Stockport Safeguarding Adults Partnership
Annual Report FYE 2021

Safeguarding
Adults
in Stockport

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Independent Chair's Introduction

I am pleased to present the 2020 -21 Annual Report on behalf of all the agencies represented on the Stockport Safeguarding Adult Board (SSAB). The reports shows that in Stockport we have continued to build on the strong partnership foundation to meet the many challenges facing agencies in ensuring that we are keeping adults at risk safe.

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

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

Independent Chair's cont'd

One of the most significant challenges we have faced as a Board since March 2020 has been dealing with the impact of COVID-19 pandemic.

The COVID pandemic has had a significant impact in Stockport as in all other areas of the country. The Board has a vital role in gaining assurance that both service users and the wider public are safeguarded during this unprecedented period.

Stockport Safeguarding Adults Board (SSAB) has continued to offer the same level of safeguarding activity in line with the Coronavirus Act 2020. SSAB's functions continued to operate by virtual conference calls with some areas of the business temporarily stepping down.

- Meetings were stepped down in Lockdown 1 and Lockdown 3 – leading to a delay against some actions;
- A number of agencies took on the additional role of safe and well checks, albeit virtually by telephone;
- We continued to monitor the impact of Covid on our care home residents and those who received domiciliary care support; with fortnightly meetings taking place with partners and the Care Quality Commission in order to identify any quality issue;
- The lack of face-to-face contact led to some risk being hidden from agencies to respond to safeguarding effectively.
- Audit schedules had been disrupted as a result of lack of capacity and availability amongst professionals;

Independent Chair's cont'd

- We continued to see a higher number of cases assessed under Section 42 where neglect was an issue. This may have been due to the impact of the pandemic, and it remains a priority for the partnership going forward;

- Moving to virtual meetings led to an increase in attendance due to the ease of partners joining meetings, which has opened up opportunities to explore smarter ways of working to improve engagement with professionals, service users and carers and families.

- Face-to-face training was initially suspended, with a caveat in place to provide virtual sessions. Online training and resources have been made available via Stockport's learning pool.

The response to COVID-19 across the partnership has been astonishing – we saw an excellent response from all agencies working with vulnerable adults and their families.

We introduced weekly safeguarding check in meetings which were well attended and allowed for a wider sharing of changes to services and agency news. We saw excellent engagement from our partners that enabled us to oversee that the safeguarding response was co-ordinated. As the months progressed the meetings moved to fortnightly and have since evolved to monthly. This good practice has remained throughout the financial year, and we will continue to meet at an operational level on a quarterly basis. I have to say a big thanks to all our front-line workers for their excellent response during such unprecedented times. We will look at the learning from our response and build the positive learning into our structures for the future.

Independent Chair's cont'd

We increased our publicity and developed a Covid -19 safeguarding website providing key safeguarding information, specific to Covid-19.

Additionally, monthly bulletins were produced and disseminated to partners providing headlines of service updates, along with guidance and useful resources for supporting and working with adults at risk during unprecedented times.

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

We developed a Covid-19 risk response and assurance register where partner agencies contributed by sharing their respective top 5 risks to SSAB for assurances.

Data performance throughout the pandemic was collected, and themes, patterns and trends were shared at each safeguarding check in meeting.

A Recovery Plan was put together to identify lessons and work on actions necessary to aim towards returning to business as usual.

We continued to respond to Safeguarding Adult Review referrals and SAR screening panels, which were all facilitated by virtual teleconference.

Independent Chair's cont'd

The Board's three year strategic plan is based around four key shared strategic priorities:

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

For 2020 – 21 we had agreed 5 thematic areas to focus on; these were based on learning from national and local safeguarding reviews; new/emerging national issues, pages 17-20 sets out what has been achieved.

The pace and scale of the work of the SSAB continues due to the commitment of the partner agencies who consistently drive for improvements in the quality of services which safeguard and promote the welfare of vulnerable adults.

Without them the pulling together of this annual report and all that we have achieved would not have been possible.

This is my last annual report as Independent Chair. It has been a pleasure and an honour working with colleagues in Stockport and I would like to wish Gail Hopper my successor all the best.

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.

2021 Health at a Glance

The current population of Stockport is 296, 217 (2020). The "If Stockport were 100 people" infographic shows a selection of key measures to give a general overview of the people of Stockport and provides a context for the challenges the borough faces.

Introduction

Welcome to Stockport Safeguarding Adults Boards (SSAB) Annual Report for 2020-21

What is Stockport's Safeguarding Adults Board?

Stockport Safeguarding Adults Board (SSAB) is a statutory, multi-agency partnership coordinated by the local authority. The Care Act 2014 requires all local authorities to set up a Safeguarding Adults Board with key statutory partners – local Police and local Clinical Commissioning Group.

The Safeguarding Adults Board's statutory core duties are to:

- Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Commission Safeguarding Adult Reviews for any cases which meet the criteria for these. The SSAB SAR Protocol can be found here.

The main objective of the Board is to ensure that safeguarding arrangements across the partnership work effectively to prevent abuse and neglect, and to protect people with care and support needs, who may be at risk of abuse or neglect.

What we do

SSAB's remit is to set priorities, agree objectives and to co-ordinate the strategic development of adult safeguarding across the borough of Stockport. It is the key mechanism for agreeing how local agencies will work together effectively to safeguard and promote the safety and wellbeing of adults with care and support needs who are at and/or are in vulnerable situations.

This report covers the work of SSAB from April 2020 to March 2021.

The report is structured into the following main sections:

- Purpose, membership and structure of the SSAB.
- Governance arrangements
- Overview of Stockport Safeguarding Adults Board activities and achievements.
- Review of achievements in relation to the business plan.
- Stockport Local context.
- Learning from SARs.
- Board priorities 2020-23.

Purpose, Membership and Structure of the SSAB

The statutory purpose of the Safeguarding Adults Board is to help and safeguard adults with care and support needs. It does this by:

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

Local authorities are responsible for the establishment of Safeguarding Adults Boards. The Care Act 2014 specifies that the core membership of the Safeguarding Adults Board (SAB) includes three strategic partners – the local authority, Local Clinical Commissioning Group (CCG) and the police.

For a Safeguarding Adults Board to fulfil its responsibilities and duties effectively, other agencies will need to be involved in its work.

The next couple of slides will explain which of the agencies are currently members of SSAB, along with an illustration our Governance arrangements.

Board Structure

The Safeguarding Adults Board (SAB) meets quarterly and is a key decision- making forum, made up of both statutory, and non-statutory partners.

Practice Improvement and Quality Assurance Partnership Groups meet on a bi-monthly basis and report to the SAB on the groups business functions and progress made against the strategic business plan.

Complex Safeguarding, Domestic Abuse and Training and Workforce Development are all joint working groups with involvement from both Stockport Children Safeguarding Partnership and Stockport Safeguarding Adults Board.

