Safeguarding Adults in Stockport

Stockport Safeguarding Adults Board

Annual Report 2017/18

TABLE OF CONTENTS

1.0. Foreword from Independent Chair

I am pleased to present the 2017-18 Annual Report on behalf of all the agencies represented on the Stockport Safeguarding Adult Board (SSAB). The reports shows that in Stockport we have continued to build on the strong partnership foundation to meet the many challenges facing agencies in ensuring that we keeping adults at risk safe.

We hope that you will find that the report helps you to better understand how organisations and people work together and the contribution the Safeguarding Board has made to this. It sets out how these arrangements can continue to improve on the basis of the Safeguarding Board and partners being able to objectively and critically learn from what works well and act to improve what may not work as well as was intended.

It is important to remember that the Safeguarding Adults Board does not deliver operational services and is not solely responsible for all safeguarding arrangements in Stockport. The Board's role is to exercise oversight and assurance in respect of safeguarding arrangements, some of which may be developed and led by others.

The Safeguarding Board itself is made up of senior leaders from a wide range of partners and agencies, including the voluntary and community sector.

Stockport Safeguarding Adult Board members are fully committed to the principle that safeguarding vulnerable people is everyone's business. We want to ensure that all the communities in Stockport are equipped to play their part in preventing, detecting and reporting neglect and abuse.

The Report outlines the work of the Board, its partners and sub groups from April 2017 – March 2018. The Report highlights the Board's progress and achievements in delivering its strategic priorities and objectives and is a joint collaboration from all agencies. The report also provides a summary of developments in Mental Capacity Act Deprivation of Liberty Safeguards nationally and work carried out in Stockport.

Safeguarding means protecting an individual's right to live in safety, free from abuse and neglect. It is also about all agencies working together to prevent the risk of abuse or neglect, while at the same time ensuring that an individual's well-being is promoted, having regard to their views and wishes in making decisions about what actions to take.

During 2017-18 we have continued to build our relationship with the Safeguarding Children Board, of which I am also the chair. We have a set of shared priorities:

- Domestic Abuse and Violence
- Neglect
- Transitions
- Complex Safeguarding

These are underpinned by 4 shared objectives:

- Governance;
- Scrutiny, challenge and quality assurance;

- Learning and development;
- Communication.

Our strategic plan covers the period 2017-2020 and the report sets out what we have achieved against the plan on pages 13 and 14.

Both the Adult and Children Boards are committed to align where appropriate our areas for focus. In order to ensure that we progress this for the past 2 years have held joint development days. The development day in January 2018 considered a number of themes:

- Adverse Childhood Experience and the impact of trauma;
- How effective are we and what do we need to improve. We recognise that we can be stronger in relation to scrutiny and challenge; our quality assurance function was under developed and work was started and had been progressed in 2018-19 to improve this.
- Considered the future arrangements for Children's Safeguarding and the impact on the Adults work – this has led us to combining a number of subgroups to maintain the all age impact. You can read more about this on pages 16-21 of the report.

At each board meeting I provide a 'chairs report' that gives members an overview on national and local developments; key issues that we need to be aware and any work that I have undertaken on behalf of the board which has include:

- Visit to Greater Manchester Fire and Rescue;
- Attendance at Strategic MAPPA Board;
- Stockport Prevent Peer Challenge;
- Greater Manchester Chairs Forum;
- National Chairs Forum.

Over the last 12 months we have seen a number of developments and improvements being put in place in order to enhance safeguarding or to minimise the risk of harm to adults at risk. These include:

- Greater Manchester police have rolled out the Herbert protocol - The Herbert Protocol is a national scheme being introduced locally which encourages carers and family members to compile useful key information which could be used in the event of a person with dementia going missing
- Stockport Metropolitan Borough Council have improved working between Adult Social Care and Pennine Care NHS Trust
- Stockport NHS Foundation Trust have established a Trust wide safeguarding group that reports directly to the Quality Committee
- Pennine Care NHS Foundation Trust have continued to attend all Serious Adult Review learning events and cascaded learning across the organisation
- Greater Manchester Fire and Rescue – continued with the Safe and Well Visits with 3,072 visits in Stockport during 2017-18
- Stockport Clinical Commissioning Group – have continued to lead on the Learning Disabilities Mortality Reviews

- Community Rehabilitation Company have developed a new protocol for transitions
- Stockport Homes – have over 50 staff designated as safeguarding champions who provide support/guidance to less experience members of staff
- Age UK have under the Wellbeing at Home Service have worked with LA teams to support people at risk of self-neglect to make changes

The partnership has continued to strengthen this year and the contributions of all partners to achieving our priorities are detailed in this report – pages 33-50.

I am particularly grateful to the Healthwatch representatives on the Board for their contributions and for helping us to stay focussed on what actually makes a difference to people's safety and wellbeing.

The pace and scale of the work of the SSAB continues due to the commitment of the partner agencies who consistently drive for improvements in the quality of services which safeguard and promote the welfare of vulnerable adults. Without them the pulling together of this annual report and all that we have would not have been possible. On behalf of the SSAB I would like to express my heartfelt thanks to all the staff in both the statutory and the independent sector and volunteers who work with vulnerable adults and their families for their continued effort; you are our 'safeguarding system' and without you none of this could happen.

Gill Frame

Independent Chair Stockport Safeguarding Adult Board.

2.0. Summary of Activity in 2017/18

Each year the SSAB reviews its strategic priorities against a 3 year plan. In January 2018, the SSAB held a development session for board members from both children's and adults' safeguarding boards. The development day was facilitated by the Independent Chair, the Head of safeguarding and learning, and with the support of both business managers on behalf of both safeguarding boards.

Recognition was given to the SSAB for the significant progress that has been made since January 2017, and a snap shot of our key achievements are outlined below.

What we have done in 2017-18

Strengthened our SAR protocol to ensure compliance with the Care Act 2014.

We worked up with the Children Safeguarding Board to amalgamate four of our sub groups; training and workforce, communications and engagement, complex safeguarding and early help and prevention. This has enabled us to strengthen our approach to all age safeguarding and so far this has been well received with strong attendance and commitment from each agency partner.

The joint early help and prevention sub group developed a self-neglect policy along with guidance for practitioners to offer the appropriate toolkits for single agency and multi-agency use. The policy has been endorsed is also available on the SAAB website.

We developed a safeguarding website raising awareness of how to report abuse and neglect. There were 1,454 website page views compared to no activity for the same period in 2016. Work continues to develop the board's website along with the aspiration to have one overarching website for both children's and adults' safeguarding boards.

The SAB has made significant progress to undertake the peer review with colleagues from Oldham Council. Further work is in progress and colleagues from Oldham will reciprocate in a review with us in Stockport. Findings from the peer review will be available in 2018-19.

The SAB continues to learn from experience and improve the dissemination of learning to ensure this is consistent throughout the economy. We have produced 7- minute briefing papers and made them accessible for practitioners, professionals and providers to read easily and have available within their own workplace.

We have a joint calendar of events with partners that create opportunities for the general public, professionals and care givers. This has proven to work extremely well, with a consistent flow of social media packs being posted to a wider audience.
Here are some examples of campaigns we have run in 2017-18.

- Dementia Awareness
- Mental Health Awareness
- World Elder Abuse Day
- Hate Crime Awareness Week

Stalls were set up promoting Hate Crime with the aim to increase awareness, reduce hate crime incidents, and to inform people of the locations of reporting centres within Stockport. We had a presence in Stockport Mersey way shopping centre with volunteers from the SAB partnership supporting us to spread the message.

Life leisure also hosted a few stalls, alongside Stepping Hill hospital who allowed us to set up a stand near the hospital café. Stockport train station also embraced the launch of the campaign, they allowed us to set up a stall in the station, where engagement from commuters and the general public was strong.

Merchandise such like, leaflets, tote bags, car stickers, DVD's and badges were handed out daily. Many people felt able to approach the stalls and share their views, stories, and ask questions. GP Surgeries also offered to display posters and leaflets in surgery waiting areas.

Social Media packs were developed and we posted tweets frequently to ensure followers could read and share news wider. One woman stopped and spoke to the team for about 20 minutes, telling them in detail of her personal experiences and where she was in life now.

We undertook a Mental Capacity Act 2005 (MCA, 2005) audit with partner agencies. The audit highlighted a recommendation for MCA training to become a mandatory requirement. The SAB endorsed the recommendation and has requested MCA training is referenced as a

mandatory requirement in the review of the Safeguarding Adults at Risk multi agency policies and procedures. A steering group is to be set up to address this action.
Making Safeguarding Personal annual self-assessments were completed. The completed MSP self-assessments suggest there is good work being done throughout all agencies. Examples of good practice were shared with the SAB and work will continue to be monitored through the quality assurance sub group. The impact from the self-assessment has begun to develop a safeguarding culture that focuses on the personalised outcomes desired by people with care and support needs that may have been abused or neglected.

Stockport CCG is embedding the 'Making Safeguarding Personal' approach across the CCG by establishing and developing:

- Accessible information to support participation of people in safeguarding support by using a multi-agency approach
- Advocacy
- Person-centred approaches to working with risk
- Developing policies and procedures that are in line with a personalised safeguarding approach
- Using GM Strategies to enable practitioners to work in this way

The QA group will hold a peer clinic in September 2018, inviting partners to evaluate peers supporting evidence and outstanding actions for assurance that systems and processes relating to MSP are sufficient and in place.

The SSAB have also asked partners to participate in the Quality Assurance Self-Assessment, whereby each organisation completes an assessment tool under the six adult safeguarding principles of the Care Act 2014. The purpose of the exercise was to give assurances to the board that agencies are working together to safeguard and improve the outcomes of Stockport residents, and to identify where additional work needs to be undertaken.

Findings from the exercise had demonstrated that local Safeguarding Policy and Procedures were being adhered, and that policies were easily accessible via each organisations own website. Some organisations are currently subject to review their policy to refresh their policies to ensure they are Care Act compliant and actions are reviewed via the Quality assurance sub group on an annual basis.

The Quality Assurance self-assessment has highlighted good areas of practice, such like training opportunities within organisations are available for staff, both face to face and by e-learning. Organisations each had a safeguarding lead within their own organisations, and someone who has the authority to direct and allocate resources as required.

The self-assessment also highlighted themes requiring further development, this has been recorded within each agencies own action plans where progress updates will be moderated at the QA sub group in September 2018.

Independent providers report quarterly on harm level incidents, this data is collected via an online survey that was rolled out in March 2017. The survey was a pilot to establish an illustration of the safeguarding themes, trends and patterns taking place within the

independent care sector. From the survey, the most frequent themes occurring appear to be falls and missed medication, which are often reported from both residential and nursing care sector. Work is being carried out to support providers with medication management, and this is an area of work that is being done with providers to ensure a robust medication policy is implemented in 2018- 19.

Falls and fractures are also a prevalent theme of harm level reporting from providers, this is a concern, particularly on the volume of falls that are reported each quarter. To overcome this concern, Stockport Together are working hard to embed a work stream initiative called Steady in Stockport. The enterprise started nine months ago and was aimed to improve the quality of care for people in Stockport. There is a pathway currently being implemented to prevent people from falling and its focus is based on public awareness raising. Further work is also underway to work on a toolkit for care homes to help reduce the risk of falling and help to live as independently and enjoyable as possible. The benefits of this work stream will make small changes in people's lifestyle, improve on their confidence and enable people to stay in control of their life.

There is a large proportion of providers who don't report harm level activity and work is being carried out to rectify the gap. The SAB has made a recommendation to SMBC to ensure harm level reporting is mandatory, and SMBC quality monitoring team aim to implement the recommendation into the provider's pre-placement contract agreements ensuring compliance. This will enable a full overview of harm level activity throughout the independent care providers, and themes will continue to be monitored.

Funding from statutory partners was sought to hold a joint SAB/SCB annual event. The event will happen on 11th October 2018, at Stockport FC.

We developed an information sharing protocol and received assurance from partner agencies that they were fully compliant. The SAAB endorsed the protocol in May 2017.

Further achievements identified throughout 2017-18 are:

- Self-neglect strategy and guidance endorsed and available for frontline staff and the wider workforce.
- Consistent attendance at SAB meetings, along with attendance at the SAB's sub groups.
- Partners continued to contribute financial resources to support the functions of the SAB, and have agreed to contribute the same funds for 2019-20.
- Strong representation in the arrangement of the Peer Review.
- A single cohesive communication and engagement strategy for both safeguarding boards.
- Service user engagement work with Healthwatch Stockport.
- A commitment to Safeguarding Adult Reviews and the embedding of learning, which we evidence to the Board.
- Continue to improve joint IT systems with the aspiration to roll out Liquid Logic in December 2018.
- Multi-agency Domestic Violence audits have taken place; findings and recommendations are to be presented to the QA sub group for scrutiny.
- Joint statement of commitment refreshed for both boards
- Training delivered to providers in relation to specific CQC standards.

The new Enhanced Quality Improvement Programme (EQUIP) has been established which is aimed at domiciliary care agencies, residential care and nursing home providers to reduce risk and improve outcomes for residents and service users.

Since the EQUIP team was introduced in September 2017, SMBC have worked with 9 providers to improve services and supported colleagues with small pieces of work, such as observing moving and handling practice, to ensure safety for carers and service user. SMBC continue to improve ways of working by using feedback given to us by providers, service users and families.

The EQUIP team complete train the trainer awards in several key areas ensuring they can offer providers the support they require in a timely and effective way. This offer helps reduce risk to residents/service users, promote better training for the provider workforce and develop strong partnership working between Adult Social Care / Clinical Commissioning Group and providers.

From the involvement offered by EQUIP, two care homes have recently moved from requires improvement, up to good on their CQC rating. The EQUIP team has spent eight months working with Cale Green and Firbank care homes, to reduce the risk to residents due to ongoing serious quality and safeguarding concerns. The team are now working with a new proposed owner to ensure learning is embedded throughout both homes, and dignity in care is established and maintained.

The EQUIP team also provides awareness sessions in harm levels, react to red (pressure care) and dignity in care. The aware sessions are an interim tool and resource, which is offered to support providers in learning specific duties before full training can be accessed by the care provider.

With the volume of care homes rated as requires improvement, the EQUIP team have developed a self-assessment tool to determine where the providers are up to on the CQC action plan. Therefore, the EQUIP team analyse the self-assessment tool and offers support and guidance to providers where required.

A medication workshop took place in November 2017 with a range of delegates from GPs, Pharmacy services, District Nursing, Adult Social Care and Independent Service Providers.

Following on from the workshop, the following areas were identified:

- Medication Policy to have flexibility built in to provide guidance in a variety of circumstances.
- The Policy must incorporate NICE guidelines (NG67).
- The terminology must reflect NICE guidelines (NG67).
- The Policy must clearly identify roles and responsibilities within medication support.
- The Policy should include a medication risk-assessment for situations where the medication support agreed in the care plan is not to be followed.

