Stockport Safeguarding Adults Partnership

ANNUAL REPORT

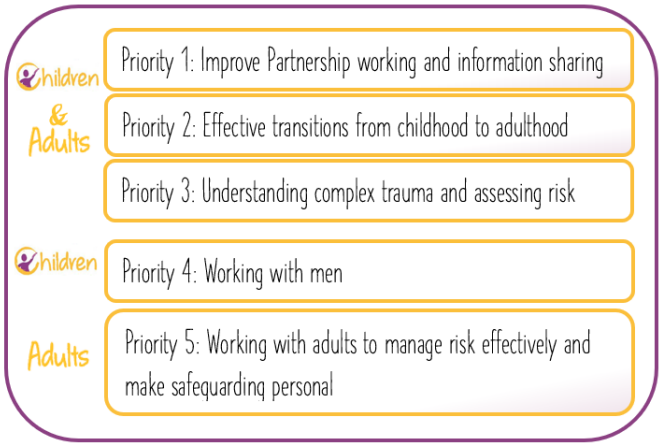
2023-24

Safeguarding Adults in Stockport

Stockport Safeguarding Adults Partnership Annual Report 2023/24

Executive Summary

This year we launched our 3-year business plan in conjunction with the Stockport Safeguarding Children's Partnership. 3 of our 5 priorities are joint with the Children's Partnership, and throughout the year we have scrutinised our progress in delivering the priorities to improve outcomes for children, adults and their families.



The Business Plan was developed through extensive consultation with our partners and reflects improvement priorities that all agencies have recognised as being important to the people of the borough.

We have scrutinised a number of areas of our work, including high levels of physical abuse, the accessibility of our website, and the experiences of young adults who have transitioned from children's social care. Each of our auditing activity has tried, wherever possible, to include the voices and experiences of adults with lived experience. This is something we want to continue to build on for next year.

The work of our Partnership this year has continued to be interactive through engagement events with partners and our collective workforce. We continue to commence each Board meeting with the voice of a service-user and have extended this into the work of our sub-groups this year.

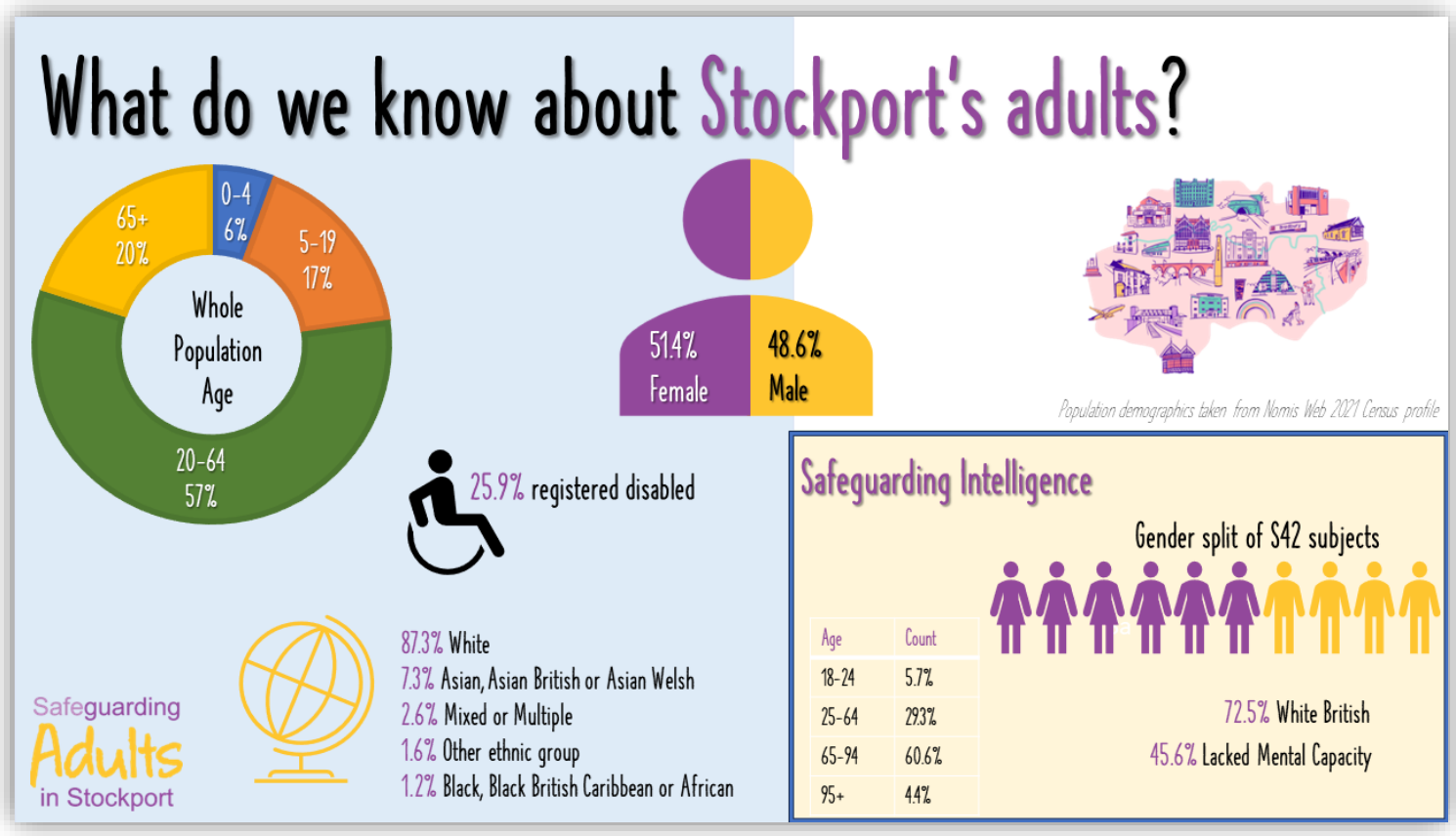
We continue to see some discrepancies in our safeguarding data through high numbers of referrals to the local authority that don't progress, and specific abuse and neglect categories that we want to understand better. This is coupled with our determination to develop and launch more sophisticated and analytical multi-agency performance data.

