

Cheshire East Safeguarding Adults Board

Annual Report

2023/24



Independent Chair's Welcome

Welcome to the Cheshire East Safeguarding Adult Board (CESAB) annual report, the production of which is one of the statutory requirements of the Care Act 2014 and covers the period April 2023 to March 2024.

I would like to start by passing on my thanks and appreciation to the CESAB team, the Board members and the membership of the various sub groups and practice learning events for their continued support and commitment towards developing our practice to ensure we listen, prevent harm and safeguard adults in our community.

I would also like to acknowledge the work and commitment of all of our frontline practitioners for their dedication and professionalism in these ever changing and challenging times. It was a privilege to attend the awards ceremony and hear about some of the amazing work, professionalism and innovation undertaken to make adults within Cheshire East safer.

The purpose of this report is to set out what achievements have been made in Cheshire East in the last twelve months in order to help and protect adults at risk from abuse and neglect.

Whilst adult safeguarding continues to experience increasing complex demand combined with added pressures of budget restrictions and the increasing costs of care. It is however pleasing to observe the great focus and determination that is made to ensure people remain the priority in our practice. It would be amiss at this point not to mention the valuable input of our service user group in ensuring we remain focused on making safeguarding personal.

It is evident whilst we continue to be presented with new risks and challenges within adult safeguarding you cannot afford to shift focus from those priorities and risks which are ever present within our community. Current research and analysis highlight Self Neglect, Domestic Abuse, and Neglect within the home, amongst the most common factors in Adult Safeguarding Reviews.



The Board continues to remain focused on meeting its vision and strategic objectives. It is committed to developing a culture of learning and continues to promote training and increasing the awareness of safeguarding. I have been impressed with the drive and determination of the Local Authority and Integrated Care Board (ICB) in offering the best quality care they can in a constant changing environment.

Moving forward we will have to work more collaboratively and smarter to continue to achieve our vision and objectives. Managing risk will become more prevalent in our day-to-day work and it will be as vital as ever that all partners work together to safeguard our community.

Kevin Bennett

Kevin Bennett, Independent Chair

CESAB

This is Cheshire East Safeguarding Adults Board's (CESAB) Annual Report for 2023-2024. The law says we must publish an annual report every year to say what we have done to achieve our goals, detail achievements made and how our partners have supported us in doing this. The purpose of Safeguarding Adults Boards is to seek and obtain assurances that local safeguarding arrangements across the partnership are in place and are robust to protect the welfare of residents in Cheshire East who may be at risk of abuse and/or neglect. The Board works in accordance with the duties outlined in the Care Act 2014 and its supporting statutory guidance.

The board has **three** core duties:

- Develop and publish a strategic plan setting out how we will meet our objectives and how our member and partner agencies will contribute
- Publish an annual report detailing how effective our work has been
- Commission Safeguarding Adult Reviews (SARs) for any cases which meet the criteria for a review.

CESAB's membership is made up of senior representatives from:

Cheshire East Council - Adult Social Care

Cheshire East Council – Housing

Cheshire East Council – Local Councillor

Cheshire Police

Cheshire and Merseyside Integrated Care Board (ICB NHS)

Healthwatch CheshireEast

Cheshire Fire Service

North West Ambulance Service (NWAS)

Cheshire Wirral NHS Trust (Mental Health)

Mid Cheshire Hospital NHS Foundation Trust (Leighton Hospital)

East Cheshire NHS Trust (Macclesfield Hospital)

