2015

STOCKPORT SAFEGUARDING ADULTS BOARD ANNUAL REPORT

REPORT ON ACTIVITY AND PROGRESS 2014 /2015

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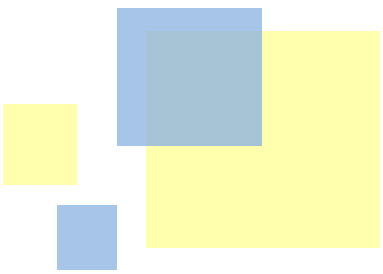


SECTION ONE

CHAIRS COMMENTS & FORWARD

The safeguarding adult's board is a partnership consisting of all the organisations with a responsibility for safeguarding adults including Stockport Council, the NHS, Greater Manchester Police and many organisations operating in the private, voluntary and independent sectors.

The reason we need to safeguard adults is because some adults are unable to protect themselves from abuse or neglect. Abuse can take many forms such as physical, sexual or financial and neglect includes poor care in a care home, hospital or in one's own home.

The reason the safeguarding adults board exists is to ensure that organisations work together to prevent neglect and abuse happening or stop it when it has taken place.

The simply stated, but hard to achieve, vision of the safeguarding adults board is that all adults living in Stockport are able to exercise their right to live in safety, free from abuse or neglect.

As I have reported in previous annual reports, the safeguarding adults board in Stockport has been unable to achieve all it needs to achieve because only one of the partner organisations I mention above – Stockport Council – has been prepared to provide funding to the Board. Other partner organisations have provided "in-kind" support in the form of valuable time of key people to chair sub groups or deliver training for example.

However everything is changing from 1st April 2015. The Care Act 2014 comes into force on that day and one of the changes the Act makes is to put safeguarding adult's boards across England and Wales on a statutory footing. This means that the case for properly funding the work of safeguarding adult's boards is much stronger and I am delighted that NHS Stockport Clinical Commissioning Group, which is responsible for local health services, and Stockport NHS Foundation Trust which runs Stepping Hill Hospital and community health services have both been able to provide funding for the partnership. This is an important step in

the right direction but I call upon the Police and Crime Commissioner for Greater Manchester to ensure that all safeguarding adults' boards across Greater Manchester receive an appropriate funding contribution from the police service - which the Care Act rightly identifies as a core partner in safeguarding adults.

The Care Act also requires safeguarding adults boards to set out the objectives it intends to achieve in an annual strategic plan. The board's first strategic plan is shown later in this report. However the focus of this annual report is on the year just gone by. And so you can read about progress achieved against our 2014/15 plan in section 2 of this annual report.

Given the lack of dedicated resources to support the partnership and the huge financial impact on Stockport Council of the Supreme Court Judgement on Deprivation of Liberty Safeguards,(DoLS) satisfactory progress has been made.

Deprivation of Liberty Safeguards are of the utmost importance. They help to ensure that people in care homes, hospitals and supported living do not have their freedom unnecessarily or inappropriately restricted. However the Supreme Court judgement considerably widened the application of DoLS and the effect in Stockport has been a 20 fold increase in applications to the Council as the local supervisory body.

Reflecting on progress achieved, it is particularly pleasing to see the introduction of a much more robust process for referring cases and deciding whether to conduct a Safeguarding Adults Review. Safeguarding Adults Reviews are required if an adult has died or suffered serious abuse or neglect and there is concerns that partner organisations could have worked more effectively to protect that adult. The purpose of a Safeguarding Adult s Reviews is to identify lessons in order to improve practice.

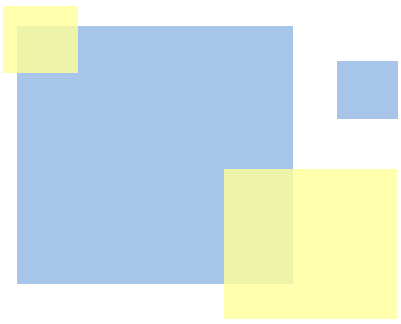
It is also pleasing to note the Stockport Council and Equity Housing "housing with care" development for up to 25 people with learning disabilities which will reduce the need to place people outside the borough. This is a very positive response to the challenges arising from an earlier Safeguarding Adults Review (then called Serious Case Reviews) into abuse of adults with learning disabilities at Winterbourne View Hospital.

I hope it will continue to be possible for the safeguarding adult's board to work closely with the safeguarding children board. A joint development day took place in October 2014 and generated a lot of ideas for helping to improve the transition to adulthood for our most vulnerable young people.

I am stepping down as independent chair of the safeguarding adults board in September 2015. It has been a privilege to serve in this role although it has been frustrating to try and lead such an important strategic partnership with such limited resources. However the injection of resources I mentioned above – which should only be seen as a down payment – should enable the safeguarding adults board to build on progress achieved with greater momentum and confidence in the future.

David Mellor

Independent Chair



SECTION 2 – BUSINESS PLAN PROGRESS

The Stockport safeguarding Adults Board (SSAB) set out 13 key objectives for progression during the course of the year, with a view to ensuring a robust safeguarding response for adults at risk living in the borough. The following sets out progress against each objective;

2.1 SSAB partners commit to ensuring that the Board is supported by dedicated resources by 31st March 2015

The Board support activity and costs are largely under written by Stockport Metropolitan Borough Council Adult Social Care. It has been acknowledged a more robust funding and resource structure is needed to enable the Board to fully perform its functions. The SSAB continued throughout the year to address funding needs with non-contributing partners. This included confirming the commitment of each partner as per the business case.

There have been planning meetings which have considered how the SSAB will commit resources in the future and the Board has been updated at each meeting. In terms of funding partners have committed as follows;

- Stockport Foundation Trust has committed £4000 per annum to support activity
- Stockport Clinical Commissioning Group has committed £8000 per annum to contribute to funding Board activity
- SMBC has reorganised its Safeguarding and Quality Service and Quality Team to support the Board and in addition agreed;
  - To commit £40,000 for one year to fund a Board administrator post
  - Utilise £750k awarded for DOLS activity to help alleviate the pressures on the Safeguarding team and to enable it to refocus on safeguarding strategy implementation.

* Partners are also committing time as a resource for example in the form of chairing or involving sub group activities

2.2 SSAB partners commit to ensuring that adequate governance arrangements are in place in respect of the Board by 31st March 2015 and that the SSAB has in place all the requirements of the Care Act 2015

An action plan has been developed setting out each requirement of the Care Act and a plan in place to address each area. The working plan is attached at Appendix A

The SSAB has been monitoring the effectiveness of the plan and the intention is for the Safeguarding Adults Implementation Group (SAIG) to oversee and ensure its implementation.

An aim for 2015 /2016 is for the Board to ensure that it is updated annually on the progress with regards to implementation.

2.3 The SSAB will continue to develop performance monitoring and audit capability by establishing and supporting a Quality Assurance and Performance Management Sub Group.

The Sub Group was formed and has begun to progress work and create a system for providing performance reports. These are based on current activity and the data is established from the Councils client database carefirst. A time focussed Sub group chaired by the SSAB Independent Chair has met to consider how partner's adherence to the policy and procedures can be monitored and explore how partners are held to account.

The Board was updated in December 2014 of progress and it was noted more Board members need to commit to developing this agenda. A terms of reference agreement also followed. A further update on the development of a performance monitoring framework is included at section 3 under stakeholder updates / sub group (section 3.7).

A new process for electronically recording Deprivation of Safeguarding work is also being developed.

2.4 The SSAB will closely scrutinise the application of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DOLS). In particular the SSAB will monitor the action plan adopted by Stockport Council to address the implications of the Supreme Court judgement

The Board received updates throughout the year on the impact of the Supreme Court judgement with regards to DOLs and the detail of this is evaluated at Section 3.5.

2.5 *The SSAB will ensure that there is a robust system in place for notifying all cases to the Board which may meet the criteria for conducting a Safeguarding Adult Case Review. The SSAB will ensure that there is a process for deciding whether or not to conduct an SCR or other form of case review*.

A time focussed sub group met to develop a protocol and process for ensuring the SSAB is able to consider situations where the criteria for such reviews are triggered.

The protocol that the SSAB has agreed is attached at Appendix B and the Board agreed to delegate its decision making, with regards to progressing any cases, to this sub group. Dates have now been set up for the 2015 / 2016 financial year and the meetings will be initially chaired by a ASC Head of Service.

A pilot panel met in December 2014 to discuss six cases against the Care Act statutory guidance criteria and this resulted in two anonymised cases being forwarded to the Board for consideration. In both cases it was agreed learning had already been evidenced as part of the safeguarding process and there was no need to commission further review.

In addition ASC has amended its safeguarding administrative systems to ensure Inquiry Chair persons have the opportunity to highlight cases where they feel consideration should be given to a Serious Adult Review

The SSAB has agreed to pilot the approach for 12 months where upon its effectiveness will be reviewed in 2016. A key role for the Board administrator will be to support the administrative process required to ensure that the sub group is able to consider the data and information available.

2. 6 The SSAB will ensure that all partners sign up to and comply with the Stockport All-Agency Safeguarding Adults Policy.

Negotiations with the Pennine Care NHS Foundation Trust (PCFT)with regards to the Inquiry Officer role within the policy were on-going throughout the year. The principles of the policy have been agreed at senior manager level within the organisation and PCFT provided an update on the position at the December 2014 Board meeting.

The Trust is now undertaking inquiries on behalf of the Board in independent hospital settings and a protocol to agree responsibilities is in the process of being finalised.

All partners are complying with the requirements of the policy which will need to be updated as part of the 2015/ 2016 strategic business plan.

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2.7 The SSAB will prioritise the work of the Communications sub group -raising awareness of the safeguarding adults agenda remains a high priority.

A Communications Sub group was formed and chaired by SSAB members from the Stockport Clinical Commissioning Group and Stockport Signpost for carers. This sub

group has been working to identify the resources required to implement the action plan in order that the SSAB can strengthen its profile locally,.

It is noted that this group will require access to financial resources to further publicise Board activities and develop a more recognisable profile.

Greater Manchester Fire & Rescue Service has continued to raise awareness of fire safety as part of their preventative agenda and report back to the SSAB as appropriate.

2.8 The SSAB will monitor the implementation of the Winterbourne View action plan to ensure that safeguarding is at the heart of the new arrangements for the care of people with learning disabilities

The Board set a requirement to receive regular updates on the action plan twice yearly

Phase 1 of action plan is now in place and phase 2 will be in place by April 2015. Out of borough placements continue to be an issue, and strategies are in place to conduct out of borough reviews. The Action Plan is attached at Appendix C.

In addition the council in partnership with Equity Housing, has developed a new housing with care development for people with learning disabilities. The services consists of 25 self-contained apartments with staff on site 24 hours per day. Six of the flats have been identified as short term assessment units and the Better Care Funded has contributed to the financial viability of this service (£0.5million) which will reduce the potential for people needing to receive non forensic services out of borough.

The government has commissioned Community Treatment Reviews for all people with a learning disability, autism and mental illness living in secure accommodation. Stockport MBC, CCG and Pennine Foundation trust meet regularly to discuss support plans for those in secure accommodation and who are ordinarily resident in Stockport. Whilst the number of fluid this equates to six people at the end of March 2015.

2.9 The SSAB will monitor progress following sign up to the "Making Safeguarding Personal" Programme which aims to achieve a shift from a professionally led, process driven approach to a person-centred, outcome focussed approach.

The revised Multi agency policy implemented at the start of 2014 revised procedures to ensure that people are involved in the decision making process. For example at case conference stage this has been separated into a `Part A' and `Part B' approach to ensure individuals and / or the advocates can attend meetings and fully contribute.

Officers from the Council have attended events in Birmingham in August 2014 and a follow up event in Manchester in December 2014.

An action plan linked to a new harm level model has also been developed and the intention is to present this to the SSAB in the summer of 2015.

The SSSAAB agreed that the action plan would be monitored by the SAIG and any concerns highlighted to SSAB.

The Multi agency policy will need further revision to fully address the MSP principles and this will be a focus for 2015 /2016.

2.10 The SSAB will monitor the impact of personalisation on safeguarding by scrutinising a report annually.

During the course of the year 39 people were subject to a safeguarding referral whilst they had an active direct payment. Of this two people were subject to inquiries relating to financial abuse which represents approximately 0.4% of the total number of referrals proceeding to inquiry.

An example of one personalised approach impacting on safeguarding considerations can be illustrated through the following brief case study.

One of the two cases referred to above involved a person employed as a Personal Assistant via a Direct Payment and who was previously given a prison sentence for fraud against a vulnerable adult (in 2011). The risks associated with this were discussed with the Police and a risk assessment was completed and which will progress to a risk panel hearing. The persons mental capacity to understand the risk balanced with the Local Authority's duty of care to protect the individual, will be central to progressing.

SMBC has amended its recording data to enable Inquiry chair person's to record such events and so as to ensure the impact can be monitored.

2.11 The SSAB will support the continued development of the Multi-Agency Adults at Risk System (MAARS) and will monitor the outcomes achieved

- *Since* May 2013, the MAARS (Multi Agency Adults at Risk System) process has been piloting a single referral point for partner agencies to register concerns about adults at risk or who are vulnerable. Cases of adults at risk continue to increase and are placing disproportionate pressure on Adult Social Care, Community Safety, the police and fire services, health and homelessness services. Furthermore there is increasing concern about the numbers of calls concerning vulnerability received at the Contact Centre and

Social Work teams are dealing with unprecedented levels of complex vulnerability.

- In addition to this has been the need to work in a more proactive way to tighten up the interface and working arrangements for looked after children (LAC) making transition who have additional needs/ vulnerabilities alongside that LAC with disabilities. LAC colleagues have agreed the referral pathway via adults contact centre for screening/ referral to determine whether criteria met for an adult's assessment. However not all LAC referred to the adult contact centre will meet criteria for Learning Disabilities (LD) and often these young people's needs are rooted in vulnerability rather than disability. Currently these cases are refused by LD service and increasingly these cases are referred to MAARS as the safety net to flag up with colleagues to explore a collaborative approach in the best interests of these young people. In the future these cases will be referred to MAARS at the age of 17.

- Through the MAARS pilot there has been an aim to achieve an improved collaborative response to the most vulnerable and disengaged in the community. Many of these vulnerable people are known to several agencies and MAARS aims to ensure that the individual is understood in the context of the knowledge and expertise held by each relevant agency. The legitimate sharing of information is essential and it enables each agency to better target support, reinforce the aims of other professionals and to reiterate a consistent message to the individual, which reinforces both individual agency outcomes and those of MAARS. Each case is underpinned with intensive Supporting People funded housing support to stabilise or establish a home environment and to prevent or resolve homelessness. The MAARS process utilises the Supporting People referral infrastructure and in one year 57 referrals were made, all on the basis of risk.