Further work is underway with this area of work with the anticipation that the policy will be implemented in the 2018/2019.

What we want to do in 2018-19

- Address the increasing complexity of clients in our alcohol services and/or alcohol misusers who are not engaging in alcohol treatment.
- Ensure effective decision-making and local ownership of outcomes from investigation outcomes of section42 enquiries.
- Ensure safeguarding investigations throughout both statutory and non-statutory partners is fully compliant within the expectations of the Care Act 2014.
- Appoint two Independent Reviewing Officers to undertake Case Conferences for Pennine Care NHS FT Section 42 investigations. Additionally, this resource will support safeguarding investigations in private mental health settings such as The Priory.
- Transfer accountability of Case Conferencing Section 42 investigations from Pennine to the Adult Safeguarding Team.
- Gain feedback from CQC inspection, along with the peer review, and produce an action plan to make any formal improvements.
- Refresh Stockport's Multi agency safeguarding adult's policy and procedures.
- Develop an overarching medication policy for Stockport MBC and commissioned care providers.
- Ensure learning from reviews is embedded in multi-agency practice.
- Continue to conduct Multi agency audits, in particular to patients discharge from hospital and MCA legislation in practice.
- Strengthen our approach to Quality Assurance and progress the development of the performance dashboard. .
- Develop domestic abuse training and coordination in line with the domestic violence strategy.

3.0. The National Context

The Care Act 2014 statutory guidance determines that although the local authority is the lead agency for making enquiries, it may require others to undertake them. The local authority retains the responsibility for ensuring that safeguarding adults' enquiries are referred to the right place and acted on. The local authority, in its lead and coordinating role, should assure itself that the enquiry satisfies its duty under section 42 to decide what action (if any) is necessary to help and protect the adult and by whom and to ensure that such action is taken when necessary. In this role, if the local authority has asked someone else to make enquiries, it is able to challenge the body making the enquiry if it considers that the process and/or outcome is unsatisfactory.

The Care Act 2014 has also clarified that self-neglect may not prompt a section 42 enquiry. An assessment must be made on a case-by-case basis and depends on the individual's ability to protect themselves by controlling their behaviour. The assessment should take account of how the situation is impacting on the individual's well-being, impact of their behaviour on others or consider if the behaviour is as a result of abuse or neglect from others.

4.0. Local Context

The population of the United Kingdom was estimated to be 65,110,000 as at 30th June 2015, by the International Migration Statistics published in November 2015. Since mid-2005, the UK

population for people aged 65 and over has increased by 21%; that of those aged 85 and over has increased by 31%.

Stockport is the third largest borough in Greater Manchester and was estimated to have a population of approximately 290,050 residents in Stockport as at 31st May 2018, an increase of 3,300 since 2014.

Stockport has seen a trend of population growth and continues to become more ethnically diverse, especially in younger populations to the west of the borough. Immigration rates in Stockport are lower than national averages.

The picture of change for Stockport is similar to the rest of Greater Manchester and England, in that the proportion of older residents is increasing. However, we already have a much higher proportion of older residents that the rest of the country.

The population of Stockport has more older adults and fewer younger adults than the national average. Stockport's total population has been relatively stable over last two decades, fluctuating between 280,500 and 287,000. It is now predicted to rise over the next ten years. The Joint Strategic Needs Assessment identified a number of key risks for our older population:

- 33% of older people live on their own leading to the danger of social isolations.
- 11,400 people have a history of falling, a key risk for loss of independence.
- By age 65, 58% of the population have one long term health condition, 20% have two or more. By age 85 the proportion rises to 87% for one and 53% for two or more long term conditions. (JSNA 2016)

Stockport Adult Service is the lead agency that safeguarding concerns are reported to. The Council, on receipt of concerns has a duty to record and to determine what, if any, actions need to be followed up. Stockport Adult Service has a duty under the Care Act 2014 to promote the well-being of people in its local area and to support a preventative agenda.

Stockport Adult Service has a duty to carry out enquiries or cause others to do so, if they reasonably suspect that an adult who has care and support needs (whether or not Stockport is meeting any of the needs) is experiencing, or at risk of abuse and neglect and as a result of the care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Adult abuse is often under-reported. However, in Stockport there has been an increase of safeguarding alerts year on year since the introduction of No Secrets 2009.

SSAB continues to meet on a bi-monthly basis throughout the year to analyse, develop and improve practice, to ensure that individuals living in Stockport with care and support needs are protected from abuse and neglect.

The SSAB was set up in Stockport in 2004 and had its position significantly strengthened as a result of the Care Act (2014) which, alongside the Mental Capacity Act (2005), provides the legislative foundation for Adult Social Care in England and Wales. The Act brought much welcomed change, most notably in the safeguarding arena and strengthened the position of

Safeguarding Adults Boards by creating a statutory duty under S42 – S46, to protect individuals who have care and support needs from experiencing abuse and neglect or the risk of this occurring.

Vision, Values and Strategic Objectives

Our Vision is that residents of the Stockport Borough can live safely, free from harm, and abuse or the fear of abuse, in communities which:

- have a culture that does not tolerate abuse;
- work together to prevent abuse;
- know what to do when abuse happens.

Our values illustrate the approach the board will take in delivering its vision

- People have the right to live their lives free from violence and abuse.
- Safeguarding adults is a shared responsibility of all agencies, and agencies commit to holding each other to account.
- The individual, family and community should be at the heart of safeguarding practice.
- High quality multi-agency working is essential to good safeguarding.
- We respect that adults have a right to take risks and that this will sometimes restrict our ability to act.
- There is a commitment to continuous improvement and learning across the partnership.

We have delivered on our strategic priorities during 2017-18.
Our achievements are:

Domestic Abuse and Violence

- Strategy on a page
- Developing a coordinated response to all levels of risk
- One additional IDVA
- Multi-agency audits have been conducted
- Preparation for joint targeted area inspection on Domestic violence and abuse

Neglect

- Significant Learning from Joint SCR/SAR
- Neglect Workshop RIPFA
- Developed a Self Neglect Strategy
- Increased awareness of Self Neglect within the workforce

Transitions

- Reviewed the structure and membership of Early Help & Prevention sub group to promote better joined up working
- Development of Multi Agency Adults at Risk Panel
- Oversight of transition to Adult Services for those with SEND
- Transitions steering group with reps from ASC and CSC
- 2 X Transitional social workers in ASC
- Autism lead in adult social care
- Planning for transitions in care plans

- Learning circles to improve the skills and knowledge of staff across Stockport family and Stockport together

Complex Safeguarding
- Building on successful CSE, missing and children missing education work already established
- Joint Sub Group agreed
- Development of Strategic Plan
- Working session achieved to develop work plan

5.0. Health in summary

The health of people in Stockport is varied compared with the England average. Life expectancy for both men and women is similar to the England average.

Health inequalities
Life expectancy is 9.6 years lower for men and 9.7 years lower for women in the most deprived areas of Stockport than in the least deprived areas.

Adult Health
The rate of alcohol-related harm hospital stays is 739 worse than the average for England. This represents 2,091 stays per year. The rate of self-harm hospital stays is 231, worse than the average for England. This represents 640 stays per year. The rate of smoking related deaths is 277, this represents 475 deaths per year. The estimated levels of adult smoking are better than the England average. (Source: Public Health England – Health profile published July 2017)

Mental Health
There are over 2,400 people registered with a Stockport GP with a severe mental health disorder, those in the most deprived areas are over three times as likely to be experiencing a severe mental health problem as those in the last deprived areas.

There are 26,000 people registered with a Stockport GP with a history of depression and there are 40,000 people registered with a history of anxiety. Those aged 25-59 have the highest rates, peaking for people in their 40s. Women are nearly twice as likely to be diagnosed as men and there is also a clear deprivation trend.

The under-75 mortality rate for those with serious mental illness in Stockport is almost four times higher than that of the average for the borough. This is particularly driven by high rates of smoking– national research suggesting that 85% of the mortality gap is due to smoking.

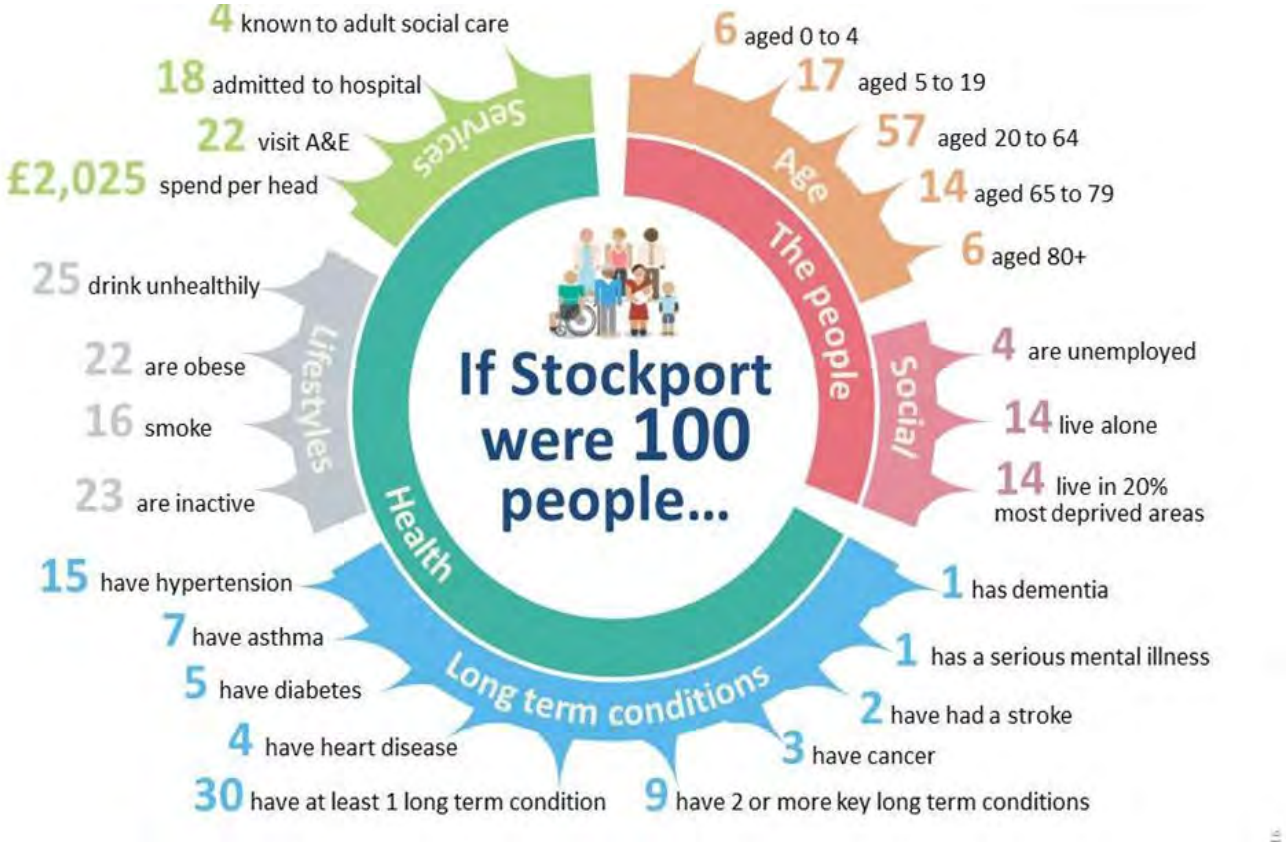
Stepping Hill Emergency Department attendances with a psychiatric diagnosis have risen by 94% in seven years to 1,975 in 2014-15. Those aged under 45 are most likely to attend, especially those aged 15-24 for self-harm. There are 700 hospital admissions a year for deliberate self-harm predominantly from those aged 15-44, and those who live in the most deprived areas are more than four times higher than those who live in least deprived areas.

Suicide Rates
Suicide rates for men in Stockport are high compared to the northwest region of the UK. Roughly 30 deaths a year occur due to suicide and deaths of undetermined intent, with those

aged 35-44 the key risk group. *(Source: Public Health England – Suicide Prevention Profile Feb 2017 Update.)*

If Stockport were 100 People

The "If Stockport were 100 people" infographic shows a selection of key measures to give a general overview of the people of Stockport, and provides a context for the challenges the borough faces.



Further detail on these subjects and others can be found on the Stockport Joint Strategic Needs website: http://www.stockportjsna.org.uk/

6.0. Stockport Safeguarding Adults Board (SSAB)

The Stockport Safeguarding Adults Board (SSAB) is a statutory, multi-agency partnership coordinated by the council as determined by the Care Act 2014. The Board, in its role, provides strategic leadership across the Council in safeguarding adults' arrangements. The Care Act 2014 sets out core duties of the Safeguarding Adults Board (SAB), which includes:

- Produce an Annual Report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adults' reviews and subsequent actions.

- Publish a strategic plan for each financial year in consultation with the local Healthwatch and the local community.

- Consult and produce a three-year plan for what it will do and how it will work.

- Carry out Safeguarding Adults Review (SAR) in accordance with Section 44 of the Act into cases where an adult at risk dies as a result of abuse or neglect or experiences serious abuse or neglect, and there is reasonable cause for concern about how agencies have worked together to safeguard that person.

SSAB expects that all partners will work together to operate within the requirements of the Act and together as partners, set a remit to set priorities, agree objectives and to coordinate the strategic development of Safeguarding Adults across the local area.

SSAB provides a key mechanism for agreeing how local partner agencies work together to effectively safeguard and promote the safety and well-being of adults who have health and support needs who are at risk of abuse, including neglect and are unable to protect themselves against exploitation from others.

The Board's vision is guided by the statutory Principles of Safeguarding Adults and this is reflected in the Board's strategy:

- **Empowerment:** people being supported and encouraged to make their own decisions and give 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:** and transparency in safeguarding practice.

SSAB membership

We have one Independent Chair who brings expertise and a clear guiding hand to both the adults and children's safeguarding boards, who makes sure that the SSAB fulfils its roles effectively.

The Board has the core statutory members of the SSAB as determined by the Care Act 2014. The board is made up of:

- Stockport Adult Social Care
- Stockport NHS CCG
- Greater Manchester Police (GMP)
- Stockport NHS Foundation Trust
- Pennine Care FT
- Stockport Healthwatch
- National Probation Services
- Greater Manchester Fire & Rescue Service
- Age UK Stockport
- Community Rehabilitation Company (CRC)
- Seashell Trust
- Stockport Healthwatch
- SMBC Strategic Housing

SSAB partners commit to ensuring that the Board is supported by dedicated resources that consist of a number of multi agencies that attend the board on a bi-monthly basis throughout the year.

7.0. Stockport Safeguarding Adults Board sub-groups

This year the roles and composition of the SSAB sub-groups were consolidated where possible to ensure that they will continue to support the work of the Board and deliver on its annual plans which contain the activity required to deliver the priorities. Each sub-group now has renewed Terms of Reference in place, which are reviewed regularly to ensure that they support the SSAB's strategic priorities.

