Safeguarding Adults in Stockport

Stockport Safeguarding Adults Board

Annual Report 2016/17

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1.0 Foreword from Independent Chair

I am pleased to present the 2016-17 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 are 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 as the Safeguarding Board and partners objectively and critically learn from what works well and act to improve what may not work as well intended.

This reporting year has been a very significant one for safeguarding adults in Stockport. The Board has established itself on a stronger footing during this year with a complete review of our governance structures and foundations. We are in a better position moving into 2017-18 to continue to develop our partnership arrangements to support and protect the most vulnerable.

The Safeguarding Adults Board Annual Report 2016-17 outlines the work of the Board over the last twelve months and how partner agencies have worked together to improve the safety of adults at risk of abuse. The report contains details of how safeguarding has been promoted and developed over the last year through the Board and its sub-groups. The report also describes how the Board intends to continue this in the future.

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 has increased the number of front line police officers able to attend incidents of domestic abuse;
- Stockport Metropolitan Borough Council awarded a total of £103K to 19 care/nursing homes to carry out a variety of projects to encourage independence and reablement of their residents;
- Pennine Care NHS Foundation Trust – Pathfinder Stockport has a ‘pathway to employment’ programme which supports vulnerable service users in employment;
- Greater Manchester Fire and Rescue – enhanced focus on learning opportunities which is evidenced by the review of an e safety learning package;
- Stockport Clinical Commissioning Group – Care Homes Awards took place and gave staff well-deserved recognition for their dedication and commitment;

- National Probation Service – seconded a full-time probation officer into the Stockport Youth Offending Service to ensure that young people are transitioned into adult services in a safe manner;
- Stockport Homes – deliver a wide range of services which provide bespoke and tailored support to vulnerable adults.

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 partnership has continued to strengthen this year and the contributions of all partners to achieve our priorities are detailed in this report. 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 Annual Report contains a number of case studies provided by our partner agencies that bring 'to life' the experience of vulnerable people who use services in Stockport.

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 achieved 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 sectors 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 Introduction

Stockport Population

Stockport is a large town in Greater Manchester, 7 miles south-east of Manchester city centre. There are links to Greater Manchester and the city centre, and there is easy access to the countryside that belongs to both Derbyshire and Cheshire East. Stockport has a great history and has a variety of attractions including the Stockport viaduct that carries the mainline railways from Manchester to Birmingham and London. This structure has been featured as the background in many paintings, and particularly by the famous artist, L. S. Lowry.

Demographics

The population of Stockport is expected to grow. There are currently more births than deaths, the population is living longer and there are significant planned housing and economic developments. Added to this, the population is likely to be needier. Birth rates and numbers have grown most rapidly in deprived areas, where there are more children at risk; we have an ageing population with more health needs; and more people living in one person or lone parent households. The population of Stockport continues to become more ethnically diverse, especially in younger populations to the west of the borough, although immigration rates in Stockport are lower than national averages.

Age group	2016 estimate	2019 projection	Change expected
18-64	171,036	170,209	-0% (-827_
65-74	30,440	31,350	+3% (+910)
75-84	18,912	20,216	+7% (+1,304)
85+	7,797	8,349	+7% (+522)
Aged 18+total	**228,185**	**230,124**	**+1% (1,939)**

Socio-economic

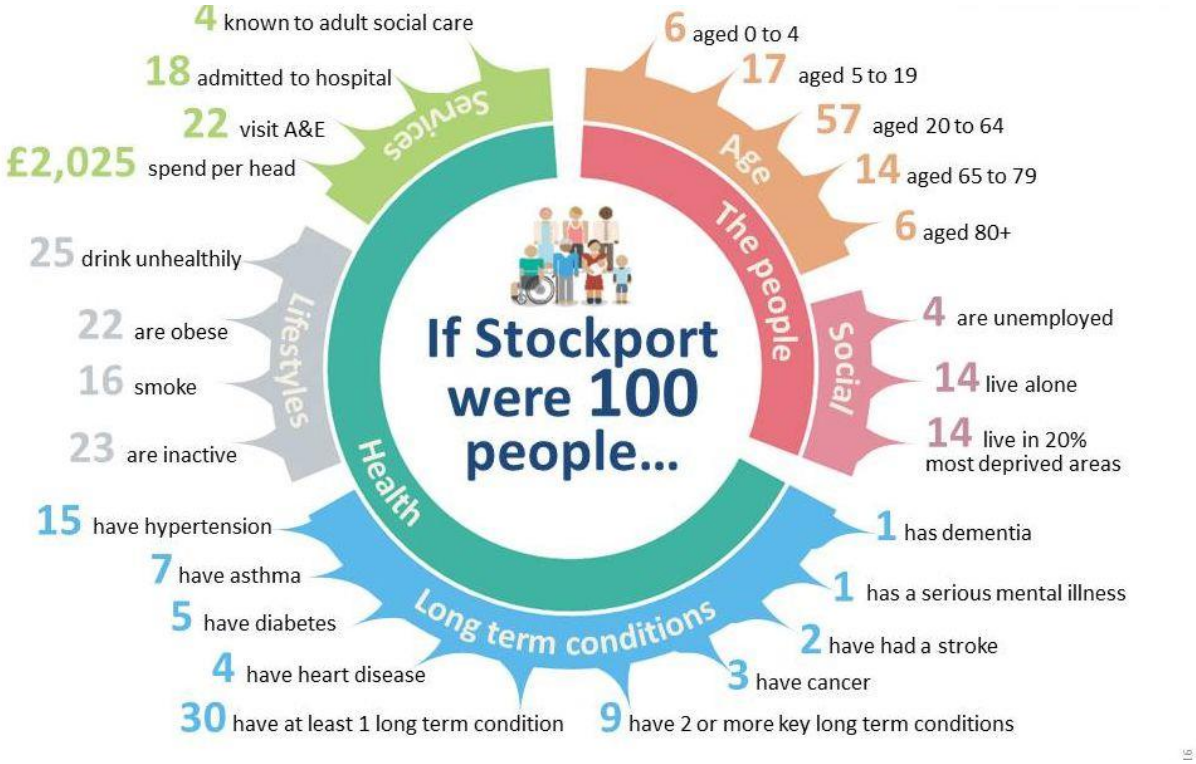
Stockport has pockets of severe deprivation, but that deprivation is not particularly widespread. 14% of the population lives in the nationally ranked 20% most deprived areas, 28% in the least deprived. 85% of working age people who claim out of work benefit do so because of ill health or disability – half of which relate to mental health. 13,800 working age people in Stockport are claiming disability related benefit and 2,200 people in Stockport are claiming Job Seekers Allowance. There are an estimated 30,000 low income households in Stockport and an estimated 36,400 people living in poverty (including 10,400 older people living in poverty).

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.

Rather than being comprehensive, selected measures were chosen to show holistically the current situation in Stockport, in order to provide background information for consideration of different initiatives.

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



Vulnerable groups

At some point in our lives we are all likely to need some support, be that from family, friends, the NHS or social care services. Some groups are more likely to require support than others. There are people within our community who are more likely to be vulnerable or at risk due to their personal circumstances.

The table shows a headline indicator for each risk characteristic and is based on best estimates available (all numbers should be treated as indicative).

People with mental health problems	6,500 (benefit uptake) / 16,500 (depression) / 30,000 (low wellbeing)
People with learning disability	1,225 (adults with moderate or severe) / 5,250 (adults total)
People with autism	2,500 (modelled)
People with physical disability / sensory impairment	11,600 (benefit uptake) / 98 young people aged 0-25 receive continuing care
People with long term health conditions	124,000 with at least one condition (SHR)
Older people	55,600 aged 65+ (ONS)
People at risk of loneliness or social isolation	38,500 people living alone (Census)
Carers, including young carers	32,000 (Census)
Asylum seekers / refugees	100 asylum seeker households (benefit uptake)
BME communities: South Asian	10,000 (Census)
BME communities: Black Caribbean and Black African	2,000 (Census)
Gypsies & travellers	1,720 (modelled)
Immigrants (last 10 yrs)	6,400 resident in UK less than 10 years (Census)
LGBT	17,000 (modelled)
Domestic abuse victims	5,000 incidents in year (report to CLT) / 3,000 children domestic abuse referral
Drugs / Substance misuse	900 adults in drug treatment (NDTMS) / An estimated 7,000-9,000 drug users
Alcohol misuse	60,000 adults unhealthy drinking (ALS)
Offenders	75 new young offenders, 800 probation clients
Homeless	500 households (Stockport Homes)
Workless	2,700 (benefit uptake), 410 NEET
Veterans	22,500 (modelled)

3.0 Summary of Activity 2016/17

This report covers the activity of Stockport's Safeguarding Adults Board (SSAB) for the period 2016/17 and sets out its Business Plan for 2017/18.

The Care Act 2014 put adult safeguarding on a statutory footing from April 2015. Throughout 2015/16 we undertook activity to ensure the Adult Safeguarding Board was strategically ready for the new responsibilities the act brings for adult safeguarding.

During 2016-17, the board worked hard to focus on a long-term goal and to ensure a vision with clarity of governance and accountability. SSAB has established a constitution that represents a multi-agency arrangement that is made up from statutory, non-statutory and voluntary organisations. This has set out our vision, values and high-level strategic priorities and it also sets out the relationship of the Board to other key partnerships within the Borough including Stockport Safeguarding Children Board.

In July 2016, we refreshed the 15-17 Business plan and reduced the number of priorities from seven to five in 2016/17.

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

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

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

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

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

To ensure that SSAB fully complies with the requirements of the Care Act 2014

SSAB members have risen to the challenge, with a range of members who have confirmed financial contributions to support the functions of SSAB. Furthermore, the SSAB appointed a Business Manager in August 2016 to further drive forward the work required of the SSAB to ensure the board is compliant with its duties and requirements.

As a requirement of the Care Act 2014, the Annual Report is also part of the Board's function in law. SSAB has been established since 2004 from guidance of 'No Secrets 2000', and now the Care Act 2014. SSAB has produced safeguarding annual reports year on year, and this year will be our 13th annual safeguarding adults report.

SSAB has developed a Risk Register to identify areas of risk which may affect the function of the SSAB. In previous years, the Board has experienced changes in its membership due to restructures within partner organisations, or beyond any of its control.

The Board has recently addressed this matter and now has a full constitution of board members with the governance of supporting sub groups. Furthermore, we have developed a document called the Statement of Commitment which sets out Stockport's arrangements for carrying out the functions of Stockport Safeguarding Adult Board (SSAB) in accordance with legislation and guidance. All partners have endorsed the statement and are fully committed to delivering the board's expectations.

More information about how the Statement of Commitment performs, can be found here: http://www.safeguardingadultsinstockport.org.uk/wp-content/uploads/2017/08/SSAB-Statement-of-Commitment-January-2017.pdf

SSAB has also agreed a Memorandum of Understanding (MoU) with Stockport Safeguarding Children's Board (SSCB) and Safer Stockport Partnership (SSP). This document sets out the expectations of the relationship and working arrangements between each Board and covers respective roles, functions, membership of the boards, and arrangements for challenge, oversight, scrutiny, and performance management.

The Independent Chair of both SSAB and SSCB have formally agreed to the arrangements set out and are subject to a bi- annual review.

Through consultation with board members SSAB determined its sub group architecture for 2016/17. The challenge identified throughout the year has been to ensure attendance so that sub groups are fully quorate in order for panel members to meet the strategic objectives and actions throughout the financial year. Attendance has been a key area throughout the year, and does at times compromise quoracy of meetings. Poor attendance is due to agencies' resources and service capacity. To overcome this, the Independent Chair has challenged agencies, and further developments arose from a joint development day in January 2017, when three subgroups were merged with other subgroups from Stockport's children board.

In the autumn of 2016 the board conducted an audit to assess the impact of the implementation of the Care Act 2014 on SABs and to capture the effects of making Safeguarding Adult Boards (SABs) statutory partnerships. This was part of a sector-led improvement initiative within the Care and Health Improvement Programme at the Local Government Association (LGA) which was designed to inform the Department of Health and other stakeholders about the progress of SABs, the impact of the Care Act 2014, and to support further development of SABs.