- Upto June 2014 the Board considered the following data;

  Throughput to MAARS is 56 cases in one calendar year. Of these:

  - 96% of these cases are known to the Police
  - 24% Anti-Social behaviour
  - 34% vulnerable and targeted by others
  - 64% drugs and alcohol
  - 22% threatened with homelessness
  - 10% sleeping rough
  - 60% mental health issues
  - 12% Care leavers

  - Key high level outcomes from this proposal are

  - Increased numbers living independent lives without support, or with minimum non statutory support
  - Better access to services – housing support could provide link to employment support and health services;

- A reduction in social isolation and improved community inclusion;

- A range of housing solutions and support to access those which are the best match for the individual/family based on natural available support assets, positive community engagement and sustained employment
- Improved living environments which reduce known risks and increase personal resilience.

- A great deal of learning has taken place in the last two years and has contributed to a better understanding of what currently limits the ability to respond appropriately. For instance, individuals can be in contact with several unconnected services at any one time. Previously there have been cases where services are working without ensuring that compatible support outcomes are being identified. This has been considerably improved by MAARS.

- The MAARS evaluation data needs to be considered by the Board at least annually and this should be an agenda item for the 2015 /16 financial year. has actually been considered by the Board

2.12 The *SSAB will work closely with Stockport Safeguarding Children Board (SSCB) on issues of mutual concern.*

A joint development day between SSAB and SSCB was held in October 2014 and a joint programme of work was developed thereafter.

This resulted in a bid being made for a central f=government grant to support safeguarding and transition work.

The aim during 2015 / 2016 will be to bring together the administrative support elements of operating both the Children's and Adults Boards which are chaired by one Independent Chair.

Update to be provided on joint programme of work to SSAB

2.13 SSAB to monitor implementation of training strategy.

An Annual training strategy and report was presented to the Implementation Group and electronically to the SSAB

Maintaining the high volume of free training has been challenging during the course of the year as a consequence of staff reductions and key stakeholders moving posts etc.

Updates relating to the impact of training are at section 3.7

2.2 – The Strategic Plan for the years 2015 – 2017 is attached at Appendix E

2.3 – The updated Terms of Reference for the Board are attached at Appendix F

SECTION 3 - Stockport Safeguarding Adults Members Report/Annual Statements

Each SSAB member is required to complete an update on progress with regards to safeguarding and as follows;

3.1 Independent Sector-

3.1.1 ***Independent Options -*** *Learning Disabilities –*

Independent Options primarily provides the following services to people with a learning disability;

* Home support

* Supported housing

* Short breaks service

* Operates the shared lives scheme

* Various activities to enable people to access the community

a) *The Adult Safeguarding focus throughout 2014/15 has included;*

- Reviewing and updating the Adult Safeguarding Policy and procedure in line with Stockport's policy.
- The company has now included a section on the manager's operational report for safeguarding concerns.
- Completed DoLS referrals for the Short Breaks Service.
- Continued to have a rolling staff training programme and ensuing that all staff has their refresher training on time.

b) Organisational achievements have included;

- Safeguarding training remaining a high priory for the company's staff.

- A service user document called ‘Keeping Safe’ developed by a Service User Sub Committee group has been given to all service users.
- This document has been included in the IO Safeguarding policy and procedure.

c*) Internal governance and quality arrangements for safeguarding have considered;*

- The inclusion of a section in the Board of Trustees meeting called Compliance where the company would report and discuss any safeguarding issues.
- the internal quality assurance system includes a section on safeguarding and outcomes of any issues

d) *Key areas of challenge the organisation sees going forward for 2015/16 are;*

- Reviewing and updating the Mental Capacity Policy in relation to DoLs.
- Making DoLs referrals for the Supported Living and Shared Lives services.
- Training session for the Shared Lives carers

e) *Training activity is as follows;*

- Number of Employees **119**
- Number of front line staff **93**
- Front Line Staff received safeguarding training **86**
- Number of Supervising staff **17**
- Number of Supervising staff who have received training **17**
- Total number of staff training **110**
- All staff are targeted for training however the company is targeting the Shared Lives Carers.
- Independent Options uses Stockport Staff Development service for all safeguarding training.
- Discussion in team meetings with staff about when and how to make safeguarding alert.
- In house MCA and DoLS training by a manager trained by Stockport Development team.

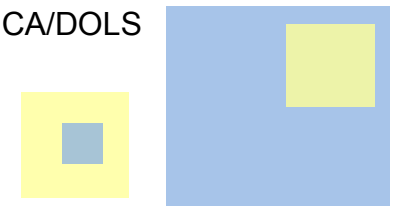
3.1.2 – Independent Home care sector update

To follow

3.2 Stockport NHS Foundation Trust

a) National & Local Developments in respect to Safeguarding adults have included;

- Impact of the Supreme Court Judgement in respect of MCA / DOLS on ward operations
- Actions identified by Internal Audit (MIAA) -***Significant assurance received***
- Appointment of Safeguarding Specialist Nurse with focus on MCA/DOLS



b) Developments post Winterbourne View
Has involved the adoption and achievement of Greater Manchester CQUIN to improve the experience of Adults with Learning Disabilities

c) The Adult Safeguarding focus of the organisation throughout 2014/15 involved;

- Training staff in Adult Safeguarding responsibilities and MCA and DoLS
- Reviewed and revised internal governance framework and revised assurance process with CCG designated Nurses

d) The FT has made the following progress in respect of Safeguarding Adults throughout 2014/5.

- At the end of March 2015 the position was as follows in terms of training compliance;
- MCA / DOLS trained staff = 47% (a significant improvement from 4% mid last year)
- Adult Safeguarding Level 2 trained staff = 82.4%
- Securing funding for and appointment of Safeguarding Specialist Nurse
- Adoption and achievement of Greater Manchester CQUIN to improve the experience adults with Learning Disabilities

e) Governance arrangements are embedded within the attached;

Safeguarding Governance Process.

f) The key areas of challenge going forward for 2015/16 include;

- Training continues to challenge some areas
- Compliance with MCA and DoLS – liaison with Supervisory Body
- Impact of Care Act 2014 yet to be assessed

g) Internal training/information sharing delivered in respect of Safeguarding Adults, MCA &DoLS

- All staff receive basic awareness at induction
- Clinical staff receive MCA and DoLS and Safeguarding Adults Level 2 and both of these subjects are considered as Essentials Training (mandatory)

- As at 31.03.2015 the Trust had a total of 5729 staff - clinical 4017 and non-clinical 1712
- To date of the clinical staff, 82.4% are up to date with their adult level 2 safeguarding training. This is a mandatory requirement that must be fulfilled every three years therefore this is a rolling figure that is monitored each month.
- All clinical staff receive training
- As described above the Trust measures this training as a percentage of staff who need to be compliant in a three year rolling programme.
- Level 2 Adults - 817 (82.4%)
- MCA & Dols – 856 (47%)
- KWANGO – 146 – the Trust stopped using Kwango in June 2015 and moved across to e-learning on our systems however we do encourage face to face learning rather than e-learning
- All clinical staff at L2 and face to face and e-learning

- L1 – Induction – all staff
- L2 – alerter
- L3 – referrer

3.3 **Pennine NHS Foundation Trust (PCFT)**

a*) National & Local Developments for Pennine Care NHS Foundation Trust (PCFT) in respect to Safeguarding adults have included;*

* PCFT has undergone a restructuring process of safeguarding roles within the organisation to include a Named Nurse Adults and Children (mental health) for Stockport and Tameside.

* Recruitment of an Adult Safeguarding Specialist Practitioner for Stockport and Tameside.

* Development of a Safety Improvement Strategy group encompassing 4 patient safety domains with a 3 year plan that proactively seeks to learn from care delivered to patients by systematically reviewing care following investigations of incidents, complaints, and claims.

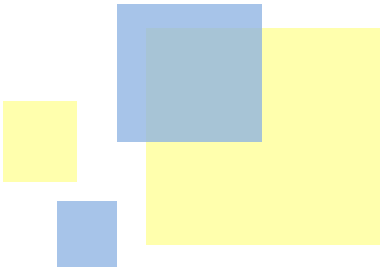
* Lessons learned are shared by disseminating information through to the various Trust sub committees, the local borough Clinical Business Units, and via the internal governance structures.

This Safety Improvement Plan builds on the Trust's Quality Strategy to improve patient safety and patient experience thus adhering to the safeguarding agenda.

- The Quality Strategy commits Pennine Care NHS Foundation Trust to improve the quality of patient care that is delivered to our service users, ensuring that it is safe, effective, and patient centred.

- Establishment of the following Trust sub-committees that will have responsibility within the 4 patient safety domains:

- Inpatient Falls Prevention Group
- Pressure Ulcer Strategy Group
- Tier 4 Group; Trust wide community mental health teams
- Acute Care Forum
- Safeguarding Adult Forum
- Drugs and Therapeutic Committee



b) Developments post Francis Report

Following publication of the Francis Report, PCFT developed a comprehensive report and action plan to address things the Trust do well and to identify areas for improvement.

There have been many developments with an emphasis on improving outcomes for patients some of which are: -

- Safer staffing
- Modern matron allocated to all inpatient areas
- A number of 6 Cs events within Stockport services involving service users and staff
- Compassionate Care Strategy developed
- Clear & measurable goals for next 5 years
- Nursing Conference with an attendance of 300 and, 2000 staff engaged
- New Nursing and Allied Health Practitioner forums commenced March 2015 agenda items include; revalidation of nurses and of HCP staff, preparation for FCC implementation for all support and health care workers supported by Organisation Learning and Development
- Duty of Candour embedded within Trust Safeguard reporting system
- Whistleblowing Policy reviewed and developed to ensure it meets the requirements of the Duty of Candour.
- Divisional Business Units reporting on post Francis Action plan to Executive Board Lead
- Review of supervision arrangements across PCFT mental health and learning disability services.

c) Developments post Winter Bourne Review.

Monthly MCA and Dols sessions are delivered to qualified Mental Health staff across PCFT and are required to have three yearly updates.

PCFT have been active members of Stockport's Winterbourne View sub group.

*d) Care Act 2014.*Updates include;

- Restructure of safeguarding roles within the organisation to include a Named Nurse for MH Child and adult safeguarding for Stockport and Tameside.
- Appointment of Adult Safeguarding Practitioner for Stockport.
- Attendance at local operational sub groups
- Plans for case file reviews to ensure the Care Act principles embedded in practice.
- Plans are in place for the delivery of face to face Level 2 Adult safeguarding including PREVENT Safeguarding training for Q3 2015

e) The Adult Safeguarding focus of the organisation throughout 2014/15

Plans for neighbourhood model implementation and focus on borough specific forums.

A significant number of developments are described above which followed the Francis report.

f) SSAB engagement

The following named managers have been identified as attend Adult Safeguarding Board meetings;

Jackie Stewart (JS)-Service Director

Dil Jauffur (DJ)-Directorate Manager

Catriona Harley (CH Specialist Safeguarding Adult Practitioner)

Board-DJ or JS

Implementation Group-CH

Training-CH
Audit, Quality & Performance Group-CH

g*) The progress your organisation has made in respect of Safeguarding Adults throughout 2014/5.*

- Steady increase in training compliance with e-learning Adult Safeguarding
- PREVENT training being delivered as an additional aspect to courses within the PCFT training dept. where possible.
- Adult safeguarding practitioners and Named Nurses have completed Train the Trainer PREVENT.
- Delivery of MCA and DOLs training.
- Revised Safeguarding structure
- Posters and increased visits to ward staff promoting safeguarding agenda and being an advisory, point of contact. Increased presence on wards and within teams.

h) PCFT organisational achievements in respect of safeguarding adults.

- Appointment of an adult safeguarding practitioner.
- Revised adult safeguarding policy
- L1 Safeguarding Adult training achieved 74.3%
- PREVENT Training delivered to 60.9% workforce
- Plans to develop a L2 adult safeguarding training
- Channel Panel arrangements agreed
- Review of supervision arrangements across mental health services

i) Internal governance and quality arrangements for safeguarding have been over 2014/15

- Safeguarding Adults Group
- SUI internal and external Safeguard reporting system
- Patient Safety Investigation Group
- Integrated Governance groups across all business units.
- PCFT Trust Quality Group

j) Key areas of challenge you see as an organisation going forward for 2015/16

Service transformation and redesign for Stockport community services as part of on-going efficiency management.

k) What internal training/information sharing have you delivered in respect of Safeguarding Adults, MCA & DoLS

Stockport figures March 2015;

Adult Safeguarding Level 1 e-learning	74.3%
Prevent	60.9%

3.4 Stockport Clinical Commissioning Group

a) National & Local Developments for your organisation in respect to Safeguarding adults.

- MCA and DoLS
- Implementation Of Do Not Attempt Cardio Pulmonary Resuscitation
- Serious Incident Framework

Local Developments

- Threshold Task and Finish Group
- Pressure Ulcer reduction in Stockport (PURIS)

MCA and DoLS compliance and reporting for Providers

b) Developments post Frances report

This is a key thread throughout the CCG and is monitored through various work groups and the Quality and Provider Management Committee (QPMC)

c) Developments post Winter Bourne View.

- The CCG works jointly with SMBC to complete the Self-assessment tool and improve service delivery

- The CCG monitors the Learning Disability CQUIN

- The CCG has also reviewing all out of area placement and worked jointly with SMBC to bring service users closer where appropriate

d) Care Act 2014.

CCG have briefed the organisation on the care act on and are scoping the requirement for the CCG

e) The Adult Safeguarding focus of your organisation throughout 2014/15.

- To ensure that the providers from which services are commissioned, deliver a safe system that safeguards vulnerable adults

- To ensure robust systems are in place to learn lessons from cases where adults die or are seriously harmed and abuse or neglect is suspected

To be a member of the Local Safeguarding Adult Board

f) *The progress your organisation has made in respect of Safeguarding Adults throughout 2014/5.*

As a CGG we quality assure our provider in relation the Safeguarding Adults

We have developed CQUIN with providers to improve outcomes in relation to Adults to Risk

We also have monitored existing systems in relation to Adults at Risk through Key Performance Indicators (KPI).

The organisation has continued build multiagency relationships which has allowed for integrated approach in relation to Quality, Safeguarding Adults, MCA and DoLS .

g) *Your organisational achievements in respect of safeguarding adults.*

- Improved training figure across commissioned services.
- All CCG trained in Prevent, and Safeguarding

Ensuring safeguarding is a key consideration in the development of any new services.

h) *What your internal governance and quality arrangements for safeguarding have been over 2014/15.*

A monthly Safeguarding paper goes to Quality and Provider committee.

