Staffordshire and Stoke-on-Trent
Adult Safeguarding Partnership Board

Abuse must stop

SSASPB Annual Report 2017/2018

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'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 5610015

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

Front cover includes photographs of Staffordshire and Stoke-on-Trent, from top right clockwise: 'tree stories' Stoke-on-Trent; a Safeguarding Manager with a member of the Public at Stoke-on-Trent Carer's week event held at the King's Hall, Stoke; Trentham Gardens; The Weeping Window at Burslem, Stoke-on-Trent; a Stafford Carer's Hub event; Cannock Chase; Lichfield Cathedral and Stafford Castle

2. INDEPENDENT CHAIR FOREWORD

It is my privilege as Independent Chair to write the introduction to this Annual Report of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board.

The Annual Report provides an overview of the work of the Board and its sub groups illustrated with case studies (pages 15-17) as to how the focus on Making Safeguarding Personal is making a positive difference to ensuring that adults with care and support needs are supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse and neglect.

As the Independent Chair my role is to provide leadership and constructive challenge to ensure that board members work effectively together and make a positive difference to adult safeguarding. It is vitally important that our safeguarding adults services are as good as they can be, because the populations of Stoke-on-Trent and Staffordshire include some very vulnerable adults needing support to help keep them safe from harm.

As the Board has matured, the openness and willingness to both challenge and be challenged has developed and that culture is vital if we are to meet the challenges ahead. Those challenges will be significant. The changing demographics locally and nationally, and continued budgetary pressures on all agencies, make joint working all the more important. In Staffordshire and Stoke-on-Trent we have created the right environment for that work to take place and have strong levels of commitment from partners to make it happen.

It is against this background that 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. This commitment is vital to sustaining the effectiveness of the partnership work.

I am particularly grateful to all who chair the Board Sub-Groups and the Board Manager Helen Jones and the Board Administrator Hannah Sherwood who work so hard behind the scenes to ensure that our business programme works efficiently.

I look forward to working with you again next year.

John Wood QPM

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

The Care Act 2014[i1] 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 coordinating 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[ii] 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 35.

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 36.

Safeguarding Adults – A Description of What It Is

The statutory guidance[iii] 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

[1] Please refer to page 38 for references

regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances".

Abuse and neglect can take many forms. The various categories as described in the Care Act are shown at Appendix 3, page 37. The Board has taken account of the Statutory Guidance in determining the following vision.

<u>Vision for Safeguarding in Staffordshire and Stoke-on-Trent</u>

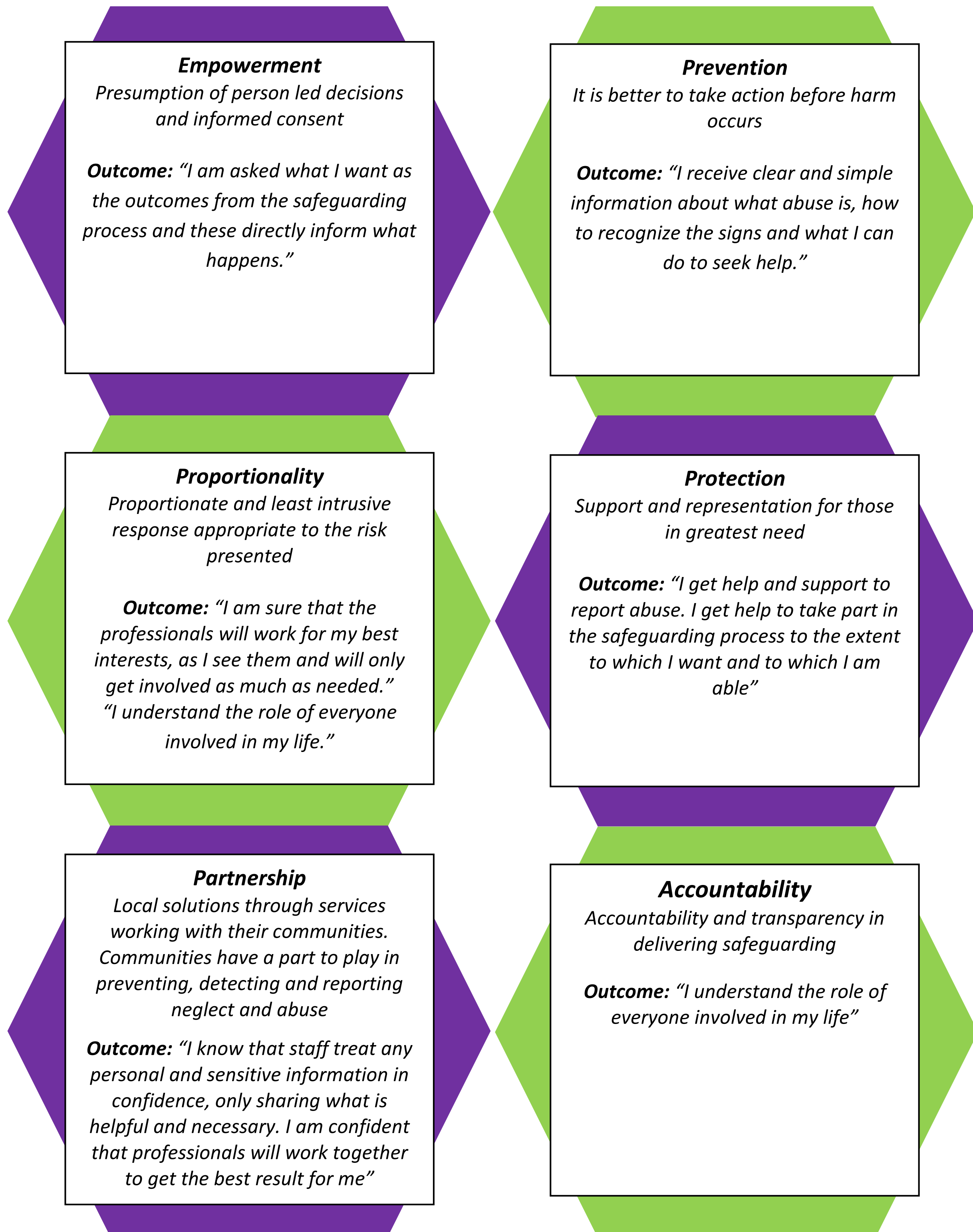
'Adults with care and support needs are supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse and neglect.'

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.

Promoting the work of the Board at the Managers Quality Networking Forum in 2017

4. SAFEGUARDING PRINCIPLES

The Department of Health (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 will be used by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board and partner agencies with safeguarding responsibilities to benchmark their adult safeguarding arrangements:



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.

Executive sub-group

Chair: Kim Gunn; Designated Nurse Adult Protection (North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups)

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 overarching Strategic Priorities of the Board are delivered. The Executive membership is made up of the Chairs of the six sub-groups, Officers to the Board, the Board Manager and the Board Independent Chair.

During 2017/18 the sub-group has:

- Monitored the progress against the three Strategic Priorities (leadership in the independent care sector, transition into adulthood and engagement)
- Monitored the activity towards mitigation of risk using the SSASPB Risk Register
- Managed the Board membership process
- Received presentations from a number of connected partners whose areas of business have links to adult safeguarding including Prevent and the lead for the Staffordshire and Stoke-on-Trent Suicide Prevention Strategy.
- Received updates on CCG progress with the Learning Disabilities Mortality Review (LeDeR) programme
- Monitored the SSASPB budget
- Driven the review of the Strategic Plan, including planning a Development Day and review of the Strategic Priorities.
- Received updates from both Local Authorities regards Large Scale Enquiries (LSEs) and Deprivation of Liberty Safeguards (DoLS) authorisation backlogs
- Received and approved request to facilitate and fund the independent review of an urgent Care Home closure
- Agreed the appointment of four new sub-group chairs into vacancies following retirements and transfers out of Safeguarding
- Approved final drafts of SSASPB documents
- Responded to a consultation from Staffordshire County Council regarding the future social care provision for people with mental health conditions
- Considered how to best engage with the prisons sited in Staffordshire
- Provided evidence against the Tier 1 self-assessment which was approved at Board.

Policies and Procedures sub-group:

Chair: Steve Dale Adult (Adult Safeguarding Manager) Staffordshire County Council to October 2017, Jackie Bloxham (Adult Safeguarding Co-ordinator) Stoke-on-Trent City Council to December 2017 followed by Ruth Martin who took over Steve Dale's role at SCC.

Achievements:

- Reviewed the SSASPB Section 42 Procedures and placed the refreshed document on the SSASPB website
- Conducted a detailed piece of work on the section of the Procedures which covers Large Scale Enquiries. This included partner consultation and engagement with Commissioners.
- Proposed how Staffordshire and Stoke-on-Trent link into the West Midlands Regional Policies and Procedures including Safeguarding Adult Review and People in Positions of Trust policies.
- Reviewed the SSASPB Escalation Policy at the request of the Executive sub-group
- Provided feedback and guidance on the District and Borough Council Safeguarding Policy
- Reviewed Making Safeguarding Personal material from a variety of sources nationally and selected three to be placed on the SSASPB website
- Commenced the review of the SSASPB Financial Abuse guidance to support the new Strategic Priority for 2018/21 - 'Financial and Material Abuse'
- Commenced the production of a Safeguarding in Prisons Framework for adoption in Staffordshire and based on good practice seen in Hampshire.
- Supported a Domestic Homicide Review (DHR) in Stoke-on-Trent by updating the Procedures to address one of the recommendations that came from it

Safeguarding Adult Review (SAR) sub-group

Chairs: Javid Oomer; Detective Superintendent – Safeguarding & Protection (Staffordshire Police) followed in March 2018 by Jennie Mattinson; Detective Superintendent – Head of Partnerships and Safeguarding (Staffordshire Police)

Safeguarding Adult Review referrals:

During 2017/18 there was 1 referral for consideration of a Safeguarding Adult Review under S44 Care Act 2014.

- The case was one of self-neglect and was referred in September 2017. It did not meet the criteria for a statutory SAR as it was assessed that the agencies involved had done all that they could to engage the adult with services offered and available to him. The scoping panel recommended that there should be a half day table top review to try to identify if more could have been done. This was done and it confirmed the belief that partners had done all that they could; this was further reinforced at the Inquest where HM Coroner reported the death as natural causes to which self-neglect and alcoholism had contributed.

Safeguarding Adult Reviews (SARs): Concluded in 2017/18

During 2017/18 the final report of one Safeguarding Adult Review was presented to the Board. A brief overview of the case (which has been anonymised) together with its findings is produced below.

John was a man in his sixties with a mild learning disability and a diagnosis of a mental health disorder together with other medical conditions including difficulty with swallowing following a series of minor strokes. For many years he had lived in a small residential home.

His swallowing difficulties led to the recommendation by a Speech and Language Therapist that John ate a fork mashable diet; this consists of soft textured food being more easily swallowed and requiring minimal chewing. In September 2015 a Section 42 enquiry was commenced following concerns about adherence to this diet and a care plan was agreed. John had also started to help himself to food from the kitchen, especially at night, and in mid-March 2016 a multi-disciplinary meeting proposed that the home employ night waking staff to reduce the risk of John eating inappropriate food. On 26th March 2016 the morning staff found John deceased between his bedroom and the kitchen. He had left his bedroom during the night and choked on food that was not fork mashable.

The inquest concluded that John had died as a result of choking with a secondary cause being cerebral vascular disease.

