Safeguarding Adults in Stockport

Safeguarding Adults Board

Annual Report

Year Ending 31 March 2012

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

NHS
Stockport

Section1 - Contents

Section 2 - Opening Remarks by Board Chair

I was privileged to become independent chair of Stockport's Safeguarding Adults Board in September 2011 succeeding the Director of Adult Social Care Terry Dafter whose professional advice and guidance has been extremely valuable.

My first task was to conduct a review of the effectiveness of the Safeguarding Adults Board. The review identified a number of challenges including the need for the board to become more dynamic, proactive and stronger at scrutinising and holding partner agencies to account. Encouraging progress has been made and several of the recommendations emerging from the review have been actioned.

During the year the safeguarding adult's board concluded a serious case review following the murder of a 22 year old male in 2009. The young man faced a number of difficulties in his short life. Lacking family stability, he was looked after by Stockport Council as a child and continued to be supported by them until he reached the age of 21. He was believed to have a milder form of learning disability although there had been no formal diagnosis. He was not able to engage successfully in education or employment despite considerable support nor did he sustain tenancies for long and suffered regular accommodation instability. He became estranged from his family and marginalised from society. And amongst those he formed relationships with were those who ultimately took his life.

The serious case review shed light on two of the most challenging issues currently facing colleagues involved in safeguarding; how we help vulnerable young people safely and successfully make the transition to adulthood and how we ensure that colleagues in all partner organisations have a shared understanding of what constitutes vulnerability and respond appropriately. The serious case review was published in June 2012 and both the safeguarding adults board and the safeguarding children board are working together to implement the action plan drawn up in response to the review.

As independent chair of both boards I hope to work with colleagues to address further areas of mutual interest and concern.

It would be remiss of me not to draw attention to the fact that safeguarding adult's boards - which currently lack a statutory basis and

the resources necessary to fully support strategic partnership arrangements - are very much the 'poor relations' when compared with other areas of strategic partnership activity.

The safeguarding adults' board prepared its first business plan which will guide the activity of the board over the period 2012 to 2014. These will be very challenging years in which to make progress as a result of the economic climate and the changes partner agencies are making in response to reduced budgets. However partnership working in Stockport continues to be a key strength and it is clear that partner commitment to the safeguarding agenda remains undimmed.

One of our key challenges as a board is to raise the level of general awareness of adult safeguarding issues. The publication of this annual report is intended to contribute to this and also allow others to hold the safeguarding adults board to account in fulfilling our primary role - which is to ensure that arrangements for keeping the most vulnerable adults safe are as effective as possible.

David Mellor
Independent Chair of Stockport Safeguarding Adults Board

Section 3 - National and Local News

3.1 Serious Case Review

The Serious Case Review into the death of Adult A was commissioned by the Safeguarding Board in March 2010. An Independent Author was identified and Individual Management Reviews and Chronologies were obtained from all the organisations that had involvement in the care and support of Adult A. The completed Overview Report was agreed by the Board in December 2011. After discussion it was further agreed that an Executive Summary would not be required and that the Overview Report, together with the multi-agency action plan would be published in its entirety, supported by a press release. The Board was keen to adopt this proactive approach to publication. At the time of preparation of this Annual Report, it is expected that publication will be sometime in April/May 2012.

As you will have read in the opening remarks by the chair, publication went ahead in June 2012 and both the board and the implementation group are actively engaged in monitoring the completion of the multi-agency action plan.

Included in the Terms of Reference for the Serious Case Review was a commitment to review the current protocol for commissioning and conducting future SCRs and it is expected that this first SCR will provide valuable insight into this piece of work which will be completed in 2012/13.

3.2 Independent Board Chair

You will see from the opening remarks on page 2 of this annual report that the Safeguarding Board has a new chair. It had been the view of the Board for some time that the appointment of an independent chair was a positive development and to this end we embarked on a recruitment drive in late 2010. Last year's annual report advised that this had been unsuccessful but that further options were being explored. It is with great delight that we are able to report that David Mellor was appointed to this position for an initial two year period commencing from 1 September 2011. It is seen by the Board as a bonus that David is also the Independent Chair of Stockport's Local Safeguarding Children's

Board and it is anticipated that this will provide many opportunities to learn from a considerably more established, statutory based organisation.

3.3 The Mental Capacity Act (2005) and the Deprivation of Liberty safeguards (2009)

As advised in last year's report, the responsibility for supporting the implementation of the Mental Capacity Act (2005) and the administration of the Deprivation of Liberty Safeguards (2009) transferred from a joint funded NHS/LA service to the Local Authority's Safeguarding Adults Service. The service was renamed The Safeguarding Adults and Mental Capacity Act Service (SAMCAS) and the decision to transfer pre-empts the expected national transfer of responsibilities following the abolition of Primary Care Trusts from April 2013.

The responsibility for development and delivery of related training has transferred to the Training Subgroup, the operational monitoring has been incorporated into the remit of the Safeguarding Adults Implementation Group and the governance of all MCA and DoLs related activity has been has been included in the business of the Safeguarding Adults Board.

The first report on DoLs activity can be read in section 4.2 below.

3.4 Personalisation and Safeguarding

Adult Social Care plays an important role in the protection of members of the public from harm and is responsible for ensuring that services and support are delivered in ways that are of a high quality and are safe. As the personalisation of adult social care services progresses and Personal Budgets become a more popular option, people will have greater choice and control over their support and may choose to spend their money on non-regulated support services and activities.

For people choosing these types of support, access to effective advocacy and good risk assessment and risk management will be essential to support them through these processes. This is particularly important where adults are deemed to be vulnerable for a variety of reasons and so may be at risk of abuse. There have been concerns

locally around the recruitment of Personal Assistants (PAs) where, as an organisation, we are unable to impose mandatory Criminal Records Bureau checking so potentially exposing these vulnerable adults to risk.

The training sub group is working to implement training around safeguarding specifically for Personal Assistants in recognition of this issue. As an organisation, we must ensure the correct balance between protecting people and enabling them to make positive life choices, including assessing the risks associated to those choices.

If people are supported internally to choose and purchase different support options then positive risk taking must be considered and a quality framework put in place that supports people to manage risk. To further safeguard people who choose services independently, and may also self-fund them, a marketplace registration process has been developed to ensure minimum standards are in place before organisations are enabled to advertise their services on the online marketplace.

The importance of the relationship between personalisation and safeguarding is acknowledged in the Safeguarding Boards' Business Plan.

3.5 Dignity in Care

The Dignity in Care Campaign launched by the Department of Health in 2006 continues to stimulate national debate in an effort to create a care system where there is zero tolerance of abuse and disrespect of adults.

Locally, an extensive programme of activity was undertaken to raise awareness of dignity in care, share good practice, embed dignity into mainstream practice and inspire local people to take action. As a result of these efforts approximately 300 individuals are signed up as Dignity Champions and are active in Stockport.

On 1 February 2012 - National Dignity Action Day, over 70 people from local health and social care organisations attended an interactive workshop organised by staff from Stockport Council, Age UK Stockport and NHS Stockport. The day offered an opportunity for individuals and professionals working in care settings to share experiences and discuss and explore many of the complexities that can surround dignified care and share best practice.

Consideration has been given to the promotion of the Daisy Accreditation Scheme within Stockport. The Accreditation is about demonstrating that an organisation delivers care with dignity and respect. At the present time there is no mandatory requirement to be accredited around dignity, however in the interest of service users' quality and safety the Daisy Accreditation demonstrates to the public those organisations which are seeking to meet every user's needs.

The monitoring of Dignity in Care activity in Stockport is included in the Safeguarding Adults Board's business plan and delegated to the Safeguarding Implementation Group as a standing agenda item in recognition of the importance of this issue in promoting good practice for the prevention of abuse and to underpin any subsequent actions needed to protect vulnerable adults.

Section 3 - Training Report and Statistics

4.1 Training Report

Key Achievements in 2011 – 2012

- This year saw the Training Strategy expand to incorporate the training needs of the Mental Capacity Act also.