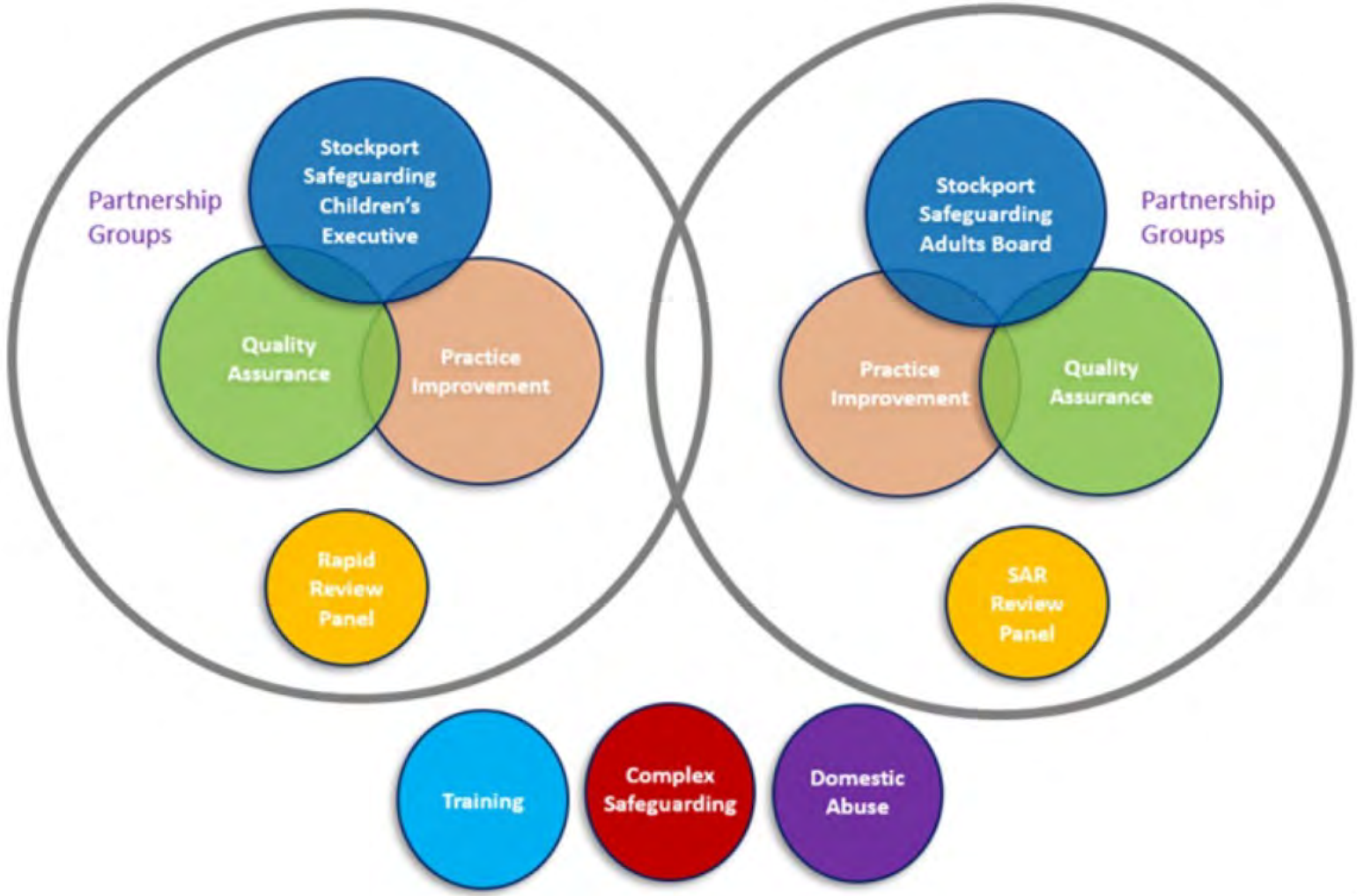
Board Support Team

SSAB Partners

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

Governance Arrangements

Stockport Safeguarding replaced both former safeguarding partnerships (Stockport Safeguarding Children's Board (SSCB) and Stockport Safeguarding Adults Board (SSAB)) with effect from September 2019 and established its new governance arrangements to combine the responsibility for safeguarding children and adults under the guidance of Working Together 2018 and the Care Act 2014. The illustration below provides details of this new structure:



Governance Arrangements – Partnership Groups

Practice Improvement Partnership

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

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

Quality Assurance Partnership

Chaired by the Designated Nurse for Safeguarding Adults CCG

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

Domestic Abuse Steering Group

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

Develops and drives the strategic approach to tackle Domestic Violence and Abuse across Stockport for children, adults and families. Partners work together to deliver on the strategy action plan and identify needs in relation to services and approaches to tackle Domestic Violence and Abuse. The Domestic Abuse Steering Group will become a Partnership/Board from April 2021.

Complex Safeguarding

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

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

Training and Workforce Development

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

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

SAR Review Panel

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

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

Vision, Aims and Values

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

Our values that underpin the vision

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

Aims of the Safeguarding Board

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

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

Values – How we work together

The Strategic Plan (2020-23)

Stockport Safeguarding's new strategic priorities were agreed as part of the consultation and engagement on the new partnership arrangements replacing the two former safeguarding boards (Stockport Safeguarding Children's Board and Stockport Safeguarding Adults Board). The focus of the partnership's work has centred around these priorities which are overarching across both adults and children's safeguarding.

The Board's three year strategic plan is based around four key shared strategic priorities:

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

In order to meet the four strategic priorities the following five thematic areas were agreed:

- Transitions
- Implementation of Liberty Protection Safeguards (LPS)
- Neglect/Self Neglect
- Safe Sleep
- Homelessness

The following slides will demonstrate the progress made against the 3-year strategic plan throughout 2020-21.

Achievements by the Safeguarding Adults Board & Partners

Thematic Area	We said we would	What we have done
Transitions	• Review and update our Multi agency Safeguarding Adults Policy, Procedure and Guidance.	• The new SAB Multi-Agency Safeguarding Adults Policy has been published as a web-based resource hosted on the website. • Transition plans for those with SEND are well embedded with SEND social workers sitting in the Learning Disability team. • A few multi-agency safeguarding workshops have been held to review the Team Around the Adult (TAA) process to ensure that all agencies are taking a lead as appropriate in this process to embed in practice across the partnership. • Feedback from the workshop sessions has enabled the commission of an external author to assist in drafting the revised procedures, and to incorporate a Think family approach across all practice. • Think Family is being embedded into training programmes and offer extended across both children/adult workforce. • A MAARS desktop review was completed to look at cases of young people's (17 to 25-year-olds) experiences. • MCA and capacity assessments training was commissioned, and two training sessions were delivered to both children and adult workforce.

Achievements by the Safeguarding Adults Board & Partners

Thematic Area	We said we would	What we have done
Implementation of Liberty Protection Safeguards (LPS)	• We will implement LPS and measure its effectiveness, with receipt of assurance, challenge and scrutiny against new guidance. • Introduce Safeguarding and Mental Capacity Forums to both children and adults services in preparation of LPS. • Review and refresh the SABs Safeguarding and MCA training programme. • Gain assurance from SAB partners about the steps being taken within their respective organisations to develop and improve MCA practice. • Develop a multi-agency themed audit linked to MCA and learning from serious cases.	• Due to delay of LPS until April 2022 data collection for LPS is not possible. However, we have continued to monitor DOLS datasets and monitor themes, patterns and trends. • Feedback received from both audit and at the Multi Agency Safeguarding Adults workshop does not provide strong confidence that the workforce fully understand the application of MCA. • To address this gap in knowledge the Safeguarding and MCA Forum was tested and proven to be of interest to frontline practitioners. Further sessions are scheduled throughout the year with the aim to recruit and select MCA champions. • The production and delivery of MCA pocket guides were commissioned and delivered within the partnership and the workforce. • MCA and capacity assessment training was commissioned and delivered to 22 delegates and further training is to be delivered in 2021-22.

Achievements by the Safeguarding Adults Board & Partners

Thematic Area	We said we would	What we have done
Neglect/Self Neglect	• We will ensure the all-age strategy is consistently applied within the Partnership and we will develop mechanisms to ensure that data on self-neglect is scrutinised. • Develop material promoting wider awareness of adult abuse and neglect and the work of SSAB across a number of platforms.	• An all age Communication strategy was completed and approved by Practice Improvement Partnership in late 2020. • Private, Voluntary and Independent (PVI) guidance was completed and shared with the PVI sector. • Lead partner agencies have completed ownership and delivery off the adults self neglect Action Plan. • Links are being made across the PVI sector and with a range of safeguarding training being delivered forms part of the business-as-usual for SSAB. • Developed and strengthened our Data Performance Dashboard to extrapolate self-neglect data that has continued to report into the monthly check-in meetings. • Produced 7 Minute Briefing papers about Adult Grooming and Cuckooing, along with Scams, Fraud and awareness on Adult Safeguarding. • Social Media Campaigns throughout the year continue to raise awareness of Neglect/Self Neglect.

Achievements by the Safeguarding Adults Board & Partners

Thematic Area	We said we would	What we have done
Homelessness	• We will develop more effective practice and bring in wider partners, and where possible, people with lived experience of homelessness. • We will join together an increasingly co-ordinated approach that is embedded both in everyday practice and strategic decision-making. • We will measure the effectiveness of day-to-day practice against the Stockport Homelessness Strategy.	• In January 2020, we delivered a multi-agency workshop to gain understanding and position of rough sleeping and homelessness in Stockport. • A series of wider system Health & Homelessness seminars were held and jointly co-ordinated by the Housing Strategy team, Stockport Homes and the Clinical Commissioning Group, to identify priorities and build recommendations into the revised 2021 – 2024 strategy. • Appointed a Social Worker within Adult Social Care, with the link back into Stockport Homes. • The revised Homelessness strategy consultation concluded and resulted in a co-produced All-Age Homelessness Strategy. • Stockport Homes, have implemented initiatives to ensure that anyone at risk of homelessness was given immediate help and support and that those who were street homeless were given access to safe accommodation.