The final report was shared with the National Network of Safeguarding Adults Boards Chairs, and sent to LGA and Department of Health (DH). The recommendations from the audit have also informed the priorities and work plan for the Network in 2017.

The National Network of Chairs report gave us information on the work that the group have focused on throughout 2016-17.

The Report tells of a national telephone survey that was taken to explore joint adult and children's safeguarding boards. The findings from the survey suggest that careful consideration must be taken for it to work effectively. Stockport has begun to approach this concept by working more closely with children's services. Transitions from children's services to adulthood is a joint priority for both Safeguarding Boards, and some sub groups have already joined forces to carry out the business of the board.

Further work is necessary to agree and recommend a formula for funding contributions to SABs. This seems to be a continuous challenge on a national level and Independent Chairs continue to address this with statutory and non-statutory partners.

The SSAB produced a financial forecast to partners to demonstrate the income and expenditure of the board's costs. The Independent Chair raised this with its partners to agree a contribution that was equitable and proportionate for the coming year.

Since April 2015, the National network group have continued to review Safeguarding Adult Reviews (SARs), and to look at the impact of a SAR in a way that is meaningful and helpful. Some of the key areas from the report suggest a directory that lists all qualified people who can do SARs. The Business Manager for SSAB attends a Greater Manchester (GM) forum that represents Business Managers from other areas within GM. The group has developed a depository that consists of a number of qualified independent authors at a local and national level, who can provide boards with the experience, background, knowledge and qualifications required to conduct a SAR.

A copy of the report can be found here:
http://www.safeguardingadultsinstockport.org.uk/wp-content/uploads/2017/06/07-NATIONAL-NETWORK-of-SAFEGUARDING-ADULT-BOARD-CHAIRS-ANNUAL-REPORT-pdf.pdf

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

Making Safeguarding Personal (MSP) continues to be a priority for SSAB, and further work is required. Stockport is currently working closely with directors of adult social services northwest regional group to develop a common framework audit tool that will evidence the quality of service delivery. The audit framework tool will aim to support councils, SABs and their partners in assessing how far they are making a difference to the safety of people who are at risk of abuse or neglect.

The audit framework tool will help us to develop a common dashboard template, incorporating where possible benchmarking through national safeguarding indicators and data returns, designed to answer the following questions:

- How are we making a positive difference to adult safeguarding?
- How can we be sure that intervention is made with people to achieve the outcomes they want?
- Have we supported people to be any safer?

We are currently developing the MSP audit framework tool and we aim to pilot it in late 2017, with a view that further updates will be available in 2017/18.

Operational safeguarding managers have access to intelligence to support MSP and the effectiveness of IT systems. The data analysis is shared and reviewed with managers on a monthly basis for review and discussion. Further work is required to quality assure all agencies' systems and to consider how they are being used and modified to improve person-centred practice.

NHS Digital (formerly HSCIC) uses information and technology to improve health and social care; it is an arms-length body of the Department of Health, which provides information on health and social care in England.

At present, NHS Digital asks local authorities to submit MSP data throughout all safeguarding practice within the borough of Stockport. We have begun to capture MSP data in terms of measuring desired outcomes for adults at risk; this began from autumn 2016, and a full annual projection will be available for 2017/18.

To raise awareness of adult safeguarding among professionals and the wider community

A review of safeguarding policies and procedures has been developed, and was implemented in January 2016. A new process has been implemented for Safeguarding Adult Reviews (SAR). The review aims to ensure our policies are Care Act compliant and align with both Children's Serious Case Review (SCR) and Domestic Homicide Review (DHR) processes, and will reflect best practice.

The Northwest Safeguarding policy has also recently been developed by SABs across the North West to meet the requirements of the Care Act 2014 and the Department of Health Statutory Guidance. The Northwest Safeguarding adult's policy is designed to support current good practice in adult safeguarding and outlines the arrangements which apply to all local authorities within the Northwest region. Stockport endorsed the policy and will continue to support it until it is next reviewed. The policy is reviewed bi-annually and will be brought to board for further discussion.

Throughout 2016, Stockport council redesigned its website, and this has recently been refreshed to ensure all up to date safeguarding policies and guidance are available for the general public and professionals. The council website is continuously being updated with new local and national information.

The SSAB Policy and Procedures documents are available on Stockport Council Website - https://www.stockport.gov.uk/policy-and-procedures

During 2017/18, the Board continues to develop a SSAB website, which will help raise the awareness of adult safeguarding within the Borough and host a range of tools for professionals including the policy and procedures.
SSAB website can be found here: http://www.safeguardingadultsinstockport.org.uk/

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

Since the Care Act 2014, we have commissioned two SARs and one Comprehensive Learning Event. SSAB have agreed to action seven-minute briefing papers as a method of learning. This will ensure that learning is disseminated to practitioners and the wider public in a way that information can be translated and understood.

Training opportunities have been provided for the workforce of partner agencies in the private, voluntary, independent and health sectors. Stockport council provided six briefing sessions on harm level reporting to ensure professionals fully understood the harm level process and they were aware of their responsibilities.

Video footage based on harm level reporting is also available on Stockport council's website providing professionals and providers with information and guidance to support decision-making, and to create a consistent approach to the response and investigation of adult protection in the most appropriate pathway.

For sight of video, please click here:
https://www.stockport.gov.uk/information-for-providers/harm-levels-guidance

Stockport Safeguarding Adults and Quality Service have proactively been out to visit providers who have required extra support to understand Stockport's safeguarding harm levels and reporting. This has proven to be successful and has led to some providers purchasing bespoke safeguarding adults training from Stockport's workforce development team.

Stockport's quality assurance officers conduct monitoring visits with providers, and discuss Stockport's Multi-Agency Policy for Safeguarding Adults at Risk to ensure the provider understands the policy. If any issues are identified, the quality officers will raise them with the quality team manager who will then implement an action plan to improve the service delivery.

From providers' harm level 1 & 2 reports, themes and trends have been identified throughout 2016/17. The biggest two themes that could impact on the health, well-being and safety of the vulnerable individuals are errors made in the administration of medication and management, and frequency and number of falls within an individual's own home or in a care home.

There is a Multi-Agency working group which is looking at ways to prevent the number of falls within the community, including nursing and residential homes, as well as falls within a hospital setting. The group plans to deliver workshops for providers that will look at a number of factors including, why people may fall, the conditions, the environment, the medication people are taking and how best to minimise any risks. Further updates will follow in 2017/18.

As Stockport Together it was noted there was no overarching medication policy in line with the new National Institute for Health and Care Excellence (NICE) guidelines. This was also an issue within the domiciliary care agencies whose organisational medication policies are inconsistent.

Stockport Safeguarding Adults and Quality Service are in the process of arranging a medication workshop specific to domiciliary providers in both internal and external services to gain a baseline of the current position in order to develop a plan for the future. Stockport aims to create a more up to date Stockport Together policy as mentioned above to ensure that domiciliary care providers have their own medication policies that will dovetail with Stockport Together. Additionally, free training for all domiciliary providers is offered to ensure providers are working similarly to each other, and to improve good practice.

We have a safeguarding newsletter that is distributed to providers on a quarterly basis. The newsletter generally provides information and updates on both local and national issues. Each newsletter has been sent to approximately 230 people, with

‘open’ rates of about 30-35%, which is a good rate for this kind of newsletter. So far topics covered in the briefings include Dignity in Care, Harm Levels, Emollients & Smoking, Financial Scamming, and Funding for Training, DBS Checks and accessing Stockport Council Training.

During 2016/17 the SSAB commissioned two Local Safeguarding Adult Reviews and one Comprehensive Learning Review. The reviews and resulting lessons learned are overseen by the training and workforce subgroup with progress reports back to the Board. They form a key element of the SSAB Learning and Improvement Work Plan and activity regarding case-file audits and analysis of safeguarding systems and processes.

In 2017/18, we will be able to provide detail as to how our Lessons Learned Action Plans have improved safeguarding outcomes for adults across all the areas included within the scope of the plans.

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

Following the submission of the findings from a baseline study on transitions in September 2016, the Board held a joint workshop with the Children’s Safeguarding Board in November 2016. The workshop was well attended by delegates from a range of social care, support, criminal justice, education, community and voluntary sector services. The aims of the day were to explore the learning from the baseline study undertaken on transitions for vulnerable young people, and to develop a strategic action plan which will be monitored through the Children’s and Adults Safeguarding Boards.

The joint workshop directed people to look at the key areas, explore recommendations and to prioritise and formulate a strategic action plan that would drive forward the key changes needed to improve the journey for vulnerable young people into adulthood.

By the end of the joint workshop participants felt they had a better understanding of the key issues raised by the report, particularly raising the awareness of autism.

Several discussions took place in mixed groups giving the opportunity for delegates to learn from each other and share their views, challenges and experiences with each other.

Overall, the day was a good networking opportunity for professionals from a range of services to meet and forge new working relationships.

Achievements have been seen based on the action plan, and here are some examples of success:

- Care leavers plan has been updated to reflect the learning and incorporated into current work-streams

• Recommendations regarding Autism have been embedded within 0-25 SEND strategy and Adults Autism strategy

• Recommendations regarding Preparation for Adulthood have been embedded within Preparation For Adulthood (PFA) action plan

• Transitions are now a joint priority for both Safeguarding Boards, and the emphasis is to have an oversight of Transitions Action plan where highlights and exception reporting is made by the relevant strategic bodies.

Adult Social Care (ASC) has two permanent transition workers who work closely with children's services to assess and facilitate a smooth transition for children into adult services. In addition to this resource, ASC are working to increase the number of transitions workers to enable them to start working with young people earlier and ensure that they have a better experience during transitions.

Practice has changed in the interface between children's and adult services. There is now dialogue between the transitions lead and professionals from Children's services, and assessments are carried out to establish the level of need rather than whether people meet a criterion or not. ASC has also developed policies to underpin this change in practice and requires further work to ensure it is consistently applied.

Stockport has reviewed the transitions pathway for young people with special education needs and disabilities and this will be launched by December 2017. This will involve working in a more integrated way across health, education and social care to identify those young people who are likely to have care and support needs post-18 and into adulthood.

4.0 National Context – What is safeguarding Adults?

We reported in last year's Annual Report the new arrangements that each local authority area must have in place under the Care Act 2014 regarding safeguarding adults. They are set out here again as they form the basis of the Board's key functions and challenges. The Care Act 2014 legislation became statutory on 1st April 2015. The Board moved from 'shadow form' to becoming fully established at this point.

Safeguarding is described as protecting adults and children from abuse and neglect. The Care Act is a response to the recognition that the law and practice around this issue had become complex. The Care Act has made the following changes in regard to safeguarding adults:

Safeguarding Adults Boards are now statutory. The Board has an experienced independent chair and the statutory members are the Local Authority, the Police and the CCG. The board is required to have a safeguarding plan and will publish annual reports detailing what it has done during the year to achieve its main objectives and implement the strategic plan as well as detailed findings of any SAR and subsequent actions.

The Safeguarding Adults Board aims to work with local people and partners so that adults at risk are safe and able to protect themselves from abuse and neglect, and so they are treated fairly, with dignity and respect with access to the services that they need.

Each individual's wellbeing is central to any safeguarding process; this includes ensuring that the person's views, wishes, feelings and beliefs inform decisions and actions as much as possible.

4.1 Six key principles underpin all adult safeguarding work

SSAB strives to protect adults at risk, taking into account the six adult safeguarding principles promoted by the Government:

- Empowerment – taking a person-centred approach, whereby users feel involved and informed.
- Protection – delivering support to victims to allow them to take action.
- Prevention – responding quickly to suspected cases.
- Proportionality – ensuring outcomes are appropriate for the individual.
- Partnership – information is shared appropriately and the individual is involved.
- Accountability – all agencies have a clear role.

