Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB)

2024-2025 Annual Report

Contents

1. Welcome and introduction from the SSASPB Independent Chair

Welcome to the Staffordshire and Stoke on Trent Safeguarding Adults Partnership's annual report for the period 2024/25. The Care Act 2014 requires the partnership board to publish its annual report detailing the work undertaken to deliver on its priorities as part of our three-year strategic plan together with the actions taken following publication of Safeguarding Adult Reviews.

This year has seen the board develop a new three-year strategic plan together with a new board mission and supporting priorities. These came into effect in April 2025.

The partnership board continues to enjoy the support, commitment and enthusiastic engagement of its partners but continues to make efforts to broaden the partnership's membership and perspectives both at board and sub-group level.

In May 2024, Government wrote to safeguarding adults' boards across the country making requirements of them in relation to rough sleeping. A board champion has been appointed and key representation added to the board. A multiagency partnership including District Council and voluntary sector membership has been set up, working on improving support and pathways to reduce the number of people rough sleeping.

The number of Safeguarding Adults Reviews continues to grow nationally, and the partnership has seen a significant increase especially for issues linked to self-neglect. This now forms one of our new priorities and work continues to reduce the impact of self-neglect on individuals and ensure that carers and practitioners are supported in understanding current best practise and escalation routes.

Following the Government's announcement to abolish NHS England several oversight bodies, the Integrated Care Board has started a significant restructure process which will see it become a much smaller commissioning body. As one of the three statutory partners of the board we are working closely with the ICB to understand the impact, offer support and challenge to ensure that the safeguarding of adults remains a key focus.

Thank you for taking the time read this report which I hope assures you of the work the partnership is undertaking to keep people at risk of harm, safe from abuse and neglect. I would like to thank our members for their support especially the sub-group chairs and the business unit support team who we rely on to ensure our coordinated delivery.

Adrian Green

Independent Chair

Staffordshire and Stoke-on-Trent Safeguarding Adult Partnership Board

2. Introduction to SSASPB and strategic priorities

Priority 1: EFFECTIVE PRACTICE

Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) is a statutory Board established under the Care Act 2014. Safeguarding Adult Boards (SABs) have a key role to seek assurances as to the effectiveness of the multi-agency relationships and working arrangements relevant to safeguarding adults. This includes the work of the SSASPB to initiate debate and discussion about emerging issues in the safeguarding of adults with care and support needs at risk of abuse or neglect as well as promoting formal research and encouraging professional curiosity about sources of risk as a means of helping effective multi-agency responses.

The expectation of partners approaches to safeguarding is underpinned by the six safeguarding principles, to shape how they work in partnership with professionals, adults at risk and their support networks, and to hold services accountable for their practice.

Membership is made up of local partners who have specific responsibilities or contribute to the effective protection of adults with care and support needs in the area. Our statutory partners include two local authorities (Staffordshire County Council and Stoke-on-Trent City Council), Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) and Staffordshire Police.

We also have representatives from health and social care providers, Healthwatch, emergency services, housing services, prisons and probation, private / independent and voluntary providers and representatives of community and voluntary groups who capture the voices of adults, carers and their families.

What was the SSASPB seeking to achieve:

1. That Making Safeguarding Personal (MSP) is meaningfully implemented and embedded in practice by all partners, (other than in exceptional circumstances when it may be less appropriate) and that its effectiveness is measured to give confidence.	2. The assessment and reviews of mental capacity and Deprivation of Liberty Safeguards (DoLS) is of a good standard and includes the perspective of service users/carers, with appropriate skilled advocacy in place.
3. There is awareness and understanding that there can be increased risks in relation to safeguarding when a person moves between services, such as when a person is discharged from hospital to their home or other community settings.	4. That amongst connected partners professionals and leaders are alert to the sources of risk for vulnerable adults in the communities and residential settings particularly the hidden voices and people falling between the eligibility gaps.
5. Safeguarding partners commit to improve our response to self-neglect, including that we will explore what experiences led, and sustain, a person to live in this way rather than judge self-neglect and substance use to be a lifestyle choice and we will consider wider social, physical and mental health factors rather than rely on substance use to explain a person's circumstances. We will recognise the impact of trauma, substance use, and the coercive and controlling effects of addiction, on a person's mental capacity to make decisions about their self-neglect and substance use.	

Priority 2: ENGAGEMENT - Improve awareness of adult safeguarding

Continue to develop and enhance the Board's communication plan to raise awareness of:

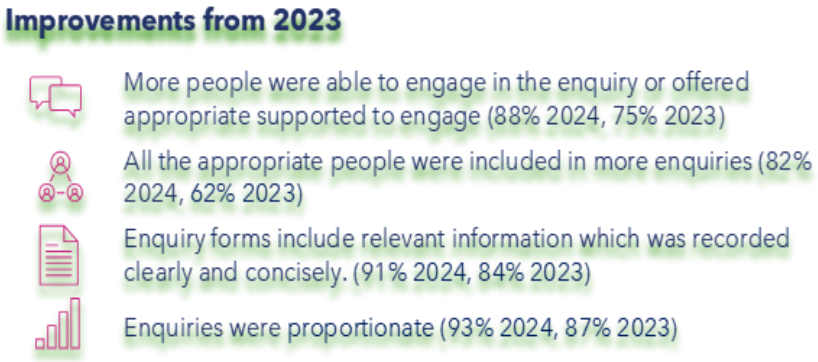
- what constitutes abuse and neglect
- when and how to report it
- what happens after a report is made
- concerns that are not abuse or neglect and how these should be reported
- practical things that can be done to prevent or reduce the risk of abuse or neglect occurring

The next section provides an overview of individual partners and SSASPB Subgroup activity to achieve these aims.

3. SSASPB Partner activity related to the Strategic Priorities

Staffordshire County Council

Making Safeguarding Personal (MSP): Safeguarding training has been available to all staff with a focus on making safeguarding personal. Our Care Market development team have also developed on-line training for providers which is available through the social care learning Academy.



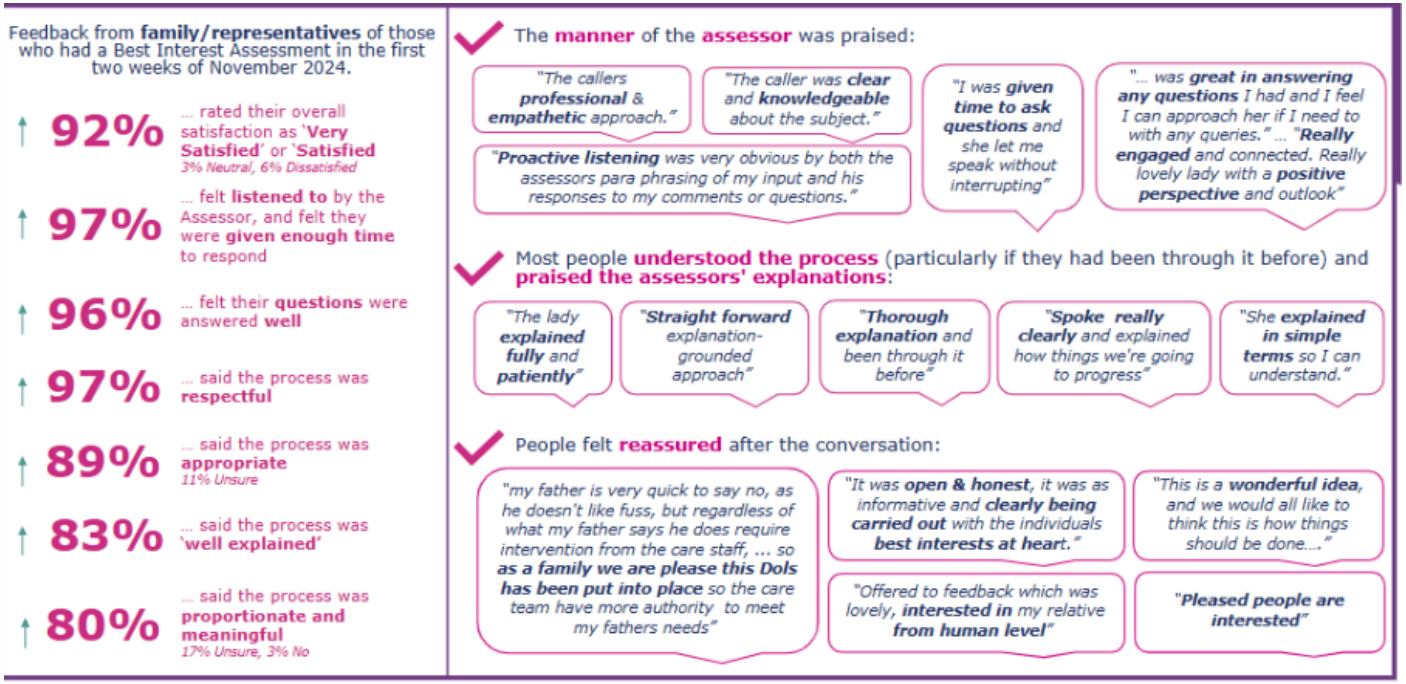
Audits continue to be completed, monthly audits reviewing concerns received by the Staffordshire Adult Safeguarding Team (SAST) that have been closed as not requiring Section 42 enquiry and those that have gone forward for enquiry. The quarterly audits across the safeguarding pathway review decision making throughout a Section 42 and how well the principles of making safeguarding personal have been embedded.
This is now enhanced by feedback being requested from the adults who have been engaged in an enquiry to ascertain their views. The number of responses has been small at this stage but we will continue to develop this over the next 12 months.

Mental Capacity/DoLS: We have completed audits and reviews of the use of advocacy alongside our advocacy partners, ASIST, which highlighted that training would be beneficial to improve the use of and recording of advocates.

The training has been completed and guidance updated which has led to significantly improved practice and recording of the use of advocacy.

More people were able to engage in the enquiry or offered appropriate supported to engage up 13% (88% 2024, 75% 2023)

We have continued to audit the DoLS and seek feedback from the persons representative and the providers and we receive consistently positive feedback.



QUALITY INFORMATION DoLS AUDIT

JUNE/JULY 2024

ASC Quality and Performance Team

BASIC INFORMATION

29/30	... appropriately completed the first section of the form
28/30	... fully evidenced consultation with all relevant parties and the rationale for any non-consultation is clear

MENTAL CAPACITY ASSESSMENT

28/30	... fully evidenced practical steps taken to support the person, along with the rationale for the approach
28/30	... fully corroborated the conclusion reached, with reference to others' views on the person's capacity
30/30	... fully described and evidenced the impairment or disturbance of the mind.
30/30	... clearly showed the BIA's professional opinion

BEST INTEREST ASSESSMENT

25/30	... fully evidenced consideration of the person's ascertainable views and any objections
29/30	... fully evidenced consideration of the person's presentation and if the arrangements were stable.
29/30	... fully evidenced consideration if the deprivation of liberty is in the person's best interests, including taking into account the views of others
28/30	... fully evidenced why the person is in their current or planned placement
19/30	... fully evidenced consideration of alternative options such as other placements or adjustments to care plans
29/30	... fully evidenced consideration of the harm that will be avoided by depriving the person of their liberty
27/30	... fully evidenced consideration of the proportionality of the arrangements

Timescales for completion of dols has continued to improve and we have reduced the numbers waiting for a DoLS to be complete.

It was identified at this time that there is was lack of evidence that alternative options were being considered within best interest decision making. This was raised within Best Interest Assessor (BIA) forums, with appropriate guidance given to practitioners. This has resulted in an increase of recording and evidence of the alternatives considered in recent audits, which are completed quarterly .

Transfer across services: Staffordshire County Council has well embedded Discharge to Assess that are clearly defined and supports people leaving inpatient facilities. Practitioners work in a strength-based way and will consider risks to a person's wellbeing when looking at moves and seeks to ensure that there are plans in place to mitigate risks associated with moves to different settings.

The guidance relating to home closures/provider failures also recognises the increased risks for people and has welfare checks embedded within the process, these are to ensure that people remain well following move of accommodation.

There is a clear pathway in place for those with care and support needs entering or leaving prisons within Staffordshire with a dedicated team to support this. This is done to reduce delays in appropriate services being in place on release and to reduce anxiety for the adults leaving the prison setting.

Preparing for adulthood has been a strategic priority area for Staffordshire County Council over the past 12 months. We have been building on the improvements made last year with a renewed approach and the development of a joint project between Children's and Adult services. We have implemented a transitions team that works with all young people from 14 no matter what their primary need is.