- A Safeguarding Adult's Competency Framework has been written and agreed by the SA Board laying out minimum knowledge and skills required for different roles outlined within the policy.

- A one day event entitled; 'Safeguarding in employment: Key challenges in Social Care' was commissioned. This event was delivered by a barrister and provided essential learning on safeguarding and the law. It was targeted at social work practitioners and their managers.

- Two half day trainings on Mental Capacity Act were commissioned and delivered by a barrister. One of these sessions focused on making Best Interest decisions, and the other gave an update on case law relevant to Deprivation of Liberty Safeguards.

- A workshop delivered by the Independent Safeguarding Authority (ISA) was arranged to give an overview of the implementation of the Vetting and Barring scheme and answer practical questions in relation to the scheme.

- A new Referrer refresher course has been introduced offering a shorter training for those needing a refresher that focuses on specific areas of the referrer role in more detail.

- A new training on Deprivation of Liberty Safeguards has been designed and delivered on two occasions and was very well attended by both provider services and social work practitioners – it is intended to offer this out to Residential Care Homes to be delivered on site to ensure that all staff are aware of this legislation.

- The Safeguarding Adults and Mental Capacity Act Practitioner's Forum has run quarterly and offers an opportunity for Social work practitioners to explore complex cases.

- The publication of quarterly newsletters has been a way of keeping all partner agencies up to date with developments both nationally and locally and includes information on training.

- Two updated E-learning training tools were purchased at the end of the year for Deprivation of Liberty Safeguards and Mental Capacity Act.

- A new E-learning training tool for Safeguarding Adults was also purchased at the same time to be rolled out to certain designated groups such as Dentist Practices and GP's.

Training updates

Train the trainers – this was a new initiative to support provider services to deliver Alerter training in house using the Alerter training pack to ensure consistency and that all competencies are met. However, we have only actually run this course twice and trained people due to low take up.

Training was offered to informal carers as part of their training programme, but was not taken up at all so both courses were cancelled.

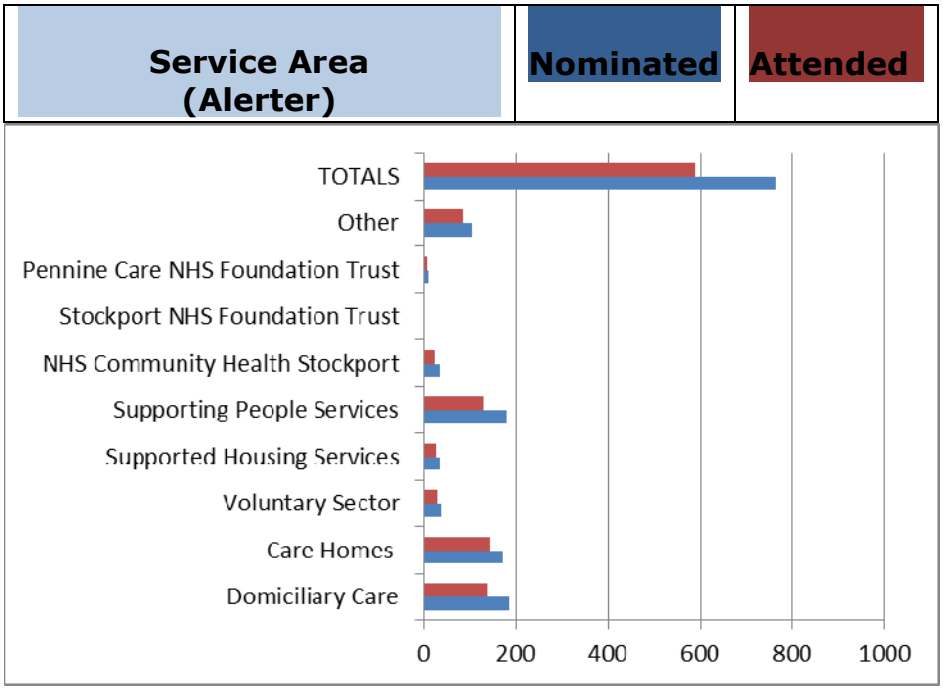
It was intended to offer training on the Channel Project and two training dates were set up - however due to low numbers for the courses these had to be cancelled and we are looking at other ways to inform people of the project e.g. through information on the safeguarding web page.

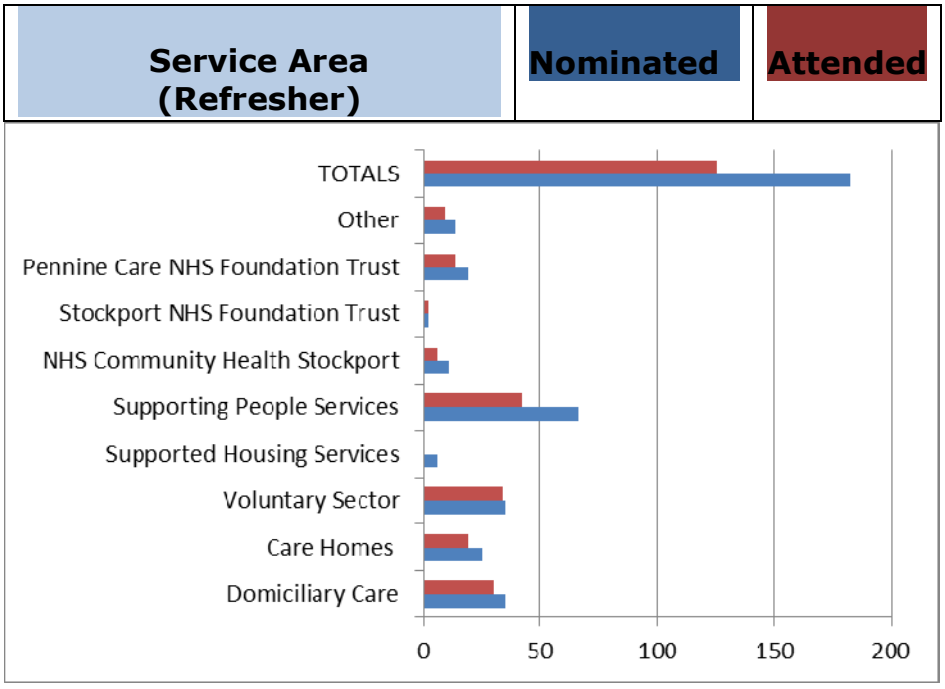
The uptake of both the Alerter training and the Referrer training has been disappointing, especially in the final quarter of the year when a good number of the scheduled trainings were cancelled. This is the first year where the number of people trained has dropped from the previous year.

Please note that a full list of trainings offered can be found in the Safeguarding Adults and Mental capacity Act Training Strategy 2012 – 2013, along with the identified training priorities for the coming year.

4.2 Training Statistics

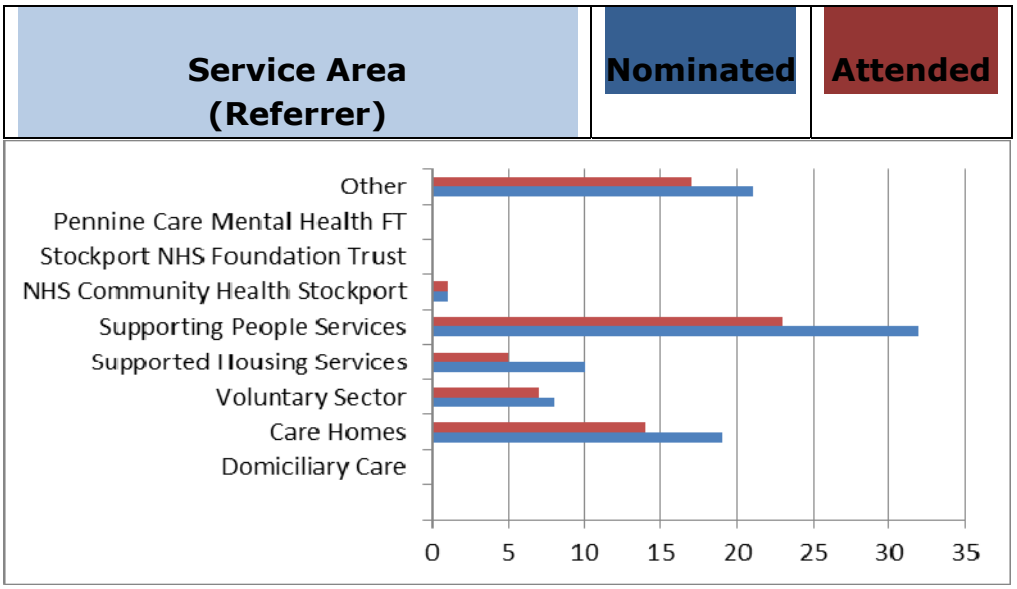
4.2.1 Alerters and Alerters Refresher training

