Stockport Safeguarding Children Partnership and Safeguarding Adult Partnership

Business Plan 2023 - 2026

Safeguarding Children in Stockport

Safeguarding Adults in Stockport

What do we know about Stockport?

- **17.8%** aged 0-14
- **9.5%** aged 15-24
- **52.4%** aged 25-64
- **20.3%** aged 65+

294,800 people living in the borough in 2021

(ONS 2021 census)

18.1% Disabled under the Equality Act

76% adult care homes rated Good or Outstanding (*as at March 2023)*

(Data at March 2023 taken from Q4 SSAP dashboard)

38% live in areas of higher than average deprivation

(2020 JSNA)

- **3207** open referrals between April 2022 – March 2023
- **271** Section 47 enquiries initiated
- **54** Graded Care Profile 2 assessments initiated to end March 2023
- **482** children in care
- **245** children with a Child Protection Plan

(Data at March 2023 taken local authority Tableau report)

7.3% Asian
2.6% Mixed
1.6% Other
1.2% Black or Caribbean *(ONS 2021)*

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

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

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

913 accepted referrals into substance misuse treatment services (*START data in SSAP Q4 dashboard)*

37.8% children in year 6 overweight or obese
65.1% Adults overweight or obese
12.8% Adults who smoke

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

89 Stockport's CLA reported missing during 2022/23 *(Data at March 2023 taken local authority Tableau report)*

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

Safeguarding Children in Stockport

OUR VISION:

We want the people of Stockport to live safe, healthy and where possible, independent lives

Safeguarding Adults in Stockport

ENABLERS:

- Restorative practice
- Workforce stability
- Commitment to the Partnerships
- Inclusive practice

METHODOLOGY:

- Data collection and analysis
- Quality assurance and audit
- Listening to the lived experience of our children, adults and families
- Challenge and scrutiny from the Partnership

Children & Adults

- Priority 1: Improve Partnership working and information sharing
- Priority 2: Effective transitions from childhood to adulthood
- Priority 3: Understanding complex trauma and assessing risk

Children

- Priority 4: Working with men

Adults

- Priority 5: Working with adults to manage risk effectively and make safeguarding personal

WORKING WITH:

- Health and Wellbeing Board
- Supporting Families Executive
- Stockport Family Partnership Board
- One Stockport Safer Partnership
- Domestic Abuse Partnership Board
- Early Help Board
- Multi-Agency Adults At Risk System
- NHS Greater Manchester Locality Board

SHARED VALUES:

- Co-production with children, adults and all partners
- Non-discriminatory and inclusive practice at all levels
- Constructive and supportive challenge
- Culture of continual improvement across all agencies

About our Business Plan

Our business plan is written for all services who work with children and adults in Stockport. In developing the plan we have consulted extensively with our partners from both the children and adult partnerships. We recognise that our consultation did not include the engagement with children, young people and adults that we would have wanted. This will be an area of improvement that the business unit will focus on for future annual reviews of this plan.

It sets out what our main focus will be over the next 3 years and how we will work with our residents.

Our Plan has been written in plain English to make sure everyone can understand it. We have also made an easy read version of our plan for anyone with a visual impairment or learning difficulty. The easy read version can be found here. Versions are available in other languages through emailing lsb@stockport.gov.uk

By working together we can make sure that all children, adults and their families who need support to remain safe, healthy and independent get the best possible outcomes from us.

Each priority in our Plan is structured around 3 main areas:

- **Why?** Why have we chosen this particular area as one of our priorities?
- **How?** What actions are we going to take as a Partnership to address our findings?
- **So what?** What difference will the children, adults, families and practitioners of Stockport see as a result of our work? How will we know if we've made a difference?

This plan will be delivered by all partners of the Stockport Safeguarding Children's Partnership and Stockport Safeguarding Adults Partnership. We want to make sure that as we develop and grow as a Partnership, we have the right foundations in place where strong, effective, and restorative safeguarding practice can flourish.

