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HEALTH AND WELL BEING BOARD
Agenda

Date	Thursday 11 January 2024
Time	10.00 am
Venue	Lees Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL

Notes

1. DECLARATIONS OF INTEREST- If a Member requires advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Constitutional Services at least 24 hours in advance of the meeting.

2. CONTACT OFFICER for this agenda is Constitutional Services Tel. 0161 770 5151 or email constitutional.services@oldham.gov.uk

3. PUBLIC QUESTIONS - Any Member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the contact officer by 12 noon on Monday, 8 January 2024.

4. FILMING - The Council, members of the public and the press may record / film / photograph or broadcast this meeting when the public and the press are not lawfully excluded. Any member of the public who attends a meeting and objects to being filmed should advise the Constitutional Services Officer who will instruct that they are not included in the filming.

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Recording and reporting the Council's meetings is subject to the law including the law of defamation, the Human Rights Act, the Data Protection Act and the law on public order offences.

Please also note the Public attendance Protocol on the Council's Website

https://www.oldham.gov.uk/homepage/1449/attending_council_meetings

MEMBERSHIP OF THE HEALTH AND WELL BEING BOARD
Councillors Brownridge, J. Harrison (Chair), Mushtaq, Nasheen, Shuttleworth and Sykes

Item No

1 Apologies For Absence

2 Urgent Business

Urgent business, if any, introduced by the Chair

3 Declarations of Interest

To Receive Declarations of Interest in any Contract or matter to be discussed at the meeting.

4 Public Question Time

To receive Questions from the Public, in accordance with the Council's Constitution.

5 Minutes of Previous Meeting (Pages 1 - 10)

The Minutes of the Health and Wellbeing Board Meeting held on 2nd November 2023 are attached for approval.

6 Oldham Safeguarding Annual Report 2022-23 (Pages 11 - 60)

To receive and discuss the Oldham Safeguarding Adults Board: Annual Report 2022-23 (with supporting Single-Agency Statements and Business Plan 2023-2024).

7 Joint Strategic Needs Assessment Website Update

Report to follow

8 Oldham Suicide Prevention Strategy and Plan Update (Pages 61 - 114)

To consider the Suicide Prevention Strategy and Plan Update presented by Rebecca Fletcher and Vicki Gould.

9 Prevention and Early Intervention for Mental Health in the Community A (Pages 115 - 132)

Social Prescribing Report to be presented by Laura Windsor-Welsh and Ayesha Alves-Hey

10 Prevention and Early Intervention for Mental Health in the Community B (Pages 133 - 148)

TOGMind report to be presented

11 Prevention and Early Intervention for Mental Health in Schools

Presentations to follow.

HEALTH AND WELL BEING BOARD
02/11/2023 at 10.00 am

Present: Councillor J. Harrison (Chair)
Councillors Brownridge, Mushtaq and Nasheen

Also in Attendance:

Rebecca Fletcher	Iterim Director of Public Health
Sayyed Osman	Deputy Chief Executive Oldham Borough Council
Jayne Ratcliffe	Deputy Managing Director, Health and Social Care Services
Paul Rogers	Constitutional Services
Charlotte Stevenson	Consultant in Public Health (Healthcare)
Anna Tebay	Public Health Service
Dr Henri Gillier	Independent Chair Oldham Safeguarding and Adults Board
Sepeedeh Saleh	Public Health Registrar
James Wainwright	Oldham Sport Development
Pritesh Patel	Oldham Sport Development
Lorraine Black	First Choice Homes
Martcha Thomas	

1 **APOLOGIES FOR ABSENCE**

Apologies for Absence were received from Mike Barker, Anthony Hassall, Majid Hussain, Gerard Jones, Councillors Shuttleworth and Sykes, Tamoor Tariq, Laura Windsor-Walsh Paul Clifford and Christina Murray.

2 **URGENT BUSINESS**

There was no urgent business for this meeting of the Health and Wellbeing Board.

3 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

4 **PUBLIC QUESTION TIME**

There were no public questions for this meeting of the Health and Wellbeing Board to consider.

5 **MINUTES**

That the Minutes of the meeting of the Health and Wellbeing Board held on 7 September 2023, be approved as a correct record.

6 **ANNUAL REPORT OF THE OLDHAM ADULT SAFEGUARDING BOARD**

The Health and Wellbeing Board received and considered the Oldham Safeguarding Adults Board 2022-23 Annual Report and 2023-24 Business Plan which was presented by Henri Gillier, Independent Chair, Oldham Safeguarding Adults Board.

The Oldham Safeguarding Adults Board (OSAB) is a statutory partnership set up to safeguard adults at risk of experiencing abuse, neglect or exploitation. As part of its statutory duties the Board is required to produce an Annual Report setting out the safeguarding concerns it has dealt over the last year, as well as a Business Plan setting out future ambitions and actions to help keep people safe in Oldham. The purpose of this report is to share the Board's agreed 2022-23 Annual Report and 2022-24 Business Plan with members of the Health and Wellbeing Board for their consideration.

The role of the OSAB is to assure itself that organisations and agencies across Oldham are working together to protect and enable adults to live safely. This means helping people to make decisions about the risks they face in their own lives as well as protecting those who lack the capacity to make these decisions.

The Board has three main statutory duties which are to:

- Produce a **Strategic Business Plan** setting out the changes the Board wants to achieve and how organisations will work together.
- Publish an **Annual Report** setting out the safeguarding concerns it has dealt with in the last year as well as plans to keep people safe in the future.
- Undertake a **Safeguarding Adult Review** in line with Section 44 of the Care Act where it believes someone has experienced harm as a result of abuse, neglect or exploitation.

The Board's 2022-23 Annual Report provides information on the number and type of safeguarding concerns reported in Oldham along with the actions taken to adopt learning from the Safeguarding Adult Reviews. Central to this has been the collection and sharing of firsthand experiences by adults 'at risk' and family members who have experience of safeguarding issues and services in Oldham.

In summary, a total of 2175 safeguarding referrals were made in 2022-23 and of these referrals 430 became the subject of a formal Safeguarding Enquiry. The data shows that the number of referrals received more than doubled compared to the number received in 2018-19 and increased by 16% compared to 2021-22. Some of this increase may be due to safeguarding awareness campaigns designed to encourage the residents of Oldham to report their safeguarding concerns and training provided to professionals in Oldham about making safeguarding referrals and the criteria for formal enquiries. However, whilst the number of overall referrals has increased, the number of serious safeguarding enquiries remains relatively consistent over the last four years.

A total of 4 Safeguarding Adult Reviews were completed in 2022-23, which was double the number completed the previous year. Common themes emerging from Safeguarding Adult Reviews involved the multi-agency management of risk; Complex and Contextual Safeguarding including cuckooing, financial abuse, and exploitation; and safeguarding transitions.

The Board's Business Plan has been shaped by the partner agencies and based on the key learning themes emerging from Safeguarding Adult Reviews, Audits and operational work. As a result, the Business Plan sets out a challenging programme of work, designed to prevent and reduce future safeguarding incidents and implement an effective 'all age' safeguarding offer. The Business Plan is designed to focus on action and is being actively promoted and shared across agencies to highlight the aims of the Board and promote the wide range of resources and information available through the Board's website and fortnightly joint children's and adults safeguarding bulletins.

Henri Gillier made drew attention to the growing number of safeguarding referrals and emphasized that this is not an alarming factor but that the referrals are being talked about. He added that the majority of the referrals are from older people. He pointed to the need to broaden the recognition of safeguarding that is in place and the need to reach out to the relevant communities.

Dr Patterson informed the Board that over the last three years significant progress has been made and the report underlines that fact. There are less cases been taken forward.

Sayeed Osman, Deputy Chief Executive, acknowledged the progress that had been made and going forward by the Oldham Safeguarding Adults Board. He referred to the challenging aspects of childrens placements and drew attention to the need not to overlook the housing challenge because housing quality was important.

Henri Gillier informed the Board that the Oldham Safeguarding Adults Board has made significant progress over the last twelve months, producing clear multi-agency safeguarding procedures, policies and training programmes designed to translate the learning from serious safeguarding incidents into effective practice. The Board has also aligned its processes with those across Greater Manchester and is working as part of a national network of Safeguarding Adult Boards, sharing ideas and best practice. He emphasised the need to improve the engagement of care homes as well as individuals in their own homes.

Jayne Ratcliffe, underlined the significant work that has been achieved and building on what has already been achieved is important. She emphasised preparations for Care Quality Commission (CQC) assessments which cannot be overlooked.

Henri Gillier stated that CQC inspections are important and an event is planned in December with regard to CQC readiness.

The Chair, on behalf of the Board, thanked Henri Gillier for his presentation of the Oldham Safeguarding Annual 2022-23.

Resolved – that the Board endorses and notes the report.

7 **IMPROVING PHYSICAL ACTIVITY UPDATE - HEALTH AND WELLBEING PRIORITY**

The Health and Wellbeing Board received a report submitted by Pritesh Patel, Sport Leisure and Wellbeing Service Manager which provided brief information to the Board on Oldham's Moving More and Physical Activity whole system approach in reducing inactivity in our borough, and thus improving the health and wellbeing of our residents and our communities.

The Board was informed that as part of the Health and Wellbeing strategy 2022 -2030, one of the five key priorities is 'Increasing Physical Activity', and it is also clear that physical activity can contribute to several of the other priorities in the strategy too.

It is noted in the strategy that "we will know that we have achieved our goals" in Increasing Physical Activity, because activity levels in Oldham residents will increase, and the % gap between Oldham and England activity levels will close.

The % gap when the strategy was written was 6.3% (2020/21). The latest data shows that this has now reduced to 4.6% (2021/22) and has been reducing consistently since 2018/19. This is positive but is caveated with the small Active Lives.

28.5% of Oldham residents are inactive, which has seen a 4.7% decrease in the last 12 months which is positive.

The Board received a detailed power point presentation from Pritesh Patel on
'Moving More & Physical Activity – A Whole System Approach'. The presentation highlighted the following which is set out in the Health and Wellbeing Strategy -

Vision
Oldham residents are happier, healthier; they feel safe, supported and they thrive in this vibrant & diverse borough

Principles
Resident focused, Well-manged health & care system, Champions of equality, Prioritise Prevention

Priorities (5)
Supporting our residents to gain the knowledge and skills to confidently make choices and participate in decisions about their own health;
Giving children the best start in life;
Improving mental wellbeing and mental health;
Reducing smoking;

Increasing Physical Activity.

The Goals are set out as follows –

- We will support **ALL** residents to build movement in to their **every day lives**
    - **Supporting VCF organisations** to be able to provide services and work with their communities to increase Physical Activity
    - Improving communication with both residents and businesses to **embed the message that Movement matters**, for people of all abilities
    - **Celebrating and championing positive examples of Moving More** through the #Oldham #MoveMoreFeelbetter social media campaign
    - Taking a **strength based – community approach** to improving physical activity and moving more through the Local Pilot principles and place-based working
- We'll help our children, young people, and their families to Start Well
    - Raising awareness of initiatives such as The Daily Mile & Oldham's 50 Things to do before you're Five
- We'll help our working age residents to Live Well
    - Working collaboratively across GM to improve Oldham's active travel infrastructure and help residents move more in everyday life
- We'll help our older people to Age Well
    - Continuing to use local knowledge to tailor the physical activity offer and ensure residents feel safe and secure

The presentation concluded as follows –

Next Steps - A Whole System Approach

- Be an active advocate and champion for Moving More – little habits make a big difference.

- Use #Oldham #MoveMoreFeelBetter if active on social. If you share your experiences and your activity with others, no matter how big or small, it creates a new norm, and it will inspire others. (Brief to be shared post meeting)

- Support our residents, team members, colleagues, family members and loved ones to Move More
    - Walking meetings, Take the stairs instead of the lift, Stand up from your desk from time to time, stand / walk whilst you are on a call, or fake commute if working from home.

- Widening our place-based approach to physical activity and reducing inequalities (through the Local Pilot) in Glodwick and Failsworth, to other districts where the need is evident and where we can support residents to Move More.

Rebecca Fletcher, Interim Director of Public Health, endorsed the presentation and emphasised that making a difference for all Oldham residents was key. She highlighted the following –

- Early years – playing outdoors as well as at the childrens centre
- Include Family Hub plans
- Supporting people with long term conditions
- Physical environment is important
- Walking from your home safely

Resolved – That the Board notes and endorses the report.

8 **UPDATE ON MEASLES RISK AND PREVENTION**

The Board receive a report submitted by Dr Charlotte Stevenson, Consultant in Public Health, which provided an update on measles risk and prevention in Oldham.

The Board was given the following background –

- Uptake of routine childhood immunisations fell globally during the COVID-19 pandemic.
- Coverage for the Measles, Mumps and Rubella (MMR) vaccination programme in the UK - a two dose vaccine given at 1 and approximately 3 years of age – fell to the lowest level in a decade.
- Of particular concern here is measles, which poses a high risk and is easily transmitted across unvaccinated populations.
- Around 20-40% of those with measles will be hospitalised with higher rates in babies, and adults over 25 years of age.
-

The July 2023 the national "Risk Assessment for Measles Resurgence in the UK" was published by UKHSA. This concluded that "there is a high risk of imported cases leading to outbreaks in specific population groups … and geographies … with some risk of limited spread to the wider community".

Vaccine Uptake –

- Uptake for the first dose of MMR vaccine in children aged 2 years in England is 85.6%. This is well below the 95% target set by the World Health Organisation (WHO), needed to eliminate the disease.
- Earlier this year the WHO and UK Health Security Agency (UKHSA) issued warnings about the low levels of vaccine

coverage and risks of measles resurgence, including recommendations for actions to prevent this. The UK has never met the WHO target of 95% coverage and so under-vaccination is an issue across the age groups. Of key concern are teenagers and young people where national data indicates rates are low.

- Recent vaccination data for Oldham indicate that by their 5th birthday, 94% of children in Oldham had had the first dose of the MMR vaccine: 80% had had both doses.

With regard to National actions and recommendations –

- The UK strategy for eliminating measles and rubella includes 4 key parts:
    i. Achieve and sustain MMR coverage at > 95% for 2 doses of the vaccine in the routine childhood programme (by 5 years of age)
    ii. Achieve coverage of > 95% for 2 doses in older age groups through opportunistic and targeted catch up programmes
    iii. Strengthen surveillance through rigorous case investigation and testing
    iv. Ensure easy access to high quality, evidence based information for health professionals and the public

In Oldham –

Leadership changes have recently taken place in relation to this work:

i. The childhood immunisations and vaccinations group was disbanded earlier this year. A new group will take its place and continue work on key areas including improving access to childhood vaccinations, community insights and engagement, and systems working with primary care.
ii. This group will report to the Pan-GM Measles group, who provide strategic input to reverse the overall falling vaccine uptake rates in the childhood immunisations programme and increase the coverage for the MMR vaccination programme in the region.

Primary care have been actively engaged in improving vaccination uptake and on outbreak preparedness

v. Work is ongoing to increase the number of children invited to clinics and increase the number and duration of clinics.
vi. Issues around reliability and consistency of primary care data on clinical systems have created challenges in understanding details of coverage rates.
vii. An automated electronic data transfer solution is required to achieve high quality data and enable effective targeted action to improve coverage rates across the borough.

Community insights and communications, building on community engagement work during the COVID pandemic, form a critical part of vaccination uptake work in Oldham.

viii. In the past this has involved Oldham Council's neighbourhood teams, Oldham youth council, and work with school communities through school nurses and the Oldham Council communications team.

ix. Further work is underway to develop links with Action Together in Oldham, bringing in key community and voluntary sector organisations to collaborate in this work. This will allow two-way communications with residents about vaccinations in a way that meets their needs: sharing valuable community insights and responding to felt needs existing within different groups.

Additional areas of work beyond vaccination uptake include measles testing, infection prevention and control measures, and system outbreak response. Steps relating to these areas are outlined in the action plan for Oldham.

Rebecca Fletcher emphasised the need to get MMR rates up with a view to protecting the community.

Jayne Ratcliffe drew attention to the effect that measles has on adults as well as children. Getting the message to adults in their own homes as well as adults in care homes.

Resolved - that the Board commits to continued support of plans to improve uptake of the MMR vaccine in children ages under 5 years and in older at-risk groups, namely unvaccinated individuals in older age groups. These plans include:

(i) Establishment of a new group, involving NHS and local authority colleagues, responsible for improving childhood vaccine uptake rates in the borough;

(ii) Improving data systems to deliver high quality vaccine coverage data to inform and support efforts to improve vaccine uptake; and

(iii) Work with communities to optimise access to vaccines and engagement in the programmes for under 5s and catchup vaccinations in older age groups

9 **WINTER PLANNING UPDATE**

The Board received a report from the Integrated Care Partnership which set out the National approach for winter planning 2023-24 and Gm ICB Tier 1 Allocation -May 2023. The report also gave details of the Winter Vaccination Programme 2023-24 for Covid and Flu vaccinations.

Rebecca Fletcher, Interim Director of Public Health, referred to a broader approach to winter wellbeing which should include the cost of living, people keeping warm and vulnerable people which should be taken on board. She suggested that a post winter report showing what went well and the lessons learned from the 2023-24 winter and how the Winter 2024-25 Programme can include those factors.

Resolved – that Oldham Integrated Care Partnership be requested to submit a post winter 2023-24 update report to the Board which indicates what went well and lessons learned the implications for the 2024-25 Winter Programme.

The meeting started at 10.00 am and ended at 11.58 am

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Report to HEALTH AND WELLBEING BOARD

Oldham Safeguarding Adults Board: Annual Report 2022-23 (with supporting Single-Agency Statements and Business Plan 2023-2024)

Portfolio Holders:
Councillor Barbara Brownridge, Cabinet Member for Health and Social Care

Officer Contact: Jayne Ratcliffe, Director, Adult Social Care (DASS)

Report Author: James Babyk-Glynn, Business Manager, Oldham Safeguarding Adults Board

Ext. 07970843338

Date: 2 November 2023

Purpose of the Report
The Oldham Safeguarding Adults Board (OSAB) is a statutory partnership set up to safeguard adults at risk of experiencing abuse, neglect or exploitation. As part of its statutory duties the Board is required to produce an Annual Report setting out the safeguarding concerns it has dealt over the last year, as well as a Business Plan setting out future ambitions and actions to help keep people safe in Oldham. The purpose of this report is to share the Board's agreed 2022-23 Annual Report and 2022-24 Business Plan with members of the Health and Wellbeing Board for their consideration.

Requirement from the Health and Wellbeing Board
Members of the Health and Wellbeing Board are asked to consider and comment on the Oldham Safeguarding Adults Board 2022-23 Annual Report and 2023-24 Business Plan.

Background
The role of the OSAB is to assure itself that organisations and agencies across Oldham are working together to protect and enable adults to live safely. This means helping people to make decisions about the risks they face in their own lives as well as protecting those who lack the capacity to make these decisions.

The Board has three main statutory duties which are to:

- Produce a **Strategic Business Plan** setting out the changes the Board wants to achieve and how organisations will work together.
- Publish an **Annual Report** setting out the safeguarding concerns it has dealt with in the last year as well as plans to keep people safe in the future.
- Undertake a **Safeguarding Adult Review** in line with Section 44 of the Care Act where it believes someone has experienced harm as a result of abuse, neglect or exploitation.

Reflecting on the last year: 2022-23 Annual Report
The Board's 2022-23 Annual Report provides information on the number and type of safeguarding concerns reported in Oldham along with the actions taken to adopt learning from the Safeguarding Adult Reviews. Central to this has been the collection and sharing of firsthand experiences by adults 'at risk' and family members who have experience of safeguarding issues and services in Oldham.

In summary, a total of 2175 safeguarding referrals were made in 2022-23 and of these referrals 430 became the subject of a formal Safeguarding Enquiry. The data shows that the number of referrals received more than doubled compared to the number received in 2018-19 and increased by 16% compared to 2021-22. Some of this increase may be due to safeguarding awareness campaigns designed to encourage the residents of Oldham to report their safeguarding concerns and training provided to professionals in Oldham about making safeguarding referrals and the criteria for formal enquiries. However, whilst the number of overall referrals has increased, the number of serious safeguarding enquiries remains relatively consistent over the last four years.

A total of 4 Safeguarding Adult Reviews were completed in 2022-23, which was double the number completed the previous year. Common themes emerging from Safeguarding Adult Reviews involved the multi-agency management of risk; Complex and Contextual Safeguarding including cuckooing, financial abuse, and exploitation; and safeguarding transitions

Looking Forward: 2023-24 Business Plan
The Board's Business Plan has been shaped by the partner agencies and based on the key learning themes emerging from Safeguarding Adult Reviews, Audits and operational work. As a result, the Business Plan sets out a challenging programme of work, designed to prevent and reduce future safeguarding incidents and implement an effective 'all age' safeguarding offer. The Business Plan is designed to focus on action and is being actively promoted and shared across agencies to highlight the aims of the Board and promote the wide range of resources and information available through the Board's website and fortnightly joint children's and adults safeguarding bulletins.

Appendices

1. OSAB Annual Report 2022-23 plus supporting OSAB Single-Agency Statements 2022-23
2. OSAB Business 'Plan on a Page' 2023-24.

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OLDHAM SAFEGUARDING ADULTS BOARD

ANNUAL REPORT 2022-23

Contents

Helping people live safely in Oldham

What is Safeguarding?

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect." Care Act 2014

Safeguarding is also about respecting an individual's views, wishes, feelings and beliefs when acting in the interests of their wellbeing.

Oldham's Safeguarding Adults Board is responsible for leading adult safeguarding arrangements in the borough. It does this by bringing together a huge number of teams and organisation to ensure services work together effectively; helping people to live free from harm and protecting their human rights.

