Stockport Safeguarding Adults Partnership

Annual Report 2021/22

Safeguarding Adults in Stockport

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Safeguarding Adults in Stockport

Introduction to Stockport Safeguarding Adults Partnership

Stockport Safeguarding Adults Partnership (SSAP) is the local statutory multi-agency partnership established under Section 43 of The Care Act 2014[2]. The partnership consists of the three statutory safeguarding partners (Stockport Metropolitan Borough Council, Greater Manchester Police, and Stockport NHS Clinical Commissioning Group), as well as a number of other agencies and organisations working in the borough. A full list of partner agencies is provided at Appendix B.

The Partnership has three core functions, which are to:

- Develop and publish a strategic plan which sets out how we will prioritise our work
- Write and publish an annual report assessing our effectiveness
- Commission Safeguarding Adult Reviews for any cases meeting the criteria set out in Section 44 of The Care Act 2014.

This report sets out our activity over the last year from April 2021 to March 2022.

Our partnership has developed this year as we have welcomed a number of new individuals and experienced staffing turnover across a number of our partner agencies. We have acknowledged and embraced the challenges and opportunities presented to us as a result of this turnover, as we look ahead to delivery of our business plan. The illustration opposite shows our Governance Structure, which sets out the 2 sub groups that are joint with the Safeguarding Children Partnership, and the 2 groups that are focused solely on adult safeguarding priorities. A summary of our governance arrangements is shown at Appendix C.

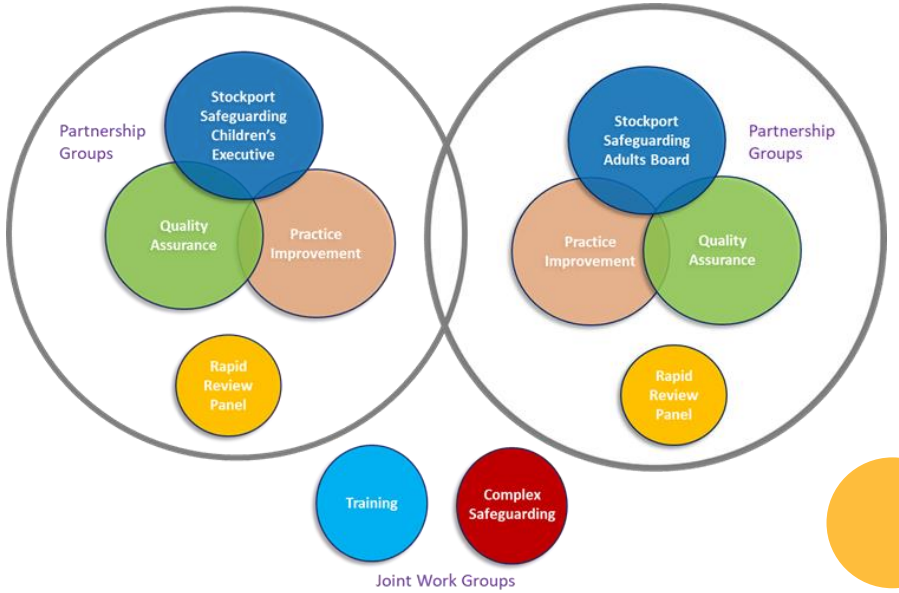
The core objective of the partnership is to coordinate and collectively hold partners to account to ensure they are protecting children and young people / vulnerable adults in Stockport borough who are, or maybe at risk, and timely learning from serious safeguarding incidents is shared and implemented.

The joint strategic plan for the adults and children's partnerships in Stockport was agreed in September 2021 and is being implemented over a two year period, with an expectation that priorities will be delivered by 2023. Progress is reviewed quarterly by the independent scrutineer with sub group chairs, to ensure this remains a key focus and doesn't gather dust on a shelf.

The partnerships work closely with other relevant multi agency partnerships in Stockport, including the Safer Stockport Partnership, the Domestic Abuse Partnership Board, Health and Well-being Board and the Children and Families Partnership Board. A Corporate Safeguarding Accountabilities meeting meets quarterly and is chaired by the Leader of the Council, which provides senior politicians and the chief executive with assurance about safeguarding measures and activity boroughwide.

Safeguarding children and adult partnerships across Greater Manchester work together, through their independent chairs/scrutineers and business managers, to share learning and achieve consistency of standards and practice. This provides opportunities for wider learning and reduces duplication.

The GM connections link with the work of the Safeguarding Alliance, a periodic meeting of the 10 chief executives, in GM, who seek and share learning and assurance, about safeguarding children. This also reduces the need for some areas of work to be repeated in 10 LA areas.



Safeguarding Adults in Stockport

Independent Chair's Introduction

This is my first contribution to the Stockport Annual Report since taking up the post of independent chair and scrutineer in the autumn of 2021 shortly after publication of the last report and the 2021-23 Joint Strategic Plan.

It has been an unusual time to take up a new role, for myself, two Business Managers and several partnership representatives. The children and adult partnerships have continued to meet regularly throughout the pandemic period, but the absence of face-to-face working has inevitably had an impact on building professional relationships as virtual meetings, whilst bringing some benefits, do limit the creation of effective working relationships particularly for those new to post and/or the local area.

I have met in person with many partners over the last 9 months and found this very helpful. I am grateful to everyone who shared both valuable time and their views with honesty as to how they see the partnership, what works well and how this can be further improved. As a partnership, there are clear strengths to build on in Stockport and a willingness to further develop from partners with whom I met.

The year this report focuses on has been one that has again been directly affected by the global pandemic. Whilst agencies locally and nationally have built experience in dealing with this over the last two years, it has continued to impact on services, how practice is monitored and quality assured and how training and development is provided.

Partnership meetings have continued to be held virtually, but hybrid arrangements will be introduced from the autumn. The children and adult partnerships will also come together face to face for the first time in a development event to rebuild relationships with those colleagues who have not met in person in over two years and to meet new ones. This provides a watershed for further change and development, and I look forward to the learning opportunities it will create.

It has been useful to attend and observe sub-group meetings and to explore how arrangements work in Stockport as part of my introduction to the area. A number of questions have been raised about roles, responsibilities and membership, so reviews of terms of reference and membership have taken place, to ensure the focus of arrangements are clear, and key agencies are appropriately represented on the partnerships. This has taken account of changes and developments in key agencies, referred to in this report and has reviewed identified gaps in membership.

Gail Hopper, Independent Chair and Scrutineer

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

Safeguarding Adults in Stockport

Independent Chair's Introduction

The role of statutory partners

During the last year, major changes have been underway in the NHS as a result of the Health and Care Act 2022 and these were implemented in July this year. The NHS has experienced enormous challenges over the last two years, due to the pandemic and this latest change, which removed Clinical Commissioning Groups and introduced Integrated Care Boards as the statutory commissioning body for the NHS has created further pressures. Health partners have worked closely with the partnerships to ensure that from a safeguarding perspective, changes have had limited effect.

Greater Manchester Police has also faced a challenging year, following a difficult inspection by HMICFRS and the workforce changes that followed. We have been pleased to welcome new leadership in Stockport with the clear commitment to delivering safeguarding responsibilities that has resulted.

Finally, changes in the local authority have meant that that children and adult services have been brought together as a single People's service with a continued focus on developing integration. An inspection by Ofsted of children's social care early in 2022 resulted in a good judgement and recognition of the impact of a strong partnership. Changes in adult health and care legislation in 2022 means that after a decade without inspection, this will once more be part of the CQC function. Like other local authorities, Stockport can expect a future inspection of the quality of its social care service. The timing of this is not known.

Independent Scrutiny

The purpose of independent scrutiny is to provide assurance, monitoring and challenge to the quality of agencies work and to:

- Provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children and vulnerable adults, including appropriate arrangements to identify and review serious safeguarding cases.
- Act as each partnership's constructive critical friend, in which role the scrutineer will remain a key driver to promote reflection, which will ensure continuous improvement in the effectiveness of local safeguarding.
- Judge how effectively the arrangements are working for children, their families, vulnerable adults and practitioners.

The following six step approach provides a useful tool for partners to use separately and together in developing their contribution to the partnership and building on its effectiveness. It is relevant to the work of both partnership boards and informs my approach to independent scrutiny[1]:

Step 1 The three core partner leads are actively involved in strategic planning and implementation	**Step 2** The wider safeguarding partners (including relevant agencies) are actively involved in safeguarding children and vulnerable adults
Step 3 Children, young people and families are aware of and involved with plans for safeguarding children In the case of vulnerable adults this directly involves them in developing their own plan	**Step 4** Appropriate quality assurance procedures are in place for data collection, audit and information sharing
Step 5 There is a process for identifying and investigating learning from local and national case reviews	**Step 6** There is an active programme of multiagency safeguarding children and adults training and workforce development

Safeguarding Adults in Stockport

Independent Chair's Introduction

My approach during this first year has in part, picked up the from my predecessor and has continued to include:

- Chairing the Children's Safeguarding Partnership
- Chairing the Adults Safeguarding Partnership
- Chairing the Joint Partnership in which both children's and adult partnerships come together to focus on shared issues
- Chair the meetings of sub-group chairs
- Member of the Stockport Children and Families Partnership Board and Stockport Family Partnership Board

The following arrangements have been introduced with the support and engagement of the two Business Managers, to further strengthen partnership arrangements. Some are referred to above.

- Regular meeting with the leaders of the three statutory partners
- Membership of the Safer Stockport Partnership
- Quarterly review of progress against priorities in the Strategic Plan
- Review and completion of outstanding actions that not previously been finalised on behalf of the partnerships
- A development day in September 2022 with members of both partnerships
- Review of both partnership meeting and membership arrangements
- Introduction of a Learning from Practice sub-group to undertake regular review of progress against workplans arising from and SAR reports (see below)

Learning and analysis with the Business Managers, the process of familiarisation and feedback from agency representatives, (for which we are grateful), and reviews of activity have revealed several issues. It includes the following examples, which have led to further plans for improvement. Some are complete whilst others are underway.

- Lack of clarity in adult safeguarding procedures.
- Impact of workforce changes /instability on the timely completion of Safeguarding Adult Reviews and implementation of work plans arising from these (reference to Learning from Practice sub group above).
- Dated and cumbersome guidance and procedures in some aspects of adult safeguarding. Work had commenced but not been completed. The Business Manager has worked with partners to address this and I am assured that progress is now being made in this area.
- The multi-agency audit programme has slowed this year with fewer being completed compared with previous years. This will be a priority for me next year to make sure we are developing in the right areas.
- Stockport is an outlier in Greater Manchester in that the number of Safeguarding Adult Reviews (SAR), referred and undertaken is extremely low, in comparison with other similar areas. An audit of referrals is now underway.
- There is no current workforce development needs analysis in relation to the safeguarding adults arrangements.
- Data is variable and appears to rely disproportionately on information provided by the local authority.