Safeguarding enquiries are a corporate duty for councils when they have reasonable cause to suspect that an adult in their area has a need of care or support, is at risk of abuse or neglect, and as a result of those care and support needs is unable to protect themself.

- Formal Safeguarding Adult Reviews are mandatory if an adult at risk dies in circumstances where abuse or neglect is known or suspected. The review must identify lessons learned and apply those lessons to future cases.
- Relevant partners must co-operate with the local authority in regard to supplying information.
- Councils have a duty to fund and arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or a SAR where the adult has substantial difficulty in being involved in the process and where there is no other suitable person to represent them, and for people who have no one else to speak up for them.
- The Council's power, under section 47 of the National Assistance Act, to remove people from insanitary conditions has been repealed.
- There is now a duty of candour on providers regarding failings in hospital and care settings.
- There is a new offence for providers – of supplying false or misleading information in the case of information they are legally obliged to provide.
- It re-enacts existing duties to protect people's property when in residential care or hospital.

4.2 What types of abuse are there?

There are different types of abuse, all of which result in harm to an individual:

Physical abuse - including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

Domestic violence - including psychological, physical, sexual, financial, emotional abuse, and honour based violence.

Sexual abuse - including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Psychological abuse - including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

Financial or material abuse - including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Modern slavery - encompasses slavery, human trafficking, and forced labour and domestic servitude.

Discriminatory abuse - including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

Organisational abuse - including neglect and poor care practice within an institution, care setting (such as a hospital or care home), or in one's own home.

Neglect and acts of omission - including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

Self-neglect - this covers a wide range of behaviour such as neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Abuse can be a single act or repeated acts over a period of time.

5.0 Developing the SSAB Strategic Plan 2017-2020

In 2016/7, the Board undertook a joint development day working jointly with members of the Stockport Safeguarding Children Board. As a full partnership we discussed and agreed what our vision, values and strategic objectives should be under the Care Act 2014.

A full review of the SSAB strategy was undertaken and a Strategy on a Page was developed jointly with the Stockport Safeguarding Children Board. The strategic objectives were agreed and have been incorporated into the SSAB business plan for 2017/2018, which will be underpinned by actions needed to improve outcomes for adults at risk in Stockport.

The Four key priorities will be the focus of our work over the next three years.

- Self neglect
- Transitions
- Complex safeguarding
- Domestic violence and abuse

SSAB recognise and consider Mental Health as a priority area also, and Mental Health will thread through the four key areas outlined in the business plan. The Implementation Group will take responsibility for monitoring progress against the plan, and progress will be reported to the SSAB twice a year.

In our Strategic Plan 2017- 2020 we set out the actions we will take next year to help us achieve each of these ambitions. You can read the Strategic Plan 2017 -2020 in full and it can be found on:
https://assets.contentful.com/ii3xdrqc6nfw/2yipYZl6FWiyu2C0siQUyq/eab7dd9d4698e0653f40be31fb9b1a62/SSCB_SSAB_Strategic_Plan_2017_-_2020.pdf

5.1 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 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

6.0 Governance

Following a joint development day, in January 2017, with members from both SSAB and Stockport's Safeguarding Children's Board, a piece of work was carried out to look at the sub group structures for both boards.

A new structure of board membership and the sub groups was reviewed to ensure it was fit for purpose. This has developed communication between both boards and developed joint sub groups to carry out the work of the joint strategic business plan 2017-2020.

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

The Head of Safeguarding and Learning also attends both Boards. Training opportunities are well established for both safeguarding boards, and training leads have merged with a view of joining the training and workforce development sub group with a more co-ordinated approach to training delivery. That focus has now been introduced into the format of the SSAB business plan 2017/18 and will reflect in future actions and ambitions throughout the forthcoming year.

SSAB has modernised the subgroups directly under the governance of the Board and each subgroup is responsible for delivering an action plan that supports the Board in delivering its agreed priorities and overall business plan.

SSAB has six sub-groups that each meet six times per year; three are joint groups with Stockport's Safeguarding Children's Board. These subgroups are responsible for delivering the Board business plan and report to the Implementation Group.

The joint subgroups are: Training and Workforce, Communication and Engagement and Early Help and Prevention. They are each constituted from members of both children's and adult's safeguarding boards, and we will review the Statement of Commitment to reflect the new governance structure.

The SAR screening panel meets as and when required and consists of safeguarding leads from all statutory partners. This group oversees and quality assures all SARs undertaken by the SSAB and provides advice to the SSAB Chair on whether the criteria for conducting a SAR has been met.

The GM Learning Disability Learning Review group meet bi-annually. The group is linked to the LeDER programme, which is an initiative commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England.

It is reported that within Greater Manchester (GM) we have approximately 160 deaths each year of people with learning disabilities. Therefore, one of the key recommendations from the LeDER programme was for greater scrutiny of deaths, particularly of people with learning disabilities.

The LeDER programme has rolled out a review process for the deaths of people with learning disabilities that will provide support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision.

The GM group consists of a Multi-Agency panel who will review all deaths of an adult aged 18 -74. Stockport will have six reviewers who have been trained as reviewers in 2016 but will need refresher training. There are two reviewers from Continuing Health Care, two from Stockport NHS FT, and two provided from Stockport local authority.

Stockport CCG have also provided the Local area Contact Officer role, and this is to ensure that the cases will be allocated to a reviewer in a timely manner and that the adequate support for the reviewers are in place to quality assure the reviews and to make appropriate recommendations to any multi-agency meeting if required. Information sharing is also achieved via a secure web based platform to which practitioners have access.

The local reviewers will conduct health and social care reviews. The reviews are not investigations and would be alongside statutory reviews where relevant, for example, if a SAR was commissioned relating to the death of someone with a learning disability, then it would be likely the SAR would take precedence and the reviewers would link in with the SAR process. This would avoid families being approached twice.

Quarterly reports on themes and trends along with actions identified will also be reported to GM Transforming Care Partnership Board.

7.0 Safeguarding Adult Reviews (SAR's)

A Safeguarding Adult Review is aimed at establishing whether there are lessons to be learnt from the circumstances of a specific case. It interrogates and highlights both good practice and areas that require improvement regarding the way in which local professionals and agencies work together to safeguard adults at risk. In addition, it aims to review the effectiveness of procedures; inform and improve local inter-agency practice; improve practice by acting on learning and preparing or commissioning an overview report.

Where there are less serious failings in multi-agency practice or procedures, a less formal review can be held. In Stockport, we refer to this as a Comprehensive Learning Review, and the objective is similar to a Safeguarding Adult Review, to identify areas for improvement regarding effective safeguarding practice. In some cases, incidents will highlight areas for improvement for one agency alone and this would lead to a Single Agency Learning Review.

During 2016/17 the SSAB commissioned two Safeguarding Adult Reviews and one Comprehensive Learning Review. The reviews and resulting lessons learned plans are overseen by the training and Workforce Subgroup with progress reports back to the Board. They form a key element of the SSAB Training Strategy Plan and activity regarding case-file audits and analysis of safeguarding systems and processes. In 2017/18, we will be able to provide detail as to how our Lessons Learned Action Plans have improved safeguarding outcomes for adults across all the areas included within the scope of the plans.

One of the Safeguarding Adult Reviews has recently concluded and the report and recommendations are available here:

https://www.stockport.gov.uk/safeguarding-adults-reviews/mrs-rogers-safeguarding-adult-review

The Safeguarding Adults Review found inadequate management at the care home amongst other issues.

What did we learn?

- The timeliness in assessing and providing adaptive equipment prior to any emergency admission to a care home.
- The hub bed was a practical and pragmatic solution that provided immediate and short term needs with the objective of rehabilitation and a return home with the appropriate care package.
- That care homes have an emergency admissions procedure so that incoming resident's needs are appropriately assessed in the most efficient way.
- To have access and the ability to obtain GP medical information relevant to the resident's effective care as soon as practicable.
- Good recording keeping to ensure the views of the resident, their family and health and social care professionals are considered, and that handovers between shifts is key to good quality care.
- Timely referrals for assessment or re-assessment by health and social care professionals, including NHS Continuing Healthcare, cannot be under-estimated.
- If the person's condition is deteriorating rapidly the person should be fast tracked for urgent support.
- To consider if the person had stayed in their home, had Adult Social Care been able to secure a provider to undertake additional daily home visits. This would have had several benefits including: being in familiar surroundings and perhaps greatest of all, direct contact between family and health and social care professionals had it been needed.
- Medication errors, particularly relating to running out of a prescribed medicine: a position that could and should have been avoided by competent management.
- Sharing of information between professionals involved could have been better. This could, in part, have been compensated by an excellent written care plan.

- The term, 'family support' was used in the care planning without specifying what this meant. The details of 'family support' should have been explained properly and recorded. This would have helped professionals who were assessing needs, and providing services to build the family support into the overall care package.
- Residential homes and other organisations providing staff and services to residential homes are contractually committed to engaging with Safeguarding Adult Reviews in accordance with Section 45 Care Act 2014.

What have we done?

For the SAR, an extensive report was commissioned with an accompanying action plan. The oversight of the delivery of these actions is undertaken by the Board's quality assurance sub group, and further work is to be carried out with workforce development sub group to ensure learning is cascaded. A 7 minute briefing paper is also in development and will be available on the SSAB website once it is live.

A further SAR is underway which is relating to self-neglect and will provide really useful learning to influence the Self Neglect strategy that is currently being developed in Stockport. The expected date of completion for this SAR will be January 2018.

7.1 Comprehensive Learning Review

A case was referred to SSAB Multi-agency SAR panel in February 2016. The panel determined the case did not meet the criteria for a SAR; however, it elected to hold a Comprehensive Learning Review.

The Learning Review concluded in April 2017 and concerned a middle aged woman who lived in supported accommodation from where she was admitted to hospital suffering from nausea and persistent vomiting.

The woman was later discharged from hospital and admitted to a residential care home, where the placement was short term with a view she would return home. Whilst at the care home, her health had deteriorated rapidly and she was readmitted to hospital where she died.

An independent author was commissioned by the board to conduct a learning event on the case. The event was very well attended with professionals from all agencies involved and lessons learned are below:

Lessons learned

- All partners should have a robust patient discharge procedure to consider the views of an individual, family and/or close friends, and to ensure both mental health needs and physical health are considered within an assessment of needs.

- That residents in care homes are treated with dignity and that care home staff can recognise when residents are unwell, and that staff can take appropriate action to secure treatment.
- Residential care homes are to keep accurate and full records on the care they provide to residents.
- Hospital based social workers have the time and resources to complete comprehensive assessments of need on vulnerable patients.
- Professionals in its constituent agency keep accurate and full records of the services they provide to vulnerable adults, including discussions, assessments and decisions relating to capacity under the Mental Capacity Act 2005.

Further updates and learning from the Comprehensive learning event will be provided in 2017/18.

8.0 Safeguarding Adults Annual Return (SAR) 2016/17

The Local Authority is required to collect and return safeguarding adults data to the government through the NHS Digital, formerly the National Health and Social Care Information Centre (HSCIC). This is known as the Safeguarding Adults Return (SAR) dataset.

SAR is a mandatory report which local authorities need to produce relating to the number of reported concerns for adults who are at risk. An adult at risk is a vulnerable adult who has both support and care needs.

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 2016/17 has been extracted from the safeguarding team's database.

There were 2,824 Safeguarding Alerts recorded by the Local Authority, which resulted in 493 referrals into a Section 42 enquiry. In addition to that, 274 level 3 alerts were raised.

- 59.4% of the alleged victims were female and 40.6% were male.
- 75.7% of the alleged victims were white, with the remaining 2.2% being Asian / British Asian, Black / African Caribbean / Black British or not known. For 22.1% of cases, we have no data; this is because we may not gather what the ethnicity of the individual is. This ought to be a concern and does need to be reviewed to ensure that information about ethnicity is collected and recorded on Carefirst.