It will give all of our meetings a purpose and structure. Our independent chair and scrutineer will hold all partners to account to make sure that we don't have any delays in delivering improvement against our priorities.

Previous versions of the business plan have included priorities around domestic abuse, which now sits with the One Stockport Safer Partnership (OSSP). This plan clarifies our position and information sharing arrangements between the Partnerships' structures, and how we will both seek, and provide, assurance from OSSP. Where there are specific joint pieces of work, for example around Domestic Homicide Reviews (DHRs), clarification is provided in the governance section of this plan around our working arrangements.

The plan is dynamic and will be reviewed on an annual basis which may result in changes to our priorities.

Sitting alongside this is our delivery plan which sets out the detail of how we will put our plan into action.

We will make sure that in all of our work:

- ✓ we embed the principles of equality, diversity and inclusion in all of our work with children and adults
- ✓ we have children's and adults' voices at the heart of everything we do
- ✓ we pay attention to the *how* and *so what* elements of our business plan

Joint Priority: Improve partnership working and information sharing

WHY?

Our Rapid Reviews show a need to improve information sharing and seeking in 67% of cases in 2022/23, with reviews telling us that not all agencies know what information should be shared, and the system was not always supportive of information sharing. This is also seen in Safeguarding Adult Reviews and Domestic Homicide Reviews.

Learning from our CSPRs shows agencies are sometimes unaware of the broader significance of information they hold but that isn't always shared with multi-agency professionals.

The National Panel has identified *"weak information sharing and seeking within and between agencies"* as a key practice episode in the national review into the deaths of Star and Arthur.

A slow-down in the rate of Safeguarding Adult Review referrals has meant the Safeguarding Partnership suggests that not all staff are aware of the criteria and purpose of a SAR.

An audit of MAARS cases in January 2023 showed that for some adults not all agencies are aware of who else is involved.

HOW?

By April 2024:

- Develop and launch multi-agency training on effective information sharing and seeking, and professional curiosity. Attendance and engagement at training will be monitored through the Training & Workforce Development Sub-Group
- Relaunch SAR criteria and refresher training across Partnership.
- Complete a thematic review of all CSPR, SAR and DHR learning around information sharing, from action plan reviews at the Learning From Practice Sub-Group.
- Hold development sessions that prioritise building and maintaining professional relationships.

By April 2025:

- A multi-agency audit of MAARS will be completed and presented to the Adults Quality Assurance Partnership to explore how services work together and share information on risk and vulnerability.
- Review the Information Sharing Agreement and support a relaunch through briefings and learning circles. This will include engagement work with children & young people, adults and their families.

SO WHAT?

- ✓ Children and young people will be supported in a holistic way where all agencies take account of context and family history.
- ✓ Adults who have experienced serious abuse or neglect will be subject to high-quality Safeguarding Adult Reviews that result in strengthened multi-agency safeguarding practice.
- ✓ Professionals will have access to a full range of family history, previous trauma, and contextual information that allows more streamlined and effective working with children, adults and their families.
- ✓ Where adults are supported via MAARS or Team Around the Adult, they are aware of who is involved, and why. The proportion of cases seen where this is an issue in audit will reduce by 25% in 2023/24 and 50% in 2024/25.
- ✓ Information sharing as a theme in Rapid Reviews will reduce to 40% in 2023/24 and 20% in 2024/25.
- ✓ As a result of awareness raising and new training, the number of SAR referrals to the Safeguarding Adults Partnership will increase by 25% in 2023/24 and 25% in 2024/25.

Joint Priority: Effective transitions from childhood to adulthood

WHY?

We have seen an increase in the number of care leavers coming through services, requiring multi-agency support with independent living.

Learning from our Rapid Reviews and CSPRs has highlighted heightened risk for young people who need support in adulthood.

There is a Greater Manchester wide ambition to be a trauma informed city region by 2024.