Awareness and the voice of adults: Staffordshire County Council have embarked on accessible information project to better improve the access that people have for information. This includes having British Sign Language (BSL) interpretation on our website including the safeguarding pages. All or information is being converted into easy read and whilst this is not fully in place yet, this will be happening over the next 12 months.

Our data recording of protected characteristics has continued to improve and we have a priority on equity and focusing on groups who are seldom heard, including Gypsy Roma and travelling communities, east Staffordshire and those who identify as neurodivergent.

This will remain a focus over the next 12 months when we will continue to review our progress.

Self-neglect: Staffordshire County Council have introduced a specific self-neglect audit into our ongoing cycle of audits and elements of self-neglect are included in the strength-based practice audits that are completed monthly. The most recent audit identified that there had been improvements in the following areas:

- ✓ Engaging people
- ✓ Consideration of mental capacity
- ✓ Multi-agency working
- ✓ Decision making

There are continued areas for practice development including the identification of self-neglect and recognition of health indicators.

To support these areas, practice guidance has been introduced including a 'clinical crib sheet' that supports the exploration of people's health needs and impact on social care needs.

Trauma informed practice training has been well attended, and this is now available through our annual training prospective.

Making Safeguarding Personal (MSP):

Audit and Quality Assurance

Safeguarding is now a consistent focus across all audits—both through dedicated safeguarding reviews and as a core element embedded in wider audit themes. This ensures safeguarding remains central to all aspects of practice and service delivery.

Voice of the Adult: Audits ensure that the adult's voice and desired outcomes are central to the safeguarding process.

Integrated Feedback: Adult feedback is directly captured through the audit process and is linked to wider quality assurance mechanisms, ensuring a holistic view of safeguarding effectiveness.

In 2024/2025, 170 case audits were completed, an increase of 12 from the previous year, with feedback gathered directly from the adult at risk in 107 of those cases.

Performance Monitoring

Performance Dashboards include key Making Safeguarding Personal (MSP) indicators, for example in 2024-25, the following outcomes were recorded:

703 enquiries were completed in 2024-25. 62% of adults involved in enquiries had capacity to understand what the safeguarding risks and process was, 38% did not. Where adults lacked capacity, 83% required a representative, 17% did not.

66% of adults in the safeguarding enquiry process were asked about their desired outcomes, which are recorded in the safeguarding enquiry reports. Of these, 52% were able to express their desired outcome, with 60% of outcomes, fully achieved and 35% partially achieved.

Although there are improvements to be made, these metrics provide a clear view of how well MSP principles are being applied and the impact on individuals.

Workforce Development

Staff Training Records: Evidence that staff across all safeguarding partners have received training on MSP principles. Making Safeguarding Personal Training was commissioned via Expert Citizens in 2024 to coproduce the training. From January to July 2024, 149 staff attend across all the sessions. This was following the Andrew SAR and included representatives from Housing as well as Adult Social Care Assessors.

Practice Standards and Workforce Development

Best Interest Assessors (BIAs) receive training from a diverse range of sources, ensuring their knowledge remains current and aligned with legal and ethical standards. Qualified BIAs demonstrate a strong understanding of their responsibilities, including the need to balance the rights and views of all interested parties.

Regular supervision, alongside peer and mentor support, provides ongoing oversight and reflective practice opportunities.

Quality Assurance and Audit

The Corporate Audit Team conducted a comprehensive audit of Mental Capacity Act (MCA, 2005) and Deprivation of Liberty Safeguards (DoLS) related practice. Following this a work plan was developed to implement audit recommendations, focusing on process improvements and smarter workstreams. This has now been signed off as complete as all evidence gathered, changes implemented to demonstrate recommendations from the audit were addressed.

Managing Demand and Risk

The backlog of DoLS assessments remains a challenge due to rising demand. Triage arrangements are in place to ensure that high-risk cases are prioritised, protecting the most vulnerable individuals.

The Local Authority is working with our pool of qualified BIA's to supplement assessment capacity and support quality assurance efforts

Transfer across services:

The Integrated Discharge Hub, led by a director, has been established in the last 18 months to strengthen links between Health and Adult Social Care and the Royal Stoke Hospital. The Hub ensures a person-focused approach to discharge planning, supporting individuals through each stage — from hospital to intermediate care, and then to home or long-term care.

Seamless Inter-Team Transfers – the new Front Door was implemented in April 2024 with a clear protocol for teams transferring people for longer term work. A seven-step process was introduced alongside the new front door service to:

- Define team responsibilities.
- Standardise how onward referrals are made.
- Improve coordination and reduce delays in service delivery.

Changing Futures Programme -Through case coordination, Changing Futures supports safe transitions across services — including hospital admissions, prison transfers, and accommodation moves. Services remain involved as long as needed to ensure continuity and effectiveness of support.

While there is a waiting list for Care Act and Occupational Therapy assessments and reviews, a clear risk management tool and process has been implemented and is operational to mitigate potential harm and ensure a line of sight to senior managers.

To better manage demand and improve service planning for young people with increasingly complex needs, there has been investment in a dedicated transition team. The team offer:

- Early Engagement: The team will begin working with individuals from the age of 14, allowing for early identification and resolution of potential barriers to transition.
- Extended Support: Support will continue until the young person turns 25, ensuring continuity and stability during a critical life stage.
- Integrated Planning: The team will collaborate closely with health and children's services to develop fully resourced care plans before individuals reach 18.
- Professional Resources: Additional staffing and expertise will be provided to meet the growing complexity of needs during transition.
- Notification to Adult Social Care (ASC) from age 14 for young people likely to transition. From age 16, an in-reach offer from ASC ensures joint planning and smoother transitions.

The goal is to ensure continuity of support and avoid gaps in care.

Awareness and the voice of adults: Changing Futures promote partnership working across all sectors and disciplines; communication regarding of the benefits of this approach are undertaken at all levels and have ranged from frontline workers to senior leaders.

- Changing Futures have identified training opportunities in relation to safeguarding and Adult Protection to be co-produced with the ASC Safeguarding Lead and Expert Citizens and delivered by the insight academy with availability to all cross-sector partners.
- Case coordinators promote MDT/joined up working arrangements, regardless of eligibility, in identifying risks of harm/self-neglect and coordinating multi-agency plans in managing risks to the customer.
- Peer mentor/recovery coordinator role provides advocacy support for adults with experience of multiple exclusion from services.
- Case Example – joined up approach to Child Protection and Adult Protection incorporating Housing, Maternity services, CDAS etc. Advocating for the 'hidden voice' of an adult who has experienced significant trauma and exclusion from services resulting in having children removed historically.

Self-neglect: Changing Futures promotes person-led, trauma-informed approaches to supporting customers with complex multiple disadvantage needs. This is underpinned by MDT working arrangements and access to free co-produced training to promote best practice, recovery and rights-based practice values.

MCA assessments with adults acknowledges the coercive and controlling effects of addiction and Best Interests meetings are increasingly being utilised to identify least restrictive responses to supporting adults' complex needs.

Case Example - X is currently detained under Section 3 of the Mental Health Act.
X has been assessed to lack capacity regarding her care, support needs, and future alcohol use.
X's MDT, including ward staff, parents, and community support workers, identified a Community Court of Protection DoLS and supported accommodation as the least restrictive option to manage risks and support her recovery.

Health Annual Report Submission 2025 *– on behalf of Staffordshire and Stoke on Trent Integrated Care Board (SSOT ICB), University Hospital of North Midlands (UHNM), Midlands Partnership Foundation Trust (MPFT), North Staffordshire Combined Healthcare Trust (NSCHT) and University Hospital of Derby and Burton (UHDB) and primary care services.*

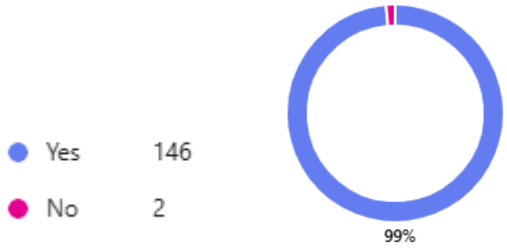
In the past year, the health system has worked hard to develop the health safeguarding collaborative. Partners within the collaborative are SSOT ICB, UHNM, MPFT, NSCHT and Primary Care. UHDB are more aligned to Derbyshire Integrated Care Board but also engage within some of our health-related groups and forums as well as engaging with the work of SSASPB via SSOT ICB where appropriate. The collaborative allows healthcare partners to have one voice for all of health within Staffordshire and Stoke-on-Trent, consistently supporting the whole health and care system for safeguarding adults.

All providers continue to have their own internal governance systems, but the health safeguarding collaborative huddle meetings and quarterly scrutiny and oversight group enable us to collate and analyse

all health data as one. As of January 2025, the collaborative has a structured audit programme with quarterly themes relating to statutory reviews.

We have developed our use of MS Teams video conferencing to help with real-time sharing of information and workstreams across all our organisations, as well as an integrated dashboard across all providers. Our advice quality feedback form has been implemented in Q4 and from over **1000** advice enquiries from front-line staff across the collaborative, 20% provided feedback. **50%** of the responses used the word ***'helpful'*** in the free text comment box provided.

1. Do you feel you now have the knowledge and skills to manage your case following the advice given?



2. Did you receive a timely response?

Around one third of enquiries relating to adult safeguarding to date have resulted in a recommendation to make an adult safeguarding referral in line with the multi-agency policy and procedures. The remaining two-thirds received guidance which aided the practitioner to manage any risks or access alternative pathways.

Training and awareness

In addition to mandatory safeguarding adults' and Mental Capacity Act training, there have been bespoke sessions across the health system on supporting survivors of sexual abuse, 'lads like us' (lived experience of abuse), non-fatal strangulation awareness, and radicalisation – local input from the Police.

Development of a safeguarding specific training platform which is hosted by Midlands Partnership Foundation Trust (MPFT) for all other health providers. Currently 2253 staff have signed up including 210 GP practice staff. There is a wide range of training that can be accessed online at a time most convenient for the staff member.

The Primary Care learning programme for all GP practice clinical staff is formed following the JSSAT (Joint safeguarding self-assessment tool) and there are bi-annual practice safeguarding lead supervision sessions. This is in addition to the regular safeguarding training that Primary Care staff are expected to undertake in accordance with contractual obligations and in line with the latest Royal College of General Practitioners all age safeguarding standards (October 2024).

UHDB have recruited a clinical educator for domestic abuse and sexual violence to raise awareness with staff.
North Staffordshire Combined Healthcare Trust (NSCHT) delivered development sessions on Learning from safeguarding adults reviews (SAR) which looked at learning from both local and national reviews.

MPFT held a domestic abuse awareness week for their staff which included sessions relating to LGBTQ+, male victims of domestic abuse, survivors of domestic abuse and honour-based violence.

Each year in November for adult safeguarding awareness week, the collaborative puts on a week of learning sessions. Several of the sessions in 2024 related directly to the SSASPB priorities of the past 3 years including developing professional curiosity and working together to promote a person-centred approach (making safeguarding personal).

Wider partnership working

Health partners have continued to be active partners to SSASPB contributing to the Board and all its Subgroups including provision of Chair for Audit and Assurance and Prevention and Engagement as well as Deputy Chair for SAR. We have worked on various task and finish groups including policy and procedures, self-neglect guidance as well as taking a lead in the multi-agency practitioners forums.

In the past year we have commenced working together as a collaborative to respond to actions and recommendations from safeguarding adult reviews (SAR) where we can provide a pan-health response. We have provided assurance to the Board in relation to hospital discharge processes and health commissioning oversight.

The ICB has developed a dashboard of review themes and associated factors from SARs and DARDRs. This will help to inform future learning and development across the provider collaborative. An example of this is the plan for the November 2025 Primary Care practice safeguarding lead supervision session being on self-neglect. The agenda for this session includes speakers from our multi-agency partners and will be focussed on how to pragmatically manage cases where there is self-neglect present.

Staffordshire Police

Over the past year, Staffordshire Police has continued to strengthen its role in protecting and safeguarding vulnerable adults. This has been achieved through a combination of improved data insight, targeted operational activity, and sustained partnership working. We work collaboratively within the Adult Safeguarding Enquiry Team (ASET) to investigate abuse and neglect of adults with care and support needs, regularly partnering with health services, social care, and the Care Quality Commission to respond to concerns in care homes and provider settings. We also have an established professional and open relationship with the Coroner's Office, ensuring that all relevant deaths are reviewed and referred appropriately and are not missed opportunities.