The Safeguarding team quality assures any providers we commission services from.

We also do quality walk rounds

i) What are the key areas of challenge you see as an organisation going forward for 2015/16.

- Domestic Violence
- Compliance with MCA and DoLS
- Accountably Framework
- Co-commissioning
- Care Act
- Health contribution to Safeguarding

j*) What internal training/information sharing have you delivered in respect of Safeguarding Adults, MCA &DoLS (if applicable) please consider:*

All the CCG staff has to complete online training in Safeguarding. The CCG employs approximately 80 staff

The CCG has trained approximately 300 staff in

- MCA and DoLS training to out of hours GP service/ Dentist/ GPs
- Prevent Training to all CCG staff
- MCA and DoLS training for Care Home Staff
- Trained Governing Body

3.5 Stockport Metropolitan Borough Council SMBC

a) National & Local Developments for your organisation in respect to Safeguarding adults.

- The Care Act 2014 has required SMBC to undertake extensive work to prepare for the care Act and the statutory requirements that will come into effect from 1st April 2015. A range of work groups have been redeveloping the approach to ensuring assessments are undertaken within the ethos of the legislation and procedures and systems have been updated to reflect the changes which has required staff to be retrained in numerous areas.

  In addition and with regards to safeguarding the Council has supported the Board to draw up an Action Plan attached at Appendix A and which sets out the approach.

- Deprivation of Liberty Safeguards (DOLS) – The Supreme Court judgement of March 2015 continues to have a major impact on operations as the council as Supervisory Body attempts to address all the legal ramifications. There has been various case law established over the period which has added further to a lack of clarity and some interpretation as to how the measures should be implemented. The Council has dealt with over 700 DOLS applications and over 250 still requiring processing.

- In light of government policy ASC has been working to restructure along the lines of a locality neighbourhood model working as part of an integrated community service with the Foundation Trust. Roles have been evaluated and safeguarding requirements have been at the core of decision making

- In light of the fact over 50 % of SMBC safeguarding activity is spent responding to safeguarding concerns in care homes, ASC has completely restructured its service and internal governance arrangements. In order to balance this with the continued challenges of DOLS implementation both he safeguarding service and Quality team have been brought together to form one Safeguarding & Quality team. The services primary objectives will be to co-ordinates DOLS requirements and improve and support best practice in care homes. Where this fails the new team will lead on all safeguarding inquires where abuse is alleged and this will ensure amore joined up approach through the centralised recording of intelligence. Locality teams will continue to respond to and ensure SMBC is able to adhere to its duties under the multi-agency procedures

- The Learning Disability Service and CCG continue to work towards improving performance with the NHS England self-assessment and with the purpose of addressing the inequalities that people with a learning disability face

- SMBC continued to ensure its teams responded appropriately to the 650 plus safeguarding referrals it progressed during the period. This involved allocating Inquiry Officers and ensuring each part of the process is chaired by an appropriately trained team Manager or Assistant team Manager

b) Developments post Winter Bourne View

- SMBC has worked closely with the CCG in developing and implementing the Action Plan at Appendix C.
- SMBC during the period agreed to fund the employment of two practitioners for a six months period to review all those living in out of borough placements and with the purpose of establishing how the person can be supported to return to Stockport if appropriate
- SMBC has worked with Equity Housing Group to develop a new housing with care model that will come on line I may 2015. The scheme will consist of 24 self-contained apartments that will befit from on-site 24 hour care. Six of the flats will be used for short term non forensic assessment. The assessment and commission element of the learning disability partnership will work closely with the provider arm of the partnership to ensure the multi-disciplinary team can used its combined skills to reduce the need to place out of borough and provide an option for people to return to
- SMBC, Pennine Trust and the CCG meet regularly to discuss the plans in place to enable the people in secure accommodation who are ordinarily resident in Stockport to be stepped down. This links to the Community Treatment Reviews that have been undertaken as part of the Transformation modelling work

c) The Adult Safeguarding focus of your organisation throughout 2013/14

- The primary focus of SMBC as the Supervisory Body has been to develop the systems processes and human resources to enable it to deal with a tenfold increase in its DOLs referral rates. This has required a rota of best Interest Assessors to be developed and trained, developing a list of Section 12 Doctors able to complete capacity assessments and strengthening the administrative availability to coordinate this process which requires six assessments to be completed. Signatories are ASC heads of Service who have continued to take on this role
- Maintaining the ability to promptly respond to and lead safeguarding inquires has been a core area of activity
- Preparing for the care Act so as to ensure Part 1 requirements can be adhered from 1st April 2015 has been a key area of activity as has ensuring the Board is resourced and supported

d*) The progress your organisation has made in respect of Safeguarding Adults throughout 2014/15.*

- The areas identified at `a' to `c' above highlight the areas of progress. In addition;
- Temporary funding has been secured to support the employment of a temporary full time Board Administrator for a period of 12 months to support the administrate functions of the Board
- Realigning job descriptions as part of the internal restructure so as to enable more of a focus on the new strategic requirements of the Board

e) Your organisational achievements in respect of safeguarding adults.

- Ensuring the council has been able to respond to a high volume of safeguarding referrals in accordance with the five stages set out within the Multi agency policy
- Continuing to offer Alerter training at no cost to providers (see performance at section 2.7)
- The Council has committed £750k of its reserves to support the implementation of a system able to start to address the implications of the Supreme Court judgement with regards to DOLs
- The reconfiguration of its in house services so as to ensure a more centralised and efficient way to respond to and proactively progress practice in care homes

- Developing a revised approach to DOLS administration with the use of Information Technology at the core

f*) What are the key areas of challenge you see as an organisation going forward for 2014/15*

- A key challenge will be to continue to meet the DOLs requirements and respond to the high level of applications. Training BIA from existing teams already under pressure will be a challenge as the service endeavours to increase its pool of retrained assessors. Maintain a register of qualified Section 12 Doctors to undertake the assessments from within the cost framework will all present challenges as will commissioning reassessments for all those DOLS about to expire. It is forecast that upto 1500 DOLS could be in place by the end of 2015 .2016
- Working with Coroner office to ensure people at end of life are not disadvantages if they are subject to a DOL is a key area of activity
- Maintaining a training strategy at no cost and at the same frequency will remain a challenge as the number of people available to deliver training reduces
- ASC will continue to face budget challenges and maintaining a prompt response to alerts will require constant reprioritisation by locality and service specific teams

g) *What internal training/information sharing have you delivered in respect of Safeguarding Adults, MCA &DoLS (if applicable) please consider*:

SMBC has led on coordinating safeguarding training at all levels and the data is highlighted at section 3.7 below

Internally all Social Workers and their managers have been trained in the new requirement of the care Act and this equates to over 100 people plus support and transformation employees.

3.6 Greater Manchester Police

3.6.1 National & Local Developments in respect to Safeguarding adults.

Stockport PPIU has recognised the increasing demand around VA investigations and has increased staffing of VA investigators from two to five.

3.6.2 Care Act 2014.

The Care Act 2014 will not impact significantly directly on police but the Criminal Justice and Courts Act 2015 will and training has been given to PPIU police staff and joint agency training will be conducted in October.

3.6.3 The Adult Safeguarding focus throughout 2014/15.

The police want to expedite the alerts to police so that early contact is made to afford golden hour investigative opportunities. Meetings of managers has allowed better multi-agency working and shared training has commenced.

3.6.4 The progress made in respect of Safeguarding Adults throughout 2014/5.

The team has expanded and has a new Detective Sergeant appointed to drive forward the team's development and to establish a body of detective constables to support this for both safeguarding and investigation

3.6.5 Organisational achievements in respect of safeguarding adults.

Safeguarding Adults incorporates Domestic Abuse and we have 2 Detective Sergeants and 14 constables dedicated to adult protection. This is a significant resource of specialist officers dedicated to improving delivery but also seek reduction through initiatives. Stockport has been the pilot division for force initiatives which have streamlined processes reducing waste and reducing time for interventions and information sharing.

3.6.6 Internal governance and quality arrangements for safeguarding over 2014/15

There is a monthly force TCG process that reviews monthly performance around vulnerability. There is a QA process and dip sampling of work has shown generally a raised standard of dealing with incidents or shown some areas for development where further training has been given..

3.6.7 Key areas of challenge as an organisation going forward for 2015/16.

The greatest threat to policing is the reduced budget and shrinking workforce

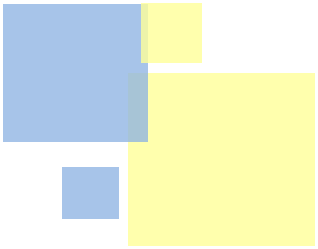
3.6.8 Internal training/information sharing have you delivered in respect of Safeguarding Adults,

Most frontline staff have received enhanced vulnerability training and the intention is that all will ultimately receive this.

Pilots run at Stockport have been rolled out across GMP and then further additional training has been delivered locally by PPIU to colleagues.

There is an ongoing pilot around VA to reduce waste and focus resources of specialist officers to high risk/complex cases and look at better management of medium and standard risk cases to ensure speedy and proper referral processes. In the case of high volume individuals, longer term work by INPT officers around problem solving and multi-agency approaches.

All specialist officers undergo bespoke specialist courses which are run centrally and there is a desire to make all investigators detectives which is a rolling programme. All child abuse investigators are detectives and a further 6 are currently training to be detectives in the coming year



. ***3.7 Health watch***

Health watch Stockport (HWS) have made the following comments with regards to safeguarding adult's activity in Stockport;

3.7.1

a) HWS have representation on several NHS bodies and so have the opportunity to raise any Safeguarding issues through those bodies. Such issues can also be fed back to the SSAB by HWS.

b) The Enter and View Team may become aware of concerns during their work and it would be helpful to ensure that there are good communication channels between this team and the ASC Quality Team/Safeguarding Quality group

c) HWS may become aware of safeguarding issues via general feedback or survey work so we should ensure that HWS knows how and where to report any such concerns.

d) HWS would support and welcome greater integration with the Children's Safeguarding Board. As well as being a positive move to work in a more joined up way, it would help to jointly plan policy and strategic approaches. It would also avoid possible duplication of some areas of work

e) The role is not a HWS representative on the Board, but a lay person rep role. HWS has stressed how important it is / was to gain the crossover in the work going on in HWS and the children's safeguarding board and this has been acknowledged.

f) Also HWS are concerned about the effects of the personalisation agenda, especially in the context of serious budget reductions so we welcome the inclusion of this item on the 2015-16 Strategic Plan.

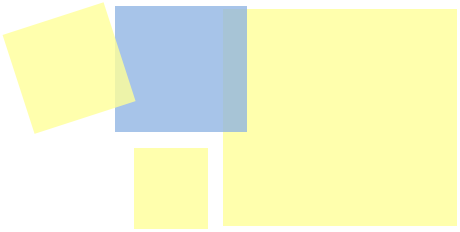
3.7.2 HWS would find a review of Board member roles helpful. This is relevant to HWS as a non-professional member. In addition HWS makes the following comments for Board members to consider over the coming year;

a) Would an annual or 6 monthly larger reporting and feedback session, with wider representation, be more effective?
b) The DOLS pressures are a concern as they are likely to result in a reduced level of preventative and supportive input to other service users.
c) SSAB and confidentiality. Do the Care Act requirements imply that SABs should be involved in individual cases (not SARs dealt with outside SAB meetings)? Confidentiality should not be necessary unless this is so. If individuals are to be included on the Board's agenda and accountabilities, the membership and role of members is even more crucial to clarify.

3.8 Greater Manchester Fire and Rescue Service

a) In Stockport, GMFRS continues to engage with our "partner" agencies to develop and deliver more collaborative working arrangements whereby we can more readily identify those individuals within our community who are at increased risk of fire. This is achieved by the development of sustainable partnership arrangements and includes the development of more formal "partnership agreements" under the auspices of the Greater Manchester Fire and Rescue Service "*Partnership Model and Referral Pathway for People at Increased Risk of Fire*".
b) These include reciprocal training, well defined referral pathways and the development of bespoke inventions to maximise opportunities to both identify and provide support for vulnerable adults within the communities we serve within the Borough.

c) In addition, through our local Community Safety Manager, we continue to make key contributions to the work of the Stockport Adult Safeguarding Board and the development of the Board's Prevention Strategy to develop and communicate the emerging Prevention agenda within the Borough. Furthermore, by being an active member of relevant sub-groups, we seek to support and develop the emerging ethos and approach in response to the Care Act and the now statutory nature of the Stockport Safeguarding Adults Board.
d) GMFRS continues to seek to safeguard vulnerable adults especially those at increased risk of fire through the implementation of the recently reviewed and up-dated Safeguarding Policy to provide and enhance support for our local staff delivering our services within the Borough. In order to effectively achieve this aim all staff now have access to the recently developed Safeguarding E-learning package and, more specifically, those staff identified as "Designated Safeguarding Officers" within the Borough have recently successfully completed their DSO "refresher" training.



3.9 Pennine NHS Trust

3.9.1 The SSAB will ensure that all partners sign up to and comply with the Stockport All-Agency Safeguarding Adults Policy.

Negotiations with the Pennine Care NHS Foundation Trust (PCFT) with regards to the Inquiry Officer role within the policy were on-going throughout the year. The principles of the policy have been agreed at senior manager level within the organisation and PCFT provided an update on the position at the December 2014 Board meeting.

The Trust is now undertaking inquiries on behalf of the Board in independent hospital settings and a protocol to agree responsibilities is in the process of being finalised. This protocol is complete and

Pennine Care NHS Foundation Trust provides mental health services to people living in the boroughs of Stockport and Tameside. It also provides mental health and community services in Bury, Oldham, Rochdale and Glossop, as well as community services in Trafford.

Services are located in hospitals and in the community and work closely with local councils, other NHS organisations and the community and voluntary sector.

Pennine provide a range of services for people who have serious mental illness such as schizophrenia and bipolar disorder, as well as more common mental health problems including depression, anxiety and dementia.

3.9.2 *National & Local Developments for Pennine Care NHS Foundation Trust (PCFT) in respect to Safeguarding adults have included;*

- PCFT has undergone a restructuring process of safeguarding roles within the organisation to include a Named Nurse Adults and Children (mental health) for Stockport and Tameside.

- Recruitment of an Adult Safeguarding Specialist Practitioner for Stockport and Tameside.

- Development of a Safety Improvement Strategy group encompassing 4 patient safety domains with a 3 year plan that proactively seeks to learn from care delivered to patients by systematically reviewing care following investigations of incidents, complaints, and claims.