We have seen an increase in the number and complexity of young adults referred into the Multi-Agency Adults At Risk System (MAARS):

- 26% of all referrals into MAARS in 2022/23 were for adults aged under 30.
- 29% of all MAARS cases feature vulnerability to criminal exploitation
- 41% of MAARS cases are for support with housing

2 of the last 4 SAR referrals received since April 2022 were for young adults aged under 20.

HOW?

By April 2024:

- Facilitate a learning hub event with a focus on transitions. From this, we will consider our offer to helping young adults live independently.
- Develop a working group under the Complex Safeguarding Sub-Group to focus on transitional safeguarding.
- Review and refresh MAARS and Team Around the Adult guidance across all agencies working with children and adults in Stockport.

By April 2025:

- Multi-agency audits on MAARS and transitional safeguarding practice.
- We will include learning from the Greater Manchester Adolescent Framework in local multi-agency practice.
- The local authority will share learning from regional and national work around Changing Futures initiatives.

SO WHAT?

- ✓ Young adults will understand their journey through services, who will remain involved in their care and how to access support at a time when they need it most.
- ✓ More young people will experience a planned and systemic transition between services, without going into crisis to get a safeguarding response.
- ✓ Young adults will be supported through a coordinated multi-agency response (Team Around the Adult) when they need more intensive support.
- ✓ Young adults will develop their independence and be supported to maintain tenancies. We will see a reduction in the rate of housing-related referrals to MAARS for young adults to 30% in 2023/24 and 25% in 2024/25.
- ✓ We will have clear multi-agency agreement about the offer to care leavers.
- ✓ As a result of the Complex Safeguarding Sub-Group there will be a multi-agency offer to young adults to support child and adult survivors of exploitation and reduces future risk. Reduction in exploitation cases to MAARS to 24% in 2023/24 and 15% in 2024/25.

Joint Priority: Understanding complex trauma and assessing risk

WHY?

Statutory safeguarding reviews across children and adults over the last 12 months have told us:

- All Rapid Reviews and CSPRs over the last 12 months have included learning around understanding complex trauma and assessing risk. This includes learning on how unaddressed trauma and distress can lead to family relationships breaking down.
- Parents who have experienced trauma themselves need additional support when parenting their own children.
- A SAR referral for a young adult with complex needs highlighted the importance of assessing risk, and sharing information on risk with multi-agency professionals.
- The use of victim-blaming language can have a negative impact on children and young people's development.

53% of MAARS referrals over the last 12 months had 3+ different risk factors identified. Reporting to the joint executive safeguarding partnership in March 2023 showed increasing complexity of MAARS referrals in the last 12 months.

HOW?

By April 2024:

- Develop and launch refreshed guidance on trauma-informed and restorative practice.
- Thematic review of Caring Dads programme (as referenced in the children's priority on the next page) to understand the impact of parenting support programmes.
- Develop operating guidance on high-quality risk assessment approaches.

By April 2025:

- Develop and launch guidance on trauma informed reporting and the use of language when working with children, adults and families.
- Multi-agency audit on risk assessments and trauma informed practice.
- Multi-agency audit of MAARS (as referenced in the joint priority on page 5).
- Assurance reporting to the Complex Safeguarding Sub-Group on developments against this theme.

SO WHAT?

- ✓ The proportion of Rapid Reviews where complex trauma and risk assessments is identified as a theme reduces from 100% to 80% in 2023/24, and 60% in 2024/25.
- ✓ The number of MAARS referrals with 3+ complex vulnerabilities identified will reduce to 48% in 2023/24 and 44% in 2024/25.
- ✓ Practitioners will be aware of how to work with children and adults in a trauma-informed way. Victim blaming language will not be used in risk assessments.
- ✓ Parents will feel supported by multi-agency professionals to develop strong and resilient parenting techniques.
- ✓ Practitioners will be confident in completing high-quality risk assessments, which support effective information sharing and early intervention with children and adults.

Children's Priority: Working with men

WHY?

