



Stop adult abuse

Edition: 1

Date: 3rd April 2020

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# SSASPB Newsletter

## Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board



### 1. Welcome

Welcome to the first Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board newsletter. We hope to produce the newsletter twice a year which will provide the opportunity to share information about the work of the Board. In this first edition we will update you on some of our learning events, which between them were attended by 425 front line practitioners, in this edition we will also cover the importance of the use of the SSASPB Escalation policy and introduce the Early Intervention Project developed by Staffordshire Police.

### 2. Note from the Independent Chair

It is my privilege to produce this note introducing the first newsletter of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board, or SSASPB. The newsletter has been produced to help extend the reach of key messages and communication that is so important in effective partnership working. Amongst its many responsibilities the SSASPB is an important source of advice and assistance. The website <https://www.ssaspb.org.uk> has a wide range of practical information and guidance on adult safeguarding related matters as well as providing contact points for advice and referrals.

As you will see from the contents page this newsletter is predominantly about learning and provides the opportunity to communicate directly to the email boxes of thousands of practitioners who have a shared commitment to safeguarding adults. It is important to the SSASPB that this newsletter serves a useful purpose and your comments and suggestions on the content of this edition and items for future inclusion are very welcome. You can send messages by email to [ssaspb.admin@staffordshire.gov.uk](mailto:ssaspb.admin@staffordshire.gov.uk)

May I take this opportunity to thank you for the valuable work that you do to help ensure that the most vulnerable members of our communities who have needs for care and support and are at risk of abuse and neglect and unable to protect themselves are kept safe.