Mental Capacity Act Audit

We conducted a multi-agency audit to review a number of cases on the Application of Mental Capacity.
The audit's aims were to examine Stockport's current position and awareness of how to apply the Mental Capacity legislation within frontline practice.
Self-assessment audits were completed and a learning event was conducted where partners could share examples of good practice and support professional challenge where necessary.

Learning Points	Evidence of Impact
The sample of cases that had been audited did not give specific insight into Black, Asian and Minority Ethnic (BAME) groups.	The audit tool has been updated to include BAME groups as a performance indicator for all future audits. This includes a section on the service user's feedback also to help gain the voice of the person and make safeguarding personal.
Consider joint training sessions for front line staff across different services to make more inclusive for key workers.	We commissioned external training sessions for front line staff across the multi agency partnership on the subject of MCA, decision making and young people. 22 delegates attended both and further sessions are scheduled throughout 2022.
Guidance to be provided to Practitioners around the best interest assessment process.	We created 2 page MCA guides and disseminated wide within the Partnership. The guides are available both in lanyard style and electronically for the workforce to access. Safeguarding and MCA Forum was formed to help recruit Safeguarding and MCA champions to disseminate information and learning wider across the partnership. The Forum meets Quarterly and has met twice this financial year. We have 130 subscribers within the adults workforce who have enrolled .
Partnership learning day to be considered for dealing with complex cases; and guidance to be provided to Practitioners around the best interest assessment process.	Learning Hub Model drafted and approved. Events throughout 2020-21 were postponed due to impact of Covid. Dates have been reconfirmed and are scheduled for Autumn 2021.

Training & Development

The work of the partnership group was, in common with others, was greatly impacted by the pandemic.

The main issues faced were:

- Social Distancing and Lockdown requirements preventing the delivery of most face-to-face training, at both multi-agency and single-agency levels.
- Difficulties during the start of lockdown in running training courses remotely – these issues were reduced towards summer of 2020.
- Increased workload of the Health and Social Care workforce, restricting the ability of that workforce to attend training events.
- Members of the training pools have been under additional pressure from within their own organisations to reduce input to sessions in order to focus on their own agencies business during the pandemic. This has led to Stockport Safeguarding Children Partnership (SSCP) training manger and staff from the Council's workforce development team facilitating more sessions.

Due to restrictions arising from COVID 19, it was not possible to hold our joint annual Safeguarding conference in 2020-21. However, once Covid-19 restrictions have been fully lifted then considerations will be given as when to reinstate a face-to-face annual conference.

Training & Development Achievements

Despite these challenges, the group continued to meet during 2020-21 and attendance at the partnership group continued to be very good with a wide range of agencies represented.

The group's achievements during this time included:

- Our whole training program was transferred to virtual and some sessions have been reduced in length to reduce on screen time. This is set to remain the case whilst guidelines dictate. Learning can be moved to face to face or a mixture of the two as needed.
- During 2020-21 a total of 600 delegates have attended multi-agency training sessions delivered via online webinars and a further 1,500 have completed a safeguarding related e-learning course via Learning Pool.
- The introduction of the Safeguarding and MCA forum, which has seen a consistent growth in attendance during its 3 meetings to date. Various resources have been shared including an article on MCA and Covid-19 vaccinations and a SharePoint site has been set up to allow members/champions to share resources.
- MCA capacity assessment training session was delivered in February 21 attended by a wide range of partners across Children's and Adults to encourage an all age approach to MCA.
- Review and development of SSAB and SSCP websites.
- Part time SAB Training Manager was successfully appointed to deliver a comprehensive Safeguarding multi agency training programme, and will work alongside SSCP Training manager, and continue to include Think Family throughout our training materials.

Our considerations for 2021-22 include reflection on the new joint priorities and key actions identified from the Joint Boards development day in May 2021.

Training & Development

Multi-agency training attendance 2020-21:

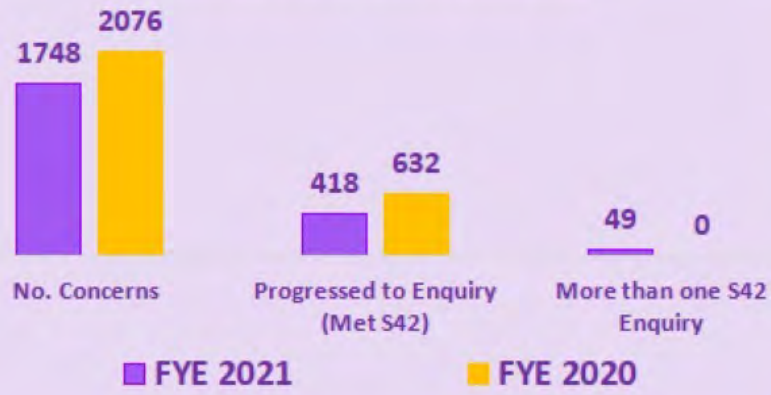
Courses	Webinar	e-learning	Total
Safeguarding Adults - introduction	53	355	408
Safeguarding Adults – Manager Training		27	27
Mental Capacity Act		203	203
Domestic Abuse	126	291	417
Self-Neglect and Hoarding		96	96
Coercive Control		112	112
Dignity in Care		120	120
Modern Day Slavery and Human Trafficking	51		51
Self-Harm		82	82
Care Act – Adult Safeguarding and the law	80		80
Hate Crime	22	90	102
Homelessness	28		28
Total	**360**	**1376**	**1726**

Training & Development Impact

Training Impact - Feedback from delegates	Priorities for 2021-22
1. "Very informative training, obtained a better awareness and understanding relating to this subject." 2. "It's crucial to understand safeguarding and to engage with it, and the course gave me the confidence to be straightforward about risk, and to report concerns with specific details." 3. "It has influenced my practice in recognising how important that first visit to the victim is, as all information needs to be collected, as you may only get one chance" 4. "Attending training and meeting with people online has allowed for more participation from agencies, as they have more time available and can attend remotely as they don't have to travel." 5. "Increased my knowledge on the subject and enables me to provide advice to colleagues where required and also to answer any questions arising in safeguarding training" 6. "I have become involved in the MCA and DoLs focus group and hope that this peer guidance and sharing of experiences will improve practice."	**Redesign our multi-agency training offer to:** • Respond to revised Safeguarding Adults policy and the new roles and responsibilities defined within it. • Introduction of LPS and the associated multi-agency training needs. • Support recovery from Covid-19, including emerging safeguarding themes and additional support required by the multi-agency workforce. • Increase awareness of key safeguarding issues amongst wider economy, including the introduction of more communication material and 'essential awareness' training courses.

Performance Data – Adult Enquiries

No. of People Referred

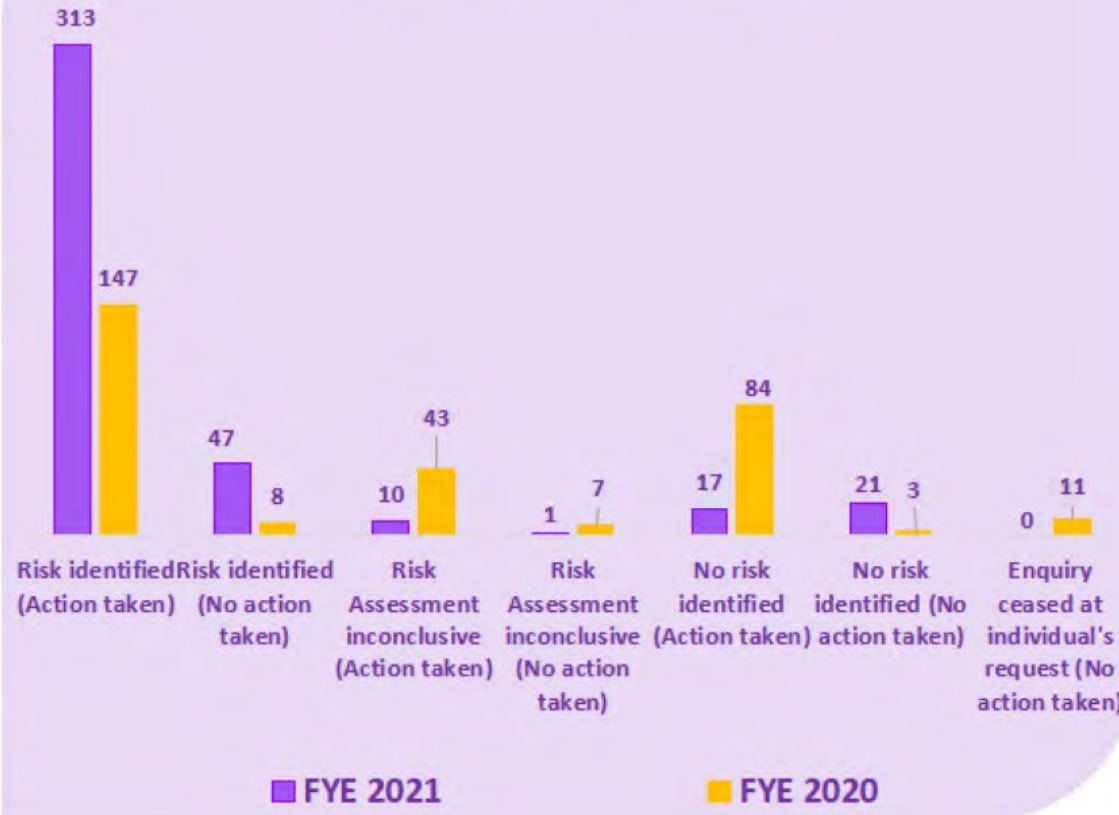


More than one S42 Enquiry was not recorded data in FYE 2020.

