Safeguarding Adults in Stockport

Safeguarding Adults Board

Annual Report

Year Ending 31 March 2013

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

NHS
Stockport

Section1 - Contents

2. Chair's Foreword

The purpose of this annual report is to record the work of the Stockport Safeguarding Adults Board (SSAB) during the financial year 2012-13, to enable the Board to be held to account for what it has achieved or not achieved and to raise awareness of the safeguarding adult's agenda amongst the wider community.

The safeguarding adult's board is the key local forum which brings together partner agencies to ensure that arrangements for safeguarding adults are well co-ordinated and effective. In particular that robust multi-agency policy and procedures are in place, supported by multi-agency training so that staffs have the necessary skills and confidence.

Current membership of the Board is shown at appendix 1. Clearly it is a priority to widen membership to include the local Healthwatch and a greater range of providers.

Solid progress has been made in a number of key areas over the past year. The multi-agency safeguarding adult's policy has been fully revised and is supported by a sound training and development strategy. The first serious case review commissioned by the Board was published during the year following the murder of a young man who had been a looked after child and had become marginalised from society. This review strongly influenced the establishment of a multi-agency forum for considering the cases of adults at risk who for a variety of reasons are not engaged with or are not considered eligible for current services. (see section 4)

Key areas of work for the year ahead are to develop a performance framework for the Board to be better informed about the effectiveness of services and to get the Communications Sub Group of the Board fully functional so that we can continue to enhance awareness of the need to safeguard adults at risk.

Additionally there have been a number of major national developments such as the publication of the Care and Support Bill, changes in the Care Quality Commission, the re-organisation of the NHS and the exposure of scandals at Winterbourne View and Mid Staffs Hospital which will have significant local implications.

This is the second annual report published since I became independent chair of the Safeguarding Adults Board. Last year I observed that the Safeguarding Adults Board appeared to be the "poor relation" of strategic partnership boards in the borough. I am compelled to repeat the point this year. The Board lacks the capacity to plan and carry out its strategy and objectives. The very late publication of this annual report is but a small example of this lack of capacity. It is vital that capacity is enhanced over the

coming year if we are to function effectively as a Board and prepare for the implementation of the Care and Support Bill which will put Safeguarding Adults Boards on a statutory basis and require the preparation of an annual strategic plan amongst other things. Currently the Board is almost exclusively funded by Stockport Council. It is neither appropriate nor equitable for a key partnership board to be funded primarily by just one partner and it is hoped that progress can be made on securing funding from all core partners over the coming year.

Another deficiency which must be addressed over the coming year is the lack of governance arrangements for the Board. Currently no body holds the Safeguarding Adults Board to account. This lack of oversight of an area of such high priority represents a risk which must be addressed. The Health and Wellbeing Board for Stockport came into being in April 2013 and it is hoped that the requirement to share this annual report with that Board will help to address the accountability deficit which currently exists.

However it continues to be a privilege to serve as independent chair of Stockport Safeguarding Adults Board and I would like to pay tribute to the many colleagues working in both the public and private, voluntary and independent sectors for their commitment to the mission of ensuring that all people in the Borough are able to live a life free from harm.

David Mellor
Independent Chair of Stockport Safeguarding Adults Board

3. The Serious Case Review for Adult A

3.1 The Serious Case Review into the death of Adult A was commissioned by the Safeguarding Board in March 2010. The completed Overview Report was agreed by the Board in December 2011. The Report, a Summary by the Independent Chair of the Board and the Multi-agency Action Plan were published on 3rd September 2012 together with a press release. It was a decision of The Board to adopt this proactive approach to publication.

3.2 The documents can be found at:

http://www.stockport.gov.uk/services/socialcarehealth/adultsocialcare/safeguardingadults/

3.4 Monitoring of the completion of the action plan is jointly shared between the Safeguarding Children Board and the Safeguarding Adults Board with each Board signing off on the appropriate actions.

3.5 In order to effectively share the learning from the Serious Case Review an engagement event was arranged by the Adult and Children Safeguarding Training leads. This was held on 31st January at Fred Perry House and was well attended by a wide range of professionals from Children and Adult Social Care, Health Services, the Police and the Independent, Private and Voluntary sectors.

3.6 The morning session provided opportunity to look in detail at the specific issues arising from the Serious Case Review including the challenge of creating quality services that support the transition from childhood to adulthood, the significance of mental capacity and decision making skills in determining interventions and the change in statutory responsibilities as people reach the age of 18.

3.7 The afternoon session was used to present to attendees a new model of service which had been developed over the previous 12 months; to subject it to constructive analysis and criticism prior to piloting it. For more detail on this see section 4 below

3.8 Additionally a series of case studies based on the events of the serious case review and which were used to support learning on the day are also available at the link above.

4. Multi Agency Adults at Risk Scheme (MAARS)

4.1 This initiative, originally called "The Vulnerable Adults in the Community Working Group" was convened in January 2012 following discussion between Adult Social Care (ASC) and The Stockport Community Safety Unit. (CSU) Some of other key drivers included:-

- Issues of hate crime in Stockport and whether we could learn from some of the national work on serious case reviews e.g. David Askew and Fiona Pilkington.
- Findings from Stockport's Serious Case Review (Adult A)
- The number of referrals made to the Adult Social Care Contact Centre where no action is taken due to not meeting the eligibility criteria.
- Growing concerns within the CSU Anti-Social Behaviour Team about some of the people they are involved in and how services work together to protect adults at risk.
- The centralisation of Greater Manchester Police – Public Protection Division and work on vulnerable victims.
- The need to promote an awareness of individual agencies roles and responsibilities in relation to 'adults at risk'.
- The issue of balancing risk and choice and equipping professionals to understand the issues of positive risk taking.

4.2 The group is chaired by Vince Fraga – Head of Modernisation (ASC) and the vice chair is Helen Boyle – Community Safety Strategic Manager and it reports jointly to the Safeguarding Adults Board and the Safer Stockport Partnership Board.

4.3 The model being developed is based loosely on that of the MARAC (Multi Agency Risk Assessment Conference) used in high risk domestic abuse cases and will bring together a range of services committed to offering support to those individuals who for a variety of reasons do not engage with or are not considered eligible for current mainstream services.

4.4 Following the engagement event the working group will further refine the model with the intention of piloting next year.

5. Multi Agency Policy and Procedures Revision

5.1 Action D2 of the current Safeguarding Board business plan provided for extensive revision and updating of the 2nd edition policy and procedures. This was led by The Safeguarding Adults Service and the Workforce Development lead. The Stockport Multi-Agency Safeguarding Adults Policy and Procedures is the local code of practice that has been formulated and agreed in response to No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse, (DOH 2000).

5.2 A first draft for consultation was ready in November 2012 and 3 formal consultation events were held in January and February 2013

5.3 The first event was for Board and Implementation Group Members, the second for a range of service providers and the third for operational staff in the Local Authority's Adult Social Care and Pennine Care NHS FT. Additionally a wide ranging electronic consultation was carried out.

5.4 The third edition of Stockport Safeguarding Adults Policy and Operational procedures went live October 2013

Some of the key differences within the third edition of the policy are:

- Adoption of the term "Adult at Risk" as a replacement for "vulnerable adult". This places the emphasis on the risk to the individual as a result of the actions of others rather than some inherent vulnerability of the person themselves.

- Placing the victim at the centre of the investigation and ensuring they are supported to retain control.

- Clearer differentiation between the responsibility of all organisations to develop their services in ways which build appropriate measures to safeguard the welfare of their client and the specific operational adult protection investigations procedures that are to be instigated when it is believed that an adult is being harmed or at risk of harm.

- The policy and procedures will be web based for professionals and public allowing for easier access of the specific information required as well as enabling on-going updating as circumstances and expectations change.

6. Training Sub Group Report

The SA Training Strategy was mainly delivered to plan. Key achievements are outlined below in section 6.1 and targets not met are outlined in section 6.2. The statistics for the multi-agency safeguarding adults training delivered are outlined in section 6.3.