Cheshire Probation Service

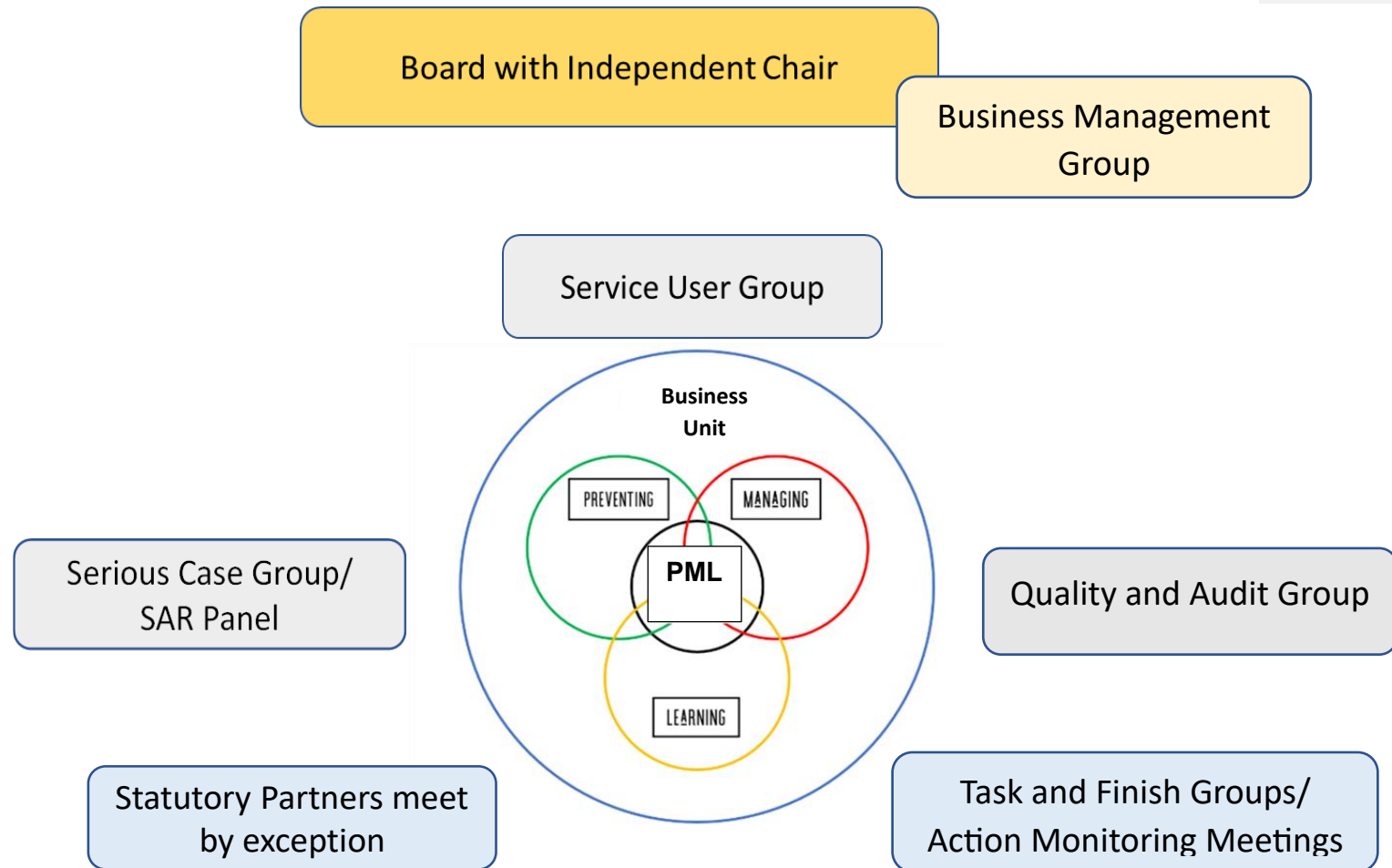
Styal Prison

Spectrum Community Health CIC

Voluntary and Faith sector

Service User Representation

CESAB STRUCTURE 2023/24: The Board explored new ways of working in 23/24 and chose to trial using a thematic workshop model instead of the classic subgroups it had worked with for a number of years. This was to better reflect board's strategy and to make better use of partners time & resources. These new thematic groups structured their work on the three pillars of - prevention, managing and responding to concerns and learning lessons and shaping future practice. PML for short. PML uses a workshop style structure which has all three subgroups meet simultaneously, in the same room, all working on the same topic. The aim is to prevent delays in action being taken, reduce the likelihood of tasks not being completed and improve the interaction and collective responsibility felt by the groups.



Strategic Priorities

The Annual Report 2023/2024 provides an overview of the Boards' achievements against the CESAB three-year Strategic Plan 2022-2025.

Our strategic plan centres around four ambitions –

| Ambition One | Ambition Two | Ambition Three | Ambition Four |
|---|--|---|---|
| Embed person centred approaches to adult safeguarding | Improve awareness of adult safeguarding across all communities and partner organisations | Enabling staff to respond to complex safeguarding by working in partnership with Key Partners | Learn from experience and Safeguarding Adult Reviews to improve how we work |

Full strategic plan available at www.stopadultabuse.org.uk

“Our vision is that people with care and support needs in Cheshire East are able to live their lives free from harm”



CESAB Meetings 2023/24

During the period 1 April 2023 and 31 March 2024 the Board met 4 times and was supported by the PML workstream and 3 subgroups – The Service User Group, the Quality and Audit Group, and the Serious Case Group (Safeguarding Adult Reviews). The Board focused on the following four areas of Adult Safeguarding during 2023/24

Safeguarding and gender-based violence: Suicide and Domestic Abuse: In July 2023 the links between Domestic Abuse and Suicide were explored by the Board. The Domestic Abuse and Sexual Violence Lead for the Local Authority highlighted the local data relating to intimate partner violence, suicidality and self-harm. Local DASH data indicated that 58% of Domestic Abuse victims in Cheshire East are feeling depressed or having suicidal thoughts, and 44% of Domestic abuse victims state the person causing the individual harm has threatened or attempted suicide.

What next? The Cheshire East Domestic Abuse Hub (CEDAH) has an action plan of suicide prevention awareness raising, pathways of support and specialist suicide training. Progress will be fed back to CESAB in 18 months' time. CESAB are linking with Manchester Metropolitan University to further explore the relationship between Domestic Abuse and Adult Safeguarding Processes.

This theme was in line with the Protection Ambition of the CESAB three-year strategy: Ensure the safety and wellbeing of people at risk of abuse and neglect in Cheshire East

Safer Recruitment & Overseas Recruitment: In October 2023 the Board explored issues surrounding safe recruitment and overseas recruitment in our care settings. Safer recruitment is a set of practices to help make sure each agencies' staff and volunteers are suitable to work with adults at risk. It's a vital part of creating a safe & positive environment and making a commitment to keep adults at risk safe from harm. Safer recruitment means thinking about the safeguarding of adults, and promoting their welfare, at every stage of the recruitment process - to minimise the risk of employing unsuitable staff to work and care for adults with care & support needs by having robust selection and recruitment procedures in place.

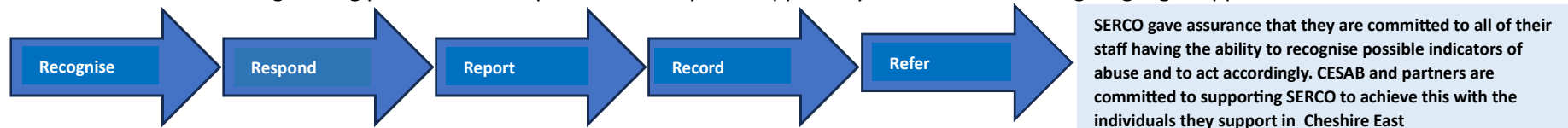
What Next? Safer recruitment should be a continuing process of improvement for settings whose work or services involve contact with adults at risk. Following this meeting, the Board sent an audit to all care settings and partner agencies to seek assurance around current recruitment and DBS practices. The analysis of this audit was very robust with all respondents having safe recruitment practices, 4% had staff with expired DBS checks but processes were in place to re-check these employees in the near future.

The SAB Training Officer is working with all care settings in Cheshire East to offer free of charge Level 1 Safeguarding Training to all new employees

*This theme was in line with the **Protection Ambition** of the CESAB three-year strategy: Ensure the safety and wellbeing of people at risk of abuse and neglect in Cheshire East*

Adult Safeguarding and asylum seekers & refugees in Cheshire East: Following on from discussions in 2022 regarding asylum seekers & refugees in Cheshire East, in April the Board welcomed SERCO to give a presentation. One of SERCO's roles within the UK is to manage those individuals going through the immigration process. In Cheshire East there are a number of hotels and hostels being used as immigration accommodation, the board sought assurance from Serco that this accommodation provided safe housing and services that ensure the safety and care of the people seeking asylum.

What next? Asylum seekers are subject to the SAB safeguarding processes and procedures in the same way as others in the community, the Board will ensure that adult safeguarding processes are in place to identify and support asylum seekers including language support if needed.