Each sub group chair is responsible for reporting successes, developments and any barriers to progress to the executive. The implementation sub group of the board is the group which ensures delivery against priorities is on track. Where progress is not being made the implementation group make recommendations to the Board on what needs to change for progress to then be made.

The sub-groups benefit from multi-agency representation with staff from statutory and non-statutory agencies attending and contributing to the work. We are moving to better involve people who use services or their representatives in the work of the subgroups through Healthwatch and our other Board Partners.

The Quality Assurance sub-group

The Quality Assurance sub group meets bi monthly to support the Safeguarding Adults Boards to take a strategic overview of the quality of safeguarding activity across its area of responsibility. The group reviews and analyses data and performance information as well as the outcome of audits.

Partner agencies feedback in line with Making Safeguarding Personal (MSP), is integral to supporting improvements in provision and practice to ensure effective prevention and early intervention. The principles of MSP continue to be promoted to ensure that they are fully embedded across the Local Authority. MSP annual self -assessments were undertaken in 2017. The purpose of the self-assessment was to provide the Board with an overview of the Safeguarding Adult arrangements in place relating to MSP and to look at the strengths and development areas so that good practice was shared and learning was embedded. The group continues to maintain an oversight of the performance of MSP across the statutory agencies and the monitoring processes continue.

Communication and Engagement Sub-group

The role of the Joint Communication and engagement sub group is to promote awareness of Adult Safeguarding throughout Stockport and engage with the public. The focus of the group during the financial year was to raise awareness of adult safeguarding and the work amongst children's and adult professionals, and the general public.

This year the Sub Group devised and delivered a media and communications strategy, for the publication of a Safeguarding Adult Review. This work brought together communication leads, from across relevant organisations, to ensure the publication was co-ordinated, and key areas of improvements required, and undertaken were clearly communicated. The strategy was agreed by the SSAB in September 2017 and is also available on a one page summary format.

The sub-group developed a work plan to ensure that the actions below were achieved:

- Review of publicity materials
- Further developments of the joint SSAB/SSCB website
- Commitment to Hate Crime Awareness week both locally and nationally.

- Developed the joint event calendar enabling partners to maximise opportunities for further awareness raising
- Developed material on transitions for both SSAB/SSCB websites
- Supported regional or national campaigns via twitter and SSAB/SSCB websites
- Disseminated SAR/SCR learning effectively with the use of 7 minute briefing papers

Priorities for 2018/19 are:
- Undertake themed based awareness campaigns to develop community awareness and engagement of adult abuse and its impact with a focus on: hoarding, self-neglect, domestic abuse, complex safeguarding, financial abuse and transitions
- Promote World Elder Against Abuse Day June 15th 2018
- Continue to launch local and national campaigns and work collaboratively with partners to ensure public engagement and awareness-raising continues
- To develop a Safeguarding Newsletter to reach partners and the wider workforce
- Deliver the Joint Safeguarding Annual Conference in October 2018.
- Development of the Stockport Safeguarding Boards joint website.

Complex Safeguarding Sub-group

The Complex safeguarding Sub Group oversees effective partnership working in tackling:
- Honour based violence and forced/sham marriage
- Sexual Exploitation
- Serious Organised Crime
- Modern Slavery and Trafficking
- Female Genital Mutilation
- Radicalisation and Extremism
- Missing from home, care, education

In November 2017, a complex safeguarding workshop was held with 28 attendees from across children and adult services.

The workshop focussed on:
- An introduction to complex safeguarding
- Completion of a gap analysis/self-assessment against each area of complex safeguarding
- What the key aims and priorities should be for a joint complex safeguarding strategy and action plan
- What contributions agencies can make to these plans
- Consideration of conference event planning in 2018

The joint complex safeguarding sub group had its inaugural meeting in February 2018. The terms of reference were agreed and are embedded into the Board's Statement of Commitment. The complex safeguarding strategy was endorsed and work streams are in place for each area of complex abuse and exploitation. Small task and finish groups will lead on this work with representation from both adult and children's services to ensure the issues for each area are fully considered and included within the work plans.

There are challenges in terms of bringing together the adult and children's work and it will take time to bring representatives, and in turn the workforce, to the same level of understanding, awareness and delivery of services to protect and safeguard those at risk of complex abuse and exploitation. However, the benefits of working together are significant, and will ensure that both children and adult services effectively support victims.

The membership from adult services has been agreed and a joint chair from Adult services leads the group to ensure co-operation and engagement from this sector of the workforce.

The timetable for focus over the next three years will be:

- 2018-19 - Female Genital Mutilation (FGM), Honour Based violence (HBV) and Forced Marriage and Serious organised crime – County lines
- 2019-2020 - Modern Slavery and Trafficking, Radicalisation and Extremism/Prevent
- 2020-21- Sexual exploitation and Missing from home, care and education

The three areas have been prioritised because the Child sexual exploitation (CSE) and missing strategy/action plan is well embedded, with much of the work completed.

FGM, forced marriage and HBV are work streams that are undeveloped areas with the potential to progress further into the strategy.

Serious organised crime and criminal exploitation are a key focus for GM complex safeguarding strategy (as a link to county lines and trapped agendas), this is also a priority for Stockport with clear unmet need. Further development to report in 2018-19.

A complex safeguarding event is being planned with consideration to incorporate the plans into a safeguarding annual conference in the autumn 2018.

Training and Workforce Sub-group

The Training and Development sub-group has now combined with representation from both Adults and Children's sub groups. The joint sub group has an established programme of multi-agency safeguarding training which is accessible to both statutory and non-statutory partners, care and support staff and housing providers. The training programme covers both safeguarding adults and safeguarding children allowing for joint training events which cover the issues from both the child and adult perspective. The work of the sub group is supported by both the SSAB and SSCB Board manager, training co-ordinators and administrative support.

This year in particular, there has been a focus on commissioning and developing new training courses focused on neglect, including self-neglect, dignity in care, legal literacy and the Care Act, learning from Safeguarding Adult Reviews (SAR's) and courses linked to the SSAB priorities.

In response to an identified training need, the sub group considered the reoccurring issues relating to the recent Domestic Violence Homicide Reviews (DVHR). A workshop took place to review the homicide review reports and look at the recommendations. As a result, the group developed a robust training matrix and have identified training to help identify early signs of domestic violence, how to respond and the appropriate referral pathways.

The importance of learning from safeguarding adult reviews both locally and nationally was also a subject of discussion resulting in the development and delivery of training which both raises awareness of the safeguarding adult review (SAR) process, and also includes some of the themes arising from some SAR's. During November 2017, a series of SAR briefings took place in Stopford House to disseminate learning and updates of recent SARs that had been undertaken. These events were excellently attended and the feedback from over 100 delegates had been very positive.

The SAR workshops covered subjects relating to The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) along with standards in Dignity in care and the significance of effective

record keeping. As a result delegates had further insight into the new SAR process and there was a large interest for delegates to enrol to become dignity in care champions.

During 2017/18, there were a number of e-learning courses on a wide range of topics. Statistics on which online courses are being accessed are below. The feedback from these courses has been excellent so far, with satisfaction scores of 98% or above for all courses and with almost 100% of people who have completed the courses stating that they will be able to apply what they have learnt in their work. The plan is to continue to develop this offer over 2018/19. See table below.

Training 2017/18	Classroom Training	E-learning	Total
Basic Safeguarding Adults Awareness online training		498	498
Safeguarding Adults Alerter classroom training	424		424
Referrer/Provider Manager full day course	67		67
Mental Capacity Act/Deprivation of Liberty Safeguards	59	189	248
Safeguarding Children overview		419	419
Investigation Officer	23		23
Dignity in Care		41	41
Self-neglect	77	75	152
Self-harm		42	42
Domestic Abuse		75	75
Hoarding		36	36
Early Help Assessment	83	31	114
Modern Slavery and Human Trafficking		39	39
Total	733	1,445	2,178

The impact of training on practice

This year work has been on-going to demonstrate the impact of training on the practice of staff and ultimately on the care and support they provide to adults. Evaluation forms are completed by participants 2 months after each training event and these have shown an increase in knowledge of attendees post training. Of those that responded over 80% of delegates stated that they can still remember learning points from the course. Some comments received include:

- *I am able to make better and more confident decisions due to my increased knowledge.*
- *I have used some of the information gained to assist supervisees to reflect on their practice in*
- *I have more awareness on how to work with young parents who have been through the looked after system - what and how their experience effects how they work with professionals.*
- *I expected more] Practical strategies, it was more of a lecture style which I enjoyed, very good.*
- *I am better able to identify and recognise potential concerns and direct/refer and work with appropriate services in Stockport to help support families.*

- *It has strengthened my therapeutic work with children. I have used breathing exercises with children who are re living trauma.*
- *Using the techniques outlined in the "building positive relationships" course I was able to challenge a mother using alcohol and drugs to see how it was affecting her parenting. We broke down the changes she needed to make and looked forward to how things might look in the future. She was encouraged by this which made the process more meaningful and achievable.*
- *PowerPoint presentation sent after the training was minimal – I was advised that there was no need to take notes as the presentation would be sent. However, I did not feel the presentation reflected the amount of information discussed by the Speaker.*
- *The course was a great opportunity to work with other facility services in Stockport and to be aware of each other's role*
- *A really good interactive day and I got to meet lots of other health professionals and share professional experience's with them which I found very beneficial*
- *Expected more practical skill based tasks to link to social work practice*
- *Brilliant, demonstrative and engaging training which all workers should attend*

Early Help and Prevention Sub-group

The focus of the Early Help and Prevention sub group has been on a number of key work streams. The transitions work stream has been focusing on children with SEND pathways, transitioning appropriately into adult services and looked after children who need adult social care working with a transitions workers. Additionally, a missing work stream has been outlined, and work is underway specifically at the hospital, led by the hospital police officer to set up missing protocol. Additionally, the Early Help and Prevention sub group provides governance for the MAARS panel and significant work has been done to improve the effectiveness of the MAARS panel, creating a protocol for working with adults with multiple safeguarding needs, and introducing the team around the adult process.

8.0. Safeguarding Adult Reviews & Multi Agency Learning Reviews

The Safeguarding Adults Board had one SAR which concluded during 2017-18. As the review progressed it become apparent the case was complex and the decision was made by both Stockport Safeguarding Children Board (SSCB) and SSAB that the review was to be joined up with both children's and adults' partners. An independent author was commissioned with the view the appointed author would work in collaboration with partners to produce one joint overview report, including both the Adult and the Child's experience in order to capture the learning across the life course.

The review was completed and endorsed by the Safeguarding Board in March 2018. The report emphasised the need for more holistic working across adult and children services, and is soon to be public facing along with the 7 minute briefing paper on the SAB website.

Lessons learned

- Information sharing
- Understanding that an adult's right to make 'unwise decisions' under the Mental Capacity Act (2005) does not supersede a child's human rights
- The importance of conducting honest and respectfully challenging conversations
- Working with people and partners to develop multi-agency, realistic risk assessments and plans
- Understanding the needs of carers
- Hearing the voice of the child and young person

- Understanding and working with people who self-neglect
- Child neglect: understanding the causes and links to adult self-neglect
- Think Family: Strengthening Families and Communities

What have we done?

- An extensive report was commissioned with an accompanying action plan.
- Work is to be carried out with workforce development sub group to ensure learning is cascaded.
- A 7 minute briefing paper is in the development and will be available on the SSAB website once completed.
- A self- neglect strategy has been developed and endorsed by both SSAB and SSCB.
- The review of both Adults' and Children's training programmes are underway with a view to develop mechanisms to establish an effective, all -age neglect training programme.

In addition to the concluded review, two other SARs were submitted to SSAB and have both progressed to Safeguarding Adults Reviews. All learning will be shared in 2018-19 along with a concise overview report.

Health Review

A case that didn't meet the criteria for a SAR but was felt to suit a single- agency health review took place in 2017-18, from the health review, there are some lessons to be learned and these are reflected in the key learning points.

Lesson learned

- 21 days delay of information sharing.
- There are some examples of good record-keeping by doctors and medical staff. However, documentation and timely recording is a key part in the decision making process.
- Face to face meetings or telephone communication between Consultants would be advantageous in supporting care throughout any admission.
- Multi-agency meetings were not held. In complex cases, it would be important to encourage Consultant to Consultant contact.
- The understanding and application of the Mental Capacity Act (2005) is legislatively essential. All health care professionals working with the Act need to ensure a sound understanding so they play their full role in its application.
- Recognition of eating disorders/issues in older people needs to be acknowledged and understood.
- Anxiety may cause people to have difficulties around understanding and making decisions about their own care. Practitioners need to consider how calming a patient's fears may affect their reactions and compliance.
- Clear documentation is paramount, particularly when difficult conversations are held and who was present helps support the practitioner.

What have we done?

A number of recommendations based from the review have been put forward to Stockport NHS FT and Pennine Care NHS FT. Furthermore, an action plan has been populated and sent to both Health partners with the recommended actions, with key outcomes. Both health partners have until October 2018 to feedback on the progress of the action plan.

Multi- Agency Learning Review (MALR)

A case was referred to the SAR consideration panel in November 2017. The case had not met the criteria for a SAR but had been appropriate for a Multi- Agency learning Review (MALR). An

independent author was commissioned and further updates and learning will be provided in 2018-2019.

Developed learning and sharing
It was reported in the 2016-17 annual report, that the Stockport Safeguarding Adults Board had commissioned 1 safeguarding adult review, and 1 comprehensive learning review. Both reports were completed in 2016-17, and we have learned the common themes occurring across Safeguarding Adults Reviews include effective communication and good information sharing, and are nationally the most common challenges.

Training was delivered based on themes specific to information sharing and effective communication.

Stockport Safeguarding Adults Board was keen to disseminate the learning from the reviews in a variety of ways to reach as many people as possible.

The methods included the following:
- Three workshops in relation to learning from the safeguarding reviews.
- Sessions was professionally videoed so that the information could be widely shared.
- 7 minute briefings - short blocks of information which enable a quick overview of the learning.
- Presentations to partner agency teams.
- Themes included in all multi agency training.
- Lessons learnt from the reviews had been shared at provider forums.
- Learning shared both locally and nationally via the SCIE SAR national library.

Coroner links
The Board recently strengthened links with the local Coroner. The Coroners look for patterns but it can be challenging to gain the whole picture at an inquest. A working relationship between the Board and the Coroner has been developed, and the coroner is notified of any suspicious deaths that the Board may be aware of, and share information and learning from Coroner reports.

9.0. Safeguarding Adults Activity 2017-18

The Council collects information about safeguarding adults work in Stockport, so we know how well people are being safeguarded. This information helps the Stockport SAB decide what their next steps should be.

