STOCKPORT SAFEGUARDING ADULTS BOARD

ANNUAL REPORT

2015 /2016

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SECTION ONE

I am pleased to present to you the Stockport Safeguard Adult Board (SSAB) Annual Report for 2015/16. The purpose of our annual report is to provide information for all those involved in the work of, or who are interested in Safeguarding Vulnerable People in Stockport. The report summaries the progress that has been made against the objectives we set ourselves in our Strategic Plan for 2015/17 ; it highlights the key achievements and the challenges that have been faced as a Board and it also sets the scene for the work we will do next year.

This reporting year has been a very significant year for safeguarding adults. For the first time safeguarding adults is based on a legal framework from 1st April 2015 and all councils are required to have a Safeguarding Adults Board. Stockport has had a Safeguarding Adults Board since 2004 and was therefore well placed to implement the new Care Act in relation to safeguarding adults. The Board continues to work hard to make sure that the Care Act principles are central to how we work.

The Safeguarding Adults Board Annual Report 2015-16 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.

I became the Independent Chair of the SSAB at the beginning of March 2016, following the resignation of the previous Chair in October in 2015. The Board went through a period of instability towards the end of 2015/16 with a number of key board members leaving the Stockport area; however other Board members have continued their support to the Board during this time, and whilst a number of developments have been progressed the Board has not been in a position to progress some elements of the Strategic Plan. During April and May 2016 a great deal of work has been undertaken to re-establish the Board and agree its priorities for 2016/17.

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:

- Delivery of PREVENT training that excelled against target to a wide range of clinical staff as well as administration staff – **Pennine Care NHS Foundation Trust (PC NHS FT)**
- Collaborative working across all Health and Social Care throughout the borough of Stockport. – **Stockport Metropolitan Borough Council (SMBC)**
- Recruitment to a full time Dementia Matron - **Stockport NHS Foundation Trust (NHS SFT)**
- The Designated Nurse has worked with SMBC, NHS SFT and Public Health to drive up standards in Care Homes with Nursing -**NHS Stockport Clinical Commissioning Group (SCGG)**
- Established Vulnerable Adults Working Group to improve internal practises and communication – **Greater Manchester Police (GMP)**

- Recognition to changing trends and demographics by adapting services to Adaptations and Older Persons Support Team – **Stockport Homes**

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 managers 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 achieving 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 would not have been possible. On behalf of the SSAB I would like to express my heartfelt thanks to all the staff in both the statutory and the independent sector and volunteers who work with vulnerable adults and their families for their continued effort; you are our 'safeguarding system' and without you none of this could happen.

Gill

Gill Frame

Independent Chair Stockport Safeguarding Adult Board.

SECTION 2 – Background and Context

Care Act 2014

Since 2015 Stockport's Safeguarding Adult's Agenda has been driven by the implementation of the Care Act 2014, which replaces the longstanding guidance 'No Secrets'. This is a welcome change as it not only elevates the Board to a statutory status it brings adult safeguarding into the legislative arena. A key factor to this and of significant importance to the business of Safeguarding Board is the legal duties in working in partnership with key agencies and organisations. This is not new within Stockport and there is a good track record of collaboration, but this will solidify those relationships as well as improve our effectiveness in working together.

There are 6 key principles of safeguarding adults within the Act and articulate the need to ensure that we are guided by these in everything we do.

- Empowerment;
- Prevention;
- Proportionality
- Protection
- Partnerships
- Accountability

What this means in both our policies/procedures and practice is that they are underpinned by these principles and need to guide us throughout our approaches to safeguarding adults at risk.

Making Safeguarding Personal

It is important to highlight within the principles above the new requirement within the Act to implement the Making Safeguarding Personal agenda. This is key to our ambitions to move away from a process driven response to concerns and focus on the individual, their families, carers and representatives. This challenges us to not revert to a professionals knows best attitude but instead work within person centred approaches and to involve those concerned within the process more fully.

Making safeguarding personal means it should be person led and outcome focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

Joint strategic needs assessment (JSNA)

The 2015/16 Joint Strategic Needs Assessment (JSNA) is part of an on-going process which develops a shared understanding of health and care needs in Stockport and uses intelligence to identify priorities. This is to help local partners work together to deliver change which improves the health and wellbeing of people in Stockport and reduces health inequalities.

Below is a summary of the key trends in health and wellbeing arising from the detailed analysis which provide a high level profile of Stockport and also the key priorities for health and wellbeing for the next three years.

The overall objectives for health and wellbeing in Stockport are to improve life expectancy and reduce health inequalities. A number of key strategic priorities have been identified to help us achieve these objectives.

Demographics

The population of Stockport is now 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	2014	2017	2020	% increase 2014-2020
18-64	169,600	169,650	169,600	-
65-74	29,500	30,850	31,300	+6%
75-84	18,750	19,200	20,550	+10%
85+	7,400	8,300	9,200	+24%
TOTAL	**286,750**	**290,050**	**294,400**	**+3%**
Total 65+	55,650	58,350	61,050	+10%

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).

Vulnerable groups

At some point in our lives we are all likely 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)

Adults at Risk

It is important for the business of the Safeguarding Adults Board that we identify and define the individuals that we are focussing on. The term 'Adult at Risk' was adopted by the Stockport SAB in 2013 following the preference expressed in the No Secrets Review by those subject to safeguarding procedures. It can be used interchangeably with the term 'Vulnerable Adult. The Care Act Guidance reinforces this by referring to adult throughout or adult at risk

The Care Act 2014 **section 42** (1) states Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the Local Authority is meeting any of these needs) *and;*
- Is experiencing, or at risk of abuse or neglect*; and*

- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect

The Care Act defines an Adult at Risk as a person aged 18 or over who:

- still receives children's services *(the level of care and support is not relevant, and the young adult does not have to have eligible needs for care and support under the Care Act, or be receiving any particular service from the Local Authority , in order for the safeguarding duties to apply- as long as the conditions set out above are met)

- receives any adult social care service* (including carers services) provided or arranged by the local authority or receives Direct Payments in lieu of Adult Social Care services or funds their own care and has social care needs or otherwise has social care and/or health needs.

- falls within any other category prescribed by the secretary of state

- is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse by the cared for person

- is unable to demonstrate the capacity to make a decision and is in need of care and support.

In the context of Safeguarding Adults, the vulnerability of the adult at risk is related to their care needs and how able they are to make and exercise their own informed choices, free from duress, pressure or undue influence of any sort, and to protect themselves from abuse, neglect and exploitation and is not related to their age or disability etc. This effectively broadens the definition of 'at risk' for a range of individuals and makes specific local authority duties in relation to them but also demonstrates the need for multi-agency working and specifically sharing best practice and resources. It is important to note that these statutory duties apply regardless whether the adult's needs are being met, regardless of mental capacity and regardless of the setting they occupy. For instance, there is now a duty to address the needs of those who self-neglect.

Abuse is defined by the Stockport SAB as

With the introduction of the Care Act the Safeguarding Board has identified the definitions and circumstances that characterise abuse. In its purest form abuse can be defined as 'An act or omission, a violation of an individual's dignity, human or civil rights, by any other person or persons which results in significant harm to the physical, emotional or social wellbeing of an adult at risk'.

Abuse or neglect can take many forms and the circumstances of the individual case will be considered. The Care Act categorises abuse into the following categories

- Physical abuse
- Domestic violence
- Sexual abuse
- Psychological abuse

- Financial or material abuse
- Modern Slavery
- Discriminatory abuse
- Organisational abuse
- Neglect and Acts of omission
- Self-Neglect

Harm Levels Guidance

Under the Care Act 2014, there is a responsibility that any provider of any service that becomes aware of abuse or neglect does have a duty to correct this, protect the adult at risk as soon as possible and inform Stockport Local Authority, CCG and CQC.

Stockport Local Authority does provide have harm level guidance for all their provider services to support decision making in the most appropriate pathway to address adult protection concerns.

Stockport workforce development team work in partnership with all provider services and harm level guidance is incorporated into the safeguarding referral training as well as the safeguarding alerter training.