Working with men has been highlighted as a theme in 50% of rapid reviews between April 2022 and March 2023.

A learning hub held in July 2021 focused on working with men and highlighted areas to improve upon in practice across the Partnership. Out of 16 cases audited, 56% of birth fathers' details were included in the birth records

The thematic review of safeguarding children under 1 from non-accidental injury ("The Myth of Invisible Men") specifically focused on men within a child's household and found evidence that agencies need to be more proactive in involving men in work with universal through to specialist services.

Since 2018, the National Child Safeguarding Panel has considered 257 raid review cases of babies under 1 year old, seriously harmed or killed through non-accidental injury. Specifically, in these cases, men (fathers and step-fathers) were a greater source of physical abuse to these babies than their mothers.

We are currently not fully measuring the impact and satisfaction of the Caring Dads programme.

HOW?

By April 2024:

- The Safeguarding Partnership will hold quality assurance activity in this theme to seek assurance.
- Facilitate courses aimed at supporting men, including *Caring Dads* and *New Beginnings*. Success measures will be developed and implemented to understand impact of the programmes.
- Multi-agency guidance will be developed on:
  - how to complete comprehensive risk assessments that include men
  - Reducing the risk of non-accidental injuries
  - Equality, Diversity and Inclusion

By April 2025:

- Complete a thematic review on the theme of *men's voices* to inform practice improvement and understand barriers to engagement with services.
- Section 11 assessment activity will include a specific query on this theme to seek assurance that practice improvements are having a positive impact on the children & young people of Stockport.

SO WHAT?

- ✓ Working with men as a theme in rapid reviews to reduce to 35% in 2023/24 and 25% in 2024/25.
- ✓ Fewer children will experience non-accidental injuries, and where these occur, all agency records will include complete information on family context and direct work and interventions delivered to the family.
- ✓ Records for children and young people will be more complete and comprehensive, including records of all significant males. Increase in recording of details of key males from 56% to 70% of audited cases in 2023/24.
- ✓ Practitioners will feel confident in working with men and understanding their role within the family and the wider holistic plan. Fewer rapid reviews, CSPRs and audits that highlight gaps in engaging fathers and key males, measured through audit work.
- ✓ More fathers in Stockport will be supported through the Caring Dads programme, with all agencies aware of the impact of the programme through reporting to the Quality Assurance Partnership.
- ✓ Multi-agency practice improves to deliver stronger engagement with fathers, measured by annual audit.

Adult's Priority: Working with adults to manage risk effectively and make safeguarding personal

WHY?

Adults at risk experience abuse and neglect in different settings:

- Data shows higher levels of safeguarding Section 42 safeguarding enquiries that included physical abuse (51%)
- 47% of all Section 42 safeguarding enquiries included neglect and acts of omission
- 45% of all MAARS cases in 2022/23 featured self-neglect
- Only 16% of safeguarding referrals to Adult Social Care progress to an enquiry.
- 71% of adults aged 18-64 reported feeling safe in 2021/22 *(reported in ASCOF data to March 2022)*

Adults are not routinely asked about their Making Safeguarding Personal outcomes – 70% of adults were asked in 2022/23.

We have seen a decrease in the number of Safeguarding Adult Review (SAR) referrals made to the Partnership. We need to ensure that all agencies are aware of the criteria and process.

Only 9% of referrals to MAARS in 2022/23 were repeat referrals.

HOW?

By April 2024:
Refresh multi-agency guidance around the following themes, which will be co-produced with adults with lived experience where possible:

- Person In A Position Of Trust (PIPOT)
- Physical abuse
- Financial abuse
- Self-neglect and hoarding
- Deprivation of Liberty Safeguards (DoLS)
- Equality Diversity and Inclusion

We will refresh SAR guidance across all agencies.

Develop and launch a decision making risk matrix for all professionals to support decision making and encourage professional curiosity.

We will launch a revised multi-agency performance framework, which will include evidence of single-agency audit and assurance work.