In terms of alleged victim's primary reason for needing support:

- 71.9% required physical support, for example to get dressed or to bathe
- 7.2% who receive mental health support – 6.7%% of whom receive support for memory cognition
- 9.4% had a learning disability
- 1.4% with sensory impairment
- 3.4% who receive social support such as help with shopping

8.1 Safeguarding Activity

Adult Safeguarding Referrals made to the Local Authority in 2016 - 2017

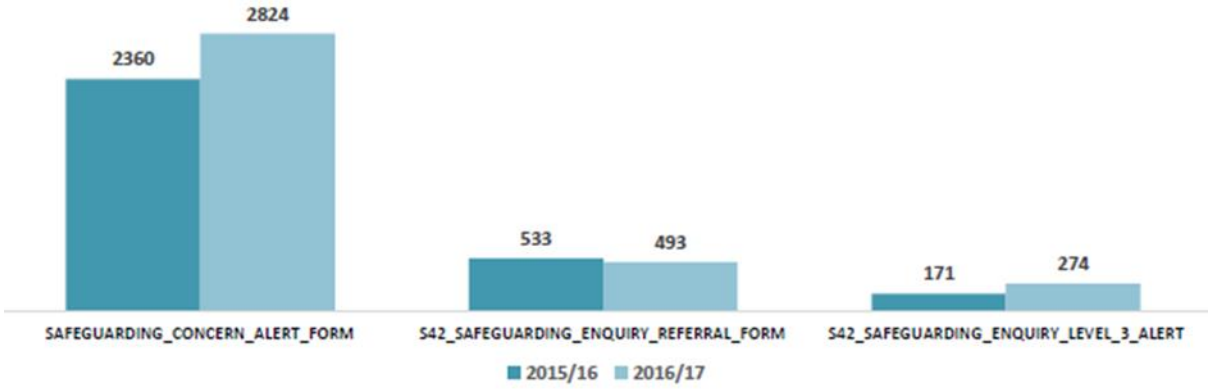


Figure 1: This section shows the number and type of Adult Safeguarding referrals received by the local authority, and compares this to the pattern from the previous year.

There has been an increase of safeguarding alerts year on year since the introduction of No Secrets 2009.

In 2016/17 the number of safeguarding alerts increased by 464. This would suggest there is an increased awareness of the harm level reporting process of safeguarding adults within the borough, and staff do understand their duties when responding to allegations of abuse.

The increase in referrals can also be attributed to the greater engagement with adult safeguarding training and the increased general awareness of safeguarding issues.

Number of Section 42 Cases Concluded during the year

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.

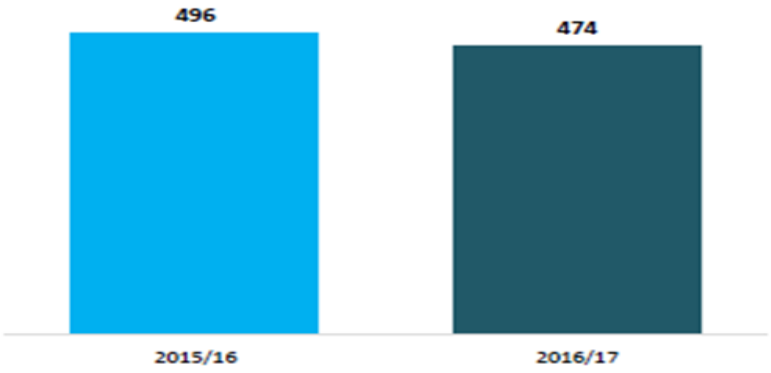


Figure 2: the graph shows the number of Section 42 enquiries that concluded throughout the financial year. The table would suggest that there was a reduction in 2016/17 by 22 cases. This is a similar comparison to the previous year and has no significant change.

Gender Profile

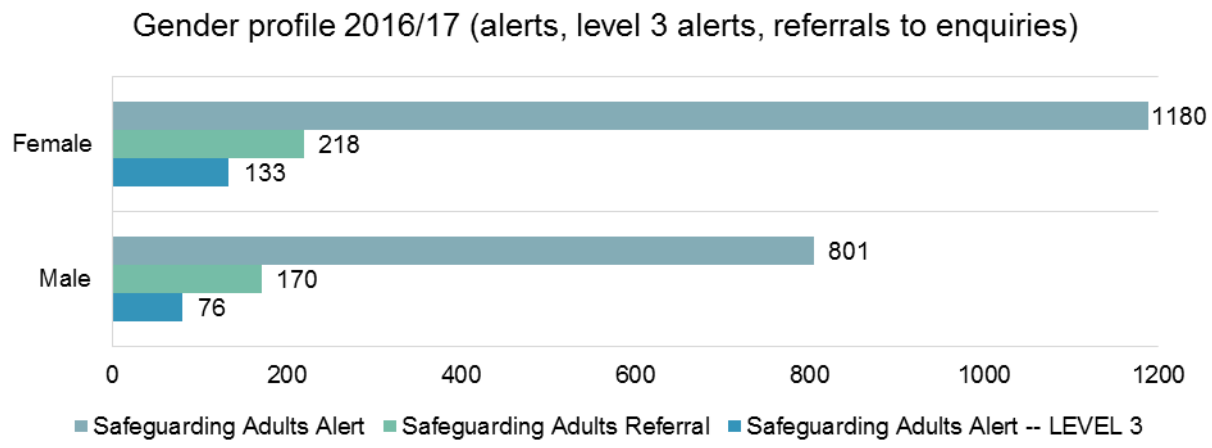
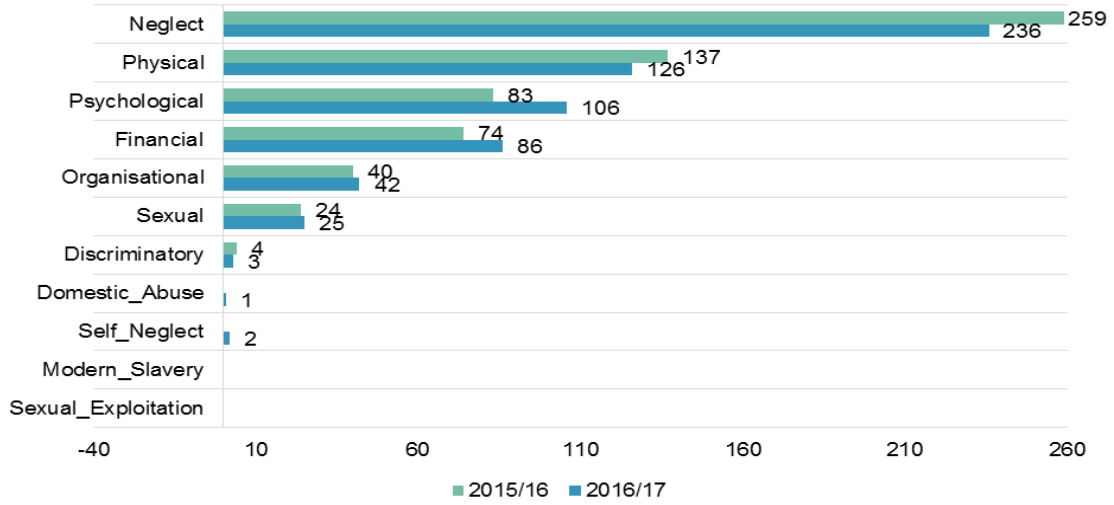


Figure 3: The data in this section represents safeguarding concerns and referrals and gives a breakdown by gender for 2016/17.

In Stockport the data based on enquiries by gender strongly reflects the national picture from the Safeguarding Adults Collection data which showed that females have a higher Section 42 enquiry rate than males.

Concluded Cases by Type of Risk



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

Figure 4: These patterns of abuse have been consistent in quarterly reports to local authority safeguarding management teams. The most commonly investigated form of alleged abuse was neglect or acts of omission with 236 investigations. One of the reasons for this category being the highest, is that the gathering of evidence is most obtainable and leaves an outcome less difficult to prove.

Physical abuse overtook psychological abuse and financial abuse as the most common form of abuse alleged to be perpetrated by someone known to the adult at risk.

Instances of neglect and acts of omission, physical abuse and discriminatory abuse reduced in comparison to last year, whereas all other areas of risk increased.

New categories of risk were introduced during 2016 and the collection of Modern Slavery; Sexual Exploitation, Self-Neglect and Domestic-Abuse from April 2017 onwards will allow us to report on these categories next year.

Concluded Cases by Location of Risk

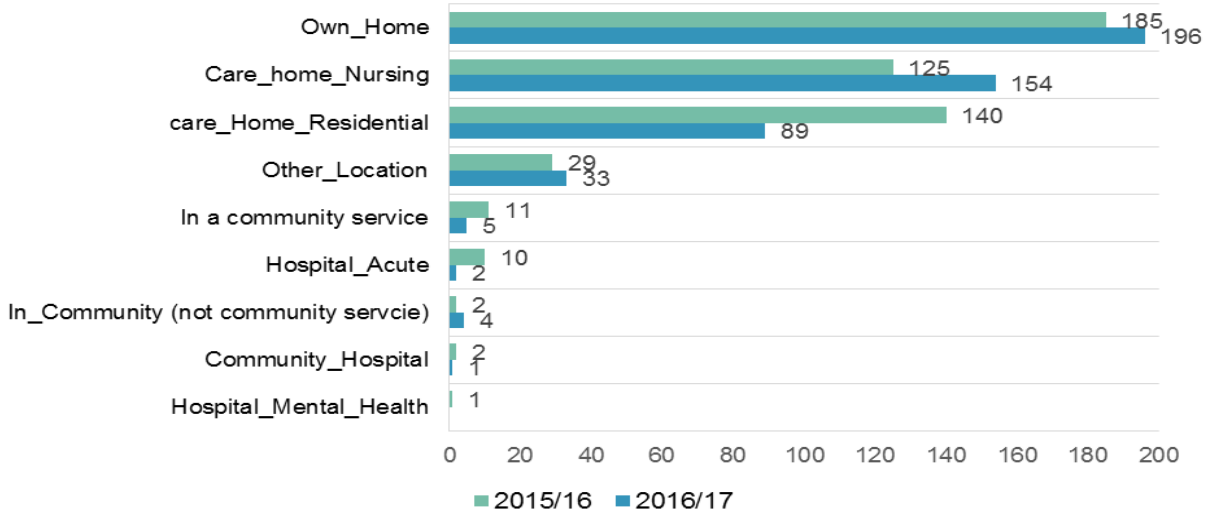


Figure 5: provides an overview of the locations where the risk arises.

You will see the risk in the person's own home has increased by 6%, Nursing homes up by 23%, and residential care down by 36%, compared to 2015/16.

Who were the alleged victims of abuse?

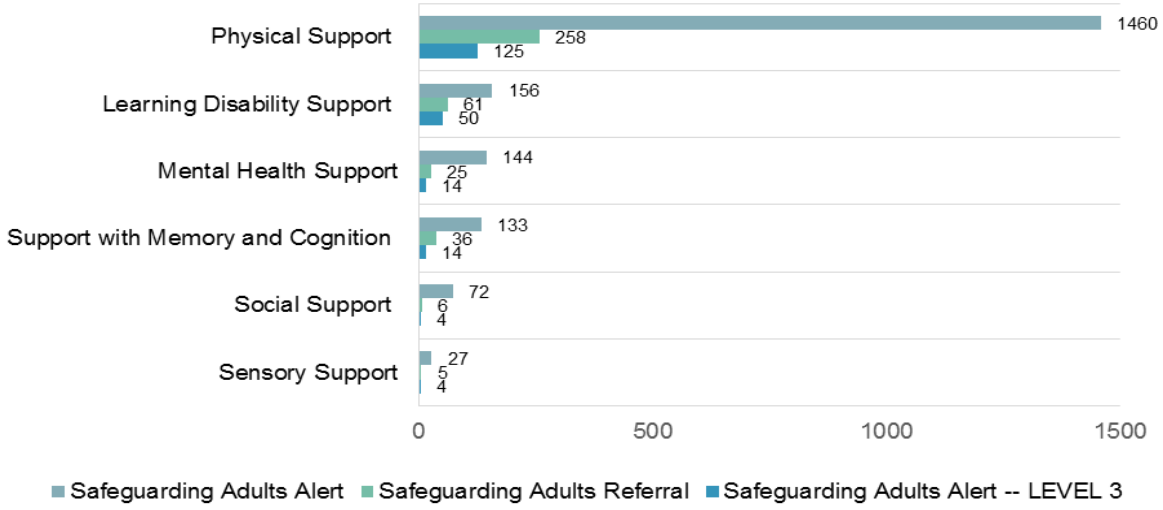


Figure 6: shows the number of people experiencing the highest reported number of safeguarding concerns by primary support, plus an illustration to give an account of what was an alert, what constitutes a safeguarding referral and what is processed within a safeguarding investigation process.