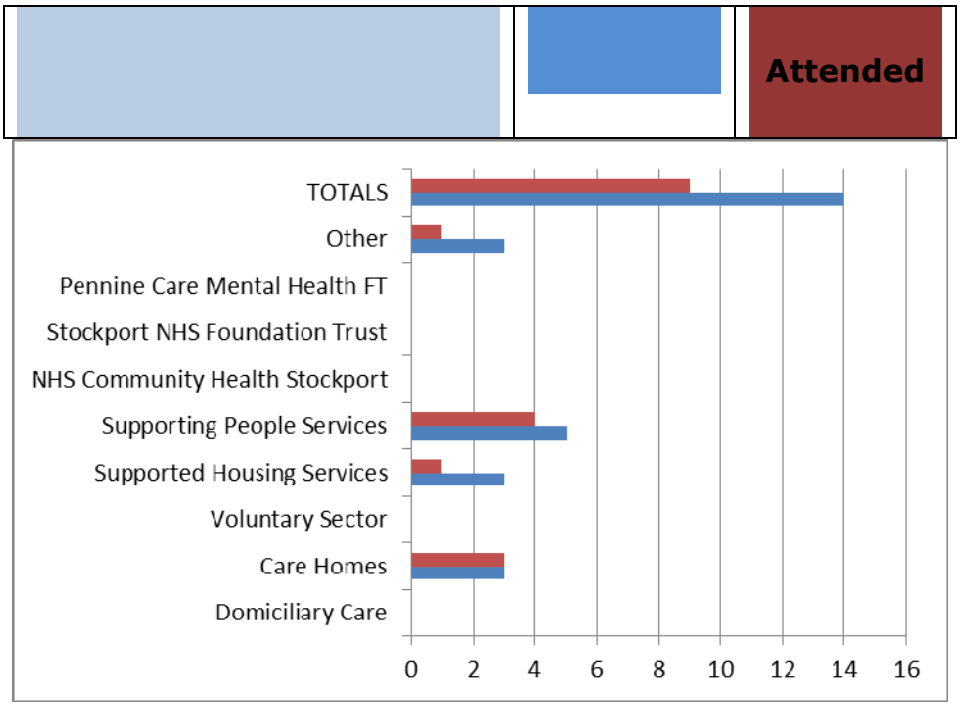




Overall attendance was 714 giving an attendance rate of 72%, up from 68% last year. However this cannot detract from the large drop in numbers attending. This reduced from 1190 last year to 714 this year. The number of courses having to be cancelled due to the low take up was at its highest and is a reflection of the financial pressures which is impacting at all levels of health and social care.

4.2.2 Referrers and Referrers Refresher Training





The actual attendance was 76 giving an attendance rate of 68%, which as with alerter training was up on last year. However, unlike the alerter training the actual attendance was up by 25% on last year. This suggests that providers may be targeting their managers and providing in-house training for Alerters.

4.2.3 Inquiry Officer Training

This two day course is offered to all designated Inquiry Officers irrespective of any previously completed training. The designated posts named in the current policy are qualified social workers, community psychiatric nurses and community nurses in the Learning Disability Partnership.

The role has been extended within the Pennine Care NHS Foundation Trust to include a small number of therapists based in the three Locality Resource Centres who also have Care Coordinator responsibilities.

The course was delivered twice in 2011/2012 and was attended by 28 designated staff. This training has now been completed by 214 designated staff though a proportion of staff have attended as an update to earlier training.

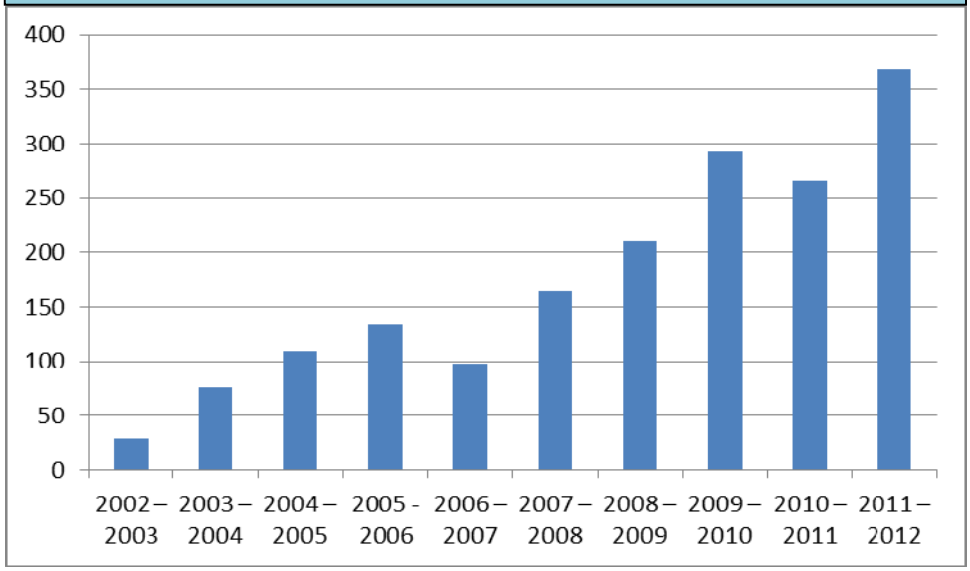
On completion of the two days we have continued to offer a third days training specifically commissioned externally to provide a more detailed insight into the complexities of preparing and carrying out interviews in individual inquiries.

Section 5 - Performance Information

5.1 Safeguarding/Adult Protection Investigations

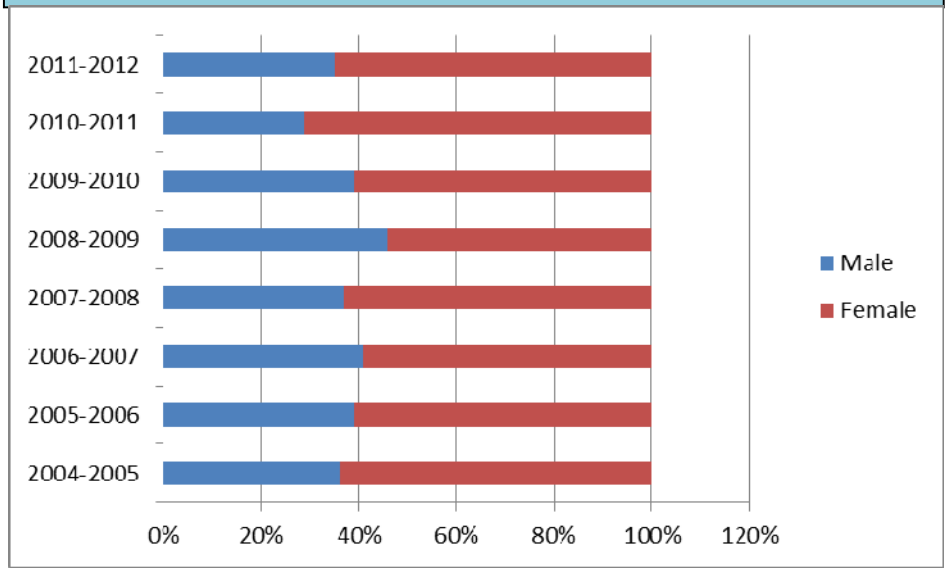
NB: Tables 1, 2 and 3 relate to the total number of referrals received in the year.
Tables 4 to 7 relate to completed cases only which number in total 315.
Tables 4, 5 and 6 have multiple entries.