A further area of continued exploration, supported by the work of the Learning from Practice sub-group will be on the effectiveness of the role of partners in implementing work plans and actions. Some reliance on the role of the business unit in relation to this, raises concerns about how improvements can be achieved if all leaders and managers do not drive this work forward.

Gail Hopper

Safeguarding Adults in Stockport

What do we know about the people of Stockport?

- **9.7%** aged 15-24
- **51.9%** aged 25-64
- **19.9%** aged 65+

294,200 people living in the borough in 2020 *(Nomis web)*

38% live in areas of higher than average deprivation *(2020 JSNA)*

92% White British in 2011 *(ONS)*

14,500 children with more than one ACE *(2020 JSNA)*

451.1 (per 100,000) Alcohol related admissions to hospital *(as at March 2022)*

1800 (per 100,000) Over 65s admitted to hospital due to falls *(as at March 2022)*

87.1% Take up of flu vaccinations in over 65s *(as at March 2022)*

65.1% Adults overweight or obese
12.8% Adults who smoke

86.8% adult care facilities rated Good or Outstanding *(as at March 2022)*

All data not referenced taken from https://bigstockportpicture.co.uk/corporate-performance-dashboard/

Partnership activity: Our year in numbers

Practice and engagement

953 Delegates attending safeguarding training

12 MAARS Panel meetings held

5 Social media campaigns

Scrutiny and Assurance

Safeguarding Adult Review referral received **1**

Safeguarding Adult Review published **1**

Multi-agency audits completed **2**

Safeguarding Adults in Stockport

What did we say we would do this year?

In our Annual Report for 2020/21 we identified a number of priorities we wanted to achieve this year. We said we would prioritise improvements in frontline safeguarding practice, ensuring that we heard vulnerable adults' voices, and seek assurance that all professionals working with vulnerable adults were following safeguarding guidance.

To do this we identified 5 thematic areas to focus on, and progress against these is shown below.

Thematic area	What did we achieve?	What else do we need to do?
Transitions	This has been a main focus of the local Complex Safeguarding Sub Group, with ongoing work reported to the Executive Board.	We will facilitate a Learning Hub with a focus on transitional safeguarding, including those cases discussed at MAARS panel.
LPS Implementation	A working group to oversee LPS implementation was put on hold due to national delays in central government issuing the draft guidance and consultation.	We will respond to the national consultation once it is published. We will then utilise the Safeguarding Adult Partnership to coordinate and scrutinise implementation across agencies.
Neglect and Self-neglect	The business plan for last year said that we would prioritise work around neglect and self-neglect. Our work this year has not progressed as much as we would have wanted due to ongoing operational pressures experienced by our partner agencies.	We will review and refresh our Self-Neglect strategy and guidance. We have more to do around understanding and addressing neglect as a Partnership.
Contextual safeguarding	We strengthened the joint working links between children and adult social care at our Complex Safeguarding Sub Group, and have been linking in with the work of the GM Complex Safeguarding Hub. This is work in progress.	We will continue to progress the Stockport approach to exploitation of vulnerable adults. Develop and roll out resources around Modern Slavery and Human Trafficking, FGM and Honour Based Abuse and Cuckooing.
Homelessness	Stockport Homes provided assurance to the partnership, reporting on the response around developing a homelessness strategy and how it is being delivered. This includes additional resources. This has provided a clearer understanding of how the pandemic affected the borough's response to homelessness.	Continue to scrutinise and support delivery of the homelessness strategy, including ensuring Care Act Assessments are completed and appropriate safeguarding measures implemented, including Team Around the Adult meetings.

Key achievements this year

In spite of some of the operational challenges posed by the ongoing COVID-19 pandemic, we continued to work together as a partnership to continue delivering and developing to provide excellent services for the adults and families of Stockport.

- ✓ We launched our joint **Quality Assurance Framework** which covers both the Safeguarding Children Partnership and the Safeguarding Adult Partnership.
- ✓ Launch of the **single agency safeguarding toolkit** to support single agency learning and assurance
- ✓ We developed and launched our new **learning feedback form** which allows partners to feedback following the dissemination of learning from reviews.
- ✓ The local authority successfully **co-located the safeguarding front doors** for children and adults.
- ✓ Stockport NHS Foundation Trust led on a review of **multi-agency discharge pathways** including implementation of a new discharge panel.
- ✓ Following learning from a multi-agency learning review, we developed and launched a **Financial Abuse Toolkit** to help practitioners identify financial abuse in vulnerable adults.
- ✓ We responded to national research and developments with dedicated plans and working groups for **NICE Care Home Guidance** and the LGA's **National SAR Analysis** research paper. Both action plans have led to improvements in the strategic work of the Safeguarding Adults Partnership.
- ✓ A new online **referral form for the Multi-Agency Adults at Risk System (MAARS)** was launched, streamlining referral processes for professionals into this panel.
- ✓ Our Quality Assurance Partnership oversaw the launch of a **suicide prevention pack** for professionals.
- ✓ Greater Manchester Fire and Rescue Service introduced a new **Home Fire Safety Assessment** which is designed to target resource at individuals who have an increased fire risk.
- ✓ Adult Social Care introduced their new **online referral portal** for professionals to raise concerns for individuals to the front door.
- ✓ We supported delivery of community-based awareness raising events and campaigns around **hate crime** across the borough, engaging directly with vulnerable adults and victims.

Safeguarding Adult Reviews

This year we saw a drop in the number of referrals we received for Safeguarding Adult Reviews. Regional analysis shows that Stockport is an outlier in this data[3]. Our hypothesis is that we have seen concerns for families raised through different routes as referrals for both Rapid Reviews and Domestic Homicide Reviews increased. This will be tested through an audit of SAR and DHR referrals, which will take place next year.

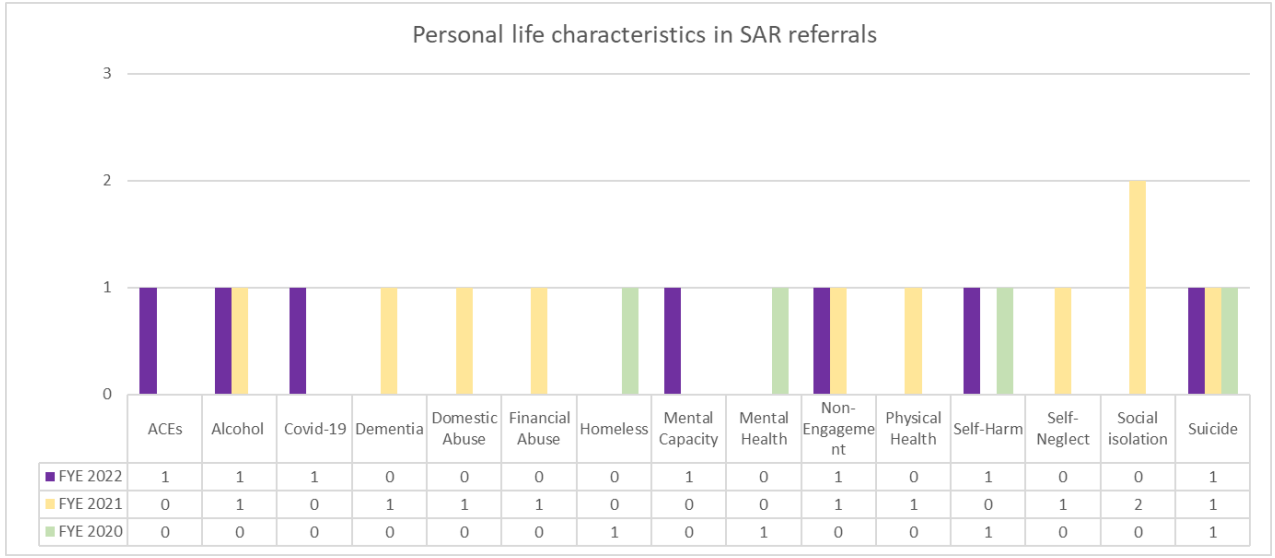
Our analysis shows that locally there has been a pattern of annual increases and decreases in referral rates, as illustrated in the table opposite. However, we need to ensure that the Safeguarding Adults Partnership is not missing opportunities for reviews and learning. For this reason, and to increase professional confidence around SAR referrals, next year we will be relaunching targeted learning and briefings around the SAR referral process.

Looking at the referrals received over the last 2 years, 58% (11) were for men and 42% (8) for women. The most common age categories were 55-64 (26%) and 45-54 (21%).

Year	SAR Referrals Received	Referral outcome		
		Did not meet SAR criteria	Met SAR criteria	Other review commissioned
2018/19	12	5	2	5
2019/20	5	3	1	1
2020/21	18	12	1	5
2021/22	1	1	0	0

The referral received in 2021/22 was for a man in his early 60's who completed suicide. We have seen an increasing trend of suicide in referrals for both Safeguarding Adult Reviews and Domestic Homicide Reviews, and in 2022 we will be holding a thematic learning event which will explore some of our emerging themes from referrals and completed reviews.

SAR referrals received by the Partnership evidence that adults have multiple and complex vulnerabilities. Based upon the available data, there does not appear to be a clear priority for us to focus on, as themes / characteristics appear in conjunction with one another. There is work to do on embedding our work around suicide awareness and prevention, and this will be picked up through work in conjunction with the Safer Stockport Partnership as we share learning from SARs and DHRs.



Safeguarding Adults in Stockport

Priority Area: Neglect and Self Neglect

Local Context

Data at the end of Q4 2021/22 showed that completed Section 42 enquiries for Neglect and Acts of Omission were higher in Stockport (167.7 per 100,000) than the Greater Manchester Average (156.6 per 100,000) and North West Average (137.9 per 100,000)[4]. There are significantly fewer Safeguarding Concerns for self-neglect than regional averages, however self-neglect was the third highest identified concern for cases presented at MAARS Panel this year.

The performance data tells us that there is more work to be done around Neglect and Self-Neglect and this will be reflected in our priorities for next year.

Our progress in this area has not been as substantial as we would have hoped this year, and as such we will prioritise this through discussions and scrutiny at our Practice Improvement Partnership and Quality Assurance Partnership. In particular, we have more to do in hearing adults voices and their lived experiences where we are aware of concerns regarding neglect and self-neglect.

Our last multi-agency audit on self-neglect took place in 2019. We will therefore be exploring this theme through a learning hub next year, as we want to ensure that the lower rates of self-neglect we have seen locally are an accurate reflection of adults living in Stockport and no cases have gone unreported or addressed through other routes.