Who are the Safeguarding Board?

By law, the Board's membership must include Oldham Council and the Oldham based teams from Greater Manchester Police and NHS Greater Manchester Integrated Care.

Working as a collaborative, the Board brings together representatives from the following sectors and services:

- Voluntary sector organisations
- Healthwatch Oldham
- Probation Service
- Greater Manchester Police
- Pennine Care NHS Foundation Trust
- Northern Care Alliance NHS Foundation Trust
- Public Health
- Oldham Housing organisations
- Greater Manchester Fire and Rescue Service
- Oldham Council
- NHS Greater Manchester Integrated Care

The Board is managed by an Independent Chair who is responsible for providing safeguarding leadership and oversight. Through the work of the Board, the Chair seeks assurance from partner agencies that they are working together effectively to help keep people safe.

Safeguarding is everyone's business

There are many different types of abuse and neglect such as financial and sexual abuse, domestic violence, elder abuse, modern day slavery and even self-neglect; all of which can happen at home, in the community or within places where care is provided.

The safeguarding responsibilities of the Board are just part of the solution. Our greatest resource for identifying and reporting safeguarding concerns are families, friends, and members of the public. So, our mission for 2023-24 is to ensure that safeguarding is everyone's business by encouraging people to be curious, highlighting the signs to look for and making it easy to make a safeguarding referral.

The Board has three core duties:

1. Conduct a Safeguarding Adult Review where there is evidence to suggest that someone has experienced harm as a result of abuse or neglect.
2. Produce a Strategic Plan setting out the changes the Board wants to achieve and how organisations will work together to help keep people safe.
3. Publish an Annual Report setting out information on safeguarding trends locally, the actions of the Board over the last year, and priorities for the coming year.

This Annual Report provides an overview of safeguarding trends in Oldham during 2022-23. It also provides information on the Safeguarding Adult Reviews commissioned by the Board and how the learning from these reviews has shaped and improved the way services work in Oldham.

Profile of abuse and neglect in Oldham

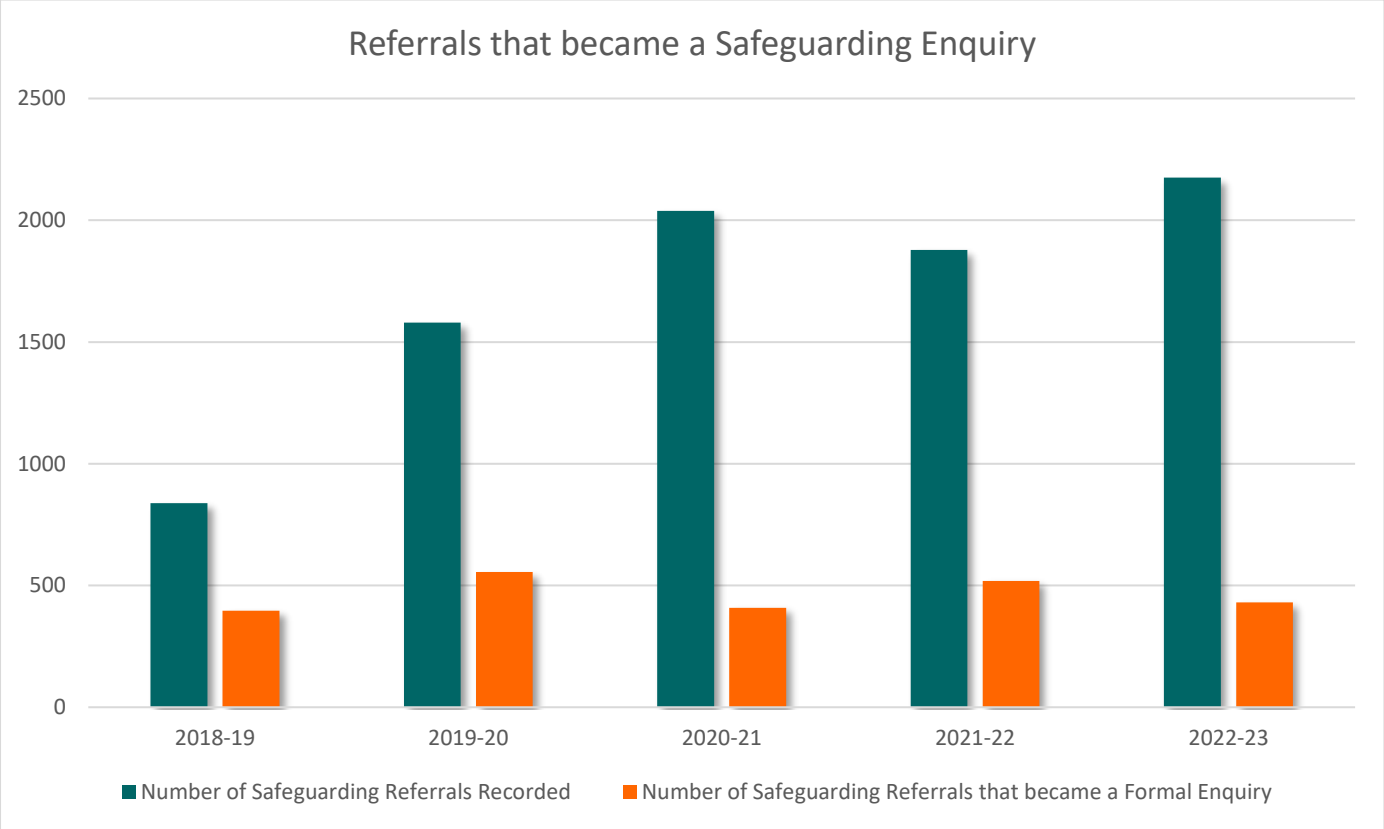
The following information shows the numbers and types of safeguarding abuse recorded for Oldham residents in 2022-23. This data has been compared to the numbers and types of safeguarding abuse from previous years to help us understand any changes or new types of safeguarding concerns that need to be addressed.

Safeguarding referrals that became a formal safeguarding enquiry

Each safeguarding referral received is investigated and if we believe that an adult with care and support needs is at risk of serious abuse or neglect and is unable to protect themselves because of those needs, the referral becomes the subject of a formal safeguarding enquiry.

The purpose of a formal safeguarding enquiry is to ensure that the referral is investigated, to gather more information, to collect the views of the adult at risk of serious abuse or neglect and the views of anyone else who may be relevant, and to prevent, or stop, abuse from occurring.

The chart below shows the number of safeguarding referrals that have gone on to become formal safeguarding enquiries over the last five years.



During 2022-23, a total of 2175 safeguarding referrals were received and of these, 430 became a formal safeguarding enquiry. The number of safeguarding referrals increased by 16% in 2022-23 compared to the previous year.

Some of this increase may be due to safeguarding awareness campaigns designed to encourage the residents of Oldham to report their safeguarding concerns and training provided to professionals in Oldham about making safeguarding referrals and the criteria for formal enquiries.

Whilst the number of overall referrals has increased, the number of those that have led to formal safeguarding enquiries has remained relatively consistent over the last five years with an average of 460 each year.

Sex, age, and ethnic group of safeguarding referrals

Of the 2175 safeguarding referrals in 2022-23, 60% related to women and 40% related to men.

This is the same proportion as previous years and, as women make up 52% of the total adult population in Oldham, this means that the percentage of safeguarding cases per head of population in 2022-23 were slightly higher for women than for men.

safeguarding referrals were about women in 2022-23

safeguarding referrals were about men in 2022-23

Of the 2175 safeguarding referrals in 2022-23:

- 930 (43%) were 18-64 years old
- 265 (12%) were 65-74 years old
- 473 (22%) were 75-84 years old
- 506 (23%) were 85 years old or older

Considering different age groups, during 2022-23, it was recorded that over 50% of all safeguarding referrals related to someone aged 65 or over. Whilst the percentage of people aged 85 years and over has increased slightly from 20% to 23% the breakdown by age group has remained consistent over the last few years.

Of the 2175 safeguarding referrals in 2022-23:

- 82% were White British
- 7% were Asian/Asian British
- 1% were Black/African/Caribbean
- 1% were Mixed/Other Ethnicity
- 9% were Unknown/refused information

Considering the ethnicity of Oldham residents, during 2022-23, it was recorded that 82% of all safeguarding referrals related to White British people. This is the largely the same proportion as previous years and, as White British people make up 65% of the total adult population in Oldham, this means that the percentage of safeguarding cases per head of population in 2022-23 were slightly higher for White British people.

Overall the 2022-23 figures suggest that White British people aged 65 and over were more likely to be the subject of a safeguarding referral compared to any other group.

Number of closed safeguarding referrals and enquiries

2253 safeguarding referrals and enquiries were closed in 2021-22

2631 safeguarding referrals and enquiries were closed in 2022-23

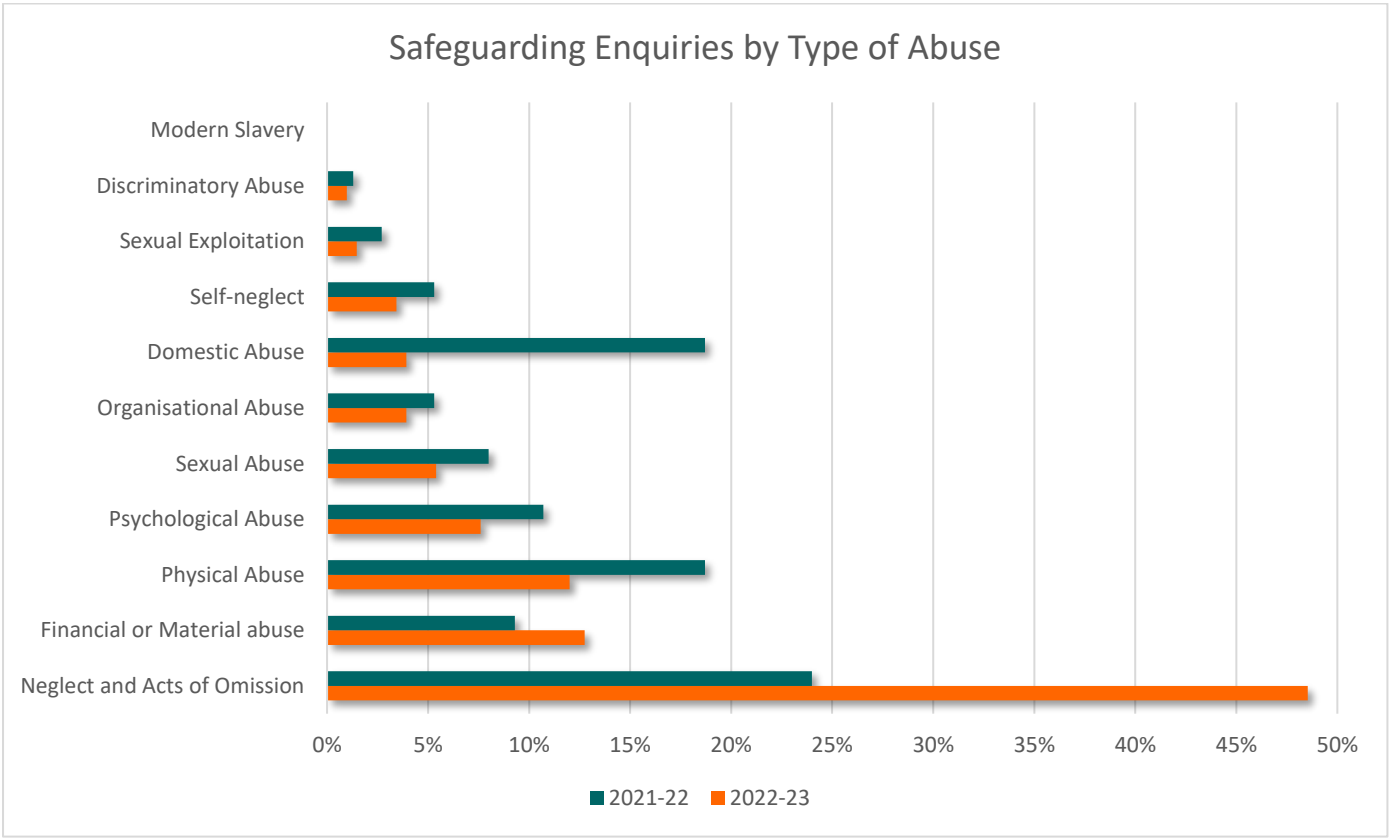
During 2022-23, a total of 2631 safeguarding referrals and enquiries were closed which is more than the 2175 safeguarding referrals received in the year. This is due to a push by Oldham's Strategic Safeguarding Service to increase the number of timely closure of referrals and enquiries and includes the closure of outstanding cases from 2021-22.

Mental Capacity

A person lacks mental capacity if their mind is impaired or disturbed in some way, which means they are unable to make a decision at that time as they cannot understand the information relevant to the decision; retain that information; or use or weigh up that information as part of the process of making the decision. Examples of how a person's brain or mind may be impaired include mental health conditions, dementia and intoxication caused by drugs or alcohol misuse. The 2022-23 figures include a higher proportion of complex safeguarding enquiry cases compared to 2021-22 with **46%** of the closed safeguarding enquiries involving people who lacked capacity to make their own decisions. This had increased from 40% in 2021-22.

Types of safeguarding abuse

The chart below shows a breakdown of the **types of safeguarding** abuse investigated in 2022-23 compared to 2021-22. Some safeguarding investigations can involve the recording of more than one category of abuse for the same person and these are the cases that often involve multiple agencies working together to ensure those involved are safe.



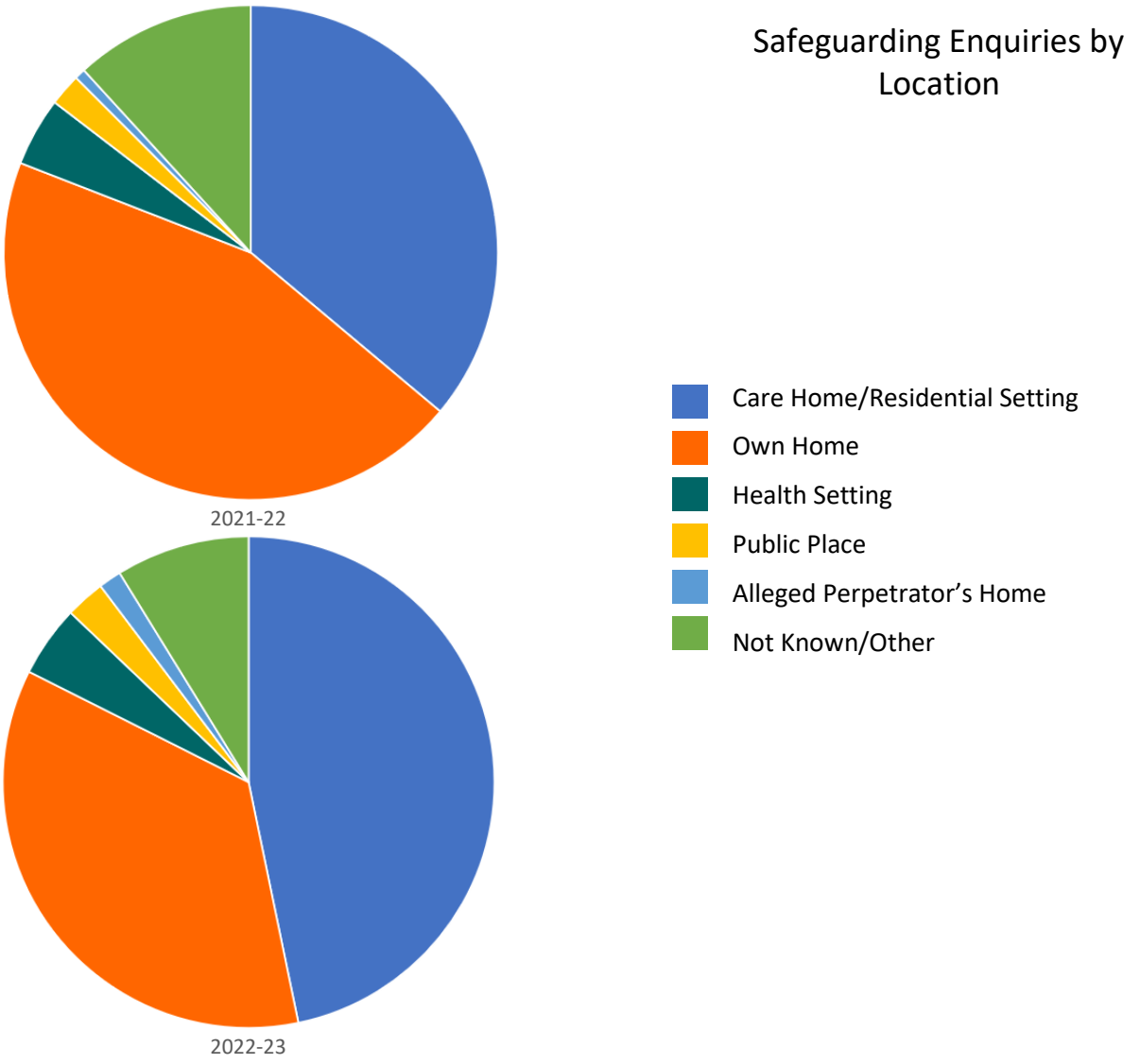
Modern Slavery is an umbrella term for all forms of slavery, human trafficking, and exploitation. It includes holding a person in a position of slavery, servitude, forced or compulsory labour, or facilitating their travel with the intention of exploiting them soon after. In 2022-23, there were ten safeguarding referrals received related to Modern Slavery in Oldham. None of these progressed to a safeguarding enquiry. As it is often the case that the potential victims do not have care and support needs, these cases are usually responded to through alternative processes rather than via a safeguarding enquiry. Local professionals are being encouraged to recognise the signs of Modern Slavery and provided with the details of the alternative processes that can be used to respond to concerns about Modern Slavery through new multi-agency training, practitioner guidance and briefings that the Board introduced in 2022-23.

The most common form of abuse in 2022-23 related to neglect and acts of omission. These are cases where a person who is responsible for the support of an adult at risk has failed to provide adequate care or essentials such as medicines, nutrition, heating etc. Neglect and acts of omission has consistently been the most common form of abuse over the last four years. Levels have increased from 24% in 2021-22, to 48% of cases investigated in 2022-23.

Conversely, there has been a decrease in the percentage of discriminatory, organisational, physical, and sexual abuse cases investigated in the last year.

Where the abuse took place

The charts below show that for both 2021-22 and 2022-23 the most common places where the reported abuse or neglect took place was within a care home/residential setting or the person's own home.



The Safeguarding Adults Board review safeguarding data regularly. In 2022-23, the Board oversaw further development of a detailed data 'dashboard'. The insights from this are used by the Board to review safeguarding resources such as training and guidance and where appropriate, adjust the way services work together to keep people safe in Oldham.

Safeguarding – what does good look like?

When Oldham Safeguarding Adults Board report on safeguarding data, we often focus on safeguarding enquiries, because this is a statutory responsibility. But this is only part of the picture. In 2022-23, Adult Social Care worked with other partner agencies to deal with a further 1,745 safeguarding referrals that did not meet the criteria for a safeguarding enquiry, but often involved a great deal of work to keep people safe and well.

In Fred's case a referral was made about self-neglect and hoarding. Fred is a 79 year old gentleman who lives alone in his own property. He has been known to many services over the years, including the Police, the Fire and Rescue Service, Social Prescribing, Adult Social Care, Environmental Health, his GP, Age UK Oldham, and Mind.

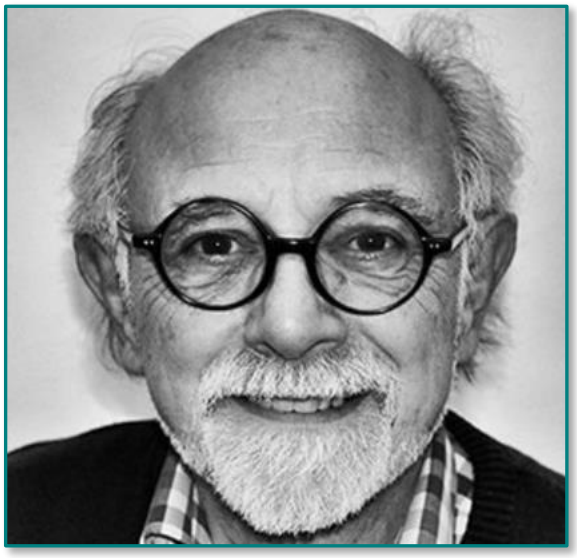
A private personal assistant (PA) is a person that helps someone to manage their household or personal-related tasks. Fred's wife was diagnosed with dementia. There was a private PA (PA) going into their house, to support him and his wife. His wife's dementia deteriorated, and she is now being cared for in a residential home. The private PA support was cancelled. Fred can be described as a 'person who hoards'. Most of the items he hoards are electrical equipment, electronics, and gadgets. These items are quite expensive, and he has been targeted by some local people. He has also had two serious electrical fires and did not request any medical support for his burns. Fred was reluctant to accept support from services and was neglecting himself by not eating or drinking properly, not attending GP appointments and became increasingly depressed and expressed suicidal thoughts. A safeguarding referral was made due to concerns about self-neglect and hoarding behaviour.

Professionals from some of the services in Oldham that knew Fred started to use Oldham's Team Around the Adult approach. This is designed to bring together a range of different representatives from across the Safeguarding Partnership to provide support for someone. Members of the Team Around the Adult began to meet to work in partnership with Fred to explore some of the risk that was known about and develop and deliver support that was focused on solutions that would last. A Team Around the Adult can do this by asking for advice or support from representatives from other services and organisations who do not necessarily know or meet the person. Sometimes the representatives from these services will join the Team Around the Adult.