Table 1 – Total Referrals



Comment: The total of 368 referrals represents an increase of 51% over the previous year. The total number of completed investigations at 315 represents an increase of 24%. It must be remembered that number of completed investigations includes referrals which were commenced in the previous year.

Table 2 – Completed Investigations by Gender (%)



Comment: With some slight variations the split between male and female victims remains roughly one third/two thirds.

Table 3 – Referrals received by Age and Client Group

Client Group	Age Band				Total
	18 to 64	65 to 74	75 to 84	85 +	
Physical Disability, Frailty and temporary illness inc. sensory loss	12	24	48	108	192
Mental Health (inc. dementia)	22	8	20	14	64
Learning Disability	44	5	2		51
Substance Misuse					
Other vulnerable adults	21	8	14	18	61
Totals	99	45	84	140	368

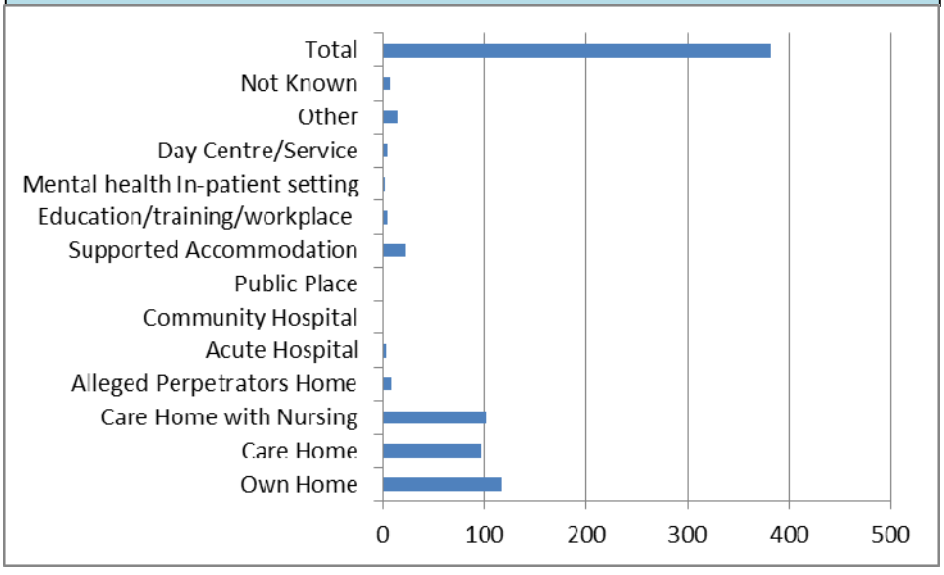
Comment: Although we no longer record 'older people' as client group it is still the case that the likelihood of abuse increases significantly over the age of 65. The current proportion is 26% under 65, 74% over 65.

Table 4 – Completed Investigations by Type of Abuse and Age					
Type of Abuse	**Age Band**				**Total**
	18 to 64	**65 to 74**	**75 to 84**	**85+**	
Physical	**50**	**18**	**33**	**61**	**162**
Psychological/ Emotional	**29**	**8**	**11**	**25**	**73**
Sexual	**10**	**1**	**3**	**3**	**17**
Neglect or Acts of Omission	**26**	**16**	**31**	**61**	**134**
Financial	**22**	**17**	**25**	**27**	**91**
Institutional	**5**	**0**	**6**	**16**	**27**
Discriminatory	**0**	**0**	**0**	**2**	**2**
Total Incidents	**142**	**60**	**109**	**195**	**506**
Incidents of Multiple Abuse	**49**	**215**			**264**

Comment

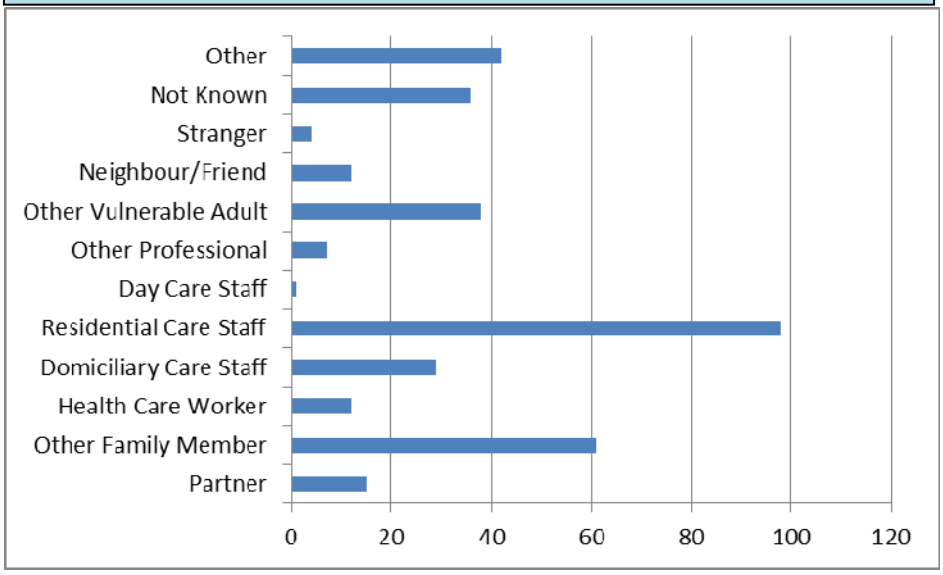
Comment: The types of abuse have risen broadly in line with the increase in referrals. The biggest increases were in neglect (52%) and financial abuse (47%)

Table 5 – Completed Investigation by Location of Abuse



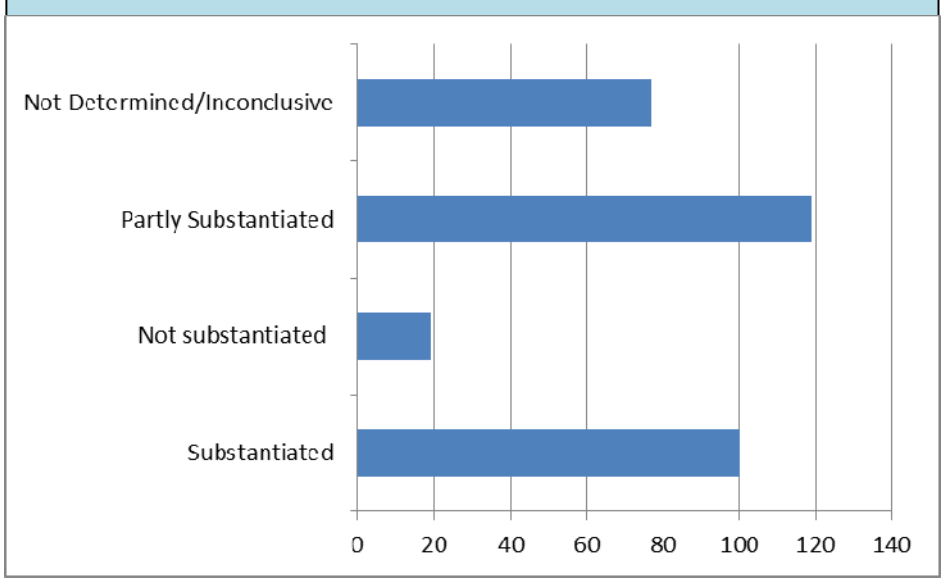
Comment: Referrals from staff employed in social care (including care home staff) rose by 81% and evidences a greater awareness and preparedness to respond to concerns. However it should be noted that not all alleged abuse incidents within care homes are allegations against the service. Some are reports of incidents concerning family members, visitors and other service users – (see below to compare referral source against alleged perpetrator).

