

# Safeguarding Overview and Scrutiny Committee - Thursday 04 January 2024

# Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2022/2023

#### **Recommendations**

I recommend that the Committee:

a. receives the SSASPB Annual Report in accordance with the requirements of the Care Act 2014 Statutory Guidance (02.09.2022): Chapter 14 Paragraph 160)

b. provides feedback and challenge to the work of the SSASPB

#### **Local Member Interest:**

NA

**Report of:** Mr John Wood, Independent Chair of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

### **Summary**

# What is the Overview and Scrutiny Committee being asked to do and why?

- 1. To scrutinise the work of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB), and to consider or comment on the progress that the Board has made since the last report.
- 2. To comply with the requirements of the Care Act 2014 Statutory Guidance (Chapter 14, Paragraph 160) which states that the SSASPB must send its Annual Report to several bodies including the relevant overview and scrutiny committee meeting of the Local Authority.

## Report

#### **Background**

3. Safeguarding Adult Boards (SABs) became statutory under the Care Act 2014 which states that the main objective of a SAB is to assure itself that



local safeguarding arrangements and partners act to help and protect adults in its area who:

- a. Have needs for care and support
- b. Are experiencing or at risk of abuse and neglect; and
- c. As a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse and neglect.
- 4. The SAB has a strategic role to oversee and lead adult safeguarding and is interested in a range of matters that contribute to the prevention of abuse and neglect. These include the safety of patients in local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services. SAB partners also have a role in challenging each other and other organisations where there is cause for concern that actions or inactions are increasing the risk of abuse or neglect.
- 5. The SAB has 3 core duties:
  - a. To publish a strategic plan
  - b. To publish an Annual Report
  - c. To undertake Safeguarding Adult Reviews in accordance with criteria
- 6. This Annual Report of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) covers the period 1<sup>st</sup> April 2020 to March 31<sup>st</sup>, 2021. Mr John Wood was the Independent Chair of the Board throughout the period. The report provides an overview of the work of the Board and its sub-groups and illustrated with case studies as to how the focus on Making Safeguarding Personal is making a positive difference to ensuring that adults with care and support needs are supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse.
- 7. Adult Safeguarding Data: Staffordshire overview for the reporting period 1<sup>st</sup> April 2022 to 31<sup>st</sup> March 2023:

The safeguarding partners 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 and unable to protect themselves. Reported concerns can progress to a formal enquiry under Section 42 of the Care Act 2014, if the duty of enquiry requirements are met.



a. **Concerns reported:** There have been 15,680 occasions when concerns have been reported that adults with care and support needs may be experiencing or at risk of abuse and neglect. This number has increased by 2,543 from 2021/22 which was reported as 13,227. Following initial assessment it was determined that the duty of enquiry requirement was met in 17% of those reported concerns, a decrease of 4% from 2021/22 reflecting a downward trend, a further 4% fewer than the figure of 25% in 2020/21.

In the context of rising numbers of reported concerns and the lower proportions of these meeting the duty of enquiry requirement the reasons for the fluctuations have been explored by safeguarding partners.

The number of people who meet the threshold for a Safeguarding enquiry under Section 42 is broadly unchanged. It is the increase in the total number of concerns that has contributed to the reducing conversion rate.

Safeguarding concerns range from the very serious to the relatively trivial. 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 a proportion of concerns are found to be low level incidents which have led to no harm to the individual. Concerns such as these are triaged early and, when no other actions are needed, they will be closed. Examples include concerns regarding medication errors, service user incidents, missed and late care calls. In other situations, appropriate actions have been taken by others to reduce the risk and therefore a Section 42 enquiry is not required.

Arising from the increasing number of reported concerns there are discussions currently amongst safeguarding partners to develop a mutual understanding of what constitutes a safeguarding concern and to ensure that referring thresholds are understood with the aim of ensuring proportionate ongoing management to protect resources to deal with the more serious cases.

b. **Age:** Of the people subject of a Section 42 enquiry, those aged 75 to 84 years (26.9%) represent the largest cohort followed by 85 to 94 years (25.1%). Last year these age groups were reversed with 85 to 94 being the most prevalent at 25.2% compared to 24.9% for 75 to 84 years.