Risk Outcomes

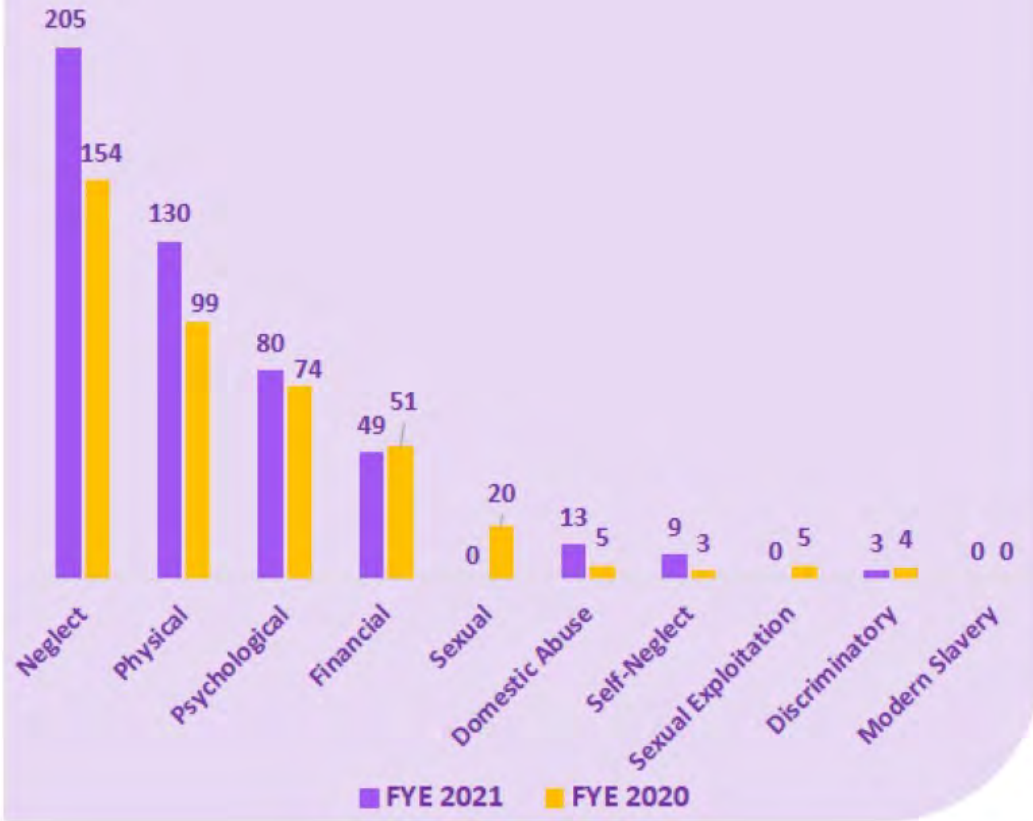
A Safeguarding Concern occurs when any safeguarding issue is first raised with Adult Social Care. This is reviewed and triaged and if it is considered a safeguarding matter it will advance to an Enquiry.

Section 42 Enquiries & Risk Outcome Measure



Performance Data – Section 42 Risk Type & Location

Type of Risk

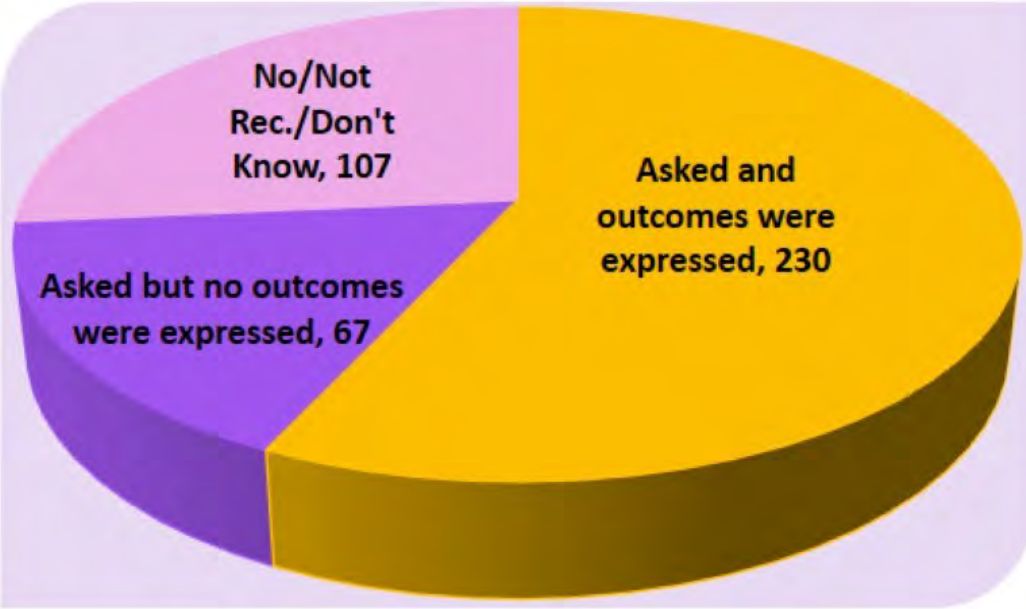


In FYE 2021, the main two types of risk remain Neglect and Physical.

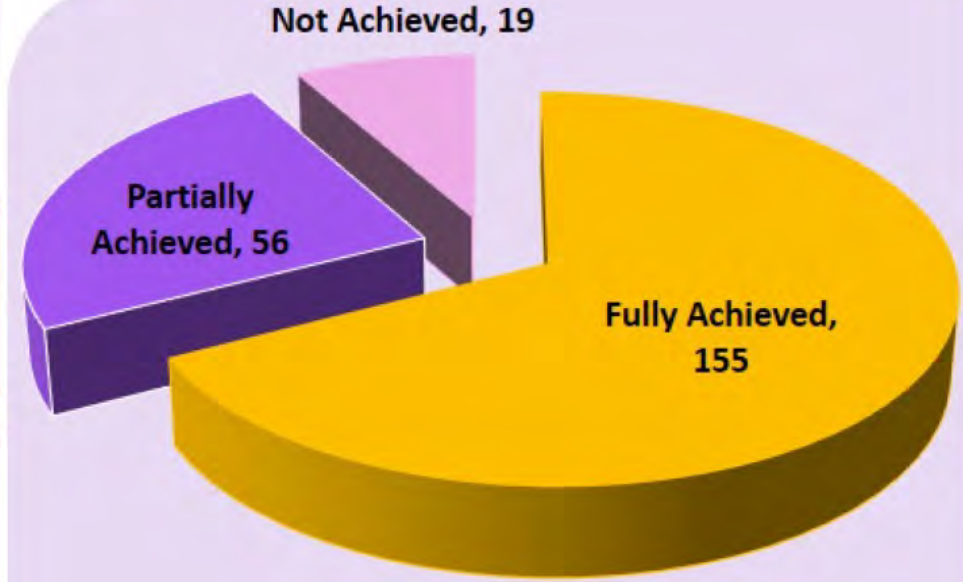
Location of Risk

There was a significant increase within Residential Care Homes and a significant decrease within Own Home in FYE 2021, both of which may have been due to the impact of Covid-19.

