Safeguarding Adults in Stockport

Annual Report 2019/2020



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Independent Chair's Introduction

I am pleased to present the 2019-20 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 keep adults at risk safe.
We hope that you will find that the report helps you to better understand how organisations and people work together and the contribution the Safeguarding Board has made to this. It sets out how these arrangements can continue to improve on the basis of the Safeguarding Board and partners being able to objectively and critically learn from what works well and act to improve what may not work as well as was intended.



The Annual Report outlines the activities and achievements of the Board and its partners over the last year and how well we have delivered on our priorities and actions in the Business Plan. It is our account to the community of the work we have done to safeguard and enhance the wellbeing of adults with care and support needs.

2019 -2020 was the final year of our 3 year strategic plan and pages 15 – 20 set out our achievements in relation to:

- Transitions;
- Neglect;
- Domestic Abuse;
- Complex Safeguarding.

Our vision is 'working in partnership to support and safeguard the people of Stockport to enable them to live safe, healthy and, where possible, independent lives'.

Independent Chair's Introduction (cont.)

In January 2020 we held our joint development day with colleagues from the Safeguarding Childrens Partnership; and extended the invitation to other key safeguarding leads – with approximately 40 people attended and all relevant agencies represented. At this event we took the opportunity to determine our Strategic Plan and priorities for the next 3 years are:

- To improve frontline practice.
- Receive assurance that Safeguarding arrangements are embedded in all agencies commissioning strategies and service specifications.
- Keep the focus on our most vulnerable children and adults.
- Effectively engage with our frontline Practitioners, Service Users, families and/or their representatives.

For 2020 – 21 we have agreed 5 thematic areas to focus on; these are based on learning from national and local safeguarding reviews; new/emerging national issues; feedback from front line practitioners at the Safeguarding Conference, pages 40/41 set out more detail of the plan.

At this session we also took the opportunity to reflect on the effectiveness of the partnership and what we need to do to improve. We considered 3 areas:

- How we learnt from case reviews – areas of strength were identified as Programme of Learning; 7 Minute Briefings. What we need to do more of measuring the impact of the learning through multi agency auditing and undertake a thematic review of learning.
- Our quality assurance processes – areas of strength included QA Process & Datasets (Dashboards); Multi-Agency sharing; Multi-Agency Audits; Quality Assurance Partnership. What we need to do more of – the assurance dataset needs to include data from the wider partnership with more focus on outcome – always asking ourselves the so what question.
- How well we engaged with the wider partnership – areas of strength included Website; Safeguarding Networks; Workshops; Learning Circles; dedicated Training Officer; Sub Groups; Development Days; quarterly newsletters. What we need to do more of – partner agency ensuring that the work of the Safeguarding Adults Board is cascaded within their organisation; improve our engagement with the voluntary sector; determine our model for the 'learning hub approach'; and undertake front line conversations.

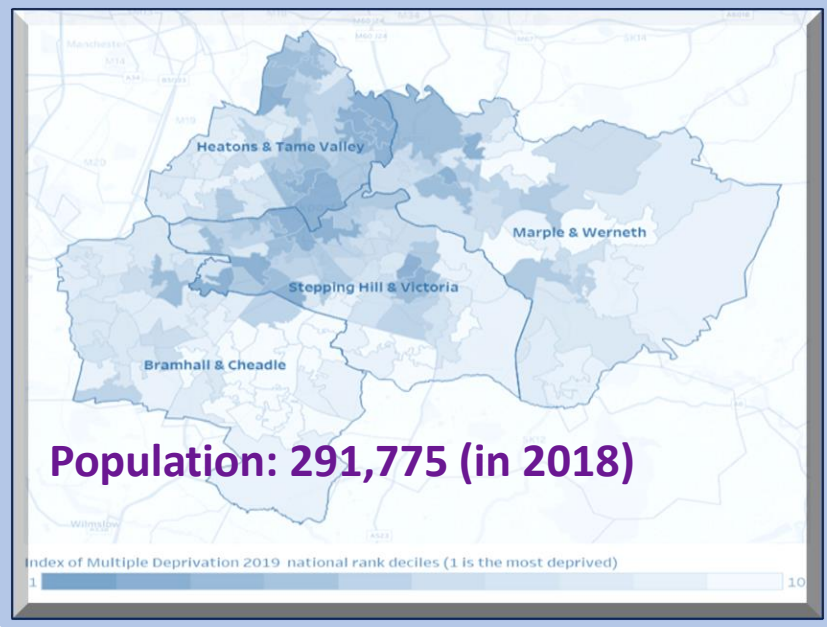
Independent Chair's Introduction (cont.)

The Liberty Protection Safeguards (LPS) are the legislative framework for authorising a deprivation of liberty and should come into force in October 2020. They will replace the current process which is called the Deprivation of Liberty Safeguards through the Mental Capacity (Amendment) Act 2019 which received royal assent on 16 May 2019. The change in legislation will be a challenge going forward; however, during 2020 -21 as a Safeguarding Partnership we will ensure that training, practice guidance and appropriate roles are in place to effect a safe transition to the new arrangements.

As this reporting year came to an end, day to day business of the Partnership had become affected by the impact of the Coronavirus pandemic. The UK Government imposed lockdown restrictions on the evening of Monday 23rd March 2020 and key partners were expected to respond to the crisis prompt. Our initial response to the pandemic is set out on page 22 of the report. We saw excellent engagement from our partners in virtual weekly covid safeguarding meetings that enabled us to oversee that the safeguarding response was co-ordinated. I have to say a big thanks to all our front line workers for their excellent response during such unprecedented times. We will look at the learning from our response and build the positive learning into our structures for the future.

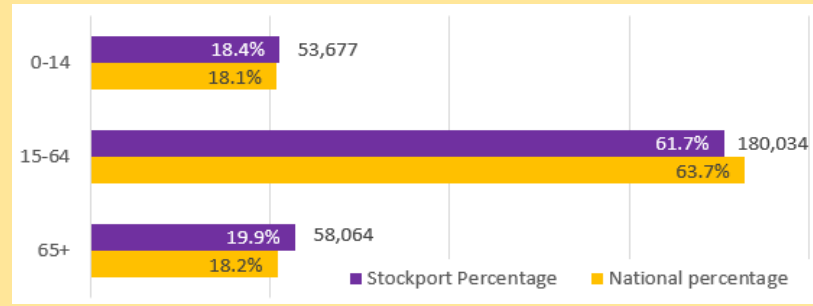
The pace and scale of the work of the SSAB continues due to the commitment of the partner agencies who consistently drive for improvements in the quality of services which safeguard and promote the welfare of vulnerable adults. Without them the pulling together of this annual report and all that we have, 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.

Stockport Demographics



Population: 291,775 (in 2018)

AGE



DIVERSITY

Stockport is less diverse than the National Average, with most identifying as White British – but this is changing.

HEALTH

44% of the GP registered population have a long-term health condition.
22% of life of the average person will be spent in ill-health.
There is an ageing population with increasing complex needs.

POVERTY

Small areas rank within the 2% most and 2% least deprived in the UK. 38% of the population live in areas of higher than average deprivation. The 65+ group is more represented in less deprived areas.

LIFE EXPECTANCY

Males are expected to live to 79.9 years and females to 83.3 years, rates similar to the national average.

EFFECTS

The increase in the dependency ratio increases the burden on expenditure and services. People who live on their own are at higher risk of social isolation.

GROWTH

The 65+ group has grown by 18% in the last 10 years.
38,535 people live in one person households, 21,657 of whom are aged 65+.

Welcome to Stockport Safeguarding Adults Board Annual Report 2019-2020

Welcome to Stockport Safeguarding Adults Boards (SSAB) Annual Report for 2019-2020.
The law says that we must publish a report every year to say what we have done to achieve our main goals and how our members have supported us to do this.
So this report says who we are and what we did between April 2019 and March 2020.

What is Stockport's Safeguarding Adults Board?

Stockport Safeguarding Adults Board (SSAB) is a statutory partnership between the Council, Police, NHS and other organisations that work with adults with care and support needs in our borough.

The job of the Board is to make sure that there are arrangements in Stockport that work well to help protect adults with care and support needs from abuse or neglect.

The Board is led by an Independent Chair (Gill Frame) appointed by the local authority. She reports to the Director of Adult Social Care and the Cabinet Member for Health and Social Care, in Stockport Council.

What does Safeguarding Adults mean?

Safeguarding Adults means stopping or preventing abuse or neglect of adults with care and support needs.

Adults with care and support needs are age 18 and over and may:

- have a learning disability;
- have a mental health need or dementia disorder;
- have a long or short-term illness;
- have an addiction to a substance or alcohol; and/or
- are elderly or frail due to ill health, disability or a mental health illness.

Vision, Aims and Values

Our vision is 'working in partnership to support and safeguard the people of Stockport to enable them to live safe, healthy and, where possible, independent lives'.

Our values that underpin the vision

- Be excellent
- Be of service and accountable
- Be honest and open
- Learn from experience
- Respect and value everyone
- Be kind and work together

Aims of the Safeguarding Board

The Safeguarding Adults Board has extended the definition of safeguarding to include prevention and promotion of welfare and has a remit to promote the safety and welfare of all adults at risk in Stockport, in addition to continuing to lead in the well-established area of protection for those who are vulnerable. The aims to:

- To develop and agree local policies and procedures for inter-agency work to protect adults at risk;
- To audit and evaluate how well local services work together to protect young people, and adults at risk;
- To put in place objectives and performance indicators;
- To encourage effective working relationships between services and professional groups, based on trust and mutual understanding;
- To ensure agreement across agencies about operational definitions and thresholds;
- To improve local ways of working based on knowledge from national and local experience and research, and to ensure lessons learned are acted upon;
- To undertake safeguarding adult reviews where an adult has died or in certain circumstances has been seriously harmed;
- To help improve the quality of safeguarding practice through inter-agency training and development;
- To raise awareness within the wider community of the need to safeguard adults at risk and promote their welfare.

Values – How we work together



Stockport's Safeguarding Adults Board (SSAB)

The full SSAB is made up of 14 partners (representatives listed on next page), working with adults at risk across Stockport and at times invite guest speakers and additional attendees as relevant matters arise. SSAB provides scrutiny and challenge as to how well the partnership in Stockport works together to support adults at risk.

