Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board
Abuse must stop

Issue Number 1-24/25

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Welcome

Foreword from the Independent Chair of SSASPB

Welcome to our latest Spring 2024 Staffordshire and Stoke-on-Trent Adults Safeguarding Partnership Board which seeks to keep you informed on what the partnership is doing, the great learning that is available to you and update you on emerging issues within practise.

As the newly appointed new independent chair for the Board, I want to say a big thank you to my predecessor John Wood and to the members of the Board for their hard work, commitment and making me feel so welcome. Safeguarding is a vital area of work, and I am looking forward to working with everyone and ensuring the Board's multi-agency partners continue to work together effectively to support staff and keep people with care and support needs safe.

The theme of this Spring newsletter is Continuous Learning. Through Safeguarding Adult Reviews (SARS) and audits, the Board has identified several re-occurring issues which are causing concern as they have led to significant adverse outcomes and warrant intervention through awareness raising and professional development. Within this newsletter you will find useful links to websites providing you with more information and building on the newsletter's content.

This newsletter provides you with information on the Safeguarding Adults Review Library (access via www.nationalnetwork.org.uk). This is a great tool enabling you to use keyword such as 'self neglect' or domestic violence to search across all the published SARs nationally enabling you to appreciate issues and recommendations wherever they have occurred.

The Board believes strongly in the importance of learning from the multi-agency work being undertaken, to offer and support practise improvement and to deliver front line training. This is crucial if we are to continue to develop and avoid having the same outcomes and frustrations. One of the priorities of the Board is to support you as practitioners and care staff so please let us know if there are topics that you want the Board to cover in other newsletters or in our Practitioner Forums. Suggestions are always welcome so please contact us via ssaspb.admin@staffordshire.gov.uk

The next Practitioner Forum will be held on 2nd July 2024 and the subject will be Professional Curiosity and you should receive an invitation link from your Board member or Adult Safeguarding Lead in the next few weeks.

You will read that Stoke-on-Trent City Council are holding a 'Festival of Practice' to be held between 10th and 14th June 2024. The Board applauds this initiative and thanks everyone involved for their efforts to host this event.

Remember, Safeguarding is everyone's business. If you see neglect, abuse or exploitation or are concerned that it may be occurring then you must report it. Be professionally curious and accept professional challenge as a way of offering reassurance or accepting learning in a supportive profession. I hope you enjoy the newsletter.

Adrian Green, Independent Chair

This newsletter is dedicated to Learning from Reviews, Case Studies and Audits

Safeguarding Adult Reviews (SARs) have a statutory footing through section 44 of the Care Act 2014, and the purpose of undertaking a SAR is to learn lessons.

This is where you can found out more about Staffordshire and Stoke-on-Trent SARs

Safeguarding Adult Reviews (SARs) (ssaspb.org.uk)

The national network of Safeguarding Adult's Board Chairs hosts a library of all published SARs www.nationalnetwork.org.uk This is researchable by theme for example Self Neglect, Hoarding, Domestic Abuse etc.

Within this edition, there is learning from case studies from North Staffordshire Combined Healthcare Trust and Staffordshire Fire and Rescue Service. Midlands Partnership Foundation Trust have very kindly produced a section on Professional Curiosity as this is a recurring theme from local and national SARs.

Learning from audits

The Audit and Assurance sub-group of the SSASPB is responsible for providing the narrative behind the data report in the Annual report and for seeking assurances regarding partners' policy and process compliance through audits.

Self-neglect as a theme is disproportionately represented in SARs. In the recent 2nd National SAR analysis overseen by Professor Michael Preston-Shoot it was reported that 60% of the 652 SARs reviewed included self-neglect as a theme.

Locally there have been 3 reviews which involved self neglect.

David 2017 – Stoke-on-Trent

Andrew 2019 – Stoke-on-Trent

Gillian 2023 – Staffordshire

These reviews can be found on the SSASPB website:

Safeguarding Adult Reviews (SARs) (ssaspb.org.uk)

In response to the SARs Andrew and Gillian the SSASPB conducted a Self-Neglect audit with a very detailed audit tool to try to learn more about why there are so many SARS featuring self-neglect and what action is needed to address the learning. Participating partners were the Integrated Care Board (GPs), Midland Partnership Foundation Trust (MPFT), North Staffordshire Combined Health Trust (NSCHT), University Hospital North Midlands (UHNM), University Hospital Derby & Burton (UHDB), Stoke-on-Trent City Council (SoTCC), Staffordshire County Council (SCC), Staffordshire Police and Staffordshire Fire and Rescue Service (SFRS).