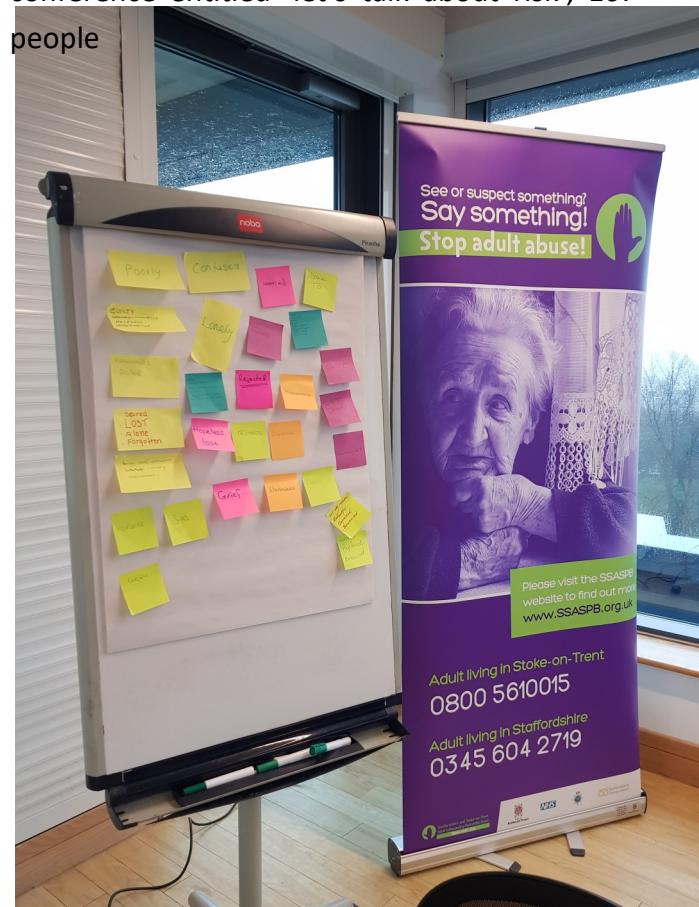
John Wood

## 3. SSASPB learning events

The SSASPB held seven learning events on the topic of self-neglect, following the identification of lessons learnt from a Multi-agency Learning Review. Content included an overview of lessons learnt from the review by Helen Jones the Board Manager, a presentation covering hoarding was delivered by Mick Warrilow from Staffordshire Fire and Rescue Service, a presentation by VOICES of Stoke which included a question answer session with an Expert Citizen and a presentation about adult safeguarding by Ruth Martin Safeguarding Team Leader from Staffordshire County Council supported by Jackie Bloxham Adult Safeguarding Team Manager from Stoke-on-Trent City Council . The feedback from the events has been very good and the vast majority of those in attendance felt that the session was valuable, informative and useful to their work. The SSASPB are planning to run similar learning events in 2020 including the theme of financial and material abuse which is a strategic priority for the Board. The local Clinical Commissioning Groups (CCGs) funded three events intended to raise awareness of a number of issues including adult safeguarding, domestic abuse and the impact of the Intercollegiate Document: Roles and Competencies for Health Care Staff. Forty-eight people, mostly practice managers attended. In November 2019 the SSASPB hosted its first adult safeguarding attended, the conference speakers included the drama group AFTA thought from Liverpool who interacted with those present through dramatisation of a scenario where professionals worked with managed risk to improve the opportunities for a young adult with a learning disability. Professor Alison Brammer and Dr. Laura Pritchard-Jones from Keele University delivered a presentation which outlined the legal framework of working with risk. Ruth Martin Safeguarding Team Leader from Staffordshire County Council spoke about how working with risk positively could enhance the lives of adults with care and support needs. There followed four case studies giving practical examples from Stoke-on-Trent and Staffordshire, where working positively with risk had improved opportunities for adults with care and support needs. The feedback gathered at the conclusion of the event was overwhelmingly positive, with nearly everybody reflecting that the event had improved their awareness of working positively with risk and its benefits.

conference entitled 'let's talk about risk', 167 people





## 4. SSASPB partner: Staffordshire Police

### **Early intervention Project;**

The Early Intervention Project is aimed at reducing repeat demand within Policing. Vulnerable adults are coming to the attention of the Police through escalation of their behaviour. It is believed that this may be to access a crisis service to address their needs when they are not able to do this through other pathways. Several face to face interviews were undertaken with individuals who were causing repeat demand at a time when the crisis was not present and, using early intervention assessments was able to identify common themes such as alcohol/substance misuse, social isolation, finance, mental health and physical health issues. Individuals were not only known to Staffordshire Police but in most cases had presented demand to other services such as ambulance, housing and mental health.

3 problems have been identified;

1. Treating the symptom (presenting demand) not the cause (demand in context).
2. Intervention happens too late or not at all.
3. Driven by organisational and service boundaries, agencies are only interested in doing their bit.

Following on from research and previous successful partnership interventions such as the Family Intervention Project Staffordshire Police decided to use the 'key3 worker' model, a method of service delivery involving a person who works in a guide role with people. This person acts as a single point of contact for the individual, helping them to coordinate their care, not only within the healthcare system, but also across systems (employment, social services, financial resources, recreation, mental health, transportation, substance misuse, etc). The main concept of the key worker's role is to empower people by providing them with support, resources and information tailored to meet their individual needs.

Police Community Support Officers (PCSO) known as Early Intervention Officers (EIOs) are provided with a structured training and awareness programme that included Department of Work and Pensions, adult safeguarding, drug and alcohol services, dementia champions and mental health services. The programme also offered awareness raising in motivational interviewing, cycle of change and active listening skills. The EIOs were also trained in the use of an Early Intervention assessment, action planning and risk assessment.

## Case Studies demonstrating Early Intervention Officers in action

### Case Study 1

'J' was a frequent caller to the police. He would often call 999 requesting whisky and reporting that his fire had been left on by carers. J was diagnosed with dementia and already had a social worker working with him. His local Police Community Support Officer (PCSO) visited J frequently. She identified that the domiciliary care providers could improve the standard of their care for him as their lack of support was having a negative impact on J's emotional wellbeing. The PCSO also identified that there was a lack of food being purchased for him and that he would only leave his bed to use his commode. With frequent communication between the PCSO, the mental health team and adult social care, the decision was made for a review of his care package and a best interest meeting took place. As a result of this meeting, J agreed to move into a residential home whereby he receives around the clock care. This was a good outcome for J who no longer felt that he had to ring the Police for help and which followed Making Safeguarding Personal and Best Interest Assessment principles. His wellbeing improved and he was able to take outside walks which he had been previously unable to do.

