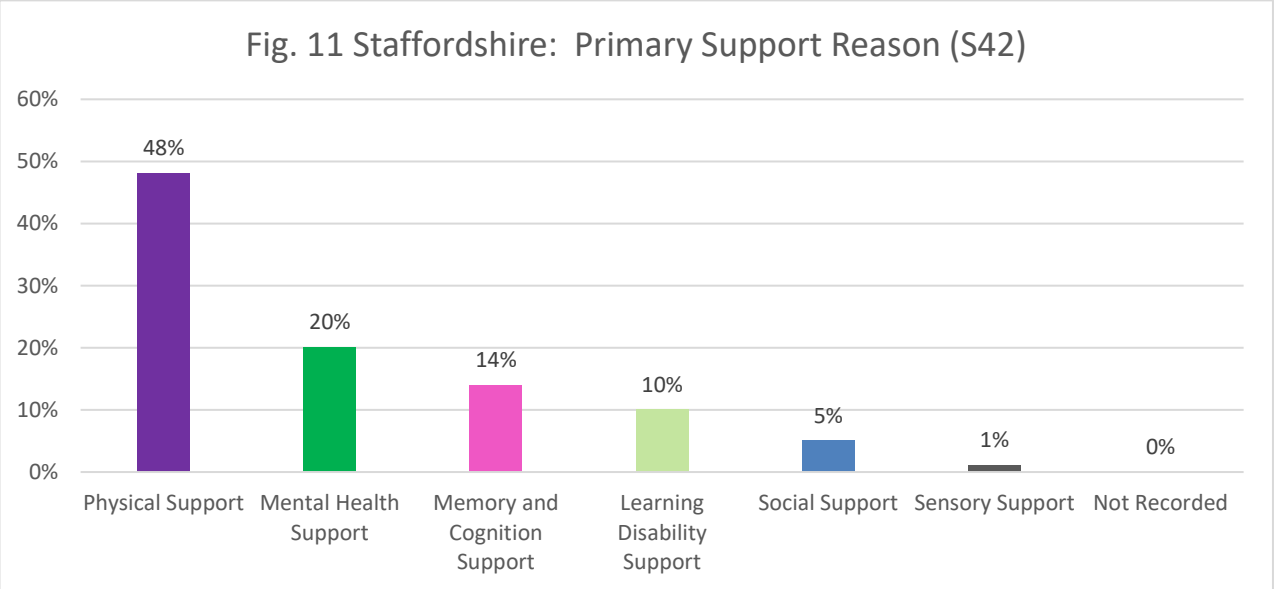
Staffordshire:

The pattern is similar in Staffordshire with the majority of declared ethnicities as 'White British' 91.9%, an increase from 87.8% last year. There has been an improvement of 'Not Recorded' reduced to 2.2% from 6.2% last year.

Note: The Board has promoted the importance of accurate ethnicity recording in 2022/23 through its Practitioner Forums, learning events and Newsletter. This coincides with the more accurate recording reflected in this years' data and the progress is acknowledged.

