Safeguarding Adults in Stockport

Stockport Safeguarding Adults Board

Annual Report 2018/19

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Foreword from Independent Chair

I am pleased to present the 2018-19 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 keeping adults at risk safe.

We hope that you will find that the report helps you to better understand how organisations and people work together and the contribution the Safeguarding Board has made to this. It sets out how these arrangements can continue to improve 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.

Safeguarding is about people -their wishes, aspirations and needs. What we as a Board do has to be judged in terms of whether it has placed adults in need of safeguarding at the centre of its work. How well we hear and respond to what people want is the measure of our success. I am confident we have the right mechanisms in place to carry out our role,

Stockport Safeguarding Adult Board members are fully committed to the principle that safeguarding vulnerable people is everyone's business. We want to ensure that all the communities in Stockport are equipped to play their part in preventing, detecting and reporting neglect and abuse.

During 2018-19 we have continued to build our relationship with the Safeguarding Children Board, of which I am also the chair. We have a set of shared priorities:

- Domestic Abuse and Violence;
- Neglect;
- Transitions
- Complex Safeguarding

These are underpinned by 4 shared objectives:

- Governance;
- Scrutiny, challenge and quality assurance;
- Learning and development;
- Communication.

Our strategic plan covers the period 2017-2020 and the report sets out what we have achieved against the plan – pages11.

Both the Adult and Children Boards are committed to align where appropriate our areas for focus. In order to ensure that we progress this for the past 3 years have held joint development days. The development day in January 2019 considered a number of themes:

- Overview of developments from a local and Greater Manchester perspective;
- Reconfirmed the vision and agreed the values that underpin our vision – the values are shared values with the Childrens Partnership and can be found at page 8 of the report;
- Reviewed the current subgroup arrangements and brought these in line with the arrangements for children which saw a reduction in the number of subgroups to 2 focussing on Quality Assurance and Practice Improvement with 3 joint working groups – Complex Safeguarding, Early Help and Prevention and Training. In 2019-2020 we will embed these new arrangements into the core business of the Board.

Over the last 12 months we have seen a number of developments and improvements being put in place in order to enhance safeguarding or to minimise the risk of harm to adults at risk. These include:

- Produced our Self Neglect Strategy and Practice Guidance and provided a range of training to front line practitioners;
- Developed a Complex Safeguarding Strategy – jointly with the Safeguarding Childrens Partnership;
- Delivered a number of Safeguarding Adult Review Briefing Sessions;
- Participated in a Peer Review with Oldham Council – page 18;
- Expanded our training for professionals and organisations working with vulnerable adults, with almost 3000 people attending a variety of programmes – page 21;
- We have improved our communication through quarterly newsletters; more information available on the website;
- Supported the Dignity in Care Competition in February 2019 – which showcased the work of the Independent Sector.

One of the key areas of challenge this year and likely to continue into 2019-20 for some Board partners, and particularly for staff in the Safeguarding Board unit, has been the growth in the number of requests for the Board to consider undertaking a Safeguarding Adult Review (SAR). You can find out more details about SARs in section 9 (page 22) of this report. SARs are concerning but they can also act as 'a window on the system', so that we can ask not just what has happened in this individual case, but what it tells us about the appropriateness and quality of agencies with responsibility to safeguard people who are at greater risk and unable to protect themselves in our communities.

The Liberty Protection Safeguards (LPS) are the legislative framework for authorising a deprivation of liberty and will 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 2019-20 as a Safeguarding Partnership we will ensure that training, practice guidance and appropriate roles in place to effect a safe transition to the new arrangements.

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.

Independent Chair

2.0 Introduction

This report explains who is involved in the work of Stockport Safeguarding Adults Board (SSAB), how the SSAB has conducted its business during the year, what has been achieved, and the SSAB's relationship with other partnerships.

This is demonstrated through a summary of the work of the sub groups and SSAB to achieve its objective:

- What has been done during the year to implement its strategy.
- What each member organisation has done during the year to implement the strategy.
- A summary of the findings of the completed and current Safeguarding Adults Reviews arranged by the SSAB under section 44 (Care Act 2014).
- How learning from SARs and other sources has been implemented.

The report therefore assists analysis and evaluation of achievements, areas for further work and will form the basis for the consultation on the strategic plan for the coming year.

As per guidance laid out in the Care Act 2014, this report will be submitted to:

- The Chief Executive of Stockport Council
- The Leader of Stockport Council
- The Chair of Stockport's Health and Wellbeing Board
- The Police and Crime Commissioner for Greater Manchester Police (GMP)
- The Chief Officer of Healthwatch Stockport
- The Clinical Commissionning Group (CCG) Governing Body

Information regarding SSAB, including this report, can be found on the following link:
Stockport Safeguarding Adults Board Website

3.0 The role of the SSAB

SSAB is a statutory body that works to make sure that all agencies are working together to help keep adults in Stockport safe from harm and to protect the rights of adults to be safeguarded under the Care Act 2014, Mental Capacity Act (MCA) 2005 and the Human Rights Act (HRA) 1998.

SSAB has a strategic role that involves:

- Assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
- Assuring itself that safeguarding practice is person-centred and outcome-focused.
- Working collaboratively to prevent abuse and neglect.
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred.
- Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

How the SSAB fulfils its role

It does this by overseeing and coordinating the effectiveness of the safeguarding work of its member and partner agencies.

Developing and actively promoting a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal'.

In addition, working alongside other partnerships in Stockport, SSAB is also interested in seeking assurance about the responses to a range of issues, which can contribute to the wellbeing of the community and the prevention of abuse and neglect, such as:

- The safety of people who use services in local health and social care settings, including mental health
- The safety of adults with care and support needs living in social housing
- The effectiveness of interventions with adults who self-neglect
- The quality of local care and support services
- Making connections between adult safeguarding and domestic abuse

Vision, Values and Strategic Objectives

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

In February 2019, the SAB refreshed its values jointly with colleagues from the Children's Safeguarding Partnership (SSCP). Our refreshed values that will underpin the vision are:

Membership of the SSAB

Local authorities are responsible for the establishment of Safeguarding Adult Boards. The Care Act 2014 specifies that there are three core members, namely, The Local Authority; Clinical Commissioning Groups (CCG); the Police and any other agencies it considers being partners.

During 2018-19, membership of SSAB comprised Senior Officers from the following member organisations.

- Stockport Adult Social Care
- Greater Manchester Police
- Stockport Clinical Commissioning Group
- Stockport NHS Foundation Trust
- Age UK Stockport
- Cheshire and Greater Manchester Probation (CRC)
- Elected Member
- Greater Manchester Fire & Rescue Service
- National Probation Service
- Pennine Care Foundation Trust
- Seashell Trust
- Stockport Healthwatch
- Stockport Public Health
- Stockport Metropolitan Borough Council - Strategic Housing

Members have sufficient seniority and leadership within their own agency to speak on its behalf, to commit resources and agree actions and to represent their agency should the SAB need to hold it to account.

4.0 Stockport Context

The resident population of Stockport is approximately 291,045, which has increased by approximately 1500 people this year, of whom currently 78.3% of the population are aged 18+ (228,113).

The table illustrates that statistics based on residents of Stockport reflect those at national level.

	Total Population	Males		Females		Age 0-14 yrs old		Age 65 and over	
Conversion	No	No	%	No	%	No	%	No	%
England	55,619,430	27,481,053	49.4%	28,138,377	50.6%	10,048,364	18.1%	10,030,511	18.0%
Stockport	291,045	142,630	49.0%	148,415	51.0%	53,187	18.2%	57,643	19.8%

In Stockport, the adult population aged 65 and over is 57,643, which equates to 19.8% of all adults aged 18 years and over. The population aged 85 years and over is 8,023 (2.8%), which has steadily increased by 5.8% (442) since 2015.

Life expectancy at birth has increased by 10% over the last 20 years. Males in Stockport are now expected to live to age 79.7 and females to age 83.0 years, which is similar to the national average. The gap between both genders has narrowed, as male life expectancy has grown more quickly than female life expectancy.

The population of Stockport continues to become more ethnically diverse, especially in younger populations to the west of the borough. Immigration rates in Stockport are lower than national averages.

5.0 Arrangements

The board is chaired by Gill Frame who is independent of all the organisations mentioned previously, and is accountable to the Chief Executive of the Local Authority. The key roles of the Chair are to provide leadership, promote collaborative working, offer constructive challenges, hold member agencies to account, act as a spokesperson for the SSAB, and ensure that interfaces with the other strategic boards are constructive.

SSAB met five times during 2018-19. In addition, the SSAB met with members of the Safeguarding Children Board at a joint development day, which enabled colleagues to discuss and work towards a more integrated approach across both Boards' functions.

The development day allowed members to:

1. Look at the overview of both children and adults perspectives from a local and Greater Manchester level
2. Review the SSAB business plan and to look at future priorities for 2019-20.
3. Develop and confirm the values and vision of the new future safeguarding partnership arrangements.

6.0 Future Arrangements

The Stockport Safeguarding Childrens Board in line with Working Together 2018 has reviewed their governance arrangements and moved to a more flexible working arrangement, enabling a greater focus on front line practice and reducing bureaucracy. The SSAB will mirror these arrangements in 2019-20. Stockport Safeguarding Children Partnership (SSCP)

The new arrangements are to be led by three partners: Local Authority; Police and Stockport CCG to work together with relevant agencies for the purpose of safeguarding and promoting the welfare of adults at risk in Stockport.