The legacy of ' No Secrets' is that all those involved in the provision of health and social care will undergo appropriate training to ensure all staff meet the relevant level of competency in relation to safeguarding adults at risk

6.1 Key Achievements in 2012 – 2013

6.1.1 To address the training needs identified from the Serious Case Review (SCR) an action plan was implemented as outlined below all actions were signed off by the SA Board in June 2013.

- Prepare a case study to be used in trainings highlighting the issues of the SCR.
- Ensure learning from the SCR is incorporated into all trainings and disseminated widely through the use of blogs, newsletter etc.
- Ensure Multi-agency Mental capacity Act and decision making training is provided to address issues for relevant staff in both adults and children's services.

6.1.2 Mental Capacity Act and Deprivation of Liberty Safeguards training has been developed for residential care homes and delivered to all Borough Care managers as a pilot in July 2012. The training is now available to all registered care homes, to be delivered on site, in order to improve awareness and understanding of this legislation and the requirements of care homes in meeting this.

6.1.3 A questionnaire was devised and sent out in September 2012 to establish how providers are training their staff in safeguarding adults. To date 32 providers have returned the questionnaire and the Training Sub Group is developing a strategy to improve this uptake over the next year. This is to satisfy a request from the SA Board to ensure that all providers are meeting the training requirements of the Safeguarding competency framework.

6.1.4 A one day event on MCA entitled; 'Safeguarding in employment: Key challenges in Social Care' was commissioned and delivered in Jan 2013 by a barrister. The course provided essential learning on safeguarding and the law. It was targeted at social work practitioners and their managers.

6.1.5 A flier outlining possible issues that those employing their own Personal Assistants through a person budget should be aware of and where to find

additional information was compiled and is now being given to service users by the Choosing and Purchasing team.

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

6.1.7 In Jan 2013 a very successful consultation event was held about the on-going work that has been done by the 'Adults at risk' group to support the development of the new 'Multi-agency Adults at Risk System' (MAARS).

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

6.1.9 The new E-learning training tool for Safeguarding Adults has proved very successful as a method of meeting the training needs of certain groups of staff such as dental practices and General Practitioners. The role of E Learning is being reviewed and further expanded for the coming year.

6.1.10 The NHS foundation Trust as made Safeguarding training a CEQUIN for the Trust to prioritise this area of training. This has led to the development of a SA training strategy and a more structured approach to the training which will be further developed in the coming year.

6.1.11 A new Referrer refresher course introduced last year has had a very poor take up with a number of courses being cancelled due to low nominations. This is going to be addressed in 2013/2014 through a revision of both the referrer courses and reverting to just one referrer's training covering all the essential competencies. However, overall this year saw a similar number of provider managers trained as in the previous year.

6.1.12 A group of service users in disability services called the 'A Team' offer interactive peer training on 'Keeping yourself safe' which they deliver in service settings and also to schools at their discovery days. This year they delivered at least 8 sessions of this particular programme in various venues across Stockport.

6.2 Training Targets Not Met

6.2.1 'Train the trainers' – this course has unfortunately been cancelled twice due to awaiting the revised policy and procedures and is now scheduled for the autumn. This training supports provider services to deliver Alerter training in house using the Alerter training pack to ensure consistency and that all competencies are met. There is now quite a lot of demand for this training from provider services.

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

6.2.3 It was intended to offer training on the Channel Project (Channel Project is a key element of the *Prevent* strategy. It is a multi-agency approach to protect people at risk from radicalisation. Channel uses existing collaboration between local authorities, statutory partners (such as the education and health sectors, social services, children's and youth services and offender management services), the police and the local community to:

- identify individuals at risk of being drawn into terrorism;
- assess the nature and extent of that risk; and
- develop the most appropriate support plan for the individuals concerned

Two training dates were set up however due to low numbers for the courses these had to be cancelled and we are looking at other ways to inform people of the project e.g. through information on the safeguarding web page and including this information on the Inquiry officer training.

6.2.4 Inquiry officer refresher training – dates were in place to deliver this training during 2012/2013, however this were cancelled awaiting the revised multi-agency policy and procedures and a refresher course is now planned for early 2014

Please note that a full list of trainings offered can be found on the Staff Development website:

http://www.stockport.gov.uk/services/socialcarehealth/adultsocialcare/staffdevelopment/training/adultsocialcarecourses/safeguardingadults/?view=Standard

The Safeguarding Adults Training Strategy for 2013/2014 outlining the priorities identified for the coming year can be found on the Safeguarding Adults website:

http://www.stockport.gov.uk/services/socialcarehealth/adultsocialcare/safeguardingadults/

The Safeguarding Adults Competency Framework can also be found on the safeguarding Adults website:

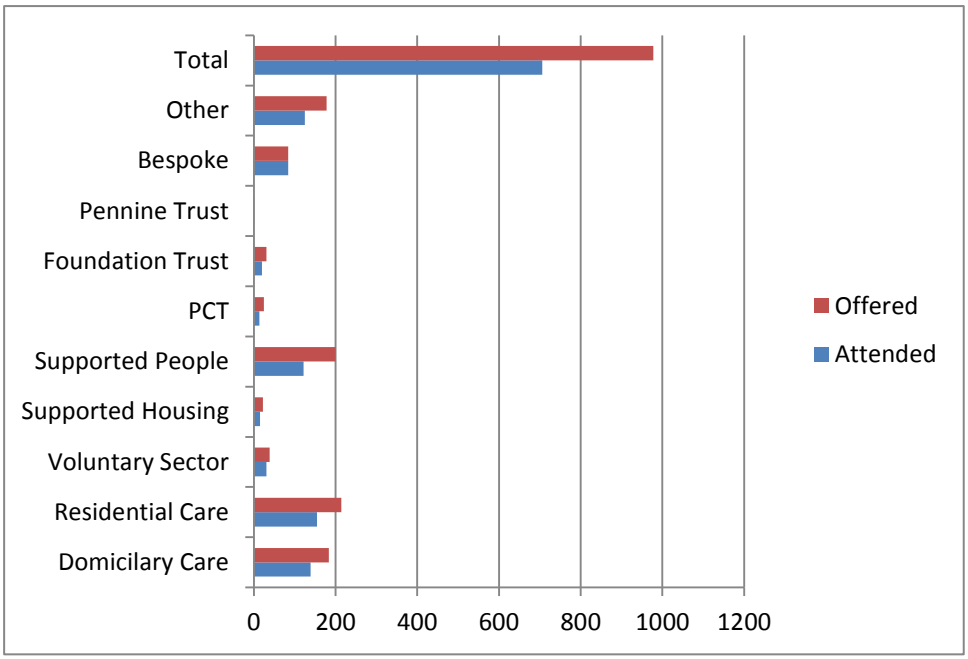
6.3 Training Statistics for the multi-agency safeguarding adults training.

6.3.1 Alerters and Alerters Refresher Training

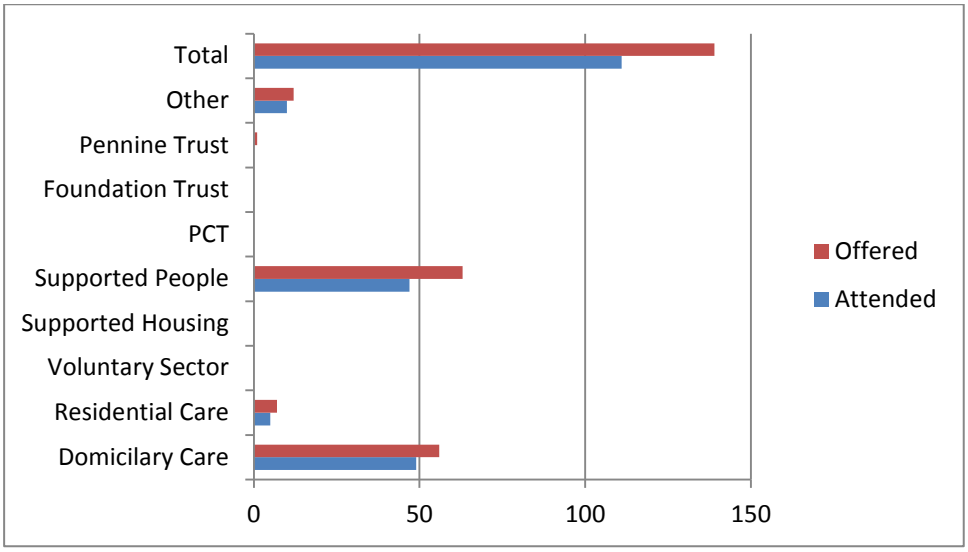
Overall 817 people have attended the Alerter and Alerter refresher trainings this year; this is a similar number of staff trained through the programme as the previous year (714 in 2011/2012).
1117 places were offered, giving an attendance rate of 73% (similar attendance rate to last year).

