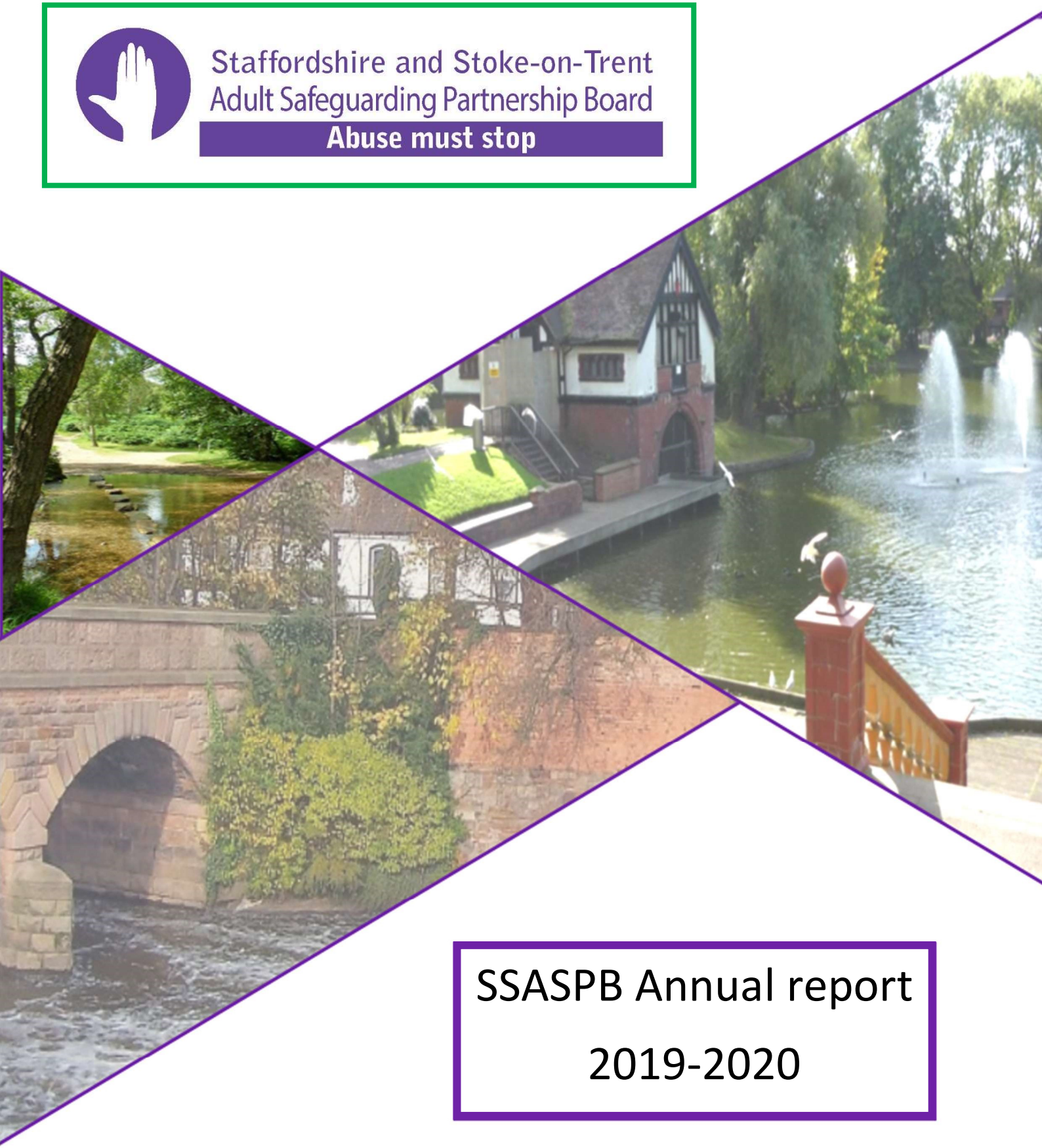
Staffordshire and Stoke-on-Trent
Adult Safeguarding Partnership Board

Abuse must stop



SSASPB Annual report 2019-2020

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

Front cover includes photographs of Staffordshire and Stoke-on-Trent, from largest to smallest: Hanley Park in Stoke-on-Trent, Bridge over the river Trent in Burton-on-Trent, Cannock Chase Stepping Stones.

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.

As the Independent Chair, my role is to lead collaboratively, give advice, support and encouragement but also to offer constructive challenge and hold main partner agencies to account. I also ensure that interfaces with other strategic functions are effective. As an Independent Chair, I can provide additional assurance that the Board has some independence from the local authorities and connected partners.

This report provides a look back at the work by the partners of the Board and its sub-groups over the year 2019/20. The range of work includes broad and targeted community engagement to raise awareness of the importance of safeguarding as well as requirements to record, report on and respond to individual safeguarding experiences and importantly to identify the learning and required action when things go wrong.

This work is illustrated with case studies (pages 16-21) 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 which is a fundamental right of every person.

The year ended with adult safeguarding in the spotlight as the United Kingdom went into lockdown in the final week of March 2020 due to the spread of the new coronavirus, COVID-19. Care homes and adults with care and support needs who were not visible, or unable to receive their usual support, were of huge concern.

The response to the safeguarding aspects including care of adults at risk, the implications for hidden adults arising from shielding, the response to homeless adults and rough sleepers with care and support needs, and trying to establish the risks and lived experience of those adults with care and support needs at increased risk of exploitation and domestic abuse reached national consciousness. The impacts of these lived experiences will be reported in 2020/21.

As the Board has matured, the openness and willingness to both challenge and be challenged to provide assurances as to the effectiveness or services or where improvements are required has continued to develop. That culture is vital if we are to remain effective in continuing to meet our statutory responsibilities and the Board collectively recognises that it is vitally important that our safeguarding services are as good as they can be to meet the needs of some very vulnerable adults needing support to help keep them safe from harm.

At the time of writing this foreword, the Board has adapted its approaches to seeking assurances and acted as an important conduit for communicating relevant targeted information recognising that Local Resilience Forums are co-ordinating and driving pandemic responses. The declared pandemic has underlined just how important adult safeguarding is - more than at any time since the Care Act was enacted.

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 add thanks to the inspectors

from the Care Quality Commission with whom safeguarding partners have developed constructive working relationships through established channels of communication and early intervention.

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 acknowledge the 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[2] 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 38.

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 29.

Safeguarding Adults – A Description of What It Is

The statutory guidance[3] 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

[1] Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/contents
[2] SSASPB Board membership list: https://www.ssaspb.org.uk/About-us/Board-Agency-Membership.aspx
[3] Care and support statutory guidance: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

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 40. The Board has taken account of the statutory guidance in determining the following vision.

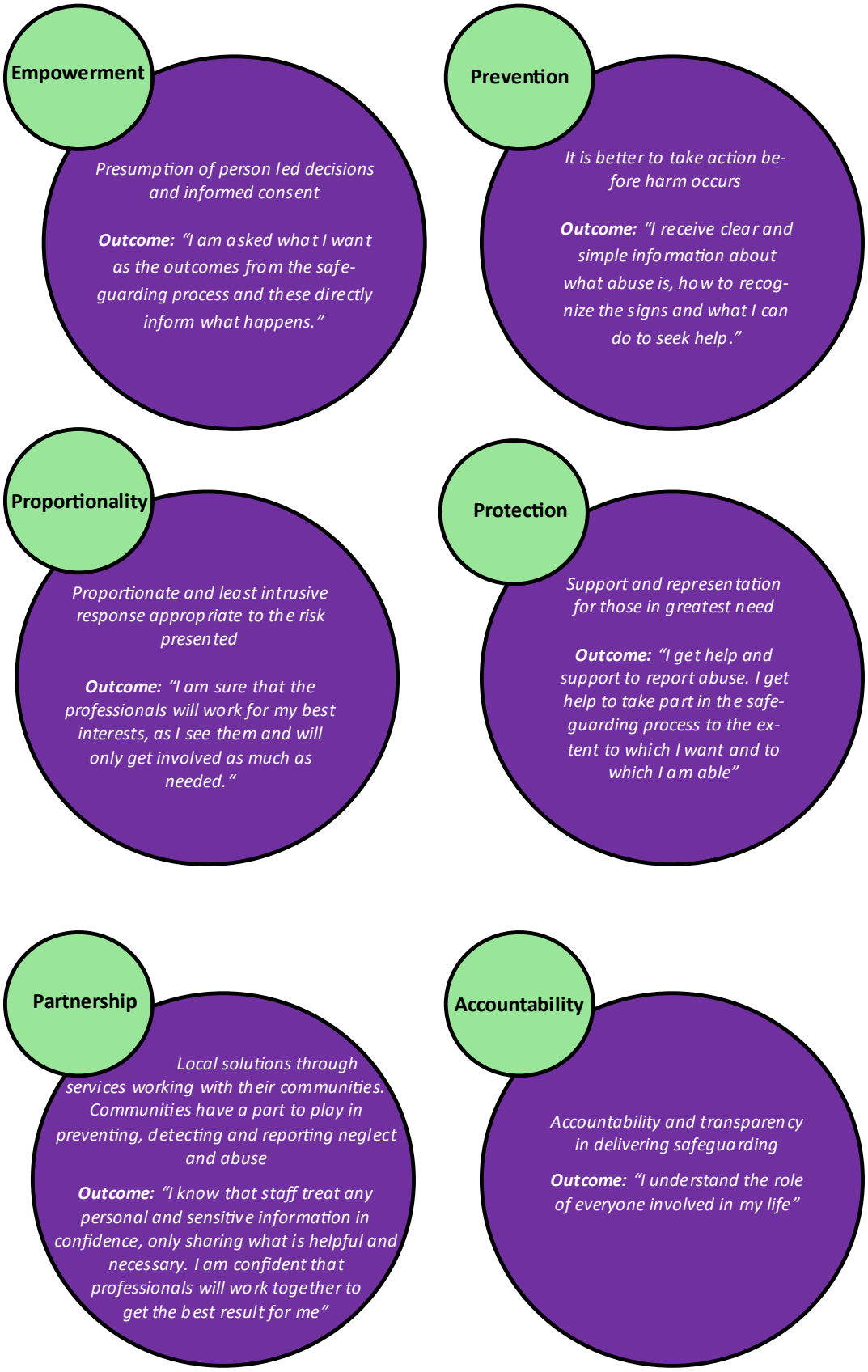
Vision for Safeguarding in Staffordshire and Stoke-on-Trent

'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.

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 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.



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 for Adult Safeguarding North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups

Vice Chair: Lisa Bates, Designated Nurse for Adult Safeguarding, South Staffordshire 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 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 2019/20 the sub-group has:

- Monitored the progress against the three Strategic Priorities (Leadership in the Independent Care Sector, Financial and Material Abuse and Engagement)
- Monitored the activity towards mitigation of risk using the SSASPB Risk Register
- Reviewed the membership of the Board and managed the Board membership process
- Reviewed the sub-group chairs in accordance with the SSASPB Constitution
- Managed and monitored the SSASPB budget
- Planned, organised and facilitated the Board Development Day held in June 2019 and the follow-on actions
- Reviewed the Strategic Plan
- Received 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
- Overseen the arrangements for the SSASPB Safeguarding Conference held on 4th November 2019. The conference speakers and content were designed to enhance the skills of practitioners
- Determined how the Board links with other strategic fora e.g. Prevent, Domestic Abuse
- Agreed partner funding contributions for the period April 2020 to March 2023
- Arising from review of SSASPB budget enabled surplus financial contributions received in 2019/20 to be returned to funding partners to be used to support operational Adult Safeguarding responsibilities
- Sought and received assurance that Private hospitals in Stoke-on-Trent and Staffordshire are engaged with their partner organisations and CQC

- Reviewed the activity and achievements of Dr Lorna McColl for the Designated Adult Safeguarding GP initiative.
- Sought assurance on the response from Staffordshire Police to the Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) publication 'The Poor Relation'
- Monitored the progress of all Safeguarding Adult Review referrals received in 2019/20

Safeguarding Adult Reviews sub-group

Chair: Simon Brownsword, Detective Superintendent 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 ensuring that the SAR protocol is revised at least annually and that any SAR referrals comply with the process. The sub-group also has responsibility for identifying and cascading the lessons learnt from any reviews.

During 2019/20 there were 5 referrals considered for a Safeguarding Adult Review.

'James'

In March 2019 a referral was received outlining the circumstances around the death of 'James' a 28 years old man from Stoke-on-Trent who had been rough sleeping in the City centre. James was involved with numerous agencies including Probation, Police, Children Services, HM Prison services, Voluntary Sector services, a Mental Health Trust, Housing, Community drug and alcohol services and an acute Hospital.

Relevant organisations were asked to complete a detailed chronology of their involvement with James in the 10 months prior to his death. The information was considered at a SAR scoping meeting held in June 2019. A total of twelve agencies submitted chronologies and information; an indication of James's complex circumstances.

After careful consideration of the information shared it was unanimously agreed that the criteria for a SAR was not met. However, the process highlighted the need for a better understanding of the gateway for confidential information sharing between two of the organisations. It also identified a learning point that there is a need for documentation to clearly support the rationale for decisions made.

'Andrew'

A referral was received on 9th September 2019 in relation to the death of a 37 years old man from the Stoke-on-Trent area. He had complex needs and sadly died at home alone lying undiscovered for several days. A scoping meeting was held on 17th December 2019 which resulted in a recommendation to the SSASPB Independent Chair that the Section 44(1) Care Act 2014 criteria had been met. The recommendation was approved. The findings of the review will be provided in the Annual Report 2020/2021.

'Paul'

On 24th September 2019 a referral was received outlining the death of Paul a 52 years old man from Staffordshire who had lived with an acquired brain injury for some years. He had also become dependent upon alcohol. There were concerns about the length of time taken between the request for a care package,

predominantly to address his alcohol consumption, and for it to be put in place. Sadly, Paul died before the package had been arranged. The matters at issue were between two organisations and a Serious Incident Clinical Review (SI) had been conducted. The action plan had been shared with the SAR sub-group. It was agreed that the criteria for a SAR would not be met and that the learning had been achieved through the SI process.