The following two groups will underpin the Stockport Safeguarding Adults Board:

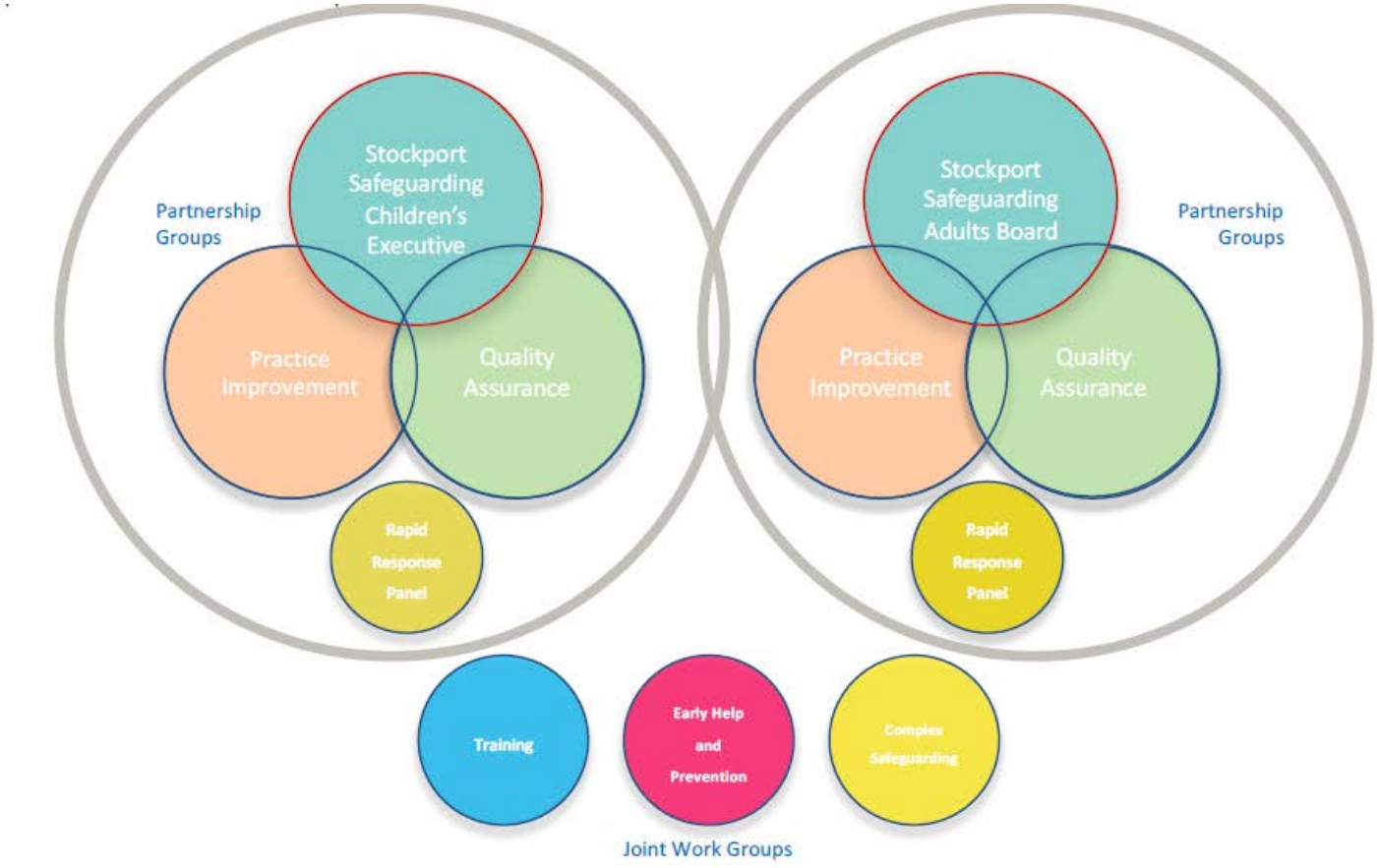
- Practice Improvement Partnership
- Quality Assurance Partnership

Furthermore, there are going to be three joint Adult and Children Partnership Working Groups, known as:

- Complex Safeguarding
- Early Help and Prevention
- Training and Development.

Alongside the new arrangements there will be a number of wider partnership forums. A development day will look back on the previous year and reflect what has been achieved. A six-monthly review of the new arrangements will be undertaken, and we will closely monitor this, so that we can decide whether to amend the new safeguarding arrangements.

The proposed new arrangements:

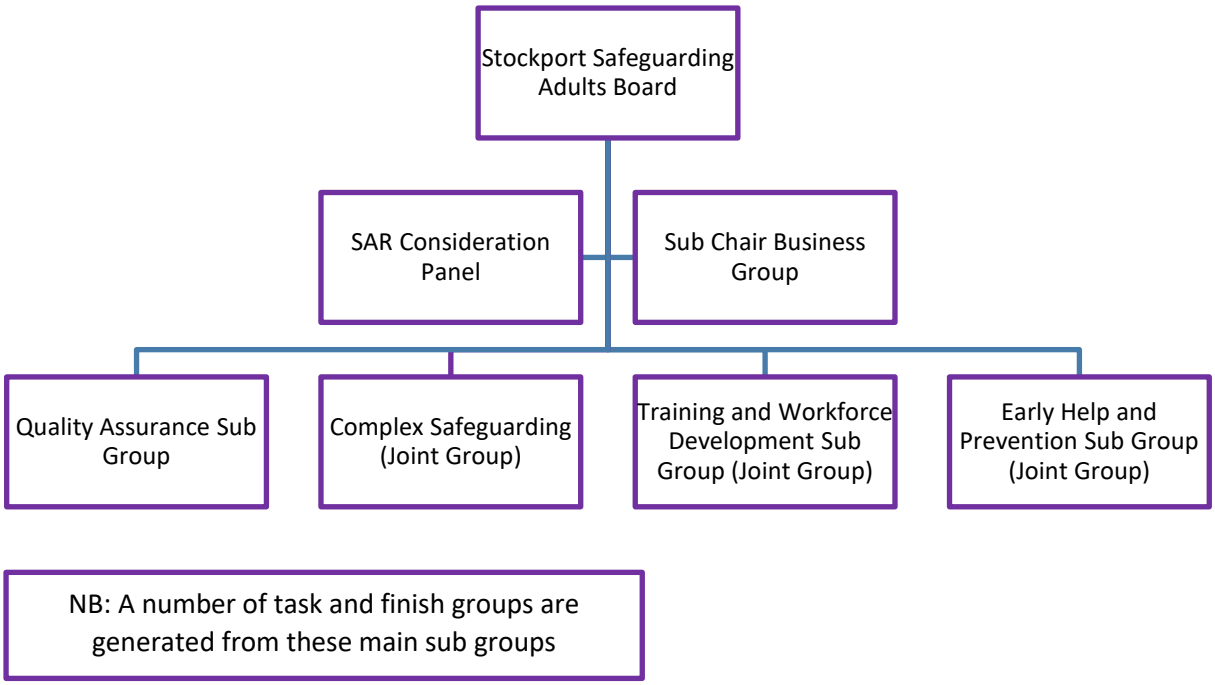


7.0 Progress against the SSAB Priority areas

Most of the work of the Board is allocated to and completed through multi-agency sub groups. Each of the sub groups is responsible for delivering an action plan that supports the board in delivering its agreed priorities and overall business plan.

The sub groups provide partner agencies with the opportunities to review practice; identify and share good practice; identify and improve areas of weak practice; test progress against

priorities and challenge each other to collectively improve arrangements to prevent abuse and neglect and to safeguard adults at risk.
In 2018-19, the SSAB had four working sub groups, each with specific terms of reference.



The Sub Chair Business Group includes the Chairs of the sub groups alongside the Chair of the SSAB, and statutory partners if not otherwise represented. The role of this group is to ensure the objectives and priorities outlined in the Business Plan are implemented; drive the development of good practice; coordinate the work of the sub groups to reduce duplication and promote shared resources across partnerships.

Sub groups meet bimonthly. The Chair of each sub group is a member of the SSAB Business group. Additional meetings take place as required to consider Safeguarding Adult Review referrals; this function sits with the SAR consideration panel.

What we have done in 2018-19

This year the SSAB undertook significant work to consolidate its governance and to progress against actions identified within our Strategic Plan.

7.1 Quality Assurance Sub Group - One of the main aims this year was to achieve and implement a robust dataset to give the Safeguarding Board oversight and assurance. The dataset would assist in understanding the effectiveness of adult safeguarding across Stockport and how we are making a difference.

In order to achieve this, we:

- implemented a Quality Assurance Framework (QAF);

- worked with partners to develop a suite of performance indicators allowing us to produce a dashboard on the following areas;
    - Safeguarding Concerns
    - S42 Enquiries
    - Mental Capacity
    - Making Safeguarding Personal (MSP)
    - Types of risk and location
    - Harm Levels
    - Deprivationof Liberty Safeguards (DoLS)

The performance dashboard has allowed us to look at conversion rates of safeguarding concerns that have later reached to S42 enquires. It is fair to say, currently, the data collection is very much local authority led. The SAB has recognised this, and further work is underway to strengthen the contribution from statutory partners to gain a clear account on what the data tells us.

We have produced a schedule of audits for 2019-20, they are;

- Mental Capacity
- Did Not Attend Appointments / No Replies
- Carers Assessments

In 2018-19, we completed two audits, one on domestic abuse, and the other on patient discharge planning from hospitals.

Patient discharge from hospital - we found 94% of cases were discussed daily with a multi-agency team approach. Furthermore, 82% of patients/care givers/ advocates were fully aware of their discharge plan. This presents a strong measure and does suggest good examples of practice. Some of the emerging themes from the aidit were:

- Discharge checklists not completed, or partially completed.
- Documentation of conversations with patient/relatives/providers is required to ensure discharge is fully understood.
- Limited record keeping of decisions demonstrated.
- Application and lack of documentation in mental capacity assessments.
- Information packs to be accessible throughout all wards for any complex discharge on admission to hospital.
- Good evidence of risk assessments, although it could be interpreted that mental and physical health needs were not holistic in the assessment.
- Patient experience – Privacy and dignity is paramount in all of the patient's journey, including discharge upon reaching their destination.
- Previous safeguarding concerns needs to be considered, including MSP when involving a patient discharge.