### Staffordshire Police: Case Study 2

'K' was a woman who was repeatedly calling Staffordshire Police, sometimes up to 11 times per day. She had dementia and lived alone as her dog was removed from her care due to un-intentional neglect. She would phone the police daily to report the theft of her dog. Owing to her vulnerabilities, a safeguarding concern was forwarded, and K was supported through the Police Early Help Project which aims to support people to keep themselves safe. K's local Police Community Support Officer (PCSO) visited and while there checked her fridge which was full of out of date food. She had no support around her home or for personal care and she was extremely isolated. K's neighbours were estranged from her and lacked awareness of her needs. The PCSO worked closely with K's allocated Social Worker, and subsequently a care company became involved. The PCSO frequently provided the social worker with a list of calls that she would make to the police and these were used to identify when K appeared to be most anxious. The care calls were then centred around these times which also ensured that K's care needs would be sufficiently met.

As a result of frequent care package review meetings and communication between agencies, K now receives a minimum of 9 hours of care each day, is taken out to her favourite places and has recently been to the theatre to watch her favourite stage show. K has built a great rapport with the care givers and the calls to the Police have stopped completely. The PCSO organised a dementia awareness raising event for members of K's immediate community so that they had a better understanding of her needs.

## 5. Lessons Learnt from reviews

Safeguarding Adult Boards have a statutory responsibility to conduct reviews in certain circumstances. For more information about the criteria please click [here](#). The purpose of undertaking the reviews is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account as other processes exist for that.

Since 2013 there have been several SARS and Multi-agency Learning Reviews conducted by the SSASPB. There are three recurring lessons to learn:

- Practitioners should expect their decisions to be challenged and, in turn, challenge others - whether they are part of their own or another organisation. Challenge is healthy and will be encouraged. If agreement cannot be reached, the Board has an Escalation [Policy](#) explaining how to escalate professional disagreement.
- Complex cases which involve the engagement of many organisations benefit from the appointment of a 'lead professional' to assist with clear focus and multi-agency planning. This person may be from any organisation connected with the adult about whom there are concerns and will usually be the one who is best placed to achieve the engagement of the adult.
- Practitioners should always fully document the reasons for their decisions. These must be recorded in clear language and acronyms explained on first use.

These lessons to learn have also been highlighted following the academic review of SAR findings in several regions in England.



## 6. Mental Capacity Act Guidance

The Board has worked together to create a three part Mental Capacity Act guidance. This consists of a guidance leaflet, a guide to assessing mental capacity and additional information and appendices. These are intended to help Mental Capacity assessors when making an assessment and expand the knowledge of those who work with adults who may lack mental capacity. The guidance is available on the SSASPB website and can be found [here](#). The leaflets are also available in a printed format, if you would like some leaflets please contact us at SSASPB.admin@staffordshire.gov.uk.

## 7. SSASPB Annual Report 2018/19

The SSASPB publishes an Annual Report which contains information about the work of the Board and includes case studies of safeguarding in action, please find a link to the website where the document can be found here. [Annual Report](#)

## 8. Raising an Adult Safeguarding Concern

If you think that an adult with care and support needs is being abused or neglected:

**If the adult lives in Stoke-on-Trent:**

Telephone: 0800 561 0015 at any time

Minicom: 01782 236037

**If the adult lives in Staffordshire:**

Telephone: 0345 604 2719

Monday to Thursday 8:30am to 5pm, Fridays 8:30am to 4:30pm, excluding Bank Holidays

0345 604 2886 at any other time