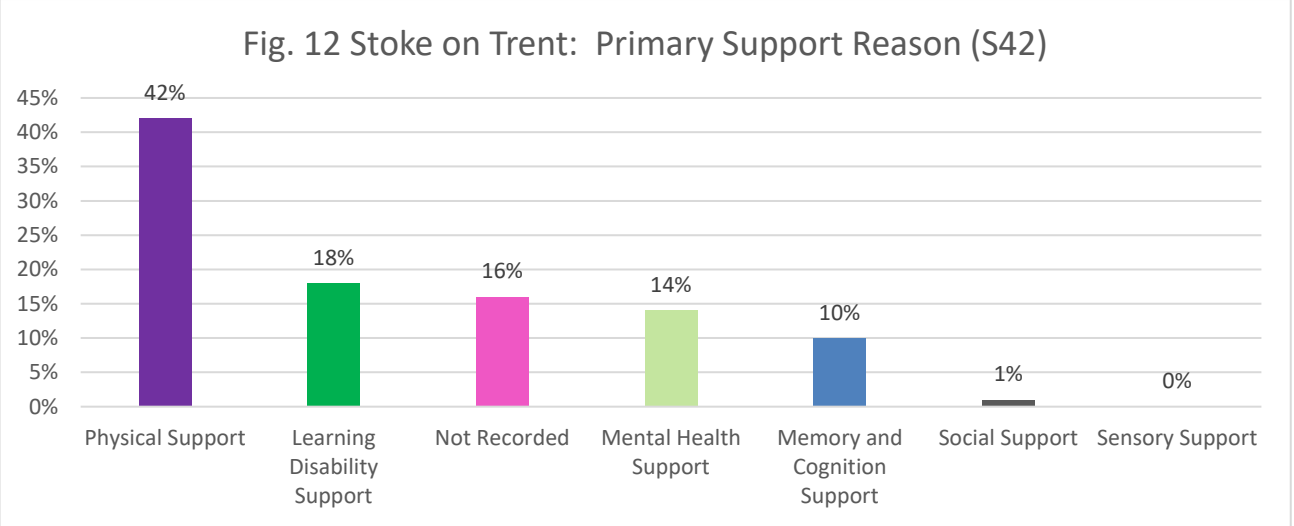
Primary Support Reason

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 2022/23 (48%) exactly the same percentage as reported last year. The second most prevalent primary support reason is Mental Health Support at 20% reflecting a 6% increase on last year. It is to be noted that there has been a significant decrease in the category of 'not recorded', which is down to 0% compared to 17% in 2021/22.



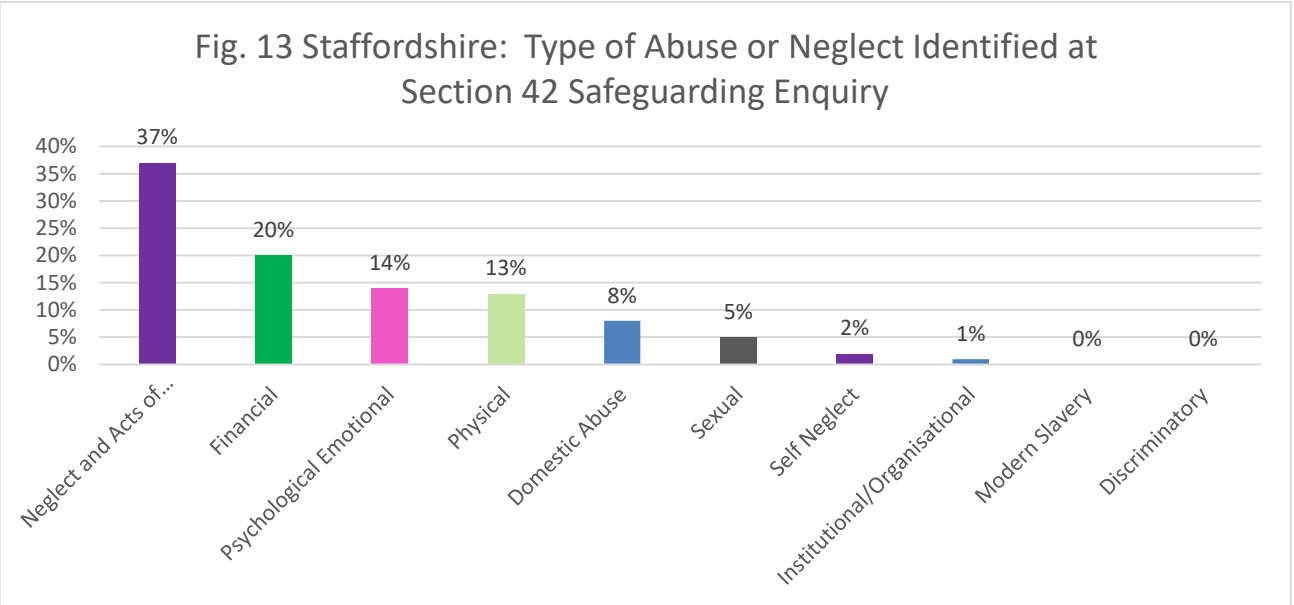
Stoke on Trent:

Physical Support similarly represents the largest proportion of primary support reasons recorded in Stoke on Trent at 42%, an increase from 39% last year, followed by learning disability support with 18% which is a reduction from 24% compared to last year.