Stockport Council submits returns annually to the Department of Health (DH) for collation and comparison of the key data across all authorities in England. The following commentary

includes extracts from the data, trends and areas for improvement and development in Stockport.

A safeguarding Concern occurs when any safeguarding issue is first raised with Adult Social Care. After a Concern is received it is reviewed, considered and risk assessed. It will either be dealt with through another route if not considered to be a safeguarding matter, or it will advance to the next stage of the safeguarding process for fuller investigation and formal intervention. This is called a Section 42 Enquiry.

Data on the Safeguarding concerns received in 2017/18 has been extracted from the safeguarding team's database.

Safeguarding Concerns

(NB. The figures below related to SMBC managed concerns only. Figures are not available for those concerns managed by providers.)

Table 1

Financial Year	2016-17	2017-18
Safeguarding Adults Alerts	2,897	3,679
Safeguarding Adults Alerts Level 3	284	272
Total	3,181	3,951

In 2017-18 we received 3951 Safeguarding alerts, split between 3,679 standard alerts and 272 level 3 alerts (data is correct at 21st June 2018).

In 2017-18 there were 662 referrals that reached to section 42 enquiries. See table 2

Section 42 enquiry referrals

Table 2

Financial Year	2016-17	2017-18
Safeguarding Adults Alert Level 3 (considered to be referrals)	284	272
Standard Safeguarding Referrals	517	390
Total	801	662

Safeguarding referrals have reduced from the previous year; this could be related to the safeguarding adult's team, who look at the alerts in relation to care homes. The safeguarding team has implemented a robust triage system to ensure that all safeguarding processes only apply where appropriate.

Another contributing factor is the implementation of the new EQUIP team who work in partnership with the safeguarding adults team. The EQUIP, which is a new care home

improvement team was set up in January 2018 to offer support, guidance and signposting to drive improvements and consequently the quality of service provided.

However, the number of alerts have significantly increased and this the subject of an review to understand whether alerts are being appropriately raised and if it is found not, a training programme will be implemented across agencies.

Number of Section 42 Enquiries Concluded

A safeguarding enquiry is the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult to a more formal multi-agency response.

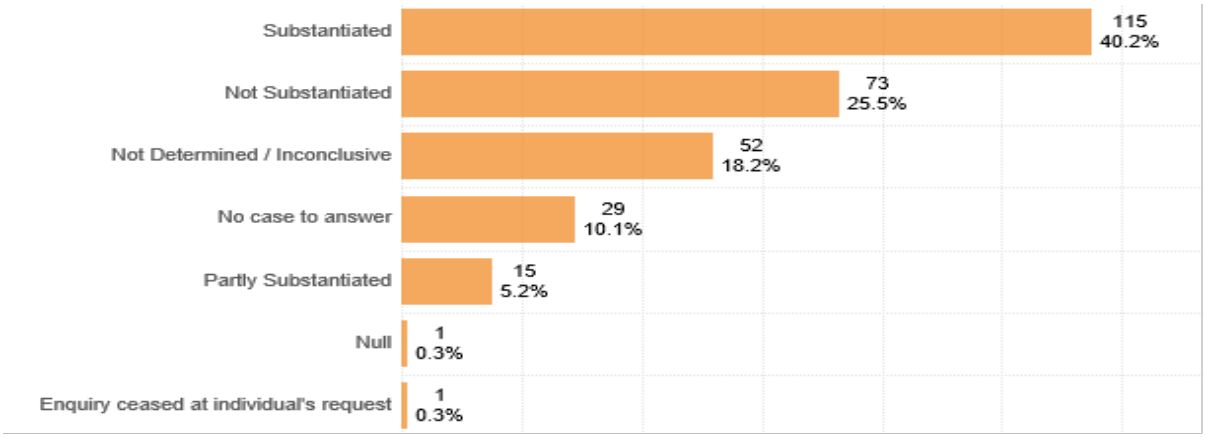
A concluded safeguarding enquiry is when all of the necessary information-gathering is complete and all of the necessary actions have been agreed. This can include cases that began in a previous reporting period.

Table 3

There were 286 concluded enquiries throughout 2017-18. The outcomes from the 286 enquiries were 115 substantiated, 73 not substantiated, 52 cases inconclusive, 29 with no case to answer, and 15 partly substantiated. See table 4

Table 4

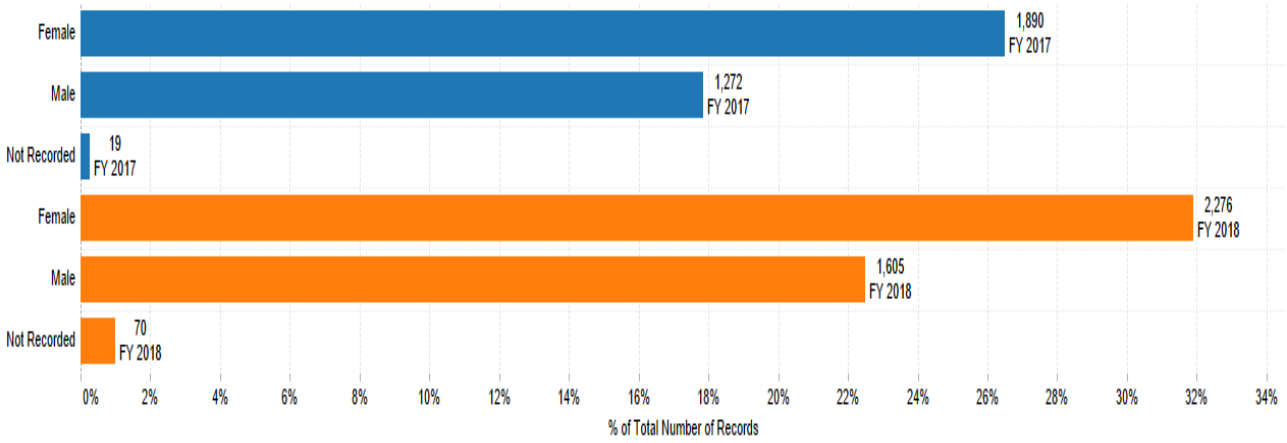
Outcomes from concluded enquiries in 2017-18



March 2011 census estimates that the gender breakdown of Stockport is 51.1% females and 48.9% males. Allegations of abuse against females consistently remain higher than against males, which is a reflection of the general population of females.

Table 5

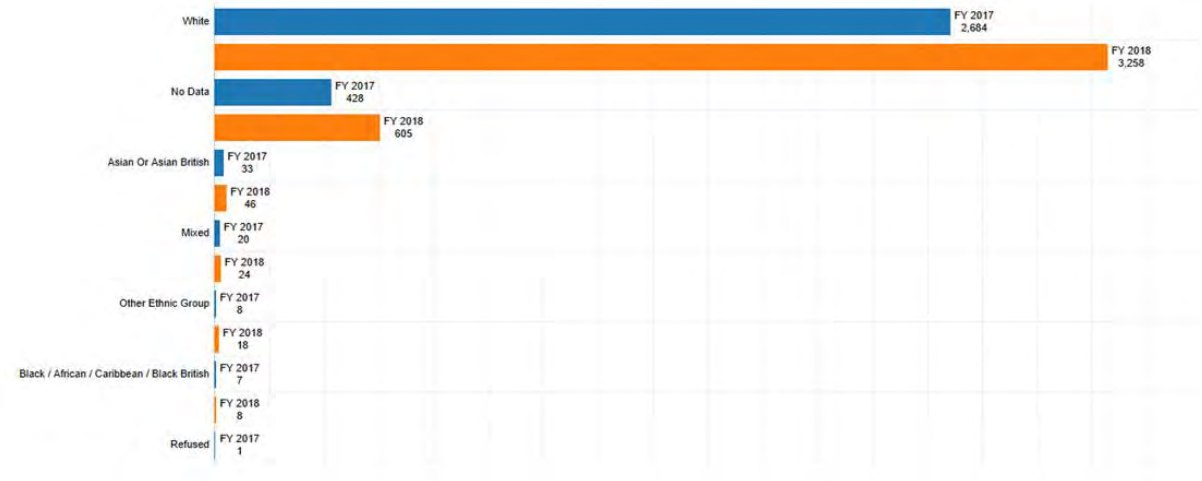
Individuals involved in safeguarding concerns 2016-17 compared to 2017-18 by gender



In 2017-18, 57.6% of the alleged victims were female and 40.6% were male, whereas 1.7% were reported unknown. These figures have increased in comparison to 2016-17. Non recorded data is not a mandatory field and further work is required to ensure case management systems capture this information as a mandatory field.

Table 6

Individuals involved in safeguarding concerns by ethnicity 2017-18

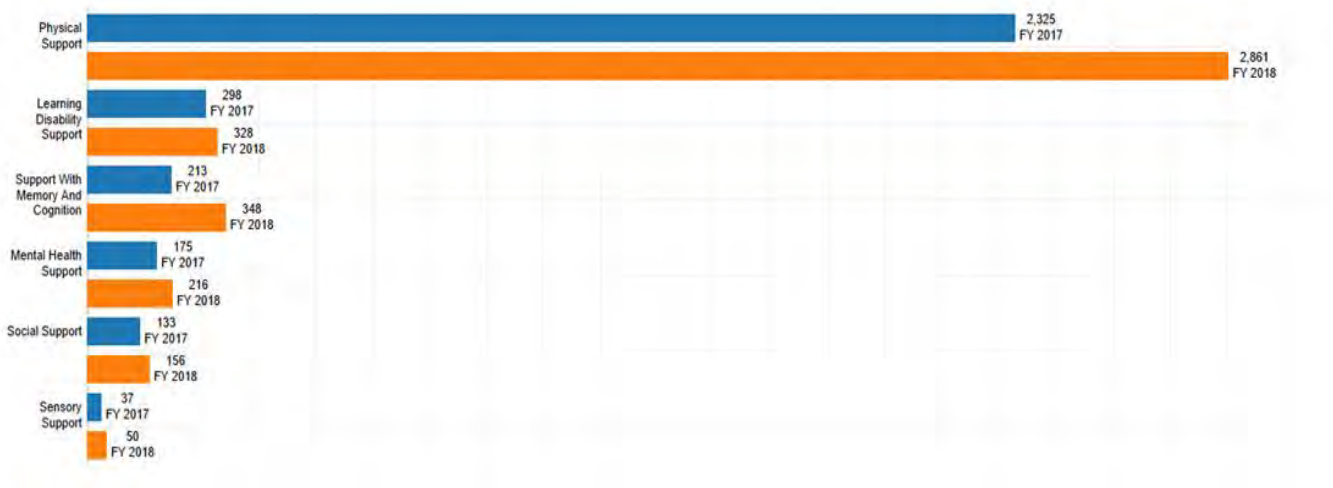


Although safeguarding referrals remain highest within the White British community, there is a small proportion of 1% of Asian communities who have been involved in a safeguarding concern. This is significantly low and could actually be higher if data were recorded accurately.

82% of the alleged victims were white, with the remaining 1% being Asian, 0.2% Black and a significant proportion of 15.3% where no ethnicity was recorded. This is a high percentage of non-recorded data, and it doesn't give a true account of the ethnicity breakdown in Stockport. This highlights inaccurate data and a recommendation has been made for this to be a mandatory measure when moving systems to Liquid Logic.

Table 7

Primary reasons of support



In 2017-18 in terms of alleged victim's primary reason for needing support:

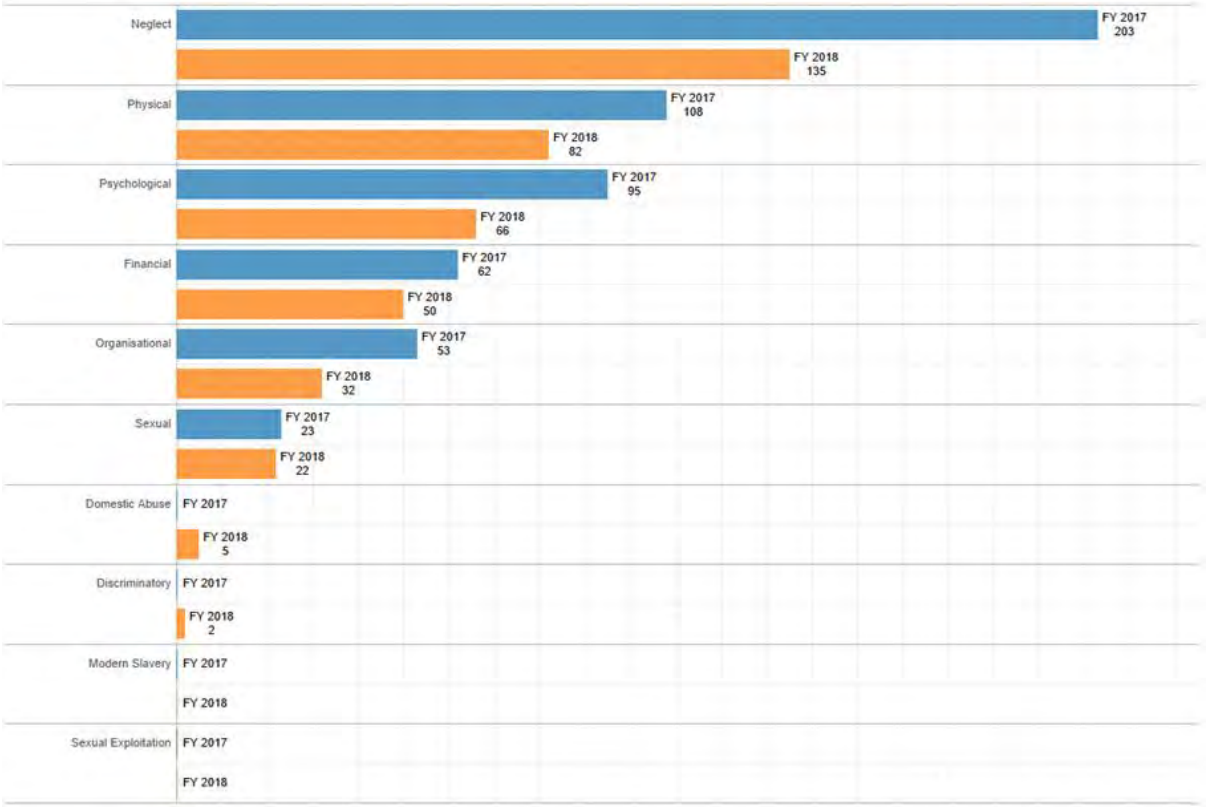
- 72.3% required physical support, for example to get dressed or to bathe
- 5.46% receive mental health support
- 8.8% receive support for memory and cognition from brain injury or dementia related
- 8.3% had a learning disability
- 1.2% with sensory impairment
- 3.94% receive social support such as help with shopping

For the past few years, the data collection in Stockport has consistently evidenced that the highest numbers of concerns reported were on behalf of people with a physical disability. This is likely to reflect the age profile, as well as the ability of the relevant individuals to speak up for themselves or report concerns to others.

