Topic:	Annual Report of Staffordshire and Stoke on Trent Adult Safeguarding Partnership 2015/16
Date:	8 December 2016
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Report Type	For information / discussion

1. Introduction

The Care Act 2014 provides the statutory requirements for adult safeguarding. It places a duty on each Local Authority to establish a Safeguarding Adults Board 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 Adults Board (Staffordshire and Stoke-on-Trent Adult Strategic Partnership Board in this case) is to help and protect adults in its local area by co-ordinating and ensuring the effectiveness of what each of its members does. The Board role is to assure itself that safeguarding partners act to help and protect adults who:

- have needs for care and support; and 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 Adults Board has three primary functions:

- It must publish a strategic plan that sets out its objectives and how these will be achieved.
- It must publish an annual report detailing what the Board has done during the year to achieve its objectives and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews or any on-going reviews.
- It must conduct any Safeguarding Adults Review where the threshold criteria has been met.

The annual report for the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board 2015/16 is submitted to the Staffordshire Health and Wellbeing Board in accordance with the provisions of the Care Act 2014. The key headlines from the report are summarised below.

2. **Headlines summary**

During the year a total of 4,457 safeguarding concerns were recorded equating to an average 12 per day which halts a trend of annual increases. The reduction from 4,789 in 2014/15 is largely attributable to the revised criteria for Section 42 enquiries in the Care Act.

The percentage of safeguarding concerns assessed as meeting the threshold for a Section 42 Care Act Safeguarding Enquiry dropped to 71.7% in 2015/16 from 80% in the previous year. This is considered to be as a result of increased awareness by the Contact Centre staff receiving reports of concerns being more confident to signpost concerns to other, more suitable, routes. Such outcomes include, by way of example, an assessment of need rather than a formal safeguarding enquiry.

Due to the limitations of the Staffordshire County Council adult social care case management system the referral source cannot currently be identified for individual safeguarding concerns and this information has not been collected for the past 2 years. A service-wide upgrade is scheduled for 2016/17 and it is believed that this information will be available in the future with the potential for historical data to be included.

The Care Act 2014 introduced new categories of abuse: Modern Day Slavery, Self Neglect, and Domestic Abuse. IT systems are to be updated to capture these new categories, but it comes with a challenge as Domestic Abuse may also be sexual or physical abuse. The matter is being discussed nationally as it would be unhelpful to report figures where there is double-counting. The introduction of the new categories makes it difficult to make comparisons between pre-Care Act and post-Care Act data.

The main source of risk to adults with care and support needs continues to come from those known to them. This has been the trend for 6 years, but IT systems do not currently record the actual relationship to the adult.

In relation to the location of neglect and abuse the two most prominent settings are the person’s own home in 47% of occasions with 38% in a residential care home. The need for better understanding to address the level of abuse and neglect a in residential care/nursing setting was a key factor in the Board determining issues in ‘Leadership in the Independent sector’ as one of its strategic priorities.

Data is collected on the primary support reason for care and support. The vast

majority of reported concerns are in relation to the adults over 64 years with a physical primary support reason (2135). The second largest reason was adults aged under 64 years with a learning disability (691).

During the reporting period the Board finalised one Safeguarding Adult Review. The summary finding states, at page 16, that

It is apparent that many professionals in their specialist fields endeavoured to follow best practice to care effectively for S but were hampered by their lack of collaboration and understanding of the Mental Capacity Act 2005 and Mental Health Act 1983.

The Annual Report contains a number of messages to Commissioners, at page 35, including:-

- *Commissioners should monitor the compliance rates of their provider organisations in relation to training provided and the impact on practice in relation to Adult Safeguarding; Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).*
- *Commissioners need to be assured that there is a sound understanding of Mental Capacity Act legislation and that it is applied in practice.*
- *The financial pressure on some local care providers is now extreme and this may not be conducive to positive and safe care for service users. This is demonstrated by the increased rate of service failure and the significant difficulties in identifying good leadership in some services. Quality monitoring in the independent care home sector is a powerful proxy in terms of safeguarding surveillance, harm reduction and prevention. Poor quality care has a substantial impact upon safeguarding practice. Commissioners of health and social care packages should ensure that adequate quality monitoring systems are in place to assist this.*
- *Commissioners should ensure that their providers are cognisant of lessons learnt, as identified through Safeguarding Adult Reviews and other learning review processes. Commissioners should seek assurance that learning is routinely used to improve practice.*

3. Recommendations

3.1. That Commissioners act upon the findings of this report

3.2. That the Board note this report