Area	Self-Neglect per 100,000
Stockport	12.2
Greater Manchester Average	41.8
North West Average	40. 6

Area	Neglect & Acts of Omission per 100,000
Stockport	167.7
Greater Manchester Average	137.9
North West Average	156.6

What have we achieved this year?

- GMFRS have implemented *safe and well interventions* to help support vulnerable adults who may be self-neglecting

What will we do next year?

- We will develop and deliver multi-agency training on neglect and acts of omission
- We will continue to analyse and share learning from other SABs both regionally and nationally to benchmark our current position on neglect and self-neglect, via our sub-groups
- We will deliver a learning hub with a focus on self-neglect to extract and explore learning from current practice, and to inform a refresh of our strategy and practitioner toolkit
- We will begin the refresh our multi-agency Self Neglect strategy

Priority Area: Complex Safeguarding

Local Context

Stockport has low reported cases of Modern Slavery compared to other Greater Manchester local authority areas[5], however we wanted to ensure that this year we were supporting all professionals to recognise and respond to cases of Modern Slavery and Human Trafficking. This resulted in completion of our Modern Slavery Strategy, written and delivered in conjunction with the Safeguarding Children Partnership and Safer Stockport Partnership.

We have seen an increase of adults with multiple vulnerabilities presented at MAARS Panel, and 15% of cases were referred by the Leaving Care Team.

An audit of MAARS, which entailed both cases and processes, was completed by the SSAP Business Unit in August 2020. The audit acknowledged some of the complexities of cases that transition from children to adult services, and the need for better improved case recording and processes in place to support individuals.

Area	Modern Slavery	Sexual Exploitation
Stockport	0.4	1.3
Greater Manchester Average	1.1	2.3
North West Average	1.3	2.8

As our multi-agency guidance for MAARS is developed and launched next year, we have more to do around scrutinising the cases heard at MAARS, and understanding the needs of this cohort.

What have we achieved this year?

- We started working with a national community of practice group supported by Research In Practice and LGA to support the work of our Complex Safeguarding Sub Group
- We finalised our Modern Slavery Strategy in conjunction with the Safeguarding Children Partnership and Safer Stockport Partnership

What will we do next year?

- We will explore our approach and collective offer to young people moving from children to adult services
- We will further develop our analysis and understanding of MAARS Panel to strengthen our oversight of the cohort of adults being discussed under that process
- Develop and roll out resources around Modern Slavery and Human Trafficking, FGM and Honour Based Abuse and Cuckooing in support of our new strategy

Priority Area: Domestic Abuse

The Domestic Abuse Partnership Board launched the Stockport multi-agency Domestic Abuse Strategy this year, which was shared at the Joint Executive Board in March 2022.

There were significantly fewer Section 42 enquiries completed for domestic abuse in Stockport compared with the North West average. The same is true for psychological abuse. However, rates of physical abuse present in completed Section 42 enquiries were significantly higher than the Greater Manchester average, and in line with the North West average[6].

Area	Domestic Abuse	Physical Abuse	Psychological Abuse
Stockport	3.5	96.4	39.5
Greater Manchester Average	14.1	75.7	50.9
North West Average	34.5	98.2	77.7

Governance structures and partnership arrangements in Stockport have been strengthened this year to establish the Domestic Abuse Partnership Board which has a dedicated remit of domestic abuse in Stockport. One major piece of work that was completed last year was a multi-agency MARAC audit, overseen by the Domestic Abuse Training and Coordination Manager.

Next year we will continue to work alongside the Safer Stockport Partnership and strengthen assurance reporting between the Safeguarding Adults Partnership and Domestic Abuse Partnership Board to ensure work is not being duplicated across local governance structures.

What have we achieved this year?

- We received information from the Safer Stockport Partnership regarding an audit of local MARAC processes and repeat cases. Assurance about the actions following the findings is still awaited due to personnel changes.

What will we do next year?

- We will continue to seek assurance from the actions following the findings of the MARAC audit.
- We will support the local authority in their White Ribbon[7] accreditation
- We will be auditing all Safeguarding Adult Review and Domestic Homicide Review referrals to seek assurance around review pathways and share any identified learning without delay

Development Spotlight: Homelessness

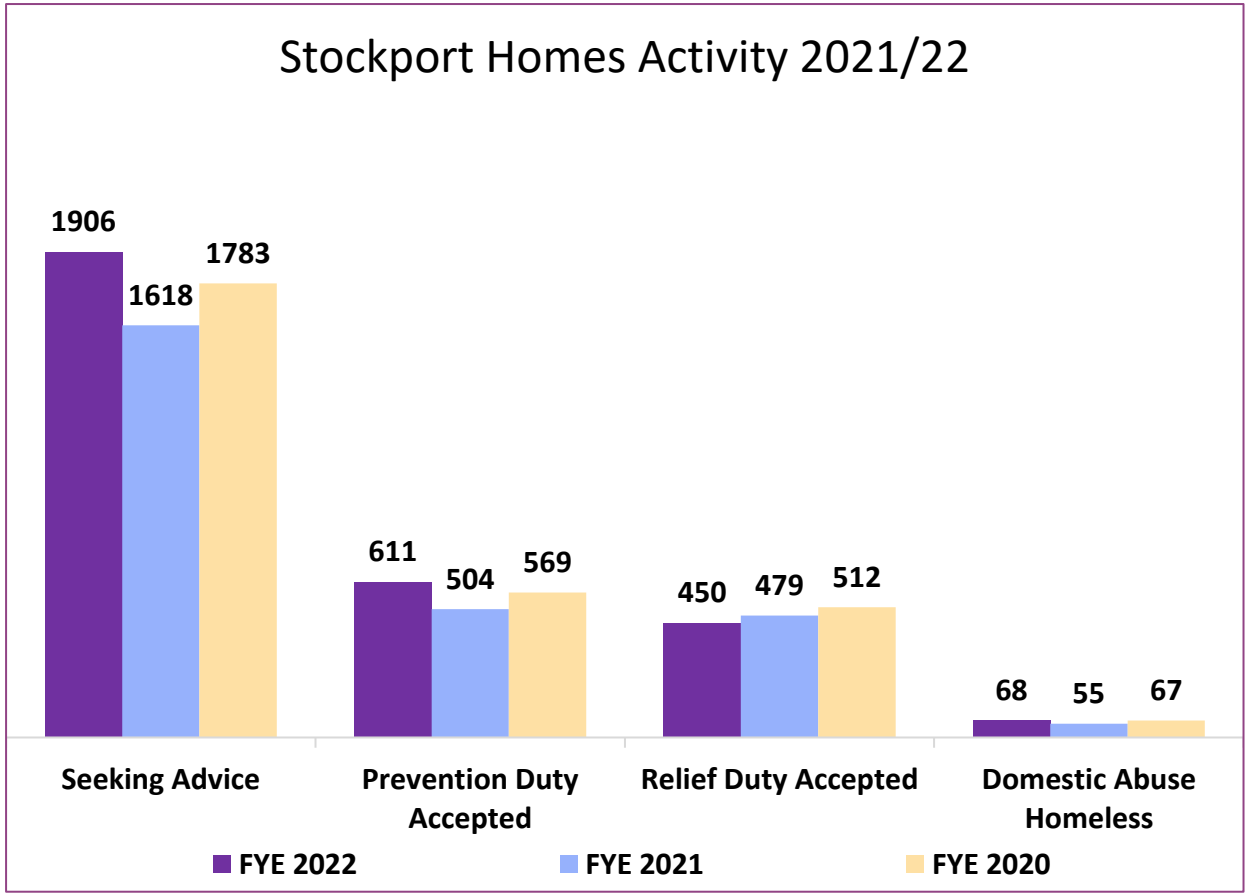
We have worked with Stockport Homes Group to strengthen our response to homelessness in Stockport, through a number of operational and strategic developments. Stockport Homes have launched their new Homelessness Strategy[8] and have already seen developments and improvements including:

- ✓ Appointment of a new Homelessness Intensive Support Worker
- ✓ Appointment of a Hospital Discharge Worker
- ✓ Launch of the Care Leaver pre-tenancy initiative
- ✓ Dedicated worker in MASSH funded by Stockport Homes Group

The impact of the pandemic has seen an increase of people seeking homelessness advice from last year, and a slight increase in the numbers of people subject to domestic abuse homelessness. 39% of cases discussed at MAARS this year included housing / homelessness as a theme.

Our Quality Assurance Partnership scrutinises performance activity around homelessness activity undertaken by Stockport Homes.

As we move into 2022/23 we need to retain our collective focus on safeguarding vulnerable adults at risk of homelessness in light of ongoing cost of living increases. We will continue our oversight of this work throughout 2022/23.



Safeguarding Adults in Stockport

Multi-Agency Safeguarding Policy and Procedure

This year a great deal of work has taken place to review and update our multi-agency safeguarding policy and procedure guidance. This is an important document that sets out local guidelines and expectations around safeguarding adults in Stockport.

We wanted to make sure that this work wasn't completed in isolation, and to make sure all partners were included, we facilitated a number of workshops with the support of an external consultant.

The outcome of this work is a refreshed set of procedures with a simplified definition and explanation of Section 42 processes and how to identify a vulnerable adult who may have care and support needs.

We know that there is more work to be done in this area, and we will continue to refine this to include stronger guidance on our local MAARS and Team Around the Adult processes, as well as guidance for provider-led enquiries where the local authority causes others to make enquiries under Section 42 of The Care Act 2014.

The outcome of this work will be a shared understanding of safeguarding pathways in Stockport, the threshold criteria for different referrals, and a much richer understanding across the partnership regarding consent for information sharing and the principles of making safeguarding personal.

Our current multi-agency safeguarding policy and procedure can be found here and will be updated throughout next year to ensure it remains up to date and accessible for all staff working in Stockport. This will be a priority in our training programme next year, and we will seek assurance around the use and application of these procedures once embedded.

Safeguarding Adults in Stockport

How well do we know ourselves?

The governance structure includes our **Quality Assurance Partnership** which is used to scrutinise and challenge performance information from a number of partner organisations in Stockport.

We have developed our approach to performance information and data analysis to include wider partnership analysis.

In addition to performance reporting through the Quality Assurance Partnership, we also facilitate Harm Levels reporting for all providers. This year the Harm Levels Report was changed to make it more usable and helpful in analysing care providers' performance for specific strengths and areas for development.

Our audit activity was not as strong this year as we have seen in previous years and this is highlighted as an area for development later in this report.