A comparator table from the previous year to the present is above.

Table 8

Type of risk from concluded enquiries



The reason for low reporting particularly relating to domestic violence, sexual exploitation and modern slavery is perceived to be an educational need and further work is required in order to teach practitioners and the workforce to report these themes accurately.

A person can have more than one type of risk recorded for any specific safeguarding enquiry.

The most commonly investigated form of alleged abuse was neglect or acts of omission with 135 investigations. This has reduced significantly from the previous year, although it still remains the most prevalent measure.

One reason for this category being the highest is that the gathering of evidence is most obtainable and leaves an outcome less difficult to prove.

Table 9

Concluded Cases by Location of Risk

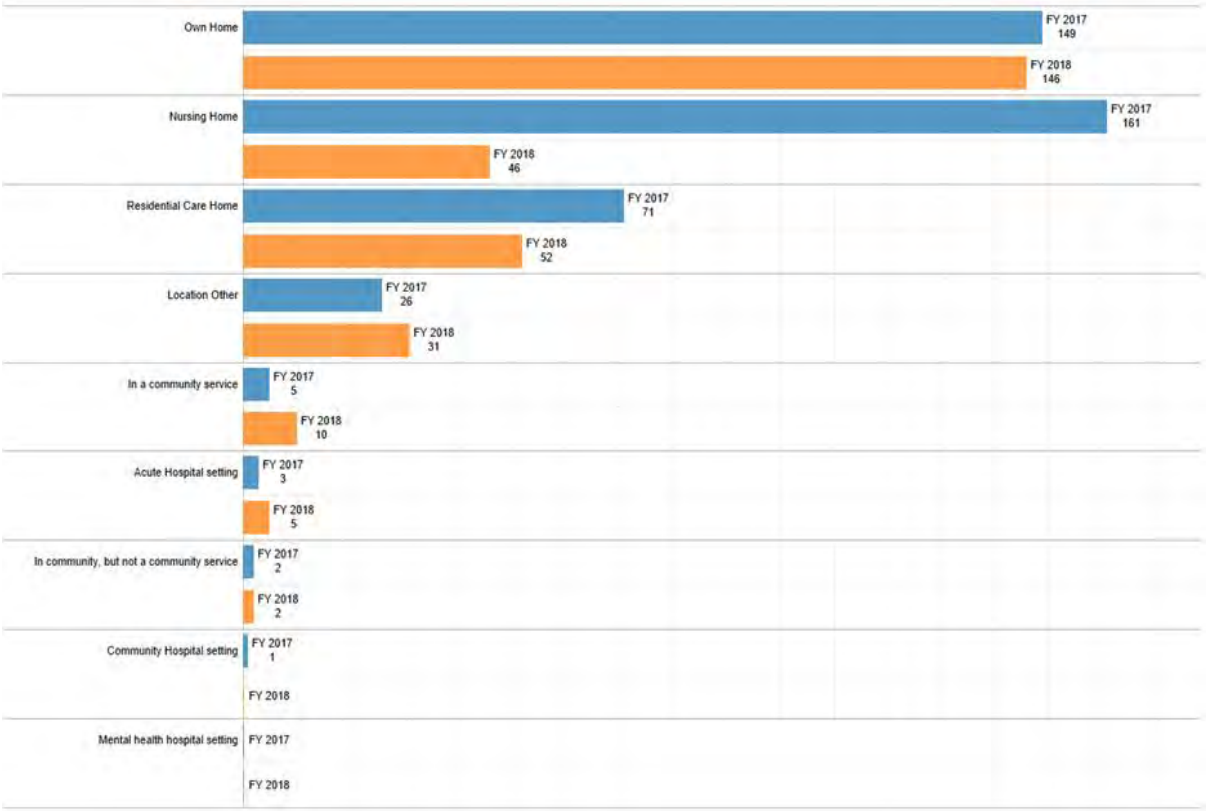


Table 9: provides an overview of the locations where the risk arises.

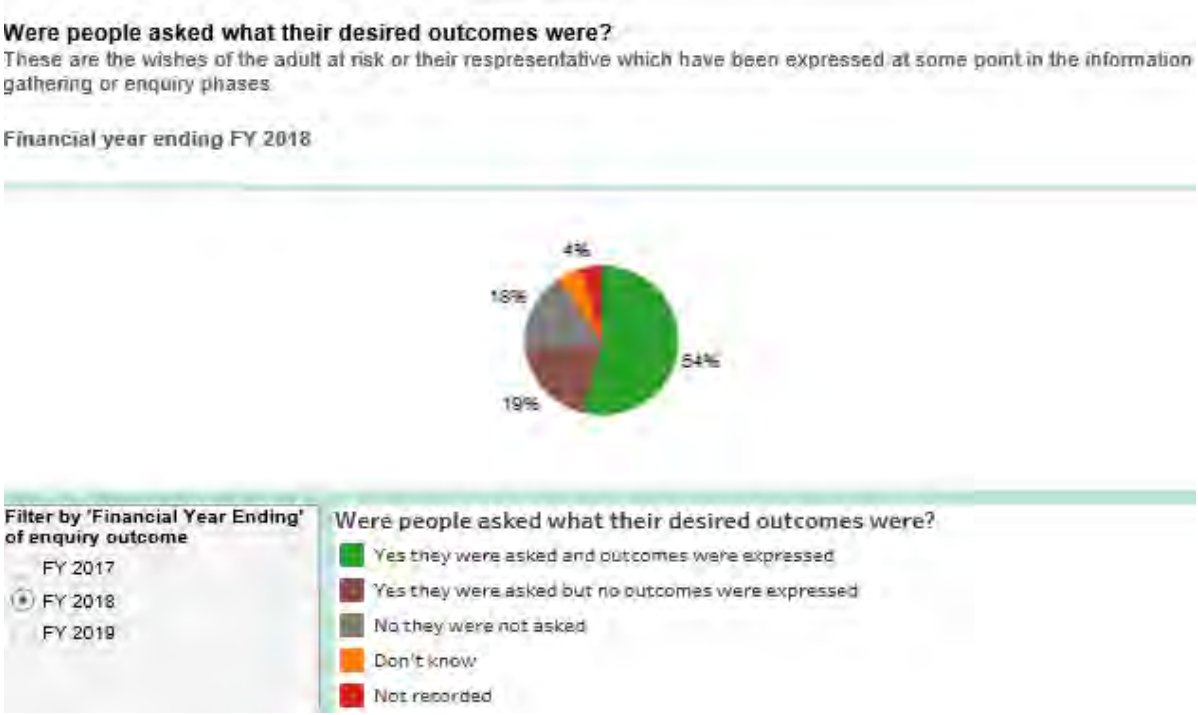
You will see the risk in the person's own home is very similar to the previous year, although a significant reduction in Nursing homes by 71%, and residential care down by 27%, compared to 2016-17. This reflects the support and intervention provided from the joint funded EQUIP team who have consistently provided support and guidance to both the residential and nursing care sector. It is also possible that under reporting occurs in the nursing care sector, where further enquiries would need to be made to determine if this was the case.

A low level of reports also comes from mental health hospital settings. This requires further development and with the implementation of the new proposed safeguarding structure, we should begin to see this measure of reporting improve.

Making Safeguarding Personal (MSP)

MSP is about having conversations with people about how to respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, well-being and safety. The Care Act advocates a person-centred rather than a process driven approach. MSP questions were added to Carefirst effective from 17th October 2016. The questions set on Carefirst comply with the standards set by NHS digital, ensuring they are comparable with all other authorities across England.

Table 10



In 2017/18, individuals who were involved in a safeguarding enquiry were asked what outcome they wanted from the investigation. 54% had been asked and an outcome was expressed. 19% were also asked and no outcomes were expressed, and 18% of people were not asked at all, whereas 4% of enquiries were not recorded.

Table 11

Table 11 demonstrates how the principles of MSP are applied to practice and how desired outcomes had been achieved.

64% of service users had outcomes achieved, whereas 24% of cases were recorded where the outcome was partly achieved, with a further 9% of cases where the outcome was not achieved.

The desired outcomes expressed by service users and / or their representatives may not always be achievable. For example, it may be that desired outcomes expressed at the beginning of the process may change during the process based on information that is made available.

Other factors may be other issues that are not part of the safeguarding concerns but can impact on the views or wishes of individuals. For example, it may be that the relevant person died as a result of physical illness during a safeguarding process. This may have an impact on the views of those involved in the proceedings and can sometimes affect the desired outcomes for the proceedings that may not be achievable.

Deprivation of Liberty Safeguards & Mental Capacity
The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law under the 2009 addendum to The Mental Capacity Act 2005 which authorises the necessary deprivation of liberty of a resident in a care home, or a patient in hospital, who lacks capacity to consent to their care and treatment.

The authorisation allows the deprived person to be kept safe from harm, in the least restrictive way, appropriate to the individual's assessed best interest. The deprived person has a legal right to challenge the deprivation if they object to it, in the Court of Protection. This is known as a 21a challenge.

The Supervisory Body (the Local Council) is responsible for the authorising of Deprivations of Liberty Safeguards within legal timeframes. Requests for a standard authorisation should be processed within 21 days. Urgent authorisations, issued by care homes or hospital, should be completed within 7 days.

Current Arrangements
The Local Authority provides resources for the following functions:

- The undertaking of best interest assessments
- The commissioning of Mental Health assessors to complete mental health assessments
- The scrutiny function before authorising the Deprivation of Liberty Safeguards.
- The appointment of the Relevant Person's representative and IMCA where appropriate
- Supporting the 21a challenges to the authorisation in the Court of Protection

The Best Interest Assessors (BIA) are all employed by Stockport Council and are either social workers or Occupational therapists (OTs) who undertake the BIA assessments in addition to their usual council duties.

DoLS Statistical Overview Report 2017/18

DoLS applications continue to rise, up approximately 15 % on 2016/17. The total number of completed assessments, there was 1436 referrals in 2017-18, of which 657 had been assessed and signed off. The remaining referrals will have been triaged as low and placed on the waiting list.

Challenges

1. Best Interest Assessors - The number of Best Interest Assessors available to take allocations in the locality teams is reducing. The demand pressures of business as usual make it harder for people to find the time to undertake the BIA duties. Staff are requesting to be removed from the rota and are not being replaced.
2. Signatories - There are fewer signatories than there were last year as the senior management team changes and the pressure of work is leading to fewer forms being signed off by the current signatories.

Risks

1. Potential for increased ligation from illegal deprivations - breaches of Article 5(4) – 'right to speedy review' of a deprivation of liberty. (Could lead to damages up to £5k per litigant.)
2. Reputational risk to the LA for illegal deprivations.
3. Risk to vulnerable adults having unchecked restrictions on their lives.
4. Risk of negative scrutiny from coroner.

Actions to mitigate the risk

The local authority has taken a long term approach with the intention to improve the process and employ a DoLs Coordinator to manage the flow of the process more effectively. Additionally, two Best Interests Assessors have been funded to reduce the backlog and improve timeliness.

10.0. Future Priorities

SSAB is dynamic and already progressing against the business plan 2018/19 that will see the next 12 months being transformational in how the board performs its functions for the children, families and adults at risk in Stockport.
The Board has agreed four key priorities to drive its work for the next three years.

Here is some of what we need to do more of in 2018/19:

- Ensure learning from reviews is embedded
- Multi agency audits, at least three per financial year.
- Improve scrutiny of data performance
- Communication
- Sub group attendance
- Develop domestic abuse training

- Develop and trial a self-neglect policy and process that will offer the appropriate toolkits for single agency and multi-agency use
- Learn from experience and improve how we work ensuring the dissemination of learning is consistent throughout the economy
- Financial Capacity and Resource for the Board
- Future arrangements and ensuring the safeguarding system remains strong

11.0. Partner Reports

Greater Manchester Police (GMP)

As an organisation GMP recognise the demographics of the borough and understand the need to respond accordingly in order to deliver safeguarding successfully and to enable individuals to achieve their desired outcomes. This is attained by focusing on the priorities identified and linked with the Adult Safeguarding Boards. The following areas of work have been undertaken over the past year in line with the Board's strategic priorities.

Achievements over 2017-18

- Senior Police continue to attend the Safeguarding Adult Board on a regular basis and continue to Chair monthly Vulnerability Meetings involving all key partners from across the Borough in order to oversee our multi-agency response to Domestic Violence and Abuse
- Stockport Police remain proud to be a partner on the Multi-Agency Safeguarding Partnership and continue to develop our processes to gain greater focus and research into reported adult safeguarding matters
- Stockport police have embedded the STRIVE Programme as a multi-agency approach to tackling Domestic Abuse in the early stages by awareness and behavioural change courses
- Awareness of the Herbert Protocol has been rolled out to all officers across the Borough by email and briefings. Officers have an understanding that helpful information is contained within the Herbert Protocol Forms and that information is available to all staff and officers via the GMP Intranet

Key challenges and priority for 2018-19

- Demand linked to mental health cases within the community continues to be a challenge
- To upskill officers and ensure that they have the skills to make informed decisions to support people with mental health needs
- To build on the safeguarding training undertaken in the previous year
- The police have trained all new officers and staff moving to the Stockport policing team. This equates to other new officers and staff being trained in Domestic Violence and abuse, safeguarding, National Crime Recording Standards and DASH risk assessments
- The police are planning to roll out Adult Safeguarding training to all Criminal Investigation Department detectives in the forthcoming year
- To continue to develop integrated partnership working by Adult Social Care having a representative located in the MASSH
- A further desire to secure a member of Pennine Care NHS Foundation Trust Community Mental Health Team to join the MASSH
- Increase Independent domestic violence advisors (IDVA) and hope to introduce a designated early intervention IDVA to work with standard and medium risk domestic abuse cases
- The Brinnington Placed Based Integration model is underway. A full evaluation of this model is being undertaken relating to domestic abuse

Training

13 officers attended and passed the A221 Safeguarding course.

Greater Manchester Fire Service (GMFRS)

The Stockport Fire and Rescue Service continues to work collaboratively with the local authority and partner agencies. Our primary aim is to reduce the risk of harm from fire to those most vulnerable within the community. We do this not only by home fire safety visits, but working with partners on the Safeguarding Adults Board to identify those at highest risk and provide the advice and support to improve safety. Our safeguarding responsibilities include regular attendance at the Safeguarding Adults Board, to provide support and challenge to the partnership so that we can be assured we are effectively responding to the abuse and neglect of adults at risk.