*In line with the **Protection and the Prevention Ambition** of the three-year strategy: Ensure the safety and wellbeing of people at risk of abuse and neglect in Cheshire East. Identify local solutions through services working within diverse communities across Cheshire East*

Self-Neglect: Following on from the board's first PML session (*reported on the next page*), the January 2024 Board meeting was focused on Self Neglect. This included feedback from the PML session and of multi-agency case file audits. Self-neglect was recorded in 596 safeguarding cases from 1st April 2022 to 30th December 2022. This increased to 786 from 1st April 2023 to 30th December 2023: an increase of 32%.

What Next? To share the feedback from people with lived experience with Housing and the Local Authority Equality, Diversity and Inclusion forum. To use this feedback to inform our offer to support people who may be experiencing self-neglect or hoarding. To monitor the actions of the PML to improve practice around self-neglect, this will be reported back to board in 18 months.

*In line with the **empowerment ambition** of the three-year strategy: Ensure the voice of people at risk of abuse and neglect, influence safeguarding practices across Cheshire East. Also, in line with CESAB Strategy **Partnership Ambition** - Work as a multi-agency board to ensure there is effective partnership working and leadership across all agencies for safeguarding adults at risk of abuse and neglect.*

PML – January 2024: SELF-NEGLECT

The Board held its first PML (*prevention, managing and responding to concerns and learning lessons and shaping future practice*) event in January 2024, the focus of this session was on the key challenges around Self Neglect. All Agencies were invited to take part, to provide assurances to the Safeguarding Adults Board about what is working well, what needs to improve and what actions need to be taken next. Lived experience from members of the Cheshire East Hoarding Support Groups were heard, and the Workshop also considered the key learning from the 'MERVYN' SAR, which was completed by the SAB in 2020, together with themes from national and local SARs and Discretionary Reviews. Following the PML Session 7 recommendations were presented to the SAB for improvement in safeguarding practice when dealing with concerns around Self-Neglect. This included a publicity campaign on the different forms of Self-Neglect



Self-Neglect 7 Minute Briefing

SELF-NEGLECT: AN OVERVIEW

This briefing is part of a series on self-neglect. Each briefing should be read alongside your Safeguarding Adults Board multi-agency policy, procedures, and practice guidance.

SELF-NEGLECT: DEFINITION

Self-neglect covers a wide range of behaviour relating to care for one's personal hygiene, health or surroundings, and includes behaviour such as hoarding. Three recognised forms of self-neglect include:

- Lack of self-care – this may include neglecting personal hygiene, nutrition and hydration or health (e.g., non-attendance at medical appointments)
- Lack of care of one's environment – this may result in unpleasant or dirty home conditions, and increased risk of fire due to hoarding
- Refusal of services that could alleviate the above

MENTAL CAPACITY

One of the first considerations should be whether the person has mental capacity to understand the risks associated with the actions/lack of actions. Any action proposed must be with the person's consent, where they have mental capacity, unless there is a risk to others (such as a fire risk due to hoarding, or public health concerns). In extreme cases of self-neglect and/or hoarding behaviour, the very nature of the environment should lead professionals to question whether the person has capacity to consent to the proposed action or intervention and trigger a mental capacity assessment. Consider if the person has the functional capacity to make a particular decision and executive capacity which is the ability to carry out the decision. Please see links below for further information on executive capacity.

The Care Act Statutory Guidance recognises it can be difficult to distinguish between whether a person is making a capacitated choice to live in a particular way (which may be described as an unwise choice or decision) or whether:

- The person lacks mental capacity to make the decision; or
- There is concern regarding the adult's ability to protect themselves by controlling their own behaviour.



Self-Neglect 7 Minute Briefing

SELF-NEGLECT AND HOMELESSNESS

This briefing is part of a series on self-neglect. Each briefing should be read alongside your Safeguarding Adults Board multi-agency policy, procedures, and practice guidance.

WHAT IS HOMELESSNESS?

Homelessness is usually defined as being without a home. It can mean that a person does not have a place to live, or that they do not have a home that meets their needs. It can also mean that a person does not have a home that they can afford to live in.

CAUSE AND EFFECT

Adults who are homeless have a range of needs and support needs that are often related to the causes of their homelessness. These needs may include mental health issues, physical health issues, substance use, and other social issues. It is important to consider these needs when providing support to homeless people.

RESONANCE

The Homelessness Reduction Act 2017 (HRA) means that people who are homeless are more likely to be housed. However, it is important to note that the HRA does not cover everyone who is homeless. For example, it does not cover people who are homeless because of their own actions, such as those who are homeless because of their own drug or alcohol use.



Self-Neglect 7 Minute Briefing

SELF-NEGLECT AND HOARDING

This briefing is part of a series on self-neglect. Each briefing should be read alongside your Safeguarding Adults Board multi-agency policy, procedures, and practice guidance.

DEFINITION OF THE HOARDING

Hoarding disorder is a mental health condition that is characterised by an excessive accumulation of items, often with a compulsive nature. It is a form of obsessive-compulsive disorder (OCD). Hoarding is now considered to be a standalone mental disorder and is included in the 10th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Hoarding can also be a symptom of other mental disorders, such as depression, anxiety, and bipolar disorder.

TYPES OF HOARDING

- Acquisitive hoarding** – this is the most common type of hoarding. It involves the accumulation of items, often with a compulsive nature. It is often associated with OCD and anxiety.
- Emotional hoarding** – this is a form of hoarding where the person hoards items because they are emotionally attached to them. It is often associated with depression and anxiety.
- Digital hoarding** – this is a form of hoarding where the person hoards digital files, such as photos, videos, and documents. It is often associated with anxiety and depression.

DIAGNOSTIC CRITERIA FOR IDENTIFYING A CASE OF HOARDING DISORDER:

- Persistent difficulty discarding or parting with possessions, regardless of their monetary value.
- This difficulty is due to a perceived need to save items and the distress associated with discarding them.
- The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas.
- The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The hoarding is not attributable to another medical condition or mental disorder.



Self-Neglect 7 Minute Briefing

SELF-NEGLECT AND SELF-CARE

This briefing is part of a series on self-neglect. Each briefing should be read alongside your Safeguarding Adults Board multi-agency policy, procedures, and practice guidance.

THE ISSUE

A lack of self-care is one aspect of self-neglect. It includes neglecting personal hygiene, health, nutrition, or hydration, as well as neglecting safety and/or well-being. It can include not taking medication, not following professional advice about health or care needs, refusing care, support or treatment, not going to appointments, and not seeking help.

MENTAL CAPACITY

Ensuring that the risks created by a particular decision are clearly and honestly explained to allow the person to make an informed choice. This might involve telling someone that they are putting their life at risk. Consider whether a person has "executive capacity" – a person's ability to implement a decision they have made.