All guidance is available on the SMBC website:

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

http://www.stockport.gov.uk/2013/2996/1201778/harmlevelsguidance

Post Winterbourne View

There is close scrutiny from central Government about the cohort of people who are inappropriately placed in Long Stay Hospitals as a result of the Winterbourne View scandal. This is now termed 'Transforming Care' and is overseen by NHS England. It is still felt that more could be done to ensure people are not 'left' in hospital without rehabilitation plans. We are part of the Greater Manchester Fast Track programme focusing on resettling people back into their Communities. The Community Learning Disability Team are prioritising people who are ready for discharge and identifying suitable accommodation for people to return to Stockport. We are on target to meet the timescales governing the programme.

There is also activity looking at all aspects of this issue including workforce development across the region to ensure there is sufficient skilled staff able to meet people's needs, ensuring the market is responsive and ensuring all areas have Risk Registers.

SECTION 3 - BUSINESS PLAN PROGRESS

The Stockport safeguarding Adults Board (SSAB) set out 7 key objectives for progression during the course of the year, with a view to ensuring a robust safeguarding response for adults at risk living in the borough. The following sets out progress against each objective;

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

   In line with the Care Act 2014 (section 42) Stockport Safeguarding Adults Service undertook a review and revision of its multi-agency policies and procedures. This ensures that Local Authority will make enquiries or causes others to do so if it believes an adult is experiencing or is at risk of abuse or neglect.

   Stockport has a well-established safeguarding board and at the end of the year appointed a new independent chair to replace David Mellor. A priority for next year will be a full review of the Boards terms and organisational architecture.

   A new contract was established for an independent advocacy service for safeguarding commissioned with Stockport advocacy.

   There has been continued development of the Council's Multi-agency safeguarding and Support Hub (MASSH). This provides an integrated approach to the delivery of services for vulnerable families, adults, children and young people, including those at risk of child sexual exploitation (CSE) and those experiencing or witnessing domestic abuse. This work has involved integrating and co-locating a range of services and agencies with enhanced information sharing at the point of identification of need. As well as the MASSH the Multi-agency adults and risk system (MAARS) is now well established and continues to address the needs of complex individuals who are difficult to engage.

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

   The spirit of 'Making Safeguarding Personal is captured within the Local Authorities policies and procedures. A key principle in this is the support for individuals to make decisions and give informed consent and identify their own safeguarding outcomes to protect themselves and others. This is inherent in the way meetings are conducted and how individual planning is undertaken. Specific to this is how case conferences are approached in two part process. This ensures that the individuals only attend the parts of the meeting most relevant to them, allowing to them to engage in a bespoke protection plan.

   The board recognises there is further work needed to establish and understand how theory is embedded into practice across all partners involved in safeguarding adults. There is an accepted understanding that an audit is required to capture how the principles of the care act that focus on person-led and outcome focussed approach to safeguarding will help the board identify how Stockport has responded to the Making Safeguarding Personal agenda. To assist with this, a task and finish group will be set up to progress an audit on behalf of the board.

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

   The promotion of the importance and significance of adult safeguarding remains a key priority for the SSAB. Despite the reductions in budgets available for training and courses, the Council continues to provide free Averter Training to the private and voluntary sectors. In addition, advice and support is available to individual providers and organisations to support the implementation of the Multi-agency policies and procedures.

   There is a continued commitment for training to those individuals self-employed under the direct payment scheme.

   A Harm Level guidance session was open to all external providers with nearly 100 hundred participants across the private and voluntary sectors.

   The SSAB is limited in how wide it can publicise due to budget pressures in the system. However, work continues to join up messages and avoid duplication as well as find ways to use existing forums to promote the adult safeguarding agenda.

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

   In concordant with the Care Act 2014 Stockport Safeguarding Adult service developed a Safeguarding Adults Review (SAR) process to ensure that the SSAB's statutory responsibility under the Care Act 2014 are met in relation to Safeguarding Adults Reviews. A subgroup of the SSAB considers all cases referred to it that may meet the criteria and makes recommendations to the SSAB via the chair in relation to reviews and the sharing of lessons learned

   A quarterly safeguarding adult's practitioner's forum is managed via the Safeguarding service and staff development and offers a learning environment for staff to share good practice examples, developments within safeguarding thinking and research into practice and lessons learned.

   In October 2015 it was agreed between Stockport Council Adult Social Care, and Stockport Clinical Commissioning Group to meet monthly, to ensure clear joint working in relation to quality issues and concerns. The scope of the discussion was the provision of health & social care support within Care Homes, Care Homes with Nursing, and Home Care. This regular meeting was already in existence but there was recognition of the need to formalise the process and extend the discussions to a wider group of partners. This group has now been formally established as the Quality Issues & Concerns Group.

5. *Develop preventative strategies which aim to reduce instances of abuse and neglect.*

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

The last year has been challenging as services have been required to make significant savings in both commissioning budgets and staffing costs. The MAARS process has continued to operate throughout this time and has effectively aligned its approach with the newly commissioned Targeted Prevention Alliance and the Alliance for Positive Relationships as well as other preventative services.

A key priority for 16/17 will be the development of a full business case to put MAARS on formal footing within the Council and to seek permanent funding for a team to coordinate activities across the range of partner organisations and departments.

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

   In late 2015 Stockport submitted a bid to the DfE, supported by both Safeguarding Boards, to undertake a piece of work which explores a more effective bridge between Children's and Adults Services to ensure that support planning is done in partnership and commences on a collaborative basis from the age of fourteen. It aimed to ensure that pathways are aligned and a more seamless journey is provided for the young person as need demands.

   It was recognised that Stockport has a strong track record of partnership working including a highly effective Multi Agency Safeguarding and Support Hub (MASSH), success in turning around 'Troubled Families' and the development of the Multi Agency Adults at Risk System (MAARS). However, it was also acknowledged that there are parallel but separate approaches undertaken that address vulnerability. Evidence had shown that children in need without appropriate support can be particularly vulnerable to a range of negative influences which can include offending behaviour, sexual and wider forms of exploitation, domestic abuse and substance misuse. Most commonly, these individuals are ineligible for adult services and are often picked up in preventative services in crisis.

   Funding for the project was confirmed at the end of June 2015. This was set to be a 12 month project with a full time officer from 1st April 2015 but the delayed notification and other organisational changes meant that this could not be established. This baseline study was a key component of the project. Other aspects were not realised but there remained a commitment to provide this information in order to inform future practice. A final report has been drafted that will be agreed in the 2016/17 business cycle of both the Children's and Adult's Safeguarding Boards. It is envisaged this will be the foundation for a full business case to drive organisational change and new ways of working.

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

The Quality Issues and Concerns Meeting (QIC) has the following purpose:

- Facilitating the joint consideration of quality issues at a local level in a consistent way and ensuring regular communication between commissioners, regulators & health partners.

- To focus and prioritise key issues to help prevent provider failure and/or a loss of provision within the Care Home/Home Care market

- To identify areas where providers can benefit from additional support to improve current quality of provision & manage risk.

- Ensuring that actions & responsibilities are identified in relation to any concerns noted and feeding general themes and recommendations (e.g. training issues) into the `Stockport Together' work-stream on care homes & home care.

- Ensuring that any providers are made aware of any information pertaining to them which is considered within this forum & that they have the opportunity to comment & respond to any recommendations arising which may impact on their provision.

SECTION 4 – Learning and Improvement

Lessons learned from previous case studies:

Stockport Safeguarding Adults Board and its respective partners are committed to learning in order to improve the outcomes for vulnerable adults. We recognise we have to further our development for opportunities to learn from previous safeguarding investigations. We are working better at performance management and looking at ways to improve our Safeguarding Adult Audit processes. Other areas for development we want to focus on are our Multi agency case reviews, specifically those cases that don't meet the criteria for a Serious Adult Review (SAR).

Since the Care Act 2014 was implemented, SMBC has not yet commissioned a formal SAR due to the criteria for conducting a SAR has not been met.

Therefore, there are a summary of cases that are included in the report to demonstrate how lessons have been learned to improve on practice.