In summary, there was 9 recommendations and health partners have been asked to update on their progress against each of the recommedations. Evidence continues to be provided when change has been implemented to improve service delivery.
Actions completed since the audit are:

- Reviewed hospital discharge checklist.
- Dementia care matron appointed who delivers training for all clinical inductees.
- Monthly surveys completed by volunteers with in-patients.
- The Transfer Unit is now managed by the Clinical Site Co-ordinators.
- A full staffing review has been undertaken and is soon to increase within the transfer unit.
- Reviewed the criteria for admittance to the transfer unit.
- Assessment tool developed in order to identify patients appropriately to use the transfer unit.
- The emergency department has a 'flagging' system to allow for previous. Safeguarding issues to be entered to hold a memory of the safeguarding alerts.

Quality Annual Self Assessment - The QA partnership has contributed to, and assisted in the implementation of, the Safeguarding annual self assessment for partners to complete in Stockport; We found that partners were honest, open and transparent in submitting their assurance statements. Overall, compliance levels were strong, with evidence to support against each of the six standards. Some change has been implemented since the previous self assessments, such like;

- The development of a Dataset Performance Dashboard
- Adult Social Care representative attends the complex safeguarding forum
- Stockport CCG now publish safeguarding newsletter
- Adult Social Care IT system updated to ensure a question is raised to establish whether a person feels safe
- GMFRS continue to carry out priority Safe and Well visits within 24 hours of receiving a referral
- GMFRS signed up to the Herbert Protocol
- GMP created new integrated safeguarding team in the MASSH to promote joint working with adult services
- Daily multi-agency risk meeting takes place discussing around 5 high risk cases per day.
- GMP Training delivered to all divisional officers in relation to multi agency referrals
- Stockport NHS FT updated all job descriptions to include a paragraph explaining their safeguarding responsibilities
- Adult Social Care have identified a representative at Stockport MARAC meetings

Furthermore, the QA partnership has reviewed the effectiveness of Safeguarding Adult Reviews and monitored learning and outcomes based on recommendations from SARs.

We have continued to monitor the quality of care providers through monitoring of quarterly harm level reports. This information forms part of the monitoiring process completed by

quality monitoring officers; for example, low compliance rates indicate there may be a problem with the provider.

The quarterly harm level report also provide patterns, themes and trends which have predominantly been related to slips, trip and falls, and medication errors. Steady in Stockport have been invited to talk to providers to share information and discuss preventative techniques. CQC medication inspector has also been asked to attend future provider forums to advise providers on good practice.

The QA partnership also made a recommendation to include harm level reporting to the Stockport multi-agency safeguarding policies and procedures, with reference that harm level reporting is a mandatory requirement. This will also be introduced in the refreshed safeguarding training programme, and will aim to increase compliance levels.

In 2019/20, the QA partnership will be reviewing the following:

- Stockport's Multi agency safeguarding adult's policy and procedures
- The SSAB statement of commitment to reflect the new multi-agency safeguarding arrangements for 2019-20
- Evidence gathered and monitored of partners' progress against recommendations from the Adult Peer Review
- The QAF, which we continue to develop and test. This includes performance data, analysis and auditing, to ensure consideration is given to the views and needs of Stockport residents
- Partners' MSP annual self-assessments to verify and identify any areas for improvement in line with the SSAB Strategic Plan 2017-20
- SAR actions plans to scrutinise and monitor partners' progress against the recommendations
- Strengthening our relationships with independent providers and inviting a representative from the sector to join the Quality Assurance Partnership
- Completion of MCA audit, and audit on self-neglect as a paired exercise between local partners.

7.2 Early Help and Prevention (EHP) - The role of the Early Help and Prevention Sub Group is to agree, implement and review the annual work programme across all partner agencies. The EHP sub group has been an important part of the ongoing work of the SSAB and is an essential part of the SSAB Strategic Plan.

Stockport's joint strategic plan sets the strategic direction for prevention in adult safeguarding and the main priority of work for the different agencies and partners that care for and support vulnerable adults in our community. It represents an ongoing collaboration between these partners using a framework for the partnership work in safeguarding adults at risk from abuse.

This year, this sub group has focused on a number of key issues:

- Self-neglect strategy and guidance developed and rolled out
- Multi agency audits conducted including Domestic Violence, patient discharge from hospital and MCA legislation
- Work with safeguarding leads to develop a strategy in line with the Herbert Protocol for dementia patients missing from home
- Implementation of the Domestic Violence and Abuse Strategy
- Support for national and local campaigns throughout Stockport – including Phoenix Week of Action, Elder Abuse Day, Yellow Sofa Campaign and Hate Crime Week
- New Transition pathway evaluation – led to an increase in the number of young people eligible for support from Adult Social Care
- Identification of presenting factors at Multi agency adults at risk system (MAARs) for 18-25 year olds, and audit of 15-18 year olds on a plan to seek best practice in supporting those young people
- Improvements in working relationships across Children's and Adult Services, including Education, Health & Social Care

In 2019-20, the EHP sub group will:

- develop an action plan for Neglect as a key priority;
- develop material on transitions for the websites in a variety of formats;
- review and implement the policy for Missing Adults from Hospitals;
- develop our approach for vulnerable children who do not meet the threshold for Adult Social Care needs;
- embed learning on transitions into place-based practice;
- develop engagement strategies for the wider community.

7.3 Complex Safeguarding – The group is a joint sub-group to Stockport Safeguarding Children Partnership (SSCP). The main aim of the group is to ensure there is a joint steer to the safeguarding response of complex abuse and exploitation within Stockport. The group has been responsible for the development and implementation of the complex safeguarding strategy, which oversees effective partnership working in tackling:

- Honour based abuse and forced/sham marriage
- Sexual Exploitation
- Serious Organised Crime and Criminal Exploitation
- Modern Slavery and Trafficking
- Female Genital Mutilation (FGM)
- Radicalisation and Extremism
- Missing from home, care, education

In 2018-19, the complex safeguarding sub group:

- implemented the Complex Safeguarding Strategy;
- strengthened the membership along with consistent attendance at SAB sub group meetings;
- implemented three task and finish groups to take forward the strategy and work plan for Honour Based Abuse and Forced Marriage (FM); Female Genital Mutilation; Serious Organised Crime and Criminal Exploitation;
- completed the strategy and work plan on Honour Based Abuse and Forced Marriage;
- grew a group to progress the Complex Safeguarding Dataset;
- hosted a Complex Safeguarding Conference on the 13th March 2019, with over 150 delegates watching presentations on the following topics:
    - GM Complex Safeguarding strategy - Jayne Horan GM lead
    - Stockport Councils own ASPIRE children's complex safeguarding team
    - Honour Based Abuse and Forced Marriage awareness- Project Choice
    - Organised Crime, County Lines and Child Criminal Exploitation-Dean Coady OBE
    - FGM - Peggy Mulongo NESTAC
    - Domestic Abuse Awareness - Stockport Without Abuse.

The day was informative, lively and well received by delegates. Since the conference, Project Choice have been involved in awareness raising sessions with several agencies, and have assisted with the writing and implementation of the HBV and FM strategy.

In 2019-20, we will:

- finalise the Female Genital Mutilation strategy and its work plan, share with SSAB for consultation, and sign off;
- commission further training on FGM awareness;
- develop a complex safeguarding dataset and that will link into the GM complex safeguarding steering group;
- continue progress on the Criminal exploitation and Serious Organised Crime strategy;
- monitor the progress and implementation of the Modern Slavery and Trafficking, Radicalisation and Extremism/Prevent strategy;
- launch the Honour Based Abuse and Forced Marriage strategy and host four workshops across both children's and adult's services with input from third sector organisation Project Choice to raise awareness and knowledge.

7.4 Training and Workforce Development – The subgroup has the responsibility to oversee the development and delivery of multi-agency safeguarding adults training provision. The subgroup has responsibility to increase awareness of safeguarding and co-ordinate single and multi-agency safeguarding adults training.

This year, this sub group has focused on a number of key issues:

- Raising awareness of the SAR process and sharing learning from SAR's (both in single and multi-agency training), ensuring that briefings on learning from SAR's were produced and disseminated
- Commencing work on a multi-agency training matrix
- Commissioning new training courses, including self-neglect and hoarding, dignity in care and legal literacy, to run during 2019-20
- Confirming and implementing the multi-agency training plans 2019 for both adults and children's training
- Delivering five SAR briefing sessions to ensure the learning from safeguarding adult reviews are embedded in multi-agency practice

7.5 Peer Review - In 2017-18, Chairs and representatives of the Stockport and Oldham Safeguarding Boards agreed to undertake a reciprocal peer review. A multi – agency review team was identified and the peer review took place during the summer of 2018.

The peer review teams focused on:

- Efficacy and Quality of the All Age MASH
- Outcomes and experiences for people, including deprivation of liberty safeguards (DoLS)
- The Safeguarding Adults Board and the relationships between partners
- Contribution of Health Services
- Workforce and the Neighbourhoods

Findings from the peer review did highlight that there were many similarities between the issues faced in Stockport and Oldham and many of the recommendations did reflect the challenges that the public sector faces with increasing demand and increasing complexity across the adult agenda.

Key Learnig Points summarised:

- Continue to build on positive work to date, whilst considering how engagement and communications with GMP can improve.
- Work with universities to increase/improve placements of students in local authority setting to secure a better flow of job ready graduates.
- Improve understanding around use of Section 42 amongst staff/partners.
- Continue to improve multi-agency practice around transitions and links with 'Think Family".
- Consider how existing DoLS authorisers can be mobilised to improve capacity in this area.
- Review safe discharge arrangements in partnership with Stepping Hill.
- Consideration of data sharing between SMBC, NHS FT, GMP and PCFT on safeguarding cases.

- Consider approach for building capacity/knowledge base in palliative and end of life care in care homes.
- Consider impact of inappropriate Safeguarding referrals via NWAS and training in this area.
- Improve information sharing RE; MCA using recognised systems between SMBC and PCFT.
- Improvements to be able to monitor and record Care Act assessments via Liquid Logic implementation.
- Continue to build on positive work in culture change of joint working and transparency.
- Stockport to review the new SAB dashboard to ensure it continues to be an effective product for improving oversight and scrutiny of the board.
- Review of multi-agency safeguarding policy and procedure.
- Consider wider role of Health watch in reviewing concerns in Care Home settings.