  These 4 domains have been identified as:
  - falls prevention and reducing avoidable harm
  - safe discharge, transfer and leave from inpatient facilities
  - reducing hospital and community acquired avoidable pressure ulcers
  - reducing omitted and delayed medications

- Lessons learned are shared by disseminating information through to the various Trust sub committees, the local borough Clinical Business Units, and via the internal governance structures.

This Safety Improvement Plan builds on the Trust's Quality Strategy to improve patient safety and patient experience thus adhering to the safeguarding agenda.

- The Quality Strategy commits Pennine Care NHS Foundation Trust to improve the quality of patient care that is delivered to our service users, ensuring that it is safe, effective, and patient centred.

- Establishment of the following Trust sub-committees that will have responsibility within the 4 patient safety domains:
  - Inpatient Falls Prevention Group
  - Pressure Ulcer Strategy Group
  - Tier 4 Group; Trust wide community mental health teams
  - Acute Care Forum: Safeguarding Adult Forum
  - Drugs and Therapeutic Committee

3.9.3 Developments *post Francis Report*

Following publication of the Francis Report, PCFT developed a comprehensive report and action plan to address things the Trust do well and to identify areas for improvement.

There have been many developments with an emphasis on improving outcomes for patients some of which are: -

- Safer staffing
- Modern matron allocated to all inpatient areas
- A number of 6 Cs events within Stockport services involving service users and staff
- Compassionate Care Strategy developed
- Clear & measurable goals for next 5 years
- Nursing Conference with an attendance of 300 and, 2000 staff engaged
- New Nursing and Allied Health Practitioner forums commenced March 2015 agenda items include; revalidation of nurses and of HCP staff, preparation for FCC implementation for all support and health care workers supported by Organisation Learning and Development
- Duty of Candour embedded within Trust Safeguard reporting system
- Whistleblowing Policy reviewed and developed to ensure it meets the requirements of the Duty of Candour.
- Divisional Business Units reporting on post Francis Action plan to Executive Board Lead
- Review of supervision arrangements across PCFT mental health and learning disability services.

3.9.4 Developments post Winter Bourne Review.

PCFT have been active members of Stockport's Winterbourne View sub group and are dedicated towards promoting a culture that actively challenges poor practice whilst delivering compassionate care across the system.

Monthly delivery of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs) training will ensure better outcomes for its patients and service users with learning disabilities, autism and behaviours that challenge

Qualified Mental Health staff across PCFT are required to have three yearly updates.

3.9.5 Care Act 2014.

Safeguarding adults from abuse is a key priority for PCFT with the need to raise the profile of adult safeguarding increasingly embedded in the workforce as part of their everyday business in this area. There have been a number of developments with an emphasis in adhering to this Act including:

- Restructure of safeguarding roles within the organisation to include a Named Nurse for MH Child and adult safeguarding for Stockport and Tameside.
- Appointment of Adult Safeguarding Practitioner for Stockport.
- Attendance at local operational sub groups
- Plans are in place for the delivery of face to face Level 2 Adult safeguarding including PREVENT Safeguarding training for Q3 2015

3.9.6 The Adult Safeguarding focus of the organisation throughout 2014/15

PCFT has cooperated with its relevant partners in fulfilling its duties and functions in relation to both the preparation and implementation of the Care Act.

Plans for neighbourhood model implementation and focus on borough specific forums will ensure that outcomes for adults are linked to the overarching safeguarding principles set out in the Care Act 2014:

A significant number of developments are described above which followed the Francis report.

3.9.7 SSAB engagement

The following named managers have been identified as attending Adult Safeguarding Board meetings;

Jackie Stewart (JS) - Service Director

Dil Jauffur (DJ) - Directorate Manager

Catriona Harley (CH Specialist Safeguarding Adult Practitioner)

Pennine Trust also have nominate staff to attend the sub groups

3.9.8 The progress the organisation has made in respect of Safeguarding Adults throughout 2014/5.

PCFT has proved itself to be an innovative and resourceful provider and has been dedicated in meeting the changing agenda around Adult Safeguarding. This has demanded a committed and trained workforce who will continue to work with partners to support and protect those adults who suffer abuse. Progress to date has included:

- Steady increase in training compliance with e-learning Adult Safeguarding
- PREVENT training being delivered as an additional aspect to courses within the PCFT training dept. where possible.
- Adult safeguarding practitioners and Named Nurses have completed Train the Trainer PREVENT.
- Delivery of MCA and DOLs training.

- Revised Safeguarding structure
- Posters and increased visits to ward staff promoting safeguarding agenda and being an advisory, point of contact.
- Increased presence on wards and within teams.

3.9.9 PCFT organisational achievements in respect of safeguarding adults.

- Appointment of an adult safeguarding practitioner.
- Revised adult safeguarding policy
- L1 Safeguarding Adult training achieved 74.3%
- PREVENT Training delivered to 60.9% workforce
- Development of a L2 adult safeguarding training
- Channel Panel arrangements agreed
- Review of supervision arrangements across mental health services
- Agreed response protocol for independent hospitals safeguarding referrals.

3.9.10 *Internal governance and quality arrangements for safeguarding have been over 2014/15*

The Trust's Quality Strategy commits Pennine Care to improve the quality of patient care that is delivered to our service users, ensuring that it is safe, effective, and patient centred. The essential components that will ensure this success are:

- Safety culture
- Leadership
- Staff training and skills
- Effective measurement and evaluation tools
- A robust communication strategy to support delivering improvements and informing staff of progress in the key safety improvement domains identified.

A number of internal sub groups ensure these components are delivered and meet the adult safeguarding agenda and include:

- Safeguarding Adults Group
- SUI internal and external Safeguard reporting system
- Patient Safety Investigation Group
- Integrated Governance groups across all business units.
- PCFT Trust Quality Group

3.9.11 Key areas of challenge going forward for 2015/16

Service transformation and redesign for Stockport community services as part of on-going efficiency management.

3.9.12 What internal training/information sharing have you delivered in respect of Safeguarding Adults, MCA & DoLS

Stockport figures March 2015;

- Adult Safeguarding Level 1 e-learning 74.3%
- Prevent 60.9%
- MCA – 133 qualified staff are trained including medical staff.

3.10 Sub Group Activities

3.10.1 Training Sub Group

The strategy is attached at Appendix B and was reviewed in February 2015. Priorities were set by the Training Sub Group for 2015 /2016.

a) In summary the following training was delivered over the course of the year;

Course	Sessions	Delegates
Alerter training	41	771
Alerter refresher	10	243
Alerter train the trainer	1	40
Referrer	7	96
Inquiry officer – 2 day initial training	1	26
Inquiry officer – investigations (3rd day)	2	33
Inquiry officer – refresher	6	85
Totals	**68**	**1,294**

b) The data is further illustrated by attendees from specific sectors;

Course	Sessions	Delegates	SMBC	Care Home	Home Care	Other PVI
Alerter training	41	771	167	144	360	100
Alerter refresher	10	243	116	36	89	2
Alerter train the trainer	1	40	0	4	24	12
Referrer	7	96	3	22	62	9
Inquiry officer – 2 day initial training	1	26	17	3	5	1
Inquiry officer – investigations (3rd day)	2	33	27	2	4	0
Inquiry officer – refresher	6	85	71	0	14	0
Totals	**68**	**1,294**	**401**	**211**	**558**	**124**

3.10.2 Performance Sub Group

The Statutory Returns for 2014-15 and have now been submitted and will enable comparison at a national level. . The national report will be made available from the HSCIC in the autumn of 2015. At that point Stockport MBC will repeat the exercise of analysis and summary to provide to the Independent Chair of the Safeguarding Board. This analysis will set a national context around our annual performance and allow the Board to set local priorities where relevant.

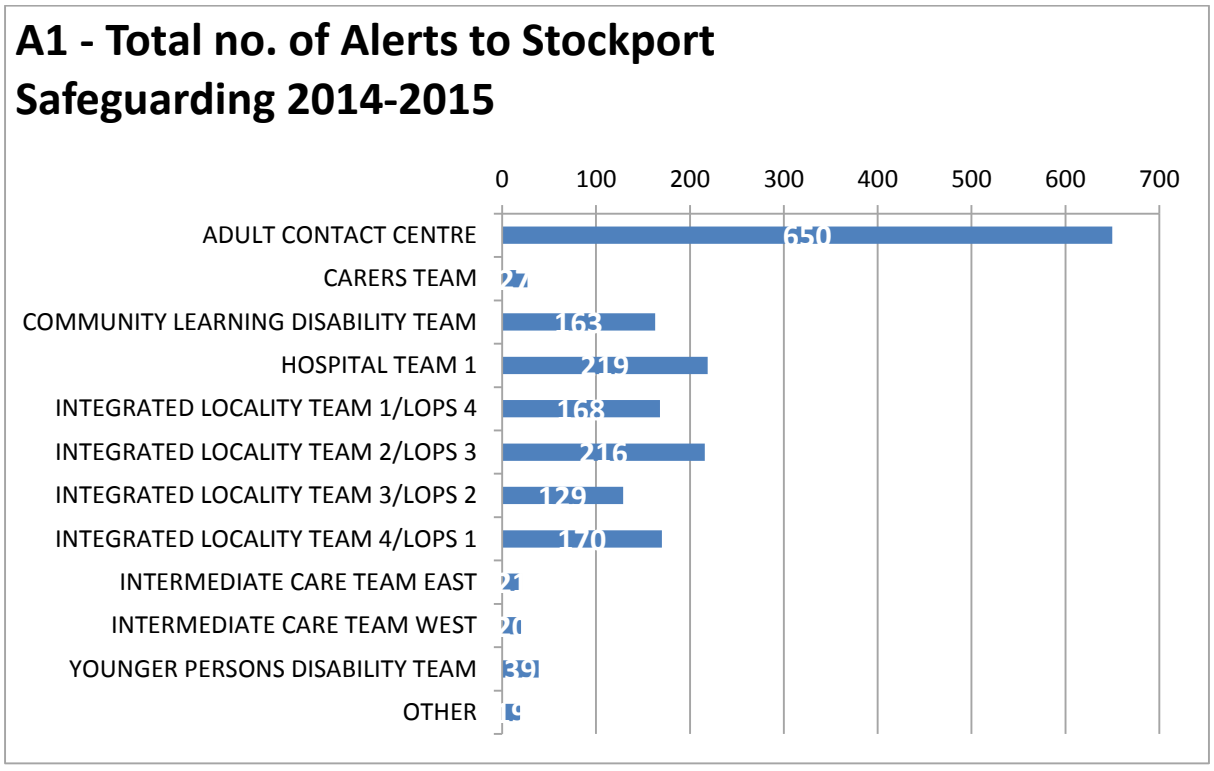
A more detailed analysis of local results will also be undertaken over the next few months to look at what our data is saying locally and to look at how effective the different stages of the current process are.

SMBC have also undertaken extensive work on the DOLS system subsequent to extracting annual statistics. DOLS has caused significant issues in the year around the pressure on staff which has subsequently led to issues with data quality. CSS are now supporting the business development to migrate the data from its current spread sheet into the ASC core client database, Carefirst. This move should address all of the data quality issues we experience this year.

SECTION 4 – SAFEGUARDING ACTIVITY OVER THE PERIOD 1ST APRIL 2O14 TO 31ST MARCH 2015

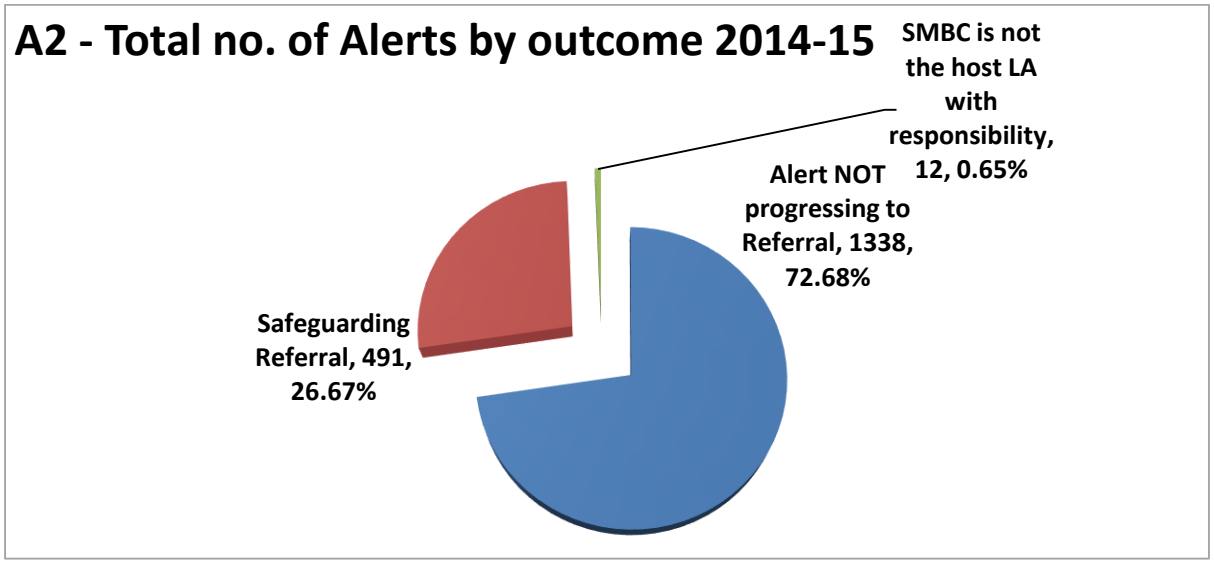
It should be noted the figures are approximate and obtained from extracting data from the Councils client database which is used to record activity at different points of the five stage process.