The circumstances were referred to the SSASPB and a statutory Safeguarding Adult Review under S44 Care Act 2014 commenced and an independent reviewer appointed. The review report was received at an Extraordinary Board of the SSASPB which was held on 16th March 2018 and the findings are replicated below:

Finding	Title
1.	There was poor verbal and written communication which needs addressing for person centred care to be effective
2.	There was a lack of a holistic and coordinated approach to the complex needs of adults with care and support needs
3.	There is a potential disconnect between the information from quality inspections of care homes, individual safeguarding enquiries and wellbeing assessments meaning that all information needed to address the circumstances of adults with care and support needs is not available and not addressed
4.	The confusion about roles and responsibilities undermined care planning and safeguarding planning
5.	The Lack of clarity regarding who should carry out a mental capacity assessment with John regarding food choices and actions left him at risk
6.	There was a lack of recognition, assessment and action to address the risk of choking in adults with learning disabilities

A small group of people representing each of the agencies involved has met to produce an action plan in response to the findings. Progress is to be reported in to the Board via the SAR and Executive sub-groups.

What we have done:

In addition to the management of the SAR referral the sub-group has:

- Overseen activity for the statutory SARs that were already in progress
- Overseen activity for ongoing Multi-Agency Learning Reviews
- Worked closely with the Learning and Development sub-group who are to determine how lessons learned are to be cascaded and develop any products to support this
- Used the Board Managers National Network to consider good practice developed by other SABs
- Reviewed the SAR protocol to ensure continuous improvement
- Contributed to the West Midlands Region SAR Repository to share learning whilst the National SAR library in being developed
- Provided content for SAR training to UHNM partner and adult Safeguarding leads
- Received regular updates on the Learning Disabilities Mortality Review (LeDeR) process and agreed the links between SARs and LeDeR reviews
- Maintained close contact with Community Safety Partnerships who are managing current Domestic Homicide Reviews (where they involve adults with care and support needs)
- Agreed to pilot another Board's decision making template to assist with SAR decisions at scoping panels
- Started to consider the impact of the implementation of the General Data Protection Regulations (GDPR) on information sharing with particular reference to non-statutory reviews.
- Updated the items owned by the SAR sub-group on the SSASPB risk register

Learning and Development sub-group

Chair: Shirley Heath, Head of Adult Safeguarding (Staffordshire and Stoke-on-Trent Partnership NHS Trust) who retired in September 2017 and handed over to Angela Jervis in the same role.

During 2017/18 the sub-group has:

- Planned to deliver 4 multi-agency lessons learned events which are to take place across Staffordshire and Stoke-on-Trent and are to be based on the findings of local Safeguarding Adult Reviews, Multi-Agency Learning Reviews and Domestic Homicide Reviews
- Planned and developed the content of a full day multi-agency learning event (which was held in early May 2018) topics included domestic abuse, hoarding, Prevent, learning lessons from Safeguarding Adult Reviews and self-neglect with a focus on adults with care and support needs
- Sought assurance that Adult Safeguarding is being delivered within partners agencies to the relevant workforce. Wherever possible compliance rates are monitored.
- Considered how to evaluate the training that is delivered and a process is to be piloted in 2018/19
- Developed a training peer review template with which to share findings with the sub-group
- Reviewed and updated the SSASPB owned Adult Safeguarding Awareness training package and placed it on the dedicated SSASPB website. Commenced the review of the Mental Capacity Act package.
- Sought assurance that partners have included the 'coercion and control' element of Domestic Abuse in direct response to the findings of a Stoke-on-Trent Domestic Homicide Review and a SSASPB SAR.

Plans for 2018/19 include:

- Delivery of 4 multi-agency lessons learned from Safeguarding Adult Reviews, Multi-Agency Learning Reviews and Domestic Homicide Reviews training events
- Evaluation of the full day learning event held on 3rd May and attended by 87 front line staff so that others may be delivered and improved upon where
- Piloting the proposed training evaluation process for individual agency and multi-agency training
- Production of 'lessons learned' briefing material for cascade amongst partner agencies
- Finalise the review of the SSASPB owned Mental Capacity Act training package

Mental Capacity Act sub-group:

Chair: Karen Capewell, Strategic Manager Safeguarding Quality and Commissioning, Stoke-on-Trent City Council

The Mental Capacity Act (MCA) sub-group is responsible for raising awareness of, and seeking assurances from safeguarding partners as to the effectiveness of their implementation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) legislation in Staffordshire and Stoke-on-Trent.

During 2017/18 the sub-group has:

- Commenced a significant piece of work which will result in Mental Capacity Act guidance for practitioners
- Received assurance reports with regards to the use of advocates in Safeguarding processes across connected organisations
- Identified information items which would be a useful resource for practitioners and are to be placed on the SSASPB website
- Been a forum for discussion and review of cases, both local and national, where MCA/DoLS has been a key feature, the learning in terms of good practice and areas for improvement have been shared with front line practitioners
- Monitored relevant case law and other Safeguarding Adult Board Safeguarding Adult Review findings from which to learn lessons and amend local practice or procedures
- Considered other training material to support the SSASPB Mental Capacity Act training package

District Council sub-group:

Chair: David Smith; Principal Officer Communities and Partnerships (Staffordshire Moorlands District Council)

The District Council sub-group reports into both the Staffordshire Safeguarding Children Board (SSCB) and the SSASPB, having a Business plan with both elements in it. The sub-group has met four times in 2017/18 as outlined in the SSASPB Constitution and has been well attended by representatives from District and Borough Councils across the County.

In 2017/18 the sub-group has:

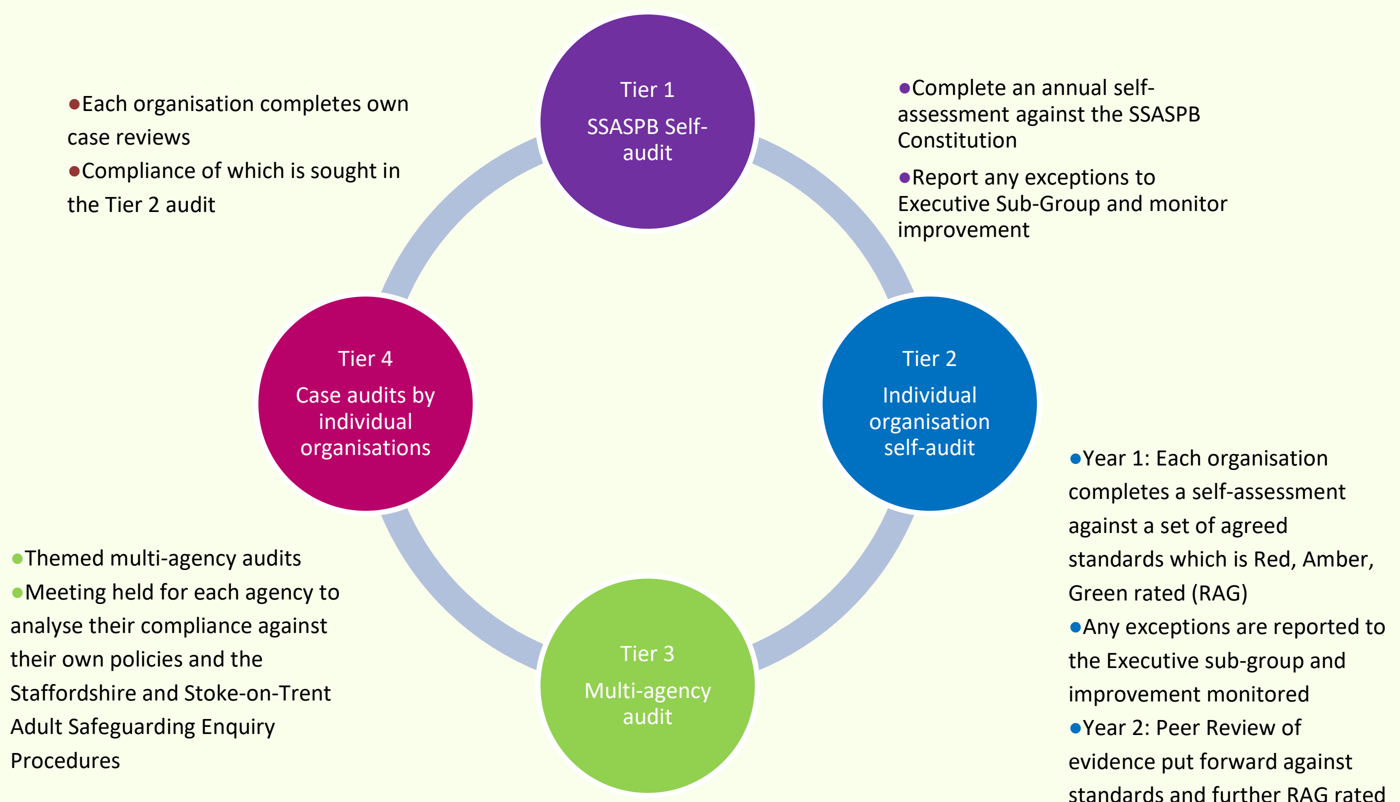
- Developed a template for parish councils to use to create parish safeguarding policies
- Refreshed the template policy that forms the basis of local district/borough policies. Changes have been made to reflect statutory and other changes
- Contributed to the Tier 2 Individual Organisation audit, attending a full day peer audit event together with other Adult Safeguarding partners.
- Considered how to better engage with housing providers
- Assisted with the distribution of information leaflets into local communities
- Contributed to other work streams which are child focussed as this sub-group also reports into the Staffordshire Safeguarding Children Board (SSCB)

Performance, Monitoring and Evaluation:

Chair: Sharon Conlon, Head of Safeguarding, Midlands Partnership Foundation Trust. Deputised by Ruth Martin, Adult Safeguarding Manager SCC, between October 2017 and March 2018.

What we have done:

- Continued to be supported by the Families First Performance Team under the Board agreed Service Level Agreement
- Used the agreed performance report template to monitor quarterly performance by contributing agencies
- Produced the Performance content of the SSASPB Annual Report 2017/18
- Conducted and reviewed audits in line with the 4 Tier Audit model see below including;
- Tier 2 audits (individual organisation audit against an agreed list of standards)
- Tier 3 audits (multi-agency themed case file audits)
- Tier 4 audits (single agency audits). Agencies conduct the audits and report themes and trends back to the sub-group in rotation.
- Commenced the planning to pilot a post Safeguarding S42 Enquiry questionnaire providing support to Making Safeguarding Personal and the Engagement Strategic Priority
- Considered the implications of General Data Protection Regulations compliance on the Tier 3 multi-agency case file audits



Tier 1: The Tier 1 audit utilises the Board's Constitution in the form of a self-assessment. Following a review of the constitution in October 2017 a tier 1 audit was undertaken in December 17 and considered at February Executive sub-group meeting.
Tier 2: Following the Tier 2 audit that was completed in summer 2017 a peer review event was held on the 9th February 2018 so that participating organisations may review each other's evidence against the standards, providing opportunity for challenge and improvement.

Tier 3: There were two Multi-Agency Case File Audits (MACFA) in 2017/18**.** The themes were Making Safeguarding Personal (July 2017), Adult Sexual Abuse (November 2017). On each occasion one or more cases were discussed in detail and the MACFA tool was used to understand where there was good practice, lessons learned and areas for improvement.

The MACFA process is particularly important to the SSASPB as it helps to mitigate the potential risk that the Board may not be sighted on front-line practice. Whilst small in number, the 'deep dive' audits were found to be informative in examining front-line practice. Although time consuming for partner agencies in the research and collation phase the benefits gained outweighed any concerns regarding this.