The Partnership experienced a significant increase in Safeguarding Adult Review (SAR) referrals this year with three SARs for six adults commissioned through the year.

Our focus for next year will include:

- ✓ Refresh and re-launch our multi-agency training programme.
- ✓ Recruit an adult with lived experience to be part of our Partnership Governance.
- ✓ Refresh our Quality Assurance Framework.
- ✓ Complete ongoing SARs.
- ✓ Develop a mechanism to share learning from SAR referrals that do not progress.
- ✓ Continue to develop and strengthen our scrutiny and oversight of performance data.
- ✓ Bolster our multi-agency auditing activity.

- ✓ Continue with the roll-out of our Risk Matrix and Safeguarding Thresholds tool.
- ✓ Scrutinise safeguarding referral processes to reduce the number of inappropriate referrals.
- ✓ Launch a new website offer in conjunction with the Safeguarding Children's Partnership.
- ✓ Supporting the implementation of Right Care Right Person.
- ✓ Seeking assurance that there are no disproportionality issues when looking at individuals going through safeguarding processes.



Chair's Introduction

I have now held the role of independent Chair and Scrutineer of the Adult Safeguarding Partnership for over two years. It remains a privilege to hold this position and work with a Partnership that is committed to continual improvement and delivery of the most effective approach to safeguard adults who most need support.

In the last year we have seen a gradual improvement in contributions from partners, demonstrated through more regular attendance and increased engagement in Partnership activities.

It was reassuring at the Annual Safeguarding Conference to see wider partner contributions and presentations and during our Development Day, acknowledgement by all partners that there is still much more to do, to understand and meet the needs those Stockport residents who are minoritised. The challenge next year is to demonstrate progress in inclusivity, by engaging with communities to better understand and meet their needs.

Progress is being made on delivering some of the agreed priorities, and this is supported by the chairs of sub-groups and the Partnership, who closely review progress and acknowledge where more work is needed. One of these areas is the joint priority of Complex Safeguarding, where we focus on young adults who have transitioned from Children's Safeguarding arrangements. This carried over from the previous business plan, due to limited progress and my challenge to the Partnership is to ensure this doesn't happen again, through collective and focused action.

Positively, it has been good to see the impact of partners' work to broaden awareness of Safeguarding Adult Reviews and when referrals should be made in their respective organisations. The improvements in the last year demonstrate that this was taken seriously.

The Partnership still relies too heavily on data gathered by the council, which inevitably provides only a partial picture of the quality of safeguarding activity and can only be strengthened by timely partner contributions. I am assured that work to address this is underway and I look forward to seeing a stronger and broader performance framework that the Partnership can rely on.

A striking issue when reflecting on the last year is how much progress has been made in the transformation of adult social care, by Stockport Council, following changes in leadership. The openness of the council in welcoming external review and scrutiny of their improvement work and sharing this with the Partnership is to be commended. Progress in improving the quality of safeguarding practice and the positivity of social care practitioners and managers that I met with, shows this work is moving forward positively. This, along with the willingness of the Partnership, to acknowledge when improvements need to be made and a lack of defensiveness make this a positive Partnership to work with. We look forward to this continuing as we prepare for the implementation of Right Care Right Person as well as other multi-agency developments.

I look forward to continuing to work with the Partnership over the next year and seeing continued developments in meeting the needs of Stockport residents.

Gail Hopper

Independent Chair and Scrutineer

Summary

Our annual report is an opportunity for the Partnership to celebrate our collective achievements and reflect on areas where we feel there is more work to be done, and identify priority actions for the coming 12 months and beyond.

What did we say we would do this year?
In our last annual report, we said we would: • Launch our new 3-year Business Plan, in conjunction with the Safeguarding Children's Partnership. • Continue our work on exploitation, transitions and complex safeguarding. • Review multi-agency approach to self-neglect. • Review our Safeguarding Partnership governance and sub-groups to ensure we have the right structures and membership to deliver safeguarding practice and change. • Promote SAR guidance across partner agencies to encourage increased reporting and learning opportunities.
What difference have we seen?
• The new risk matrix and safeguarding thresholds, developed and launched towards the end of the year, has started to standardise safeguarding practice and multi-agency responses. • A significant increase in the number of Safeguarding Adult Review (SAR) referrals received from partners. • Learning from SAR 8 (Martin) has supported colleagues in redesigning how safeguarding concerns relating to self-neglect are managed. • Performance reporting is now mapped against our Business Plan priorities, giving partners greater grip and assurance on delivery of our Business Plan. • The proportion of adults asked about their desired Making Safeguarding Personal[1] outcomes increased this year, exceeding the target set in our Business Plan.
What do we need to do next year?
• Continue to deliver on our Business Plan priorities. • Further refine the safeguarding thresholds tool and embed into multi-agency safeguarding practice. • Work as a Partnership to ensure the right referrals are made to the right services, through initiatives including *Right Care Right Person* and our new Risk Matrix and Safeguarding Thresholds tool. • Refresh our multi-agency Quality Assurance Framework. • Progress with multi-agency work around transitional safeguarding and exploitation. • Use our data analysis for SARs as well as multi-agency operational safeguarding data to better understand the demographics of the individuals who experience our services.

Delivering our Business Plan

This year we launched our updated Joint Safeguarding Partnership Business Plan[2] which followed extensive consultation with partners; it was important for us not to develop a plan in isolation that all partners would struggle to deliver or not feel a sense of ownership. The new plan, launched in July 2023, contains 3 priority areas that are jointly owned between the Children and Adults Safeguarding Partnerships, and one for the Safeguarding Adults Partnership.

Alongside publication of our new 3-year Business Plan, we took the opportunity to realign sub-groups to ensure multi-agency activity, including that of the Business Unit, was driving progress against our agreed strategic priorities. This means that we are able to track how all discussions and activities at our Practice Improvement Partnership and Quality Assurance Partnership sub-groups align against business plan priorities.

All data included in this section, unless otherwise referenced, has been taken from our Quality Assurance dashboards presented to the Stockport Safeguarding Adults Partnership Board.

Priority 1: Improve partnership working and information sharing

Where are we at the end of this year?