Case Study A: A patient was referred to the Accident & Emergency department because of events in their life they have tried to cope with the pressures through drug and alcohol misuse.

Issues included drug and alcohol misuse, loss of children, housing and networks. Patient had a number of physical health issues and was expressing suicidal ideas. Patient was at further risk of sexual and financial exploitation and was typically a hard to reach patient.

Concerns were growing as to potential for significant harm to self and others as final arrangements were agreed to place children for adoption.

By using the safeguarding adults policies and procedures, meetings were arranged that involved a number of appropriate professionals who would meet together to discuss risks, concerns and how best to manage the case, this is known as joint up working. This included sharing information with Children's services.

Key points: from this case included the potential challenges in multi-agency working and the need to ensure whole patient care- not just that mental health needs be addressed. Highlighted the impact of physical health on mental health and how other types of abuse easily become exacerbated when patients lead chaotic lives.

Learning points: Challenges around attitudes of various professionals highlight the need for practitioners to be skilled in managing difficult safeguarding processes to ensure fair access to services.

Case Study B: A safeguarding adult's alert was raised by a family member of a resident in a Stockport care home. The alert included concerns about the timeliness of medical intervention for the resident following a fall.

The resident lacked capacity to consent to a safeguarding investigation and once family were approached a full safeguarding investigation proceeded by Adult Social Care under the multi-agency safeguarding procedures.

The care home provider requested the GP to review one of their residents. The reason for GP review was that staff believed the resident might have had an unwitnessed fall earlier that day as they had noticed changes to their level of mobility.

The GP reviewed the resident on the same day at their weekly walk round and instructed the provider to arrange an ambulance in order for the resident to be admitted to hospital for an x-ray for a suspected fractured neck of femur. The GP expected this to be followed through the same day.

The provider had arranged transport and was informed that this was not available until the following afternoon. The GP was not informed that transport was not available on the same day and the resident was admitted to Stepping Hill Hospital the following afternoon, more than 24 hours after the GP review. An x-ray revealed that the resident had a fractured neck of femur.

Issues identified: The investigation highlighted that there had been miscommunication on behalf of both the provider and the GP. The GP reported that at the time, they had been unaware that the provider had not fully understood their instructions and had believed that the patient would be admitted immediately to hospital for x-ray.

Findings: It became apparent that there were a number of gaps in the provider policy around GP reviews. There was no written system to record which residents the staff wanted to book in for GP review.

Staff were reliant on verbal handovers from each other which were then verbally reported to the GP. It was identified that this often meant the information given to the GP was limited and residents who needed a review were sometimes missed. There was no process to record decisions made by the GP on the walk round which led to confusion for the provider about what was expected from them.

There was no formal means to document who would take responsibility for actions and no indication of timescales for these to be completed following the GP review. In this case, it was identified there had been confusion about who should call for an ambulance and when this should be done.

A different member of staff from the provider attended the GP reviews each week. It was not always a member of staff with the authority to ensure that actions from the GP reviews were carried out. It was identified that there was a lack of consistency in terms of following up actions week to week.

Staff reported that they felt unsupported and unsure about how to communicate concerns to the GP outside of the weekly walk round. It was identified that there was a lack of clarity around how staff could escalate their concerns when they felt a situation was increasing in urgency.

Learning Points: Actions have been in place for three months. The new process has been observed in practice on three occasions by the Quality Team and the new system has improved communication between the provider and the GP in that there is a clearer and more robust system of communication.

Completion of the new handover sheets by the provider ensures that they maintain an audit trail of their actions which provides assurance to Stockport MBC as part of Quality monitoring.

The GP and provider feel that the learning has led to positive changes in terms of their working relationship and the service they deliver to residents.

Training and development opportunities provided across partner agencies.

Our front line workers also have the opportunity to learning and review their practice through a range of multi-agency and single agency training programmes. The tables below set out the range of training opportunities provided. As a Board we recognise that providing training and learning opportunities on their own do not always lead to an improvement in quality. As part of the journey as a Board towards the culture of continuous quality improvement we will be looking at ways to measure impact of training.

Greater Manchester Fire and Rescue Service (GMFRS)

GMFRS employs in excess of 2,100 staff in a combination of uniform "front line", Community Safety and "support" staff roles all of whom are required to successful complete the E-learning Safeguarding package referred to above.

Within Stockport the Community Safety Manager/Community Safety Team Leader (CSM/CSTL) are accredited and trained as Designated Safeguarding Officers (DSO's).

The DSO training is subject to the same 3 year "best practice" refresher regime as other public sector organisations whilst the E-learning package is monitored for successful completion and regularly reviewed to ensure its currency and "fitness for purpose".

Pennine Care NHS Foundation Trust

Pennine Care have provided the following training information which is taken from their Annual Report:

Pennine Care have **459** employees within the borough of Stockport and the table below demonstrates a high attendance of mandatory training in Adult safeguarding level 1 as well as Prevent.

Adult Safeguarding Level 1	Target:95% 407/459 (Mandatory)	Actual: 88.7%
Prevent	Target:85% 401/459 (Mandatory)	87.4%
MCA and DOLs	151 staff trained across Stockport borough	2015/2016

have a Supervisory role and all receive safeguarding training.

In respect of care staff, all professionals have a vast range of courses available. The training provided at Seashell offer:

- Registered managers L5 Management
- Team Leaders L3 vocational and L4 management and MCA/DOLS
- RSW vocational qualification and autism /interveners /deaf awareness and signing (relevant to area of work).

Stockport Homes

There are **532** individuals employed with Stockport Homes and **290** of which include line managers of frontline services. Out of **290** employees identified **108** individuals attended one or more workshops, conferences or seminars in relation to Safeguarding Adults.

There are **43** frontline managers, Team Leaders and Supervisors **19** of these Managers/Supervisors attended one or more workshops, conferences or seminars in relation to Safeguarding Adults.

In relation to Safeguarding Adults there are key groups who have attended more in depth or focussed training. These areas are Temporary Accommodation, Carecall & Concierge, Independent Living Services and key members of the Anti-Social Behaviour team.

Other services receiving training include the Area Housing Teams, Housing Options, Customer & Community Involvement and Customer Facing individuals from the Technical & Commercial Services Directorate.

Stockport Homes have delivered and coordinated a range of workshops and conferences including Dealing with Domestic Abuse, Supporting Adults with Drug & Alcohol issues, SafeTALK (Suicide prevention) and Safeguarding Adults Level 1 & 2. Our Safeguarding programme is embedded below:

NHS Stockport Clinical Commissioning Group (SCCG)

There are **135** employees within SCCG who have to complete a basic awareness of ELearning on Adult safeguarding and this is repeated every three years.

There are the smaller number of clinical staff of which **25** include the continuing health care team and the safeguarding team who complete a more in depth face to face training which is refreshed every three years and this is due to take place in September 2016.

There are approximately **7** staff who would supervise and all of these have been trained in safeguarding and are aware of the multi-agency policies and procedures.

SCCG have received funds to embed MCA and DOLS training in the health economy and over the last 18 months SCCG have delivered bespoke MCA training for their health economy. SCCG have also focused specific training with their transitions team, their hospital staff and most recently delivered tailored training to St Anne's hospice.

Several opportunities have been carried out to ensure staff across the health economy have received MCA & DOLS and further bespoke sessions are being arranged for the forthcoming year. Below is a summary of professionals who have received training.

Mental Capacity & DOLS:

- 75 GP Masterclasses
- 25 Dental Staff
- 156 Various Staffing Groups
- 45 Mastercall front line staff
- 25 GP Safeguarding Leads

Prevent training: 72 NHS SCCG Staff, 30 GP Safeguarding Leads and 25 Dentists

Stockport Metropolitan Borough Council

Stockport Council's Workforce Development team continues to provide training at different levels. During 2015/16 over 1,227 places were filled on Safeguarding training provided by that team at various levels, a similar number to those filled in 2014/15. This is broken down as follows:

	Care Home	**Home Care**	**Stockport Council staff**	**Grand Total**
Alerter Training (open courses)	119	270	221	610
Alerter Training (bespoke courses)	16	54		70
Alerter Refresher	28	125	94	247
Referrers Training	8	49	9	66
Mental Capacity Act/DOLS	1	23	26	50
Inquiry Officer Training		5	12	17
Harm Level Briefings	35	42	38	115
Other	20	15	17	52
Grand Total	**156**	**472**	**362**	**1,227**

Stockport NHS Foundation Trust

Stockport NHS Foundation Trust have provided the following training information which is taken from their Annual Report:

The trust has an ongoing training programme for MCA/DOLS and Adult Safeguarding which is embedded in the trusts training and development plan with significant improvements in compliance.