Number of People with Safeguarding Concerns by Ethnicity

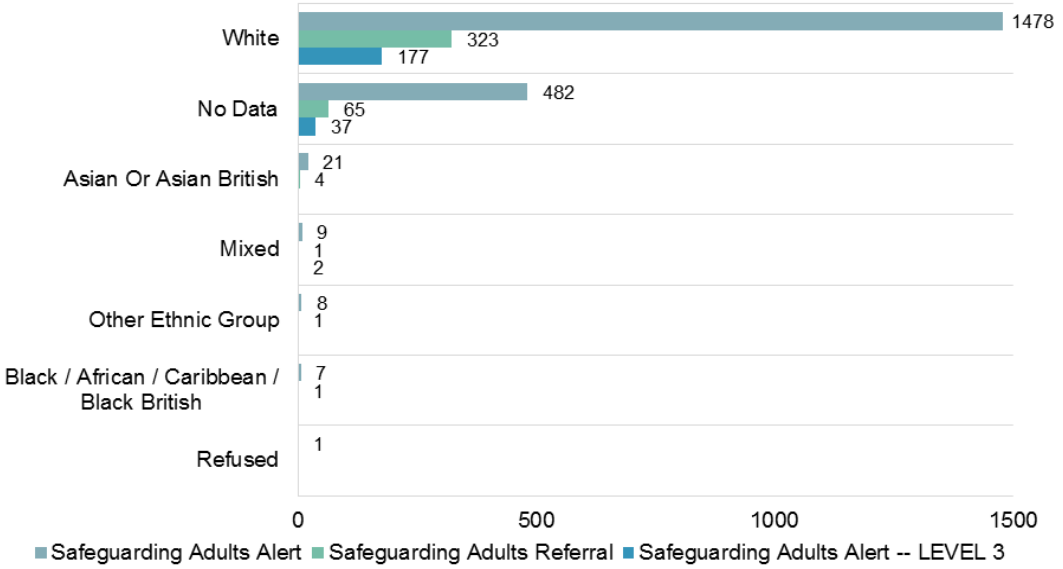


Figure 7: reflects the ethnicity breakdown of alerts and enquiries on an annual basis. Black and minority ethnic groups make up a very small percentage of alerts and the percentage of service users overall from Black and ethnic minority groups is 2.2%.

There is a large percentage of no data being recorded which is a cause for concern and further action is required to ensure the quality of data based on ethnicity is recorded correctly.

9.0 MAKING SAFEGUARDING PERSONAL

Making Safeguarding Personal (MSP) continues to be a priority for 2017-18 as will developing an audit programme to evidence quality of service delivery.

A key part of the Care Act 2014 is MSP and the establishment of a person-centred approach to safeguarding adults across all agencies. The SSAB has begun to encourage the development of an MSP approach across all agencies in the borough.

Making Safeguarding Personal is about having conversations with people about how to respond in safeguarding situations in a way that enhances their involvement, choice and control as well as improving quality of life, wellbeing and safety. The Care Act advocates a person-centred rather than process-driven approach."

Here is an example of good practice that relates from a safeguarding alert received by the Adult Safeguarding and Quality Service (ASQS) from the hospital due to concerns raised by a patient who was concerned about returning to the care home.

The patient said they were being denied water or fluids to drink which left the individual concerned about returning to the care home. The individual felt other residents felt the same way, which left the individual wanting to advocate for others.

The ASQS Social Worker met with the individual who said they were not being listened to. They reported that they were frightened about returning to the placement and that they were concerned for the welfare of the other residents in the care home who were unable to express their views.

Consent was obtained and ASQS began to investigate. The ASQS social worker liaised with the hospital social work team to make the person's views known and requested an assessment of need to consider other options, other than returning to the care home, as this was causing distress. The ASQS social worker informed the ward staff of the person's low mood and anxiety. A referral to the mental health liaison service was discussed with the individual. The ASQS social worker met with the manager of the care home to discuss the concerns and review the resident's care plans.

MSP Outcome following the investigation:

- Following assessment, an alternative intermediate care placement was offered with a view to the individual returning home after a period of rehabilitation. The outcome was met and the individual did not have to return to the care home; they were able to go home where they felt safe and able to access food and fluids whenever they wanted.

- The individual made an impact statement and stated that they wanted things to change for the other residents in the care home.

- The provider manager confirmed that following the investigation, jugs of juice and water are put out for residents. They gave assurance that staff regularly ask residents if they would like anything to eat or drink throughout the day.

- Additional training was recommended for the providers including person centred practice and dignity in care.

- The provider agreed to introduce "about me" pages for each resident to include personal preferences and wishes.

- The provider agreed their admission process would be reviewed to ensure information for new residents covered all aspects of their care.

The recommendations were shared with Stockport Safeguarding Adults and Quality Service so that the recommendations could be incorporated into the provider's annual quality monitoring review.

9.1 Making Safeguarding Personal Data

At present, NHS Digital asks the local authority to submit MSP data throughout all safeguarding practice within the borough of Stockport. We have begun to capture MSP data in terms of measuring desired outcomes for adults at risk beginning from October 2016. At present we have very limited MSP data to analyse and report, and the data presented here does not reflect the whole financial year.

At the commencement of the enquiry process, the adult concerned or their appropriate representative should be asked to indicate the outcomes they would wish to have from the offset. In 2016/17, 59% of enquiries had outcomes identified by the person concerned or their appropriate representative.

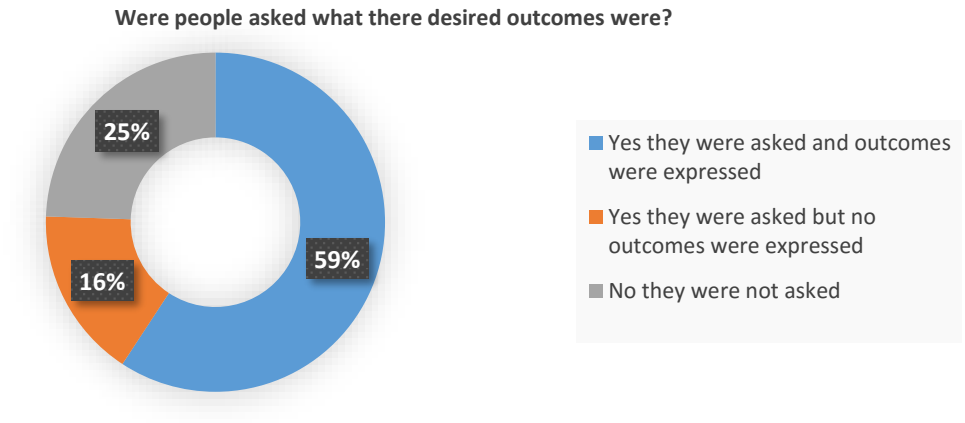


Figure 8: details the number of people who were consulted over a five month period. There were 184 people who were asked what their desired outcome was: 59% were asked and their outcomes were expressed; 16% were also asked and no outcomes were expressed, and finally 25% of people were not asked.

There could be justifiable reasons to this, and one being mental capacity to make decisions. Although this could be the case, further work is necessary to ensure advocates and representatives are consulted and that performance data can capture such data accurately.

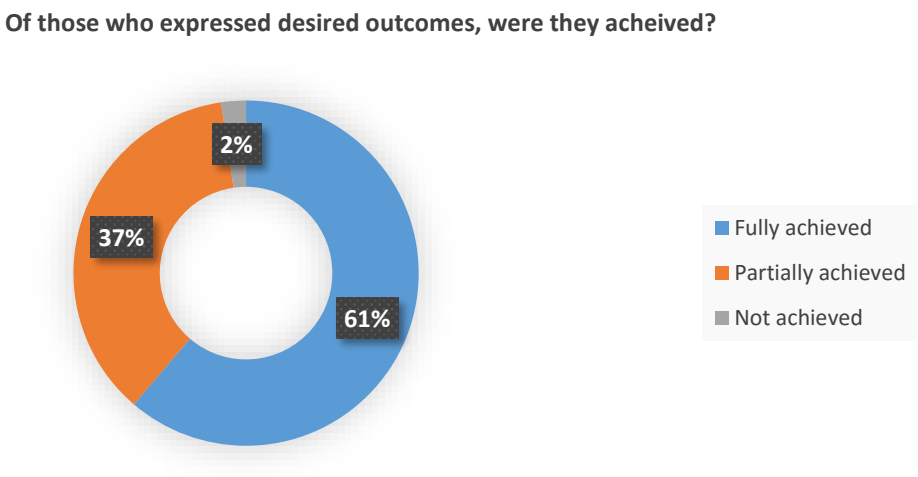
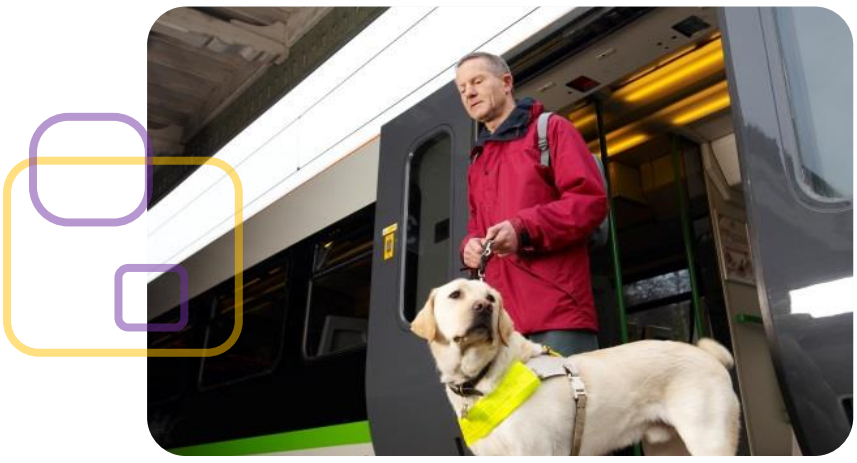


Figure 9: provides a breakdown of the number of desired outcomes that have either been achieved, partly achieved or were not achieved. There were 61% of outcomes that were fully achieved, 36% that were partially achieved and 3% where the outcomes were not achieved.

During 2016, a new service user feedback leaflet has been introduced to ensure that individuals involved in safeguarding investigations have an opportunity to provide feedback on their experience and to contribute to the cycle of improvement.

Face to face interaction also takes place, particularly if the individual lacks capacity to consent to a safeguarding investigation. All comments, feedback and desired outcomes are documented throughout the safeguarding process, and the inquiry officer reviews with the person concerned, as to whether they feel their outcomes have been achieved.



10.0 Training & Workforce Development

Stockport Council has provided training to professionals across the Borough on a range of subjects relevant to Adult Safeguarding. Training has been both multi-agency with a range of organisations coming together to be trained and organisationally specific. In 2016/17, 1613 professionals were trained in either a classroom setting or through E-learning.

The Training Sub-Group has continued to meet on a quarterly basis throughout the year. Attendance at the group has been relatively consistent and all meetings have been able to take place.

The Training Sub-Group has started to send periodic 'Safeguarding Briefing' newsletters to providers and partners. Two have been sent to date with another in production at the time of writing.

The group ran Dignity in Care events for Home Care and Care Home providers. In association with the Daisy Mark Accreditation, over 80 representatives attended to learn about Dignity in Care and receive practical tips as to how they could apply dignity in care in their organisations. Several providers subsequently applied to have the Daisy Mark accreditation in their homes.