Overview of the findings from the audit:

The key themes and trends identified from the audit:

Lack of identification of lead professionals, no follow up after referral to other agencies leaving single agencies to manage the risk.

Inconsistency regarding multi-disciplinary team responses (MDT).

A lack of understanding of the current self-neglect protocol and guidance.

Little documented evidence of the steps taken to engage the adult. Instances where there was no consent prior to commencing referrals and gaining input from the individual.

Better use of advocacy services may have assisted adult engagement.

Lack of documented rationale to support decision-making.

Poor integration of information management systems (to enable better information sharing).

42 % of GPs who participated in the audit said that they would not be confident in making a Mental Capacity assessment where an adult may be self neglecting.

The current SSASPB Self-neglect guidance is being revised, (May/June 2024) and will address the findings from the audit and other feedback.

Although, not specifically identified in the self-neglect audit, a recurring theme from SARs highlights the lack of professional curiosity. Please see more information on pages 6 & 7 of this newsletter. This theme is also reflected Nationally as seen in Professor Michael Preston Shoot's Analysis of Safeguarding Adult Reviews: April 2017 – March 2019.

Analysis of Safeguarding Adult Reviews: April 2017 - March 2019

Professional Curiosity is the theme of the next SSASPB Practitioners Forum which will be held on Tuesday the 2nd July 2024. Attendance will be by invitation through your SSASPB member.

Learning from Case Studies: Fire Safety

Staffordshire Fire and Rescue Service (SFRS) are members of the SSASPB. They are committed to sharing learning from incident reviews from other areas and wish to share this case study so that there can be learning locally. This learning is via Joint Organisational Learning Notes (JOLN) and more information about learning from fire incident reviews can be found here: www.jesip.org.uk

Following an incident, a JOLN was received by SFRS with details of an accidental fire that resulted in fatality. The following learning was captured:

Fire Crews were called to an automatic fire alarm at an assisted living development. On arrival the crew were confronted with an established fire in a ground floor flat where a man was found deceased.

Following a Fatal Incident review, it has been identified that the deceased was known to the Fire and Rescue Service who had completed a Safe and Well Visit on two occasions with the deceased, issuing a number of fire safety interventions including fire retardant throws and bedding to complement the careline system and linked smoke detection in the hall and heat detection in the kitchen.

The occupier was a smoker, heavy drinker and was restricted to his bed. The occupier's bed had been moved from the bedroom to the lounge, but unfortunately the interventions issued by the Fire and Rescue Service and his care line system had not been moved with him, thereby raising the risk of serious injury or death from smoking whilst in bed.

On receiving the JOLN SFRS checked their procedures to confirm their processes in this regard and could confirm that some measures were already in place to ensure the room layout was not altered following the installation of a Portable Suppression System (PPS). There will also be consideration as to what other measures are needed to ensure a similar incident does not occur in Stoke-on-Trent and Staffordshire.

To further ensure that health workers eg; Domiciliary Care Providers, Social Care and Health, District Nurses etc. are aware, the Directors of Health and Care for both Staffordshire and Stoke-on-Trent were notified, and confirmed they will share the learning. The SSASPB were also informed, resulting in this case study being included in the newsletter.

Learning from Case Studies 2: Modern Slavery/Sexual Exploitation

Eva was a patient in her 30s with a diagnosis of an acquired brain injury and Human Immunodeficiency Virus (HIV) associated neurocognitive decline. She was admitted to psychiatric inpatient care due to a decline in her mental state. She was underweight and not able to talk in sentences.

Eva was not a UK national and had no next of kin or family locally. Six months into her admission, the ward persisted with their research and through the Czech Embassy finally located and contacted Eva's Mum. Mum reported that Eva was kidnapped 16 years ago, taken to the UK and exploited. She was very distressed but relieved as she had thought Eva was dead as she'd not heard from her for 3 years. She said that Eva had been forced into sex work.

Eva had no passport and no documents, and there was no record of entry into the country. She was in a relationship with a man who was from Turkey. He wanted to take her to Turkey so he could care for her however the ward staff were concerned as he presented as very controlling. Unfortunately there was insufficient evidence to instigate proceedings under a safeguarding framework.