A MULTI-AGENCY RESPONSE

Self-neglect cases often require a multi-agency response, whether this is under safeguarding adult procedures or as part of multi-disciplinary working more generally. There needs to be a clear understanding of the person's needs or wishes. It is important to ensure that the person's views are taken into account. A multi-agency approach often works well, with a small core group of professionals established to identify mental health and other risks. Where concerns in neglecting their self-care, health professionals (particularly GPs and community nurses) are likely to be crucial in understanding and managing risks. It is essential that health professionals are involved in Section 42 enquiries involving someone who is neglecting their health and care needs.

Following the PML, 7 information sheets around self-neglect were issued:

- Self-neglect an overview
- Self-neglect and homelessness
- Self-Neglect and Hoarding
- Self-Neglect and Self Care
- Self-Neglect and Engagement
- Self-Neglect and Trauma
- Self-Neglect and alcohol & Substance Misuse

all 7 can be downloaded at www.stopadultabuse.org.uk

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Quality and Audit Group: The core function of this group is to provide multi-agency scrutiny and assurance about the impact of partnership work intended to keep adults at risk safe. During the 23/24 period the group focussed on the following –

- **Mental Capacity Act Audit:** The Mental Capacity Act audit was undertaken to address aspects of learning identified from the Mervyn Safeguarding Adults Review.
- **Domestic Abuse and Older People:** A deep dive was undertaken to understand themes and trends in respect of adult safeguarding concerns (including cases progressing to safeguarding enquiry under s.42 Care Act 2014) where the alleged perpetrator has been recorded as the victim's partner or a family member, in line with Domestic Abuse Act 2021 definition of "personally connected", and victim is an older person (aged 65+).
- **Analysis of SARs, DARDs** (*Domestic Abuse Related Death Reviews, previously termed DHRs*) **and LeDer reviews** (*Learning from Deaths Reviews, now known as Learning from Lives and Deaths of people with a learning disability and autism Reviews*) Common themes include professionals not following the Mental Capacity Act, the individual experiencing mental health, self-neglect and/or drug and alcohol dependency.
- **s.42 type of risk:** Cheshire East Safeguarding Adults Board wanted to find out which categories of risk were most likely to progress to s.42 enquiry.

The "top three" categories of risk progressing to s.42 enquiry in percentage terms (percentage of cases progressing to s.42 compared with total number of safeguarding concerns for each category) are:

1. Discriminatory abuse
2. Organisational abuse
3. Modern Slavery

- **Making Safeguarding Personal:** Making Safeguarding Personal is a standing agenda item for Cheshire East Safeguarding Adults Board Service User Reference Group. In 68% of Concluded Safeguarding S42 Enquiries, individuals were asked, and their desired outcomes were expressed. Where outcomes were expressed, in 96% of Enquiries, these outcomes were either fully or partially achieved.
- **Self-Neglect:** Cheshire East Safeguarding Adults Board undertook a multi-agency self-neglect audit to understand what the barriers are to working with people who self-neglect, what is working well, and what we can do to improve practice. Following analysis of the audit, Cheshire East Safeguarding Adults Board produced guidance for professionals in February 2024, "Understanding Why some Service Users are Seldom Heard".

Key Safeguarding Data for 2023-24

406,500 adults live in Cheshire East



89,200 are aged 65 or over.



18% more women than men were alleged victims of abuse in 23/24.
(59 % of women, 41% of men)

The age groups of people who were involved in safeguarding concerns or enquiries –

| Age Range | Number of adults |
|-----------|------------------|
| 18-64 | 2,080 |
| 65-74 | 617 |
| 75-84 | 1,215 |
| 85-94 | 1,078 |
| 95+ | 215 |

Total number of individuals who have had concerns or enquiries – **5,205**

6,088 safeguarding concerns raised during the year. (individuals may have more than one concern)

1,223 concerns became s.42*enquiries.



*Under Section 42, Care Act 2014

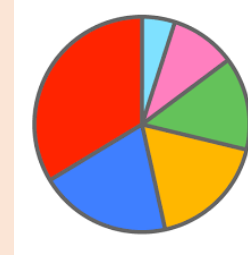
96% of individuals were happy with the outcome of their Safeguarding enquiry
(Concluded S.42 enquiries)



6396 Care Concerns received.



12,484 Total of all safeguarding and Care Concerns received in 23/24



810 (66%) concluded s.42 safeguarding enquiries listed the source of risk as someone known to the person at risk

267 (22%) concluded s.42 safeguarding enquiries involved service providers

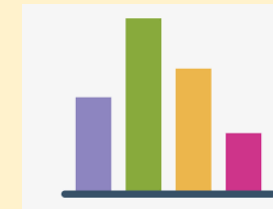
231 (19%) listed the source of risk as someone not known to the person at risk



11% Increase in the number of concerns raised, up from **5,475** last year.



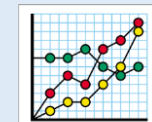
3% decrease in the number of enquiries started, down from **1,261** last year.



496 enquiries involved allegations of neglect.

299 enquiries involved alleged physical abuse.

Abuse or neglect occurred in the person at risk's home **647** times.



3,688: White British.

111: Black and ethnic minority people had Safeguarding concerns.

(Please note that ethnicity is self-reported, and individuals might choose for their ethnicity not to be recorded. There were **305** cases where the individual refused for their ethnicity to be recorded or where ethnicity was not known.)

Service User Group 2023/24:



After noting the numbers of service users being asked about MSP had declined following the pandemic, the group designed a wallet sized card for Safeguarding Practitioners. The wallet card focused on the 6 Making Safeguarding Personal (MSP) questions listed within the 2023 Local Government Association's Outcomes Framework. With the assistance of the Service User Group these questions are now in an easy read format that is accessible. The language was simplified wherever possible, and any necessary complicated words or terms explained. This card has now been launched across all social work teams in Cheshire East and with the local hospital safeguarding teams. The Group are now monitoring the impact data of these cards.



The Service User Group enjoyed meeting each other face to face again during 2023/24, this was after a break and also a period of online engagement throughout the pandemic and the following post-Covid 19 recovery period.

The group expanded and grew this year with representation now including individuals with physical disabilities, learning disabilities, brain injuries, mental health conditions, carers, and residents from care home settings.