SSAB meet quarterly and have the following statutory responsibilities under the Care Act 2014:

1. Ensure Statutory Partners are appropriately represented on the SAB.
2. Develop and produce a 3 year Strategy and an annual Business Plan in order to direct the work of the Board that reflects priorities.
3. Publish a SAB annual report/accountability statement highlighting the Board's progress and achievements in meeting stated objectives in the Strategic Safeguarding Plan and ensuring this is widely reported across partner agencies and organisations. All SSAB Annual Reports can be found **here.**
4. Learn from the experiences of individuals, through undertaking Safeguarding Adult Reviews (SARs) in accordance with the national guidance of best practice and the Board's SAR protocol. The SSAB SAR Protocol can be found **here.**

SSAB Partners

Agency	Representative
Stockport Adult Social Care	• Director of Operations Adult Social Care • Principal Social Worker Head of Safeguarding Quality and Workforce • Head of Safeguarding and Learning • Service Manager, Workforce Development
Greater Manchester Police	• Superintendent, District Commander • Detective Superintendent
Stockport Clinical Commissioning Group	• Executive Nurse • Designated Nurse for Adult Safeguarding
Stockport NHS Foundation Trust	• Deputy Director of Nursing and Midwifery
Age UK Stockport	• Senior Lead
Cheshire and Greater Manchester Probation (CRC)	• Interchange Manager
Elected Member	• Cabinet Member
Greater Manchester Fire & Rescue Service	• Community Safety Manager
National Probation Service	• Head of Probation
Pennine Care Foundation Trust	• Deputy Managing Director Mental Health and Learning Disability • Head of Safeguarding
Seashell Trust	• Voluntary/3rd Sector
Stockport Healthwatch	• Representative
Stockport Public Health	• Lead for Substance Misuse & Public Health Representative
Stockport Metropolitan Borough Council - Strategic Housing	• Strategic Head of Place Management • Strategic Housing Lead

Funding Arrangements for SSAB

Staffing Costs: £89,880

Annual Conference &Publicity: £5,000

Safeguarding Adult Reviews: £10,000

Quality Assurance: £17,000

Total Expenditure: £121,880

Contribution from Local Authority: £70,000

Contributions from Partner Agencies:
Greater Manchester Police £13,400
Stockport CCG £38,000
Carried Forward from 2018-19 £3,102
Total Income £124,502

Funding of Stockport Safeguarding Adults Board is received both in monetary terms and in kind. It is acknowledged that every organisation faces financial challenges each year; therefore it is with appreciation that partner members give their time and resources to support the functioning of the board.

The following table sets out the expenditure and income for 2019-20.

We had £121,400 to spend. This money represents the contributions from Greater Manchester Police (GMP), Stockport Council, and contributions from Stockport Clinical Commissioning Group (CCG).

This was enough money to pay for what we planned to do, and for us to keep some saved up in case we needed to carry out any Safeguarding adult reviews (SARs). The Board kept a close watch over how money was being spent.

Learning and Development - Adults Safeguarding

Stockport provides a range of safeguarding adults training for staff at all levels. It ranges from basic awareness raising training to training for managers of staff undertaking investigations.

Bespoke training is provided on topics including domestic abuse, self-neglect and hoarding, human trafficking and female genital mutilation.

Partner agencies also provide a range of training for their staff. Safeguarding adult's basic awareness e-learning is a web-based training portal and is available to all Stockport staff and those working in the private and independent sectors, carers and volunteers working with adults. Training is provided free of cost to the recipient.

In late October 2019, to coincide with National Safeguarding month, the joint safeguarding annual conference was held at Stockport Town Hall. Almost 200 people from different staff members from multi-disciplinary frontline health and care attended the event with the aim of raising awareness, sharing best practices and exchanging ideas around various different safeguarding topics.

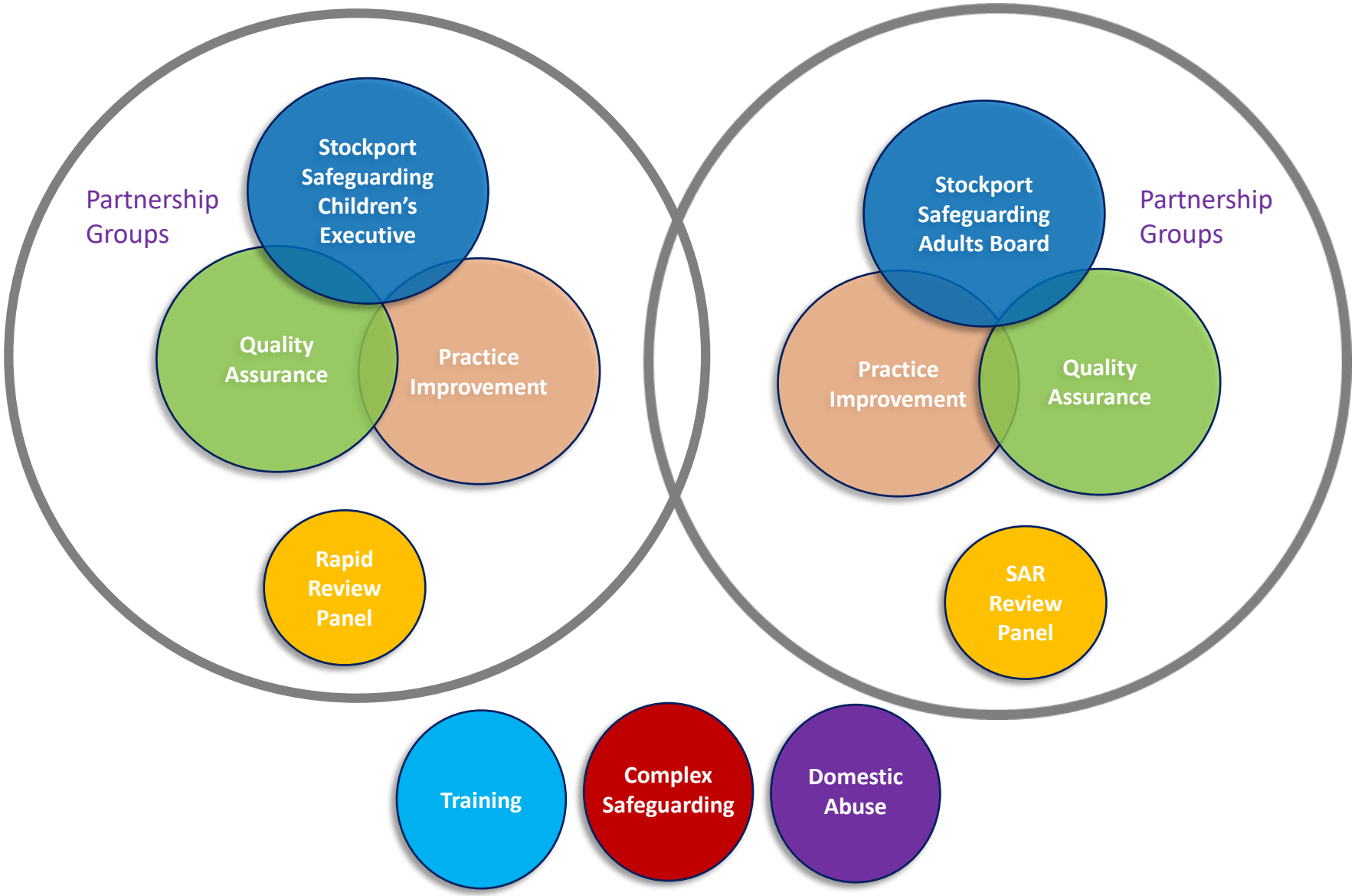
The main focus of the event was Liberty Protection Safeguards, Hate Crime, Self-Neglect and Hoarding followed with a theatre-based company presenting real life scenarios on the impact of young carers and families living with dementia.

Participants found the event useful, with lots of new contacts created and ideas shared.

Delegates also took part in an interactive survey that helped to inform the priorities for our Joint Safeguarding Strategy of 2020-23.

Each priority was built into the new 2020-23 strategic business plan relating to the six principles of safeguarding.

Governance


Partnership Groups
Stockport Safeguarding Children's Executive
Quality Assurance
Practice Improvement
Rapid Review Panel
Partnership Groups
Stockport Safeguarding Adults Board
Practice Improvement
Quality Assurance
SAR Review Panel
Training
Complex Safeguarding
Domestic Abuse
Joint Work Groups

Sub Groups

Practice Improvement Partnership

Chaired by the Deputy Director of Nursing and Midwifery, Stockport NHS Foundation Trust

The work of this subgroup is underpinned by a Learning and Improvement Framework, to build on the experience, knowledge and skills that staff require for working with service users and families. It also oversees Safeguarding Adult Reviews (SARs), identifying best practice; learning from inspections, and research to continuously improve the quality of services and outcomes for adults at risk.

Quality Assurance Partnership

Chaired by the Designated Nurse for Safeguarding Adults CCG

Receives and analyses performance data from agencies in relation to the safeguarding agenda. It monitors progress on LSAB priorities and ensures a programme is in place to audit and evaluate multi- agency safeguarding practice.

Domestic Abuse Steering Group

Chaired by Detective Chief Inspector for the Stockport Borough, Greater Manchester Police

Develops and drives the strategic approach to tackle Domestic Violence and Abuse across Stockport for children, adults and families. Partners work together to deliver on the strategy action plan and identify needs in relation to services and approaches to tackle Domestic Violence and Abuse.

Complex Safeguarding

Co Chaired by the Practice Leader, Stockport Family and the Principle Social Worker, Adult Services. Stockport Council

Develops, implements and monitors the SSAB Complex Safeguarding Strategy and Action Plan to ensure there is a co-ordinated multi-agency response to Sexual Exploitation, Missing Adults, Modern Day Slavery/Trafficking, Female Genital Mutilation, and Honour Based Violence/Forced Marriage.

Training and Workforce Development

Chaired by the Service Manager for People and Organisational Development, Stockport Council

Responsible for ensuring that high-quality, up to date, effective, all age focused and all age multi-agency training is provided alongside single-agency safeguarding training.

SAR Review Panel

Chaired by the Head of Service, Safeguarding and Learning, Stockport Council

Considers serious safeguarding incidents and the potential for multi-agency learning through statutory Safeguarding Adult Reviews (SARs) or other non-statutory processes such as Multi-Agency Learning Reviews (MALRs).

The Strategic Plan (2017-2020)

The vision of the SSAB is translated into action through the three-year Strategic Plan and this is underpinned by a more detailed Business Plan which is reviewed and refreshed annually. The current Strategic Plan (2017-20) is based on four priorities:

- Transitions
- Neglect
- Domestic Abuse
- Complex Safeguarding



The following slides will demonstrate the progress against the strategic plan 2017-2020 at the end of the 3-year delivery.

