**Stop adult abuse**

Edition: 01/2022

Date: 11/05/22

In this edition


1. Welcome

2. SSASPB Annual Report and More Accessible Annual Report

3. Engagement challenges

4. MaRG

5. Understanding the criteria for a Safeguarding Adult Review (SAR)

6. Raising an adult safeguarding concern


# SSASPB Newsletter

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

## 1. Welcome from the Independent Chair

It is my privilege to write the introduction to this Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) newsletter. It is produced as part of the ongoing plan to develop and enhance SSASPB communications to broaden awareness of:

- What constitutes abuse and neglect of adults with care and support needs who are at risk and unable to protect themselves
- When and how to report abuse and neglect
- What happens after a report is made
- Concerns that are not abuse and how these should be reported
- Practical things that can be done to prevent or reduce the risk of abuse or neglect occurring

As you will read below this newsletter provides information on:

- The publication of a more accessible SSASPB annual report. This is the first time in this format and your feedback is very welcome by email to ssaspb.admin@staffordshire.gov.uk
- The publication of a Safeguarding Adult Review (SAR), expected May 2022, the learning from which illustrates the challenges for practitioners in dealing with complex personal circumstances including factors around self-neglect and the cognitive impairment of alcohol dependent drinkers.
- In recognition of the challenges associated with complex cases that do not meet the eligibility criteria for formal support and can ‘fall through the gaps’ page 3 summarises the focus of a Multi-Agency Resolution Group (MARG) in Stoke-on-Trent which is gaining momentum with the recent appointment of a new Chair independent of the connected partner agencies.

It is important to continue to remind ourselves that from experience, safeguarding concerns are often hidden and when do they come to light are difficult to substantiate due often to the capacity and vulnerabilities of the adult concerned. When adults with care and support needs have experienced abuse or neglect it usually occurs in their home, whether their own or a care home, and perpetrated by someone who they know and should be able to trust. Either a member of their own family, or friend, or someone working in a position of trust. These experiences should remind us of the need to be particularly vigilant and to look for the signs during these particularly challenging times.

There have been significant challenges for partner organisations for more than 2 years associated with the COVID-19 pandemic.

Whilst there is a gradual return to a new normality it is evident that COVID has not gone away but its harmful effects have to some extent been mitigated with the excellent work to develop and administer the vaccine programme.

I once again take this opportunity to acknowledge that the Safeguarding Adults Board is well supported and commitment from partners is strong not only in terms of individual's personal and professional commitment to driving ongoing outcome focused activity but also the ongoing partnership resourcing for the vital work of the Board.

Looking ahead the SSASPB Strategic Plan is currently being reviewed and refreshed. Once approved this will be widely circulated amongst safeguarding partners to enable contributions to be co-ordinated to improve safeguarding outcomes for those adults at risk of abuse and neglect.

This newsletter provides an opportunity for you to request content in future editions that you may find of interest and help. Please use the email link ssaspb.admin@staffordshire.gov.uk

I conclude by mentioning the SSAPB website that has been refreshed to better comply with Accessibility legislation. The website can be accessed here.

Thank you for reading.

John Wood, Independent Chair

## 2. SSASPB Annual Report and More Accessible Annual Report

One of the statutory duties of a Safeguarding Adult Board is to produce an Annual Report. The report outlines what the Board has done to ensure that partners are working together effectively to help and safeguard adults with care and support needs. This is the most recent SSASPB Annual Report (2020/21)

In 2021, and for the first time, the Board have produced a more accessible version of the Annual Report. This was produced for the Board by young adults supported by Rockspur who are a user led not for profit company providing day opportunities and supported living for younger adults with learning difficulties/disabilities and autism. The work is all theirs and we are delighted with it. We are looking forward to working with them again in 2022 on this year's version.

## 3. Engagement challenges

The SSASPB recently received and approved an independently authored Safeguarding Adult Review (SAR) which looked at the circumstances leading up to the death of a 38yr old man in our area. 'Andrew', as he is referred to, was seen by a professional/practitioner on 309 occasions in the 18 months leading up to his death. This was a complex situation and more information will be available when the review is published. The report further reinforces the importance of demonstrating creativity, patience, tenacity and professional curiosity with regards to encouraging the engagement of adults with those seeking to support or help them.