The 16% shown as not recorded in the chart above is better explained as 'not known at the point of recording' as the adults were not known to Adult Social Care and, at that time, their needs not assessed. There are plans to move the recording of this information to later in the safeguarding process.

Types of Harm or Abuse identified at Section 42 Safeguarding Enquiry

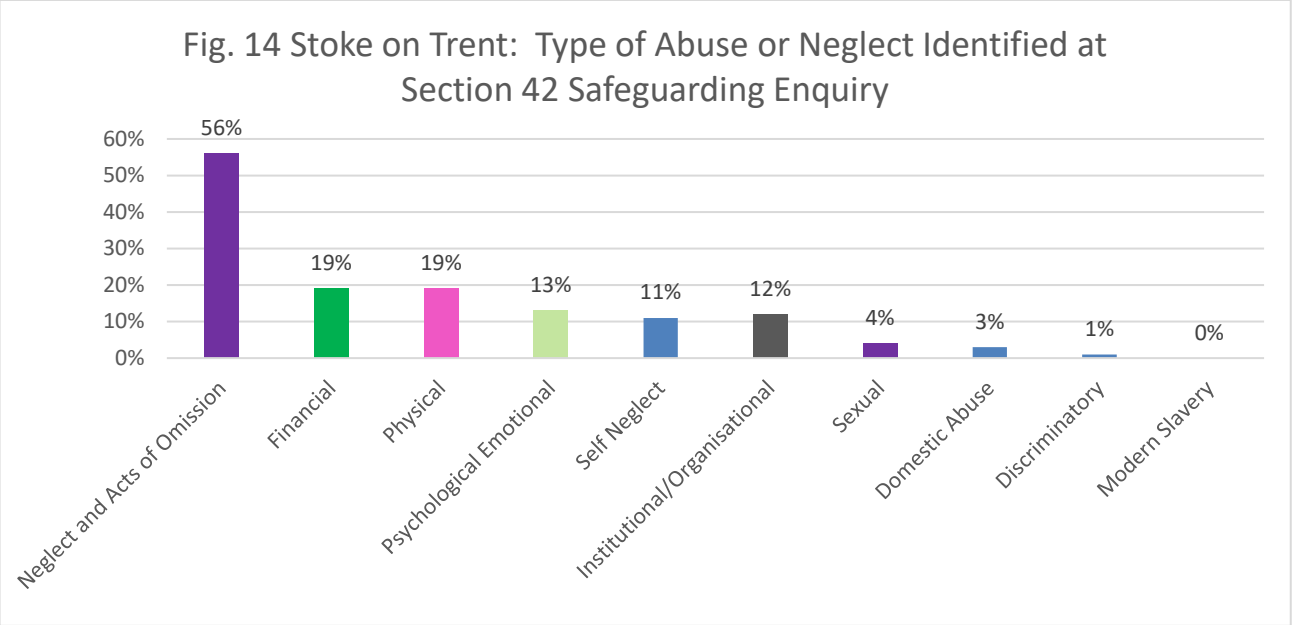
The below information shows the types of abuse and neglect reported in comparative proportions:



Staffordshire:

There are no significant changes to the percentages reported in 2021/22. Neglect and acts of omission continues to be the most prevalent type of abuse at 37% and is the same as the figure reported in 2021/22. Financial abuse remains similar at 20% compared to 19% last year. Physical abuse has reduced to 13% from 17% last year.

It is believed that organisational abuse remains under-reported at 1%. This is believed to be owing to there being only one type of abuse that can be recorded in Staffordshire case management systems and other categories are selected at the point of recording to describe the abuse e.g. physical abuse.