'Brenda'

On 26th September 2019 a referral was received outlining the circumstances of the death of Brenda an 87 years old woman from Staffordshire who died at her home address following a period of ill health. The Independent Chair agreed with the recommendation made by the scoping panel held on 2nd December 2019 that the criteria for a SAR under Section 44(1) Care Act had been met. A Safeguarding Adult Review has started but has been pended during the Coronavirus/COVID-19 pandemic. At the time of writing, it is planned that the review will recommence in June 2020. The findings will be reported in the next annual report.

'Joan'

A referral was sent to the SSASPB on 8th November 2019. At the time of writing the referral has not yet been scoped as there is an ongoing criminal investigation and dependent upon the outcome the question of a Domestic Homicide Review. Whilst these parallel investigations take place information sharing outside the Police led investigation will not take place. A decision by the Crown Prosecution Service is awaited and an update will be given in the Annual Report 2020/21.

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
- Maintained links and reporting relationships with Community Safety Partnerships that are managing Domestic Homicide Reviews (where they involve adults with care and support needs)
- Attended specific Safeguarding Adult Review training delivered by Social Care Institute of Excellence in September 2019
- Clarified the relationship between Section 76 Homelessness Act 2018 and SAR processes. The circumstances of each homeless person will be considered against the Care Act 2014 criteria
- Reviewed the process to select Independent SAR reviewers

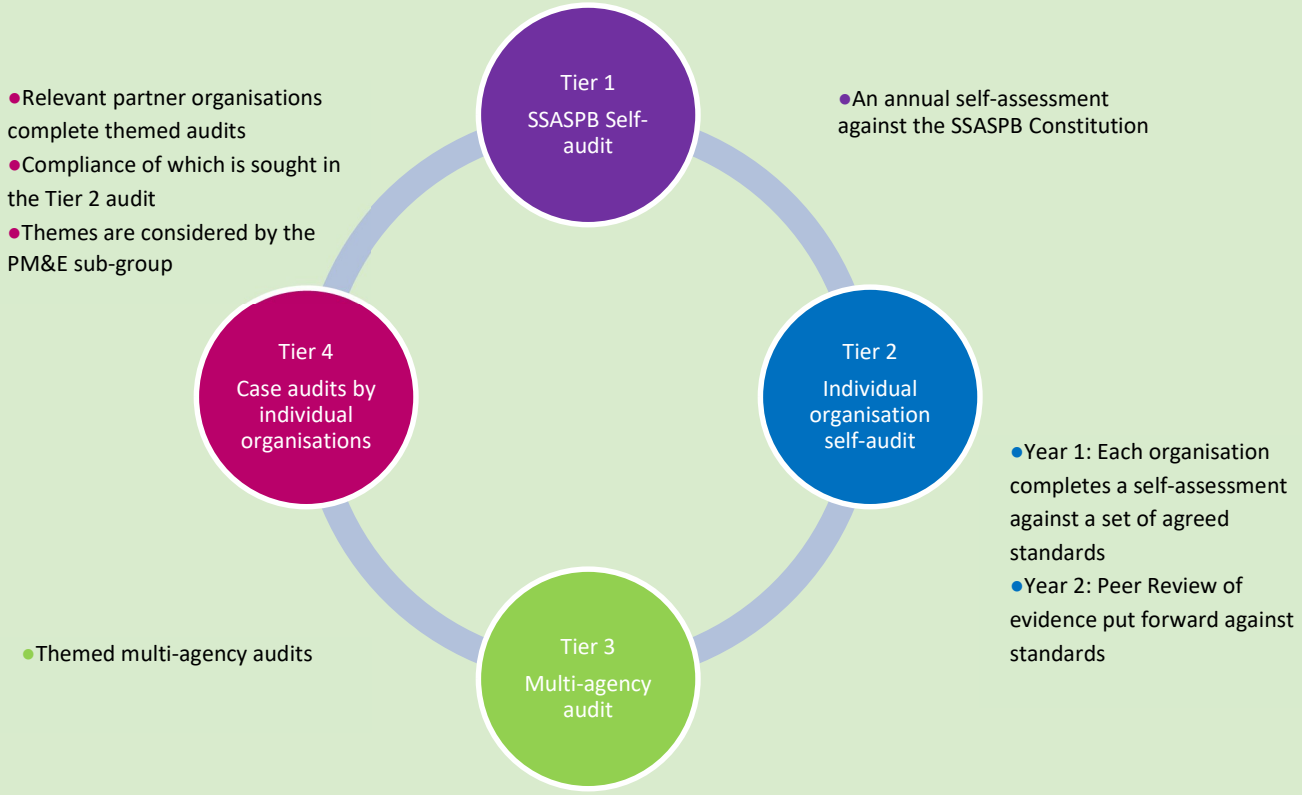
Audit and Assurance sub-group

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

Vice Chair: Claire Histead, Deputy Head of Safeguarding / PREVENT Lead, Midlands Partnership Foundation Trust to 28.08.19 followed by Amy Davidson Head of Safeguarding, North Staffordshire Combined Healthcare Trust to present.

The SSASPB 4-tiered audit framework:

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



- Revised the terms of reference to incorporate elements transferred from the Learning and Development sub-group.
- Refreshed the SSASPB Performance and Quality Assurance Framework.
- Provided the detailed narrative from relevant partners to explain the performance data contained in the Annual Report
- Conducted the Tier 1 audit (Compliance with the SSASPB Constitution)
- Reviewed the list of partners from whom the Board seeks assurance about the compliance rate and quality of training provided using the Tier 2 audit
- Conducted the Tier 2 audit (Individual Agency Assurance self-audit) and received an excellent response with 27 returns
- Preparations were made for the Tier 2 peer review to take place in March 2020. This has been postponed to November 2020 and will be conducted in a revised format due to the COVID-19 pandemic
- The standards chosen for closer scrutiny through the audit were Standard 1(11): 'The organisation can demonstrate that it has a quality auditing system that checks policy compliance and the learning informs practice, performance and policies', and the whole of section 4: 'Training and Workforce Development'. The full list of Tier 2 standards is shown in appendix 4. The findings will be reported in the 2020/21 Annual Report
- Agreed the themes for and held three Tier 3 Multi-agency Case File Audits. These were on the themes of: Repeat referrals for the same category of abuse within 12 months, Neglect and Acts of Omission and Financial Abuse
- Agreed to support the West Midlands Regional data set collection. This will be progressed during 2020

Prevention and Engagement

Chair: Jo Sutherland, Statutory Service Lead and Principal Social Worker Staffordshire County Council

Vice Chair: Sarah Totten, Strategic Manager – Early Intervention, Contact and Hospital Adult Social Care, Health Integration and Well Being, Stoke-on-Trent City Council

This sub-group was formed after a review of the structure of the SSASPB at its Development Day held in May 2018. One of its key functions is to drive the work in support of the Engagement Strategic Priority. It had been agreed that the sub-group initially concentrates on the Engagement element with a commitment to develop a Prevention focussed workstream in the autumn of 2020.

More information can be found on Page 14 in the Strategic Priority section.

Policies and Procedures sub-group - Virtual

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

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

In response to the recommendations from the Development Day held on 18th May 2018, the sub-group now works virtually. 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 have reviewed the below documents;

- Information sharing Guidance for practitioners document
- Considered the self-neglect guidance and what should be added to the SSASPB website
- The Escalation Policy
- Staffordshire Fire and Rescue Service's Safeguarding flowchart was considered for inclusion on the SSASPB website
- Safeguarding Enquiry Procedures initially reviewed virtually and met on the 19th January 2020 in person
- Considered and advised on the selection of photos for new SSASPB banners
- The Adult Sexual Exploitation content for the SSASPB website

6. BOARD DEVELOPMENT AND IMPROVEMENT ACTIVITY

The SSASPB Development Day was held on 7th June 2019 and attended by 24 Board members. The purpose of the day was for members to reflect on the responsibilities of the Board and what it is seeking to achieve with a constructive challenge as to its effectiveness.

The agenda included:

Update on actions from the previous Development Day in May 2018

- Review of Board member induction arrangements
- Shared understanding of the difference between safeguarding and quality of care concerns
- Member awareness of the role and relevance of the Board and associated accountabilities
- Review and refresh of the Strategic Plan
- Review of the membership and structure of the Board

Roles and responsibilities of Board members

- Examining what the Board is seeking to achieve; its aspirations and how it demonstrates effectiveness

Safeguarding in practice

- Considered the questions - are safeguarding partners sufficiently challenging of each other? Is the Board given early warning of systemic safeguarding concerns?

Outcome focus

- How does the Board demonstrate that it is collectively adding value and making a positive difference?

Strategic plan

- Conducted the annual review considering the question as to how it could be enhanced and the appropriateness of its priorities

Consideration of chairing arrangements post 31st March 2020

- Discussion of the arrangements after the tenure of the current Chair.

The matters arising and associated actions from the discussions have been examined by the Board Executive sub-group. The key outcomes include:

- Revised the strategic priorities by concluding as complete the priority relating to Leadership in the Independent Care Sector. Agreed a new priority Financial and Material Abuse. The next annual review will be conducted in 2021.
- Reviewed membership to ensure that the most appropriate organisations are engaged to support the Board's vision
- Confirmed that the Board constitution covering responsibilities remains fit for purpose
- Initiated and hosted a conference for front line practitioners and managers on the theme 'Let's Talk About Risk'
- Summarising specific actions in a tracker that is regularly reviewed and updated by the Executive sub-group.

7. PERFORMANCE AGAINST 2019/22 STRATEGIC PRIORITIES

In the reporting period (1st April 2019 to 31st March 2020) the two Strategic Priorities were:

- Engagement
- Financial and Material Abuse

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

Strategic Priority: Engagement

Lead: Helen Jones, Board Manager

The activity around this priority is managed and co-ordinated by the Prevention and Engagement sub-group. The sub-group is chaired by the Statutory Service Lead and Principal Social Worker for Staffordshire County Council with the Strategic Manager for Early Intervention, Contact and Hospital Adult Social Care for Stoke-on-Trent City Council as vice chair.

Engagement is a broad term and for the purposes of the work of the Board this means engagement 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:

Board partners have developed a range of methods to engage and communicate. In recognition of the advances in technology the SSASPB website is kept up to date and opportunities are taken to signpost visitors. The website serves as a useful repository for adult safeguarding information illustrated by the 58,774 visits between April 1st 2019 and March 31st 2020. The most visited sections are those relating to Safeguarding Adult Reviews and What is abuse? For those reading this report electronically the website can be accessed here.

The SSASPB has a focus on ensuring that the learning gained from a variety of reviews and audits is cascaded for practice to be improved. The following sections provide an illustration of some of that activity.

District and Borough Council adult safeguarding awareness programme.

During 2019/20 the SSASPB Business Manager and the Safeguarding Team Leader, SCC attended 4 events attended by District and Borough Council representatives who often come into contact with adults with care and support needs. The content was very much led by the audience and started with a brief introduction to the work of the Board and adult safeguarding awareness, followed by a question and answer session. The overall feedback from the evaluation sheets was 'very good' with a practical application to their day to day work.

Self-neglect learning events.

Following a review into safeguarding partner involvement with a male aged in his 50s where self-neglect was a contributory factor to his death the SSASPB organised learning events. The aim of the event was to improve the understanding of the lived experience of self-neglect. A total of 7 events were attended by 214 people, mostly professionals who work directly with adults with care and support needs.

One of the presenters, Lee, spoke candidly about his life experiences including periods of self-neglect and substance misuse. He is now a mentor with VOICES, Stoke-on-Trent after time as a volunteer sharing his experiences. He had a huge impact on those in attendance who were often visibly moved by his presentation. Many people acknowledged the benefits of speaking directly with someone who could give 'lived experience' of self-neglect and many recognised the value of his input through the evaluation of the event.

These events included presentations on themes of 'Adult Safeguarding and Self-neglect' presented by Ruth Martin Safeguarding Team Leader, SCC and Jackie Bloxham Adult Safeguarding Team Manager Stoke-on-Trent City Council and 'Self-neglect and Hoarding' presented by Mick Warrilow and Rio Case from Staffordshire Fire and Rescue Service.

The events received excellent feedback on the evaluation forms completed by practitioners. The successful format will be revised for future learning events having regard to the need to be COVID-19 compliant.

SSASPB Conference – Let's Talk About Risk

This event was held on 4th November 2019. It was attended by 167 people, most of whom were frontline practitioners including the voluntary sector, Council members and Strategic Managers. The purpose of the conference was to encourage front line practitioners to work with risk and remain within the various legal frameworks pertaining to adult safeguarding.

The conference programme started with a production from Afta Thought a professional training company who delivered a range of thought provoking practical illustrations of Making Safeguarding Personal and positive risk taking. This production set the scene for the presentations and discussions that followed on themes including:

- Legal literacy: working positively with risk
- Duties and responsibilities in safeguarding
- Positive risk management case studies on Financial Abuse; Hoarding and Self-neglect; Mental Health and Midwifery

The feedback from the evaluation forms was extremely positive with the vast majority of delegates indicating that the event was 'excellent' or 'very good' and would positively impact on their working practice.

Arising from the event a number of opportunities have been pursued to forge stronger links on adult safeguarding matters with a voluntary sector organisation which supports a wide network of carers of adults and with the School of Law at Keele University.

Other engagement:

In June 2019 the Board Manager visited a service-user group meeting hosted by the Midland Partnership Foundation Trust. The meeting was chaired by a service user and another who was present was very actively engaged in multi-agency work. The service-user group agreed to assist the Board with consultation on

publicity material aimed at service users and their carers' and families. The group was pleased to see that the Board had produced easy to read material (Section 42 enquiry questionnaire) and encouraged more use to be made of this method of communication.

On Monday 19th June 2019 the Board Manager met Healthwatch Board members Dave Rushton (Stoke-on-Trent) and Karen Jones (Staffordshire) to discuss how they could support the engagement Strategic Priority. Arising from the discussions the Board Manager produced two briefing notes: one to provide a 10-minute overview of the work of the Board and Adult Safeguarding and a second with additional information to include data and lessons learnt from reviews. The briefing notes have been posted on the SSASPB website and can be used by any partners to raise awareness of adult safeguarding and the work of the SSASPB.