In spring 2017, the group ran two Self-Neglect full day workshops in conjunction with the RIPFA, the University of Sussex and the University of Bedfordshire. Over 80 people attended the workshops and the subsequent feedback was excellent. The message from both workshops left us with inspiration to start work on a Strategy and procedure document to underpin Stockport's approach to self-neglect. A robust policy and procedure is a key deliverable within the strategic business plan 2017/18 and will be implemented by 2018.

The training sub - group has begun the process of moving to a joint Adults and Children's sub-group in line with the proposals approved at both SSAB and SSCB, with meetings to discuss the proposed format and practicalities of the new meeting.

The aspirations for workforce development in 2017/18 are to:

- continue the transition to the new sub-group structure;
- support the priorities identified in the SSCB and SSAB Strategic Plan;
- support the dissemination of the learning identified at SARs and Learning Events;
- improve our ability to monitor the impact of training that is delivered, with a view to including metrics relating to this in future reports;
- run events for partners in the Public, Voluntary and Independent sector to help them plan for and make the most of CQC inspections, including the creation of action plans to address issues identified;
- support PREVENT training within Stockport;
- continue to develop e-learning options regarding Safeguarding, and to provide alternatives to classroom based training where appropriate;

- develop a joint Children and Adult basic awareness course that organisations can roll out as mandatory training to all employees where they currently do not have anything in place.

The Council's Workforce Development Team, part of People & Organisational Development, continues to provide training relating to Adult Safeguarding. This training is open to those who work in the borough with adults and families, and is mostly provided at no cost

During 2016/17 the team introduced a new e-learning platform containing new introductory 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 80% or above for all courses and with 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 2017/18

Training 2016/17	Classroom Training	E-learning	Total
Basic Safeguarding Adults Awareness online training		173	173
Safeguarding Adults Alerter ½ day course	613		613
Referrer/Provider Manager full day course	39		39
Mental Capacity Act/Deprivation of Liberty Safeguards	76	103	179
Investigation Officer 2 day course	40		40
Investigation Officer refresher course	39		39
Harm level briefings	117		117
Dignity in Care	80	35	115
Self-neglect	80	51	131
Self-harm		49	49
Domestic Abuse		85	85
Hoarding		33	33
Total	**1084**	**529**	**1613**

In recent years there have been ongoing issues with attendance at the free-of-charge training provided by Stockport Council, with some provider's block booking places and then not sending delegates on the day. To counter this, two measures have now been introduced:

- A non-attendance charge of £45 per delegate, which is strictly enforced for repeated non-attendance from an organisation

- A new online booking system where the delegate's name needs to be provided at the point of booking and where reminder messages are sent to delegates in advance on the course. This has significantly reduced non-attendance, with attendance rates since January 2017 up from about 55% to 83%.

11.0 Future Priorities

SSAB is dynamic and already progressing against the business plan 2017/18 that will see the next 12 months being transformational in how the board performs its functions for the children, families and adults at risk of Stockport.

The Board has agreed four key priorities to drive the work of the Board for the next three years.

Here is some activity that is currently underway to ensure work of the board for 2017/18 will be achieved:

- A Safeguarding Adult Peer Review to take place with a neighbouring authority that will promote collaborative working with and focus on the impact of the Care Act 2014.

- To consolidate and join up with children's training sub group to review the current offer regarding both adult and children training products including development of a workforce development approach to embed effective practice across all partner agencies

- Develop and trial a self-neglect policy and process that will offer the appropriate toolkits for single agency and multi-agency use

- The Communications and Engagement work of the board will continue to develop across communities and voluntary sector groups, and to promote active involvement of service users, their families and advocates on Board work

- Develop a website on behalf of SSAB

- To learn from experience and to improve on how we work and ensure the dissemination of learning is consistent throughout the economy

- Create a joint calendar of events with all partners to create opportunities for the general public, professionals and care givers

The Strategic Business plan 2017/18 provides a full summary of the key deliverables for the SSAB. The strategic plan will be overseen by the Implementation group who will report to the SSAB on progress.

The Strategic Business plan can be found here:
http://www.safeguardingadultsinstockport.org.uk/wp-content/uploads/2017/08/SSAB-Business-Plan-2017-19.pdf

12.0 Partner Reports

Greater Manchester Police (GMP) - has increased the numbers of front line officers who are able to attend incidents of domestic abuse in Stockport. Additionally, they have provided training to support officers, which has enabled a more focused and effective management of serious domestic abuse cases and has provided adequate safeguarding on the vulnerability of the victims and their families.

Throughout the last twelve months the total number of officers who have received training in respect to National Crime Recording Standards is 369 which promotes the accurate recording of crime and enables the police to appropriately safeguard adult victims of crime. This particularly increased officers understanding surrounding victims who do not have capacity to report crimes themselves and to accurately reflect incidents of domestic abuse.

Fifty four officers who joined the front line during 2016/17 have also received training to enable them to conduct Domestic Abuse, Stalking and Honour based violence (DASH) risk assessments, which is a significant step forward in keeping victims safe. Officers use a common checklist and have the techniques for identifying, assessing and managing risk.

Officers continue to receive additional training regarding complex safeguarding needs of individuals, giving officers the confidence to refer cases to the correct agencies where necessary.

Challenges for 2017/18

Safeguarding is everybody's responsibility GMP has given vulnerability training to all frontline staff, to increase awareness and initial response in dealing with safeguarding. Despite the continued financial challenges the police and other partners face we are determined to achieve the best outcomes for the people in our communities.

- GMP continue to develop joint training opportunities for staff to enhance skills and knowledge to address emerging threats around mental health assessment and understanding each other's roles with regards to safeguarding adults

- Managing the ever increasing demand linked to mental health and ensuring staff are appropriately trained and skilled to make informed decisions so that all assessments around individuals support are correct to ensure they are appropriately placed, rather than incorrect assessments and time spent within Hospitals.

Stockport NHS Foundation Trust-

The Safeguarding of all our patients remains a priority for Stockport NHS Foundation Trust (SNHS FT) and is a fundamental component of all care delivered.

SNHSFT supports the work of the SSAB and is represented by the Deputy Director of Nursing and Midwifery.

There is active engagement in Safeguarding Adults Reviews and the Board sub-groups and attendance and participation is a priority.

The Stockport NHS FT strategy for Nursing and Midwifery 2015 – 2020 has five themes, one of which is care of the vulnerable patient – as below.

“We continue to make significant changes and investment to ensure that the care of our most vulnerable patients is to the highest of standards. Our strategic approach to Dementia and Delirium is currently being reviewed in partnership with carers and key stakeholders.

The dementia strategy promotes a focus on:

- Environment
- Staff training
- Ensuring therapeutic support to patients through a variety of activities, to develop a mutually rewarding interaction
- Involvement of carers
- Patient pathways

The Trust continues to build on the work to date, to promote staff knowledge with regard to Deprivation of Liberty and Mental Capacity assessments, and to ensure that our safeguarding teams work together across acute and community areas, to maximise the application of safeguards to all our vulnerable patients.

The Trust fully complies with the requirements of the Care Act 2014 and to champion the ‘Making Safeguarding Personal’ agenda.

Safeguarding leads meet monthly to talk at an operational level with the Director and Deputy Director of Nursing and Midwifery to give a full report on the performance of any safeguarding matters.

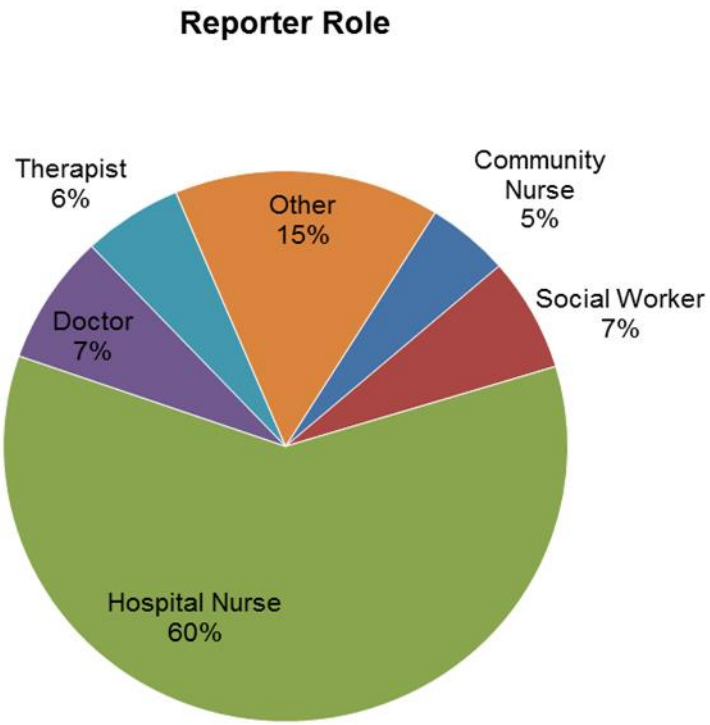
All staff within the organisation have a responsibility to help prevent abuse / harm to adults at risk, ensuring that where abuse is suspected, it is acted upon quickly and proportionately to protect the adult at risk.

In line with previous years, there has been an increase in referrals / concerns raised in respect of adult safeguarding within the Trust. There were a total of 464 safeguarding adult concerns raised in 2016/17, which was an increase of 74 concerns on the previous year.

2016/17	Year End
Concerns Raised	464 (last year 390)
Referred to Adult Social Care (ASC)	268 (last year 256)

The numbers may be higher as occasionally alerts are sent directly to ASC and the team are not informed, this has been raised with managers for action, as in some cases, referrals are not always appropriate.

All known concerns/alerts are logged onto a database by the Adult Safeguarding team. The highest numbers of alerts are generated, as would be expected by Emergency Department staff. However, other areas are now showing an increase in reporting concerns which is reflecting increased awareness across all areas. Nursing staff remain the highest reporting group.



Some of the safeguarding concerns raised with the safeguarding team require the application of statutory safeguarding duties in accordance with legislation (Care Act 2014) and Stockport Multi-agency Safeguarding Policy and Procedures. Other concerns require a different response and preventative interventions such as urgent re-assessment of care needs which can prevent escalation to safeguarding.

Although raising concerns demonstrates that staff are aware of their safeguarding duties, it should be recognised that the reason for raising a concern is to reach a good outcome for the person involved.

Making Safeguarding Personal (MSP) is a person-centred and outcomes focussed approach. Staff are now prompted to ask the patient when raising a safeguarding concern what they would like to see as a result of raising the concern. SNHSFT will continue to work with SSAB to develop MSP model.

48 safeguarding alerts were raised against the Trust in 2016/17. These came from a variety of sources including care homes and some directly from CQC. When an alert is raised against the Trust an incident report is completed and the business group is asked to investigate. In reality this number should be higher. However, there is poor compliance in reporting incidents where there have been lapses of care and patients have sustained significant harm e.g. where patients develop category 4 pressure ulcers. However the Trust has a good record of reporting and investigating these types of events via the incident reporting system so it is not to say that these are not investigated and lessons learnt.

During December 2016 / January 2017 a number of alerts were raised that related to poor discharge planning. These were monitored by the Deputy Director of Nursing and this trend now seems to have slowed. The Trust now works within an Integrated Transfer Team framework to improve the timeliness and quality of discharges.

HM Coroner has requested that where it is known that a person who has died is the subject of an open safeguarding investigation, the death is reported to the Coroner. The safeguarding team now check on a daily basis for any open safeguarding cases in order to ensure Coroner's Office is informed.

In 2016/17, we report that 213 Deprivation of Liberty Safeguards (DoLs) applications had been completed. This is comparable with last year's figure of 214 applications. The majority of these referrals came from the wards within the medicine business group, followed by M4 – fracture neck of femur ward.

The Trust has 2 members of staff trained as reviewers as part of the LeDeR programme (Learning from deaths of people with Learning Disabilities). Within the time frame of this report we have reported one death into the programme, as this is a requirement.