This group continues to monitor how Making safeguarding Personal is utilised in Cheshire East. The group regularly reviews safeguarding data & existing practices, to ensure the development of more person-centred approaches, and also to identify any new areas for improvement. By listening to this group, CESAB can assure that adult safeguarding processes align with the needs and experiences of adults at risk in Cheshire East.



Making Safeguarding Personal:
Did we get it right?

Questions for the worker to ask:

1. Were you included and updated?
2. Were you supported to feel safe?
3. Did you feel listened to?
4. Are you happy with the end result?
5. Do you now feel safer?
6. Is there anything else you want to say?

What individuals should expect
We will:

- Listen to you
- Understand your views and wishes
- Take you seriously
- Treat you with respect
- Support you to feel safe
- Keep you informed and involved
- Tell you what will happen next

Stopping Adult Abuse – everyone's business
If you are concerned about someone, please contact
0300 123 50 10
www.stopadultabuse.org.uk



Information Card designed by
Cheshire East Service User Group:
Cheshire East Safeguarding Adults Board



SAFEGUARDING ADULT REVIEWS (SARs): Under the Care Act 2014, the SAB is responsible for the coordination of Safeguarding Adults Reviews (SARs). These independent reviews are commissioned where there has been an incident of serious harm or death involving an adult at risk, and its focus is on capturing learning. They set out to establish what may have gone wrong and to identify where agencies or individuals could have acted differently or worked better together.

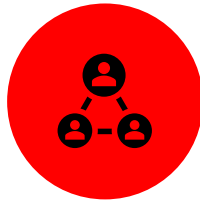
In 2023-24 CESAB concluded ONE safeguarding adults review – ANTON: The SAB commissioned a Safeguarding Adults Review following the death of ‘Anton’.

Anton was Slovakian. He was 64 when he died. It is understood he had come to England 12 years previously. He had no family and appeared to be socially isolated. His understanding of the English language was poor. Anton had poor physical and mental health and was known to many services. Anton died of pneumonia in November 2021. This SAR examines issues around having limited English language, self-neglect, poor engagement with services and mental capacity. It should be noted that these events occurred during the COVID pandemic when national lockdowns were established, placing restrictions on contact from family, friends, and professionals. The Review also highlighted how COVID placed increased strain on systems, and how cases of hoarding and self-neglect were harder to detect. The Review highlighted the importance of professionals utilising their ‘Professional Curiosity’ including considering why people may initially be reluctant to accept support and how to strengthen translation support for individuals who do not have English as a first language. The full report and a 7-minute briefing can be found on our webpages www.stopadultabuse.org.uk

What we learnt from ‘ANTON’ SAR –



The importance of multi-agency working in a timely manner.



The Importance of the use of interpretation services to overcome language barriers.



The importance of professional curiosity, especially why people may initially be reluctant to accept support.



The importance of frontline staff being aware of, and are able to use, robust alcohol and drug screening tools.



The importance of clearly recording on casework recording systems when an individual has language barriers.



An understanding of self-neglect and the effects this can have on physical health.



The Importance of third sector groups to help support and keep people safe in our communities.

Discretionary Safeguarding Adult Reviews (D-SARs):

CESAB can also exercise discretion and arrange a Discretionary SAR in any case involving an adult at risk in its area where it believes that there will be value in doing so. This may include where an agency believes there are lessons to be learned for all involved which will improve multi agency working, practice and information sharing. Each D-SAR results in a 7-minute briefing, this report provides the key themes and recommendations surrounding the review. The expectation is that team leaders across the multi-agency will present these briefings to their staff, on a regular basis. During 2023/24, CESAB conducted four D SARs, briefings can be downloaded from www.stopadultabuse.org.uk

Safeguarding Adult Reviews – Partner Assurance 2023/24

CESAB conducted a self-assessment process with its partners to reflect on how their agency has incorporated the recommendations made within the ‘Anton’ Safeguarding Adults Review. Partners gave assurance of the following:



All Board partners gave assurance that they use translation services and provide materials in native languages for vulnerable individuals who are not English speakers.

All settings take actions to ensure staff are aware of how to support adults who have English as a second language or very limited use of the English language. This included agencies sharing Anton’s case with staff to raise the awareness of identifying the importance of identifying the native language of service users to effectively communicate.

All Board partners provided assurance that their organisation take actions to ensure all frontline staff are aware of, and are able to use, robust alcohol and drug screening tools such as the AUDIT tool to identify and record the level of substance related risk for clients.



The ‘Anton’ SAR highlighted the importance of raising awareness with frontline staff about socially isolated people who may be at risk of abuse and neglect (including self-neglect). All partners were able to give assurance that the 7-minute briefing of Anton’s case has been shared in their setting. Partners also emphasised the importance of the Complex Safeguarding Forum when managing such cases.

2023 also saw the development of the Cheshire East Hoarding Support Groups, partners valued this initiative and highlighted how person-centred and empowering this is for the individuals concerned.

Partners were able to document various forms of training from E-learning modules focussing on self-neglect, to single agency training sessions, and also SAB training events that covered the topic of Self-Neglect.

Awards Ceremony November 2023

The Cheshire East Safeguarding Adults and the Safer Cheshire East Partnership aim to prevent abuse where possible and act quickly and appropriately when it does happen. The Boards recognise that across Cheshire East there are many carers, health and social workers plus volunteers doing fantastic jobs, sometimes under very difficult circumstances. The 2023 Safeguarding & Dignity Awards were an opportunity to celebrate and recognise good practice in organisations, teams, individual workers or volunteers with regards to treating individuals with dignity and supporting and protecting children and adults at risk from abuse, harm or exploitation. Successful nominees were invited to attend a celebratory event during Adult Safeguarding Week in November 2023. The event was a celebration of individuals and teams who go the extra mile to treat individuals with dignity or to support and protect children and adults at risk. The awards celebrated many winners from across Cheshire East.



National Safeguarding Adults Week November 2023

Cheshire East Safeguarding Adults Board supported National Safeguarding Adults Week 2023 with a range of activities that made people aware of the different types of abuse that some people experience. The National Adult Safeguarding week was an excellent opportunity to promote adult safeguarding and the work that a number of organisations are doing to protect residents across Cheshire East. Safeguarding Adults Week 2023 saw organisations coming together to raise awareness of important safeguarding issues. The aim was to highlight safeguarding key issues, facilitate conversations and to raise awareness of safeguarding best practice. The week enabled more organisations and individuals to feel confident in recognising signs of abuse and neglect and recording and reporting safeguarding concerns. The theme for Safeguarding Adults Week 2023 was 'Safeguarding: Best Practice'. Each day focussed on a different topic, with a range of events such as webinars, conferences for professionals, and awareness events with the Public. We were fortunate to work in collaboration with our Fire and Rescue partners and had the use of Safety Central, Cheshire Fire and Rescue Service's award-winning education centre at Lymm for three days. Using this venue allowed our SAB Trainer and Fire Safety Delivery Staff to work together to provide interactive sessions for Care Sector employees.



