Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

Abuse must stop

SSASPB Annual Report 2023 to 2024

NHS

City of Stoke-on-Trent

Staffordshire County Council

Staffordshire Police

'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'.

If the abuse occurred in Stoke-on-Trent: Telephone 0800 561 0015

If the 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

1. Contents

1. **Independent Chair Foreword**

This comprehensive report is informative in several ways. It brings visibility to the work done through the Board and illustrates, once again, how it adds value in the enormous amount and range of safeguarding activity done in partnership, much of which builds on learning from good practice as well as where things have gone wrong.

The constant challenge for the Board – and it continues to be a big one - is to demonstrate and evidence that the necessary changes in practice needed in response to the learning from recurring themes have been implemented by safeguarding partners to mitigate the potential for future recurrences of harm. I continually observe that the challenge is made more difficult by many of the partner organisations being in positions of constant structural change, with increasing workload demands, and the reality of having to do more with less resources.

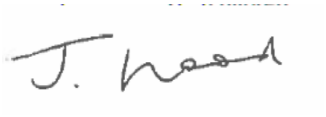
As you will read there are five themes to the Effective Practice priority. The report demonstrates the inclusive approach to safeguarding and reflects the appetite of the partners to tackle and make progress on a range of recurring themes. The updates of actions and their positive impacts, some illustrated with case studies, have lengthened this report.

After 9 years as the Independent Chair, it is time for me to retire from a role that it has been my privilege to perform. I have seen that faced with competing demands partners have demonstrated support for safeguarding. I have seen the Board mature with a willingness to constructively challenge each other in pursuit of assurances about the effectiveness of safeguarding arrangements. My assessment is that the Board is served well by members who know what they are doing and there is evidence of a strong commitment to serve the adults at risk of abuse and neglect.

Whilst progress in safeguarding is being made there is more to do. Despite year-on-year increases in reporting there is still under-reporting of abuse and neglect. There is more to do on awareness raising and more to do on demonstrating that the voice of the adult has been heard.

As always, I am immensely grateful to all who chair the Board Sub-Groups; all who provide and facilitate the many training and learning events that are always well received; and the Board Manager Helen Jones who I observe has made an outstanding contribution, much of which is unseen, to ensure that our business programme works efficiently. I also acknowledge the vital role performed by the Local Authorities Overview and Scrutiny functions in their constructive feedback that is used to enhance the value and relevance of the Board Annual Report.

I conclude with good wishes to my successor Mr Adrian Green who is very much looking forward to his role.



2. About the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

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

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

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

A Safeguarding Adult Board has three primary functions:

1. It must publish a Strategic Plan that sets out its objectives and how these will be achieved.
2. It must publish an Annual Report detailing what the Board has done during the year to achieve its objectives and what each member has done to implement the strategy.
3. It must conduct a Safeguarding Adult Review where the threshold criteria have been met and share the detailed findings and on-going reviews within the annual report.

2. Composition of the Board

The Board has a broad membership of partners in Staffordshire and Stoke on Trent and is chaired by an Independent Chair appointed by Staffordshire County Council and Stoke-on-Trent City Council in conjunction with Board members. The Board membership can be found here.

The Board is dependent on the performance of agencies with a safeguarding remit for meeting its objectives. The strategic partnerships with which the Board is required to agree responsibilities and reporting relationships to ensure collaborative action are shown in the Governance Structure and can be found here.

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

3. Safeguarding Adults – A description of what it is

The statutory guidance[2] for the Care Act 2014 describes adult safeguarding as:

"*Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time, making sure that the adult's wellbeing is promoted including where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances".*

Abuse and neglect can take many forms. The various categories as described in the Care Act are shown here. The Board has taken account of the statutory guidance in determining the following vision:

Vision for Safeguarding in Staffordshire and Stoke-on-Trent

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

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

4. Safeguarding Principles

The Department of Health 2011 (DoH) set out the Government's statement of principles for developing and assessing the effectiveness of their local adult safeguarding arrangements and in broad terms, the desired outcomes for adult safeguarding for both individuals and agencies.

These principles are used by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board and partner agencies with safeguarding responsibilities to benchmark their adult safeguarding arrangements.

The principles can be found on page 5 of the SSASPB Adult Safeguarding Enquiry Procedures.

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

5. What have we done?

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

6. The Board

Independent Chair:	John Wood
Vice Chair:	Ruth Martin Principal Social Worker, Staffordshire County Council.

The Board oversees and leads adult safeguarding across our area and is interested in a range of matters that contribute to the prevention of abuse and neglect. These include the safety of patients in the local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders.

At every quarterly Board meeting the Chair reminds Board members of their statutory responsibility to seek assurances that there are effective arrangements in place to protect adults with care and support needs who are at risk of abuse and neglect and unable to protect themselves and assurances that agencies are working together effectively. The Chair goes on to say that constructive challenge, as always, is welcomed and encouraged.

<u>During 2023/24 the Board has:</u>

Received a presentation from the City Director, Stoke-on-Trent City Council, the Director of Adult Social Care and Health Integration and the Lead Member for Adult Social Care on the Target Operating Model which has a focus on early intervention through an integrated partnership approach across health, social care and voluntary and community sectors. The Board sought assurances from the improvement plan that enables delivery of improved outcomes to meet the needs of adults with care and support needs. The initial presentation and discussions were followed by the Board receiving an update on progress towards implementation of the Target Operating Model.

Received a presentation from the Assistant Chief Constable, Staffordshire Police on the revised structure of the Public Protection Unit. A key change is in the providing of a Detective Superintendent Head of Adult Safeguarding. The implications of the changes for connected operational partners were examined and discussed. The Board received assurances that the structural changes would address the previously expressed concerns of a mismatch between crime investigation and safeguarding.

Continued to contribute to the review of the arrangements and working of the Multi-Agency Safeguarding Hub (MASH) and received updates on the review at three of the quarterly Board meetings. Assurances were provided to the Board that the embedding of the new model of working with revised approaches to meet the requirements in each Local Authority area was progressing according to plan.

Confirmed that the 4 actions from the Internal Audit of the SSASPB in 2022/23 were completed, including revisions to the SSASPB Risk Register.

Received a presentation from the chair of the Staffordshire and Stoke-on-Trent Quality, Safeguarding and Information Sharing Meeting. QSISM examines quality and safeguarding matters in care settings and aims to support providers through challenges aiming to prevent escalation. Themes and trends from the meetings in 2023/24 were discussed. The Board sought assurances on recurring themes, including practitioner understanding of thresholds for reporting safeguarding concerns which is a matter of continuing focus for connected partners.

Received a presentation from the Safer Custody Lead for Prisons in the West Midlands Region and the Regional Safeguarding Lead for Practice Plus Group (healthcare provider) to outline the arrangements for safeguarding and associated healthcare in prisons. Prisons are not subject to the statutory requirements of the Care Act but in practice follow safeguarding principles. The matters discussed included staff training, reporting of safeguarding concerns and how these are assessed and supervised. The discussion prompted actions amongst connected partners for improved liaison arrangements to respond to the practical difficulties that are experienced when detained persons are released from custody at short notice.

Received an update on the arrangements for the out of area placements of people with Learning Disabilities and autism prompted by the learning from the findings from the Whorlton Hall Safeguarding Adults Review. Assurances were sought and provided in relation to the commissioned arrangements locally and governance through reporting and oversight to the Learning Disability and Autism Partnership Board.

Received a presentation from Staffordshire Police on Right Care, Right Person. It is a model designed to ensure that when there are concerns for a person's welfare linked to mental health, medical or social care issues, the right person with the right skills, training and experience will respond with the most appropriate service taking primacy. Assurances were provided that Staffordshire Police has engaged with an extensive range of interested parties to ensure clarity of responsibilities and to mitigate risks that may arise from a change in Police response.

Examined annual assurance reports regarding Large Scale Enquiries and constructively challenged reasons for recurring themes.

Examined annual assurance reports regarding Deprivation of Liberty Safeguards including reasons for and responses to the increasing number of DoLS applied for.

Received a presentation from Staffordshire Police on Pitstop, a new approach to responding to adults who are vulnerable and may have needs for care and support. Pitstop is a trial initiative between Staffordshire Police and the Local Authority that at the time of producing this Annual Report is ongoing and pending evaluation.

Received a presentation from the Staffordshire County Council lead officer for the Integrated Co-occurring Needs (ICON) project. The project is about the response to adults with vulnerabilities and multiple needs whose personal circumstances don't meet the eligibility criteria for support through the Care Act 2014 or other eligibility. The discussion focused on how in partnership there could be an effective alignment of mainstream working for adults with multiple needs. From the discussion there is a willingness from connected partners to work together with pledges of support.

Received updates on the progress of the Stoke-on-Trent City Council Multi-agency Resolution Group (MaRG) and the Changing Futures programme and discussed how these link to the themes within the

Effective Practice priority. The discussions have helped to further strengthen the links between the work of the Changing Futures programme and resulted in the appointment of an Expert Citizen to the SSASPB.

Promoted and supported the Ann Craft Safeguarding Adult week, hosting multi-agency awareness raising events and encouraging partners to run events within their organisations.

Contributed to the funding and agreed to work in collaboration with Faith Associates to produce online Child Protection and Adult Safeguarding Guidance and Toolkit for Faith based establishments. Reflecting local demographics bespoke guidance will be produced for Christian, Islamic, Jewish, Hindu, Sikh and Buddhist faiths. Working to a Regional collaboration there will be the opportunity to explore the future development of guidance for other faiths.

Assessed, through a structured discussion, the potential for abuse and neglect of adults with care and support needs to be hidden or undiscovered within communities. Abuse and neglect can take many forms. Assurances were provided of positive actions to raise practitioner awareness of the signs of abuse that may be hidden including provision of training to encourage professional curiosity and intervention. Actions were raised to provide more granular detail in recording safeguarding concerns, actions for the Domestic Abuse Commissioning and Development Board that will inform the refresh of the Domestic Abuse strategy and actions for the Prevention and Engagement sub-group in relation to awareness raising.

A standing agenda item on matters arising from links with others partnership boards and fora enables visibility and alignment on matters of safeguarding relevance.

Strengthened cross partnership working through the development of a protocol with Safeguarding Children Board, Health and Wellbeing Board, Integrated Care Board and the Police and Crime Commissioner supported through a quarterly engagement meeting.

A standing agenda item for inspection, organisational review and peer review updates from partners that facilitates constructive discussion about areas of good practice and offers support to meet organisational challenges. Subjects have included CQC readiness assessments in preparation for the forthcoming Adult Social Care inspections.

7. Executive Sub-Group

Chair:	Ruth Martin, Principal Social Worker, Staffordshire County Council.
Vice Chair:	Sharon Conlon, Associate Director Safeguarding Staffordshire and Stoke-on-Trent Integrated Care Board.

The Executive sub- group has responsibility for monitoring the progress of all sub-groups as well as its own work-streams. The core work of the Executive sub-group includes:

- receiving and considering regular updates of activity and progress from sub-groups against their Business Plans;

- ensuring that the core functions of the Board's Constitution are undertaken and that the Strategic Priorities of the Board are delivered.

The Executive membership is made up of the Chairs of the sub-groups, Officers to the Board, the Board Manager and the Board Independent Chair. Organisations represented include the Statutory Partners (which are Stoke-on-Trent City Council, Staffordshire County Council, Staffordshire Police and the local Integrated Care Board); the Midlands Partnership Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT).

Conducted annual review of attendance and engagement at Board and sub-groups in accordance with the SSASPB Constitution. Meetings overall are well attended with members frequently providing and evidencing constructive challenge to drive relevant activity. The Independent Chair contacted a few members where attendance was inconsistent.

Reviewed and approved the business documents for the Executive sub-group including terms of reference, business plan and the SSASPB communication plan.

Examined assurance updates from both Local Authorities regarding Large Scale Enquiries (LSE's). The recurring themes were noted and challenged. Actions were raised to seek improvements around recurring themes.

Examined assurance updates from both Local Authorities regarding Deprivation of Liberty Safeguards (DoLS) authorisation backlogs. Considered the updates and progress on previous actions in relation to improvements in timeliness of assessments, which are linked to Effective Practice priority theme 2.

Received a presentation on the themes arising from the Learning from Lives and Deaths Programme (LeDeR). The presentation and discussion identified many themes found in the findings from Safeguarding Adult Reviews. The SSASPB Business Manager has a made key contribution in aligning work programmes and actions.

Approved expenditure of the SSASPB budget in accordance with delegated financial accountabilities. Considered the financial reports prior to reporting to Board meetings.

In response to a recommendation from Internal Auditors revised the SSASPB Risk Register which was approved by the Board. The risks to the SSASPB have been regularly reviewed by Executive sub-group.

Considered the preparedness of the SSASPB for the CQC Adult Social Care Assessment process. The SSASPB has examined the audit tool developed by Hackney SAB and confirmed that the SSASPB Tier 1 audit covers the areas for consideration.

Initiated a Task to Finish Group to review and revise the Stoke-on-Trent and Staffordshire Self-Neglect pathways in response to several SAR referrals where it was found that there was a need for improved practice when Mental Capacity needs to be assessed.

Sought assurances from partners about activity in support of Preparing for Adulthood. It was noted that whilst some young adults have had experiences that do not fully meet their needs each Local Authority is working to address concerns.

Received report of the online abuse audit and confirmed the actions arising.

Received a briefing on the NHS collaborative and considered the implications and opportunities for improved alignment, effectiveness of services and accountabilities.

Considered several Board membership requests in accordance with the SSASPB membership procedure.

Reviewed the annual data from the SSASPB website in relation to number and purpose of visits. It was decided that in future the responsibility for overseeing the Board website will be transferred to the Prevention and Engagement sub-group. This will strengthen the approach to awareness raising and the impact that this has on safeguarding.

Received assurances from partners of organisational activity in response to the SAR Andrew action plan. The comprehensive action plan (64 pages) was submitted to the Board and approved as complete.

Identified the issues for consideration of a structured discussion by the SSASPB to seek assurances around the hidden abuse in all forms and neglect of adults with care and support needs.

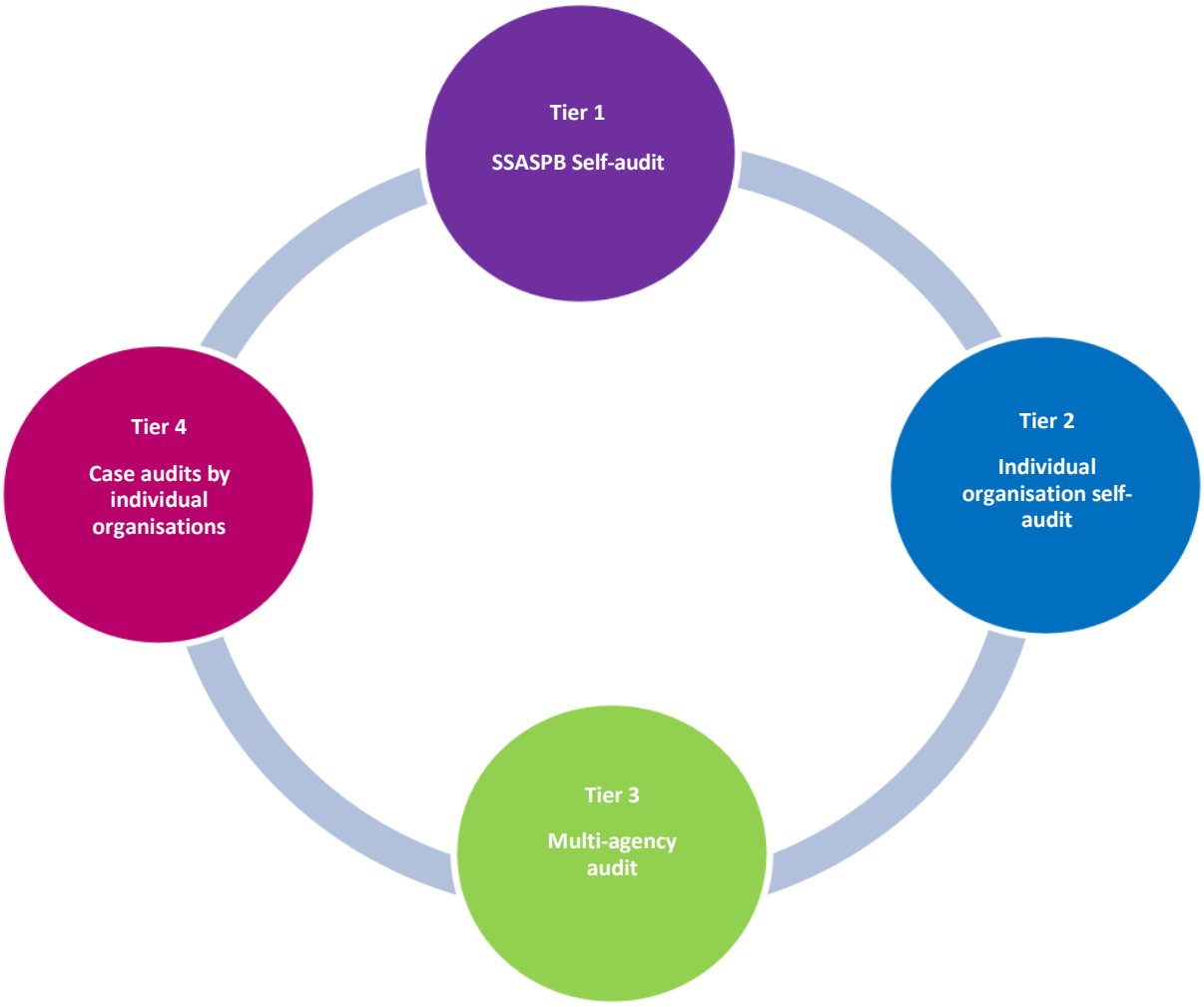
Through Regional and National Adult Safeguarding networks received updates and initiated actions on a range of themes. These included - learning from SARs; encouraging support for the Insight national project that prepared for winter pressures on Local Authorities and connected services; confirming local links between the SSASPB Business Manager and Department for Work and Pensions on matters of mutual relevance; and sharing the findings of research into financial abuse from Barnet and Islington with a briefing note for practitioners in the SSASPB area.