In May 2018 the General Data Protection Regulations (GDPR) were introduced which will challenge how we conduct these Tier 3 audits and is currently being considered.

Tier 4: The Board seeks assurance that single agency audits are being undertaken through the Tier 2 audit. Each agency is allocated a date to present its audit findings to the Performance, Monitoring and Evaluation (PM&E) sub-group meetings which is then scrutinised by safeguarding partners.

6. PERFORMANCE AGAINST 2016/18 STRATEGIC PRIORITIES

In the reporting period (April 2017 to 31 March 2018) the three Strategic Priorities were:

- Engagement
- Transition between Children and Adult Services
- Leadership in the Independent Care sector

Progress reporting towards Strategic Priorities has been a standing agenda item at Executive sub-group meetings. A summary of progress is outlined below.

Strategic Priority 1: Engagement

This strategic priority has a number of strands including the aim to raise awareness of adult safeguarding and, where relevant, the work of the Board with adults who have care and support needs, their families and carers, members of the public and professionals. Much of the work that supports this strategic priority was as a direct result of the SSASPB Development Day held in January 2016.

A summary of the work we have done this year:

- Continued to update the dedicated SSASPB website. The number of visits to the website has increased by 52% over a comparable period and further development work is planned for 2018/19

- Refreshed and distributed the SSASPB promotional material which is also available electronically on the website
- Produced articles for inclusion in local publication; in hard copy and electronic formats.
- Presented to the Managers and Quality Networking Forum at Staffordshire County Showground which attracts over 250 delegates all of whom are connected to adult care and health service provision.
- Staffed stands at a number of events throughout the County including the Stoke-on-Trent Carers week event at the King's Hall (photograph on the front cover, top middle picture)
- Used Twitter as a means of communication, the photograph from the Stoke-on-Trent carers week event was shared over 1,400 times on the day.
- The Performance, Monitoring and Evaluation sub-group has lead on the Section 42 enquiry questionnaire project which will be launched in October 2018, and is linked to the Making Safeguarding Personal element of our engagement plan.
- The Executive sub-group is leading on plans for a Safeguarding week planned for summer 2019.
- The Executive sub-group lead on a piece of work which identified that very few complaints are made to the Local Authorities which are connected to Safeguarding.
- Visits to Carers hubs across the County continue and have been a valuable source to assist with identification of what is important to them (safeguarding). The main concern is the financial abuse of adults with care and support needs; this has been included as a new Strategic Priority for 2018/2021.
- Board representatives have been invited to revisit the Carers Hubs to help with the understanding of matters such as Adult Safeguarding trends and Deprivation of Liberty Safeguards; demonstrating responsiveness by the Board to those closely connected to adults with care and support needs.

The following exemplify Making Safeguarding Personal and our effective cross-agency collaboration:

Midlands Partnership Foundation Trust (MPFT): Safeguarding in action

An adult safeguarding concern was raised by a local housing provider for an individual with mental health needs. The adult had commenced a relationship with someone that was identified by the referrer as being a repeat perpetrator of domestic abuse. The concern was received by the senior practitioner in adult safeguarding to make decision with regards to the need to conduct further enquires under Section 42 Care Act 2014.

During the planning stage of the referral the senior practitioner consulted with the police with regards to any information that could be shared to support the female to protect herself and if any role for the police could be identified. This led to the finding that the source of risk had a conviction for a serious violent offence against their ex-partner in addition to other domestic abuse related convictions.

As a result of the planning discussion with the police it was agreed that a joint enquiry would take place by the police and Section 42 Enquiry Officer from the mental health community team. Part of this enquiry would also involve the police, with support of the S42 enquiry officer, making a disclosure to the female under the 'right to know' element of the Domestic Violence Disclosure Scheme.

The knowledge of this conviction ensured that the individual was able to make informed decisions about the future of their relationship and establish a safeguarding plan that was personal to their circumstances.

This case is a great example of how agencies can work together to support and empower adults with care and support needs to make informed decisions, to live free from abuse and have support that is personal to them using system and legislation in a proactive way.

Safeguarding in action: North Staffordshire Combined Healthcare Trust (NSCHT)

Elizabeth is in her 70s and has received support from mental health services for most of her adult life. She has been married for many years and has two adult children. Elizabeth and her husband argued frequently throughout their marriage and she reported to her mental health worker that these arguments had escalated into physical violence. Following the disclosure, an adult safeguarding referral was raised and an Adult Safeguarding Enquiry (Section 42 Care Act 2014) was undertaken with the involvement of several agencies that were supporting both parties with their care and support needs.

Overview of the Safeguarding Enquiry

Elizabeth initially wanted to stay at home with her husband. Her support worker explored the risks associated with returning to an environment whereby violent incidents could reoccur, however Elizabeth remained resolute therefore this was supported and safety measures were discussed. Her disclosure was reported to Staffordshire Police and a referral was made to Multi-Agency Risk Assessment Conference (MARAC) with Elizabeth's involvement and consent. Elizabeth's mental health team spoke with her husband, and he confirmed that he had assaulted his wife. He regretted his actions and said that he was becoming increasingly unable to support his wife with her mental health needs. Various supportive alternatives were explored with both to help them with the problems they were experiencing, however during this time Elizabeth decided to leave the marriage and the marital home; therefore her mental health team arranged alternative accommodation for a short period of respite.

Elizabeth and her husband were central throughout the Safeguarding Enquiry. Their wishes and feelings were ascertained and documented, and they were both supported by their children. Elizabeth's husband was supported by Adult Social Care due to having care and support needs of his own. It was acknowledged that both were at risk of the experience of abuse from one another as it emerged that Elizabeth had been physically violent towards her husband.

Outcome

Elizabeth's husband acknowledged that although he loved his wife, it would be safer for them to live apart. She wanted to leave the marriage and chose to move to a supported living environment, which she had previously refused however she appeared to be enjoying respite and recognised that she was benefitting from increased support. Their children supported them with managing their finances and other civil matters.

University Hospitals of North Midlands (UHNM) and Adult Safeguarding Enquiry Team (ASET), Staffordshire County Council: Safeguarding in Partnership.

A safeguarding referral was received for a young adult, Louise, with a learning disability who was found to be pregnant. This was a late-booking, as she was already a number of weeks pregnant, and it was already known that she lacked mental capacity to consent to sexual activity. She did not understand how she had become pregnant. A criminal enquiry commenced which was led by Staffordshire Police. The safeguarding work led by Staffordshire County Council's Adult Safeguarding Enquiry Team, involved close liaison with Louise, her family, Staffordshire Police, the social worker for the young woman, children and families services, and midwifery services from UHNM. A learning disability nurse was involved to help Louise understand the progress of her pregnancy and preparation for birth without undermining the criminal investigation and potential court case. During her pregnancy Louise showed she could learn a great deal if information was given in the right way. Once the baby was born Children's and Families services worked with Louise and her family to help her learn to care for her baby. Following police agreement, Louise was offered support to learn about sexual activity and she was subsequently assessed as having full mental capacity on this matter. A lot of consideration was given during the work to the timing of various processes as the case was being heard in the Court of Protection and she was involved in Child Care

proceedings. Advocates were involved both for adult safeguarding and child care. During all of the work Louise was clear that she wanted to maintain her relationship with her boyfriend and this was respected although there were difficulties and risks. Both of these were achieved through close work with her, her family and a range of agencies and professionals.
This was a complex episode of work for all involved and risked being overwhelming for Louise and her family. At times professionals needed to negotiate which aspects of work would take precedence due to Court proceedings and which could be done at a later date. At the Court of Protection (CoP) the judge commended the Trust for excellent preparation and dedication to support the lady concerned.
Making Safeguarding Personal was at the heart of the adult safeguarding approach and helped everyone involved to understand what she wanted to achieve and focussed minds on how best to support her. It is a credit to her and her family's commitment and determination that she is now living at home with her baby and she is still in contact with her boyfriend.

Partnership working – Stoke-on-Trent City Council and North Staffordshire Combined Healthcare NHS Trust

An adult safeguarding concern was raised by Harplands Hospital (North Staffordshire Combined Healthcare NHS Trust) – concerning the alleged wilful neglect/ill treatment by a Person in Position of Trust towards an older man who was in receipt of inpatient services.
The member of staff had failed to administer pain relief at prescribed times, recording that the Adult had been sleeping at the time. This was seen by another person who confirmed the occurrences.
Information was shared within the Multi-Agency Safeguarding Hub (MASH) which identified that another agency had information about the same member of staff being involved in another safeguarding incident within the past twelve months. This increased the risk presented by the member of staff and resulted in the information being shared with the employer. The employer was then able to take steps to prevent the member of staff continuing to present risk to adults with care and support needs.

Staffordshire Police: Successful prosecution for offences against an adult with care and support needs.

'A' was employed as a domiciliary carer for an elderly woman in her 80s and, whilst having access to her home, stole £20 cash and her engagement and wedding rings. These items were of great sentimental value as they belonged to the victim's mother and their loss caused the family great upset. He then sold the rings to a shop who dealt with second hand jewellery from which they were sold on. Staffordshire Police's Adult Safeguarding Enquiry Team undertook an investigation which resulted in the apprehension of 'A' who pleaded guilty to four charges; including theft of the rings, theft of £20, fraud by false representation and committing an act with intent to pervert the course of justice at Stoke-on-Trent Crown Court.
Below is some of the press release content relating to the case:

A man who stole two rings and cash from a vulnerable woman in her 80s who he was supposed to be caring for has been jailed for 2 years.

The court heard how 'A' was employed as a domiciliary carer where he attended the homes of elderly people to provide care and support and such is considered to be in a position of trust. Whilst visiting a home in, Stoke-on-Trent in June 2017 he stole a 22ct plain gold ladies wedding ring that belonged to the victim's late mother and an 18ct gold ladies engagement ring with a small cluster of diamonds that belonged to the victim's late aunt. He also stole £20 from the victim's purse on a separate occasion.

The sentencing reflected the weighting applied to 'A's position of trust. Unfortunately the rings were never traced; the victim and her husband have since passed away.

Stoke-on-Trent Safeguarding Conference

On 29 March 2018 Stoke-on-Trent City Council developed, organised and facilitated a half day conference for residential care providers, focusing on Safeguarding Older People. The session ran from 9.30-12.30 at Bentilee Neighbourhood Centre.

28 individual people attended from the residential care sector including registered managers and care home staff. Included in the above figure were training providers, telecare representatives and recruitment agencies all of whom chose to take a promotional stall to the event to offer advice and information to the delegates, supporting local business growth and information sharing. The overall aim of the conference was to support improved quality within the residential care sector by building strong networks, ensuring correct and relevant information is shared and learning through real examples how to improve and sustain high quality care.

The conference focused on three main topics:

General Data Protection Regulation - GDPR (delivered by the Information Governance Lead from SOT City Council)

- What is changing and why
- Data Controllers and Data Processors
- Sufficient Guarantees
- Incidents and how to avoid them

Learning from Local Safeguarding Enquiries (delivered by the Strategic Manager for Safeguarding from SOT City Council)

- Local Authority Duties
- Monitoring
- Approach
- Facts and Figures
- Themes
- Next Steps

Care Quality Commissioner Inspections (delivered by CQC Inspector)

- When to notify the CQC following a safeguarding referral
- How to notify the CQC
- Good examples of CQC notifications
- Regulations and Inspections
- Next Steps

Due to the time restrictions of the event, table top discussions were limited however the guest speakers invited questions from the delegates and all power point presentations were forwarded the following day. Evaluations provide evidence that the aims and objectives were met and the delegates felt that the conference was informative, interesting and helpful. Further support around CQC inspections and Deprivation of Liberty Safeguards training was requested along with the feedback that more notice is required with more time scheduled for interaction and table top discussions. Based on the feedback, the authority will arrange subsequent conferences and networking opportunities to ensure continued peer learning and sharing of best practise.