Table 6 – Completed Investigations by Perpetrator



Comment: In 74 cases the alleged perpetrator was identified as a partner or family member. These incidents would also meet the definition for domestic abuse. – *"Domestic Abuse is defined as any violence or other abuse between family members, current or former partners in an intimate relationship, whenever and wherever the incidents occur. It may include physical, sexual, emotional or financial abuse."*

Table 7 – Completed Investigations by Case Conclusion



Comment: The conclusion 'partly substantiated' refers to cases involving multiple categories of abuse where at least one, but not all categories were substantiated.

The category of 'not determined/inconclusive' at 24% is a slight reduction on last year's figure of 25% and further evidences a greater confidence on the part of Case Conference decision makers in assessing the information and reaching a firm conclusion.

A further source of statistical information on safeguarding activity derives from the database maintained by the Safeguarding Adults Service which forms a record of all the instances whereby advice has been sought from the SAMCAS. The advice may have led to the making of a formal referral, resulted in signposting to another agency or the interpretation of the procedures in a particular case. Advice was given in a total of 148 individual cases during 2011/12. This represents a reduction of 37% on last year's reported figure and when read in conjunction with the significant increase in referrals (51%) can reasonably be interpreted as a growing confidence in the invocation of the procedures without recourse to advice. It will be interesting to see how next years' figures compare.

5.2 Deprivation of Liberty Safeguards

As the Supervisory Body (SB) for the Local Authority and NHS Services in Stockport, the SAMCAS receives requests to commission the required series of six assessments when a Managing Authority (MA) (hospital or care home) believes it may be depriving somebody of their liberty. The request may be preceded by the MA issuing itself with an Urgent Authorisation, where deprivation is believed to already be occurring, or may be for a Standard Authorisation where the MA expects to be receiving an individual into its care and that this may amount to a deprivation of liberty.

In addition to the 29 DoL assessments detailed below the SAMCAS provided informal advice in 35 other cases relating to both DoLs and MCA issues

1. Number of Requests		
Number of Urgent Requests	19	
Number of Standard Requests	10	
Total		29
2. Client Group		
Long Standing Illness	6	
Physical Impairment	3	
Mental Health Condition	16	
Learning disability	4	
Total		29
3. Age Group		
18 to 64 years	12	
65 and over	17	
Total		29
4. Location		
Care Home	23	
Hospital	6	
Total		29
Out-of-Borough	17	
Stockport	12	
Total		29
5. Outcome		
DoL Occurring and Authorised	18	
DoL Not Occurring	11	
Total		29
DoLs occurring and authorised with conditions	10	

6. Board Members Reports

6.1 Stockport Community Safety Unit

Key achievements between Adult Safeguarding and Community Safety

Performance – 2011-12

- The Safer Stockport Partnership has seen eight years of sustained crime reduction across the Borough.
- All crime continues to fall with a 5% decrease this year.
- Serious Violent Crime – 14% reduction.
- Serious Acquisitive Crime (Burglary, Robbery Car Crime) – 8.75% reduction.
- There has been a decrease in bogus/distraction burglary from 35 to 29 in last year a 17% reduction.
- Anti-Social Behaviour has seen a reduction of 21% of reported incidents.

Neighbourhood Policing Teams (NPTs)

- Improvements to NPTs and more resources going to NPTs, but with increased responsibilities through new policing model PMIT.
- Confidence Plans for each NPT developed with a number of 'Confidence Weeks' delivered in 2012. This is to improve confidence in how Police and Council deal with issues that matter to public. All this year's confidence measures have been met in Stockport.

Police Public Protection and Investigation Unit

- The new PPD has taken on the management responsibility for the Divisional Public Protection Investigation Units (PPIUs), which will remain based on divisions and staffed in accordance to demand. It also draws together the existing Serious Crime Division units such as the Safeguarding Vulnerable Persons Unit, the Sex Offender Management Unit and the Sexual Crimes Unit.
- In addition, a new Serious Sexual Offences Investigation unit will be introduced this summer to deal with all cases of rape across Greater Manchester ensuring a consistent approach for victims, no matter what the circumstances of the incident are, and help to bring more offenders to justice.
- Police systems have been improved to risk assess vulnerable victims and any actions for partner agencies can be quickly passed on.
- Information on vulnerable adult incidents over two years:
  2011-12 = 3710
  2010-11 = 3661

SIPS

- Four Stockport Intensive Partnership Sweeps (SIPS) delivered across all Priority 1 Areas.

Substance Misuse

- Drug treatment continues to be effective with the partnership exceeding its local target on getting people into treatment.
- The Drug Action Team has successful gone live with a national pilot of Payment by Results (PbRs) in April 2012.
- Integration of alcohol and drugs continued in 2011-12.

Doorstep Crime/Bogus Callers

- Joint work between Age UK, CSU and Adult Social Care on doorstep crime action plan refreshed 2012-13.
- Evaluation of No Cold Calling Zones (NCCZs) completed and a further 2 new zones have been established in Offerton. There is currently 9 NCCZs that cover 1800 properties across Stockport.
- Further analysis of doorstep crime will be carried out in order to identify any potential hotspots for consideration for additional NCCZs.
- Nearly 400 properties in Stockport have improved security through our 'Target Hardening Scheme' with Victim Support Services (VSS).
- Effective joint work between VSS and Age UK through the Handy Man Service has been helpful in tackling work on bogus callers and burglary.
- Successful bid for partnership funding for 20 'Care Call' door step crime alarms for those identified as most vulnerable or most at risk.

Hate Crime

- New GMP Partnership Core Team (1 x Sgt and 2 x PCs) have been established within the Community Safety Unit one area of responsibility is Hate Crime.
- A new guidance pack has been developed by GMP and can be found on GMP website.
- Proactive work on 3rd party reporting centres is currently on-going.
- Roll-out of training to all GMP on Hate Crime.
- A disabled community member has been recruited on to the GMP Independent Advisor Group (IAG).

Domestic Abuse

- MARAC (Multi Agency Risk Assessment Conferencing) continues to go from strength to strength with more partners involved in the process of managing high risk cases.
- Some excellent media work rolled out through a number of Communication Campaigns.
- Domestic Violence Homicide Reviews have become a statutory function for the SSP from April 2011. Unfortunately, the Safer Stockport Partnership is currently reviewing a current death (February 2012) and Adult Social Care colleagues are involved in process and are represented on the Overview Panel for the case.

Targeting the vulnerable/ASB (Anti-Social Behaviour)

- Increased case load of adult on adult anti-social behaviour over the April 2011-March 2012 period. Neighbour disputes have over taken juvenile nuisance as the key type of anti-social behaviour reported.
- Through the vulnerable victim matrix there were 18 red cases identified from April 2011- March 2012.
- 1438 Interventions were carried out by the ASBAT team against perpetrators of anti-social behaviour.
- Improvement in communication between ASBAT and NPTs via use of new Neighbourhood Management System (GMP data system) is working very well.

Priority 1 Areas/Neighbourhood Management

- All Priority 1 Areas now have a Neighbourhood Management Board in place with 'Safer' Theme Leads to manage community safety work in each area. Each area has a 'Safer' Action Plan.
- The has been 7 Participatory Budget Events (You Say, We Pay) with £184,741 distributed to 81 community groups in our Priority Areas.

Improving links to Adult Social Care (ASC)

- The CSU and ASC are currently jointly working together to look at vulnerable victims. A local steering group has been set up to scope out the need of vulnerable victims in Stockport. The aim of the group is to develop a care pathway through the council's contact centre for these individuals. The aim is to prevent crisis situations for victims and reduce demand in the system. Key deliverables will be:

    - A shared definition of vulnerable/at risk adult;
    - Information sharing protocols;
    - Refined referral and outcome processes.

6.2 Stockport NHS Foundation Trust

This section outlines the work undertaken at Stockport NHS Foundation Trust to address adult safeguarding issues over the last year.