The peer review saw evidence of commitment and enthusiasm. Staff were knowledgeable and helpful and keen to demonstrate both the good work that had been done and their awareness of the gaps in service that needed to be addressed.

Following the peer review consideration was given to the findings in the context of recommendations for improvement. Furthermore, an improvement plan was produced and built into the SABs exisiting plans.

Joint Safeguarding Annual Conference 2018

In October 2018, the Stockport Safeguarding Children's Board (SSCB) and the Stockport Safeguarding Adults Board (SSAB) hosted a conference for practitioners from different agencies throughout the borough, from both children's and adult services. Two hundred people attended the conference. Two external speakers also joined us:

- Steven Richards from Edge Training and Consultancy limited, who presented on the understanding of Mental Capacity Act 2005, from the age of 16 plus.
- A parent of a child diagnosed with Autism and Learning Disabilities who shared the views of a parent and young person on transition from child to adult services.

Participants were also able to watch AFTA Thought, who are a drama-based theatre company made up of writers, actors and facilitators who brought topics of domestic violence, mate crime and self-neglect to life.

Delegates reported they left the event feeling inspired to apply their understanding within the workplace and gained a greater knowledge and understanding of the four key priorities.

Highlights of the day can be found via the Video links here.

Feedback from delegates who attended the Annual Safeguarding Conference:

I was pleasantly surprised by the breadth of content covered in relation to joint working across Children's and Adult services, particularly in relation to transition and family working

I thought the conference was really informative and well put together - I enjoyed it, many thanks

It has brought Domestic Abuse issues to the forefront of my mind when dealing with families and made me more aware of signs to look out for

The drama performance was very good. It was good to meet up with other providers and share ideas.

Best joint safeguarding conference yet - enabled time to learn, reflect and network

Brilliant talk by a woman with an autistic son. She provided insight into the highs and lows and highlighted potential threats such as mate crime etc. This has given me a better understanding of how to identify vulnerabilities when supporting a young person with autism

The mental capacity act - case studies were excellent and we have started to use the template for documenting capacity assessments as suggested in the conference

During 2018/19, there were a number of e-learning courses on a wide range of topics. Statistics on which courses are being accessed are below. The plan is to continue to develop this offer over 2019-20.

Multi-Agency training completed between 1/4/18 and 31/3/19

Multi – Agency Training Report 2018-19	Classroom	E-learning	Total
Safeguarding Adults - introduction	547	255	**802**
Safeguarding Adults - MCA & DOLS	129	98	**227**
Safeguarding Adults - Enquiry Officer training	33		**33**
Safeguarding Adults - Referrer Training	17		**17**
Safeguarding Adults - Legal Literacy	77		**77**
Safeguarding Adults - Manager Training	20		**20**
Safeguarding Children - introduction	93	442	**535**
Safeguarding Children - Neglect	37		**37**
Safeguarding Children - level 2/3 training (various courses)	197		**197**
Safeguarding Children - allegation management	10		**10**
Safeguarding Children - working with teenage vulnerability	16		**16**
Safeguarding Children - Education & Early Years settings	436		**436**
Child Abuse		21	**21**
Dignity in Care		55	**55**
Domestic Abuse		135	**135**
Hate Crime		15	**15**
Modern Slavery and Human Trafficking		64	**64**
Self-Harm		41	**41**
Self-Neglect and Hoarding		101	**101**
Joint SCR/SAR Briefing	102		**102**
Total	**1,714**	**1,227**	**2,941**

In 2019-20, training workforce sub group will:

- develop domestic abuse training programme in line with the Domestic Abuse and Violence Strategy;
- identify a task and finish group to start developing a competency framework to provide standardised expectations for safeguarding training across partner organisations.

8.0 Communications and Publicity

Achievements in 2018-19:

- Published a quarterly safeguarding newsletter
- Developed a suite of information leaflets for different aspects of safeguarding, all of which are available electronically, by hard copy and on the Safeguarding Adults Board website.
- Mainatained a joint calendar of events so partners have insight into events taking place throughout the year.
- The SSAB developed a Domestic Abuse leaflet to raise awareness of Domestic Abuse. This included information in an easy read format on; what Domestic Abuse is, what it includes, contact details of services available throughout Stockport and to encourage people to report it.
- We received 3,631 website page views compared to 1,454 for the same period in 2017-18. Although this figure has increased, the objective is to generate more hits to strengthen engagement with professionals and the public.
- Social Media campaigns have reached people via Twitter to raise awareness about Stop Adult Abuse Week, Hate Crime awareness week, Domestic Violence and Abuse, Elder Abuse and several more.

In 2019-20, we will:

- develop one overarching safeguarding website for both children's and adult's safeguarding boards;
- continue to promote local and national campaigns and work collaboratively with partners to ensure public engagement and awareness raising continues;
- promote a campaign to raise awareness of domestic abuse amongst older adults;
- review and strengthen the process for Safeguarding Adult Reviews and Domestic Homicide Reviews to ensure any response from a serious safeguarding referral is timely and consistent.

9.0 Safeguarding Adult Reviews (SAR consideration panel)

The purpose of the SAR consideration panel is to consider referrals of any case which may meet the statutory criteria and to make decisions on this basis; to arrange for and to oversee all SARs; and to ensure recommendations are made, messages are disseminated and that lessons are learned.

Section 44 of the Care Act 2014 requires the SSAB to arrange a SAR when a case meets the statutory criteria:
1. that is when an adult in its area dies as a result of abuse or neglect whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
2. or, if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

The completion of a SAR is to ensure that relevant lessons are learned, professional multi-agency safeguarding practice is improved, and to do everything possible to prevent the issues in question happening again.

Achievements in 2018-19

This year there have been nine new referrals for consideration of a SAR, one of those resulted in a Domestic Homicide review (DHR), and will be overseen by Stockport Safer Partnership (SSP). The other referrals received did not meet the criteria for a SAR, although at the end of 2018/19 it was considered there was one case from which learning could be gained and a single agency learning review will take place in 2019-20.

During 2018/19, the SAR consideration panel has completed three SARs and one multi agency learning review from the previous year. Of these, three SAR reports have been published. A local learning review was also finalised. Family were involved throughout the process and have stated that they are in agreement with what was produced.

The three SARS generated themes identified in relation to Self-neglect, Domestic abuse and interfamilial relationships, Mental Capacity, Sharing of information and the importance of multi-agency working.

Additionally, five learning events took place to share the findings from three SARs and a Joint SCR/SAR. Attendance was strong and well received with feedback from the sessions being very positive.

In total, 190 professionals from both children's and adults' services attended the five sessions.

Because of the recommendations from the SARs, essential policies procedures and guidance documents have been produced; for example, Multi-Agency Self-neglect policy has been implemented and rolled out to practitioners. Following on from this, workforce development have commissioned six bespoke training sessions on self-neglect and hoarding. Other recommendations made have begun, such as the daily risk management meetings, which are chaired by the Police to improve agency accountability and to provide support for staff involved in high risk domestic abuse cases.

Additionally, action plans from the SARs, and the learning review have been populated to ensure recommendations from the reviews are monitored and achieved. Agencies are expected to provide evidence of their progress before sign off at the Board.

SAR Analysis

The SAR consideration panel received nine SAR referrals in 2018/19; the analysis shows us that 66% of referrals were for male victims, and 34% for females. Although the number of SAR referrals is small, this is broadly similar to the previous year, with a reduction of one referral.

All of the SAR referrals involved people from a White British background. The type of abuse described in the SAR referrals relates to neglect in 56% of cases, self-neglect in 22% of cases, 11% in self-harm and 11% with a case resulting to murder. This case resulted in a Domestic Homicide Review (DHR).

In seven of the SAR referrals received, the person involved had died. This suggests that there may be an over-representation of SAR referrals where a person has died and there are concerns about neglect leading to the death. In addition, the SAR referrals made in 2018/19, 56% of cases involved a person living in a care home, whereas 44% lived in their own home in the community, suggesting that work may be required to encourage appropriate referrals from hospitals within the borough.

Learning from Safeguarding Adult Reviews and the changes we have made:

SAR 3 - Click here for access to the full SAR report and 7-minute briefing paper.
SAR 4 –The full SAR report and 7-minute briefing paper can be found here.
SAR 5 –The following SAR report and the 7-minute briefing paper demonstrates an overview.

What have we done?

- Commissioned Independent authors to produce extensive reports along with accompanying action plans.
- Quality assurance sub group continues to monitor the progress of the action plans, and assurance is provided to SSAB once actions have been completed.
- Disseminated SAR learning effectively with the use of 7-minute briefing papers.
- Published the overview reports on the SAB website.
- Relaunched the self- neglect strategy and guidance.
- Produced a self-neglect leaflet aimed at practitioners and the public.
- Workforce development implemented an all -age neglect training programme.

Provided five learning events to the wider workforce to share the findings from the SARs.

Priorities for 2019/20

- Continue to deliver SAR learning workshops to ensure that learning from SARs are widely disseminated.
- Refresh and update SAR Protocol in light of national/best practice guidance.
- Develop a SAR referral form that is standard for the Greater Manchester footprint.
- Continue to develop a repository of safeguarding learning, and ensure completed SARs are shared with the National SAR library.

- Develop and implement a training programme to include domestic violence and abuse.
- Conduct a thematic review of SARs and local learning reviews to establish what progress has been made from completed SARs.

10.0 Safeguarding Adults Activity 2018-19

The Council collects information about safeguarding adults work in Stockport, so we know how well people are being safeguarded. This information helps the Stockport SAB determine what their next steps should be.

Stockport Council submits returns annually to the Department of Health (DH) for collation and comparison of the key data across all authorities in England. The following commentary includes extracts from the data, trends and areas for improvement and development in Stockport.