Feedback was also gained from non-participants to help understand the reason for declining to attend. The majority of people stated that it was due to the short notice period, particularly as it was towards the end of the financial year. This simple step can be taken in future when arranging subsequent conferences.

Strategic Priority 2: Transition

This priority is led by the SSASPB with support from the Stoke-on-Trent Safeguarding Children Board (SCB) and the Staffordshire Safeguarding Children Board (SSCB).

Young people with ongoing or long-term health or social care needs may be required to transition into adult services. Transition takes place at a pivotal time in the life of a young person, part of wider cultural and developmental changes that lead them into adulthood; individuals may be experiencing several transitions simultaneously.

The transition to adulthood covers every aspect on a young person's life. Supporting disabled young people in their transition to adulthood can be a challenge to service providers. This is because the process must be individual to the needs and aspirations of each young person and local options for disabled young people may vary geographically.

In April 2018 the SSASPB invited both Stoke-on-Trent and Staffordshire Local Authorities to report recent progress towards meeting the challenges faced by Preparing for Adulthood (as it is more commonly known in recent times) and the following is a synopsis of the presentations delivered to the Board.

Stoke-on-Trent:

Stoke-on-Trent has introduced an Enhanced Transition Team. This means that all transition referrals are handled by one team. An adult social care social worker is introduced to the young person at the age of 16 or earlier if thought beneficial. The approach to transition incorporates all influencing legislation and engages with the young person at the most appropriate time for them from the age of 14 upwards. The young people within the transitioning cohort are well known by the team as a result of meetings held every 6 weeks at which their current needs are discussed.

Where complex cases are identified there is an opportunity for co-working involving adult social care and Children's services which helps to build early relationships with the young person and their family. It also includes the early involvement with health services, and facilitates the identification housing solutions. The

transition forum is a multi-disciplinary forum where complex cases can be highlighted and where pathways outside Adult Social Care can be discussed and understood. It includes representation from: Child and Adolescent Mental Health Service (CAMHS), Education, Community learning Disability, health services, Children's Social care, Adult Social care and others by invitation or their request to attend. The work of the Enhanced Transition Team links directly to the strategic imperatives of the "Preparation for Adulthood Strategic Group".

There has been a focus on transitioning for those with mental health needs. There is now a named transition lead in the CAMHS and clearer pathways will be added to the local offer. There remains the challenge for those who do not reach adult mental health thresholds including emotional health issues and Emerging Personality Disorders.

Stoke-on-Trent continues to seek improvement in connection with Transition and the following are examples of the focus of this work. They have developed a questionnaire for use with young people and their families to evaluate the transition process. This has been sent to parents and the Preparing for Adulthood Board for scrutiny and feedback prior to testing.

There is specific workforce training for Social Workers in Adult Social Care which is being evaluated in the field of Family Therapy and working with Young People on the Autistic Spectrum in response to an increasing mix of Young People with Autism Spectrum Disorder (ASD).

There is continued development of specialist community resources to support individual needs. Work has commenced with both specialist music providers and local Universities to support young people with ASD.

Staffordshire:

Staffordshire reported that they have a Preparing for Adulthood project. The project seeks to develop a seamless system and processes which include young people, their family or carers, children and adult services and partners and aspires to a number of outcomes including:

- Improved experience of transition for young people as result of jointly owned pathway
- Reduced cost of care through improved planning, preparation and delivery of transition. With all partners contributing appropriately
- Better set and manage (jointly) realistic but aspirational expectations
- Earlier joint planning and preparation – sharing and making best use of data to avoid surprises
- Jointly take a whole life approach to focus on outcomes and maximising independence
- Workforce developed and supported to work in new way (Whole life, outcome focus, maximise independence, not just maximum entitlement)
- Transition should be collegiate and not feel like a move from 'Us to Them'. Should jointly hold the baton during the Transition process

The project is ongoing and has the support of the Transformation Support Unit with a Senior Project Lead. It has a variety of phases including the development of an All Age Disability strategy, the autism offer and the approach to market development. The Board received detail on the governance and monitoring of the project which is being driven by appropriate senior managers and Assistant Directors. The Board agreed with the proposal that Transition now be closed down as a Strategic Priority of the SSASPB and this update will also be included in both the Stoke-on-Trent and Staffordshire Safeguarding Children Boards' Annual Reports.

Strategic Priority 3: Leadership in the Independent care sector

Strategic Lead: Lisa Bates; Lead Nurse of Adult Safeguarding (South Staffordshire Clinical Commissioning Groups)

Many people have been shocked by the revelations highlighted in national high profile cases of poor care and worse, outright abuse, in our health and care system. Such instances, whilst fairly rare, remind us that the way care and support is provided to individuals and their families can have a major effect on their whole quality of life. It is the leaders in the system – operating at all levels from the practice of individual staff members to the strategic planning of commissioners – that set the tone and culture of organisations. It is they who ensure that high quality care is provided day in and day out – or, sadly, that the opposite is sometimes the case.

Leadership in the Independent Care Sector is as a major source of concern for the Safeguarding Board due to its recurring theme locally within Large Scale Enquiries and Safeguarding Adult Reviews. These processes have evidenced a trend of poor or absent leaders in the system running parallel with poor care standards, regulatory failure and high levels of safeguarding concerns. The strategic partners have continued to work collaboratively to improve oversight and support arrangements to this sector and have implemented a number of measures with the ambition of reducing duplication, developing shared and consistent reporting systems and partnership with our commissioned services.

Progress 2017/18

The Safeguarding Adult Board gains assurance from statutory partners following the development of clear pathways for the sharing of quality and safeguarding information. Since the 2016/17 report there is now a clear escalation process from the Quality and Safeguarding Information Sharing Meeting (QSISM) to the Board in addition to an annual report which is presented by the Chair of QSISM.

During 2017/18 the Board have received presentations providing detailed assurance of Quality improvement work within this sector from both Stoke on Trent and Staffordshire Local Authorities, the Care Quality Commission, the CCGs and Staffordshire Care Provider Forum. In addition, the Local authorities produce a quarterly brief outlining the services in the Large Scale Enquiry process and any trends/themes identified within.

The Quality Assurance of Care homes is now a collaborative process between Local Authorities and CCG's with shared reporting processes benefiting in the early identification of concerns and robust intelligence.

The Clinical Commissioning Groups have created a Nursing Home Quality Assurance meeting with attendance by LA to review both positive and negative issues and clear escalation process to QSISM.

The Board have joint funded the appointment of a General Practitioner to support the Multi-Agency Safeguarding Teams and increase engagement with Primary Care. The Board have agreed to facilitate a planned "lessons learnt" event funded by SSASPB to review urgent closure of a Nursing Home in Stoke on Trent.

Staffordshire County Council and the CCGs have developed a joint Local Authority and Clinical Commissioning Group Procedure Guide for the management of provider failure. Staffordshire County Council and the CCGs have agreed to pilot a Nursing Home Performance Improvement Response Team to be hosted by Staffordshire LA which will provide support to homes who are failing to achieve regulatory standards.

The importance of leadership is also highlighted in inspections of commissioned care homes conducted by the Care Quality Commission (CQC).

The following gives an example of Leadership in the independent care sector;

Adult Safeguarding, Partnership Working: Clinical Commissioning Groups (Stoke-on-Trent and Norths Staffs)

The Safeguarding Team in North Staffordshire and Stoke-on-Trent CCGs work closely with both Local Authorities (Staffordshire County Council and Stoke-on-Trent City Council). This includes completing and joint-working Section 42 enquiries. The Safeguarding Team have also developed very strong working relationships with the Local Authorities with regards to information sharing about issues in individual care homes. This works particularly well in Stoke-on-Trent, with the team supporting the LA on quality monitoring visits to care homes. This provides a clinical view on issues within a home and forms part of any action plan issued to a home to work to. This joint working provides a clear oversight of any issues and helps to drive up standards and quality within a failing provider, the main purpose being to ensure that residents have a quality of life and are safe and well cared for.

Strong links have also been developed with CQC and information sharing is more seamless which enhances the triangulation of information between CQC, the CCGs and both Local Authorities. This helps ensure that any failing homes are identified earlier and appropriate action and input can be taken to prevent any potential crisis occurring.

The following have been proposed to the Board for continuation of the priority into 18/19.

- The Board to seek assurance that the monitoring of paid staff within this sector under disciplinary/criminal processes is appropriately managed and information sharing to professional bodies and/or other providers is proportionate to the issues identified.
- The Board to seek assurance against threshold decisions in relation to “neglect” cases and clear pathway for referral to ensure cases are being placed into the right process.
- The Board to seek assurance that delays with statutory reviews is not resulting in potential harm/neglect of individuals whose needs have changed.
- The Board to ensure effective information sharing and gathering processes in relation to LSE’s/independent providers with special measures are effective with the multi-agency and Primary Care.
- The Board to seek assurance that commissioners of independent sector services are ensuring that service users/families/Next of Kin are aware of Adult Safeguarding and how, where and when to raise concerns.

7. ANALYSIS OF ADULT SAFEGUARDING PERFORMANCE DATA

Analysis of Adult Safeguarding Performance Data 2017/18

Introduction

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

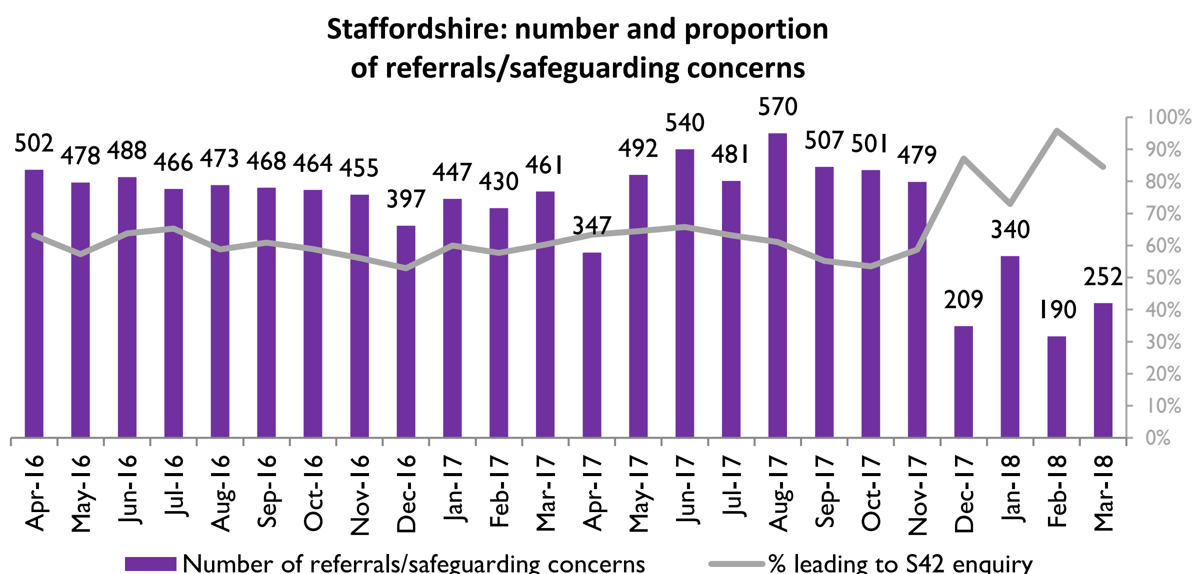
Summary

1. Staffordshire – a reduction in reported referrals due to change in recording practice. Stoke-on-Trent – slowly increasing, but a reduction in proportion of safeguarding referrals
2. Stoke-on-Trent – Primary support reasons have changed, reduction in physical disabilities and increase in learning disability and mental health support
3. Across both LAs – Neglect and physical abuse, represent the largest types of harm or abuse
4. Staffordshire – primary location of harm or abuse is in the victims own home; In Stoke-on-Trent the location is more evenly distributed across own home, residential home and nursing home
5. There is a reduction in the number of concerns made against people in positions of trust which are investigated by the police and are at a 3 year low