Several Board partners participated in the inaugural National Adult Safeguarding week (18th to 25th November 2019) which was initiated through the Ann Craft Trust charity. The activities through the initiative were well received locally. This will become an annual programme that the SSASPB will support.

The SSASPB Practitioners forum commenced this year. It is a quarterly event where front-line staff are encouraged to discuss multi-agency working on specific themes. These fora have been introduced to identify any areas where there are challenges to safeguarding policy compliance within organisations so that there can be a better mutual understanding of partner roles, changes in procedures and enable practice improvement. Topics this year included, Safeguarding and Decision Making and use of the SSASPB Escalation Policy.

NHS England provided the Board with funding to bring GP practice managers together to raise awareness in a number of areas including Adult Safeguarding, Domestic Abuse and the requirements of the NHS Inter-Collegiate learning and development document. A total of 48 practice managers and other staff from GP surgeries came to the 3 events held in Stoke-on-Trent, Chasewater and Uttoxeter.

The following case studies exemplify Making Safeguarding Personal and cross-partner collaboration.

Case Study: Midlands Partnership Foundation Trust

'Michael' was subjected to Domestic Abuse for many years. Despite several agencies offering support, he had always declined as he felt that it wouldn't change things because it had gone on for so long. Over time Michael developed confidence in the network of support offered to him. He agreed that he may benefit from spending some time, for short periods at a day service, away from the home address. However, Michael's step-daughter (who lived with him and his wife) was against this saying that he couldn't afford the service.

When safeguarding enquiries were made it became evident that Michael was being financially abused. He was encouraged to attend the day service and was visited there by a safeguarding worker every week. Michael developed confidence in the discussions with the safeguarding worker and over a period of time expressed a wish to leave the house and the abusive situation to live on his own and take control of his life.

Other agencies became involved, including the Police, and with this multi-agency support he left his wife, stepdaughter and former home. It appears that Michael had been financially abused to the amount of tens of thousands of pounds over the years. He now lives happily on his own, with frequent visits to friends through the day service. He has become far more outgoing, enjoying his independence and lives his life without abuse.

Case study: University Hospitals of North Midlands

A 79 year old female, 'Margaret' attended a routine outpatient appointment at the University Hospitals of North Midlands accompanied by her son. She appeared very distressed and anxious at the appointment and staff had concerns for her welfare based upon the indicators seen. Time and space was created to allow for a discussion with her in private and she was asked if she had any concerns.

Margaret disclosed that she was living with a violent and aggressive son who often "flies off the handle", often without reason. She said that her son had a formal diagnosis of a mental health disorder with addiction problems and that he also had suicidal thoughts, as did she on occasions. She explained that on the day prior to her hospital appointment, when in the car with her son, he was aggressive and shouted at her. The behaviour was noted by a police officer who happened to be adjacent in a traffic queue and was prompted to ask if everything was okay.

Margaret explained to the clinic staff that she was too frightened to accept support. Recognising the sensitivities staff sought advice from the UHNM safeguarding team as to what could be done to help. Margaret gained the trust of the staff and consented to the making of a safeguarding referral. She was also willing to accept support from domestic abuse services New Era. Staff also engaged with the Mental Health Liaison Team to determine if the patient's son was known to their service and if he required on-going support. The information was also relayed to the patient's GP.

This case illustrates the diligence of the staff to recognise the signs of abuse and creating a safe environment for the disclosures to be made with the patient's consent which were immediately followed by prompt actions to assess and mitigate risks. This is an excellent example of effective multidisciplinary team working and proportionate information sharing between UHNM, community teams and services and the patient's GP.

Case Study: North Staffordshire Combined Healthcare Trust

Paula is a 46-year-old woman with a long history of contact with mental health services. She lives with psychosis, low mood and anxiety. She has been the victim of domestic abuse in many relationships throughout her adult life.

During 2019 she restarted a relationship with a man who had previously frightened and controlled her. Paula has a care co-ordinator (Sam) who she had worked with to create a safety plan that she could follow without her partner's knowledge.

When Paula began missing appointments, her family raised concerns that her partner had moved into her flat and that he was preventing them from visiting. The care co-ordinator Sam visited Paula at her home address to conduct a safe and well check but experienced challenge from her partner. Paula's partner said that she was very unwell with migraine and had been in bed for the past few days. Paula suffers frequently with migraine and was awaiting an appointment with Neurology.

Sam was able to persuade the partner to let him see Paula so help could be arranged. Paula was lying in bed with the duvet pulled up underneath her chin. With the partner's agreement Sam arranged an appointment with Paula's GP at the surgery. Sam shared their concerns around domestic abuse with Paula's GP and booked a double appointment so that Paula could have the opportunity to talk about her needs. Sam completed a referral to the Multi-agency Risk Assessment Conference (MARAC) and made an adult safeguarding referral.

Paula attended the surgery and her partner was asked to wait in reception which he reluctantly accepted. During the appointment Paula disclosed that her partner was very controlling and was not allowing her to have access to anything in her flat or have contact with her family. She was spending most of her time in bed at his request and she couldn't look at her mobile phone without him being abusive, so she had stopped using it. She had no way of keeping herself safe.

All of Paula's appointments take place at the surgery which was seen as a safe place. Paula was terrified of becoming pregnant therefore GP prescribed the contraceptive injection as a one off. This method is not usually used with women of Paula's age, but assessed as safe and the most discreet way of her receiving contraception. Paula now has an Independent Domestic Violence Advocate (IDVA) who attends her appointments. A safety plan has been devised so that Paula may discreetly report that she is at risk, this is then reported to the Police who will immediately respond as information has been shared with them that they can quickly retrieve.

Case Study: Staffordshire Police

After the death of his wife George moved from the family home into a local authority bungalow. He became friends with the woman who lived next door who had an adult granddaughter. The neighbour's granddaughter was a drug user and known to the Police. She became a frequent visitor to George's address, inviting along her friends and associates.

George was very vulnerable during this period and calls began coming through to the Police from his home. Early Intervention Officers became involved and over time George built up trust with them. George disclosed that drug dealers had moved into his bungalow – a situation known as 'cuckooing'.

Through this period George became drug dependent with a £70 a day crack cocaine addiction. He spent more than £70,000 of his life savings supporting not only his drug habit but also that of his neighbour's granddaughter. He became estranged from his family and lost all his friends.

George has been able to withdraw from drugs, initially with the support of the Community Drugs and Alcohol team. The Police Early Intervention Officer facilitated his getting back in touch with his family resulting in sustained and regular contact with his sons. The officer also supported a move from the bungalow into a retirement village. George was very excited with the move, made new friends and is feeling much safer there. He remains drug free and is enjoying renewed contact with his family.

Case Study: CCG

Following several safeguarding allegations relating to a local nursing and care home there was joint response from the Adult Safeguarding and Nursing Home Support Nurse from the Clinical Commissioning Group (CCG) and staff from the Local Authority Adult Social Care and Commissioning team to consider how the home could be supported to improve their provision of nursing and care.

The home was going through a period of management change and it was recognised that there were several staffing issues which were adversely impacting on the care received by residents.

Due to the concerns raised, the nursing home was also placed under an enhanced quality monitoring programme with the local authority. Joint quality visits (CCG/LA) were undertaken and contributions were made to the action plan by the nurse. This included signposting and support regarding best practice. The

home was able to use this information to improve their care delivery, reduce risks and improve their resident's quality of life.

As the enhanced quality monitoring programme continued, the partnership working between health, the local authority and the home helped to bring about improvements. When the regulator, the CQC inspected the home the rating had improved. The home acknowledged that the input from the two organisations had been invaluable in supporting them and enabling them to develop their care for the benefit of residents and achieve their improved CQC rating.

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

'Bahati' was an elderly lady who lived with her family. She was of Pakistani origin and had recently returned to the UK after a lengthy period away. Bahati had physical health concerns and lived with anxiety and depression. She had been under the care of mental health services previously. An interpreter was required to support with the language barrier.

Bahati attended the Emergency Department of the University Hospitals of Derby and Burton (Queens) due to complexities with underlying health conditions. During the attendance she disclosed that she had been a victim of domestic abuse from two members of her family. She shared that this had been verbal abuse, and sometimes she was physically hurt. The family members had made threats to harm her with a knife and threats to kill her. They constantly informed her that they wished for her to die. Bahati was scared to go home and the fear was exacerbating her physical health. She disclosed that the two family members drank alcohol heavily and that this often made the abuse worse.

The Emergency Department Staff identified that Bahati was at significant risk of harm. She was isolated and had no support outside of the family network. Her physical needs also meant that she was unable to protect herself from this abuse. The Emergency Department Staff Nurse completed an Adult Social Care Referral with Bahati's consent. She shared that she wanted the abuse to stop and did not feel safe to return home. A discussion was held around informing the Police and although nervous of the outcome, Bahati provided her consent for this information to be shared. There were no concerns relating to her mental capacity to make these decisions. The Staff Nurse who was caring for her also identified that the CADDA (co-ordinated action against domestic abuse) DASH domestic abuse, stalking and 'honour'-based violence) / safelives checklist was required and completed this. Bahati scored 7/24. The Staff Nurse then contacted the Trust Safeguarding Team as was unsure if this would meet the score for inclusion at MARAC (Multi-Agency Risk Assessment Conference). After a case discussion, it was referred into MARAC on professional judgment due to the risk of honour-based violence and the many threats to kill.

As part of the safety plan Bahati was admitted to hospital to ensure her safety whilst the Police and Adult Social Care investigated the concerns. The Police interviewed Bahati on the ward and a plan made for her to be supported by the hospital to attend the Police Station upon her discharge.

During the admission the family had contacted the hospital on a number of occasions – They informed the ward staff that Bahati was making the allegations up and that her mental health meant she was "crazy". At this stage it was unclear if these calls were an attempt at further coercion and control from the abusers. Concerns were further raised when an anonymous call was received informing staff that everything that Bahati had shared was true and she was being abused by members of her family. On discharge Bahati was

supported to attend the Police station to provide a statement and also meet with the Social Worker. As a result her safety needs were met and she was supported to find alternative accommodation.

Strategic Priority: Financial and Material Abuse

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 only 10-20% of incidents are reported. During 2019/2020 the proportion of Section 42 enquiries where Financial and Material Abuse was identified was 18% in Staffordshire and 15% in Stoke-on-Trent. The average for England in 2018/19 was 14%.

The activity around this priority is managed and co-ordinated by a sub-group chaired by the Safeguarding Team Leader Staffordshire County Council that reports to the Executive sub-group.

There is a key focus on raising awareness. Trading Standards have provided training to staff working at the Multi-Agency Safeguarding Hub. Training has also been provided to Staffordshire Trading Standards regarding Safeguarding duties of local authorities.

Throughout the year data has been collected and is being considered on an ongoing basis between agencies regarding their current work around financial and material abuse to help build a picture of what is happening locally.

Staffordshire County Council has worked with Staffordshire Police and Action Fraud to compare data and ensure that if an allegation is made by or on behalf of an adult with care and support needs to Action Fraud this is shared with the respective Local Authority.

Stoke-on-Trent City Council have examined their financial abuse referrals to identify the type of abuse and which pathways the referrals go through.

Arising from the learning from this activity financial abuse guidance has been amended and approved and distributed to partners. It has been posted on the SSASPB website for reference.

The data gathering exercise has raised a number of questions about the types of financial and material abuse. Staffordshire University has agreed to allow research projects to be initiated that will help to address questions related to vulnerability of victims to particular types of financial and material abuse including so called 'rogue trading' and 'doorstep crime'. The results of the research and action taken in response to conclusions and recommendations will be reported in the Annual Report for 2020/21.

The following case study provides an illustration of the positive action that is taken when financial and material abuse is reported.

Case Study: Stoke-on-Trent City Council

Within a period of 2 months two separate and anonymous adult safeguarding referrals were made reporting concerns about a woman called 'Andrea' who was suspected to be a victim of financial exploitation by a neighbour. The person believed to be financially abusing Andrea was known within the local community to be a drug user.

On each occasion Andrea had been spoken to by the same team member from 'First Contact' at Stoke-on-Trent City Council. Andrea said that she had no concerns but was grateful that her neighbours were looking out for her.

In August 2019 a senior safeguarding social worker made the link between Andrea's circumstances and those of others nearby. A joint approach between Staffordshire Police and Adult Social Care was agreed. On this visit Andrea once again reiterated that she had no concerns and that she helped the neighbour by giving her money for gas and food. Andrea was asked if her bank card and details were safe and she informed that they were. Andrea stated that the neighbour might become upset should the Police talk to her about the issues and she asked that the Police didn't visit the person thought to be exploiting her.

Andrea agreed to a referral to a support worker to help to manage the risk and the worker visited the following day to build rapport and to commence communications with Andrea's bank.

The following week the support worker invited Andrea to the neighbourhood Community Centre. Arising from her reflections Andrea began to recognise the risk posed to her from her neighbour. Andrea owns her own property and asked if she could be supported to move to another property, as she did not feel able to ask the neighbour to stop visiting her. She also disclosed that she was fearful that she may have her windows or her home damaged as a result of disclosing anything to the Police and was worried about how the situation will impact on her health. At that stage she still did not want to make a formal complaint.

The following week the support worker took Andrea to the bank for a meeting and it was established that approximately £10,000 had been taken from the bank account. Andrea made a full disclosure to the support worker and requested Police involvement. Andrea is happy with the outcome.

The following were examples of good social work practice using:

- Asset based Social Work Practice – making the most of local community support networks which were community support groups.
- Positive local links and relationships with the Police
- Making Safeguarding Personal, which enabled Andrea to be in control of the process and all decisions.
- Risk reduction was a key element of this work including supporting Andrea to visit the bank, purchase of a safe for her home to keep cards and money safe, emotional support from the stress of the situation, benefits check to increase current income, discussion with lifeline services to provide a 'safe word' should Andrea consider herself to be at risk from the neighbour so that they can contact the Police urgently.