Key achievements 2017-18

- Attending safeguarding meetings to contribute to the safety planning with partners and adults at risk
- Safe and Well visits have continued with 3,072 visits in Stockport during 2017/18
- Presenting at sub groups of the Board, to help highlight and develop the partnership approach
- GMFRS Safeguarding Policy Review Group meets quarterly to keep up to date with national and local developments
- Community Safety Teams have received training to recognise and report the signs and symptoms of more complex issues such as honour based violence, modern day slavery, domestic abuse, female genital mutilation and forced marriage
- Bridgewater Community Healthcare NHS Trust began using Offerton Fire Station to host Dementia Driving Assessments
- GMFRS has produced Hoarding Guidance for staff
- Over 2,000 (approx. 95%) staff have successfully completed and achieved the Safeguarding Adults e-learning training
- Safeguarding lunchtime learning sessions available on a quarterly basis, covering topics, such as child sexual exploitation, extremism and radicalisation, and surviving and prospering in the workplace

Key challenges and priorities for 2018-19

- GMFRS is currently experiencing a period of exceptional change and review, under the Greater Manchester Combined Authority (GMCA)
- A significant change in senior management within the service, and the recent publication of the Kerslake Report
- Mental Capacity is often an issue in such cases and staff will work closely with partners, including mental health services, to assess capacity and balance this against the safety of the individual
- GMFRS are working towards becoming a dementia friendly organisation
- GMFRS has begun supporting the Herbert Protocol (HB), raising awareness of the scheme to all members of staff within the wider GMCA, whatever their role

Training

- Safeguarding Adults e-learning training - Over 2,000 (approx. 95% of staff)
- Advanced safeguarding training - 11 staff attended in March 2018
- Other Youth Engagement related training - 24 staff attended

- Domestic Abuse - 48 members of support staff to date during 2017/18

Prevent training
The introductory workshop to Prevent is about supporting and protecting those people that might be susceptible to radicalisation, ensuring that individuals and communities have the resilience to resist violent extremism.

It is aimed at frontline staff and provides them with:
- Awareness and understanding of the Prevent agenda and their role within it
- The confidence and ability to use existing expertise and professional judgement to recognise potentially vulnerable individuals who may be susceptible to messages of violence

Modern Day Slavery
All fire protection staff have received a briefing on modern day slavery delivered by GMP's Operation Challenger team, covering:
- What is modern day slavery
- Case studies for each type of exploitation
- Signs and symptoms - what should GMFRS staff be looking for
- What is a harm reduction visit
- What to do? How to refer?

Online Safety
Stockport & Tameside Community Safety Team recently participated in training delivered by GMP, designed to equip participants with a basic level of knowledge sufficient to keep themselves safe and to provide information and advice to others on keeping safe whilst using the internet, including basic information on common terminologies and types of crimes involving an online element.

Quarterly safeguarding lunchtime learning sessions:
Sessions for staff and volunteers have taken place during 2017/18 and have included:
- Countering Far Right Hatred and Division
- Child Sexual Exploitation
- Domestic Violence and Honour-Based Abuse
- Extremism and Radicalisation
- Surviving and Prospering in the Workplace

Mental Health First Aid at Work
The training is being rolled out across the service to operational firefighters and support staff. It provides practical skills to spot the triggers and signs of mental health issues, the confidence to step in, reassure and support a person in distress, and enhanced interpersonal skills such as non-judgemental listening.

Stockport Metropolitan Borough Council (SMBC)

Every community has a part to play in recognising and reporting adult abuse. Stockport Council as lead for adult safeguarding is working in partnership to help secure freedom from abuse and neglect for those in the Borough. In collaboration with service users, carers, residents and our partner organisations, we aim to stop abuse from happening in the first place.

Stockport Council is the lead under the Care Act 2014, for making enquiries or causing others to do so when it believes an adult is experiencing, or at risk of, abuse of neglect. This means that when we become aware of a concern, we make contact with the person being abused, to establish together what action should be taken and by whom. There has been significant progress on a number of issues over the year.

Integrated Transfer team at Stepping Hill Hospital – aimed at reducing delayed transfers of care and ensure good risk management when transferring out of hospital to home or care.

Stockport NHS, Stockport Adult Social Care and Voluntary sector workers have officially come together as new team to run a 'transfer to assess' service at Stepping Hill Hospital which aims to discharge patients from hospital as soon as they are medically fit and carry out longer term care needs assessments in their home or community setting.

The Integrated Transfer Team will actively identify elderly patients across hospital wards who are medically fit to leave a hospital bed and arrange their transfer home or to a community environment working closely with colleagues to ensure all additional requirements are put swiftly in place enabling patients to spend less time in hospital beds.

Improved working between Adult Social Care and Pennine NHS Foundation Trust

The new mental health team structures are now in operation i.e. The East CMHT Recovery Hub and the Supported Living Team are now based at Baker Street and the West CMHT, Recovery Hub and the Early Intervention Team continue to be based at Councillor Lane. The Baker Street office is shared with an Integrated Neighbourhood team, which will improve communications.

Plans are being explored for part of the mental Health Access team to be based within an all age adult MASH team from Dec '18, which will improve communications at the front door.

Work is underway to recruit to two posts within the Adult Safeguarding Team, the new roles will be responsible for chairing safeguarding case conferences for people open to the Mental Health CMHTs (both working age Adult and Older People), Mental Health hospitals within the borough and those relating to people living in the SMBC provider Learning Disability tenancies. The role will also offer a guidance and support role to staff working in these services and will provide a quality assurance element to the investigation process. It is expected that these posts will be filled in October '18.

Stockport Adult Safeguarding Service

The Stockport Adult Safeguarding Team (in conjunction with the area teams), works with care homes, nursing homes and domiciliary care providers in the Stockport area to ensure that every safeguarding alert receives a person centred and proportionate response.

The team operates in line with Making Safeguarding Personal, which explores how to support and empower people at risk of harm to resolve the circumstances that put them at risk.

We aim to ensure that our providers work in line with Stockport's All Agency Safeguarding Adult Policy to achieve positive outcomes for people. Where we identify something that is working really well, this is shared with other care providers.

We work alongside the Quality team to make sure that local providers know about national best practice and new standards and guidelines for improving the quality of care.

We aim to encourage practice that generates a more person-centred set of responses and outcomes;

- To **promote well-being** and **prevent** abuse and neglect from happening in the first place
- Ensure the **safety and wellbeing** of anyone who has been subject to abuse or neglect
- **Take action against those responsible** for abuse or neglect taking place
- **Learn lessons and make changes** that could prevent similar abuse or neglect happening to other people (e.g. through learning and development programmes for staff)

In addition to managing single concerns about individuals, we take the lead on Provider Concerns. This is a process that involves both the adult safeguarding team and the quality monitoring team working closely to manage serious safety and care issues in organisations through an enabling approach, while holding providers to account to improve.

Stockport NHS Foundation Trust (SNHS FT)

SNHS FT fully supports the work of the SSAB. The Trust is represented at SSAB by the Deputy Chief Nurse, with the Named Nurse Adult Safeguarding deputising as and when required.

During the last year there have been significant changes in senior leadership across the Trust in terms of Adult Safeguarding which has led to a revised governance structure.

A Trust Safeguarding Group (Adults and Children) has been established reporting to the Quality Committee and in turn the Trust Board. The group is responsible for providing information and assurances to the Quality Committee that it is safely managing all issues relating to safeguarding.

The Trust has also implemented the following actions to enhance patient safety

- The establishment of weekly Patient Safety Summits where incidents are reviewed and consideration is given as to whether these are safeguarding incidents
- Patient Safety Walk rounds
- Senior Team walk rounds

SNHS FT gives assurance via Stockport Clinical Commissioning Group that both Adult and Children's safeguarding duties are being met. This assurance is reviewed quarterly.

Key challenges and priority for 2018-19
The past year has been a challenging one for the Trust having been given a rating of "requires improvement" by the Care Quality Commission in March 2016 and again in October 2017. In September 2017 the trust was identified as being 'challenged' in relation to quality, performance and finance by NHS Improvement.

Following these reports the Trust developed a comprehensive action plan which was shared with SSAB in March 2018.

Improvement Priorities for 2018/19
The Trust Board, in partnership with staff and Governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2018-19, which will be monitored via quarterly reports to our Quality and Safety Improvement Group, include:

Safety

- We aim to achieve a 50% reduction in avoidable stage 2, 3 and 4 pressure ulcers (in both acute and community) by March 2019
- We aim to achieve a 10% reduction in in-patient falls, with 25% reduction in falls with moderate and above harm by March 2019
- We aim to achieve 100% compliance with the Malnutrition Universal Screening Tool (MUST) by March 2019

Effectiveness

- We will undertake a review of discharge planning process and establish a baseline and target for improvement by March 2019

- Following a successful pilot we will launch our ACE Ward Accreditation programme. We will undertake 6 ward accreditations per quarter with quarterly reports provided. By March 2019 we will have scoped and piloted the ACE programme for community, maternity and paediatrics
- We will improve on a range of metrics relating to the Deteriorating Patient and NEWS introduction (metrics to be determined through AQuA program) for improvement by March 2019

Experience

- We will undertake a strategic staffing review with a report to board in October 2018
- We will deliver 4 work-streams identified through our staff retention programme
- We will triangulate staffing levels with harm
- We will achieve an improvement in the top 5 worst performing questions from the inpatient survey by 5% measured in the 2018 in-patient survey
- We will Introduce a suite of Always Events in Q1 (metrics to be determined by 30 June 2018) with 100% achievement by March 2019
- The above areas are as identified in the Trust Annual Quality Account, in particular respect to Adult Safeguarding the Trust is giving close scrutiny to the Mental Capacity Act (MCA) and its application in practice and to the use of Deprivation of Liberty Safeguards (DoLS) for our patients
- The Trust is fully committed to continue to support the work of the Safeguarding Adult Board although the number of sub-groups is proving a challenge to full engagement and we welcome and support plans to review these

The Trust aims to meet the goals described in the Improvement Priorities above.

To improve the application of the MCA in practice across all areas of the Trust – the use of MCA has been shown to be a theme in multiagency Safeguarding Adult Reviews and the Single Agency Health Review to which the Trust has contributed.

The aim of our training is to ensure that the workforce is competent and confident in discharging their safeguarding responsibilities and our ambition is to ensure that the effectiveness of training we deliver is reflected in the practice of the workforce and the care given to our patients. We are still awaiting the Adult Intercollegiate document which may require us to review our training strategy.

Training

Adult safeguarding training is recorded against all clinical staff profiles as a Mandatory Compliance Competency. It is recorded as a percentage rather than a number.

- The Trust position at the end of March was 87.49% compliance, against a target of 85%.
- Compliance with MCA / DoLS training was recorded at 93.13%.

Pennine Care NHS Foundation Trust (PCFT)

PCFT continues to ensure that the Trust effectively executes its Safeguarding Adults at Risk duties and responsibilities. PCFT remains committed to safeguarding all our service users, their families and carers. Our Safeguarding Strategy and associated three year work plan reflects our commitment and drive to ensure effective safeguarding is a shared responsibility both at a local level and with partner agencies. We strive to continually improve systems and processes, and to develop a clear strategic approach to safeguarding across all our services.

PCFT is monitored through the Clinical Commissioning Groups Safeguarding Children, Young People and Adult at Risk Contractual Standards and Training Recommendations framework.

Key PCFT staff support the SSAB delivery plan through attendance at local sub groups. These include contribution to the joint SSCB/SSAB Complex sub group, supporting work around completion of the All Age Neglect Strategy, the development of a local Self Neglect tool to assist practitioners, contribution to both a children's Domestic Abuse and adult Domestic Abuse audit alongside supporting any Task and Finish groups that have evolved. These include specific task and finish groups and attendance at Channel, MAARS and MARAC panels.

Key achievements 2017-18

- Attendance at SAR practitioner events has been positive and we continue to develop and cascade 7 minute briefings that reflect the SAB's four thematic priorities
- All contractual standards were met
- PCFT internally collates Prevent and FGM dat.
- Review of the Trusts Transitions Policy for young people requiring transfer to adult mental health services
- PCFT Memory Assessment and Treatment Service received a commendation award from the Royal College of Psychiatrists having achieved 90% of the sustainability standards
- PCFT Stockport Young Onset Dementia Team collected one of the Trust's Principles of Care Awards for its tailored care packages and compassionate care offered to patients and their families
- PCFT "Moving On Group "mental health rehabilitation unit won The Trust's Care Award in recognition of their promoting a range of different activities to aid with rehabilitation

These awards provide assurance that harm, neglect and abuse are prevented.

Customers' feedback

Without question, the staff are friendly and the service is fantastic. The food is delicious and the drinks are made perfectly. I would highly recommend this cafe to anyone on the unit or anyone in the hospital.

The cosmopolitan style Oasis Café located at Stepping Hill Hospital which is run by, and for, people recovering from mental health issues held its 10th anniversary celebration.

The café provides a welcome sanctuary for patients and relatives.

KEY CHALLENGES AND PRIORITIES FOR 2018-19

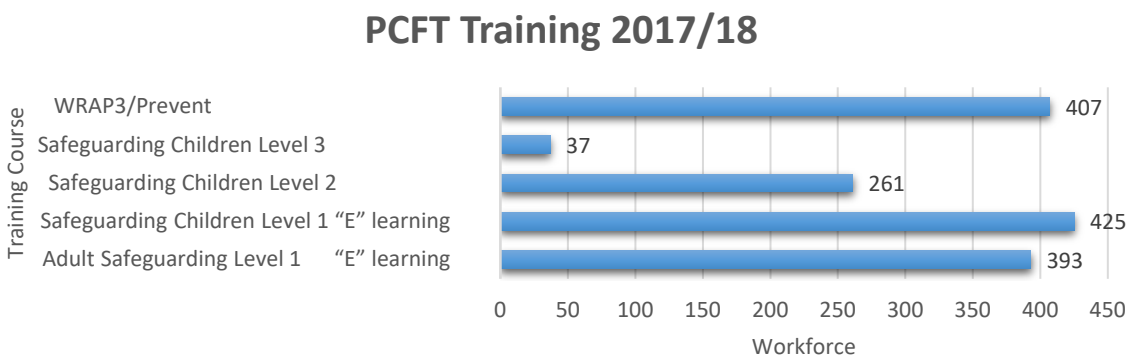
- The existing PCFT/SMBC safeguarding referrals response protocol where PCFT manage both internal and local borough independent hospitals requires urgent review
- The importance of collecting accurate, meaningful data is recognised, and we continue to work with partner agencies to overcome these challenges
- The safeguarding team is currently located within Springhill Cottage with the RAID team- no admin cover is available and space is limited which impacts on the working environment
- The safeguarding team is busy, with an increase in calls and reviews of incidents etc noted
- Maintaining attendance at Sub groups can be challenging. This will be better managed under the newly appointed Assistant Director (AD)
- The Named Nurse role covering two boroughs impacts on key groups sometimes being attended
- In partnership with SSAB and Stockport CCG there is an aspiration to develop a safeguarding outcome form that is centrally processed by ASC regarding safeguarding adults referrals
- Development of specific adult safeguarding training packages to include Self Neglect.
- Cascade the Supervision framework to include development of a Standard Operating procedure (SOP) on safeguarding and Supervision Training package

The PCFT safeguarding team have 3 audits planned within the PCFT to include:

- Safeguarding issues with CMHTs
- Safeguarding supervision
- Practitioner awareness of safeguarding policies

KPMG will undertake a safeguarding audit across adults and children during July 2018 with plans to speak to frontline practitioners and meet with key safeguarding colleagues within PCFT.

