Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

Abuse must stop

SSASPB Annual Report 2020-21

NHS

City of Stoke-on-Trent

Staffordshire County Council

Staffordshire Police

1. CONTENTS

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

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

Adult living in Staffordshire – Telephone: 0345 604 2719

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

2. INDEPENDENT CHAIR FOREWORD

It is my privilege as Independent Chair to write the foreword to this Annual Report of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board. This report provides a look back at the work by the partners of the Board and its sub-groups over the year 1st April 2020 to 31 March 2021.

The year began and ended in lockdown due to the COVID-19 pandemic which has had devastating impacts in many ways on the health and wellbeing of millions of people both here in the United Kingdom and throughout the world.

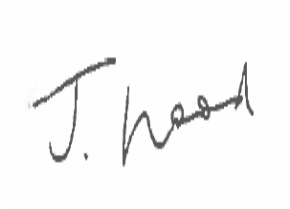
At the beginning of the year care homes and adults with care and support needs who were not visible, or unable to receive their usual support, were of huge concern due to the stringent restrictions on social interaction. Safeguarding partners adapted their approaches to become more supportive of front-line operations whilst at the same time remaining vigilant as to the implications for hidden adults arising from shielding; homeless adults and rough sleepers with care and support needs; and the experiences of those adults with care and support needs at increased risk of exploitation and domestic abuse.

The Board has adapted its approaches to seeking assurances as to the effectiveness of safeguarding arrangements using a range of methods to communicate and engage. The response to the necessary changes has demonstrated the strength of local partnership working which has become even more cohesive and visible over time.

I would again like to take this opportunity to acknowledge the commitment and enthusiasm of all of our partners and supporters including the statutory, independent and voluntary community sector who have a clear focus on doing their best for those adults whom we are here to protect in these most challenging of times and consistently demonstrate a strong commitment to do that. I also again thank the inspectors from the Care Quality Commission with whom safeguarding partners have developed constructive working relationships through established channels of communication and early intervention particularly through the COVID-19 pandemic.

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

I conclude this foreword by offering, on behalf of the Board partners, our condolences to all those who lost loved ones in social care settings, hospitals, secure institutions, or in their own homes during the pandemic. I would also like to again acknowledge the enormous role of all professionals who delivered services to adults with care and support needs, often at considerable personal cost.



John Wood QPM

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

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

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

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

A Safeguarding Adult Board has three primary functions:

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

Composition of the Board

The Board has a broad membership of partners in Staffordshire and Stoke-on-Trent and is Chaired by an Independent Chair appointed by Staffordshire County Council and Stoke-on-Trent City Council in conjunction with Board members. The Board membership is shown at Appendix 1, page 40.

The Board is dependent on the performance of agencies with a safeguarding remit for meeting its objectives. The strategic partnerships with which the Board is required to agree responsibilities and reporting relationships to ensure collaborative action are shown in the Governance Structure at Appendix 2, page 41.

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".

[1] Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/contents

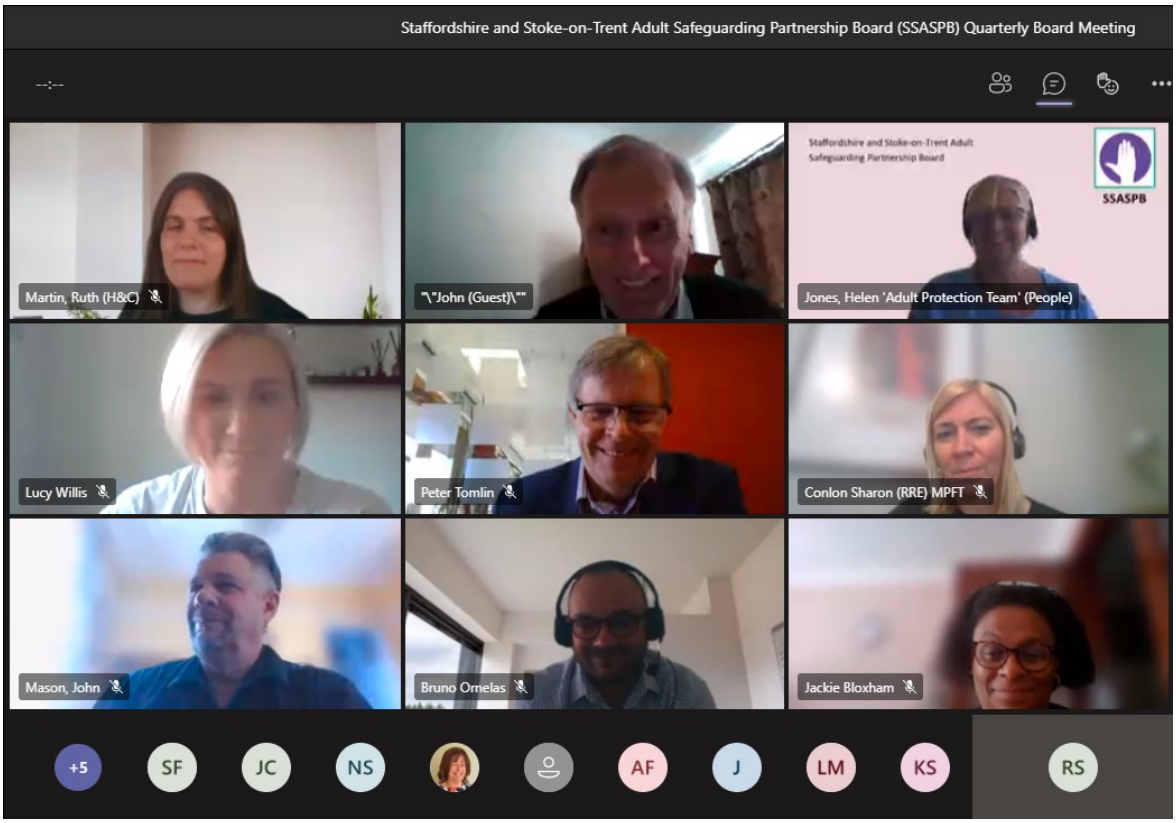
[2] Care and support statutory guidance: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Abuse and neglect can take many forms. The various categories as described in the Care Act are shown at Appendix 3, page 42. The Board has taken account of the statutory guidance in determining the following vision.

Vision for Safeguarding in Staffordshire and Stoke-on-Trent

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

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



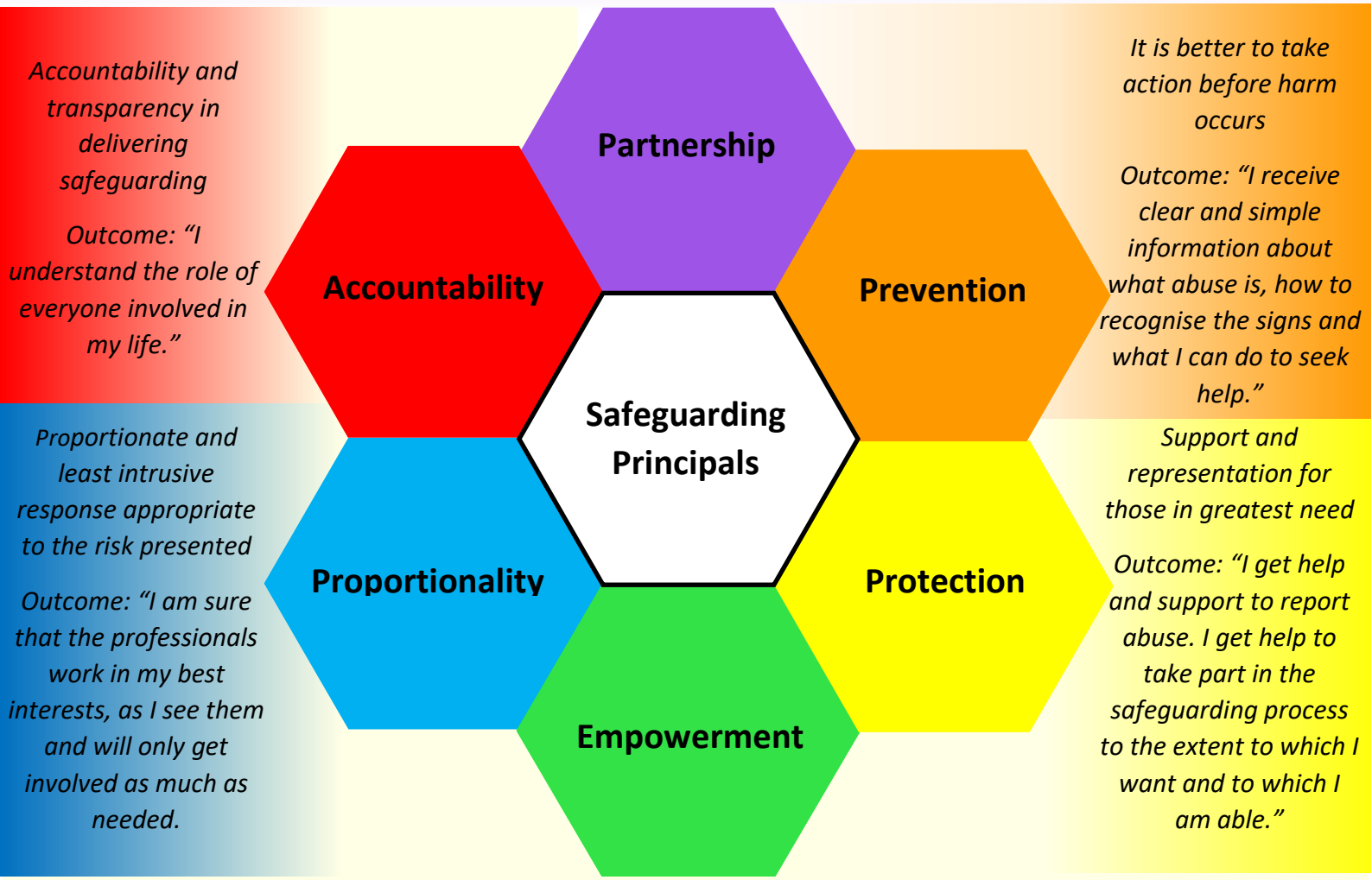
All of the Board meetings this year have been hosted virtually.

4. SAFEGUARDING PRINCIPLES

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

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse

Outcome: "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me"



Accountability and transparency in delivering safeguarding

Outcome: "I understand the role of everyone involved in my life."

It is better to take action before harm occurs

Outcome: "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

Proportionate and least intrusive response appropriate to the risk presented

Outcome: "I am sure that the professionals work in my best interests, as I see them and will only get involved as much as needed.

Support and representation for those in greatest need

Outcome: "I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able."

Presumption of person led decisions and informed consent

Outcome: "I am asked what I want as the outcomes from the safeguarding process, and these directly inform what happens."

5. WHAT WE HAVE DONE

This section outlines the work done in partnership during the year to help and protect adults at risk of abuse and neglect in our area. It also highlights some of the key challenges that have been encountered and consequent actions.

Board

Independent Chair: John Wood

Vice Chair: Lisa Bates, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent Clinical Commissioning Groups and Kim Gunn, Designated Nurse for Adult Safeguarding North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups April 2020 to August 2020.

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 and awareness and responsiveness of further education services.

During 2020/21 the Board has:

- Sought and received assurances from connected partners as to the working practices that were adapted in response to the COVID-19 pandemic and received assurances that adult safeguarding was not adversely impacted by the provisions for 'easements' relating to Adult Social Care
- Received a presentation from the CQC Inspection Manager for Staffordshire and Stoke-on-Trent on the work of the CQC within regulated care home settings. Discussed how inspection and regulatory practice had been adapted in response to the COVID-19 pandemic and the associated challenges resulting from it. Received assurances from the CQC Inspector that they were conducting research and follow ups into COVID infection management in regulated settings
- Encouraged the Local Authorities to contribute to the Safeguarding Adults Insight Project to gather data on the impact of COVID-19 on adult safeguarding and subsequently discussed findings
- Received a presentation from the CQC Inspection Manager on the work of the CQC within independent hospitals. CQC responded to the Independent Chair's request for assurance that adult abuse and neglect was being identified and addressed in independent hospital settings in Stoke-on-Trent and Staffordshire
- Actively raised awareness and promoted widely the importance of whistleblowing in response to the CQC publication Closed Cultures (published June 2020)
- In response to a challenge from a Board member considered the question 'How does the Board hold the safeguarding system to account in the midst of the COVID pandemic'? The discussion was informed by contributions from visitors, the Chair of the Staffordshire and Stoke-on-Trent Quality and Safeguarding Information Sharing Meeting (QSISM) and the Executive Director of Nursing and Quality from the Staffordshire and Stoke-on-Trent Clinical Commissioning Groups and focused on: -
    - Safeguarding issues and concerns during the COVID pandemic, particularly in relation to care homes
    - How the SSASPB ensures the effectiveness of safeguarding arrangements during the changed arrangements
    - Escalation procedures: how the policy and procedure is promoted and used and what if any blockages there are to use and progression
- Received updates from both Local Authorities detailing the response to the Department of Health and Social Care regarding 'Support Package for Care Homes'

- Considered and discussed the findings from the national research into the deaths of adults with Learning Disabilities due to COVID. Sought assurances from partners as to local position regarding adults with Learning Disabilities (LD) and subsequently prompted challenges and escalations as to the support for adults with LD locally
- Received assurances that relevant partners are planning for the changes to be brought about by the transition to the Liberty Protection Safeguards scheduled for April 2022
- Received and discussed the updated policy for safeguarding in publicly owned prisons and discussed similar arrangements for private prisons
- Reviewed the attendance at Board meetings and sub-groups. Despite the increased operational demands caused by the pandemic excellent attendance has been sustained through the virtual platform of Microsoft Teams
- Considered and discussed the review of the Multi-Agency Safeguarding Hub (MASH) and determined the future assurance role of the Board

Executive sub-group

Chair: Kim Gunn, Designated Nurse for Adult Safeguarding North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups April 2020 to August 2020.