Alerters & Alerter Refresher
Offered: 1117 places
Attended 817 places

Training Course (Alerter)



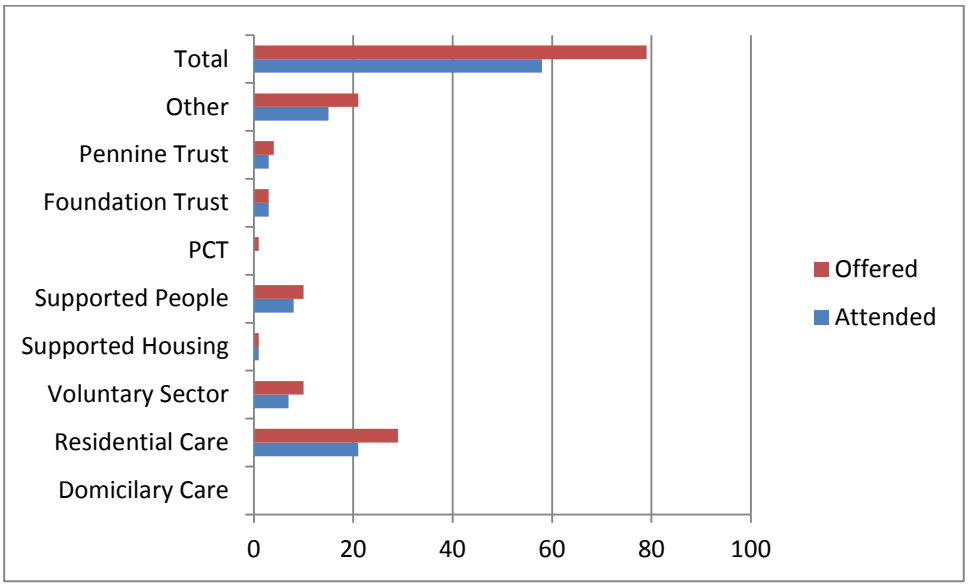
Training Course (Alerter Refresher)



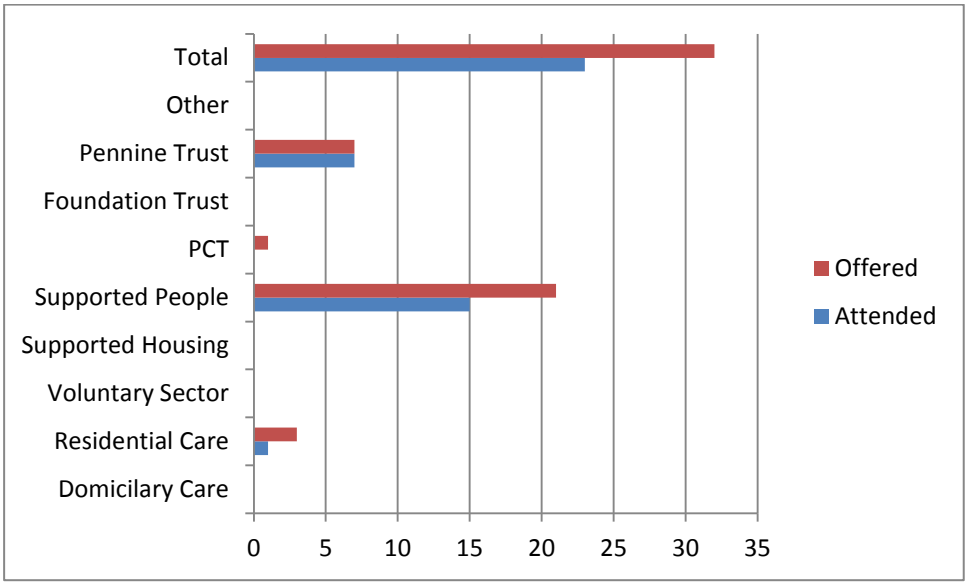
6.3.2 Referrers and Referrers Refresher Training.

Overall 81 people have attended the referrer and referrer refresher trainings this year. This is a 7% increase on the previous year (76 in 2011/2012)

Training course (Referrer)



Training course (Referrers Refresher)



6.3.5 Inquiry Officer Training

This two day course was delivered in the summer of 2012 for bureau social work staff carrying out the role of Inquiry officer. Two courses were run, training a total of 24 people

The one day course on Investigation techniques was delivered to 16 staff that had completed the 2 day course.

7. Performance Information

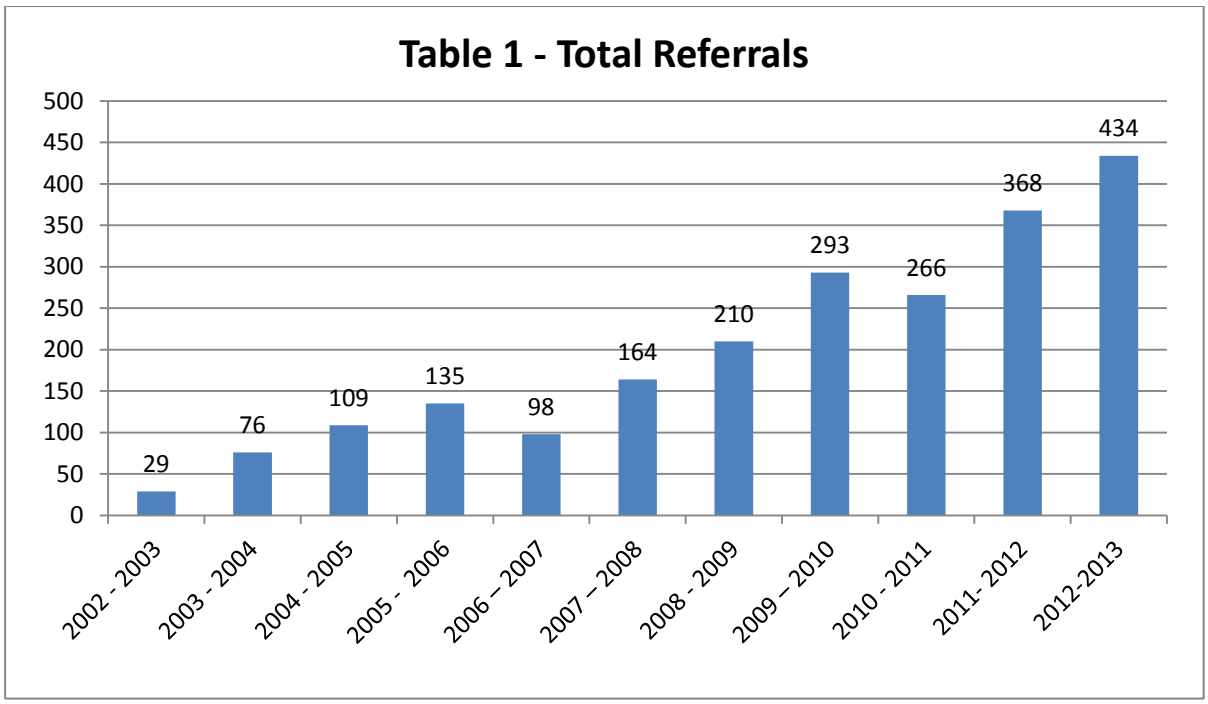
7.1 Introduction of "Alert" category

From 1st May 2012 a category of "Alert" was introduced on to the electronic social care record. This enables a formal record to be made for all concerns raised at the Contact Centre whether they progress to a referral or not. It allows for a historic record search on receipt of any future information and provides a better picture both of levels of activity and any escalating concerns for named individuals, leading to more informed decision making and judgement of risk.