Insights and Performance

Our ongoing programme to enhance internal performance reporting through Power BI, a dynamic data visualisation and analytics tool, has delivered tangible benefits. Over the last 12 months, advances in investigation quality data have provided teams across the force with greater visibility of local trends. This information, governed through tactical and strategic boards, with overarching governance oversight driven by the Audit and Assurance Board, is enabling us to identify areas for improvement, enhance safeguarding responses, and ensure that victims receive the right support.

Operational Safeguarding

Over the past twelve months, we have continued to manage a number of operations linked to significant incidents within care settings. These include both ongoing and concluded investigations into suspicious deaths, with concerns relating to neglect, drug overdoses, and potential cases of Gross Negligence Manslaughter.

Raising Awareness - National Adult Safeguarding Week

In November 2024, Staffordshire Police actively supported National Adult Safeguarding Week, which this year focused on the theme of partnership working. Activities included internal briefings on the end-to-end journey of a safeguarding referral, targeted inputs on self-neglect, and a 60-second operational update for frontline officers on the use of Adult Police Protection Notices (PPNs), reflecting the growing prevalence of self-neglect in adult safeguarding cases.

To raise public awareness and reinforce our commitment to tackling these crimes, we issued a press release titled *"Jailed Care Home Workers Caught Out by Hidden Camera."* This centred on a complex case of wilful neglect (outlined in the case study later in this report) and served as both a preventative measure and a public assurance that such offences are taken seriously by the police and our partner agencies. You can read more about the case here: Cruel Staffordshire care home staff caught in act after victim's daughter plants hidden camera - Stoke-on-Trent Live

Right Care Right Person (RCRP)

February 2025 marked the first anniversary of the Right Care, Right Person (RCRP) approach in Staffordshire. This national initiative, which began locally, ensures that individuals in crisis receive the right support from the most appropriate agency. Over the past year, we have:

- Enhanced crisis response in partnership with mental health services.
- Strengthened multi-agency collaboration with the NHS, local authorities, and voluntary organisations.
- Equipped officers and staff with increased confidence and knowledge to respond effectively to mental health-related incidents.

RCRP is now embedded as daily business across the force; Staffordshire Police will, however, continue to monitor the implementation and effectiveness of this service reviewing cases where care is signposted, or concerns are raised to ensure learning is captured and the right outcomes are achieved for those in crisis.

Innovation - Pitstop Pilot

As highlighted in our previous annual report, **Pitstop** is a joint early intervention initiative designed to respond quickly to safeguarding concerns through close multi-agency working. It officially launched in March 2025 within the Stoke-on-Trent Local Policing Teams.

The initiative has already shown clear benefits, including improved joint working with Adult Social Care, supported by regular weekly case review meetings. Early feedback highlights more informed decision-making, better targeted referrals, and stronger working relationships between partners.

Staff in the Stoke-on-Trent Harm Reduction Hub one of ten across Staffordshire managing daily safeguarding referrals have also received enhanced training, which has helped improve the quality and consistency of our overall safeguarding response.

Looking Ahead

As we move forward, our focus remains on innovation, partnership, and early intervention. Our approach is increasingly shaped by the "voice of an adult," ensuring that lived experiences inform how we design and deliver safeguarding services. By embedding this perspective into our practice, we aim to create a more responsive, compassionate, and effective system of support.

Case Study: Protecting a Vulnerable Adult – A Multi-Agency Response to Wilful Neglect

In September 2023, Staffordshire Police worked alongside partners to investigate and secure convictions in a case of wilful neglect involving a 79-year-old woman residing at a Staffordshire care home.

Sheila, a 79-year-old woman with complex care needs, was living at the Nursing Home in Burton upon Trent and required 24-hour support. Over time, one of her daughters, Susan, became increasingly concerned about the number of unexplained bruises appearing on Sheila's arms. She began documenting the bruising with photographs and, worried something wasn't right, installed a small hidden camera disguised as a digital clock in her mother's room.

On 26 September 2023, Susan reviewed the footage and was deeply distressed by what she saw, carers treating Sheila with little dignity, causing her visible distress. She immediately reported her concerns to the care home, which then submitted a safeguarding referral to the local authority.

A multi-agency strategy discussion took place and confirmed that the case met the safeguarding threshold. A formal investigation was launched, supported by partner agencies. The carers involved were interviewed and denied any wrongdoing. However, the case was submitted to the Crown Prosecution Service (CPS), and both individuals were later convicted at Crown Court of wilful neglect under the *Criminal Justice and Courts Act 2015*.

Wilful neglect refers to the intentional or reckless mistreatment of an adult who lacks the mental capacity to make decisions about their care. It is a criminal offence even if no physical harm is caused. In this case, both carers received custodial sentences of three months and ten weeks, respectively.

This case highlights the power of strong partnership working and the importance of gathering clear evidence. It also demonstrates that the CPS is prepared to prosecute, and the courts will deal with these offences seriously.

Equally, it reinforces the need to listen to the voice of the adult. In safeguarding, we often talk about hearing the voice of the child, but not all adults can speak up, and some may be too afraid to do so. Sheila could not speak for herself, but her family acted on instinct and concern. Because of their actions, justice was served, and Sheila's care has since improved. Her family has shared that she is now far more peaceful and settled following changes to staff.

Our Adult Safeguarding team remains committed to making sure that all adults at risk are listened to, protected, and treated with dignity especially those who cannot speak up for themselves.

Healthwatch (Staffordshire and Stoke-on-Trent)

Making Safeguarding Personal (MSP): Healthwatch Staffordshire is actively sharing relevant data with key partners and stakeholders through a collaborative, two-way exchange. Our Enter & View (E&V) programme continues to evolve, with a new focus on expanding this to new areas such as pharmacies and others to broaden our reach and impact. We are also working closely with partners to explore how Healthwatch can provide enhanced support and share valuable insights and intelligence gathered.

Mental Capacity/DoLS: Healthwatch signpost and guide patients or carers alike when giving feedback on their experience of DOLs and support by escalating any reoccurring themes to the SSASPB board, Social Care and the ICB.

Transfer across services: Healthwatch Staffordshire has been emphasising to partners the importance of sharing data and the impact on risk assessment and management if it is not, doing so together with the promotion of GDPR compliant practise.

Awareness and the voice of adults: Healthwatch Staffordshire being closer to vulnerable communities (Healthwatch intelligence network) is able to gain that valuable feedback from voices that would otherwise not be heard and amplify to key leaders and service/policy designers on their service offer inclusive of promoting professional curiosity. Healthwatch has been advocating at high level meetings on the importance of how all partners, individually holding data on vulnerable people may not equate to risk of abuse of neglect, however when this data is shared with other partners, who also hold sensitive information, it helps to build the full picture of what could be then deemed as a safeguarding concern.

Self-neglect: Healthwatch Stafford has been and will continue to work with drug and alcohol commissioners and key stakeholders on the Staffordshire Alcohol Strategy. Healthwatch Staffordshire has been critical to provide key resident feedback on their experiences of drug and alcohol services. Furthermore, we have benefitted from engaging with partners from Stoke- on- Trent services to ensure that the strategy is consistent for Stoke and Staffordshire residents.

Staffordshire Fire and Rescue Service (SFAR)

Making Safeguarding Personal (MSP): Continued delivery and monitoring of Olive Branch sessions to partners with plans to update and improve the content in Autumn 2025. Olive Branch Training was designed by Staffordshire Fire and Rescue Service to support those who regularly visit vulnerable members in our communities to recognise fire risks in the home. We train a wide range of professionals including social workers, domiciliary care providers, occupational therapists, police officers and others, to confidently identify potential fire hazards and associated risks and how to make a referral for a Home Fire Safety Visit, helping to ensure that those most at risk receive the appropriate support from our service. Once our staff engage with the occupier, ongoing support is provided until the risks are reduced or eliminated. This may include multi-agency collaboration and partnership working to address wider needs and ensure long-term safety.

In January 2025, there was a service wide refresh of Safeguarding training levels 1 & 2 to ensure Making Safeguarding Personal (MSP), capacity and consent and safeguarding principles are covered extensively throughout the training packages.

The introduction of Prevent Forums in October 2024 gave opportunities for frontline staff to come together and receive input from partners and training on areas of specialisms or considerations for their roles to adapt delivery and engagement with the public. Topics included so far are PREVENT training and referral process, drug addiction, neurodiversity, modern slavery, sexual harassment delivered by various partners including Staffordshire Police, Burton Addiction Centre and New Era.

Mental Capacity/DoLS: SFRS do not conduct DoLS or Mental Capacity reviews. Level 2 Safeguarding Training continues to raise awareness of these to aid understanding around capacity and consent.

Transfer across services: The Fire and Health Partnership team has been successfully established and integrated into the care pathway. This service continues to provide an assured service to partners and often a mechanism to identify concerns or areas where additional support is needed.

Most recently a vulnerable young person who was temporarily housed in Staffordshire has moved to an alternative accommodation provision in another area of the country. They posed a significant fire risk, and

having been involved in a Section 47 Safeguarding Review for this young person, SFRS has shared information with colleagues in the area where they will be based. Recognising the importance of multi-agency but also cross border working partnerships in relation to safeguarding.

Awareness and the voice of adults: SFRS continues to build on a variety of ways in which SFRS engages with its communities. The introduction of the Fire and Health Partnership Teams has allowed us to access and provide further support to some of the most vulnerable in our communities.

These teams have access to a wide variety of settings including domestic dwellings and residential settings and are all aware of recognising signs of abuse. SFRS also have supporting guidance, policies and procedures in place to report sources of risk or concerns with care within communities or residential settings (Ie CQC referrals)

There have been previous incidences of good practice and escalating concerns with other care providers or even requesting or considering SARs.

Self-neglect: During the quarterly Prevent Forums (frontline workers training) practitioners received input from the Burton Addiction Clinic which highlighted how trauma and the controlling effects of addiction can impact people's lives and how staff can best work and engage with people who are affected by substance abuse.

SFRS continue to routinely sign-post adults, where appropriate, for support from, for example, commissioned services, GP, Social Care and Health, Environment Health or other professionals to help to ensure that adults with needs for care and support are supported.

Continued attendance and support at local authority vulnerability hub meetings where those at risk of abuse and neglect may be sign posted for a Home Fire Safety Visit or further engagement. Prevent delivery teams provide continued support adults who misuse drugs and alcohol and pose a fire risk both with advice or fire prevention and suppression systems.

Voluntary, Community, and Social Enterprise (VCSE) organisations

Support Staffordshire have continued to support the VCSE sector through training and awareness raising. Self-neglect is specifically addressed in Voluntary Community and Social Enterprise (VCSE) Adult Safeguarding Training, illustrated with lived experiences using self-neglect case studies. Learners have given positive feedback upon achieving learning outcomes and putting learning into practice.

Hidden harm is incorporated into Voluntary Community and Social Enterprise (VCSE) Adult Safeguarding Training. VCSE organisations are engaged in some cases with adults with care and support needs who are hidden from statutory provision and may fall between eligibility gaps. Increasing awareness amongst these VCSE organisations is helping to support these adults.

Stats for 2024-2025 are:

- Safeguarding training courses and attendances – 6 Courses, 35 attendees
- One to one support with safeguarding matters – 17 organisations

VAST: As the Local Infrastructure Organisation for Voluntary, Community and Social Enterprise Sector Organisations in Stoke-on-Trent, VAST works to ensure best practice in all areas of delivery. We work with our members to ensure they have appropriate safeguarding policies and procedures in place for the work

they do. In addition to providing this bespoke support as required, we delivered one safeguarding training session to thirteen attendees in December 2024.

Trent & Dove have continued to provide mandatory Safeguarding Training for all its staff, with those directly involved in providing organisational advice as Designated Safeguarding Leads receiving additional specific training. As part of our wider commitment, we are rolling out mandatory training for all staff in terms of Domestic Abuse. Both training is also offered to key partners and stakeholders we work with.

ASIST Advocacy Services

Community awareness of adult abuse and neglect and how to respond:

ASIST have:

- Increased their staff training in relation to recognising and reporting abuse and neglect.
- Continued to raise awareness with other organisations in relation to the importance of advocacy within Safeguarding processes.
- Updated their policies and procedures.

Asist ensure outcomes are tracked and chased from the local authority with the adult informed and included, ensuring they do not 'get lost' in the system.

Through internal discussions and training Asist are more, aware, able and confident at reporting abuse and neglect.