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

The Executive sub- group has responsibility for monitoring the progress of all sub-groups as well as its own work-streams. The core work of the Executive sub-group includes receiving and considering regular updates of activity and progress from sub-groups against their Business Plans; it ensures that the core functions of the Board's Constitution are undertaken and that the Strategic Priorities of the Board are delivered. The Executive membership is made up of the Chairs of the sub-groups, Officers to the Board, the Board Manager and the Board Independent Chair.

During 2020/21 the sub-group has:

- Monitored the progress against the Strategic Priorities (Engagement and Financial and Material Abuse)
- Discussed how the partnership response to the COVID-19 pandemic was being monitored on matters relating to adult safeguarding
- Tasked the Audit and Assurance sub-group with checking what lessons were being learned both locally and nationally following the discharge of adults with care and support needs from hospital into care and nursing homes during the early phases of the pandemic
- Checked local activity against the National COVID Assurance framework that had been distributed through the National Board Business Manager network
- Prioritised work of the Board following the introduction of the first national lockdown in March 2020. Lower priority meetings were postponed until the technology for remote working became more widely available, however the Board continued to function and fulfil its statutory responsibilities during this period
- Produced a briefing note to advise the Partnership of the decisions taken regarding work prioritisation to keep them informed of the impact of the pandemic

- Monitored the demands placed upon the partners in Board sub-groups releasing them to be operationally responsive to the demands caused by the pandemic when it was necessary
- Agreed to support a research project proposal by Dr Laura Pritchard-Jones from Keele University to study the impact of 'COVID-19 on Adult Social Care and Safeguarding: a Large-Scale mixed methods study'
- Considered a report produced by the CQC outlining the impact that COVID-19 had on deaths of adults with a Learning Disability. Followed up the national findings locally with Health and Wellbeing Boards and the Learning Disability Mortality Review Programme (LeDeR)
- Sought assurance that both Local Authorities had responded to a letter from the Minister for Care in which they had outlined their plans regarding the support package for Care Homes
- Received a presentation from Lindsey Boughey covering the new oversight arrangements for CCG-Commissioned placements for those with a learning disability, autism or both in independent mental health hospitals
- Agreed to examine best practice regionally and nationally for the management of complex cases which don't meet the criteria for formal adult safeguarding
- Engaged with the review of the Multi-Agency Safeguarding Hub (MASH)
- Supported the production of guidance for Safeguarding in Prisons which is used by the 7 adult prisons in Staffordshire
- Sought assurances on agencies' response to the publication 'Adults Missing from Care Settings' published by Missing People in October 2020
- Planned the Partnership's contribution to the Ann Craft National Adult Safeguarding week in November 2020 and reflected afterwards on the achievements. Acknowledged the excellent work done by many partners to support the awareness raising initiative
- Agreed to support a piece of academic research led by King's College which looked at practice with regards to self-neglect and homelessness
- Contributed to the feedback sought following the publication of the draft National Institute for Health and Care Excellence (NICE) Guidance for Safeguarding Adults in Care Homes on the 26/02/21
- Made decision to refresh the dedicated SSASPB website and to make it more accessible, approving the funding to do so
- Directed and approved the contents of guidance explaining what the differences are between a Safeguarding concern and a quality concern in response to outcomes from the Tier 3 audits
- Oversaw the development of the SSASPB Annual Report
- Received updates from Regional and National Adult Safeguarding fora through membership at various meetings
- Monitored the activity towards mitigation of risk using the SSASPB Risk Register
- Reviewed the membership of the Board and managed the Board membership process
- Managed and monitored the SSASPB budget
- Reviewed the Strategic Plan
- Received assurance updates from both Local Authorities regarding Large Scale Enquiries (LSEs) and Deprivation of Liberty Safeguards (DoLS) authorisation backlogs
- Approved final drafts of SSASPB documents
- Reviewed the SSASPB Constitution
- Monitored the progress of all Safeguarding Adult Reviews

Safeguarding Adult Reviews sub-group:

Chair: Simon Brownsword followed by Superintendent Carl Ratcliffe, Staffordshire Police

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

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

In the Annual Report 2019/2020 the following 3 cases were introduced, an update is provided for each.

'Andrew': A SAR conducted under S44(1) Care Act 2014 – Mandatory Review (Stoke-on-Trent)

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

A referral was received in September 2019 in relation to the death of a 37-year-old white British man living in social housing in the Stoke-on-Trent area.

Andrew had complex needs arising from mental ill-health, substance misuse, grief following the death of his mother, poor health generally, indifference to whether he lived or died and fluctuating engagement with service providers. Following the death of his mother his alcohol consumption increased and he lost his job due to non-attendance.

In the last few months of his life Andrew called for the attendance of an ambulance on several occasions, but when admitted to hospital would discharge against medical advice. He attempted alcohol detoxification without success. Multiple services were engaged with him, but the success of any intervention was short lived and contact with him was often difficult. He died in September 2019 before being found by Police after they had forced entry into his flat following reported concerns about his wellbeing.

Andrew died from gastrointestinal bleeding with self-neglect as one of the key contributory factors. There were concerns outlined in the collated chronology regarding how agencies worked together, and it was evident from the information shared at the Safeguarding Adult Review scoping meeting that there were lessons to learn. A SAR was conducted under S44(1) Care Act 2014 (Mandatory review) lead by an Independent Reviewer.

Key findings from the SAR:

Domain 1: direct practice with individuals

- The Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) should seek assurance that partner agencies are promoting trauma informed practice, particularly with people who use substances and self-neglect and that this should be reinforced through training sessions, learning events and one-to-one management meetings

- The SSASPB should consider how to promote the routine analysis of safeguarding concerns so that patterns and escalation are identified and acted upon

- There should be consideration of creating the role of "lead practitioner". This would be the staff member with the best relationship with a hard to engage client. This role would lead on engagement

and coordination and should not be limited to staff in statutory organisations but should be recognised by each partner as the lead worker

- Stoke-on-Trent City Council should identify how to improve its response to adult safeguarding concerns and how information is recorded, in the light of this safeguarding adults review and the review of David. This could include training and monitoring interventions supported by case audits and case discussions in one-to-one and team meetings

Domains 2 & 3: Agency and interagency practice

- The SSASPB should promote the existence and the function of the Stoke-on-Trent Multi-Agency Resolution Group (MARG) as a forum to which practitioners can bring cases to that are complex to manage and which may need extra impetus and coordination. Staffordshire County Council should consider the creation of a similar forum to manage difficult cases.

Domain 4: Board level

- The SSASPB should use the themes identified in the Alcohol Change UK report, the review of David and this review of MP to revise or create new practice guidance for working with people who use substances and self-neglect. This guidance should be reinforced through training sessions, learning events and one-to-one management meetings

- The SSASPB should lead a multi-agency survey to identify people in whom the themes identified in this review (and the Alcohol Change UK report and the review of David) are present. This could be used to identify and highlight risk, prompt referral to the MARG and the use of new interventions

- The SSASPB should seek assurance that the MARG is operating effectively and is being used appropriately

- The Board is developing an action plan to respond to the findings and support service improvements

'Anne': A SAR conducted under S44(1) Care Act 2014 – Mandatory Review (Staffordshire)

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

On 26th September 2019 a referral was received outlining the circumstances of the death of Anne a divorced 87-year-old white British woman from Staffordshire who lived alone in social housing.

Anne had enjoyed generally good health and independence until the summer of 2019 when there appears to have been a rapid decline in her ability to take good care of herself. When Anne needed support from a domiciliary care provider this was arranged and funded by herself.

Anne experienced falls at home in the summer of 2019 resulting in conveyance to hospital by ambulance. On her last visit Anne was assessed and returned to her home address. It was the belief of the domiciliary care provider that Anne would be admitted to hospital and accordingly the previously provided care package was not continued. Anne was discovered deceased in the hallway of her home address several days after being returned home from the hospital. (The hospital was not in the area local to where Anne lived)

It was determined that there had been neglect and that there were lessons to learn from reviewing how partners worked with each other prior to Anne's death. A SAR was conducted under S44(1) Care Act 2014.

The overview report was produced by the SSASPB Business Manager, who was independent from the service providers, with the following recommendations:

Recommendations and Learning

- The SSASPB is to seek assurance that Commissioners, care agencies and Hospitals agree and document their role in ensuring that there is continuance of care in circumstances where an adult with care and support needs is discharged from A&E particularly as an out of area patient (i.e. not admitted to hospital)
- The SSASPB is to reinforce the need for clear documentation and record-keeping, particularly where more than one organisation may need to respond to or act upon the comments. Decision-making is to be supported by clear rationale with acronyms explained
- The SSASPB is to seek an inclusion in the West Midlands Regional Self-Neglect guidance to address the following finding 'Where adults with capacity are living at home in unsafe conditions that could put the adult's health at significant risk, steps should be taken to explain the potential risk to support the adult in making their own decision'
- The SSASPB are to task Commissioners with ascertaining the feasibility of adults (with care and support needs who appear unkempt, are assessed as frail and are living in isolation without a package of support) having an Occupational Therapy home assessment prior to discharge
- So that lessons may be learned from the review a briefing note is to be produced by the SSASPB which will give an overview of the circumstances leading to the SAR and will include all the recommendations contained in section 7 of this report

'Joan': after consideration by the scoping panel, it was determined that the criteria for a SAR had not been met.

During 2020/21 three SAR referrals were received. Two were considered to not meet the criteria for a SAR, however one of these was directed into the Learning Disability Mortality Review Process (LeDeR).

The third SAR referral was submitted in May 2020. It involves a white female in her 80s who lived in her own house and who self-funded a live-in carer. Her death was attributed to sepsis. The review has been concluded but the report is yet to be approved, therefore the update will be given in next year's Annual Report.

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
- Developed a 'Review in Rapid Time' process to enable the prompt identification of lessons to learn to make improvements in policy, process, and practice where appropriate. It will not be suitable for all cases and in particular those that are complex
- Maintained links and reporting relationships with Community Safety Partnerships that are managing Domestic Homicide Reviews (where they involve adults with care and support needs)
- Oversaw the progress of all ongoing SARs. There was some time slippage in the writing of the overview reports for two of the less complex reviews, but the learning action plan was not dependent upon this and was progressed expeditiously

- The SSASPB Business Manager is a member of a national working group to refresh the Social Care Institute for Excellence (SCIE) Quality markers for SARs which will ensure that there is a consistent approach to SARs Nationally
- Provided detailed assurance against the 29 Improvements recommended by Professor Michael Preston-Shoot in his academic analysis of SARs (Published September 2020)
- Identified that there must be improvements in three recurring areas of Adult Safeguarding Practice:
    - Better recording of the rationale for decision-making to be made in case files
    - Use of the SSASPB escalation policy to resolve professional disagreements as soon as possible
    - Appointment of a lead professional to drive multi-agency resolution in complex cases
- Sought assurances against recommendations from Professor Michael Preston-Shoot's work in which he suggests that there are still lessons to learn from the tragic death of Steven Hoskin in 2006 (St. Austell, Cornwall)
- Received training entitled 'Legal Literacy and Adult Safeguarding' to improve the sub-group's knowledge of the Care Act interpretation with reference to SARs

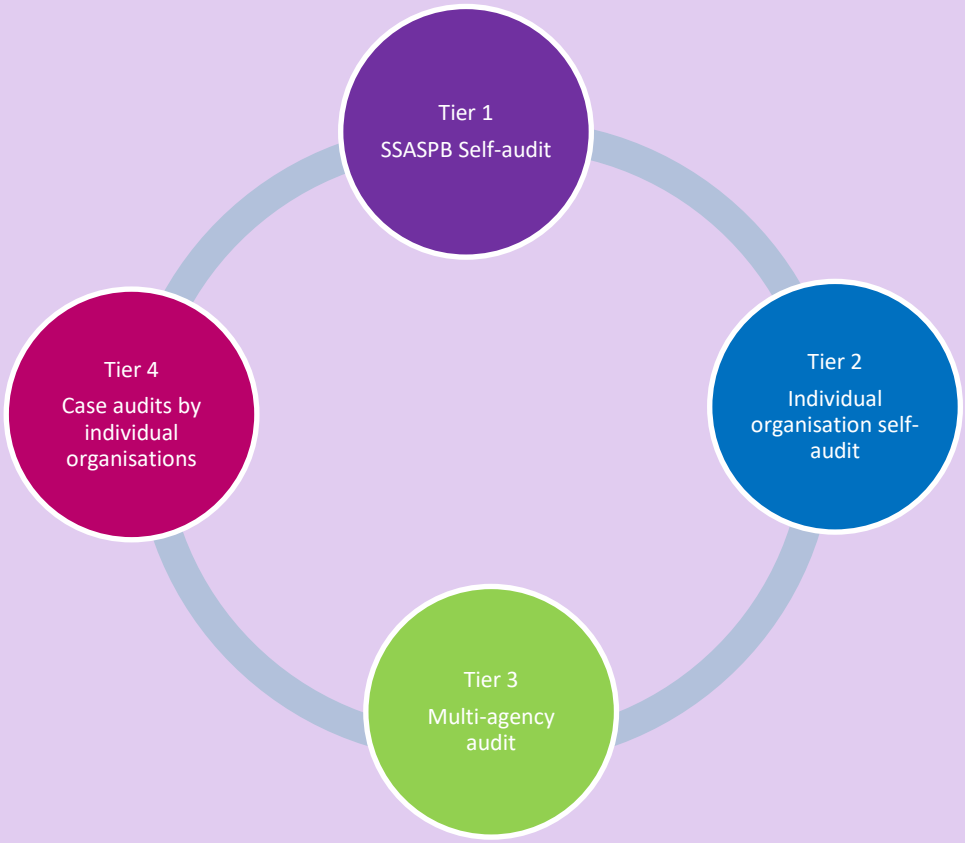
<u>Audit and Assurance sub-group:</u>

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

Vice Chair: Amy Davidson Head of Safeguarding, North Staffordshire Combined Healthcare Trust to January 2021.