**Safeguarding
Adults Week 2023**
Monday 20 – Friday 24 November
#SafeguardingAdultsWeek

ann craft trust
acting against abuse

Learning and Development: update by Debbie Waterhouse, CESAB Training Officer

There continues to be a focus on training those in the Care Sector, with targeted training for those who are identified by the Governance and Care Concern Teams as needing support in relation to safeguarding. Again, this area continues to be extremely challenging; staff recruitment and retention being one of those factors, with an increase in overseas recruitment in recent years, to fill in the skills gap in the sector. We continue to offer a hybrid of training (face to face and via Teams). The training for Licensed Drivers in Cheshire East has continued at a pace, in collaboration with Cheshire East Licensing Team, and will continue through 2024-2025. Learning recommendations from our Statutory and Discretionary SARs continue to be embedded in all the courses the Project delivers.

The role is being developed and new partnerships are being forged to ensure that we continue to work together with people and organisations to prevent and stop both the risk and experience of abuse and neglect; we continue to work alongside the authority to ensure that safeguarding is embedded. The biggest challenge for the Safeguarding Adults Board (SAB) Training Officer role, is that the funding that has been in place since 2019, ceased in August 2023. In 2022/23 academic year, the project delivered training to an overall total of 1301 individuals. This exceeded the funding conditions set by the Lifelong Learning Fund. However, due to changes in European funding, the funding criteria changed in 2023 and the SAB Project no longer meets the scope of the new conditions, therefore, the Project is seeking to source more secure funding from elsewhere. The Project has however, successfully secured a one-off temporary funding contribution from the Safer Cheshire East Partnership (SCEP) to continue the training until February 2025.

Figures of individuals trained in 2023/24.

| Care Providers (Level 1 Safeguarding) | Licensed Driver Training (Level 1 Safeguarding) | Sexual Abuse and Domestic Violence | Care Concern |
|---|---|------------------------------------|--------------|
| 1275 | 437 | 38 | 165 |
| TOTAL TRAINED = 1915 <i>(Statutory Partners -174 - Non-Statutory Partners -1741)</i> | | | |

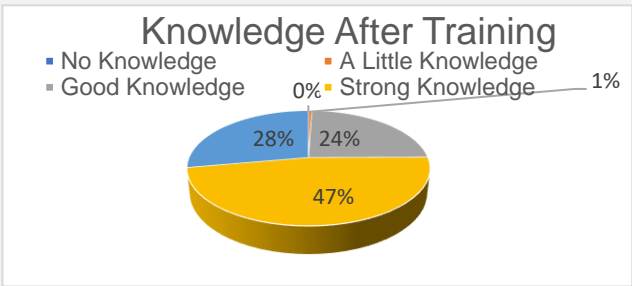
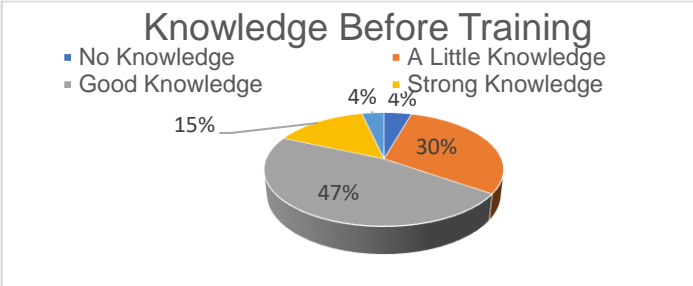
In November 2023, National Safeguarding Adults Week was run and alongside our partners in the Cheshire Fire and Rescue, training sessions were offered to partners in the domiciliary care sector, over a number of days. This was held at Safety Central Headquarters.

- In February 2024, the Safeguarding Childrens Partnership in Cheshire East (CESCP) ran a learning week for their partners and colleagues. One day focused on a 'Marketplace'; it focused on the child's journey from birth to adulthood. The training officer attended and as a result, requests for training were taken.
- Domestic Abuse and Sexual Violence training resumed in December 2023 –with 3 sessions undertaken, there are 6 additional sessions being offered in 2024.
- Training, in collaboration with the Deprivation of Liberty Safeguarding (DOLS) team is being arranged with the registrars' service in Cheshire East, focusing on abuse, forced marriage and mental capacity.
- Training delivered to the Environmental Protection team in Cheshire East, focusing on safeguarding and recognising abuse.
- DOLS process training to be offered to care staff, is in the final stages of development in collaboration with the DOLS team manager and will be offered very soon.
- Learning and Development section on the CESAB website updated and relaunched.

Level 1 Safeguarding Adults Training: Care Delivery Staff

Prior to the training, 34% of people said that they had no knowledge, or little knowledge of adult safeguarding. This included knowledge and understanding of key legislation, Making Safeguarding Personal, signs and indicators of abuse and how to report adult safeguarding concerns.

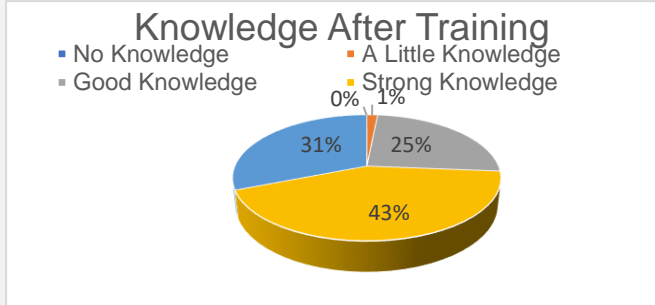
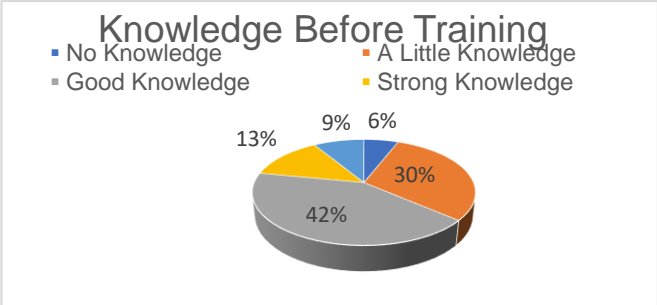
After the training 99% of people said that they had good, strong, or very strong knowledge of adult safeguarding. Of these, 24% had good knowledge, 47% had strong knowledge of adult safeguarding and 28% had very strong knowledge of adult safeguarding.