Contributed to the development of the 2023/24 Annual Report.

Overseen the recruitment process for the appointment of a new Independent Chair of the Board consequent to the retirement of the current Chair in March 2024.

8. Audit and Assurance Sub-Group:

Chair:	Sharon Conlon, Associate Director Safeguarding Staffordshire and Stoke-on-Trent Integrated Care Board.
Vice chair:	Laura Collins, Named Nurse for Safeguarding, North Staffordshire Combined Healthcare NHS Trust



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

Tier 2 Individual Organisational audit: in year 1 each organisation completes a self-assessment against a set of agreed standards, in year 2 there is a peer review of evidence put forward against specific standards.

Tier 3 Multi-Agency Audits are themed multi-agency audits, the themes come from questions raised following receipt of the annual data report.

Tier 4 Individual Agency audits which can be requested by the Board or one of the sub-groups with the purpose of seeking more detailed information about a trend or theme which becomes apparent.

During this year the Audit and Assurance sub-group has:

- Completed the annual Tier 1 audit. This helps the Board to understand where the challenges are and where it can evidence that it is meeting the requirements set out in the SSSPB Constitution (link)

- Agreed to review the Tier 2 data capture after the appointment of the new SSASPB Independent Chair (appointed in April 2024)

- Responded to an action allocated to it by the Executive sub-group after a request from the Safeguarding Adult Review sub-group. The SAR sub-group tasked the Audit and Assurance sub-group with identifying how to audit to what extent lessons are learned from SARs with particular reference to the recurring themes. It was agreed that the following were included in every Tier 3 audit going forward: Was the rationale for key decision-making recorded? Was the escalation policy used when it would have been beneficial to do so? Was a lead professional appointed to improve multi-agency team work? Were the principles of the Mental Capacity Act considered and applied in circumstances of self-neglect.

- Provided detailed narrative to the annual data report contained in the 2022/23 SSASPB Annual Report

- Responded to an increase in SAR referrals where self-neglect was the main theme. The sub-group conducted an in-depth Tier 3 Multi-agency audit of 30 self-neglect concerns, supported also by a self neglect review which involved 50 GPs.

<u>The key themes and trends identified from this discussion are as follows:</u>

Identifying lead professionals – There tended to be no follow up after referral to other agencies highlighting a lack of ownership. Single agencies are therefore left holding the risk.

Inconsistency regarding multi-disciplinary team responses (MDT).

A lack of understanding of the self-neglect protocol, guidance and risk matrix.

A lack of responsibility to engage the adult themselves – Issues around obtaining consent prior to commencing referrals and gaining input from the individual. Better use of advocacy services where appropriate to support this will be beneficial.

Documentation: Lack of rationale for decision making.

he potential for improved multi-agency working is likely to be hampered by multiple IT systems used by different agencies with no links between services.

The sub-group will pick up the response to these findings in 2024/25, a review of the self-neglect pathway is already underway.

9. SSASPB Annual Report 2023/24 – SAR Sub Group content

Chair:	Superintendent Vicky Lee, Staffordshire Police.
Vice Chair:	Chris Harris, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)

The Safeguarding Adult Reviews (SAR) sub-group has responsibility for management of SAR referrals from the point of receipt through to the approval of the final report and delivery of the improvements action plan. This includes receiving at each meeting updates on ongoing SARs. The sub-group also has responsibility for identifying and cascading the lessons learned from any reviews conducted by other SABs.

During 2023/24 a total of seven SAR referrals were received by the SSASPB. Following assessment, one met the criteria for a SAR, the other six did not. It was found that there was learning to be gained from three of the referrals and this initiated single agency reviews. Information is provided on the referral meeting the SAR criteria.

'Gillian' a SAR conducted under Section 44(1) Care Act 2014 – Mandatory Review

Gillian (not her real name) was a 69-year-old white British female who lived alone in a warden aided complex. She had a medical procedure in 2014 which resulted in complications and left her unable to walk. She became bedridden and was assessed as requiring full assistance with hygiene, dressing and food. Her sister was a frequent visitor and assisted with errands, laundry, and shopping. She had a domiciliary carer visiting three times a day for 30 minutes each time with an additional 15 minutes per week to change the bedding. The housing manager at the premises also visited to check on her welfare.

Gillian drank up to 58 bottles of wine per month which she paid for and was provided for her by her carers and sister. It is believed that her use of alcohol was a coping mechanism for her condition. She ate very little, often only biscuits, despite fresh food being provided by her sister.

It was recorded by her carers that Gillian was 'difficult' often verbally aggressive, uncooperative, and slapped their hands when they tried to provide personal care for her. The care provider attempted to withdraw from their contract to provide care but were encouraged to remain supporting her.

When Gillian's skin broke down, she was resistant to carers tending to the resulting sacral bed sores or change her incontinence pads. The sores became infected and following a call by the housing manager for an ambulance she was assessed as not having the mental capacity to refuse treatment and was taken to hospital where sadly she passed away 3 days later.

'Following consideration of both the information that was shared and of the threshold for holding a SAR; the Independent Chair of the SSASPB agreed that the criteria for a SAR S44(1) Care Act 2014 – Duty to Review - has been met as:

- Gillian had needs for Care and Support,
- the adult had died, and self-neglect has been recorded on an interim Inquest Report by the Coroner,
- there is reasonable cause for concern about how SAB members and other relevant persons worked together to safeguard the adult

The review is ongoing at the time of writing. An update will be provided in the 2024/25 Annual Report.

<u>Update on SARS from the 2022/23 Annual Report:</u>

SAR Andrew

The SSASPB approved the final report of 'Andrew' in April 2022. Briefly, the SAR was about the learning from the death of a 37-years-old white British man who was living in social housing in Stoke-on-Trent. Andrew had multiple needs arising from mental ill health, substance misuse, grief following the death of his mother, poor health generally and indifference to whether he lived or died and fluctuating engagement with service providers.

Over the last 18 months of his life Andrew was seen on 307 occasions by 11 service providers. Andrew died from gastrointestinal bleeding with self-neglect as one of the key contributory factors. There were concerns as to how agencies worked together.

What the SSASPB has done in response to the findings

The Andrew SAR has provided significant and extensive learning that is continuing. The findings and lessons learned are a regular focus of discussion amongst practitioners and scrutiny processes.

During the review of the SSASPB Strategic Plan 2022-25 the themes from the SAR of self-neglect and adults with multiple needs who don't meet the eligibility criteria under the Care Act 2014 were specifically included within the themes of a new strategic priority to seek assurances of Effective Practice. Updates on partner organisation activities and outcomes linked to the themes are found at 18 to 38.

The final version of the SAR action plan which extended to more than 60 pages, reflecting the scale of activity undertaken by partners, was signed off as complete in September 2023.

SAR 'Frank and Elsie' - Below is a reminder of the Findings from the Review.

The SAR involved a white British male (81years) and a white British female 72years, neither of whom had capacity and resided in a nursing home in Staffordshire. The names Frank and Elsie are not their actual names have been used to protect their identities.

There were concerns that there was insufficient focus and multi-agency working with regards to the risks presented by Frank to Elsie and others. There were numerous incidents of both physical and sexual violence to other residents and physical assaults/sexualised behaviour to staff. The incidents were reported to Staffordshire Police.

What the SSASPB has done in response to the two findings

System finding 1: Staffordshire safeguarding policies and procedures recognise sexual abuse as a category. However, there is no local policy or procedure about how sexual safety can be maintained specifically in residential care settings, including how to respond to incidents, assess and manage risk. This is despite recognition of the extreme vulnerability of residents and problematic sexualised behaviour of some residents being acknowledged as common. This leaves disparate and sometimes contradictory efforts by different agencies to support the individual and protect others, with no effective multi-agency working or effective oversight of risk management within a home, or of placement decision making, whether routine or in emergencies following evictions.

Finding 1 response: Working through a Task to Finish group SSASPB partners have created several practical products to respond to the learning, these include:

- a podcast (which is a popular method of learning and often requested by practitioners)
- Specific guidance from Staffordshire Police outlining what to do if a criminal offence is believed to have happened and what to expect from a Police investigation
- A guidance sheet for care staff to help manage behaviours of residents where there may by sexual abuse.
- A list of useful reading resources

Systems finding 2: 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.

Finding 2 response: The SSAPB hosted a learning event that took place on 22nd November 2023 timed to coincide with the Ann Craft National Safeguarding Adults Week. The event was titled 'The Mental Capacity Act and Sexual Safety (consent)' and the Board was delighted that Doctor Laura Pritchard-Jones, Senior Lecturer at the Law School at Keele University agreed to present it. The event was attended by 104 people and included a very active question and answer session with a panel of Adult Safeguarding Leads from the statutory partners (both Local Authorities, ICB and Police) and key Health Providers including the Midlands Partnership Foundation Trust and North Staffordshire Combined Healthcare Trust.

SSASPB learning events are now routinely evaluated and the responses indicated that attendees found this academic input very useful as well as the interactive methods to ask questions, give scenarios and learn from each other. The slides from the event were shared widely so that people unable to attend could access them and extend the learning.

The SSASPB is promoting the use of formal and accurate language to describe sexual behaviour and to normalise the use of terms that some may find difficult to use both in conversation and written reports and in the production of well-informed risk assessments.

Clive Treacey: A SAR conducted under Section 44(4) Care Act 2014 – Discretionary Review (Staffordshire)

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

A referral was received on 8 November 2022 about Clive Treacey a 47-year-old white British man from Staffordshire who died in January2017. Ordinarily, the identity of a person subject of a review would be anonymised, but his family wish the circumstances of his lived experiences to be widely known and communicated.

Clive had a learning disability and diagnosis of autism and epilepsy. He grew up within a loving and supportive family. At the age of 18 years, he attended a residential college and went on to reside in a variety of residential settings as an adult. It was alleged by Clive that he was sexually abused whilst in one of the placements in Cheshire. It is then reported that the source of risk followed Clive into subsequent placements.

Clive had been detained under the Mental Health Act 2005 (MHA) for a decade. He gained an unwarranted reputation for being complex and challenging, and someone for whom a community setting was only properly considered during the later years of his life. A LeDeR (Learning from Life and Death review - formerly known as a Learning Disability and Mortality Review) was conducted on behalf of NHS England which identified that there were financial and systemic barriers that thwarted Clive residing in community settings and remained in settings that were poorly equipped to meet his needs.

Concerns have been raised that the safeguarding alerts that Clive's family and professionals raised over the course of his life through community and specialist hospital settings were not adequately responded to. It has been raised that these were missed opportunities to intervene and had these matters been responded to more effectively, this may have altered the course of events that followed.

Clive was not kept safe from harm, and it is believed that he experienced sexual abuse whilst in the care of some providers. Questions have been raised regarding the effectiveness of his safeguarding and the police response to this. The reviews by NHS England and LeDeR were not able to ascertain what safeguarding and police actions followed these serious incidents.

It was decided that a Safeguarding Adult Review would be conducted jointly by Staffordshire County Council and Cheshire East Council. The focus of the SAR is to be how policies, procedures and practice have changed since the early 1990s when the abuse is alleged to have taken place and to seek assurances that future risks for others can be mitigated. The review was published on 18th April 2024 and is on the SSASPB website SAR Clive - Final (ssaspb.org.uk)

Other SAR sub-group activity

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

- Approved the Business Plan revised version for 2023/24.
- Approved the revised SAR Protocol. Going forward the SSASPB will adopt the West Midlands SAR guidance in its entirety (14 Local Authorities/13 SABs) and have a Stoke-on-Trent and Staffordshire Local Procedure which outlines the local process.
- Agreed to revise the SSSPB SAR process to include an Initial meeting of all known partners in any SAR referral within 5 working days of receiving a request for information. This is to better inform the pre scoping process.
- Agreed to include a paragraph in the local SAR policy to cover situations where there is a Conflict of Interest involving any person involved. A recommendation has been made for this to be included in the Regional SAR Guidance.
- Considered the consistency of approach to complaints in several SSASPB documents and agreed that consistent wording is to be used. Agreed that all matters pertaining to complaints about any aspect of the SSASPB, including SARs, will include a reference to the Local Government Ombudsman publication (revised in 2016) and to include an automated link on the SSASPB website so that updates may be captured.
- Agreed that SAR Final Reports would be retained indefinitely (as most are published and in the public domain) and papers that contribute to the report are retained for 15 years.
- Engaged with Community Safety Partnerships that are managing Domestic Homicide Reviews (where they involve adults with care and support needs).
- Continued to actively raise awareness amongst practitioners of the previously identified recurring lessons to learn from SARs.
- Engaged with the Safeguarding Adult Board Managers National and Regional Networks to share good practice developed by other SABs. Considered the findings of a SAR in Lewisham 'Joshua' and the implications for practice locally.

- Promoted to practitioners' webinars made available nationally that are relevant to SARs.

- Tasked the Audit and Assurance sub-group with auditing to what extent lessons were being learned and effective practice embedded from SARs.

- Considered the early findings from the second SAR national analysis by Professor Michael Preston-Shoot. This will be published in Spring 2024. The analysis indicates that there has been an increase in the percentage of SARs focused on neglect including self-neglect which is consistent with what is being seen locally.

10. Performance against 2022/2025 Strategic Priorities.

10.1 Collated Effective Practice themes

Theme 1:

That Making Safeguarding Personal (MSP) is meaningfully implemented and embedded in practice by all partners, and that its effectiveness is measured to give confidence.

What is Making Safeguarding Personal?

It is about developing a safeguarding culture that focuses on the personalised outcomes desired by people with care and support needs who may have been abused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing, and safety. Fear of liability or negative outcomes may lead to risk-averse decision-making by practitioners.

All safeguarding partners have confirmed that there are person centred approaches embedded in their training, procedures, information sharing, risk mitigation, staff supervision, management reviews and oversight with single agency and cross agency escalation arrangements. Throughout the partnership there are many examples of good practice embedded in organisational approaches, the following are typical:

- support and practice are person centred using a strengths-based approach, underpinned by principles of empowerment, choice and self-determination.

- Where service users have additional support needs or vulnerabilities and may struggle to engage with the service, services work with them to identify if it is appropriate to involve a third party in the provision of support. In such cases, both the service user and the third party have a clear understanding of the support provided and have agreed the boundaries to this involvement, for example, agreeing how information is to be communicated, and whether the third party is to be present at all support sessions.

- There is a reflective practice approach used in the supervision of staff.

Staffordshire County Council

There has been a cycle of 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 safeguarding have been embedded in practice. Part of this is around the Making Safeguarding Principles ensuring that the adult has been at the heart of the enquiry with their views and wishes clearly recorded.

Outcomes of these audits found the following –

- Three quarters of people were able to engage in the enquiry or were offered appropriate support to engage. Nearly all of those with capacity to make decisions were enabled to engage. (empowerment)
- The appropriate people and agencies were contacted as part of nearly all enquiries. (partnership)
- 87% of enquiries were felt to have been proportionate to the safeguarding concern; this means that the least intrusive response was given. (proportionate)
- Auditors agreed with the outcome of 92% of the S42 enquiries, suggesting that our decision making is robust. protection, (accountability)
- Nearly all enquiries evidenced or partly evidenced appropriate support or signposting at the conclusion of the enquiry helping to keep people safe and reduce the likelihood of future harm. (protection)
- Nearly 100% of outcomes identified by people were achieved. (empowerment)
- All safeguarding plans are supporting adults to be safer now and in the future by including actions and support which are appropriate given the findings of the Section 42 enquiries. (protection, accountability)

<u>Stoke-on-Trent City Council</u>

The Liquid Logic recording system has questions about Making Safeguarding Personal and asks if the adult's outcomes have been achieved. The Local Authority has more to do around this as only 54% of people have their responses recorded. Of those, 90% say their outcomes are fully achieved.

Alongside data gathering the Quality Assurance Officer has implemented an audit cycle that focuses on Safeguarding and particularly Making Safeguarding Personal. Audits are showing clear areas for practice development regularly highlighting the need for the voice of the adult to remain prominent throughout the process, to keep them central to safeguarding and decision making.

Training programmes are devised and developed from themes found including learning workshops to emphasise advocacy and the voice of the adult within daily safeguarding practice. Other areas of focus are about effective recording to accurately reflect the practice which takes place in person.

A new suite of safeguarding training has been provided by the Local Authority commissioned through the Insight Academy who work with Expert Citizens to provide 'real life' individuals in the interviews and videos used during the training. The training includes a specific element for qualified staff undertaking Section 42 enquiries, a second element for Managers who are undertaking the 'Managing Officer role' and thirdly

'Making Safeguarding Personal – The Human Connection' that is open to all assessing staff to implement and embed the practice.

There is increasing evidence of a culture shift and transformation within the Local Authority with more work in co-production that feeds into development of assessment styles, commissioned services and training reflecting a learning organisation.

Midlands Partnership Foundation Trust (MPFT)

MSP is embedded into the Level 2 and Level 3 adult safeguarding training that is mandatory for all staff. In an audit undertaken by MPFT safeguarding service it was consistently found that staff were aware of the need to capture the adult's thoughts, wishes and feelings at the point of referral. Compliance with this was very high in those referrals that were scrutinised.

Case Study 1: MPFT

'Thomas' is a 60-year-old man living in Stoke-on-Trent. His care and support needs included leg ulcers, mobility issues (he had not been out of the property for 13 years), obesity, a learning difficulty and chronic mental health issues. His wounds to his legs were also at risk of infection due to Thomas refusing to take a bath and a shower. He urinated in bottles due to mobility issues and these were kept near to electrical appliances causing a fire risk in his home.