1.0 Progress to date

- The Trust's Safeguarding Committee, chaired by the Deputy Director of Nursing and Midwifery has continued to meet bi-monthly throughout 2010-2011.
- The committee has robust terms of reference and aims to provide the strategic direction for the Trust to ensure that all safeguarding requirements for adults and children are achieved.
- The committee reports to the Patient Experience and Staff Development Committee (PESD).
- The Trust continues to be represented at the Stockport Safeguarding Adults Board by the Deputy Director of Nursing and Midwifery.
- The Trust is represented at the Implementation sub group of the Adult Safeguarding Board by the Senior Nurse for Safeguarding.
- The Trust is represented at the Valuing People Partnership Board by the Deputy Director of Nursing and Midwifery, this is held quarterly.
- The Safeguarding Committee continues to work to the local standard operating procedure to complement the All Agency Safeguarding Adults Policy which includes a flow chart to demonstrate clearly to staff what to do when a concern is raised.
- A microsite is updated as required with information for staff.
- All clinical areas have an information file for staff relating to Learning Disabilities.
- A Dementia Steering Group with multi agency representation hosted by the Trust continues to meet quarterly in order to implement the Dementia Strategy and improve patient care. A robust action plan has been developed and is under constant review. Measures have already been introduced such as new signage, coloured jugs and beakers, coloured toilet seats.
- The Trust has been involved in a national audit regarding the care of dementia patients, and is awaiting the findings.
- The Trust has been involved in a regional audit regarding the care of patients with learning disabilities (Oct 2011) and is awaiting the findings.
- The Trust has completed a safeguarding audit self-assessment tool (November 2011) required by NHS Stockport and this will be reported on through the Safeguarding Boards. There were no areas of noncompliance.
- The Deputy Director of Nursing and Midwifery has been invited this year to the local Autism Board and now attends on a regular basis.
- The Stockport Local Implementation Network meeting for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) was previously attended by the Deputy Director of Nursing and Midwifery but this meeting

has been discontinued. Business is dealt with through the Stockport Adult Safeguarding Board.

- There is a Learning Disability Liaison Nurse employed by SBC who previously worked for 15 hours per week at the Trust. This has been reduced to 7.5 hours per week.
- The Trust has access to a free 20 minute telephone advisory service provided by Beachcroft solicitors, and further to that can access legal advice through a senior manager when required.
- The Trust completed an audit regarding the mental capacity act and consent in October 2010 – January 2011 and the safeguarding committee have been presented with a report and an action plan.
- The Trust signed up to Mencap's 'Getting it Right' campaign.

2.0 Training

- The Trust has adult safeguarding awareness training on Trust induction and mandatory training with access to taught sessions and e-learning available to all staff. The Senior Nurse for Safeguarding monitors the figures monthly.
- Health Care Assistants receive Adult Alerter training.
- MCA/DOLS training has been addressed through the consent training
- Specific training sessions in relation to the legal issues surrounding MCA were held in 2010-2011 and was well attended by medical, nursing and Allied health professional colleagues.
- An e learning package is available for all staff to access and a requirement for all clinical staff to complete the learning within six months of starting at the Trust is in place.
- A learning disability DVD has been developed and nursing teams are using this for training at local level.

Future work

The Trust aims to focus on:

- Collaborative working with external partners.
- Develop guidance on restraint.
- Continue to attend external committees and groups as previously described.
- Increase the numbers of staff trained in adult safeguarding.
- Continue to raise awareness of safeguarding issues.
- Integrate Community Health Stockport into the Foundation Trust.

6.3 NHS Stockport Adult Safeguarding 2011-12

- Contracts with Stockport NHS FT and Community Health Stockport included safeguarding standards which were monitored via a self-audit. The audit was followed up by the Designated Nurse and evidence reviewed. Both organisations have an action plan which is being monitored. Pennine Care FT is monitored by NHS Heywood, Middleton and Rochdale.
- The designated nurse is working with Mastercall, St Anne's Hospice, Cheadle royal and BMI Alexander to ensure they have the appropriate systems and processes in place to protect vulnerable adults
- All contracts in 2012-13 will include the safeguarding standards and the providers will be required to provide evidence of compliance to the commissioners using the self-audit tool.
- 26 GP practice representatives attended a briefing by the designated nurse which reminded them of their safeguarding responsibilities. A Safeguarding Vulnerable Adults Tool kit published by the BMA was circulated to the attendees and also to the practices that didn't attend.
- GPs and Dental Practitioners have been provided with a link to the Kwango Adult Safeguarding E-learning which was purchased by the safeguarding board. Feedback in respect to uptake has been positive.
- A standing agenda item on the new Clinical Commissioning Board meeting is the inclusion of a patient story. The story of an adult with learning disabilities was discussed. The outcome of this story was an article was included in the GP pathfinder bulletin, which is circulated to all GPs, which included links to specific issues/training in respect to providing GP care to adults with LD.
- During 2011-12 the profile of Adult safeguarding has been raised within health and by strengthening the commissioning and governance arrangements for safeguarding to all contracts this will further embed the agenda for 2012 and onwards.
- The Designated Nurse has been in post for 12 months and it is now evident that there is insufficient capacity for the current post holder to undertake all aspects of the safeguarding agenda hence in 2012-13 an additional post will be recruited to.

6.4 NHS Community Health Stockport

Following on from last year's Annual Report, the first Safeguarding Adults Progress Report was presented to Community Health Stockport Patient Safety and Governance Committee in December 2011 and subsequently to Community Health Stockport Committee. The format took that of Safeguarding Children's Reports which had been presented regularly to

Committee and began the process of putting reporting structures for Adult Safeguarding on an equal par with the work long embedded in the organisation regarding children's safeguarding. Further Safeguarding Adult Quarterly reports have been produced

Incident Reporting

The organisation's internal on-line incident reporting system which was upgraded in 2010/11 to include the facility to identify safeguarding concerns has continued to improve our ability to understand the involvement our staff have in potential safeguarding adult scenarios. The system enables possible safeguarding incidents to be categorised and reported and the Safeguarding Advisor has a role in monitoring all of these; ensuring incidents do not get missed and identifying trends or particular issues as part of the Quarterly reporting arrangements.

A total of 42 incidents recorded on the electronic Incident Reporting System were related to safeguarding adult concerns. 24 of these (57%) related to incidents occurring with adults resident in care homes. The main reasons for reporting were categorised under:

- Poor standards of care.
- Emotional abuse.
- Patient non compliance.
- Suspected financial abuse/theft.

A Safeguarding Adults Flow chart has been developed and forms part of the revised Community Health Stockport Safeguarding Adults Implementation Policy (March 2012). It clearly demonstrates what staff must do if they have a safeguarding adult concern and incorporates a Manager's Decision Making Tool and Team Around the Person Incident Review and Decision making Support Tool to help practitioners and managers decide whether a concern should be reported made to the Local Authority.

Safeguarding Adults Advisor Role

The role of the Safeguarding Advisor has continued to be embedded during 2011/12 and advice is being sought by the staff from a variety of services. The Safeguarding Advisor helps to ensure staff follow guidelines in a timely and effective way, offering support and advice to staff as required and ensuring that the organisation is compliant with the Multi-Agency approach to managing Safeguarding concerns.

Actions from last year's Annual Report resulted in a Safeguarding Adults Advisor data base being established to record advice given to managers and staff about potential Safeguarding issues. The data base also records information including:

- Has an incident report been completed?
- Summary of Concerns.
- Whether a Decision Making Tool was completed.
- Whether a referral to the Adults Contact Centre was required to instigate Safeguarding Procedures.

The data base is useful for audit purposes as not all concerns are subsequently required to be reported as incidents to the Local Authority

Advice was sought about:

- Mental Capacity issues and patient non-compliance e.g. who to contact for an assessment when Mental Capacity is in question.
- What to do if a person is deemed to have capacity to make decisions, yet is choosing to make decisions that are directly detrimental to their health.
- How to use the decision making tools and what to report through the Local Authority Contact Centre.
- Setting up meetings and agreeing Action Plans with care home managers where there were concerns that were not safeguarding but had the potential to become a safeguarding concern.
- Liaising with the Local Authority Contract Compliance staff.
- Talking through suspected emotional abuse/theft concerns.
- Reflective supervision. Learning lessons from incidents and sharing lessons learned.