The Trust have a total of 4605 employees, 3107 of which are front line clinical staff and all receive mandatory safeguarding training. MCA and DOLs training has been delivered to 82.49% of professionally trained staff and 89.98% have received mandatory training in Adult Safeguarding.

All clinical staff are targeted for Adult Safeguarding, MCA and DOLS and receive this as part of their mandatory programme and this involves face to face training.

For Prevent training the Trust are targeting all their staff at level 2, face to face training as well as cascade training that will be passed onto other individuals within their agency.

Clinical staff are receiving level 3 training with a particular emphasis on this for clinical staff working in Community, Child and Family and the Emergency Department

For 2016 /17 Prevent training will be recorded on the compliance matrix and will monitored monthly to ensure a trail is being achieved within the workforce.

Bespoke training has also been provided to support their teams which has helped contribute to the increase.

Awareness training and production of support materials in relation to DoLS has contributed to the significant increase in DoLS applications and remains ongoing.

As discussed earlier, Stockport are working to develop a positive learning environment to ensure that practice is continually improved and information is shared on a monthly basis. SMBC facilitate a Quality Issues & Concerns Group that provides a multi-agency strategic oversight of the provision of social care and health related commissioned services in the Borough.

This mechanism of oversight is an important part of ensuring that where appropriate effective action is taken to mitigate against risks within services providing care and support. The focus of the meeting now agreed, is on provision commissioned by ASC & Health, & regulated by the Care Quality Commission (CQC).

The meeting provides a regular focal point for collaborative working across health and social care, with provision for continued work to develop and agree the supporting governance including the creation of links to feed themes & concerns into the wider governance of `Stockport Together' as this evolves, whilst also ensuring robust links, via the Quality Team, to ongoing work & `business as usual' with specific providers & operational colleagues.

SECTION 5 - Safeguarding Adults Activity (SAA) 2015/16

The Safeguarding Adults Activity (SAA) records details about safeguarding activity for adults aged 18 and over in England. The collection includes demographic information about the adults at risk and details of the incidents that have been alleged.

All Councils with Adult Social Service Responsibilities are required to complete the return and submit the data collected to the Health and Social Care Information Centre.

The Council uses this information to identify patterns and trends which in turn translates into directing attention to areas of concern or where practice can be improved. In isolation this information is limited but when used along with the softer intelligence the Council has it provides a rich picture of activity and volume of work.

Alerts and Referrals Received

The following data shows that there is a significant amount of alerts raised where there is a concern for an adult. Not all of these are for an individual who might be considered at risk and would either not meet the Care Act definition or would be below the threshold for harm for instance where there is a subjective assessment of an individual's living conditions. However, there is still a significant number that would go on to requiring a consideration of a formal investigation.

In 2015/16, there were 2,937 safeguarding alerts and referrals raised. 2,329 of these were Safeguarding concerns whilst 608 went on to a formal investigation.

Figure 1 details referrals and alerts raised in 2015/16 each month. The data shows that there are on average 240 concerns raised each month.

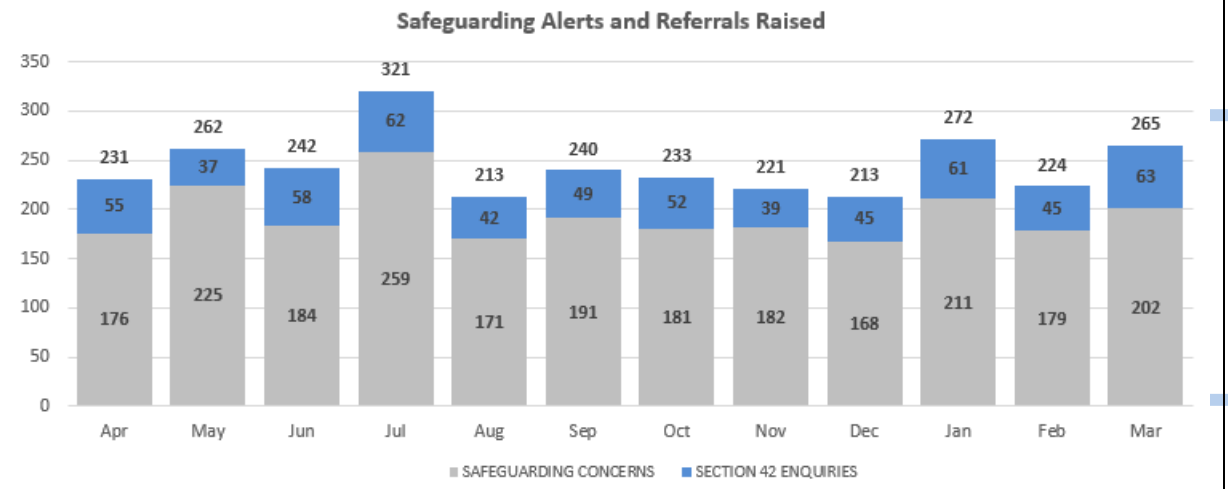


Figure 1 – Alerts and Referrals 2015/16 by type of concern

Figure 2 provides a breakdown of the age profile for alerts and referrals received in 2015/16. The data shows that the majority of cases related to individuals aged 85 or over (999 cases). This would be expected due to the sheer numbers of individuals who have health and support needs and where reporting / identification would be more prevalent e.g. care environments.

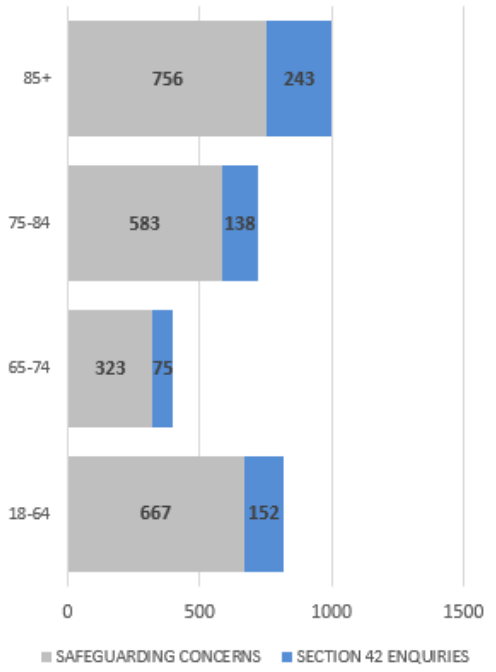


Figure 2 – Alerts and Referrals Age Profile

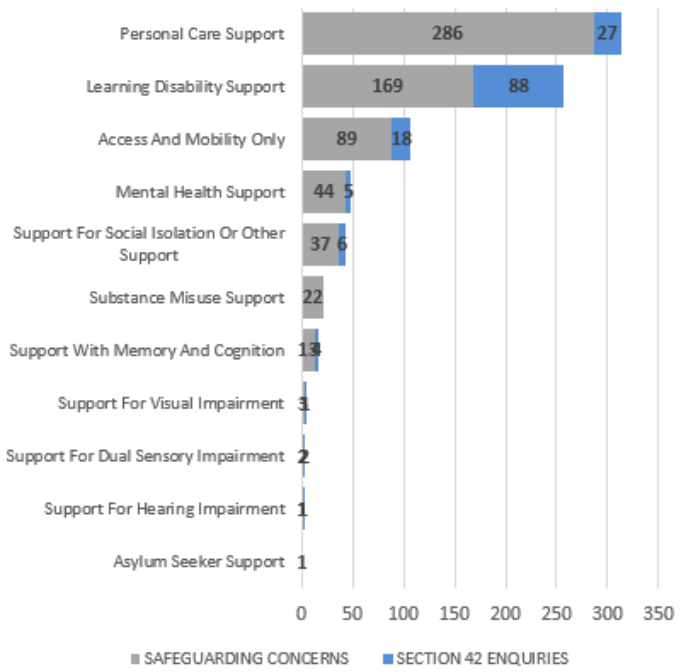


Figure 3 – Alerts and Referrals (18-64 age range)

The 18-64 age range accounts for 29% (1,718 out of 5,880) of all adults that Stockport supported with an ongoing package of care. This is expected due to the lower number of individuals under the age of 64 receiving care and support services.