He has a history of being frequently in financial crisis. The district nurses were becoming frequently concerned that adults who he called 'friends' were visiting his home and exploiting him for money, food and taking his prescribed medication. He refused a care package preferring for his 'friends' to go shopping for him for food and support him with meals. They would often not give any change when they had been shopping. Thomas was in debt for gas and electric and he would often spend £400 on phone games.

When his social worker discussed the concerns with Thomas, he was deemed to have capacity to make decisions around his care and support needs and he preferred to have his friends provide support. When his 'friends' made threats towards him, a police officer from the harm reduction hub visited him and the alleged perpetrators.

Safeguarding meetings were arranged with representation from Stoke-on-Trent Adult Social Care, District Nursing, the local harm reduction hub, housing officers and the GP surgery. A plan was put in place.

Over time Thomas has built trust with all the professionals involved. It was suggested that he consider a visit to a nearby retirement housing complex where further support around his care needs could be provided. The nurses purchased some clothes, supported him with showering, and paid for a taxi so he could visit the complex.

After a few months on the waiting list Thomas moved into the supported living flat. The social worker and the District Nurses facilitated everything to ensure the move was safe and he had all the equipment he needed. He now has support via the in-house care providers at the residential complex. This is 3 calls a day with personal care, prompts with medicine, nutrition, preventing and supporting isolation and flat management. The social worker has helped with bills. The nurses have referred the adult for psychological support within Midlands Partnership Foundation Trust.

Although Thomas is still letting his friends visit him at his new home, they are not allowed key or fob entry.

The members of the Multi-Disciplinary Team have kept in touch with each other frequently by email, informing each other of visits and actions taken. Thomas's experience is a positive illustration of a

safeguarding culture that focuses on enabling the personalised outcomes desired by people with care and support needs who have been abused.

North Staffordshire Combined Healthcare Trust (NSCHT)

Making Safeguarding Personal audits are completed to examine safeguarding referrals into the Local Authority and whether the persons voice was reflected and, if they lack capacity, that this is clearly identified and has been assessed. Audits over the last year have provided positive assurances that MSP is evident in referrals made.

University Hospital Derby and Burton (UHDB)

The audits of safeguarding referrals demonstrate involvement of the patient, family, recording of consent and what the patient wishes to achieve from the referral.

Staffordshire Police

Prior to 2023 Making Safeguarding Personal was not widely known or understood across the organisation. It now forms part of training for everyone joining the Adult Safeguarding Enquiry Team (ASET) and Harm Reduction Hubs. The local authority partner in ASET has been very supportive and provided training, which has helped to improve the quality of investigations and decision making and enhanced the interactions with and outcomes for people with care and support needs who are at risk of abuse and neglect.

ASIST – Advocacy services

ASIST has collected feedback from individuals involved in safeguarding and used the feedback to inform the process and implement improvement changes. Feedback indicates that people are feeling more involved and have a better understanding of the process.

Staffordshire Fire and Rescue Service (SFRS)

SFARS has continued to provide Olive Branch Training that aims to raise awareness of fire safety issues in the home to those that are involved with caring for the elderly, disabled and vulnerable daily on how to identify fire hazards and other risks to understand how to deal with these risks and to refer them on to the appropriate organisation.

UHNM

The feedback from the local authority in relation to whether the adult's views were gathered during Section 42 enquiries has at times identified that there is further learning to be embedded in practice. The process to gain feedback resulting from Section 42 enquiries remains under review.

Theme 2:

The assessment and reviews of mental capacity and Deprivation of Liberties Safeguards (DoLS) are of a good standard and includes the perspective of service users/carers, with appropriately skilled advocacy accessed where appropriate.

Mental capacity is frequently raised in relation to adult safeguarding. The requirement to apply the Mental Capacity Act (MCA) challenges many professionals and requires utmost care, particularly where it appears

an adult has capacity for making specific decisions that nevertheless places them at risk of being abused or neglected.

The Board has received the following assurances from connected partners.

Stoke-on-Trent City Council

Best Interest Assessors receive training from a wide range of sources that keeps their practice up to date and qualified assessors have a good understanding of their responsibilities to balance the needs of all interested parties that equips them to perform their role. There is regular oversight of practice through staff supervision with the additional provision of peer and mentor support.

During the year the internal Corporate Audit Team has completed a thorough audit of the service. The audit found social work and Best Interest Assessors practice in terms of Mental Capacity decisions making to be of a good standard. A work plan has been developed to implement the recommended changes to processes and smarter workstreams.

The backlog of DoL's assessments remains an ongoing challenge due to the increasing numbers received by the Local Authority. There are triage arrangements in place to ensure that high risk cases are prioritised. At the time of this Annual Report the Local Authority is working with contracted providers to supplement its assessments and quality assurance work.

Case Study 2: Stoke-on-Trent City Council

'Donna' lives in supported accommodation and receives care and support to help manage her diabetes and needs relating to her mental health, specifically suicidal thoughts. Donna is supported by community nursing to help manage her diabetes and by staff to ensure care plans are followed, which includes restriction of certain foods by locking cupboards.

There have been a significant number of safeguarding concerns documented about the legal discrepancies regarding Donna's capacity to manage her diabetes, her risk-taking behaviours in relation to her diet and administration of insulin, and the care planning restrictions in place to try and manage this.

Donna had been assessed to have capacity in relation to managing her diabetes, with care plans restricting fizzy drinks and sugary foods by locking them away. Donna had support from District Nurses to administer Insulin. Given the variability in her mental health and the frequency of safeguarding concerns regarding risks from her attempts to overdose on either insulin or to sabotage her blood sugar through sugary foods, the question of whether fluctuating capacity was likely, was discussed.

There was also concern because whilst Donna was assessed to have capacity regarding her management of diabetes, she was assessed to lack capacity in relation to Care and Residence such that she needed 2:1 support. This support was in place predominantly to manage wider risks from self-harm but included measures in relation to Donna's attempts to misuse food and insulin with potentially dangerous consequences.

Whilst capacity is date and time specific, analysis of whether decisions are capacitous or unwise requires different considerations. This legal complexity required assessment of capacity by examination and triangulation of a range of data. The directions from the multi-agency safeguarding planning discussion requested health colleagues to complete this assessment as they were deemed to have the right level of knowledge for this specific decision.

The outcome was that the Transforming Care Team took on responsibility for ensuring that capacity was appropriately considered and assessed as part of the application to the Court of Protection for Deprivation of Liberty. A review of staffing identified the overuse of agency staff and unclear care plan presentations. These matters were addressed with new information for staff and a more regular support team for Donna to meet her needs.

Staffordshire County Council

There have been several audits of DoLS assessments over the past year which have included ensuring that appropriate consultation has occurred with the adult and with relevant carers.

The authorisation process along with the audits is designed to monitor that where an independent specialist advocate is required one has been requested/is in place.

The Performance Team has sought feedback from adults and carers as to how the DoLS process has been for them, asking if they felt included and whether their views had been taken into consideration. This audit is planned to be completed every three months. Mental capacity assessments have been a focus, and we have been developing new forms that better capture the views of adults and their carers. We have also held practitioner workshop around this to inform the practice guidance that will accompany the new form.

There have been 144 people contacted regarding their DoLS assessment and the results were as follows:

- 75% rated their overall satisfaction as ‘Very Satisfied’ or ‘Satisfied’.
- 94% said the process was respectful.
- 90%felt listened to and that they were given time to respond.
- 91% felt their questions were answered well.
- 87% thought the process was proportionate.
- 86% found the process meaningful.
- 80% thought the process was appropriate.

Further audits focusing on capacity assessments and best interest decisions are planned over the next 12 months when the new paperwork and guidance is embedded.

University Hospital Derby and Burton (UHDB)

UHDB has implemented a 2-year project which has included a team of MCA educators working with doctors and nurses in each area of the hospital to promote and embed MCA good practice. Large scale quarterly audits are undertaken which demonstrate significant improvement in professional practice. UHDB has also undergone external audit in relation to MCA and DoLS that found "significant assurance" in performance.

Further audits focusing on capacity assessments and best interest decisions are planned over the next 12 months when the new paperwork and guidance is embedded.

UHNM

MCA/ DoLS training package has been reviewed and revised by the Multi-Disciplinary Team that includes medical, nursing, Allied Health Professionals and legal to include practical guidance and applicable case scenarios. Training completion rate has remained above the Trust target of 90%.

UHNM has commenced collaborative working with one of the local DoLS teams to improve the quality of referrals. County audit data has demonstrated good practice and an increase in the identification of when an MCA is required and subsequent DoLS. Complex cases are escalated to the local authority.

MPFT

MCA and DoLS are stand-alone bespoke training packages. The training is reviewed and update regularly and is part of the mandatory training framework for frontline staff to ensure that they have the necessary skills and knowledge to use the provisions of the MCA in their practice. Compliance with training is monitored and reviewed both internally and externally.

The Trust mental health legislation team have a team site that staff can access to enable to them to keep their knowledge and skills up to date and access any addition resources that they may need.

NSCHT

Assessment and review of MCA and DOLS is covered in Trust mandatory training and staff are aware how to access an IMHA if required. Monthly audits are conducted in the inpatient areas of DoLS referrals to monitor compliance.

ASIST

ASIST receive requests for advocacy support where there is no family member or friend able to act in the best interests of the person deprived of their liberty. When advocates have raised concerns regarding capacity assessments, local authority DoLS teams have been found to be responsive, with assessments being re-visited and on occasions amended.

Healthwatch

The Healthwatch team understands how DoLS allow restraint and restrictions to be used only if they are in a person's best interests and are necessary and proportionate. Extra safeguards are needed if these restrictions and restraint will deprive a person of their liberty. When patients contact Healthwatch we will consider capacity, best interests and what is proportionate, and refer the adult to the appropriate advocate when required.

Staffordshire Police

Staffordshire Police does not formally conduct mental capacity assessments or have responsibility for conducting DoLS assessments. There is a need however for police officers to understand the processes, and know when and how to intervene, as part of understanding the vulnerabilities of people within communities.

Staffordshire Police has in conjunction with board partners initiated a pilot scheme 'Pitstop' to scope and implement a triage function designed to make informed assessments of risk in collaboration with relevant partners, to respond to complex matters where there are MCA and DoLS considerations.

Theme 3:

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 over 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.

The 'Andrew' SAR has been a significant influence in gaining a universal commitment amongst safeguarding partners to providing training and awareness raising on this theme. There is a willingness and a demand to attend learning events hosted by the SSASPB and connected partners reflected in strong attendance rates and positive feedback from training inputs.

Staffordshire Police

The learning from the 'Andrew' SAR was a key influence in the decisions made by Staffordshire Police in its revision of the structure and review of the Statutory Review Team in March 2023. This restructure has refocused the organisation to respond to the themes and to implement identified need for changes arising from the learning from SARs.

By way of illustration of an improved response, the initial Police Protection Notices completed by front line staff are reviewed by supervisors and issues pertaining to self-neglect are subjected to a review. Arising from this approach the force, in conjunction with board partners, agreed to consider the use of an integrated triage function designed to make informed assessments of risk.

A pilot scheme has been introduced, Pitstop (Partnership Integrated Triage) in two local authority areas. This involves partners in jointly considering police information, that has already been through police decision making and determined that partnership triage is required, with a view to identifying risk of harm, needs and vulnerability so that appropriate problem-solving approaches can be developed to circumstances including self-neglect. The pilot scheme will be formally evaluated at its conclusion.

Staffordshire County Council

Audits are reflecting that people's stories are being listened to with recording of conversations and professional curiosity, as opposed to just assessing need, and people's strengths are being identified and factors that influence behaviour are being explored. This way of working is better at identifying factors and viewing the person's whole story and not just focus on, for example, the hoarding and/or self-neglect.

Trauma Informed training and the learning events regarding 'Andrew' SAR have continued and are being expanded. The advanced mental capacity training considered fluctuating capacity. 125 people have attended the MCA training and have positively reflected, with 85% stating that this has improved their understanding and practical application of the legislation.

This has also identified that further training around the impact of alcohol and drug use on capacity is required and this is being planned for the next 12-month training cycle. Drug and alcohol services have been recommissioned and a more multi-agency response is being explored. Work with public health is continuing in relation to working with people with multiple needs, particularly those with trauma and substance use.

There has been training around self-neglect, working with people with No recourse to Public Funds (NRPF). The PITSTOP pilot in conjunction with Staffordshire Police has identified the need for further training for all partners in relation to self-neglect.

Case Study 3: Staffordshire County Council

'Jane' (not her real name) is a 40-year-old woman with multiple physical health needs. Jane lives with her husband and teenage daughter. Jane requires support with activities of daily living and, at the time concerns were raised, it was understood that this support was being provided by family members. Jane did not have a funded package of care in place.

Jane became unwell and was admitted to hospital. She was found to have sepsis caused by severe infected open wounds to both her legs and her sacral area. Due to the severity of the wounds Jane required emergency surgery which could have a life-changing impact. The hospital had raised concerns that Jane may have been neglected by her informal carers. The level of risk was assessed as high, and the concerns were sent to the Adult Safeguarding Enquiry Team for investigation.

Jane was initially reluctant to talk with the Safeguarding Practitioner. However, through empathy, skill, determination and support from a trusted health professional, the Safeguarding Practitioner was able to develop a rapport with Jane. It became apparent that this was a case of self-neglect, rather than neglect by family members. Jane had been hiding the extent of her injuries from her family and stated that she would not have allowed them to seek medical attention. The Safeguarding Practitioner was able to establish that Jane was fearful of hospitals due to past experiences. Jane had also been reluctant to accept a care package due to concerns with a previous care provider.

Jane did make a good recovery and was transferred to a rehabilitation ward in a local community hospital. She was keen to be discharged to her home address, but the Safeguarding Practitioner ensured a multi-disciplinary meeting took place with Jane, her family, and all involved professionals before she left hospital.

On her return home, Jane agreed to support from her family, a care agency and other health professionals. As it was now understood that the concern related to self-neglect, a Multi-Agency Planning Meeting (MAPM) was convened under the self-neglect protocol. The meeting enabled information sharing and discussion of protective measures that could be put in place to reduce the risk of Jane coming to further harm because of self-neglect.

A safeguarding plan was developed with input from Jane, family, and all involved agencies. Jane was involved throughout the safeguarding process and was able to express her wishes and feelings. It was recognised that it would not be possible to mitigate the risks completely, but professionals were able to work in with Jane, her family and other agencies and escalate concerns as soon as they arose. She was able to remain living in her own home in accordance with her wishes. At the time of writing, Jane continues to be supported by her Social Worker, the District Nursing team and care agency.

<u>Stoke-on-Trent City Council</u>

Trauma Informed Training is mandatory for all Social Care Practitioners. By way of an example, co-produced and designed by people with lived experience through the Insight Academy, Trauma Informed Practice mandatory training was delivered to 208 Social Care practitioners through the Insight Academy following the 'Andrew' SAR. Feedback from practitioners has been extremely positive, with the following comments being typical of many received:

"Really enjoyable training. Having the trainer's first-hand input and the videos from the people involved and listening to their stories brought the training to life".

There is a golden thread of working closely with Expert Citizens to ensure all case studies demonstrating impact are inclusive of customer lived experience.

The Case Manager roles embedded in the Changing Futures programme work across the network, i.e., workers from Concrete and Brighter Futures are embedded in teams.

There is Public Health investment in drugs and alcohol strategy to build on and develop a prevention and recovery strategy co-produced with people with lived experience.

There is a Research Champion to embed best practice in academic research and learning into daily practice.

NSCHT

There is regular liaison between Consultant Nurses in their respective specialist areas (dual diagnosis and multiple disadvantages) where adults presenting with complex needs are at risk of or experiencing self-neglect alongside addiction.

High Volume Users Team are developing an alcohol pathway within their service in response to the increasing presentation of adults with alcohol addiction to their service. The team are using the Alcohol Change UK document 'How to Safeguard Highly Vulnerable Dependent Drinkers' to develop the pathway.

During Adult Safeguarding Week a presentation about Trauma Informed Approach was delivered to Health partners by Consultant Nurse.

MPFT

New 7 Point Briefings have been created in relation to Substance Misuse, Trauma and Safeguarding. This builds on the point briefings relating to SARs, hoarding and self-neglect that are widely and easily accessible to all staff.

Self-neglect has been discussed with all teams in safeguarding supervision. Frontline staff are encouraged to discuss any concerns that they may have about an adult that they feel is self-neglecting on a 1:1 basis with their named professional. Collectively, a decision will be made on the next steps which may include – talking to other professionals involved, calling an MDT meeting, making an urgent referral for a social care assessment, mental capacity assessment.

Empirically, it feels as if practitioners are both requesting more advice from named professionals and incorporating joint, or multi-agency work into their practice.

The self-neglect audit has now been completed providing benchmark data to complete further audit work to evidence improvements in practice. Completion of mental capacity assessments is identified as lacking within this audit, which has prompted planned mental capacity training for clinical leads, for example. Haywood Hospital are having a month dedicated to Mental Capacity workshop discussions.

Positive case working is being identified and shared widely, including with SSASPB partners, to highlight good and positive outcomes for people.

Humankind

Links made with safeguarding partners has enhanced joint working and increased confidence throughout the workforce to ask probing questions about underlying circumstances, such as sharing past experiences with substance misuse and mental health and capacity that may be a barrier to referral. Involvement in a working group that is looking at substance misuse as a care and support need is having a positive impact on how referrals are discussed.

Case study 4: Humankind

'Laura' is 55 years of age, has had a very successful career and owned her home. She became dependent on alcohol when her marriage broke down. She was diagnosed with Korsakoff syndrome, following a psychotic episode whilst detoxing in 2021, when she was consuming up to a litre bottle of vodka a day.