Performance Data – Making Safeguarding Personal



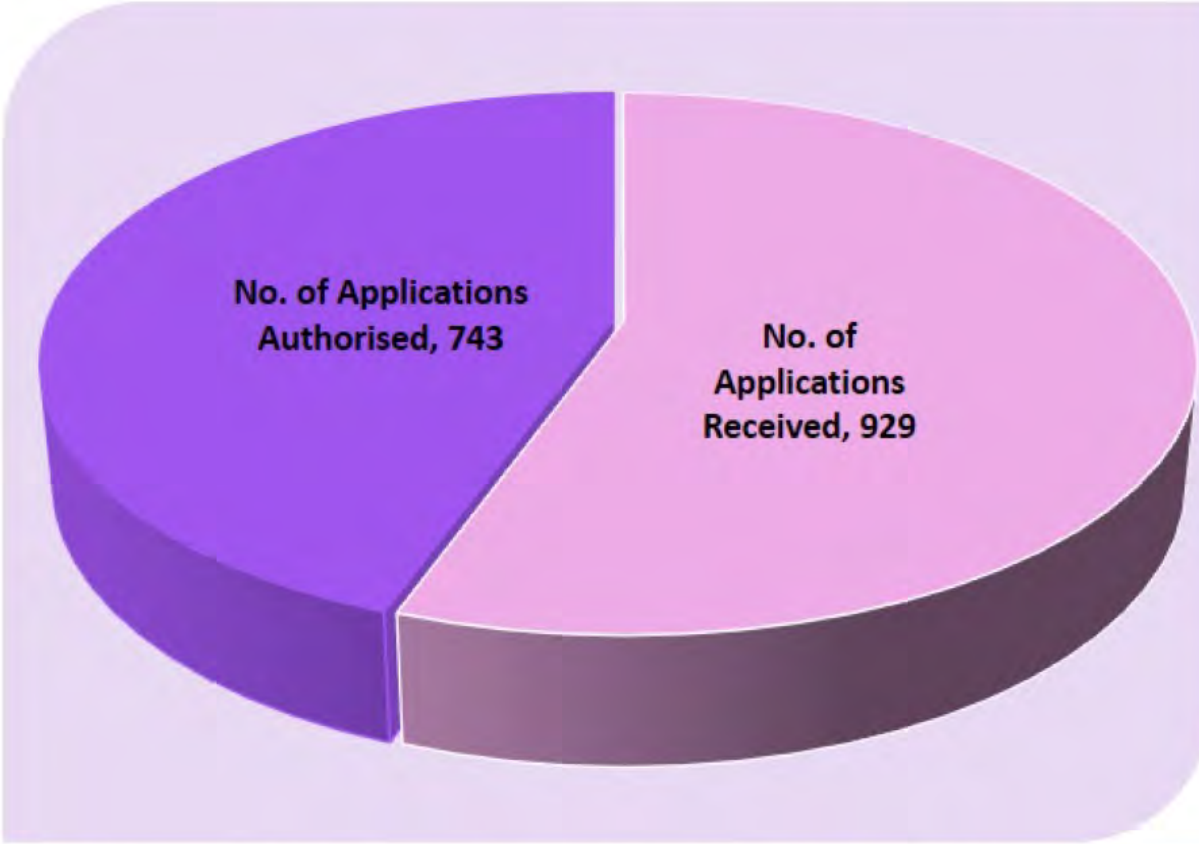
In FYE 2021, 292 people (70%) were asked what outcomes they would like, 230 expressed a preference.



In FYE 2021, out of the 230 people who expressed an outcome preference, we were able to meet 92% of these fully or partially.

An area of concern continues to be the number of individuals reported as "No/Not Recorded/Don't Know". This is an area of ongoing investigation for 2021/22.

Performance Data – DoLS



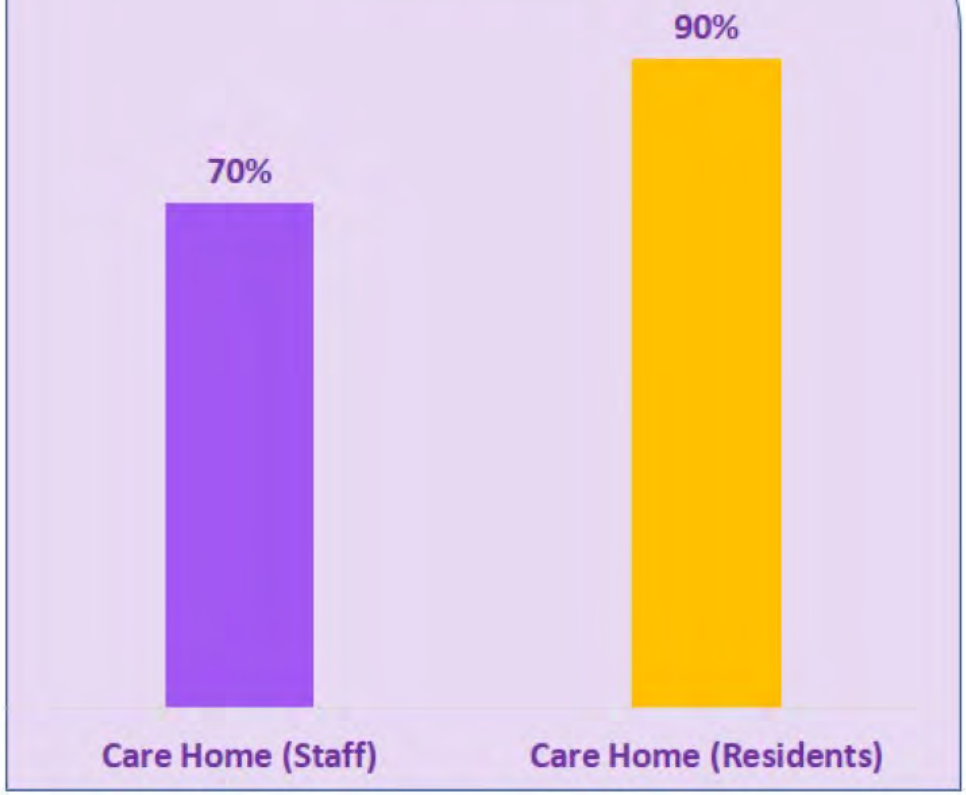
In FYE 2021, the two main sources of DoLS were Hospitals and Care Homes.

Cases are managed using the ADASS triaging guidance low, medium and high depending on the level of restriction on and objection of the deprived person.

An in-depth detailed breakdown of Adult Enquiries, Section 42s and DoLs was not possible in FYE 2021 due to extrapolation and accuracy issues with the system changeover to Liquid Logic.

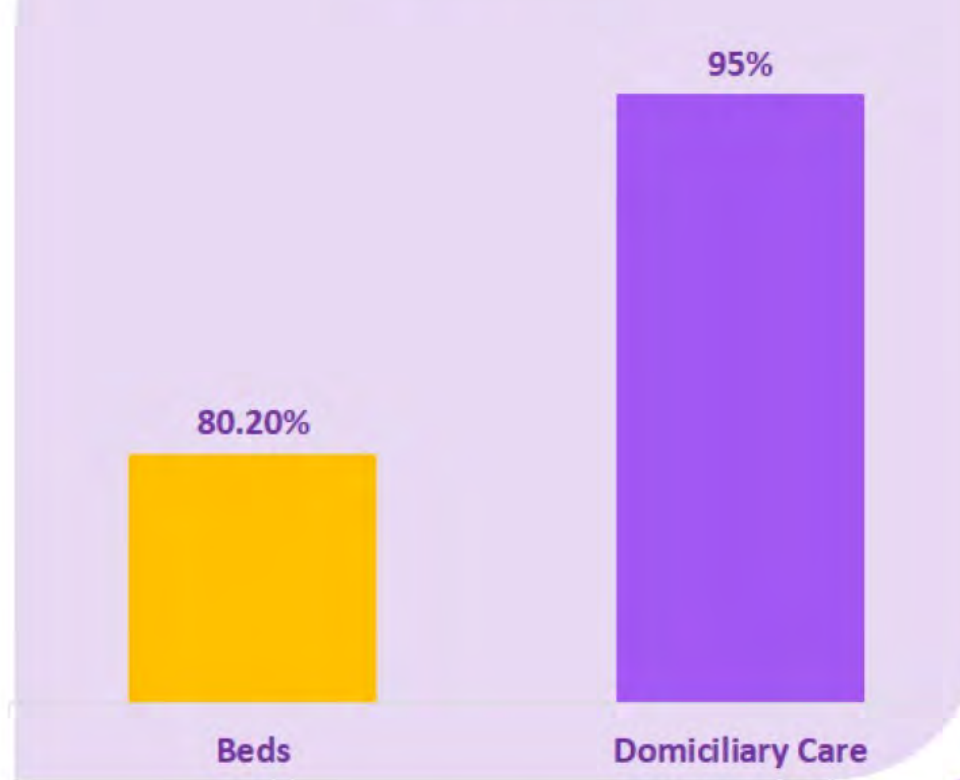
Performance Data – Care Provision

Vaccinations



At the end of FYE 2021, the national average for vaccinated care home staff was 66%.