Achievements by the Safeguarding Adults Board & Partners

Transitions

We said we would

1. We said we would develop our approach for vulnerable children who do not meet the threshold for Adult Social Care needs.
2. We said we would develop material on transitions for the websites in a variety of formats and embed learning into place-based practice.
3. We said we would review and implement the policy for Missing Adults from Hospitals, and look at new ways to engage with the wider community.

What we have done

1. New transition social workers have been employed in adult social care and planning now starts at 15 years of age. The Multi-Agency Adults at Risk Panel has been refreshed and supports cases where vulnerable young people present chaotic lifestyles and are not eligible for adult social care support by developing a multi agency plan.
2. Delivered learning circles for both children and adult services to develop a better understanding of SEND and transitions in relation to Social Care responsibilities.
3. Produced Information and guides to young peoples parents, carers and professionals on preparing for adulthood and transitions.
4. Developed one overarching safeguarding website for both children's and adult's safeguarding boards where information on transitions can be obtained.
5. A Missing Persons policy was produced for staff to follow if a person goes missing from Hospital and weekly meetings take place with both GMP and Hospital safeguarding team to ensure incidents are dealt with effectively.

Most of the work of the Board is allocated to and completed through the multi-agency sub groups. In 2020-21, we will progress work identified within the joint strategic plan 2020-23

Achievements by the Safeguarding Adults Board & Partners

Self Neglect

We said we would

1. We said we would test and apply the Quality Assurance Framework (QAF) that was introduced last year and audit a number of cases of self-neglect.
2. Increase awareness of self neglect and develop material and resources for the websites in a variety of different formats.
3. Develop mechanisms to ensure that data on self-neglect is scrutinised.
4. Continue to promote local and national campaigns and work collaboratively with partners to ensure public engagement and awareness raising continues.

What we have done

1. Stockport Safeguarding Adults Board arranged a conference in October 2019, with a focus on Self-Neglect and Professional Curiosity.
2. We relaunched Stockport's self-neglect and hoarding policy via SAB website, safeguarding newsletter, briefing papers and training sessions.
3. We commissioned a Multi-Agency Self-Neglect and Hoarding training programme that reached out to 155 participants (91 council, 52 NHS, 5 Stockport Homes, 7 Other agency)
4. We conducted a multi-agency audit to review a number of cases that involved adults at risk from self-neglect, including hoarding. Recommendations were taken away from the audit day and action plans are currently underway with key partners. To see what we learned please refer to slide 19.
5. Since the implementation of Liquid Logic in April 2020 Self-Neglect data should become more accessible in the future for us to establish baseline data.
6. Both children and adults safeguarding websites have been refreshed to create an interface between both partnerships, and enable seamless accessibility for our audience.

In 2020-21, we will ensure the all-age strategy is consistently applied within the Partnership and we will develop mechanisms to ensure that data on self-neglect is scrutinised.

Achievements by the Safeguarding Adults Board & Partners

	We said we would	What we have done
Domestic Violence and Abuse	1. We said we would continue to promote local and national campaigns and work collaboratively with partners to ensure public engagement and awareness raising continues. 2. We said we would have clear pathways for services to access and ensure a domestic abuse training programme in line with the Domestic Abuse and Violence Strategy was rolled out.	1. We have strengthened representation from Children and Adults Services at MARAC meetings led by the police. 2. A daily risk meeting for domestic abuse is now held in the Multi-Agency Support and Safeguard Hub. 3. A complete pathway to services was undertaken and updated pathways now available for all professionals. 4. We have created a network of Domestic Abuse champions and train the trainer sessions are soon to take place. 5. An all-age Domestic Abuse Training Programme is now available to the wider workforce, with an aim to extend wider to colleagues at the police. 6. Created Social Media Campaigns throughout the year to continue to increase awareness. 7. Commissioned external training to deliver on the Psychology of Victimisation for all police officers and GPs in Stockport.

In 2020-21 we want to address awareness raising in BAME communities and agree to collect a robust dataset to measure impact on the good work taking place.

Achievements by the Safeguarding Adults Board & Partners

Complex Safeguarding

We said we would

1. We said we would continue to progress the Criminal Exploitation and Serious Organised Crime strategy.
2. Monitor the progress and implementation of the Modern Slavery and Trafficking, Radicalisation and Extremism/Prevent strategy.
3. Launch the Honour Based Abuse and Forced Marriage strategy.
4. Finalise the Female Genital Mutilation strategy and its work plan.
5. Develop a complex safeguarding dataset that will link into the GM complex safeguarding steering group.

What we have done

1. We developed and endorsed a Complex Safeguarding Strategy jointly between children and adult services.
2. Comprehensive training programme was delivered on:
   a, Female Genital Mutilation (FGM)
   b, Honour Based Violence (HBV) & Forced Marriage
   c, Modern Slavery & Human Trafficking
3. Alongside the training programme a well received complex safeguarding conference was held in March 2019 with a total of 175 attendees.
4. We incorporated Honour Based Violence into the new all-age basic safeguarding awareness course to ensure this was featured within basic awareness training.
5. A learning event took place to introduce 7 minute briefings and launched the Honour Based Violence strategy with frontline workers.
6. Developed one overarching safeguarding website for both children's and adult's safeguarding boards.
7. Carried out a detailed programme of public awareness-raising throughout 2019-20.

Next Steps are to complete both the Female genital mutilation strategy and to finalise the Child exploitation strategy and action plan. A further priority is to ensure that the SAB has oversight in adult services response to complex safeguarding risks, exploitation and abuse.

Achievements by the Safeguarding Adults Board & Partners

	We said we would do	What we have done
Progress against Strategic Business Plan	1. We said we would continue to seek assurance from each other and the community that the services we provide and the approach we take, works well to keep adults at risk safe.	1. We have reviewed the safeguarding responsibilities and arrangements in line with the new Stockport Safeguarding Children Partnership (SSCP). 2. Continued to monitor the new developments of the Mental Capacity Amendment Bill 2019, and identified the implementation of the new Liberty Protection Safeguards (LPS) as a key priority. 3. Gathered evidence and monitored partners' progress against the recommendations made from the Adult Peer Review with Oldham in 2018. 4. SAB performance dashboard has been strengthened and extended to include data from other statutory partners. 5. Harm levels data continues to be collected and monitored with greater engagement from providers. 6. We have produced and audit programme in line with SSCP that has a clear focus on outcomes. 7. We continue to produce and circulate our safeguarding newsletter four times a year.

In April 2020, the new shared strategic plan 2020-23 was developed with a set of new strategic priorities. The partnership decided to agree that any unmet actions from 2019-20, relevant to the new strategic plan 2020-23 were to be carried over for completion.

Self Neglect Audit

We conducted a multi-agency audit to review a number of cases that involved adults at risk from self-neglect, including hoarding.

The audit's aims were to examine Stockport's current position and awareness of self-neglect and its referral pathway.

Learning Points	What we have done
More consideration was to be given to understand the rationale as to why an individual missed an appointment and their reasons should be recorded	We relaunched the Multi-Agency self-neglect policy and guidance and increased training sessions to deliver 6 full day training sessions on self neglect, hoarding and MCA, this included accuracy of record keeping and legal literacy.
The implementation of the Local authority's new Information system (Liquid Logic) would improve better information sharing with external agencies for both children and adult services.	Liquid Logic was implemented at the end of this financial year. Since the implementation took place, access to both children and adult systems are permitted.
There was a lack of professional challenge in some cases.	Partners were actioned to support Professional Challenge, to include the theme within their safeguarding training, and to develop the application of Escalation Policies within and across agencies. SSAB developed a Multi Agency Escalation Policy to the workforce within and across agencies.
A think family approach was not being undertaken by all agencies. Further work needed to be done to ensure the Think Family approach is embedded throughout all services.	Think Family is being embedded within our training programme and the offer is extended across children/adult workforce. Online version also developed and the think family approach was reinforced in our annual Safeguarding conference with a joint adult and child focus.

Response to Covid-19

As the financial year came to an end, day to day business of the Partnership had become affected by the impact of the Coronavirus pandemic. The UK Government imposed lockdown restrictions on the evening of Monday 23rd March 2020 and key partners were expected to respond to the crisis prompt.

The recent introduction of the Care Act Easements, due to Covid-19, had not changed statutory duties in relation to adult safeguarding. Stockport Safeguarding Adults Board continued to offer the same level of safeguarding in line with the Coronavirus Act 2020.

The SAB's functions continued to operate by virtual conference calls with some areas of the business temporarily stepping down. Face-to-face training was suspended until further notice, with a caveat in place to provide virtual sessions over the forthcoming months. Online training and resources were also available via Stockport's learning pool for the workforce to access until easements had begun to relax.

We continue to respond to Safeguarding Adult Review referrals and SAR screening panels took place by virtual teleconference. A decision was made by the three statutory partners that if a referral met the the criteria to undertake a SAR, the review would take place by a virtual approach until SSAB resumed to normal service.

During the unprecedented time, we increased our publicity and developed a Covid -19 safeguarding website providing key safeguarding information, specific to Covid-19. Additionally, weekly bulletins are being produced and disseminated to partners with highlights of service updates, along with guidance and useful resources for supporting and working with adults at risk during these times.

Social Media platforms have also been utilised to inform twitter users of the resources and services available.

Communication was vital throughout such uncertain times. We introduced safeguarding weekly check in meetings aligned with colleagues from Stockport Children Safeguarding Partnership. The purpose of the meetings was to look at emerging themes and to share what was working well with partners. This was well received from the partnership and was an opportunity for partners to share and support good examples of practice.

We developed a Covid-19 risk response and assurance register where partner agencies contributed by sharing their respective top 5 risks to the SAB for assurances. The SAB maintained oversight of the register and agencies self assessments helped to inform the Covid-19 risk register, and to assist to escalate any new/emerging risks. Data performance throughout the pandemic will be collected and themes, patterns and trends will follow in the forthcoming year.

Training & Development

The training programme has been reviewed and updated during the year with a number of new courses being delivered.

During 2019-20, the focus has been on developing an All-Age training programme and the highlights of the year include:

- Self-Neglect and Hoarding
- Basic Safeguarding Awareness Course (All-Age)
- Domestic Abuse Awareness Course (All-Age)
- Application of Mental Capacity Act 2005

In March 2020, training was cancelled until further notice due to Covid-19 pandemic and the social distancing requirements.