A multi-agency risk assessment and risk action plan was agreed by all the professionals involved in the Team Around the Adult. The Social Worker involved had known Fred when his wife lived at home, they were able to establish a positive working relationship with him. A private PA was put in place and is now supporting Fred with paying his bills, organising his finances, and helping him to clear the clutter in his house. Fred is now getting all the right benefits that he is entitled to. His finances and debts are being managed and he is accepting practical and emotional support from his private PA. The hoarding in the property is also reducing.

The Team Around the Adult continue to meet once every month. They make sure they are reviewing the risk assessment together and sharing all new information. Fred was asked about what his wishes were, what he would want to happen. "To have my wife living back home," he said, "and to organise my house." Through really positive multi-agency commitment and support Fred is some way to achieving his positive outcome.

Message from the Independent Chair



This annual report from the Oldham Safeguarding Adult Board once again demonstrates the multi-layered complexity of safeguarding needs and vulnerabilities of local residents. These needs and vulnerabilities can manifest in acts of neglect and omission from carers (formal and informal), incidents of domestic conflict and abuse, exploitation in a variety of relationships and settings and vulnerabilities caused by or contributed to from compromised mental capacity.

The members of the safeguarding adult partnership need to be aware of the variety of these dimensions and complexities and ensure that their service responses are sufficiently robust to meet the challenges contained in the demands of safeguarding.

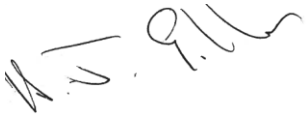
Strategic approaches currently employed by the local partnership include:

- Awareness raising initiatives on dimensions of safeguarding need
- A focus on the prevention of abuse, neglect, and exploitation
- Multi-agency training to establish a common knowledge base of safeguarding need
- Structured cross-agency working to meet multi-dimensional complex need
- Quality assured evaluations of local safeguarding practice initiatives

It is a hallmark of an effective safeguarding partnership that public awareness of safeguarding is heightened and that demand for service is high. These hallmarks are evident in the Oldham partnership arrangements.

The partners are committed to ensure that good quality safeguarding services are available to all communities in the borough, that these services innovate to meet the changing needs of residents and that the public have confidence in the skills, abilities, and resources of the local safeguarding partners.

The spirit of this commitment will be taken into the final year of the current three-year strategy for safeguarding in Oldham and during 2023-24 we shall be consulting on how this strategy should be refreshed for the future.



Henri Giller
Independent Chair
Oldham Safeguarding Adults Board

Safeguarding Adult Reviews

The Board has a legal duty to carry out a **Safeguarding Adult Review (SAR)** if it believes that someone has died of, or experienced, serious abuse or neglect. The aim of a SAR is to review the way agencies worked together to safeguard an individual or family. Learning from the review is shared across agencies and used by the Board to review the way services operate in order to prevent a similar situation.

Central to the process is the involvement of the family or the individual, if they are still alive. This ensures that we capture the experiences of people who use services and use this insight to inform any changes.

The following information shows the increase in the number of reviews commissioned by the Board in 2022-23 to compared to the previous year.

2021-22 **2 Safeguarding Adult Reviews**

2022-23 **4 Safeguarding Adult Reviews**

Common themes emerging from SARs involved the multi-agency management of risk; Complex and Contextual Safeguarding including cuckooing, financial abuse, and exploitation; and safeguarding transitions which is the term used to describe the period of change in a young person's life as they move from childhood to adulthood and the way services in Oldham support young people between the ages of 14 and 25, as they move from children's to adults' services.

The findings below came from a SAR completed in 2022-23.

Peter

Peter was in his early 70's when he was found deceased in his flat by police. He lived alone and had managed his own finances and medication.

Peter had a reduced cognition score although no formal diagnosis was made. A reduced cognition score means a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life.

Peter had been able to communicate to many agencies that there were issues and that he had been deemed to have mental capacity to return home from hospital a few days before he died.

There were several disclosures of financial abuse and exploitation by two younger males in the local area. Information was shared that the males were taking Peter's money, his bank card, his medication, and his phone. One of the males also tried to prevent professionals from accessing Peter. Paid carers commissioned to support Peter felt unsafe going into Peter's home because of the two males being present inside or outside of the flat. Five safeguarding referrals were made.

As it appeared Peter had mental capacity, it was left to him to stop letting people into his property. Although Peter's carers called police on his behalf to report that males were constantly harassing him, there was not a significant amount of recognition of exploitation and cuckooing and how this could have had an impact on decision making and capacity.

There was evidence of social care, police, and Peter's housing association sharing information, but there was little escalation within services and no multi-agency meetings planned.

The SAR suggested the need for clear guidance about what housing providers and other agencies could do to respond to exploitation including financial abuse and cuckooing and how they could escalate issues and report concerns better.

Listening to lived experience

In 2022-23, Oldham Safeguarding Adults Board worked in partnership with Age UK Oldham, Healthwatch Oldham and Oldham's Domestic Abuse Partnership, to carry out research to understand the domestic abuse experiences of people aged 55 and over. Through a mix of in-depth one to one interviews and focus group discussions, over forty residents in Oldham shared their stories and feedback; with experiences ranging from long standing abuse by an intimate partner to abuse from wider family members.

The research report can be found on the OSAB website: Opening Doors: Understanding the experiences and responses to older victims of domestic abuse in Oldham - A research report by the Oldham Safeguarding Adults Board and Oldham Domestic Abuse Partnership.

The research found that abuse can be triggered by life changing situations such as retirement, disability or taking on an informal caring role. The findings included that there was a need for a different response for older survivors. One of the survivors said:

> *"It is a subject that is still taboo, especially with the older generation whose mindset is 'I've made my bed, so I have to lie in it.'"*

The feedback has been used to highlight the different forms of abuse experienced by people in later life as well as the barriers they face accessing help and support. It will also be used to review the appropriateness of current domestic abuse assessments and support options for older survivors.

We found that the majority of cases involve a gradual escalation of abuse as part of a long term relationship. 45% of survivors said that the abuse got more coercive and controlling over time with perpetrators monitoring and restricting their social contacts, movements, and finances. Often, due to the subtlety of coercion and control, older survivors did not recognise the behaviour as abuse until it escalated to a point where the severity of it made it difficult to leave. Equally, practitioners in Oldham did not recognise these very early signs linked to coercion and control.

The Board launched 'Eggshells' a short film designed to help promote an understanding of these types of situations and to help everyone recognise the signs. The film focuses on domestic abuse experienced by older adults and was introduced as part of National Safeguarding Adults Week and just ahead of White Ribbon Day. Made By Mortals were asked to lead production of the powerful film. It was co-produced with a team of professional artists, partners from health and social care and a group of women from Oldham who courageously shared their lived experience as a way of helping others going through the same experiences. This vital film finishes by encouraging people to visit a new website: www.eggshells.org.uk for information and support in Greater Manchester. The website includes a collation of key links put together to support the film.

The film has now been viewed more than **245,000** times! You can watch Eggshells by clicking on the poster below or at www.eggshells.org.uk.

The research findings and campaign video were also shared widely as part of a new multi-agency training course that has been rolled out to Safeguarding Adult Boards across Greater Manchester.

Working in Partnership in 2022-23

The role of Oldham Safeguarding Adults Board is to ensure that organisations across Oldham work together to help adults live safely. Each year the Board produces a business plan which translates its agreed ambitions for a three-year period into an annual programme of work. The work of the Board is also shaped by learning from Safeguarding Adult Reviews (SARs) and people's feedback about their experiences of accessing services. The Board's achievements in 2022-23 included:

- **Team Around the Adult (TAA) and the Adults Complex and High Risk Panel (CaHRP)** – Agencies have continued to embed the procedures set out in the Tiered Risk Assessment and Management (TRAM) Protocol. For cases involving complex issues and risk, such as Fred's, the Protocol helps agencies coordinate support effectively through regular TAA meetings. Cases considered to be high or critical risk are escalated to the Adults CaHRP. The Panel brings together senior safeguarding leads and heads of services and departments for case discussions that require their oversight and to enable them to provide additional support to help problem solve.

> *"The TRAM protocol and the Panel was very supportive. I was case managing a high risk case and professionals at the Panel offered guidance and advice and helped me think out of the box."*
> An Oldham Professional

- **Preparing for Adulthood: Oldham's Transitions Policy** - Following multi-agency collaboration between adults and children's services in Oldham, a joint Transitions Policy was produced. The policy sets out best practice for how services should work together to support not only young people with care and support needs but also those at high risk of experiencing harm or abuse and likely to need support as an adult. Training for all professionals with the aim of embedding this policy will be rolled out in 2023-24.
- **Multi-Agency Training** – As a result of the Workforce Development Strategy for 2022-23, the Board oversaw the design, development, and piloting of 8 new multi-agency training sessions and the delivery of 12 different sessions through a pool of voluntary multi-agency trainers. Sessions included those related to Hoarding Awareness; the Mental Capacity Act; and Risk Management in Oldham. A total of 837 professionals representing 45 different services attended these sessions – both of these figures almost doubled from the previous year when 431 professionals representing 23 different services attended!
- **Adult Complex Safeguarding and Exploitation Strategy** - Following publication of the Greater Manchester Child Exploitation Report and review of cases in Oldham, the Board came together with the Children's Safeguarding Partnership at a joint learning event to hear about the lived experiences of victims and survivors and to agree to prioritise future actions. The Board published it's Adult Complex Safeguarding and Exploitation Strategy setting out it's understanding of complex safeguarding and exploitation, it's approach to tackling adolescent and adult exploitation and how partners would work together to improve the lives of those at risk of exploitation. The strategy was purposely designed to be read alongside the Children's Strategy.
- **Safeguarding Awareness** - The Board has supported numerous public campaigns to raise awareness of safeguarding issues including information on how to raise a safeguarding concern being sent to all residents in Oldham via the free local newspaper. See some examples below; click on the image to see a larger version.

Each year, partner agencies provide a summary of their own safeguarding work for publication as **Single-Agency Statements**. The following pages provide summaries from Adult Social Care and the Oldham based teams within NHS Greater Manchester Integrated Care and Greater Manchester Police as the three lead agencies on the Board.

Partner Contributions: Adult Social Care, Oldham Council

Oldham Council is responsible for providing a range of public services to support local communities. One of the main services it provides is **Adult Social Care** which has a statutory duty to prevent, delay, assess and meet the care and support needs of adults under the Care Act 2014. Adult Social Care is also responsible for assessing and authorising deprivations of liberty for adults where it is deemed to be in an individual's best interests. Social Care sits within the Adult Community Health and Social Care Service.

Where does safeguarding fit?

Safeguarding is the top priority in Adult Community Health and Social Care. The service provides the first point of contact to report safeguarding concerns and works with individuals and advocates to ensure individual's outcomes are at the centre of this process and protect those who are unable to protect themselves from abuse and neglect.

We work with other agencies to help people identify and manage risks and have a duty to work with our care providers, reviewing the quality of services to ensure the delivery of high quality and safe care.

Safeguarding in 2022-23

Safeguarding trends included:

- **Complex and Transitional Safeguarding** - Referrals for individuals at risk of criminal and sexual exploitation have continued to be a trend in 2022-23. Referrals for young people moving into adulthood have also continued to be a trend. These two trends are closely connected. Thematically, both of these areas require person centred, trauma informed responses, mental health assessments, mental capacity assessments (often executive functioning), an outreach approach, the use of legal frameworks, and intensive multi-agency partnership working to assess, manage and reduce risks to an individual's safety and wellbeing.
- **Preventative safeguarding responses and risk management work** undertaken at safeguarding referral stage has also been a trend. We have seen a 15% increase in safeguarding referrals in comparison to the previous year.

Our major successes included:

- **One Team Approach** - Workforce capacity challenges have required us to work creatively and flexibly to deliver a safe safeguarding service. A centralised safeguarding team responding to safeguarding concerns and completing safeguarding enquiries in locality teams has supported safe delivery. Embedding triage risk rating systems has allowed teams to work more flexibly.
- **Allegation Management** - We have undertaken awareness raising regarding allegation management concerns and these are now being consistently reported. The Allegation Management Lead role has now been embedded and work has been undertaken to enhance the infrastructure needed to respond to these concerns effectively.

Our Priorities for 2023-24

- **Making Safeguarding Personal (MSP) –** We aim to deliver high quality safeguarding practice through personalised, strengths based and outcome focused conversations. The Strategic Safeguarding Service will be working to support consistency across the service in the holding and recording of MSP conversations throughout 2023-24.
- **Co-production -** We will be exploring ways in which we can understand the experience of people using our safeguarding services, what helps them, what does not, and how we can co-produce effective safeguarding responses.
- **Adult MASH Review Update and Strategy –** A review and strategy for the Adult Social Care safeguarding front door will be progressed.
- **Care Home Safeguarding** - We will continue to monitor care home safeguarding trends by provider, category of abuse and outcome. We also aim to enhance our data reporting and analysis through conversations with residents, referrers, providers, commissioners, and multi-agency partners in support of high-quality safe care.

Partner Contributions: NHS Greater Manchester Integrated Care

NHS Greater Manchester Integrated Care is a new NHS organisation, overseen by a Board, and is in charge of the NHS money and making sure services are in place to put plans into action. Made up of representatives from the NHS and the local council, we are responsible for making decisions about health services in our area. The partnership operates at three levels: neighbourhood, locality and Greater Manchester and has a single vision and strategy. Hospitals, GPs, community services, voluntary services and others have come together to form 'provider collaboratives' within all three levels, helping to join care and help people live well across Greater Manchester's ten boroughs.

Where does safeguarding fit?

NHS Greater Manchester Integrated Care are committed to providing the care that Oldham people need, to ensuring safeguarding responsibilities are met and to reducing inequality whilst improving outcomes for those in need or at risk. Safeguarding is fundamental to every aspect of the organisation as we ensure that all our NHS Commissioned Providers such as the GP practices, hospital, community services and Mental Health services are fulfilling their responsibilities to safeguard those using their services.

Safeguarding in 2022-23

The year saw the recruitment completed to all posts within the ICB safeguarding team. The complements of the full Safeguarding Team to the Oldham Integrated Care place-based team brings expertise from learning disability, mental health, nursing, and social work.

Strengthening safeguarding practice across primary care and those delivering nursing care packages has remained a priority during these changes.

Our major successes included:

- **Assurances** - All GP practices met with the safeguarding team to review their safeguarding assurance audit, providing an opportunity to discuss any gaps in practice and knowledge and support to develop an action plan to meet those areas.
- **Transitions** - An area of growing concern where we have focused our support is the transition of complex care packages from children to adults.
- **Vaccination** - Oldham has seen a low uptake of the Covid vaccination and flu jab, particularly amongst residents who have a learning disability. A process has been established to support the vaccination programme for those patients who lack mental capacity to consent which guides practitioners to assess mental capacity, consider making best interests decisions, and escalating cases as needed for decisions to be made in the court of protection (when disagreements arise between health professionals and family members).
- **Routine Enquiry** – we have further developed Routine Enquiry for domestic abuse/violence with GPs. Routine Enquiry involves asking all women at assessment about abuse regardless of whether there are any indicators or suspicions of abuse. It was established in maternity, sexual health, health visiting, substance misuse and mental health settings. A series of newsletters and training sessions have aimed to include this into General Practice.

Our Priorities for 2023-24

- **Further Strengthening Practice around Domestic Abuse** - we aim to employ an Independent Domestic Abuse Advisor role within Primary Care services to with GP practices on specific cases and work closely with the Local Authority Independent Domestic Violence Advisor (IDVA) team.
- **Modern Day Slavery -** we aim to work with key partners to further strengthen the offers that are currently available across Greater Manchester. The Oldham Modern Slavery toolkit will be shared across the Greater Manchester ICB footprint to ensure that a consistent approach is taken.
- **Changes to Safeguarding Approach** - The change of safeguarding approach from locality to a whole system will take some time to embed. The change brings exciting opportunities for safeguarding learning to be shared and embedded across the Greater Manchester footprint to promote good practice and early identification of themes.

Partner Contributions: Greater Manchester Police

Greater Manchester Police (GMP) are responsible for providing a first line response to the needs of the community. This includes fighting crime, keeping people safe and safeguarding vulnerable people.

Where does safeguarding fit?

Vulnerability remains the number one priority within GMP and we work in partnership to protect vulnerable adults living in and visiting our communities.

All GMP staff work internally and externally with partnership agencies to safeguard against all forms of abuse including domestic, financial, psychological, neglect and sexual abuse, as well as adults at risk of abuse or exploitation.

We work to ensure that we achieve the best possible outcomes for all individuals whilst also considering the wider threat posed by perpetrators.

Safeguarding in 2022-23

Key issues for GMP in 2022-23 included:

- **Domestic Abuse –** There has been an increase in reporting of domestic abuse with a focus on encouraging reporting, and accurate crime recording. Our focus has been on quality investigations. There has been a significant increase in domestic abuse victims disclosing rape, which is in part due to the work of Independent Domestic Violence Advocates (IDVAs) and other agencies engaging victims, but also an increase in confidence in reporting to the police. A MARAC, or multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic abuse cases. The number of cases referred to the MARAC have doubled over the last three years, from 582 to over 1000 cases, with 38% of these cases being repeat victims and/or perpetrators.

Our major successes included:

- **Equipping our teams -** Following the publicised case in Rochdale, there has been an increased focus for detectives to consider the presence of mould at the scene of unexpected deaths. There is work ongoing to equip our detectives to deal with these cases and in particular where hoarding has been a factor.
- **Mental Health Joint Response Cars -** have been implemented allowing mental health practitioners, accompanied by a police officer, to attend any calls that the Force Contact, Crime and Operations (FCCO) branch receives regarding someone in mental health crisis. This allows the person to receive the care that they need, when they need it.
- **Domestic Abuse Day of Action -** Oldham Police take Making Safeguarding Personal seriously and ran a very successful Domestic Abuse Day of Action locally. We engaged with partners so there was a range of activity undertaken. Ten high risk perpetrators were arrested. School engagement officers and a mental health and trauma practitioner delivered a talk at a school about healthy relationships, control, and consent. The IDVA service set up an information stall within the Spindles shopping centre advising the public about domestic abuse and dangerous relationships and showing the 'Eggshells' awareness video. There were also joint visits to the top harm cohort to attempt to prevent future re-offending and Domestic Violence Protection Order (DVPO) checks were completed with MASH and IDVAs.

Our Priorities for 2023-24

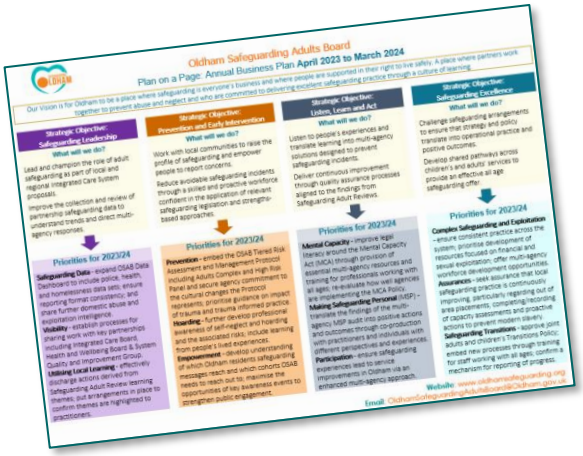
- **Domestic Abuse** - Additional resources will be invested once the force Domestic Abuse Arrangements Review (DAAR) Project is approved so there is a consistent approach across Greater Manchester. We will work in partnership to improve MARAC using the findings from a recent Safe Lives inspection.
- **Domestic Homicide Prevention Strategy** – evidenced based approach to repeat domestic abuse offending through partnership working.
- **Improving our intelligence function** - to support hidden forms of harm for adults at risk.

Plans for 2023-24

The Oldham Safeguarding Adults Board has made significant progress over the last twelve months, producing clear multi-agency safeguarding procedures, policies and training programmes designed to translate the learning from serious safeguarding incidents into effective practice. The Board has also aligned its processes with those across Greater Manchester and is working as part of a national network of Safeguarding Adult Boards, sharing ideas and best practice.

In 2023-24, we expect to see structural changes being embedded following new legislation set out in the Health and Care Bill to improve health and care for all through increased integration, joined-up planning, and prevention and the Mental Health Act White Paper outlining plans to change the law about when you can be detained and receive mental health treatment without consent. These changes include the introduction of the Liberty Protection Safeguards, designed to protect adults aged 16 and over who lack the capacity to consent to care or treatment, and the Care Quality Commission taking responsible for assessing local authorities' delivery of their Care Act functions, including its duty to support multi-agency safeguarding arrangements, impacting across the partnership. Responding to these challenges will require effective safeguarding leadership and accountability at the most senior levels in Oldham.