Figure 3 details the primary support reasons of those referrals relating to 18-64 year olds. The data shows that largest group is **Personal Care Support** (313 cases) followed by **Learning Disability Support** (257 cases). This would be in keeping as they are the largest area of where services are provided.

Case Outcomes (Concluded Investigations)

Figure 4 details the type of risk presenting from investigations. The data shows that 41% of investigations related to allegations of Neglect and Acts of Omission, 23% related to physical abuse, 14% related to psychological abuse, and 12% related to financial or material abuse.

Within the area of neglect and acts of omission presenting with the largest level of case outcomes would be consistent with an area like Stockport due to the high level of registered care homes and supported living services. A great deal of activity and resources are expended in dealing with this in both a proactive and reactive manner.

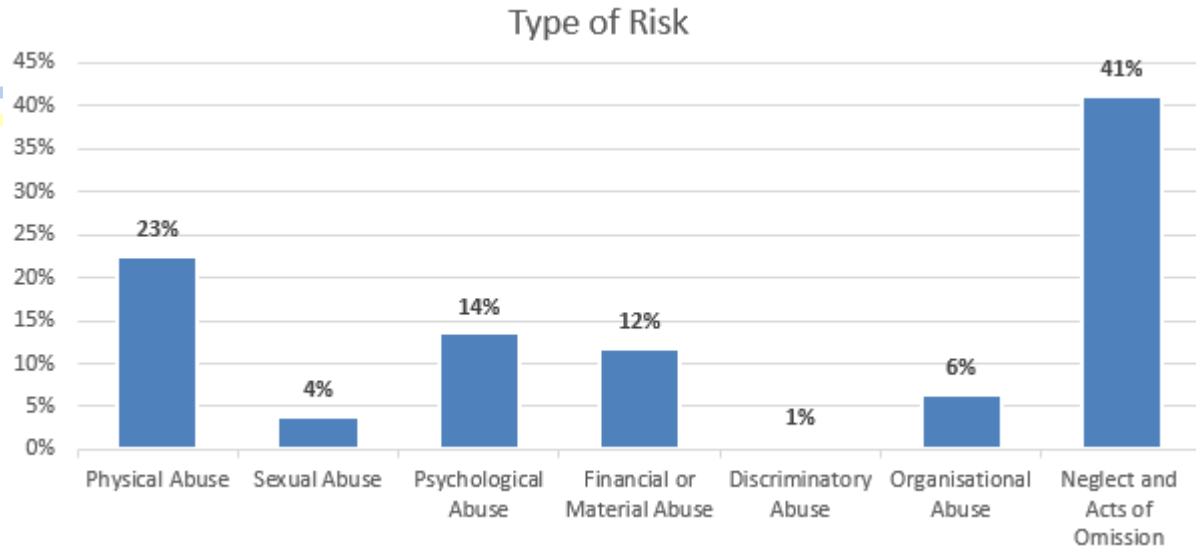


Figure 4 – Concluded Section 42 Enquiries by Type of Risk

Figure 5 details the conclusion of the investigation for section 42 enquiries. The data shows that in 44% of concluded cases, the allegation was substantiated, either fully where there is only a single category of abuse considered or in part where there is multiple categories identified and some are substantiated whilst others are not. A further 35% of allegations were not substantiated. In addition, 21% of allegations could not be determined due to a range of reasons including availability of information or witnesses for instance.

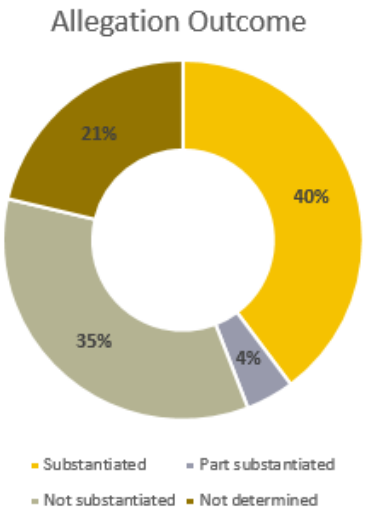


Figure 5 – Concluded Section 42 Enquiries by allegation outcome

Figure 6 – Concluded Section 42 Enquiries by type of Action Taken

Figure 6 details the action taken. The data shows that 39% of concluded cases required no action to be taken, 14% had action taken but the risk remained, 32% had action taken and the risk was reduced, and 15% had action taken and the risk had been removed. It is important to note that this is determined after a protection plan is devised with the individual, their family, carers and staff.

SECTION 6 – Stockport Safeguarding Adults members Report/Annual Statement 2015/16

Greater Manchester Fire and Rescue Service (GMFRS)

Key Areas for Consideration	
National and Local Developments	• Assimilation of key Care Act recommendations relating to Safeguarding, Transitions and Partnerships into GMFRS training, procedures and practice • Enhanced focus on "hoarding" with its inclusion in the definition of "self neglect" • Refresher training for Designated Safeguarding Officers (CSM/CSTL) under the "3 year" best practice guidance • Introduction of "Brigade wide" monitored Safeguarding E-learning package Introduction of "Safe and Well" visits to both build on the success of previous Home Safety Checks (HSC)
Developments for ensuring a Duty of Candour is embedded	Not specifically applicable at this stage but the principle underpins our community engagement and response interventions
Care Act 2014 – Compliance Update	• Development and implementation of a specific Hoarding policy to complement the inclusion of hoarding in the Care Act (Self Neglect) • Safeguarding E-learning package being reviewed in the light of Care Act implications
The Adult Safeguarding focus of your organisation throughout 2015/16	• Refresher training for Designated Safeguarding Officers (CSM/CSTL) • Increased effective and appropriate utilisation of bespoke "in house" Safeguarding referral
Progress made in relation Making Safeguarding Personal	• Embedding principles of Making Safeguarding Personal (MSP) – Care Act Compliance/Safeguarding focus
Organisational Achievements	• Implementation of "Brigade wide" monitored Safeguarding E-learning package with only a small number of staff yet to complete the package • Embedding a knowledge and understanding of safeguarding issues within the delivery of our Safe and Well interventions • Organisational recognition of the fundamental role of the DSO
Internal Governance Arrangements	• Reinforcement of the role and function of the GMFRS Safeguarding Policy Review Group • Weekly monitoring of the designated Borough based Safeguarding "mailbox" through which referrals are channelled to partner agencies (CSM/CSTL) • Monitoring of written records on our PAIROF (Persons at Increased Risk of fire) register (CSM/CSTL)
Key areas of challenge	• Ensuring Safeguarding remains a fundamental focus as we move into further change in terms of both resources and service delivery • Managing the capacity/demand dynamic given GMFRS now deal with more individuals with increasingly complex, challenging and chaotic lifestyles and needs Identify further opportunities to develop further "partnership" opportunities