Data contained in the tables below has been extracted from the safeguarding team's database (correct as at 30.04.19).

A safeguarding Concern occurs when any safeguarding issue is first raised with Adult Social Care. After a Concern is received it is reviewed, considered and risk assessed. Either it will be dealt with through another route if not considered a safeguarding matter, or it will advance to the next stage of the safeguarding process for fuller investigation and formal intervention. This is called a Section 42 Enquiry.

Table 1: Safeguarding Concerns

Financial Year	2017-18	2018-19
Safeguarding Adults Alerts	3,747	3,567
Safeguarding Adults Alerts Level 3	278	364
Total	4,025	3,931

Table 2: Section 42 enquiry referrals

Financial Year	2017-18	2018-19
Safeguarding Adults Alert Level 3 (considered to be referrals)	278	364
Standard Safeguarding Referrals	406	308
Total	684	672

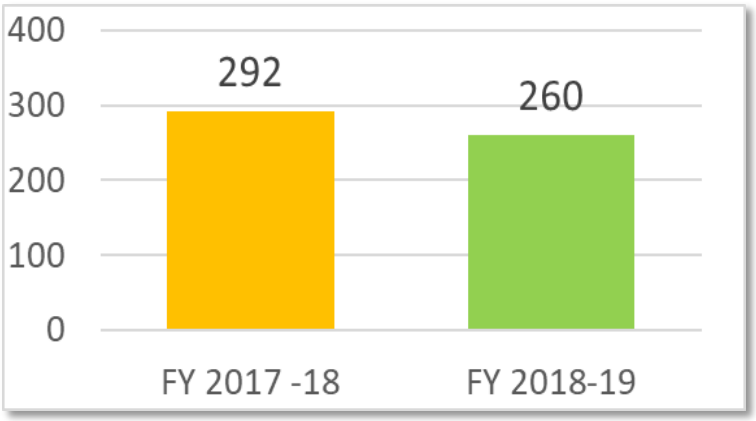
Safeguarding concerns and referrals go through the Adult Social Care contact centre, on receipt of the referral they are screened, triaged and dealt with as appropriate. The volume of referrals have reduced only marginally by 2% from the previous year, suggesting stability in the number of enquiries and referrals received. The gap will likely reduce further, as some data may still be to be entered.

Number of Section 42 Enquiries Concluded

A safeguarding enquiry is the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult to a more formal multi-agency response.

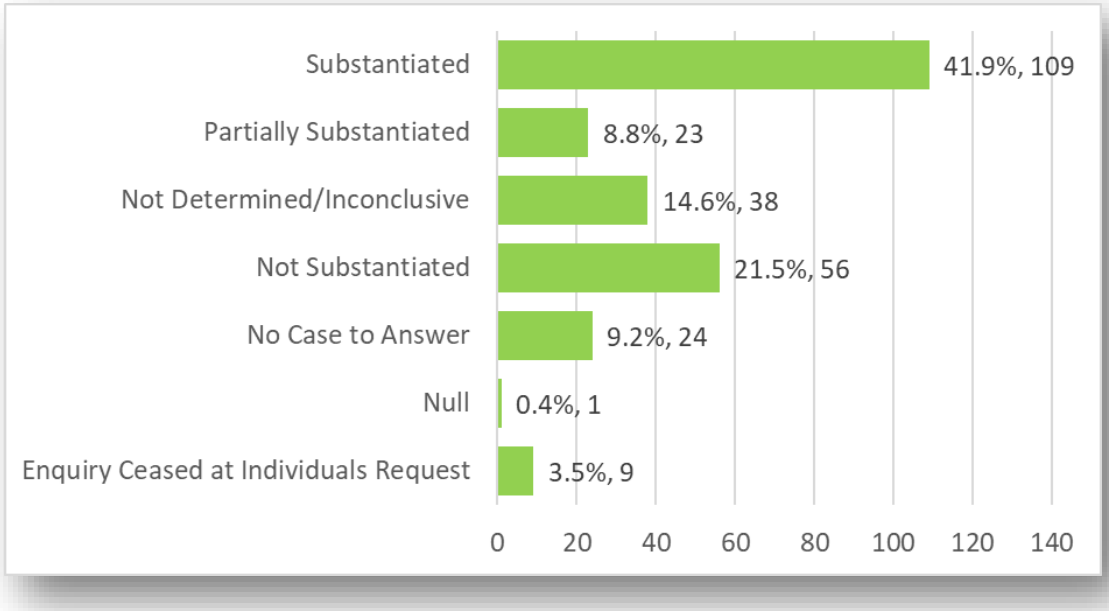
A concluded safeguarding enquiry is when the entire necessary information gathering is complete and all of the necessary actions have been agreed. This can include cases that began in a previous reporting period.

Table 3: Section 42 Enquiries concluded within the year



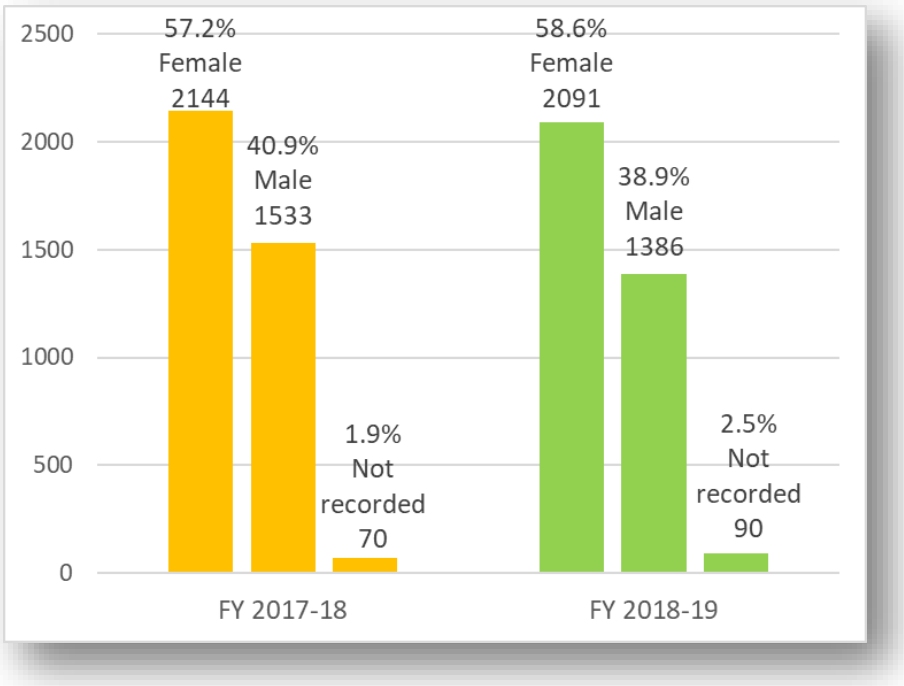
There were 260 concluded enquiries throughout 2018-19. Of these, 41.9% were substantiated, and 8.8% were partially substantiated, which means when more than one category of abuse has been alleged. 21.5% of case were not substantiated and 9.2% with no case to answer.

Table 4: Outcomes from concluded enquiries in 2018-19



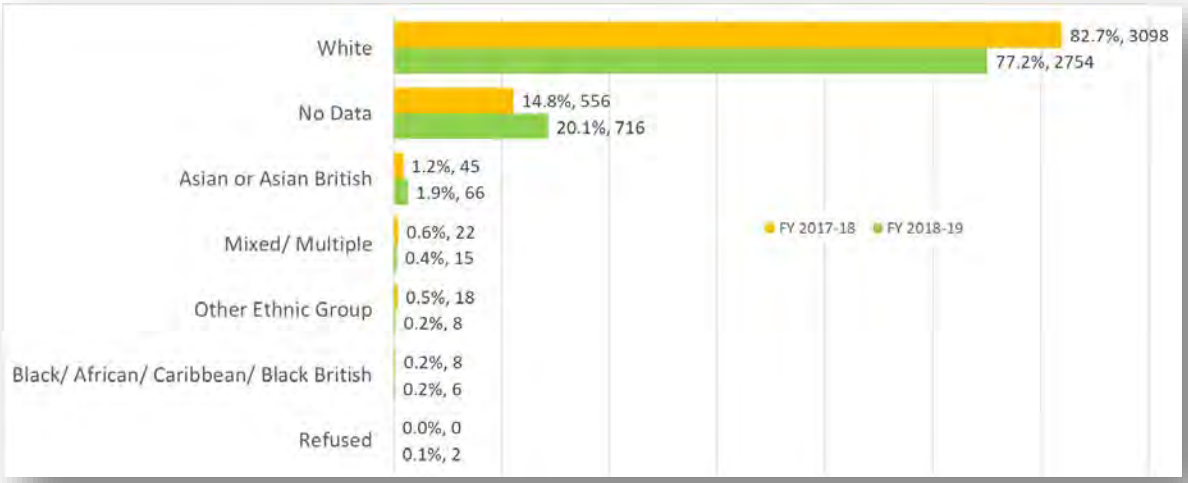
March 2011 census estimates that the gender breakdown of Stockport is 51.1% females and 48.9% males. Allegations of abuse against females consistently remain higher than against males. Whilst the gender makeup accounts for some of this, it is still the case that females are more likely than males to experience safeguarding concerns.