For the first 11 months – 1st May 2012 to 31st March 2013, adult social care recorded 1255 alerts. All were screened and either closed as inappropriate, signposted to other services or progressed to Safeguarding referrals. As you can see from table 1, this produced 434 referrals.

7.2 Adult Protection Investigations completed within the multi-agency procedures.

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

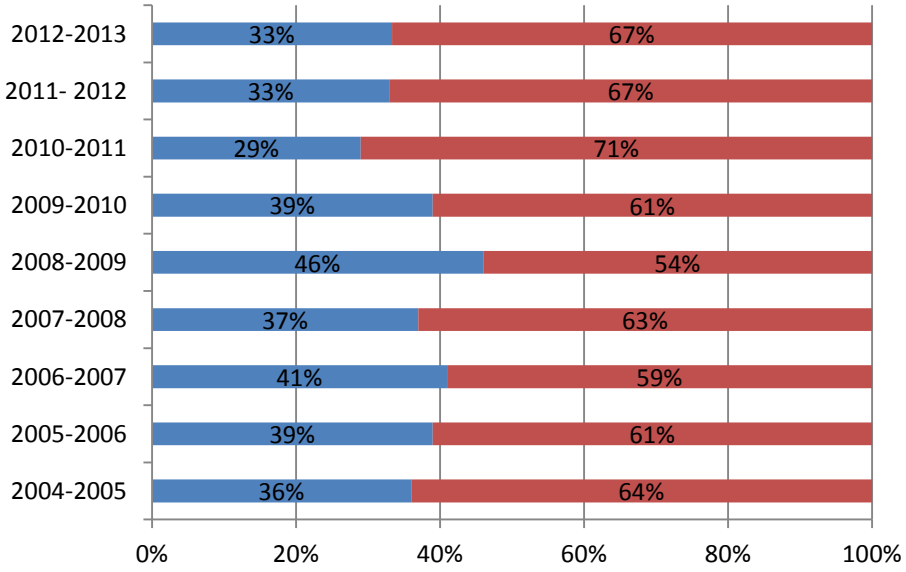


Comment:
The figure of 434 referrals is the total number of new cases opened in during 2012/13 and represents an increase of 18% over the previous year. Not all the 434 referrals have been concluded at this time, as some investigations remain on-going at the time of writing this report and will be included in the completed figures reported on in 2013/14

During the same period (2012/13) a total of 408 investigations have been completed which, compared with last year, represents an increase of 29%. This figure for completed investigations includes referrals which were commenced in the previous year 2011/12.

The 18% increase in referrals can be attributed to the greater engagement with adult safeguarding training and increased general awareness of adult protection issues in light of media coverage of cases such as Winterbourne View and Mid Staffordshire NHS Foundation Trust. This is borne out by increases in referrals from service providers (see table 5.)

Table 2 – Completed Investigations by Gender (%)



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

Table 3 – Referrals received by Age Band and Client Group					
Client Group	**Age Band**				**Total**
	18 to 64	**65 to 74**	**75 to 84**	**85 +**	

Physical Disability, Frailty and temporary illness inc. sensory loss	**10**	**21**	**71**	**139**	**241**
Mental Health (inc. dementia)	**25**	**10**	**47**	**42**	**124**
Learning Disability	**55**	**8**	**5**	**0**	**68**
Substance Misuse	**0**	**0**	**0**	**0**	**0**
Other vulnerable adults	**1**	**0**	**0**	**0**	**1**
Totals	**91**	**39**	**123**	**181**	**434**

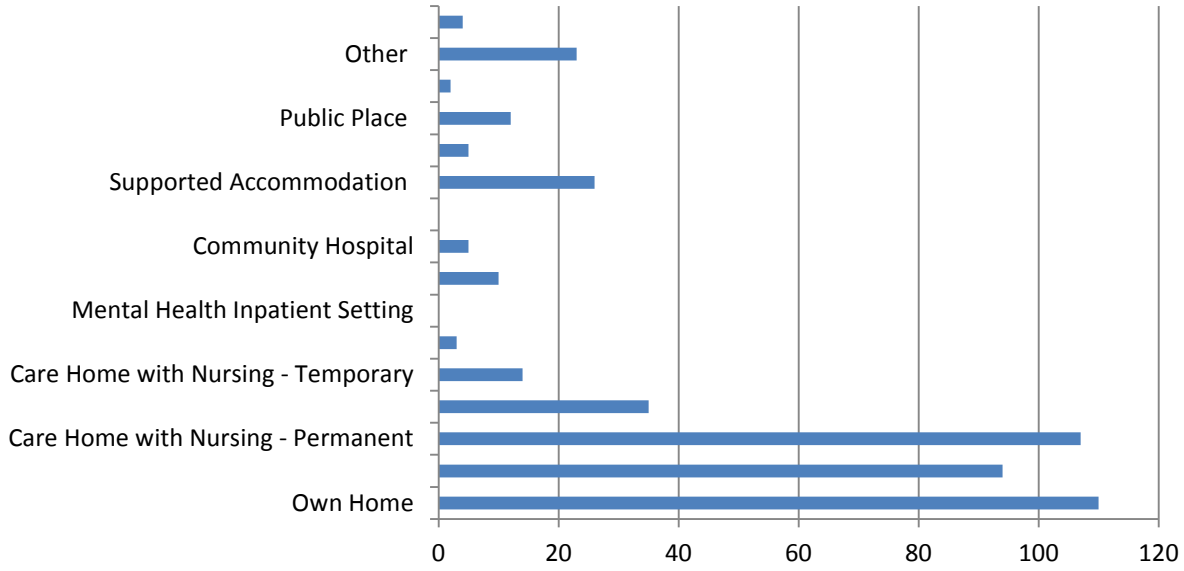
Comment:
Although we no longer record 'older people' as a separate client category it is still the case that the likelihood of abuse increases significantly over the age of 65. The current proportion is 21% under 65, 79% over 65.

Table 4 – Completed Investigations by Type of Abuse and Age					
Type of Abuse	**Age Band**				**Total**
	18 to 64	**65 to 74**	**75 to 84**	**85+**	
Physical	49	14	66	95	224
Sexual	5	1	2	1	9
Psychological /Emotional	35	9	17	20	81
Financial	19	8	15	15	57
Neglect	19	18	54	89	180
Discriminatory	1	0	0	0	1
Institutional	7	3	14	18	42
Total	135	53	168	238	594
Multiple abuse	35	12	35	47	129