Challenges 2017/18

Due to a backlog in the Local Authorities, the majority of DoLS applications are unauthorised. Over the year 39 applications were authorised by the Supervisory Bodies – the previous year 34 were authorised. This will be recorded on the Trust risk register.

SSAB are aware of this backlog in the service. Stockport is not the only Supervisory Body where applications are made and the problem is not unique to Stockport.

In addition, the key challenges for 2017/18:

- Year on year increase in referrals / concerns raised to Stockport NHS FT adult safeguarding team
- Mental Capacity Act and DoLS compliance and ensuring that this is embedded into practice

The Trust aims to:

- To continue to build and develop MCA and DoLS knowledge and compliance in order to build this into practice.
- To have high visibility prompts and flow charts directing Mental Capacity Assessments and DoLs applications in all clinical areas to help guide staff.
- To review safeguarding training, in line with the anticipated Adult Intercollegiate document.
    - Adult safeguarding training is recorded against all clinical staff profiles as a Mandatory Compliance Competency.
    - The Trust position at the end of March was 80% compliance, against a target of 95%.
    - It is recognised that this is below expectations and business groups need to address this and take action to meet the target.
- To review Prevent training in line with anticipated reviewed framework of training.
- To review Prevent policy to ensure staff are equipped to manage a situation where they believe a person is at risk of / may have become radicalised.
- To continue engagement and work with LA on Domestic Abuse and Self-neglect.
- To be responsive to local and national developments in all aspects of the Adult Safeguarding arena
- To re-build the Trust Adult Safeguarding microsite making safeguarding information easily accessible to all staff

Greater Manchester Fire Service (GMFRS) - has continued and is fully committed to work in partnership of the Board and its sub-groups, together with a similar approach with the Children's Board as both Boards work more closely together.

GMFRS currently utilises 2 separate engagement and recording systems for fire related interventions for both Children and Young People and Adults. However, with the forthcoming introduction of a newly developed information management system, there will be one system available with access to safeguards built in.

GMFRS has a greater focus on Safeguarding, specifically as active members of a now statutory Safeguarding Adult's Board. This has led to an enhanced focus on learning opportunities within the organisation which is evidenced by the review of an E-learning package and greater consideration of any relevant outcomes from any Safeguarding Adult Reviews.

In addition greater focus on levels and quality of referrals made are monitored through performance to encourage enhanced service delivery and appropriate onward referrals.

Challenges for 2017/18

- Managing the balance between capacity and demand with increasingly complex, challenging and chaotic lifestyles and needs

- The introduction and delivery of a more health and wellbeing orientated GMFRS “Safe and Well” visit, we deal with individuals

- Maintaining existing partnership arrangements/agreements given the external pressures on our “partners” as well as ourselves

- Ensuring that Safeguarding remains a fundamental focus as we anticipate further change in terms of both resources and service delivery

- Embedding the MSP and MECC principles within GMFRS culture and practice

Stockport Metropolitan Borough Council (SMBC) - Care Homes in Stockport were invited to apply for grants for capital projects that would create positive change for residents by enhancing the living environment, incorporating residents’ ideas and wishes, and offering opportunities for engagement with the local community.

SMBC awarded a total of £103,372 to 19 care/nursing homes to carry out a variety of projects including creating a traditional pub-style lounge; creating a café-style area to encourage independence and Reablement; creating multi-sensory and wildlife gardens; installing outdoor gym equipment; introducing tablet computers and helping residents use them for reminiscence and communication with family and friends.

Outcomes of the projects will be evaluated later in the year with real case outcomes.

Stockport’s Quality monitoring team has worked in a pro-active way to identify and prioritise quality issues and concerns in relation to the care home and home care providers in the borough.

Stockport's Quality monitoring team hosts monthly meetings led by Stockport Council Adult Social Care (ASC) in partnership with Clinical Commissioning Group (CCG) & Care Quality Commission (CQC) colleagues. It facilitates the joint consideration of quality issues at a local level & helps ensure regular communication between commissioners, regulators & health partners.

Colleagues ensure that providers are made aware of any information pertaining to them which may arise at the monthly meeting and providers have the opportunity to comment and respond to any recommendations arising which may impact on their provision.

CQC inspections have taken place within Stockport and the inspections are structured in relation to five areas; Safe, Effective, Caring, Responsive & Well-Led. The possible ratings from an inspections are `outstanding' `good', or `requires improvement' and those causing most concern are rated as `inadequate'.

The current quality ratings in care homes and home care have shown a level of improvement since last year but still present a significant challenge in terms of where we want to be. Additional resources have been allocated to create an `enhanced quality improvement team' (EQUIP) which will work across health and social care to help support and sustain improvement in provision. This team aims to be established and staff fully inducted by September 2017, when the team will roll out across the whole sector.

The Quality team have strengthened links with Healthwatch Stockport to ensure the user voice is heard. An `afternoon tea' event was held jointly with Healthwatch Stockport, with people using home support services in the Heaton's area. This has been a positive development and three further events are being planned in other areas of Stockport to give residents in other areas the same opportunity.

Next steps

- Further training for providers in relation to the specific CQC issues
- Working with colleagues who have additional expertise to undertake reviews and audits at a local level on specific themes.
    - property condition survey (care homes)
    - medication procedures (home care)
    - client finance and prevention of fraud (Learning disability and home care)
    - business continuity and contingency (all)
    - electronic monitoring systems (home care)
- Go live with the full Implementation of the new EQUIP strategic programme
- Continuation of service user engagement work with Healthwatch Stockport
- Partnership working in relation to the quality issues, and concerns meetings, and to ensure that the views of GPs and others are fed into the meeting.
- Improved quality and outcomes reporting and escalation processes across health and social care
- Improved IT systems
- Development of a single cohesive communication and engagement strategy
- Continue to report to the Joint Commissioning Steering Group and SMBC SMT.

Pennine Care NHS Foundation Trust - a number of established internal governance arrangements/groups within the Trust ensure a robust management and scrutiny of incidents and oversees the strategic and operational management of safeguarding adults and children across PCFT.

These include Integrated Strategic Safeguarding Group (ISSG), Quality Group, and Patient Safety Investigation Group (PSIG), Integrated Governance groups across all business units, a Safeguard report system and Safeguarding forums.

PCFT Pathfinder Stockport has a “Pathways to Employment” programme which supports vulnerable service users in to employment. A number of ex-service users have been supported in to volunteering with the service, providing practical support to current service users in their recovery. They are then supported in to paid employment within the service. As a wider undertaking, Pennine Care has also offered employment opportunities across the Trust, in departments such as administration, estates and training.

In the last year the Trust has participated in, local case reviews for adults and these are on-going and the learning from the reviews has been used to inform best practice in the organisation and in partnership working.

Further goals achieved for 2016/17 are:

- Assessment and risk documentation to include that staff undertake a more detailed enquiry around safeguarding adults.
- Development of a Safeguarding toolkit for ward/in-patient units delivered via a schedule of visits by safeguarding team

- Development of a Quality Plan
- Development of a staff handbook that is available for all staff
- Continued cascade and development of 7 minute briefings that are both topical and case learning specific
- Positive working relationships maintained with board partners and sub groups with evidence of attendance at all meetings.

Challenges for 2017/18

- Delivery of the Trust's Quality strategy which has been informed by the CQC findings from the 2016 inspection to ensure services, systems and processes are fit for purpose, are effective and reliable and have the patient voice at the centre.

- Delivery of the safeguarding agenda including training and support for staff around undertaking safeguarding investigations within a limited resource.

- Amalgamation of a number of sub-groups for both children's and adult's board will need to ensure parity across both agenda.

Case Study

This case relates to a young adult female patient who was admitted on to a mental health ward. The alert raised by the ward sister described concerns about a male agency staff member who displayed inappropriate behaviours to this patient which warranted further investigation and that a strategy meeting be arranged in line with Stockport adult safeguarding procedures. Immediate actions undertaken included escalation to senior managers within PCFT, HR and the suspension of the staff member.

Further enquiry identified coercive behaviours of concern as recognized this patient as a young, single parent with little family support, mental illness, and where social services were involved with her child. Additional information confirmed that another young adult female patient with a child also had experienced the same behaviours but hadn't disclosed to staff and was no longer on the ward. The patient was offered additional counselling, and encouraged to report to the police. Evidence from the patient in the form of texts were shared to support the HR process. The child's social worker was pivotal in offering support and reassurance that this incident would not impact on further parenting assessments and the patient's mother was also updated with the patient's consent and a family meeting facilitated.

In relation to the other discharged patient from whom there were similar allegations the ward liaised with her neighbouring authorities to alert them of this concern and request that safeguarding procedures also be implemented.

The Outcome and Key Points Raised:

- Appropriate action was taken and the DBS was notified.
  The caring and positive ward environment fostered a relationship between the night staff and this patient which allowed her to disclose the safeguarding concerns.
- Challenges in completing the HR process included that a couple of other patients that needed to be interviewed had cancelled dates.
- The Strategy meeting identified a robust protection plan for this patient, her child but also the other young female adult patient who was discharged and where there were similarities in their presentation.
- This case demonstrated good information sharing across agencies and boroughs, identified detailed records and collaborative working. This resulted in this patient's child social worker being able to continue with her parenting capacity assessment thus highlighting safeguarding vulnerabilities around relationships for this young mum. In this instance this was acknowledged to be helpful.
- The case highlights the potential risks in using agency staff- despite DBS checks in place and training offered by PCFT and the agency, the complexities and needs of people with mental health difficulties can expose them to potentially coercive relationships from those who work in the health service.

Stockport CCG - 2016/17 saw excellent examples of joint working with the Adult Social Care Quality Team and the continuing healthcare team (CHC) in care homes where the CQC have found the home to be inadequate. There have been very good examples of collaboration between all agencies to ensure positive outcomes were achieved for residents, families and providers.

The Care Home Awards 2016/17 took place and gave staff in this sector a deserved recognition for their dedication and commitment to this sector. This is planned again for 2017/2018.

Assurance templates have been developed and sent to providers to demonstrate the CCGs responsibility to ensure safeguarding systems and processes are in place in organisations from which the provider is contracted. This assurance is robust and where systems and processes are not satisfactory, Stockport CCG have implemented action plans to support the provider to improve their arrangements.

React to Red training is designed for care home staff to identify the first signs of pressure area damage and to react appropriately. To date, 9 training sessions have taken place at venues across Stockport; some of these have been within care homes for in-house staff only and others have been open to all care home/domiciliary care staff across the Borough to attend. The evaluations were very good and Stockport CCG saw a drop in high grade pressure ulcers in the care home sector.

Challenges for 2017/18

- To ensure there is a clear template used in all MCA assessments and to audit how clinicians assess and document decision based assessments

- To engage fully with the SSAB sub group work and activity. This will be easier to achieve on the appointment of the Designated Nurse for Adult Safeguarding.

- To embed the learning from the recent safeguarding adult 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 role alongside meaningful contribution at Channel Panel where GP information would be extremely useful

National Probation Services - The Stockport National Probation Service (NPS) has a full time Probation Officer seconded into the Stockport Youth Offending Service. This role is specifically targeted towards ensuring that young people are transitioned to adult services in a collaborative, effective and safe manner. In addition to this the Stockport NPS also has a Probation Officer specialising in the case responsibility, risk management and rehabilitation of young persons between the ages of 18-24.

The Stockport NPS is committed to ensuring that safeguarding work is outcome focussed with the aim to ensure that clients are supported by partnership agencies whilst maintaining effective risk management and public safety.

Challenges for 2017/18

In regard to safeguarding, achieving representation at all sub group meetings is a challenge due to available resources and spans of control.

Stockport Homes - Stockport Homes, as the largest provider of social housing within the borough, is committed to its responsibilities with regard to safeguarding adults at risk across the borough.

Many Stockport Homes staff and their partner contractors meet with customers in their own homes on a day to day basis for various reasons, for example carrying out or inspecting maintenance issues, new bathroom installations, neighbour nuisance problems, financial advice and so on. As such, these staff have a privileged insight into tenants' lives that other agencies and professionals may not.