Newcastle upon Tyne Safeguarding Adult Board (SAB) have produced this superb short video, please take 2 minutes to watch it. it's a powerful tool which gets the message over far better than words. The Board has produced a one page guidance based on an original also produced by Newcastle-upon-Tyne SAB.

Engagement in its broadest sense continues to be a Strategic Priority for the SSASPB. In the revised Strategic Plan for 2022-2025 there will be a specific area of focus on those adults who are all too often referred to as 'non-engaging'. More about this work will be included in future newsletters. In the meantime please share the video and guidance widely.

## 4. The Multi-agency Resolution Group (MaRG) in Stoke on Trent

The MaRG was established in 2018 in response to an identified gap in provision for individuals with multiple needs, for whom established services were not able to meet their needs within existing provision. This group brings together representatives from public, private and third sector organisations in Stoke-on-Trent. The primary purpose of MaRG is to manage risk and coordinate services using a solution focused approach to unblock barriers to service access and empower practitioners to support adults experiencing multiple disadvantages across the city.

For illustration, the term multiple disadvantage includes, but is not limited to, combinations of homelessness, substance misuse, mental health issues, domestic abuse, and contact with the criminal justice system where the person is not already engaged in the services they need to manage risk at an acceptable level.

The MaRG is a multi-agency advice and decision-making group. As such, participants should be of sufficient seniority within their organisation to make decisions about the allocation of resources against a coordinated multi-agency plan to manage and reduce risk.

Since its conception the MaRG has considered over 50 cases and helped to reduce the risk and demand on services from these individuals.

The Changing Futures Programme launched in 2021, a 3-year programme to improve services and systems for individuals facing multiple disadvantage and prompted a review of the MaRG. In order to support ongoing development of the MaRG, and ensure its alignment to the Changing Futures, the group agreed that it would be appropriate to now appoint an independent chair. The role of the chair will be to support the approach to collaboration and risk sharing, raise the profile of the MaRG profile and develop links with other agencies to expand the partnership approach.

For more information on the Changing Futures programme or the MaRG please email Gemma.Finn@stoke.gov.uk

## 5. Understanding the criteria for a Safeguarding Adult Review (SAR)

Safeguarding Adult Boards (SAB) have a statutory duty to undertake SARs under Section 44 Care Act 2014 which states:

(1) a SAB must arrange for there to be a review of a case involving an adult in its area with **needs for care and support** (whether or not the local authority has been meeting any of those needs) if:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions **worked together** to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) condition 1 is met if:

(a) the adult has died, and

(b) the SAB knows or **suspects that the death resulted from abuse or neglect** (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) condition 2 is met if:

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The key elements to the criteria are that the adult **must** have needs for care and support, **and** it is suspected that death has resulted from abuse or neglect (or if alive that the adult has experienced serious abuse or neglect ) **and** that there are concerns about how agencies have worked together. A further key element is that there must be lessons to learn from any review of the circumstances leading to the death (or serious abuse/neglect).

SARs are intended to improve multi-agency working, hence the reference to 'working together'. They will not be used to solely review the actions of a single agency, the relevant agency should have their own complaints or internal review procedures for that. It will help you to consider the following 'are the circumstances I am considering an example of a system failure – or does it look like the abuse or neglect was caused by the actions of an individual who made a mistake or used poor judgement'. Despite best efforts anyone can make a genuine mistake or error and whilst these may have serious consequences the focus for a SAB is about how agencies work together.

SARs are not punitive, effective review and learning is dependent upon the co-operation of all organisation involved in the review and this may be negatively impacted upon if the review was used for punitive processes. Of course there may be critique about the actions of an organisation but this is how improvements are made for the benefit of adults with needs for care and support. SARs must not be used or offered to resolve complaints, there may be a parallel complaints process but the SAR must be kept separate from it.

The **SAR referral form** is accessible through the SSASPB website. The form contains the criteria for a SAR and seeks specific information to support each element of the concern which needs to completed in full yet needs to be concise with sufficient clarity that will enable the review panel to analyse and consider. Please ensure each section is completed and do not add copied case notes. Furthermore, it is expected that the authorising sign off Manager has scrutinised and supports the referral to the board prior to submission.
The SAR sub-group of the Board has a broad membership and your organisation may have a representative who attends. Please contact them in the first instance if you believe you have identified circumstances where the SAR criteria may be met. Email ssaspb.admin@staffordshire.gov.uk if you need help to identify your SAR representative.

## 6. 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:**
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