CQC Ratings



At the end of FYE 2021, there were no Care Homes or commissioned Domiciliary Care Agencies rated inadequate in Stockport.

Performance Data – Harm Levels

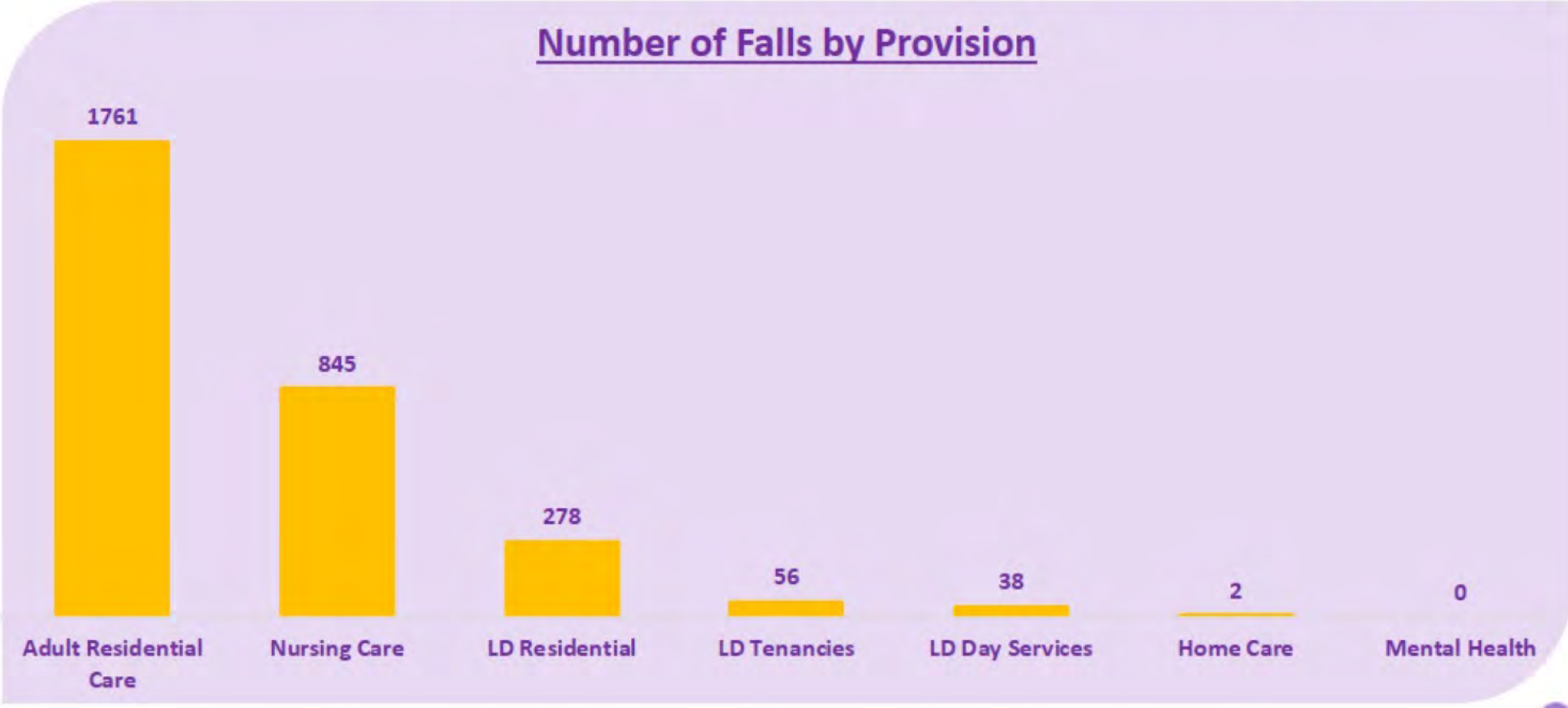
Harm Level Totals

An on-line Survey is conducted on a quarterly basis to obtain and monitor Harm Level data from across the Care Provision within Stockport. Overall, compliance is quite good and data is shared with the Care Providers. Where non-compliance occurs, the ASC Quality Monitoring Team are notified so they can support and work with Providers.

Slips, Trips and Falls, Medication Errors and Behavioural being the three main themes was a regular pattern across the quarters. Communication/Records is showing as high, however this data was skewed by one submission error by a Provider. 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.

Types of Safeguarding Incidents

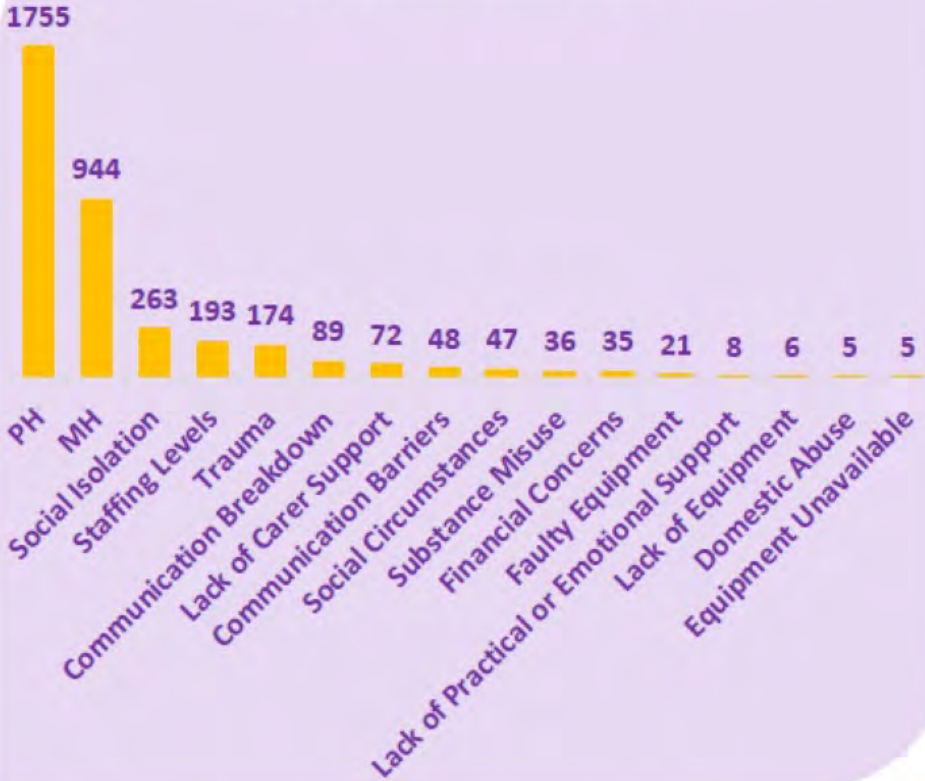
Performance Data – Harm Levels (cont.)



The most frequent location of Slips, Trips and Falls was in Adults Residential Care which was a common theme throughout the year. As previously mentioned, this is an area that the Quality Monitoring Team continue to offer extra support to the Care Provider Network in collaboration with Steady in Stockport.

Performance Data – Harm Levels (cont.)

Risk Factor Totals



Solution Totals

The three main risk factors were Physical Health, Mental Health and Social Isolation and these were a regular pattern throughout the year. Social isolation is not usually as high and staffing levels as a risk factor increased from October 2020 but these were both due to the Covid-19 pandemic.

In addition to the identified solutions, other good practice identified by Care Providers included: review of internal unit design to allow for greater and more positive service user interaction; increased use of floor and chair sensors; purchase of specially designed drinking vessels maintaining dignity of service users; good practice "chats"; use of distraction techniques and different ways of managing anxiety for service users with behavioural issues.

Safeguarding Adult Reviews (SARs)

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

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

The law says SSAB must arrange a SAR when:

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

Safeguarding Adult Reviews Activity

A significant amount of work was overseen by the group, and in addition to the cases outlined in this section of the report, other non-statutory reviews and reports were also considered and monitored.