4.1 Alerts received

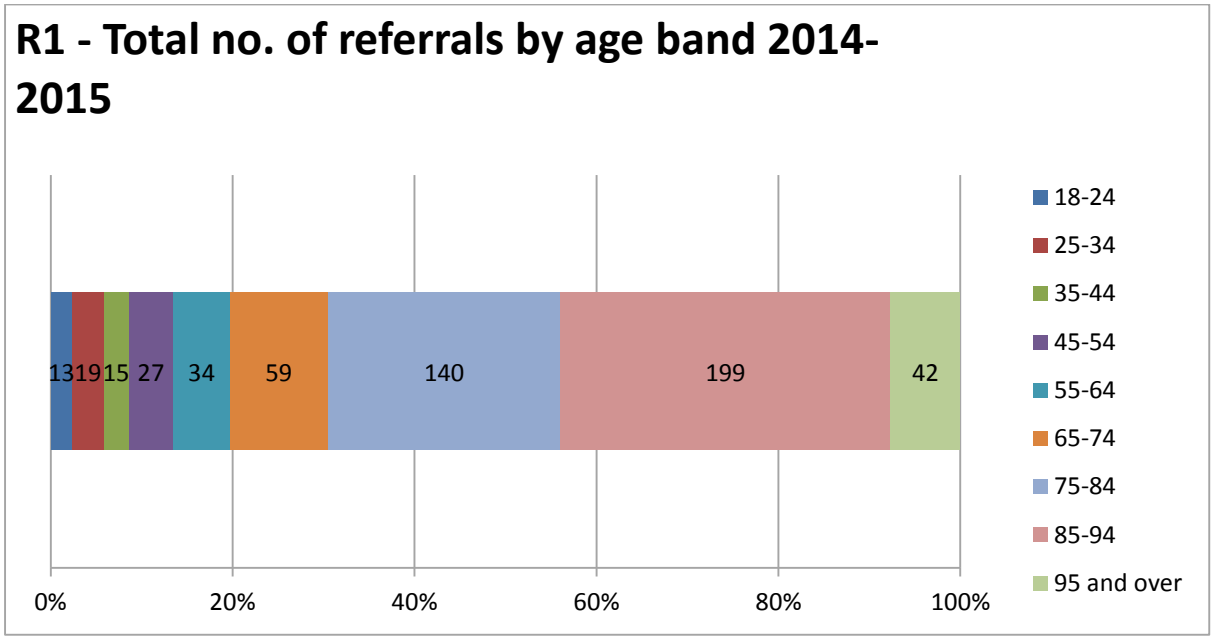


1809 alerts received

4.2 Alerts outcome

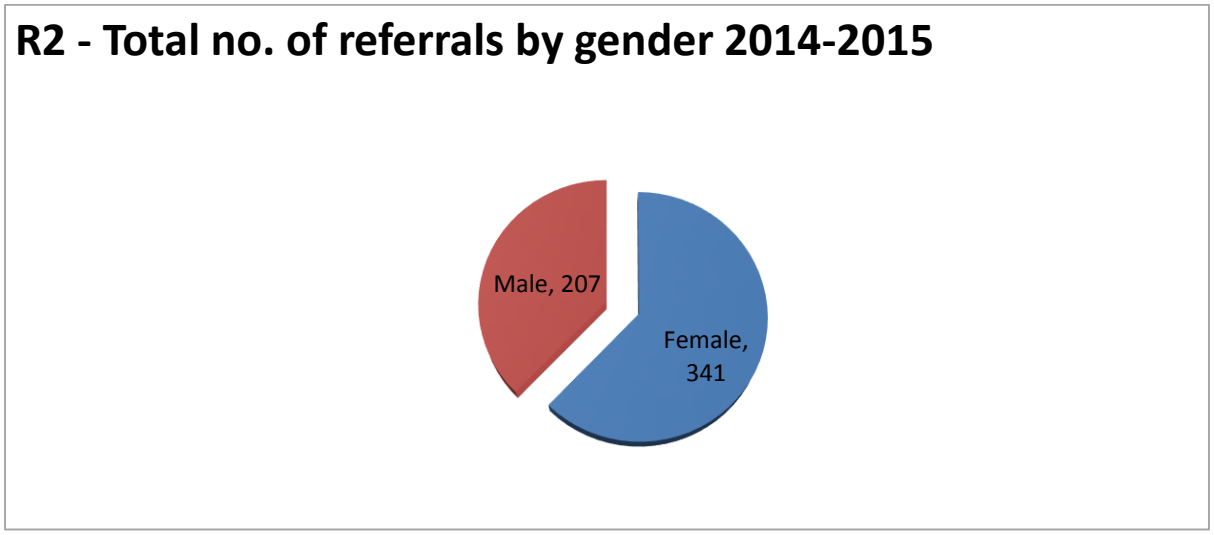


4.3 Alerts by age band



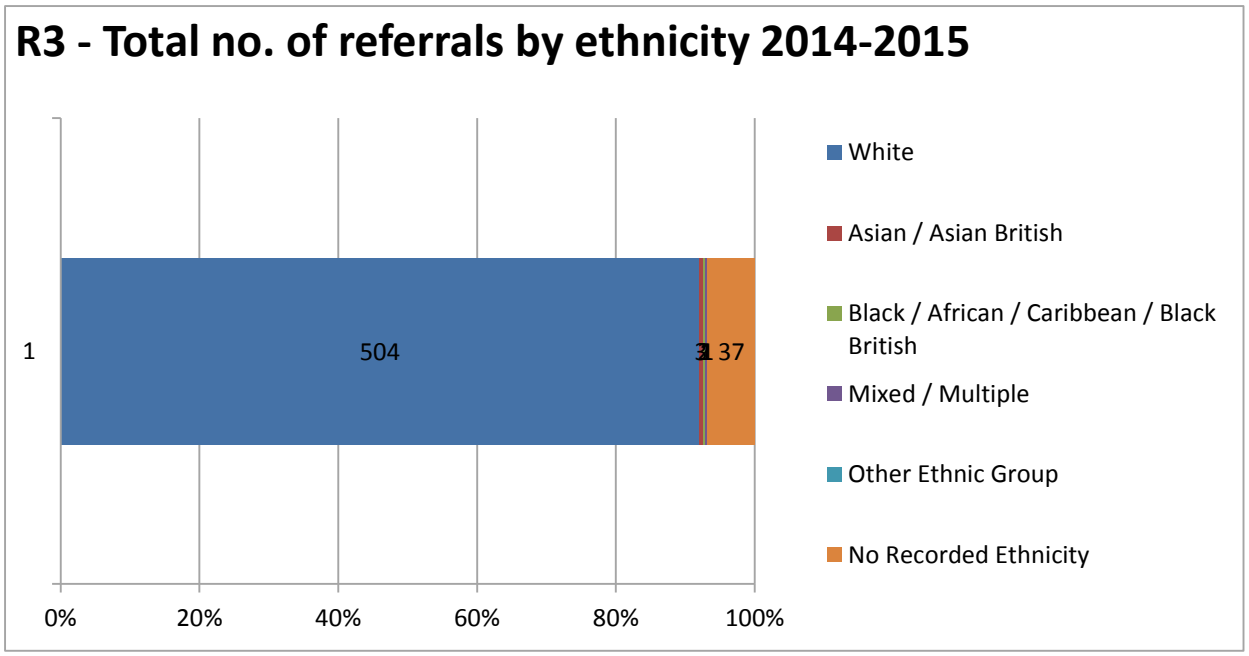
548 proceeded to investigation (Strategy meeting and beyond). 69% of the people referred are aged 75 years plus which potentially relates to the number referred from care homes

4.4 Referrals by gender



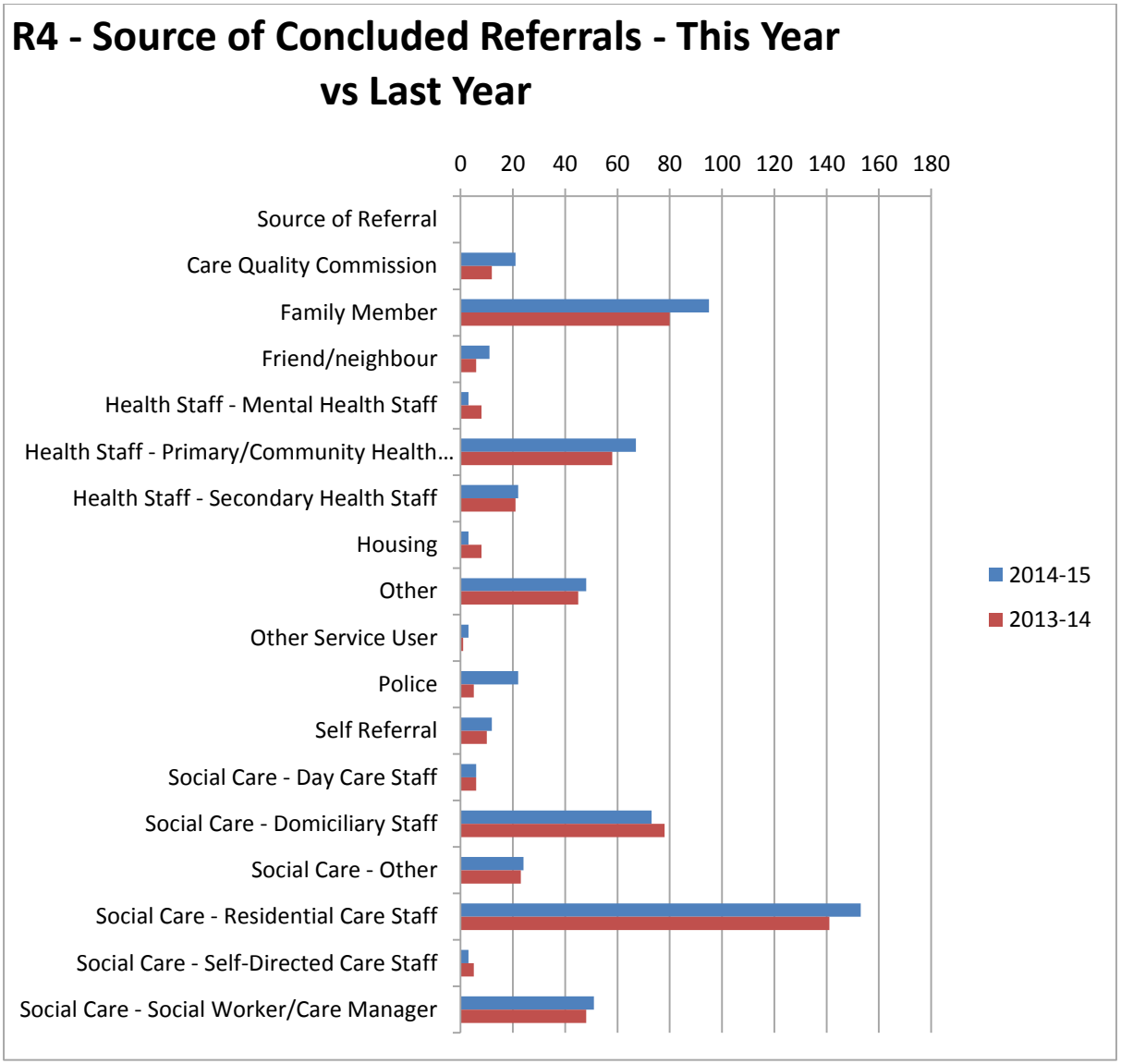
38% of referrals are male and 62% female

4.5 Referral by ethnicity



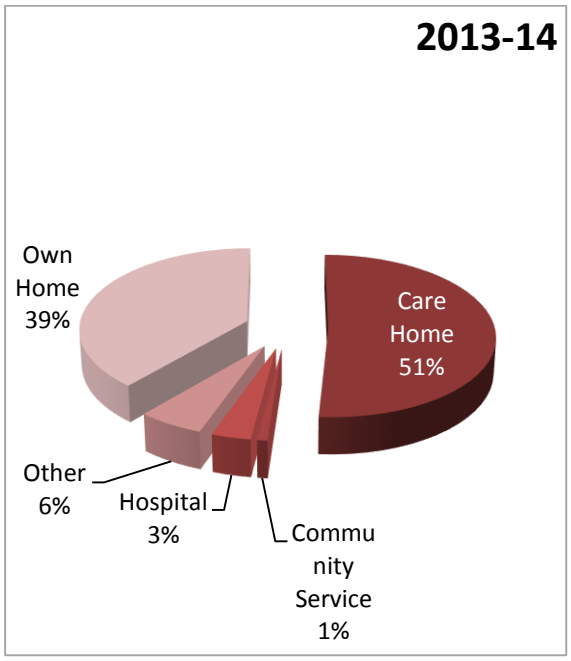
95% of the people referred as the subject of the alleged abuse are white British