We have used opportunities, for example the annual Safeguarding Adults Conference, to bring partners together and share key messages and learning. We wanted to ensure this priority was aimed at strategic partnership working, and information sharing at an operational level. This ensured that developments and improvements were made at both levels.
We continue to work with the One Stockport Safety Partnership (OSSP) to share learning and work including domestic abuse, and learning from Domestic Homicide Reviews.

How can we measure our effectiveness?

- The number of SAR referrals from partners increased from 2 in 2022/23 to 15 in 2023/24.

What have we delivered?	What do we still need to do?
✓ Training on SAR referral processes and recent learning delivered across the Partnership. ✓ A multi-agency development day in November 2023 with a focus on anti-racist practice and equality, diversity and inclusion. ✓ Updated practice guidance and a 7-minute briefing on *professional curiosity* developed. ✓ Updated MAARS governance arrangements to align more closely to Adult Social Care. ✓ Peer-visits have been introduced between partner agencies. ✓ Launched a quarterly Safeguarding Partnership newsletter (in collaboration with the Safeguarding Children's Partnership).	✓ Encourage our partners to develop and deliver operational improvement actions. ✓ Multi-agency learning event on information sharing as part of Section 42 enquiries. ✓ Continue to embed our programme of peer-visits between partners, and analyse the insights and learning this delivers. ✓ Understand how partners can work together to address modern slavery, exploitation and trafficking concerns.

Priority 2: Effective transitions from childhood to adulthood

Where are we at the end of this year?

This remains an ongoing priority for the Partnership. We haven't yet made the progress intended. Last year our partners agreed to amend how Complex Safeguarding governance was delivered through the introduction of working groups. These have struggled to get off the ground and progress cannot be demonstrated, and in December 2023 we sought agreement from the Joint Safeguarding Board to revert back to more regular meetings of the sub-group. Our data shows a decrease in the number of young adults receiving a safeguarding response which we will explore in more detail in 2024/25 so we can understand and respond to this trend.

How can we measure our effectiveness?

- We have seen a decrease in the number of young adults aged 18-25 referred into MAARS[3] this year (10.8%) compared with the previous year (16.3%).
- At the same time, we've seen a decrease in the same age group referred in to the local authority (5.7% this year compared with 6.4% last year).
- 25% of all referrals in to MAARS this year were for adults experiencing exploitation.

What have we delivered?	What do we still need to do?
✓ A joint learning hub with the Children's Partnership was completed in April 2023. ✓ Reviewed governance and remit of the Complex Safeguarding Sub-Group.	✓ Complete delivery of the learning hub action plan. ✓ Review how transitional safeguarding is addressed at a strategic level through our partnership governance. ✓ Engage in multi-agency strategic development work around multiple disadvantages and early help. ✓ Promote the use of MAARS panel to provide community-based support for young adults who won't always meet the threshold for statutory safeguarding interventions.

Priority 3: Understanding complex trauma and assessing risk

Where are we at the end of this year?

Although this is a joint priority with the Children's Partnership, we have still worked to ensure appropriate development on adult safeguarding is addressed. This has included finalising development work on a new approach to risk assessment and management through our risk matrix and safeguarding thresholds tool, which was initially launched during Adult Safeguarding Week in November 2023. SAR referrals received this year show there is more work to do to ensure safeguarding practice consistently acknowledges previous trauma in addressing adults' safeguarding concerns.

How can we measure our effectiveness?

- 47% of all MAARS referrals this year were for adults who had 3 or more different vulnerabilities identified in their referral (compared with 73% last year)

What have we delivered?	What do we still need to do?
✓ Physical abuse audit completed to understand the prevalence within our Section 42 data. ✓ New risk matrix and safeguarding thresholds document launched	✓ Continue work to refine the risk matrix and safeguarding thresholds document based on practitioner feedback. ✓ We want to ensure that adults with multiple vulnerabilities or those who are experiencing complex trauma are receiving the right support from the right agency.

Priority 4 in the business plan is solely for the Safeguarding Children's Partnership and is therefore not addressed here.

Priority 5: Working with adults to manage risk effectively and make safeguarding personal

Where are we at the end of this year?

We continue to include *why we are here* case studies at the start of each Safeguarding Partnership Board meeting to ensure adults' voices are at the heart of our discussions. A new streamlined performance report has been introduced at a Board level to give partners assurance regarding safeguarding activity.

How can we measure our effectiveness?

- The proportion of adults asked about their Making Safeguarding Personal outcomes has significantly increased from 72.0% in 2022/23 to an average of 84.8% this year.
- The proportion of self-neglect cases referred into MAARS panel (39%) has remained consistent with last year (41%).
- We saw a repeat referral rate of 15% into MAARS in 2022/23. This dropped to 12% in the first three months of this year however due to changes in MAARS governance this data is no longer captured. One of our priorities for next year is to strengthen our oversight of MAARS performance data.
- The proportion of safeguarding referrals to the local authority that do not progress to a Section 42 enquiry increased to 87% at the end of this year compared with 84% in 2022/23.

What have we delivered?	What do we still need to do?
✓ New operating guidance on Person In A Position Of Trust (PIPOT) and Financial Abuse have been approved at the Executive Board. ✓ Audit completed to understand high levels of physical abuse in S42 data.	✓ Agree updated and sophisticated performance data to ensure partners have proportionate and relevant safeguarding assurance. ✓ Finalise and launch our updated multi-agency performance framework and dashboard. ✓ Strengthen MAARS performance data in reporting to the Safeguarding Partnership. ✓ Complete scrutiny work into Section 42 referral and enquiry processes to measure progress of improvements made.

How have adults' voices and experiences shaped our work this year?

We start each meeting of our Executive Board with a case study or service user story to remind us *why we are here* and this year we extended this approach across some of our sub-groups. Whilst we know there is more work for us to do as a Partnership to hear adults' voices and understand their experiences, we have made improvements this year in grounding our conversations and developments in real-world experience.

The Safeguarding Adults Partnership Board watched a service user from Pennine Care's Substance Misuse service read a poem he had written about his experiences "*Goodbye Mr Heroin*".

We heard about a service user who is in her 40's and has a learning disability. She was experiencing wilful neglect and coercion and control.

Martin's parents (one of our SARs) gave rich feedback to a practitioner learning event which we also shared with members of the Safeguarding Partnership Board.