The resumption of classroom training is not expected until autumn 2020 due to:

- Social distancing advice
- Ability of services to release staff for training

Additional training will be made available online over the coming months with innovative methods to ensure training and learning is delivered to the partnership and its workforce.

Considerations for 2020-21 include the exploration of further funding arrangements for an Adult Safeguarding Training Manager, mirroring the role funded by the Children's Partnership. Options for this resource are currently being explored and is an aspiration of the training sub group.

Training & Development

Achievements in 2019-20	Priorities for 2020-21
Domestic Abuse training • 170 attended in 2019/2020 Self-Neglect training • 116 attended commissioned courses Competency Framework • Available by clicking here Contributed to development of SSAB and SSCP websites Conferences: • Domestic Abuse • Complex Safeguarding • Joint Annual Safeguarding	Redesign of multi-agency training offer to: • Reflect new joint strategic priorities • Respond to new policy and new roles defined within in Introduction of LPS • Multi-agency training needs Main response to results of the training needs survey: Themes identified are: • Transitions • Drug/alcohol abuse • Complex safeguarding

Training & Development

Multi-agency training attendance 2019/20:

	Classroom	e-learning	Total
Safeguarding Adults - introduction for the Adult's Service workforce	525	255	780
Safeguarding Adults Enquiry Officer initial training	15		15
Safeguarding Adults Referrer Training	38		38
Mental Capacity Act	50	153	203
Domestic Abuse: Basic Awareness	170	115	285
SAR Briefing	42		42
Self-Neglect and Hoarding	116	52	168
Coercive Control		94	94
Dignity in Care		80	80
Modern Day Slavery and Human Trafficking	21	35	56
Self-Harm		50	50
MAPPA awareness sessions	36		36
Total	1013	834	1847

Training & Development

In January 2020, a training survey was carried out to with 57 participants varying from frontline staff from various key agencies. The survey was conducted to look at whether staff had sufficient knowledge on the Safeguarding Adults Boards four priorities, and to establish whether staff were confident to fulfil their day to day jobs.

Most staff said they were confident in the awareness of Neglect, Self Neglect and Domestic Violence. However, some respondents said they had not received training and would welcome future training sessions in Transitions and Complex Safeguarding.

Future training requests to be considered for the forthcoming year. were:

- Mental Health
- Hate Crime
- Safeguarding those with Learning Disabilities
- Complex Safeguarding
- Hoarding
- Transitions
- Domestic Abuse
- Suicide
- Female Genital Mutilation
- Liberty protection Safeguards
- Mental Capacity Act

Here are just a few of the evaluations received from frontline staff who attended our multi-agency training throughout 2019-20.

The course simply made me much more aware of the signs to look for and a better understanding of the nature of FGM and the sensitivity of the subject.

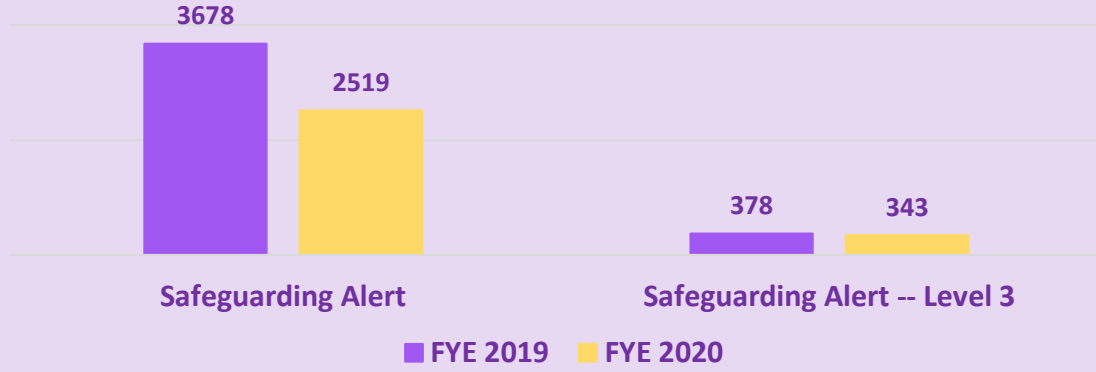
I now have a greater understanding of different types of Domestic Abuse and the signs to look out for. The raised awareness enabled me to disseminate to staff and to revisit frequently to maintain staff vigilance and understanding. Thank You.

I used my learning and information from the course and delivered safeguarding training to all staff. I think it also changed my approach when dealing with situations and evidencing and recording information.

This helped me to give the correct guidance to counsellors regarding who to report concerns to and the most up to date services to recommend to victims of abuse. Found it really useful.

Performance Data – Adult Enquiries

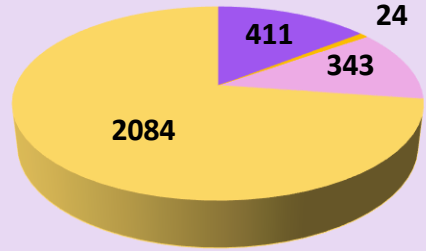
Count of Concerns



There is a significant reduction in the number of Concerns following the triaging of NWAS safeguarding concerns. There is now a steady position of around 700 concerns on a quarterly basis.

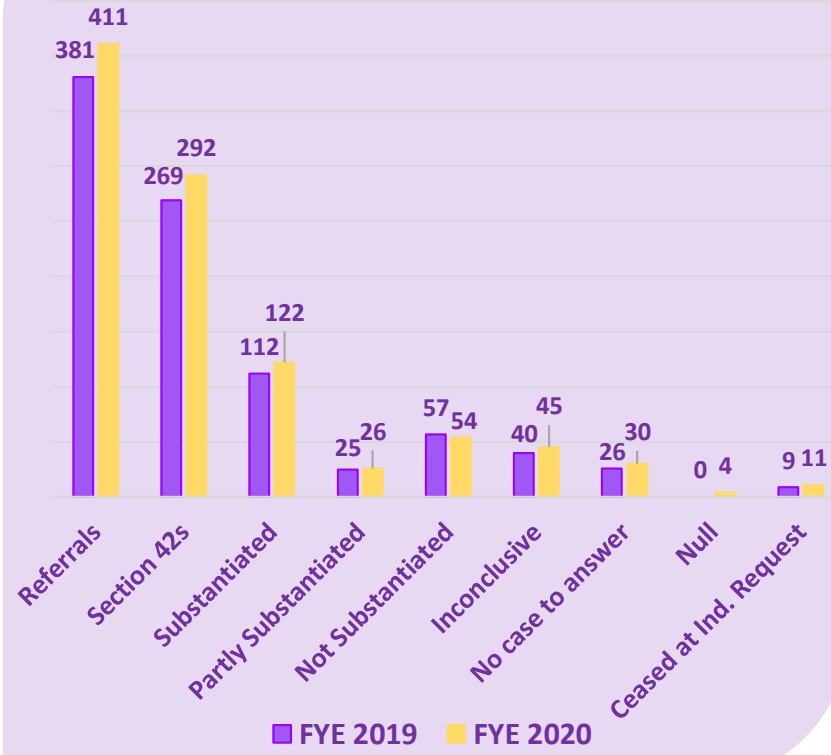
Progression to Referral

Total Number of Concerns: 2862

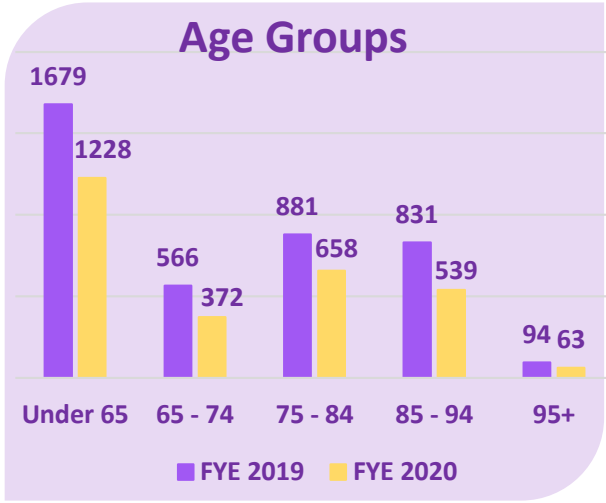


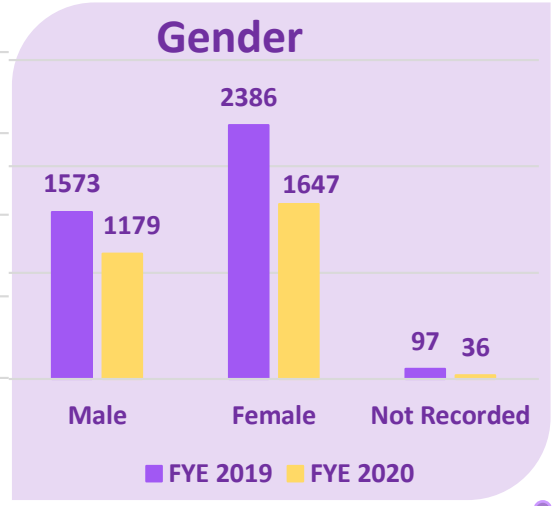
A Safeguarding Concern occurs when any safeguarding issue is first raised with Adult Social Care. This is reviewed and triaged and if it is considered a safeguarding matter it will advance to a Referral.