The Board are currently in the final year of a Three-Year Strategy which set out its strategic aims from April 2021 to March 2024 by identifying the partnership's shared vision and direction for safeguarding adults within Oldham. The Board sets out its wider priorities in the annual Plan on a Page. The Board's priorities for 2023-24 (click on the image below to take a look):



Highlights of the key plans for 2023-24 are included below. The Board will:

- continue to work alongside the Safeguarding Children Partnership to support the development of local **safeguarding transitions** processes, encourage the 'buy in' of all agencies and support a programme of work to put the policy into practice; relevant SARs will continue to be used to understand and utilise the systemic learning when Transition cases present learning opportunities.
- prioritise a programme of multi-agency audits and **quality assurance** reviews focusing on risk management and the application of the Making Safeguarding Personal (MSP) principles which aim to develop an outcomes focus to safeguarding work. The Board will translate the findings of the MSP audit into positive actions through **co-production** with practitioners and individuals with different perspectives and experiences.
- ensure **complex safeguarding and exploitation** remain priorities for the year. The Board will produce practitioner guidance and referral pathways for each of the areas of exploitation recognised in the strategy - cuckooing, modern slavery/criminal exploitation, sexual exploitation, and financial abuse. Once these essential tools are complete, multi-agency training will be developed and offered to all practitioners. Together with local community groups, we want to design and launch a local communications campaign about the signs of exploitation and how to report any safeguarding concerns.
- review, interrogate and risk manage **safeguarding data** and trends through a bespoke Partnership Data Dashboard. The dashboard will be expanded to include police, health, and homelessness data sets and share further domestic abuse and exploitation intelligence. The Board will seek assurance from partners about mitigating actions where appropriate.
- prioritise the **use of local learning** and effective completion of the actions derived from Safeguarding Adult Reviews. These actions can vary from one-off pieces of work, such as producing and sharing a new briefing, to broad, multi-agency projects or events or substantial system changes.

Useful Contacts

What to do if you are worried about an adult

Abuse and neglect can happen anywhere, be carried out by anyone and it can take many different forms. If you are experiencing abuse, or you think someone you know is experiencing or is at risk of being abused or neglected, and they are not able to protect themselves then please report it.

The Oldham Adult Referral Contact Centre (ARCC) has been set up to help adults and families looking for support. In addition, the Oldham Multi-Agency Safeguarding Hub (MASH) has been set up to help people who want to report a safeguarding concern. Both services can be contacted using the following details:

0161 770 7777
or
Adult.Mash@oldham.gov.uk
or
ARCC@oldham.gov.uk

Stay in touch

The work of the Board is supported by the Board Business Unit who help the Board to carry out its legal roles and signpost residents and professionals to information, advice, and training resources. If you would like to keep in touch and find out more about our work through our bulletins, please contact us at:

Oldham Safeguarding AdultsBoard @oldham.gov.uk

Or visit our website:
www.OSAB.org.uk

Support Our Work

Please follow us on Twitter and share our content to raise awareness of safeguarding and what people can do to keep safe in Oldham:

@SafeguardOldham

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Oldham Safeguarding Adults Board

Plan on a Page: Annual Business Plan **April 2023 to March 2024**

Our Vision is for Oldham to be a place where safeguarding is everyone's business and where people are supported in their right to live safely. A place where partners work together to prevent abuse and neglect and who are committed to delivering excellent safeguarding practice through a culture of learning.

Strategic Objective: Safeguarding Leadership

What will we do?

Lead and champion the role of adult safeguarding as part of local and regional Integrated Care System proposals.

Improve the collection and review of partnership safeguarding data to understand trends and direct multi-agency responses.

Priorities for 2023/24

Safeguarding Data - expand OSAB Data Dashboard to include police, health, and homelessness data sets; ensure reporting format consistency; and share further domestic abuse and exploitation intelligence.
Visibility - establish processes for sharing work with key partnerships including Integrated Care Board, Health and Wellbeing Board & System Quality and Improvement Group.
Utilising Local Learning - effectively discharge actions derived from Safeguarding Adult Review learning themes; put arrangements in place to confirm themes are highlighted to practitioners.

Strategic Objective: Prevention and Early Intervention

What will we do?

Work with local communities to raise the profile of safeguarding and empower people to report concerns.

Reduce avoidable safeguarding incidents through a skilled and proactive workforce confident in the application of relevant safeguarding legislation and strengths-based approaches.

Priorities for 2023/24

Prevention - embed the OSAB Tiered Risk Assessment and Management Protocol including Adults Complex and High Risk Panel and secure agency commitment to the cultural changes the Protocol represents; prioritise guidance on impact of trauma and trauma informed practice.
Hoarding - further develop professional awareness of self-neglect and hoarding and the associated risks; include learning from people's lived experiences.
Empowerment - develop understanding of which Oldham residents safeguarding messages reach and which cohorts OSAB needs to reach out to; maximise the opportunities of key awareness events to strengthen public engagement.

Strategic Objective: Listen, Learn and Act

What will we do?

Listen to people's experiences and translate learning into multi-agency solutions designed to prevent safeguarding incidents.

Deliver continuous improvement through quality assurance processes aligned to the findings from Safeguarding Adult Reviews.

Priorities for 2023/24

Mental Capacity - improve legal literacy around the Mental Capacity Act (MCA) through provision of essential multi-agency resources and training for professionals working with all ages; re-evaluate how well agencies are implementing the MCA Policy.
Making Safeguarding Personal (MSP) **-** translate the findings of the multi-agency MSP audit into positive actions and outcomes through co-production with practitioners and individuals with different perspectives and experiences.
Participation - ensure safeguarding experiences lead to service improvements in Oldham via an enhanced multi-agency approach.

Strategic Objective: Safeguarding Excellence

What will we do?

Challenge safeguarding arrangements to ensure that strategy and policy translate into operational practice and positive outcomes.

Develop shared pathways across children's and adults' services to provide an effective all age safeguarding offer.

Priorities for 2023/24

Complex Safeguarding and Exploitation - ensure consistent practice across the system; prioritise development of resources focused on financial and sexual exploitation; offer multi-agency workforce development opportunities.
Assurances - seek assurance that local safeguarding practice is continuously improving, particularly regarding out of area placements, completing/recording of capacity assessments and proactive actions to prevent modern slavery.
Safeguarding Transitions - approve joint adults and children's Transitions Policy; embed new processes through training for staff working with all ages; confirm a mechanism for reporting of progress.

Website: www.oldhamsafeguarding.org
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OLDHAM SAFEGUARDING ADULTS BOARD

SINGLE-AGENCY STATEMENTS

2022-23

Introduction

In addition to the Oldham Safeguarding Adults Board's Annual Report setting out information on safeguarding trends locally, the actions of the Board over the last year, and priorities for the coming year, agencies are invited to provide highlights of their own safeguarding work for publication as **Single-Agency Statements**. The following pages contain the statements from Oldham Safeguarding Adults Board partner agencies.

Adult Social Care, Oldham Council

Oldham Council is a Local Authority who commit to work cooperatively to serve the population of Oldham. We have statutory responsibilities to signpost, support and provide services to the people of Oldham. Oldham Council and our partners are committed and protect people to live safely, free from abuse and neglect. This is multi-agency partnership working with our communities and partners. We endorse a strong prevention strategy. We endorse our commitment to work in line with the Safeguarding Adults Multi-Agency Policies and Procedures. This is our priority.

We are passionate about safeguarding adults. We promote and protect the human rights, wellbeing, and safety of the people of Oldham to live fulfilled lives.

We have very specific statutory legal duties for preventing, delaying, assessing, and meeting care and support needs of adults under the Care Act 2014. We also have statutory duties to undertake safeguarding enquiries for adults over eighteen years old and to organise Oldham's Safeguarding Adults Board. Within the Mental Capacity Act (MCA) 2005, we are responsible for organising assessments and authorising deprivations of liberty for adults. These are facilitated for individuals in hospitals and care home accommodation when a person is receiving care and treatment deemed to be in an individual's best interests. We also ensure that individuals and their representatives have the information needed to challenge their deprivation if they wish to do so through a 'Section 21A Challenge' process.

Oldham Council undertake these statutory responsibilities as part of Oldham Cares Integrated Care Organisation and deliver them through our Adult Community Health and Social Care services.

Safeguarding and Oldham Council

Safeguarding is our top priority in Adult Community Health and Social Care at Oldham Council. We work with adults aged over eighteen years old who have care and support needs. We support and promote independence and strength-based support to enable individuals to stay well and live safely in their communities, free from abuse and neglect.

Our approach is to work in partnership with adults to make safeguarding personal to everyone by understanding what is important to a person and what they want to happen to stay safe and well. We take a multi-agency approach to safeguarding, working in partnership with other agencies and organisations to support the safety and wellbeing of adults.

We promote the safety and wellbeing of adults. This begins with prevention through strength-based assessments, signposting and building community capacity. This can be facilitated through the assessment and management of risk, ensuring least restrictive approaches whilst promoting wellbeing. The aim of this approach is to prevent abuse by empowering people and communities to be resilient and build support networks to be able to safeguard themselves. We also promptly respond to concerns of abuse and neglect for adults with care and support needs. This involves a coordinating response to concerns, arranging meetings, completing safeguarding enquiries and direct work with individuals and their advocates. We complete protection planning and review plans where an adult is experiencing or at risk of abuse or neglect. At all times we aim to ensure individual's outcomes are at the centre of this process to empower and protect those who are unable to protect themselves from the experience of abuse and neglect.

Our approach is to respond proportionately and in the least intrusive way to the individual at risk. We work with individuals to ensure that they are not illegally deprived of their liberty, and that the care and support they receive is necessary and proportionate to manage the risks to their wellbeing. Alongside our work with individuals, we also work with our care providers, reviewing the quality of services to support the delivery of safe care through support, prevention, and intervention.

The final part of our approach is to work at a systems level to strategically develop and maintain the effectiveness of the safeguarding system in Oldham.

Safeguarding in 2022-23

Throughout 2022-23 key safeguarding themes and trends for Adult Social Care have been:

- Complex Safeguarding - Concerns for individuals at risk of criminal and sexual exploitation have continued to be a trend in safeguarding referrals received by Adult Social Care throughout 2022-23. Thematically, they are complex, requiring person centred, trauma informed responses, mental health assessments, mental capacity assessments (often executive functioning), an outreach approach, the use of legal frameworks, and intensive multi-agency partnership working to assess, manage and reduce risks to an individual's safety and wellbeing.
- Transitional Safeguarding - Safeguarding concerns for young people moving into adulthood have also continued to be a trend in safeguarding referrals received by Adult Social Care. This trend is closely connected to complex safeguarding and thematically also requires the practice responses described above to effectively assess, manage and reduced risks to an individual's safety and wellbeing.
- Who are we working with? - A data informed approach has continued to be used to understand more about the residents we are working with in relation to concerns of abuse, and how we may work most effectively to both prevent and respond where there is a risk of abuse. Safeguarding concerns relating to people living in their own homes and care homes were most frequently reported to Adult Social Care. Neglect and acts of omission remains the highest category of abuse investigated in safeguarding enquiries. Safeguarding enquiry activity predominantly related to adults with physical support needs and learning disabilities.
- Preventative safeguarding - Preventative safeguarding responses and risk management work undertaken at safeguarding concern stage has also been a trend this year. Adult Social Care have seen a 15% increase in safeguarding concerns reported in 2022-23 in comparison to the previous year.

Our top safeguarding achievements in 2022-23 included:

- Complex Safeguarding - Ongoing strategic and operational progress has been made to support our understanding of and response to complex safeguarding. Since June 2022, Adult Social Care has received 93 safeguarding concerns relating to sexual exploitation or abuse. Care Act safeguarding enquiries were required in 43% of cases. Overall risk was reduced for 47% of people, risk was removed for 47% of people, and remained for 6% of people following Care Act safeguarding enquiries and protection planning.
- Transitional Safeguarding - Strategic progress has been made by Children's and Adults Social Care in this area in 2022-23 through the creation of a Transitions Hub. The Hub's work supports strong operational prevention and statutory responses to young people moving into adulthood, including those who are at risk of abuse.
- A One Team Approach - Workforce capacity challenges and safeguarding demand across Adult Social Care have required us to work creatively and flexibly to deliver a safe safeguarding service in 2022-23. The temporary use of a centralised safeguarding team to respond to safeguarding concerns and completing safeguarding enquiries in our locality teams has supported the delivery of a safe service. Embedding triage risk rating systems and a cross service approach to demand has allowed teams to work flexibly in times of peak demand to ensure safeguarding concerns were responded to effectively. Completion of safeguarding enquiries in proportionate timescales and consistent outcomes of risk reduction or removal following safeguarding enquiries and protection planning have been able to be maintained due to this approach.
- Allegation Management - Working in accordance with Oldham Safeguarding Adults Board procedures, awareness raising regarding allegation management concerns has been undertaken in Adult Social Care in 2022-23. Allegation management concerns are now being consistently reported. The Allegation Management Lead role has now been embedded and further work has also been undertaken to enhance the infrastructure needed to respond to these concerns effectively.
- Partnership Working - Adult Social Care have consistently supported the work of Oldham Safeguarding Adults Board, contributing effectively to strategy, board priorities and subgroup activity including the development of policy and procedure, creating and delivering multi-agency training, quality assurance audits, SAR screenings, SAR review panels and delivering against SAR action plans.

Safeguarding Adult Review Learning

Oldham Council representatives worked with partners to develop the OSAB Tiered Risk Assessment and Management (TRAM) Protocol as a direct result of Safeguarding Adult Review learning and feedback from individuals with lived experience. The TRAM protocol endorses mental capacity and individual personal outcomes to lead the multi-agency response. This ensures individual's outcomes are at the centre of all multi-agency working. The TRAM protocol has been adopted by all partners within Oldham's Safeguarding Adults Board.

Making Safeguarding Personal

Adult Social Care have worked in partnership with Oldham Safeguarding Adults Board members to contribute to the creation and delivery of OSAB's multi-agency Tiered Risk Assessment and Management (TRAM) Protocol including the Adult Complex and High Risk Panel (CaHRP). The need for this protocol and panel was recognised from SAR learning. Adult Social Care have actively contributed throughout 2022-23 to the creation, review and revision of the protocol, the delivery of Adults CaHRP and the delivering of the associated training.

In addition, the Strategic Safeguarding Service is supporting the wider service to understand how to deliver the Team Around the Adult approach. Adult Social Care are embedding use of this approach in our practice and actively referring cases to Adults CaHRP to ensure they have appropriate multi-agency risk management plans in place.

Successful Multi-Agency Safeguarding Work

A dedicated operational response to disclosures of non-recent sexual exploitation was implemented by Adult Social Care in 2022. The focus of this work is on wellbeing, safeguarding, and public protection via a person-centred approach. A dedicated and co-ordinated multi-agency partnership approach is in place operationally and strategically to support survivors in adulthood and to assess and manage any ongoing risk to the individual or public.

Safeguarding Priorities in 2023-24

Adult Social Care's key safeguarding priorities going into 2023-24 will be:

- Delivering and evidencing high quality safeguarding services - Adult Social Care will be continuing to prepare for the implementation of Care Quality Commission (CQC) regulation and evidencing the delivery of safe and high-quality safeguarding services.
- Making Safeguarding Personal (MSP) - Adult Social Care aims to deliver high quality safeguarding practice through personalised, strengths based and outcome focused conversations. The Strategic Safeguarding Service will be working to support consistency across the service in the holding and recording of MSP conversations throughout 2023-24.
- Co-production - Adult Social care will be exploring ways in which we can understand the experience of people using our safeguarding services, what helps them, what does not, and how we can co-produce effective safeguarding responses.
- Adult MASH review update and strategy - An updated review and strategy for the Adult Social Care safeguarding front door will be progressed in 2023-24.
- Care home safeguarding - Adult Social Care will to continue to monitor care home safeguarding trends by provider, category of abuse and outcome. We also aim to enhance our data reporting and analysis through conversations with residents, referrers, providers, commissioners, and multi-agency partners in support of high-quality safe care.
- Complex and transitional safeguarding - Adult Social care will continue to progress and implement strategic plans for complex and transitional safeguarding in partnership with Children's Social Care and the wider safeguarding partnership.

Key Challenges

The main challenges going forward will be workforce capacity and increased safeguarding demand. A dedicated workforce strategy, Adult Social Care's Target Operating Model, and preventative and strengths-based approaches will be in place to support us to address these challenges and continue the delivery of preventative and responsive safeguarding services.

A strategic partnership approach will also be taken through conversations with top referring partners to ensure that people at risk of abuse are supported to access the most appropriate safeguarding support and pathways from the point of disclosure or concern.

Greater Manchester Police

Greater Manchester Police is responsible for providing a first line response to the needs of the community. This includes fighting crime, keeping people safe and safeguarding vulnerable people.

Safeguarding and Greater Manchester Police

Vulnerability remains the number one priority within Greater Manchester Police and it is essential that we all work together to protect vulnerable adults living in and visiting our communities. As a force, it is essential that we are in a position to identify and protect the most vulnerable and ensure that our officers and staff are equipped to safeguard and protect vulnerable victims of crime, through early identification of risk and a robust response to identified criminality.

All Greater Manchester Police staff work internally and externally with partnership agencies in order to safeguard vulnerable people. This includes victims of all forms of abuse including domestic, financial, psychological, neglect and sexual abuse, as well as adults at risk of abuse or exploitation. We work to ensure that we achieve the best possible outcomes for all individuals whilst also considering the wider threat posed by perpetrators.

Safeguarding in 2022-23

The key adult safeguarding themes to emerge within the last year include an increase in reporting of domestic abuse with a real focus on encouraging reporting, and accurate crime recording. Domestic abuse is the priority for Oldham district and our focus has been on quality investigations. There has been a statistically significant increase in domestic abuse victims disclosing rape, which is in part due to the work of Independent Domestic Violence Advocates (IDVAs) and other agencies engaging victims, but also an increase in confidence in reporting to the police.

A MARAC, or multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, IDVAs and other specialists from the statutory and voluntary sectors. The number of cases referred to the MARAC in 2022-23 have continued to increase. The numbers have doubled over the last three years, from 582 to over 1000 cases, with 38% of these cases being repeat victims and/or perpetrators.

Since the introduction of non-fatal strangulation (NFS) as a specific criminal offence on 6 June 2022, there has been an increase in recording as GMP staff became better at identifying this as an offence. We have recorded 65% more NFS offences in the last five months compared to the first five months (49 offences vs 81 offences). Controlling and coercive behaviour has seen an 18% increase over the last six months compared to the previous period (114 offences vs 134 offences).

This increase in recording, reflects a truer picture of the crimes occurring in our community and can in part be credited to increased understanding of these offences, aided by training courses such as 'Domestic Abuse Matters' which was attended by all officers within the force.

With a relentless focus on domestic abuse perpetrators in Oldham there has been a 38% increase in the number of perpetrators arrested and charged with domestic abuse. There has also been an increase in the number of civil orders issued, particularly with Domestic Abuse Protection Notices in order to better protect victims.

In Oldham, we have committed further resources to tackling domestic abuse with Operation Resolute, ahead of the force's domestic abuse arrangements review. The focus is both on arresting domestic abuse perpetrators promptly and taking on the more complex investigations. There is a district-wide review being undertaken ensuring that threat, risk and harm is appropriately prioritised and that matters are dealt with in a timely manner.

Following the publicised case at Rochdale, there has been an increased focus for detectives to consider the presence of mould at the scene of an unexpected death. There is work ongoing with HM Coroners and the Serious Crime Division to equip our detectives to deal with these cases and in particular where hoarding has been a factor.

GMP performance in terms of responding to the public has improved dramatically and 999 calls are now answered within four seconds. Our attendance at Grade 1 incidents, where an immediate response is required, has improved and in Oldham nearly 90% are attended within the target of ten minutes.

Mental Health Joint Response cars have been implemented across GMP with the main aim of allowing mental health practitioners, accompanied by a police officer, to attend any calls that the Force Contact, Crime and Operations (FCCO) branch receives regarding someone in mental health crisis. This allows the person to receive the care that they need, when they need it and is seen as best practice.

Operation Lioness was developed to address public safety concerns in our Violence Against Women and Girls (VAWG) strategy. This focusses on areas that have a night-time economy. Officers in both uniform and plain clothes were deployed into hotspot areas and utilised a range of policing powers in order to keep women and girls safe, with a wider impact on the whole community. Licensing officers have been working with premises to increase licensees' understanding of vulnerability and the responsibilities of licensees and their staff to support safety.

Safeguarding Adult Review Learning

GMP has developed an organisational learning hub and embedded organisational learning throughout. We have a process in place where all incidents are reviewed and debriefed. There is a monthly bulletin which highlights the top three learning points in addition to 7-minute briefings which are disseminated and discussed in team briefings.

The GMP Multi-Agency Safeguarding Hub (MASH) team are all trained in triaging and aware of risk factors and how to make use of the OSAB Tiered Risk Assessment and Management (TRAM) Protocol. The Prevention Hub is now established and is identifying repeat callers to the police who may be at risk in order to develop problem solving approaches, to safeguard the caller, but also reduce demand for all agencies.

Cuckooing and modern slavery is being highlighted through intelligence and acted upon, in order to safeguard vulnerable people.

The force policy for Adults at Risk was written by Detective Chief Inspector Lindsay Booth from Oldham who has embedded the Making Safeguarding Personal principals throughout.

Successful Multi-Agency Safeguarding Work

Oldham Police take Making Safeguarding Personal seriously and ran a Domestic Abuse Day of Action locally, known as D-AVRO, which was very successful. During D-AVRO, we engaged with all our partners so there was a range of activity including primary, secondary and tertiary. Ten high risk perpetrators were arrested. School engagement officers, a mental health and trauma practitioner from the Council delivered a talk at Oasis Academy about healthy relationships, control and consent. The IDVA service set up an information stall within the Spindles shopping centre advising the public about domestic abuse and dangerous relationships and showing the 'Eggshells' awareness video. There were also joint visits to the top harm cohort to attempt to prevent future re-offending and Domestic Violence Protection Order (DVPO) checks were completed with MASH and the IDVAs resulting in one arrest to offer safeguarding to the victim.