In addition to the day to day housing management services, Stockport Homes provide enhanced services to older people living in sheltered housing schemes across the borough and our tenancy sustainment service provides support to individuals with care and support needs who may be at greater risk of abuse and neglect. We also work very closely with our tenants to ensure our services are meeting their needs but also working to improve the quality of life on our estates and build stronger communities.

To demonstrate our commitment to safeguarding adults at risk we:

- Ensure all new staff attend safeguarding awareness training as part of their induction.
- Delivery of 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.

- Safeguarding Children and Adults at Risk Policy, Procedure and processes in place and regularly reviewed to ensure accuracy and compliance with all relevant legislation
- Senior Strategic (Assistant Chief Exec) and Operational leads for Safeguarding (Head of Independent Living) within Stockport Homes.
- A wide range of staff, at all levels and within all service areas of the organisation, are involved in Safeguarding activity, with 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.
- Significant training has been undertaken with the workforce, with training delivered appropriate to their particular role and duties (see below)
- Information shared regularly with Safeguarding Champions (for example learning from SAR's) which is then communicated by the Champions to wider team members as appropriate
- Securing additional funding and resources to deliver more services to vulnerable customers, for example. Motiv8 which works with the most socially excluded individuals across GM and TalentMatch which works with young people who are NEET
- Recognition of and response to changing trends and demographics with respect to vulnerable adults, e.g. 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; expansion of the Pantries.

Case Study B

Adult B presented as homeless to Stockport Homes and was placed within a Temporary Accommodation Scheme. Once resident it soon became clear that Adult B was struggling with maintaining their personal hygiene. There were several occasions where other residents had complained about urine and faeces on the floor in the shared bathrooms. Adult B also self-harmed and had cut them self on a number of occasions. Adult B also became very confused with household items on a number of occasions such as the washing machine; despite staff regularly demonstrating appropriate use. Adult B was on medication for their mental health issues and took medication to manage their alcohol dependency. It was unlikely that Adult B took this regularly, there were also times when Adult B seemed to lack understanding as to what their medication was for and also a number of occasions where they advised staff that medication had gone missing.

Staff never witnessed Adult B cooking anything for themselves and staff were aware that other residents cooked meals for Adult B. When offered food parcels Adult B only ever took items that were ready to eat or microwave meals.

Adult B did get into a lot of arguments with other residents at the scheme. Due to confusion as to what day/time it was, Adult B would knock on doors around the scheme throughout the day and night. It would appear they did not sleep well and residents complained that Adult B often kept them up all night. Adult B also had regular mood swings with staff members and frequently presented as angry or frustrated.

Temporary Accommodation Staff struggled to cope with Adult B's needs and balance the desire to accommodate and support Adult B, with the needs of other residents within the scheme also.

Adult B required a level of personal care which cannot be provided by staff and over time their mobility declined, with staff moving Adult B to a ground floor flat to address such needs.

Staff made regular appointments with the GP for Adult B to address multiple issues and also supported Adult B to attend regular appointments at the hospital. Staff carried out a referral to adult social care to gain some assistance for Adult B. The team also kept social care up to date with details of any incidents.

Adult B regularly attended Hospital and Temporary Accommodation staff regularly liaised with the hospital/adult social work team to update them on Adult B's increasing health needs and vulnerability. This joint working and sharing of information led to a conclusion that Adult B required supported accommodation in order to meet her needs and funding was secured via ASC to enable a move to appropriate accommodation with additional support.

Some examples of how SSAB partners have contributed to having a workforce appropriately trained in safeguarding

13.0 Financial Information

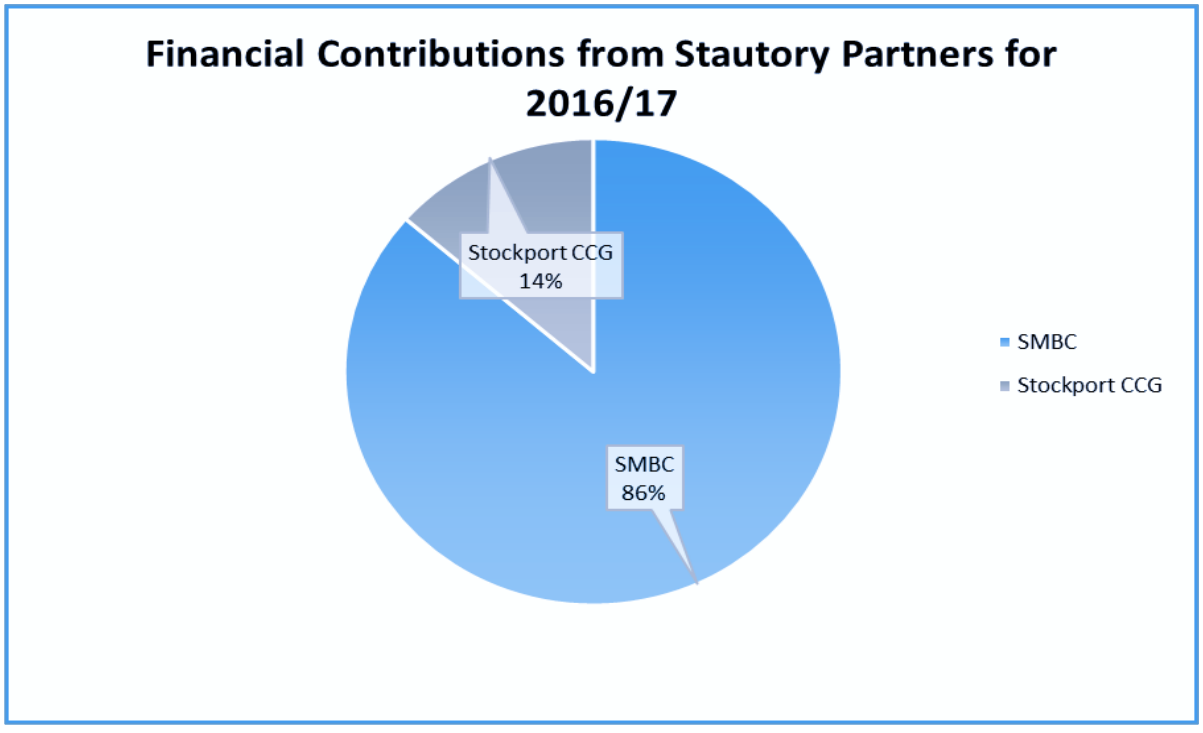
The Board receives financial support for the day to day activity which is largely endorsed by Stockport Metropolitan Borough Council Adult Social Care.

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’s 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 2016/17 the table below demonstrates the statutory investors.

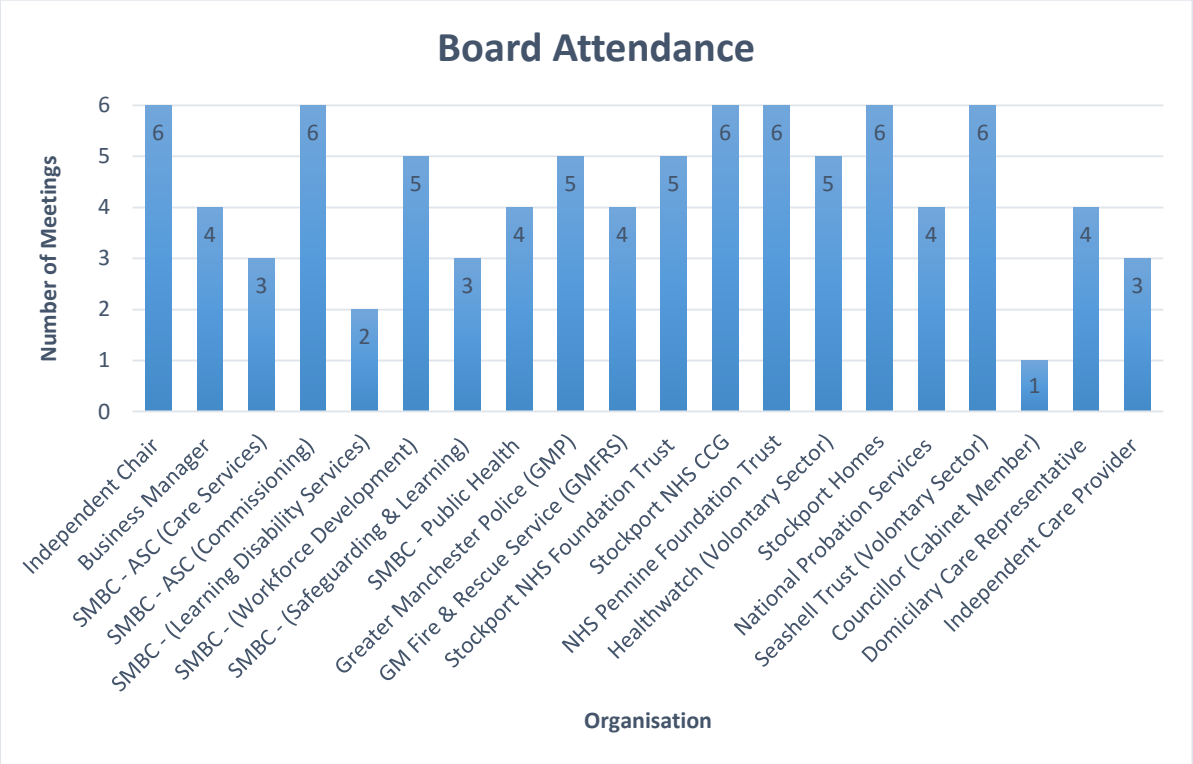


13.1 Board Attendance

The board members have been joined by a number of new representatives from organisations throughout the year. This has proved to be very positive and instrumental to the board.

The appointment of Stockport's Head of Safeguarding and Learning was made mid-year, alongside the appointment of the Safeguarding Adults Board Business Manager, and most recently the appointment of a local Councillor Wild, who joined the board in March 2017.

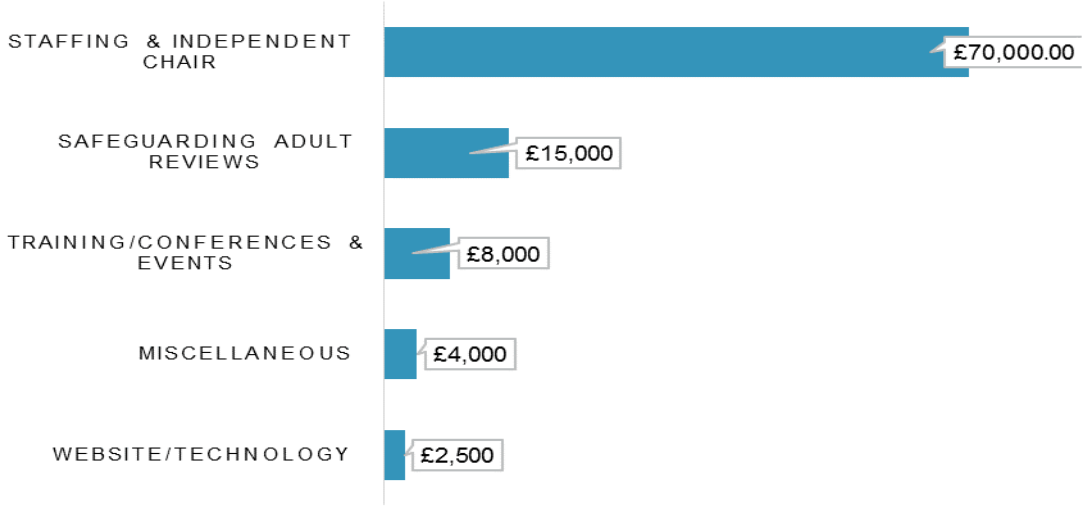
In consideration of the Care Act 2014 we do have a fully established Board that has representation from both statutory and non-statutory organisations. We are confident that the SSAB is represented by the right local statutory and voluntary agencies who are engaged appropriately with the committees.



The chart above shows that for the period in 2016/17 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.

13.2 SSAB Allocated Expenditure 2016-17

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.



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