Staffordshire and Stoke-on-Trent 2019/20 performance report overview

Number of safeguarding concerns received by the Local Authorities in 2019/20

Staffordshire	Stoke-on-Trent
4150	3945

Staffordshire: 59%

Stoke-on-Trent: 47%

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

Most prevalent 4 types of abuse 2019/20

Staffordshire		Stoke-on-Trent	
Emotional	12%	17%	Emotional
Financial Abuse	18%	21%	Financial Abuse
Physical abuse	22%	25%	Physical abuse
Neglect and acts of omission	35%	50%	Neglect and acts of omission

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

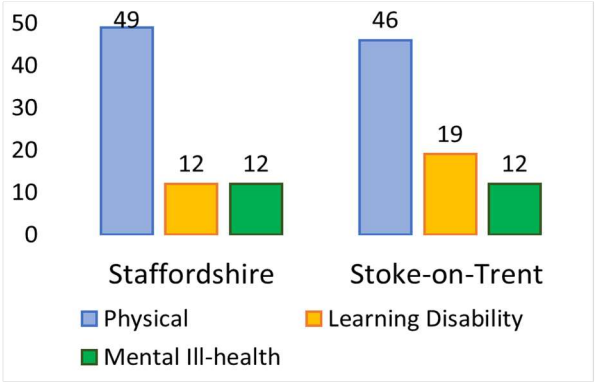
Staffordshire

2017/18	2018/19	2019/20
97	97	98

Stoke-on-Trent

2017/18	2018/19	2019/20
82	89	96

Primary Support reason in percent for 2019/20



Number of SARs in 2019/20

SAR referrals	SARs
5	2

8. ANALYSIS OF ADULT SAFEGUARDING PERFORMANCE DATA

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

At the beginning of 2019-20 Stoke-on-Trent Adult Social Care switched from using Care First to Liquid Logic. This has resulted in some process changes, data recording changes, and some manual transferring of data from one system to the new one. It has created some year on year changes in the data sets and this has been recorded and documented in the statutory returns 2019-20.

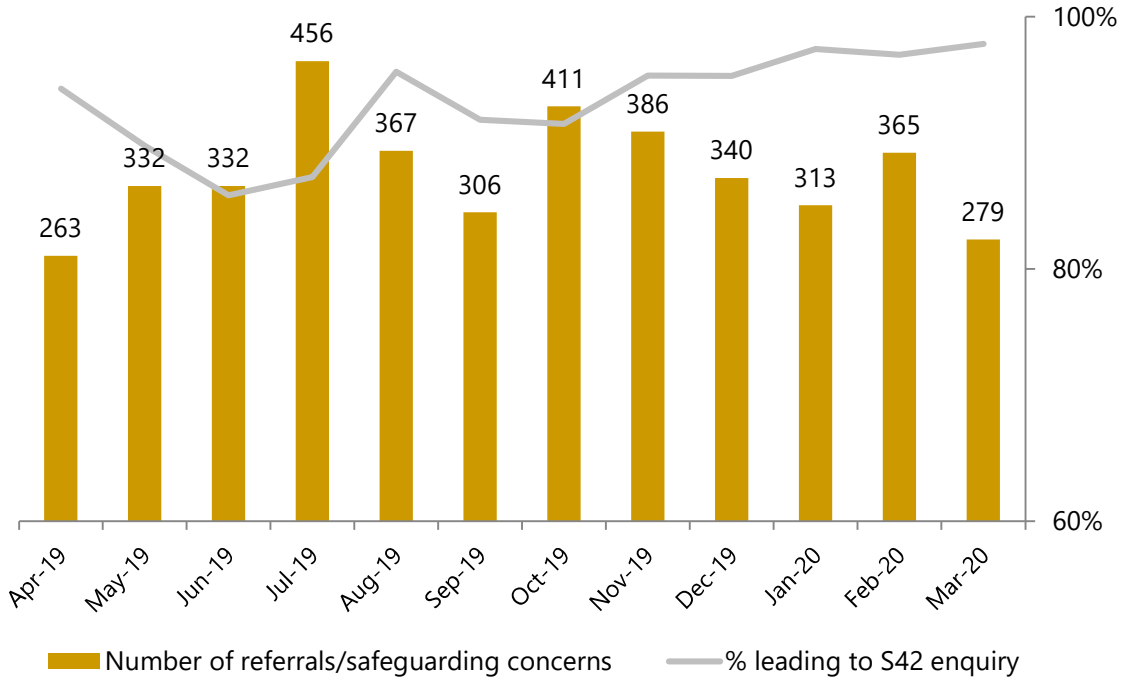
Number and proportion of referrals/safeguarding concerns

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. This accounts for similarities in the numbers between both LAs which could reasonably be assumed to vary more due to the difference overall population sizes.

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

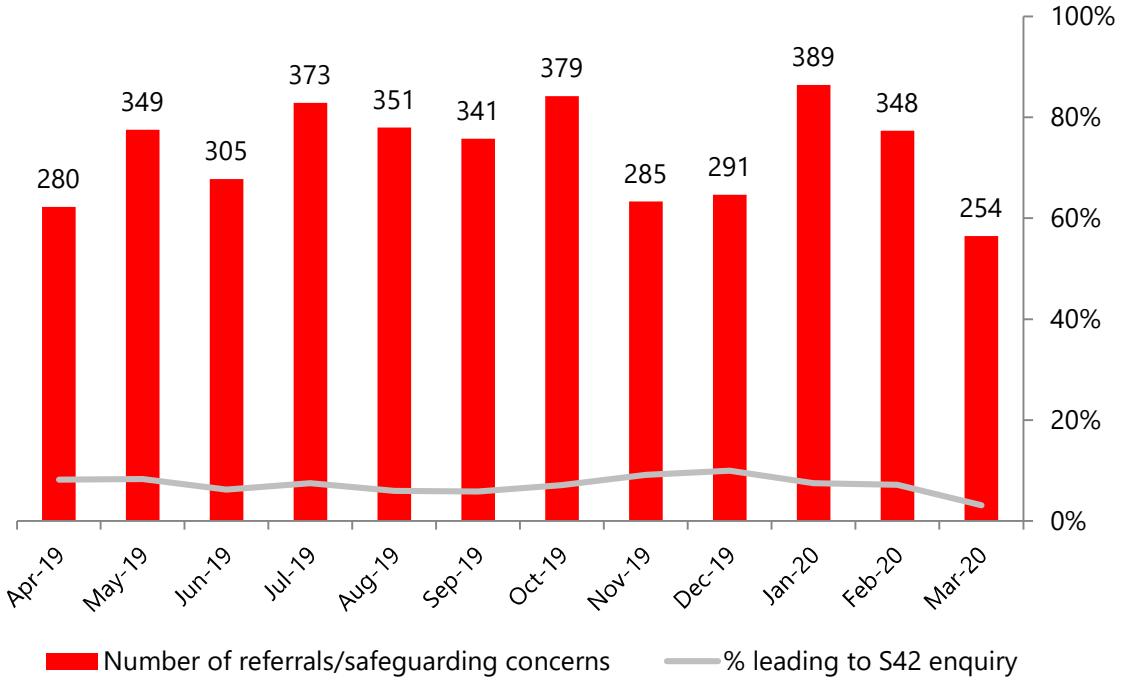


During the course of the year, in Staffordshire, there have been 4150 occasions when concerns have been reported that adults with care and support needs may be at risk of or are experiencing abuse or neglect. The total figure has increased by 439 (11%) occasions from 3711 in 2018/19. There has been a dip in referrals in

March 2020, this reflects a natural trend where the number of referrals increased from March to December but then falls from December to March.

The expected trend from 2018/19 was that there would be an increase in referrals that meet the threshold for a Section 42 enquiry with the intention that all referrals meet this threshold which would indicate better initial assessment. While there have been some dips overall, there is a trend towards the 100% goal. The average is 93% with the highest figure at 98% in March 2020.

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



In Stoke-on-Trent there were 3945 reported safeguarding concerns in relation to adults with care and support needs during 2019/20. This is an increase of 911 from 3034 compared to 2018/19 which is an increase of 30%. The conversion rate has been reduced from 9% to 7% due to a much higher volume of concerns raised, the actual number of concerns that are converted into Section 42 enquiries remains at a similar rate. 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% of those occasions which has decreased from 9% in 2018/19.

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 an 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 Sec42)
- Staffordshire record this decision as – Section 42 enquiry completed (either no ongoing risk, closed at adult's request, concerns substantiated or unsubstantiated)

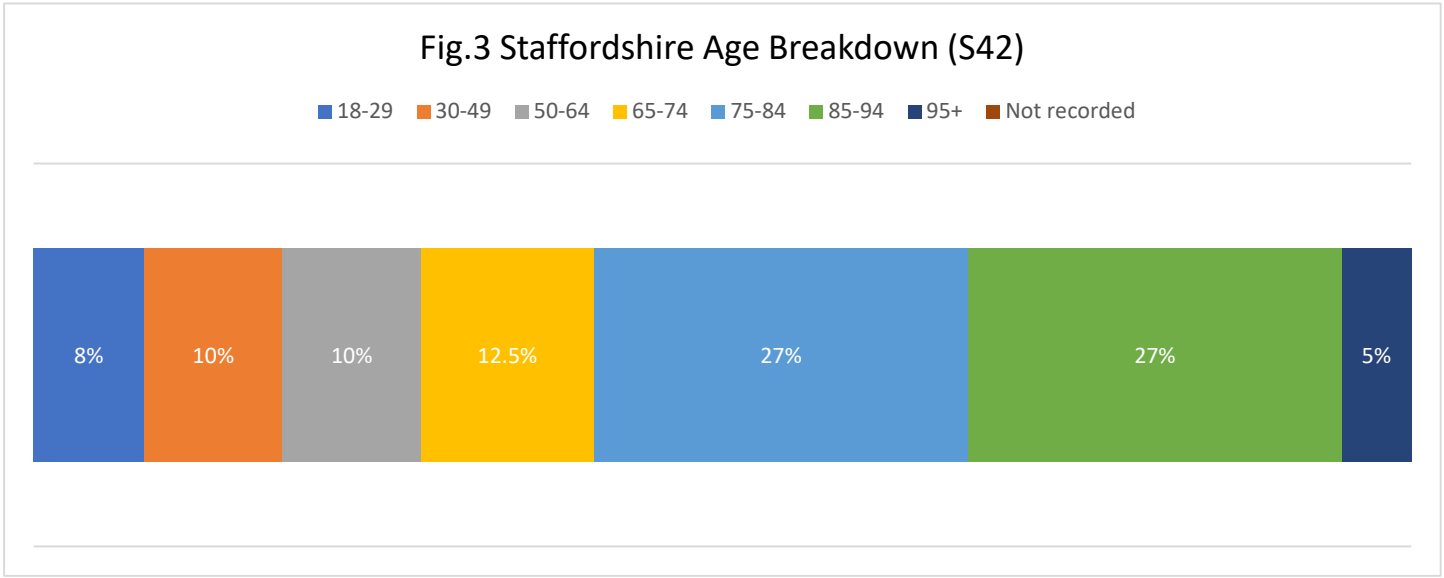
In essence Staffordshire and Stoke-on-Trent Local Authorities follow the same procedures but the recording on systems is an internal decision for each authority. This review has illustrated that both authorities are taking the same steps to ensure adults are safe and risks minimised.

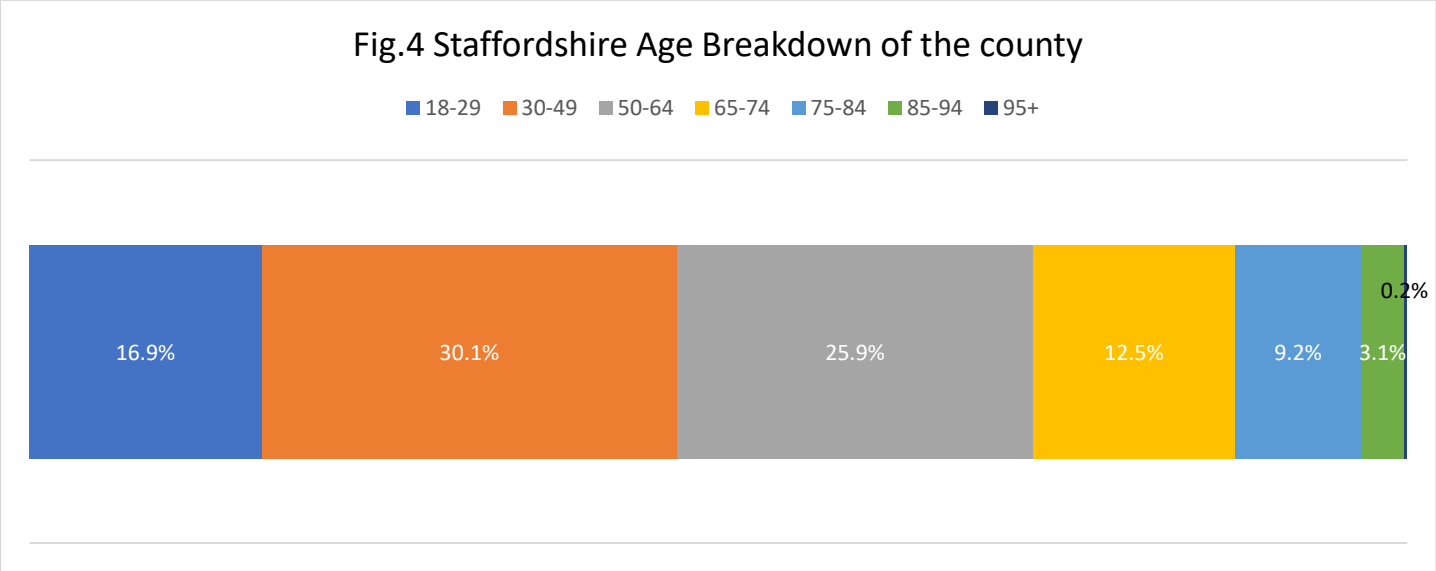
This difference in recording is replicated throughout the country with a wide variation in conversion rates for Section 42 enquiries between 12% and 69%. Both authorities have been involved in the work of the Local Government Association in an attempt to reduce this variance. The Local Government Association has announced that it will produce further guidance to make the process for recording a Section 42 clearer.