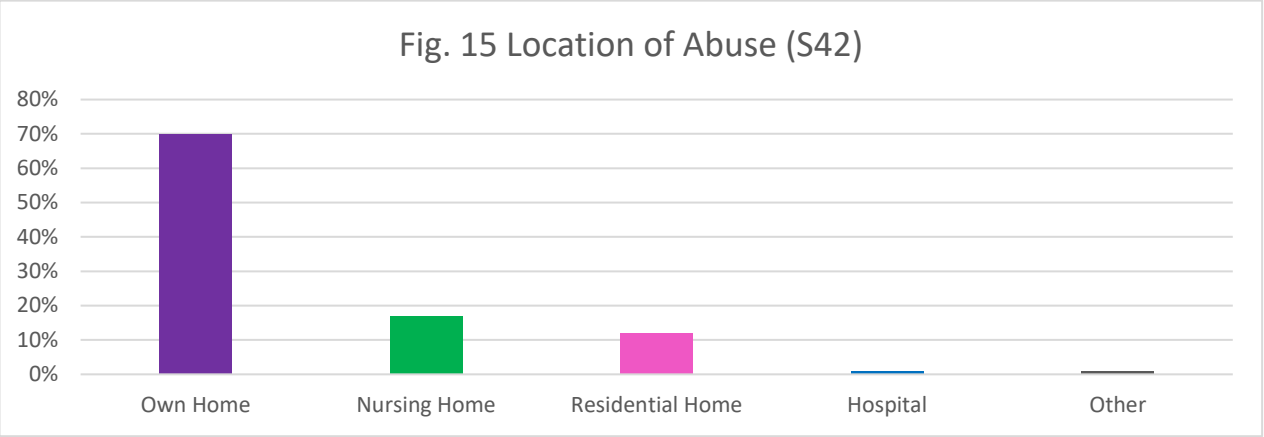
Stoke-on-Trent:

The percentage of neglect and acts of omission cases has decreased to 58% from 61% last year. Financial abuse has increased to 19% from 12% last year. Self-neglect concerns continue to increase to 11% this year. This compares to 7% last year and 2% in 2020/21. It is believed that this may be attributable to the awareness raising of self-neglect as a category of abuse following the well-attended learning events that followed the Safeguarding Adult Review of 'Andrew'. The increase in practitioner recognition of self- neglect should be seen as a positive development.

Organisational abuse, where more than one category of abuse can be recorded, is better reported in Stoke-on-Trent than Staffordshire where the recording arrangements are different.