Laura would regularly call the Police to make reports that were often confused. In one week, she made 6 calls to the Police in 6 days to make various reports of crimes that had not occurred that emanated from her drunken state. There was a time when Laura was regularly admitted to hospital and to detox. Referrals were made to Social Services due to her vulnerability but were swiftly closed without extensive assessment.

When working with professionals she could become guarded and would dis-engage. Following a referral to Humankind her case worker was able to establish a rapport which was the foundation of a trusting, therapeutic relationship. The case worker found that some men were taking advantage of Laura's vulnerability, regularly visiting her home and supplying her with alcohol, with evidence of drug use in the property. There was concern that Laura was a victim of 'cuckooing'.

After several referrals to Safeguarding the Humankind worker began to work with a proactive social worker who took the concerns seriously, especially when two men were present at Laura's home who she described as her 'bodyguards' when they were actually using her house as free accommodation. The social worker organised a Multi-Disciplinary Team meeting that resulted in a cross-agency risk assessment. Carers were arranged to visit daily due to Laura's incontinence and self-neglect. However, during this time mental health services continued to refuse to conduct an assessment due to alcohol use, even during abstinent periods.

Several referrals were made for Laura to attend detoxification, but she continually declined. There was an added complication that a lot of respite care and even women's refuges declined to receive Laura due to the risks she posed.

Following a few more unpleasant incidents Laura eventually agreed to attend detox and in May 2023 she completed the treatment without any major issues. After a period of respite and with continued support she is doing well.

Case study 5: Humankind

'Wilma' is a 66-year-old woman who has a long history of alcohol use. She has completed 4 inpatient detoxes followed by periods of abstinence. The situation was escalated following concerns about her increasing frailty and declining health. She was unable to attend appointments at the hub as she was housebound, and it was considered that outreach home visits would better meet her needs.

Wilma needed assistance with her personal care, dressing/undressing, food preparation, and personal shopping. Wilma's daughter was her main source of support and dealt with her personal affairs. Following her daughter's death responsibility for her care passed to her sons.

A referral was made to Humankind to provide support. Wilma was unwell with little or no nutritional intake. She was consuming around 15cl of brandy each day as she reported she experienced tremors without alcohol. The Humankind worker had concerns about 3 of Wilma's sons. She reported all were in addiction either alcohol and / or drugs. Wilma is not able to read or write. The Humankind worker contacted Department of Work and Pensions on Wilma's behalf to resolve an issue with Housing Benefit.

The Humankind worker made a Safeguarding referral for self-neglect and financial exploitation as Wilma's sons were seen to be financially exploiting her, visiting to use her phone, shower, washing machine, and eat her food. Wilma was dependent upon her sons to go to the shop to purchase alcohol, cigarettes and essentials. They used this opportunity to take her money.

Arising from the referral a Care Act assessment was conducted that resulted in a care package. Tenancy support was put in place and the benefits support officer was asked to ensure her income is maximised. Wilma was taken to her GP for a full check-up and medication review. Following a referral to the Vulnerability hub the local Police were made aware of the exploitation and now monitoring Wilma's home to ensure that her sons are no longer having the opportunity to continue the exploitation.

Wilma has remained abstinent from alcohol without the need for inpatient detox. She is stronger, is eating better, and can self-care her activities and daily living and currently waiting for supported housing.

<u>Staffordshire Fire and Rescue Service (SFRS)</u>

SFRS staff attend local authority vulnerability hub meetings where those at risk of abuse and neglect may be sign posted for a Safe and Well Visit. Prevent delivery teams regularly support adults who misuse drugs and alcohol. Our teams are non-judgemental and support people whatever their circumstances. Our offer of support will include, for example, the issue of fire-retardant bedding, smokers bins, assessment for Portable Suppression Systems (PSS) along with other considerations to include linked smoke alarms and the use of Assisted Technology.

Where appropriate SFRS routinely sign-post adults 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.

To help ensure that partners are aware of our offer we also provide "Olive Branch" fire safety training. Now delivered online, at no charge. The training portal can be accessed at any time.

<u>Support Staffordshire</u>

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.

In 2023/24 VCSE held six Adult Safeguarding Training Courses which involved 66 participants, and 18 organisations were supported through One-to-One engagement.

Healthwatch

The Healthwatch team has benefitted from the training that has been offered and has a focus on identifying self-neglect and understanding its causes. Healthwatch has been probing the barriers to the non-engagement with services within the seldom heard communities. Links have been developed with ASIST to provide advocacy.

Trent & Dove Housing

Links made with safeguarding partners and the focus on awareness raising of the issues associated with self-neglect has enhanced joint working that has produced mutual benefits. There have been tangible improvements in how Trent & Dove has managed complex cases where hoarding has been identified and linked to social isolation. Arising from an identified need Trent & Dove now provide a befriending service with a trained member of the team able to offer telephone support to customers in situations of isolation.

Theme 4:

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.

Ensuring safety during any transition process is vital for the patient's well-being. Mitigating risks requires adequate planning, good coordination, and sufficient support after discharge. During the year the SSASPB has received assurances from several connected partners that organisational policies and procedures have been reviewed and updated and that role related training, including cross agency training, is being provided to practitioners. There has been additional progress in helping to ensure effective practice as follows.

Stoke-on-Trent City Council

Links between Health and Adult Social Care and the Royal Stoke Hospital have been strengthened through a new development of an Integrated Discharge Hub under the leadership of a Director. The aim of these arrangements is to help ensure a person-focused approach to discharge planning at each stage of the journey between hospital to intermediate care before returning home or moving into long-term care where required.

Locality Teams and specialist Social Work Teams in the Local Authority have a strong relationship base and written protocol when transferring individuals between teams. Shared access to health records helps to provide awareness of movement of patients in the locality with a focus on reducing 'hand-off's' as much as possible. To help ensure that funding disputes do not delay or interfere with meeting care and support needs there are joint protocols with a clear dispute procedure with Commissioning Support Unit for Continuing Healthcare (CHC) funding.

Through the Changing Futures Programme, case co-ordination enables safe transitions between services e.g. when an individual is admitted to hospital, goes into prison, moves into accommodation. The services remain involved for as long as required to ensure that arrangements all work effectively.

Transitions from children to adult services has been identified as an area of weakness requiring further attention and resourcing. Some families say their experience of transition to adult services feels as if the support they have relied upon is suddenly not available, it's a "cliff edge" and transition planning often happens too late and without sufficient collaboration between children and adult services.

The local authority is making provision for children from the age of 14 years to be notified to Adult Social Care (ASC) to plan to support the needs for children who will likely transition to ASC. From 16 years there is an in-reach offer to the young person from ASC for plans to be jointly understood and supported, so that all transitions are planned and implemented in a way that continues to provide suitable levels of help and support.

Staffordshire County Council

The pathways and guidance regarding to people transitioning between settings have been updated. The pathways cover people leaving hospital, release from prison or moving from children to adult services. The refreshed guidance makes clear that as people move between services any changes in primary need are managed well and that current teams remain responsible until handover has been completed.

Supervision and management oversight reviews the effectiveness of the arrangements supported by monthly audits to review if risks have been appropriately identified and responded to.

As part of the Preparing for Adulthood project there is a triage meeting that reviews all young people and signposts or refers them for appropriate assessments. This is seeing a reduction in the number of young people coming to adult services as they turn 18 years.

The Accessibility project is ensuring that information for service users is available in formats that are more accessible to people and communities, particularly where there are barriers to engagement. The is for people to have awareness of what they can expect and who can help etc.

The feedback from peer reviews and audits provides assurances that risks are being noted and addressed.

University Hospital North Midlands

Through the involvement of the Lead for Vulnerable Patients in the meetings to review all incidents that may meet the threshold for Serious Incident reporting (frequency twice weekly) there are opportunities for the Trust Safeguarding Team to pick up on safeguarding issues. Involvement in the Trust's Patient Experience Group enables the Safeguarding Team to triangulate information, and review themes and trends.

Both staff training and Trust policies for Adult Safeguarding and Domestic Abuse now include a section on the considerations to promote and enable a safe discharge from hospital. The awareness raising coincides with the monitoring and oversight arrangements finding a reduction, compared to the previous year, in the number of concerns raised by the local authority in relation to unsafe discharges from hospital.

UHDB

When patients attend the Emergency Department there are lateral checks to safeguard the adult, prompting where relevant referrals to Adult Social Care and other safeguarding partners. Passwords are created to be used between health, police, and other required agencies, to ensure protection of the patient as they move between departments through the hospital. This arrangement has improved cross agency communications to the benefit of the patient.

MPFT

MPFT routinely use one health and care record to determine if someone is known to another health or social care agency. This information is available via current electronic patient records. This has been further

strengthened in 2024 by using GP connect. Frontline practitioners can review GP records for clinical care purposes to ensure that appropriate follow-on care is in place.

Discharge from hospital have a dedicated discharge facilitation team. In mental health settings there is a requirement to complete a seven day follow up for anyone who is being discharged from a mental health bed.

Healthwatch

Healthwatch has been working with patients and partners around hospital discharges and how there is an emphasis on patient well-being during the transition from an acute care setting to the community. Prioritising risk assessment and safety protocols with effective communication helps prevent negative outcomes for patients and supports positive transitions. Healthwatch is working with partners to ensure patient safety and highlight good practices to encourage positive discharges.

NSCHT

The inpatient wards routinely communicate with the Safeguarding Team when they identify safeguarding issues when adults are admitted to and discharged from hospital. The regular professionals/discharge planning meetings help to ensure appropriate safety planning. It is a positive reflection of the effectiveness of the combined arrangements that there have been fewer Section 42 enquires arising from discharge issues compared to the previous year.

ASIST

Arising from a shared knowledge and understanding of risks ASIST has seen, over the past 12 months, an increase in the number of referrals for Care Act assessments arising from adult discharges from hospital.

SFRS

Working in partnership with the Midlands Partnership Foundation Trust, SFRS has been commissioned to provide a Home from Hospital (HfH) service. The staff providing this service have received role related training. Through this service there have been occasions when a patient has been seen to need additional support. In such situations concerns have been raised with the Integrated Discharge Hub (IDH) at the hospital prompting the provision of emergency care packages for the patient. In a further illustration of the HfH service SFRS collected a patient from hospital to take them home. During the journey it became apparent that the patient had an underlying health issue, and the patient was taken back to hospital.

SFRS have helped patients in many practical ways including performing a Safe and Well Visit, fitting smoke alarms, removing trip hazards, making refreshments, ensuring the patient has easy access to the toilet and resolving heating issues.

Humankind

Practitioners have an enhanced awareness of the risks involved in transitioning between services and discharge that is now routinely reflected in safety plans developed in conjunction with Safeguarding Champions.

Theme 5:

That amongst connected partners professionals and leaders are alert to the sources of risk of abuse and neglect for adults with care and support need in communities and residential settings particularly the hidden voices and people 'falling between the eligibility gaps'.

Substance misuse and mental health needs are two of the primary concerns for many people experiencing multiple disadvantages. It is clear from discussions with people with lived experience that adults with co-occurring conditions face significant barriers to accessing support for either their substance use, mental health problems, or both. This priority has a focus on seeking assurances that there is access to appropriate support and treatment for people with co-occurring conditions facing multiple disadvantages.

Stoke-on-Trent City Council

Staff are alert to the sources of risk in several ways. From a commissioning perspective there is the requirement for providers to report any concerns about safeguarding. There is a range training and awareness raising with a focus on equipping staff to be professionally curious. Weekly case discussions in teams include peer reflective discussions, share ideas and professionally challenge. This scrutiny helps to keep the workforce curious and reflective.

Through Quality Assurance arrangements there is a focus on engaging with people both receiving and working in services, as well as their families, reviewing complaints including from whistleblowers, and generally asking questions with an element of professional curiosity.

Where Carers are identified and offered an assessment the emphasis is on their ability to maintain the caring role. Both parties are spoken to separately to gain a holistic picture. It is good practice to exercise professional curiosity and ask brave questions, this is part of relationship building and creating trust where disclosures can be made safely. Concerns mistakenly referred to as carer breakdown should be treated as safeguarding when there is identified abuse or neglect.

There is more to do to ensure robust oversight of receiving care in their own homes, supported living, in receipt of a Direct Payment or paying privately for care.

The Changing Futures programme has a specific remit in relation to adults with needs for care and support who may fall through eligibility gaps and may also find it difficult to engage with services. Changing Futures has developed links with a range of partners including the Multi-Agency Resolution Group (MARG) that has a key role in tracking case progression. Through engagement with the Changing Futures programme some adults not previously known to Adult Social Care are able to have Care Act Assessments leading to a structured approach to mitigation of risk and safeguarding.

There are currently 18 community lounges in Stoke-on-Trent which provide an alternative front door for accessing help and support. Locality Connectors facilitate these lounges and will refer any safeguarding concerns that have not been reported through the formal routes. Data indicates that the use of the community lounges is increasing with more people attending with needs for complex in-depth support.

Case study 6: Stoke-on-Trent City Council

'Steph' was introduced to the Changing Futures programme by her social worker who had co-ordinated a multi-agency response to meet her complex health and social care needs. Despite a multi-agency approach, support for Steph remained inconsistent - partly due to services not being responsive enough and partly due to a lack of trust between Steph and services which would often lead to Steph's case being closed.

At the time of introduction several organisations were involved including tenancy support, local police, drug and alcohol service, local authority housing team and adult social care. Previously there had been additional support from secondary mental health services and a specialist dual diagnosis consultant. At the point of her introduction to Changing Futures Steph was sofa surfing at a friend's house whilst she waited for a local authority property which was being prepared for her to move into. Concerns regarding Steph's deteriorating mental health had been raised by the Multi-Disciplinary Team, however, despite several inpatient admissions for assessment and previous treatment for symptoms of psychosis Steph's community aftercare remained poor and the secondary mental health service discharged her. The reason given for this was that Steph was not ready to address her mental health needs due to ongoing alcohol use. Steph reported feeling judged and stigmatised by this response stating that her alcohol use is to cope with the symptoms of her mental distress. As a result of this Steph was reluctant to re-engage with mental health services.

The decision was made that Changing Futures Women's Community Coordinator could provide a positive role model to build trust and rapport with Steph, to provide opportunities to get involved with community activities and build positive relationships and new friendships, as well as working to rebuild trust with mental health services so this need can be met.

After several months of relapses concerns were raised by the professionals involved about the ongoing situation and following a visit from Steph's social worker an assessment took place, and Steph was sectioned under the Mental Health Act 1983 and admitted to a mental health ward. After a week-long inpatient stay Steph returned home to build her rehabilitation.

Whilst it is known that mental health issues and substance use are often co-occurring, this dynamic continues to act as a barrier to people accessing support. Although there were potentially multiple opportunities to assess Steph's mental health throughout, it was only when under Section that this took place. It is important to recognise that trust and faith in services played a played a part in Steph's case to accessing the support she needs, and that when this trust and faith is lost it can take a considerable effort to regain.

There has been a clear improvement in Steph's mental wellbeing and Changing Futures continue to provide support. Steph has reconnected with the Expert Citizens community group and is actively participating in activities such as attend the Changing Futures community of practice, to bring the voice of lived experience to the forum.

Staffordshire County Council

The recording of safeguarding data has improved and there has been a reduction in the number of 'unknown' responses in reports of safeguarding concerns. The complete data picture helps to better identify where we may not be hearing the voices of certain communities or people at risk of certain types of abuse. The improved data collection is helping to improve engagement with marginalised groups.

Staffordshire County Council is an active participant with the Dynamic Support Register that is used to ensure that people with complex and co-occurring needs are receiving the support that they need.

In relation to Preparation for Adulthood (PFA) there are now regular Triage meetings where individual young people are discussed and monitored, this is to ensure that people are not at risk of falling between the gaps during that transition period.

The process regarding Persons in Person of Trust has been reviewed and enhanced. The Adult Safeguarding Enquiry Team being co-located with Staffordshire Police identifies actions being taken and investigations occurring for persons in positions of trust which enables shared accurate records.

After joining the No Recourse to Public Funds network there is access to details of people's immigration status which enables support to be provided at the right time and in the right way. The adult may not otherwise have access to appropriate social care due to their status.

Staffordshire Police

It has been identified that many of the vulnerable people that Police encounter need help and support but may not meet the threshold criteria for a Section 42 enquiry. The absence of adequate data has rendered it difficult to spot trends, themes and protect those adults who have historically have 'fallen through the gap'.

Arising from discussions with connected partners there was concern about the people outside of the statutory threshold. This led to the introduction of a pilot scheme Pitstop which promotes sharing information between connected partners with the aim of building a comprehensive picture of vulnerabilities that require multi-agency intervention.

At the time of this Annual Report, Pitstop was subject of a formal evaluation of its effectiveness and consideration of extension.

NSCHT

Professional curiosity is a theme that is discussed in safeguarding supervision to encourage staff to ask questions and to use their skills to critically analyse information and think the unthinkable. Discussions on key themes that come from case reviews helps practitioners to reflect on current cases during supervision. Over the year there has been an increase, compared to the year before, in the escalation of concerns to the Safeguarding Team reflecting staff awareness and positive interventions.

Case study 7: North Staffordshire Combined Healthcare

'Eva' is a woman aged in her 30's with a diagnosis of an acquired brain injury and HIV associated neurocognitive decline. Eva was admitted to psychiatric inpatient care due to a decline in her mental state. She was under-weight and not able to talk in sentences.

Eva is not a UK national and had no next of kin or family locally. Six months into her inpatient care, the ward contacted her mother ('Linda') in the Czech Republic through the Embassy. Linda reported that Eva was kidnapped 16 years ago and taken to the UK and had believed to have been exploited and forced into sex work. Linda was very distressed and thought Eva was dead as she had not heard from her for 3 years.