<u>The SSASPB 4-tiered audit framework</u>:

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



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

Tier 2 Individual Organisational audit in year 1 each organisation completed 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:

- Provided the detailed narrative from relevant partners to explain the performance data contained in the Annual Report
- Held an extraordinary meeting which was dedicated to discussing the local and national assurances being sought following discharges of patients from acute settings into care, nursing, and residential settings during the first wave of COVID-19
- Held two Tier 3 Multi-agency Case File Audits. These were on the themes of: Financial and Material Abuse (in support of the Strategic Priority) and Persons in a Position of Trust
- Sought assurance that the accuracy of the recording of ethnicity of adults involved in Section 42 enquiries would improve – this was mainly as a result of the limitations of Information Technology (IT) and case management reporting, however there was a notable improvement towards the end of the reporting period
- Considered the findings of the National 'Insight' report
- Requested that the promotion of 'whistle blowing to address closed cultures' was included in the SSASPB newsletter 2/2020
- Worked with Staffordshire Police to produce a detailed summary in this Annual Report to illustrate its Adult Safeguarding investigation work
- Cancelled the Tier 2 peer review process because of the operational demands placed on partners during pandemic peaks. There will be no peer review of the data capture of 2019, instead there will be a full Tier 2 Audit in the early autumn of 2021. This decision was made to reduce the Board demand upon partners during the pandemic
- Completed all elements of the sub-group business cycle including the review of the Audit and Assurance Business Plan and Terms of Reference

Prevention and Engagement

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

Vice Chair: Helen Jones, SSASPB Business Manager

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 pages 16-23.

Policies and Procedures sub-group

Chair: Ruth Martin, Adult Safeguarding Team Leader, Staffordshire County Council

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

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

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

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

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

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

Practitioners forum

This forum is for practitioners to come together to discuss operational matters which relate to adult safeguarding. The discussion topics originate from various sources including the practitioners themselves, themes from national research or publications and from Safeguarding Adult Reviews.

The forums are co-ordinated by Safeguarding Leads from the Board partner organisations and include representatives from Stoke-on-Trent City Council, Staffordshire County Council, North Staffordshire Combined Healthcare Trust, and the Midlands Partnership Foundation Trust.

The demands on frontline practitioners during the COVID-19 pandemic has limited forum activity over the past 12 months but a forum on the subject of Adult Safeguarding Plans facilitated a useful discussion between a broad range of practitioners representing a variety of connected partner organisations.

A discussion of the issues arising from the CQC report 'Closed Cultures' stimulated discussion about the practical issues around whistle-blowing in organisations and the opportunity to raise organisational awareness.

6. PERFORMANCE AGAINST 2019/22 STRATEGIC PRIORITIES

In the reporting period (1st April 2020 to 31st March 2021) the Strategic Priorities were:

- Engagement
- Financial and Material Abuse

Progress reporting towards Strategic Priorities is a standing agenda item at Executive sub-group meetings and is also reported at the quarterly Board meetings. A summary of progress is outlined below.

Strategic Priority: Engagement

Lead: Helen Jones, SSASPB Business Manager

The activity around this priority is managed and co-ordinated by the Prevention and Engagement sub-group.

Engagement is a broad term. For the purposes of the work of the Board this means engagement in raising community awareness of adult abuse and neglect and how to respond with several key groups of people including:

- Adults with care and support needs
- Carers and advocates
- Professionals and Volunteers
- Members of the public
- Board partners

What we have done to engage with the key groups

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

The Board and its sub-groups continued to meet throughout the year to drive the strategic priorities and core duties of the Safeguarding Adult Board. The Board Business manager was a member of the multi-agency Vulnerable Adults Task Group that was put in place to maintain oversight of the operational capabilities of connected partners in response to the impact of COVID-19. Meetings of the Group provided business continuity updates and opportunities for wide engagement to seek assurances that adults at risk of abuse and neglect were being safeguarded.

The attendance at meetings and webinars through electronic platforms has brought numerous opportunities for practitioners to share good practice and learn from others through involvement in regional and national work. A positive development has been that the 13 Safeguarding Adult Boards in the West Midlands region are collaborating on a programme of webinars on topics of mutual relevance and benefit.

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

- Refreshed the SSASPB website to enhance accessibility, applying best practice. The website is a focal point for adult safeguarding information illustrated by the 63,588 visits between 1 April 2020 and 31 March 2021. The most visited sections are those relating to What is abuse? and How to report. The Board has received numerous compliments on its improved accessibility and practical usefulness

both locally and nationally. For those reading this report electronically the website can be accessed here

- Broadened the membership of the sub-group to include Rockspur, a provider supporting younger adults with learning disabilities; Your Housing; Housing Plus; Voiceability advocacy providers; and Asist. Middleport Matters have joined the prevention and engagement sub-group to support Board engagement with a local community
- Commissioned Rockspur to help the Board to produce a more 'accessible' (easier read) version of this Annual Report
- Used Twitter to promote Adult Safeguarding and the work of the Board and other Safeguarding Adult Boards
- Published two newsletters which are widely distributed electronically and very well received, these available on our website. Subjects covered included whistleblowing, closed cultures, promotion of the SSASPB Annual Report, spotlight on the Police and their early intervention project, promotion of the use of the escalation policy, Mental Capacity Act guidance and adult abuse, what it is and how to raise a concern
- Produced an electronic Induction package for new members to support their integration into the work of the Board
- Prepared a briefing on the work of the Board for anyone to use in their own organisation in support of raising awareness of the Board, its statutory responsibilities, and strategic priorities
- Planned three learning events to promote the understanding of and response to Financial and Material Abuse from the perspective of Adult Safeguarding, Trading Standards and Domestic Abuse (these took place in the summer of 2021 and were delayed by the impact of the pandemic)
- Included the Voluntary Sector in Board events, this has been made easier by the use of the electronic platforms
- Planned numerous locally hosted events in support of National Adult Safeguarding week held in November 2020. Feedback received illustrates that the activities were successful in awareness raising. Promoted other events that were hosted both regionally and nationally
- A short video presented by Ruth Martin, Acting Principal Social Worker (adults) for Staffordshire County Council in which she raises explains what adult safeguarding is, and how to report concerns, was posted on the Board website. Acknowledgement to Staffordshire Police for its production

Whilst some approaches to safeguarding have had to be adapted during the year the focus on Making Safeguarding Personal has been maintained. Making Safeguarding Personal requires engagement with an adult with care and support needs at an early stage to establish the individual's desired outcomes that are then supported by a person-centred approach to make this happen. There is an emphasis in those conversations about what would improve an individual's quality of life as well as their safety. The Board has been actively advocating for this approach to be sustained through strategic and operational adult safeguarding work in Staffordshire and Stoke-on-Trent.

The following case studies exemplify MSP and cross-partner collaboration.

Case Study: North Staffordshire Combined Healthcare Trust

Dawn was known to the local Community Mental Health Team (CMHT) as a service user. She was experiencing domestic abuse from her teenage son. Following a safeguarding referral, the Staffordshire

Adult Safeguarding Team asked the CMHT to carry out safeguarding enquiries (under Section 42 Care Act 2014).

Dr J was appointed to lead those enquiries and following good practice contacted the Safeguarding Team of the North Staffordshire Community Health Trust (NSCHT) for guidance.

Making contact with Dawn during the COVID-19 pandemic and associated social restrictions was difficult as her son lived with her and at times D was very reluctant to speak to the Doctor on the phone.

When Dr J was able to speak with Dawn without her son being present, she was able to discuss what it was like to live with him and the risks that he posed to her. As well as discussing the risks the Doctor also established what Dawn wanted as a desired outcome, ensuring that she was central to any safeguarding plan.

This was a complex situation as Dawn's son also had care and support needs and she was his main carer. Dr J sought to confirm that the service user and her son were both receiving the support they needed now and that both had information on how to access any relevant services they may need support from in the near future.

Dr J gained Dawn's consent to contacting relevant services to share information. The Doctor also explored a referral to specialist domestic abuse services, but Dawn declined and said that Children's Social Care were assessing and supporting the family and she was happy with this support.

This is a good example of Making Safeguarding Personal which ensures that the adult is at the centre of any steps taken to protect them.

Case Study: Staffordshire County Council, Adult Safeguarding Team

'Lucy' is a 31-year-old woman who has been deaf since birth. Her first language is British Sign Language (BSL).

Physically, Lucy is able to manage her own care needs, but on occasions has drank alcohol to excess at times which can impact on her ability to take care of herself and make safe decisions. She has a history of substance misuse and poor mental health and been subject to abusive personal relationships.

Lucy was referred into the adult safeguarding service following concerns about domestic abuse whilst she was pregnant. She disclosed that she had received significant injuries from an assault and explained that her partner had tried to choke her many times in the past. At the time of referral Lucy was not receiving any services or support from Adult Social Care.

Lucy was to some extent aware of the risks presented by the relationship with her partner and, after initially wanting to remain with that person, changed her mind and stated that she wanted to leave.

After Lucy had made her decision a large number of professionals and agencies became involved including safeguarding, the local district team, Midlands Partnership Foundation Trust sensory team, Children and Family services, Staffordshire Police, a Housing provider and Domestic Abuse services (initially New Era and then Sign Health) who provided specialist domestic abuse support for deaf people.

Regular safeguarding plan review meetings were held with all involved to consider how best to support Lucy. She received support from communicator guides and built up a positive relationship with service providers.

The input from Sense (Charity that works with people who are deafblind and the MPFT sensory team was particularly important for Lucy in terms of providing practical support and developing her self-confidence. Lucy was supported to access refuge accommodation at the time when she was ready.

The team also worked with refuge to make sure any equipment specifically needed to support Lucy was provided (such as specialised fire alarms for people who are hard of hearing). Any emerging concerns were identified promptly, and any consequent actions were considered in conjunction with the safeguarding plan.

She will remain in a safe place until she is able to move to live in a different area that will keep her and her unborn child safe.

Case Study: Stoke-on-Trent City Council, Adult Protection Team

Tricia was an elderly woman who had significant health issues and was terminally ill. She lived with her adult son and had a care plan which included care calls together with regular visits from palliative care nurses. Her son also contributed to her care plan.

The Local Authority received a safeguarding referral from the care providers reporting that the son was being verbally aggressive to some of the carers and was obstructing his mother's care by turning off her air flow mattress, which had been put in place to prevent tissue damage, and generally neglecting her needs, particularly overnight.

A Section 42 (Care Act 2014) enquiry was allocated to the Clinical Commissioning Group Safeguarding nurses with support from the Local Authority. Arising from enquiries further concerns were raised which heightened risk concerns.

Tricia's wishes were central to the focus of the safeguarding plan, and she wanted to remain living with her son, with him continuing to have some responsibility for her care.

Although Tricia had always demonstrated the ability to make decisions about her treatment and care, her health conditions had made communication difficult. She subsequently developed a urinary tract infection that impacted on her confusion and whilst in this state, of confusion, she made further disclosures about son's behaviour. The disclosures added further complexity as she became more ill.

The situation constantly changed, and a continual appraisal of the risk was required to achieve a proportionate and reasonable tolerance of acceptable risks. There was regular communication between all engaged partners, particularly the carers visiting daily.

The Local Authority and Health partners worked closely together. Firstly, by jointly educating the son on his mother's clinical needs and how his actions were adversely impacting on her treatment and care. The son was surprised and hadn't thought about the impact of his actions.