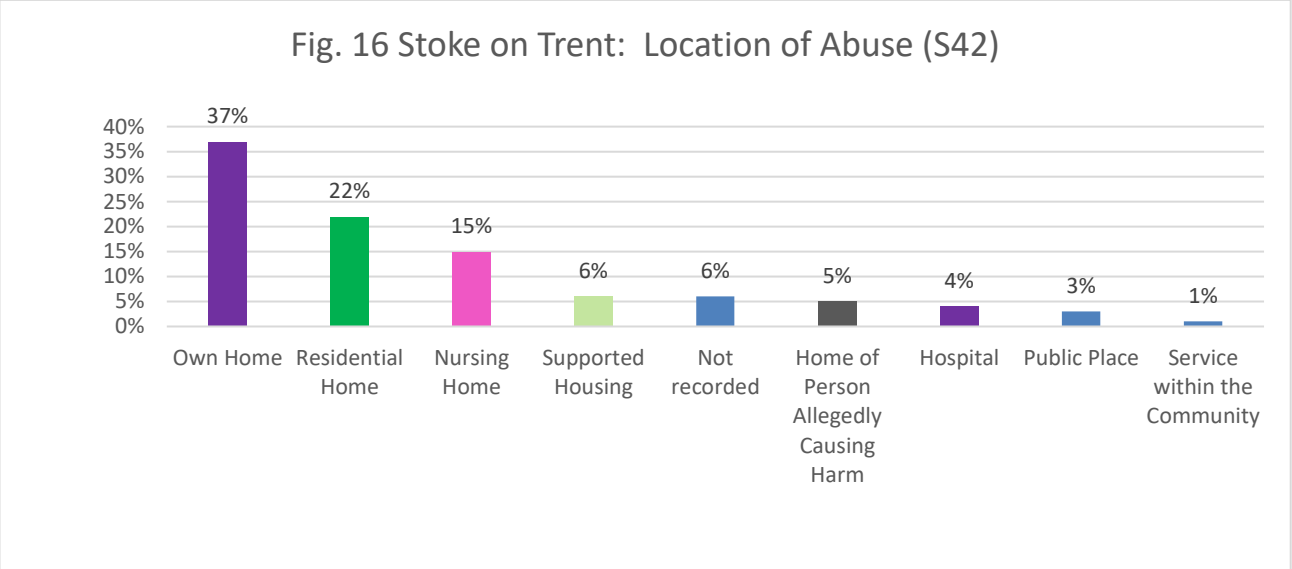
It should be noted that there can be relatively small numbers of adults in types of abuse which can cause a percentage change to appear more pronounced. In Stoke on Trent more than one type of abuse may be reported for a single case, as illustrated above in relation to organisational abuse. The total cases therefore total 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 (70%) compared to 62% in 2021/22. The next most common locations in Staffordshire were Independent nursing home at 17% a slight increase from 16% last year and residential home at 12%, an increase from 11% last year.



Stoke on Trent:

The most prevalent location of abuse in Stoke on Trent is in the person's own home 37% an increase from 26% the previous year. This was followed by 22% in an independent residential home and 15% nursing home. Stoke-on-Trent's recording system allows for a broad type of location, for example, public place, supported housing etc.

Through audit it has been identified that some practitioners record a care home as a person's own home. Work continues to improve consistency in recording standards. For this report "own home" also includes the categories of supported accommodation whilst hospital also includes those locations recorded as mental health inpatient setting or community hospital that are recorded separately on the Stoke on Trent local authority recording system.