Number and proportion of referrals/safeguarding concerns

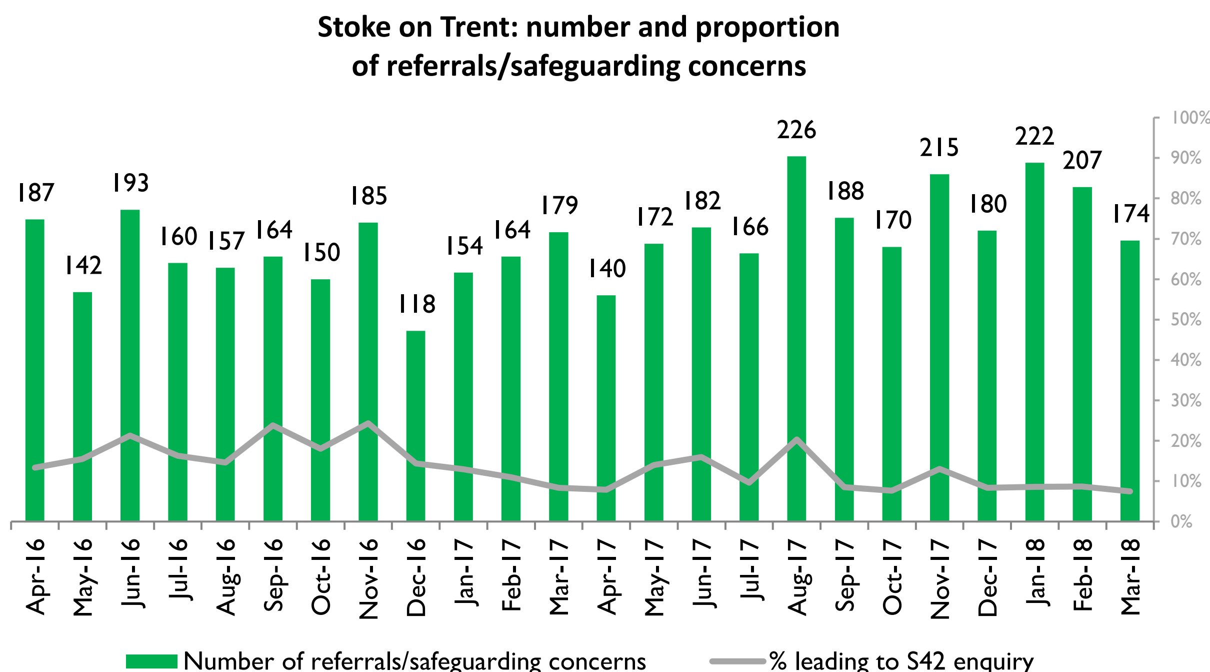
The safeguarding partners in Staffordshire and Stoke-on-Trent have established and widely publicised the procedures for reporting concerns that an adult with care and support needs may be experiencing or is at risk of abuse or neglect. Reported concerns can progress to a formal enquiry under Section 42 of the Care Act 2014 if the criteria for the duty of enquiry requirement are 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. This accounts for similarities in the numbers between both LA which could reasonably be assumed to vary more due to the difference overall population sizes.



During the course of the year in Staffordshire there have been 4908 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 decreased by 621 occasions from 5529 in the previous year 2016/17 which is a decrease of 11%. The reported concerns averaged 409 per month; but there has been a reduction of nearly 50% each month from December 2017 onwards. The reason for this reduction is due to a change in recording practice, only those referrals that meet the threshold are now recorded as a referral.

Following initial assessment it was determined that the duty of enquiry requirement was met on 3198 of those occasions which is 65% of the total reported. This proportion is higher than the 61% in the previous year. For referrals from December 2017 onwards, the proportion of referrals where the threshold was met increased to an average of 85%.



In Stoke-on-Trent there were 2242 reported safeguarding concerns in relation to adults with care and support needs. This is an increase of 289 from 1953 in the previous year an increase of 14.8%. This is the second annual rise in the past 2 years. The reported concerns averaged 186 per month.

Following initial assessment it was determined that the duty of enquiry requirement was met on 621 of those occasions which is 28% of the total reported. This proportion is higher than the 19% in the previous year.

The increases in the number of concerns in Stoke-on-Trent is most likely to be due to a combination of improved training and awareness raising leading to better recognition of abuse and neglect amongst safeguarding partners and non-professionals as well as better understanding of referral routes and information sharing. Despite the changes this year it is believed that abuse and neglect is still under reported and is expected to rise. This has been acknowledged in national research, particularly for those adults with care and support needs aged over 65 years.

The wide variance in conversion rates for Section 42 enquiries between Staffordshire and Stoke-on-Trent is due to differing local approaches and practice. This is mirrored nationally where conversion rates vary between 12% and 69%.

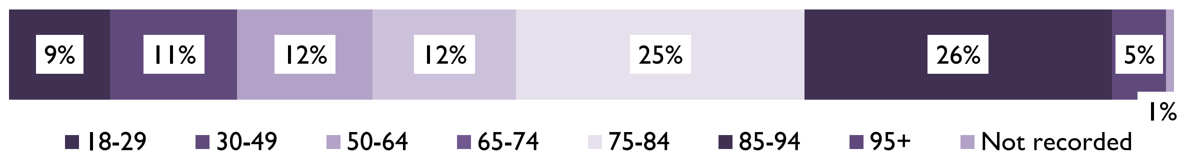
The following pages provide an analysis of the findings under various headings from the concerns that have resulted in a formal Section 42 enquiry.

ABOUT THE PERSON

To build the 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 the adult having need for care and support and this information is provided below.

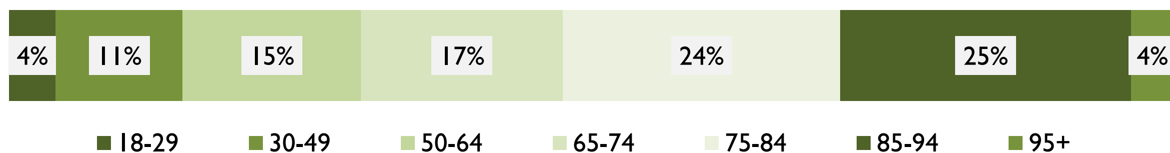
Age breakdown

Staffordshire



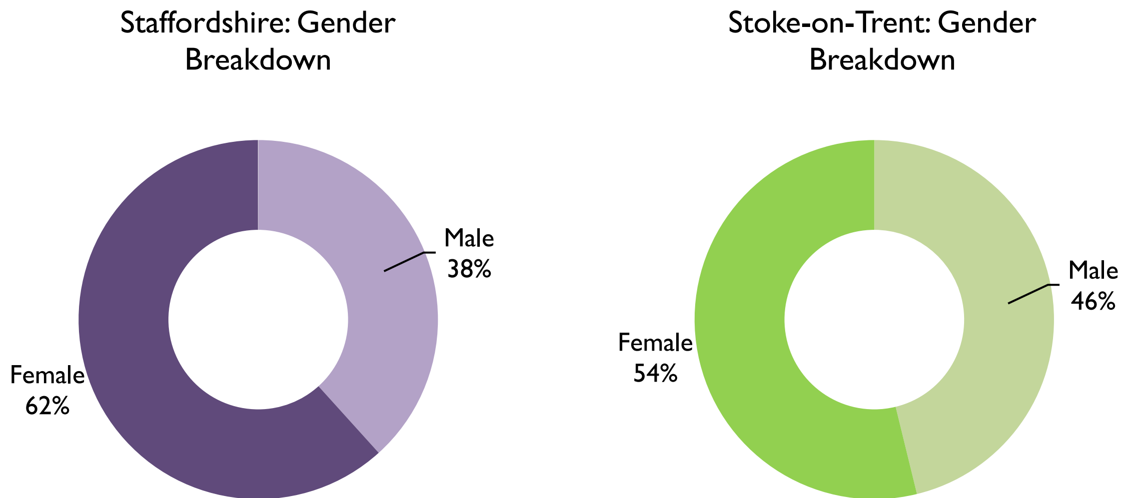
Of the people subject of a Section 42 enquiry, those aged 85-94 (26%) represent the largest cohort, closely followed by 75-84 (25%), and then 65-74 (12%). There has been a small change in the population this year and the proportion of over 75 year olds has increased by 4 percentage points to 56% (from 52% in 2016/17). In a very small proportion of cases no data has been recorded.

Stoke-on-Trent



For Stoke-on-Trent, the largest cohort represented is those aged 85-94 (25%), followed by 75-84 (24%), and then 65-74 17%). The proportion of people aged 65 and over has decreased by 5 percentage points to 70% from 75%.

Gender



Staffordshire

Females represent the majority of adults' subject of a Section 42 enquiry (62% over the year), males representing 38%. Improvements in recording mean that there were no records without a gender recorded and this will likely account for the increase in females from 2016/17.

Stoke-on-Trent

Stoke-on-Trent has a much lower proportion of females in their cohort compared to Staffordshire, with 54% being female and 46% being male.

Recording systems are being reviewed to reflect how gender categories can be broadened to be fully inclusive.

Ethnicity

	Staffs	Stoke-on Trent
White	92.0%	91.1%
Asian	0.9%	1.6%
Black	0.4%	0.8%
Mixed	0.3%	0.0%
Other	0.1%	0.0%
Refused	0.6%	6.5%
Undeclared / Not Known	5.7%	0.0%

Staffordshire

The majority of individuals (S42) are 'White' (92%), followed by Asian (0.9%).