There was also a realisation that the son potentially had his own needs and needed help to understand all of the information as well as a recognition that the son was experiencing his own grief and was possibly in denial about his mother's prognosis. A key part of the partner agencies' role in supporting Tricia was to work with and support her son as she had expressed her desire to remain being cared for at home for as long as possible.

Following a period of intensive support provided by care staff, community nurses as well as safeguarding nurses, Tricia chose to move into respite as her health declined. Tricia's decision was frustrated by her son's refusal to let his mother leave the house and the involvement of the Police and Ambulance services were required to ensure safe transfer to the respite care home.

Tricia passed away peacefully in the respite care home but had been able to determine how and where she was cared for in the last few months of her life.

There were several key elements that worked well in Making Safeguarding Personal including:

- The shift in approach from following a routine process to empowering the adult to make decisions around protection
- There was a focus on partnership working and accountability, clear leadership and a co-ordinated multi agency response
- An emphasis on proportionality and ensuring least intrusive response

Case study: University Hospitals of North Midlands

The Safeguarding Adults Team of the University Hospitals of North Midlands (UHNM) received a telephone call from a secretary working in the Outpatient Department explaining that she had made several attempts to contact an outpatient who had not attended a follow up appointment.

When the secretary contacted the partner of the outpatient to arrange another appointment, she spoke to a male who was very distressed. The male disclosed fears that he was in danger from the outpatient and was scared.

Recognising the risks, the secretary initially advised that the Police should be contacted. The male shared that his partner was not at the home address, but he was fearful that upon their return he would be in danger. He went on to disclose further allegations of abuse that were of great concern including the use of a weapon.

The secretary stated that UHNM could help and obtained the partners' name and address and advised that she needed to escalate her concerns. She immediately contacted the Safeguarding Adults team.

From the information provided it was apparent that prompt action was needed. The decision was made that it was proportionate and necessary to make the Police aware of the situation.

In response to the report the Police immediately dispatched officers to the home address and the person suspected of Domestic Abuse was arrested. The adult at risk was found safe and well. Arising from the Police investigation a Domestic Violence Protection Notice (DVPN) was issued to provide on-going protection.

This case is a good illustration of the diligence of the secretary in identifying the adult's concerns, then responding sensitively and positively by escalating the situation to the UHNM Safeguarding Adults team which was followed by effective safeguarding partnership working between UHNM and the Police.

Strategic Priority: Financial and Material Abuse

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

The activity around this priority is managed by the Financial and Material Abuse group which meets when necessary.

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

It is strongly suspected that the number of victims of financial or material abuse who have care and support needs is likely to be massively under reported. Nationally it is estimated that between 10 – 20% of incidents are ever reported but this is not widely recognised. Coupled with this, perpetrators exploit the vulnerabilities of the victims and perceive that the risk of detection is low which contributes to this offending being a significant problem.

The intention of the priority is to raise awareness of Financial and Material abuse and how this can be best combated in our local communities.

In the last year there has been significant impact on this strategic priority due to COVID-19. There was a reduction in the work that the Board was able to complete during this time as resources were reallocated to statutory responsibilities. Many of the workstreams of the financial and material abuse strategic priority have by necessity been either curtailed or postponed.

However, safeguarding partners have continued to respond to reports of concerns. During 2020/21 financial or material abuse was identified in 15% of Staffordshire and 26% of Stoke-on-Trent completed Section 42 safeguarding enquiries.

The types of financial and material abuse are broad in nature and whilst doorstep crimes feature, it is incidents that involve someone known to the adult that often lead to a Section 42 enquiry being completed. The following case studies provides an illustration of the positive action that is taken when financial and material abuse is reported.

Case Study: Staffordshire County Council

Barbara had been supported by carers employed by a care agency for a lengthy period of time. She received 3 calls a day and carers assisted her with shopping as well as meeting her personal care needs.

Barbara advised her son that she had been contacted by her bank after a computer software company in Dorset had attempted to take money out of her account. Fortunately, the transaction had been stopped. Barbara's son thought it odd, and when he checked her account found that unusual cash withdrawals had been made, with some transactions twice in a day. Barbara could not recollect why money had been withdrawn. The only other person who had access to the bank card was one of Barbara's carers.

During some of the care calls Barbara would ask her carer to go to the cashpoint and withdraw cash from her account. To enable her carer to do this Barbara gave the carer her bankcard and pin number. Barbara said that she trusted her carer because she is an associate of her family.

Barbara's son contacted Staffordshire Police and raised his concerns. Police shared the information with Staffordshire County Council through the Multi Agency Safeguarding Hub. A joint enquiry was commenced.

The enquiry identified that Barbara is able to go out to withdraw money herself. Whilst she finds it difficult to access and use a cash machine, she can easily access the Post Office and goes in there now to withdraw her own money. With the help of her son Barbara is now able to access her bank account online and is able to check her statements. She is able to identify whether money was being taken that shouldn't.

Barbara has implemented protective measures to reduce the risk of future incident. Her two sons have a Lasting Power of Attorney in place and can support with accessing her money if she is unable. She has no further need for safeguarding support.

The care worker was subsequently suspended from her role and has since ended her employment with the care agency and will make the necessary referrals to the Disclosure and Barring Service.

Case Study: University Hospitals of Derby and Burton on Trent (Queens Hospital Burton)

Joe is a 72-year-old man who was admitted to hospital following a fall at home and a deteriorating wound. He has a range of health conditions for which he receives care and support.

During Joe's admission he disclosed to the nurse in charge that he had not been eating well over the past 4 to 5 days due to people coming to his home and asking for money. He explained that he paid these people requested amounts between £40 - £80 each time so that they would leave his home.

The nurse in charge completed a safeguarding referral in relation to concerns of alleged financial and material, psychological and emotional abuse. The nurse discussed her concerns with the Trust's safeguarding professional who offered to help.

Joe consented to meet the safeguarding professional and during discussion expressed his concerns, similar to the initial disclosure to the nurse in charge that this had been an on-going situation. The alleged perpetrators (sources of risk) lived locally, they would often visit requesting money and this often made him feel nervous and not want to eat. Joe stated that he no longer wanted the people to contact him or request money. He had informed the Police but was not aware of progress on his case.

The Trust's safeguarding professional took a holistic approach and established that Joe lived with his brother, who was very supportive, and he has a package of care in place. He was keen to return home following discharge. Safety planning was discussed, and Joe stated that if he felt unsafe, he was able to contact the emergency services, which he had done in the past, by informing the Police.

Joe consented to a safeguarding referral and named the alleged perpetrators. He consented for the information to be passed to the Police and stated his desired outcome that he no longer wanted contact with the alleged perpetrators. Staffordshire Police was subsequently contacted and informed of the Joe's concerns. Police confirmed that similar concerns had recently been reported to them.

Joe's medical record was updated, with an alert to indicate that a safeguarding referral had been made and contact details for the relevant local authority to enable the hospital ward staff to ascertain further information regarding the progress of the referral and facilitate Joe's safe discharge when appropriate.

Outcome:

- Following liaison with Adult Social Care Staffordshire Police conducted an investigation with the outcome that one of the sources of risk was convicted at Court and sentenced to serve 7 months in prison. A second source of risk was convicted and sentenced to Community Service with restrictions
- It was assessed that Joe was safe to return home and the information was incorporated into the discharge planning. Adult Social Care updated the patient record, which supported nursing staff to access relevant up to date information regarding the progress of the safeguarding referral
- A safe discharge plan was implemented. Joe was discharged home with a package of care consisting of two care calls. The allocated Social Worker completed a follow up post discharge
- The Social Worker visited the patient to obtain his view regarding the safeguarding outcome. Joe has no further concerns

Other areas of progress for the Strategic Priority:

- Received and reviewed dissertations produced by five students from Keele University. Recommendations and resultant activity from these will be considered in 2021-22
- Learning events on Financial and Material Abuse for practitioners were arranged for dates in 2020-21, however these were delayed due to COVID-19

Staffordshire and Stoke-on-Trent Adult Safeguarding performance report overview 2020/21

Number of safeguarding concerns received by the Local Authorities in 2020/21

12,176	4,195
Staffordshire	Stoke-on-Trent

Staffordshire	Stoke-on-Trent
57%	49%

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

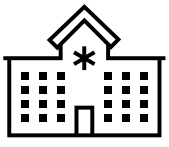
Most prevalent 4 types of abuse 2020/21

Staffordshire		Stoke-on-Trent	
Emotional	12%	14%	Physical abuse
Financial Abuse	15%	16%	Organisational Abuse
Physical abuse	18%	26%	Financial Abuse
Neglect and acts of omission	36%	58%	Neglect and acts of omission

Percentage of Safeguarding Enquiries where the wishes of the adult were met and partially met

Staffordshire			Stoke-on-Trent		
97	98	98	89	96	98
2018/19	2019/20	2020/21	2018/19	2019/20	2020/21

Location of Abuse



	Own Home	Residential Home	Nursing Home	Hospital
Staffordshire	66%	12%	11%	3%
Stoke-on-Trent	37%	24%	16%	1%

7. ANALYSIS OF ADULT SAFEGUARDING PERFORMANCE DATA

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

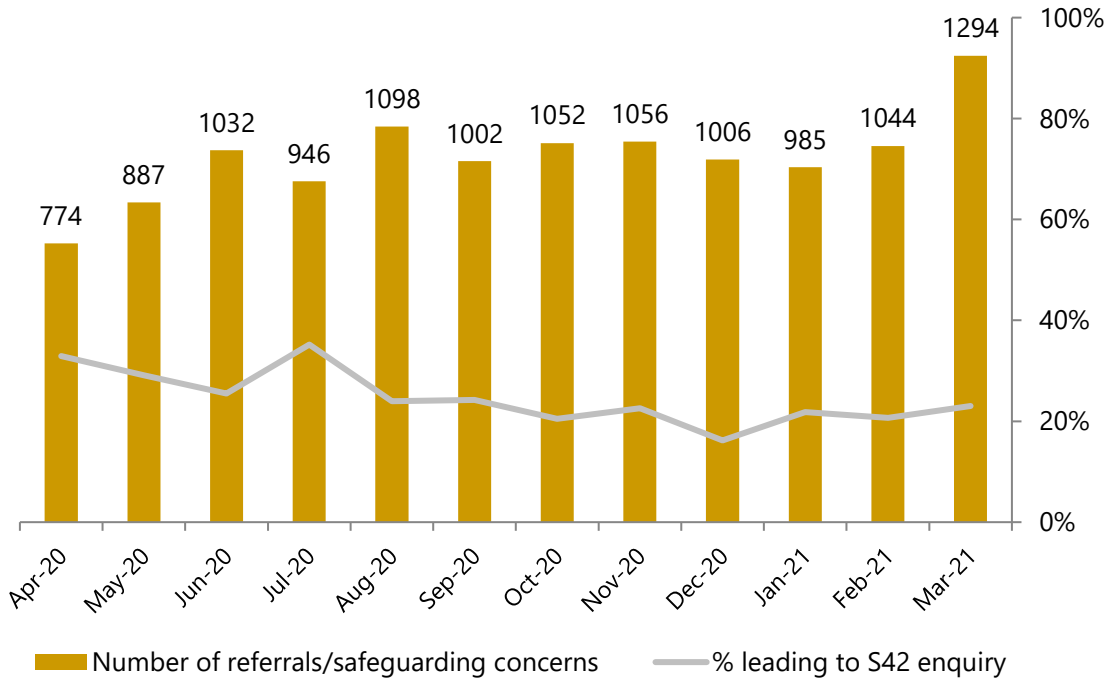
Number and proportion of referrals/safeguarding concerns

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

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

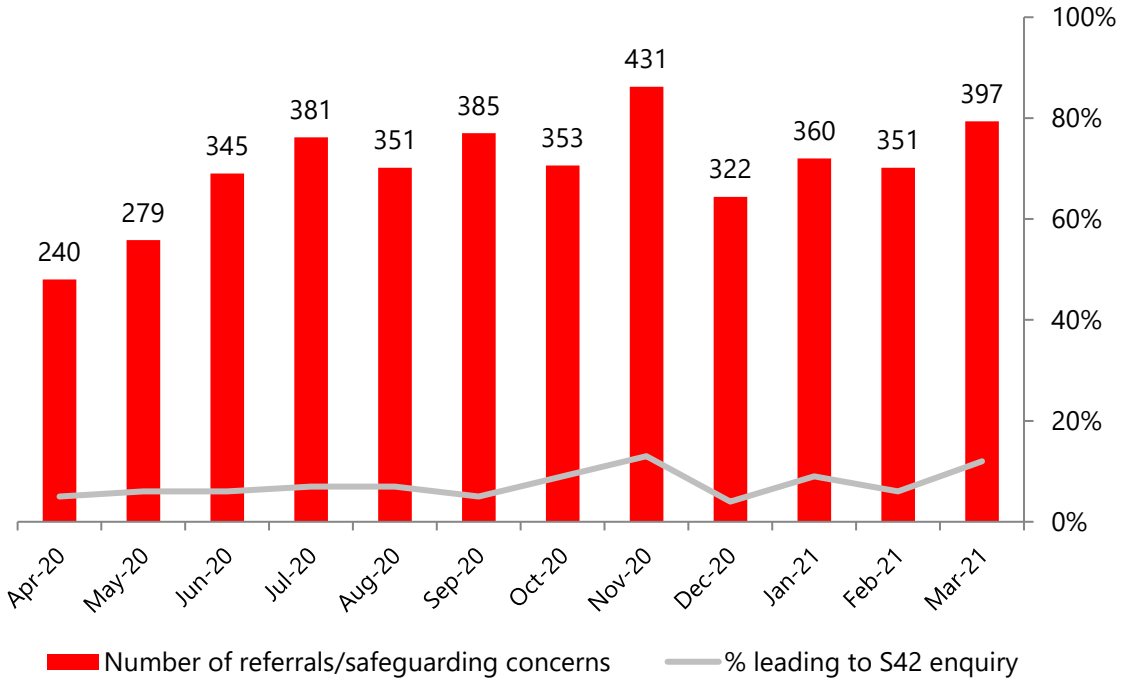
It should be noted that there is a difference between how both LAs capture and report this data. See table below.