Table 5: Individuals involved in safeguarding concerns 2017-18 compared to 2018-19 by gender



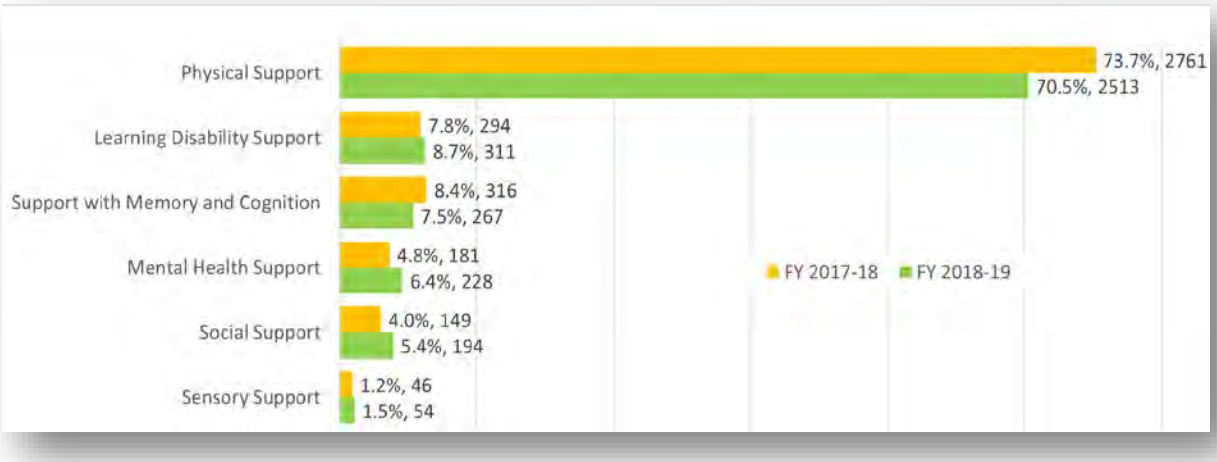
In 2018-19, 58.6% of the alleged victims were female and 38.9% were male, 2.5% did not have their gender recorded. Gender will become a mandatory field when we switch to our new management system Liquid Logic in September 2019, and this will give a more accurate overview.

Table 6: Individuals involved in safeguarding concerns by ethnicity 2018-19



Although safeguarding referrals remain highest within the White British community, the spread of concerns does not fully coincide with the ethnicity breakdown of the area. This may be due to the lack of data with "No Data" accounting for 20.1% of all concerns. This is a high percentage of non-recorded data, and with the introduction of Liquid Logic, this data collection will be mandatory and will help to improve data accuracy.

Table 7: Primary reasons of support



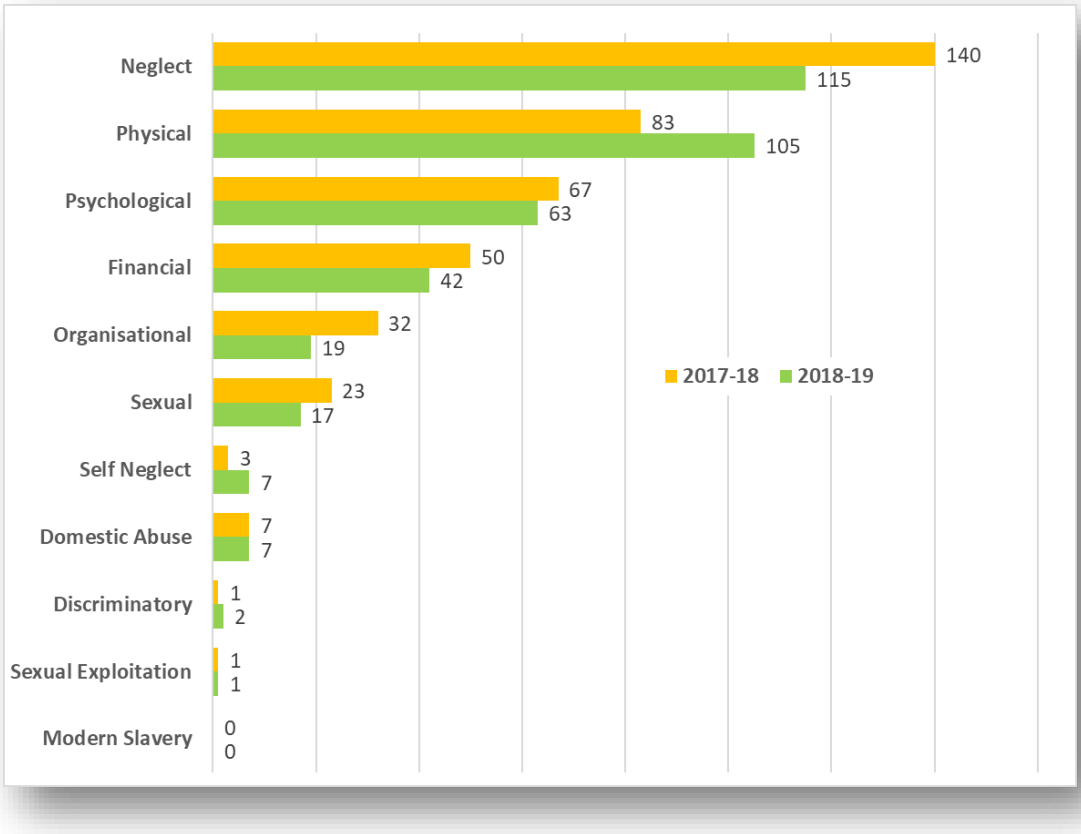
In 2018-19 in terms of alleged victims' primary reason for needing support:

- 70.5% required physical support, for example to get dressed or to bathe
- 8.7% had a learning disability
- 7.5% receive support for memory and cognition from brain injury or dementia related

- 6.4% receive mental health support
- 5.4% receive social support such as help with shopping
- 1.5% with sensory impairment

For the past few years, the data collection in Stockport has consistently evidenced that the highest numbers of concerns reported were on behalf of people with a physical disability. This is likely to reflect the age profile, as well as the ability of the relevant individuals to speak up for themselves or report concerns to others.

Table 8: Type of risk from concluded enquiries



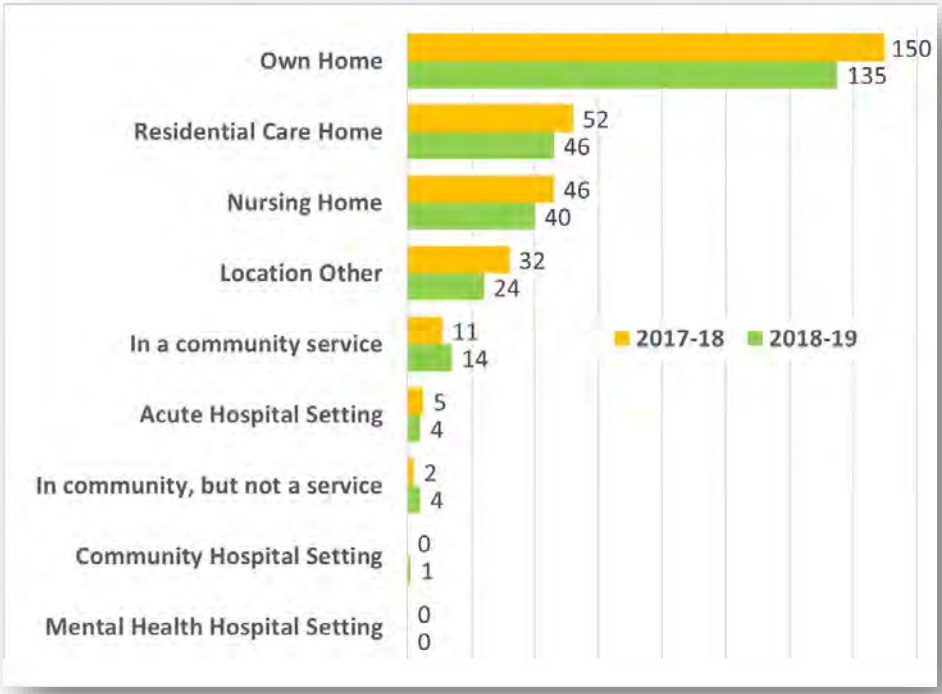
The most commonly investigated form of alleged abuse was neglect or acts of omission with 115 investigations. This has reduced by 18% from the previous year, although it remains the most prevalent measure.

The SAB notes that in line with national statistics, physical abuse, neglect, and omission of care continue to be the most reported categories of abuse.

There is a slight shift with the types of risk identified above. This would suggest there is a better identification of risk intepretted within the contact centre in adult Social Care. You will also note a low level of recording relating to domestic violence, sexual exploitation and modern slavery. This is an educational need that the SSAB recognises and work is being

done through the relevant task and finish groups to address awareness raising, training and recording of themes correctly.

Table 9: Concluded Cases by Location of Risk



You will see the risk in the person's own home has reduced from last year by 10%, in Nursing homes by 12%, and residential care is down by 13%, compared to 2017-18. This reflects the support and intervention provided from the joint funded EQUIP team who have consistently provided support and guidance to both the residential and nursing care sector.

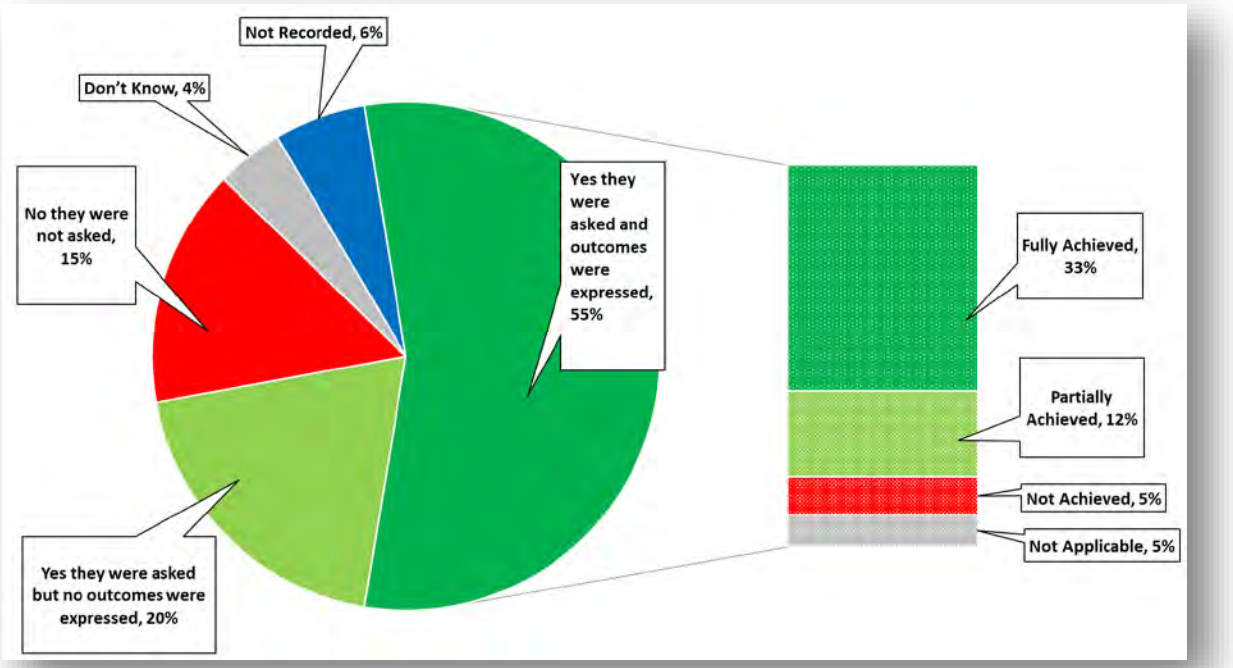
There has also been a significant increase in CQC ratings across the sector, which reflects an overall improvement in the care delivery. Stockport ASC have also commissioned an increase in the number of new care providers, which has resulted in providers offering more choice.