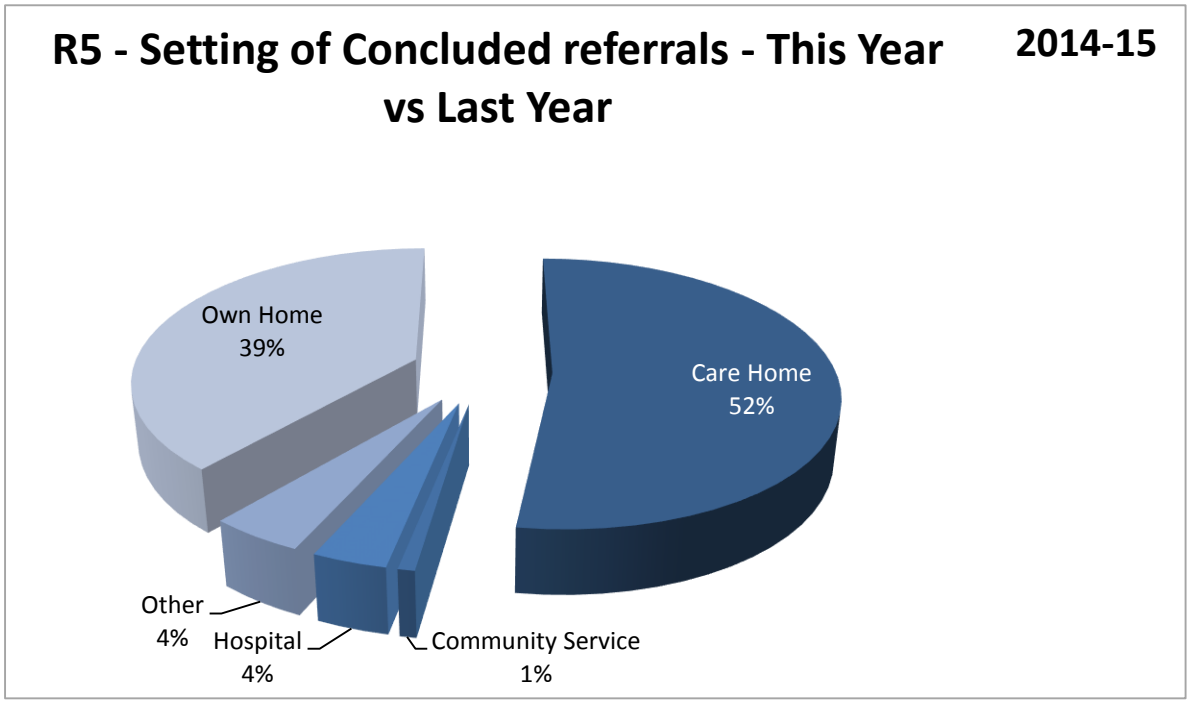
4.6 Source of referrals



Needs further analysis and checking

4.7 Settings of concluded referrals (comparison to previous year)

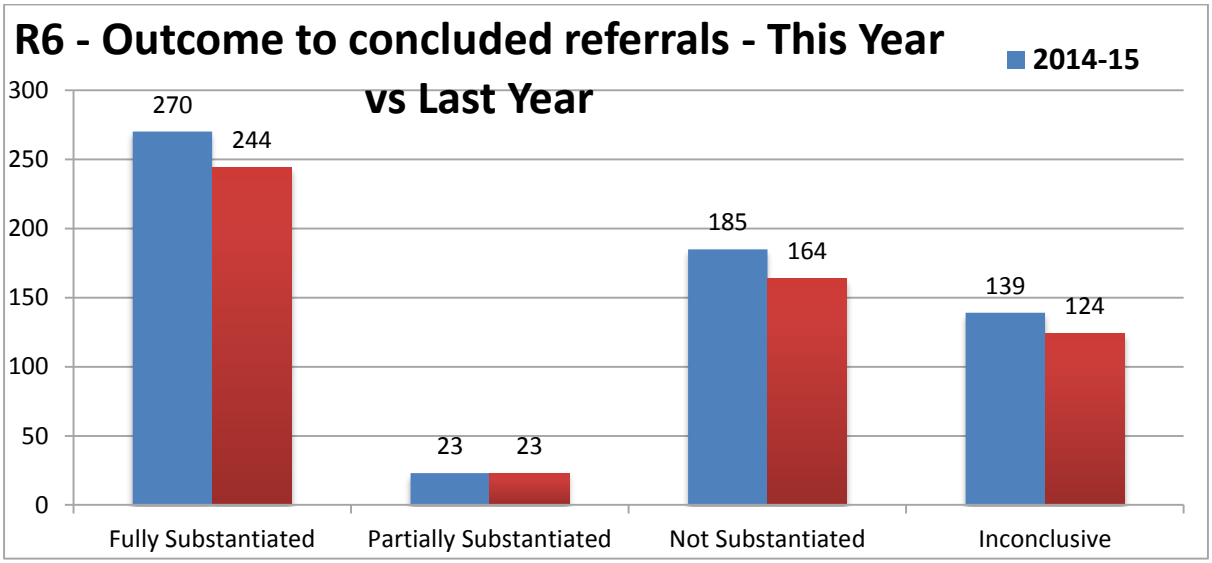




The number of cases progressed in a care home setting remains consistent at just over half the total. Year on year the number is increasing and further work is required to more fully evaluate the reasons. A key aim of the restructured service will be to work with care homes

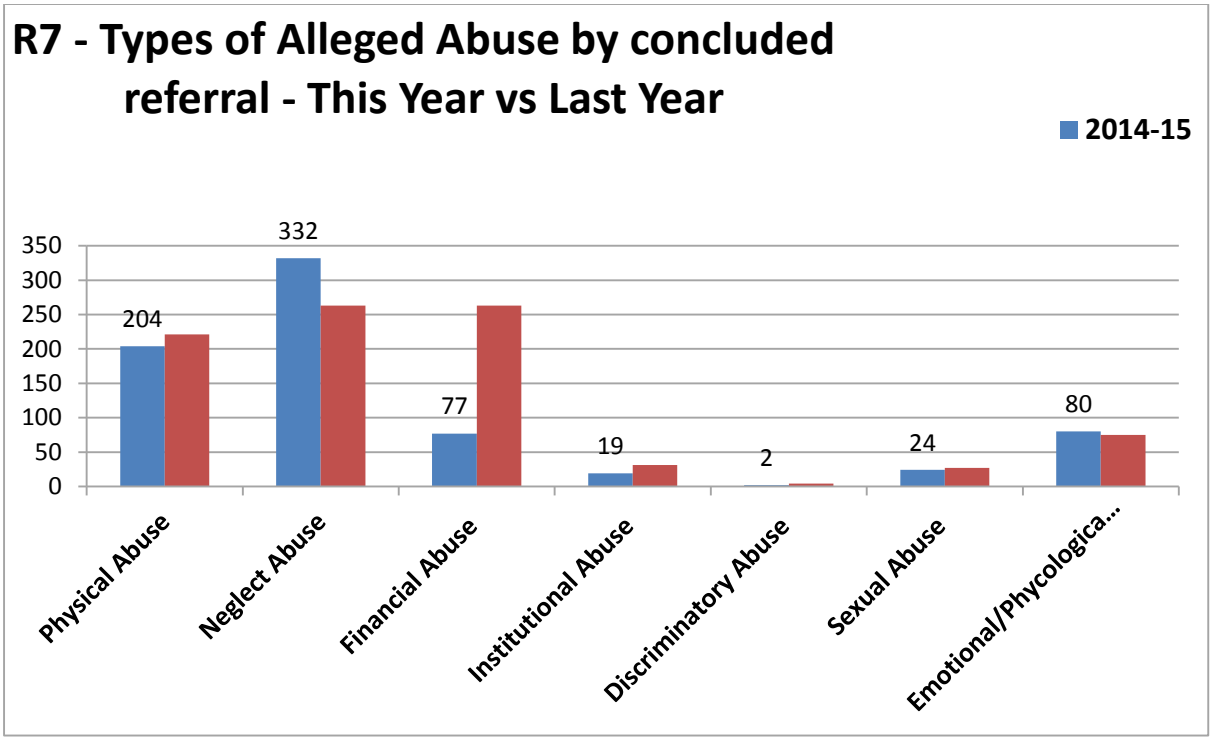
in a more proactive way and to drive up standards. The remaining volume remains comparable to the previous year.

4.8 Outcome of inquiries



The number of cases fully substantiated has increased when compared to the previous year however the number of cases recorded has inconclusive has increased. Further work is required to understand what data and information was not available from which to make an informed decision.

4.9 Categories of abuse



It is noticeable that the number of cases recorded under the financial abuse category has reduced significantly when compared to the previous year which is in contrast to the number of neglect categories which has increased.

The reasons for this are being evaluated with Locality team managers and there is no evidenced explanation at the point of this report being written. Theories include threshold's being dealt with through "Care Management" as opposed to Safeguarding. In addition there is discussion as to whether under the Making Safeguarding Personal programme practitioners are not progressing if the person is stating they do not want anything to happen.

APPENDIX A - Care Act Action Plan

Requirement	Reference to Guidance	Proposed action
1. SSAB to publish a strategic plan with objectives and actions which MUST be developed with community involvement and consult with Healthwatch	14.114 - 115	SSAB to decide how to resource co-ordination of plan - Consider how to engage the local communities in development of plan – consultation event? Engagement sub group? An annual plan with objectives has been produced year on year
2. SSAB to produce yearly report to include summary of any SARS and how the SAB has acted on learning/findings from the SAR	14.117 14.119 14.121	An Annual Report has been produced since 2006. SA Board to consider how this report will be resourced (who will do and any monetary requirement to release them) as currently no resource allocated to this Consider revised format to include points raised in 14.119 of guidance such as how SA is linking in with other parts of system and how well agencies are co-operating and collaborating. Review also format, easy read version? Where published/circulated as per 14.121
3. SA Board required to conduct SAR's in certain circumstances	14.122	HoS currently facilitating a work group to relook at Stockport`s approach to this

		and initial recommendations presented to Board Complete action plan for SCR's as per this year's business plan
LA must provide advocacy	14.1 & 14.76 of guidance (p191) Provide advocacy 'where adult has substantial difficulty being involved in the process and there is not another appropriate adult to help them' 14.80	Customer Journey Board progressing as is Prevention work stream. SSAB to seek assurance from ASC that there is sufficient advocacy in place to meet this requirement of the Care Act. NB> Check case law from Court of Protection
Recommendation	**Reference to guidance**	**Proposed action**
SA Board should 'identify role, responsibility, authority and accountability' of each professional group	14.104	Review roles and responsibilities of each partner group?
SA Board should 'establish how it will hold partners to account and gain assurance of the effectiveness of its arrangements'.	14.104	SA Board to consider if further work required in relation to this
SA Board should 'determine it's arrangements for peer review and self- audit'.	14.104	SA Board to discuss and agree a protocol for self-audit Trafford interested in working through a reciprocal peer review.
SA Board should establish mechanisms to consult with all partners and people who care and support, families and carer representatives and members of the community	14.104 Consultation required for - Feedback/experience of enquiries/investigations - Yearly strategic plan - 'The development of policies and strategies' 14.119 – progress on delivery of policies - community awareness of adult abuse	SA Board to agree best way to engage identified groups – engagement sub group? Or part of communications sub group?
SA Board should 'develop strategies to deal with the impact of issues of race, ethnicity, religion, gender etc.'	14.104	SA Board to consider if current strategies robust enough

Communications sub group to consider specific areas of Communication highlighted in the Care Act Guidance	14.108 - Info about how the SA Board functions should be 'easily accessible to partner organisations and the general public' 14.140 - Review of leaflets to ensure involvement of adults at risk n process and that they are advised that they can nominate an advocate. Additionally to consider specific reference to informal carers	Review info written on how the SA Board functions and how it is accessed Communications sub group to review leaflets available
Membership of SA Board – 'SAB's are expected to involve a much wider range of organisations and individuals	14.109 14.111	Wide range of attendees but sporadic attendance and possibly not at the right level. Review membership and in particular consider; NW ambulance, representatives of housing providers, probation and prison services, members of advocacy and carer groups, representative of children's safeguarding, pensions service, job centre plus and public health Consider if we are getting sufficient in-put of practitioners to SA Board
Key role of SA Board to develop preventative strategies	14.113	SMBC structure being revised to more fully focus resource on prevention by joining QT and SAMCAS SSAB to consider if sufficient emphasis is given to preventative agenda by the Board.
SA Boards to consider 'drawing up a common agreement relating to confidentiality'	14.141	SA Board to review if multi-agency confidentiality agreement required
SA Board to ensure that training strategy 2015 onwards meets areas outlined in the guidance	14.164	Refined training programme been in place for many years. Training sub group to ensure that training strategy April

		2015 makes reference and provision for training for elected members and reviews training available to personal assistants
Revision to policy & procedures	14.60 Also IO refresher feedback from hospital team 14.54 14.56 14.62 14.68 14.90 – 14.99	Clarity on who leads on an investigation, particularly when it is health Review objectives of enquiry in policy and reference to guidance More reference to making safeguarding personal and emphasising the importance of the person's wishes Recording required referenced to guidance – particularly wishes of adult at risk Decision making required reference to guidance Identify an appropriate person to facilitate the adult's involvement update to policy and procedures required to link to increased advocacy requirement of Act Update on functions of SA board as per guidance
Clarity of thresholds – how different levels of adult protection addressed	14.34	Complete thresholds document with consultation with providers, partners and community
Making safeguarding personal 1. Enquiry should be informed by preferred outcomes of the individual 2. The views of adults at risk who have been through the process should inform the development of policies and procedures	14.39 'what happens as a result of an enquiry should reflect the individual's wishes whenever possible and be in their best interests 14.51 & 14.52	Participate in Making SA personal to move forward this agenda. Update policy re keeping adult at risk at centre of process and changes to procedures e.g. strategy meeting.

APPENDIX B

Stockport All Agency Safeguarding Adult Review (SAR) Protocol

Introduction

The Care Act Statutory Guidance sets out the procedures that Stockport Safeguarding Adults Board (SAB) should have in place to ensure compliance. The Statutory guidance is listed within sections 14.133 to 14.148. The guidance in section 1 below is taken directly from this Department of Health publication outlining the requirement's in relation to SAR's. Sections 2 & 3 of this document outline Stockport's procedures for considering cases for a SAR, and conduction of SAR's in compliance with the Care Act 2014

Section 1 Care Act Statutory Guidance for SAR's

1.1 Criteria for a SAR
The Statutory guidance for the Care Act outlines for following criteria for a SAR

1.1.1SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

1.1.2 SABs must also arrange a SAR if an adult in its area has not died, but the SAB know or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

1.1.3 SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support. Please note that informal cares should be included for consideration

1.1.4 The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.

1.1.5 SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

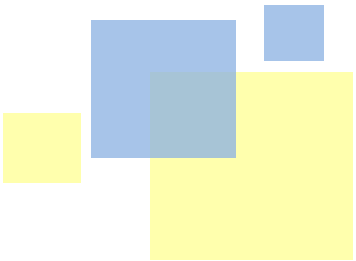
1.2 Principles & Purpose of a SAR inquiry

1.2.1 All SAR's should ensure the six key safeguarding principles are at the core of activity as follows:

- Empowerment – People being supported and encouraged to make their own Decisions and informed consent.
- Prevention – It is better to take action before harm occurs.
- Proportionality – The least intrusive response appropriate to the risk presented.
- Protection – Support and representation for those in greatest need.
- Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability – Accountability and transparency in delivering safeguarding.

1.2.2 The following principles should be applied by SABs and their partner organisations to all reviews:

- there should be a culture of continuous learning and improvement across the Organisations that work together to safeguard and promote the wellbeing and Empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- SABs should agree Terms of reference for any SAR they arrange and these should be published and openly available. When undertaking SARs the records should either be anonymised through redaction or consent should be sought.
- Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. The adult who is the subject of any SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them.
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; and
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.



1.2.3 The process for undertaking SARs should be determined locally according to the specific individual circumstances. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected. The recommendations and action plans from a SAR need to be followed through by the SAB.

1.2.4 The SAB should ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. The SAR should also communicate with the adult and, or, their family. In some cases it may be helpful to communicate with the person who caused the abuse or neglect.

1.2.5 It is expected that those undertaking a SAR will have appropriate skills and Experience which should include:

- strong leadership and ability to motivate others;
- expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;
- collaborative problem solving experience and knowledge of participative approaches;
- good analytic skills and ability to manage qualitative data;
- safeguarding knowledge;
- inclined to promote an open, reflective learning culture

1.3 Time frame for completion of a SAR

1.3.1 The SAB should aim for completion of a SAR within a reasonable period of time and in any event within six months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings. Every effort should be made while the SAR is in progress to capture points from the case about improvements needed; and to take corrective action.

1.4 The Purpose of a SAR

1.4.1 SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council

1.4.2 It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

1.5 Findings from SARs

1.5.1 The SAB should include the findings from any SAR in its Annual Report along with the actions it has taken, or intends to take in relation to those findings. Where the SAB decides not to implement an action then it must state the reason for that decision in the Annual Report. All documentation the SAB receives from registered providers which is relevant to CQC's regulatory functions will be given to the CQC on CQC's request.