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



During the course of the year 2020/21, in Staffordshire, there have been 12,176 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 8,026 occasions from 4,150 in 2019/20. There has been a significant change in the figures presented as previously Staffordshire County Council only reported the number of concerns that progressed to a formal enquiry stage. This year the duty of enquiry requirement was met in 25% of reported concerns. Staffordshire is continuing to explore how data can be captured more accurately through their performance management system.

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



In Stoke-on-Trent there were 4195 reported safeguarding concerns in relation to adults with care and support needs during 2020/21. This is an increase of 250 from 3945 compared to 2019/20 which is an increase of 6.5%. In Stoke-on-Trent the first contact workers carry out fact finding/information gathering on each safeguarding concern prior to being passed on to a manager who then makes the decision on whether or not the concern is moved onto a S42 enquiry or an alternative route to S42. Therefore, a lot of work is done at first contact stage which may be viewed as an enquiry all be it a telephone call or further discussions with the provider and or adult at risk falling in line with Making Safeguarding Personal. Following initial assessment, it was determined that the duty of enquiry requirement was met on 7.5% of occasions when a concern was raised.

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

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

- Staffordshire record this decision as – Section 42 enquiry completed (either no ongoing risk, closed at adult's request, concerns substantiated or unsubstantiated)

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

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

About the Person

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

Fig.4 - Staffordshire Age Breakdown of the County

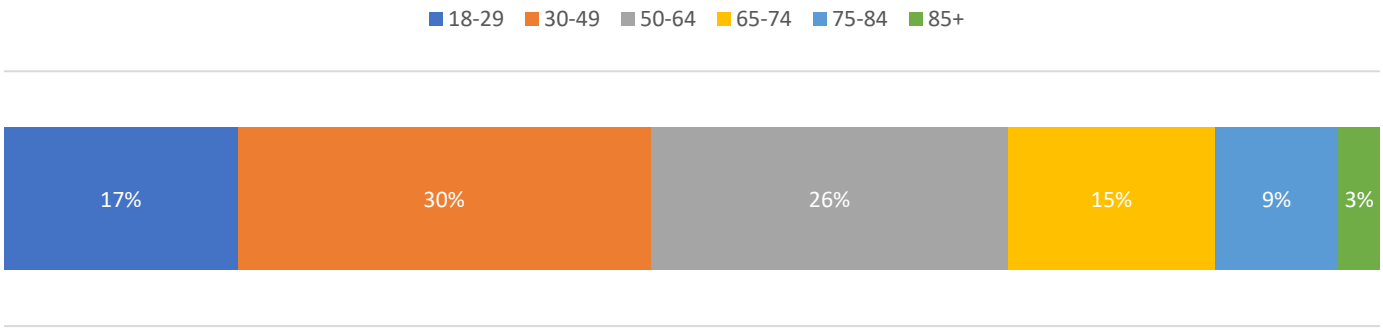
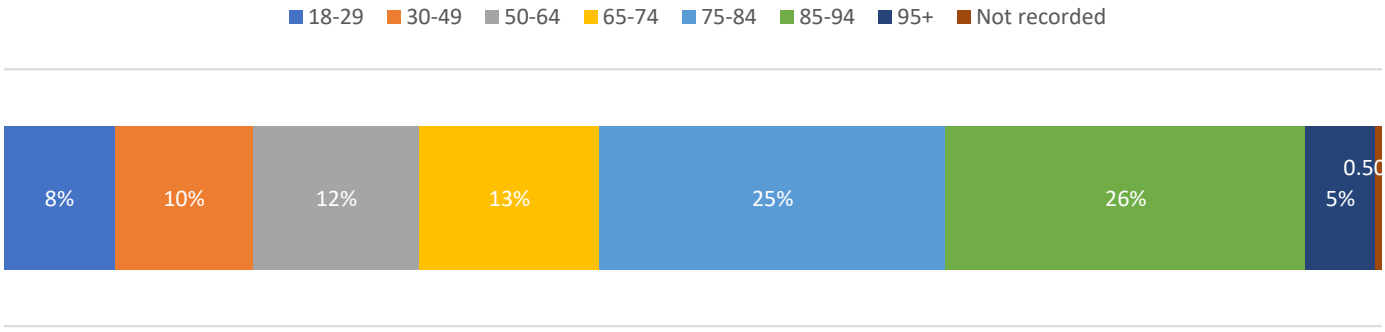


Fig.3 - Staffordshire: Age Breakdown (S42)



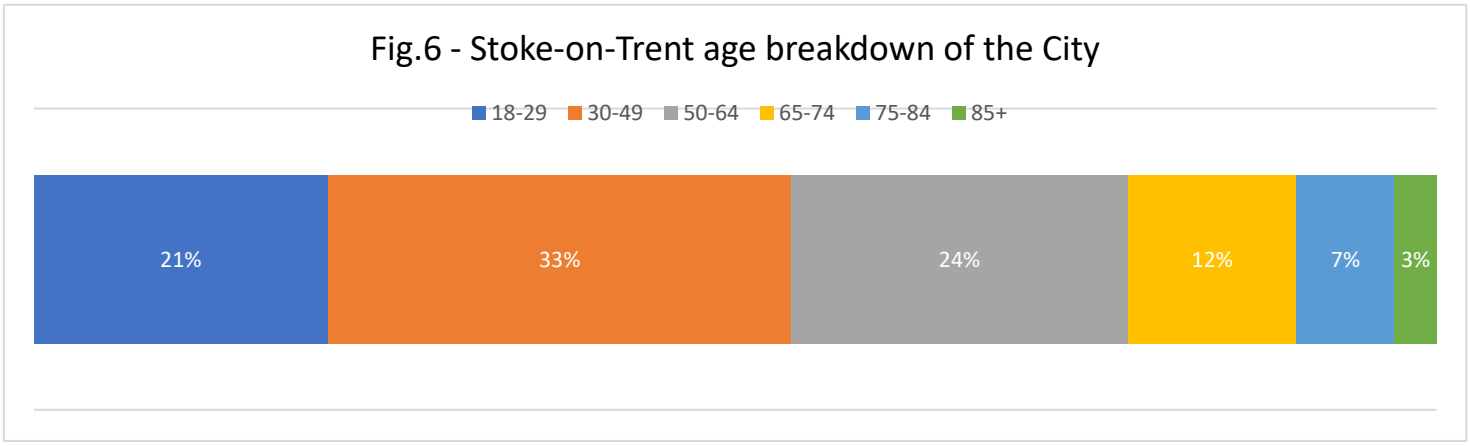
Staffordshire

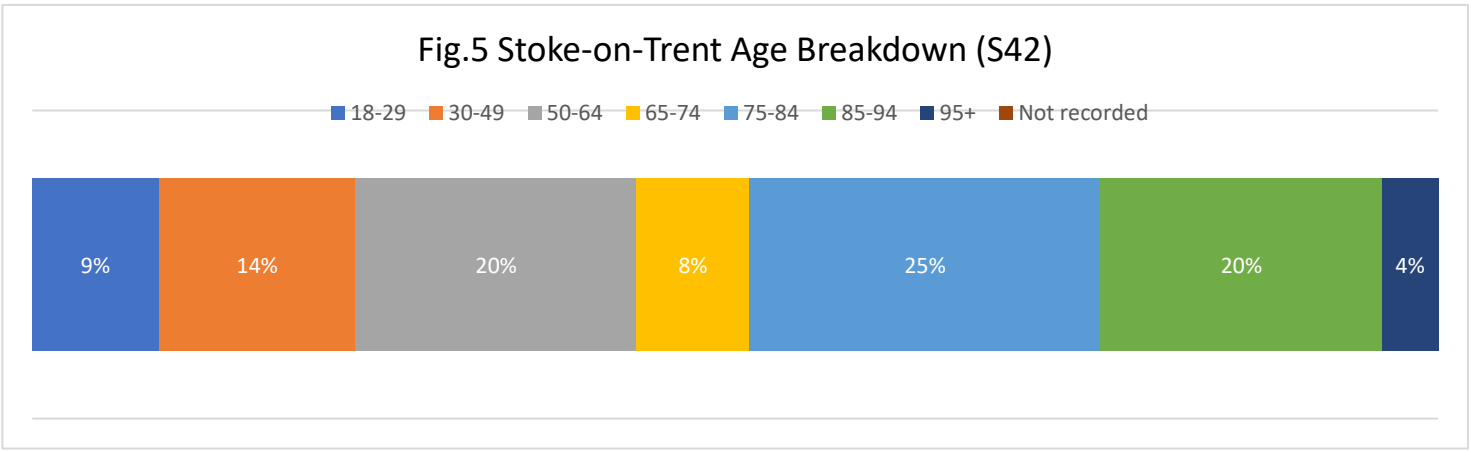
Of the adults who have been the subject of a Section 42 enquiry, those aged 85-94 (26%) represent the largest cohort, followed by 75-84 (25%), there has been very little change in age percentages this year compared to last year. Only in 0.5% of cases has no data been recorded.

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. 3% of the population in Staffordshire are aged 85 or over, however 32% of safeguarding concerns relate to this age group. The average life expectancy for a man living in Staffordshire is 79.7 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 would seem to fit in with the national picture in the last few years.

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





Stoke-on-Trent

For Stoke-on-Trent, the largest cohort represented is those aged 75-84 (25%), followed by 85-94 and 50-64 (both 20%). There has been a 3% increase in adults over 75 who have been subject of a Section 42 enquiry.

When comparing the age breakdown with the general Stoke-on-Trent population figures, it is apparent that people over 65 are disproportionally overrepresented for Section 42 enquiries and that 24% of referrals are regarding 3% of the adult population in Stoke-on-Trent, those 85 or over.

Men in Stoke-on-Trent have a life expectancy of 76.5 years and for women 80.2 years, there are also more concerns raised for women this year which may be because there are more women who are older and the older the population the more needs, they may have for care and support. Staffordshire residents on average have a higher life expectancy than Stoke-on-Trent which may explain why Staffordshire has more referrals for their older populations that Stoke-on-Trent.

Rate of Individuals with S42 Enquiries by Age Group (England)

Age Group	**18-64**	**65-74**	**75-84**	**85+**
Rate per 100K Adults	141	287	847	2635
Percentage	4%	7%	22%	67%

When comparing against the national safeguarding statistics above it will be seen that the majority of individuals involved in Section 42 safeguarding enquiries reported by Local Authorities between 1st April 2019 and 31st March 2020 were aged 85 and over, 67%. Both Staffordshire and Stoke-on-Trent are below this average.

Gender

Fig.7 - Staffordshire: Gender breakdown (S42)

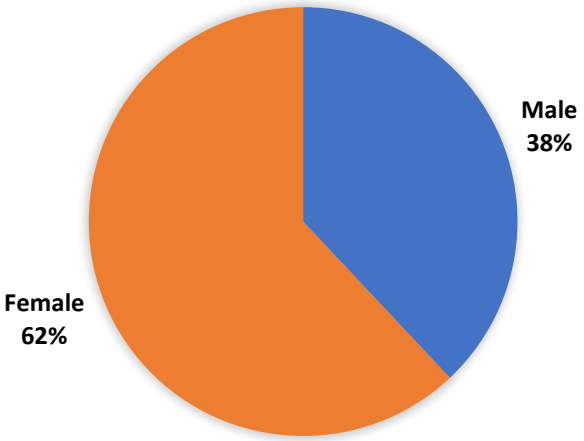


Fig.8 - Staffordshire: Gender breakdown of the County

Staffordshire

Females represent the majority of adults' subject of a Section 42 enquiry, with 62% over the year and males representing 38%: the same as last year. Females are overrepresented (by 12%) when compared to the overall Staffordshire gender breakdown. This may be partially due to the fact that women have a higher life expectancy 4.8% (3.8 years) more than men and as a population is more elderly, they may have more needs for care and support.