Safeguarding Priorities in 2023-24

The key GMP adult safeguarding priorities for 2023-24 include:

- Domestic Abuse – as there has been an increase in both our arrest rate and solved outcomes for victims. Additional resources will be invested once the force Domestic Abuse Arrangements Review (DAAR) Project is approved so there is a consistent approach across Greater Manchester.
- Working in partnership to improve MARAC - using the findings from a recent Safe Lives inspection.
- Domestic Homicide Prevention Strategy – evidenced based approach to repeat domestic abuse offending through partnership working.
- Embedding use of the Prevention Hub processes - across the adult framework, following the success with children.
- Improving our intelligence function - to support hidden forms of harm for adults at risk.
- Improving understanding of hoarding and impact of mould on special procedure investigations (death).

Key Challenges

The key challenges for Oldham are replicated nationally in policing. Following the success of the uplift programme, which focused on bringing people from a range of backgrounds and communities, and with a range of different skills into policing, there is an inexperienced workforce who require training and support to deal with the complexities of safeguarding. There is a national issue around the shortfall of detective resources, which again is being addressed through the uplift programme, but there is a knowledge and experience gap. Locally, we are managing this with enhanced training and coaching, using both internal resources and externally through the Oldham partnership training offer. There is a force performance management framework and analytical capability to assess gaps in performance, with a clear governance structure so that issues can be quickly identified and addressed.

GMP has competing demands which are directed by governmental priorities, in addition to the local needs of the people of Greater Manchester. GMP Plan on a Page underpins our approach to improving and ensuring that we move towards being an outstanding force. The national project of Right Care, Right Person is being introduced and will bring opportunities to Oldham to ensure that as a partnership we continue to work closely together.

NHS Greater Manchester Integrated Care

NHS Greater Manchester Integrated Care is a new NHS organisation, overseen by a Board, and is in charge of the NHS money and making sure services are in place to put plans into action. Made up of representatives from the NHS and the local council, we are responsible for making decisions about health services in their area. The partnership operates at three levels: neighbourhood, locality and Greater Manchester and has a single vision and strategy. Hospitals, GPs, community services, voluntary services and others have come together to form 'provider collaboratives' within all three levels, helping to join care and help people live well across Greater Manchester's ten boroughs.

NHS Greater Manchester Integrated Care are committed to providing the care that Oldham people need, to ensuring safeguarding responsibilities are met and to reducing inequality whilst improving outcomes for those in need or at risk.

Safeguarding and NHS Greater Manchester Integrated Care

Safeguarding is fundamental to every aspect of the organisation as we ensure that all our NHS Commissioned Providers such as the GP practices, hospital, community services and mental health services are fulfilling their responsibilities to safeguard those using their services. Our approach is one to support those providing services in Oldham to do so to the best of their ability, recognising vulnerability and risk and having the appropriate methods in place to respond.

NHS Greater Manchester Integrated Care are responsible for the provision of effective clinical, professional, and strategic leadership in regard to safeguarding adults, including the quality assurance of safeguarding through their contractual arrangements with all provider organisations and agencies, including independent providers.

The Safeguarding Team is a fundamental part of our commissioning and contractual process; ensuring NHS funded services are delivering safe and effective care. We are committed to the protection of adults and preventing abuse. The Designated Nurse Safeguarding Adults for the Oldham locality represents NHS Greater Manchester integrated Care on the Oldham Safeguarding Adults Board as a professional advisor and on various Subgroups. The Head of Nursing and Quality for the Oldham locality provides the executive level oversight on the Board.

The Safeguarding Team maintain excellent operational links with Primary Care, the team deliver regular safeguarding training sessions as well as opportunities to discuss updates and learning from reviews in the GP Safeguarding Lead Forum. The Designated Professional Team undertake assurance activity with all commissioned providers.

Safeguarding in 2022-23

This year saw an organisational shift from the ten locality Clinical Commissioning Groups across Greater Manchester joining to become one Integrated Care Board. The year also saw the recruitment completed to all posts within the ICB safeguarding team, which had been carrying some vacancies previously. The complements of the full Safeguarding Team to the Oldham Integrated Care place-based team brings expertise from learning disability, mental health, nursing and social work.

Strengthening safeguarding practice across primary care and those delivering nursing care packages has remained a priority during these changes. An area of growing concern where we have focussed our support as a team is the transition of complex care packages from children to adults. Cases become complex when themes arise around mental capacity and consent, exploitation, and balancing people's safety and choices around the care they receive.

All GP practices met with a member of the safeguarding team over 2022/23 to review their safeguarding assurance audit. This provided the opportunity to discuss any gaps in practice and knowledge and support to develop an action plan to meet those areas. Oldham has seen a low uptake of the Covid vaccination and flu jab, particularly amongst residents who have a learning disability. A process has been established to support the vaccination programme for those patients who lack mental capacity to consent which guides practitioners to assess mental capacity, consider making best interests decisions, and escalating cases as needed for decisions to be made in the court of protection (when disagreements arise between health professionals and family members).

Safeguarding Adult Review Learning

Safeguarding reviews give us the benefit of hindsight and the opportunity to change to make things better. One area we have focused on this year is the development of Routine Enquiry for domestic abuse/ violence with GPs. Routine Enquiry involves asking all women at assessment about abuse regardless of whether there are any indicators or suspicions of abuse. It was established in maternity, sexual health, health visiting, substance

misuse and mental health settings. A series of newsletters and training sessions have aimed to include this into General Practice.

Significant work has also taken place across partnerships in Oldham to embed the learning identified from SAR cases in relation to the importance of independent interpreters being used, for individuals who do not speak English as their first language. Case reviews have identified that the lack of interpreters used in some cases has led to individuals unintentionally being subjected to health inequalities from services. The ICB are committed to reducing health inequalities across our system.

Successful Multi-Agency Safeguarding Work

The Designated Professional for Safeguarding Adults has supported the Safeguarding Adults Board to develop multi-agency pathways and policies, particularly the development of a Complex Safeguarding and Exploitation Strategy for adults, Pressure Ulcer Safeguarding Guidance, a Domestic Abuse Policy and a Mental Capacity Policy.

Safeguarding Priorities in 2023-24

To further strengthen practice around domestic abuse within Oldham, we aim to employ an Independent Domestic Abuse Advisor role within Primary Care services. This role will work with practices on specific cases, particularly those that are assessed as high risk and work to strengthen systems GPs use to record and report domestic abuse. The funding for this post has been agreed and will cover the post for a fixed term two year period. The post will work closely with the Local Authority IDVA team but will be managed by the Designated Professional for Safeguarding Adults within the ICB Oldham locality.

The Designated Professional will aim to work with key partners from the Safeguarding Adults Board to further strengthen the offers that are currently available across GM in relation to Modern Day Slavery. The Oldham Modern Slavery toolkit will be reviewed to strengthen existing pathways for individuals identified as victims. The toolkit will be shared across the Greater Manchester ICB footprint to ensure that a consistent approach is taken to tackling modern slavery and we are committed to working across the system to reduce silo working and health inequalities. Modern slavery is when an individual is exploited by others, for personal or commercial gain. Whether tricked, coerced or forced, they lose their freedom. This includes but is not limited to human trafficking, forced labour and debt bondage.

The Designated Professional will work collaboratively with the OSAB and the Greater Manchester system to ensure all safeguarding priorities are cited, and any national issues are discussed at a locality and system level.

Key Challenges

The NHS Greater Manchester Associate Director of Safeguarding and Nursing has designed a safeguarding structure which reflects a system wide approach to safeguarding and aims to bring all ten localities together to work in a holistic and cross area supportive way. The change of approach from locality to a whole system will take some time to embed and understand the requirements of the designated professionals role for locality and the system. Statutory safeguarding requirements within all localities will continue to be maintained along with the statutory ICB contribution to the OSAB. The change brings exciting opportunities for safeguarding learning to be shared and embedded across the Greater Manchester footprint to promote good practice and early identification of themes. The integrated system will also provide robust safeguarding governance across Greater Manchester.

Action Together

Action Together Community Interest Organisation is the infrastructure organisation for the voluntary, community, faith and social enterprise (VCFSE) sector in Oldham, Rochdale, and Tameside. We connect people with what's happening in their community, develop community ideas into action, strengthen local organisations, and provide strategic influence for the charity and voluntary sector.

Safeguarding and Action Together

Safeguarding runs through everything we do within the organisation. Our approach is to ensure that all our staff and volunteers have awareness and training at the right level for their role with us. This means that all our staff and volunteers including our emergency response volunteers undertake a Safeguarding awareness training session that covers both Safeguarding Children and Safeguarding vulnerable adults. Our Social Prescribing teams receive further detailed training as part of their induction and ongoing Continuing Professional Development.

We also deliver Safeguarding Children and Vulnerable Adults awareness training to anyone in Oldham who works or volunteers in the VCFSE as part of our regular training programme. We also support VCFSE organisations to achieve our Quality in Action Award, the locally recognised quality assurance award for VCFSE groups and organisations. One of the Question and Answer modules focusses on Safeguarding

and ensures that groups and organisations have appropriate Safeguarding policies, procedures, and training in place for their staff and volunteers, and also focuses on safer recruitment practices for staff and volunteers.

Safeguarding in 2022-23

The key adult safeguarding themes for Action Together in 2022-23 were risk of suicide or self-neglect, closely connected with housing issues and the need for a multi-agency approach between substance misuse services and mental health.

As the Local Infrastructure Organisation for the Voluntary, Community, Faith and Social Enterprise (VCFSE) Sector one of our key functions is capacity building for volunteers and staff in the sector. To this end, we deliver a regular programme of Safeguarding Adults at Risk Training. In 2022-23, we invested in refreshing our train the trainer offer for our team who deliver this training to staff and have updated our training materials to reflect recent Safeguarding Adult Review learning.

We have refreshed our Designated Safeguarding Lead (DSL) level 3 training. Our DSL provided support for the community groups who were delivering 'Warm Banks' as part of the cost of living crisis response.

Within the Social Prescribing Service, our top achievements were working closely with the Adult Referral Contact Centre (ARCC) as the new adult front door, being able to discuss cases before referral to ensure any possible safeguarding issues are highlighted at the start and so an informed multidisciplinary team approach can be implemented at the earliest possible point. We have also embedded the new Adults Complex and High Risk Panel (CaHRP) process and have successfully escalated cases where it has been complex or challenging to engage other professionals in the Team Around the Adult approach.

Safeguarding Adult Review Learning & Making Safeguarding Personal

We have embedded Safeguarding Adult Review learning into our refreshed training materials for the VCFSE sector workforce and have shared the learning materials via our regular comms channels within the sector which includes new web articles, our training bulletin, and our 'Community News' bulletin reaching around 1500 staff and volunteers in the sector.

The Social Prescribing team have attended training and briefings hosted by the Safeguarding Board. We have embedded the Team Around the Adult approach to ensure a consistent approach to working across prevention and those who need additional support. Several Link Workers have now started to take the lead at Team Around the Adult meetings. We have worked directly with the Local Authority Safeguarding Lead on a case that needed a Team Around the Adult approach around risk associated with hoarding, self-neglect and being taken advantage of by people in the community.

Successful Multi-Agency Safeguarding Work

Mr F was referred to Social Prescribing by the MASH team. Mr F is substance dependent and has a diagnosis of Schizophrenia. He lives with a friend who he met while living in a children's care home, he is also known to be the perpetrator of domestic violence toward his friend. He had been stopped carrying a knife and was also known to be the victim of attacks in the community. He had wounds from intravenous substance use that were not being treated.

Mr F is also deaf and had not received any support with his hearing aids which had resulted in his friend pretending to be him when professionals had been ringing. Mr F had a long history with substance services. Due to the risks and staff struggling to get the appropriate professionals involved we escalated the case to the Adults CaHRP, following on from meetings with the District Nursing team who also had significant concerns but were unable to visit the address due to risk. A referral was then accepted to Changing Futures resulting in Mr F being able to receive the intensive support for those experiencing multiple disadvantage. The outcome has been that we have collectively been able to work differently around how Mr F has his health needs met.

Safeguarding Priorities in 2023-24

Action Together priorities for 2023-24 will include:

- Further development of the workforce development offer for the VCFSE around adult safeguarding key themes, we have secured some external grant funding to increase our capacity to develop our broader workforce development offer, and a key priority will be around safeguarding.
- The Social Prescribing team will continue to contribute to the development of place-based integration to ensure multi-disciplinary team and integrated working improve outcomes for residents.
- The Social Prescribing delivery model will be transformed to enable us to place a Link Worker within the ARCC team. This is a key development to ensure that the step-up and step-down pathway between Adult Social Care and Social Prescribing continues to be stronger
- Development of the relationship between Social Prescribing, Adult Social Care and Children's Social Care and Early Help to strengthen the whole family, whole household approach.

Key Challenges

We expect that the key challenges going forward in relation to Adult Safeguarding for Social Prescribing will be for us to continue to have the ability to respond to the level of demand, both in terms of the number of referrals, and the complexity of people's situations. We will continue to demonstrate our commitment to integrated working to ensure improved outcomes for adults.

Age UK Oldham

Age UK Oldham is a local autonomous charity offering services and support for older people in the borough. Aiming to improve their quality of life we work both independently and in partnership with other local statutory and voluntary organisations to provide practical services and timely effective support for those who need it the most.

Safeguarding and Age UK Oldham

Safeguarding is fundamental to the work we do and is everyone's responsibility. Training of all staff, volunteers and contractors who meet routinely with older people is essential, ensuring they recognise any potential issues and instilling confidence in them to assist.

Equally important is our prevention strategy, both in taking a person-centred approach to individuals and ensuring our services are designed to help people to live safely and independently for as long as possible.

Much of the work we do involves seeing people in their own homes giving us an opportunity to offer assistance if improvements are needed and have an oversight of their relationships with others.

Keeping a watchful eye and making sure that we have regular contact with older people, their families and partner agencies is key to ensuring their safety and wellbeing.

Developing a relationship with our participants helps us to identify problems as they arise. For example, our Falls Prevention team keeps in contact with participants at our weekly classes and through telephone welfare calls. Also, our Life Story project volunteers are trained to pass on any concerns identified through visits and phone calls. We then proactively offer support in order to maximise independence and reduce vulnerability.

Safeguarding in 2022-23

During the past year the 'Cost of Living Crisis' has affected pensioners on a fixed income and for some, led to an increase in referrals relating to Hoarding. This has emerged as a concern for older people who have become anxious and isolated in later life and often leads to self-neglect and poor health. Taking time to grow relationships whilst slowly helping to declutter their homes in a non-judgemental way is how we at Age UK Oldham gain trust and slowly introduce other agencies, services and activities to augment their support network and prevent reoccurrence.

Becoming victims of scams has become more prevalent in this age group. Living alone without support leaves householders open to doorstep, phone, mail and online criminals who are adept at recognising signs of potential vulnerability. Older people are more susceptible to financial abuse when they become lonely or isolated and most of our services delivered in the local community focus on prevention and inclusion to ensure that people have the confidence to approach our staff with their concerns.

Prevention has always been our mantra and so:

- When campaigning to raise awareness of scams, we flooded our charity shops, community settings, activity groups, care settings, home deliveries etc with literature bearing the headlines 'STOP LOCK CHAIN CHECK' and distributed leaflets demonstrating the various devious ways people could be hoodwinked. We clearly outlined very simple clear strategies to avoid being coerced and urged people to say NO until they had followed advised precautions.
- We took advantage of the Oldham Safeguarding Adults Board wide variety of training offers with the online sessions being particularly valuable and accessible. This meant that we have been able to reach every level of our workforce and have great examples of safeguarding alerts from staff who come into contact with the general public and have recognised issues of concern in areas that would not have come to our attention. For example, one of our charity shop staff recognised possible signs of coercion and possible mental health distress in a customer. We immediately alerted the Safeguarding team who confirmed our suspicions and then were able to act at a very early stage to support the individual involved.
- From our experience, the development of Oldham's Adult Referral Contact Centre team and our growing relationship with their staff has enabled closer working relationships. It has given us greater opportunities to discuss possible safeguarding issues informally to agree the best routes forward.

Safeguarding Adult Review Learning

A Safeguarding Adult Review case that we were involved in recently highlighted the importance of multi-agency information-sharing. In this case we were brought in to provide a regular delivery service to a vulnerable person who had a high level of complex needs. Unfortunately, we were not privy to the full complexities of this case which resulted in us missing vital clues such as being unaware that the individual may have been restricted by others when communicating with us. We learnt a valuable lesson here that non-acceptance of services and/or lack of response should not always be taken at

face value and should be followed up.

Another valuable lesson learnt here is that organisations involved in multi-agency case working need to communicate with each other fully and recognise the importance of every agency's touch point with an individual – no matter how 'low level' this interaction may be. Having contact with clients in this way enables us to gain and share information (albeit confidentially) which is highly invaluable in alerting and managing risks.

Successful Multi-Agency Safeguarding Work

We have learnt to consider what an individual wants regardless of how it fits into the statutory systems, and we work with people to enable them to make real choices without judgment. For example, we worked with a client who experienced low mood and lived in a hoarding environment who we supported in a person-centred way. We offered support at the pace they wanted, to build up trust and prevent distress and anxiety and we worked in the 'Team Around the Adult' Model with multi-agency professionals to optimise how best they could be supported. Although it took a considerable length of time, working with what this client wanted provided us with a successful outcome. This demonstrates how we have incorporated new protocols and learning from Safeguarding Adult Reviews.

Safeguarding Priorities in 2023-24

We are positive that training from OSAB has been invaluable and is reaching all levels of staff. We find the sessions engaging and user-friendly in that they provide options for flexible, remote learning. The continued provision of a choice of dates also contributes to the higher uptake of the training by our staff.

Our continued offer to provide home visits (including benefits claims and form-filling) remains a key priority for us, especially as the aftermath of Covid generally changed working practices and reduced face-to-face contacts. This in-person contact is paramount in recognising risks and raising alerts for safeguarding in the community.

Key Challenges

The lack of funding for established preventative services will be a key challenge. We will continue to deliver an efficient and effective service that meets the objectives of our funding agreements and will collect and share data to prove the value. This will support us with future funding applications. We will support and work with partner organisation to optimise resources.

We will continue to deliver high quality, social activities which support people living with early dementia, low mood, anxiety, isolation etc - all the issues that leave people vulnerable to scams, cuckooing etc. We will provide information and support at these sessions to prevent such safeguarding incidences.

Access to primary care is a challenge for older people and their carers in that they are often not able to get a GP appointment at an early stage to support with diagnoses and pathways of early help and support. We will continue to provide our support services to those in need to help to alleviate the pressure these clients face.

Healthwatch Oldham

Healthwatch Oldham (HWO) is the consumer champion for health and social care in Oldham. Our role is to gather the views of local people to help shape the way services are provided, understand what is important to service users, and hold services to account. HWO plays a key role engaging with hard to reach and vulnerable groups across Oldham.

Safeguarding and Healthwatch Oldham

HWO carries out four key roles that support the safeguarding agenda. These are to ensure the voices and experiences of service users are heard and fed into the planning of services; to help shape the design and delivery of health and social care services; to hold services to account; and to support the resolution of any NHS complaints and ensure lessons are learnt. HWO achieves this by:

- listening to people, especially the most vulnerable, to understand their experiences and what matters most to them, and involving people in the commissioning and scrutiny of health and social care services
- influencing those who have the power to change services so that they better meet people's needs now and into the future
- enabling people to monitor and review the commissioning and provision of care services
- providing information and signposting support
- empowering and informing people to get the most from their health and social care services and encouraging other organisations to do the same

- working with a network of health champions to improve services and to empower local people
- providing an independent complaints service.

HWO representation ensures compliance with the statutory Care Act requirement to include Healthwatch organisations as part of the development of strategic plans. Through our NHS Complaints work, HWO is a key independent resource for people to report safeguarding concerns and incidents.

HWO ensures that the person is placed at the heart of any review and has evidence to show that lessons learnt, particularly from safeguarding incidents, are used to reshape services and inform the training of front-line staff.

HWO is also a member of the Oldham Advocacy Steering Group designed to give adults at risk a voice to challenge services and report on safeguarding issues.

HWO has policies to ensure all staff are trained in safeguarding and the Mental Capacity Act and clear processes are in place to ensure safeguarding cases are subject to wider scrutiny by senior staff who are the named safeguarding leads for Healthwatch. Where appropriate, cases are escalated to statutory partners.

Safeguarding in 2022-23

One of the key safeguarding themes that we have picked up over the last year, include the difficulty asylum seekers and refugees have faced in registering with GP practices. This is because some Practices have rules, around asylum seekers and refugees needing ID and proof of address to register. In our view this put asylum seekers and refugees at safeguarding risk. Information has now been shared by Oldham ICB with GP Practices to outline the national guidance from NHS England allowing asylum seekers and refugees to register with a GP. In addition, issues in relation to the following have been raised with us: dentistry, people living with dementia, and cancer screening targeting the LGBT community.

Successful Multi-Agency Safeguarding Work

We were commissioned by the CQC to undertake engagement work to understand the experiences of family members and loved ones who will have accompanied mothers through the maternity services journey. This has help identify risks, and safeguarding issues, during the maternity experience and journey.

Safeguarding Priorities in 2023-24

- Hospital Discharge Project: we hope to work with Royal Oldham Hospital to identify safeguarding issues that may arise out of hospital discharge experiences.
- Our Young People Mental Health Survey will soon be published to identify safeguarding links to young people's mental health.
- We want to build on our Wheelchair Users Survey and Report and hope this will become part of a larger piece of work looking at peoples' experiences of accessibility and helping raise awareness with all services, in particular health and social care, on the challenges faced by those who require the use of a wheelchair.