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.



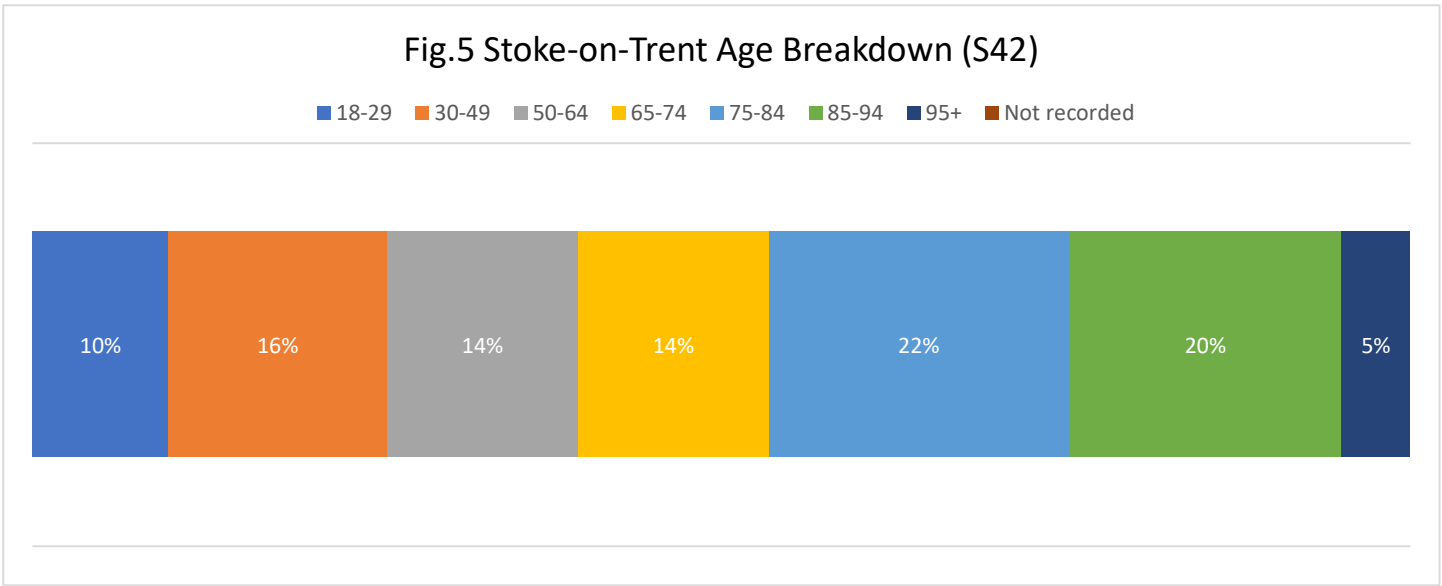


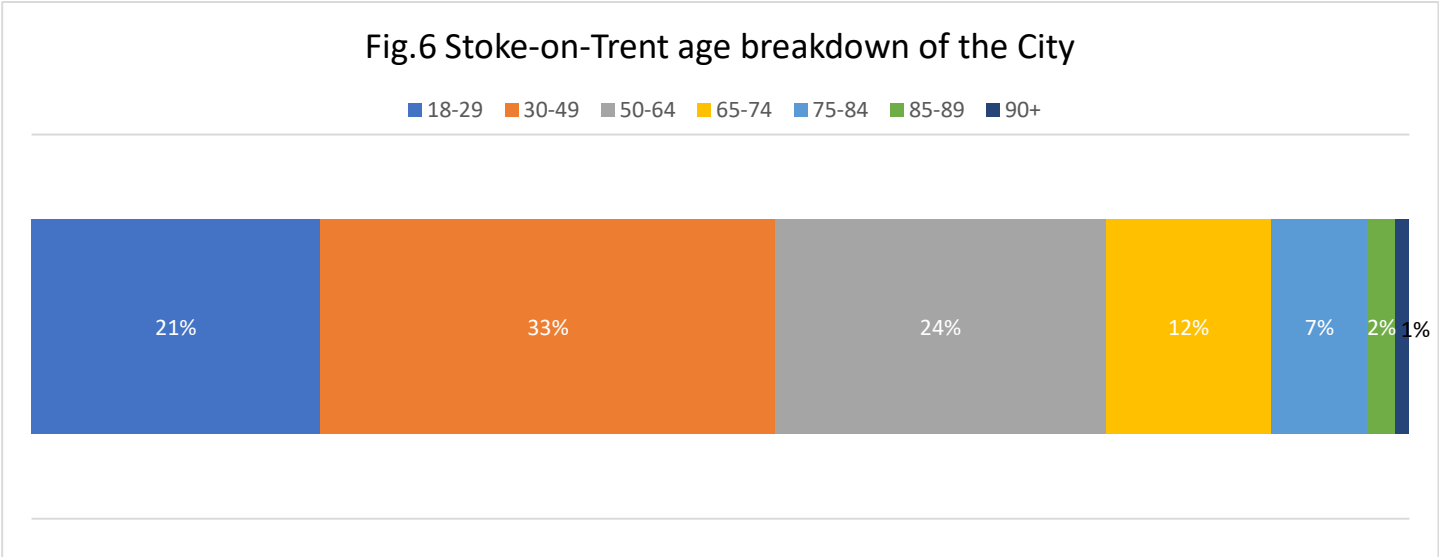
Staffordshire

Of the adults who have been subject of a Section 42 enquiry, those aged 75-84 and 85-94 (both 27%) represent the largest cohort, followed by 65-74 (12.5%), there has been very little change in the population this year compared to last year. Only in 0.5% of cases has no data been recorded. The number of safeguarding referrals counted by Staffordshire County Council reflect the number of safeguarding screens that are opened by staff and does not reflect the number of calls that come into the centre but are dealt with in other ways.

When comparing the age breakdown with general Staffordshire population statistics, it is evident that people in the 65+ age groupings are disproportionally overrepresented for Section 42 enquiries.

Please note that due to the age bands given by the Office of National Statistics the last two bands do not match the Section 42 breakdown above.



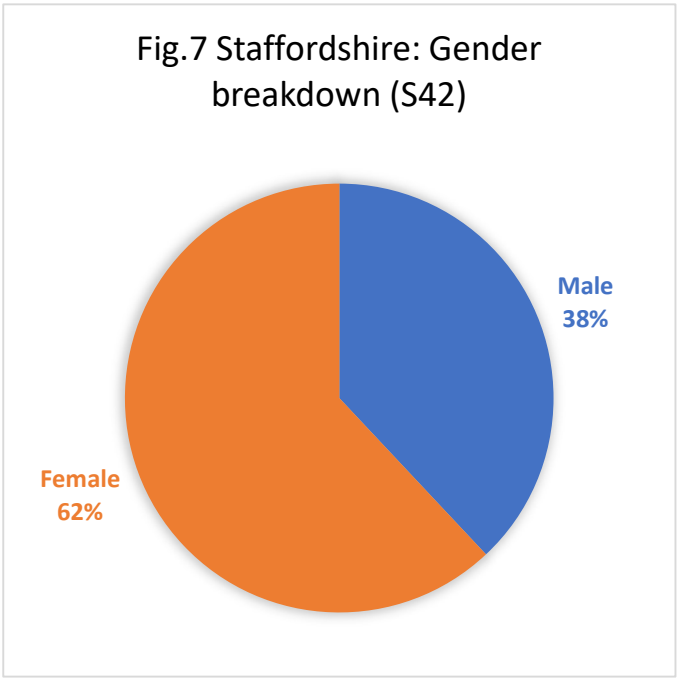


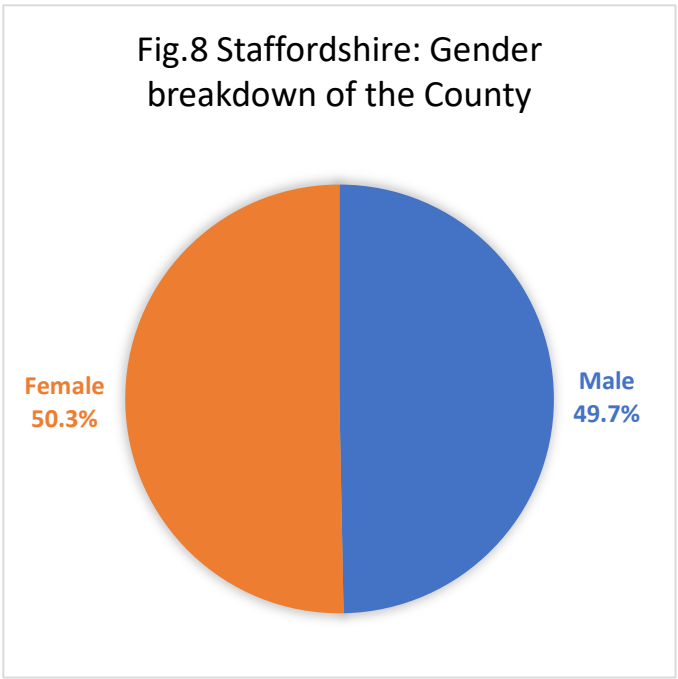
Stoke-on-Trent

For Stoke-on-Trent, the largest cohort represented is those aged 75-84 (22%), followed by 85-94 (20%), and then 30-49 (16%). There has been a slight increase in adults over 75 that have been subject of a Section 42 enquiry by 3%, which is in line with the 6% growth for the age cohort across Stoke-on-Trent. There can be a large variation in age breakdown in different quarters of the year, this is due to the comparatively small number of enquiries made which can move the age brackets a more significant amount than Staffordshire but there is not a very large variation generally year on year.

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.

Gender





Staffordshire

Females represent the majority of adults' subject of a Section 42 enquiry, with 62% over the year and males representing 38%; similar to last year. Females are overrepresented (by 11%) when compared to the overall Staffordshire gender breakdown.

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

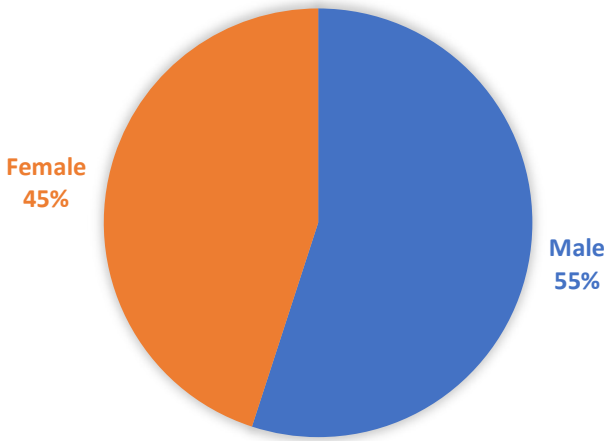


Fig.10 Stoke-on-Trent: Gender breakdown of the City

Stoke-on-Trent

Stoke-on-Trent has a lower proportion of females in their cohort compared to Staffordshire, and the proportion females have decreased compared to 59% last year with a corresponding increase for men. This is not an unusual statistical movement. Younger males are closely associated with the homeless population of Stoke-on-Trent. Tracking in 2020 had 74% of the cohort for known rough sleepers as being male, with the majority being under 40 years of age. This is key context for the higher proportions of males in the safeguarding system.

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	81.6	86.4		88.6	93.6
Not Known	5.9	-		7.6	-
Pakistani	2.7	4.2		0.36	0.8
Indian	2.2	0.9		0.39	0.8
Black Caribbean	2.2	0.3		0.39	0.3
Other White British	1.6	1.9		1.32	1.6
White Irish	1.1	0.3		0.65	0.5
Not Stated	0.5	-		-	-
Bangladeshi	0.5	0.4		0.03	0.1
Black African	0.5	1.0		0.03	0.2
Any other Asian Background	0.5	1.4		0.18	0.4
Gypsy /Roma	0.5	0.1		0.03	0.1
Mixed White/Caribbean	-	0.3		0.03	0.5
Any other Black Background	-	0.1		0.13	0.1
Arabic	-	0.2		0.05	0.1
Any other ethnic group	-	0.5		0.03	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' (88.6%, a slight decrease from last year), followed by 'Other White British at (1.32%).

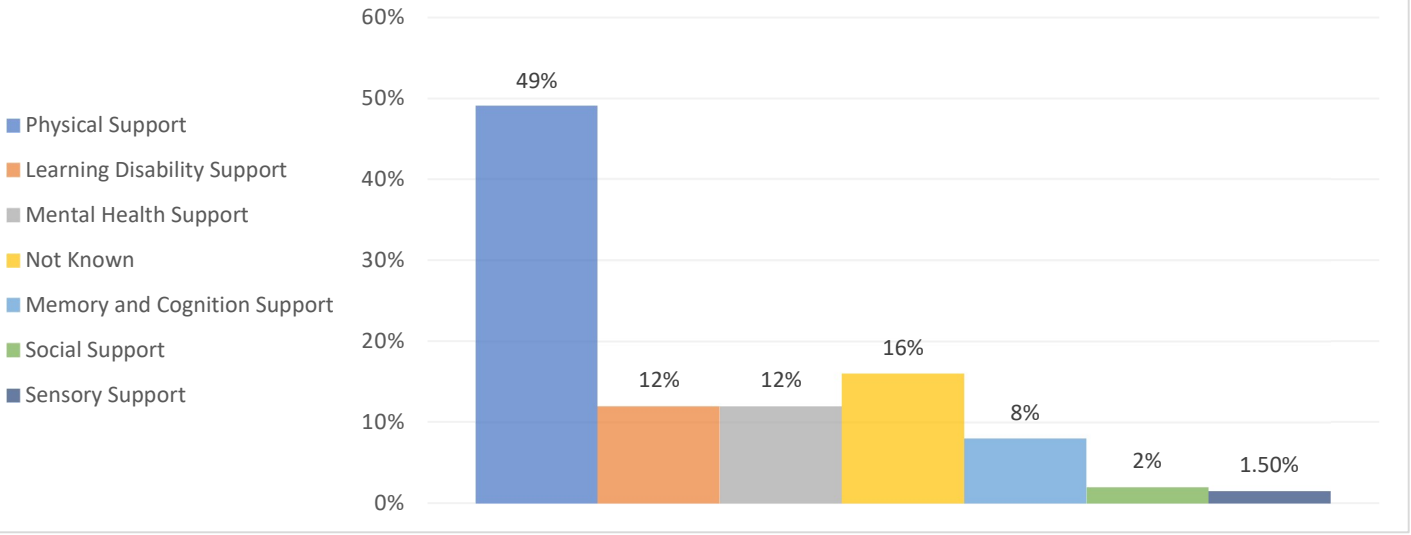
Stoke-on-Trent

The pattern is similar in Stoke-on-Trent, the majority of declared ethnicities are 'White' (81.6%, a slight decrease since last year), followed by Pakistani (2.7%)

Anecdotally, it is known that people from ethnic minority populations are disproportionally under-represented for Section 42 enquiries; however, for both local authorities (Staffordshire 7.6% and Stoke-on-Trent 5.9%), there are records where the adult do not have their ethnic background captured which limits the usefulness of any comparison to the wider population. There has been a decrease in the 'Not Known' category of ethnicity from 2018/19.