Through the **Practice Improvement Partnership** we have strengthened reporting of how learning from local reviews as well as national changes in legislation and thematic analysis are embedded in practice. We will build on this next year by introducing a standing item at the Practice Improvement Partnership to celebrate good practice. This will also support our development work to embed adults' voices and their lived experiences in our work.

Next year we will continue to strengthen scrutiny and assurance reporting through improved data collection and analysis from the local authority and a renewed focus on audit activity through the launch of the learning hub model. These events will bring together partners to explore specific practice themes through collaborative multi-agency audit activity.

We will also launch Learning From Practice sub group which will focus on monitoring and reviewing actions from all reviews for children and adults to ensure that drift and delay in implementation is avoided in all instances.

Performance Information Headlines

We have developed data dashboards that are presented on a quarterly basis to our Quality Assurance Partnership, as well as other specific forums – for example a Hate Crime data dashboard is presented to the multi-agency Hate Crime partnership. Domestic Abuse reporting is completed via a dashboard to the Domestic Abuse Partnership Board, under the Safer Stockport Partnership governance structure. This ensures that information is not duplicated and scrutiny repeated across different governance structures. We have more to do in terms of incorporating feedback and adult voice in our data reporting and will prioritise this next year. Some of the main performance information headlines we have seen this year are summarised below, and the detail of some key data is shown on the next pages of this report.

- Steady increase in the number of Safeguarding Concerns reported through to ASC, with a marked increase in the number of S42s in the last quarter of the year.
- Steady number of alerts/concerns raised by Age UK, although a decrease in the latter quarter of the year.
- No fire deaths reported from GMFRS and the number of Safe and Well Interventions (Home Fire Safety Assessments) has increased this latter quarter and less reported than in FYE 2021.
- Relatively stable number of MAARS cases throughout the year.
- The majority of Care Homes continue to remain rated as “Good “ by the CQC.
- Increase in the number of Harm Level submissions from Care Providers and less reported anomalies within submissions. Reduction within Slips, Trips and Falls compared to the previous financial year.
- Numbers of homelessness presentations are not dissimilar to those in 2020/21, although there has been a continuing increase in the amount of households asked to leave private rented tenancies.
- Fairly stable Hate Crime figures although slightly higher than the last financial year.
- Substantially higher number of MARAC cases compared to the same timeframe last year. The percentage of repeat cases has recently continually increased after a long period of stability.
- GMP Beat Area Domestic Abuse incident figures are higher than in previous financial years.
- The number of Home Fire Safety Assessments delivered has increased during the latter quarter, when compared to previous quarters during 2021/22. One fire death reported from GMFRS in 2021.

Safeguarding Adult Activity

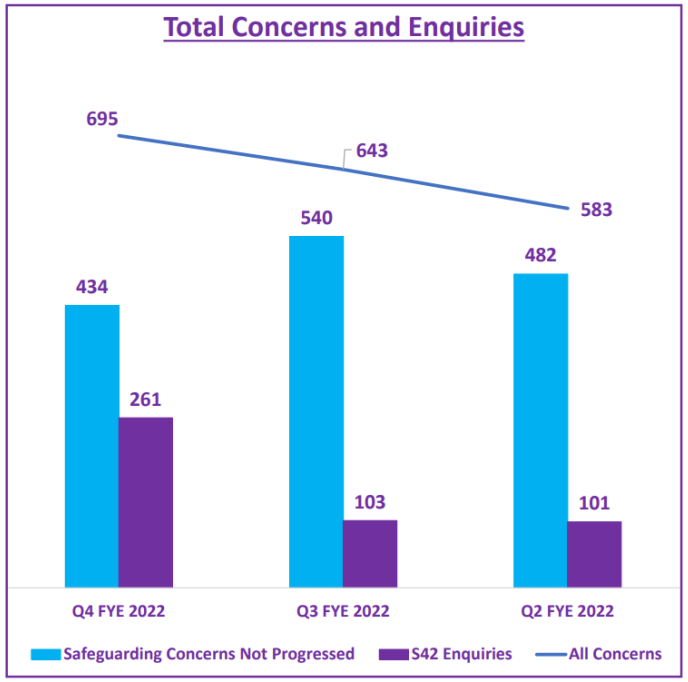
The rate of safeguarding concerns started per 100,000 this year was lower than the North West and Greater Manchester averages[9], although we did see an upward trend of concerns throughout the year[10]. The rate of concerns progressed to a safeguarding enquiry was lower than the North West average but in line with the Greater Manchester average.

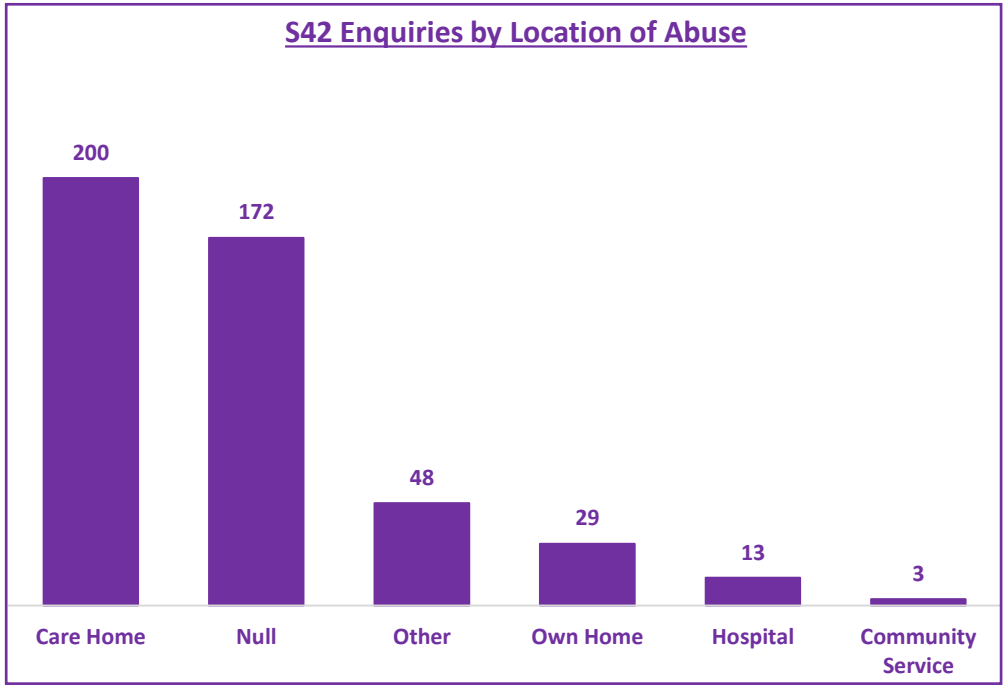
Direct comparisons with last year are not possible as due to data collection issues, scrutiny of performance information from Adult Social Care did not commence until Quarter 2.

Area	Rate of safeguarding concern started per 100K	Rate of safeguarding concerns progressed to enquiry per 100K
Stockport	786	241
North West Average	971	310
Greater Manchester Average	1226	240

The majority of S42 enquiries were for adults in care homes, with a very small proportion (29 enquiries) for adults living in their own home. This is a significant decrease from the previous 2 years and continues the downward trend of this location. One possible explanation for this could be the progressive easing of lockdown restrictions over the last 24 months and more adults gaining more freedom in movement and accessing their communities and other locations.

A focus for data analysis and scrutiny next year will be improving quality and reducing the frequency of *null* and *other* in data recording.





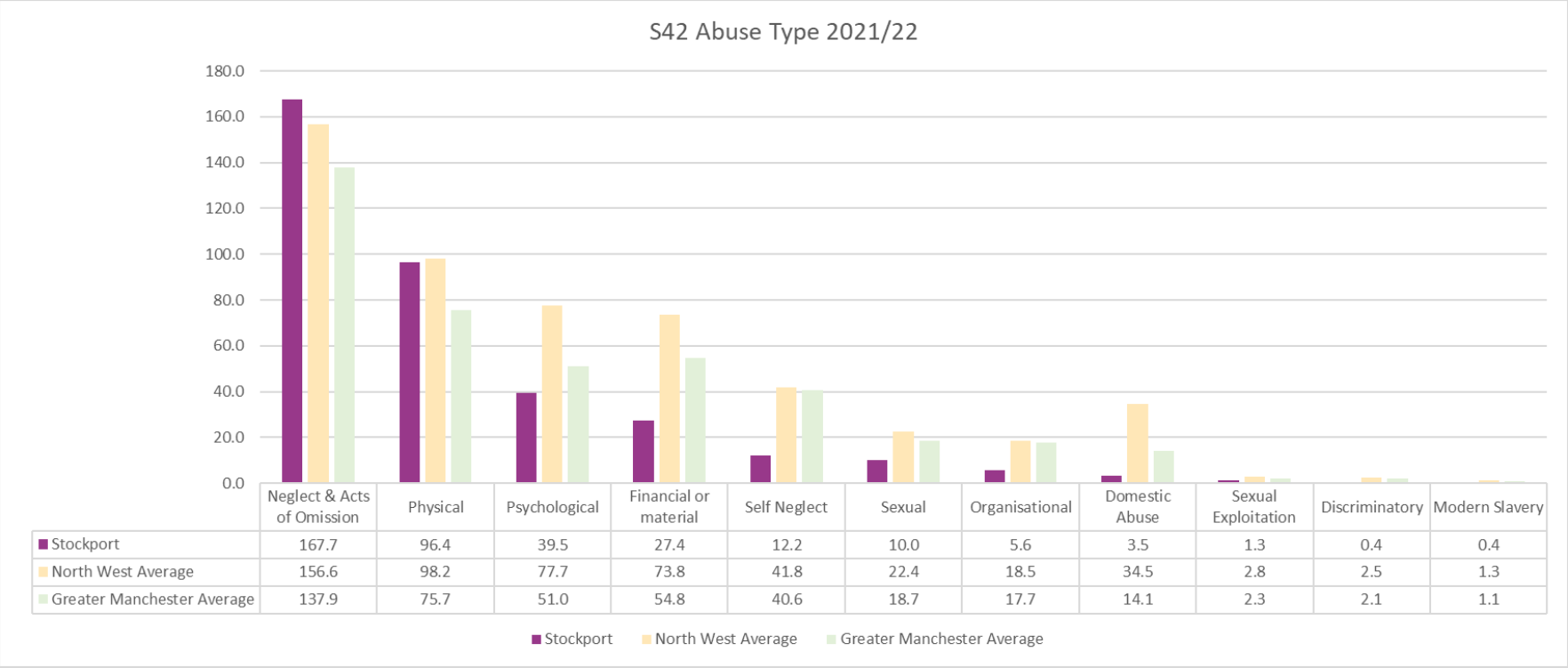
Safeguarding Adult Activity

The most common enquiry type recorded this year was *neglect and acts of omission* which matched with comparator data as the most prevalent enquiry type[11]. This matches last year where neglect and physical were the most prevalent types of risk.