Eva had no passport and no documents, and there was no record of her entry into the UK.

Eva was in a relationship with a man 'Marko' who was from Turkey. He wanted to take Eva to Turkey so he could care for her. However, the ward staff were concerned as he presented as very controlling.

At the beginning of her contact with mental health services Eva alluded to being forced to work, but it was not clear whether this was disordered, or delusional thinking related to substance misuse.

Arising from the new information from Eva's mother, a safeguarding referral was made under the category of Modern Slavery and Domestic Abuse, alongside an application to the Court of Protection to enable Eva to be placed outside of the area with limited contact with 'Marko'.

Eva has made progress since admission and is now speaking in full sentences, however, due to her condition she still needs 24-hour support in nursing care.

SFRS

Through its activities within communities SFRS staff fulfil a valuable role as the 'eyes and ears' in identifying neglect and abuse. The Service has developed many single referral pathways with partners across Stoke-on-Trent and Staffordshire. By way of an illustration SFRS was requested by a domiciliary care provider to provide a Safe and Well visit to a lady with dementia who had burnt her hair. On arrival at the address the SFRS team found a lady who had burns to her face, head, and shoulders that required immediate treatment. After arranging medical assistance, the SFRS team raised a safeguarding concern as the carer attending the lady had left her alone without making provision for medical assistance.

Case study 8: Staffordshire Fire and Rescue Service

Whilst making safe and well visits to houses in Stoke-on-Trent a crew from Staffordshire Fire and Rescue Service visited the home of 'Martha'. The crew found evidence of the property being in a state of disrepair including a leak in the roof, which was preventing Martha from sleeping upstairs, as well as concerns regarding the overall safety within the home. The crew established that Martha spoke only a very basic level of English, and her first language was Greek. The house had been her son's property, but he had died, and she was living there alone.

There was limited information as to how Martha was meeting her personal care and daily living needs but there was a level of vulnerability which prompted a safeguarding referral to Stoke-on-Trent Adult Social Care.

A social worker visited Martha to make an initial assessment which prompted the involvement of an interpreter able to speak in Greek which helped to understand her situation and needs. The presenting risks concerned the home environment as well as how Martha was meeting her day to day needs and managing financially.

Martha explained that she has dual Greek and Ethiopian nationality. When she originally came to the UK she had a bank card, however, this had subsequently gone missing from her bag. She also explained that she had been receiving ongoing support from her next-door neighbours were also asylum seekers from Ethiopia and she was able to converse with them as and when required.

The Care Act assessment identified that Martha could address her personal care needs, prepare meals and drinks independently, and walk alone. Martha was assessed to have capacity in relation to where she resides and view of her care and support needs. She refused any offers of moving to alternative accommodation. Martha did not meet the eligibility criteria for a formal homecare service from Adult Social Care, however, her vulnerability and lack of familial and local resources prompted the need for involvement of a Multi-Disciplinary Team.

This case illustrates the diligence of the SFRS crew in following up on their concerns of vulnerability to enable a range of help to be provided in relation to the safety of Martha's home, and referrals to a range of sources of help including a social worker who specifically works with individuals who are classed as being of

no recourse to public funds / seeking asylum, as well as referrals to other relevant agencies including a European Union Settlement Scheme to consider an application for Martha to remain in the UK.

Humankind

Staff are reporting improved confidence to discuss cases with adult safeguarding teams around hidden harm, using a strength-based approach within assessment. A mutually beneficial working relationship has been developed with the Integrated Co-occurring Needs (ICON) project that is working with adults who have multiple needs with complexities but do not meet eligibility criteria for some services.

Healthwatch

Healthwatch has a focus on vulnerable people with additional needs who can fall through gaps highlighted, for example, from persistent non-attendance to appointments and being disproportionately underrepresented in partner organisation's data**.** Healthwatch engages with adults who do not fit the eligibility gaps and supports them to engage with advocacy services.

UHNM

The training provided to staff has increased to be above 85% for Level 2 and Level 3 at the year end. The continuous raising of awareness of potential sources of risk and the sharing of the learning from case reviews coincides with an increase in safeguarding referrals emanating from the emergency departments.

Support Staffordshire

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.

ASIST

Asist continue to challenge the gaps in advocacy provision for adults that do not meet eligibility criteria. Holding regular conversation's regarding this group of people and the identified risks, working together to attempt to mitigate risks.

Staffordshire Women's Aid

All needs and risk assessments consider the full history of abuse experienced, including any previous incidents and patterns of repeat incidents, the type, severity and escalation of abuse and any previous abusive relationships. These are regularly reviewed throughout support.

MPFT

MPFT has created a seven-point briefing to include in safeguarding supervision sessions to encourage our staff to be professionally curious.

10.2 Engagement

The activity around this priority is managed and co-ordinated by the Prevention and Engagement sub-group which meets bi-monthly and is chaired by Laura Collins (North Staffordshire Combined Healthcare

Trust). This is a sub-group with a broad membership and attended by partners with a good knowledge and insight into operational practice.

Considerable progress has been made over recent years raising awareness of adult safeguarding. The Board and its connected partners have produced and distributed a wide range of information using a variety of methods that feedback suggests has been well received. These activities appear to have had the desired effect of contributing to an increase in safeguarding alerts and reports.

It is recognised that there is more to be done on raising 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 following activities have been completed through the sub-group:

Provided a variety of online learning events that were attended by a total of 727 practitioners in 2023/24

Hosted a learning event on the themes of mental capacity and self-neglect in support of the findings of SAR 'Andrew' attended by 191 practitioners.

Hosted a learning event on the themes of mental capacity and sexual safety in support of the findings of SAR 'Frank and Elsie' attended by 104 practitioners.

Hosted Practitioner Forum event on theme of Managing Allegations against staff working in partner organisations attended by 122 practitioners.

Hosted Practitioner Forum event on theme of Older People and Domestic Abuse attended by 156 practitioners.

Learning evaluation: As part of the commitment to evidence Effective Practice, the Workforce Development Officer at Stoke-on-Trent City Council has developed a method to evaluate the impact of SSASPB hosted learning events. This was initially trialled with feedback sought from nearly 200 attendees. Post event evaluations indicate that everyone responding to the request stated that their knowledge and daily practice had improved. It is recognised that there is more to do to increase post evaluation feedback from busy practitioners.

The SSASPB newsletter was published on 1st June 2023. The format of a concise document with links to access more information is proving popular. Topics included: The Voice of Mrs X – a lived experience in the form of a case study about communicating with adults who may have cognitive impairment; the findings from a multi-agency audit about on-line abuse of adults with needs for care and support; and

learning lessons from Safeguarding Adult Reviews. There was also promotion of the Stoke-on-Trent City Council Festival of Practice week.

December 2023 Newsletter: Content included: An introduction to the work of the Senior Social Worker for 'Homes for Ukraine' at Stoke-on-Trent City Council who has a primary focus of helping to ensure the well-being of Ukrainian guests and their hosts and to identify any safeguarding risks; Escalation – why we have to encourage it and how to do it; Our new approach to learning from SSASPB hosted events – with thanks for the work of Anna Woodberry, Workforce Development Officer at SoTCC who is making an impact on how we engage with and hear from practitioners.

Co-production work/engagement: An evidence bank has been developed to gather illustrations of co-produced work and engagement with adults with lived experience.

Facilitated the gathering of information for a refresh of the SSASPB website that is accessed on a monthly average of more than 3,000 occasions. The sub-group is producing and sharing resources making them accessible through the SSASPB website.

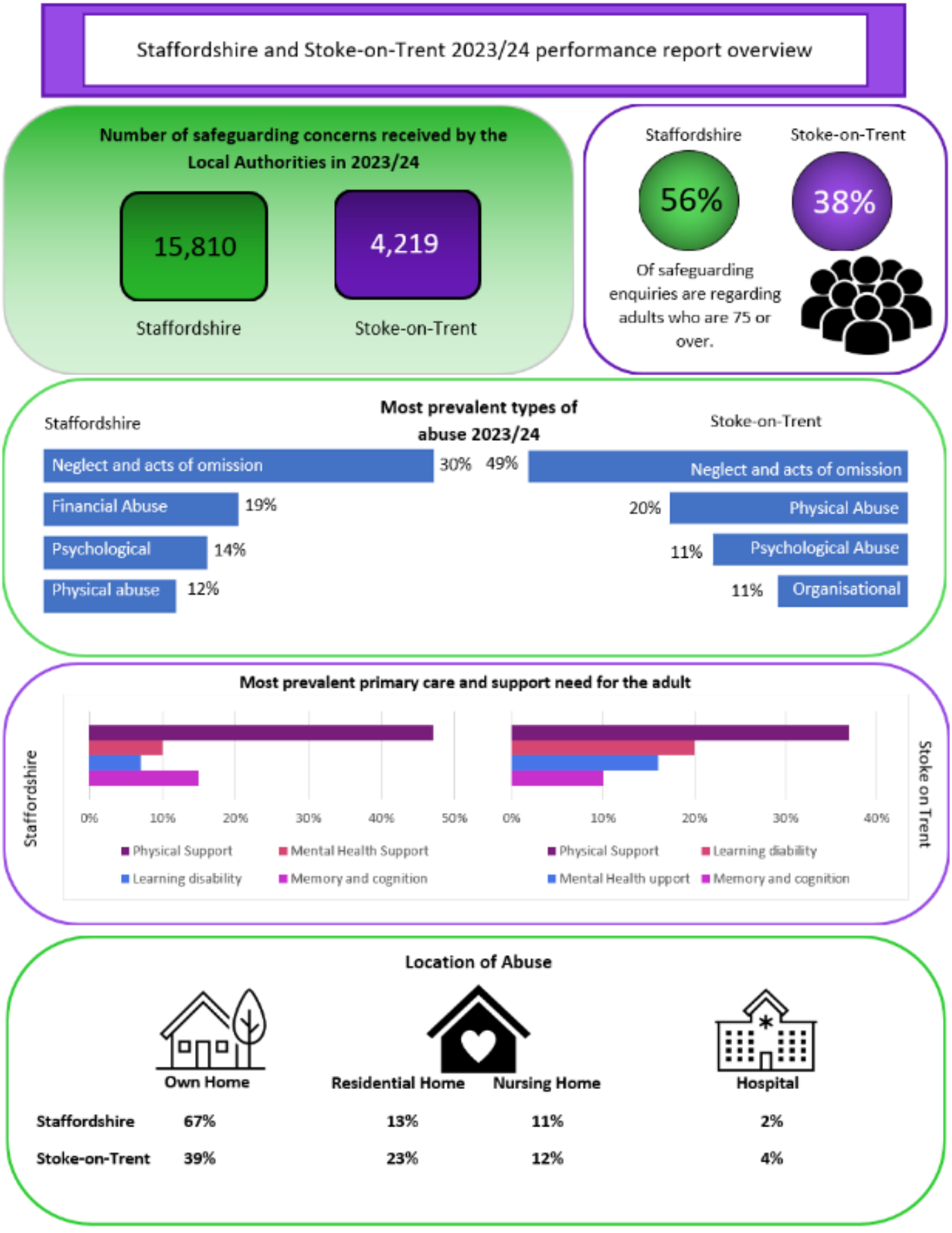
Developed a version of the wording of the Strategic Priority 'Effective Practice' in the 'I statements'[3] format which can be found on the website SSASPB strategic plan

Contributed to a project that will have national application to describe in an animated form the ten categories of abuse and neglect of adults in the Care Act 2014. The animations are widely welcomed as a form of effective communication.

Supported the Ann Craft Trust National Safeguarding Adults Week in November 2023 and supported partner organisations to host their own organisational events.

[3] Making It Real - SCIE

11. Staffordshire and Stoke-on-Trent 2022/23 Performance Report Overview



12. 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%.

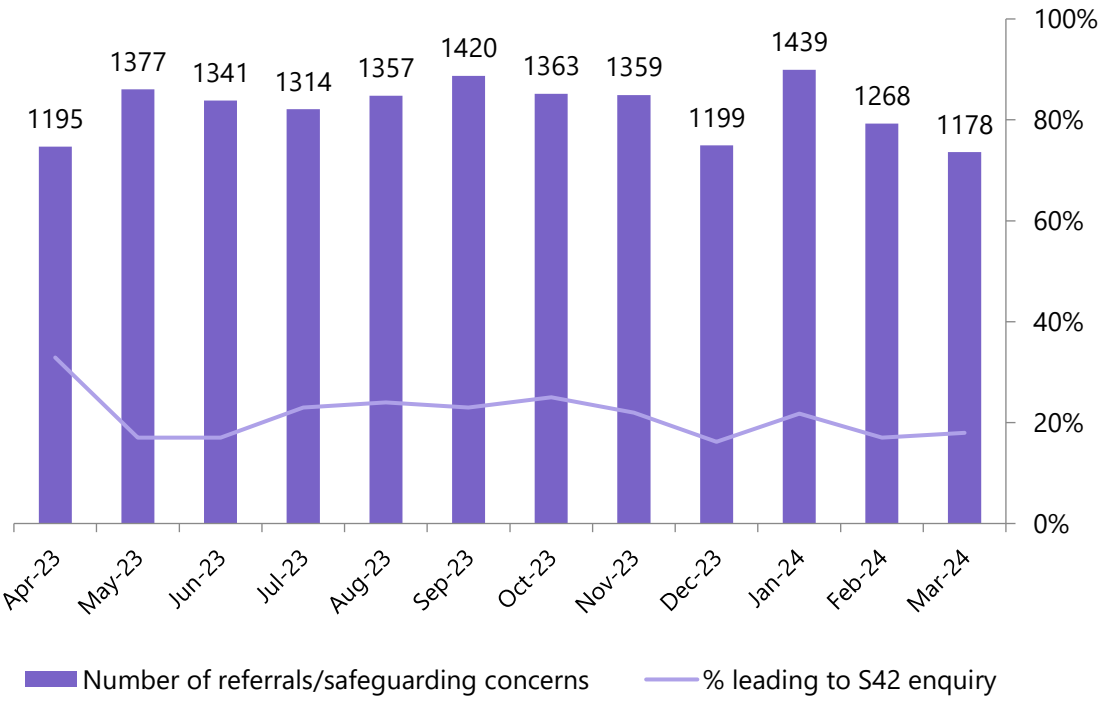
A. Number and proportion of referrals/safeguarding concerns

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

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

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

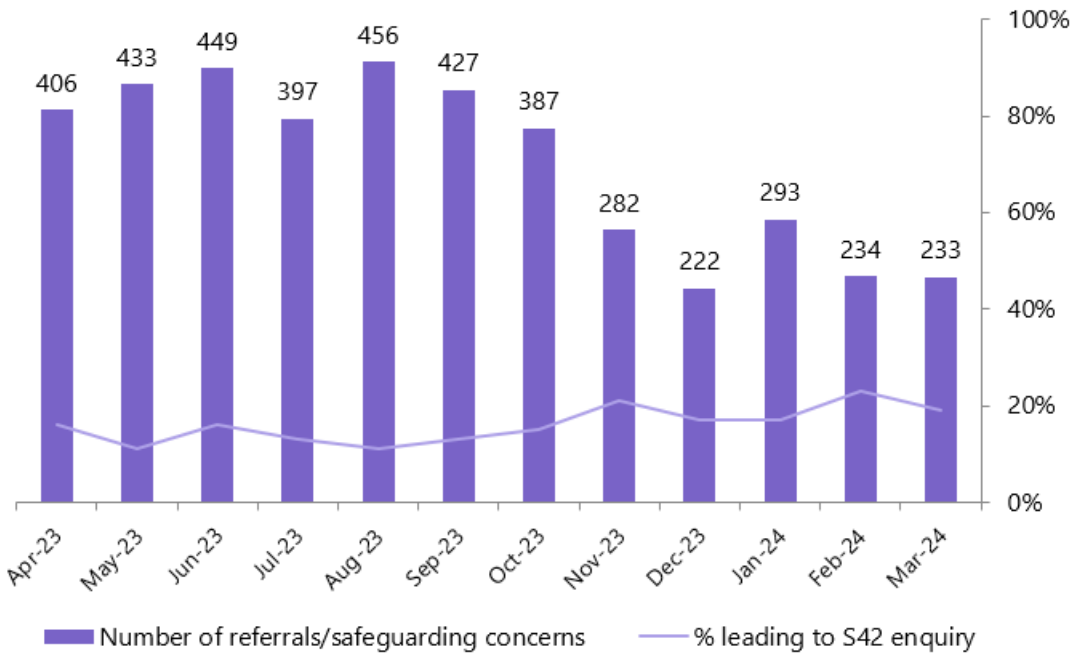
Fig.1 - Staffordshire: number and proportion of referrals/safeguarding concerns



During the course of the year 2023/24 in Staffordshire there have been 15,810 occasions when concerns have been reported that adults with care and support needs may be at risk of or are experiencing abuse or neglect. The total figure has increased by 130 occasions from 15,680 in 2022/23. In comparison to Nationally, this figure is slightly lower and is possibly due to monthly qualitive reports.

The reasons for the percentage decrease in concerns meeting the duty of enquiry threshold have been explored. The information gathered from audits, indicates that this could be related to the type of concerns raised, for example, there are more concerns relevant to quality issues and or requests for assessments. Monitoring of those concerns that do not meet threshold will continue over the next year to better understand this.

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



In Stoke-on-Trent there were 4219 reported safeguarding concerns in relation to adults with care and support needs during 2023/24. This is a decrease of 1007 from 5226 compared to 2022/23 which is a decrease of 21.3%.

Following initial assessment, it was determined that the duty of enquiry requirement was met in 15% of occasions when a concern was raised. This is up from 11% in 2022/23. This is an upward rising trend therefore predict a continued increase.