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

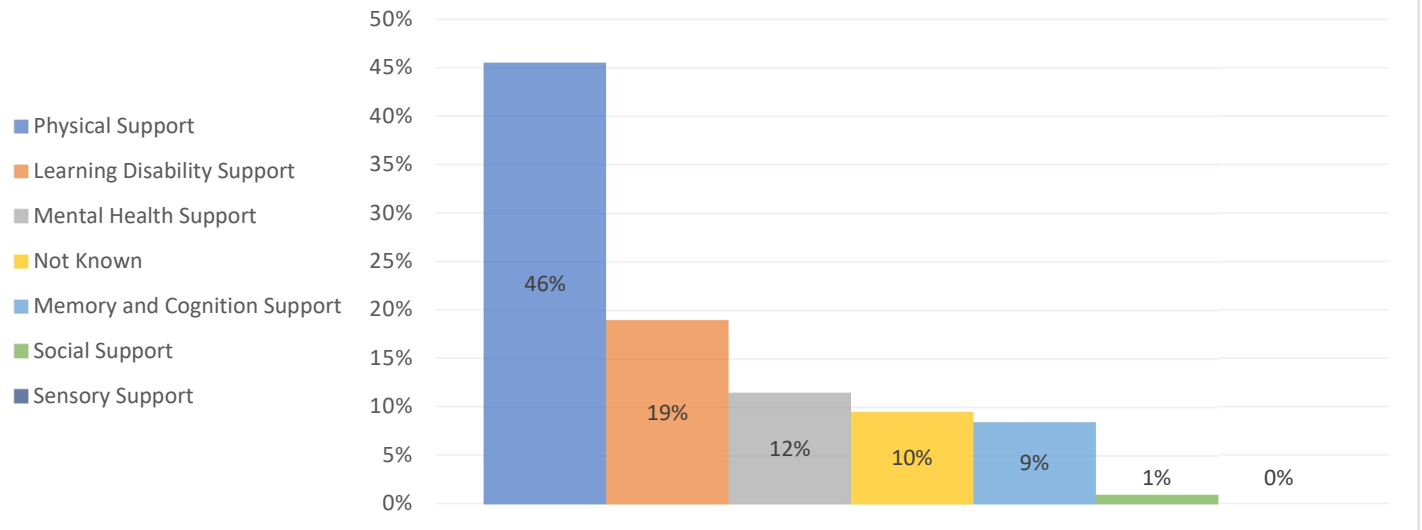
Fig.11 Staffordshire: Primary Support Reason (S42)



Staffordshire

Physical support continues to be the most common primary support reason in Staffordshire in 2019/20 (49%) a decrease of what was reported last year (61%) but in line with the year before at 49%. This is then followed by learning disability support (12%) and mental health support (12%). 'Not knowns' have increased from last year.

Fig.12 Stoke-on-Trent: Primary Support Reason (S42)



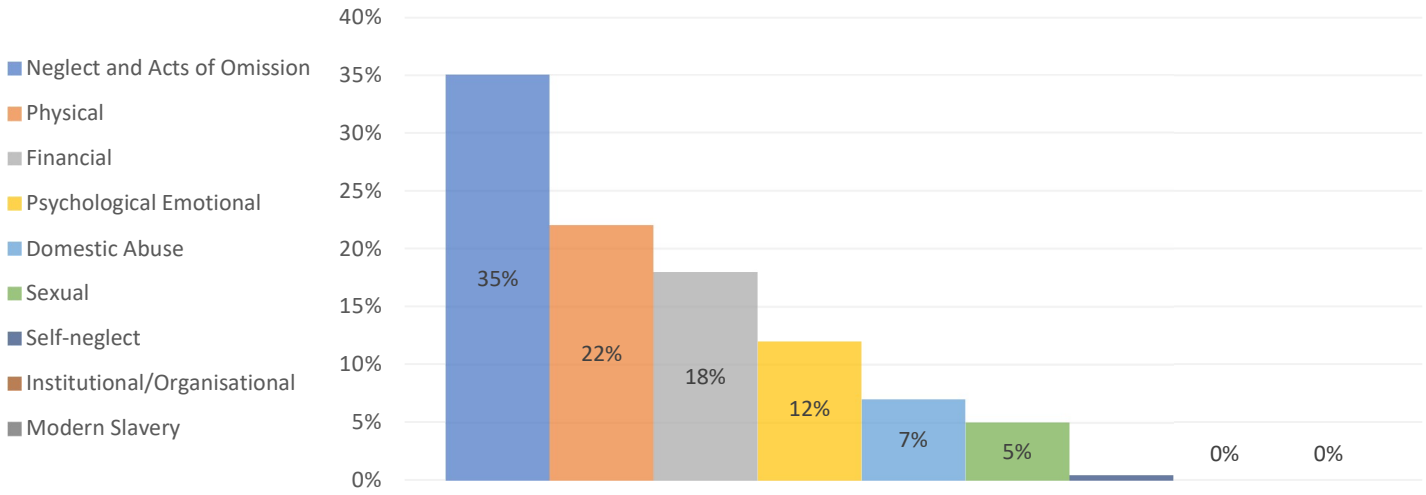
Stoke-on-Trent

Physical support similarly represents the largest proportion of primary support reasons recorded in Stoke-on-Trent at 45.5%, followed by learning disability support with 19%, a decrease of 2% since last year, mental health support accounts for 11.5% which has also decreased from last year. The unknown category has also increased from 5 last year to 28 this year, the matter has been acknowledged by the Council and there are plans in place to improve recording.

Types of Harm or Abuse identified at Section 42 safeguarding enquiry

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

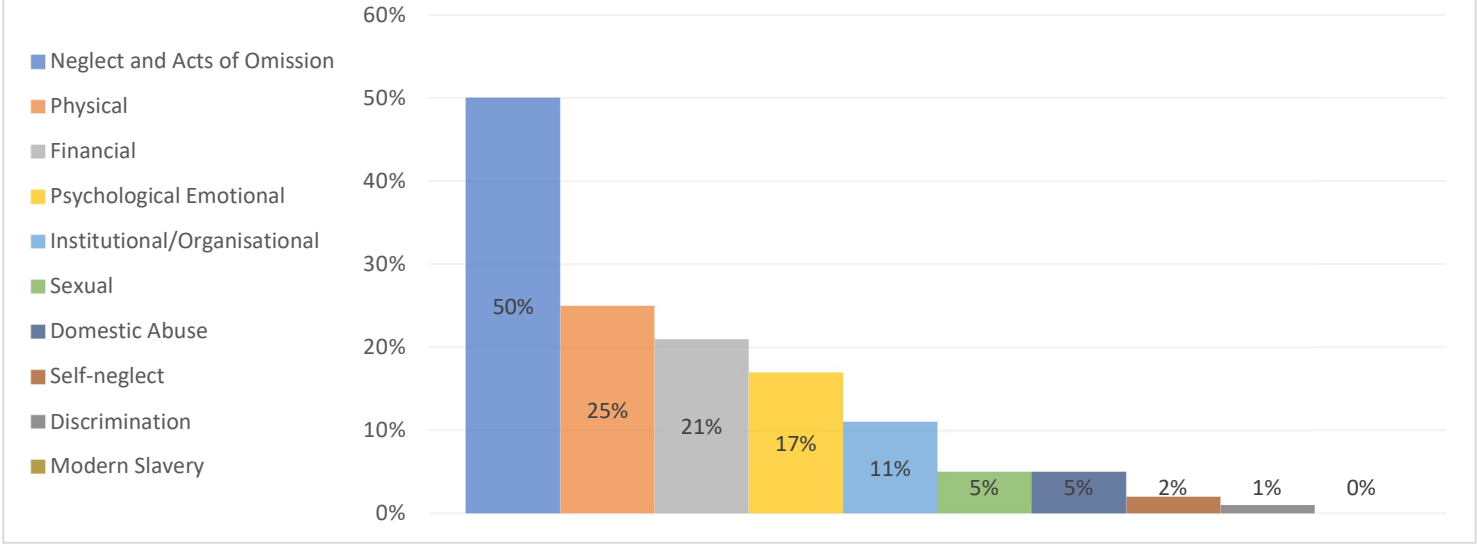
Fig. 13 Staffordshire: Types of harm or abuse identified at S42 safeguarding enquiry



Staffordshire

Neglect and Acts of Omission/Physical harm/financial abuse continue to be the most frequent types of harm and abuse identified for Section 42 safeguarding enquiries in Staffordshire, together accounting for 75% of all harm/abuse recorded. Neglect and acts of omission show a slight increase from last year; whilst financial abuse has decreased (2%) in 2019/20.

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



Stoke-on-Trent

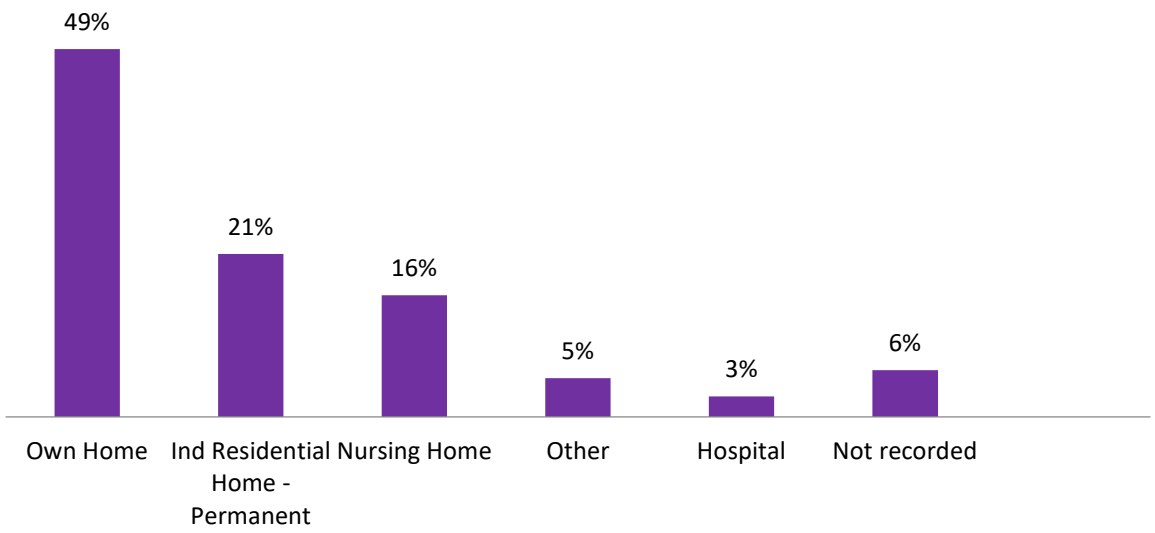
The percentage of neglect and acts of omission cases has increased from 2018/19, 45% to 50%. One Care Home has been subject of a Large Scale Enquiry and this has created a relative surge in referrals in the middle of the year. There is a comparatively large increase in institutional abuse as this has been better recognised and recorded separately from other types of abuse, from 0% in 2018/19 to 11% in 2019/20. The proportion

of adults with cases of financial abuse has reduced There can be relatively small numbers of adults in types of abuse which can cause a percentage change to appear more dramatic than it is in reality. In Stoke-on-Trent more than one type of abuse may be reported for a single case and therefore there are more than 100% of cases as there are cases where more than one type of abuse has been reported.

Since 2016/17 new categories of Sexual Exploitation, Discrimination and Modern Slavery have been included.

Location of abuse

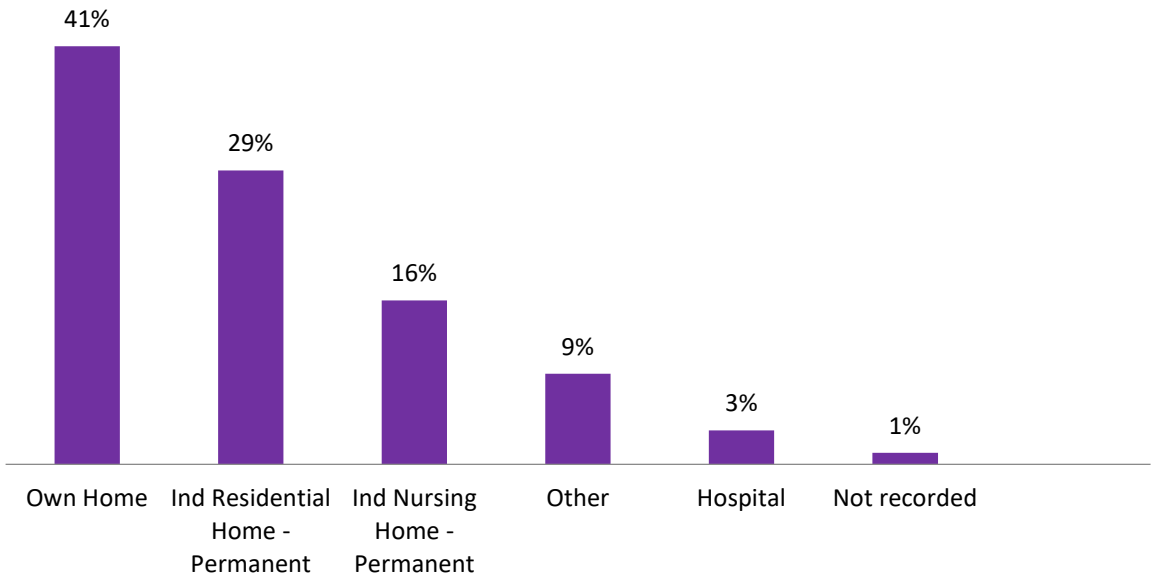
Fig.15 Staffordshire: Location of abuse (S42)



Staffordshire

Of those people subject of Section 42 enquiries, the most significant amount (49% were in the person's own home. The next most common locations in Staffordshire were residential homes (21%) and nursing homes (16%) which are the same percentages as last year.