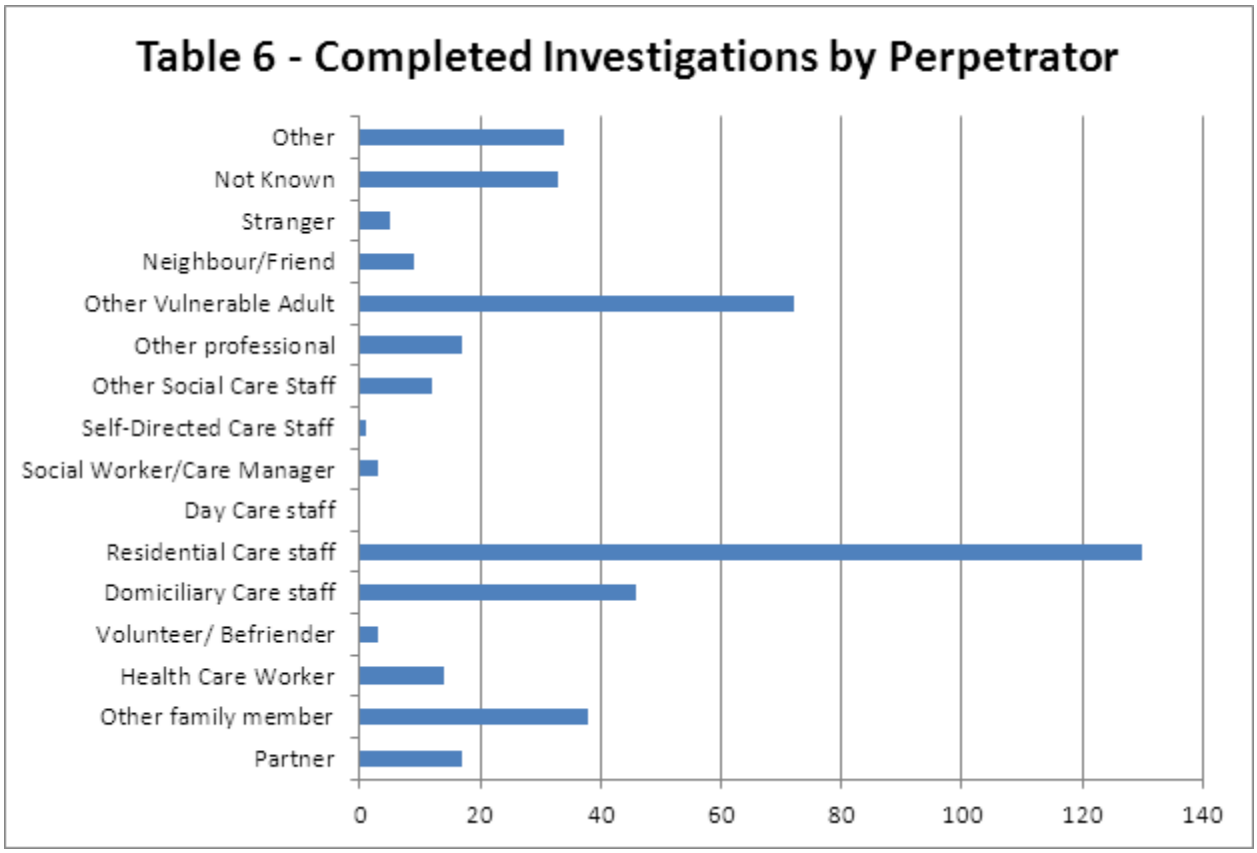
Comment:

The proportions in the types of abuse have risen broadly in line with the increase in referrals. Physical abuse and neglect/omission of care continue to represent the greatest number of alleged abuse incidents accounting for 68% of the referrals. There has been a 50% increase in the reporting of institutional abuse which demonstrates a greater awareness and recognition of the way in which service delivery can and does contribute to abusive practice.

Table 5 – Completed Investigation by Location of Abuse

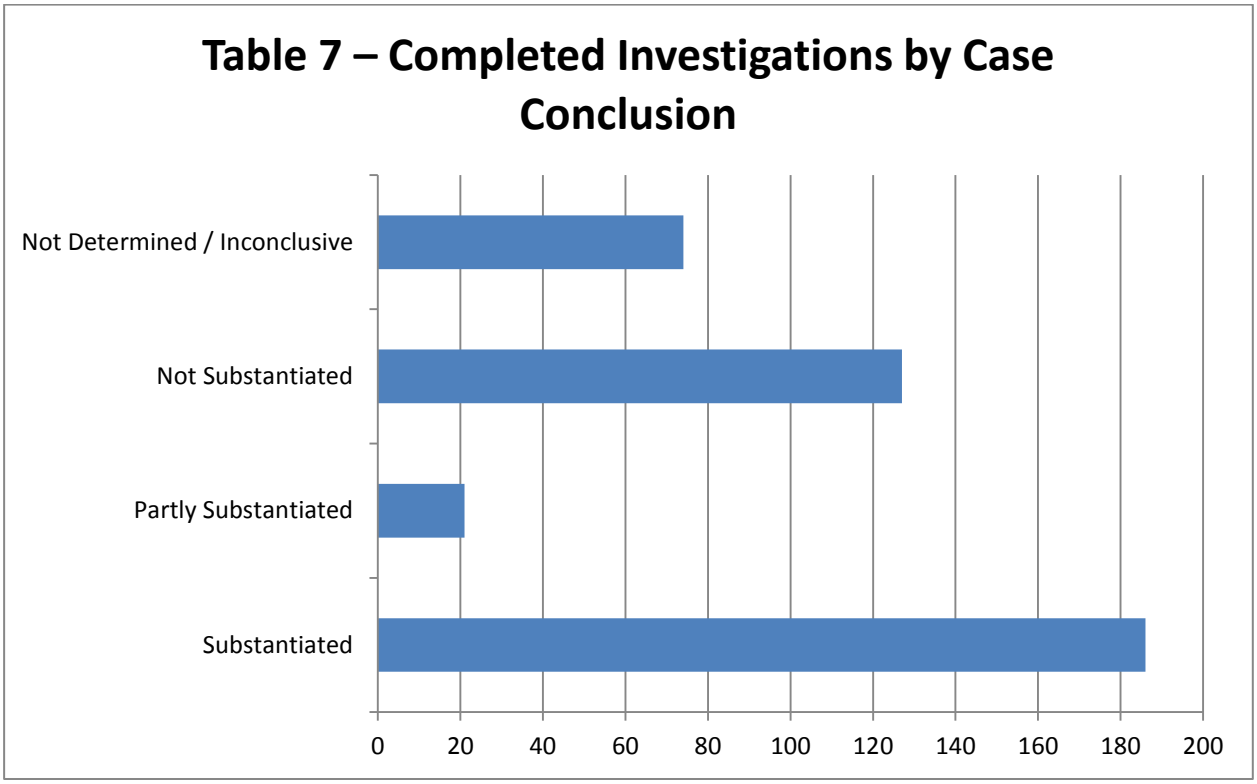


Comment:
Referrals from staff employed in social care (including care home staff) rose by 81% and evidences a greater awareness and preparedness to respond to concerns. However it should be noted that not all alleged abuse incidents within care homes are allegations against the service. Some are reports of incidents concerning family members, visitors and other service users – (see table 6 below for details of alleged perpetrator relationship).



Comment:

In 55 cases the alleged perpetrator was identified as a partner or family member. These incidents would also meet the definition for domestic abuse. – *"Domestic Abuse is defined as any violence or other abuse between family members, current or former partners in an intimate relationship, whenever and wherever the incidents occur. It may include physical, sexual, emotional or financial abuse."*



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

The category of 'not determined/inconclusive' at 18% is a continuation of a reduction over the past two years from 25% and further evidences a greater confidence on the part of Case Conference decision makers in assessing the information and reaching a firm conclusion.

7.3 Deprivation of Liberty Safeguards (DoLs)

The DoLs provide protection to adults in hospitals and care homes that do not have the capacity to consent to their care and treatment and the manner in which it is provided. Care Homes and hospitals must make requests to the Supervisory Body for authorisation to legally deprive someone of their liberty if they believe it is in their best interests. The safeguards also provide a legal process of challenge by the deprived person or their representative similar to that within mental health statute.

As the Supervisory Body (SB) for the Local Authority and NHS Services in Stockport, the SAMCAS receives requests to commission the required series of six assessments when a Managing Authority (MA) (hospital or care home) believes it may be depriving somebody of their liberty. The

request may be preceded by the MA issuing itself with an Urgent Authorisation, where deprivation is believed to already be occurring, or it may be for a Standard Authorisation where the MA expects to be receiving an individual into its care and that this may amount to a deprivation of liberty.