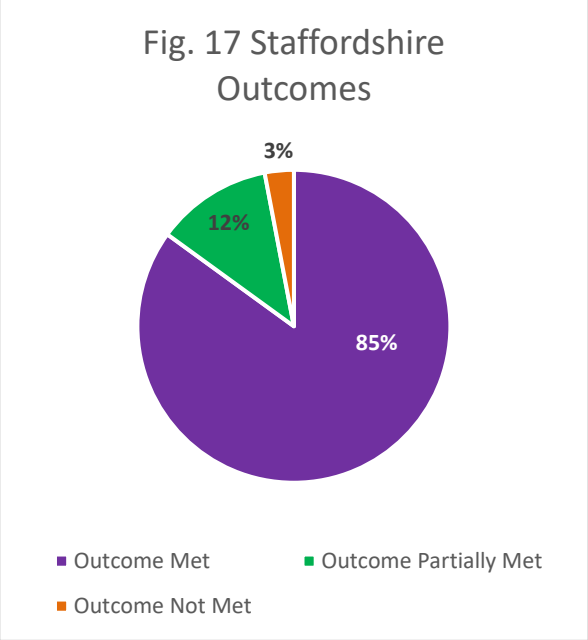
Findings of Concern Enquiries

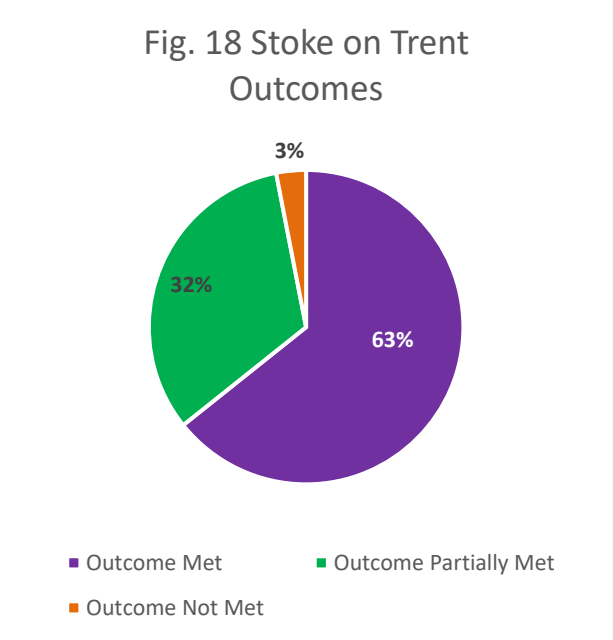
The following section provides an overview of the findings of Section 42 enquires showing what is happening to referrals with a comparison to previous years.

Staffordshire**:** 17% of adults involved in a Section 42 Enquiry had previously been involved in an enquiry in the past 12 months. This compares to 19% in the previous year.

Stoke-on-Trent: 11% of adults involved in a Section 42 Enquiry had previously been involved in an enquiry in the past 12 months. This is an increase compared to 4% last year.

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





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 whether 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 the same figure as reported 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 54% of adults subject of a Section 42 enquiry provided a response, an increase from 44% in 2021/22. 95% of these stated that desired outcomes were fully met or partially met. This is a slight decrease from 96% last year.

There is a continuous focus on accurate data capture of adults expressed desired outcomes and whether these have been met. Quality assurance audits explore the relevance and accuracy of information recorded within the Section 42 enquiries focusing on whether the outcomes identified by adults adhere to the principles of Making Safeguarding Personal.

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 remit includes proactive visits to care homes that may be on the verge of going into Large Scale Enquiry (LSE), proactive investigations on behalf of the Coroner and problem solving at repeat locations.

Whilst many 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 team has wider links to safeguarding partners, the Care Quality Commission (CQC) and Her Majesty's Coroner.

The table overleaf lists the types of incidents the Team has investigated (1 April 2022 to 31 March 2023).

Offence Type	
Non Crime or Blank	44
Care worker ill-treat/willfully neglect an individual	25
Assault occasioning actual bodily harm	30
Common assault and battery	15
Theft if not classified elsewhere	12
Rape of a female aged 16 or over	10
Sexual assault on a female 13 and over	10
Care provider breach duty of care resulting in ill treatment/neglect of individual	11
Action Fraud	5
Sexual assault on a male 13 and over	4
Sending letters etc. with intent to cause distress or anxiety	3
Theft in a dwelling other than from automatic machine or meter	3
Temporary Code – Third party report – waiting for victim confirmation	2
Wounding with intent to do grievous bodily harm	2
Engage in controlling/coercive behavior in an intimate/family relationship	2
Assault on a female 13 and over by penetration	2
Other criminal damage to other residential building £500 - £5000	2
Malicious Wounding: wounding or inflicting grievous bodily harm	1
Stalking involving serious alarm/distress	1
Non-fatal strangulation and suffocation	1
Rape of a male aged 16 or over	1
Rape of a male aged 16 or over – multiple undefined offenders	1
Burglary – Residential	1
Care workers: sexual activity with a person with a mental disorder – male person	1
Care workers: causing or inciting sexual activity (person with mental disorder) no penetration	1
Care workers: sexual activity in the present of a person with a mental disorder	1
Cause of incite the sexual exploration of a child – child 13 – 17	1
Take/make/distribute indecent photographs of a pseudo- photographs of children	1
Exposure	1
Ill treatment or neglect of a person lacking capacity by anyone responsible for that persons care	1
Fear or provocation of violence	1
Harassment	1
Total	**187**

Examples of investigations include:

- Carer convicted of ill-treatment of care home resident

  An investigation was commenced following a report was made to police that a carer had been witnessed assaulting a 78-year-old male resident at a care home. The witness reported that the carer has pushed the resident onto the bed banging his head against a wall before punching and slapping him several times around his head causing cuts and bruising. The carer then forcibly removed the resident's shirt causing him further distress.