Governance and Assurance Framework

The Northwest Safeguarding Standards for Healthcare Providers Framework was introduced in 2011 and Community Health Stockport was assessed as being partially compliant by the Primary Care Trust's Safeguarding Adults Designated Nurse in November 2011. Areas of good practice were identified along with gaps in compliance. An action plan was developed and key areas were addressed:

- The job description of the Safeguarding Adults Advisor was reviewed.
- Community Health Stockport Safeguarding Adults Implementation Policy (CHS 12) was reviewed to include; Resolving Differences of Opinion, Handling Allegations, Allegation of Abuse by a member of staff received or suspected.
- Safer recruitment was implemented. A member of the Human Resource team received training on this and was charged with cascading the learning to managers.

The Action Plan included:

- A review of access to training.

- Clear arrangements for pro-active and reactive supervision of staff involved in Safeguarding, including the Safeguarding Advisor.
- Development of a Single Assessment Process for Health and Social Care. Progress cannot be progressed until an electronic patient record is introduced for Community Health Stockport.

Representation

Community Health Stockport was represented on various multi-agency groups as well as the Safeguarding Board including:
- Safeguarding Adults Implementation Group.
- Safeguarding Training Sub Group.
- North West Regional Safeguarding network.

The Future

From April, Community Health Stockport services for adults and children (services such as district nursing, specialist palliative care, podiatry, physiotherapy, continence, health visiting, school nursing) transfer from Stockport Primary Care Trust to Stockport NHS Foundation Trust. It is the intention that the valuable community work of all these services in safeguard adults will be strengthened going forward in the Foundation Trust as new integrated governance arrangements are established.

Jane Ankrett
Associate Director- Long Term Conditions and Safeguarding Adults Board member.

6.5 Age UK Stockport - Annual Statement

Age UK Stockport is the largest independent charity in Stockport representing, working for and working with older people including carers. The Chief Executive is a member of the Safeguarding Board and there continues to be a strategic member of staff on the Safeguarding Adults Implementation Group and Training Strategy Sub-group. Both act as a representative for Age UK Stockport and also as a representative for the wider voluntary sector.

For the previous four years Age UK Stockport delivered a dedicated Safeguarding Older Adults Project (SOAP), which was initially funded for three years by Comic Relief and then for one year by Stockport Council Adult Social Care. This project enabled focused attention and much learning around its three main strands, prevention, support and recovery.

Unfortunately, due to the financial climate this funding ceased and the project ended in March 2011. Consequently 2011/12 presented new challenges for delivering effective Safeguarding support Every effort has been made to utilise learning and experience with the SOAP project to robustly embed safeguarding into all of Age UK Stockport services, to continue to work to protect older people of Stockport from abuse.

As part of other wider Age UK Stockport organizational changes in April 2011 a new generic team of workers, the Wayfinder team, was created to enable delivery from first contact and to support a more flexible response to people's needs. To ensure the safeguarding is a core part of our work all workers are now trained through specific internal training to be aware and raise awareness, and all 15+, workers within the generic team were trained to be able to identify and support on safeguarding issues. Two senior staff members have been nominated to leading on safeguarding.

New reporting mechanisms have also enabled better recording of issues. Referrals have come from a wide range of sources, with a high number of self-referrals. Whilst the SOAP project was an undoubted loss for 2011/12 the numbers evidence that wide awareness raising has continued and issues effectively identified through this different approach. Numbers are as follows:

Safeguarding Awareness contacts total 5,235

Identifying possible Issues through contacts 53 with the types of abuse as follows:

- Emotional 8
- Financial Bogus Callers 8
- Financial Other 29
- Physical/Sexual 5
- Psychological 3

Provision of practical and emotional support specifically around safeguarding 19

Supporting individual and reporting to appropriate bodies where appropriate 17 as follows:

- Adult Social Care 8
- Police 5
- Bank 4

Of the 53 supported 43 were female and 10 male, the age range was U60 -1

60-69 -6
70-79 -18
80-89 -19
90+ -6
Unknown -3
Geographically people were from across the Borough with highest numbers in Cheadle Hulme, Hazel Grove and Offerton.

Events: A key activity of the SOAP Project was **events** focused on safeguarding awareness and this has not been possible to carry on without specific funding. However small grant applications regularly submitted to external funders to try and secure funding to enable some focused events in the coming year and it will also form a part of future events for Age UK Stockport.

6.6 Signpost Stockport for Carers

Carers and Safeguarding Adults

Signpost Stockport for Carers is an independent local charity which aims to raise the profile of carers in Stockport, encouraging a wider recognition of their contribution to society and providing information and support which will assist carers in their caring roles and enable them to fulfil their own needs as individuals.

The Director is a member of the Safeguarding Adults Board, acting as both a representative for Signpost Stockport for Carers and also as a representative for the wider voluntary sector in Stockport.

Signpost Stockport for Carers, a network member of the Princess Royal Trust for Carers, supports and promotes the guidance published by the Association of Directors of Adult Social Services in July 2011 on how to protect carers from abuse and neglect, and also how to prevent cases where the carer is overloaded which can result in the carer themselves abusing or neglecting the person needing care. This guidance had its origins in a presentation from a Carers' Centre CEO and then Carers' Centre feedback at The Princess Royal Trust for Carers Network Conference 2010.

The guidance focuses on safeguarding scenarios which feature abuse, neglect or isolation, including:

- Carers speaking up about abuse or neglect within the community or within different care settings.

- Carers who may experience intentional or unintentional harm from the person they are trying to support or from professionals and organisations they are in contact with.

- Carers who may unintentionally or intentionally harm or neglect the person they support.

There are four main reasons why carers won't report abuse or neglect:

- Organisational and staff attitudes to concerns – can be defensive rather than responsive.

- Lack of someone to talk to or lack of a source of trusted advice and support.

- Worries about the impact on the care of the person supported.

- Fear of social services involvement and unwanted care alternatives.

The following factors can increase the risk of abuse where carers

- have unmet or unrecognised needs of their own;

- are themselves vulnerable;

- have little insight or understanding of the vulnerable person's condition or needs;

- have unwillingly had to change their lifestyle;

- are not receiving practical and/or emotional support from other family members;

- are feeling emotionally and socially isolated, undervalued or stigmatised;

- have frequently requested help but problems have not been solved;

- feel unappreciated by the vulnerable person or exploited by relatives or services.

The Social Care Institute for Excellence (SCIE) also advises that financial difficulties, issues of who manages finances, whether there is a lasting power of attorney and long standing relationship difficulties can also increase risk of abuse.

What can health and social care professionals do?

A central concern is that sometimes professionals place 'undue confidence in the capacity of families to care effectively and safely'. Effectively, health and social services should be more aware that they should not automatically rely on families to provide care because if carers are unsupported or put under significant stress it can increase the chances of the carer or cared for suffering abuse, neglect or isolation.

The ADASS guidance advises that there should be 'no assumptions about caring capacity or willingness' and the recommendations include:

1. Social services should evaluate how carers are included in care assessments and planning and how their role supporting the cared for is supported; whole family working should be encouraged.

2. Carers should have access to information, advice and advocacy that is understandable and empowers them to share concerns and change harmful circumstances.

3. Carers should be able to share their concerns regarding the risk of abuse and neglect without fear of automatic referral for adult protection or risk of removal of the supported person.

4. Safeguarding Adults Boards should ensure their policies, procedures and practice recognise the need to support carers and also to work with carers who are experiencing or causing harm or abuse.

5. Safeguarding Adult Boards should engage with carers and local stakeholders and work together for better safeguarding practice.

6. Local strategies should address the need to prevent and/or reduce the stress imposed on carers providing substantial care for someone with dementia with whom they live.