When drawing comparison with the population statistics of Staffordshire it is evident that adults in the 75yrs+ age groupings are disproportionally over-represented for Section 42 enquiries. Around 12% of the adult population in Staffordshire are aged 75 and over, however, 56.8% of safeguarding enquiries are related to this age group.

- c. **Gender:** Females represent the majority of adults subject of a Section 42 enquiries with 63% over the year. This is disproportionately above the population average for females in Staffordshire which is 50.3%. Females over the age of 75 years are consistently found to be most at risk of abuse or neglect.
- d. **Ethnicity:** The majority of adults involved in a Section 42 enquiry are white 91.9%, an increase from 87.8% last year. The percentage of the population of Staffordshire who self-identified as white is 90.2%. There has been an improvement of 'Not Recorded' reduced to 2.2% from 6.2% last year.
- e. **Primary Support Reason (PSR)**: Physical support continues to be the most common PSR in Staffordshire at 48% the same percentage as last year. This is followed by mental health support at 20% reflecting a 6% increase from last year. It is of note that there is a significant decrease in the category of 'not recorded' which is down to 0% from 17% last year.
- f. **Type of Abuse:** Neglect and Acts of Omission continues to be the most prevalent type of abuse at 37% and is the same figure as last year. Financial Abuse remains similar at 20% compared to 19% last year. Physical Harm has reduced to 13% from 17% last year.
- g. Location of Abuse: The most reported location of abuse in Staffordshire was the adults' own home at 70% compared to 62% in 2021/22. The next most prevalent locations were nursing home 17% a slight increase from 16% last year and independent residential home 12% a slight increase from 11% last year. Put into context the adult may consider their care/residential or nursing home as their 'own home'.
- h. **Expressed Outcomes met:** 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 had been met in full, partially met or not met. A total of 97% adults of those responding stated that their desired outcomes were fully met or partially met. This is the same figure as last year.



The reasons why the adults' desired outcomes have not been met have been explored. Amongst the reasons are situations where the outcomes set by the adult are not always achievable. By way of example, in financial abuse cases the adult may want their property/money returned but it cannot be recovered. In some instances, the adult may want staff members disciplined or sacked etc. and again this is not possible. In some situations, it is because the adult wants to either move away from or stay with the family, but the risks are too high and there is a need for appropriate proportionate action to reduce the risks.

- i. **Strategic Priorities:** During the reporting period the SSASPB Strategic Priorities were:
  - i. Ensuring Effective Practice. This is a new priority arising from a revision of the SSASPB Strategic Plan and in response to five themes of significant importance and recurring concern arising from a combination of learning events. Pages 18 32 of the Annual Report provide a comprehensive overview of the collective activities of safeguarding partners that evidences the changes in practice in response to learning experiences.
  - ii. Improving engagement with adults with care and support needs, their families, carers, members of the public, professionals and volunteers. Pages 32 33 of the Annual Report set out the range of methods that have been utilised to raise awareness, including commissioning Rockspur working with adults with autism or a learning disability to produce a more accessible version of the Annual Report.
- j. Learning from experience: The SSASPB's commitment to learning from experience is outlined in pages 11-16. As required by the Care Act 2014, a summary of the Safeguarding Adult Reviews (SAR) undertaken in 22/23 is presented. A total of five 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.

Arising from the learning from the SAR of Andrew, the SSASPB has facilitated extensive training for practitioners to help in responding to self-neglect and in trauma informed practice collectively attended by around 1,200 practitioners during the past year. This section of the report concludes with a summary of the other work that is being done through the SSASPB to support strategic priorities.



#### Link to Strategic Plan

- 8. The assurance role of the Board supports the following Staffordshire County Council strategic priorities:
  - a. Encourage good health and wellbeing, resilience and independence

### **Link to Other Overview and Scrutiny Activity**

9. Deprivation of Liberty Safeguards

#### **Community Impact**

10. There is no anticipated community impact

### **List of Background Documents/Appendices:**

Appendix 1 - Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2022/23

#### **Contact Details**

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