From October 2023 Stoke-on-Trent have made changes to the way in which safeguarding concerns are managed allowing decisions to be made prior to progression as to whether the referral was in fact a new safeguarding concern, or whether it was a duplicate referral for instance which has an impact on the volume of referrals processed as a safeguarding concern from this point.

Further changes to the Safeguarding process will commence with implementation of the Front Door working model, which enables the majority of safeguarding referrals to be considered and processed in a central location, using a strength based person centred approach to risk management.

The Local Authorities gather and interpret data differently and both comply with the recording guidelines. The Board has asked for an explanation from the local authorities about the different methods of gathering and interpreting information in relation to safeguarding concerns. The responses are summarised below.

- Both authorities review information on the initial safeguarding referral form
- Both make a decision at this point to determine if the three stage criteria is met

a- does the adult have care and support needs,

b- are they at risk or experiencing abuse

c- and as a result of their care needs, are they unable to protect themselves

- If the three-stage test is met, then a decision is made by both authorities to gather further information (called a planning discussion).

- The planning discussion will involve information gathering from various sources, both professional and family and friends and the adults view where they have capacity to be involved.

- Following this information gathering both authorities make a decision if further enquiries and exploration of safeguards for the adult is required.

- If the decision is for no further enquiries, it is at this stage that Staffordshire and Stoke on Trent make a different recording decision –

- Stoke on Trent record this decision as – No Section 42 required (but also record what other actions either care assessment request, review etc. as a non-statutory Section 42)

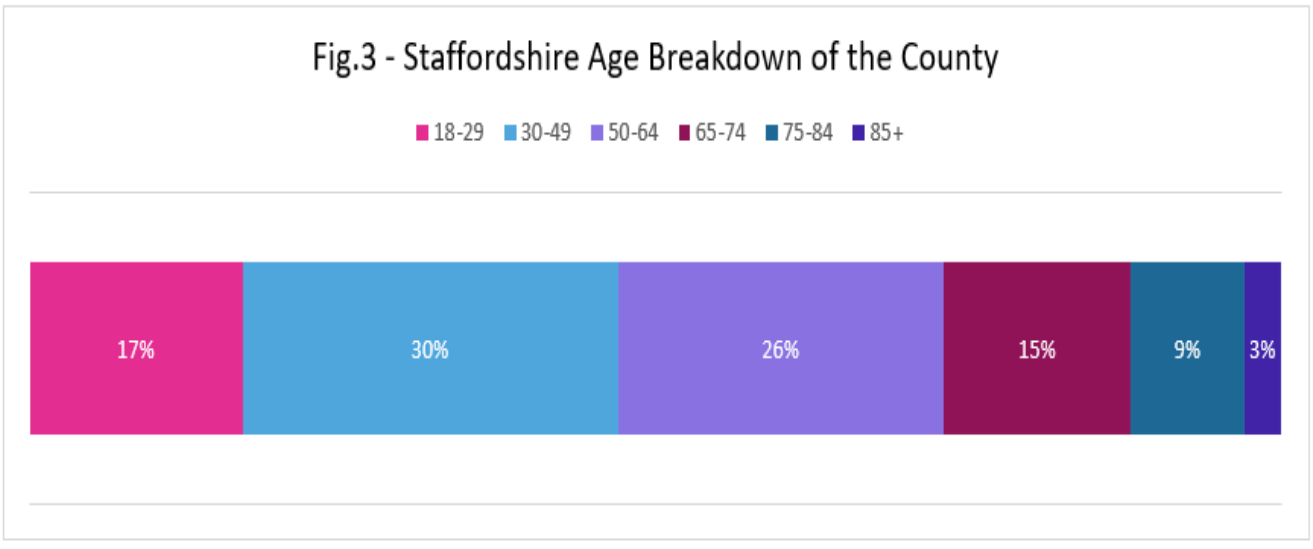
- Staffordshire record this decision as – Section 42 enquiry completed (either no ongoing risk, closed at adult's request, concerns substantiated or unsubstantiated)

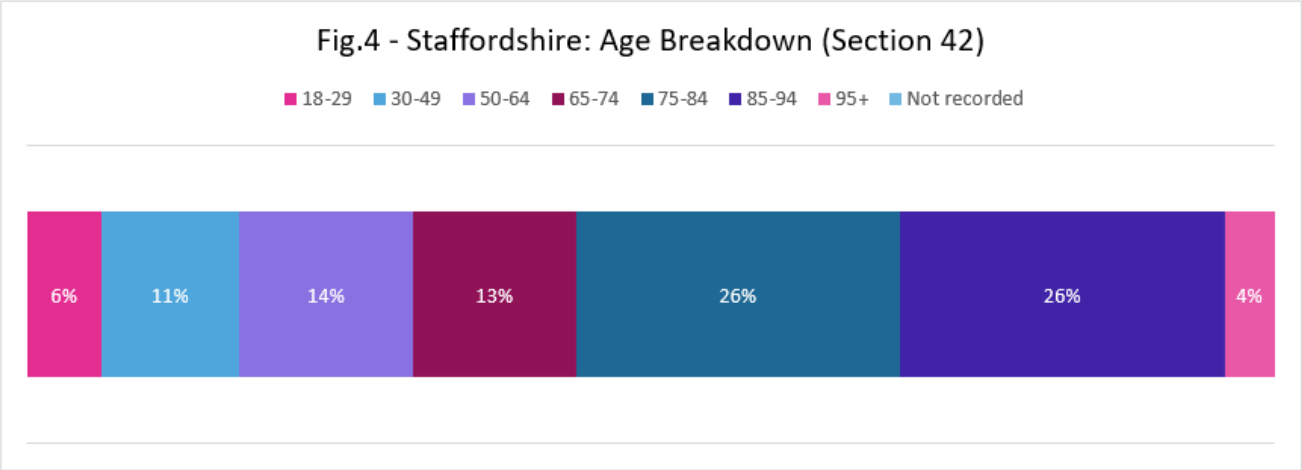
In essence Staffordshire and Stoke on Trent Local Authorities follow the same procedures but the recording on systems is an internal decision for each authority. This review has illustrated that both authorities are taking the same steps to ensure adults are safe and risks minimised. Both authorities have undertaken to re-examine their approaches to seek better alignment in recording practices and conversion to Section 42 enquiry rates.

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

B. 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.



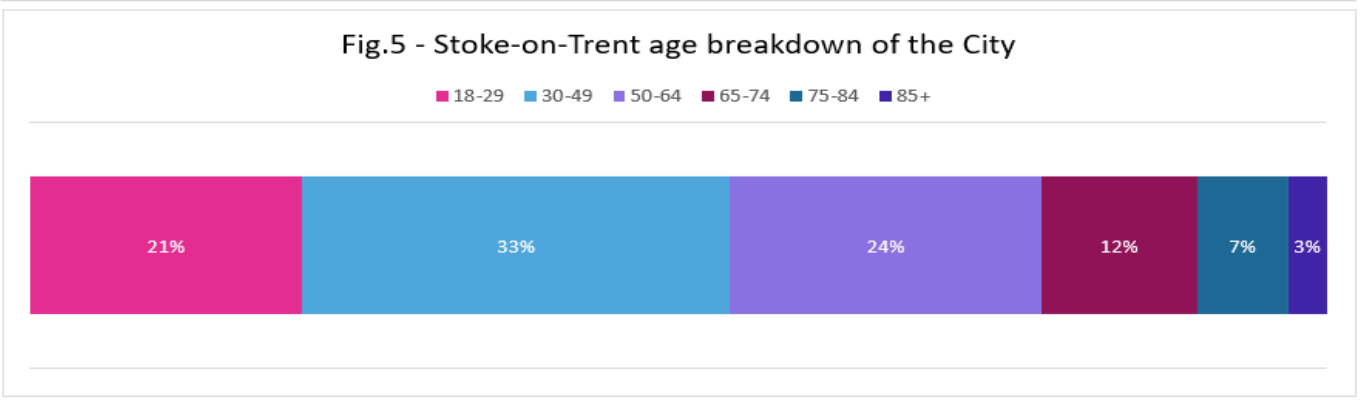


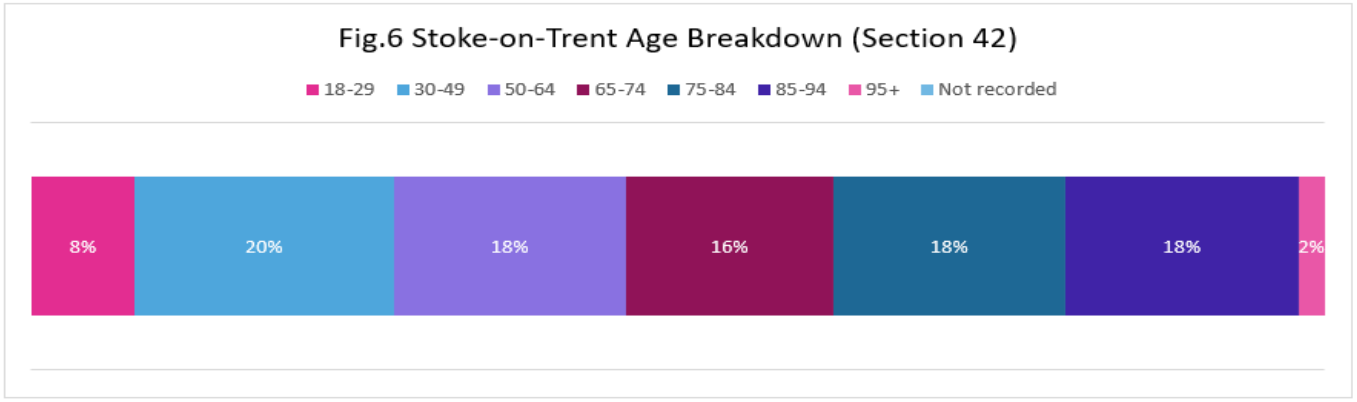
Staffordshire

Of the adults who have been the subject of a Section 42 enquiry, those aged 75–84 (26%) represents the largest cohort along with the 85-94 (also at 26%). This is Broadly similar to last year's data.

The proportion of over 75 year old's in Staffordshire data is representative of the increased likelihood of those aged over 75 being in receipt of care and support. This also links to the highest proportion of safeguarding concerns being received from those receiving care from care providers

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 as there is an increased need as a population grows older for care and support. This seems consistent with the national picture over the last few ears. **Note**: the age bands given by the Office of National Statistics conclude at 85+ and do not match the age-related Section 42 enquiries above. Also, all information is directly from the 2021 Census.





Stoke-on-Trent

For Stoke-on-Trent, there is a more even spread of ages of adults who have been involved in a S42 enquiry (Compared to Staffordshire). The cohort of 30 – 49 is very slightly higher than others at 20% compared to 18% for the cohorts 50-64 75-84 85-94 at 18%.

largest cohort is adults aged 75-84 years (21%) an increase of 1% from last year. Two categories each made up 19% of the total 50-64 and 85-94yrs. Due to the relatively small number of Section 42 Enquiries in Stoke-on-Trent small changes in numbers can significantly change the percentages.

When comparing the age breakdown with the general Stoke on Trent population figures, it is apparent that people over 65 are disproportionally overrepresented for Section 42 enquiries, 22% of the population are over 65 yet 54% of adults involved in a Section 42 enquiry are in this category. This was 59% in 2022/23.

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.

Note: All information is directly from the 2021 Census.

C. <u>Gender</u>

Fig.7 - Staffordshire: Gender breakdown (Section 42)

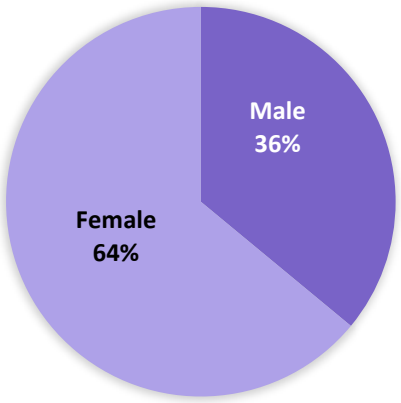
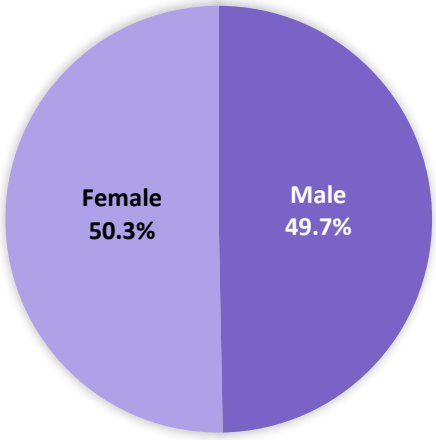


Fig.8 - Staffordshire: Gender breakdown of the County



Staffordshire:

Females represent the majority of adults subject of a Section 42 enquiry with 64% over the year.

Fig.9 - Stoke-on-Trent: Gender breakdown (Section 42)

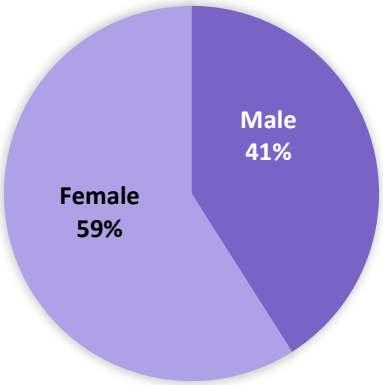
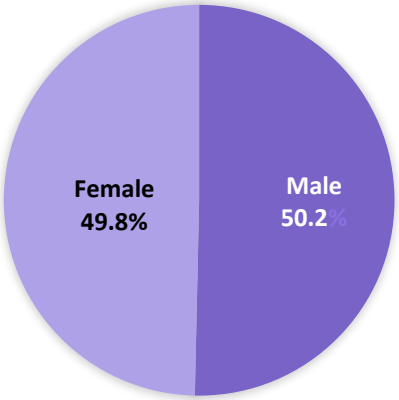


Fig.10 - Stoke-on-Trent: Gender breakdown of the City



Stoke-on-Trent

In 2023/24 59% of adults who were the focus of a section 42 enquiry process, were female. Last year this was 53%. This is not unexpected and may be partially due to the fact that women have a higher life expectancy by 4.8% (3.7 years) they may have more needs for care and support. Audits conducted by the SSASPB also highlight that woman, particularly in the over 65 years bracket appear to be more vulnerable to abuse and neglect.

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

D. <u>Ethnicity</u>

Ethnicity	Stoke on Trent section 42 enquiries	Stoke on Trent overall population		Staffordshire S42 enquiries	Staffordshire overall population
White British	84.7	78.5		86.1	90.2
Not Known	5.8	-		4.1	-
Pakistani	1.6	6.0		0.7	1.3
Any other mixed background	0.7	1.5		0.4	0.0
Black Caribbean	0.5	0.4		0.3	0.3
Not Stated	2.7	-		5.8	-
Other White	1.5	4.5		0.9	2.9

Any other ethnic group	0.5	1.8		0.4	1.4
Any other Asian Background	0.4	1.8		0.3	0.8
Indian	0.0	1.1		0.3	1.1
Mixed White/Caribbean	0.5	0.8		0.0	0.8
Black African	0.2	2.0		0.0	0.4
Bangladeshi	0.2	0.6		0.0	0.1
Any other Black Background	0.2	0.4		0.1	0.1
Arab	0.0	0.3		0.0	0.1
Gypsy /Roma	0.0	0.3		0.0	0.1
White Irish	0.4	0.2		0.5	0.4

Note: the table is presented in order of the most prevalent based on the Stoke-on-Trent figures.

Staffordshire

The majority of individuals (Section 42) are 'White British' 86.1%, a slight decrease from last year (91.9%), followed by 'Other White British at (0.9%). The Not Known category was 4.1% an increase from 2.2% last year.

Stoke-on-Trent

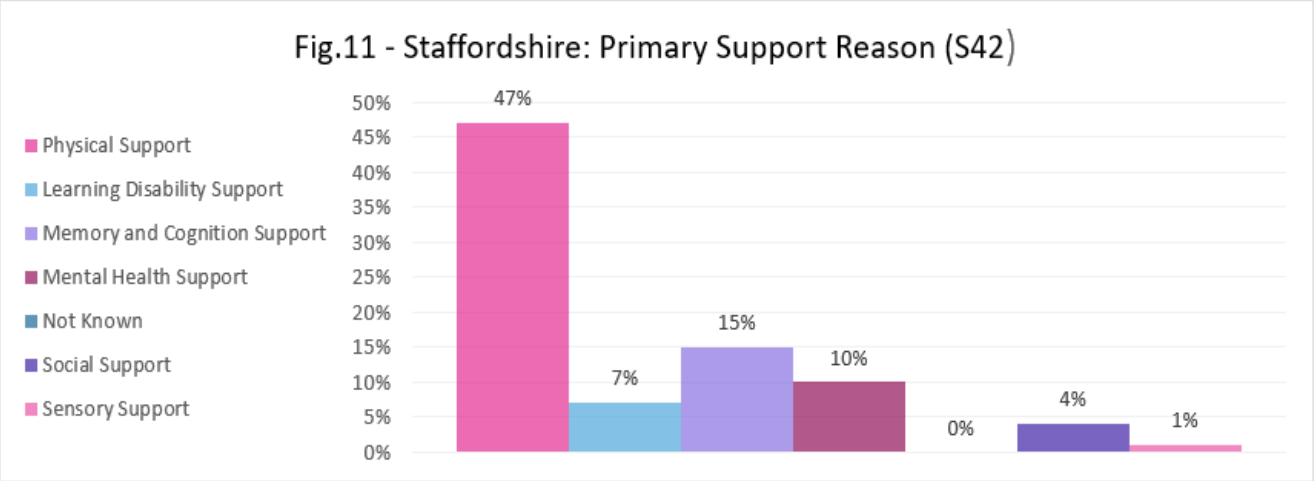
The pattern is similar in Stoke-on-Trent, with the majority of declared ethnicities recorded as 'White British' at 84.7%, a decrease from 87.9 % last year. Recording also saw an increase in the Not Known category from 4.5% last year to 5.8% this year.