Key Challenges

Given the challenges post Covid-19 our priorities are under regular review, and this should be a shared approach. We remain focused on coordinating engagement plans between partners so that they are designed to reach out to the most at-risk groups. This will include gathering views as part of the changing landscape of services as we work with the new neighbourhood clusters. This work will also support the development of the OSAB and ensure we meet our statutory duty to gather service users input as part of the development of the Safeguarding Adults Strategic Plan.

Another priority is reviewing the way that different organisational complaints processes tend to work in isolation. We hope to pick this up through our informal complaints work. Whilst confidentiality will be a key factor this means that safeguarding trends emerging across organisations are hard to identify or may be missed. We would like to work with partners to examine emerging safeguarding trends that may arise.

Healthwatch Oldham will continue to work with key stakeholders within the Oldham locality to ensure patient voice and patient experience around all issues relating to safeguarding remains a top priority.

KeyRing Living Support Network

KeyRing provide person centred support for people to live independently in the community. Our support is designed to build more interdependence and offers an alternative to traditional support. By linking in with existing community resources, the vulnerable adults we support will become active citizens who contribute to and are valued by their local community. This asset-based community development approach means that the local community assets (people, resources etc) and individual's strengths unlock sustainable community development and ensure that adults live the life they choose.

Safeguarding and KeyRing

Safeguarding is a priority in our organisation to enable us to meet the needs and manage risks for the vulnerable adults we support. We provide a person centred approach and involve our members in every safeguarding decision by gathering their views on how they want to progress whilst balancing our Duty of Care responsibilities.

We provide ongoing training to our teams and work in partnership with Oldham Safeguarding Adults Board, Adult Social Care and Health teams to ensure a joint working approach.

Safeguarding in 2022-23

In 2022-23, the KeyRing team in Oldham raised the most safeguarding alerts in relation to sexual abuse, self harm and domestic abuse.

We reviewed all of our policies and procedures including updating guidance for members and volunteers. The leadership team tried out a new way to display and order the policies and procedures and grouped them into the following headings which all have a bearing on safeguarding: Member Related; Person-Centred Support; Positive Risk Taking; Safeguarding; and Easy Read Safeguarding Guides. In addition we have developed a new member handbook, a new internal safeguarding and incident form and reporting process, a national safeguarding reference group and a new trustee with safeguarding oversight.

The OSAB Tiered Risk Assessment and Management (TRAM) protocol has been embedded into the KeyRing Team in Oldham. We have also shared the guidance with our Senior Safeguarding Lead and also presented the protocol to Area Managers across the country as good practice.

We have shared the OSAB guidance on MCA, Hoarding, Self-Neglect and Engagement with the KeyRing team in group supervision and have also offered OSAB training to the team.

Safeguarding Adult Review Learning and Making Safeguarding Personal

KeyRing have a quarterly Safeguarding Reference Group (SRG) that looks at any trends or concerns found in safeguarding logs that have a national impact so we can put measures in place to address these. These meetings cover a whole host of topics including the Making Safeguarding Personal (MSP) principles and practice as well as learning from SARs.

KeyRing is committed to 'outcomes focused safeguarding' where the individual's needs and wishes are central to the development of personal outcomes. Through the KeyRing Safeguarding process and form, we support people to:

- think through their desired outcomes and the purpose of any safeguarding intervention(s) and,
- consider how they want to be supported to recover from their experience of abuse and neglect.

By having a focus on 'outcomes' at the start, and throughout, the process ensures a greater focus on the person at the centre. Safeguarding should not restrict people from living the life they choose and the KeyRing Positive Risk Taking Policy provides guidance on creative approaches to supporting people manage their risks.

We have Easy Read Safeguarding Guides for members that follow Making Safeguarding Personal principles, that are also included in our new Member Handbook. These guides were developed in conjunction with KeyRing self-advocates.

KeyRing have recently reviewed and rolled out new safeguarding policies and procedures. The hope is by engaging well with members, these can help support excellent safeguarding practice. Our Safeguarding policies and procedures are underpinned by the six principles of safeguarding and follow the Making Safeguarding Personal principles.

KeyRing's national hub development programme incorporates core training modules that members can access on Making Safeguarding Personal, delivered by the Practice Development Lead (PDL) and developed alongside KeyRing's national Member Voice Group. Oldham managers have regular meetings with the business development lead and work through pre-tender templates which includes questions related to

safeguarding such as, '*provide an example of a safeguarding incident that you have reported to the Local Authority, detailing how Making Safeguarding Personal principles were applied and how you worked in partnership with other agencies to achieve a positive outcome for the member*,' and '*describe any connections you have with the local Safeguarding Board or safeguarding workgroups that feed into the Safeguarding Board*.' This helps keep Making Safeguarding Personal principles live for managers.

Throughout 2022-23, the SRG sessions covered key topics including any SAR learning. Managers regularly feedback their experiences as part of the group. The SRG provides an opportunity for managers to learn from each other which enables any change in practice to be identified and implemented. Oldham managers attend the SRG and have talked through a recent SAR that came out of a complaint from a family member, the process that was followed and what it entailed. Oldham managers also talked through the learning and the outcome with a group of peers as well as members of the KeyRing leadership team. Seven-minute briefings from OSAB are regularly used in the SRG and shared amongst the teams not only in Oldham but nationally. SRG regularly cover learning from serious case reviews which contain case studies from Adult Safeguarding, Child Safeguarding and Victims of Domestic Homicide Reviews. The group have covered what to expect from a SAR; case studies showing the importance of professional curiosity; and best practice examples such as the TRAM protocol in Oldham. Learning is shared and the minutes are distributed to all managers nationally at weekly meetings.

SRG have also discussed strengths based support approaches to engagement and how this relates to Safeguarding. KeyRing has a blueprint of how we should approach support and have always aimed to practice strengths based (or asset-based) support focusing on an individual's strengths and working in a holistic and multidisciplinary way which works with the individual to promote their wellbeing, but engagement in key.

KeyRing recognise Safeguarding Adults Week every year and put out special briefings. We also support and encourage teams to do themed sessions with members sharing information and resources.

Successful Multi-Agency Safeguarding Work

KeyRing were involved in a complex safeguarding review for a member who was experiencing domestic abuse and coercive control. The member has a complex mental health diagnosis and also uses none prescribed medication as pain relief for her physical health issues. At the time she was staying on a mental health ward and she needed a multi-agency approach to move back into independent living whilst minimising the risks. We worked closely within the OSAB TRAM protocol which was not initially picked up by Adult Social Care and gained advice and guidance from the Local Authority Safeguarding Lead who also joined the meetings. The Team Around the Adult meetings brought all the relevant agencies together to discuss what action needed to be taken. The case was taken to Adults CaHRP and further advice and guidance was gained. In this particular case, the perpetrator had not been apprehended by police for five months and this presented a risk to the member and staff. He was eventually apprehended and the member was able to move home safely with further support in place to meet her care and support needs.

Safeguarding Priorities in 2023-24

Our key adult safeguarding priorities for 2023-24 will be to:

- embed Making Safeguarding Personal principles and practice into our new safeguarding form and process on care control
- deliver and embed the Making Safeguarding Personal hub sessions with members using the new safeguarding guides in the members handbook
- continue to raise awareness of safeguarding themes and topics that are coming through our internal logs affecting our membership and change practice where identified as part of the SRG.

Key Challenges

KeyRing are still experiencing difficulties in recruiting to support positions and support volunteers. This has been the case since Covid-19 struck and it has created a significant issue for the health and social care sector. This affects the team capacity for the number of cases we can support and also the time available to monitor and support complex safeguarding reports. To support this we have begun to embed Making Safeguarding Personal into the staff and volunteer inductions at a very early stage and this is also included in the online training that new starters complete prior to meeting any members. We also include safeguarding good practice at every group supervision session and one to one Supervisions.

There is still some work to be undertaken to embed the OSAB TRAM Protocol on a multi-agency basis as KeyRing are still receiving varying responses from partners. Some teams are very aware of the protocol and follow it correctly however others are less aware. KeyRing will continue to promote the protocol with other professionals in Oldham.

Pennine Care NHS Foundation Trust

Pennine Care NHS Foundation Trust is proud to provide Mental Health and Learning Disability services to people across Greater Manchester. We serve a population of 1.3 million and our vision is a happier and more hopeful life for everyone in our communities. More than 4,000 dedicated and skilled staff deliver care from around 200 different locations in five boroughs.

In Oldham, our Mental Health teams provide care and treatment for people with mild to moderate conditions such as depression, anxiety or dementia, or more serious Mental Health illnesses such as schizophrenia and bi-polar disorder. Our services include Healthy Minds (psychological therapies), psychiatric intensive care, and rehabilitation services. Our Learning Disability services are for people with a moderate to profound level of Learning Disability. Our Child and Adolescent Mental Health Services (CAMHS) are committed to providing a comprehensive and targeted intervention which positively aims to promote the emotional and psychological wellbeing of our children and young people.

Safeguarding and Pennine Care NHS Foundation Trust

Pennine Care NHS Foundation Trust continues to be committed to ensuring the principles and duties of safeguarding adults at risk are holistically, consistently, and conscientiously applied at the centre of what we do. Safeguarding adults is 'everyone's responsibility'.

Our Trust Safeguarding Strategy recognises a 'Think Family' approach as children, adults and their families and carers do not exist or operate in isolation. Our safeguarding families team, including a Named Professional Safeguarding Adults provides training, advice, support and guidance to all our staff working in Oldham.

Our integrated leadership model, supported by the North Network Director for Quality, Nursing and Allied Health Professionals and Oldham Head of Quality enhances the work of our services and supports our commitment to the Oldham Adults Safeguarding Board and respective Sub Groups.

All our staff have the responsibility to promote the welfare of any child, young person, or vulnerable adult they come into contact with and in cases where there are safeguarding concerns, to Act upon them and protect the individual from harm, under the Care Act 2014.

Our Community Mental Health Team (CMHT) takes a proactive approach and will make enquires to establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. Moreover, the CMHT will support with ongoing duty work, information gathering, Making Safeguarding Personal, supporting individuals and families, working with partners, attending strategy meetings, organising, and attending case conference meetings and along with the management team taking on the role of Safeguarding Adult Manager (SAM).

All staff work in line with our Safeguarding Families Policy and local multi-agency safeguarding policy and procedures and there are robust processes for the management of incidents and complaints.

Safeguarding in 2022-23

Based on consultations undertaken by the safeguarding team, the key safeguarding themes for Pennine Care NHS Foundation Trust in 2022-23 were domestic abuse, financial abuse and disclosures of historic childhood sexual abuse.

During 2022-23:

- A MARAC lead role has been created and recruited to in the borough to allow for improved multi-agency response to domestic abuse.
- The safeguarding team has significantly increased compliance with Level 3 safeguarding training for practitioners in the Trust.
- The team has also completed work around safeguarding supervision and now offer this to adult colleagues in the form of a drop-in.
- The safeguarding team have responded to a 122% increase in consultations and advice. This demonstrates the emphasis placed on safeguarding practice by our practitioners.
- A policy has been written to support the safeguarding of those who struggle to engage with appointments.

Successful Multi-Agency Safeguarding Work

The Named Professional Safeguarding Adults has been heavily involved in the production of policies alongside the Safeguarding Adult Board's Business Unit and partners and has also written the Greater Manchester Missing Person's policy.

Making Safeguarding Personal & Safeguarding Adult Review Learning

Making Safeguarding Personal features in Level 3 Adult Safeguarding Training. The safeguarding team offer insight to all incidents received through our incident reporting system and prompt Making Safeguarding Personal throughout. Learning from Safeguarding Adult reviews is cascaded through our monthly safeguarding update through our Quality Forums. This is bolstered by lunch and learn sessions.

Safeguarding Priorities in 2023-24

Priorities for Pennine Care NHS Foundation Trust in 2023-24 will be to:

- continue to embed safeguarding supervision with adult-facing practitioners
- continue to respond to themes from Serious Case Reviews and Safeguarding Adult Reviews
- develop stronger ways of recording learning centrally
- develop guidance on peer-on-peer abuse
- enhance work on domestic abuse.

Key Challenges

Key challenges for Pennine Care NHS Foundation Trust are around compliance with the Mental Capacity Act Training and we are managing this through a Task and Finish group to overhaul the training and make it more accessible to all staff.

Northern Care Alliance NHS Foundation Trust

Oldham Care Organisation and Community Services functions come under the wider remit of the Northern Care Alliance NHS Foundation Trust (NCA). NCA provides a range of healthcare services including The Royal Oldham Hospital and the Oldham Care Organisation. NCA is responsible for delivering safe, clean, and personal care to the community it serves.

Safeguarding and Northern Care Alliance

The Care Act (2014) provides statutory legislation for adults at risk, it is expected that health will co-operate with multi-agency partners to safeguard adults. NCA Care Organisations have a responsibility to provide safe, high-quality care and support. The wider safeguarding context continues to change in response to the findings of large-scale enquiries, such as Francis (2013), Lampard (2015), legislation such as the Care Act (2014) the (2019) amendments to the Mental Capacity Act (2005) and the more recent Domestic Abuse Bill (2021).

Contextual safeguarding issues present all agencies with new challenges in recognising and responding to cross generational, cross border risks affecting all aspects of the societies in which we all live.

To represent the Oldham Adult Safeguarding Agenda, responsibility and accountability is embodied at board level and is encompassed within the NCA Chief Nurse role and responsibilities. The operational and strategic delivery of the Oldham Safeguarding Adult programme is led by the Assistant Director of Nursing for Safeguarding Adults for the Northern Care Alliance under the Leadership of the NCA Group Associate Director of Nursing for Governance & Corporate Nursing, the Deputy Chief Nurse for NCA and Director of Nursing Oldham Care Organisation.

Safeguarding in 2022-23

The Adult Safeguarding Service operate across the wider footprint of the NCA offering support and advise to all staff, service, and departments. The demands on the service remain multifaceted, complex, and challenging with varying themes emerging across the NCA landscape. The emerging themes of Self Neglect and the application of the Mental Capacity Act (2005) remain challenges with particular reference to disguised compliance and executive functioning. As such, the NCA Adult Safeguarding Service ensure this element of safeguarding remains a priority, delivering a bespoke training programme to areas identified as benefiting from additional training outside of the aligned NHS England Core Skills Framework and Mandated Adult Safeguarding Level 3 programme of training.

During the period 2022-23, the Adult Safeguarding team has continued to strengthen the existing embedded Adults Safeguarding practices across the organisation, achieving full compliance threshold for Adult Safeguarding Level 3 programme of training, as outlined in the Greater Manchester Contractual Standards Requirements.

In addition, the development of a new Standard Operating Procedure to triangulate internal governance and inquest reporting arrangements with regards to learning from SARs has strengthened connectivity offering wider contextual learning across the NCA.

The NCA Adult Safeguarding Service have successfully embedded a programme of Mental Capacity Act (2005) audit. Building on this success, the Service are currently in the process of introducing and extending the programme of audits to include Oldham Community Services.

Making Safeguarding Personal & Safeguarding Adult Review Learning

A collaboration across workstreams within Royal Oldham Hospital and Community Services includes increased visibility across all wards and departments to support with Adult Safeguarding concerns. This includes the Royal Oldham Hospital Emergency Department whereby daily drop-in sessions are facilitated by the Safeguarding Named Nurse and Safeguarding Specialist Practitioner, thus offering additional safeguarding support and placing the person at the centre of the safeguarding concern within these areas.

To ensure Adult Safeguarding measures are embedded in every day practice, Senior Management and Safeguarding Assurance visits across wards and departments are scheduled on a fortnightly basis. Identification of safeguarding concerns, are addressed during the assurance visits with additional training raised as a priority as required.

The NCA encompass a Nursing Accreditation System (NAAS) inclusive of community services and theatres. The NAAS/ CAAS/TAAS provides a programme of audit aligned with the Care Quality Commission (CQC) key lines of enquiry. Inclusive within the programme of audit are the safeguarding standards, providing further assurance that safeguarding measures are routinely audited. The Safeguarding Service support the NAAS/CAAS audit programme providing safeguarding advice with questions and answers within relevant internal learning environments within Royal Oldham Hospital.

The learning from SARs and Domestic Homicide Reviews (DHRs) are a core agenda item held within the governance structure of the Safeguarding Steering Group within Royal Oldham Hospital, discussed at length, with learning disseminated to the wider staff groups within each service, team safety huddle and Multidisciplinary Teams.

Successful Multi-Agency Safeguarding Work

The NCA Safeguarding Service are a key contributor to the Oldham Safeguarding Adult Board and it's subgroups. Recent contributions to the subgroup included the undertaking and sharing of a quality assurance audit framework conducted across Royal Oldham Hospital and Oldham Community Services. The MCA Audit Framework captures the MCA activity across the organisation and highlights specific areas for improvement with regards to the principles outlined in the legal framework, thus creating a focus when undertaking the assurance visits across Royal Oldham Hospital. The sharing of the audit model and pathway has enabled a streamlined systematic approach to the data collection and interpretation of findings with regards to multi-agency application of MCA across the borough of Oldham.

Safeguarding Priorities in 2023-24

The NCA Adult Safeguarding Service will continue to:

- work towards achieving full compliance with the Contractual Safeguarding Standards outlined in the Greater Manchester Contractual Standards for Safeguarding Children, Young People and Adults at Risk under the arrangements of the Integrated Care Board.
- deliver the Adult Safeguarding Level 3 and MCA training programme across the NCA.
- strengthen the governance and reporting arrangements for SARs and DHRs, thus embedding the recommendations and learning across the NCA.
- work towards the priorities of Oldham Safeguarding Adults Board.

Key Challenges

Despite the achievement of full compliance threshold for Adult Safeguarding Level 3 training, challenges remain with regards to staff continuing to incorporate Adult Safeguarding practices once this programme of training has been undertaken. Hence, to address this concern the Adult Safeguarding Service will continue to offer visibility, and advice to all wards and departments within Royal Oldham Hospital and Oldham Community Services offering further assurance that Adult Safeguarding practices remain embedded in every day practice.

Doctor Kershaw's Hospice

Dr Kershaw's Hospice provides palliative and end of life care for the people of Oldham who have a life limiting condition. This specialist care extends across an Inpatient unit, Community Services and a Wellbeing Centre.

Safeguarding and Dr Kershaw's Hospice

Safeguarding is at the heart of all our hospice services, supporting the provision of high-quality palliative and End of Life care, protecting the wellbeing and human rights of patients, staff, visitors, and volunteers and providing an environment that is free from harm, abuse and neglect.

Our CEO is the lead with executive responsibility for safeguarding; supported by the Medical Director and Deputy CEO/Director of Clinical Services. The Safeguarding Leads are in place to ensure that all staff and volunteers within Dr Kershaw's Hospice receive the required training, support, and supervision in relation to safeguarding, the Mental Capacity Act, Deprivation of Liberty Safeguards and PREVENT.

In the past year, the Hospice has met all its statutory requirements in relation to safeguarding children, young people, and adults, remaining fully compliant with the Care Quality Commission fundamental standards relating to safeguarding. The Safeguarding leads are trained to level 3 in the Safeguarding of Adults. A core mandatory training programme is provided to all staff. Safeguarding Adults Level 2 training compliance level is currently 97% and Safeguarding Children Level 2 compliance level is currently 98%. We have an identified lead for PREVENT and training in place for staff and have a 97% compliance rate. A Freedom to Speak Up Champion also in place, who attends meetings at a local Trust to network with other leads. Information is displayed around the Hospice to signpost staff, volunteers, and visitors to the appropriate lead person for any safeguarding concerns. Safeguarding policies and procedures and systems for reviews are in place.

We have direct links with the Oldham Safeguarding Adults Board. Our CEO is a member of the Board's Learning Hub and our Director of Clinical Services is member of the Board's Policy, Procedure and Workforce Development Sub Group. The Board's website provides additional resources including training which are promoted and made available to all Hospice staff.

We work collaboratively with other health and social care organisations and where any issues or concerns are flagged by our clinical staff, we proactively engage to discuss a partnership approach to managing these. This has been evidenced in the past via multi professional debriefs and significant events analysis.

We have a nominated Complaints Lead and information about how to raise a concern is included in our information leaflets. We have a robust recruitment process for all staff and volunteers including DBS checks and mandatory obtaining of satisfactory references, prior to offer of employment. We also monitor nursing and medical professional registration details as standard practice.

Our Hospice agreed 'Values' are embedded within the Hospice culture. Measures are in place to safeguard vulnerable populations and promote equity and dignity in service provision e.g. measures to support bereaved dementia sufferers. We were the first Hospice to be recognised nationally as becoming homeless-friendly. This is via an established link with a local GP.

Safeguarding in 2022-23

The Hospice dealt with four Adult Safeguarding concerns in this time frame. All four were completely different and did not follow a trend. The theme behind two of the concerns was vulnerable adults with acute mental health issues. The other two were in relation to concerns around communication (or lack of), shared with us by external organisations.

During 2022-23:

- The Hospice have proactive membership within the Oldham Safeguarding Adults Board governance structure.
- The hospice have tried and tested systems in place for reporting safeguarding incidents and concerns. Safeguarding incidents at the Hospice are rare but processes are in place to manage these. The hospice has an ethos and a culture of proactive and reflective learning. Any incident or safeguarding concern is seen as an opportunity to drive quality and improve systems.
- The Hospice has promoted all aspects of safeguarding training in a bespoke manner. The Hospice provides safeguarding training on adults and children and this is well evaluated.
- The Hospice ensures that it adheres to the six principles of safeguarding and this is referred to throughout the core mandatory training.
- The Hospice has expanded its Safeguarding training package to encompass Prevent and Restraint.
- The Hospice has introduced the requirement for all our trained nursing staff to complete level 3 Safeguarding Adults (previously level 2).