The Physical Abuse audit saw strong examples of Making Safeguarding Personal recording and outcomes, which shaped safeguarding interventions.

4 adult survivors of domestic abuse bravely shared their stories at our annual Safeguarding Adults Conference.

Three young adults were the focus of our Transitions and Exploitation Learning Hub. We heard their voices and experiences through this audit work.

Family members of an adult subject to a SAR and LeDeR process told us the 2 reviews were not as joined up as they could have been and they had to tell their story, and relive trauma, twice.

How have our Partners supported this work?

The Safeguarding Adults Partnership is made up of a number of agencies working across Stockport, with our 3 statutory safeguarding partners working with the Independent Chair and Business Manager to lead the Partnership's activity.

Greater Manchester Police have co-delivered Modern Slavery and Human Trafficking training alongside the Safeguarding Partnership.
Work has recently concluded on development of a Cuckooing protocol, and with the support of Stockport Homes, GMP have been sharing and embedding this across the Partnership.
Information has been shared within our sub-groups as well as at an Executive Board level around the introduction of *Right Care Right Person*[4] and the implications for Stockport. These conversations have also included input and information from North West Ambulance Service.

Stockport MBC has supported production and implementation of our new risk matrix and safeguarding thresholds tool.
The local authority has also delivered wholescale transformation regarding the response to safeguarding concerns through a redesigned offer at the 'front door'.
Adult Social Care helped to facilitate a SAR learning event in January and subsequently led on planning work for a learning disability awareness raising and networking session.
Much work has taken place this year around seeking external challenge and peer review to measure and improve practice.
Reporting on the DoLS position has been presented regularly to the Partnership Board to ensure Partners are informed of the current position in Stockport.

The local and regional implementation of the ICB[5] **NHS Greater Manchester** has continued. Our locality representatives have supported work within the Safeguarding Partnership this year including participating in decision making for Safeguarding Adult Review referrals. Colleagues supported challenge from the Partnership following a BBC Panorama investigation of a LeDeR[6] case, which resulted in scrutiny activity and the Partnership Business Manager being invited to speak first-hand to the family. NHS Greater Manchester were also integral to the Partnership responding to concerns with a local provider leading to an ongoing cross-boundary SAR at the end of this year.

What is our focus going to be next year?

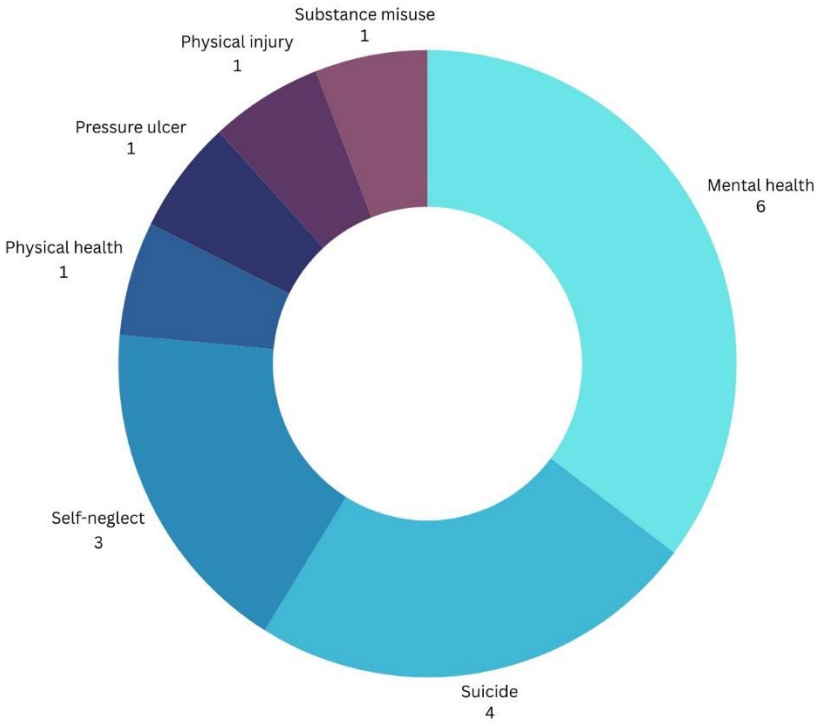
In 2024/25 we want to continue to deliver the Business Plan with input from all agencies on the Stockport Safeguarding Adults Partnership. We will deliver this through more interactive and

engaging scrutiny activities which include partners. We will also work on improving how we include adults with lived experience, and their families, carers and representatives, in appropriate safeguarding scrutiny activities.

Our performance - Safeguarding Adult Reviews

This year we saw a significant increase in the number of adults referred in for Safeguarding Adult Reviews compared with previous years. In total, 15 referrals were received, with 6 progressing to SARs (three SARs commenced for the 6 adults).

The majority of referrals involved adults who were experiencing difficulties with their mental health, followed by adults who had taken their own lives. One reason we have seen high numbers with these themes is the referrals received for 4 adults who sadly died at a local private hospital, which we are taking forwards as a thematic review to help understand what system improvements we need to make.



SAR referral themes April 2023 – March 2024

Not all referrals proceeded to SARs; the SARs that commenced during the year featured:

- Learning disability and self-neglect
- Pressure ulcer
- Mental health and suicide

Of the three SARs, one was presented to our Board in March 2024 to share learning from a practitioner event with the final report due for approval in June 2024. The second SAR is also scheduled for sign-off in June 2024. The third SAR is more complex in nature and involves 4 adults from other areas of the country and we therefore anticipate that review taking more time throughout 2024/25 to complete and ensure each of the adults' voices are heard and included in the final report.

The five-year comparison for our SAR position is shown below. The numbers relate to individuals, not SARs and so whilst 6 adults met the SAR criteria, these have progressed as 3 SARs.