7. Local strategies should include steps to reduce carer anxiety and depression.

How are we implementing this guidance in Stockport?

- Signpost Stockport for Carers is working closely with Stockport Council to grow capacity for self-protection of carers and to improve choice and control for carers as well as ensuring that carers can access a comprehensive range of information and advocacy services.

- ADASS recognises that some carers do not want statutory agencies involved but accepting this can impact upon ability to prevent harm. Signpost Stockport for Carers, as an independent carers' charity, is often able to reach families statutory agencies cannot.

- Signpost Stockport for Carers is working with Stockport Council's Carer Social Work Team to ensure that when a cared for is being assessed, the level of needs being met by the carer are recorded as well as the needs being met by social services. If the level of need is recorded only after considering what the carer is contributing, this may lead to inaccurate records of how much care carers are providing or even if there is a carer involved. This puts carers at an increased risk of becoming overburdened which, in turn, increases the risk of abuse, neglect or isolation.

- ADASS have made it clear that lack of support for carers is a safeguarding issue and that, nationally, Adult Safeguarding Boards should be engaging local carers' organisations. In Stockport, carers have been directly represented on the Adult Safeguarding Board since 2010.

Mendie De Vos – Chief Executive, Signpost Stockport for Carers

6.7 Pennine Care NHS Foundation Trust

Summary of Safeguarding Adults Annual Report 2011/12

The following report provides a summary of the work completed by the Trust during the previous 12 months and proposals for developing further the protection of vulnerable adults for 2012/13.

- In 2011 the Trust merged with community health service providers and one of the most important tasks of the Trusts Safeguarding Adults Group was to harmonise existing polices and raise awareness amongst staff regarding 'Adult Abuse'.

- In October 20121 the Trust appointed a new lead for Adult and Child Safeguarding.

- The Trust has supplied a pocket size information leaflet for community staff which was distributed with staff payslips. This pocket size leaflet includes information of what constitutes abuse, what staff should do if they are aware or suspect abuse and how to gain more information. All trust staff continue to have 24 hour access to the Safeguarding Adults Trust website where staff can access Trust policies, guidelines, procedures and a variety of information in relation to Safeguarding Adults. This website includes issues concerning domestic violence, as well as how to access Local policies, procedures and access to Local Authority alerts/notifications.

- Each borough has a designated representative who is a senior manager within the organisation attending each local borough partnership meeting. This representative also attends the Trust Safeguarding adults group.

- All newly appointed staff attend the Trust Corporate Induction which includes, level one basic awareness training in Safeguarding Adults.

- The personalised e-learning package (level 2) in Safeguarding Adults is now available to all staff across the organisation with the intention of ensuring that community health staff who have face to face contact with service users or those who provide supervision to staff who have face to face clinical contact have received this training by April 2012.

- In addition to the information from incidents reported regarding Adult protection on the Trusts electronic incident reporting system, all Safeguarding Adults Incidents will have a completed Team Investigation Report which is reviewed by the weekly Patient Safety Improvement Group. Lessons learned will be discussed and shared at the Trust Safeguarding Adults Group and Divisional Integrated Governance Groups.

- The Trusts Safeguarding Adults group continues to meet on a bi monthly basis and continues to monitor progress against the National standards.

- The Trust Care Programme Approach risk assessment documentation includes prompts for staff in relation to service user's vulnerability which would support staff to consider preventative measures to protect vulnerable adults.

- People who are known to pose a risk to others in receipt of services from Pennine Care are the subject of a plan drawn up under the Multi Agency Protection Panel Arrangements (MAPPA).

The trust Safeguarding Adults Policy now includes details concerning pressure ulcers and the triggers required to decide on whether a pressure ulcer is a safeguarding concern.

The Trust has robust systems in relation to recruitment and selection screening of staff and volunteers and ensuring that the necessary checks are completed on all newly appointed staff such as CRB and professional registration.

In addition the Trust has included within job descriptions the roles and responsibilities of staff in relation to Safeguarding Adults.

We have also been working with the Care Quality Commission to address the recording of capacity discussions for detained patients and this has been monitored closely by the Trust Mental Health Law Scrutiny Group. MCA and DOLS issues are discussed at the local Mental Health Law Forums on a bi-monthly basis with escalation to the Trust lead where necessary.
The Trust continues to monitor key performance indicators for Harm Free Care through our quality governance forums and has shown a significant reduction in the number of falls in the last twelve months.

Conclusion and Future Priorities

The Trust will continue to raise the awareness with staff members for Safeguarding Adults especially with the transfer of community health services ensuring that this remains a standing agenda item within governance meetings.

Training in Safeguarding Adults will continue to be progressed and monitored to ensure that the Trust meets the required Care Quality Commission standard. However it has been recognised that for Safeguarding Adults Managers training there is a variance of availability of training within each of the boroughs. This has been highlighted to the partnership board meetings. Level 3 training will be a focus for consideration (or delivery) in the next 12 months.

Monitoring of incidents, trends and themes will be progressed to review the level of reporting throughout the organisation and in relation to referrals to Local Authority Safeguarding Adult teams with the ultimate aim of improving safety and quality for all service users and their carers.
The Trusts Quality Group will be focusing on improving the patient experience of health care and protecting them from harm with specific goals for falls prevention, urinary tract infections following catheterisation, reduction in pressure ulcers and venous thrombo-embolisms.

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7. Future Business

As advised in last year's report the Safeguarding Board and Implementation Group members held a planning day on 16 June 2011. This event was well attended highly stimulating and very productive. We utilised material made available from the Association of Directors of Social Services (ADASS), the Safeguarding Boards Self-assessment tool produced by SSIA.

A business plan for 2012/14 has been prepared and was at the Board meeting in June 2012. It is available to view at:

www.stockport.gov.uk/safeguardingadults

Appendix 1
Board Membership as at 31 March 2012

Mendie De Vos Director Signpost Stockport for Carers	David Mellor Independent Chair	Jane Ankrett Associate Director NHS Community Health Stockport
Margaret Brade Chief Executive, Age UK Stockport	Nicola Firth Deputy Director of Nursing Stockport NHS Foundation Trust	Karen Maneely Locality Manager Pennine Care NHS Foundation Trust
Joan Beresford Head of Service, Older People's Services Stockport Adult Social Care	Ann Brooking Staff Development Stockport Adult Social Care	Sue Gaskell Designated Nurse for Safeguarding NHS Stockport
Andrew Armstrong Safeguarding Adults Manager Stockport Adult Social Care	Alison Fletcher Superintendent Greater Manchester Police	Terry Dafter Director Stockport Adult Social Care
Steve Brown Manager Stockport Community Safety Unit	Jax Effiong Greater Manchester Fire and Rescue	Bridie Meehan Owner Quality Care of Cheadle
Caron Ratcliffe Manager Apex Nursing Care	Janet Beer Head of Disability Services Stockport Adult Social care	

Appendix 2
Implementation Group Membership as at 31 March 2012

Stella Clare Commissioning and Contracts Manager Stockport Adult Social Care	David Mellor Independent Chair	Sarah Statham Supporting People Service Stockport Adult Social Care
Mike Cross Police Constable Greater Manchester Police	Ann Brooking Staff Development Officer Stockport Adult Social Care	John Abbott Team Manager Pennine Care NHS Foundation Trust
Lucie Newsam Facilitating Independent Life and Lifestyles Age UK Stockport	Trisha Wood Service Manager Disability Services Stockport Adult Social Care	Carol Moore Safeguarding Lead Nurse Stockport NHS Foundation Trust
Andrew Armstrong Safeguarding Adults Manager Stockport Adult Social Care	Pat Odell Team Manager Older People's Services Stockport Adult Social Care	Elaine Morton Team Manager Individual Solutions SK
Susie Meehan Safeguarding Adults/DoLs Coordinator Stockport Adult Social Care	Sam Dwyer Accommodation Manager Stockport Learning Disability Partnership	Adele Summers Safeguarding Adults/DoLs Coordinator Stockport Adult Social Care