In addition to the 33 DoL assessments detailed below the SAMCAS provided informal advice in 30 other cases relating to both DoLs and MCA issues

1. Number of Requests		
Number of Urgent Requests	19	
Number of Standard Requests	14	
Total		**33**
2. Client Group		
Long Standing Illness	5	
Physical Impairment	3	
Mental Health Condition	19	
Learning disability	6	
Total		**33**
3. Age Group		
18 to 64 years	13	
65 and over	20	
Total		**33**
4. Location		
Care Home	26	
Hospital	7	
Total		**33**
Out-of-Borough	15	
Stockport	18	
Total		**33**
5. Outcome		
DoL Occurring and Authorised	5	
DoL Not Occurring	13	
DoLs occurring and authorised with conditions	15	
Total		**33**

DoLs Case Study 1

Mrs S is a 78 year old lady with a history of cognitive impairment and a diagnosis of Korsakov's Syndrome. She was admitted to hospital following a fall at home and after assessment, which included a best interest decision under the Mental Capacity Act (2005), she was discharged to a care home. Her family were consulted and in agreement with this decision.
Mrs S has objected to being at the care home from the outset and constantly attempts to leave the building. Although she can be distracted, she is persistent. The home is small enough for her to be kept under constant observation without the need for one-to one supervision. However, the actions of the care staff in preventing her leaving are of a sufficiently frequent rate as to cause them to apply for a Deprivation of Liberty authorisation. They issued themselves with an Urgent Authorisation and sent this together with a request for a Standard Authorisation to the Supervisory Body.
Following assessment the Best Interest Assessor was of the opinion that this was a Deprivation of Liberty and recommended a 3 month authorisation in the hope that Mrs S would settle into life at the home.
The DoL was re assessed at the end of the 3 months and as there was no change in Mrs S's circumstances the Best Interest Assessor renewed the DoL for a further period of 6 months.
Mrs S's son has agreed to be the Relevant Person's Representative and the DoL will shortly come up for renewal.

DoLs Case Study 2

Miss X is a 50 year old female with an Acquired Brain Injury as a result of an attempted suicide. She is resistive to staff's support and requires daily insulin injections and up to 3 times daily blood tests.
In order to provide this care and treatment Miss X has to be restrained by staff on a daily basis. This was agreed as a best interest decision under the Mental Capacity Act (2005) but due to the intensity and frequency of the interventions and on the advice of Miss X's Advocate, the care home issued itself with an urgent authorisation and sent this together with a request for a standard authorisation to the Supervisory Body.
The care home is out-of-borough and the request was sent to the host authority who redirected it to Stockport. The ADASS cross boundary arrangements allow for the responsible SB to request the host authority to complete the assessments for which they would be reimbursed at a set fee of £600. However as the care home is located within the Greater Manchester area we carried out the assessments using our own assessors.
The Best Interest Assessor adjudged that this was a DoL and recommended an authorisation for 6 months. On renewal the DoL was set at the maximum period of 12 months as there is no reasonable expectation of a change in condition.

8. Partner Summaries

8.1.1 Stockport Police - Public Protection Division

The PPD has taken on the management responsibility for the Divisional Public Protection Investigation Units (PPIUs), which will remain based on divisions and staffed in accordance to demand. It also draws together the existing Serious Crime Division units such as the Safeguarding Vulnerable Persons Unit, the Sex Offender Management Unit and the Sexual Crime Unit.

The PPIU review all Domestic Abuse, Child protection and vulnerable adults' incidents that occur within Stockport with the aim of identifying vulnerability and potential safeguarding requirements. The PPIU is responsible for referrals to our partner agencies.

Domestic abuse specialist officers will deal with all high risk investigations to ensure that all elements of safeguarding for both victims and perpetrators are assessed.

Child protection specialists will deal with all sexual, physical and neglect offences on children where the abuse has been perpetrated by a person who had care/ custody/control or was in a position of responsibility at the time of the offence. This also includes certain 'child on child' rape investigations.

The Serious Sexual Offences unit is embedded within the PPD. This unit deals with the majority of rape offences across Greater Manchester ensuring a consistent approach for victims, no matter what the circumstances of the incident are, and to help bring more offenders to justice.

Police systems have been improved to risk assess vulnerable victims and any actions for partner agencies can be quickly passed on.

8.1.2 Domestic Abuse

MARAC (Multi Agency Risk Assessment Conferencing) continues to go from strength to strength with more partners involved in the process of managing high risk cases.

Some excellent media work has been rolled out through a number of communication campaigns.

Domestic Violence Homicide Reviews have become a statutory function for the Safer Stockport Partnership

Following Home Office evaluation of the pilot scheme, of which Greater Manchester was one of the chosen areas, the DVPN/DVPO (Domestic Violence Protection Notice/Order) has been utilised during 2013. This disclosure process is well embedded in safeguarding procedures. The

order is an interim measure with a view to the victim obtaining other long term safeguarding orders.

The Domestic Violence Disclosure Scheme (DVDS) – referred to as 'Claire's Law' is being trialled during 2012/13 and Greater Manchester is one of the 4 pilot areas.

8.2 Pennine Care NHS Foundation Trust

8.2.1 Key Achievements 2012/13

Pennine Care NHS Foundation Trust (PCFT) has a full time Head of Safeguarding and Professional Lead in post.

- PCFT has appointed an Adult Safeguarding Operational Manager in a full time position. The focus of this role is to support, develop and raise awareness of Adult Safeguarding across PCFT and represent PCFT as a partner agency at Stockport Adult Safeguarding Board.

- The Safeguarding adult's information leaflet has been renewed and each member of PCFT staff has received a copy in their wage slip in September 2013. The information outlines awareness and guidance on what staffs needs to do if they have a safeguarding concern. Additional information on disclosure and information sharing has been included.

- Improvement of compliance figures for required training has been a key achievement for PCFT to ensure that the electronic links make the system of reporting on incidents and staff training more reliable

- KPMG have undertaken an internal audit as part of its assurance framework for safeguarding adults. The audit report is expected in the near future. The outcomes of the audit will inform the safeguarding adult's strategic action plan for 2013/2014.

- As PCFT grows it recognises the need for clear communication channels for all staff. Each borough has its own identified safeguarding representatives for mental health, learning disabilities and community health services.

- PREVENT Health WRAP training is delivered as part of mandatory training and the numbers of trained staff are submitted on a monthly basis to The Home office. PCFT Board has received this training.
  WRAP stands for Workshop to Raise Awareness of Prevent and is designed to promote the understanding of NHS staff in recognising individuals who may be at risk of radicalisation towards violent extremism.

- Adult Safeguarding Policy has been updated.

- Safeguarding Basic Awareness training is available to all front line staff via an e-learning package.

8.2.2 Moving Forward and Key Priorities for 2013-2014

- PREVENT- Awareness raising and face to face training to all staff will be delivered as part of mandatory core skills from January 2014. An additional cohort of trainers has been identified to further this work.

- Electronic Mental Capacity Act & Deprivation of Liberty training has been made available to all staff and work is currently underway to provide frontline staff with further face to face training.

- Level one basic safeguarding training will become part of the Essential core Skills training from 2014.

- Face to face training for Adult Safeguarding level 2 is being made available via the Organisational Learning &Development department (OL&D) and the Adult Safeguarding Operational lead. This will be effective from 2014.

- A monthly update is received on all incidents of Adult Safeguarding. This monitors trends and theme across the organisation and ensures safe and effective governance is in place.

- Continue to promote partnerships and information sharing with MARAC, MAPPA (Multi Agency Public Protection Arrangements), ASBRACs (Anti-Social Behaviour Risk Assessment Conferences) and Channel Panels.

- PCFT has completed an audit plan which includes incidents/alerts which will be repeated in order to identify reporting patterns and themes of abuse across the boroughs.

- Review of Adult Safeguarding Policy within PCFT to reflect local Authority.

- Contribute to further development of Multi agency processes

- Annual report will be submitted to the Boards – Both PCFT and Stockport Adult Safeguarding Board

8.3 NHS Stockport Clinical Commissioning Group

8.3.1 Report Context

The SCCG was authorised with no conditions in relation to safeguarding. This means that in order for the CCG to be authorised there were no restriction or penalties attached in registering as CCG relating to safeguarding

Assurance continues to be a key focus for adult safeguarding. The embedding of the safeguarding policy, safeguarding standards and the requirement to complete a self-assessment in all contracts has been progressed and will continue to be embedded in all contracts for 2013-2014.