Stoke-on-Trent continue to complete demographic data accuracy audits as part of the quality assurance tasks to make improvements on these figures.

The Board has promoted the importance of accurate ethnicity recording in 2023/24 through its Practitioner Forum, learning events and Newsletter.

E. <u>Primary Support Reason</u>

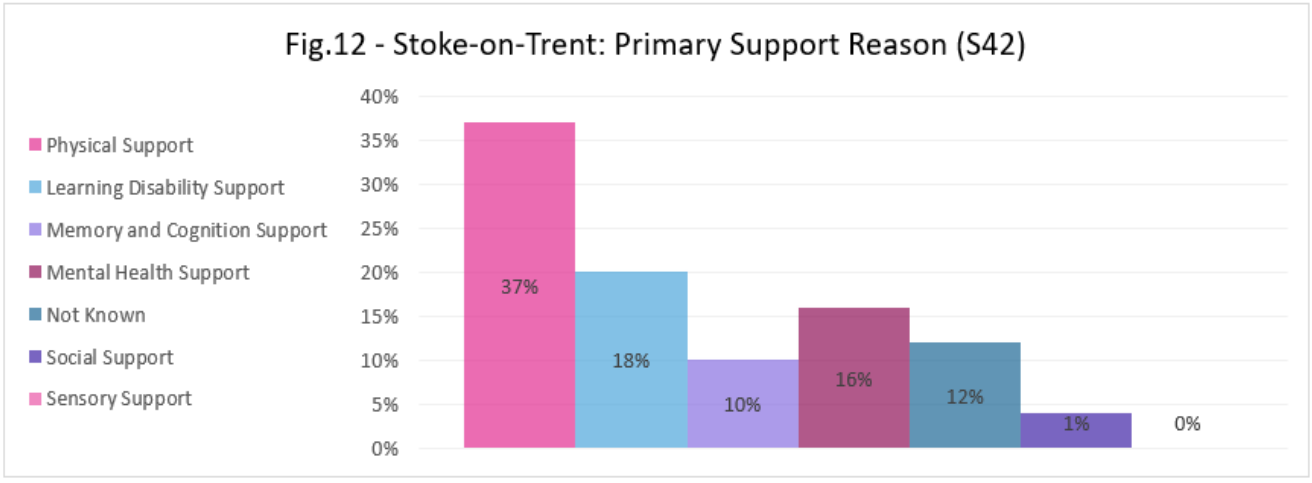
The bar charts below illustrate the type of care and support need of the adult subject of abuse or neglect.



Staffordshire

Physical support continues to be the most common primary support reason in Staffordshire in 2023/24 (47%) a slight decrease from last year (48%). The second most prevalent primary support reason is Memory and Cognition at 15% a 1% increase on last year. Of note, Mental Health support was 10% of the total in 2023/24 whereas it was 20% in 2022/23.

It has been noted that there has been a 50% decrease in those section 42 enquiries where the persons primary need is mental health. There has been a change in process from concerns being reviewed and dealt with by a central team at MPFT Mental Health to SAST making the decision and then this being sent out to relevant mental health team. In response to this we will be reviewing this process and auditing enquiries to ensure appropriate decision making is occurring.



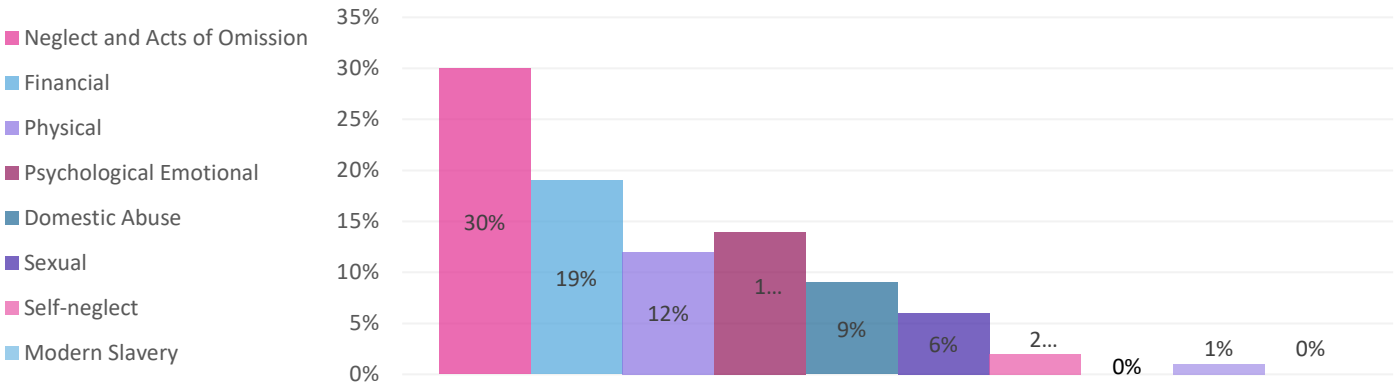
Stoke-on-Trent

Physical Support similarly represents the largest proportion of primary support reasons recorded in Stoke on Trent at 37%, followed by learning disability support with 18%. These figures were 42% and 18% respectively in 2022/23. In 2022/23 16% of Primary Support Reason (PSR) were not recorded. In 2023/24 this is 12%. Figures show a downward trend which is expected to continue; however Stoke-on-Trent continue to consider appropriate recording of Primary Support Reason within audit standards to positively impact this trend.

F. Types of Harm or Abuse identified at Section 42 safeguarding enquiry

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

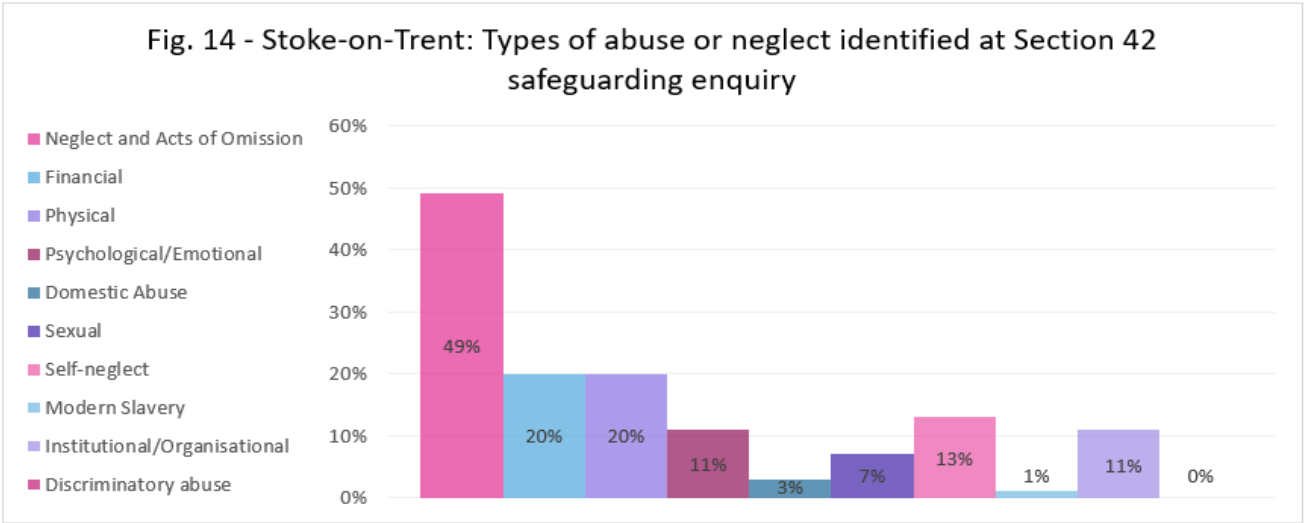
Fig. 13 -Staffordshire: Types of abuse or neglect identified at Section 42 safeguarding enquiry



Staffordshire

Neglect and Acts of Omission continues to be the most prevalent type of abuse at 30% and is a decrease on the figure of 37% reported in 2022/23. Financial abuse remains similar at 19% compared to 20% last year, and Physical abuse has reduced from 13% last year 12% this year. There are no remarkable changes to the percentages reported in 2022/23. 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.

Fig. 14 - Stoke-on-Trent: Types of abuse or neglect identified at Section 42 safeguarding enquiry



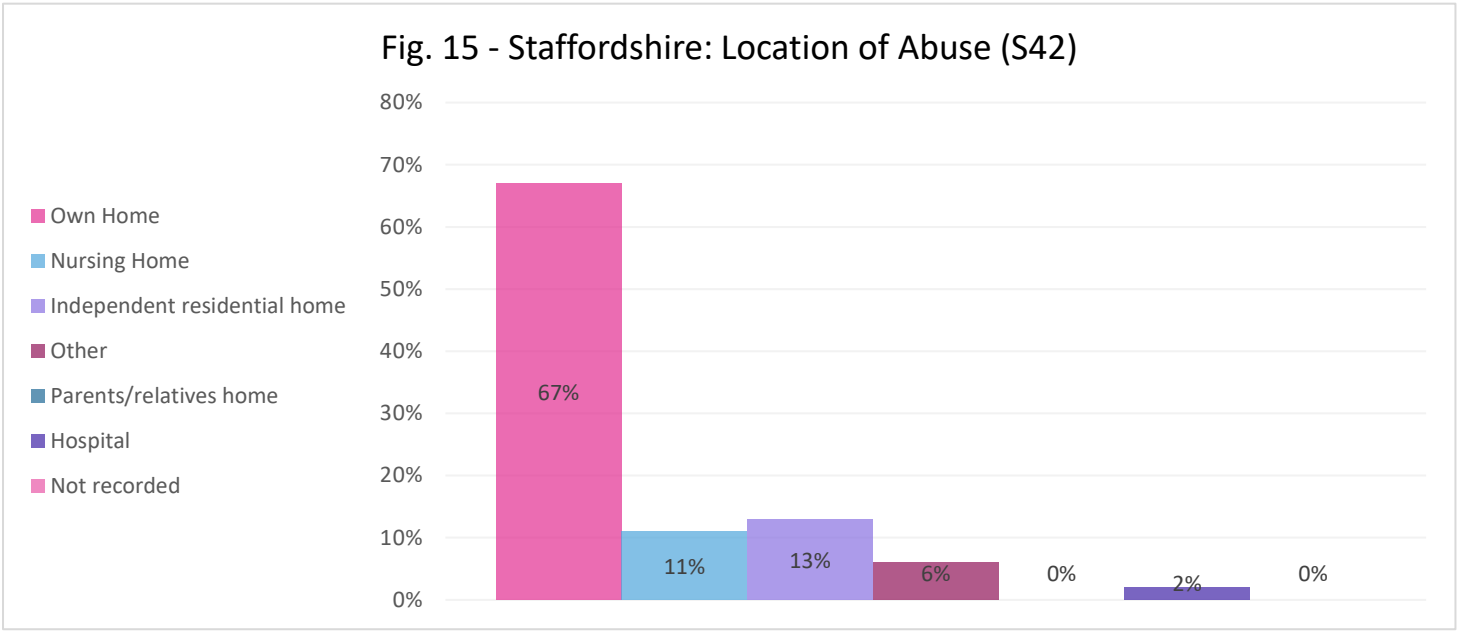
Stoke-on-Trent

The percentage of neglect and acts of omission cases has decreased from 56% last year. Financial abuse has increased from 19% to 20%. Self-neglect concerns continue to increase from 7% in 2021/22 and 11% in 2022/23, this may be attributable to the awareness raising of self-neglect as a category of abuse following the well-attended learning events that followed the SAR 'Andrew'.

Organisational abuse is better reported in Stoke-on-Trent where more than one category of abuse can be recorded.

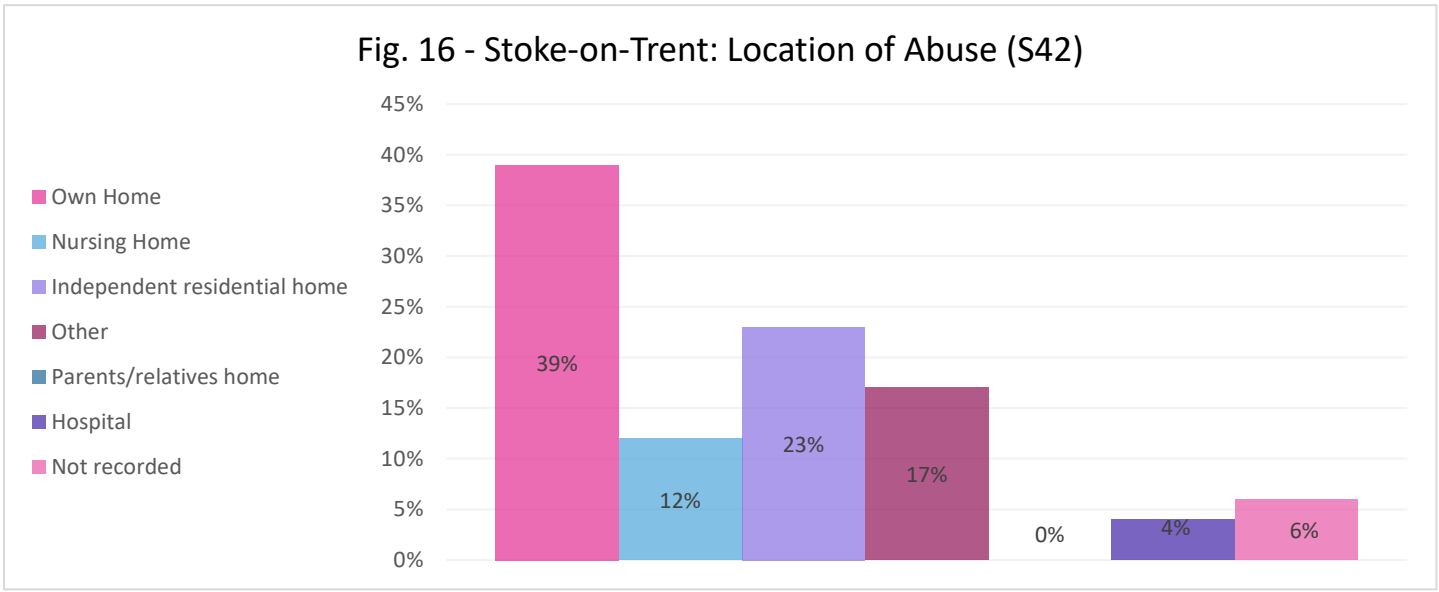
It should be noted that there can be relatively small numbers of adults in types of abuse which can cause a percentage change to appear more pronounced. In Stoke-on-Trent more than one type of abuse may be reported for a single case. The total cases are therefore more than 100%.

G. Location of abuse



Staffordshire

Of those people subject of Section 42 enquiries, the most common location of abuse or neglect was the person's own home (67%) compared to 70% in 2022/23. The next most common locations in Staffordshire were Independent Residential Home at 13% an increase from 12% last year and nursing home at 11% a decrease from 17% the previous year.



Stoke-on-Trent

The most prevalent location of abuse in Stoke-on-Trent is in the person's own home (39%) an increase from 35% the previous year. This was followed by 23% in an independent residential home and 12% Nursing Home. Location Not Known accounted for 6%.

Through audit it has been identified that some practitioners record a care home as a person's own home

H. Findings of Concern Enquiries

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

Staffordshire: Repeat referrals are at 17% and have broadly remained the same for the past two years.

Stoke-on-Trent: The percentage of repeat referrals has increased to 12% this year, last year's figure was 11% and the previous year was 4%.

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

Fig.17 - Staffordshire: Outcomes

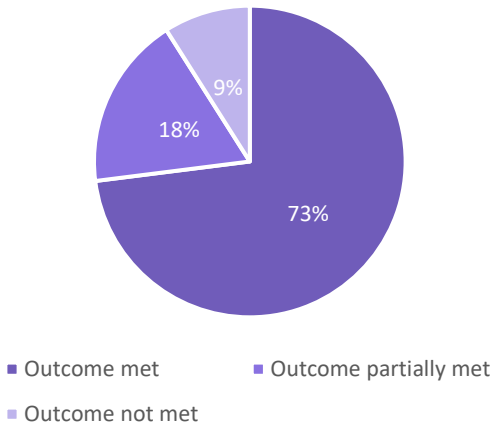
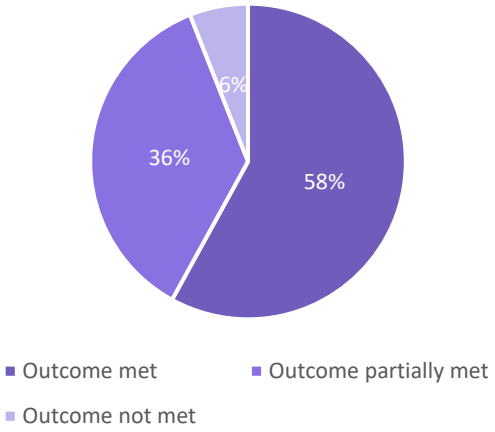


Fig.18 - Stoke-on-Trent: Outcomes



Staffordshire:

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

In Staffordshire 63% of adults subject of a Section 42 enquiry provided a response to the question of whether their desired outcomes from the enquiry were either met in full, partially met or were not met. A total of 91% of adults responding stated that their desired outcomes were fully met or partially met. This is a decrease from 97% last year.

Stoke-on-Trent:

The 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 43% of adults subject of a Section 42 enquiry provided a response, a small decrease from 44% in 2022/23. 94% of these stated that desired outcomes were fully met or partially met. This is a slight decrease from 95% last year.

13. Adult Safeguarding: Staffordshire Police

The Adult Safeguarding Enquiry Team - ASET team, primarily deal with persons in a paid position of trust who look to commit offences against our most vulnerable adults within Staffordshire who have care and support needs, therefore falling under the remit of the Section 42 Care Act 2014. They also identify and deal with modern slavery victims where adults have needs and support.