1.5.2 SAR reports should provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence. The report should be written in plain English and contain findings of practical value to organisations and professionals.

2. Stockport Procedures for SAR's

2.1 Making a referral to the SAR panel

2.1.1 There are potentially 4 groups of people who may wish to refer a case to the SAR panel for consideration:

2.1.2 Safeguarding chairs and Inquiry Officers - If you are a chair of a safeguarding investigation and you have identified that a case meets the criteria for consideration of a SAR at the case conference, there is a referral form that should be completed on Care First by the chair/Inquiry Officer following on from the case conference.

2.1.3 Any professional from a constituent agency of the Safeguarding Adults Board who is aware of an adult at risk, not currently part of a safeguarding investigation, but who meets the criteria for a SAR (see 1.1 above) can make a referral for a SAR using the SAR panel referral form.

2.1.4 The coroner, MP's and Elected Members of Stockport Borough Council can also make a referral for a SAR using the SAR panel referral form.

2.1.5 Completed forms should be sent to the Safeguarding Adults Service:
4th floor (south end)
Stopford House
Stockport Council SK1 3XE

2.1.6 Other parties, such as agencies who are not members of the Safeguarding Adults Board, family members, carers or members of the public, who consider a SAR should be commissioned, should raise their concerns via the Stockport's ASC Contact Centre Tel: 0161 217 6029

2.1.7 Please note that any death that meets the criteria for a domestic homicide review will be considered for this process.
See www.saferstockport.org.uk/partnershipaction/domestichomicidereviews

2.2 SAR panel procedure

2.2.1 All SAR referrals are initially considered by the SAR panel which meets quarterly and then reports to the SSAB.

2.2.2 The SSAB has delegated authority for reviewing and screening SAR referrals to the SAR panel (Dec 2014) who make decisions as to whether or not to proceed with a SAR

2.2.3 The SAR panel is made up of statutory SSAB members or a representative from their organisation. There will be a minimum of 4 on each panel and a maximum of 6

2.2.4 A rota will be set up for panel attendance of SSAB members or their representatives.

2.2.5 The SAR panel will be piloted for 12 months from April 2015 to April 2016. For the period of the pilot, panel chairs will be heads of ASC

2.2.6 The SAR panel will review all cases for consideration

2.2.7 Chairs of safeguarding meetings or another appropriate person, may be invited to the meeting when it is considering their case to give further information to inform the panel's decision.

2.2.8 Cases will be presented to the SSAB as an anonymised case study to vote on the outcome of the case in the following circumstances:

a) there is not a consensus of the panel
b) the SAR panel believes that there should be a SAR review (at any level)

2.2.9 The chair of the SAR panel will inform in writing the referrer of the decision.

2.3 Procedure for commissioning a SAR

2.3.1 The SSAB will consider what would be a proportionate level of review for the case. Options could include;

1) the stakeholders involved being asked to co-ordinate a review with the lead agency being commissioned to co-ordinate
2) an SSAB member is appointed within their role to undertake the review
3) an independent paid reviewer is appointed

2.3.2 In the event that the decision is to commission an independent review the SSAB will need to scope out the tasks required for the review and the associated costs. Determining how the costs of the SAR will be met will not delay the commencement of the SAR.

3. Process

3.1 Pathway for identifying cases to be considered for SAR

3.1.1 A five stage process is proposed to enable all referred cases to be reviewed by a SAR panel and then presented to the SSAB for consideration as appropriate with a recommendation

Stage 1 The chair of the safeguarding meeting or other appropriate person (as outlined in section 2 above), completes the SAR referral from. NB for referrals made by the chair of the safeguarding investigation this is done electronically on Care First as part of 'out coming' the investigation.

Stage 2 The Safeguarding Service collates the appropriate information and papers for consideration by the panel by running quarterly reports on Care first and collating any referral forms that have been submitted through another means.

Stage 3 The SAR panel meets to consider the case with representation at the panel by the chair of the safeguarding investigation or other appropriate person, to give any additional info required by the panel to make their decision

Stage 4 The SAR panel makes a recommendation for each case as follows:

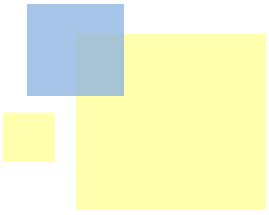
- Consider commissioning a SAR
- Consider commissioning a Learning Review
- Identified learning from the Case Conference to be disseminated (agree by who and issues of confidentiality)
- No review required

Any cases that need to go to the SSAB for consideration (see criteria in 2.3 above) are identified.

Stage 5 The SSAB considers any cases referred under criteria outlined in 2.3 (above) and makes a decision on any review required - referrers are then notified

3.1.2 The SSAB consideration of SAR's

The SSAB shall have SAR`s as a 30 minute standing agenda item and Board members will have been expected to have read the papers in advance. The SSAB shall then consider each case and make a decision as to whether the case warrants the commissioning of a full SAR or another review process



APPENDIX C - **RESPONSE TO WINTERBOURNE VIEW – STOCKPORT ACTION PLAN**

	ACTION	PROGRAMME OF WORK	LEAD PERSON/ORGANISATION	TIMESCALES	UPDATE ON PROGRESS – FEBRUARY 2015	RAG
1.	To establish a local register of people with behaviour that challenges in order to determine that the correct support is in place.	LD Joint Commissioning CCG	Gina Evans – Stockport CCG Barbara Mitchell - SMBC	September 2013	All people who currently are living OOA have been identified. Reviews will take place for all these people in 2015/16 to determine if appropriately place and if they can be more appropriately supported in Stockport.	
2.	To maintain a register of people with learning disabilities/autism and challenging behaviour in NHS funded care	This is routine work undertaken within the Stockport	Gina Evans - Stockport CCG	On-going	Three people have firm plans for discharge and two have been assessed as being appropriately placed There are currently 5 people with LD/Challenging behaviour placed out of the area in hospital beds. All have up to date reviews.	
	ACTION	**PROGRAMME OF WORK**	**LEAD PERSON/ORGANISATION**	**TIMESCALES**	**UPDATE ON PROGRESS – FEBRUARY 2015**	**RAG**
3.	In line with the Model of care (Annex A, Winterbourne Final Report) to review	SMBC/PCFT Partnership Meetings	Barbara Mitchell – SMBC Stuart Richardson -PCFT	June 2013 – September 2013.	The Health support provided by the team has been reviewed and focuses on the following pathways:	

	and re-design the specialist learning disability team to ensure that the appropriate staff and skills are in place to support people with learning disabilities, autism and those with behaviours which challenge services				- Positive behavioural Support - Dysphagia - Epilepsy - HAP - Safeguarding SALT in post and LD Physiotherapy colleagues have joined the MDT. Psychiatry pathway has been reviewed and Care First monitors health activity and informs Health focused KPI's in the PCFT contract	
4.	On receipt of the final Core Service specification, to develop a programme of review for LD services against the core specification	Joint Strategic LD Management Group	Barbara Mitchell – SMBC Stuart Richardson –PCFT Gina Evans - Stockport CCG	Commence September 2013 – September 2014	Draft Core specification received and review process has commenced.	
	ACTION	**PROGRAMME OF WORK**	**LEAD PERSON/ORGANISATION**	**TIMESCALES**	**UPDATE ON PROGRESS – FEBRUARY 2015**	**RAG**
5.	To provide training for the LD nursing team to enhance support for people who challenge services.	Review of LD Specialist Health Team	Stuart Richardson - PCFT	Training to be completed by August 2013	A five day Positive Behavioural Support module has been delivered to clinicians on the team. Implementation of supervision framework and ongoing CPD opportunities through PCFT	

6.	To deliver training to the mental health workforce to enable them to support people with learning disabilities who access their services	Pennine Care CQUIN (commissioning for Quality and Innovation)	Stuart Richardson - PCFT	Training to commence in June 2013	CQUIN successfully completed	
7.	To develop an intensive support service or crisis service to provide both timely and time limited support for people who develop behaviours which present a challenge to services	Heyse court Project Group	Austin Broomhead - SMBC	April/May 2015	See Heys Court Action Plan. Working groups developed for the following key areas: - Pathways, policies & procedures - Training & Development - Nominations - Finance - Infrastructure & community capacity.	
	ACTION	**PROGRAMME OF WORK**	**LEAD PERSON/ORGANISATION**	**TIMESCALES**	**UPDATE ON PROGRESS – FEBRUARY 2015**	**RAG**
8.	To develop more effective approaches to review people who are placed out of area and work with the Quality Team to develop suitable monitoring tools whilst exploring opportunities at each review for returning people back to Stockport	Joint Commissioning	Barbara Mitchell - SMBC	Ongoing	See OOA Action Plan. 2 full time practitioners are being recruited for a 12 month period to ensure that reviews will take place for all OOA people in 2015/16 to determine if appropriately place and if they can be more appropriately supported in Stockport.	

9.	At the agreement to commission any out of area placements, develop information for carers/parents about how they can contribute to monitoring and reviews of service users	Joint Strategic LD Management Group	Barbara Mitchell – SMBC Stuart Richardson -PCFT	August 2013	Questionnaires have been sent to 46 families whose family members had been places OOA; 7 questionnaires have been returned to date. Questionnaires require analysing.	
10.	Stockport CCG and Adult Social Care(commissioners) to develop a system of agreeing out of area placements regardless of who funds	LD Joint Commissioning	Mark Warren/Gina Evans	August 2013	This process is now established whereby Stockport CCG will fund hospital placements, with on-going in-put from LD or mental care co-ordinators where appropriate.	
	ACTION	**PROGRAMME OF WORK**	**LEAD PERSON/ORGANISATION**	**TIMESCALES**	**UPDATE ON PROGRESS – FEBRUARY 2015**	**RAG**
11.	To develop joint systems for safeguarding specifically for people with LD, autism and those with behaviours which challenge services	Routine work as part of Adult Safeguarding Implementation Group	Andria Walton and Andy Armstrong	Beginning September 2013	Check with Mark for update	

12.	To continue to develop the market with a range of providers (voluntary, independent sector) to provide person-centred/bespoke care and support for people with LD, autism and those with behaviours which challenge services	Market Position Statement	Vince Fraga and Barbara Mitchell - SMBC	October 2013	As part of the work to re-let the Choice Support contract for supported living accommodation a separate exercise was undertaken to develop a framework contract. The result is a comprehensive pool of 26 providers that will be able to support the future direction of service provision such as bringing people back into Stockport. Update March 2014 – A new provider has been allocated a contract to work within Stockport. Outsourcing of some in-house tenancies has stimulated the local market and has enabled the in-house provider to concentrate on supporting PB's` are being promoted to enhance informed choice	
	ACTION	**PROGRAMME OF WORK**	**LEAD PERSON/ORGANISATION**	**TIMESCALES**	**UPDATE ON PROGRESS – FEBRUARY 2015**	**RAG**
13.	Children and young people disability services will undertake an audit all placements against procedures and policies to assess if they are fit for purpose		Ian Donegani/John Carey	October 2013	Work is continuing on the 0-25 agenda and influences commissioning practice. Update March 2014 – M Warren to raise with Head of Children's Disability Services.	

APPENDIX D

Stockport's Multi-agency Training Stategy for Safeguarding Adutls at Risk & Mental Capacity Act

April 2014 – April 2015

1. Introduction

1.1 This document outlines the strategy for the development and delivery of Safeguarding Adults at risk (SAAR) training in Stockport. It has been prepared by the chair of Stockport's Training Strategy Sub- group (TSSG) on behalf of the group. The TSSG is a sub group of the SA Board and has representation from most of the main partners[1]. The group has responsibility for the development and delivery of Safeguarding Adults training in Stockport, and as far as possible, this is achieved through a multi-agency training

[1] In May 2014, the membership of the TSSG has representation from the following partners: Pennine Care, SAMCAS, Workforce Development SMBC, NHS foundation Trust, CCG, and an Independent Provider service.

model where trainings are delivered across partner organisations by a range of trainers. There is a multi-agency training pool that is supported to deliver the Alerter training. Additionally, the TSSG analyses training statistics to keep an overview of how provider services are meeting the requirement of Stockport's SAAR Competency framework.

1.2 Aims of the training strategy

Overall aim:

To provide a comprehensive range of high quality trainings to enable practitioners and managers from all partner agencies within Stockport, to meet the requirements of Stockport's Safeguarding Adults at risk Competency Framework and have a good understanding of their role and responsibilities under the Stockport All Agency Safeguarding Adults Policy. Training needs in relation to the implementation of the Mental Capacity Act 2005 are addressed within this training strategy due to the significance of this legislative framework for any safeguarding work

The strategy aims to:

- support the Safeguarding Adults Board and its partner agencies in meeting the requirements of national guidance
- support the development of good practice in responding to and addressing safeguarding adults issues in partner agencies
- provide a structured approach to the training required to meet these needs to ensure that all staff are trained to a high standard
- provide training in a multi-agency format that shows how partner policies link into the all agency Safeguarding Adults' policy
- raise awareness of safeguarding issues amongst Service Users and unpaid carers
- promote a consistent approach to Safeguarding Adults in Stockport
- provide training in line with Stockport's Safeguarding Adults Competency Framework (see appendix 1)

1.3 The strategic framework for Safeguarding Adults training originates from two key documents: **'No Secrets' (DOH 2000)** and '**Safeguarding Adults – A National Framework of Standards for good practice and outcomes in adult protection work'. (ADASS 2005)** This strategy has also incorporated the recommendations from the most recent **ADASS advice and guidance on Safeguarding Adults (March 2013). The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards 2009**, along with the associated codes of practice that provide the legislative framework for working with issues of capacity which is an essential element of all safeguarding work.

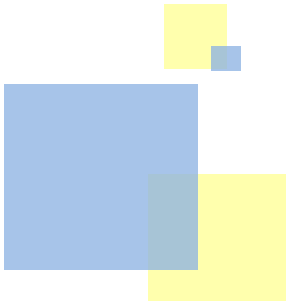
1.4 The Training Strategy also considers national reports/research relating to Safeguarding Adults and MCA to ensure that the strategy reflects national best practice e.g. the Care Quality Commission report March 2013 on MCA and Deprivation of Liberty Safeguards that found widespread misunderstanding of the legislation across services and made recommendations to address this.

1.5 Significant national developments that are likely to have an impact on the development and delivery of Safeguarding Adults practice and training in Stockport are:

- **The development of Personalisation under the Transformation of Social Care Agenda**

  This offers people the opportunity to manage their personal budget themselves employing their own personal assistants. This could change how safeguarding risks present themselves and how they are managed, and could influence practice and training. Staff Development in Stockport have introduced a training programme available for personal assistants, which includes access to the Safeguarding Adults Alerter training, however at present we do not have many personal assistants accessing this course. The TSSG has designed a flier for all those managing a personal budget and employing personal assistants to make them aware of basic ways to safeguard themselves and additional resources they can access from the Choosing and Purchasing team to inform them on safeguarding issues.