- Asist have seen an increase in referrals from LA involving advocacy at an earlier stage in the safeguarding process.
- Asist have recently presented to SSASPB
- Asist continue to be represented at SSASPB Board ~~and~~ Subgroups and on SAR panels where appropriate

Domestic Abuse partnerships

Data Collection: Through work undertaken by Domestic Abuse governance arrangements, it was identified that Adult Social Care systems were unable to clearly define the number of DA related referrals made to specialist DA providers. Analysis undertaken with these DA providers evidenced the volume of Adult Social Care DA related referrals received and as a result recognised opportunities for greater DA related awareness and training for the sector. Whilst initial work has begun in this regard, it is recommended that further investment is needed from the Adult Social Care sector to support ongoing DA related training for staffing teams. This need is evidenced within the pan Staffordshire Domestic Abuse Needs Assessment (DANA 2024), to which valuable contributions were made by Adult Social Care representation.

A recommendation has also been made that both Staffordshire and Stoke-on-Trent Adult Social Care Teams review their internal DA Policy with view to increasing DA related knowledge and understanding, and ultimately DA related referrals to specialist Independent Domestic Violence Advisors (IDVAs) supporting the older cohort and those with a disability.

Public Awareness: In support of a general under-reporting of DA nationally and locally, work led through DA governance sought to continue to raise awareness and understanding of DA, encouraging adults with care and support needs to reach out for advice, guidance and support.

HM Prison and Probation Service

There have been a series of changes during 2024 -25 that have impacted how Probation Services in Staffordshire and Stoke on Trent manage and work with adults on probation. Changes have been implemented in response to system challenges around prison capacity and short notice requirements from government requiring increased planning for unanticipated increases in adults leaving prison. We have seen an amazing response from community partners at these times to support the successful re-integration of prison leavers into Staffordshire communities.

These changes mean that we can spend more time working at greater intensity with those adults who have greater need and pose the greatest risks to others.

The Probation Delivery Unit (PDU) has also split into two new PDUs (North and South Staffordshire) ensuring we have greater oversight of and ability to embed operational practices.

We have identified adult safeguarding as being one of our priorities, alongside child safeguarding and domestic abuse, that we expect qualified Probation Officers to engage with to maintain their skills and competence as practitioners. This has come under the guise of Professional Registration which we are rolling out across Probation Services and will ensure a consistency and quality of probation practice.

This year we have made massive strides into developing our understanding of offender health. This has included the presence of the HEP C Trust in our offices and the presence of, as a pilot, Staffordshire Healthwatch at our Burton probation office to support both staff and people on probation. This has produced positive engagement.

Finally, partnership working focussing on the safeguarding risks and needs of adults on probation continues to work effectively in Staffordshire South and North PDUs, as evidenced by positive working arrangements under MAPPA and Integrated Offender Management.

4. SSASPB Subgroup activity updates

Executive Group

The Executive Subgroup has continued to meet eight times a year, receiving updates from the other Subgroups and ensuring progress against the strategic priorities. The group has ensured that recruitment and induction of both the SSASPB Independent Chair, Adrian Green, and Business Manager, Stephanie Kincaid-Banks was successfully completed. The group also agreed a job share appointment for the administration role, with an increase of 0.2% to this resource in line with demand.

A development day was arranged in July which led to approval of the closure of the previous strategic priorities and agreement for the new priorities for the next three years. The strategic plan and constitution have been reviewed in response to these changes.

The Executive Group have developed and overseen governance processes including the risk register, contingency fund provision, audit outcomes and proposed new strategic priorities following the development day.

The Board's Safeguarding Policy and Procedures were updated and the executive Subgroup approved them and ensured that they were shared appropriately on the website and to board partners.

Ruth Martin

Principal Social Worker and Safeguarding Lead - Health and Care; Staffordshire County Council

SSASPB Executive Group Chair

Audit and Assurance Subgroup

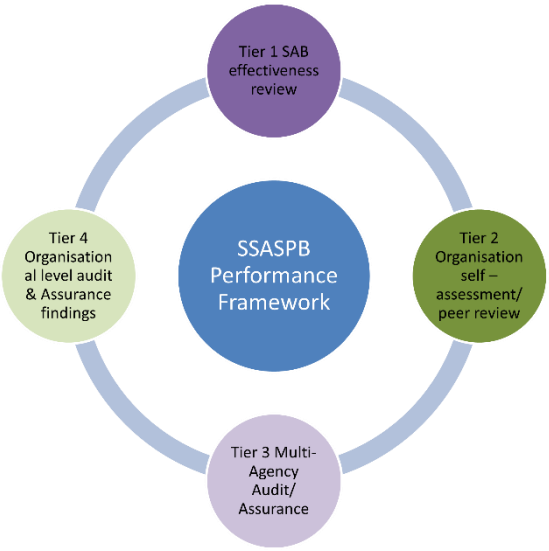
Achievements 2024–2025

The Audit and Assurance Subgroup has contributed to supporting the Safeguarding Adults Board (SAB) to assess the effectiveness and impact of safeguarding practice across the partnership, through a robust audit programme and performance oversight.

Multi-Agency Case File Audits: The Subgroup led and coordinated a programme of multi-agency case file audits, facilitating shared learning and a collaborative approach to identifying strengths and areas for development in safeguarding practice, specific to self-neglect and Person in a Position of Trust (PiPoT). These audits enabled partner agencies to reflect on decision-making, communication, and the application of safeguarding principles in complex cases.

Development and Implementation of the Performance and Audit Framework: The group implemented the refreshed the Performance and Audit Framework, establishing clearer expectations and accountability mechanisms across the partnership. The framework integrates subject specific data, qualitative findings, and outcome measures to better understand the effectiveness of safeguarding responses and to monitor trends.

Tiered Audit Programme: A key achievement has been the delivery of the structured, tiered audit programme:



- ✓ **Tier 1 – Audit of the SAB Constitution:** A comprehensive review was undertaken to assess alignment with statutory guidance and best practice. This audit confirmed that the Constitution remains fit for purpose and supports effective governance, strategic leadership, and transparency in SAB operations.
- ✓ **Tier 2 – Care Act Compliance Audit:** This audit focused on agencies' adherence to their duties under the Care Act 2014. Findings highlighted both strong commitment to safeguarding principles and areas where agencies are strengthening operational delivery.
- ✓ **Tier 3 – Multi-Agency Audit:** A thematic audit explored multi-agency safeguarding responses in cases involving self-neglect and persons in a position of trust. The audit identified positive examples of joint working, while also recommending improvements in information sharing and risk management practices.
- ✓ **Tier 4 – Single Agency Audits:** Health and Local Authority partners completed and submitted single-agency audits. These audits contributed valuable insights into organisational safeguarding arrangements and have been used to inform agency-specific improvement plans.

Impact and Learning: Learning from all audit activity has been disseminated through learning events, practitioner briefings, and shared with partners. The Subgroup continues to monitor action plans arising from audits to ensure that recommendations lead to tangible improvements in safeguarding practice.

Actions for 2025-2026

- Review the performance reporting arrangements and identify if they remain fit for purpose.
- Ensure that the multi-agency audit activity is well planned and focused on the board's priorities.
- Seek assurance that all partner agencies are completing single agency adult safeguarding audits to ensure that we have a shared understanding of practice and learning.

Sharon Conlon

Associate Director All Age Safeguarding & CYP Quality Lead; Staffordshire and Stoke-on-Trent Integrated Care Board

SSASPB Audit and Assurance Subgroup Chair

Performance and Engagement Subgroup (& Practitioner Forum)

This sub-group was formed to drive the work of the Engagement Strategic Priority.-The P&E subgroup works to a Communication and Engagement Plan that provides an overview of what has been done, what will be done and for whom – it is refreshed annually. Much of the focus of the work aims to raise awareness of what adult safeguarding is and how to report it; and will also help to prevent the abuse and neglect of adults with needs for care and support.

Performance against 2022/2025 Strategic Priorities

What have we done?

- ✓ Hosted an event for the Independent Reviewer of the Safeguarding Adult Review of 'Gillian' to present the findings and learning. This event was attended by 200 practitioners.
- ✓ Hosted Practitioner Forum events to discuss topics arising from the findings of SARs, on Professional curiosity. This event was attended by 177 practitioners.
- ✓ Supported the Ann Craft Trust National Safeguarding Adults Week in November 2024.
- ✓ Supported the inclusion of Advocacy services and Drug and Alcohol Services to the SSASPB membership in recognition of the findings from SARs locally and nationally.
- ✓ Produced the autumn and spring newsletters which was distributed widely. Topics included Advocacy, Sexual Safety in Residential Settings, Self Neglect, Learning from Audits, Modern Slavery Sexual Exploitation, Professional Curiosity and Festival of Practice.
- ✓ Produced a & point briefings on Person in a Position of Trust, Learning from SAR 'Frank and Elsie' and 'the Voice of the Adult.' These have been disseminated to all SAB members and can be accessed on the website

The Board has decided to maintain a focus on engagement under the Connect Strategic Priority for 2023/25. We will continue to focus on how to better engage with care and support needs who have experienced abuse or neglect.

Acknowledgements: Thank you to all members and partners, for their continued support and contributions to the subgroup and events.

Laura Collins

Head of Safeguarding, North Staffordshire Combined Healthcare NHS Trust

Prevention and Engagement Subgroup Chair

Safeguarding Adults Review (SAR) Subgroup

Throughout the last year there have been several changes to the chair of the SAR Subgroup. Whilst this is not ideal, the impact of this was minimised by police colleagues who sit on SAR discussions then in a position to chair. There is excellent support between the chair and the co-chair to ensure panels can meet in a timely fashion.

- The SAR group agreed on the development of a single agency report document template which has bought about consistency and improved the quality of reporting into the Exec for assurance.
- Reviewed SAR process to ensure effective and timely
- Worked with partners to develop the understanding and improve consistent application of SAR criteria.
- Assurance reporting from SoTCC about how they are prioritising carers needs and rights, including an audit of cases involving carers, assurance of prioritisation, risk assessment and additional resource to resolve assessment backlogs
- Produced a Sexual Safety toolkit to support staff in care and nursing homes in assessing and managing risks between adults (Frank and Elsie)

- Developed the Self-neglect policy into a toolkit to support a consistent response to self-neglect concerns, a recurring theme.
- Advocated at national levels for the development of
    - National guidance with respect to people in position of trust (PiPoT)
    - Achieving best evidence training in qualifying police education, and the provision of specialist investigating courses in post-qualifying training
    - Revised investigative guidance with the College of Policing, Ministry of Justice and Home Office
- Attendance at all SAR group meetings is consistent. The group have built strong relationships which in turn has allowed people to feel confident to speak openly and to professionally challenge where necessary.

John Miles

Interim Superintendent; Staffordshire Police

Safeguarding Adult Review Subgroup Chair

Policies and Procedures Subgroup

- The Policies and Procedures Subgroup meets ad hoc and is responsible for ensure the SSASPB policies and procedure remain fit for purpose.
- During this year, the group has revised the Adult Safeguarding Enquiry Procedures, available at https://www.ssaspb.org.uk/Guidance/Section-42-Adult-Safeguarding-Enquiry-Procedures.aspx
- They have developed a Self-Neglect toolkit that includes guidance and useful resource to support staff. All SSASPB policies, processes and guidance can be accessed at https://www.ssaspb.org.uk/Guidance/SSASPB-policy-process-and-guidance.aspx

Charlotte Barr; Safeguarding Team Leader; Staffordshire County Council

Mel Dixon; Quality Assurance, Audit, Policies and Procedures Officer; Stoke-on-Trent City Council

Policies and Procedures join Subgroup Chair**s**

5. Safeguarding Adult Reviews (SARs) – Cases referred in 2024/25

The Safeguarding Adult Review Subgroup members and representatives of other relevant agencies contributed to reviewing submitted cases against SAR criteria, sharing information and contributing to screening meeting discussions.

During 2023/24 a total of **32 SAR referrals were received**. This is a significant increase on the previous years (an average of five over the last three years) and the cases are reflective of the most complex areas of practice. There is no clear correlation between this increase, although it is a positive indicator that awareness of safeguarding and the SAR process is increasing in our area. There has been scrutiny of cases being referred that have not met criteria, to work with partners to ensure referrals are appropriate. However, most referrals have been meaningful in highlighting areas for challenge or assurance where SAR thresholds have not been met.

Sensitivity warning: Safeguarding Adult Reviews are focussed on reviewing an individual's circumstances and experiences to learn lessons and improve how agencies work together and with adults at risk. The cases often involve adults who are vulnerable, have complex needs and who have been experienced significant abuse or neglect. This report only provides a brief overview of circumstances, however these can be upsetting or triggering for individuals. Please consider your wellbeing before reviewing this section.

Eight (8) cases met the criteria for a SAR and will be progressed by SAR panels in 2024/25.

Ten (10) cases did not meet the criteria for a SAR but did highlight learning for individual agencies, with updates and assurances reported into the Safeguarding Adult Review Subgroup.