Key Areas for Consideration	
National and Local Developments	• On-going appraisal of the restructured safeguarding roles within the organisation. • Continued delivery of the Trusts 3 year Safety Improvement Strategy group encompassing 4 patient safety domains. Lessons learned are disseminated through to various Trust sub committees, the local borough Clinical Business Units and internal governance structures. • This Safety Improvement Plan builds on the Trust's Quality Strategy to improve patient safety and experience. • A quarterly Integrated Strategic Safeguarding Group (ISSG) receives assurance reports from the Divisions which reviews the effectiveness of both safeguarding and governance controls within the organisation. • Agreed SMBC and PCFT Response protocol which ensures PCFT manage safeguarding concerns within the organisation.
Developments for ensuring a Duty of Candour is embedded	• Changes to the Trust incident reporting requirements have been implemented that directs staff to consider this process.
What actions we have taken since the publication of the Winterbourne Review	• Monthly MCA/DOLs and Mental Health Law sessions are delivered to qualified Mental Health staff across PCFT.
Care Act 2014 – Compliance Update	• Calendar agreed for the delivery of L2 Adult Safeguarding training for 2016. • Review of the Safeguarding Families Forum ensured Trust's Safeguarding priorities are embedded across a wider workforce.
The Adult Safeguarding focus of your organisation throughout 2015/16	• Delivery of L2 Adult Safeguarding and MCA/Dols training. • Development by PCFT Risk team of a safety intelligence board that critiques safeguarding incidents entered. • Implementation of a joint Safeguarding and Governance action learning set model for wards to cascade the learning from IR's , DHR's and SCR's. • Review of Clinical Supervision policy. • Completion of a new adult safeguarding referral form.. • Development of a Trust Adult safeguarding action plan. • Development of a Trust Safeguarding training strategy.
Progress made in relation Making Safeguarding Person	• MSP will form part of the case file audit process.
Organisational Achievements	• Revised adult safeguarding policy. • Development of a L2 Adult safeguarding training package. • Trust wide agreed PREVENT protocol written. • Channel Panel arrangements in place. • Development of a Safeguarding consultation form and Information poster for all service areas. • Completion of a Trust A6 Safeguarding Children, Adults and Families booklet disseminated to all staff. • Development of a safeguarding CQC E board • Development of a quarterly Safeguarding newsletter.
Internal Governance Arrangements	• Safeguarding Families Forum Group • Trust Integrated Strategic Safeguarding Group • SUI internal and external Safeguard reporting system • Patient Safety Investigation Group • Integrated Governance groups across all business units. • PCFT Trust Quality Group
Key areas of challenge	• On-going training on MCA/DOls, L2/L3 Safeguarding adults training. • The service transformation for Stockport community services.

Seashell Trust

Key Areas for Consideration	
National and Local Developments	The Trust continue to work with our nationally recognised bodies i.e. National Association of Special Schools (NASS) and The Association of National Specialist Colleges (Natspec) to continue its work in safeguarding children and young people. This enables the Trust to access up to date safeguarding training and information. Locally the Trust were a pilot organisation on the low level threshold reporting pilot (Andy Armstrong) this was very beneficial and has supported the Trust in the new system of harm level reporting now in place. The Trust is part of the NW Colleges who are currently working on the development of resources that will support and develop our students understanding of radicalisation and the support available through PREVENT.
Developments for ensuring a Duty of Candour is embedded	The Trust continue to work hard to continue to promote an environment that enables students, staff and visitors to express any concerns they may have. Access to information/contacts that enable all of these groups express any concerns is openly available and provided. Every concern is reviewed and responded to and any relevant action taken.
What actions we have taken since the publication of the Winterbourne Review	The Trust have reviewed the post Winterbourne Review/Bubb report and are currently including recommendations/lessons learnt within the Trusts Safeguarding Development Plan.
Care Act 2014 – Compliance Update	The Trust are aware of its requirements under the Care Act 2014 and are compliant. Recent CQC inspections confirm this position.
The Adult Safeguarding focus of your organisation throughout 2015/16	The Trust always has a high focus on safeguarding and over the last year have focussed on Radicalisation and put staff through a number of Prevent and Channel training programmes.
Progress made in relation Making Safeguarding Person	The Trust continue to deliver all education and support to students in a person centred way and are working with students to ensure that all individual assessments and support plans reflect the specific needs and support of the individual. All students have an individual education programme that also reflects the needs and situation of the individual and can be supported within the residential/home setting as well through the 24 hour curriculum.
Organisational Achievements	Good CQC/OFSTED inspections that reflect the good practice in use at the Trust. Dedicated internal team who work together to proactively manage safeguarding to enable preventative actions to be utilised. Active and aware workforce who report concerns.
Internal Governance Arrangements	Weekly DSOs meeting. Termly internal Safeguarding Board. Monthly reports to executive leadership team. Safeguarding report to Governing Body meetings. Regular CQC/OFSTED Inspections. IiP Silver Award. Trust representative on SSAB.
Key areas of challenge	Continue to train and embed all elements of safeguarding across the Trust. Developing resources and materials that are appropriate and effective for students. Developing a proactive safeguarding system. Supporting and advocating for young adults to support outcomes that are in their best interests – through their programmes at the Trust and also on transition from the Trust.

Stockport Homes

Key Areas for Consideration	
National and Local Developments	• Increase in older demographic and development of Stockport Homes Older Persons Strategy & Action Plan • Restructure of Adaptations and Older Persons Services - address the challenges of an ageing population and specifically older people living in the wider community who are isolated and vulnerable • Introduction of new Outreach function – ensure SHL services and resources for older people are delivered on a wider footing.
Care Act 2014 – Compliance Update	• SHL Safeguarding Children and Vulnerable Adults Policy, Procedure and processes in place and regularly reviewed to ensure accuracy and compliance with all relevant legislation • New training provider sourced and delivered specific Care Act briefings to relevant staff (further details below)
The Adult Safeguarding focus of your organisation throughout 2015/16	• Review and updating of SHL Safeguarding Children and Vulnerable Adults Policy, Procedure and processes currently underway • Delivery of new training programme with a bespoke offering according to role and responsibilities of staff(see below)
Progress made in relation Making Safeguarding Person	• Wide range of staff involved in Safeguarding activity throughout the organisation. • Senior Strategic and Operational lead of Safeguarding within SHL (Director of Corporate Services and the Head of Independent Living). • Identification and development of Safeguarding Champions within all areas of the business. • Delivery of a wide range of services which provide support to vulnerable adults including Temporary Accommodation, Housing Support, Employability Support, Positive Engagement Officers , Sheltered Scheme Managers and CareCall Mobile Wardens.
Organisational Achievements	• Recognition of and response to changing trends and demographics by adapting services to Adaptations and Older Persons Support Team • Introduction of Intense Support Service, completion of an annual programme of Winter Welfare Visits to older households focussing on keeping warm and well during winter period etc. • Delivery of a range of Preventative Services for vulnerable adults on behalf of SMBC as a provider within the Targeted Prevention Alliance.
Internal Governance Arrangements	• Internal Audit of Safeguarding (both Children and Adults) completed in December 2015. • The Audit report found that the processes and procedures were generally well controlled with areas of good practice. • Recommendation for improvement included: - Development of an electronic, SMART form for the raising of concerns (currently underway) - Spot Checks of the quality of referrals / concerns - Identification of and profile raising of Safeguarding Champions on the staff intranet (complete)
Key areas of challenge	• Increase in thresholds to access statutory support from ASC • Lack of support for vulnerable adults following loss or reduction in other services particularly Mental Health Services and support provided by the third sector • Information governance and ensuring information is shared between appropriate agencies in a timely manner • Need for feedback mechanisms from ASC to referring organisations when a case is escalated • Ensuring staff are equipped with the necessary skills, confidence and support to fulfil their Safeguarding responsibilities.