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



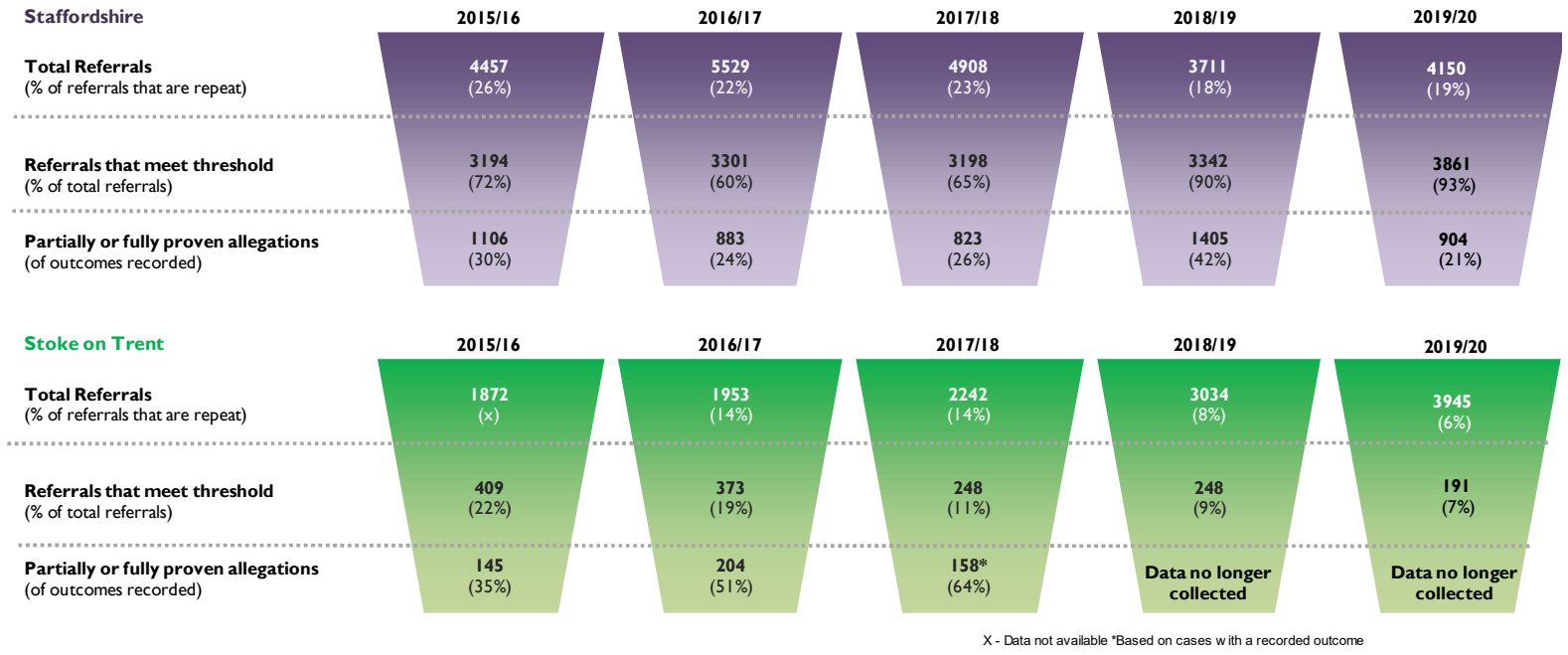
Stoke-on-Trent

The most prevalent location of abuse in Stoke-on-Trent are the person's own home (41%) followed by Independent Residential Home (29%) and Nursing Home (16%). There has been a decrease in Abuse in the person's own home by 16 referrals from last year and a decrease of abuse reported in Nursing homes by 24 referrals.

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 through to whether allegations were proven with a comparison to previous years.



X - Data not available *Based on cases with a recorded outcome

Staffordshire: Referrals have increased this year, and on average more have met the threshold of Section 42 enquiry. Repeat referrals have increased by 1% from last year from 18% to 19%. The proportion of referrals that meet threshold has increased by 3% to 93%. Partially or fully proven allegations have decreased in 2019/20 from 42% to 21%.

Stoke-on-Trent: Demand has continued to increase during 2019/20 for Stoke-on-Trent with the reported number of concerns rising by 30%. The percentage of repeat referrals has decreased from 8% to 6% with the percentage of cases that met threshold has continued a trend to decrease and dropped from 9% to 7%. Partially or fully proven allegations data is no longer collected by Stoke-on-Trent.

Note: There is an explanation for the reasons for variation in recording between Staffordshire and Stoke-on-Trent on page 24.

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

Fig.17 Staffordshire outcomes

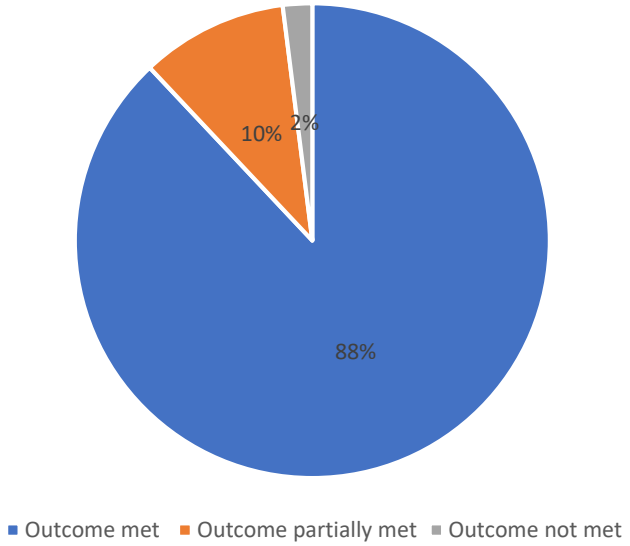
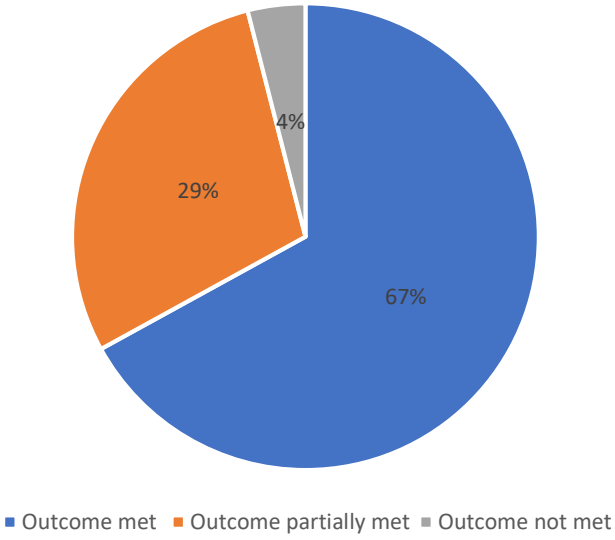


Fig.18 Stoke-on-Trent outcomes



Staffordshire

In Staffordshire the proportion of people subject of a Section 42 enquiry whose expressed outcome was met has increased from 80% last year, 98% of people expressing their desired outcomes as either fully or partly met has increased slightly from last year.

Stoke-on-Trent

The proportion of people subject of a Section 42 enquiry whose expressed outcome was met or partially met increased to 96% which shows an increase in the past two years.

Managing Safeguarding Allegations Against Staff – Person in Position of Trust

Safeguarding Adults Boards are required to establish and agree a framework and process for organisations to respond to allegations against anyone who works with adults with care and support needs.

People can be considered to be in a 'position of trust' where they are likely to have contact with adults at risk as part of their employment or voluntary work, and where the role carries an expectation of Trust and the person is in a position to exercise authority, power or control over an adult(s) at risk (as perceived by the adult at risk).

Where a person is experiencing or is at risk of abuse the multi-agency policy procedures should be followed. Each organisation is responsible for the management and handling of its own information and is also responsible for issues of disclosure.

Concerns may be raised through a variety of processes including:

- Criminal investigations
- Section 42 Enquiries
- Disciplinary investigations
- Regulatory action or quality assurance monitoring
- Reports from the public

If, following an investigation a Person in a Position of Trust is removed by either dismissal or permanent redeployment to a non-regulated activity, because they pose a risk of harm to adults with care and support needs, (or would have, had the person not left first), then the employer (or student body or voluntary organisation) has a legal duty to refer the person to the Disclosure and Barring Service (DBS). In addition, where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation such as the Health and Care Professions Council, General Medical Council and the Nursing and Midwifery Council.

If a person subject to an investigation attempts to leave employment by resigning in an effort to avoid the investigation or disciplinary process, the employer (or student body or voluntary organisation) is entitled not to accept that resignation and conclude whatever process has been utilised with the evidence before them. If the investigation outcome warrants it, the employer can dismiss the employee or volunteer instead and make a referral to the DBS. This would also be the case where the person intends to take up legitimate employment or a course of study.

The SSASPB has sought assurances that the multi-agency procedures are being complied with. This is monitored through the Audit and Assurance sub-group. The following information has been provided by Staffordshire Police in relation to the matters escalated for criminal investigations.

Staffordshire Police information

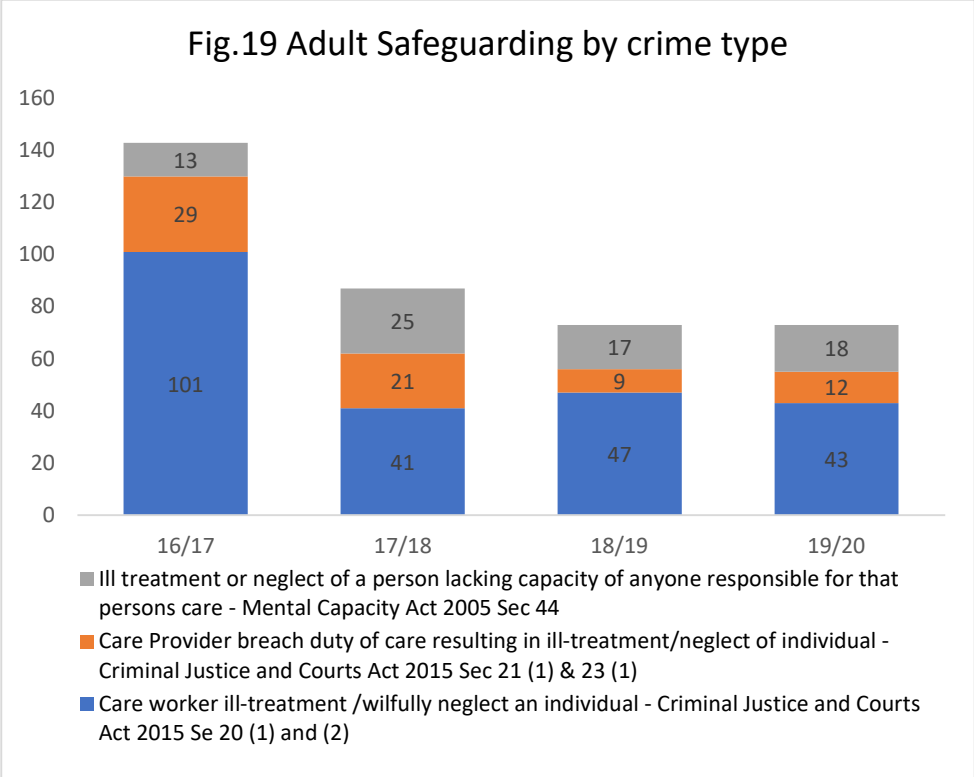


Figure 19 above illustrates that there were a total of 73 offences reported for criminal investigation in the 12 months period to 31 March 2020. The year is contrasted with previous years to indicate reporting rates over time. From analysis of 2019/20 reports:

- 1 of these offences was alleged to have occurred in 2016
- There was 1 repeat victim - both offences were at the same location
- There were 3 repeat perpetrators

- There were 10 repeat locations – 8 of these were care homes; 1 hospital; and 1 special school. 8 of these repeat locations had other adult safeguarding related offences in the previous 3 years
- 11 of the locations in the year 2019/20 were the same as adult safeguarding related offences in the previous 3 years

The analysis is used operationally to target preventative actions.