Six (6) cases did not meet the criteria for a SAR and did not require further action by partners or the Board.

As of 31st March 2024, there are **eight (8) referrals carried forward** that either have screening meetings arranged or are awaiting the Independent Chairs agreement with the SAR screening panel recommendations.

6. Safeguarding Adult Reviews (SARs) Learning and actions

All three cases in this section were referenced in last year's annual report and have concluded. This section highlights the learning and action taken following SSASPB Boards accepting the authors recommendations. Full reports, summaries and relevant tools and guidance can be found at https://www.ssaspb.org.uk/About-us/Safeguarding-Adult-Reviews.aspx?123

Clive Treacey

Clive's family requested that his real name be published to ensure his experience contributes to raising awareness and preventing future harm. The full report was published in April 2024, following SSASPB's acceptance of the seventeen recommendations made by the Independent Reviewer.

The board have also consulted with Clive's family who have at times given constructive challenge to the response that board partners have given to the recommendations. This has led to changes being made to the action's being taken. The recommendations included areas of the need for national guidance and training for teams working with and investigating abuse of adults, the use of professionals to support complex investigations and the support given to families after abuse has occurred and during the safeguarding adult review process. Several of the actions are for national responses but the board is committed to looking at our local responses and to continuously improve.

Key Learning and Actions Taken:

- ✓ SSASPB has reflected on the positive changes in multi-agency arrangements and information sharing in line with the Care Act 2014 requirements.
- ✓ Staffordshire Police have provided assurances that specialist advice is sought related to complexities in cases involving vulnerable adults, both from and used to inform Crown Prosecution Service (CPS) decisions.
- ✓ We have received presentations and assurances from the Transforming Care Team and our local authority and Integrated Care Board partners about the guidance, commissioning expectations and audit activity in place to ensure compliance with statutory guidance for out of area placements.
- ✓ SSASPB audit tools have been developed to ensure all multi-agency case file audits consider the themes in Clive's case, including making safeguarding personal, mental capacity, closed cultures and decision-making and recording.

Frank and Elsie

Following a serious safeguarding incident in which a nursing home resident, Frank, raped another resident, Elsie, the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board commissioned a Safeguarding Adult Review (SAR). The review met the statutory criteria under the Care Act 2014 to promote learning and prevent future harm.

Scope of the Review: While Elsie was the victim of the most serious incident, the review focused on how Frank—who had a known history of harmful behaviour—was placed in a setting where he had access to vulnerable adults. The review examined systemic failings, including placement decisions, risk management, and safeguarding responses.

Key Learning and Actions Taken:

- ✓ Training and Learning: In November 2023, Dr. Laura Pritchard-Jones delivered a session on Mental Capacity and Sexual Safety to 109 practitioners. Resources from this session are available for ongoing use and will be hosted under a new 'Sexual Safety' section on the SAB website.
- ✓ Policy and Practice Updates: The Board's safeguarding procedures have been revised to reflect learning from the SAR. A practitioner forum is scheduled for July 2025 to support implementation and awareness of updates, including areas such as self-neglect, safeguarding plans, and People in Positions of Trust (PiPoT).
- ✓ Sexual Safety Resource Kit: Developed and approved in March 2025. It includes guidance on risk assessment and examples of behaviours that may indicate risk. The toolkit has been widely disseminated via the SAB website, MIDOS platform, Social Care Academy, and care networks including Personal Assistants (PAs).
- ✓ Sector Engagement: The Staffordshire Association of Registered Care Providers (SARCP) is actively involved in dissemination. A podcast is in development to improve accessibility and engagement.
- ✓ Audit and Assurance: A follow-up audit is scheduled for 2025/26 to assess the visibility and impact of the toolkit.

Frank and Elsie learning brief:

7. Further reading/references:

The SAR final report – SAR Frank and Elsie Final Report

The Toolkit – Sexual Safety Resource Kit for Care Homes

6. Response:

Bespoke Mental Capacity and Sexual safety training was commissioned by a leading academic for all SSASPB partners (Nov 23) and attended by over 120 practitioners and supervisors.

The need to use accurate descriptive language to describe behaviour and body parts is being reinforced through its use in all SSASPB procedures and learning events. This will support accurate risk assessment and minimise ambiguity. Supervisors and front line staff should consider use of the Mental Capacity Act to assess capacity where this may be in doubt and conduct assessments which are recorded. Supervision should be used to discuss when to conduct one if unsure, decisions to be recorded.

5. Response:

Guidance has been produced in the form of a toolkit and has been produced with the engagement of representatives from care and nursing homes.

The toolkit includes a poster to help with immediate action following an incident of rape and other sexual assaults, a Sexual Safety Intervention guide which includes detailed information on risk and gives examples of behaviours, a leaflet for resident adults and their families and a reading list.

Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

Abuse must stop

4. Findings:

Staff in residential care are not adequately equipped to distinguish consensual sexual activity from sexual assault, based on an assessment of an individual's capacity to consent.

This is reflected in unclear language to describe sexual activities and increases the chances of downplaying both the risks an individual may pose, and the needs of others for protection.

1. Why was there a Safeguarding Adult Review (SAR)?:

A Safeguarding Adult Board must conduct a SAR when

- an adult in its area

- with needs for care and support

- experiences serious abuse (includes sexual assault) and

- there are concerns about how Board partners worked together to protect them

2. Circumstances: Frank and Elsie were residents in a Nursing home, both had dementia. Neither were able to consent to sexual activity.

Frank exhibited sexualised and physically aggressive behaviour towards women, both staff and residents. His behaviour was escalating and he was considered a risk to women.

He was particularly focussed on Elsie and was found raping her in a toilet by a member of staff.

3. Findings:

There was no specific sexual safety guidance for care/nursing homes.

It was recommended that this be developed with engagement from care and nursing home staff and managers.

The guidance is to include examples of behaviours together with what risk this may present and suggested actions to take.

Gillian learning brief

Why was there a Safeguarding Adult Review for Gillian:

Section 44 Care Act 2014 provides the following circumstances when a Safeguarding Adult Board should carry out a SAR

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect..., or c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse neglect.

1

Who was Gillian:

Gillian was a 69 year old woman who lived alone in warden controlled accommodation. After complications with her physical health Gillian became unable to walk and manger her needs for daily living. Gillian also began to consume increased alcohol and required support to manger her needs which she was not always happy to receive. Gillian died of sepsis in hospital in 2023.

2

Rec. 1: The Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) should seek assurance that partner agencies use training sessions, learning events and one-to-one management meetings to support their staff to recognise self-neglect, especially when someone is receiving care and support services, and to use the self-neglect process, including holding MDT meetings.

Rec. 2: The SSASPB should seek assurance from partner agencies that where interventions are planned for an individual who has a history of service refusal, relevant professionals are involved in planning for how they might avoid, minimise or otherwise respond to, future refusals.

3

Safeguarding Adult Review 'Gillian' 7 Point Brief

Rec. 3: The SSASPB should seek assurance from partner agencies that they listen to the needs of people who self-neglect and support and facilitate access to interventions they want and are willing to receive even if these are outside the traditional remit of services

Rec. 4: The SSASPB should assess whether the local care market and housing support has the skills available to meet the needs of people who self-neglect, and if it falls short, consider how the care market may be encouraged and supported to develop such skills in sufficient quantities.

4

Rec. 5: The SSASPB should seek assurance from partner agencies that, where appropriate, mental capacity assessments of people who self-neglect are made jointly with someone who knows them, has a relationship with them and also has an understanding of alcohol related brain damage and its impact on mental capacity.

Rec. 6: The SSASPB should consider how people can best be supported in circumstances where they are mentally capacious, self-neglect, refuse help and have made a decision about the quality of their life.

5

6

Next Steps:

The SSASPB SAR sub group will now work on an action plan to ensure that the recommendations identified by the independent author are embedded in order to improve practice.

Action may include seeking assurance from specific / named organisations, undertaking audits to understand where to target learning and training, producing a self neglect flow chart to support the embedding of the self neglect policy. The completion of these actions will be monitored by the SAR sub-group.

Further References:

The full Gillian SAR can be found here

GILLIAN FINAL May 2024

Further information on the SAR process can be found here

Safeguarding Adult Reviews (SARs)

7

Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

Abuse must stop

7. 2024/25 Analysis of Adult Safeguarding Performance Data

This section provides commentary and analysis of safeguarding data from Stoke-on-Trent and Staffordshire. Please note that in many sections the percentage has been rounded to the nearest whole number and therefore not all percentages will add up to 100%.

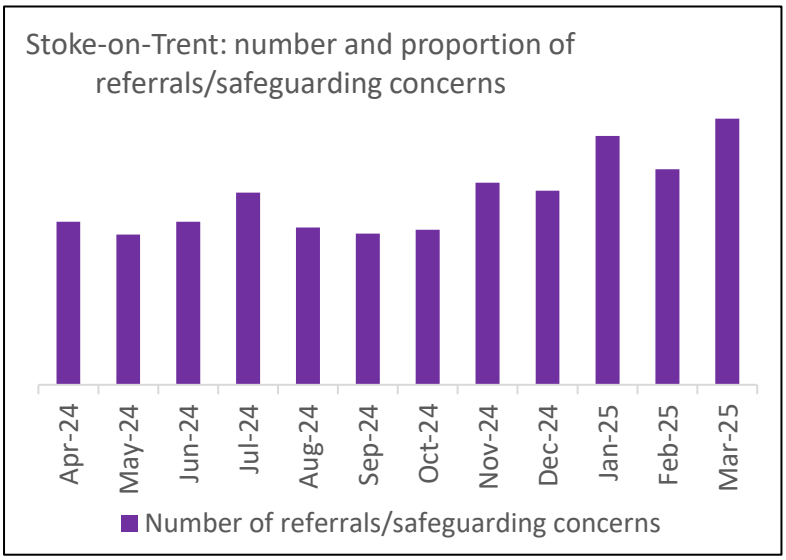
Number and proportion of referrals/safeguarding concerns

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

Number of safeguarding concerns received in 2024/45

Staffordshire	Stoke-on-Trent
16,445	3,701

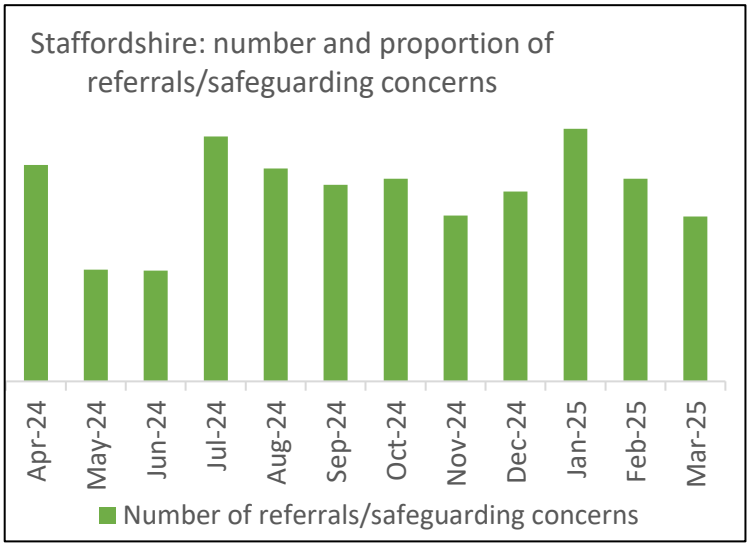
Reported concerns can progress to a formal enquiry under Section 42 of the Care Act 2014 if the criteria for the duty of enquiry requirement are met. In cases where a statutory response is not required the local arrangements ensure signposting and engagement as necessary with appropriate support services.



In Stoke-on-Trent there were 3701 reported safeguarding concerns in relation to adults with care and support needs during 2024/25. This is a decrease of 518 concerns, 12% from concerns received in 2023/24 (4219 concerns in 2023/24).

Following initial assessment, it was determined that the duty of enquiry requirement was met in 22% of occasions when a concern was raised. This is up from 15% in 2023/24.