SAR Referrals FYE 2021	
No. of referrals received	13 (resulted in 1 new SAR commencing (SAR 7), with one decision pending whilst additional information obtained to determine whether the case meets the SAR criteria).
No. of Rapid Reviews conducted	1 joint with Childrens
No. of referrals progressed as a full review	1
No. of referrals progressed as alternative learning reviews	3 (1 Multi-agency learning review (MALR 3) and 2 Single-agency reviews from PCFT and Stockport Adult Social Care)
Types of abuse reported in referrals	Financial Abuse, Self-Neglect, Physical Abuse, Substance Misuse, and Mental Health needs, the latter of which led to the person taking their own life.
No. of SAR reports published	2 (Pseudo names Ivy and Jo)
No. of lessons learned briefings shared	1 (Pseudo name Colin)
No. of 7-Minute briefings published	2 (Pseudo names Ivy and Tom)

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

Safeguarding Adult Reviews – Impact

Impact – Case Studies

The Board has completed two statutory Safeguarding Adults Reviews (SARs) during 2020-21; these concerned a woman by the name of Ivy (SAR 6) and the other being Jo (SAR 7) respectively. SAR 6 was undertaken by Mr McManus and Ms Elwood-Clarke, whereas SAR 7 was completed by MS Deborah Stuart Angus who are leading experts and researchers in the field of safeguarding, mental health and homicide reviews.

The reviews and their recommendations have already been accepted in full by the Board and will be used to support Stockport in its work to develop a robust approach to supporting residents living in circumstances of self-neglect, and suicide awareness.

SAR 6 - Ivy was 62 years old who had complex medical needs, she was morbidly obese and had recently been diagnosed with cancer. She lived at home and was visited by a care provider four times a day. On this occasion Ivy was advised to go to Emergency Department to be seen and on her return home, she was not seen by her care provider, friends or family until 13 days later, when she was being collected by her ambulance crew to attend an outpatient's hospital appointment. Ivy died several days later in hospital. To find out more please refer to our 7 minute briefing paper and look at the impact that has been made since the review was completed.

SAR 7 - Jo was a 34-year-old woman living alone, with her dog. She had two siblings, and at the time of her death, she was in touch with her Father, possibly her Sister, but not her Mother. She had struggled with mental health problems, for about 18 years, having made 13 known suicide attempts, as described by professionals, since 2012, with 8 of them occurring between 2018 and 2020 and escalation in March 2020, the last attempt being successful. 7 Minute Briefing Paper and Exec Summary can be found here.

The SARs were carried out in accordance with the principles set out in the Care Act 2014. The reviews did benefit from participation and contributions from all agencies involved in both cases, including the friends of Ivy and the family of Jo.

Multi Agency Learning Review

This was a case that did not meet the criteria for a SAR but was felt to suit a local learning review, which took place in 2020-21. From the multi-agency learning review, there were some lessons to be learned and these are reflected in the 7 minute briefing paper available here.

Safeguarding Adult Reviews – Achievements

What have we done?	
Delivered frontline visits with practitioners to measure the impact from learning, and gain feedback from the workforce on ways to increase engagement and communication for all staff relevant to practice	We refreshed our SAR protocol to ensure the process to the management and overview of safeguarding adult's referrals had a consistent approach to the consideration of Safeguarding Adults Review referrals.
We launched a SharePoint site for ease of access for partners to share and access reports and information timely.	We continue to submit learning from SARs to SCIE on completion of each SAR, and we ask that they are uploaded to the National repository for wider learning.
Reviewed SAR templates including our SAR referral and the SAR consideration report to the Independent Chair to ensure learning and good practice is drawn out from the SAR panel discussions sooner.	Delivered a workshop to look at alternative SAR methods so that issues and lessons are identified sooner, disseminated and acted upon within a short timeframe. Further work is underway to develop a hybrid framework that will deliver learning from SARs in rapid time.
Our SAR panel continues to offer challenge and scrutiny throughout the SAR report development process, to ensure the quality of reports are of a good standard.	We have developed a learning hub model and planning for its roll out is scheduled in Autumn 2021.

As a result of the learning from our reviews, recommendations and action plans have been created and are currently being implemented by all partners involved throughout 2021.

Learning Disability Mortality Review (LeDeR)

During 2020/21, 38 LeDeR reviews were completed in Stockport. Within Stockport, the programme is led and managed by NHS Stockport CCG and is delivered in conjunction with health, social care, families, carers, advocates and providers.

There are 23 recommendations arising from the LeDeR reviews completed in 2020/21. Delivering against the recommendations will require engagement across the system, and strong leadership within organisations to support learning and provide assurance of implementation and improvements.

There are several 'best practice' examples highlighted in reviews, and they illustrate the progress made across the health and social care system to ensure reasonable adjustments are considered, and that the needs and views of people with a learning disability are listened to.

To gain a full overview of LeDeR in Stockport please click here to see the LeDeR Report

There were aspects of good practice and a need for future focus in the following key areas:

- Embedding MCA and Best Interests into core practice
- A continued focus on uptake of annual health checks
- Securing expertise across the system
- A continued focus on the uptake of health screening
- Parity in medication management
- Improving inter-agency communication
- Carer assessment and support
- Improved nutrition and oral care
- Effective management of constipation
- Embedding use of health passports within medical teams
- Establishing the End of Life pathway
- Continuing to support care and nursing homes to deliver appropriate and effective care

Our Shared Strategic Priorities 2020-23

We have 4 strategic priorities for 2020-23

Our shared priorities for 2020-23 are:

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

Thematic Areas (FYE 2021)

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

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

The Board has agreed its five themed areas for 2021-22.

Transitions

Implementation of Liberty Protection Safeguards (LPS)

Neglect/Self Neglect

Contextual/Transitional Safeguarding

Homelessness

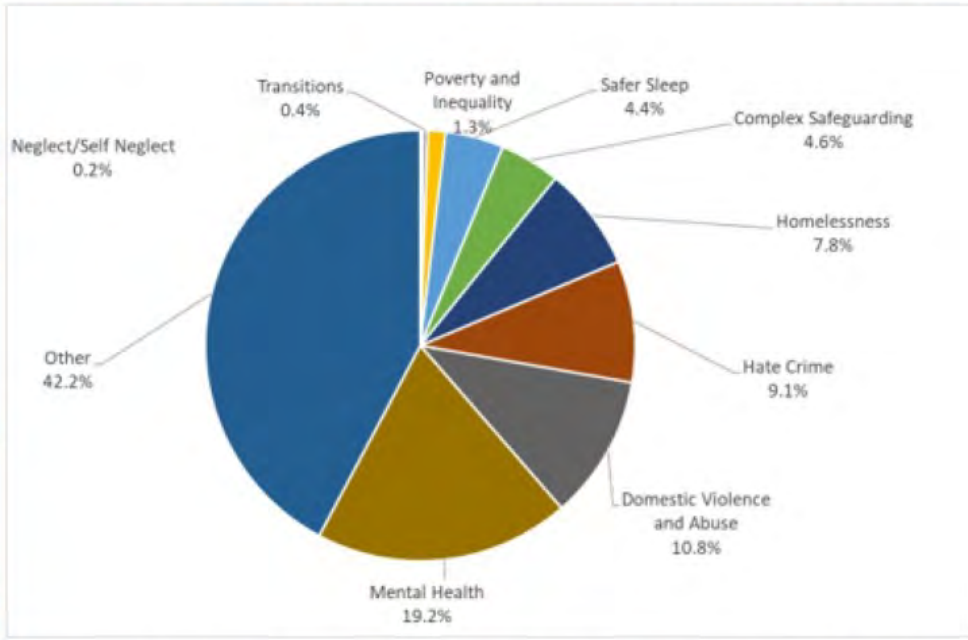
Focus Areas (FYE 2022)

- Keep the focus on our most vulnerable children and adults.
- Spring 2022, there will be a change in national legislation with the Implementation of Liberty Protection Safeguards (LPS) to replace DoLS. This will require an LPS training offer that the workforce are familiar with.
- To include learning hub events as part of the training offer to enable key learning to be cascaded across SSAB.
- Aim to recruit Safe Sleep champions to embed a whole system approach to safer sleep.
- Implement homelessness focussed frontline visits.
- Obtain views of lived experience from service users.
- Launch and monitor effectiveness of the revised multi agency safeguarding adult procedures.
- Develop a clear care and support pathway for people who live with Personality Disorders.
- Test and pilot the SCIE Rapid in Time SAR Review Framework to learn new ways of working and share lessons more timely.
- Look at our 5 thematic areas within the strategic delivery plan and consider what themes should be taken forward.

Campaigns and Awareness Raising

StockportSAB

In the period April 1st 2020 – 31st March 2021 we had 465 followers, but made over 79.3k impressions and reached over 571k twitter users. Links in our tweets were clicked 795 times. Our tweets have been viewed both locally and globally, the map below shows where users have engaged with our posts (liked, shared, commented) to our tweets.