We have seen significantly fewer instances of domestic abuse, self-neglect and financial or material abuse this year when compared against North West and Greater Manchester averages. Exploring reporting of self-neglect, and our multi-agency response, will be picked up via the Quality Assurance Partnership in the coming year to make sure that we are identifying all relevant adults who may be at risk of self-neglect.

The rate of repeat enquiries in a 12 month period was in line with the North West and Greater Manchester averages, which suggests that there are no more adults left in a position of risk following statutory intervention than local and regional comparators.

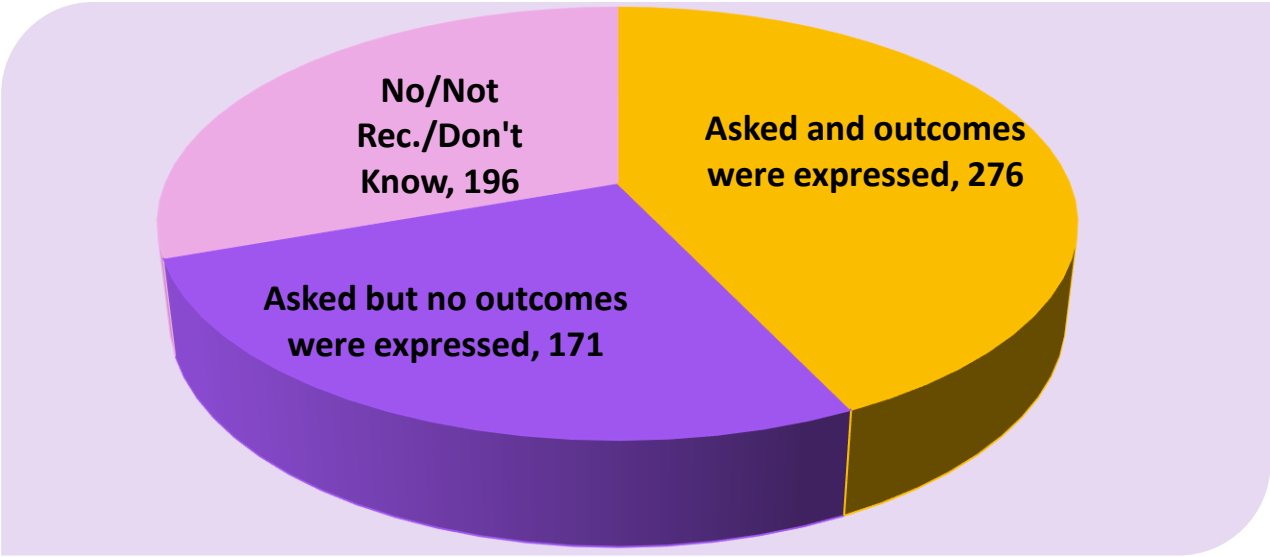
Area	Adults for whom a concern started per 100K	Adults with more than one S42 enquiry in a rolling 12 month period per 100K
Stockport	786.0	40.0
North West Average	964.4	43.4
Greater Manchester Average	1198.1	40.6



	Neglect & Acts of Omission	Physical	Psychological	Financial or material	Self Neglect	Sexual	Organisational	Domestic Abuse	Sexual Exploitation	Discriminatory	Modern Slavery
Stockport	167.7	96.4	39.5	27.4	12.2	10.0	5.6	3.5	1.3	0.4	0.4
North West Average	156.6	98.2	77.7	73.8	41.8	22.4	18.5	34.5	2.8	2.5	1.3
Greater Manchester Average	137.9	75.7	51.0	54.8	40.6	18.7	17.7	14.1	2.3	2.1	1.1

Safeguarding Adults in Stockport

Performance Data – Making Safeguarding Personal

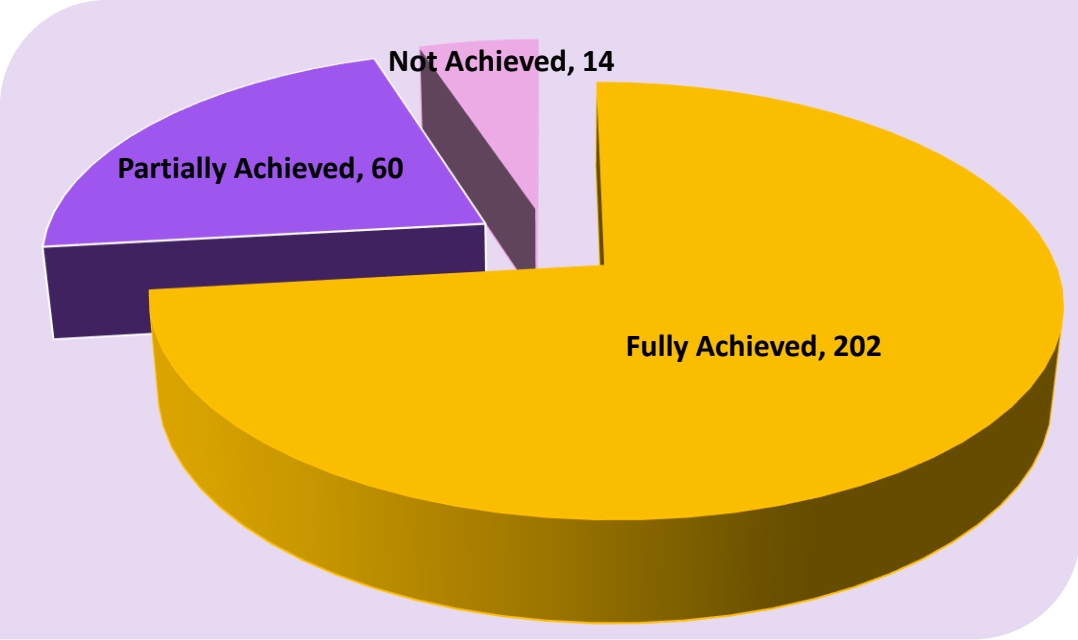


In FYE 2022, out of the 276 people who expressed an outcome preference, the local authority was able to meet 95% of these fully or partially. This is an increase from last year where 92% of outcome preferences were met (partially or fully).

An area of development continues to be the number of individuals reported as "Not Asked/Not Recorded/Don't Know"; this year 30.5% of individuals were marked as No / Don't Know / Not recorded which is higher than the Greater Manchester average (22.3%) and North West average (20.6%). We will continue to monitor this in 2022/23.

Local performance for Making Safeguarding Personal (MSP) outcomes shows that more outcomes were fully achieved in Stockport than the North West and Greater Manchester averages[12] .

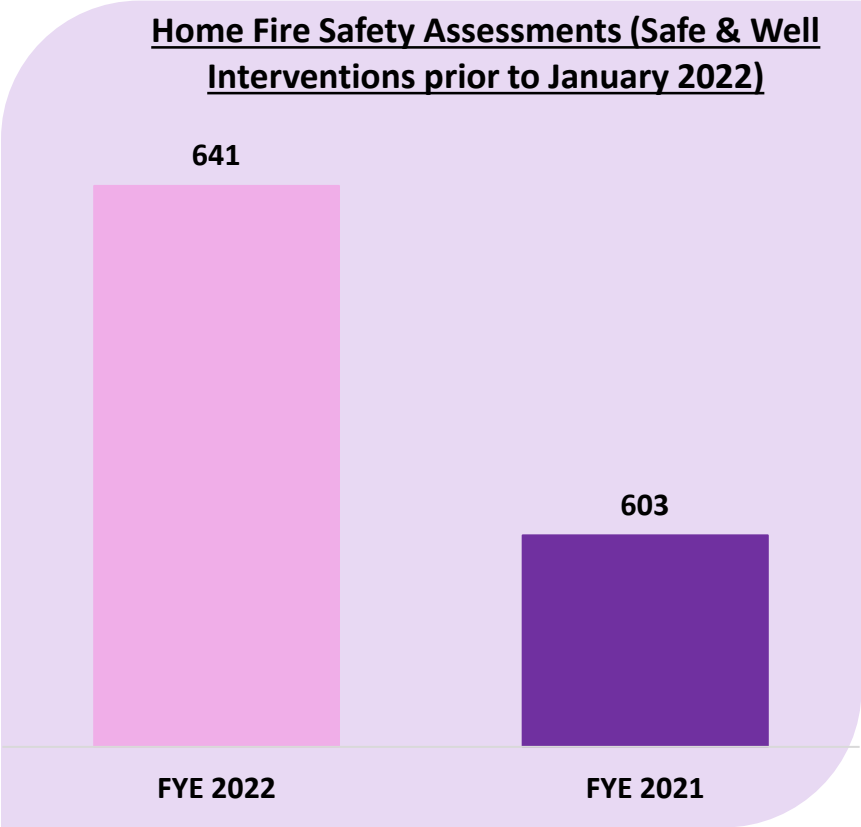
In FYE 2022, 447 people (70%) were asked what outcomes they would like, 276 expressed a preference. This is in line with performance last year where 70% (292 individuals) were asked.



Area	MSP Outcomes fully achieved per 100K	MSP Outcomes Partially Achieved per 100K	MSP Outcomes not achieved per 100K (%)
Stockport	73.2%	21.7%	5.1%
North West Average	67.3%	26.2%	6.5%
Greater Manchester Average	69.9%	22.1%	8.0%

Safeguarding Adults in Stockport

Performance Data – Fire risk and deaths



Safe and Well Intervention data was only collated from Quarter 2 FYE 2021 and replaced with Home Fire Safety Assessments in January 2022.