This year has seen an increase in the number of providers being asked to provide assurance particularly Care Homes with Nursing and third sector providers. The assurance tool was sent to all providers for them to self-assess. This was then followed up by the designated professional visiting providers to discuss their self-assessments and to examine some of the supporting evidence. This was the first year that assurances have been sought from the organisations and although they have been fully engaged in the process, it has at times been quite challenging. This has resulted in organisations recognising the gaps in their processes and taking steps to address them. Each provider has different gaps but if we were to generalise for all the providers we have sent the assurance document out to, the commonalities are safeguarding training, mental capacity and deprivation of liberty and best practice. We monitor the provider's assurance via our quality and provider committee.

8.3.2 Stockport NHS Foundation Trust

There is an action plan in place to address a number of issues which include:

- Compliance with all levels of safeguarding adults training which is being managed through CQUINs (Commissioning for Quality and Innovation)

- The understanding and application of mental capacity and deprivation of liberty.

- The Quality and Provider Management Committee has escalated the training issue and safeguarding will be continued to be monitored through quality and contracts.

8.3.3 Mastercall

The organisation is working towards full compliance in respect to safeguarding adults and is a valued member of SCCG's adult governance group.

The key purpose of this group is to ensure that each organisation is aware of its statutory responsibilities in relation to safeguarding adults and that there are effective systems in place to demonstrate that key responsibilities are being fulfilled. The group is also a focus group to ensure there is accountability between the Designated Nurse and NHS Stockport Locality Board Lead. Through this committee compliance against the standards for the Safeguarding Policy in all contracts is monitored)

8.3.4 BMI Alexander

This provider has made significant improvement this year to achieve compliance and is a valued member of SCCG's adult governance group.

8.3.5 Cheadle Royal

The organisation has strived to ensure that the adult workforce is aware of its responsibilities and is compliant with safeguarding standards and is a valued member of SCCG's adult governance group.

8.3.6 St Anne's Hospice and Beechwood Cancer Care Centre

The organisation has made significant improvement to become compliant and is a valued member of SCCG's adult governance group.

A number of third sector organisations, who are commissioned to provide mental health services, have been asked to complete a self-assessment and follow up visits have been undertaken. The self-assessments identified gaps, in relation to volunteers which have now been addressed.

The Safeguarding Team provide monthly reports to the Quality and Provider Management committee highlighting providers who are non-compliant and where insufficient evidence is being provided to demonstrate that their action plans are being progressed within agreed time scales. The committee then decide how to manage the issue.

SCCG is developing an early warning system for adult safeguarding. The early warning systems will enable a proactive response to our providers.

8.3.7 Risks

Access to specialised services for mental health and learning disabilities within Stockport remains limited and therefore SCCG has to continue to

place out of area. Out of area placements can be more challenging to monitor the quality of the provider.

There is a concern that safeguarding adults' incidents and serious incidents are being under reported within Stockport due to the lack of uptake in training. This may impact on professionals understanding of safeguarding, mental capacity and deprivation of liberties.

Due the fact that the Adult Safeguarding Board (ASB) has no statutory responsibility it does not receive any funding to support the running of the board and any board developments and relies heavily on commitment from the board members which remains difficult in times of austerity.

Despite an increase in service capacity adult safeguarding remains on SCCG risk register. This is mainly because we now know what we didn't know. However, this risk can now be managed more effectively.

8.3.8 Full Board Report

The full board report can be found in the September 2013 Governing Body Meeting Papers. The link is listed below.

http://stockportccg.org/nhs-stockport-clinical-commissioning-group/boardcommittee-papers/

8.4 Stockport Adult Social Care

8.4.1 Safeguarding has remained the highest priority for Adult Social Care with all locality and service specific social work teams seeing an increase in the number of safeguarding referrals being progressed to inquiry stage.

8.4.2 In terms of driving the personalisation agenda, a new Resource Allocation System (RAS) is being developed enabling service users to create outcome based, person centred support plans. Safeguarding is a key area of activity as services aim to ensure a positive approach to situations involving potential risk.

8.4.3 During the year it was noted a high volume of referrals related to practice of contracted providers. In order to take a more joined up proportionate approach to response, SAMCAS and the Council`s Quality Team have formed a `Quality Concerns and Action Group' which meets weekly to cross reference alerts that have been received. This has enabled a proportionate and consistent approach to be taken.

8.4.4 SAMCAS has continued to support the operation of the Stockport Safeguarding Adults Board (SSAB) and provide professional advice to a range of stakeholders across the borough with a view to ensuring the multi-agency procedures are fully implemented. In addition the number of DOLS applications has remained consistent and the team coordinates all referrals and responses including the allocation of cases to Best Interest Assessors (BIA`s). SAMCAS have continued to attend the MARAC meetings and attend the Greater Manchester and North West regional Safeguarding and Mental Capacity Act forums so as to ensure best practice is shared in Stockport.

8.4.5 A Multi-Agency Adults at Risk Group was formed in late 2012 in partnership with a range of stakeholders including the Stockport Community Safety Partnership. The group is aiming to ensuring that the council and its partners are able to consider the risks faced by those individuals who may not necessarily be eligible for social care services. This service continues to evolve. (See section 4 above)

8.4.6 Implementation of and compliance with the Mental Capacity Act Code of Practice has been a key area of activity as adult services ensure appropriate assessments are undertaken.

8.4.7 A working group was set up in January 2013 to respond to the Winterbourne View report and subsequent Department of Health Concordat. This led to a draft action plan being formulated in late March 2013. This will be reported on in detail in next year's annual report

8.4.8 A key strategic focus has been to look at how health and social care can work in a more integrated way and includes the development of refined pathways around supporting people aged 0-25 who have eligible need.

8.5 Stockport NHS Foundation Trust

8.5.1 Introduction

The profile of adult safeguarding continues to increase both at a local and national level.

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

8.5.2 Progress to date

- The Trust's Safeguarding Committee, chaired by the Deputy Director of Nursing and Midwifery has continued to meet bi-monthly throughout 2012-2013; it aims to provide the strategic direction for the Trust to ensure that all safeguarding requirements for adults and children are achieved and also monitors the progress of the Trust towards the achievement of this year's local CQUIN around Safeguarding

- The committee reports to the Clinical Quality and Safety Committee

- The Trust Safeguarding Committee continues to work to the local standard operating procedure (SOP) to complement the All Agency Safeguarding Adults Policy which includes a flow chart to demonstrate clearly to staff what to do when a concern is raised. With the launch of the revised Multiagency Safeguarding Adults at Risk Policy and Procedures in October 2013 there is a need to review the SOP to ensure it remains compliant with the policy.

- The Trust continues to be represented at the Stockport Safeguarding Adults Board by the Deputy Director of Nursing and Midwifery

- The Trust is represented at the Implementation and Training sub groups of the Stockport Safeguarding Adults Board by the Named Nurse Adult Safeguarding

- The Trust is represented at the Multi Agency Adults at Risk Steering Group (MAARS) by the Named Nurse Adult Safeguarding. MAARS is now running in pilot form led by the Local Authority, the Trust's alcohol liaison nurse attends the panel meetings. .

- The Trust has completed an audit tool to monitor Safeguarding Standards for Healthcare Providers, this has been assessed by the Designated Nurse for Safeguarding CCG and an action plan is to be developed in December 2013

- A Safeguarding and an MCA / DoLs microsite are updated as required with information for staff

- The Trust has access to a free 20 minute telephone advisory service provided by Beachcroft solicitors for issues on MCA and DOLS, and further to that can access legal advice through a senior manager when required

- The Trust is represented at the Valuing People Partnership Board, and health sub- group, by the Named Nurse Adult Safeguarding; this is held quarterly.

- A Learning Disability microsite is updated as required with information for staff.

- All clinical areas have an information file for staff relating to Learning Disabilities

- The Trust has completed a Learning Disability Health Self-assessment (as part of the wider health economy)– this is due for validation in December 2013, following this an action plan will be formulated

- There has been long-term sickness of the Learning Disability Liaison Nurse, this was not back-filled by the Local authority but the role was covered by the Named Nurse Adult Safeguarding wherever possible.
- An Admission and Discharge Good Practice Guidance Document for the Care of People with Learning Disabilities has been written and is currently with members of the Safeguarding Committee for comments.