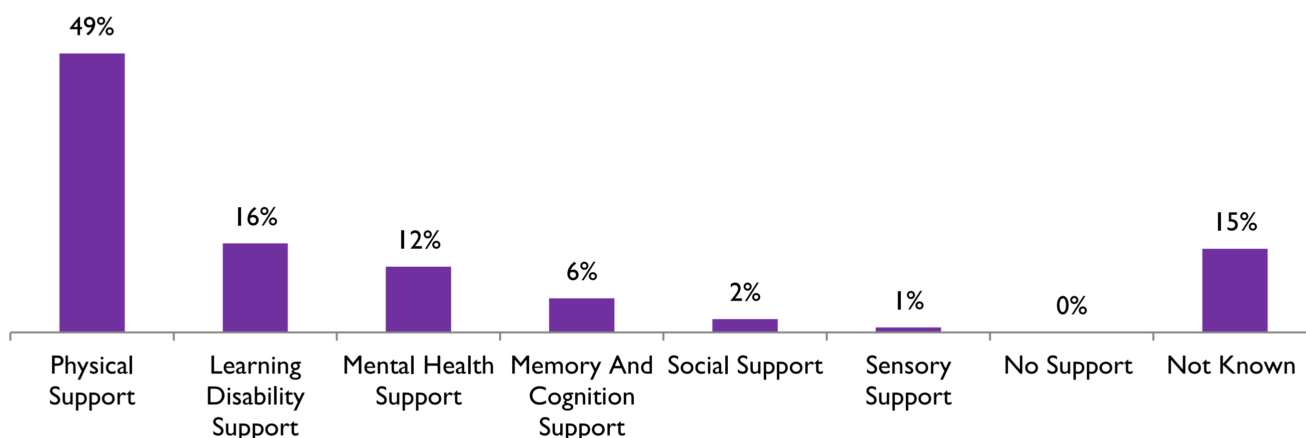
Stoke-on-Trent

The pattern is similar in Stoke-on-Trent; the majority of declared ethnicities are 'White' (91.1%), followed by Asian (1.6%).

However, for both local authorities around 6% of records do not have their ethnic background captured or has been refused which limits the usefulness of any comparison

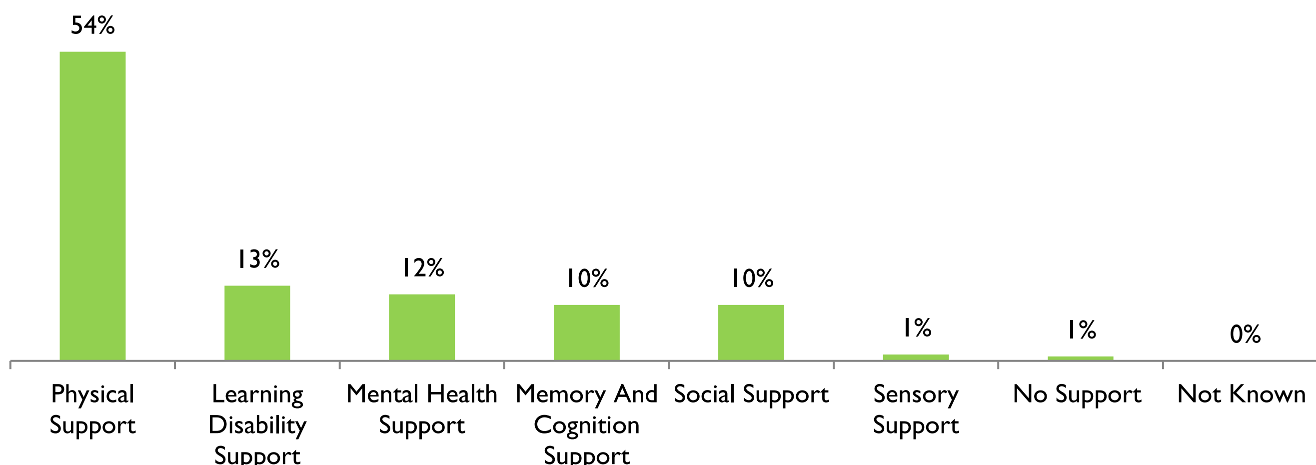
i. Primary Support Reason

Staffordshire



Physical support was the most prevalent primary support reason in Staffordshire in 2017/18 (49%), followed by learning disability support (16%) and then mental health support (12%) which was more of a factor for the older age groups.

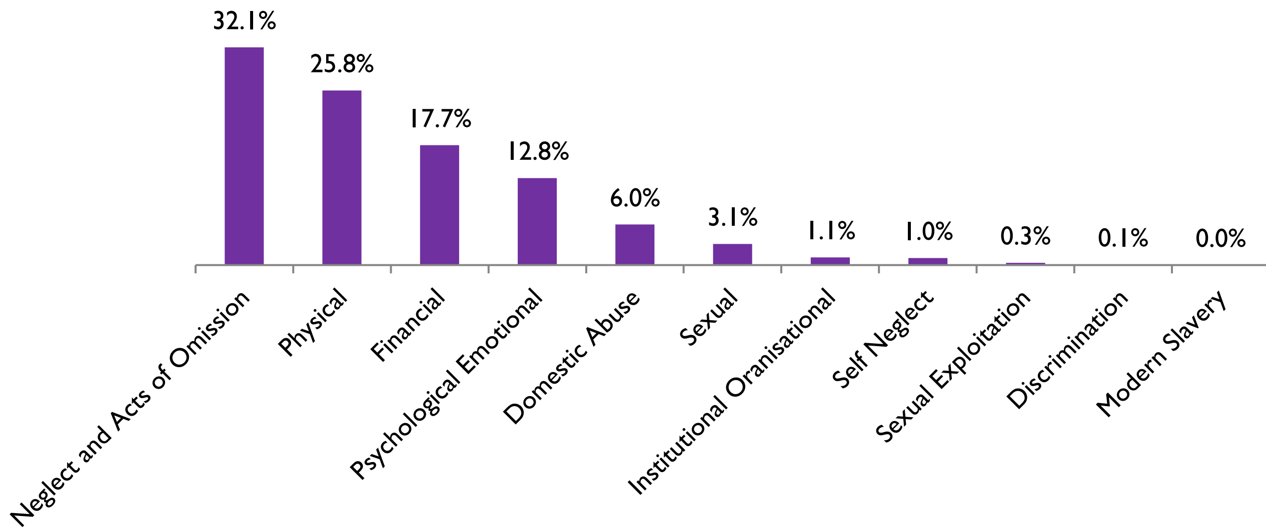
Stoke-on-Trent



Physical support similarly represents the largest proportion of primary support reasons recorded in Stoke-on-Trent at 54%, followed by learning disability support (13%) and mental health support (12%). The primary support reasons for Stoke-on-Trent have changed from 2016/17, where Physical support represented two thirds of cases.

i. Types of Harm or Abuse identified at S42 safeguarding enquiry

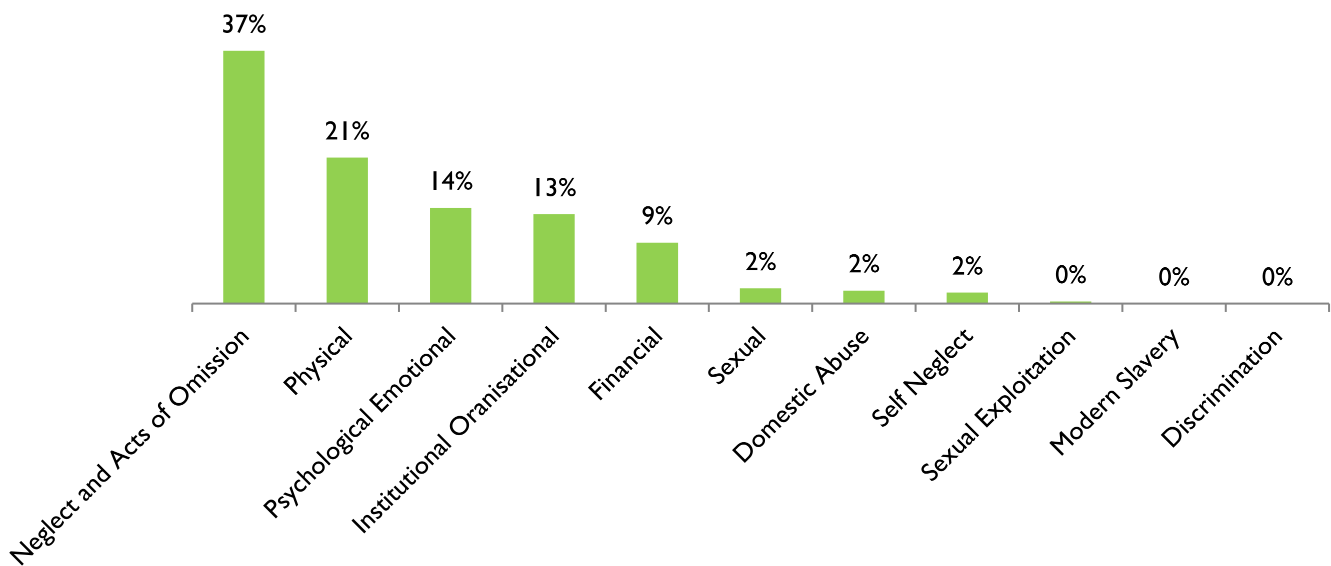
The below information shows the types of abuse and neglect reported in comparative proportions:



Staffordshire

Physical harm/abuse and neglect/and acts of omission continue to be the most frequent types of harm and abuse identified at Section 42 safeguarding enquiry in Staffordshire, accounting for 32% and 26% respectively all harm/abuse recorded. Neglect and acts of omission, show a proportional increase during the course of the year. Financial abuse represents just under one fifth of all harm/abuse in 2017/18.

Stoke-on-Trent



The trend of increasing neglect cases has continued in 2017/18 and is up to 37%. The proportion of cases where physical abuse has been reported also increased slightly when compared to 2016/17. Other categories remained proportionally similar throughout the year.

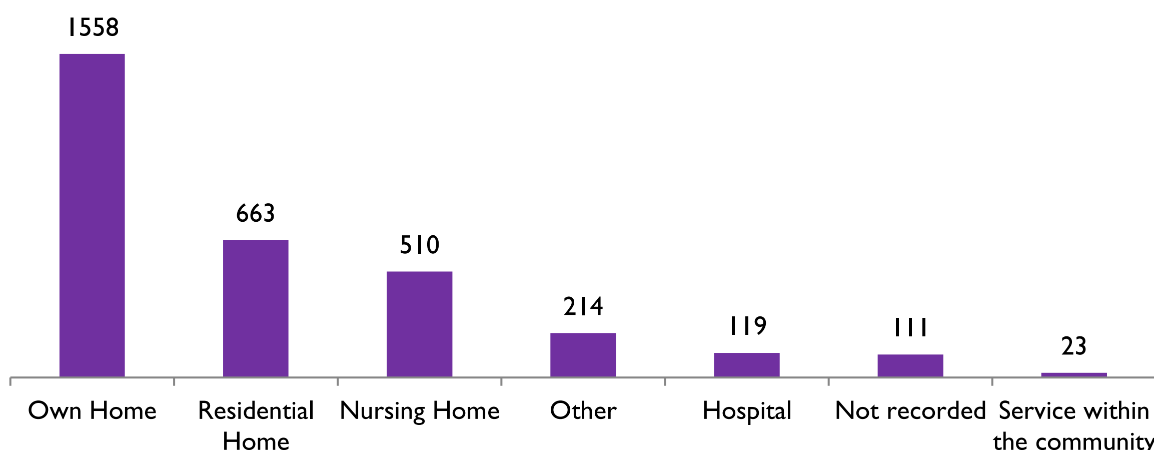
Despite the low numbers of safeguarding concerns recorded under sexual abuse, there is a risk to adults with care and support needs and particular trends for adults with a learning disability.

In 2016/17new categories of Sexual Exploitation, Discrimination and Modern Slavery were added. This year, a small number of cases have been recorded has having these features. In Staffordshire, less than 10 cases were identified as involving sexual exploitation and fewer than 5 cases for discrimination. Stoke-on-Trent reported fewer than 5 cases including sexual exploitation.

In both local authorities no cases of modern slavery were recorded.