PCFT has in place a Safeguarding Adults Training Strategy which is aligned to the Safeguarding Agenda.



In addition a training package is currently being developed to support staff when requested to undertake an Individual Management Review (IMR) for statutory reviews.

Approximately 400 PCFT staff have completed Level 3 Safeguarding Adult training. MCA training is also delivered to the workforce with refreshers courses for staff.

NHS Stockport Clinical Commissioning Group (CCG)

NHS Stockport CCG is a clinically-led statutory NHS body which is responsible for planning and commissioning health care services for the Stockport area.

NHS Stockport CCG is supported by NHSE England. The first is assurance: NHS England has a responsibility to assure itself that the CCG is fit for purpose, and is improving health outcomes. Secondly, NHS England supports the development of the CCG. Finally, NHS England is a direct and supporting commissioner, responsible for specialised services and primary care.

NHS Stockport CCG has key responsibilities towards safeguarding which are set out in the NHS Safeguarding Assurance and Accountability Framework (2015) to ensure that the services they commission have safeguarding systems and processes in place to safeguard and promote the welfare of adults and to protect those at risk from abuse.
The Executive Nurse provides overall leadership and guidance to the CCG in relation to safeguarding vulnerable groups. The Designated Nurse ensures the CCG has safe and effective systems in place to ensure patient, staff and the organisation is compliant with CQC Regulation 13, safeguarding service users from abuse and improper treatment.

Key achievements 2017-18

- Stockport CCG continues to deliver the safeguarding agenda by ensuring that the services it commissions have the necessary systems, processes, policies and procedures to protect and safeguard adults at risk
- The Designated Safeguarding Nurse continues to work in partnership with colleagues from the Local Authority and the CQC to make enquiries of concerns regarding the quality care within Nursing and care Homes across Stockport
- The Stockport Safeguarding Adult Board (SSAB) representatives are the CCG Executive Nurse and Designated Nurse Safeguarding Adults as a clinical advisor
- The Designated Nurse also attends three board sub groups, and is the chair of the Quality Assurance sub group
- Stockport CCG continues to work in partnership with colleagues from its main providers separately on a bi-monthly basis. The areas of assurance monitored include; responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards; monitoring against the NHS Provider Safeguarding Audit Tool; monitoring in relation to progress against Serious Adult Review, Domestic Homicide Review and Local Case Review action plans and monitoring of the management of allegations against staff working within healthcare providers
- The CCG safeguarding standards are included in a schedule contained within all clinical contracts for where the CCG is the lead commissioner. Within this schedule, there is a requirement for each provider to complete an annual audit based on the safeguarding standards specified in the contract. All action plans resulting from the audit findings are monitored by the safeguarding team
- Quarterly meetings are held with our main providers, Pennine Care NHS FT, Stockport NHS Foundation Trust, St Ann's Hospice, Master call, BMI and The Priory. Although the

CCG is not the lead for Pennine Care NHS FT, quarterly reviews are undertaken jointly with the Designated Nurses from six CCGs

- Stockport CCG safeguarding team have not been able to seek independent assurance from all GP practices as agreement over the completion of an assurance audit was outstanding. Substantial progress has been made in this area; a contract variation has been sent out to all practices with a modest amount of additional funding to enable practices to commit more to the GP safeguarding lead role and to complete the assurance audit annually. Attendance at the safeguarding briefings for the GP safeguarding leads is mandatory as part of the contract variation and will be reported through to this Committee and the primary Care Quality Committee

Training

The Safeguarding Team is working hard to ensure that training is planned, available and delivered across the CCG for GP's and for CCG staff. Sessions include lessons learned from local and national learning from SAR's and DHR's.

85 dentists trained in safeguarding adults/children
GP safeguarding adults lead briefing – 20 attended for a MCA

GP Masterclass – these are whole practices including reception staff/nursing and GP's
Safeguarding adult L3 – The Phoenix Project
Session 1 – 68
Session 2 – 50
Session 3 – 37
Total – 155 (71 attended the Masterclass)

Safeguarding adult L3 – Fractures & Bruising
Session 1 – 41
Session 2 – 37
Session 3 – 32
Total – 110 (94 attended the Masterclass)

Safeguarding Adult L3 – Domestic Violence and Abuse - Talk Listen Change
Session 1 – 67
Session 2 – 72
Session 3 – 56
Total – 195 (161 Attended the Masterclass)

CCG staff
Prevent 116/130- 90%
Safeguarding adults level 4 -100%
Safeguarding adults -99%
MCA -80% face to face session planned for med ops staff sept 2018

Presentations and training sessions regarding domestic abuse and the lessons emerging from Domestic Homicide Reviews have been delivered to GPs in order to raise awareness and ensure an appropriate response when such behaviour is reported or suspected.

The MCA and DoLS mandatory training for CCG staff continues through internal training system. GPs also have access to MCA and DoLS training via E-Learning.

A new Stockport CCG MCA assessment form and best-interest decision-making form that includes guidance for staff has been developed by the Designated Nurse Safeguarding Adults and shared with GP practices and CCG staff, and is available on the CCG intranet.

A GM-wide MCA policy for Primary Care staff has been developed and shared with primary care services in Stockport. A MCA and DoLS policy for CCG staff is currently being developed, this updated policy will contain the new MCA assessment form and the best interest decision-making forms for staff to access and utilise.

LeDeR (Learning Disability Mortality Review)
The overall aims of the LeDeR programme are to support improvements in the quality of health and social care service delivery for people with learning disabilities, and to help reduce premature mortality and health inequalities.
The LeDeR programme also collates and shares anonymised information about the deaths of people with learning disabilities nationally, so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements. There is a LeDeR Steering group which provide a local governance function especially in relation to action plan recommendations.

In Stockport the primary local area contact is the Head of Safeguarding/Designated Nurse Safeguarding Children and the secondary local area contact is the Designated Nurse Safeguarding Adults. There is a significant amount of work emerging from holding these roles to support the review process. Being able to sustain this role from within the safeguarding team is a concern when the amount of statutory safeguarding reviews is at such a significant level.

There are 10 LeDeR trained reviewers from across the Stockport footprint. These reviewers are currently completing the reviews within their substantive roles; hence there are delays and pressures in completing the reviews. Stockport have completed 12 reviews which is higher than the national average.

Key challenges and priorities for 2018-19
There are a number of Safeguarding challenges that the CCG will face in the coming year; the challenge to ensure Making Safeguarding Personal is ongoing, and the continued close working with all stakeholders to ensure the principles of safeguarding are embedded in practice to achieve this is paramount.

Our ambition:

- To ensure there is a clear template used in all Mental Capacity Assessments and to audit how clinicians assess and document decision based assessments
- To engage fully with the SSAB sub group work and activity

- To embed the learning from the recent safeguarding adult reviews/domestic homicide reviews/ multi agency reviews and single agency reviews and to consider a variety of means alongside formal face to face training; podcasts and webinars are a good way of disseminating learning
- To focus on the Prevent agenda and ensure staff are being trained according to their roles alongside meaningful contribution at Channel Panel where GP information would be extremely useful
- Work within the Greater Manchester safeguarding network to look at different ways MSP can be embedded into health economy practice in a consistent way
- To work closely with the SMBC quality team and the CCG quality nurse around safeguarding issues relating to poor quality care/acts of omission and neglect.
- Commencement of the GP safeguarding assurance framework led by named GP for safeguarding

Designated Nurses will benchmark Domestic Abuse training across Stockport, and link with Stockport partners to discuss the future offer of multi-agency Domestic Abuse.

Age UK Stockport

Age UK Stockport has worked throughout the year both strategically and operationally to ensure we are able to achieve the shared aim and work to progress the actions identified in the plan.

Age UK Stockport work with adults and their families, delivering Information and Advice and provide access to experts to ensure people are aware of their legal rights. The issues we support people with include, financial, residential care, community care, health, consumer and others. The service ensures people have access to independent information so individuals and families are able to make informed choices.

Key achievements 2017-18

- Under the Wellbeing at Home service the organisation has worked with Local Authority teams to support people at risk of self-neglect to make changes. We have seen this area grow through this year, and on average are supporting 5 people per month to address self- neglect, including hoarding, nutrition and care
- We have trained staff to identify and work with people at risk of self-neglect to support and encourage change
- The organisation has developed a training plan and processes specifically around hoarding and high risk living environments
- The organisation has worked to raise awareness of domestic violence and abuse, through training. Training has included Trustees, workers and volunteers
- The organisation has worked with Social Work teams on complex safeguarding cases, including supporting the Social Work teams to deliver practical support to people and their families to address issues

Key challenges and priority for 2018-19

Key area of challenge as an agency is resources, as we have seen a marked increase in the level of self-neglect / hoarding / living conditions.

- Continuation of training and update sessions for all new and existing staff and volunteers
- Identify possible funding and develop services to be able to provide additional support around safeguarding, specifically around self –neglect
- Continue to work with the multi-agency SAAB and ensure continued representation at the SAAB meetings
- Raise awareness with individuals and groups across the borough through service delivery, community events and presentations
- Continue to work with health and social care agencies in relation to individual safeguarding cases

Training

A total of 87 colleagues have received training throughout the financial year.

- Harm level training – All trustees
- Safeguarding training - New staff and volunteers
- Refresher annual training – Staff and volunteers

Stockport Homes Group (SHG)

We deliver a wide range of services which provide bespoke and tailored support to vulnerable adults including Temporary Accommodation for homeless households, Housing Support, Sheltered and Extra Care Accommodation, The Pantries and the CareCall service.

Key achievements 2017-18
SHG has a wide range of staff, at all levels and within all service areas of the organisation. There are over 50 staff designated as Safeguarding Champions who can offer support and guidance to staff who are less experienced and / or confident in dealing with Safeguarding matters.
There is a strong organisational commitment to Safeguarding with senior Strategic and Operational leads for Safeguarding.

To demonstrate our commitment to safeguarding adults at risk we have:

- Begun to develop an in-house, sustainable Safeguarding training programme delivered by a small cohort of very experienced Safeguarding Champions
- Safeguarding training has been undertaken with the workforce with a total of 235 individuals attending
- Secured additional funding and resources to deliver more services to vulnerable customers, e.g. Motiv8 which works with the most socially excluded individuals across Greater Manchester and Talent Match which works with young people who are NEET
- Development of a number of Housing First models for vulnerable households including participation in a Greater Manchester contract for entrenched rough sleepers and a partnership with thresholds for those experiencing domestic abuse
- Restructuring resources dedicated to older people to deliver services on a wider footing throughout the community, development of a dedicated Housing Options for Older People role, and an expansion of The Pantries
- Commitment to, and provision of staffing resources and accommodation, to the Brinnington PBI which supports early intervention and prevention for a range of vulnerable households
- Participation in all relevant panels and groups within the borough including MAARS, MARAC, Vulnerability Group, PBI etc.

Key challenges and priorities for 2018-19
In regard to safeguarding, ensuring staff throughout the organisation are equipped with the necessary skills, confidence and support to fulfil their Safeguarding responsibilities, and that the appropriate representation on a wide range of Safeguarding groups for both the SSAB and SSCB are maintained.

- Lack of support for vulnerable adults particularly in relation to Mental Health issues
- Increase in older demographic particular the very elderly and lack of support and services to assist them to maintain independent living
- Ensuring information is shared between agencies in an appropriate and timely manner

- Improved feedback mechanisms needed from ASC to referring organisations raising Safeguarding concerns
- Continue to bid for additional funding streams, including externally commissioned contracts, which support vulnerable customers
- Development of Safeguarding module within new Customer Relationship Management (CRM) system which will enable early alerts and sharing of appropriate information across teams within the organisation
- Expansion of SHG's training programme to ensure model is sustainable and training is delivered in a timely manner
- Ensuring key lessons from SARs continue to be shared throughout the workforce

Training

A total of 235 individuals attended Safeguarding Training including:

- Safeguarding Adults Level 1 - 33
- Safeguarding Children Level 1 - 33
- Safeguarding Adults Level 2 - 48
- Safeguarding Children Level 2 - 41
- Safeguarding Adults Basic (SMBC online) - 25
- Safeguarding Adults Alerter (SMBC) - 1
- Safeguarding Train the Trainer – Delivery - 8
- Digital Inclusion Pathway Safeguarding Briefing – 3
- Safeguarding Tool Box Talk - 43

Seashell Trust

Seashell Trust is a national charity supporting children and young adults with complex learning disabilities and additional communication needs from across the UK. We provide education and care, from 2 – 25 years, at our outstanding school and college and through our short breaks services

Key achievements 2017-18
Transitions - The transition and family services at the Trust work hard with young people, their families and services to bring about positive destinations for the leavers and follow the policy of starting the transition planning as early as possible to ensure a successful transition.

Neglect - The Trust train staff and raise awareness of neglect (inc. self-neglect), the signs of this and the action they should take in these cases.

Domestic Violence and Abuse – the Trust works with many young people who may have witnessed or been victims of domestic violence and/or abuse and their families who maybe have been/are subject to this. The Trust has raised awareness of this through training which has included Toxic Trio.

Complex Safeguarding – the Trust continues to develop and expand relationships with key agencies that support the work we undertake on complex safeguarding cases. By the very nature of the work we do at the Trust, educating and caring for young people who are high needs and low incidence, the risks and vulnerabilities are already at pinnacle. Many cases are not straight forward in that they are multi-faceted and require multi agency working.

Key challenges and priorities for 2018-19
Work involving transition planning has been discontinued as funding ceased and key personnel changed within the Local Authority.

Another challenge is the number of services with little knowledge and application of the Mental Capacity Act (MCA), particularly from schools and children's social care teams who often do not prepare young people and their families for the decision-making rights they gain at the age of 16.

For families who are applying for places at the Trust there can be a reluctance to share full / appropriate information based on the assumption that if full information is provided a place may not be offered.

Whilst the Trust accepts and understands that assessment processes need to increase scrutiny and seek more information there is still a need for increased and appropriate information-sharing between agencies.

The Trust's key priorities:

- Safeguarding Policy is updated, clear and fully compliant
- Deliver training and awareness to students, staff and visitors

- Continue to embed delivery across the Trust to ensure a fully person-centred approach
- Develop practice by learning from case reviews
- Develop Online Safeguarding programmes and embed learning
- Review the Trust's governance and compliance in relation to safeguarding
- Seashell Trust systems and reporting mechanisms to be reviewed
- Respond to recommendations detailed in an external safeguarding review commissioned by the Trust in February 2018

Training

- Induction training (Safeguarding) – 104
- ELearning (Safeguarding) – 200
- Safer Recruitment – 16
- Toxic Trio – 2 (cascaded internally also)
- Channel – 168
- Prevent – 52
- FGM – 38
- CSE – 65

Community Rehabilitation Company (CRC)

We supervise offenders aged 18 and over in the community who are sentenced by the court to either a Community Order or a Suspended Sentence Order. We also supervise people allocated to our service who are in custody and those released from prison on licence. CGM CRC commissions a service called Through the Gate which aims to help prisoners preparing to make the transition from custody through to the community.