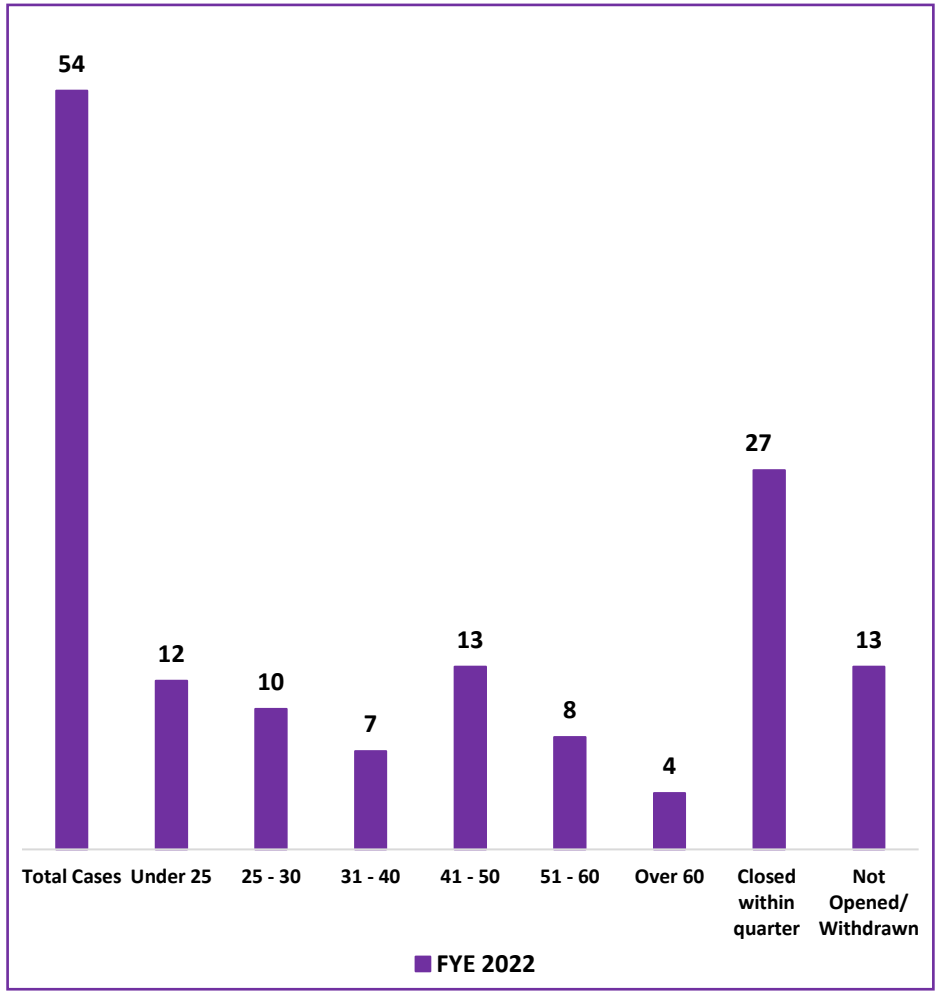
Performance Indicator	FYE 2021	FYE 2022
No. of Fire Deaths	1	0

Home Fire Safety Assessments

Greater Manchester Fire and Rescue Service (GMFRS) launched a new Home Fire Safety Assessment (HFSA) in January 2022, which involves completion of an online Home Fire Safety Check to determine the level of fire risk of an individual, and to confirm if they are eligible for a home visit (the HFSA has replaced our previous Safe & Well visits). The key change is the removal of the existing universal offer, and now only individuals with either a medium, high, or very high fire risk are eligible for a HFSA visit within the home. This enables targeting of resources to those at increased risk of fire. Any individuals who are assessed as having a low fire risk will be provided with fire safety advice on completion of the online Home Fire Safety Check. Members of the public without access to the online system can still self-refer by telephoning the GMFRS Contact Centre, who will run through the online Home Fire Safety Check with them. A dedicated HFSA page for partners is available at: Home Fire Safety Assessments Partners - Greater Manchester Fire Rescue Service, and includes details on how to make a referral.

The National Fire Chiefs Council (NFCC) have published a new Safeguarding Fire Standard that sets out priorities for Fire & Rescue Services. The Standard aims to ensure that Fire & Rescue Services are doing all that they can to support safeguarding, working proactively to promote the safeguarding of those within their communities as well as employees and volunteers, and, in doing so, reducing the risk of abuse, harm and neglect. The standard accompanies the NFCC Safeguarding Guidance for Children, Young People and Adults. Further details available at: Safeguarding | Fire Standards Board.

MAARS (MAARS is the Multi Agency Adults at Risk System)

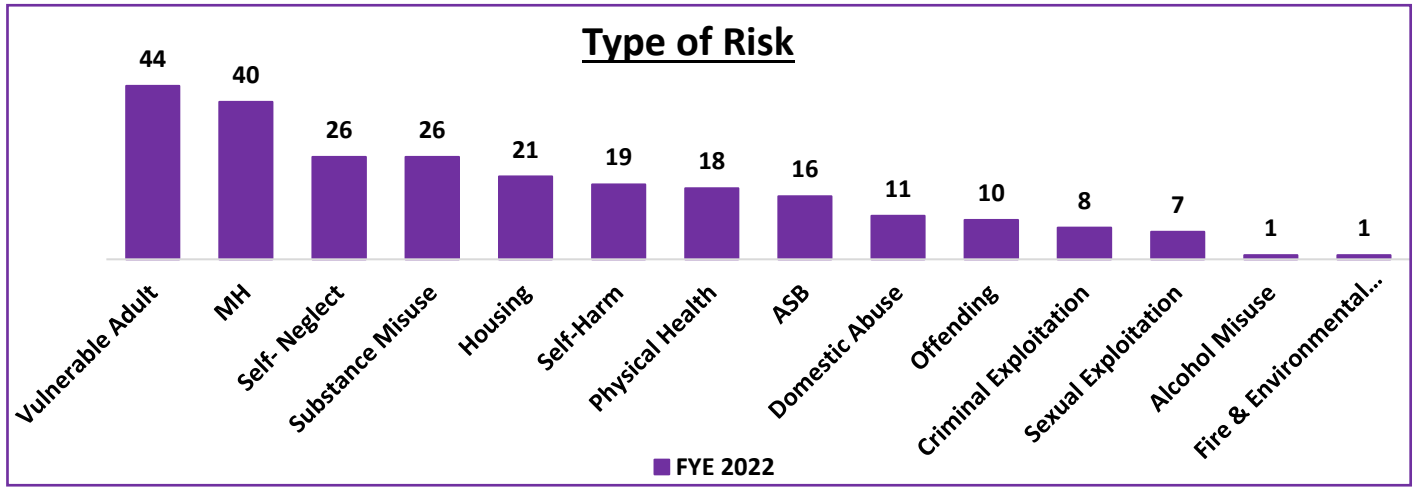


MAARS is a multi-agency forum for professionals to refer vulnerable adults who do not have care and support needs, but who have multiple vulnerabilities in the community.

Our data collection and analysis of MAARS has been an area of improvement this year and we will continue to develop this next year.

Of all the cases referred this year, 22% (12) were for young adults aged 18-25 which is a significant increase from only 4 cases in this age category the previous year. This further signifies the importance of reviewing and refining our approach to complex and transitional safeguarding across the borough.

The most common referral source was Stockport Homes, followed by the Leaving Care Team (2nd highest referral rate) and then Adult Social Care, Greater Manchester Police and Stockport NHS Foundation Trust.



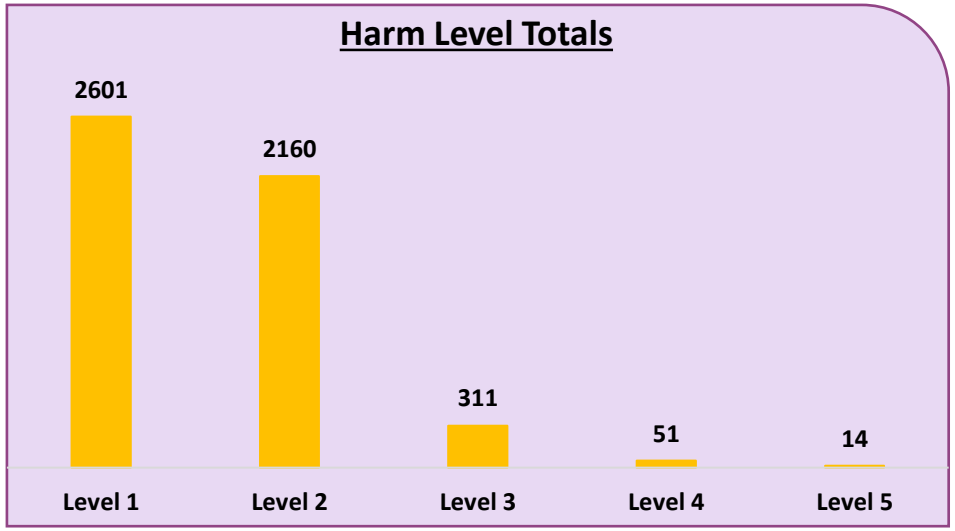
Safeguarding Adults in Stockport

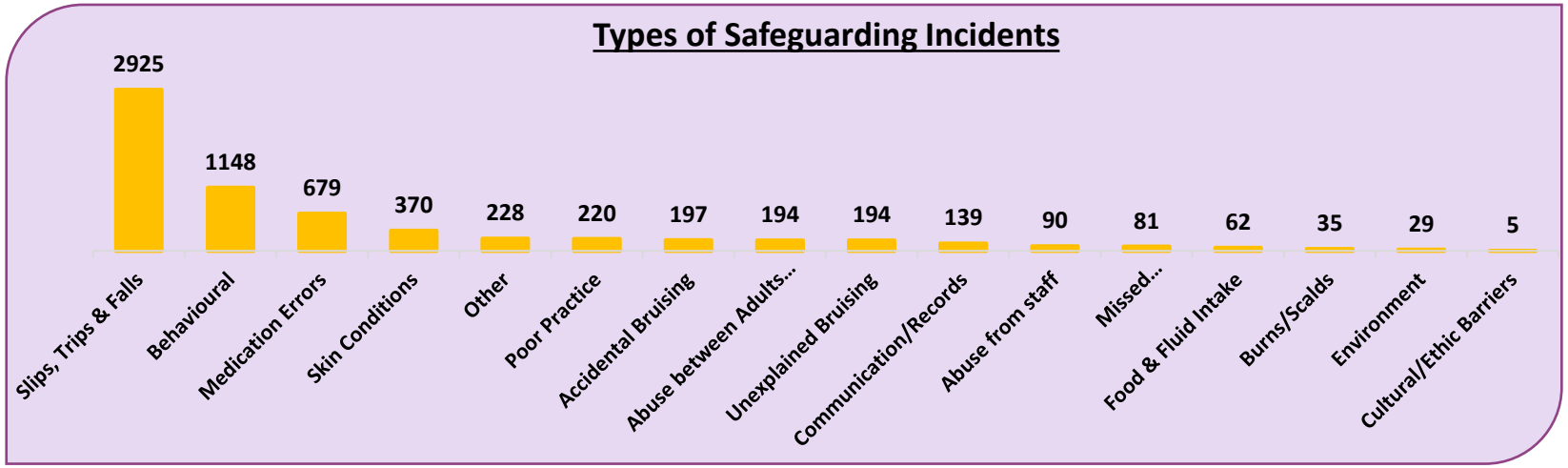
Performance Data – Harm Levels

Harm Levels were introduced across all providers to support decision making that will result in the most appropriate pathway to address adult protection concerns.