The data also highlights zero number of section 42 enquiries from hospitals who provide mental health services. This is contrary to what the harm level panel understands, as the panel assures that they receive investigation reports from Pennine Care NHS Foundation Trust for scrutiny and sign off. Therefore, modifications are necessary on the new liquid logic system to ensure S42 enquiries within psychiatric hospital settings is captured.

Making Safeguarding Personal (MSP)

MSP is about having conversations with people about how to respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, well-being and safety. The Care Act advocates a person-centred rather than a process driven approach. MSP questions comply with the standards set by NHS digital, ensuring they are comparable with all other authorities across England.

Table 10: Making Safeguarding Personal



In 2018/19, 75% of individuals who were involved in a safeguarding enquiry were asked what outcome they wanted from the investigation. 55% expressed an outcome, and of these 82% had outcome fully achieved or partially achieved.

For those who did not achieve their desired outcome, it should be remembered that the desired outcomes expressed by service users and / or their representatives may not always be achievable. For example, it may be that desired outcomes expressed at the beginning of the process may change during the process based on information that is made available.

In addition, there may be other issues that are not part of the safeguarding concerns but can impact on the views or wishes of individuals. For example, it may be that the relevant person died because of physical illness during a safeguarding process. This may have an impact on the views of those involved in the proceedings and can sometimes affect the desired outcomes for the proceedings that may not be achievable. In addition, some adults

choose to remain in contact with the perpetrator, rather than lose their support. This is often the reason that risks remain to the adult at the end of the safeguarding journey.

Deprivation of Liberty Safeguards & Mental Capacity

The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law under the 2009 addendum to The Mental Capacity Act 2005, which authorises the necessary deprivation of liberty of a resident in a care home, or a patient in hospital, who lacks capacity to consent to their care and treatment.

The authorisation allows the deprived person to be kept safe from harm, in the least restrictive way, appropriate to the individual's assessed best interest. The deprived person has a legal right to challenge the deprivation if they object to it, in the Court of Protection. This is known as a 21a challenge.

The Supervisory Body (the Local Council) is responsible for the authorising of Deprivations of Liberty Safeguards within legal timeframes. Requests for a standard authorisation should be processed within 21 days. Urgent authorisations, issued by care homes or hospital, should be completed within 7 days.

Current Arrangements

The Local Authority provides resources for the following functions:

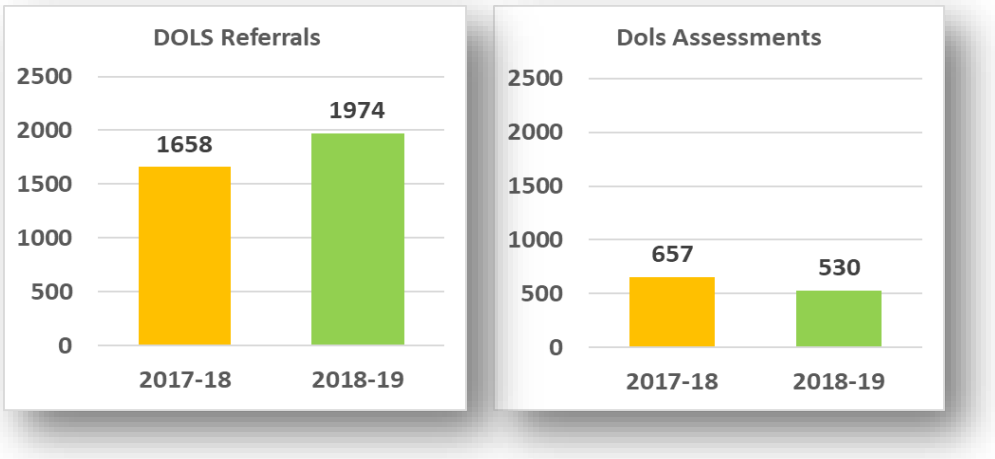
- The undertaking of best interest assessments.
- The commissioning of Mental Health assessors to complete mental health assessments.
- The scrutiny function before authorising the Deprivation of Liberty Safeguards.
- The appointment of the Relevant Person's representative and IMCA where appropriate.
- Supporting the 21a challenges to the authorisation in the Court of Protection.

The Best Interest Assessors (BIA) are all employed by Stockport Council and are either social workers or Occupational therapists (OTs) who undertake the BIA assessments in addition to their usual council duties.

DoLS Statistical Overview Report 2018/19

DoLS applications continue to rise; there has been a 19% increase since 2017/18. There were 1,974 referrals in 2018-19, of which 530 had been assessed and signed off. The remaining referrals will have been triaged as low and placed on the waiting list.

Table 11: DOLS Referrals and Assessments



Challenges

1. The changes to DOLS legislation to LPS Liberty Protection Safeguards will come into effect around mid-2020. This will widen the remit and so increase the number of individuals within scope, since it will then include young people from age 16, and deprivation within any setting including own home.
2. Ageing Demographic – increased life expectancy coupled with an increase in older people has shown an impact in the increase in the number of DOLS referrals received year on year.

Risks

1. Potential for increased ligation from illegal deprivations - breaches of Article 5(4) – 'right to speedy review' of a deprivation of liberty (Could lead to damages up to £5k per litigant).
2. Reputational risk to the LA for illegal deprivations.
3. Risk to vulnerable adults having unchecked restrictions on their lives.
4. Risk of negative scrutiny from coroner.

Actions to mitigate the risk

The local authority has taken a long-term approach with the intention to improve the process. A permanent DoLs Coordinator to manage the flow of the process more effectively was appointed in December 2018; alongside two full time 18-month fixed term contract BIA's. There has also been an increase in the number of signatories with training being provided to enable this. In addition, the BIA rota has changed from a three to an 8-week cycle enabling more staff to be on this rota less frequently, enabling staff to better manage workloads, whilst maintaining throughput.

11.0 Future Priorities

The SSAB has a business plan for each year, setting out the changes that the Board is planning to make in order to progress the three-year Strategic Plan 2017-20.

For 2019-20, the SSAB plans are to:

- To review the safeguarding responsibilities and arrangements in light of the new Stockport Safeguarding Children Partnership (SSCP).
- Monitor practice of the SAB website and develop a joint overarching website with SSCP.
- Gather assurances from partners on their implementation of Making Safeguarding Personal within their own organisations.
- Receive an updated Risk Register at every SAB meeting.
- Monitor and report on the new developments of the Mental Capacity Amendment Bill 2019, in relation to the replacement of DoLS, and the implementation of the new Liberty Protection Safeguards (LPS).
- Support the Implementation of the work plan and pathway for transitions of young people moving into adulthood.
- Raising awareness and promoting engagement with residents and partners in Stockport.
- Continue to develop working relationship with Stockport Healthwatch.
- Support the development of a joint training programme in relation to domestic violence and abuse.
- Continue to develop SAB performance dashboard with a view to broaden the requirements to complex safeguarding.
- Review Multi-Agency safeguarding adults at risk policy to ensure easy access to safeguarding referral policy and procedures.
- Ensure mental health within the joint training programmes is a key focus.
- Conduct a thematic review to look at what learning themes emerged from any SAR, or local learning reviews that we have conducted.
- Arrange and deliver the Joint Annual Safeguarding Conference.