Level 1 Safeguarding Adults Training: Licensed Drivers

Prior to the training, 39% of people said that they had no knowledge, or little knowledge of adult safeguarding. This included knowledge and understanding of key legislation, Making Safeguarding Personal, signs and indicators of abuse and how to report adult safeguarding concerns.

After the training 99% of people said that they had good, strong, or very strong knowledge of adult safeguarding. Of these, 25% had good knowledge, 43% had strong knowledge of adult safeguarding and 31% had very strong knowledge of adult safeguarding.



Stories of Difference

Keith's Story



Keith* is in his early sixties and has some physical health problems which make it difficult for him to leave his home. The local PCSO made a safeguarding referral in respect of Keith as Cheshire Police had been contacted by Keith's bank as a result of unusual activity on his account. Keith had been sending money abroad and had also been making large cash withdrawals. Keith agreed to a visit from a social worker to make further enquiries. Keith disclosed that he had been sending money to a lady in America, Sandy* who he met on an internet discussion group. Keith said that he had bought an airline ticket to travel to America to meet Sandy and had also sent Sandy money to update her passport and to pay for a flight to England so that she could visit Keith later in the year. Keith said that he wanted to purchase some US Dollars, but his bank refused the transaction and invoked the banking protocol, which led to the police being contacted, as Keith's bank suspected fraud.

Keith agreed to a visit from Cheshire East Trading Standards. Keith shared financial information with his social worker and the Trading Standards officer which revealed that Keith had taken out a loan and transferred a large amount of money to Sandy. Keith's social worker gave Keith information about the Age UK Scams Aftercare service. Keith said that after reading the information, he recognised that he had been scammed, Sandy was not who she said she was, and he felt foolish. Trading Standards and Adult Social Care worked in partnership with Age UK, Cheshire Police and Keith's bank and together they were able to recover some of the money that Keith had sent to Sandy.

Keith told the Trading Standards officer that he was lonely and had not been able to get out as his health had deteriorated since the Covid pandemic. Previously, Keith had been active in his local community, had volunteered in a charity shop and had been a member of two community groups. Keith's social worker put Keith in touch with the Local Area Coordinator and Keith is now attending a social group each week which has reduced his feelings of loneliness and isolation. Keith expressed satisfaction with the safeguarding process and said that without intervention from the local authority, he would have been at risk of losing his home. Keith said that without the information from his social worker, Trading Standards and Age UK, he felt that he would have been susceptible to being scammed again. Keith said that he now feels much better about things and is positive about his life. He is really enjoying getting out in his local community again and has started to have more contact with his family. Keith's daughter said that she can't thank professionals enough for all the support they have given to her father and said that she feels they are well equipped as a family to spot scams and fraud, which they would not have been as knowledgeable about previously.*

Stories of Difference

Margot's Story



Margot* is in her late eighties and was living independently in a flat in a retirement complex. Margot had no formal support at home but did have some informal support from a friend who would take her out for lunch, as Margot had stopped driving. There was also a warden on-site during the day Monday-Friday. Margot was very proud of the fact that she had worked as a model in London and took great pride in her appearance. Margot thrived on the company of others and went out every day, enjoying activities such as shopping, pub lunches and going out for drinks.

Kath*, the warden from Margot's accommodation made a safeguarding concern to adult social care as she was becoming increasingly worried about Margot's alcohol consumption and self-neglect. Kath also expressed concern that Margot may be being financially exploited by a younger male. Kath discussed that she had been receiving complaints from Margot's neighbours. Margot had been acting out-of-character, playing loud music into the night, asking neighbours to purchase alcohol for her and sleeping in the laundry room, and these incidents had been becoming more frequent. Kath was also worried that Margot was susceptible to exploitation, as she had been bringing a younger male, Geoff* into her flat and allowing him to stay for several nights. Margot had disclosed that Geoff was asking her for money and as a result, she did not have enough money to buy food or pay her bills. Kath explained that Geoff staying at Margot's flat was against the terms of Margot's tenancy as there was an age restriction on overnight visitors.

A social worker visited Margot at home and noted that there was evidence of self-neglect. Margot said she was embarrassed about her home and would like it to be made tidy and said she would welcome some support to maintain her personal hygiene. Margot agreed to have some help at home and the social worker arranged for a support worker to visit each day. Margot built up a good relationship with the support worker, however, the worker was concerned about Geoff's presence and said that there was always evidence of heavy alcohol consumption when he was visiting. Concerns continued to be expressed by Margot's neighbours, and while the loud music had stopped, Margot was asking neighbours to purchase alcohol on a more frequent basis. When challenged, Margot said that she didn't have any money as Geoff said he needed some money to pay his rent, and she thought he needed the money more than she did.

Kath raised a safeguarding concern as Margot's rent was overdue, and she had always been very particular about paying her bills on time. Margot's friend had also told Kath that Margot looked as though she had lost weight, and when they went out for lunch, she had caught Margot wrapping up food and putting it in her handbag. When asked, Margot said that she was taking the food home for Geoff because he had no money for food. Margot's friend also noted that Margot was not taking care of her appearance which was most unusual. A further safeguarding concern had been received as Margot's support worker had found alcohol in milkshake bottles, and it appeared that Geoff had been putting alcohol into non-alcoholic drinks to make Margot inebriated. Margot had minimised this but then admitted that a lot of her drinks "tasted funny".

Margot's social worker undertook a further visit with the support worker and Margot said that she was fed up with having no money. She said she had been a model and had owned a Bentley and now she had nothing. Margot also said she was fed up with being in the flat and she had not been out because she had no money. She said Geoff was fed up with her as she had "gone boring" since she was not going out, and she was worried that he would look for a younger woman. Margot then said that she was getting tired of him asking for money and she had wondered whether it was a healthy relationship. She said that all Geoff was interested in was alcohol and she "couldn't handle it".