They provide a consistent approach to the response and investigation of adult protection concerns across Stockport. The system can also be used to provide assurance that an internal investigation, by a provider service, is appropriate as opposed to multi-agency response. Harm Levels have created a balanced response to adult protection concerns in Stockport, ensuring the views of adults at risk and/or their representative, remains central to the process and in line with making safeguarding personal. Guidance is available on the local authority website[13] and draws on the thresholds (ADASS North East) and National Patient Safety Guidance (NHS England) and outlines 5 levels of harm and the appropriate response to each level.

Regular reporting of Harm Levels data and activity takes place via the Quality Assurance Partnership.





Each service provider is asked to complete a quarterly return for their Harm Levels reporting activity. We saw variation in compliance throughout the year with a peak of 79.5% returns in Quarter 2.

Slips, Trips and Falls, Behavioural and Medication Errors being the three main themes was a regular pattern across the quarters. Slips, Trips and Falls was an area that the Quality Monitoring Team have continued to offer extra support to the Care Provider network in collaboration with Steady in Stockport.

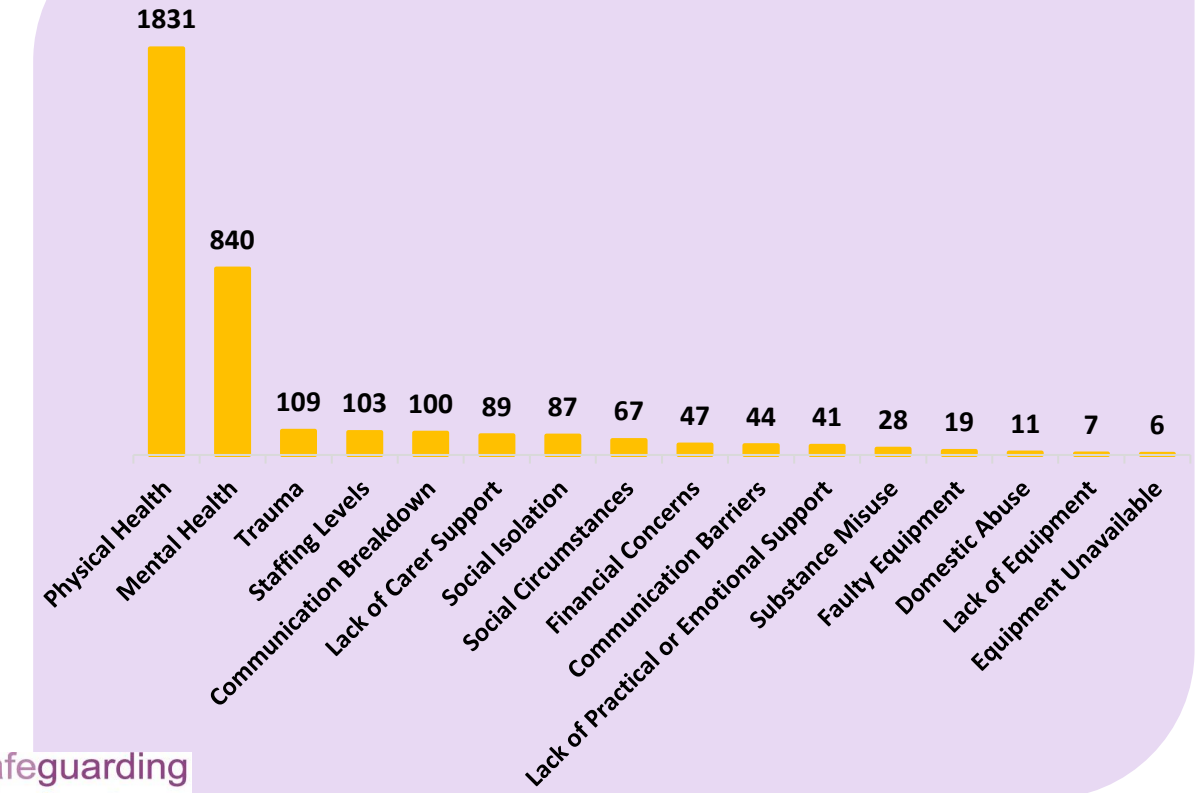
61% of all falls occurred in an adult residential care setting, followed by 29% in a nursing care setting. 3.3% occurred in a Learning Disability setting.

Safeguarding Adults in Stockport

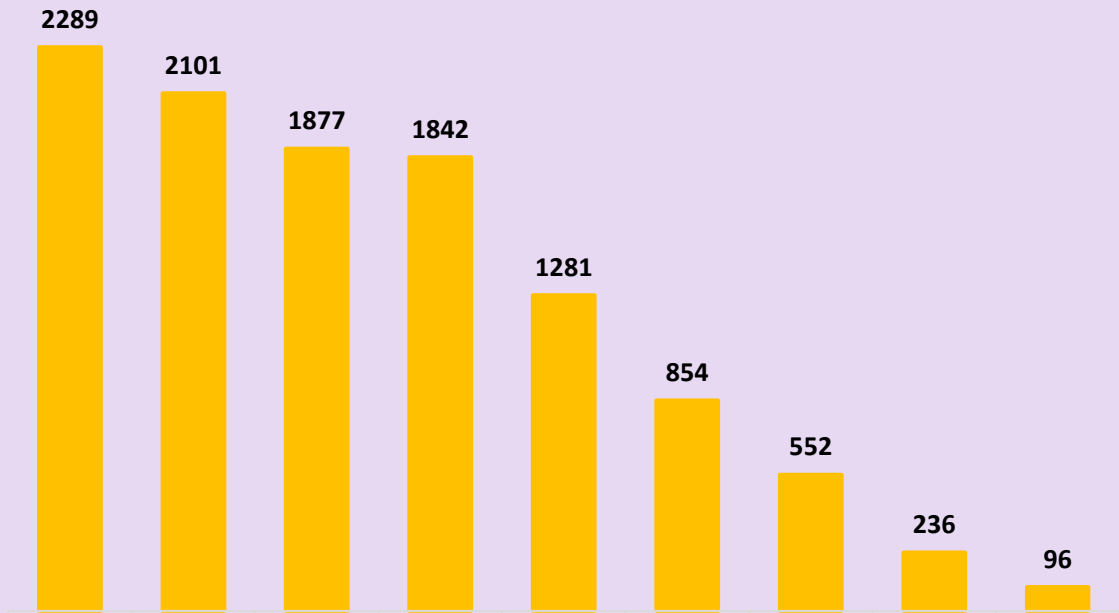
Performance Data – Harm Levels (cont.)

The three main risk factors were Physical Health, Mental Health and Trauma. During the Covid pandemic in FYE 2021, we saw an increase in Social Isolation figures; however by the end of FYE 2022 these figures were decreasing. In the last two quarters of FYE 2021, there was also a significant increase in the Staffing Levels figures, however this figure has also significantly decreased at the latter end of FYE 2022.

Risk Factor Totals



Learning Elements



Safeguarding Adults in Stockport

Learning and Development Data

This year we continued to promote the learning and development offer across the partnership, through our offer of multi-agency training. We continued to deliver training virtually this year in light of ongoing restrictions and working arrangements falling out of the pandemic.

Whilst we recognise the benefits of online training in that it can promote attendance and allow an element of flexibility for professionals, we want to bring face to face training back next year.

We will continue to develop and grow the training offer across the Partnership, and following the launch of our Modern Slavery and Human Trafficking Strategy next year, we will roll out bespoke training in line with the strategy. We will also develop and offer multi-agency training around our updated safeguarding procedures, including Team Around the Adult and MAARS processes.

As we explore new learning from practice developments and Safeguarding Adult Reviews, we will review and adapt our training offer as required.

Courses	Delegates
Modern Slavery, Trafficking and Cuckooing Learning Circles	417
Alerter Training	216
Hate Crime	101
Week of Action Exploitation GM World Social Work Day	60
Older Persons Domestic Abuse Learning Circle	40
Week of Action Exploitation Partnership Learning Circle	40
Chairing Safeguarding Adults Meetings	34
Safeguarding Adults Referrer Training	26
Enquiry Officer	19
Total	**953**

How well do we know our services?

A core part of the Safeguarding Adults Partnership revolves around seeking assurance and providing scrutiny and challenge back to partner agencies operating in the borough.

Throughout the year we have sought and received assurance in a number of key areas as highlighted below.

This has provided assurance on key practice areas across Stockport which has allowed us to refine our focus our attention on ensuring we are scrutinising and developing the right areas. For example, the additional assurance gained around learning from SAR 6 (Ivy)[14] has helped us to ensure that learning is embedded and we are not at risk as a Partnership of repeating or increasing risk.

As we develop as a Partnership and increase our engagement with vulnerable adults and communities, we will also increase our assurance oversight through our Executive Board and Sub Group structure.

Our activity, beyond audits and data reporting, to understand our collective impact includes the examples shown below.

- Share and Tell session at the Quality Assurance Partnership to understand how learning had been embedded from SAR 6
- Greater Manchester Police presented on VA referrals and risk ratings following attendance at safeguarding incidents
- Pennine Care NHS Foundation Trust and Stockport NHS Foundation Trust co-delivered an assurance presentation on their mental health offer
- Care Home and Domiciliary Care Reporting provides ongoing assurance around commissioned providers and allows us to cross reference with Harm Level reporting analysis
- The Clinical Commissioning Group has presented the LeDeR Annual Report for information and assurance
- Thematic Review on homelessness and safeguarding at the Executive Board on updates and improvements within Stockport Homes
- A residential specialist service for young people aged 16-25 with complex needs provided assurance around their response to ligature incidents
- Adult Social Care have implemented the safeguarding audit tool introduced by the Quality Assurance Partnership, with monthly completion now taking place

Audits

This year our audit activity was less frequent as in previous years, as all agencies continued to respond to the pandemic and prioritise operational work. At a multi-agency level, there were two main pieces of audit activity completed; a multi-agency audit on adults who did not attend appointments, and the statutory bi-annual adult safeguarding assurance statement.

In early 2022 we began an audit process to look at the application and outcome of Section 42 processes across our social care and health partners. This audit did not progress as planned due to a lack of responses which highlighted gaps in our multi-agency policy and procedure. Work has commenced to update and address gaps in important documentation and guidance, and we will re-visit this audit once new procedures are completed and launched.

The Safeguarding Adults Partnership has also received the findings of a MARAC multi-agency audit, although this work was overseen by the Safer Stockport Partnership. As outlined above, the partnership has not received follow up actions from this that would provide assurance of improvement.

In addition we also sought assurance around partners' safeguarding arrangements through completion of single agency audits in August 2021[15]. As we finalise and launch our revised multi-agency safeguarding procedures, we will seek assurance next year from all partners about their application of the revised procedures.