Key achievements 2017-18

- A new protocol for transitions has been published
- Staff have been trained in general transitions process and will be single points of contact, SPOCs for local transition cases
- Youth Offending Service (YOS) leads are inked in with Managers who are responsible for the management of the delivery of Intensive Community Orders
- YOS colleagues are invited to the CRC hosted annual 1 -25 away day which takes place in October each year
- There is currently a learning module available via the Virtual College, VC. The VC is an E-Learning platform which is available to all staff and offers an alternative to traditional 'class-room' learning. There is also a full review and update of exiting safeguarding training material underway
- Training has been written and released via the VC on the subject of raising awareness of suicide and self-harm, and Level 1 Safeguarding which will be delivered locally within teams
- Domestic Abuse Practice Guidance was updated in November 2017
- A bi-monthly report detailing the trends and patterns within the DA offender cohort are identified and this supports responsive practice and the mobilisation of resources in line with identified need
- All new staff have completed a training portfolio and are assessed against a competency checklist, prior to holding DA cases
- Ongoing learning is also supported through the delivery of team based 'practice Days' which cover a range of practice led topics, including DA
- CRC staff take full advantage and understand the importance of multi-agency training

Key challenges and priorities for 2018-19

- CGM CRC is still transitioning into its role and a key area of challenge is identified as ensuring that the work we do meets both quality and performance expectations
- Widen the scope of training and bring on board other practitioners within the organisation such as Community Payback officers, case managers, supervisors and other administrative staff who have previously not been required to undertake this level of training.
- Previously, we have focussed heavily on the safeguarding of children. Whilst as an organisation we believe that we are good at identifying, working with and supporting adults at risk, it is recognised that formal practice guidance in this area has not been prioritised and this is therefore a priority piece of work

Training

- 100% of staff have undertaken the mandatory safeguarding training within the CRC
- 50% have already signed up to the multi-agency SLA Online training
- Safeguarding Children & Vulnerable Adults training
- Supporting those at risk of suicide or serious self-harm
- Human Trafficking and Modern Slavery – This training package is in development and currently sits with Quality Team before going to Change Control Board for consultation.

Case Study

Adult A had asked for a self-referral asking for a general visit asking what services could help to maintain their independence. Adult A had said they had experienced a lot of falls around the home and seemed out of breath and very anxious when talking. A home visit was arranged and on the initial visit it was noted how unkempt Adult A was, not washing or changing clothes. Home was very dirty; no heating in the house, kitchen and bathroom very dirty and with unlimited amounts of food in the cupboards.

Historically, Adult A had lived with their mother until she died. Subsequently, Adult A was found to be struggling to cope alone. Permission was given from Adult A for the agency to speak with a lady who had been previously helped with their shopping when Adult A was seen struggling outside the shops. This helped gain further information in line with further enquiries.

On speaking with the lady the agency decided to approach the GP and asked for an urgent home visit, as Adult A had fallen earlier that day. The GP arrived and followed up with a call back, as the GP was very concerned. Later that day, the GP made a referral into Crisis response team, who later alerted social services and referred back into the Wellbeing at home service. An assessment was later undertaken and appointment was arranged for a deep clean in the property. New bedding was bought, a care package was put in place for additional support around the home, and a referral for a finance benefit check was taken.

A circle of support was created for Adult A, with a number of services getting involved to minimise any further risk and to reduce further isolation. The GP had regular contact and was assured the support received from the Crisis Response Team was sufficient and helping. A local luncheon club was also arranged in order for Adult A to make new friends and to ensure a wholesome meal was provided.

Adult A feels supported in the comfort of their home, no longer lonely, and happier with things happening at home. Adult A now also looks forward to attending regular sessions at a local church along with their local luncheon club.

Healthy Minds offer support with Adult A anxieties and a programme has been implemented to support Adult A with coping mechanisms whenever they become anxious.

Considering the reluctance from Adult A to engage at the initial assessment, they have proven to progress and appear much happier. The support identified has given reassurance to Adult A, knowing they can stay in their own home, rather than going into care. Adult A seems less stressed about this and is happy they can remain living at home with ongoing support from cleaning services.

12.0. Financial Information

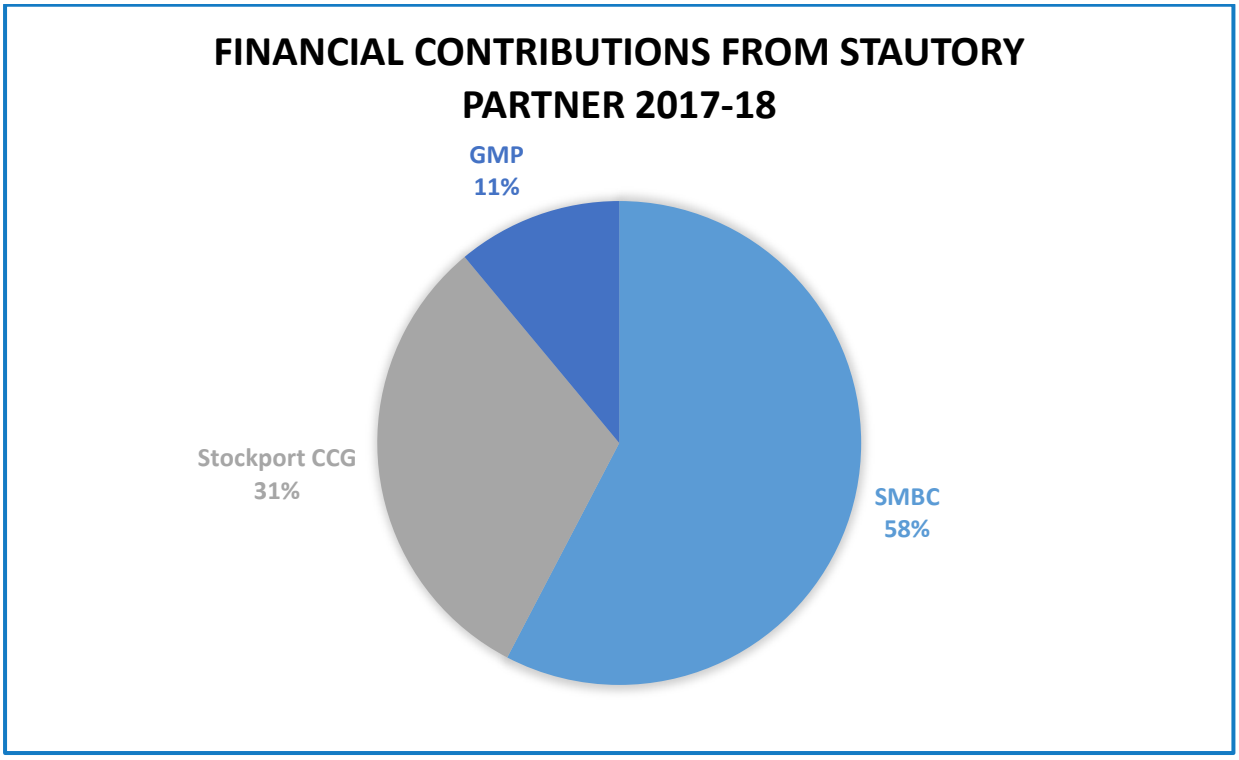
The actual budget for the Safeguarding Adults Board's functions is £121,500 per financial year. The Board receives financial support for the day to day activity which is largely endorsed by Stockport Metropolitan Borough Council Adult Social Care.

There is a contribution from Stockport Clinical Commissioning Group as well as Greater Manchester Police. All Partners are encouraged to contribute "in kind" and do so particularly in terms of employing dedicated Safeguarding Leads who hold a coordinating function within the agency.

The Council also has a dedicated social work resource working in partnership with the adult social care quality service to undertake safeguarding enquiries in the residential and nursing care sector that oversees performance.

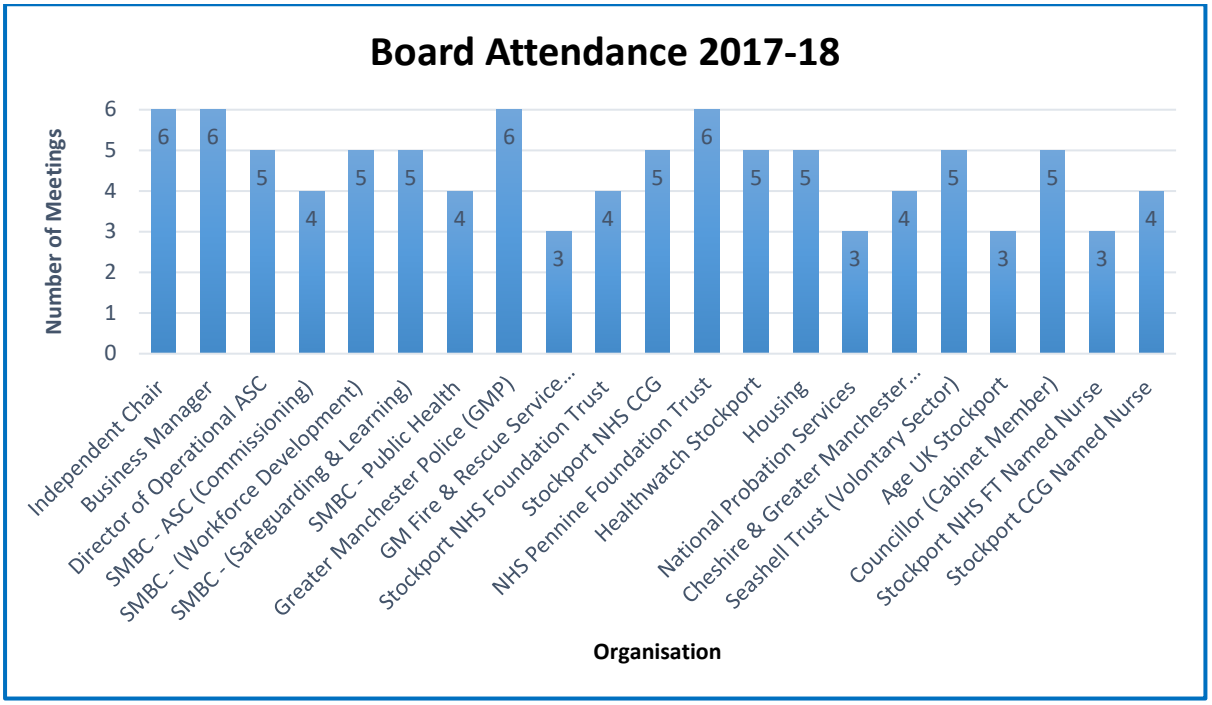
A more robust funding structure has been agreed to enable the board to fully perform its functions, and statutory and non-statutory partners have negotiated and agreed to financial contributions for the coming year.

In terms of funding for 2017-18 the table below demonstrates the statutory investors.



Board Attendance

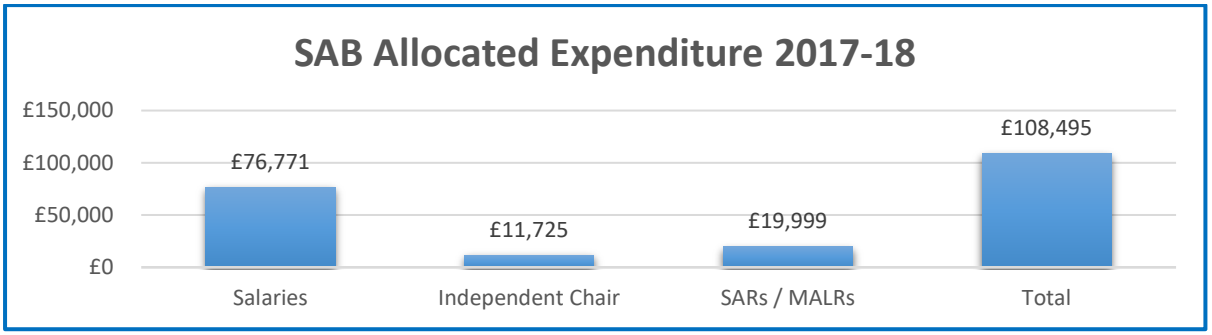
In consideration of the Care Act 2014 we do have a fully established Board that has representation from both statutory and non-statutory organisations. We are confident that the SSAB is represented by the right local statutory and voluntary agencies who are engaged appropriately with the committees.



The chart above shows that for the period in 2017-18 the Board has overall been well attended. The attendance record is provided to give a breakdown of representation from each agency as well as their attendance throughout the financial year.

SSAB Allocated Expenditure 2017-18

The Board's financial planning for 2016-17 has been completed. However, SSAB is mindful that SAR's are now statutory, and it is likely that review activity for the board will increase and may therefore become a financial pressure that will need to be monitored carefully throughout the year. The variance of £12,905 will be carried over to 2018-19, providing a cushion for the administration of commissioned SAR's underway.



13.0 Report abuse or neglect of a vulnerable adult

Everybody should be treated with dignity, have their choices respected and live a life free from fear.

Sometimes disability, illness or frailty, mean that people have to rely on other people to help them in their day-to-day living. Sadly, it is because they have to depend on others that they become vulnerable and at risk, very often from people they know such as a relative, friend, neighbour or paid carer.

What is abuse?

Abuse is very distressing and can take many forms:

- Physical (hitting, slapping , pushing or physically restraining, or the mismanagement of medication)
- Emotional or psychological (shouting and swearing to make a person afraid)
- Sexual (unwanted touching, kissing or sexual intercourse)
- Financial (money or belongings taken under pressure or stolen)
- Neglectful (not being properly cared for, mismanaging medication or being denied privacy, choice or social contact)
- Discriminatory (suffering abuse or neglect on the grounds of religion, culture, gender, sexuality or disability).
- Abuse can take place in a person's own home, in a residential or nursing home or a day centre or hospital. Unfortunately those being abused are often the least likely to bring the situation to anyone's attention.

How can we help?

If you see or know of a worrying situation, please do not ignore it. Get in touch with us at the contact details below and we will do something about it. We will also provide information and offer practical advice to the person suffering abuse, so that they can make an informed choice about any help they might need, or any action they may wish to take. If they are unable to make an informed choice, care will be taken to support and protect them.

How to report abuse or neglect

Visit our website www.stockport.gov.uk and complete the alert form and someone will get back to you

or call us on
0161 217 6029
or dial 0161 217 6024 for the Minicom

Out of hours
0161 718 2118