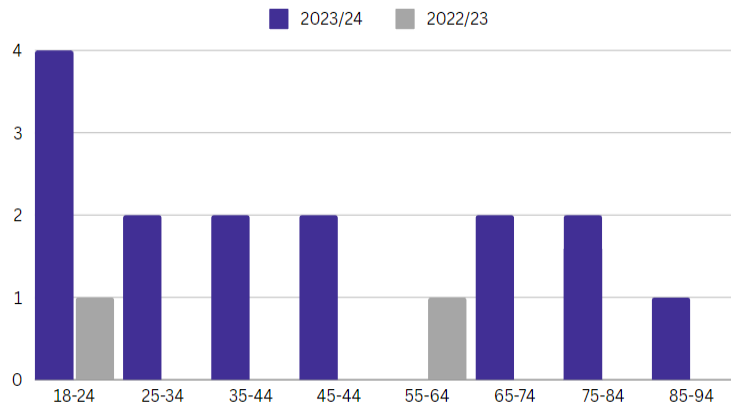
We completed a review of our SAR referral processes and spent time in the previous year working with our partners to raise awareness of the criteria, purpose, and pathway for SAR referrals. This has helped to improve our local position and is shown through the sharp increase in referrals this year compared to the previous year.

Year	SAR Referrals Received	Referral outcome			
		Did not meet SAR criteria	Met SAR criteria	Other review commissioned	Inappropriate
2019/20	5	3	1	1	-
2020/21	18	12	1	5	-
2021/22	1	1	0	0	-
2022/23	2	1	0	1	-
2023/24	**15**	**6**	**6**	**0**	**3**

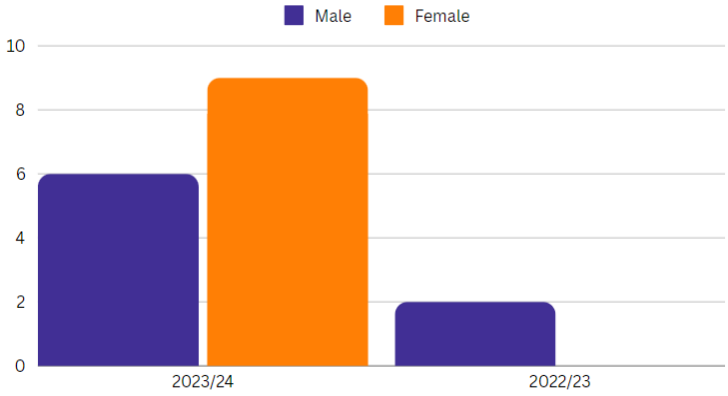
SAR referral activity 2019 – 2024

We want to ensure we continue to receive relevant Safeguarding Adult Review referrals for adults where there is useful learning for the Partnership. In 2024/25 we want to review our SAR process to streamline where possible and hold more frequent learning events for partners to share learning from reviews in a timelier manner, including learning from referrals that do not progress to a SAR.

As we have received a significantly higher number of SAR referrals this year, it is not surprising that we have seen a shift in the demographic profile of individuals. The most prevalent age category for adults was 18-24 (26.7% of all referrals).



The majority of our SAR referrals this year (60%) were for women. All of the inappropriate referrals were for men. This is a clear shift from last year where both SAR referrals were for men. All but one of the adults referred for a SAR were White British this year.



We want to ensure that we receive SAR referrals for all appropriate adults so our learning is representative of the Stockport communities and those that serve them.

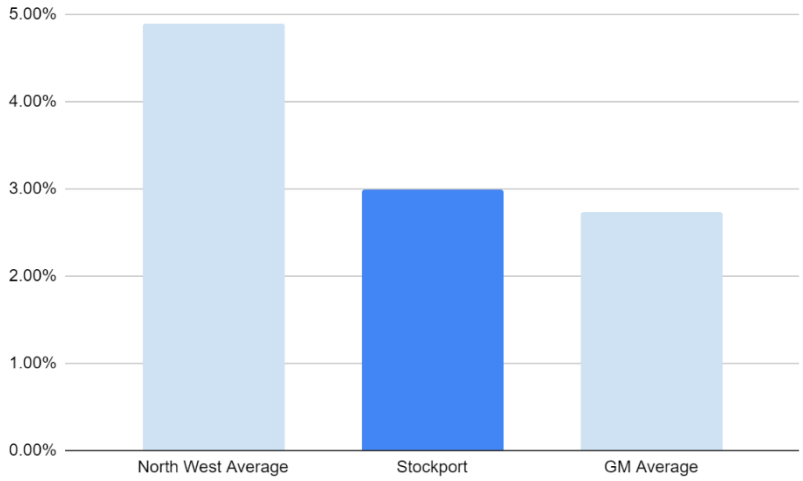
Our performance - Multi-agency safeguarding activity

Each quarter we collect and analyse a suite of multi-agency safeguarding performance data to explore trends, themes and potential areas for scrutiny and assurance. This year, we have worked extensively with colleagues in the local authority to develop a new set of performance indicators for statutory safeguarding activity. The new dashboard will come into effect in 2024/25.

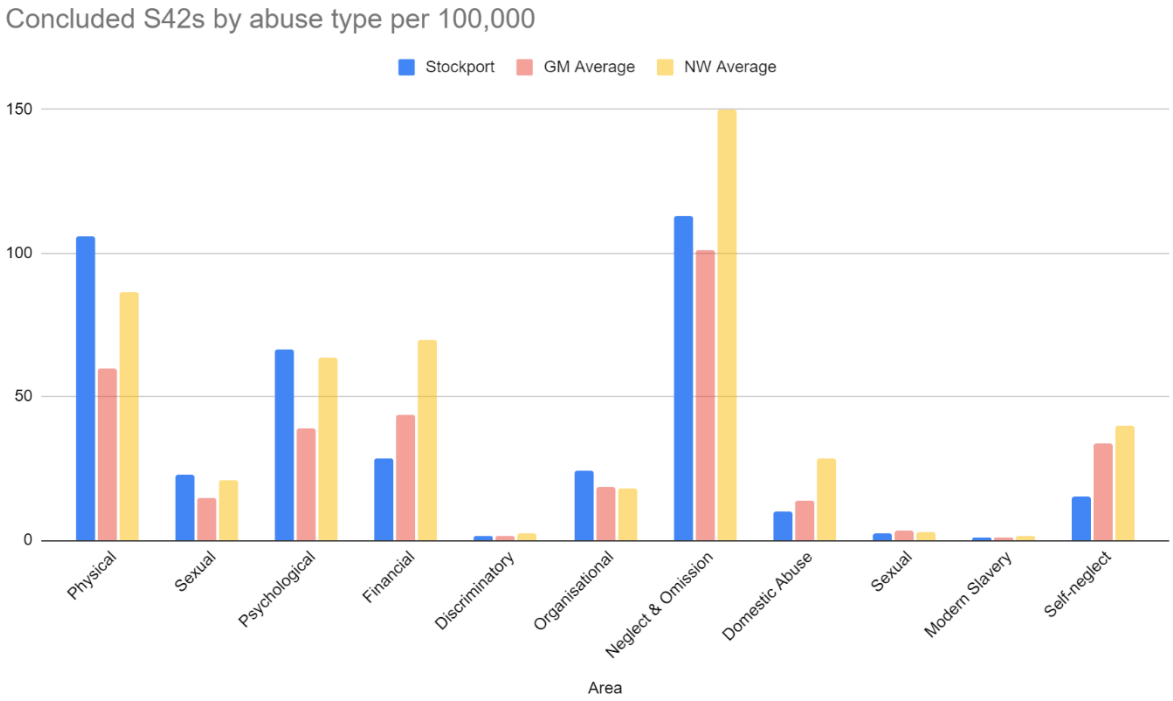
Members of the Safeguarding Partnership routinely analyse and explore multi-agency safeguarding performance data. A detailed quarterly dashboard is prepared for our Quality Assurance Partnership sub-group, and an executive summary report is taken to each meeting of the Partnership Board. Detailed performance data and analysis is available upon request through the Safeguarding Partnership.