NHS Stockport Clinical Commissioning Group (SCCG)

Key Areas for Consideration	
National and Local Developments	• SCCG will attend regional meetings for Safeguarding Adults and the Dols North West Practitioner Forum SCCG • To continue to work with providers around raising the profile of Prevent, Mental Capacity and DoLS, FGM, CSE, Human Trafficking and Self Neglect. • The SCCG received some national funding to improve knowledge within Provider organisations. The CCG also gave SMBC £1000 to improve knowledge of MCA/DOLS in Care Homes and Domiciliary care.
Developments for ensuring a Duty of Candour is embedded	• Duty of Candour is part of the NHS Standard Contract. • The CCG ensures on any review of any serious incidents/ DVHR or MHR that this provider demonstrates compliance.
What actions we have taken since the publication of the Winterbourne Review	• The CCG has a lead commissioner that has been working to review all service users post Winterbourne View and place the services users closer to home if appropriate. This is monitored monthly. • The Safeguarding Lead is also part of the Greater Manchester Community Treatment Review Team.
Care Act 2014 – Compliance Update	• The CCG is monitoring all providers to ensure their policies and procedures are Care Act compliant and where providers are not, that there is a plan in place to ensure they are.
The Adult Safeguarding focus of your organisation throughout 2015/16	• To ensure robust systems are in place to learn lessons from cases where adults die or are seriously harmed and abuse or neglect is suspected. • NHS SSCG has ensured all Primary Care has been trained around Safeguarding, Mental Capacity and Deprivation of Liberty. • NHS SCCG has also worked with the Stockport Alliance for Positive Relationship and has particularly focused on where Adult Safeguarding fits in with the Domestic Violence Agenda.
Progress made in relation Making Safeguarding Person	• The SCCG has trained all appropriate staff. • Within any internal report this is the key focus.
Organisational Achievements	• Safeguarding Self-assessment tool and contract monitoring in place. • Ensured all NHS Stockport CCG staff were complaint with mandatory safeguarding training specific to their role. • Ensured robust systems were in place to learn lessons from cases where adults are seriously harmed or have died when and abuse or neglect is suspected. • Ensured all primary care providers received training in Safeguarding, Mental Capacity and Deprivation of Liberty Safeguards. • Worked with the Stockport Alliance for Positive Relationships and has particularly focused on where Adult Safeguarding supports the prevention of domestic violence agenda. • Been a health representative at 1 Mental Health Homicide and 3 Domestic Violence Homicides • Ensured that the CCG Governing Body have received updates on the homicides and the lessons learnt that were shared across all Healthcare providers • Been an active member of multiagency forums at national, regional and local levels.
Internal Governance Arrangements	• Up to date Job Descriptions which reflected current statutory changes • SCCG are externally responsible to NHS England.
Key areas of challenge	• Court of Protect cases where someone might be subject to deprivation of liberty within their own home. • Quality of Care within care homes. • Nurse revalidation within care homes. • Availability of care homes placements across the Stockport Economy

Key Areas for Consideration	
National and Local Developments	• Implementation of the revised Safeguarding Adults structure to include a Safeguarding practitioner, reporting to the Named Nurse for Adults, with the remit to focus on Mental Capacity Assessments (MCA) and Deprivation of Liberty (DOLs) • Establishment of key trainers to deliver Prevent training across all areas of the Trust • Continued focus on reducing avoidable harms with specific targeted action to reducing stage 3 and 4 avoidable pressure ulcers and avoidable falls leading to serious hard – built into Quality Improvement Strategy • Recruitment to a full time Dementia Matron
Developments for ensuring a Duty of Candour is embedded	• Trust has duty of candour policy, and standard operational procedure to support this in place which is monitored through the Risk and Customer services department
Care Act 2014 – Compliance Update	• Safeguarding Standing Operational Procedure and alert form amended to reflect Care Act amendments and cascaded to staff.
The Adult Safeguarding focus of your organisation throughout 2015/16	• Increasing compliance with MCA / DOLS/ Adult Safeguarding Training • Revised Governance structures to incorporate combined Named Nurses for adults and children's monthly operational meetings with the Director of Nursing and Midwifery and her Deputy, and quarterly assurance meetings with the Designated CCG named Nurses using the Section 11 provider standards • To improve sharing and learning from incidents across the organisation – a revised quarterly strategic safeguarding committee established with attendees from all business groups.
Progress made in relation Making Safeguarding Person	• Making Safeguarding Personal is now reflected in the Adult Safeguarding alert forms to prompt staff to ask the person what outcome they would like from an alert being raised. This is audited after the safeguarding process by Stockport SMBC.
Organisational Achievements	• Excellent compliance with training and increased numbers of alerts indicate improved staff awareness. • The Greater Manchester Quality target for Learning Disability continued into 2015/16. The Trust achieved compliance in all areas of the indicators. Going forward into 2016/17 there will be a key performance indicator related to Learning Disability and completion of Reasonable Adjustment Care Plans. There is also a requirement that the Trust will be engaged in the Learning Disabilities Mortality Review Programme managed by the University of Bristol as part of the National Clinical Audit and Patient Outcome Programme. This has not yet been rolled in the Stockport area. • Safeguarding governance process reviewed and amended to incorporate; monthly combined operational meetings with Named Nurses, Director of Nursing and Midwifery and Deputy Director of Nursing and Midwifery. • Quarterly assurance meetings with CCG Designated Named Nurse • Quarterly Strategic Safeguarding meeting – involves all business groups with the aim of sharing learning across the organisation.

Key areas of challenge	• To continue to develop revised models of care under the 'Stockport Together' vanguard programme and ensure consistent Safeguarding procedures and governance is agreed and embedded across the organisations involved.

Stockport Metropolitan Borough Council

Key Areas for Consideration	
National and Local Developments	• In line with the Care Act and national developments further work has been undertaken in respect of vulnerable adults. Specifically a better understanding of the implications of self-neglect and the completion of the young adults transitions project.
Developments for ensuring a Duty of Candour is embedded	• The re-formation of the Quality and Concerns Action group has begun the process for wider information sharing across partner agencies and the public. This is to ensure that we have a mechanism in place that will make clear the expectations that the outcomes of investigations are communicated.
Care Act 2014 – Compliance Update	• The Multi-agency safeguarding and harm levels policy/procedures has been updated in line with the Care Act requirements.
Progress made in relation Making Safeguarding Person	• Our procedures under the multi-agency policy has now included the use of a two part case conference that includes engagement with victims and their families to agree the outcomes and desired resolution of investigations. This aims to ensure that as much information and transparency is present for individuals and their families.
Organisational Achievements	• Formation of an integrated Quality Assurance and Safeguarding Team. • All staff have received care act briefings with emphasis on safeguarding. • Continued roll out of the harm level policy and procedures. • Revision of multi-agency policy and procedures. • Increased numbers of best interest assessors. • Appointment of an Independent Chair of the Board. • Increased capacity in the service has allowed for improved vigilance on cases that are eligible for the Court of Protection. This has in turn led to more cases going forward for consideration. • External training has increased the numbers of DOLs signatories.
Key areas of challenge	• Capacity and quality within the commissioned care market. • Meeting increased demand and expectation within the continued climate of financial constraint. • Financial pressure from increased DOLs compliance and court of protection cases. • The need to understand the new categories of abuse and potential for increased demand but a lack of capacity and expertise to manage complex and chaotic individuals.

Greater Manchester Police (GMP)

Key Areas for Consideration	
National and Local Developments	• Specialist team running a pilot with CQC to improve information sharing ensuring all potential victims are identified and receive the right support. • Pilot centres on a dual investigation process and has filled gaps to provide a more comprehensive investigative strategy is applied.
Developments for ensuring a Duty of Candour is embedded	• Stockport Borough was chosen for a Domestic Abuse pilot whereby Frontline Officers were coached in enhanced communication, increasing their ability to deal with victims of abuse. • Coaching provides the officers with far greater understanding of the impact of Domestic Abuse on victims and their families • Allows a more informed assessment of the risks to individuals
Care Act 2014 – Compliance Update	• All Frontline staff have received training to enhance their awareness around Self neglect. • Force action plan reflects The Voice of the Adult. • Increased crime reporting/recording access to all. • Increased awareness around Disability Hate crime.
The Adult Safeguarding focus of your organisation throughout 2015/16	• Continue to improve our services around protecting and safeguarding the most vulnerable members of our communities.
Progress made in relation Making Safeguarding Person	• Domestic Abuse pilot proven hugely successful within the Borough is being rolled out across the rest of Greater Manchester. • Closer working with the CQC is proving very successful at providing a dual investigative process ensuring that vulnerable people are provided with the correct referrals and support. • Continued emphasis on Strive to increase early intervention opportunities.
Organisational Achievements	• Established Vulnerable Adults Working Group to improve internal practises and communication. • Strategic Lead change to increase Force profile and drive governance around Adults at risk
Internal Governance Arrangements	• Vulnerability forms a core pillar of the Borough Strategic plan. • Reinforced at monthly Tasking and Co-ordination Group calling Local Policing teams to account for their performance within this and other areas of policing. • Focus is driven down to a daily briefing ensuring it remains at the forefront of local policing.
Key areas of challenge	• Maintain the focus of vulnerability alongside competing priorities through both the Local Policing Review and restructure as well as the Public Sector Review.