9. FINANCIAL REPORT

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

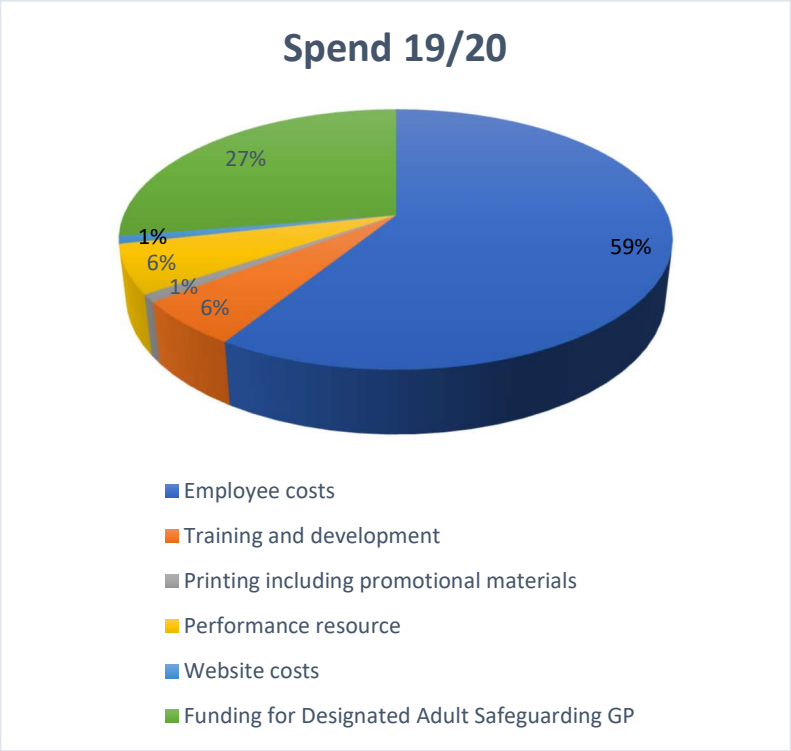
The Board wishes to acknowledge those partners who have provided rooms without cost which includes Staffordshire County Council, Stoke-on-Trent City Council, Staffordshire Fire and Rescue Service, the Clinical Commissioning Groups and Staffordshire Police.

Income: This was year 3 of a 3 year budget agreement which had been 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:

Staffing *note (i)*	£112,091
Training and development	£10,725
Catering	£205
Printing/stationery *note (ii)*	£1,803
Performance Resource	£11,500
Website costs	£1,800
Designated Adult Safeguarding GP project *note (iii)*	£52,460
TOTAL:	**£190,584**



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

(ii) Including promotional leaflets

(iii) This funding was a contribution towards the costs for a Designated Adult Safeguarding GP who supported the work of the Board between July 2018-July 2020. This was two year project and is not a recurring cost

10. APPENDICES

APPENDIX 1: BOARD PARTNERS

Statutory Partners as of 31st March 2020

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

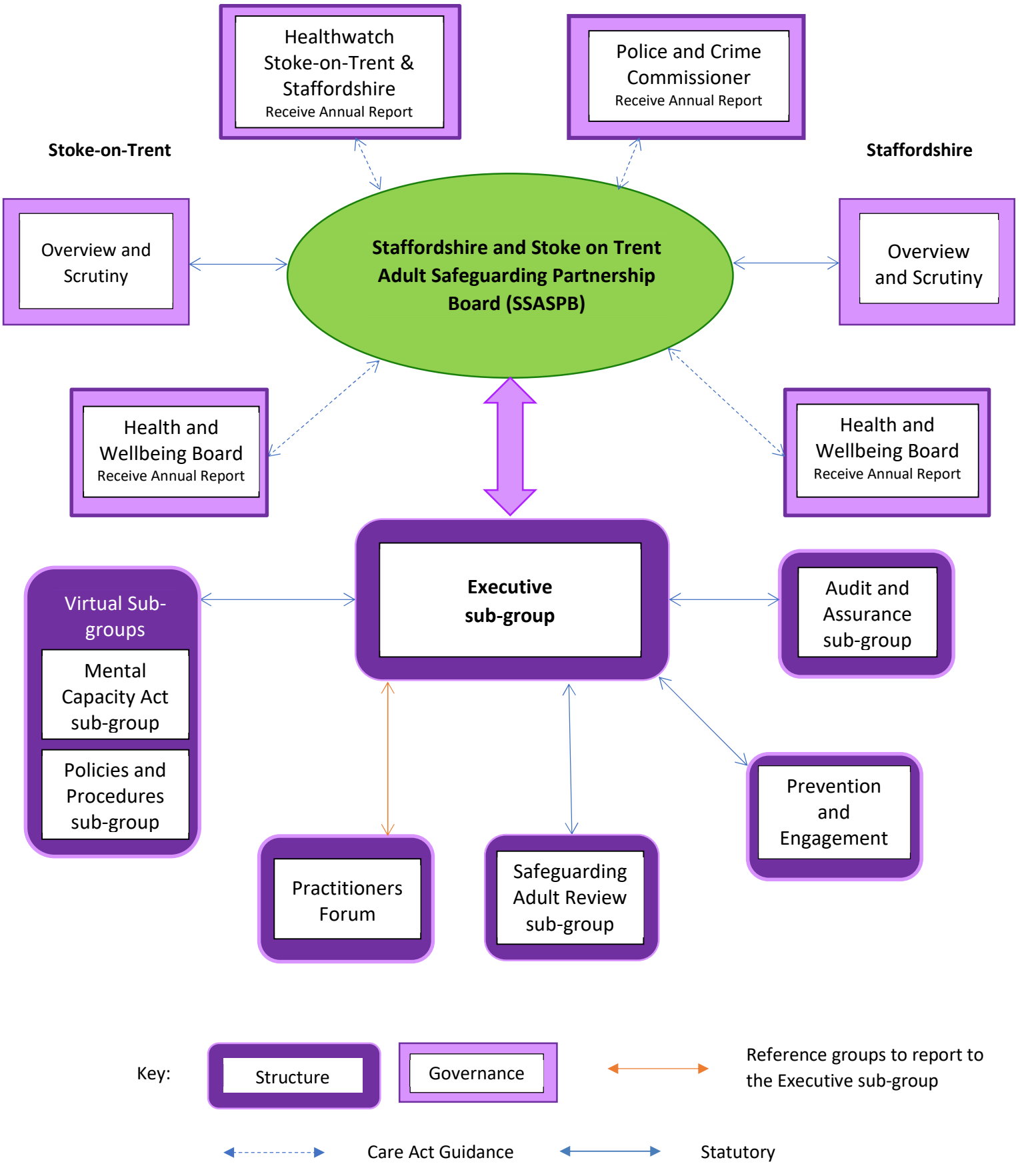
Extended Partnership as of 31st March 2020

- 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)
- 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)
- Virgin Care
- 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.

APPENDIX 4: TIER 2 AUDIT QUESTIONS

Category and Ideal Service/standard
1 Leadership, Management and Governance
1.1 The organisation has a nominated Executive lead for Adult Safeguarding
1.2 There is an operational/professional lead for adult safeguarding identified within the organisation that can provide support to staff.
1.3 This is explicitly contained within their role profile or job description
1.4 The organisation has a safeguarding policy to which staff have access
1.5 There is recognised and active leadership to safeguard adults in the organisation
1.6 Safeguarding adults is written into strategic plans within the organisation
1.7 The organisation demonstrates commitment to the delivery of the strategic priorities of the SSASPB
1.8 The organisation contributes to the SSASPB Annual Report
1.9 The organisation provides appropriate representation both in position in organisation and attendance frequency at those SSASPB meetings it needs to attend
1.10 Commissioners of services have appropriate arrangements In place to ensure oversight of safeguarding governance arrangements within organisations they commission service from
1.11 The organisation can demonstrate that it has a quality auditing system that checks policy compliance and the learning informs practice, performance and policies.
2 Safe Recruitment and PiPOT Management
2.1 Robust recruitment and employment practices are adopted which include taking up references and, where applicable, DBS checks - including when changing roles within the organisation
2.2 There is a clear standard of conduct setting clear standards for relationships between people in positions of trust and service users/adults at risk.
2.3 There are mechanisms for service users/adults at risk or their representative to make a complaint about the conduct of a member of staff
2.4 There is a whistle-blowing policy to enable staff to raise concerns outside their own chain of line management
2.5 There is a clear allegations management process through which abuse and neglect by staff is investigated thoroughly
2.6. There is a process for reviewing any concern made about any of the organisation's services.
2.7 There is evidence to indicate that lessons are learned from Person in Position of Trust (PiPOT) investigations and improvements made to policy and operational practice
3 Policy and Procedure
3.1 There is an easily accessible policy/procedure which states the importance of taking ownership and responding to allegations of adult abuse or neglect.
3.2 The above policy acknowledges and signposts to the Board's policies and procedures.
3.3 The policy has a review schedule which is monitored.
3.4 The individual organisation policy/procedures clearly outlines individual roles and responsibilities
3.5 Adult safeguarding is cross-referenced in other relevant policies.
3.6 The organisation has a multi-agency Information sharing Policy/procedure or uses the SSASPB one.
3.7 The organisation makes the Board's Escalation Policy accessible to

those staff who need to use it.
3.8 The organisation has a Mental Capacity Act/DoLS Policy
3.9 This policy is easily accessible to anyone who needs to refer to it
3.10 The MCA documentation is available to staff who need to use it
3.11 The organisation audits the use of the MCA by its staff

4 Training and Workforce Development

4.1 The organisation has a training plan which ensures that staff and volunteers at all levels have appropriate knowledge of safeguarding and competencies in relation to their role.
4.2 There is a mechanism by which to report the number of staff trained to the SSASPB by quarter or (at a minimum) at the end of the financial year.
4.3 Adult safeguarding awareness training is made mandatory to those required to receive it, this is clearly stated within the organisation.
4.4 MCA awareness training is available to those staff needing it (as identified in the organisations training plan).
4.5 Staff have access to supervision for safeguarding concerns.
4.6 Staff within the organisation who carry out safeguarding enquiries have appropriate training and competencies.

5 Practice

5.1 The organisation can demonstrate that it promotes a person-centred approach to adult safeguarding.
5.2 The organisation can demonstrate that it includes service users/victims of abuse and neglect in decision making where appropriate.
5.3 The organisation can demonstrate that it invites service users to participate in reviews about their care and support where appropriate and are kept updated.
5.4 The organisation can demonstrate that it appropriately uses advocacy as part of any safeguarding enquiries or calls for the services of an appropriate adult (Police)
5.5 The organisation can demonstrate that the service user is central to the safeguarding plan and involved in the review process?
5.6 The organisation has clear protocols for managing service user's disengagement from support
5.7 The organisation seeks feedback from service users/ adults at risk

11. 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
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 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 Childrens 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.

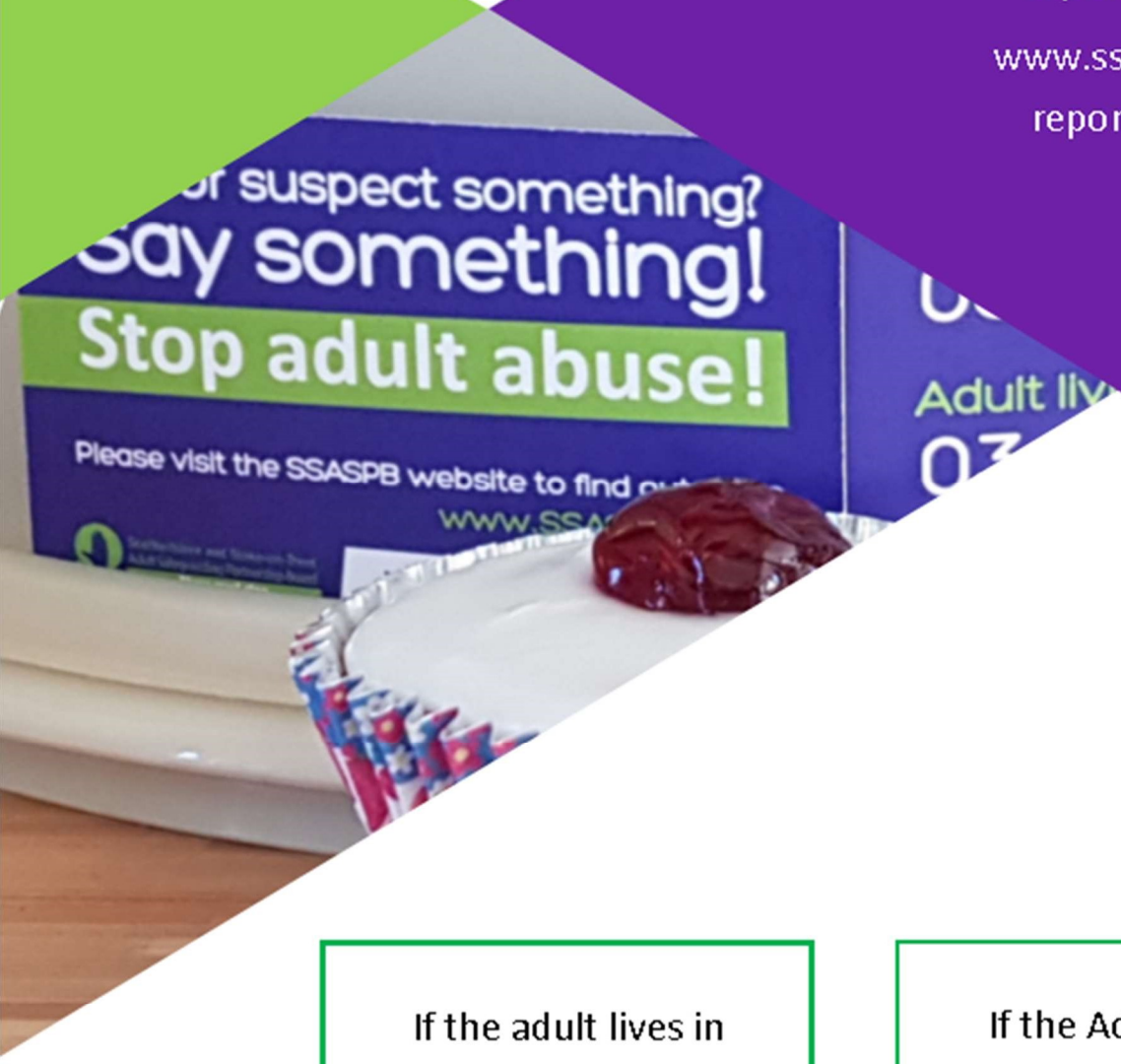
https://www.ssaspb.org.uk/Professionals/Glossary.aspx

What do I do If I have an Adult Safeguarding concern?

Report it

Please visit the SSASPB website for more ways to report a concern

www.ssaspb.org.uk/reporting-abuse



If the adult lives in Stoke-on-Trent

0800 561 0015

If the Adult lives in Staffordshire

0345 604 2719