- The compliance for safeguarding adults level 3 training is 90%. The compliance for safeguarding adults level 1 and 2 is 98%. The compliance for Prevent is 100%.

Safeguarding Priorities in 2023-24

Priorities in 2023-24 will be:

- to be a proactive member in locality safeguarding groups
- to be active participant in Greater Manchester Hospices Safeguarding forum
- to continuously develop safeguarding training, optimise staff awareness and empower them to know how to respond to any safeguarding concerns.

Key Challenges

Our key challenges will be:

- the cost of living crisis and how this will impact patients who are cared for in their own homes. We will work closely with the Local Authority and other voluntary and charitable sector organisations.
- Keeping our Safeguarding Adults and Children mandatory training compliance above 90%. We will continue to support all staff to attend training.

MioCare Group

The MioCare Group is a Council owned company who, as part of the wider integrated community health and social care service, provides a range of services to adults with Learning Disabilities and older people who require support outside of hospital; we do this with the aim of supporting people to maintain their independence and to live in their own homes for as long as possible.

Safeguarding and MioCare Group

Safeguarding is a priority for the Group and features in all elements of our operational activity, leadership and governance. We ensure that all employees are equipped with the skills, knowledge and support required in order to identify and act upon any concerns. Safeguarding training is mandatory, reiterating that all employees have a role to play in ensuring that people are safeguarded and that the safety of our service users is never compromised. Where safeguarding concerns have been identified, the Group fully investigate in line with relevant policies and procedures, instigating disciplinary sanctions where needed. The group are represented at the Board's Safeguarding Transitions Sub Group and also have Assistant Director level representation at the Learning Disability and Autism Practice Learning Group.

Safeguarding in 2022-23

Key themes in 2022-23 for MioCare included slips, trips and falls (with some resulting injuries) and behaviour related situations including between service users and against employees.

We have introduced a programme of positive behaviour support training in the learning disability portfolio and will further develop this with a 'train the trainer' model in the current year. This will help reduce behaviour related incidents, allow for a reduction in restrictions and enhance service user lives. We have also re-introduced the Quality of Life panel to support best practice in this area.

We have also invested in external support to complete Mental Capacity Assessments for a number of service users, again to support the reduction in restrictions and to enhance service user lives.

We continue to work to reduce medication errors (majority logged as low level of harm; one off incident) including reviewing medication guidance, staff briefings and increased audits and spot checks.

We have recently established a Safeguarding Working Group for the Registered Managers across all MioCare services. This group meets monthly to review and develop work in relation to safeguarding the people we support who may be vulnerable to abuse or exploitation. The group developed a safeguarding plan in line with the Oldham Safeguarding Adults Board's Strategy and which covers Safeguarding Leadership; Prevention and Early Intervention; Listen, Learn and Act; and Safeguarding Excellence.

Making Safeguarding Personal & Safeguarding Adult Review Learning

We provide information to those we support on what being safe can mean and what safeguarding is.

The person is and would be at the centre and their wishes and views are sought at the earliest opportunity.

We provide training to all staff and this is reinforced through discussion at team meetings and through the appraisal process. In addition, safeguarding information is shared at internal service spotlight meetings and with both the senior leadership team and the Board. Individual cases are discussed at the Safeguarding Working Group to ensure learning is shared and any required changes can be implemented as a result.

Staff are encouraged to join OSAB training courses and we continue to explore additional learning and development opportunities for staff and service users alike.

Successful Multi-Agency Safeguarding Work

There have been a number of examples of successful multidisciplinary safeguarding initiatives across services. One example involved an allegation made by a service user against a staff member. The service users wishes and views were sought, with statements taken and a member of staff was suspended without prejudice pending further investigation. Police and the service user's next of kin were notified (with consent). The on site social worker was informed without delay and opened a safeguarding enquiry. In the same week, police attended and afterwards a safeguarding strategy meeting was held and concluded. Being an integrated team and working together resulted in a timely approach and outcome.

Safeguarding Priorities in 2023-24

Our priorities over the coming year include to:

- embed the safeguarding working group to support the organisational safeguarding lead to drive our safeguarding approaches
- introduce new methodology for the collection of safeguarding data
- introduce safeguarding champions across all MioCare services and work collaboratively with people who use services to shape our communication strategy
- review and enhance our current safeguarding training and to introduce advanced training for safeguarding champions
- use our reflection and learning to adapt, amend and improve safeguarding processes
- introduce self-audit tools and qualitative reviews and audits
- look to partner with external organisations as and when necessary to support our continuous improvement
- continue being person centred and outcome focused
- continue being open and honest and acting without delay
- keep safeguarding on the agenda in all forums.
- maintain our lessons learnt approach adopted in order to learn and improve.
- source bespoke safeguarding training for people we support as well as staff (sourced with Age UK; on going).

Key Challenges

The people we support can have varied, complex, and challenging needs; physically, emotionally and socially. With this we can be faced with a range of safeguarding situations. We will continue to work in a multidisciplinary way, looking holistically at how we can safeguard and support those that use our service, as well as the workforce who support the service users.

Turning Point

Turning Point, Rochdale and Oldham Active Recovery (ROAR), are an organisation that support adults in the community who have problems with drugs or alcohol.

Safeguarding and Turning Point

Safeguarding is key to all the work we do with service users. Our first priority is to work with service users to identify, understand and reduce the harmful impact substance use has on themselves and others using a harm reduction approach in which safeguarding is central. This includes strategies to keep themselves and others safe.

We work with people to understand the impact of safeguarding issues such as the impact of substance use on children and loved ones, the potential for self-neglect, Domestic Abuse and self-harm or suicide. For some service users, where there are associated severe physical and Mental Health issues, we work with social care to identify appropriate care packages.

Safeguarding in 2022-23

Turning Point ROAR have been considering our pathways for support and how we can offer a wider range of services for people. There has been a significant piece of work to look at our alcohol pathway and being able to engage people who have dependant issues with alcohol and are high risk and low motivation.

We have also competed a significant amount of training and work around supporting people who use the service who are experiencing suicidal ideation. We have continuous training for staff to use safety plans.

Our top adult safeguarding achievements in 2022-23 included:

- a new alcohol pathway with an increased offer around harm reduction
- a trauma informed approach to assessments.
- suicidal ideation support plan training for all staff.

Making Safeguarding Personal

We have expanded our internal space to discuss clients with complex needs and how we can support them. A specialist team has been set up where caseloads are lower, allowing for a more holistic and person-centred approach to recovery.

Successful Multi-Agency Adult Safeguarding Work

We have been involved in a number of Fetal Alcohol Spectrum Disorders (FASDs) initiatives and events that have supported more people around increasing the understanding of impacts of alcohol.

Safeguarding Priorities in 2023-24

Priorities in 2023-24 will be to increase the offer around how we can support families as a whole in the local area, building more links with partner agencies and being able to access more client groups in communities.

Key Challenges

The team are promoting the changes to the service whilst they are in the process of moving to a new building. There have been a number of planning meetings and working groups established to make the transition as smooth as possible.

Tameside, Oldham & Glossop Mind

Tameside, Oldham and Glossop Mind (TOG Mind) are a charity that provides a range of mental health and wellbeing services. These services are available for children, young people, and adults of all ages. Interventions include crisis support, counselling, art therapy, guided self-help, coaching, group-work, peer support and others.

Safeguarding and TOG Mind

TOG Mind recognises it's responsibility to safeguard the welfare of all vulnerable or 'at risk' adults by protecting them from harm, recognising and responding to concerns and ensuring everyone within our organisation is aware of their individual responsibility to safeguard the welfare of vulnerable or 'at risk' adults. TOG Mind's policies are underpinned by our values of:

- Relationships: we listen and ask questions to understand others and to build trust. People matter to us both inside and outside our organisation.
- Aspiration: we support one another, clients, and communities to achieve better mental health.
- Learning: we seek insight and grow from experience; finding new or better ways to contribute to the field of mental health.
- Potential: we encourage personal responsibility for development by discovering and realising the abilities and energies of people.

We approach safeguarding through thorough training structures, robust policies and procedures and ensuring staff feel supported and confident in their duties. We are a person-centred and trauma-informed organisation, and this impacts how we communicate and work with clients around any risk or safeguarding concerns.

Safeguarding in 2022-23

The vast majority of safeguarding incidents seen by TOG Mind in 2022-23 related to suicide and self-harm. This spanned across both adults and children's services. Of 2743 risk and safeguarding incidents reported across the organisation, 1934 of them were in regards to suicide and suicidal ideation and 902 were in relation to self-harm. In our adult services, we have seen a slight increase of men disclosing domestic abuse, from both partners and family members.

Our top adult safeguarding achievements in 2022-23 included:

- Staff reporting feeling more empowered to arrange and drive multidisciplinary meetings with partners
- Multidisciplinary working improvements through increased contracts, co-location and partnerships with MASH, the Adult Referral Contact Centre (ARCC), mental health wards, and other Voluntary, Community and Social Enterprise (VCSE) agencies.
- Implementation of our incident reporting platform and the ability to further analyse data.
- Implementation of senior leadership incident review meetings to track patterns, training needs, and special measures of responses needed.
- Implementation of our internal safeguarding steering group.
- Re-design of safeguarding level 2 and level 3 training to tailor delivery to the organisation.

Successful Multi-Agency Safeguarding Work

TOG Mind have been involved in many multi-agency safeguarding initiatives including:

- Senior management contributing to OSAB subgroups
- Sub-contracts, co-location and partnerships with local organisations and agencies e.g. Early Help, Turning Point, Pennine Care NHS Foundation Trust, Age UK Oldham, MASH, Royal Oldham Hospital wards, and schools.
- Sub-contracts with pan-Greater Manchester organisations to implement consistent crisis offers for example, Pure Innovations Stockport, Rochdale Mind, Big Life, Groundwork Trafford, and Salford Mind.

Safeguarding Priorities in 2023-24

TOG Mind safeguarding priorities for 2023-24 will be:

- auditing safeguarding records
- defining responsibilities of safeguarding and Caldicott leads and roles and consolidating Caldicott learning and exploring internal practices.
- Improving training around Prevent and the Mental Capacity Act
- Familiarising the workforce with updated ARCC and MASH procedures and structures.

Key Challenges

Our key challenges will be managing time and resource as well as inconsistency in knowledge due to staff turnover.

Positive Steps

Positive Steps is a charitable organisation which works with children, young people, families and adults, supporting them to make positive changes.

We provide a range of services which are designed to meet our vision: people and communities inspired to take control of their lives.

Safeguarding and Positive Steps

Safeguarding is a key function for our services, be that in prevention, identification or response to safeguarding concerns.

Safeguarding in 2022-23

During 2022-23, Positive Steps recognised trends in relation to adult mental health; the impact of poverty including debt and issues concerning access to benefits; and appropriate housing linked to overcrowding, hoarding, inaccessible homes, unfit homes and homelessness.

During 2022-23, Positive Steps have:

- created better links with the Adult Referral Contact Centre (ARCC) and our early intervention and prevention service; this helps to safeguard adults and ensure they are escalated appropriately when needed.
- delivered a series of safeguarding learning events at Positive Steps for staff and volunteers including adult safeguarding themes of domestic abuse and the Mental Capacity Act.
- Offered Mental Health First Aid training which was attended by a cross-cutting group of staff in the organisation.
- Ensured a member of staff represented the organisation at a Greater Manchester Hoarding conference, working closely with our partners at Tameside, Oldham and Glossop Mind to support further learning and improved practice around this area of safeguarding.

Successful Multi-Agency Safeguarding Work

Two members of Positive Steps staff have been trained to be able to deliver domestic abuse training for the partnership. This training has been delivered to two groups of staff so far with a view to further rolling this out in 2023-24.

We have worked closely with partners to develop the emerging Living Well offer for adults with mental health issues. We now have a dedicated post for adults with mental health issues.

Safeguarding Priorities in 2023-24

Positive Steps safeguarding priorities for 2023-24 will be:

- Embedding multi-agency safeguarding and risk management pathways for adults who we identify through our prevention services and in the community.
- Continuing to work on developing the offer for adults with mental health issues as part of Living Well model.
- Developing our approach to supporting adults with housing issues and in poverty including promoting the resources around hoarding and neglect.

Key Challenges

Our key challenge will be managing the high levels of demand for services and ensuring adults receive earliest possible help to prevent escalation to safeguarding.

Greater Manchester Fire & Rescue Service

Greater Manchester Fire and Rescue Service (GMFRS) is one of the largest Fire and Rescue Services outside London with more than 1,637 members of staff and 41 fire stations, covering an area of approximately 500 square miles and a culturally diverse population of 2.8 million people. With an international airport serving over 200 destinations, a major motorway network plus over 200 train and tram stations, Greater Manchester presents some of the most operationally varied challenges you will find.

Our vision is to make Greater Manchester a safer place by being a modern, community focused and influential Fire and Rescue Service. We aim to provide the best emergency response we can to our communities; this is our primary function, but our role is much broader than this. We have focused on prevention and protection work over the last decade to try and stop incidents happening in the first place, improving community outcomes in a variety of ways, educating, and developing young people and making fire station facilities available and more welcoming to the public.

Safeguarding and GMFRS

Safeguarding is a strategic responsibility of the organisation which is centrally managed through the Safeguarding Policy and Practitioners Group chaired by the lead safeguarding officer.

All internal safeguarding processes are aligned to the organisation safeguarding policy, which was reviewed and revised in 2021. The approach to safeguarding throughout the organisation is policy driven and systematically structured. Effective compliance and monitoring of performance and practice is undertaken at an individual borough level and at an organisation wide level.

Safeguarding in 2022-23

The key adult safeguarding themes for GMFRS in 2022-23 were related to self-neglect, hoarding, mental health and substance misuse.

Our top adult safeguarding achievements or areas of progress in 2022-23 included:

- the addition of level 3 accredited training for designated safeguarding officers (DSO)
- DSO supervision support sessions
- revision of our safeguarding policy
- the successful implementation of a case management system to ensure all safeguarding concerns are effectively recorded and managed as required.
- The introduction of a new internal performance monitoring system for safeguarding referrals.

Making Safeguarding Personal & Safeguarding Adult Review Learning

The GMFRS approach to safeguarding from policy to practice strives to make safeguarding personal with the focus on the individual and their needs at all times. The GMFRS Home Fire Safety Assessments (HFSA) adopt a person-centred approach, focusing the questions within the fire risk assessment on the person, occupation (their activities) and the environment which they live in. This approach allows not only fire risks to be identified but also safeguarding concerns.

Learning from SARs is discussed at the safeguarding policy and practitioner meetings and the learning disseminated throughout the organisation to improve policy and practice. Making Safeguarding Personal and SAR learning are embedded in the learning resources provided to designated safeguarding officers and all front line staff.

Successful Multi-Agency Adult Safeguarding Work

GMFRS staff have played a key role in supporting the OSAB hoarding task force and have also provided hoarding awareness training to partner agencies. We have also supported safeguarding professionals meetings.

Safeguarding Priorities in 2023-24

Priorities in 2023-24 will be to:

- continue to develop and support designated safeguarding officers and provide improved training opportunities to all front line staff
- support the safeguarding boards throughout Greater Manchester
- streamline our safeguarding reporting and recording process and improve quality of safeguarding referrals through training and support provided to front line staff.

Key Challenges

Staffing levels within the prevention teams mean that supporting safeguarding professionals stretches the available resources and attendance at all professionals meetings is not possible. However, demand is managed through focused prioritisation to ensure all required actions from the organisation are carried out to support vulnerable individuals within the community.

Thank you from us

NHS Greater Manchester Integrated Care

Oldham Council

healthwatch Oldham

NHS Northern Care Alliance NHS Foundation Trust

GREATER MANCHESTER POLICE

Oldham age UK

Probation Service

POSITIVE STEPS
SUPPORT | CHALLENGE | CHANGE

NHS Pennine Care NHS Foundation Trust

Voice Ability

GREATER MANCHESTER FIRE AND RESCUE SERVICE

MioCare Group

KeyRing ... We're Life Changing

TURNING POINT inspired by possibility

action together

Doctor Kershaw's Hospice

NHS North West Ambulance Service NHS Trust

OPAL

Cloverleaf Advocacy

mind Tameside, Oldham and Glossop

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OLDHAM SAFEGUARDING CHILDREN PARTNERSHIP ANNUAL REPORT

1 April 2022 – 31 March 2023

This report is a public document.

It can be accessed on the website of Oldham Safeguarding Children Partnership: https://www.olscb.org/about/publications/

Approved by Oldham Safeguarding Children Partners on

Independent Chair: Dr Henri Giller

Report compiled and written by Rick Bolton, Oldham Safeguarding Children Partnership Business Manager

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Message from the Independent Chair

The year 2022-23 has been a challenging one for the Oldham children's safeguarding partnership. The conclusion of the Covid pandemic did not automatically mean a resumption of business as usual and significant pressures were faced by the partnership with respect to staffing and skills shortages, the requirements of external regulators and the emergent cost of living crisis. In the context of Oldham, this latter pressure adds to that posed by the pre-established social and economic deprivation experienced by a significant number of the local residents. Despite these forces it remains the case that:

Oldham has a vibrant safeguarding children partnership with active engagement of both statutory partners and other relevant agencies.

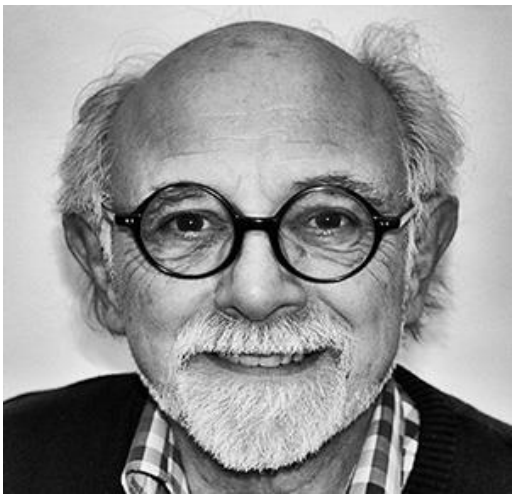
The partnership seeks to actively embrace the contributions of key stakeholders – particularly children and young people – with respect to their perspectives on the current state of service provision and how it may be improved.

The partnership pursues a variety of safeguarding priorities underpinned by robust evidence as to their local relevance.

The partnership promotes transparency and accountability in its decision making and service delivery and is committed to change and improvement in the face of challenge.

I trust that this annual report effectively communicates the commitment of the partners in Oldham to safeguarding, their pursuit of best practice, their willingness to innovate and change and their resolution to ensuring that the children of Oldham are safe.

Dr Henri Giller, Independent Chair of the Oldham Safeguarding Children Partnership



Reflections from our Statutory Partners

2022/23 has seen Greater Manchester Police [GMP] be reassessed by HMICFRS and the force taken out of 'Enhanced Scrutiny/Special Measures'. HMICFRS has, quite rightly, subjected the Force to a tough process and have set the bar deliberately high. And whilst we are now out of the 'Enhanced Scrutiny/Special Measures' nothing in these welcome developments implies any complacency on our part.

The force fully recognise that much remains to improve still further. It does however represent a tangible and substantial step on the journey set out by the Chief Constable in which we all "aspire to be the finest Force in our country".

The support and joint-agency working within the Oldham Safeguarding Partnership is strong and this along GMP's improved crime recording and investigations all combine towards our shared determination to make Oldham a safer place to live, work and visit.

The leadership within Oldham District remains focused on continuing to build and develop further on the excellent partnership we have already established. As a district, we continue to prioritise Violence Against Women and Girls (VAWG) and take a pro-active approach to safeguarding victims of sexual and violent crimes.

We continue to investigate a number of serious and complex crimes within the district and through the partnership we are determined to seek justice for the victims and safeguard all victims of crime. I will continue to share these updates on investigations when the judicial process allows me to do so.

Partnership working remains one of my main priorities and with the introduction of 'Right Care, Right Person' we move towards a new era of partnership working.

2023/24 will bring many challenges for the partnership but am also excited as we work together to further develop our multi-agency offer over the coming months and years, this will be enhanced as we move some of our safeguarding team to the new co-located premises in the Spindles.

Best wishes, Ch Supt Phil Hutchinson, District Commander, Oldham

GREATER MANCHESTER POLICE

Our Oldham Safeguarding Children's Partnership is the cornerstone of our mature and effective multi-agency response to safeguarding children and supporting families in Oldham. It has been a challenging year in which all agencies have seen high levels of demand as the legacy of COVID 19 has impacted on our community. We have maintained a relentless focus on improving complex and contextual safeguarding, domestic abuse, children's mental health, neglect, and transitions for children at all key points in their lives. OSCP has worked at pace to implement action plans from the learning from local reviews into practice improvement through a more effective Learning Hub sub-group, and a revised training offer to schools and colleges which better aligns with our key priorities. For these reasons we are confident but not complacent that we will rise to the challenges we will face in the coming year. We have recognised the need as a partnership to expand the scope and impact of early help to prevent harm to children and family breakdown and will continue to roll out better support to families where they live through our Family Hubs Programme.

Gerard Jones
Managing Director of Children & Young People (DCS)

Oldham Council

2022/23 has been a year of change within health. Integrated Care Boards were formed in July 2022, which saw the Oldham Clinical Commissioning Group merge with the other 9 localities across Greater Manchester to form the Integrated Care Board. The Safeguarding Team also experienced change in 2022 and a newly appointed Designated Children's Nurse and a newly appointed Deputy Designated Children Looked After Nurse were recruited.

2022/23 has provided challenges for the residents of Oldham following the COVID pandemic both from a health and financial perspective, this has impacted upon the safeguarding activity within health, there are significant concerns for our young people regarding neglect, criminal and sexual exploitation and children and young peoples mental health.