Stockport Safeguarding Adults Attendance Record 2015/16

SSAB partners commit to ensuring that the Board is supported by dedicated resources that consists of a number of multi agencies that attend the board on a quarterly basis throughout the year. The attendance record is provided to give a breakdown of representatives from each agency as well as attendance.

Organisation	09th July 2015	10th Sept 2015	14th Jan 2016	10th March 2016	Total Meetings Attended
Independent Chair	✓	✓	Left SAB	Left SAB	2/4
Independent Chair				Joined SAB	1/4
Adult Social Care Director	✓	✓	Left SAB	Left SAB	2/4
Adult Social Care Head of Service Contracts & Market Management	✓	✓	✓	✓	4/4
Adult Social Care Head of Service OPS/LD	✓	✓	Left SAB	Left SAB	2/4
Adult Social Care Safeguarding Adults & Mental Capacity Act Service Manager	✓	✓	✓	✓	4/4
Adult Social Care Staff Dev Manager	✓	✓	X	X	2/4
Greater Manchester Police Force(GMP)	✓	✓	✓	✓	4/4
Greater Manchester Fire Service	✓	✓	X	X	2/4
Stockport NHS Foundation Trust	✓	✓	✓	✓	4/4
Public Health (SMBC)	✓	X	✓	X	2/4
Safeguarding Adults NHS Stockport CCG	✓	X	✓	✓	3/4
Pennine Care	✓	✓	✓	✓	4/4
Independent Care Representative – Domiciliary Care	X	✓	✓	X	2/4
Independent Options –Residential Independent Provider Rep Learning Disability Providers.	✓	✓	✓	X	3/4
Healthwatch	✓	✓	✓	✓	4/4
Bluebird Care	✓	X	✓	✓	3/4
Stockport Homes	✓	✓	✓	✓	4/4
Cheshire & Greater Manchester Probation	✓	X	✓	X	2/4
Seashell Trust	X	X	✓	✓	2/4

The Board support activity and its costs which are largely underwritten by Stockport Metropolitan Borough Council Adult Social Care.

It has been acknowledged a more robust funding and resource structure is needed to enable the Board to fully perform its functions.

The SSAB continued throughout the year to address funding needs with non-contributing partners. This included confirming the commitment of each partner as per the business case.

There have been planning meetings which have considered how the SSAB will commit resources in the future and the Board has been updated at each meeting.

In terms of funding partners the table below demonstrates the Board's current investors:

Board Members/Resources	Financial Contributions 2015-16
Stockport Clinical Commissioning group	£8,000
Stockport Metropolitan Borough Council	£26,068
TOTAL	£34,068

SSAB Priorities for 2016/17

Stockport's vision is that all adults living in Stockport are able to exercise their right to live in safety, free from abuse or neglect.

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

The Board has set out its key priorities for the forthcoming year and they will be supported by a detailed action plan.

The SSAB main priorities for 2016/17 are:

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

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

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

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

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

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

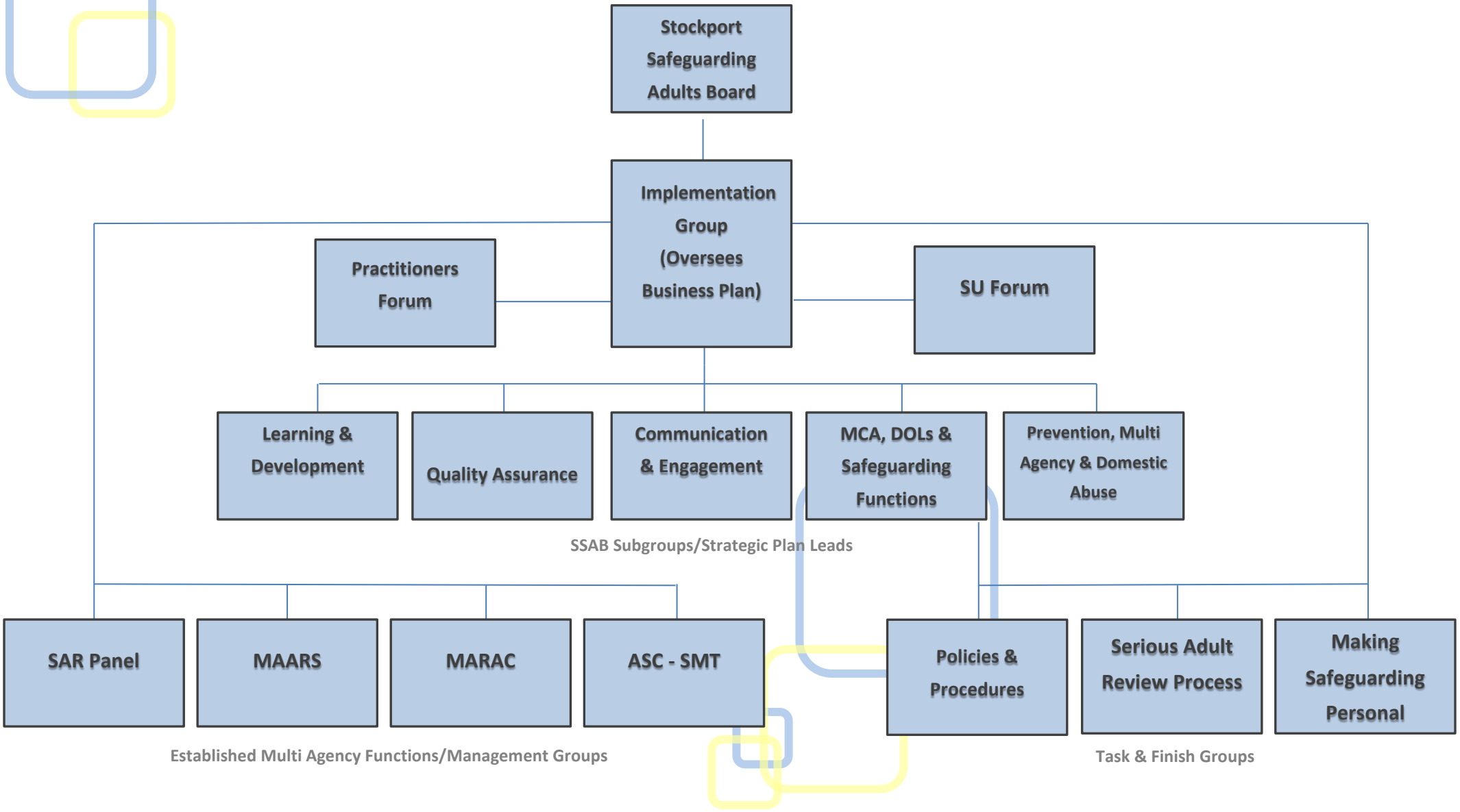
To monitor the impact of budget cuts on outcomes for adults with care and support needs and obtain assurance that effective action has been taken to mitigate risks.

Governance Assurance

The Board is supported by a number of Sub Groups that will have members from representative partners who will be responsible for ensuring progress against each of the action plans and will periodically report on progress to the Board.

The table will demonstrate the architecture of governance for 2016/17 and each group will feed up to the board on their developments, actions and priorities throughout the year.

Governance Architecture 2016/17



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تتوافر لدينا خدمة مثيرة للاهتمام فاذا كنت في حاجة لفهم هذه المعلومات باللغة العربية يرجى الاتصال بوحدة الترجمة في ستوكبورت على الرقم التالي:01614779000أو على البريد الألكتروني:Eds.admin@stockport.gov.uk

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اگر در مورد این اطلاعات احتیاج به کمک داشتید خدمات مترجمی رایگان موجود است لطفا با سازمان مترجمی استاکپورت با شماره تلفن و یا ایمیل آدرس زیر تماس بگیرید.01614779000eds.admin@stockport.gov.uk

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