Fig.9 - Stoke-on-Trent: Gender breakdown (S42)

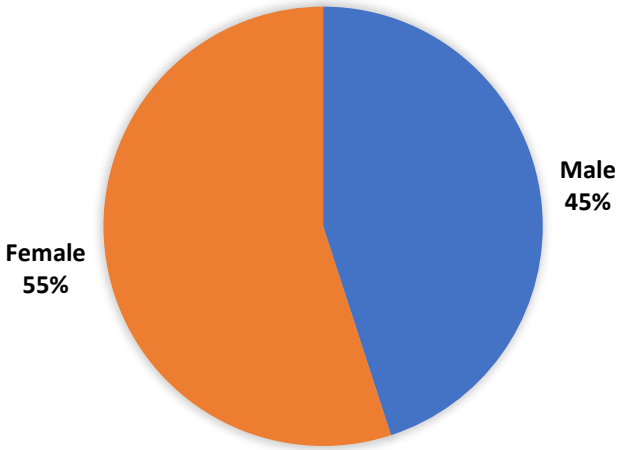


Fig.10 - Stoke-on-Trent: Gender breakdown of the City

Stoke-on-Trent

Stoke-on-Trent has shown an increase of 10% in proportion of referrals for women compared to last year, which is closer to the proportion in Staffordshire, with a corresponding decrease in the percentage of referrals for men.

This may be partially due to the fact that women have a higher life expectancy by 4.8% (3.7 years) more than men and as a population is more elderly, they may have more needs for care and support.

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

Ethnicity

Ethnicity	Stoke-on-Trent section 42 enquiries	Stoke-on-Trent overall population		Staffordshire S42 enquiries	Staffordshire overall population
White British	88.2	86.4		87.9	93.6
Not Known	4.6	-		8.4	-
Pakistani	1.3	4.2		0.5	0.8
Other White British	1.3	1.9		1.1	1.6
White Irish	1.3	0.3		0.4	0.5
Indian	0.7	0.9		0.3	0.8
Not Stated	0.7	-		-	-
Bangladeshi	0.7	0.4		-	0.1
Black African	0.7	1.0		-	0.2
Mixed White/Caribbean	0.7	0.3		0.1	0.5
Any other Asian Background	-	1.4		0.3	0.4
Any other ethnic group	-	0.5		0.1	0.1
Black Caribbean	-	0.3		0.4	0.3
Arabic	-	0.2		-	0.1
Gypsy /Roma	-	0.1		-	0.1
Any other Black Background	-	0.1		0.2	0.1

Please note that the table is presented in order of the most prevalent based on the Stoke-on-Trent figures.

Staffordshire

The majority of individuals (Section 42) are 'White British' (87.9%, a slight decrease from last year), followed by 'Other White British at (1.1%).

It is expected that the updated version of the Care Director recording system will help to reduce the 'unknown' category. Following the technical upgrade Staffordshire County Council has also held practitioners' forums to raise staff awareness and understanding of the increased functionality.

Stoke-on-Trent

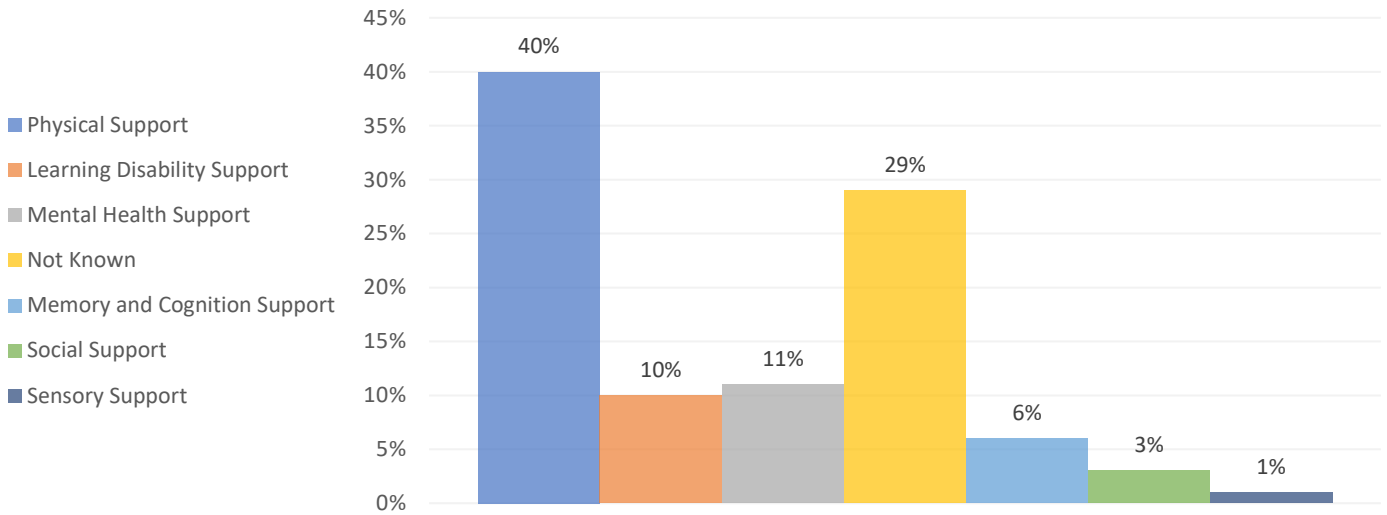
The pattern is similar in Stoke-on-Trent, the majority of declared ethnicities are 'White' (88.2%, a slight increase in percentage since last year).

It is known that people from ethnic minority populations are disproportionally under-represented in Section 42 enquiries, however, for both local authorities (Staffordshire 8.4% and Stoke-on-Trent 4.6%), there are records where the adults do not have their ethnic background captured which limits the usefulness of any comparison to the wider population.

Stoke-on-Trent City Council has continued to work with staff to improve data recording in all aspects of safeguarding including ethnicity.

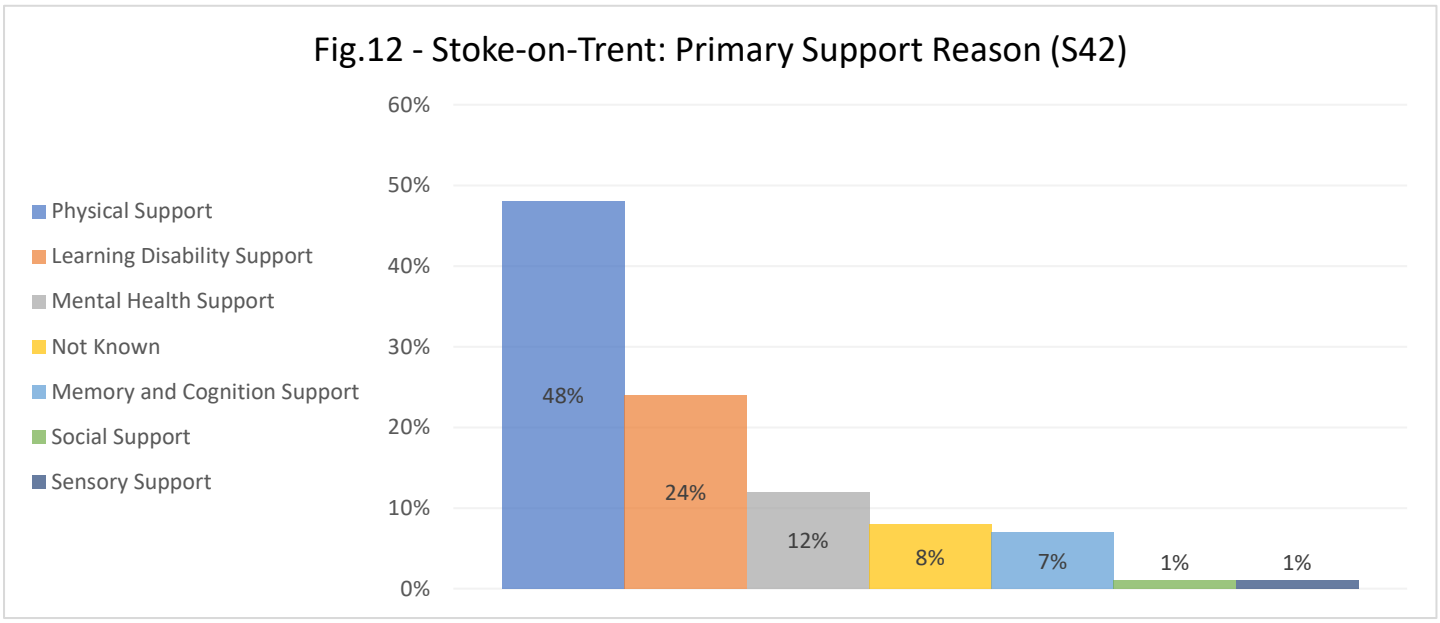
Primary Support Reason: the bar charts below illustrate the type of care and support need of the adult subject of abuse or neglect.

Fig.11 - Staffordshire: Primary Support Reason (S42)



Staffordshire

Physical support continues to be the most common primary support reason in Staffordshire in 2020/21 (40%) a decrease of what was reported last year (49%). This is then followed by mental health support (11%) and learning disability support (10%). 'Not knowns' have increased significantly to 29% (previous year 16%). The reasons for the increase in this category are not clear. It may reflect cases that are being closed at an early stage and therefore not all information is known about the adult.

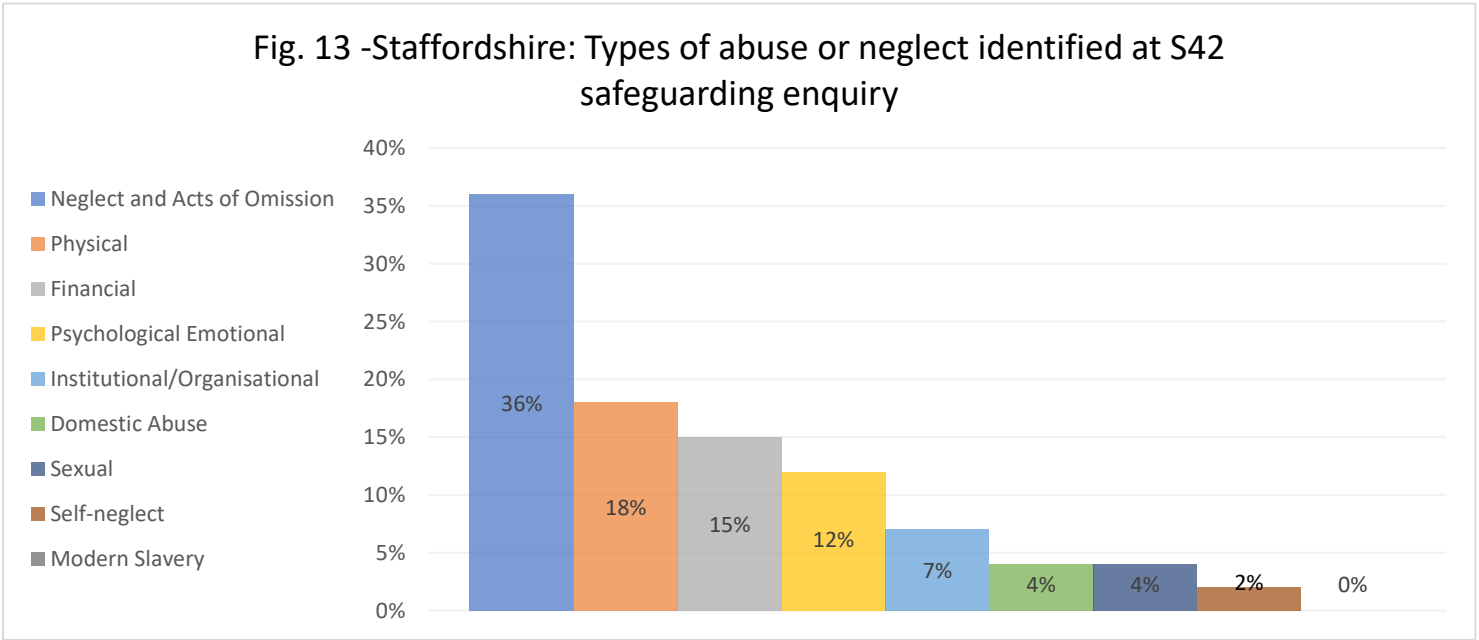


Stoke-on-Trent

Physical support similarly represents the largest proportion of primary support reasons recorded in Stoke-on-Trent at 48%, followed by learning disability support with 24%, an increase of 5% since last year. Mental health support accounts for 12% which remains at a similar level to last year. The unknown category has decreased from 10% last year to 8% this year.