The local authority saw an 8.59% increase in the number of safeguarding concerns referrals this year compared with last year. The conversion rate to Section 42 enquiries this year (13.3%) was lower than last year (16.2%)[7]. We have identified that there is more work to do around improving the quality and consistency of appropriate referrals to the local authority; whilst we hope that the introduction of the risk matrix and safeguarding thresholds tool will support this we will also progress with scrutiny work in this area next year to monitor the outcomes of the 2023 audit recommendations.

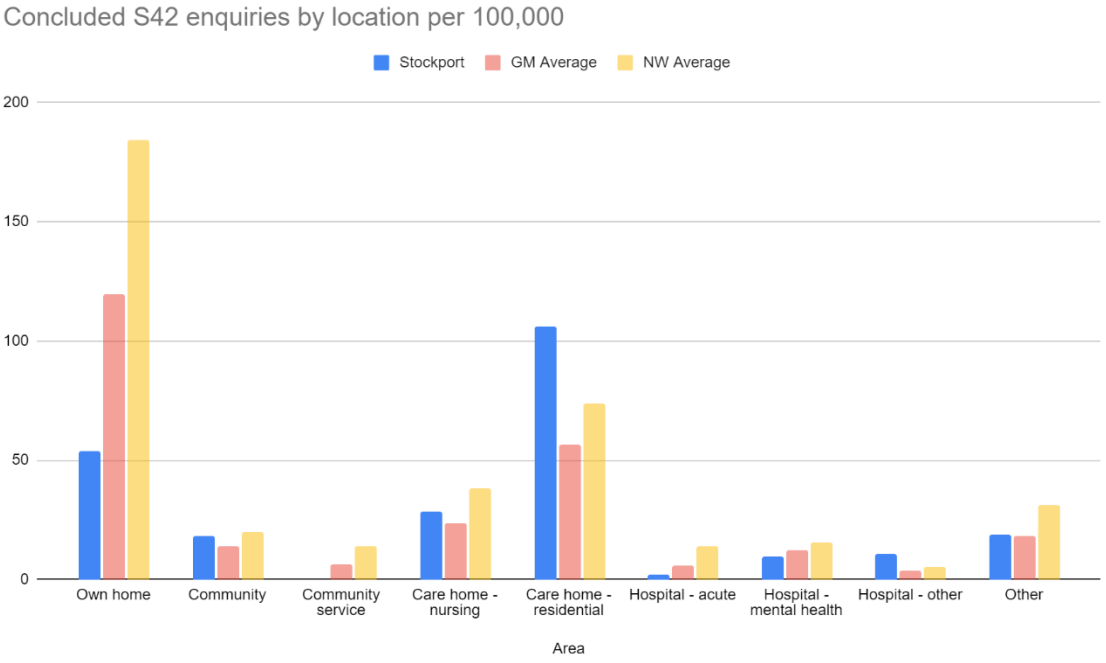
The rate of repeat Section 42 enquiries in Stockport (per 100,000 population in a rolling 12-month period) was slightly higher than the Greater Manchester average at the end of March 2024 but lower than the North West average[8].



We have continued to see significantly lower levels of self-neglect in our Section 42 safeguarding data compared to the North West and Greater Manchester averages[9]. There appear to be higher levels of physical abuse prevalent in our local data when compared against regional benchmarks, and our scrutiny work this year confirmed that there were some recording and reporting issues that were impacting this data, which we identified and addressed through a physical abuse audit in November 2023. This position matches reporting in our 2022/23 annual report regarding the most prevalent abuse and neglect categories.



There were significantly fewer concluded S42 enquiries in the individual's own home than compared with regional benchmarking to the end of December 2023. We believe that the inflated reporting of concluded S42s in residential care homes is due, in part, to the recording of physical abuse and confusion with *slips, trips and falls* as confirmed by our audit work in November 2023[10]. This location prevalence matches with last year's data where 43% of all concluded S42 enquiries had care homes identified as the location[11].



When looking at the demographic profile of adults subject to S42 enquiries, we have seen a slight decrease in the proportion of adults aged 18-24, and those aged between 75 and 94. The number of adults aged 25-64 subject to a S42 enquiry has increased from 21.5% last year to 28.5% this year.

There were fewer females subject to S42 enquiries this year (54.8%) compared to last year (58.8%). The majority of adults subject to S42 enquiries continue to be those identifying as White British.

There have been 3 fire deaths this year, compared to 2 last year. Greater Manchester Fire and Rescue Service have presented findings to the Joint Executive Board to share their learning from accidental dwelling fires (ADF). Learning shared included[12]:

- Smoking represents the most significant cause of ADF deaths across Greater Manchester.
- The biggest single cause of ADFs is cooking and cooking related fires.