By April 2025:
Complete a multi-agency audit on adult safeguarding referrals, as well as seeing how well adults are asked about Making Safeguarding Personal outcomes. Adults with lived experience included in this work.

SO WHAT?

- ✓ More adults will have safeguarding outcomes that match their views and wishes, with an increase of adults asked about their Making Safeguarding Personal outcomes will increase to 80% in 2023/24 and 85% in 2024/25.
- ✓ Adults will receive the right response, proportionate to the level of risk delivered by the right agency. They will have an active voice in their care plan. As a result we will reduce contacts to Adult Social Care that do not progress to a Section 42 enquiry from 84% to 64% in 2023/24 and 44% in 2024/25.
- ✓ Self-neglect referrals to MAARS will reduce to 25% in 2023/24 and 20% in 2024/25.
- ✓ Adults will report increased confidence and more positive experiences of accessing services as professionals understand and meet their needs. The percentage of adults 18-64 reporting feeling safe will increase from 71% to 76% in 2023/24 and 80% in 2024/25.
- ✓ Adults will receive the right multi-agency intervention at the first point of contact, and the rate of repeat referrals to MAARS will reduce and will continue to be between 7% - 10% of all referrals.

Governance and Accountability

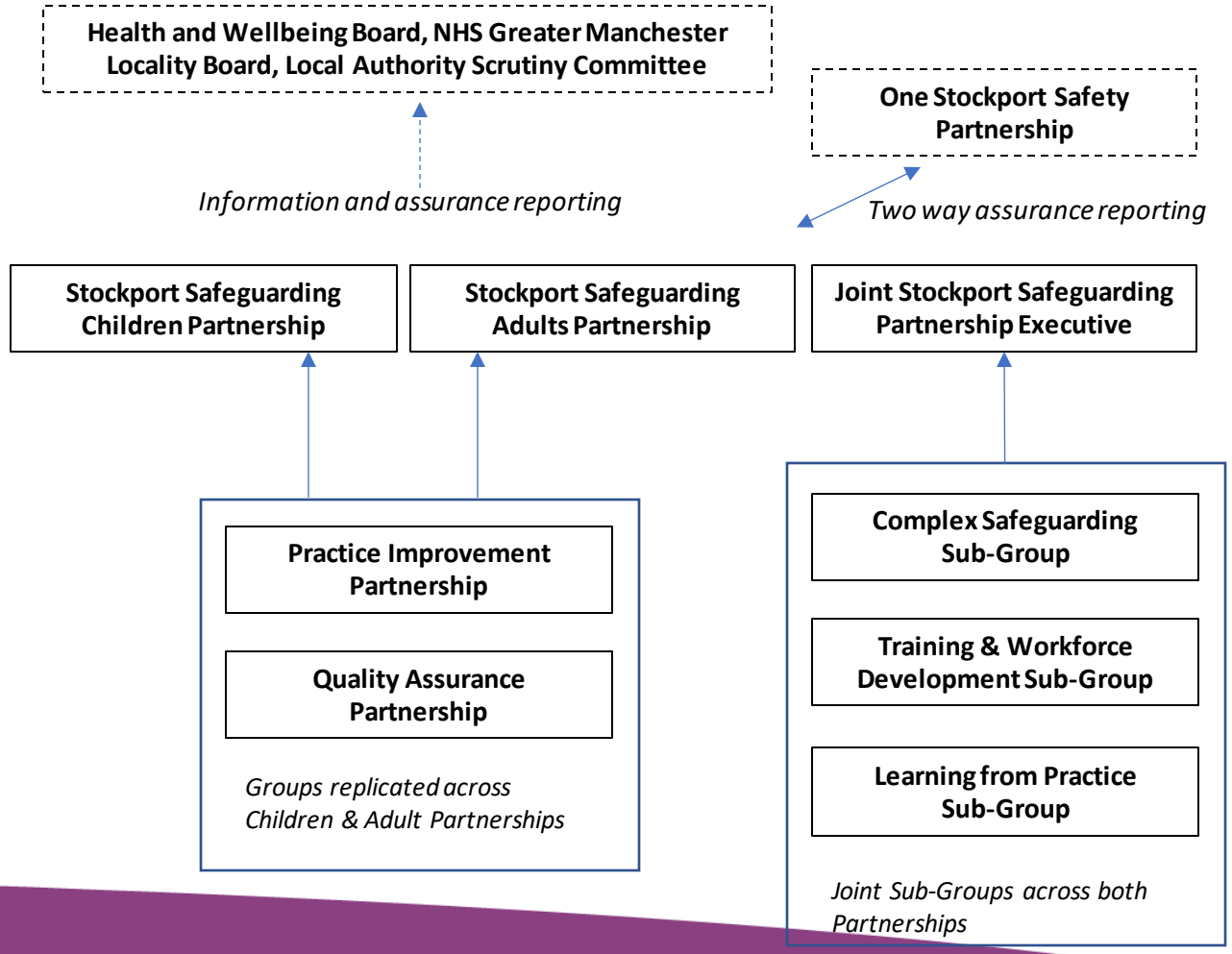
Our business plan will be monitored each quarter by the Independent Chair and Scrutineer with the chairs of all sub-groups. Progress will be shared at meetings of our executive boards.