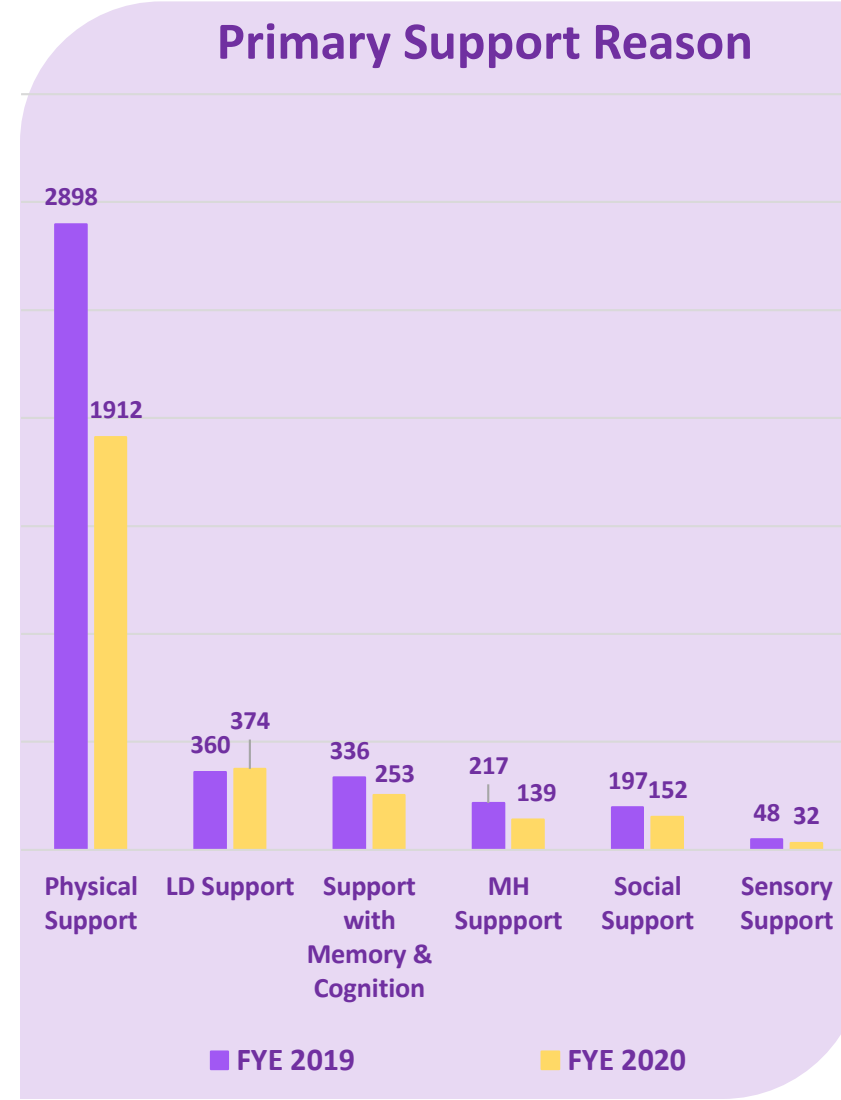
Section 42 Enquiries & Outcomes from Concluding Cases



Performance Data – Adult Concerns



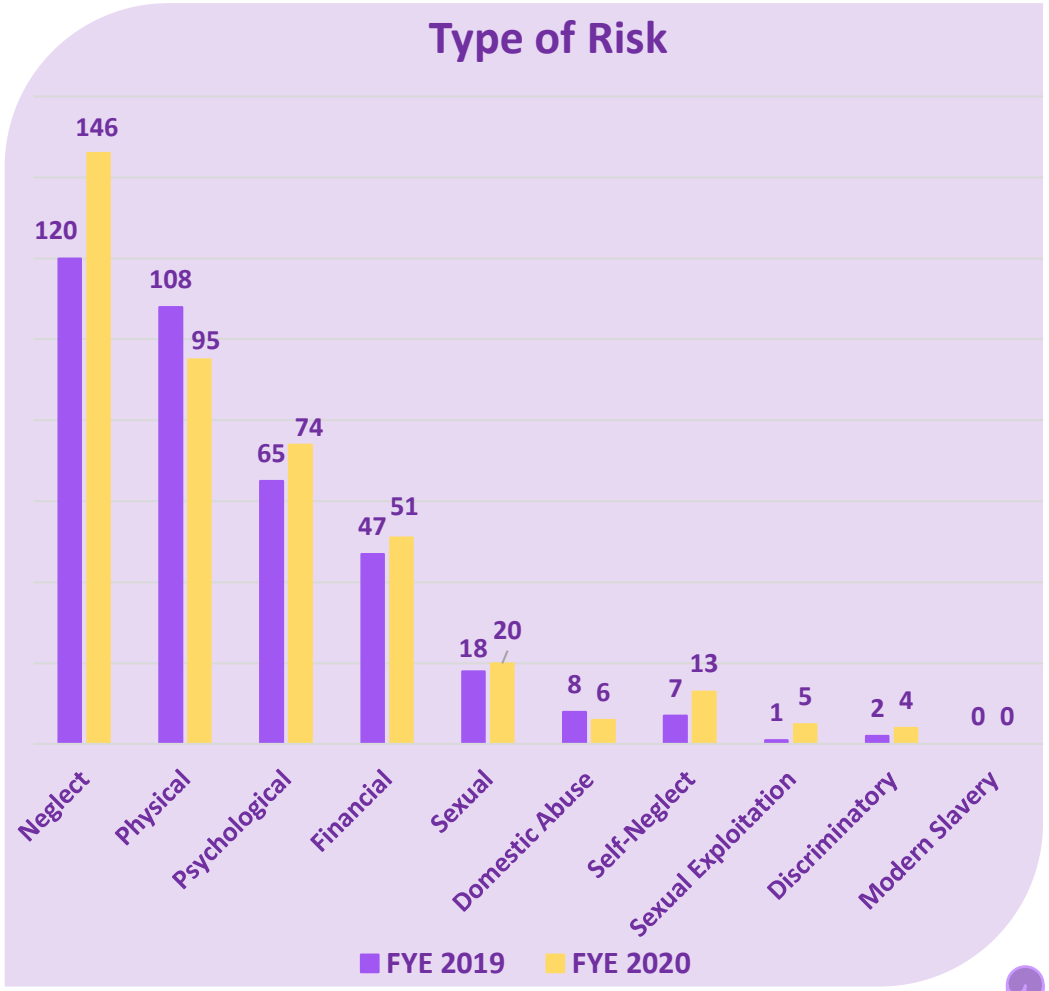


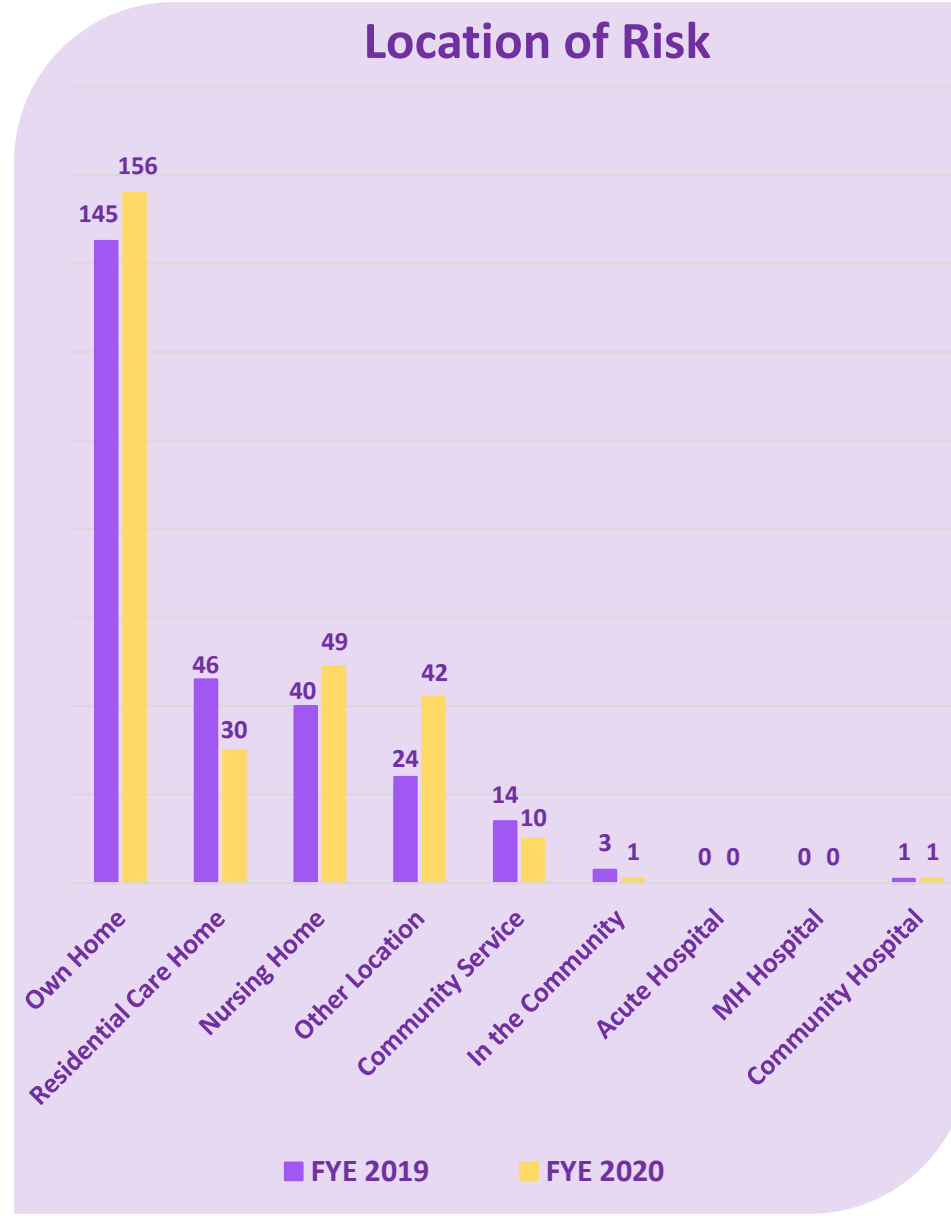


Due to the transition from Care First to Liquid Logic, there is approximately two weeks of data not available at the end of March 2020.



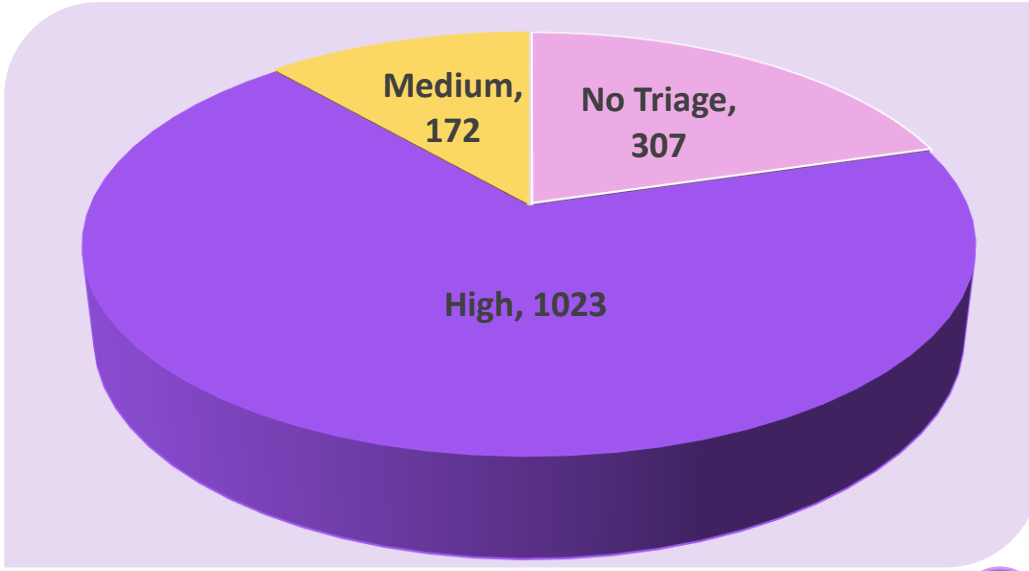
Performance Data – Section 42 Risk Type & Location





The main two types of risk remain Neglect and Physical. Next year the Self-Neglect figures may increase due to potential changes in the way of recording via Liquid Logic, as this is not currently being specifically recorded as a Section 42 enquiry.