- **The Adult Social Care Act**
  This legislation will introduce a number of changes to Safeguarding Adults practice in April 2015 including a duty for local authorities to make enquiries and Safeguarding Adults Boards to be on a statutory footing. These proposals are likely to lead to some changes in practice with implications for training.



2. Overview of Safeguarding Adults at risk training available

All trainings are advertised on the Staff Development website

www.staffdev/training/safeguardingadults. There is a facility to nominate electronically. The Staff Development team can be contacted on 0161 218 1770.

2.1 Alerter Training

Alerter training, which also incorporates basic information on the Mental Capacity Act, is available to all front line staff from provider services who deliver care in the Stockport borough. It is 3.5 hour training, delivered by members from the multi-agency training pool. Four sessions of this training are now delivered per month for groups of up to 30 staff. In addition, be spoke training can be delivered on-site. Please contact Staff Development for further information on this (either through the website or via phone Tel 0161 218 1770).

Alerter refresher Training –

It is recommended that participants attend a refresher every 2 years. This condensed training recaps the essential learning from the Alerter session and then builds on this to explore current issues in more depth with an update on local and national developments

Train the trainer's is now offered to support organisations to deliver Alerter training in house using the same training materials that meet the requirements of the competency framework. Workforce Development Stockport Metropolitan Borough Council (SMBC) can offer some ongoing support to organisations after the one day training. Some participants choose to join the SA training pool which receives ongoing support to deliver the in house sessions. Please contact Workforce Development (SMBC) for information on this.

Workbook available for managers to use with their Alerter staff in supervision sessions

A workbook is available to consolidate and integrate learning into practice. This is an optional tool for managers to use if they feel it would be helpful to support learning in practice.

2.2 Safeguarding Adults for Referrers

This is a one day training available to all staff who supervise Alerters. It is a multi-agency training that addresses the responsibilities of the referrer under Stockport's Multi-agency policy and procedures for adults at risk.

2.3 Inquiry Officer Training

This 3 day training is for all staff who may carry out the designated role of the Inquiry Officer as outlined in the Policy (SWs, CPNs and Community Learning Disability nurses). The training consists of an initial two day course delivered in house. There is an additional third day of training which is specifically about interviewing techniques. This training is delivered by an external trainer.

Inquiry Officer Refresher - a refresher training for Inquiry Officers updating on the revised policy and procedures will take place between April 2014 and Sept 2014 for all designated Inquiry officers.

2.4 Practitioner Forum (Safeguarding Adult's and Mental capacity Act)

The forum meets quarterly for 2 hours and is open to all Inquiry officers and their managers. It provides a means to discuss practice and policy issues, encourage reflection on practice and build on practitioner confidence. The varied format includes a mixture of guest speakers and open debate. The forum provides a valuable opportunity for the dissemination of relevant information and updates in additional to discussion of individual cases.

2.6 Best Interest Assessor Practitioner's Forum

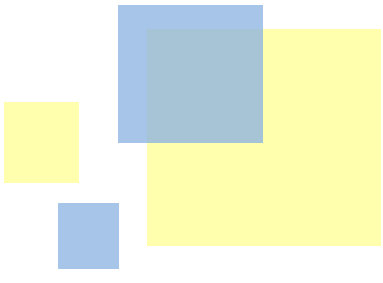
This forum meets quarterly and aims to support the BIA's to carry out their role by discussing best practice and unpicking relevant case law.

2.7 Safeguarding Adults at risk for responsible managers

Training for responsible managers is offered as required to those who supervise investigations.

2.8 Training for Admin Staff on minute taking for safeguarding meetings

Training is available on taking minutes in safeguarding Adults meetings that covers all aspects of the role from the practicalities of recording to terminology that may be used.



2.9 Service User/Carer Training

Stockport's Keeping yourself safe DVD is available from Staff Development free of charge and is aimed at raising awareness amongst service users of safeguarding issues particularly for those with a disability. Many partner organisations are working with this DVD now.

Safeguarding training for informal carers is also now available as part of our program for informal carers.

'The A Team' is a group of service users with a learning disability who are being supported to deliver peer training on safeguarding issues.

E Learning

There are three E learning programs currently available for SAAR & MCA training. These are primarily used in conjunction with other trainings to support learning. The TSSG recognises that E Learning can be a helpful learning, however, it has a number of limitations, especially in relation to SAAR training and the TTSG feel that it should only be used in conjunction with other in-put involving discussion and group activity to ensure full understanding of this complex area of practice. This approach is endorsed by the findings of the Care Quality Commission reports, who have raised concerns about the use of E Learning for provider services.

3. Overview of Mental Capacity Act training available

Mental Capacity Act training has primarily been offered through E learning tools for a number of years in Stockport. However, research by the Care Quality Commission (CQC March 2013) suggests that nationally, the MCA is often poorly implemented by providers and practitioners. Additionally there has been a Supreme Court Judgment in March 2014 that has significantly amended the definition of a Deprivation of Liberty. The TSSG feels strongly that face to face training is required for both the implementation of the MCA and DOLs to ensure a thorough understanding of the legislation and how it must be implemented.

4. Safeguarding Adults at Risk (SAAR) Development Strategy for April 2014 to April 2015

There is a training program of SAAR trainings for the coming year that will be implemented through Workforce Development (SMBC). In addition, the TSSG have identified a number of priorities for the coming year to strengthen the existing trainings outlined above, and address identified gaps in provision.

Identified priorities for SAAR training 2014 - 2015:

4.1 Support providers to have a fully trained workforce through:

- Raising awareness of Stockport's SA competency framework
- Offering train the trainers as required and supporting where necessary to implement the training
- Ensuring there are enough courses to meet demand (Alerter and referrer)

Specific focus areas for provider services this year are:

4.1.1 Ensure providers understand their new responsibilities under the revised policy and procedures through offering some briefing sessions – these were not delivered and have been carried over to this year

4.1.2 Develop and deliver training for provider supervisors on their internal investigations – this has again been carried over as an identified need specifically as we move forward with the thresholds doc

4.1.3 Organise a briefing session from the disclosure and Barring Service for January 2015 – yes completed in Jan

4.1.4 Continue gaining an overview of SA training delivered by provider services – this data is now being collated through the Quality team and the CCG on all providers. – this info is now part of the annual review and will continue to be collated as we work more closely with providers on this.

4.1.5 Develop and deliver a joint Safeguarding Adults and children's alerter course for those staff who work with both over 18 's and under 18's

A pilot was developed and delivered. This highlighted that the focus needed to be on those services working with young adults where there is currently a gap in training provision. This training still needs to be developed.

4.2 Ensure all health partners clearly understand their role in relation to safeguarding adults.

Specific priorities for health partners this year are:

4.2.1 Review training required for GP's and other staff at GP practices

Training has been delivered across GP's practices and some sessions done at specific events.

4.2.2 Review training required for DN's and their managers

This is still an identified need

4.3 Ensure that all Inquiry Officers and responsible managers are confident in their role in the SA process

Specific priorities for assessment team staff include:

4.3.1 Complete Inquiry officer refresher to all assessment teams including Pennine. – Pennine training still outstanding as have been waiting agreement re scope of responsibility for SA investigations within Pennine.

4.4 Other priorities focusing on prevention and a personalised focus in the application of the policy:

4.4.1 Raising awareness of safeguarding and adult protection amongst people with a learning disability in Stockport through the work of the 'A Team', a group of service users who deliver peer led sessions in the community on prevention – this group has continued to deliver training – Debbie Gale can provide stats of delivery.

4.4.2 Offer safeguarding adults at risk awareness sessions to service users and carers as requested – none requested

4.4.3 Offer 2 specific 'Dignity in care' workshops to tie in with Dignity in care day in Feb 2015 for provider services – not delivered due to capacity issues

4.4.4 Lessons learned – improved methodology is required to collate the lessons learned and disseminate through the forums and trainings to all staff as appropriate – practice issues have been shared through the SA forum for practitioners. This work is still on-going

4.4.5 all trainings need to emphasise the need to keep the adult at risk at the heart of the process, giving consideration to their wishes and views as outlined in ADASS national guidance 'Making Safeguarding Personal'

5. Mental Capacity Act (MCA) training Development Strategy for April 2014 to April 2015

Identified priorities for MCA training 2014 - 2015:

5.1 Support provider services to be fully compliant with the MCA

5.1.1 Offer 1 day training sessions for provider managers and supervisors on the application of the MCA including making more complex Best Interest decisions and DOLs - to be cascaded down in organisations - a number of sessions have been offered for provider managers (4)

5.1.2 Offer bespoke training in house where appropriate to front line staff

5.2 Ensuring all staff at Stepping Hill Hospital are compliant with the MCA

5.2.1 Staff to receive training on MCA as appropriate to their role through the implementation of SHH MCA training strategy which will have a CQUIN attached to it - mandatory joint training on SA and MCA and DOLs is being rolled out across the FT

5.3 Ensuring all Adult Social Care staff in assessment teams are compliant with the MCA

5.3.1 Offer bespoke training to assessment teams as required

5.3.2 Commission specialist training in MCA case law including DOLs - a DOLS legal update sessions was convened

5.4 **Ensure enough new Best Interest Assessors are trained to meet the demand of DOLs assessments that are expected due to the Supreme Court Judgment March 2014**

BIA's have been trained and staff sent on all the University training sessions

5.4.1 Secure funding to train sufficient BIA's

6. Conclusion

This Strategy outlines a model which facilitates a range of SAAR trainings that are mapped to competencies for the different roles identified in Stockport's safeguarding Adults Policy. The strategy also addresses the need for awareness raising amongst Service Users and carers. Meeting training needs in relation to the Mental Capacity Act is an integral strand of the training strategy to reflect the significance of this legislative framework in all safeguarding work.

The strategy is ambitious given the limited resources of the TSSG, however, through further developing and maintaining the commitment of all partners the TTSG is confident that this strategy will be achieved.

Written by: Ann Brooking (chair) on behalf of the Safeguarding Adults Training sub group

Agreed by: Stockport's Safeguarding Adults Board electronically June 2014

APPENDIX E – STRATEGIC PLAN

Stockport Safeguarding Adults Board Strategic Plan 2015-17

Vision

That all adults living in Stockport are able to exercise their right to live in safety, free from abuse or neglect.

Purpose

The Safeguarding Adults Board must obtain assurance that the arrangements for safeguarding adults who, because of their care and support needs, are unable to protect themselves from abuse or neglect, are as effective as possible.

Objectives

Stockport Safeguarding Adults Board has a wide range of responsibilities. It would not be possible or desirable to include them all in this Strategic Plan. The objectives set out in this plan represent the issues to which the Board will commit additional effort and resources over the lifetime of the plan.

Each objective will be supported by a detailed action plan. The Board is supported by a number of Sub Groups. The Sub Groups will be responsible for ensuring progress against each of the action plans and will periodically report on progress to the Board.

1. To ensure that Stockport Safeguarding Adults Board fully complies with the requirements of the Care Act 2014.

2. To champion the "Making Safeguarding Personal" agenda and ensure that all partner agencies commit themselves to it.

3. To raise awareness of adult safeguarding amongst professionals and the wider community.

4. To develop a positive learning environment so that practice is continually improved by learning from case reviews and analysis of performance data.

5. To develop preventative strategies which aim to reduce instances of abuse and neglect.

6. To ensure that the adult and children's safeguarding boards collaborate to focus on the effectiveness of transition of young people to adulthood.

7. To monitor the impact of budget cuts on outcomes for adults with care and support needs and obtain assurance that effective action has been taken to mitigate risks.

APPENDIX F – TERMS OF REFERENCE

Stockport Safeguarding Adults Board

Terms of Reference

Vision

That all adults living in Stockport are able to exercise their right to live in safety, free from abuse or neglect.

Purpose of the Board

The Safeguarding Adults Board obtains assurance about the effectiveness of local arrangements for safeguarding adults who, because of their care and support needs, are unable to protect themselves from abuse or neglect.

Core duties

The Board will publish a strategic plan each financial year which sets out its key objectives and says how those objectives will be met and what members of the Board will do to achieve the objectives.

The Board will publish an annual report detailing the progress the Board has made during the course of the financial year in implementing the strategic plan and achieving its objectives

The Board will conduct any Safeguarding Adults Reviews (SAR) where the criteria for conducting a SAR are met and will ensure any learning from the reviews is appropriately disseminated and is used to improve practice.

Key responsibilities

To hold partner agencies to account and gain assurance in respect of the effectiveness of their safeguarding arrangements.

To analyse and interrogate data relating to safeguarding adults, including safeguarding notifications to increase the Board's understanding of the prevalence of abuse and neglect locally.

To develop policies and strategies for protecting adults who have care and support needs. Such policies need to include the arrangements for managing adult

safeguarding and dealing with complaints, grievances and professional and administrative malpractice.

To develop preventative strategies that aim to reduce instances of abuse and neglect.

To develop strategies to deal with the impact of issues of race, ethnicity. Religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect.

To promote multi-agency training and consider any specialist training that may be required.

To monitor and review the implementation and impact of policy and training.

To provide advice and assistance to others in improving adult safeguarding mechanisms.

To balance the requirements of confidentiality with the consideration that, to protect adults, it may be necessary to share information on a "need to know basis".

To develop arrangements for peer review and self-audit of the effectiveness of the Board.

To ensure compliance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

To develop effective links with other strategic partnerships in particular the Health and Wellbeing Board and the Safeguarding Children Board.

Consultation

The Board has a duty to involve the local community in developing the strategic plan. The Board will develop a plan to discharge this duty in time for the development of the Strategic Plan in 2016-17.

The Board will take account of the views of adults with care and support needs, their families, advocates and carer representatives in discharging all core duties and key responsibilities.

Sub Groups

The SSAB will form sub groups to enable it to discharge its core duties and key responsibilities.

The SSAB may from time to time form task and finish groups to undertake pieces of work relevant to its core duties and key responsibilities.

Meetings of the Board

The Board will meet at two monthly intervals.

The Board will be quorate if there is a minimum of two thirds of members in attendance.

If a Board member is unable to attend he or she will arrange for a deputy to be briefed and to attend in their place.

The Board agenda and papers will be circulated not less than one week prior to the date of the meeting.

Minutes of Board meetings will be distributed within 10 working days of the date of the meeting.