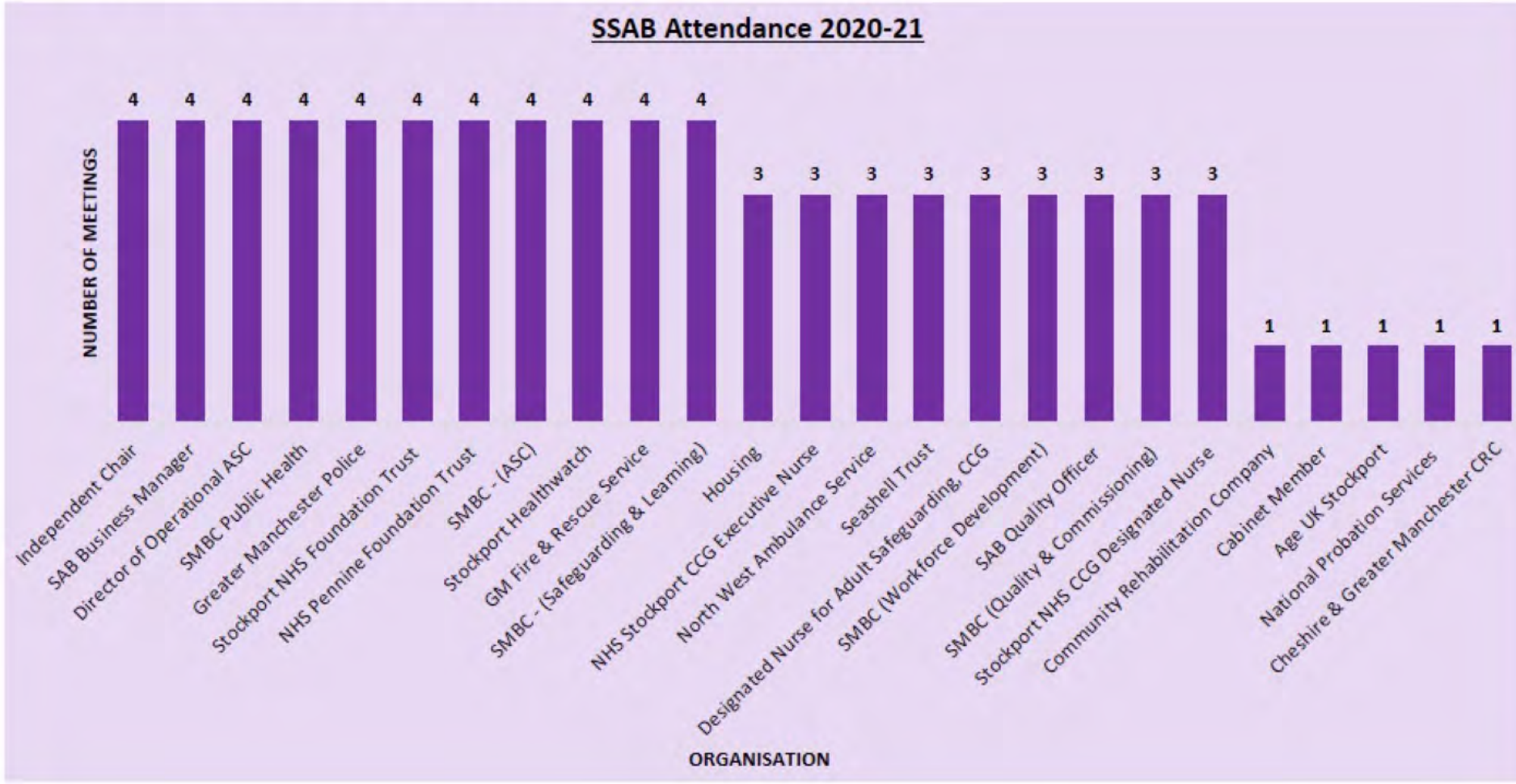


The SSCB and SSAB twitter ran a number of media campaigns throughout the year focussing on strands identified in chart above right. Unfortunately, it has not been possible to split these by account.

The other category includes tweets which promoted key information relating to Covid-19, health and wellbeing, safeguarding adults week and many other topics.

Board Attendance (FYE 2021)

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



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 need to rely on other people to help them in their day-to-day living. Sadly, it is because they need 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 and we will do something about it. We will also provide information and offer practical advice to the person suffering abuse, so that they can make an informed choice about any help they might need, or any action they may wish to take. If they are unable to make an informed choice, care will be taken to support and protect them.

How to report abuse or neglect

Visit our website **www.stockport.gov.uk** and complete the alert form and someone will get back to you

or call us on
0161 217 6029
or dial 0161 217 6024 for the Minicom

Out of Hours:
0161 718 2118

Questions about this Report

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

Remember, safeguarding is everyone's business

Response to Covid-19

As of 1st April 2021, there was 48,000 confirmed Covid cases in Stockport, and 700 confirmed deaths as a result, which is 14% more deaths in 2020 than would have been expected, a rate that is the same as the national average.

Below is a key summary of the impact of COVID-19 in Stockport as of March 2021

- 20,524 people have been diagnosed, meaning around 40-50% of these have been identified, and more than 1,900 people have been admitted to hospital as a result.
- 23% of COVID-19 deaths occurred in care homes, and mortality levels in care homes in 2020 were 55% higher than average, this is similar to the national average.
- Following national trends, Stockport residents who are younger adults, and or from BAME ethnic groups have higher rates of diagnosed COVID-19 in Stockport.
- COVID-19 is exacerbating existing inequalities in health and is particularly affecting: Older people, Males, Black Asian and Minority Ethnic Groups, and those living in deprived areas.
- National life expectancy modelling shows a loss in life expectancy of 0.9 years for females and 1.3 years for males between 2019 and 2020.
- There is still more to understand about the long-term impact of COVID19 on those who have been discharged, the duration of these effects, and the full extent of the level of increased need due to long Covid in Stockport.
- Office for National Statistics (ONS) modelling suggests that there will be both positive and negative effects on health from pandemic and the control measures, such as improvements in health due to lower air pollution but deterioration due to mental wellbeing and economic consequences.
- It is possible that any future recession due to the impact of restrictions may have as a big of an impact on health, as the direct impact of the disease.
- The long-term consequences for education, employment, the economy and our communities are likely to be significant but as yet the level of impact is still not clear. There still a number of scenarios for how the pandemic will progress over the coming months, and no certainty about the future.

SSAB has been proactive in trying to better understand the impact of COVID-19 in Stockport to ensure safeguarding awareness is promoted. We continue to contribute to the Regional and National Safeguarding Adult Board (SAB) network to provide data and information for lessons to be learnt for future waves.

Response to Covid-19 (cont.)

Hospital admissions

- By February 2021, Stockport residents had 1,900 admissions as a result of COVID-19.
- The average length of stay was 15.2 days, 33% of patients were in hospital for at least 2 weeks and 17% more than 4 weeks.
- Demographic trends were different to those for diagnosed cases: Those admitted had an older profile, those admitted were more likely to be from a white ethnic background, those admitted were more likely to be care home residents.
- At least 1,180 people have been discharged from hospital to the community after receiving care for COVID-19.
- There is still more to understand about the long term impact of COVID19 on those who have been discharged, evidences is emerging about the need for support for: Repository health care, Chronic fatigue, Diabetes, and more rapid progression from pre-diabetes to diabetes, Mental Wellbeing.
- What is not yet known is the duration of these effects, or the full extent of the level of increased need in Stockport.

Deaths

- There are significant inequalities evident in mortality rates, showing that COVID-19 has disproportionally effected the health of people in deprived areas.
- Following national trends, mortality rates for those under 50 are low, and then increase at each age to almost 50 per 1,000 for those age 90+.
- For age groups 60-79, the mortality rates for males are more double than for females.
- Taking into account the size and age structure of the population, there were 202.5 deaths involving COVID-19 per 100,000 people in England over the period March 2020 to February 2021. Mortality rates in Greater Manchester (272.4) are higher than the national average. Rates for Stockport are 193.9 which is not significantly different to the national average.

Vaccination programme

- Since the vaccine programme started in late December 2020 over 138,340 first doses of the vaccine have been given, covering 54.7% of the 18+ adult population of Stockport.
- Coverage is 95.2% for people aged 70+, 90.3% for those aged 60-69 and 74.9% for those aged 50-59 – with further vaccines secluded for these age groups over the next few weeks.
- Analysis is ongoing into the inequalities in vaccination rates and there is evidence of lower uptake in areas of deprivation and BAME groups. Work is underway to maximise uptake in all populations and as the programme continues some gaps in uptake are narrowing.
- Uptake in care home residents is at 94%, for staff the uptake is 77%.