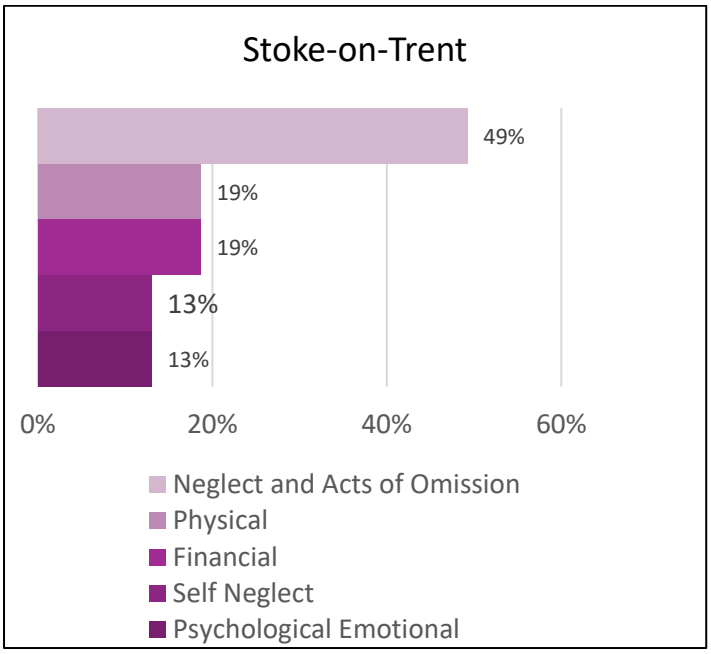
During 2024/25 in Staffordshire there have been 16 445 occasions when concerns have been reported that adults with care and support needs who may be at risk of or are experiencing abuse or neglect.

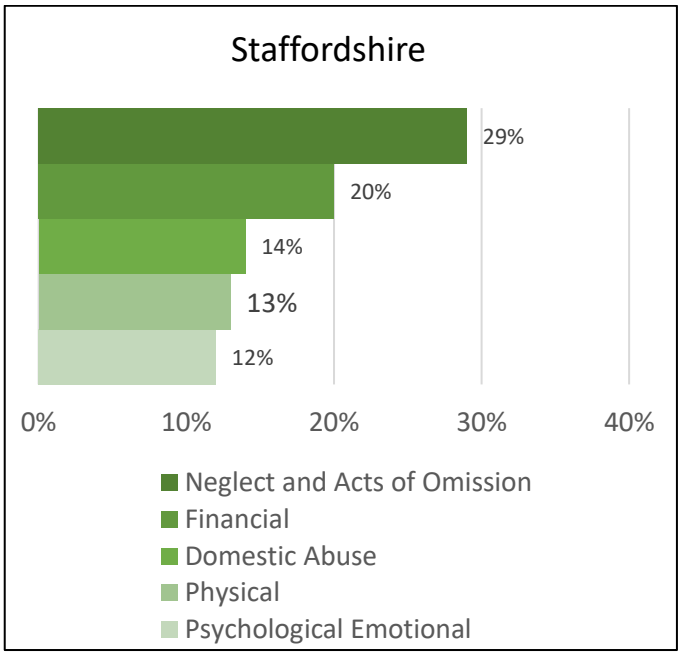


The total figure has increased by 635 occasions from 15, 810 in 2023/24 which is an increase of 3.86 % from the previous year. Training has been delivered to service provider regarding their safeguarding responsibilities, and this may have helped to ensure that whilst they are aware of their safeguarding duties, there is also a greater awareness of when other processes are more appropriate.

This year the duty of enquiry requirement was met in 19% of reported concerns, an increase of 3% from 2023/24 (16%). This is a not a significant increase and may be reflective of the overall increase in safeguarding referrals.

Most prevalent type of abuse referred





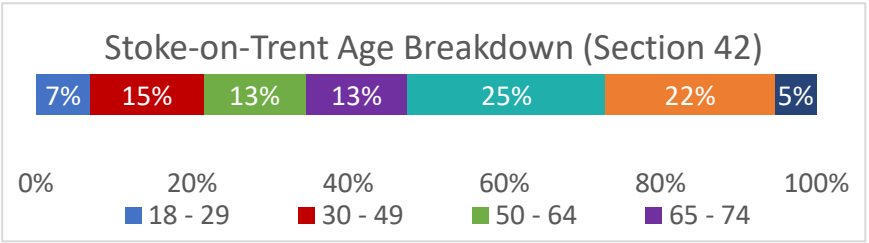
Repeat Enquiries

In Stoke-on-Trent, 11% of the adults who were the focus of a section 42 enquiry process during 2024/25 had previously been the subject of a section 42 enquiry process within the preceding 12 months. The percentage of repeat referrals was 12% in 2023/34 and 11% in 2022/23.

In Staffordshire, 20% of adults involved in a Section 42 Enquiry had previously been involved in an enquiry in the past 12 months. This compares to 17% in the previous year.

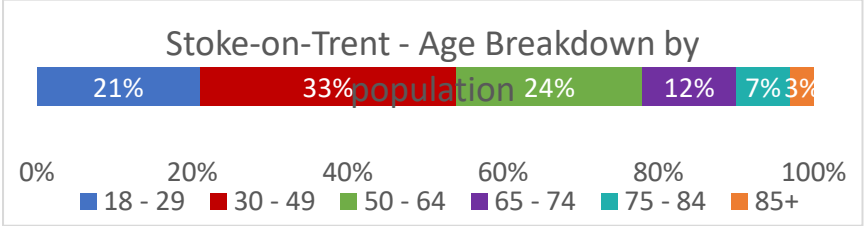
About the Person

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 care and support and this information is provided below.



Stoke-on-Trent Age data:

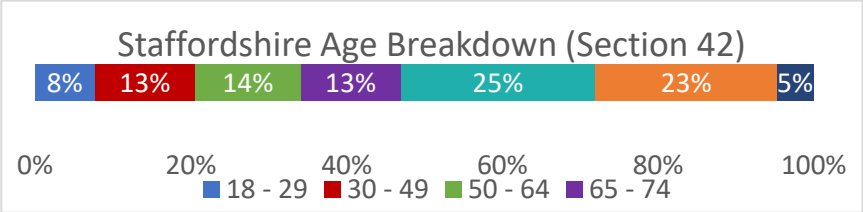
For Stoke-on-Trent, of the adults who have been the subject of a Section 42 enquiry, those aged 75–84 (25%) represents the largest cohort along with the 85-94 (22%). These cohorts have increased when compared to 2023/24 where both cohorts represented 18% each.

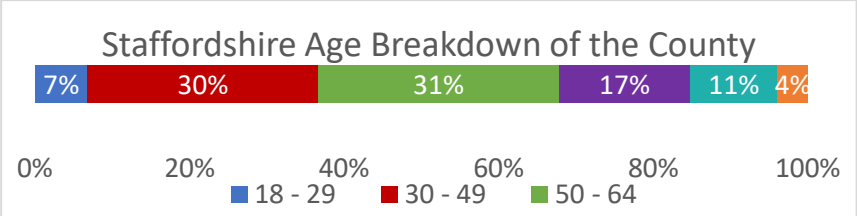


When comparing the age breakdown with the general Stoke on Trent population figures, it is important to note that it is a metropolitan area that

does tend to skew towards the younger age groups.

Staffordshire Age data:





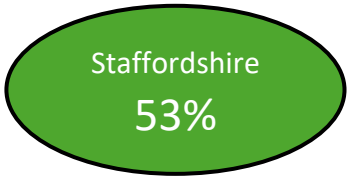
Of the adults who have been the subject of a Section 42 enquiry, those aged 75–84 (25%) represents the largest cohort followed by 85- 94 (23%).

This is consistent with the data from the previous reporting period.

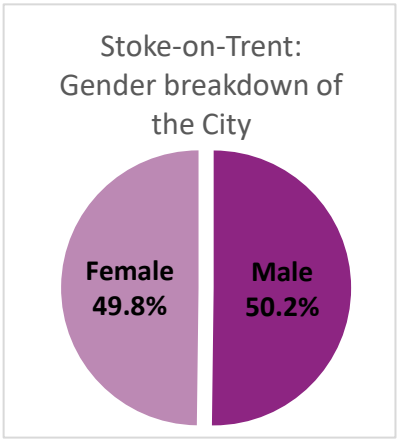
When comparing the age breakdown with general Staffordshire population statistics, it is evident that people in the 75+ age groupings are disproportionally overrepresented for Section 42 enquiries. Around 12% of the adult population in Staffordshire are aged 75 or over, however, 53% of safeguarding enquiries relate to this age group (this includes the 5% aged 95+).

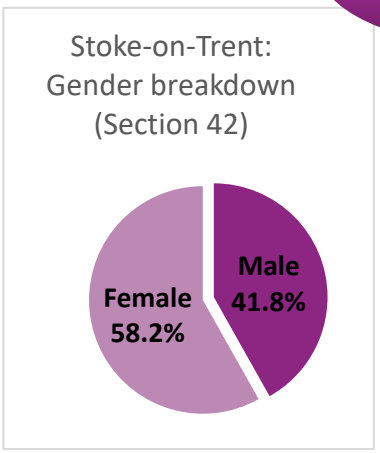
However, in the context that care and support needs can increase with ageing, some disproportionality by age is to be expected.

Percentage of safeguarding enquiries regarding adults aged seventy-five and over:



Stoke-on-Trent Gender data:



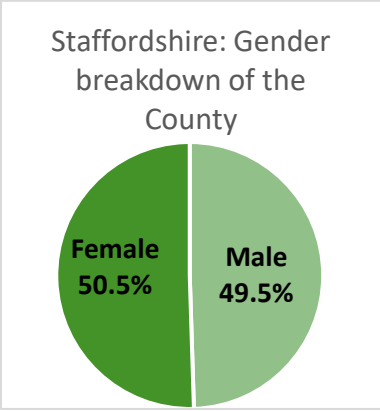


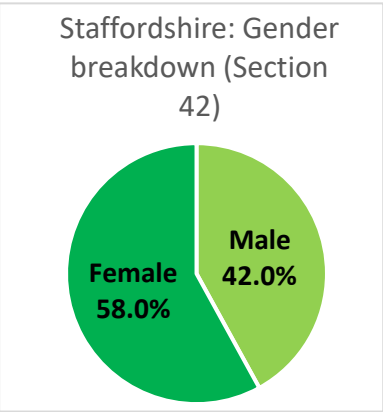
Men in Stoke on Trent have a life expectancy of 76.5 years and for women 80.2 years, there are also more concerns raised for women this year which may be because there are more women who are older and the older the population the greater the need they may have for care and support.

In 2024/25 58% of adults who were the focus of a section 42 enquiry process, were female. Last year this was 59%. This is not unexpected and may be partially due to women having a higher life expectancy by 4.8% (3.7 years) and having more needs for care and support in later life.

Audits conducted by the SSASPB also highlight that women, particularly in the over 65 years bracket appear to be more vulnerable to abuse and neglect.

Staffordshire Gender data:





Females represent the majority of adults subject of a Section 42 enquiry with 58% over the year. The average life expectancy for a man living in Staffordshire is 79.7 years and for a woman 83.5 which may explain why there are more enquiries for women than for men.

This seems consistent with the national picture over the last few years. However there has been an increase of 6% in reporting of adult males subject to a Safeguarding enquiry from 36% to 42%. It is noted that there has been an increase in the reporting of Domestic Abuse concerns, therefore this may be in part, an indication of an increasing awareness that males can also experience domestic abuse. Further understanding will be required if this trend continues.