- The Named Nurse Adult Safeguarding represents the Trust at the Autism Board, ,however meetings were suspended over the summer pending the development of an Autism Strategy for Stockport

- A Dementia Steering Group with multi agency representation hosted by the Trust continues to meet monthly in order to implement the Dementia Strategy, monitor progress against the national CQUIN for dementia and improve patient care. An action plan has been developed and is under review.

- The Trust is represented at the Stockport Older Peoples Working Group (led by CCG) by the Named Nurse Adult Safeguarding

- The Trust has participated in a review of Domestic Abuse Services in Stockport; this was initiated by the Safer Stockport Partnership.

- Links have been established with the Greater Manchester Domestic Abuse Partnership Group hosted by South Manchester FT, Named Nurse Adult Safeguarding attends the meetings.

- The Trust is represented at MARAC by named Nurse Adult Safeguarding (Multi Agency Risk Assessment Conference where high risk cases of domestic abuse are discussed)

- The Director of Nursing and Midwifery has written an action plan taking into account the recommendations of the Francis Report.

- A database has been developed to input safeguarding cases that are raised with the Named nurse Adult Safeguarding and the Safeguarding Advisor for Integrated Care however keeping this updated has proven to be challenging and this made need review

8.5.3 Training

Training of Trust staff to meet the level required in the Safeguarding CQUIN has posed a significant challenge. A Training Strategy has been written and published for all levels of staff (incorporating T&G); this was originally a two year strategy but due to the pressure of the CQUIN has now become a one-year strategy

An exercise was undertaken to determine the baseline and develop a trajectory against which we can benchmark ourselves. The aim is to achieve 85% compliance in training at all levels by the end of March 2014. The Trust has seconded a Band 7 nurse to assist in the delivery of training for one day a week to help achieve the target.

Unlike with children there is no statutory guidance around training compliance and competencies for Adult Safeguarding.

Adult Safeguarding Training Level 1 (Basic Awareness)	**Number Required**	**Adult Safeguarding Training Level 2 (Alerter)**	**Number Required**
Q2 (45%)	2614	Q2 (45%)	1685
Q3 (65%)	3776	Q3 (65%)	2434
Q4 (85%)	4938	Q4 (85%)	3183
Total	**5809**	**Total**	**3745**
Adult Safeguarding Training Level 3 (Referrer)	**Number Required**	**Adult Safeguarding Training Level 4 (Investigation of Incidents)**	**Number Required**
Q2 (45%)	231	Q2 (45%)	26
Q3 (65%)	334	Q3 (65%)	37
Q4 (85%)	437	Q4 (85%)	48
Total	**514**	**Total**	**57**

Alerter Level 2

The level 2 training will be supported with a Staff Handbook from December 2013.

Level 3 referrer training will commence in December 2013

Level 4 training – Investigation of Incidents is compliant.

From January 2013 – June 2013 monthly sessions ran providing basic Dementia Awareness for non- clinical staff; these were very well attended by facilities and estates staff. These start again in November 2013 with a push on getting admin staff through the training in order to improve communication with people with dementia.

From April 2013 dementia, delirium and depression has been included on the clinical mandatory training day.

Learning Disability Training for clinical staff has been suspended due to the long term sickness of the liaison nurse, it is hoped this will resume in early 2014

8.5.4 Governance

The Trust is compliant with Care Quality Commission (CQC) Outcome 7 on Safeguarding

All applications for DOLS are reported to the CQC, numbers are monitored by Named Nurse Adult Safeguarding

The Named Nurse Adult Safeguarding meets quarterly with the Designated Nurse for Adult Safeguarding from CCG to discuss assurance and governance on an individual basis.

The Designated Nurse for Adult Safeguarding (CCG) holds quarterly governance and update meetings with all healthcare providers across Stockport; these are attended by Named Nurse Adult Safeguarding and Safeguarding Advisor Integrated Care

The Named Nurse Adult Safeguarding meets monthly with the Team Manager Hospital Social Work to discuss progress of cases.

8.5.5 Policies

The Third Edition: Stockport Multiagency Safeguarding Adults Policy and Procedures was published in October 2013

The Trust continues to use the Mental Capacity Act and Deprivation of Liberty legislation

The Trust policies on Restraint and Specialling have been reviewed and updated currently out for comments to the Safeguarding Committee

8.5.6 Future work

The Trust aims to focus on:

Further collaborative working with partnership agencies and Greater Manchester Trusts

Learning from safeguarding incidents

Increasing the numbers of staff trained in adult safeguarding

Continuing to raise awareness of safeguarding issues and incorporating safeguarding issues into Trust policies, SOPs and guidelines

Development of Policy for Domestic Abuse including Human Resource and Occupational Health Guidance

Strengthening the role of Emergency Department in the recognition and management of Domestic Abuse

Development of Domestic Abuse Training

Development of Learning Disability Training including learning from significant incidents.

Reviewing of staff access to clinical supervision in safeguarding, particularly the clinical leads in community.

8.5.7 Conclusion

During the past year there have been significant improvements in all aspects of Safeguarding Adults within the Trust. Staff awareness has been raised, training undertaken for many staff, safe practices implemented and monitoring for assurance put into place alongside increased partnership working with Adult Social Care. Training of a large number of staff has been, and remains, a significant challenge.

8.6 Age UK Stockport - Annual Statement

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

Previously Age UK Stockport delivered a dedicated Safeguarding Older Adults Project (SOAP), which was initially funded for three years by Comic Relief and then for one year by Stockport Council Adult Social Care. Unfortunately, due to the financial climate this funding ceased and the project ended in March 2011.
As part of other wider Age UK Stockport organizational changes in April 2011 a new generic team of workers, the Wayfinder team, was created to enable delivery from first contact and to support a more flexible response to people's needs.

To ensure safeguarding is a core part of our work all workers are now trained through specific internal training to be aware and raise awareness, and all 15+, workers within the generic team were trained to be able to identify and support on safeguarding issues. Two senior staff members have been nominated to lead on safeguarding.

Safeguarding Numbers for April 2012 – March 2013 (inclusive) are as follows:

Safeguarding Awareness contacts total 4,832

Identifying possible issues through contacts 36 with the types of abuse as follows:

Emotional - 3
Financial Bogus Callers - 4
Financial Other - 16
Physical - 4
Psychological - 2
Self-Neglect - 7

Provision of practical and emotional support specifically around safeguarding 36

Supporting individual and reporting to appropriate bodies where appropriate 25 as follows:

Adult Social Care - 7
Police - 8
Bank - 1
Solicitor - 2
GP - 7

Although the overall figures are lower than the previous year in relation to awareness contacts and identifying potential safeguarding issues, the number of people supported and the number of cases reported to appropriate bodies has increased. This increase is a reflection of the increased skills and experience within the Wayfinder team, in identifying and reporting appropriate issues.

Of the 36 supported, 30 were female and **6** male, the age range was:

U60	- 2
60-69	- 4
70-79	- 12
80-89	- 13
90+	- 4
Unknown	- 1

Geographically people were from across the Borough.

Appendix 1
Safeguarding Board Membership as at 31 March 2013

Armstrong Safeguarding Adults Manager Stockport Adult Social Care	Jane Ankrett Associate Director NHS Community Health Stockport	Sam Pickering Greater Manchester Police
Ann Brooking Staff Development Stockport Adult Social Care	Jax Effiong Greater Manchester Fire and Rescue	Steve Brown Manager Stockport Community Safety Unit
Anne Buckley Owner Independent Care Agency	Joan Beresford Head of Older People's Services Stockport Adult Social Care	Sue Gaskell Designated Nurse for Safeguarding NHS Stockport
Bridie Meehan Owner Quality Care of Cheadle	Karen Maneely Locality Manager Pennine Care NHS Foundation Trust	David Mellor Independent Chair
Caron Ratcliffe Manager Apex Nursing Care	Margaret Brade Chief Executive Age Concern Stockport	Nicola Firth Deputy Director Of Nursing Stockport NHS Foundation Trust

Appendix 2

Implementation Group Membership as at 31 March 2013

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