Under Making Safeguarding Personal, Margot was asked what she would like to happen. Margot said that she would like to maintain a relationship with Geoff but that she did not want him to visit her home anymore as she couldn't trust him. Margot said she would prefer this to be a friendship rather than an intimate relationship. Margot said she wanted to be in control of what alcohol she drank, and she only wanted a glass of wine with meals. Margot also said that she wanted to pay her rent on time and wanted to go out to lunch with her friend but would prefer to go to cafes rather than pubs as she wanted to reduce her alcohol intake. Margot said that she would prefer friends to a relationship, and she would like to join some of the community groups that met in the lounge at the retirement complex. Margot's capacity was assessed under the *Mental Capacity Act 2005*, and she had the capacity to make these decisions.

Margot, Kath, and the social worker met with Geoff and explained that he was not allowed to stay overnight in Margot's flat as this would mean that Margot was in breach of her tenancy, and she could be asked to leave her flat as a result. Geoff understood this and said that he had been offered accommodation in a different area but was not sure how Margot would feel about this, so he had not yet accepted it. Margot said that she would be happy to maintain telephone contact with Geoff and that she was going to join some community groups which would mean that she would not have time to go to the pub. Margot also said that she would not be giving Geoff any more money as she realised that she needed it more than he did. Geoff said that he wanted to reduce his drinking as he did not like the way it changed his personality. He said that he had been offered a place on a detoxification programme and a condition of this was that he resided in the accommodation that he had been offered. Margot and her social worker both said that they thought this would be a positive move for Geoff.

Margot's social worker maintained contact with Margot and Geoff after the safeguarding enquiry closed. Geoff attended the detoxification programme and settled in a new area outside of Cheshire East. Margot and Geoff maintained telephone contact, and both said they were happier with this. Geoff remained abstinent from alcohol and Margot reduced her intake to only having wine with meals. Margot continued to have daily support from a support worker to help her maintain her personal hygiene and home environment. Margot resumed good relationships with her neighbours and her friend and learned new skills from attending community groups including a sewing circle, beginner's computer group and art club. Margot said that her desired outcomes from the safeguarding enquiry had been fully achieved and although she was not sure about social services involvement at first, she was pleased that she had met her social worker as her life had definitely improved. In Margot's words, she was "now living life, rather than just existing. Who would have thought I would learn new things at the age of 87?!"

****Names & locations have been changed to ensure anonymity***

New CESAB Policies and Procedures

Guidance for Missed Appointments: In conjunction with Cheshire West and Chester SAB, CESAB produced the Guidance for Missed Appointments of Adults with Care and Support Needs accessing Health and Social Care Services. This was launched in July 2023, and was developed in response to recommendations from Safeguarding Adult and Domestic Homicide Reviews across the Pan-Cheshire footprint. The guidance outlines the roles and responsibilities for organisations in respect of adults at risk who do not attend, were not brought, or who are unable to attend their appointments.

[final-sab-guidance-for-managing-the-non-attendance-of-adults-with-care-v5-3.pdf \(stopadultabuse.org.uk\)](#)

Information Sharing Agreement (ISA): The CESAB Information Sharing Agreement (ISA) was updated to include changes in GDPR & national legislation. It was re-launched in November 2023. This agreement supports the application of the adult safeguarding aspects of the Care Act 2014, and ensures the sharing of the right information, at the right time, with the right people. Underpinning the CESAB ISA is the recognition that good information sharing is fundamental to best practice in safeguarding adults. [Multi agency Information sharing agreement \(stopadultabuse.org.uk\)](#)

Hoarding Support Groups: Following recommendations from our Safeguarding Adult Reviews, CESAB were pleased to support partners from Housing and Adult Social Care with the launch of Hoarding Peer Support Groups in Macclesfield and Crewe. The purpose of the groups are to provide mutual peer support, so that people with lived experience of hoarding and associated mental illnesses are able to support each other. [hoardershelpinghoarders.com](#)

Single Agency Self-Assessment –

CESAB conducted a self-assessment process with its partners in order to reflect on their agency's safeguarding adults activity during 2023/24. This process allowed partners to consider areas such as Making Safeguarding Personal, how their agency has incorporated the recommendations made within the recent Safeguarding Adult Reviews (*reported on page 12 of this report*), and their commitments for the year ahead.

All partners were able to give reassurances that they listen to the Service User Voice, and, Making Safeguarding Personal is included in all Health and Social Care policies, training, supervision, and any discussions that managers have with Safeguarding Practitioners to support decision making.

The statutory guidance to the Care Act 2014 requires Safeguarding Adults Boards to establish and agree a framework and process to respond to allegations against anyone who works (either paid or unpaid) with adults with care and support needs. Person in a Position of Trust (PIPOT) concerns arise when there is suspicion or evidence that someone in a position of trust may have: behaved in a way that harmed, or may have harmed, an adult at risk or a child. The Single Agency Assessment process gave CESAB assurance that all its partners could outline their organisation's arrangements in dealing with allegations against a Person in a Position of Trust (PIPOT).

Our priorities 2024-25

The Board recognises more can be achieved by working together in partnership and has committed to the following areas for the year ahead, based on feedback, learning and analysis of current strengths.

Strengthening Partnerships: We will continue to strengthen our board by establishing closer working links and structures with the Community Safety Partnership (SCEP), and the Cheshire East Children’s Safeguarding Partnership (CESCP) ensuring clear oversight of wider contextual safeguarding issues.

Funding: Working with partners to help support their input, including financial contributions, to the work of the board. Sustainably into the future is a key area of work next year.

Service User Voice: Ensure the delivery of effective adult safeguarding services, with a focus on Making Safeguarding Personal, informed by the voice of adults who are at risk of neglect and abuse.

Creating a Culture of Learning: We will promote continuous improvement in safeguarding practice by learning from experience and supporting workforce development. This work will consider how we share learning from SARs and other review processes widely across the partnership, with a clear methodology for reviewing the impact on practice.

CQC Assurance: CQC will now be assessing local authorities in England. They will be looking at how well local authorities meet their duties under the Care Act 2014, this will include partnership working and adult safeguarding. CESAB partners are therefore committed to support the local authority with this process and will continue to take steps as a Board in preparation for the CQC assessment.

This report will be published on our website www.stopadultabuse.org.uk for all partners and members of the public to access. As required by the Care Act, this report will also be shared with the Chief Executive Officer and Lead Member at Cheshire East Council as well as the Police and Crime Commissioner, Heathwatch Cheshire East plus the Cheshire East Health and Wellbeing Board.

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www.stopadultabuse.org.uk