Performance Data – DoLS

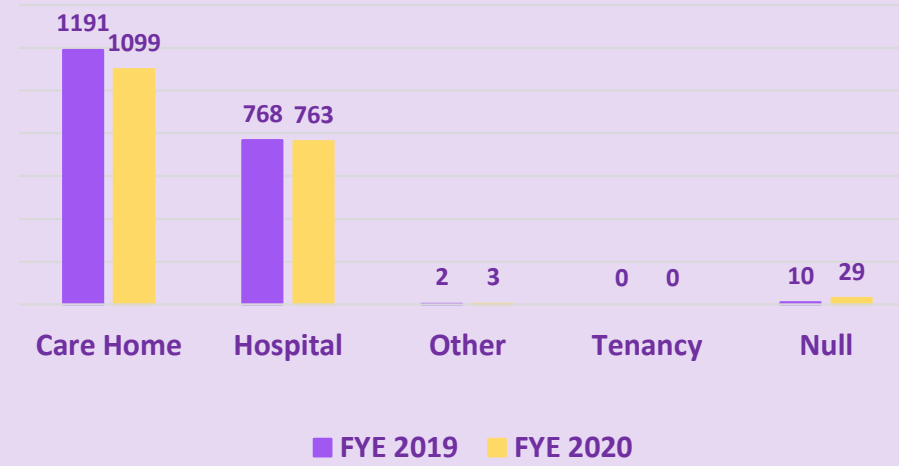


In terms of the triage decision the pie chart shows that High is the most likely at 68%.

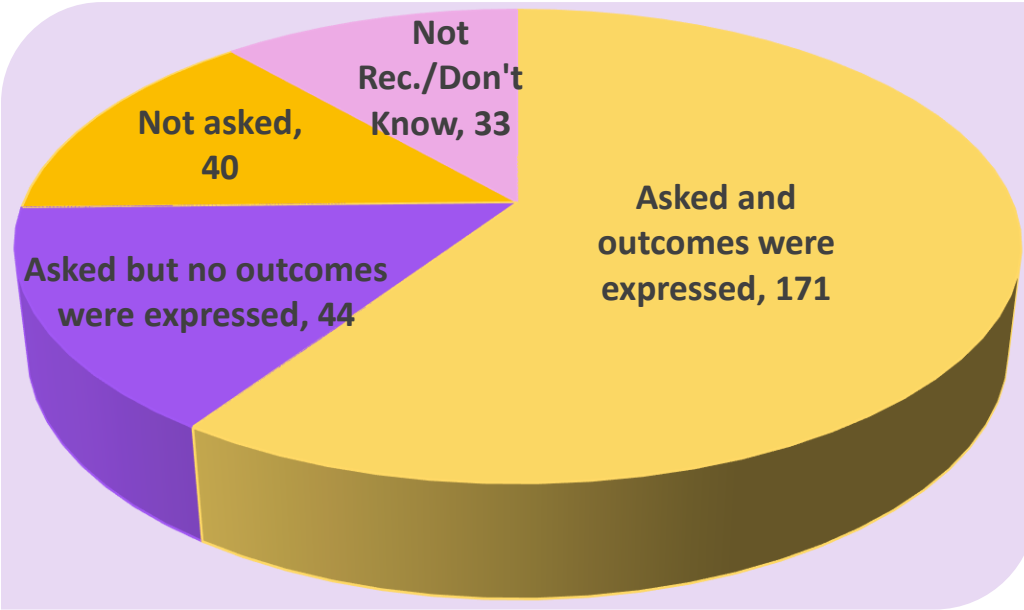
In terms of location, the source of referrals in the main are from both care homes and hospital, with 58% from Care Homes and 40% from Hospital.

Additional short term funding was agreed to improve the administration and increase the capacity of Best Interests Assessors. The appointment of two Best Interest Assessors (BIAs) and an Assistant Team Manager in late 2018 has now begun to have a positive impact on the backlog of high priority referrals. This, combined with the return of previously trained BIAs to the rota, has led to sustained greater capacity in reducing backlog of high and medium priority referrals.
The increase in the number of signatories from 2 to 6 in early 2019 has had a significant impact on the backlog of assessments requiring authorisation.

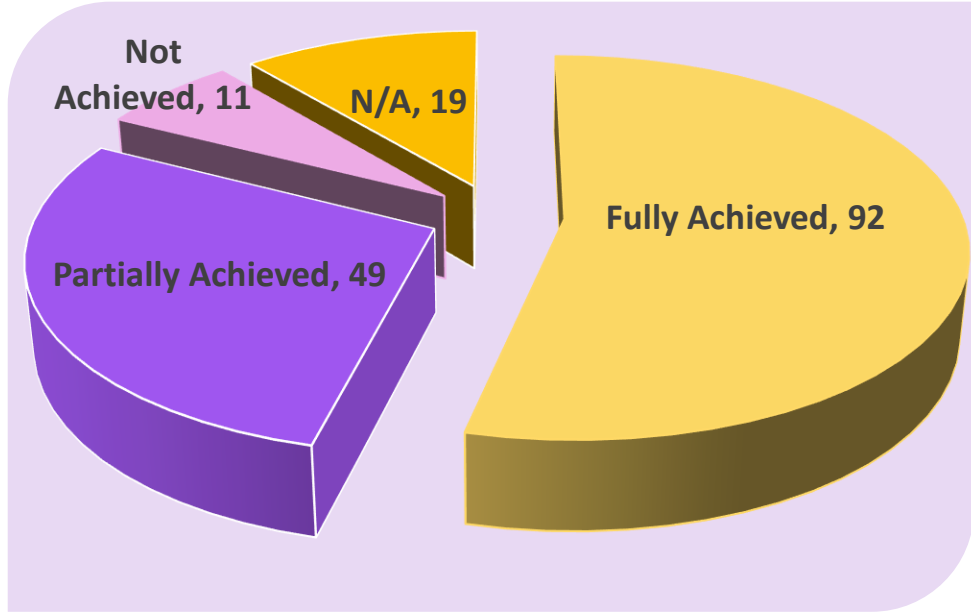
Source of Referrals



Performance Data – Making Safeguarding Personal



In FYE 2020, 215 people (75%) were asked what outcomes they would like, 171 expressed a preference.

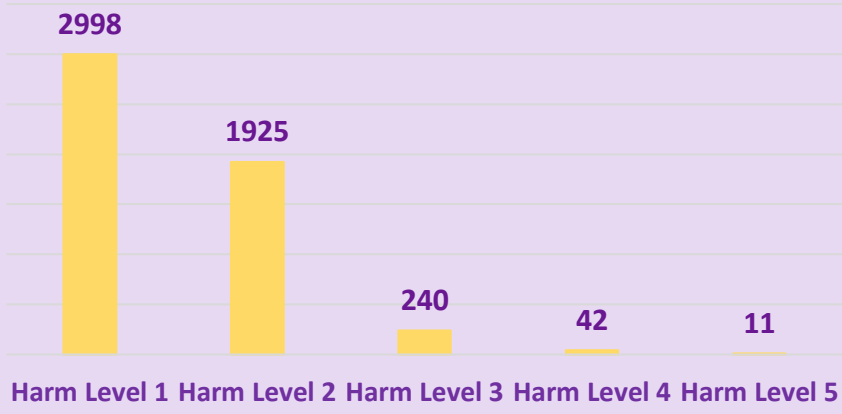


In FYE 2020, out of the 171 people who expressed an outcome preference, we were able to meet 82% of these fully or partially.

An area of concern is the number of individuals reported as “Not asked” and “Not Recorded/Don’t Know”. This is an area of ongoing investigation for 2020/21.

Performance Data – Harm Levels

Harm Level Totals FYE 2020



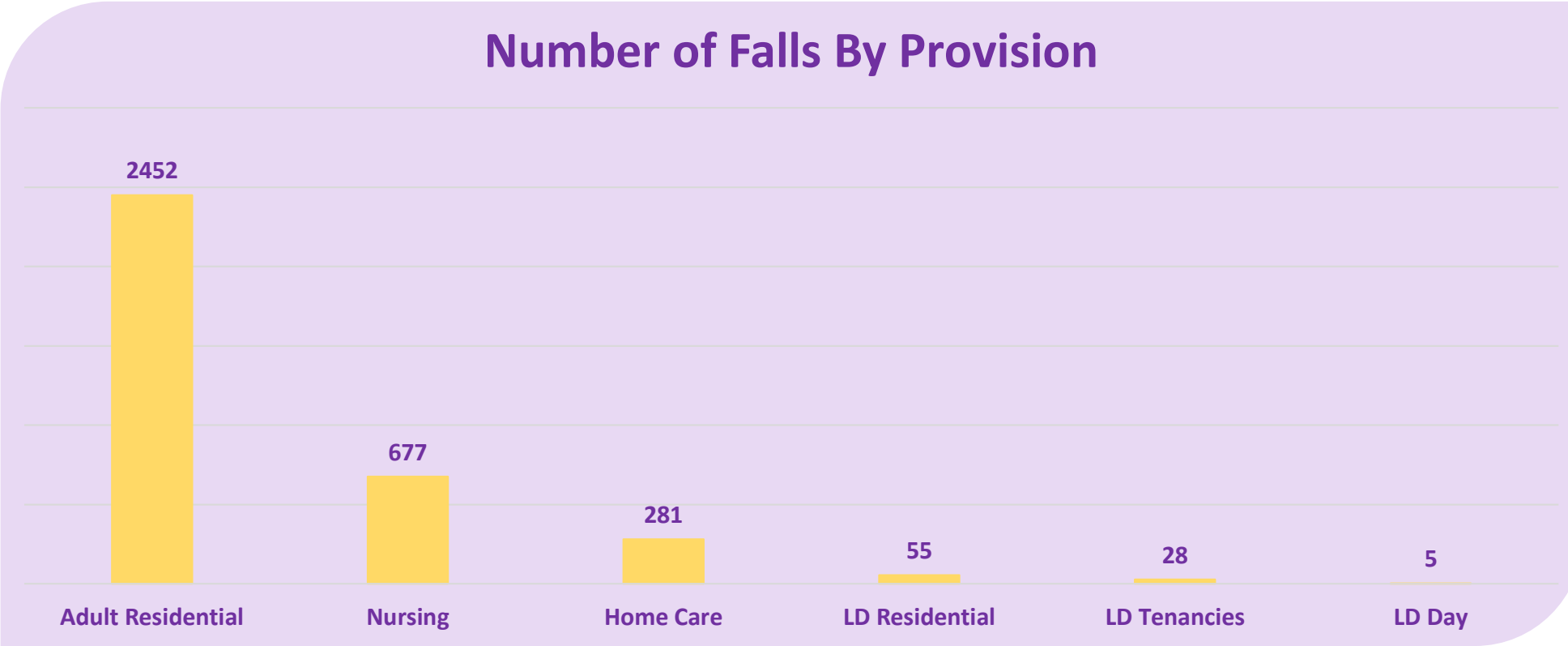
An on-line Survey is conducted each quarter to obtain and monitor Harm Level Data from across the Care Provider network. Overall, compliance is good and data is shared with care providers. Where non compliance occurs, the ASC quality monitoring team are notified so they can support and work with providers.