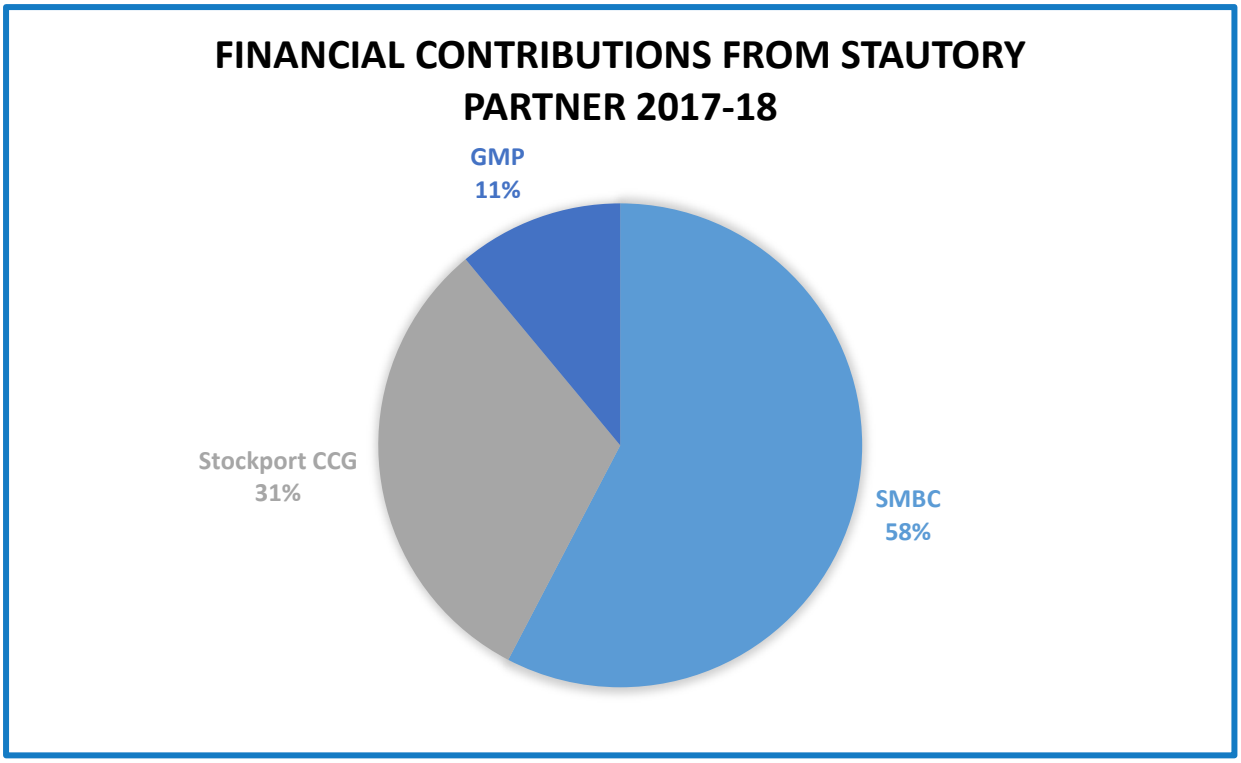
12.0 Financial Information

The work of the Board is funded through partnership contributions. The actual budget for the Safeguarding Adults Board's functions is £121,500 per financial year, and a variance of £12,105 carried over from the previous year, bringing the total budget sum to £133,505.

The three contributory statutory partners are:

- Stockport Clinical Commissioning Group (CCG)
- Stockport Metropolitan Borough Council (SMBC)
- Greater Manchester Police (GMP)

In terms of funding for 2018-19, the table below demonstrates the statutory investors.



SSAB Allocated Expenditure 2018-19

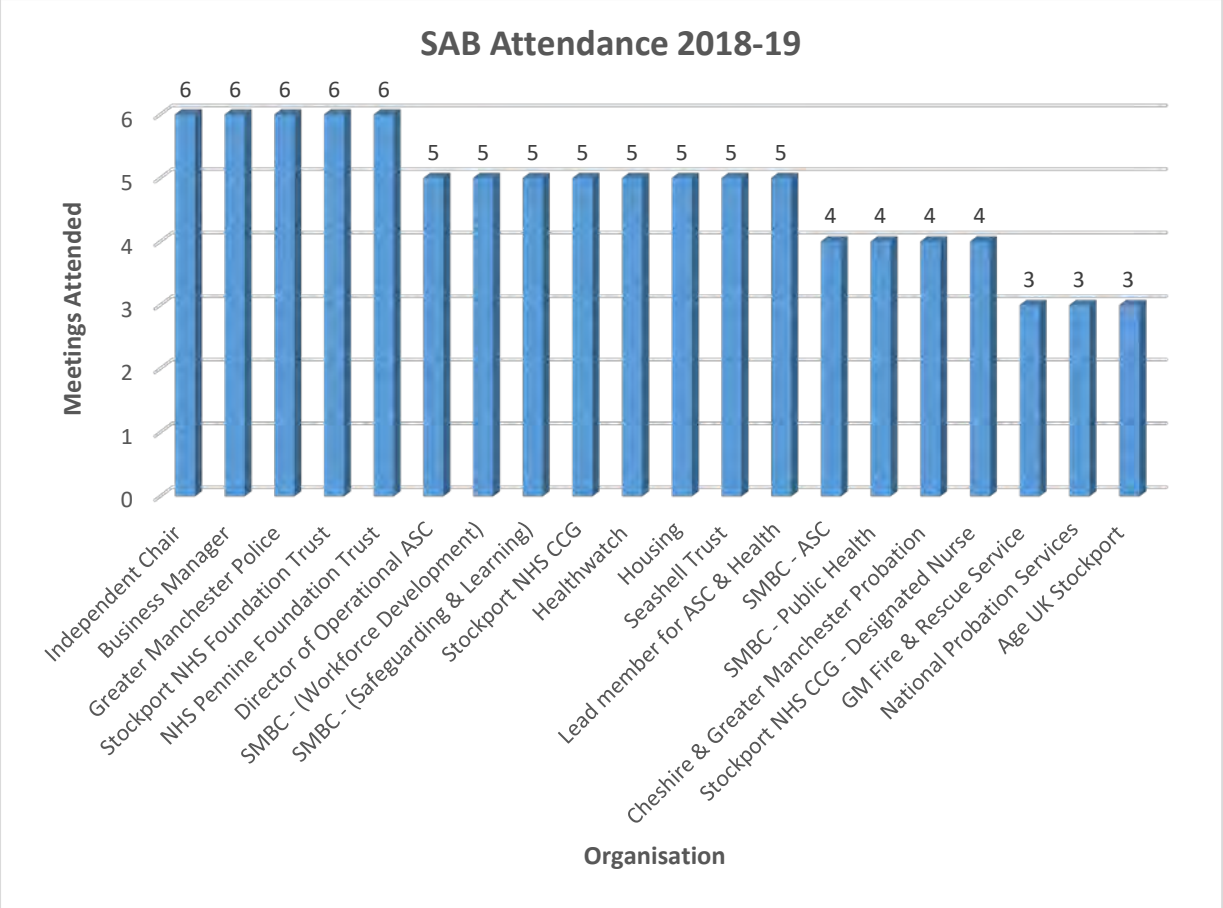
The table below tells us the actual expenditure of the Board throughout the 2018-19. Financial contributions continue from all three statutory partners, and this has enabled the resources to continue to support the functions of the SAB.

Stockport Safeguarding Adults Board Financial Report 2018-19

	2017/2018	2018/2019	2019/2020 forecast
Income			
Stockport Council	£ 70,000	£ 70,000	£ 70,000
Stockport CCG	£ 38,000	£ 38,000	£ 38,000
Greater Manchester Police	£ 13,400	£ 13,400	£ 13,400
Carried Forward		£ 12,105	£ 0
Total	**£ 121,400**	**£ 133,505**	**£ 121,400**
Expenditure			
Salaries	£ 76,771	£ 78,306	£ 79,089
Independent Chair	£ 12,525	£ 9,475	£ 12,500
SARs / MALRs	£ 19,999	£ 25,531	£ 10,000
Conference and publicity	£ 0	£ 4,600	£ 2,811
Quality Assurance	£ 0	£ 17,000	£ 17,000
Total	**£ 109,295**	**£ 134,912**	**£ 121,400**
Variance	**£ 12,105**	**-£1,407**	**£ 0**
Carried forward to 2018/2019	**£ 12,105**	**-£1,407**	**£ 0**

Board Attendance

Attendance at Stockport Safeguarding Adults Board and Sub-groups is monitored. Overall attendance is good at board level and agencies are generally well represented. The Independent Chair is committed to seeking explanations from members where attendance is not up to expectation.


SAB Attendance 2018-19
Meetings Attended
0
1
2
3
4
5
6
6 6 6 6 6 5 5 5 5 5 5 5 5 4 4 4 4 3 3 3
Independent Chair
Business Manager
Greater Manchester Police
Stockport NHS Foundation Trust
NHS Pennine Foundation Trust
Director of Operational ASC
SMBC - (Workforce Development)
SMBC - (Safeguarding & Learning)
Stockport NHS CCG
Healthwatch
Housing
Seashell Trust
Lead member for ASC & Health
SMBC - ASC
SMBC - Public Health
Cheshire & Greater Manchester Probation
Stockport NHS CCG - Designated Nurse
GM Fire & Rescue Service
National Probation Services
Age UK Stockport
Organisation

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

INTRODUCING: The Daily Risk Meeting Appendix 1

What is it?

- A short, daily (Monday – Friday) multi-agency risk meeting discussing around 5 cases per day.
- Chaired by the Police
- To enable sharing of information about victims, perpetrators and children; assessing risk; and coordinating safety plans.
- Held in the Multi – agency Safeguarding and Support Hub (MASSH), 3rd floor, Fred Perry House.
- In operation since November 2018

What is the aim?

- Share information to increase the safety, health and wellbeing of victims and their children
- Determine the risk posed by the perpetrator to an individual, their family and the wider community
- Implement an integrated risk management plan
- Improve agency accountability
- Improve support for staff involved in high risk domestic abuse cases.

What types of cases are discussed?

- Domestic Violence Cases assessed as high risk, and occasionally medium risk cases from the previous 24hrs (72hrs on a Monday).
- Most cases are identified by the Police, but other partners can identify cases for discussion as well
- **Should you have a case that you feel would be appropriate for discussion, please contact Michelle Bennett, Assistant Team Manager.**

Who attends?

- Stockport Family
- Adult Social Care**
- Stockport Without Abuse
- The Prevention Alliance
- Stockport Triage Assessment Referral Team – drugs & alcohol
- Health Visitor
- Greater Manchester Police Public Protection Investigation Unit.

****Adult Social Care is represented by the Front Door Team (usually Michelle Bennett, ATM)**

What is the pre-meeting process?

- Cases selected by Police and emailed out to partners by 8.30am
- Research done by each agency
- Research brought to the meeting / or sent in via email by 11.30am

What are the experiences and benefits to date?

- Closer working partnerships and positive relationships between participants
- Improved information sharing between agencies
- Reduction in inappropriate types of referrals between agencies
- Improved understanding of roles and remits of different participating agencies
- Some Neighbourhood cases have been discussed – enabling the allocated social worker to have a broader multi agency discussion – particularly where they are able to attend the meeting personally.

For further information, contact Michelle.Bennett1@stockport.gov.uk

14.0 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