Types of Abuse or Neglect identified at Section 42 safeguarding enquiry

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

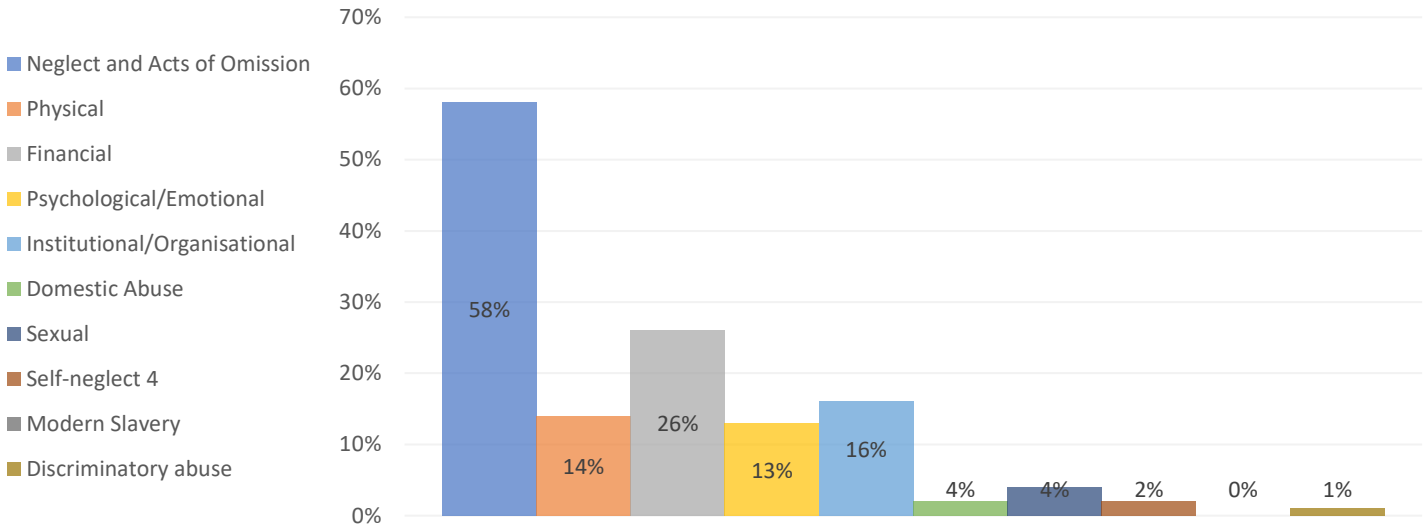


Staffordshire

Neglect and Acts of Omission/Physical harm/financial abuse continue to be the most frequent types of abuse or neglect identified for Section 42 safeguarding enquiries in Staffordshire, together accounting for 69% of all abuse or neglect recorded. Neglect and acts of omission show a slight increase from last year; whilst

financial abuse has decreased (by 4%) in 2020/21. There has been a significant increase in recognition of institutional abuse which has increased to 7%.

Fig. 14 - Stoke-on-Trent: Types of abuse or neglect identified at S42 safeguarding enquiry



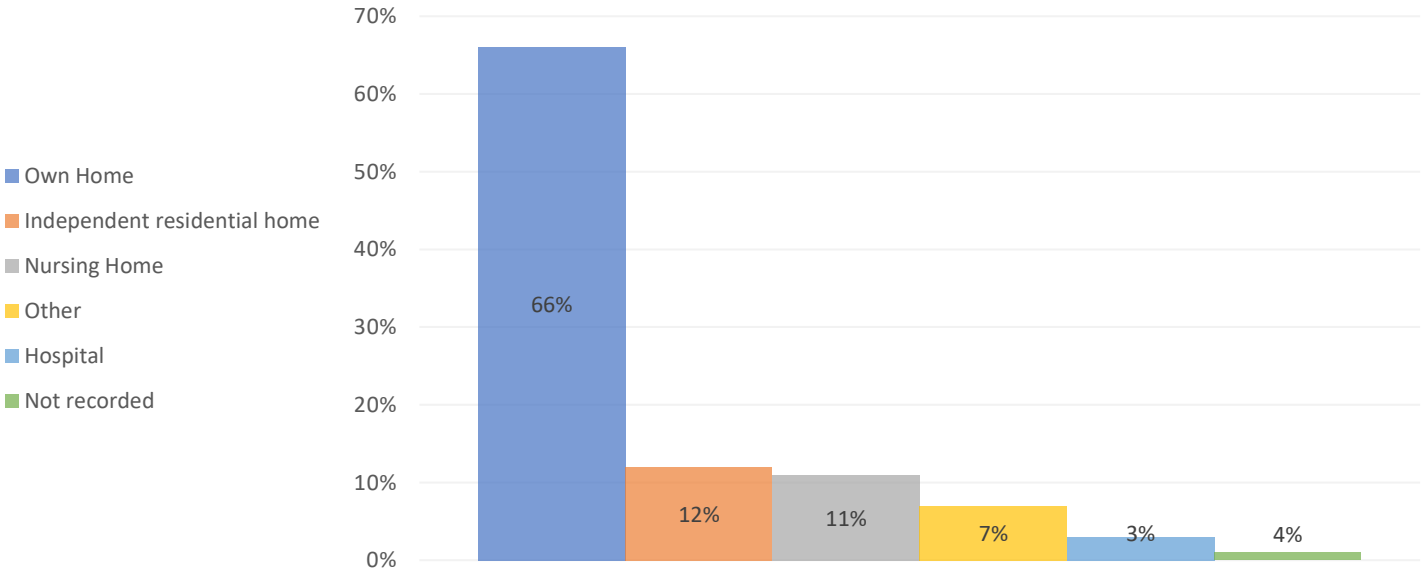
Stoke-on-Trent

The percentage of neglect and acts of omission cases has increased from 50% in 2019/20 to 58%. There is a comparatively large increase in institutional abuse due to this being better recognised and recorded separately from other types of abuse, from 11% in 2019/20 to 16%. Training has also been provided to Stoke-on-Trent City Council staff about organisational abuse, what it is, and how to recognise, which has led to a corresponding increase in this type of abuse.

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

Location of abuse

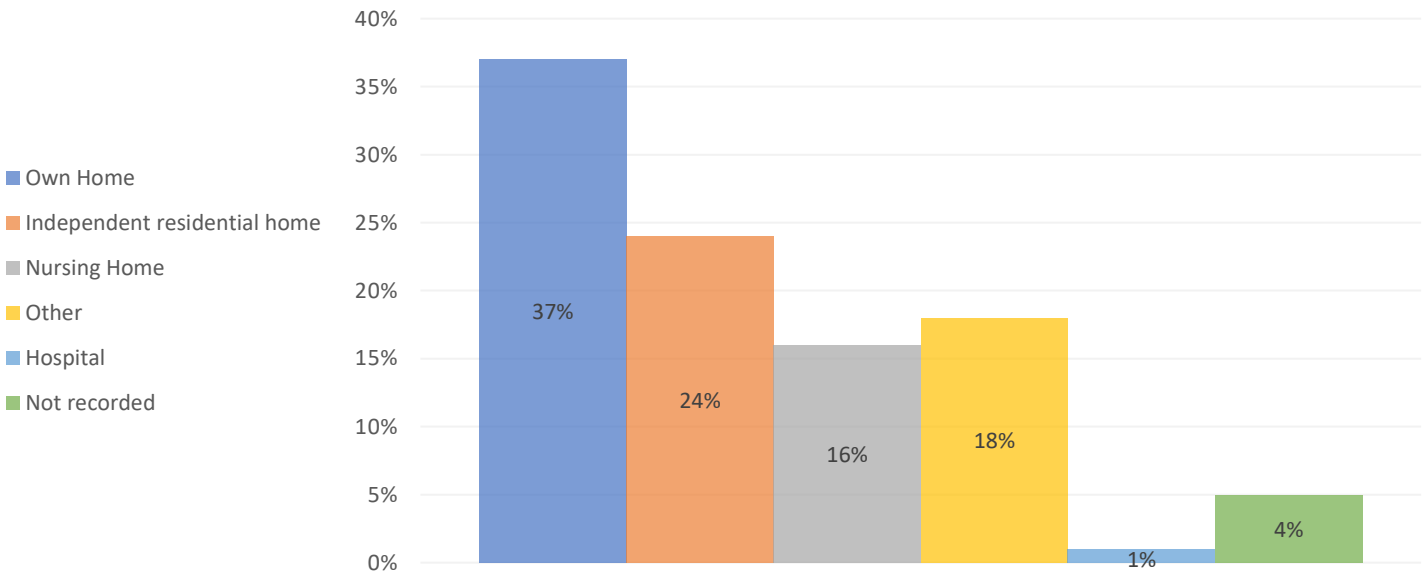
Fig. 15 - Staffordshire: Location of Abuse (S42)



Staffordshire

Of those people subject of Section 42 enquiries, the most common location of abuse or neglect was the person's own home (66%). The next most common locations in Staffordshire were independent residential homes (12%) a decrease of 9% from 2019/21 and nursing homes (11%) which has decreased by 5% from 2019/20.

Fig. 16 - Stoke-on-Trent: Location of Abuse (S42)



Stoke-on-Trent

The most prevalent location of abuse in Stoke-on-Trent is the person's own home (37%) followed by independent residential home (24%) and nursing home (16%). There has been a decrease in abuse in the person's own home by 4% from last year and a decrease of abuse reported in Independent residential homes by 5%.

Through audit it has been identified that some practitioners record a care home as a person's own home which may impact on this data.

Findings of Concern Enquiries

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

Staffordshire: Repeat referrals have decreased by 1% from last year from 19% to 18% and has remained relatively stable for the past three years. The proportion of referrals that meet threshold is 25%.

Stoke-on-Trent: Demand has continued to increase during 2020/21 for Stoke-on-Trent with the reported number of concerns rising by 6.5%. The percentage of repeat referrals has remained the same with the percentage of cases remaining at similar rates for the past three years.

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

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

Fig.17 - Staffordshire: Outcomes

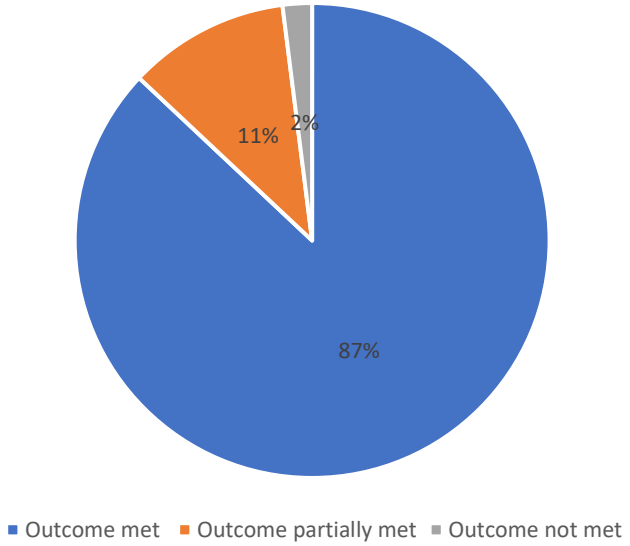
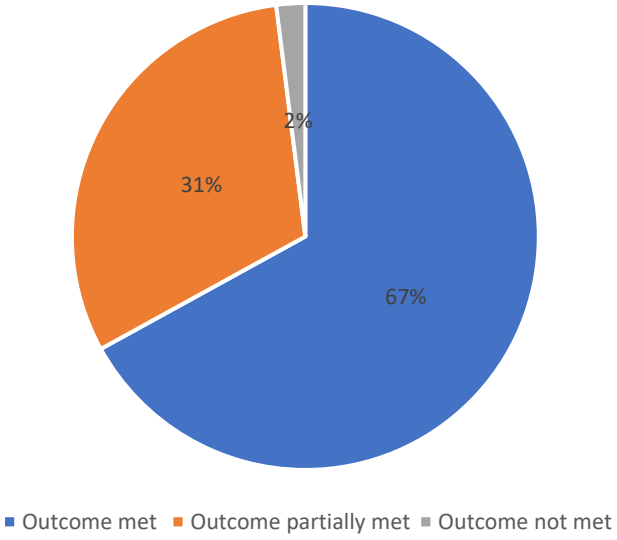


Fig.18 - Stoke-on-Trent: Outcomes



Staffordshire

In Staffordshire 98% of people subject of a Section 42 enquiry confirmed their desired outcomes as either fully or partly met. This is the same percentage as last year.

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

Stoke-on-Trent

The proportion of people subject of a Section 42 enquiry whose expressed outcome was met or partially met increased to 98% which shows a continued increase in the past three years.

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

Managing Safeguarding Allegations Against Staff – Person in Position of Trust

During the year the Audit and Assurance sub-group initiated a multi-agency audit to examine partner arrangements for managing whistleblowing and dealing with concerns and allegations relating to persons employed in a position of trust. Twenty-three individual cases were considered as a random sample of safeguarding concerns submitted to partner organisations.