The three main themes within types of harm of Slips, Trips and Falls, Medication Errors and Behavioural are a regular pattern across the quarters. Slips, Trips and Falls are an area in which the Quality Monitoring Team have been offering extra support to the Care Provider Network in collaboration with Steady in Stockport. Medication Errors have also been an area of extra learning and support provision from the Quality Monitoring Team.

Types of Harm Totals FYE 2020



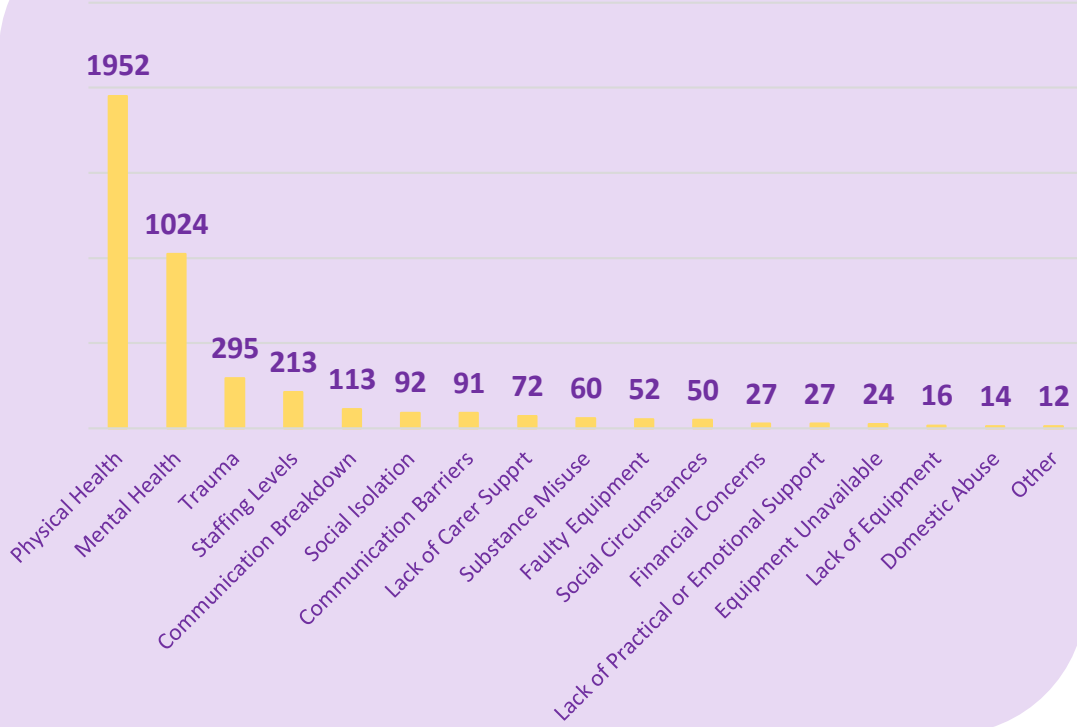
Performance Data – Harm Levels (cont.)



The most frequent location of slips, trips and falls is in Adults Residential Care which is a common theme throughout the year. As previously mentioned, this is an area in which the Quality Monitoring Team have been offering extra support to the Care Provider Network in collaboration with Steady in Stockport.

Performance Data – Harm Levels (cont.)

Risk Factors Totals FYE 2020



Solution Totals FYE 2020



The three main risk factors are Physical Health, Mental Health and Trauma and these have been a regular pattern throughout the year.

In addition to the identified solutions, other Good Practice identified by Care Providers includes: continuous use of Body Mapping; "Buddy "system for new staff and agency staff; "Lessons Learnt" sessions looking at possible scenarios and photo ID cards for Service Users containing contact numbers and emergency medical information.

Safeguarding Adult Reviews (SARs)

A Safeguarding Adult Review takes place when agencies who worked with an adult who suffered abuse or neglect, come together to find out how they could have done things differently to prevent harm or a death.

A SAR does not seek to blame anyone; it tries to find out what can be changed so that harm is less likely to happen in the future in the way it did to other people.

The law says SSAB must arrange a SAR when:

- There is reasonable cause for concern about how SSAB, its partners or others worked together to safeguard the adult; AND
- The adult died and SSAB suspects the death resulted from abuse or neglect; OR
- The adult is alive and SSAB suspects the adult has experienced abuse or neglect.
- SARs are overseen by SSAB's Safeguarding Adult Review Sub Group, made up of representatives from partner organisations and chaired by Head of Safeguarding & Learning, on behalf of the Board.

Safeguarding Adult Reviews Activity 2019-20

The SAR sub group has had a productive year with referral of submissions, training and education being delivered and there is an on-going commitment from all partners attending the SAR sub group.

In 2019-20, we received four referrals for consideration for a SAR, of the four referrals received only one met the SAR criteria and an independent author was commissioned, and is currently on-going (SAR6).

Of the three remaining referrals, one Multi Agency Learning Review (MALR 2) was commissioned following screening by the panel; the second referral was a Learning Disability Mortality Review (LeDeR) and the third was undertaken by Stockport CCG.

MALR 2 is currently underway and the LeDER is expected to take place once a decision has been reached by Her Majesty's Coroner.

Stockport CCG conducted a single agency health review. The review investigated a case involving a 63 year old man who was a resident in a care home. The events leading to his death involved a number of transfers in care whilst receiving treatment in hospital. Partners are progressing the actions against the recommendations in preparation of scrutiny and assurance.
7 Minute Briefing Paper can be found here.

Safeguarding Adult Reviews – Achievements

Achievements

- Along with Tameside, we have produced a Greater Manchester SAR Protocol that includes one generic SAR referral form containing best practice guidance for local safeguarding adult boards throughout Greater Manchester. The GM protocol has been approved in principal and is expected to be launched late 2020.
- We have continued to develop a repository of safeguarding learning, and ensure completed SARs are shared with the National SAR library.
- In September 2019, an Independent Author was commissioned to undertake SAR 6.
- In March 2020, the SAR sub group provided external training to ensure that partner agencies had the skills to write Internal Management Reports (IMRs) that would be required when completing a SAR.
- We commissioned an Independent author to undertake MALR 2 and facilitated a practitioners learning event with frontline staff and managers to assist to inform the review. Family members were also involved within the process to ensure questions were reflected within the terms of reference.
- We have disseminated the learning from a Health Review with the use of a 7-minute briefing paper.
- Three Safeguarding Adults Reviews that were agreed during previous years were completed and action plans signed off during the year.
- A training programme including domestic violence and abuse has been developed. The training was rolled out and well received with strong levels of attendance from a wide range of partners.
- We have streamlined the Safeguarding Adults Annual Report to provide SAR information accurately.

Safeguarding Adult Reviews – Learning

Areas of Learning

We completed a thematic learning review and drew out knowledge from 5 SARs and 2 Learning Reviews that Stockport had previously completed. There were five key points of learning that we had identified:

- Mental Capacity Act
- Assessment
- Information Sharing
- Policy
- Training

Mental Capacity Act & Assessment

- Implemented a Multi-Agency MCA Audit to identify good practice and future learning.

Information Sharing

- Produced an Information sharing protocol and rolled this out via a 7 minute briefing paper and is also promoted on the SAB website.

Policy

- A SAR Referral form has been introduced that is standard for the Greater Manchester footprint.
- A GM SAR Protocol has been developed in collaboration with Tameside Safeguarding Adults Partnership.
- The requirement for improved joint working with children and adult services was identified. A joint development day was held and ongoing, key partners are required to assure SSAB that there is continued progress on this issue.
- Reviewed and refreshed a number of policies and developed a Multi Agency Escalation Policy to assure partners of the procedure to ensure resolution and that good partnership working is in place.
- A mechanism was also created in our annual quality assurance self assessments to ensure key partners can provide assurances on their respective escalation processes.

Training

- A training consultant was commissioned to deliver MCA training and the introduction of Liberty Protection Safeguards (LPS) at the annual safeguarding conference, the content of the training included consent, MCA and LPS from 16 years of age and upward.
- SAR learning workshops continue to be delivered to ensure that learning from SARs are widely disseminated.
- A Learning Hub is still to be developed that will enable learning from case reviews to embed learning from SARs.
- Developed both an all-age Safeguarding and a Domestic Abuse training course with a view to think family approach.

Learning Disability Mortality Review (LeDeR)

The National Learning Disability Mortality Review seeks to review all deaths of people who have a learning disability aged 4 years upwards.
The programme has been running since 2015. The programme was set up to review all deaths, review practice, identify where care delivery can be improved, share good practice and replicate it wherever possible.

LeDeRs in Stockport

In Stockport, there have been 50 deaths reported to date for people with a learning disability, of which 15 reviews have been completed and 15 are in progress, up to February 2020.

To gain a full overview of LeDERS in Stockport please click here to see the LeDER Report.

Themes emerging from the reviews highlighted both positive practice and areas for improvement in the following areas:

- Inconsistent application of the Mental Capacity Act.
- Good uptake and coordination of Annual Health Checks.
- Inconsistent documentation of assessment sand Care Plans.
- Reasonable Adjustments not being utilised or considered.
- Limited uptake of gender or age related health screening .
- Active medication reviews in primary care
- Communication challenges between agencies and departments involved in the persons care.
- Delays in the care pathways, including observations and treatment delivery.
- These areas are explored and commented on in more detail in the CCG LeDeR Annual Report.