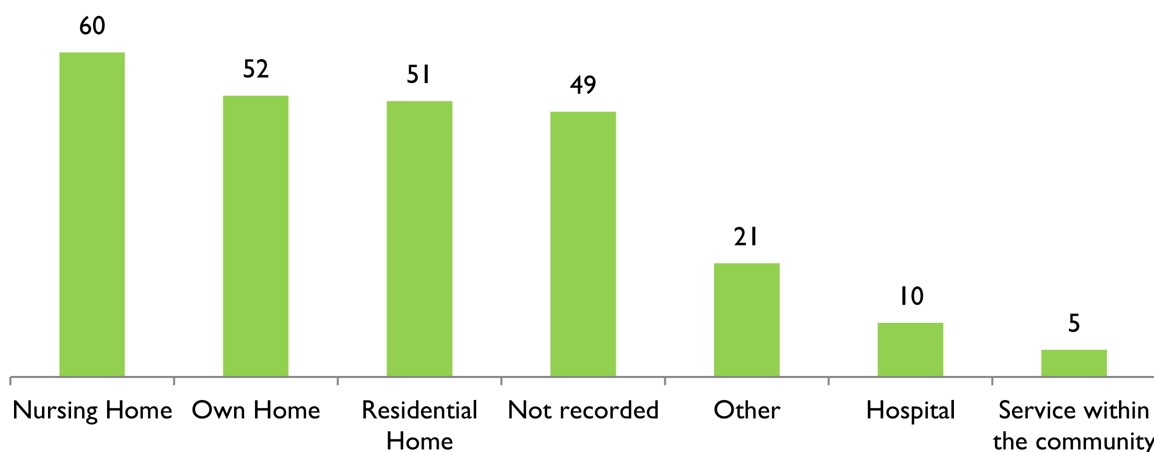
Location of abuse

Staffordshire



Of those people subject of Section 42 enquiries, the most prevalent location was the person's own home at nearly 50%. The next most common locations in Staffordshire were residential homes (21%) and nursing homes (16%).

Stoke-on-Trent



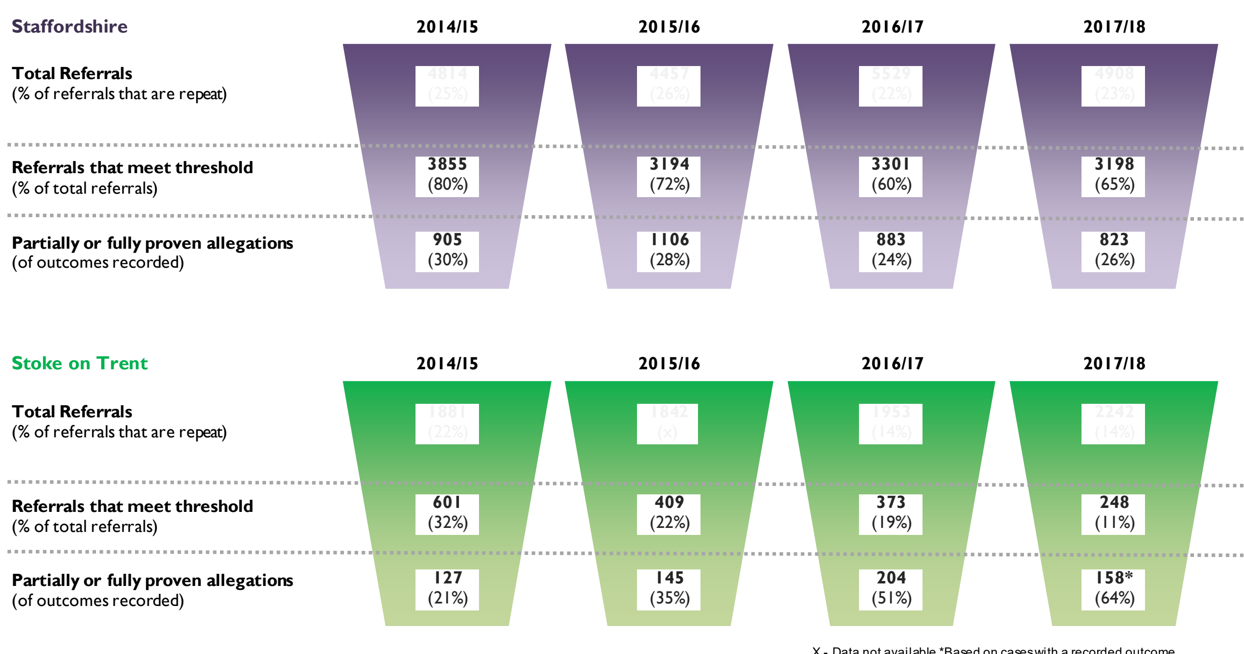
The most prevalent locations in Stoke-on-Trent represent two thirds of the location of abuse or harm – Nursing home (24%), Own home (21%) and Residential home (21%).

Large Scale Enquiries (LSEs) will impact on nursing home data due to other safeguarding concerns resulting from additional scrutiny of a service.

It is of note that in Staffordshire 1639 of the reported safeguarding concerns related to an allegation against a Person in a Position of Trust (PiPoT) an increase of 27% compared to last year.

Findings of Concern Enquiries

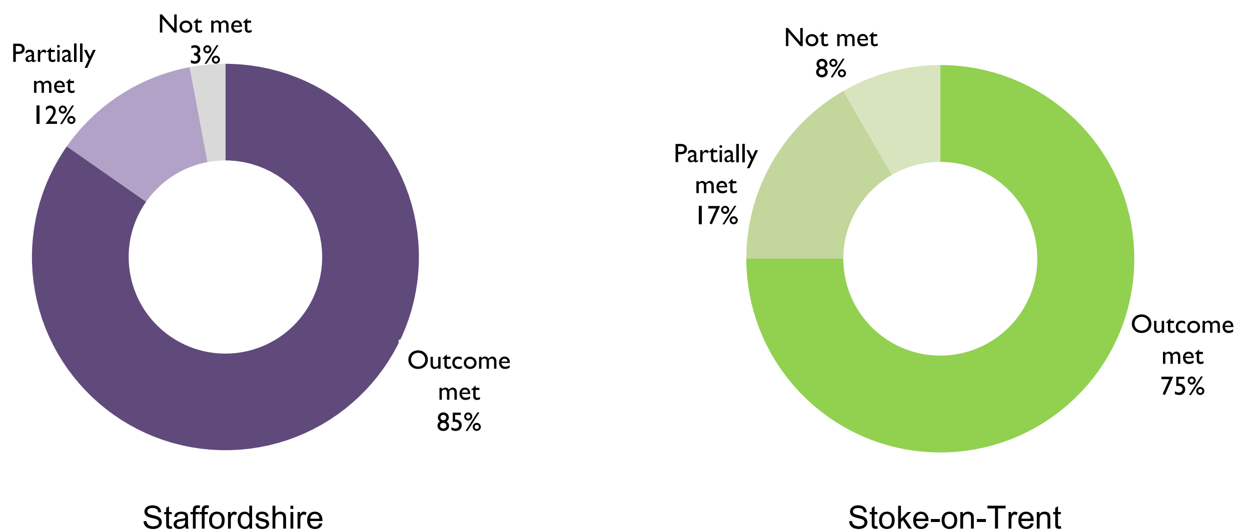
The following section provides an overview of the findings of Section 42 enquires showing what is happening to referrals through to whether allegations were proven with a comparison to previous years.



Staffordshire: Referrals have reduced year on year in 2017/18; however the overall trend over 4 years is increasing demand. The proportion of referrals meeting the threshold had been reducing, but this has increased in 2017/18; as noted earlier. However, the volume of referrals that meet the threshold has been relatively stable over the prior three years.

Stoke-on-Trent: During 2017/18 Stoke-on-Trent received an 11% increase in reported number of concerns. This represents the second year of increase after a period of stability during 2014/16. Previously, there has been a similar increase in referrals between 2013/14 and 2014/15 of 8%. Both the proportion and volume of cases meeting the threshold has continued to reduce and is now one third the rate in 2014/15 (11% from 32%).

Number and proportion of people who have a S42 enquiry whose expressed outcome was met



Staffordshire

In Staffordshire the proportion of people subject of a Section 42 enquiry whose expressed outcome was met has increased to 85% from 74% last year with over 97% of people expressing their desired outcomes as either fully or partly met. However, 3% of people reported that their desired outcomes were not met, which is a reduction of 5 percentage points from 8% in 2016/17.

Stoke-on-Trent

The proportion of people subject of a Section 42 enquiry whose expressed outcome was met or partially met decreased slightly to 92% from 95% in 2016/17.

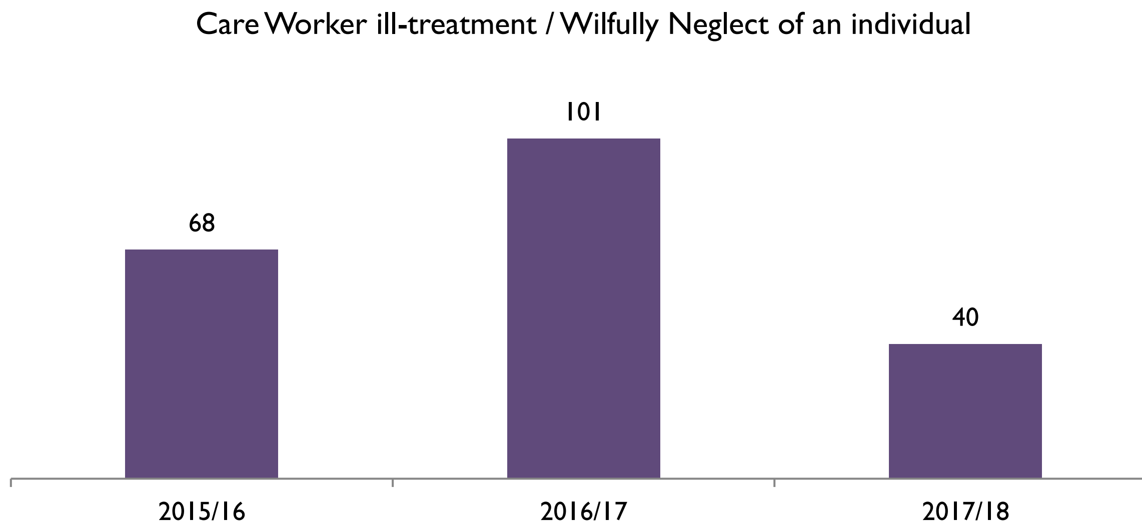
It will be noted that there have been increases in the achievement of desired service user outcomes this year particularly when taking account of outcomes defined as 'partly met'.

The increases are believed in large part to be attributed to the Making Safeguarding Personal (MSP) focus as well as improved recording the importance of which is widely recognised.

Staffordshire Police information

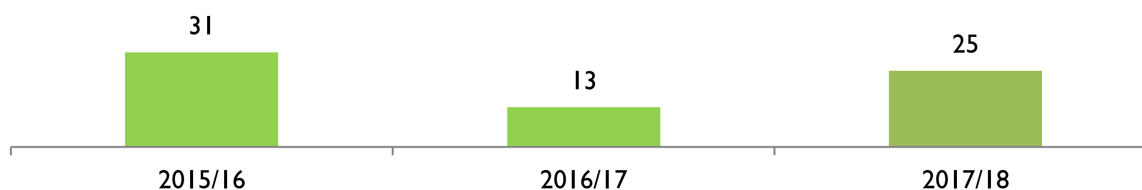
Care Worker ill treatment/wilful neglect of an individual

The annual report of the SSASPB for 2015/16 indicated an increasing number of concerns and criminal investigations involving paid care staff. In 2017/18, the number of concerns and criminal investigations reduced by 60%.