  A joint investigation was conducted by police and adult social care as the resident lacked capacity. The carer was interviewed and denied ill-treating the resident. Following the

investigation which was challenging due to the resident not having mental capacity the Crown Prosecution Service brought criminal charges against the carer for ill- treating the resident. Following a trial at Stoke-on-Trent Crown Court in March 2023 the carer was found guilty of ill treatment and sentenced to eight months in prison. On sentencing the carer the Judge commented:

"The Court of Appeal has made it clear that cases such as this almost always require custodial sentences…….not only did you maintain your innocence but you accused at least two of your colleagues of lying…….you were in a trusted, responsible position working with vulnerable people and you lost your temper."

This is an example of effective team working between police and safeguarding partners to protect adults with care and support needs from abuse by people in positions of trust.

➢ <u>Responding to Modern Day Slavery</u>

The care co-ordinator for 'Paul' contacted the Safeguarding Team at North Staffordshire Combined Healthcare Trust with concerns that Paul wasn't fully engaging but was accepting his medication. The care co-ordinator reported not being able to see Paul but, family members with whom he was living temporarily had concerns about his welfare and requested a visit.

When Paul was seen he disclosed that over the previous four weeks he had been kept hostage at an unknown address and had been made to complete tasks in return for drugs. The care co-ordinator observed that Paul's hands were injured and dirty.

An adult safeguarding referral was made to Adult Social Care and a report to Staffordshire Police. An investigation was commenced and several arrests were made on charges of assault occasioning Grievous Bodily Harm and Modern Day Slavery with the outcome that the source of harm to Paul was removed.

The case illustrates the effectiveness of the multi-agency working to respond to abuse that is often hidden.