All partners will be responsible for implementation and delivery of the plan, and providing updates and evidence of impact for their delivery. Through our shared value of constructive and supportive challenge, all Partners will be able to support each other in the delivery of this plan.

There will be instances where the Safeguarding Partnerships need to work closely with other boards, groups and committees and the detail of this is provided in our delivery plan. Where there is the opportunity for joint working through Domestic Homicide Reviews (DHRs) with the One Stockport Safer Partnership (OSSP), this will be discussed at our executive board, and assurance provided through our Independent Chair and Scrutineer who is a member of the OSSP. Reports on Safeguarding Partnership activity is currently provided to the OSSP, and we will introduce assurance reporting and information sharing from OSSP activity to our Safeguarding Partnership executive board meetings.

The plan can only be delivered effectively through the ongoing commitment of all partners to working together, and understanding activity taking place in other boards and committees.

Safeguarding Partnerships Governance Structure



Appendix A: Some key definitions

ACE	Adverse Childhood Experiences – Previous trauma and negative life experiences for children and young people
DHR	Domestic Homicide Review – a multi-agency review following the death of someone linked to domestic violence
Child Safeguarding Practice Review (CSPR)	An investigation into a serious incident, or death, of a child or young person under the age of 18. The investigation doesn't look at what went wrong or who was to blame, but how we can improve things for the future.
Safeguarding Adult Review (SAR)	An investigation into a serious incident, or death, of an adult at risk over the age of 18. The investigation doesn't look at what went wrong or who was to blame, but how we can improve things for the future.
MAARS	Multi-Agency Adults At Risk System – a multi-agency process to support adults at risk in the community outside of Adult Social Care
Making Safeguarding Personal	A way of working with adults at risk to make sure that their views and wishes are at the heart of what we do
National Panel	A national organisation that looks at all Child Safeguarding Practice Reviews and Rapid Reviews to check their quality and impact.
OSSP *Our Community Safety Partnership*	One Stockport Safer Partnership – a multi-agency Board with a focus on community safety and domestic abuse in Stockport
Rapid Review	A quick investigation into a serious incident involving children & young people under the age of 18.
Section 47 (S47)	A multi-agency child safeguarding process, led by the local authority, where a child or young person is at risk of significant harm
Section 42 (S42)	A multi-agency adult safeguarding process where an adult is at risk of, or is experiencing, abuse or neglect and is unable to protect themselves.

Where to find more information

www.safeguardingchildreninstockport.org.uk
www.safeguardingadultsinstockport.org.uk

Working Together to Safeguard Children 2018
The Care Act 2014