Ethnicity data

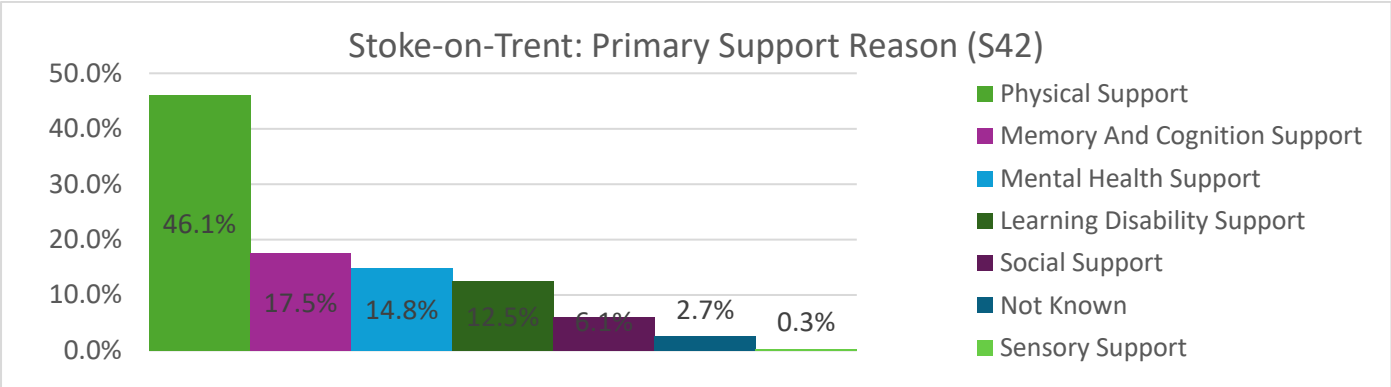
	Stoke-on-Trent Section 42 Enquiries (Apr 24 to Mar 25)	Stoke-on-Trent Overall Population (Census 2021)	Staffordshire Section 42 Enquiries (Apr 24 to Mar 25)	Staffordshire Overall Population (Census 2021)
White British	92.3%	78.5%	86.1%	90.2%
Not Known	1.8%	-	3.0%	
Pakistani	1.8%	6.0%	1.0%	1.3%
Not Stated	1.3%	-	1.1%	
Other White	0.9%	4.5%	1.0%	2.9%
Mixed White/Caribbean	0.4%	0.8%	3.0%	0.8%
Black Caribbean	0.4%	0.4%	0.5%	0.3%
Indian	0.3%	1.1%	0.3%	1.1%
Any other Mixed background	0.3%	1.5%	3.8%	0.0%
Any other Asian Background	0.1%	1.8%	0.0%	0.8%
Gypsy /Roma	0.1%	0.3%	0.0%	0.1%
Any other Black Background	0.1%	0.4%	0.0%	0.1%
White Irish	0.0%	0.2%	0.0%	0.4%
Bangladeshi	0.0%	0.6%	0.0%	0.1%
Black African	0.0%	2.0%	0.1%	0.4%
Any other ethnic group	0.0%	1.8%	0.1%	1.4%
Arabic	0.0%	0.3%	0.0%	0.1%

In Stoke-on-Trent, most individuals who were the focus of a section 42 enquiry process were 'White British' at 92.3%, an increase from last year (84.7%). The next largest declared groups were 'Pakistani' 1.8% and 'Other White' 0.9%. The 'Not Known' category was 1.8%, a decrease from 5.8% the year before, reflecting efforts to improve recording of ethnicity.

The pattern is similar in Staffordshire with most declared ethnicities as 'White British' 86.1%, there appears to be no change in this data from the previous reporting period. There has been an improvement of 'Not Recorded' reduced to 1.1% from 5.8% last year. The importance of recording accurately has been emphasised over the last year which may be the reason for the improvement.

Most prevalent primary care and support need (PSR: Primary Support Reason) 2024/25

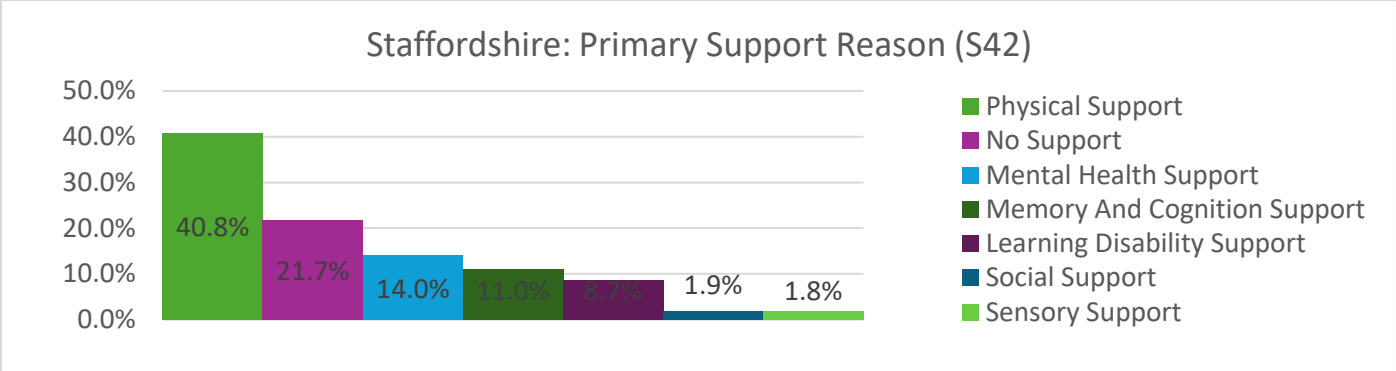
Stoke-on-Trent primary support needs:



Physical Support represents the largest proportion of primary support reasons recorded in Stoke on Trent at 46.1%, followed by Memory and Cognition Support with 17.5%. These figures were 37% and 10% respectively in 2023/24.

In 2023/24 12% of Primary Support Reasons (PSR) were not recorded. In 2024/25 this has reduced to 2.7% following efforts, including regular audits, to ensure appropriate recording of Primary Support Reason in Stoke-on-Trent.

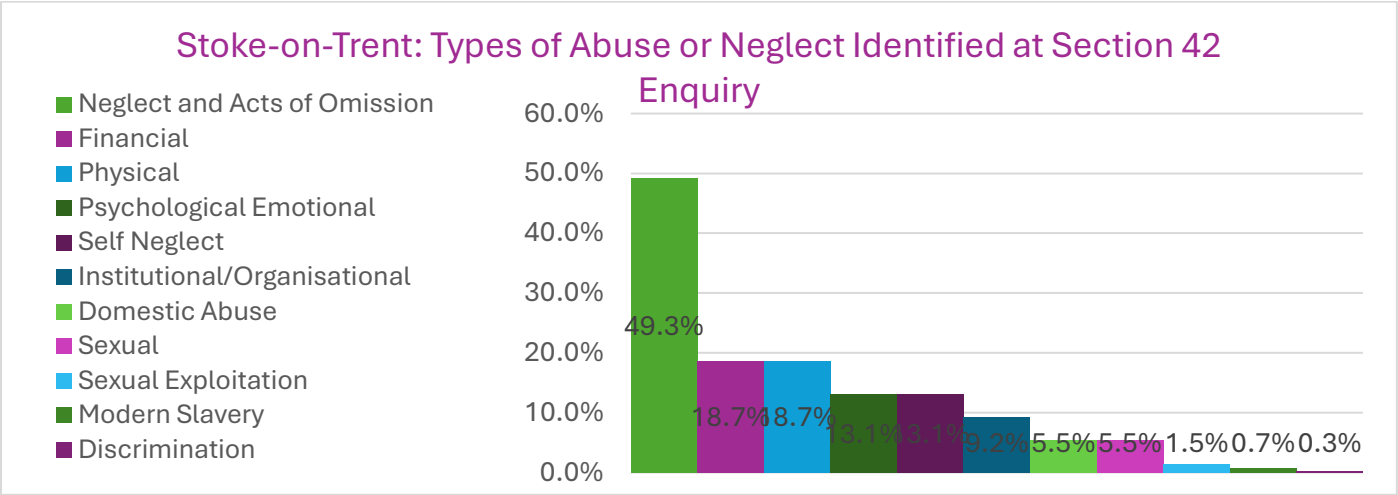
Staffordshire primary support needs:



Physical support continues to be the most common primary support reason in Staffordshire recorded at 41% a 6% difference to previous years data with a small decrease in the areas of Memory and Cognition and Social Support. With slight increase in the areas of Mental Health, Learning Difficulties and those deemed to have no primary support reason.

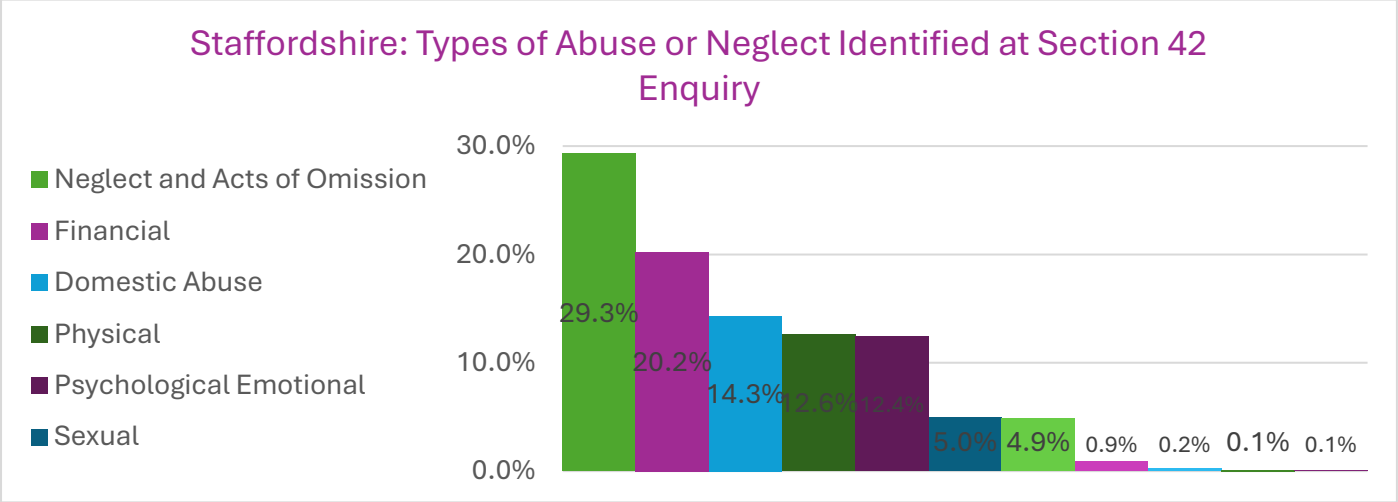
'No support' indicates that, although an adult may have care and support needs, there is no primary need documented in the system. This typically occurs when the local authority is not delivering any services to the individual. This typically applies to cases where safeguarding concerns involve adults whose support is funded by other sources, e.g. health budgets, other local authorities, or self-funded.

Types of Harm or Abuse identified at Section 42 safeguarding enquiry



In Stoke-on-Trent, Neglect and Acts of Omission was the most prevalent type of abuse at 49.3%, which is in line with last year where it was 49.5%. Financial abuse was the next most frequently reported at 18.7% along with Physical Abuse that was also at 18.7%. Last year these were 20.1% and 19.9%, respectively.

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



In Staffordshire, there are no significant changes to the percentages reported in 2023/24. Neglect and acts of omission continues to be the most prevalent type of abuse at 29%. The next most frequently types of abuse are Financial, Domestic Abuse, Physical, Psychological and emotional. There are no significant differences in the percentages from previous reporting periods.

Self-neglect is a theme which is disproportionately represented nationally in Safeguarding Adult Reviews (SAR's) and has also been a theme within three local reviews. Consequently, self-neglect has been an area of focus by the board over the last reporting year and this may be reflected in a slight increase of 3% of reported concerns. Further resources have been developed in relation to self-neglect and the Board plan further audit activity within the next reporting period to consider the impact of these and to inform further actions needed.

It is believed that organisational abuse remains under-reported at 1%. This is believed to be owing to there being only one type of abuse that can be recorded in Staffordshire case management systems and other categories are selected at the point of recording to describe the abuse e.g. physical abuse.

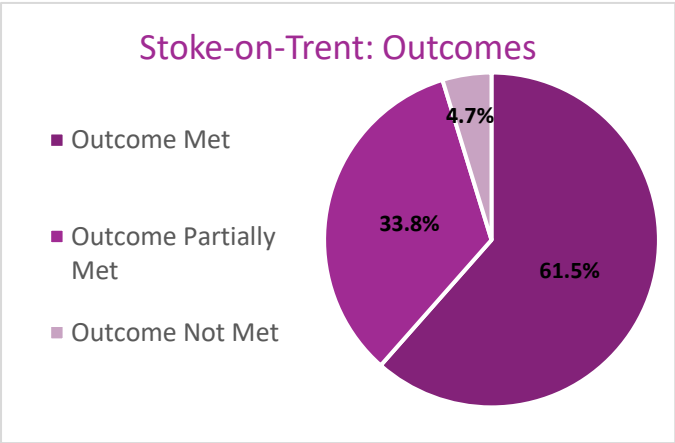
Location of abuse

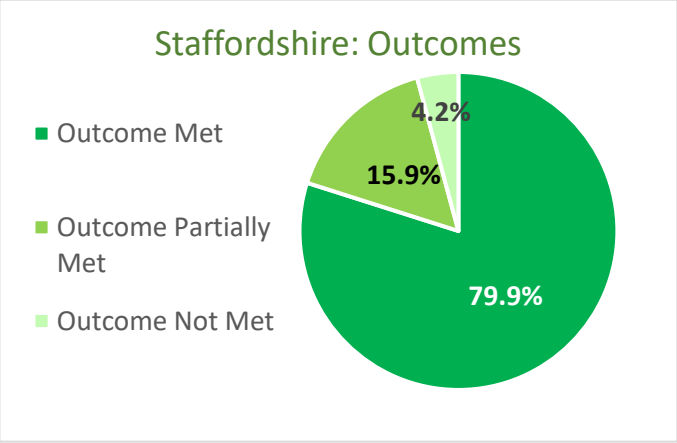
Local Authority Area	Own Home	Residential Home	Nursing Home	Hospital	Supported Housing	Community based service	Other	Not recorded
Stoke-on-Trent	33.8%	20.2%	19.1%	12%	6.8%	0.7%	14.8%	4%
Staffordshire	64.5%	12%	14.5%	3%	3.3%	0.9%	1.8%	N/A

The most prevalent location of abuse in Stoke-on-Trent was in the person's own home (33.8%) a decrease from 38.7% the previous year. This was followed by Residential Home with 20.2% and Nursing Home 19.1%. These are often seen as the largest three location types. Location Not Known accounted for 4.0%.