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

Owing to her condition Eva still needs 24-hour support in nursing care, however she has made good progress since admission including improved speech and communication.

PROFESSIONAL CURIOSITY

Professional curiosity is where a practitioner explores and proactively tries to understand what is happening with an adult, rather than making assumptions or taking a single source of information and accepting it at face value.
Practitioners **not** using professional curiosity is a recurring theme highlighted within Adult Safeguarding Reviews (SARs). It is widely recognised that there are many barriers to being professionally curious:

Disguised compliance – A family member or carer gives the appearance of co-operating to avoid raising suspicions, to allay professional concerns and ultimately to reduce professional involvement.

Not responding to accumulating risk – professionals tend to respond to each situation as it arises rather than looking at the cumulative effect of a series of incidents and information.

Professional Deference – Workers who have most contact with the individual are in a good position to recognise when risks are escalating however there can be a tendency to ask the opinion of a professional that has a 'higher status' who has limited contact with that person.

Confirmation bias – We look for evidence that supports or confirms pre-held views and ignore contrary information.

To work with adults successfully practitioners need to take a holistic view using a combination of looking, listening and asking direct questions, checking out and reflecting on all of the information received.

Look

Consider is there anything about what you see when you meet with this adult and carer which prompts questions or makes you feel uneasy?
Are you observing any behaviour which is indicative of abuse or neglect?
Does what you see support or contradict what you have been told?

Listen

Are you being told anything that needs further clarification?
Are you concerned about what you hear household or family members say to each other?
Is someone trying to tell you something but is finding it difficult to express themselves? If so how can you help them to do so?

Ask Questions

What is a typical day like for you?
Do you feel safe in your own home?
Are there people who regularly visit your home apart from those who live here?
Who is this with you at this appointment?
Are you in fear of the consequences of doing something, or not doing something?

Check out

Are other professionals involved?
Have other professionals seen the same as you?
Are professionals being told the same or different things?
Are others concerned? If so, what action has been taken so far and is there anything else which should or could be done by you or anyone else?

Reflection

Ensure that your practice is reflective and that you have access to good quality supervision.
Address any anxiety you may have about difficult conversations.
Discuss concerns with colleagues or your safeguarding team
Be aware of your own professional bias
Be confident in your own judgement. Be courageous and challenge the opinion of others if their opinion of risk varies from yourself.

Remember that respectful professional curiosity and challenge are healthy and that you are doing it in the best interests of the adult.

Leicester Safeguarding Adult Board has produced several resources which the SSASPB believe may help you to better understand Professional Curiosity and are grateful for their consent to share these resources.

PowerPoint Presentation (lcitylscb.org)
PowerPoint Presentation (lcitylscb.org)
LSCPB | Resource Packs (lcitylscb.org)

Ownership credited to Leicester SAB, Leicestershire and Rutland SAB, Leicester SCP (children) as well as Leicestershire and Rutland SCP (children) who worked jointly on these projects.

Safeguarding Adults Week: 10—14 June 2024

"Festival of Practice Week, 10-14 June 2024!

Following its success over the last couple of years, Stoke-on-Trent City Council are delighted to announce the return of its **Festival of Practice Week**, taking place from **Monday 10 to Friday 14 June 2024**!

The Festival of Practice is a week-long learning event organised jointly across the Adult Social Care and Children Social Care directorates for all professionals in Stoke-on-Trent who work with adults, children and families.

The week is fully packed with many, useful one-off free learning sessions that align with safeguarding priorities for you to tailor around your own learning. Some of these sessions will be face-to-face while the majority will be delivered virtually.

We would like to extend the invite to our multi-agency partners, such as the Staffordshire and Stoke-on-Trent Adult Safeguarding Board (SSASPB), local universities, health colleagues, Staffordshire Police and Voluntary Sector as part of our commitment to encourage a one-team approach to learning.

The Event Programme will take you through each day during the Festival of Practice, including the sessions on offer and how to sign up, which you can access here.

For any queries about the Festival of Practice, please email festivalofpractice@stoke.gov.uk

We can't wait to see you there!"

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

Contact SSASPB

SSASPB Team
Staffordshire Place 1
Tipping Street
Stafford
ST16 2LP

Email: SSASPB.admin@staffordshire.gov.uk

stop adult abuse