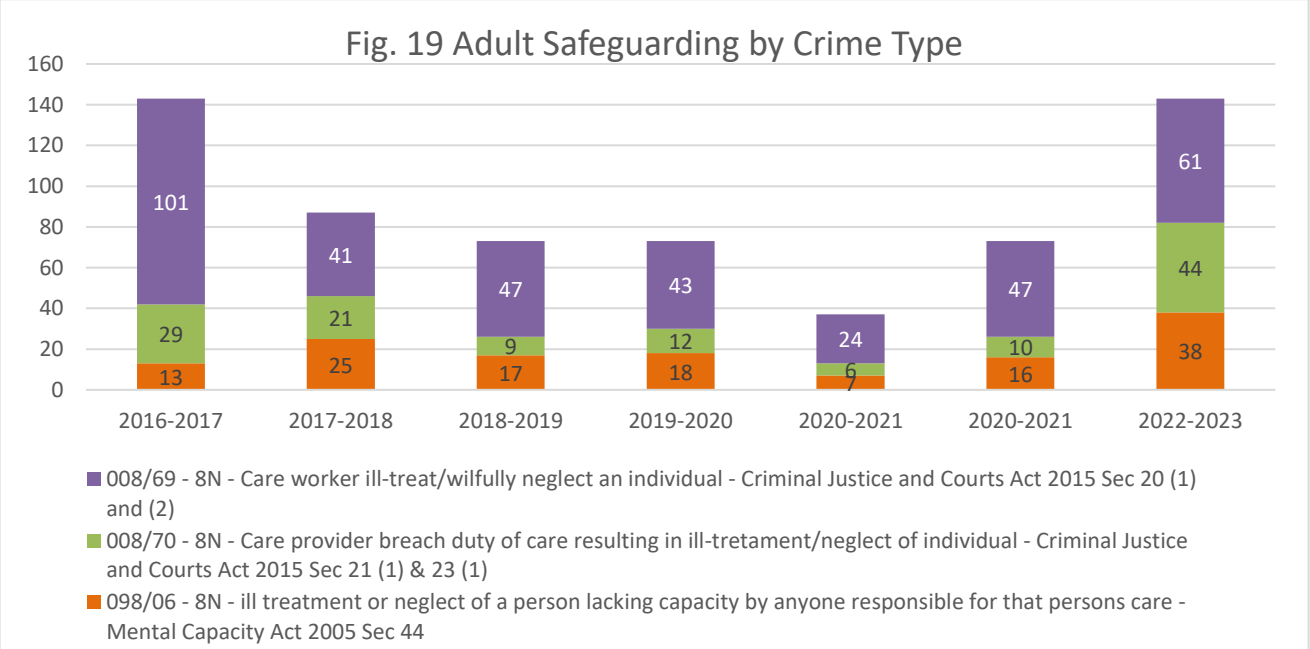
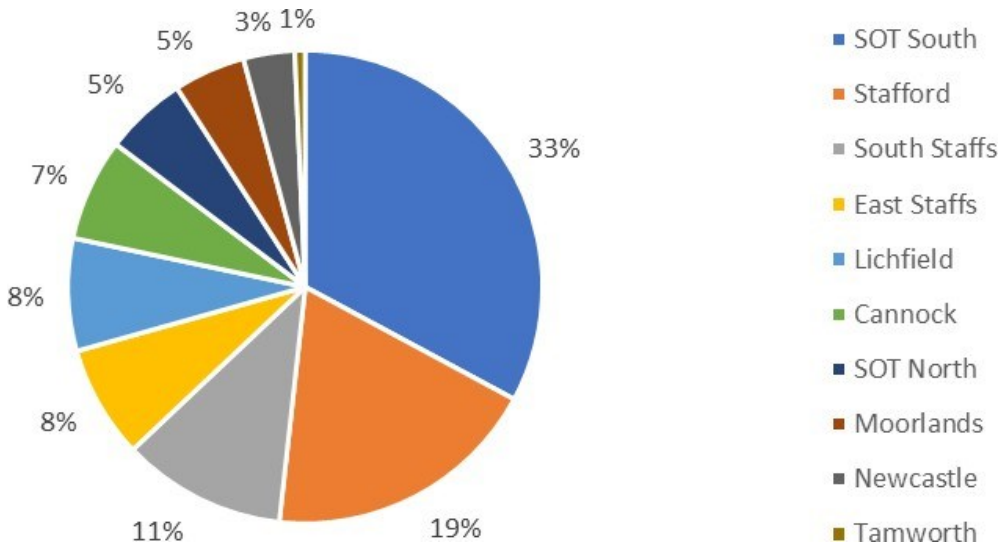


Figure 19 illustrates that there were a total of 143 offences reported for criminal investigation in the 12 months to 31 March 2023. The year is contrasted with previous years to indicate reporting rates over time. From analysis of 2022/23 reports:

- Of the Neglect offences, there are 9 repeat victims in the last 12-months period; none had been a victim in the previous 5 years.
- 1 victim has 3 associated occurrences
- 8 victims have 2 associated occurrences
- 5 out of the 9 victims had all offences occur at the same address.
- There are 6 repeat suspects in the last 12-month period, none had been a suspect/offender in the previous 5 years.
- 2 repeat offenders are linked to the same 3 crimes.
- There are 17 repeat locations in the last 12-month period. Of these 14 are care homes with 3 residential addresses.

The analysis is used operationally in conjunction with safeguarding partners to target preventative actions. The location of the crime types are illustrated below.

Fig. 20 Location of neglect type crime by Local Policing Team Area 2022/23



8. Finance Report (Draft)

The Board is supported by a part-time Independent Chair, a full-time Board Manager and a full-time Administrator. There was a period of 9 weeks when there was no administrator and so employment costs were slightly less than anticipated.

Income: This was year 1 of a 3-year budget agreement which was approved by the statutory partners in July 2022.

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

Spend:	Staffing/Employee costs	£121,369 *note (i)*
	Consultant fees	£3,738 (SAR costs)
	Training resources/catering	£252
	Website costs	£2,500
	Insurances	£2,102
	TOTAL:	**£129,961**

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