The team is made up of 11.6 officers and has their own Detective Inspector and 3 Detective Sergeants. They have been relocated to share office space with Staffordshire County Council ASET and Staffordshire Safeguarding Team, SAST. This has been a positive move, encouraging even more collaborative working and information sharing to address the safeguarding of vulnerable adults.

The offences investigated include:

- Ill treatment or Neglect of a person lacking capacity by anyone responsible for that person's care - Mental Capacity Act 2005 Sec 44
- Ill treatment of patients - Mental Health Act 1983 Sec 127
- Care worker ill-treat /wilfully neglect an individual - Criminal Justice and Courts Act 2015 Sec 20 (1) and (2)
- Care provider breach duty of care resulting in ill-treatment/neglect of individual - Criminal Justice and Courts Act 2015 Sec 21 (1) & 23 (1)
- Resident on resident offences data is also included but not resident on care worker.

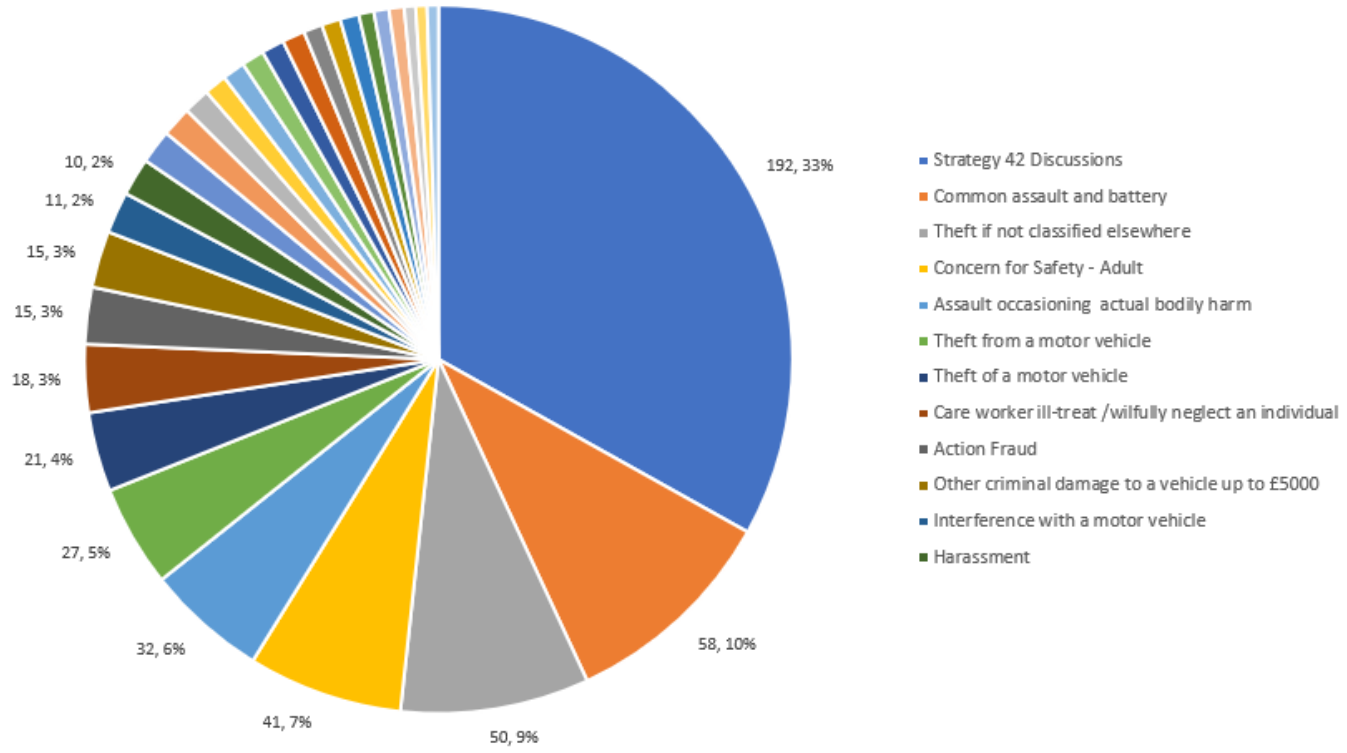
The role of the Adult Safeguarding Team has evolved over the last twelve months resulting in a new remit, taking on more investigations. This has included vulnerable adults with care and support needs that are victims of serious sexual offences, and the suspect is in a Position of trust.

Offences

Within the 12-month period between 01/04/2023 – 31/03/2024, there were 620 occurrences linked to officers within the Adult Safeguarding Team, 650 occurrences that have resulted in a Strategy Discussion where Sergeants within the Multi Agency Safeguarding Hub have assisted.

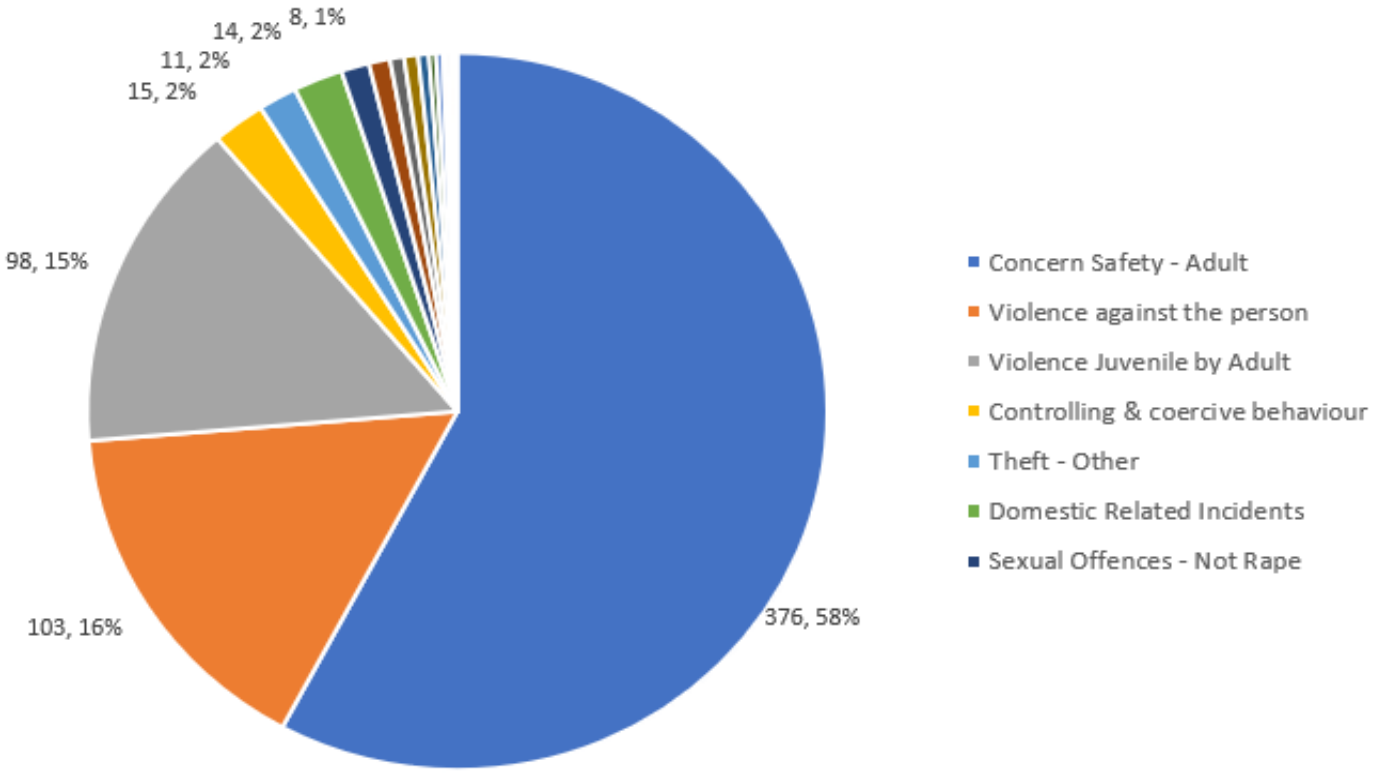
Adult Safeguarding Team:

<u>Offences investigated by Staffordshire Police between (1st April 2023 to 31st March 2024) which involved an adult identified as having needs for care and support.</u>



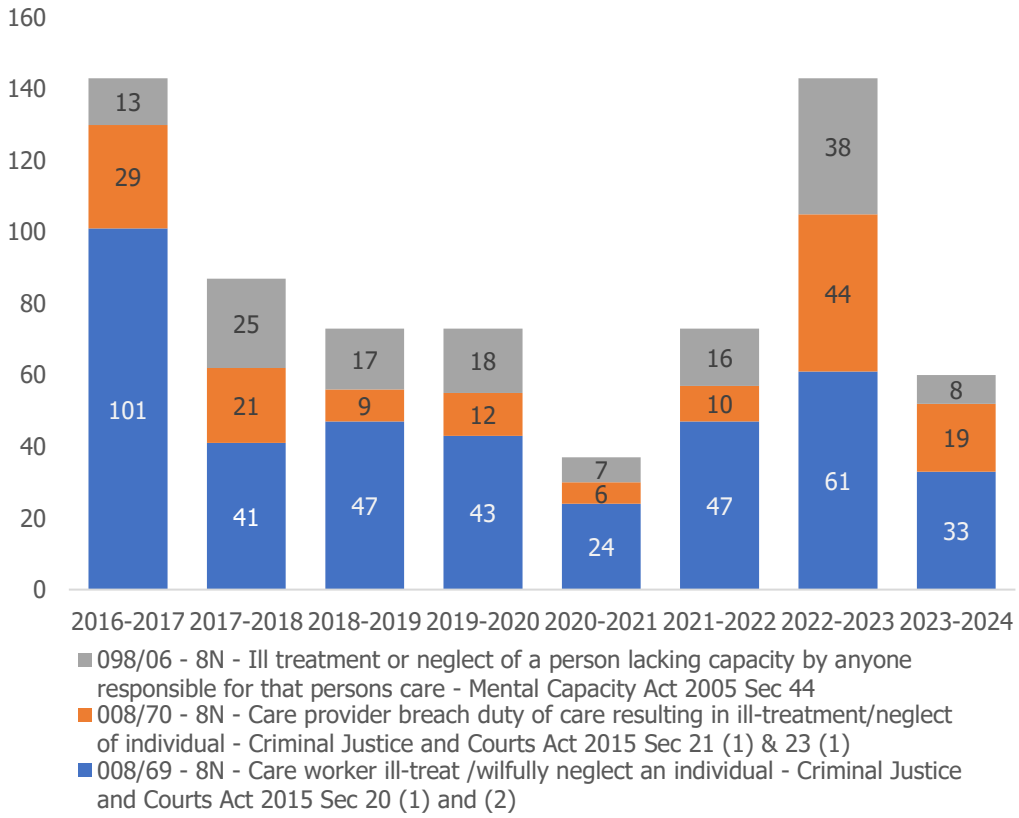
Multi Agency Safeguarding Hub - MASH

The pie chart below shows a breakdown of incidents that are dealt with by the Sergeants within the Multi Agency Safeguarding Hub will have resulted in a Strategy Discussion or Information Share as opposed to an occurrence workload. This is in addition to the work the ASET team do and demonstrates a cross-team approach to the effective delivery of safeguarding. Only those with a frequency of 8 and above are included as there are many incident types that were seen in very small numbers.



Neglect Offences

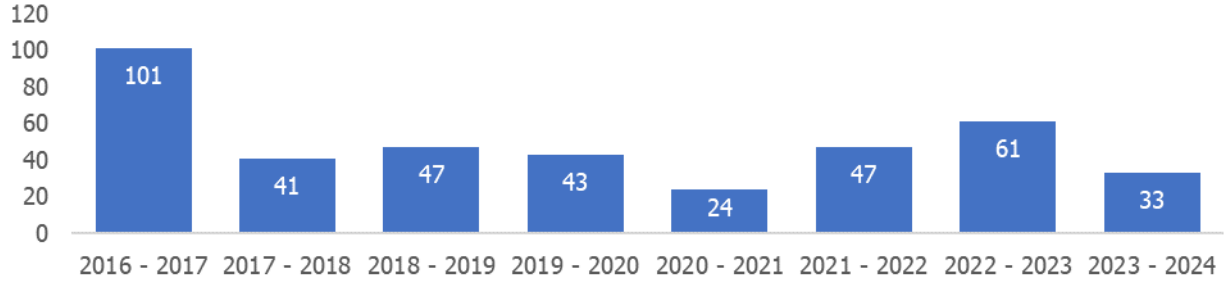
Crimes responded to by the Police where neglect of an adult with needs for care and support was identified.



There are 9 offences which were flagged as domestic abuse (15%) within this cohort in the last 12-month period. This proportion is higher than in previous years:

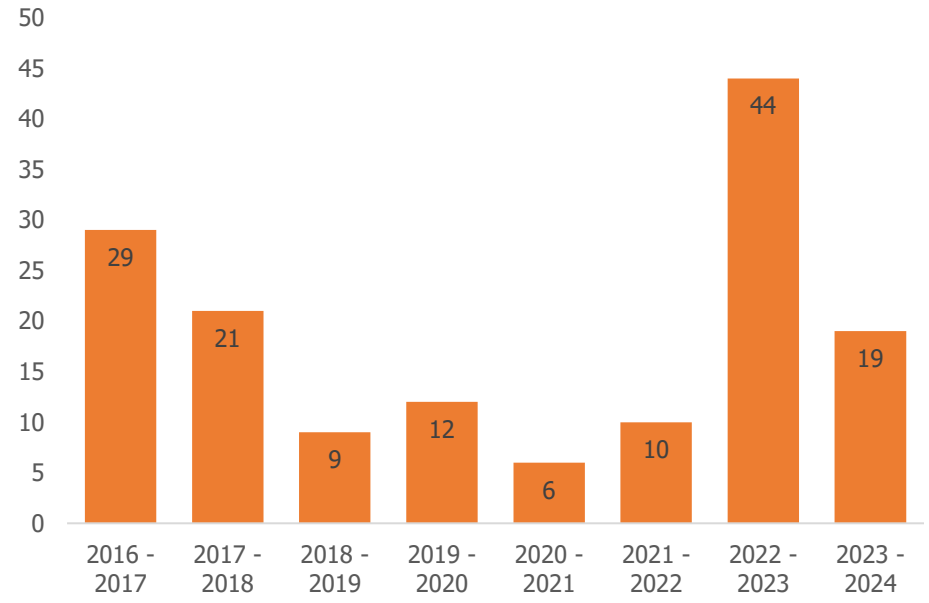
2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
10%	16%	4%	7%	15%

Care worker ill-treat/wilfully neglect an individual

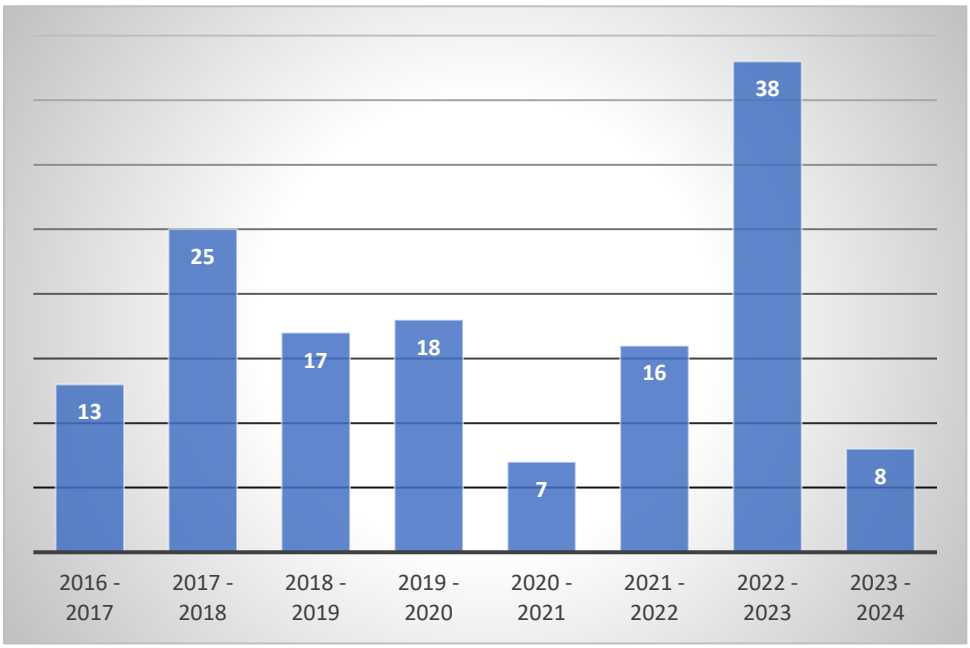


There were 5 (15%) domestic related offences in this cohort in the last 12-month period.

Care provider breach duty of care resulting in ill-treatment/neglect of individual



Ill-treatment or neglect of a person lacking capacity by anyone responsible for that person's care



There were 4 (50%) domestic related offences in this cohort in the last 12-month period.

These domestic offences range from the 24th March 23 to 12th July 23.

They include neglect concerns including financial abuse. The concerns are all surrounding family members which range from husband, niece and Grandfather.

One of the crimes has been reviewed and does not appear to be domestic. The neglect concerns relate to

The carers. The domestic marker has been recorded incorrectly.

14. Financial Report

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

Income: This was year 1 of a 3-year budget agreement which was approved by the statutory partners in July 2022.

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

Spend: Staffing/Employee costs	**£128,626** ***note (i)***
Consultant fees	**£8,700 (SAR costs)**
Training resources/catering	**£2,479**
Website costs	**£2,561**
TOTAL:	**£142,36**

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

'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