Our Shared Strategic Priorities 2020-23

In January both Children and Adults Safeguarding Partnerships came together to attend a joint development day. The event was well attended and the purpose of the day was to develop the Safeguarding Partnerships three year strategic plan 2020-23.

Feedback was collated from both front line workers who attended the Annual Safeguarding Conference in October 2019, along with Executive colleagues at the development day in January 2020. Overall, feedback obtained from both events were similar and our strategic plan was developed, articulating our priorities for the 3 years.

We have 4 strategic priorities for 2020-23

Our shared priorities for 2020-23 are:

1. To improve frontline practice.
2. Receive assurance that Safeguarding arrangements are embedded in all agencies commissioning strategies and service specifications.
3. Keep the focus on our most vulnerable children and adults.
4. Effectively engage with our frontline Practitioners, Service Users, families and/or their representatives.



Thematic Areas for 2020-21

Stockport Safeguarding Adults Board is dynamic and is currently working against the three year strategic business plan that will see the next 3 years being transformational in how the board performs its functions for the children, families and adults at risk in Stockport.

Our thematic areas are articulated further within the Safeguarding Adults Board **Strategy 2020-23**, a copy of which can be found in the Stockport Safeguarding Adults Board Website.

The Board has agreed its five themed areas for 2020-21.

Transitions

Implementation of Liberty Protection Safeguards (LPS)

Neglect/Self Neglect

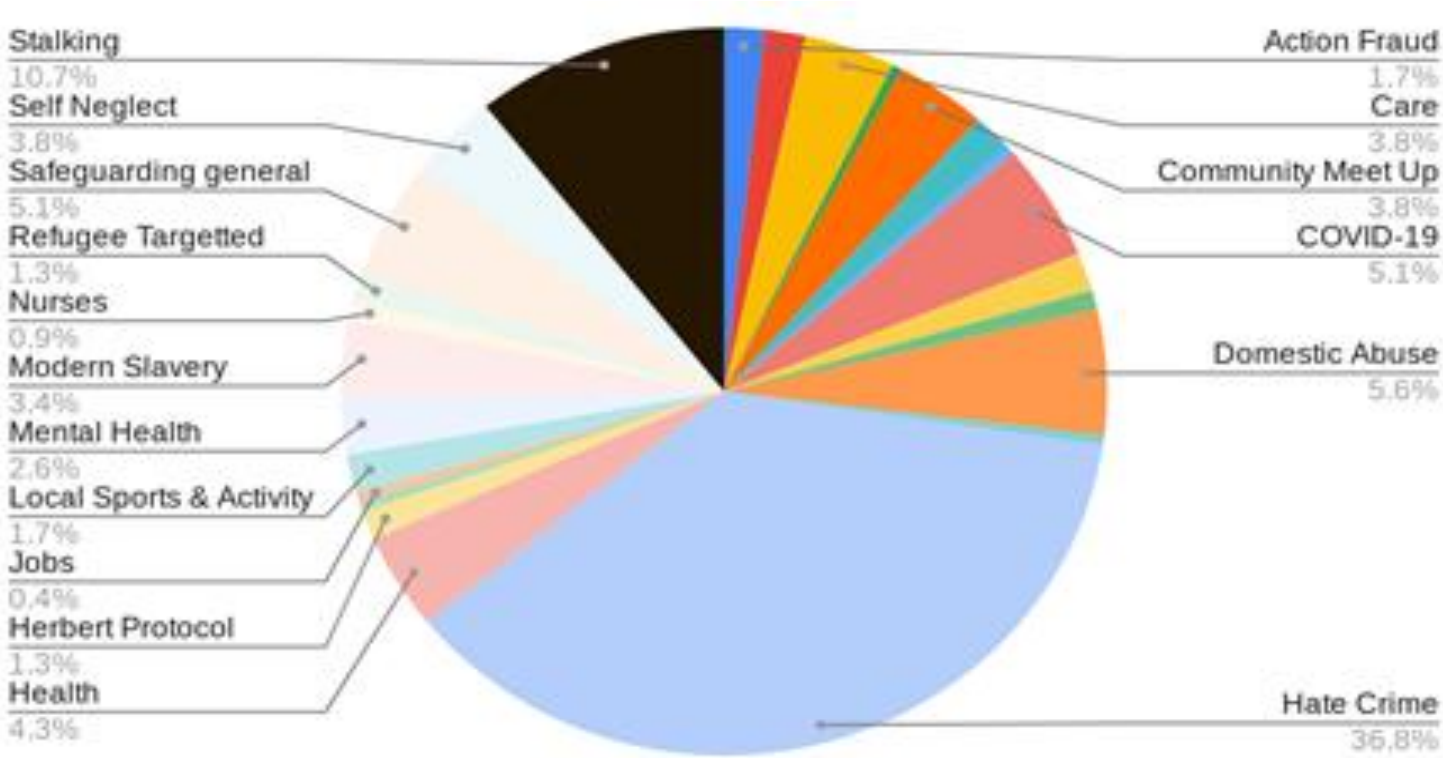
Safe Sleep

Homelessness

Work to be carried over to 2020-21

- Identify cost effective ways to undertake statutory Safeguarding Adults Reviews.
- Develop a Learning Hub to enhance and embed learning from case reviews and SARs.
- In 2020-21, there will be a change in national legislation with the implementation of Liberty Protection Safeguards (LPS) to replace DoLS. This will require a full understanding of the legal duties and an overall change in practice.
- Finalise the Female Genital Mutilation strategy and its work plan, share with SSAB for consultation, and sign off.
- Commission further training on FGM awareness.
- Continue progress on the Criminal Exploitation and Serious Organised Crime strategy.
- Develop a complex safeguarding dataset that will link into the GM complex safeguarding steering group.
- Investigative work to be continued into how data is recorded and collated across the partnership as well as improving record keeping, with the overall aim to enable greater scrutiny leading to a comprehensive picture of safeguarding adults within Stockport.
- Develop engagement and participation strategies for the wider community.

Campaigns and Awareness Raising



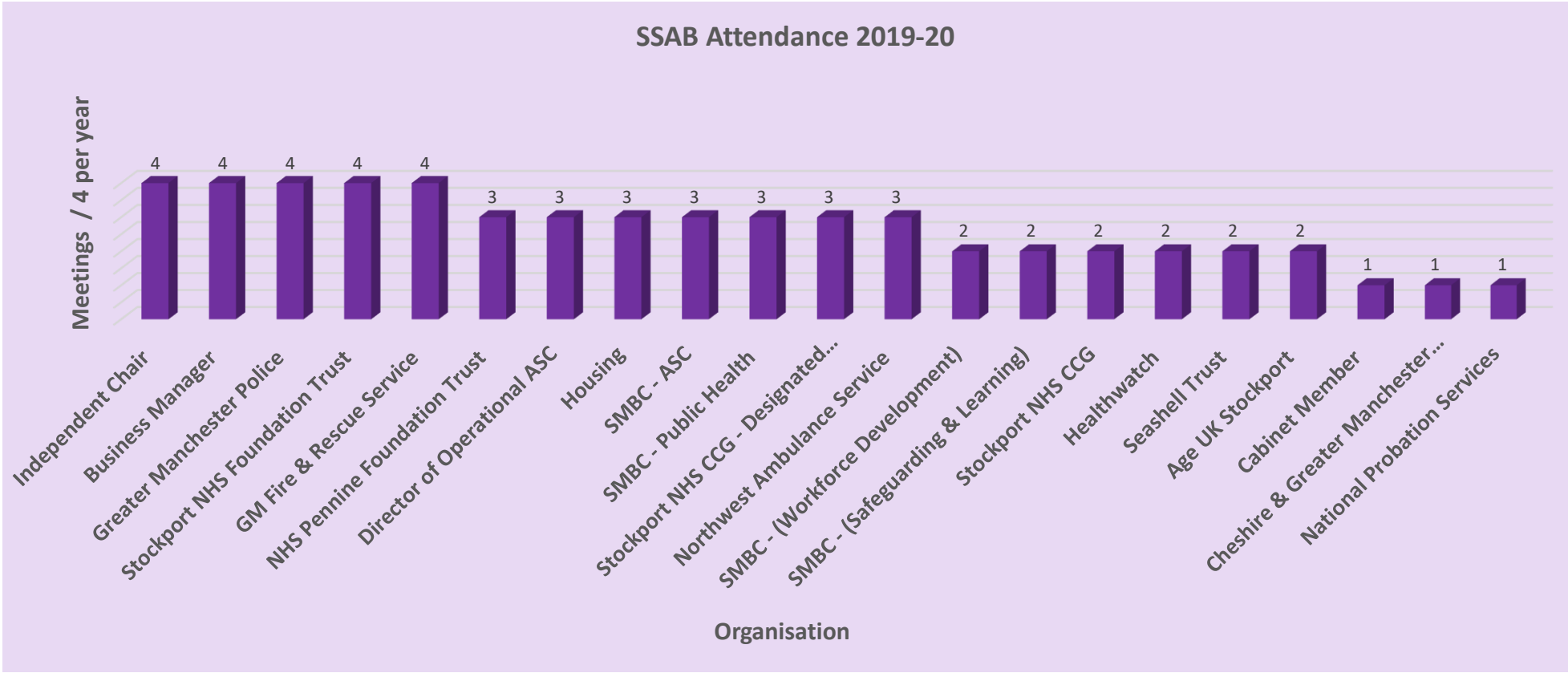
We ran a number of media campaigns throughout the year focussing on strands identified in chart above.

- We have highlighted a service 146 times (62% of our tweets)
- We have advertised an event or conference 18 times (7.5% of our tweets)
- We have encouraged participation through offering views and consultation 22 times (9.5% of our tweets)
- We have signposted e-learning 12 times (5% of our tweets)

Board Attendance

Attendance at Stockport Safeguarding Adults Board and Sub Groups is monitored. The table above demonstrates the attendance of four Board meetings throughout the year with colleagues from the Safeguarding Adults Board. The Independent Chair is committed to seeking explanations from members where attendance is not up to expectation.

Two new members joined the SAB in September 2019; Adult Social Care and Stockport's local cabinet member.



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

Questions about this Report

If you have any questions about this report, please email lsb@stockport.gov.uk .gov.uk

Remember, safeguarding is everyone's business