The number of safeguarding referrals is spread over 9 locality policing teams, with Stafford experiencing an increase. There have been no repeated victims, but there are repeat offenders. There are also 6 locations with more than 1 crime recorded and the majority occurred in care/nursing homes.

Ill Treatment or Wilful Neglect of a Person lacking capacity by anyone responsible for that person's care



There has been an increase of 12 safeguarding referrals compared to the previous year. These are spread over 8 locality policing teams with 3 teams experiencing an increase. There are no repeat victims, but there are repeat offenders. Over half of safeguarding referrals occurred in nursing/care home settings.

8. BOARD DEVELOPMENT AND IMPROVEMENT ACTIVITY

Development Day 18.05.18

The SSASPB has committed to holding a biennial Development Day for all members. This provides a number of opportunities including; reflection on the progress of the work of the Board, the identification of future challenges and aspirations, consultation on proposed Strategic Priorities and how members may contribute to the strategic plan and team building.

This year the Development Day was to be held in early March but unfortunately had to be postponed owing to exceptionally poor weather. It was rearranged for the 18th May and was attended by 29 of the Board members. The event was facilitated by an independent consultant who used data collected on the day to produce a report from which the Board will prepare an improvement plan.

The report contains the information gathered during the discussions on each of the tables in relation to

- What is working well
- What are our aspirations as a SSASPB
- What are the challenges
- What could be improved

It also captures the comments made in relation to the refresh of the Strategic Plan for the period 2018-21.

The following key points have been identified from an initial analysis of the report

- Whilst there were many positive comments about the organisation and effectiveness of the SSASPB there were also constructive comments on how it could be even better.
- There have been some contradictions in comments in part reflecting different spheres of responsibility, expertise and networking of board members.
- More work to be done around induction arrangements for board members particularly in relation to developing understanding of the contributions made by the different organisations engaged in the partnership and how these are brought together collectively.
- Safeguarding partners need to develop a shared understanding and be able to explain of some key terms, for example, the difference between safeguarding and quality.
- More work to be done around raising awareness amongst connected partner organisations and communities as to the role of the SSASPB, its responsibilities and its relevance.
- More work needed to demonstrate accountability to the SSASPB and evidenced by the challenging of activity and reporting of action in response.
- Need to review the responses in relation to the SSASPB priorities and consider how these will be incorporated into the refresh of the current Strategic Plan.

Next steps

The themes from the Development Day are to be translated into specific actions that will be tracked to completion, the required work to be undertaken by small task to finish group, and will be reported upon in next year’s annual report.

9. FINANCIAL REPORT

Budget Report 2017/18:

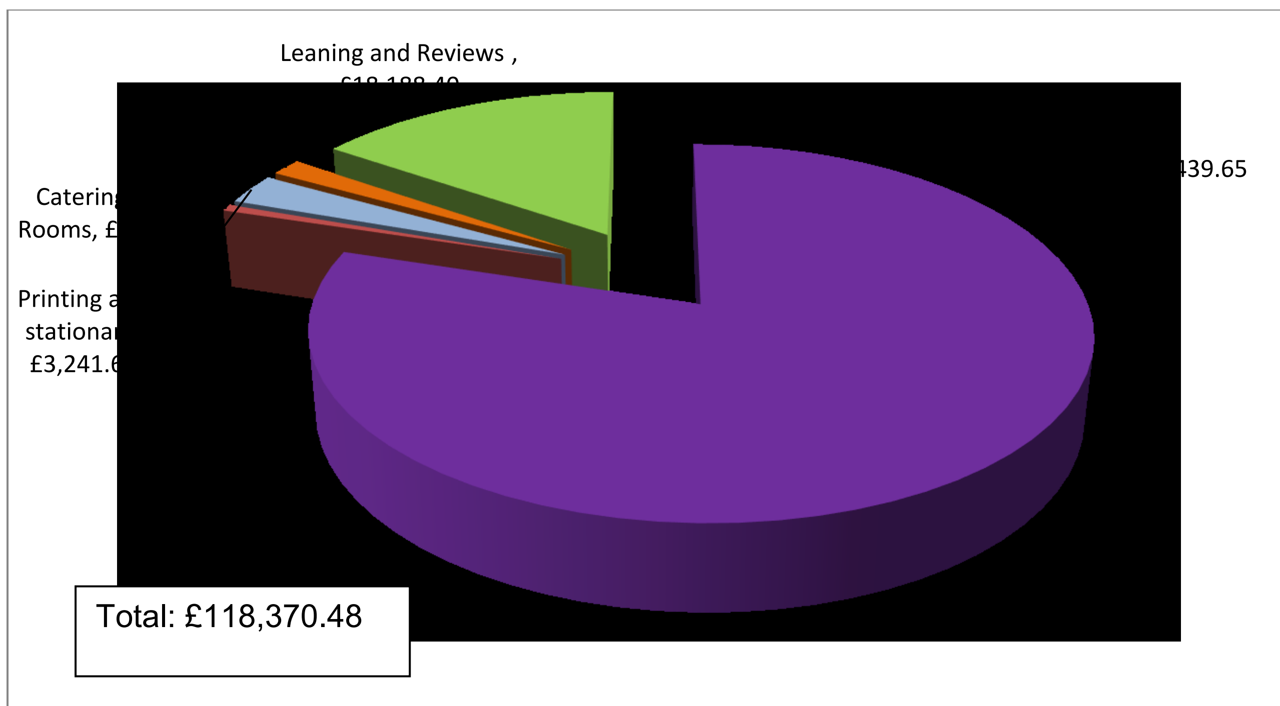
The Board is supported by a part-time Independent Chair, a full-time Board Manager and a full-time administrator. There was a change in administrator in this period resulting in nine weeks without cover or cost.

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

Income: This was year 1 of a 3 year budget agreement which was approved by the statutory partners in January 2017.

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

Spend:



Notes:

- Staffing costs include employment costs, mobile phone and travelling
- Printing and Stationary costs include promotional leaflet printing
- There were more costs associated with reviews that occurred in 2017-19 but invoices came in after the end of the financial year (£12,000, mid May 2017)

10. APPENDICES

APPENDIX 1: BOARD PARTNERS

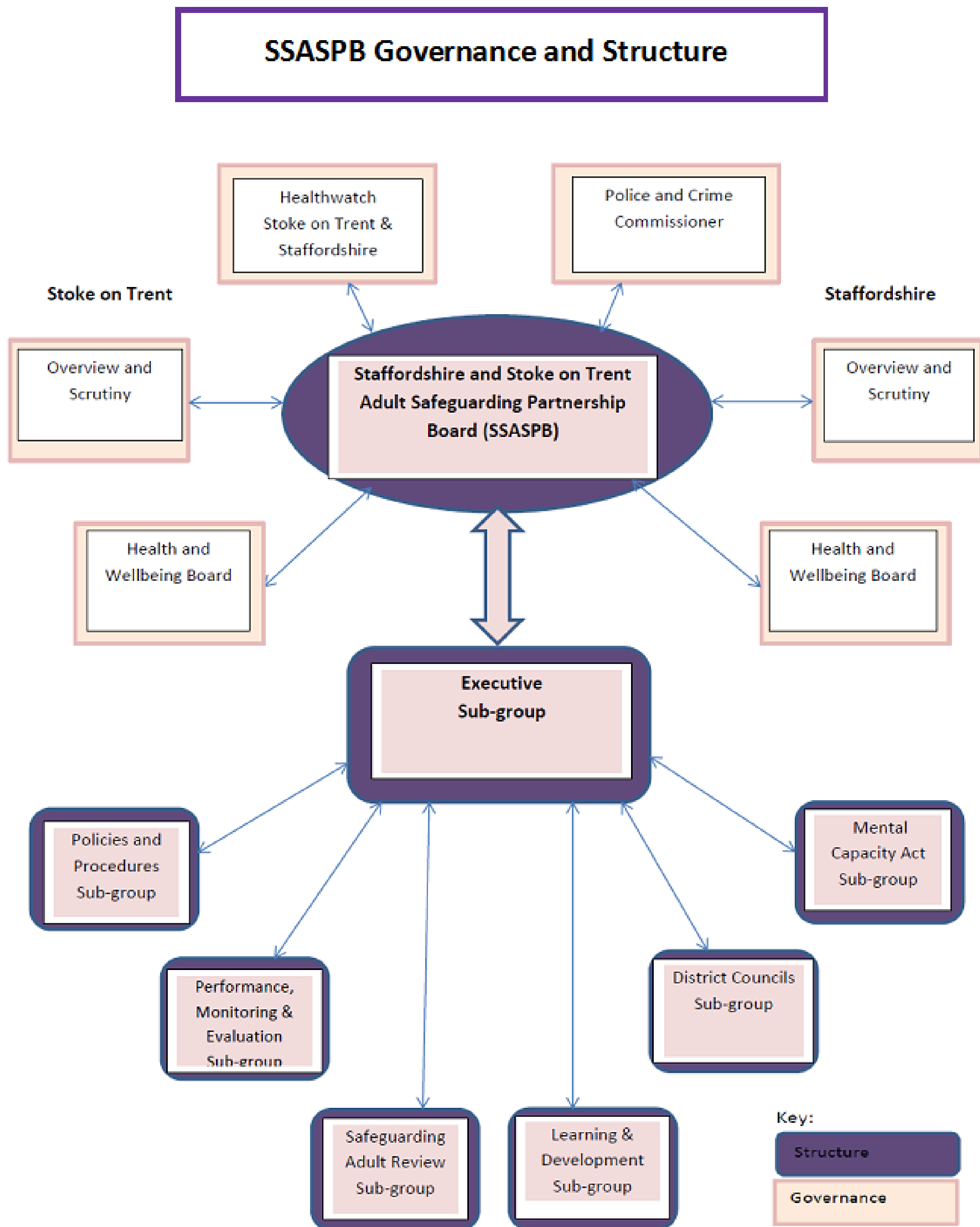
Statutory Partners as of 31st March 2018

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

Extended Partnership as of 31st March 2018

- Burton Hospital NHS Foundation Trust (BHFT)
- Community Rehabilitation Company (CRCs) (Staffordshire and Stoke-on-Trent)
- Domestic Abuse Forum
- Hate Crime Forum
- Healthwatch (Staffordshire and Stoke-on-Trent)
- Her Majesty's Prison Service (HMPS)
- Independent Futures (IF)
- Local Authority Lead members
- National Probation Service (NPS) (Staffordshire and Stoke-on-Trent)
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- Representatives from the voluntary sector
- South Staffordshire and Shropshire NHS Foundation Trust (SSSFT)
- Staffordshire and Stoke-on-Trent NHS Partnership Trust (SSOTP)
- Staffordshire Association of Registered Care Providers (SARCP)
- Staffordshire District Councils Safeguarding sub-group
- Staffordshire Fire and Rescue Service (SFARS)
- Trading Standards (Staffordshire and Stoke-on-Trent)
- University Hospitals of Derby and Burton (UHDB)
- University Hospitals of North Midlands (UHNM)
- Virgin Care
- West Midlands Ambulance Service (WMAS)

APPENDIX 2: GOVERNANCE 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.

11. REFERENCES

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

[ii] **SSASPB Board membership list:** https://www.ssaspb.org.uk/About-us/Board-Agency-Membership.aspx

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