Did Not Attend Appointments: multi-agency audit

What was the audit rationale?

- Multi-Agency Learning Review 3 found learning around how agencies engage with vulnerable adults who do not attend appointments.

What did we learn?

- The importance of effective and meaningful communication with adults who have memory loss or cognitive impairments
- Renewed focus and emphasis is needed on adults' voices in case recording
- There were some good practice examples of strong liaison with families

What are our next steps?

- Improvements to how agencies manage appointment reminders to be implemented
- Consideration to be given to where some appointments are held, including possible transport solutions where appropriate

Adult Safeguarding Assurance Statement

What was the audit rationale?

- All Safeguarding Adult Boards in England complete self-assessments / Quality Assurance Statements to seek assurance on safeguarding processes and learning in partner agencies.

What did we learn?

- Safeguarding information is accessible and available to members of the public and professionals.
- Agencies have committed to workforce development and learning
- There is some development needed in data collection and analysis to arrive at a shared understanding across the borough.

What are our next steps?

- Ensure remote / hybrid working arrangements do not infringe on the quality of supervision and collaborative working
- Review and strengthen safeguarding and care pathways (e.g. MAARS & S42 interface, hospital discharge)

Communications and Engagement

We have continued to maintain and utilise our social media presence this year to share information and engage with professionals and members of the public alike.

We increased our follower count by 22% this year, and our presence on social media had a total reach of 707,000 people.

We want to ensure that our use of social media remains relevant and supports ongoing engagement with our partners and communities.

Campaigns promoted via our twitter account this year have included:

- Neglect and self-neglect
- North West Sexual Violence Awareness Week
- Liberty Protection Safeguards
- Professional curiosity
- How to reduce risk of falls
- Hate Crime awareness weeks

One of our ongoing priorities next year is to increase our engagement with communities, and to also increase adults' voices in line with the principles of Making Safeguarding Personal.

Areas for Development

Our annual report this year has identified a number of areas for further work. These areas are summarised below and will be addressed through the work of our Sub Groups and Executive Board.

- ✓ Improve reporting and scrutiny to include **impact of our collective services** in supporting the most vulnerable adults and families in Stockport.
- ✓ We will strengthen how we disseminate learning from reviews, through establishing our new **Learning Hubs** which provide a dedicated space to explore specific safeguarding themes on a multi-agency basis.
- ✓ Our local **multi-agency safeguarding policy and procedure** document will be finalised and launched, along with refreshed training across the Partnership.
- ✓ We want to continue to develop and promote the reporting of **adults' voices** and understanding their **lived experiences** in the work we do. This will include expanding membership of our Executive Board and Sub Groups and more frequent engagement with community groups.
- ✓ Reintroduce **face to face training** back in our offer, as we move to a hybrid approach of online and in person training and learning events.
- ✓ We will reinforce **guidance around Safeguarding Adult Review referrals** to ensure that all partner agencies understand the criteria and referral processes.
- ✓ The **Terms of Reference for the Safeguarding Adults Partnership Executive** will be reviewed and updated to ensure that our work remains focussed and supports new strategic developments across the partnership, including the move to the Greater Manchester Integrated Care Board.
- ✓ We will further strengthen our approach to **performance data, including the local MAARS Panel** to be assured how safeguarding systems are working in practice.
- ✓ We will complete the **Adult Safeguarding Quality Assurance Statements** which will include specific assurance queries regarding our refreshed multi-agency safeguarding guidance.
- ✓ **Learning from Safeguarding Adult Reviews and Domestic Homicide Reviews** will be shared with all agencies as we better understand the impact of the pandemic on our safeguarding response.
- ✓ Our **Quality Assurance Framework** will continue to be delivered which will include testing how learning from previous reviews has been embedded.
- ✓ Seeking how we can safeguard vulnerable adults and families struggling with the **increasing cost of living**.

What are our priorities for next year?

Our annual report this year reflects the work that has taken place over recent years, organisational pressures and the changing policy and legislative landscape we are operating in. As we continue on our journey of prioritising and promoting the safeguarding of some of our most vulnerable residents, we will focus our attention on the below priorities.

To seek assurance that our activity continues to make a difference to the people of Stockport, we will revisit these priorities at our Executive Board meetings, and in our annual report next year. This will complement our 3 year Business Plan.

We recognise that we have more work to do to progress delivery of our Business Plan and this is reflected in our identified priorities for next year.

Thematic area	What do we need to improve?	How will we know we've been successful?
Complex Safeguarding	We will develop our approach to transitional safeguarding using learning from case reviews and practice, as well as regional and national analysis and learning.	A dedicated offer for young people who move from children to adult services, will be in place. which will clearly outline support available for those with and without care and support needs.
Neglect and Self-neglect	We will ensure that instances of self-neglect are correctly identified and recorded in our partnership data, and that information and resources for practitioners and members of the public are available and accessible.	Concerns about self neglect will be shared in a timely way. The website will contain updated links and guidance, and we will have shared learning via the Quality Assurance Partnership.
Domestic Abuse	We will continue to share information and seek assurance from the Safer Stockport Partnership in this area of work, to avoid duplication of effort across the partnership.	Both partnerships will understand the local multi-agency approach to Domestic Abuse, and senior leaders will know where reporting takes place.
Partnership Developments	We will support colleagues across the Partnership as we move to new working arrangements under the Greater Manchester Integrated Care Board (ICB).	Information shared and received at the Safeguarding Adults Executive Partnership will promote and embed new working arrangements and reporting structures in the ICB.

Appendix A: Glossary of Terms

Acronym	Definition
ASC	Adult Social Care
CCG	Clinical Commissioning Group – *will become Integrated Care Board from July 2022*
CQC	Care Quality Commission
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
FGM	Female Genital Mutilation
GMFRS	Greater Manchester Fire and Rescue Service
GMP	Greater Manchester Police
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services
ICB	Integrated Care Board
LeDeR	Learning Disability Mortality Review
LGA	Local Government Association
LPS	Liberty Protection Safeguards
MAARS	Multi-Agency Adults at Risk System
MARAC	Multi-Agency Risk Assessment Conference
MASSH	Multi-Agency Safeguarding and Support Hub
PCFT	Pennine Care NHS Foundation Trust
S42	Section 42
SAR	Safeguarding Adult Review
SSAP	Stockport Safeguarding Adults Partnership

Appendix B: SSAP Partner Agencies

Agency	Role
Stockport Safeguarding Adults Partnership	Independent Chair Business Manager
Age UK	Safeguarding Lead
Greater Manchester Fire and Rescue	Prevention Manager / Designated Safeguarding Officer
Greater Manchester Police	District Commander Detective Superintendent
HealthWatch Stockport	Safeguarding / Senior Lead
North West Ambulance Service	Safeguarding Practitioner
Pennine Care NHS Foundation Trust	Director of Quality, Nursing and AHPs Head of Safeguarding
Stockport Metropolitan Borough Council	Cabinet Member for Health & Adult Social Care Corporate Director People and Integration Director of Adult Social Care Head of Safeguarding and Learning Head of Commissioning and Infrastructure Principal Social Worker and Head of Safeguarding Senior Service Manager Workforce Development Service Lead, Aspire Complex Safeguarding Lead for Substance Misuse and Public Health Representative Strategic Head of Place Management Strategic Housing Lead
NHS Stockport Clinical Commissioning Group	Executive Nurse Designated Nurse for Adult Safeguarding & Mental Capacity Act Lead
Stockport NHS Foundation Trust	Deputy Chief Nurse Head of Safeguarding
The Probation Service	Head of PDU for Stockport and Trafford Safeguarding Lead

Appendix C: SSAP Governance

The SSAP Executive is chaired by our Independent Chair, under the new arrangements Stockport Safeguarding Partnership continued with the Independent Chair arrangements as they valued the scrutiny and challenge that an independent person brought. The Vice-Chair will be one of the three Statutory Partners nominated each year.

Practice Improvement Partnership

The work of this partnership group is underpinned by a Learning and Improvement Framework, and is responsible for overseeing case reviews; initiating, reviewing and endorsing policy and practice guidance/standards; learning from published inspections, case reviews and research to continuously improve the quality of services and outcomes for vulnerable adults and their families / carers.

Quality Assurance and Scrutiny Partnership

The work of this partnership group is to scrutinise and challenge the work of the partners by integrating a range of information and is underpinned by a Quality Assurance Framework and dataset. This subgroup is responsible for the moderation of all completed action plans for case reviews that have been overseen by the Practice Improvement Partnership and will oversee a programme of multi-agency audit.

Complex Safeguarding

Co Chaired by the Head of Service, Stockport Family and the Principle Social Worker, Adult Social Care. This group 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 Partnership Training Manager. The group is 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. The Multi-agency trainer will continue to develop the Learning Hub approach in the in the next year to ensure learning is embedded routinely for the multi-agency workforce. The dissemination and embedding of learning is available in a separate report, however, the Partnership is satisfied and assured that training has continued at a pace through a variety of methods during and following the pandemic.

SAR Review Panel

Chaired by the Head of Service, Safeguarding and Learning, the purpose of this group is to consider serious safeguarding incidents in line with Section 44 of The Care Act (2014) 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).

Appendix D: End Notes and References

1. Six Steps for Independent Scrutiny, Safeguarding Children partnership arrangement Jenny Pearce (2019)
2. The Care Act 2014 - https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
3. Greater Manchester SAR Analysis paper, presented to Safeguarding Adults Partnership Executive Board 14.07.2022
4. Data reported in North West ADASS Q4 report 2021/2022
5. Data reported in North West ADASS Q4 report 2021/2022
6. Data reported in North West ADASS Q4 report 2021/2022
7. The White Ribbon Charity is an organisation aimed at raising awareness and reducing male violence against women: https://www.whiteribbon.org.uk/
8. https://www.stockporthomes.org/find-a-home/homelessness/homelessness-strategy/#HomelessStrategy
9. Data reported in North West ADASS Q4 report 2021/2022
10. SSAP Quarter 4 FYE 2022 data dashboard – reported to Quality Assurance Partnership 23.06.2022
11. All data on this page is data reported in North West ADASS Q4 report 2021/2022
12. Data reported in North West ADASS Q4 report 2021/2022
13. https://www.stockport.gov.uk/harm-levels/harm-levels-guidance-for-service-providers
14. SAR 6 “Ivy” – published September 2020 http://www.safeguardingadultsinstockport.org.uk/wp-content/uploads/2021/04/Multi-agency-learning-review-Ivy.pdf
15. Single agency Safeguarding Audit reported at Quality Assurance Sub Group 23.09.2021