We have shared awareness raising information through our social media and will continue to monitor activity. GMFRS also presented information on this including preventative measures at our annual Safeguarding Adults Conference. Whilst we have seen a 49.3% increase in the number of home fire safety assessments this year (3,112) from last year (2,084) we have not seen a corresponding increase in referrals into either the local authority nor MAARS Panel. This will be a particular area of focus for us next year, and GMFRS will be closely linked into self-neglect auditing work scheduled for next year.

Stockport Homes Group have shared information on increased demand and homeless pressures this year through routine reporting through our Quality Assurance Sub-Group as well as exception reporting at the Executive Board. There was an 11.8% increase in the number of homeless presentations compared to last year, and a 66.3% increase in domestic abuse homeless. Looking ahead to next year we want to ensure our Safeguarding Partnership is sighted on homeless and housing pressures, which will include appointing a named Board Member responsible for homelessness.

Learning, scrutiny and assurance

The programme of multi-agency auditing activity has continued this year. Looking ahead to next year, we want to increase the number and frequency of our auditing activity, with a focus on including more front-line practitioners in the process as well as adults with lived experience.

- **April 2023 – Transitions and exploitation learning hub**
  This multi-agency audit was delivered in conjunction with the Safeguarding Children's Partnership and explored the experiences of 3 young adults who had recently transitioned from children to adult services, and who were at risk of exploitation.

- **May 2023 – website review**
  We reviewed the structure, content, and accessibility of our website in May 2023 to ensure it was up-to-date, relevant, and more importantly accessible for all. A number of improvements were made at the time including uploading our business plan as a website-accessible document. However, in January 2024 we discovered a vulnerability in our website leading to development work which we will finalise next year.

- **June 2023 – LeDeR / Safeguarding assurance review**
  We worked with partners across the health economy to complete an assurance review following a LeDeR case being subject to a BBC Panorama investigation. This work also included linking in with colleagues in another SAB as one of their adults was also implicated. This work laid a foundation for findings we heard in January 2024 where a family told us of poor joined up working and duplication where there are concurrent statutory review processes (e.g. SAR and LeDeR). We plan to write to NHS Greater Manchester to raise this issue and share this invaluable feedback.

- **November 2023 – Physical abuse deep-dive**
  Following discussion at the Quality Assurance Partnership regarding high levels of physical abuse in our Section 42 data, an audit was completed to better understand the Stockport position. The audit found that reporting of physical abuse was inflated due to the inclusion of *slips trips and falls* as well as physical harm within care homes in this data. The move away from Harm Levels reporting as well as the introduction of our new Risk Matrix and Safeguarding Thresholds tool will improve the accuracy of physical abuse reporting.

- **January 2024 – local authority review**
  The Safeguarding Partnership supported an external review of the local authority's Adult Social Care safeguarding service in January 2024. The review found strengths around governance and accountability through the Safeguarding Partnership, and made recommendations for improvement around the multi-agency training offer, and updates to some policy and procedures.

- **March 2024 – Section 42 enquiries audit**
  Work for this scrutiny exercise, led by the Independent Scrutineer and Business Manager, commenced in March 2024. This was aimed at assessing the clarity and consistency of responses to requirements made of partners to undertake enquiries into abuse or neglect. The audit was ongoing at the year end with findings due to be reported to the Executive Board in June 2024.

In addition to these specific activities, the Independent Chair offers year-round monitoring and challenge in quarterly meetings of Sub-group chairs to ensure that work of each sub group focuses

on delivery of business plan priorities. This is carried forward into the SAB and Joint Board where progress against a business plan priority is reviewed at each meeting. This ensures collective oversight and keeps the delivery of priorities high on the partnership agenda.

Next year we will refresh our Quality Assurance Framework and approach to auditing and scrutiny work. This will include an increased focus on adults lived experiences as part of our audit work.

Engagement

We know that the involvement of adults with lived experience in our work has been a development area for us in Stockport, and this year we worked to make improvements in this area.

The **annual Safeguarding Adults and Domestic Abuse Conference** this year was held in November 2023 to mark the end of Safeguarding Adults Week and White Ribbon Day[13]. The event was attended by over 100 safeguarding professionals and practitioners, and we welcomed 4 adults to the stage who agreed to share their experiences of surviving domestic abuse.

Presentations on the day were delivered from across the Partnership including Greater Manchester Police, Stockport Homes, Greater Manchester Fire and Rescue Service, and Pennine Care NHS Foundation Trust.

Our **annual development day** this year had a deliberate focus on equality diversity and inclusion, and anti-racist practice. We invited a guest speaker from Brighton and Hove Council to talk to both Safeguarding Partnerships. Partners engaged in the event and took actions away to reflect on and bring back to all agencies. We want to ensure that this was not seen as a standalone exercise, and given the demographic profile of our SAR referrals and wider population make-up, this remains a priority through all aspects of partnership working.

We know that there is more work to do, in conjunction with the Children's Partnership, to provide a **high quality, interactive web offer** for individuals, families and professionals in Stockport. The current systems are not fit for purpose. We are determined to get this right and have planned in consultation and engagement with partners and adults with lived experience as part of our design planning and testing phases.

We relaunched our **safeguarding quarterly newsletter** in January 2024, in conjunction with the Safeguarding Children's Partnership. This has strengthened our engagement and communication with partners, and practitioners in particular, to increase transparency of how the Partnership functions. This now complements our 'key messages' approach to sharing information following each Partnership Board meeting.

Multi-agency training

We have continued to deliver multi-agency training across the Partnership this year, with a focus on maintaining face-to-face classroom courses rather than online sessions. The feedback we have received from delegates tells us the benefit of in-person training events. An annual report on the multi-agency training offer has been developed and presented to the Training and Workforce Development Sub-Group.

Our programme this year has included:

Course title	Business Plan Priority			
	1	2	3	5
Alerter training	✓			✓
Enquiry officer training	✓		✓	✓
Chairing safeguarding meetings	✓		✓	✓
Modern Slavery, exploitation and trafficking			✓	
Domestic Abuse			✓	✓
Hate Crime				✓
REACH older person Domestic Abuse training			✓	✓
Coercion and Control			✓	✓
MAARS and Team Around the Adult processes	✓			✓
Risk Matrix and Safeguarding Thresholds	✓	✓	✓	✓

We know that we have more work to do to improve our multi-agency training offer, and will launch a refreshed programme in 2024/25 that continues to align with the Business Plan priorities. We analysed our multi-agency training data as a Partnership Board this year and identified where improvements could be made around increasing both the sessions offered and attendance by partner agencies. A piece of work is now underway within our sub-groups to understand the detail of training offer and content at both a single-agency level and at a multi-agency level, to prevent duplication of training and development opportunities.