In Staffordshire, of those people subject of Section 42 enquiries, the most common location of abuse or neglect was the person's own home (64%) compared to 67% in 2022/23. The next most common locations in Staffordshire were independent nursing homes at 15% a slight increase from 10% last year and residential home has remained at around 12%.

Proportion of people who were involved in a Section 42 enquiry whose expressed outcomes were met





In Stoke-on-Trent, outcomes data is collected by a social worker who has been working with the adult and able to obtain the adults opinion. In Stoke-on-Trent, 47% of adults who were the subject of a section 42 enquiry process provided a response, an increase from 43% in 2023/24. 95% of these stated that their desired outcomes were fully met or partially met. This is a slight increase from 94% last year.

In Staffordshire, it is positive that people defining the outcome that they want has increased from 63% to 71% over the last reporting period. This may be indicative of the work in ensuring that peoples expressed outcomes are established.

Of those who had defined their outcome, 96% of adults stated that their desired outcomes were fully met or partially met. This is the same figure as reported last year.

The data is collected by the enquiry worker at the close of the enquiry who will discuss with the adult or their representative their opinion on whether the enquiry has met, partially met, or not met their preferred outcome. However, it is still acknowledged that there is further work to be done to have more of an understanding.

Other performance indicators in 2024/25

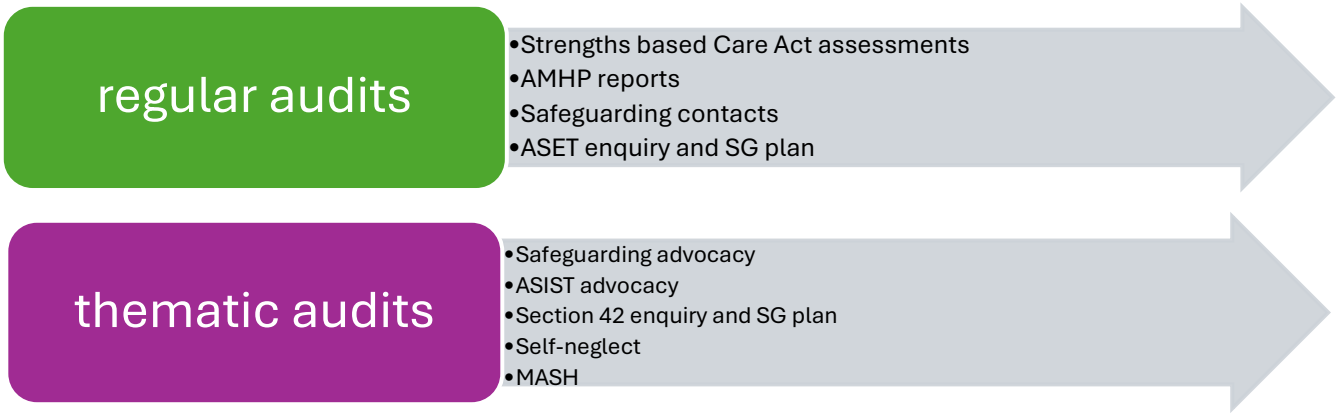
CQC feedback: The Care Quality Commission inspected Adult Social Care in Staffordshire and Stoke-on-Trent during 2024/25. Both Local Authorities were rated good overall, including a good rating for the Safeguarding domain.

CQC noted for both Local Authorities:

- Effective senior level leadership and oversight of safeguarding.
- There was a clear understanding of the safeguarding risks and issues in the area. The Quality and Safeguarding Information Sharing Meetings (QSISM) which reduce risks and prevent abuse and neglect from occurring.
- When people experienced serious abuse or neglect, action was taken to reduce future risks and drive best practice.
- There were clear standards and oversight arrangements in place for responding to information of concern and for conducting S42 enquiries.
- With reference to the Safeguarding Board, there was a strong multiagency partnership, and it was clear that the board held organisations to account on three key themes that they had chosen to work between 2023-2025.
- The SSASPB held organisations to account to get them to report against their progress on learning from SARs.

Quality of safeguarding practice: A range of audit activity is undertaken across our services to ensure that we have an overview of the quality of our safeguarding practice.

In Staffordshire County Council, a programme of regular and thematic audit activity including safeguarding elements is in place.



Key positive practice from these audits:

- ✓ All safeguarding referrals audited were of high quality.
- ✓ 99% of Care Act assessments and 98% of AMHP reports identified any safeguarding concerns and took appropriate action, including raising a safeguarding referral or taking mitigating action.

- ✓ Improvements in the proportion of people able to engage in the enquiry or being offered appropriate support to engage (88% 2024, 75% 2023).
- ✓ All the appropriate people were included in more enquiries (82% 2024, 62% 2023).
- ✓ 93% of S42 enquiries were proportionate.
- ✓ For self-neglect, improvements were seen in engaging with people, consideration of mental capacity, multi-agency working, decision making.

Areas for improvement identified:

- Increasing the number of people who are supported to express their outcomes.
- Consistently sharing findings and recommendations of S42 enquiries with relevant people and agencies.
- Continue to improve the identification of self-neglect.
- Understand the reasons for self-neglecting behaviours and the long-term impact more consistently.

Within Stoke-on-Trent City Council there is a regular audit cycle which monitors the local authorities' statutory responsibilities and can be tailored to include specific areas of focus as they arise.

Key positive practice identified from these audits:

- ✓ There was good evidence of risk management and immediate protection when supporting adults where safeguarding concerns have been raised.
- ✓ Risk management within Section 42 Enquiries – there is continued effective risk management throughout the Section 42 Enquiries to keep adults safe.
- ✓ Multi-agency working – working well with others, calling on them for expertise and involving them in decision making where required

Areas for improvement identified:

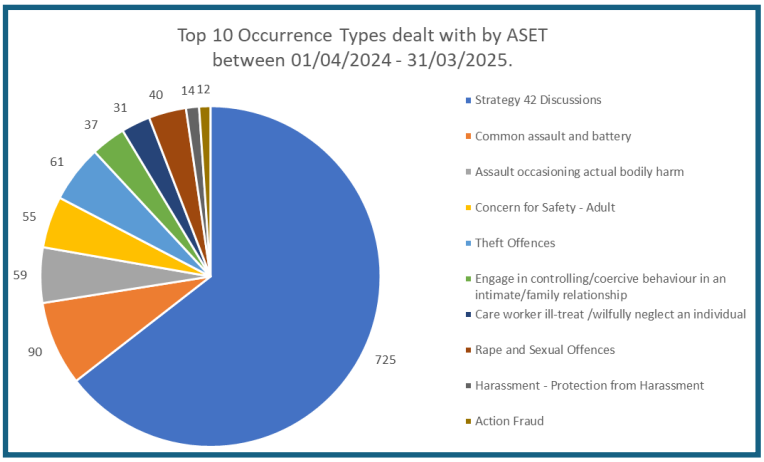
- Voice of the adult – assessments are thorough but focus needs to remain on prioritising and recording clearly the voice of the adult more consistently, for example using quotes.
- Considering past referrals – Identifying patterns and trends through previous referrals needs to continue to ensure we have all the information required to make an informed decision.
- Making safeguarding personal – **Have clearer conversations to understand what the adult wants to achieve and help them work towards it. This includes times when there are concerns about their mental capacity, and their representative may need to be involved.**

Staffordshire Police data: Between 1 April 2024 and 31 March 2025, a total of **1,192** logs were recorded where officers from the ASET team were assigned. Of these:

- **360** resulted in a criminal investigation
- **725** did not progress to a criminal investigation but involved a Section 42 strategy discussion under the Care Act 2014
- **107** led to a non-crime investigation or an enquiry into concerns for safety

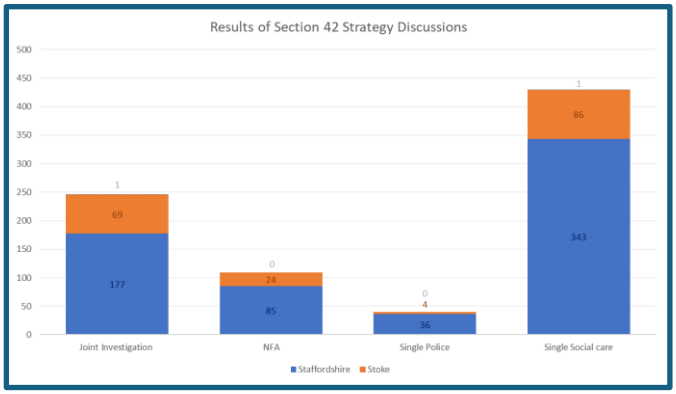
These figures highlight the breadth of safeguarding work undertaken by ASET, spanning both criminal and non-criminal interventions.

The adjacent chart shows the top ten investigations, crime types and section 42 strategy discussions managed by the Police Adult Safeguarding Team between this period 1 April 2024 and 31 March 2025.



Within this same reporting period, a number of crime investigations led by ASET have progressed to assigned outcomes. These outcomes include charges, cautions, community resolutions, and cases where evidential difficulties or other factors have prevented prosecution.

While the earlier data reflects a portion of the work undertaken by the dedicated Adult Safeguarding Enquiry Team, it does not capture the full extent of the team's remit. Many investigations are led by other departments with then specialised support from ASET, and additional safeguarding activity will then take place outside of criminal thresholds.



Since July 2024, measures have been introduced to better capture these contributions beyond criminal investigations. Although a full 12 months of data is not yet available, the six-month dataset from 1 October 2024 to 31 March 2025 provides the insight so far into wider safeguarding activity. This includes information sharing and Section 42 strategy discussions that may not meet the criminal threshold.

8. SSASPB Board Membership and Attendance

SSASPB Partner Organisation	April 2024	July 2024	October 2024	January 2025
Staffordshire County Council	✓	✓	✓	✓
Stoke on Trent City Council	✓	✓	✓	✓
Staffordshire & Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓
Midlands Foundation Partnership Trust	✓	✓	✗	✓
Staffordshire Fire and Rescue Service	✓	✓	✓	✓
Staffordshire Police	✓	✓	✓	✓
University Hospital of Derby & Burton	✓	✓	✓	✓
University Hospital of North Midlands	✓	✓	✓	✓
ASIST	✗	✓	✓	✓
Brighter Futures	✗	✓	✓	✓
Changing Futures	✓	✓	✗	✓
Domestic Abuse Providers Network	✓	✓	✓	✓
Healthwatch Stoke-on-Trent	✗	✗	✗	✗
Healthwatch Staffordshire	✓	✓	✓	✓
National Probation Service	✓	✓	✗	✓
North Staffs. Combined Healthcare NHS Trust	✓	✓	✗	✓
Practice Plus	✗	✓	✓	✓
Stafford Borough Council	✓	✓	✓	✓
Staffordshire Association of Registered Care Providers	✗	✓	✓	✓
Staffordshire Domestic Abuse Commissioning Board	✗	✓	✓	✓
Support Staffordshire	✓	✓	✓	✓
Trading Standards	✓	✗	✗	✗
Trent & Dove	✓	✓	✗	✗
VAST	✓	✓	✓	✓
West Midlands HM Prison Service	✗	✗	✗	✗

✓ Attended or sent nominated deputy

✗ Gave apologies/ did not attend

9. Contact us

You can contact the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) team by emailing ssaspb.admin@staffordshire.gov.uk

You can find out more about SSASPB on our website www.ssaspb.org.uk

Please note that SSASPB are a partnership arrangement and not the same as the local authority safeguarding teams.

If you have concerns that an adult is at risk of or is experiencing abuse or neglect, please contact either Staffordshire County Council or Stoke-on-Trent City Council safeguarding teams, dependent on where the abuse is taking place.

'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'.

Abuse occurred in Stoke on Trent: Telephone 0800 561 0015

Abuse occurred in Staffordshire: Telephone 0345 604 2719

Further information about the Safeguarding Adult Board and its partners can be found at:

www.ssaspb.org.uk