The key themes identified from the audit were:

- Although the Police were on occasions unable to take action against the source of the risk due to a lack of evidence other sanctions were used by employers to mitigate risks
- There was evidence of closed cultures in organisations
- Some carers who have built strong relationships with an adult they care for sometimes do not always maintain a strict professional conduct towards the adult

- Where there is a high turnover of care staff there can be concerns about the training and quality of care provided

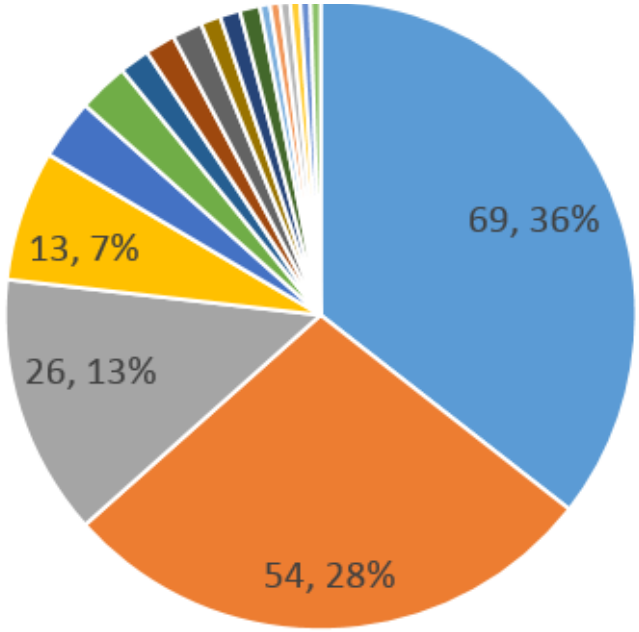
Report from Staffordshire Police and the Adult Safeguarding Enquiry Team

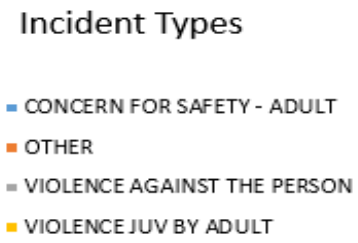
The Adult Safeguarding Enquiry Team (ASET) is a multi-agency team comprising Police detectives and Adult Social Care with a remit to undertake investigations into reports of abuse and neglect of adults with care and support needs and associated investigations into persons in positions of trust. The team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

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

The below table and chart indicate the types of incidents that the ASET investigate (20th May 2020 to 31st March 2021)

Fig. 19 - Incident types





Incident Types	Count
CONCERN FOR SAFETY - ADULT	69
OTHER	54
VIOLENCE AGAINST THE PERSON	26
VIOLENCE JUV BY ADULT	13
RAPE	6
CONCERN FOR SAFETY - CHILD	5
HARASS/STALKING	3
SEXUAL OFFENCES OFFENCES - NOT RAPE	3
SUDDEN DEATH	3
FAMILY DOMESTIC INCIDENT	2
THEFT OTHER	2
WITNESS INTIMIDATION	2
ADMINISTRATION	1
BREACH OF BAIL	1
FRAUD - ACTION FRAUD	1
FRAUD - OTHER/FORGERY	1
MALICIOUS COMMUNICATIONS	1
OWNED BY OTHER FORCE	1
Grand Total	**194**

Examples of ASET investigations include: -

Report of a domiciliary carer allegedly stealing from service user - Enquiries were made and on interview the carer admitted the offence. The outcome was the carer received a Conditional Caution, the service user received the money back and letter of apology. The carer is no longer working in the care industry.

A male victim of theft would not make complaint, due largely to loneliness. The ASET Team jointly worked with Social Care and also the Police Problem Solvers to safeguard the man and refer him to appropriate support services. The man is now better protected from theft and financial exploitation.

A female resident of a nursing home liked to walk around on her own. The one-to-one worker responsible for her care used a fire blanket, which was only to be used in an emergency, to restrict the resident to her bed to prevent her moving freely. Carer was convicted of Ill Treatment.

A male who had been living alone at home with a care package was admitted to hospital. He was released over the Christmas period with a short-term care package. Due to a breakdown in communication the male was left at home for 6 days without care support. The male was taken to hospital but died, the neglect of his care being a contributory factor.

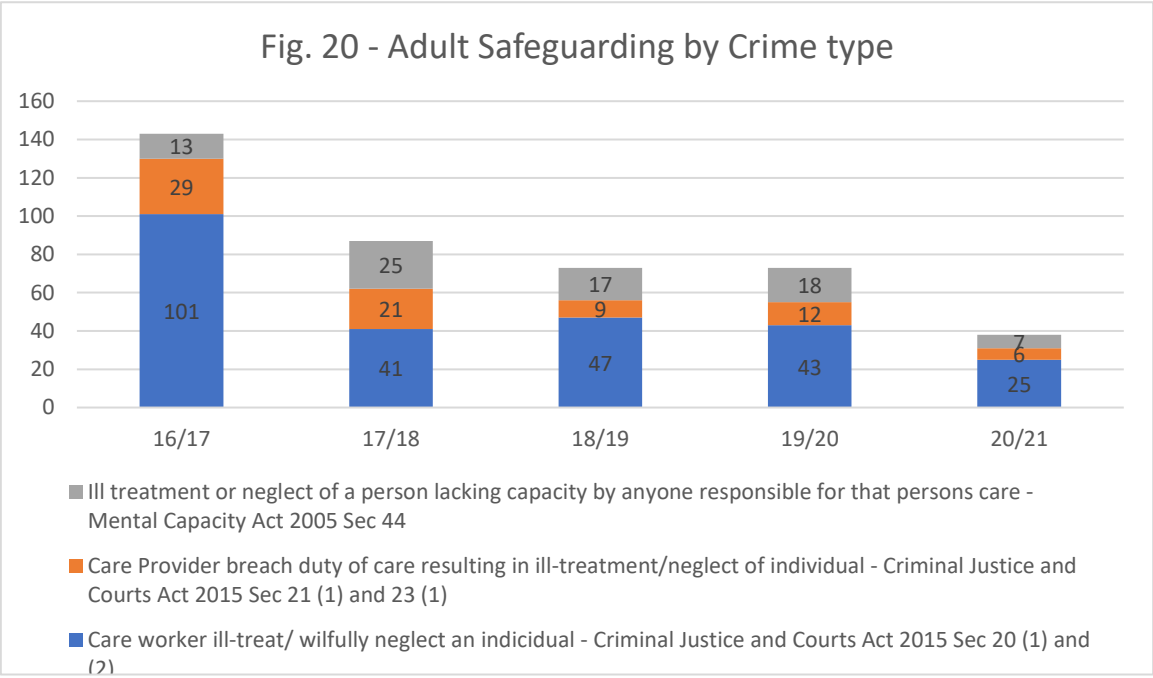


Figure 20 illustrates that there were a total of 38 offences reported for criminal investigation in the 12 months to 31 March 2021. The year is contrasted with previous years to indicate reporting rates over time.

The last twelve months has shown a reduction in reported incidents that are considered to be due to two main factors: -

- The impact of COVID-19 on residential homes and other care settings that has reduced routine visiting and accordingly the potential identification of issues for adults vulnerable to abuse and neglect
- The introduction of a new crime recording system by Staffordshire Police that has changed recording classifications resulting in some investigations not being classified or recorded as a crime type

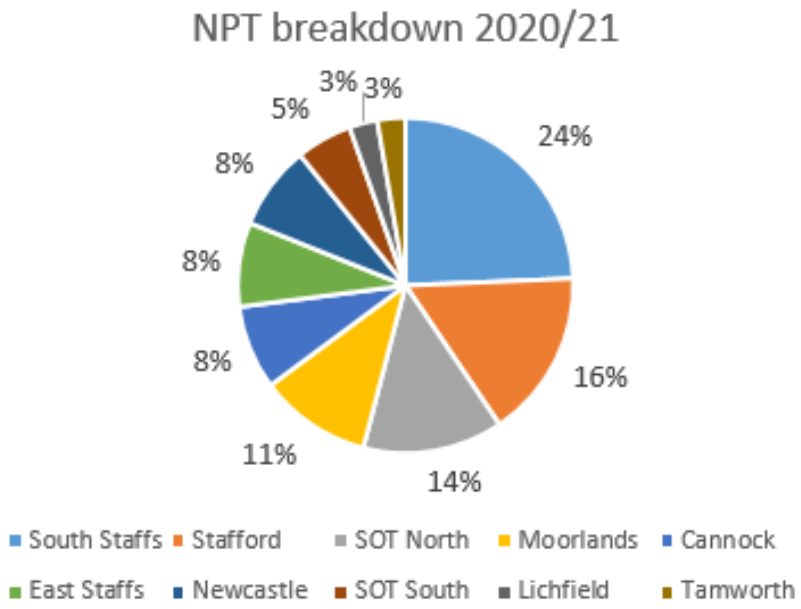
From analysis of 2020/21 reports:

- Of the Neglect offences, there are 2 repeat victims in the last 12-months period; neither had been a victim in the previous 4 years
- Both offences against the repeat victims were committed at the same location, however, both repeat victims' offences occurred at different places

- There are 3 repeat suspects in the last 12-month period, none had been known to have offended in the previous 4 years
- Both repeat offenders are linked to the same 2 adults
- There are 4 repeat locations in the last 12-month period. These are at 2 care homes; 1 mental health hospital; 1 residential address
- There are 7 locations that had 1 offence in the last 12-month period as well as other Adult Safeguarding offences in the previous 4 financial years

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

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



8. FINANCIAL REPORT

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

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

Income: This was year 1 of a 3-year budget agreement which was approved by the statutory partners in July 2019.

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

Spend:

Staffing/Employee costs	£115,329 *note (i)*
Website costs	£5,500
Consultant fees	£4,000
Insurance	£1,040
Legal Services	£ 924
TOTAL:	**£126,793**

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

9. APPENDICES

APPENDIX 1: BOARD PARTNERS

Statutory Partners as of 31st March 2021

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

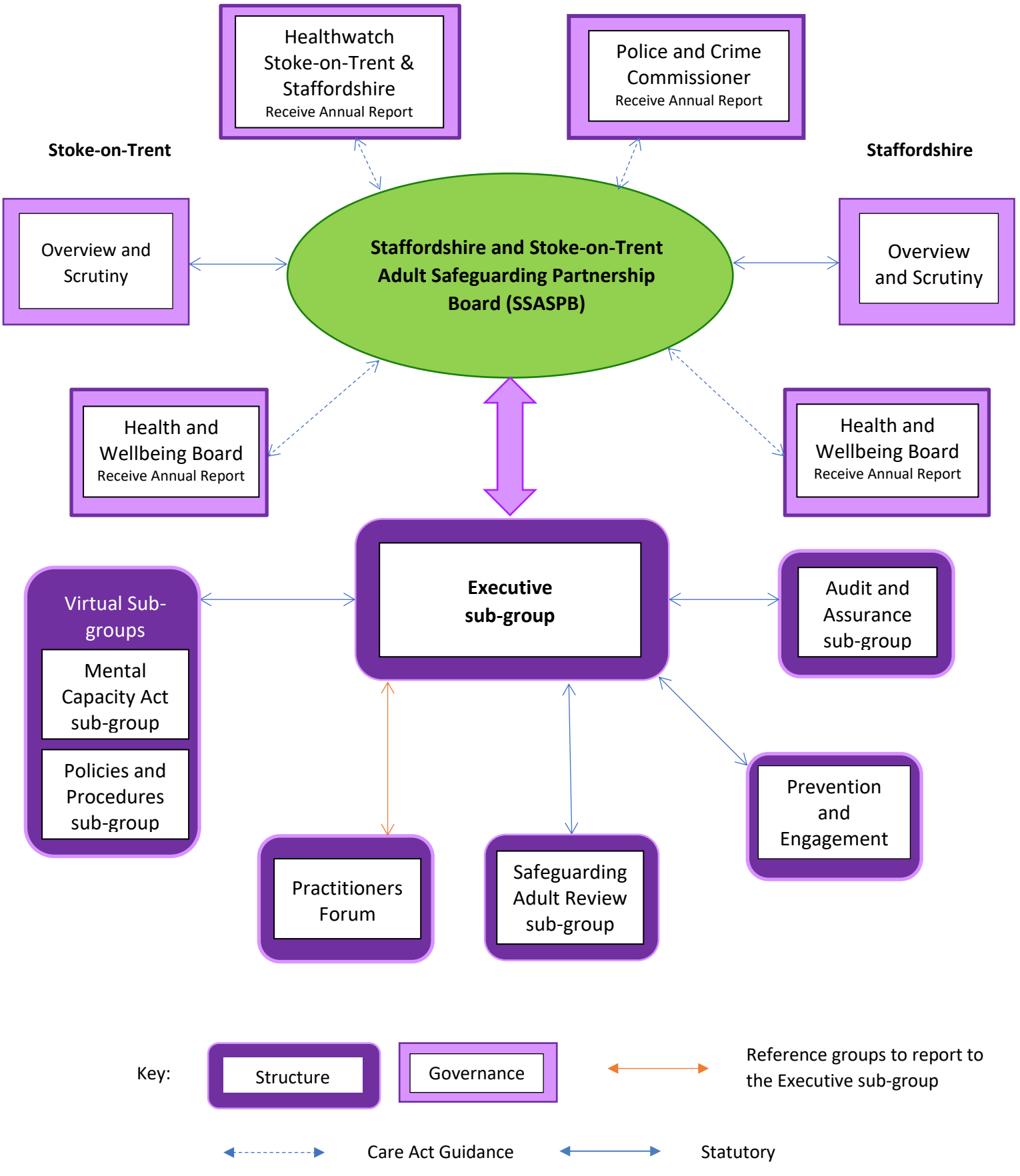
Extended Partnership as of 31st March 2021

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

APPENDIX 2: GOVERNANCE STRUCTURE

From 1st April 2020

Governance and Structure



APPENDIX 3: CATEGORIES OF ABUSE AND NEGLECT

Categories of abuse and neglect - Section 14.17 of The Care Act statutory guidance describes the various categories of abuse and neglect:

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

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

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

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

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

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

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

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

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

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

10. GLOSSARY

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

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

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

‘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