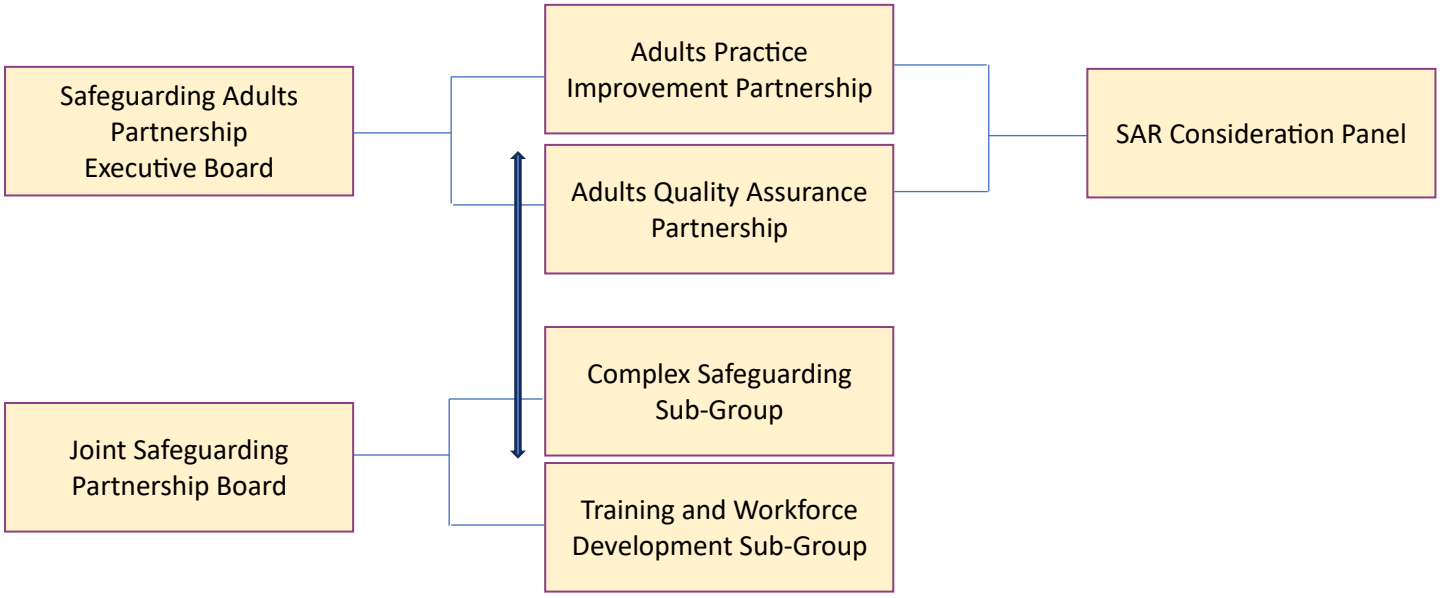
As we look ahead to next year, we will prioritise developing the training programme in line with learning from our Safeguarding Adult Reviews to ensure that we are promoting learning based on our learning from safeguarding practice.

We will introduce a new quarterly multi-agency learning circle which will share SAR learning, and an overview of SAR referrals that did not progress to a review, to ensure that front-line practitioners and Partnership Board members, are continually updated on this important area of our Partnership work.

Partners report single-agency training data through the Quality Assurance sub-group, alongside our multi-agency training data. The Joint Safeguarding Board identified and challenged some differences in how many staff attend multi-agency safeguarding training and to make sure we understand our position, sub-groups have started on a piece of deep-dive scrutiny and analysis work to explore the breadth of training offered across the Partnership.

Our Business Manager has continued to support Level 3 Safeguarding Training Days at Stockport NHS FT where learning from SARs and DHRs is shared, alongside awareness raising of the Safeguarding Partnership and the new risk matrix and safeguarding thresholds tool.

Appendix A: Governance Structure



Appendix B: Safeguarding Partnership Members

- Stockport Safeguarding Children and Adults Partnerships
- Age UK
- Greater Manchester Fire and Rescue Service
- Greater Manchester Police
- HealthWatch Stockport
- North West Ambulance Service
- Pennine Care NHS Foundation Trust
- Stockport Metropolitan Borough Council
- NHS Greater Manchester
- Stockport NHS Foundation Trust
- Greater Manchester Probation Service

Appendix C: Endnotes and references

[1] Making Safeguarding Personal (MSP) is an approach that ensures safeguarding interventions are centred around the needs, wishes and rights of individuals, supporting and empowering them to make choices and have control over their own lives. Making Safeguarding Personal (MSP) - SCIE - SCIE

[2] Business Plan 2023-2026 (ctfassets.net)

[3] MAARS is our Multi Agency Adults At Risk System – a panel to review concerns for adults who experience multiple vulnerabilities in the community Multi-agency adults at risk system - Stockport Council

[4] Right Care, Right Person | Greater Manchester Police (gmp.police.uk)

[5] Integrated Care Board (ICB) replaced Clinical Commissioning Groups (CCGs) in July 2022 NHS England » Integrated care boards in England

[6] A review following the death of an adult with a learning disability or autism https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/

[7] Reported in the 2023/24 Q4 dashboard to Quality Assurance Partnership 29.05.2024

[8] As reported by NW ADASS – Q4 2023/24 safeguarding data report

[9] As reported by NW ADASS – Q4 2023/24 safeguarding data report

[10] Physical abuse audit, reported to QAP 28.02.2024

[11] Reported in SSAP 2022/23 Annual Report Safeguarding Partnership Annual Report 2022/23 (ctfassets.net)

[12] GMFRS presentation Accidental Dwelling Fires (ADFs): Learning from Fatal & Serious Fires Report to Joint Safeguarding Board 07.12.2023

[13] White Ribbon UK A charity aimed at ending violence against women and girls