The Safeguarding Team within the GM ICB Oldham locality are committed to working jointly with partners both statutory and non-statutory to drive forward improvement and change for the benefit of all children in the borough. The Safeguarding Team work closely in collaboration with colleagues across all localities within the GM system to ensure that learning and lived experiences are recognised across GM and learning is embedded within Oldham to provide fair and equal opportunities and access to services and support for all children and young people.

Andrea Edmondson
Head of Quality & Safeguarding (Oldham Locality)
NHS Greater Manchester

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Integrated Care

Introduction

Safeguarding Partnership

The Oldham Strategic Safeguarding Partnership has been developed by Oldham Council, Greater Manchester Police, and the Oldham Clinical Commissioning Group to ensure that all children and young people in the area get the safeguarding and protection they need in order to help them to thrive.

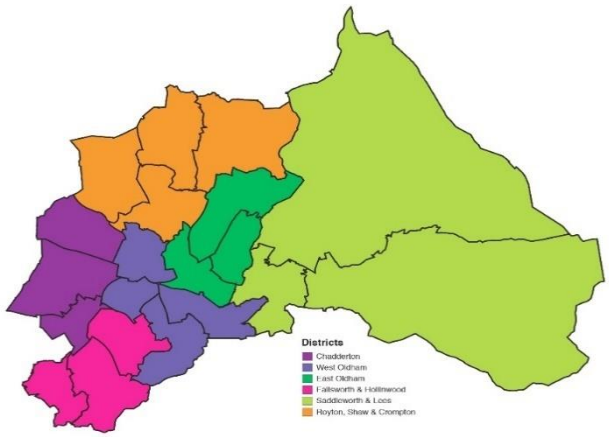
The Partnership provides leadership and accountability for the promotion of children and young peoples' well-being and the prevention and protection from harm.

Partners work together to promote a child-centred approach to safeguarding, listening to children, empowering families and, where needed, providing services that are professional, evidenced-based, and effective. The partners will continuously strive to improve and challenge each other to learn the lessons from daily practice.

Safeguarding is everyone's business, and the Oldham Safeguarding Partnership will provide lead responsibility in demonstrating what this means for all people and professionals living and working in the local community.

Our strategic aims include:

- Excellent practice is the norm across all practitioners in Oldham
- Partner agencies hold one another to account effectively
- There is early identification of new safeguarding issues
- Learning is promoted and embedded
- Information is shared effectively
- The public feel confident that children are protected



Oldham has a population of 224,900 people making it the 6th largest borough in Greater Manchester.

There is a high proportion of Oldham residents under the age of 16 years (22.7%) compared with 15.9% over the age of 65 years.

Oldham has a diverse population with 22.5% of residents and 46% of school pupils from Black and Minority Ethnic (BAME) backgrounds.

38% of children in Oldham are living in poverty – this is the highest figure in the UK

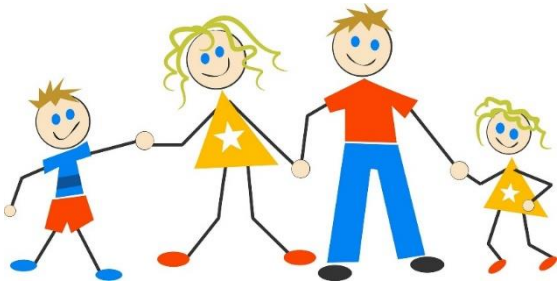
Oldham is ranked 19th worst out of 317 local authority areas on the indices of deprivation. Five areas within Oldham are ranked amongst the top 1% of the nation's most deprived areas.

Profile of Safeguarding in Oldham

Quarterly performance continues to be monitored and scrutinised by the Partnership's Performance Management Group, before being presented by exception to the Strategic Safeguarding Partnership.

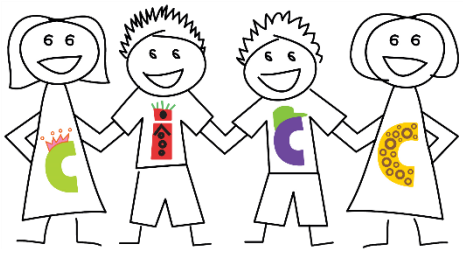
Contacts to MASH 29,647

Contacts converted to Referrals 5372



3,435 referrals made to Targeted Early Help

2906 S47 enquiries initiated



543 children looked after as of March 2023

507 children on child protection plans as of March 2023

273 children electively home educated

Safeguarding Priorities for 2022-2023

Partnership Development Session – January 2023

Reflection on the previous 12 months

In January 2023 Oldham Safeguarding Children Partnership came together to reflect on, and review the impact of the work driven by the Partnership since April 2022.

The 9 months prior had seen significant change within some of the agencies, including changes in key roles within the Partnership governance paired with significant organisational changes e.g., the transition from Clinical Commissioning Group arrangements to the Integrated Care Board.

The Partnership's five priority areas in 2022-2023 were.

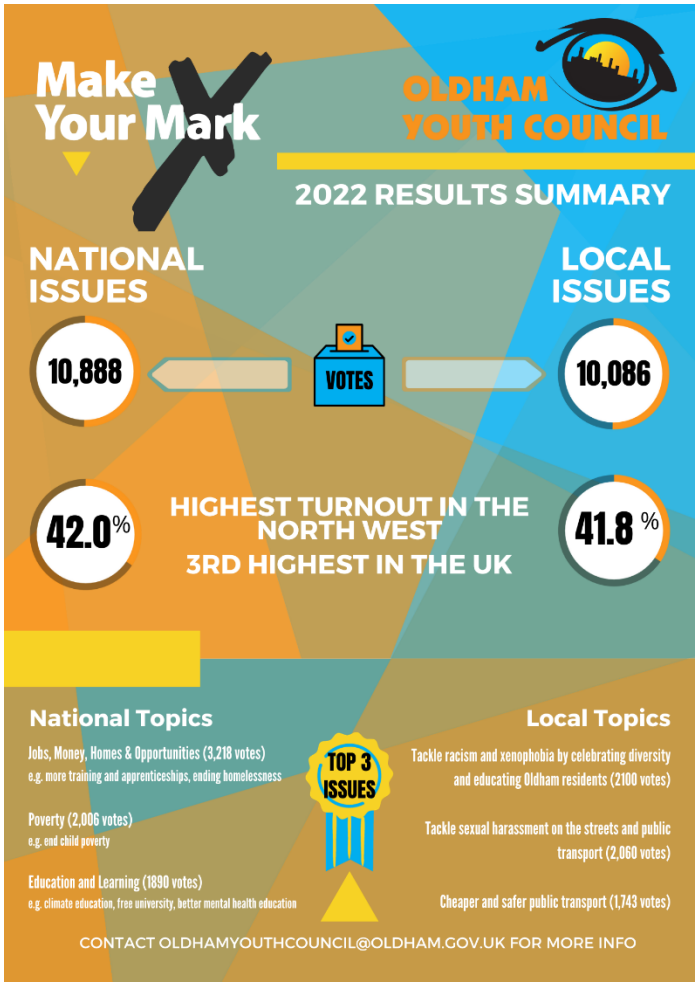
1. Neglect
2. Complex and Contextual Safeguarding
3. Domestic Abuse
4. Children's Mental Health and the impact of trauma.
5. Transitions

Voice of children and young people

Make Your Mark 2022

Every year the United Kingdom Youth Parliament (UKYP) holds a UK wide ballot called 'Make Your Mark', where all young people, 11-18, can vote on what they feel is important in their lives and what they think Members of the Youth Parliament should campaign on for the year ahead.

In 2022, young people chose 1 topic from a list of 10 topics created by Members of Youth Parliament and 1 issue from a list of 10 issues created by Oldham Youth Councillors. 10,888 young people took part in Oldham from 18 of Oldham's high schools and colleges. The top 2 topics were 'Jobs, Money, Homes & Opportunities' and 'Poverty' with the top 2 issues being 'Tackle racism and xenophobia by celebrating diversity and educating Oldham residents' and 'Tackle sexual harassment on the streets and public transport'.



You Stand Accused

From Make Your Mark it was clear that hate crime was something that young people wanted tackling. Oldham Youth Council and Oldham Council commissioned and worked collaboratively with Oldham Theatre Workshop, who produced and immersive Theatre piece called 'You Stand Accused'. aimed to educate and inspire young people to be proactive about confronting hate crime and hate speech in their communities.

Students were placed in the shoes of a hate crime 'offender' and the immersive theatre experience took place in a correction centre. The young people had the opportunity to hear and absorb victim's stories (through real testimonies and experiences) and see first-hand the consequences of hate crime activity. This powerful experience helped them understand what 'hate crime' and 'hate speech' is and the impact it has on its many victims.

Secondary schools from across the Oldham Borough were invited to bring 10 pupils from years 7 - 9 to take part in the experience with a view to forming an action group in their schools which will educate their peers around the issue. This 'Community Service' was to help spread the message and encourage awareness and empathy amongst young people within Oldham.

The performance was such a success as well as a run in June 2022, it was recommissioned for the following October.

In June, 12 schools took up the offer with 288 pupils attending the performance. The following October saw 10 schools bring across 246 pupils.

Photos below, taken from twitter, show the cast and students from Royton and Crompton School.

With the results of Make Your Mark showing that young people wanted someone to tackle sexual harassment Oldham Youth Council looked into planning a campaign around raising awareness of what street harassment was, the laws associated with it and how to report it. In researching this topic, they came across an organisation named Our Streets Now who campaign demanding the right of women, girls and marginalised genders to be safe in public space. Rather than set up their own campaign Oldham Youth Council decided to join Our Streets Now campaign.

Youth Councillors were able to attend online sessions to help to discuss what the campaign would entail and how it would be promoted. They helped produce social media content and a poster campaign targeted at hot spot areas such as bus terminuses and train/tram stops. The poster will promote a text number to report instances of sexual harassment as well raising awareness of what unwanted harassment may include.

Activity and Impact – Domestic Abuse

Domestic Abuse

Domestic abuse, and the effect it has on children and families in Oldham is sadly a repeating issue over many years of Annual Reports and plans. Oldham Safeguarding Children Partnership remains committed to preventing Domestic Abuse and making sure that the correct support is available for any child affected by it.

Over 2022-2023 there were significant areas of progress:

- There is an agreed Multi-Agency Domestic Abuse Strategy informed by SafeLives review of domestic abuse in Oldham.
- There is now an agreed Multi-Agency Domestic Abuse Policy.
- A Domestic Abuse Directory for professionals has been produced and distributed.
- Through investment, there was an increase in capacity in Domestic Abuse Team over the year.
- Implemented commissioned perpetrator offer with TLC – both for adults and children who have been abusive in their family relationships.
- Expanded provision of safe accommodation for victims of abuse and their children, through recommissioning refuge, expanded use of dispersed accommodation and buy in to men's refuge in Trafford.
- Investment in VCFSE Women's Network.
- White Ribbon status achieved for Oldham Council.
- A dedicated Senior Honour Based Violence specialist in the Domestic Abuse team.

1. Strengthen the support offer to at standard and medium levels of risk.
2. Improved communication of the support offer including increasing the availability of online self-help resources
3. Completion of a multi-agency training audit to identify gaps, and build capacity of services to support victims of abuse and their children.
4. Specific capacity building initiatives – CHIDVA, IRIS with GPs and Senior IDVA supporting Children's Services, seek additional funding for hospital IDVA.
5. Extend the commissioned intervention with perpetrators of Domestic Abuse to March 2025
6. Disruption work with the identified high harm cohort.
7. Further improving operation of Multi Agency Risk Assessment Conference (MARAC)
8. Revisiting Operation Encompass to ensure that the process provides the most appropriate, timely information to schools so children affected by Domestic Abuse can be supported.
9. There are impending changes in May 2023 to how referrals to services are processed at the 'front door' (MASH) and this presents additional opportunities for early intervention.

Activity and Impact – Complex and Contextual Safeguarding

Complex and contextual safeguarding

Complex Safeguarding is criminal activity (often organised), or behaviour associated with criminality, involving children and young adults (often vulnerable) where there is exploitation and/or a clear or implied safeguarding concern.

Over 2022-23 the partnership continued the work from the previous year regarding the Peer Review of services in the borough, and started to progressed the learning from The review into historic safeguarding practices in the borough of Oldham

The Complex Safeguarding Hub continued to evolve become and worked with over 200 young people in 2022-2023 on a range of preventative and protective interventions.

Complex Safeguarding Weeks of action:

2 successful weeks of action were undertaken by the Complex Safeguarding Hub team in October 2022 and March 2023. These weeks of action focused on raising awareness of child exploitation within the community and also with professionals.

Activities included:

- Training inputs were delivered to some schools within Oldham, reaching over 2000 students.
- Training inputs in relation to Complex Safeguarding and Appropriate Use of Language.
- Proactive community-based activities, including warrants.
- Social Media platforms utilised to raise awareness of child exploitation.
- Training inputs were delivered to some of the Care Homes within the Oldham Area.

GRIP (Group Response and Early Collaborative Intervention Project)

The GRIP project commenced in November 202, ending in March 2023. The project was implemented due to an escalation of concerns around contextual. risks, social groups and gangs in specific geographical areas in the Oldham area; Limeside and Failsworth.

Over the 18 months, the GRIP project worked effectively with 22 young people aged 11-17 and played a key part in reducing instances of youth violence and anti-social behaviour in those areas.

2023 - 2024 Key Priorities

- Continue to take robust and early action to share intelligence and challenge the operations of perpetrators of exploitation ensuring we maximise the use of all agencies and the legal powers available to us to disrupt the behaviours.
- To support the development of more in-depth analysis of local trends and themes to continue to inform and drive targeted service delivery.
- Strengthen the transitional safeguarding offer.
- Implementation of a contextual safeguarding approach – this will include an audit of processes, procedures, and forms to ensure that context is robustly considered and rooted in our practice; as well as practically implementing the approach.
- Strengthen the prevention offer for CSE, CCE and youth violence.
- Complex and contextual safeguarding to continue to be offered within the OSCB training offer, alongside training continuing to be offered within schools, colleges, faith sector, residential homes and wider partners.
- Multi-agency audits to take place.

Activity and Impact – Neglect

Neglect

The effect of neglect on children and young people can be life long, and the early recognition and support of children experiencing neglect is a core aim for the Partnership.

The response to neglect in Oldham is underpinned by several core areas:

- Prevention of the causes that lead to child neglect rather than only responding to the symptoms by understanding the scale of neglect in Oldham and how it's affecting our families.
- Protection by ensuring a strong Partnership response with a common understanding of the spectrum of neglect and a recognition of the need to work with families at the earliest opportunity to prevent harm.
- Provision of strengths-based support for families from voluntary and statutory organisations in Oldham
- Participation by providing opportunities for children, young people, and families to share their experiences in order to shape and develop our multi - agency response to neglect.

Graded Care Profile 2

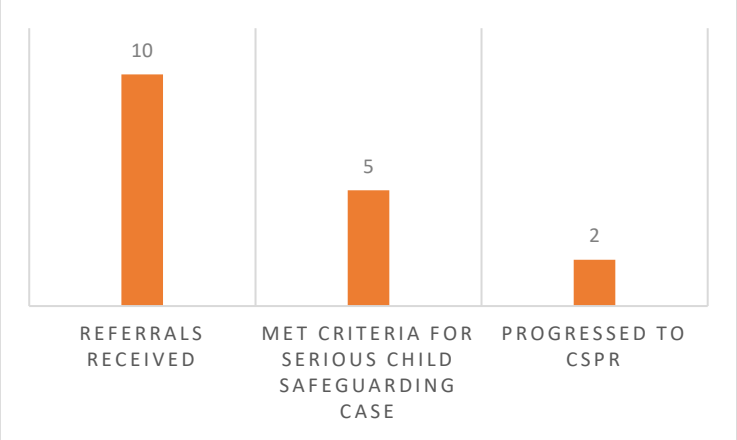
In 2022 – 2023 the partnership began to plan for the implementation of the Graded Care Profile 2 (GCP2). GCP2 is an assessment tool that helps practitioners take a strengths-based approach to measuring the quality of care a child is receiving and supports them to identify neglect.

Over late 2023 the training on the tool will be rolled out across Oldham Safeguarding Children Partnership agencies so that the new approach can be embedded.

Case Reviews

The Safeguarding Partnership has a statutory duty to review serious child safeguarding cases with the aim of identifying learning, improvements in practice and protecting children from harm.

A serious child safeguarding case is one in which, "abuse or neglect of a child is known or suspected, **and** the child has died or been seriously harmed." (WT 2018)



During the 2022-2023 period the partnership received 10 referrals for consideration of whether they met the criteria to notify to the National Child Safeguarding Practice Review Panel and therefore progress to a Rapid Review process.

In the three cases that did not progress to a Local Child Safeguarding Practice Review. One progressed as a Local Learning Review relating to Forced Marriage, and two to the new Brief Learning Review methodology introduced to the partnership in 2022 ; one relating to Deprivation of Liberty Safeguards on a young person going through transition between children's and adult services, and another which led to a thematic task and finish group relating to young children living in properties which are in poor condition and where there is evidence of clutter / hoarding.

Child Safeguarding Practice Reviews

Two Child Safeguarding Practice Reviews were concluded within 2022-2023; one which originated in early 2022, and another which started in late 2022 and completed just before the period of this annual report.

The Partnership also applied a local learning approach (called a Brief Learning Review) to several other cases where it was clear that there is learning.

Local Learning Example: Child R

Child R is a teenage girl. A Rapid Review was completed, and whilst the case did not meet the criteria for a Local Child Safeguarding Practice Review, there were issues to take forward.

Child R was taken abroad and whilst there was forced to marry an older male, and experienced abuse.

There were several key lines of learning for the Partnership from the case:

1. Professionals should be more aware of how the risks of Forced Marriage can be assessed and have greater curiosity.
2. All agencies need to increase knowledge of the legal steps that can be used to protect a young person who is at risk of a Forced Marriage.
3. The take up of training across the partnership in relation to Honour Based Violence and Forced Marriage needed to be prioritised in 2022-2023.

Response from Oldham Safeguarding Children Partnership:

A full calendar of monthly training events over 2023 is planned, facilitated by the Oldham Safeguarding Children Partnership Training Consultant and the Specialist HBV Independent Domestic Violence Advocate. This includes face-to-face training, online 'lunch and learn' sessions and written resources.

Good Practice:

Some key good practice themes were drawn out of Local Child Safeguarding Practice Reviews 2022 – 2023:

- Commitment of practitioners to engage families where there may have been some resistance.
- High levels of support provided by schools and colleges at an 'earliest help' stage.
- Decisive, timely multi-agency protective responses in situations where it was evident that harm through abuse had occurred, including the use of Police Powers of Protection and rapid progression through legal processes.

Some key themes in case reviews 2022 – 2023

Non accidental injuries to children under 1 year old.

Transitions; especially regarding children with special educational needs or disabilities.

Neglect – specifically around carers seeking appropriate medical attention for unwell child.

Recognition of cumulative harm – when a child or family re-open to services, previous involvement and assessments should be reviewed.

Quality Assurance

Over 2022 – 2023 Oldham Safeguarding Children Partnership further embedded the MACE (Multi-Agency Case Audit) model where all partner agencies come together to jointly audit a cohort of cases around a particular theme. This is a significant commitment from all partners and is completed quarterly.

In February 2023 the Partnership focussed on the theme of Early Help; are children and young people receiving the right support and intervention at the right time.

Some of the key findings from this, which will be taken forward were:

- We identified that a lot of work is being done by schools and community organisations to prevent the needs of children and families escalating, but the volume and scope of this support is not captured in the data available to the Safeguarding Partnership.
- Some cases transitioned between Children's Social Care and Targeted Early Help services, and the audit identified areas where the processes could be improved to prevent drift and delay.
- Where, for example adults in a family are receiving support from Mental Health Services or Substance Misuse Services, there are system difficulties which make it hard for children's early help agencies to become aware of the services involvement or exchanging information unless the adults mention it.
- There are some families who experience 'start again' points when they come back into services for help and support after a previous involvement.
- Repeatedly, information known to the Early Help or Children's Social Care Services was not replicated on the School Nursing record, or in some cases not on the GP records.
- Decisions taken to close cases should result from clear progress for the child and family being evidenced on the plans; on occasion there was not sufficient evidence of progression.
- The effect of staff turnover in the Children's Services sector is a national theme but the effect of it was evident in this audit; in some cases there was multiple 'reallocations' due to staff leaving and this creates situations where children and families have to tell people about their needs multiple times.
- Some cases showed that services had missed opportunities to involve the fathers / adult carers in the families in the Early Help plans.

Training and Communication

Safeguarding children effectively requires a knowledgeable and skilled workforce. By delivering multi agency training Oldham Safeguarding Children Partnership aims to provide staff with good quality training that enhances inter agency communication, cooperation and provides a place to reflect on practice.

New research, legislation and guidance and local learning means that there is a continuous demand to update members of the workforce. An effective means to achieve this is using skilled and experienced practitioners who can share their knowledge and expertise, so a training pool of staff from across partner agencies exists.

Over 2022-2023 there were 50 training opportunities with 953 attendees across variety of blended learning approaches including face to face classroom based, briefings and webinars.

Training in schools:

Oldham Safeguarding Children Partnership provide three core services to schools: Training, professional advice / support, and direct delivery of Relationships and Sex Education (RSE) and health education in schools.

Over 2022 – 2023 Oldham Safeguarding Children Partnership facilitated four training sessions to designated safeguarding leads and deputies as part of the statutory requirement to update training to support their safeguarding role in school and college.

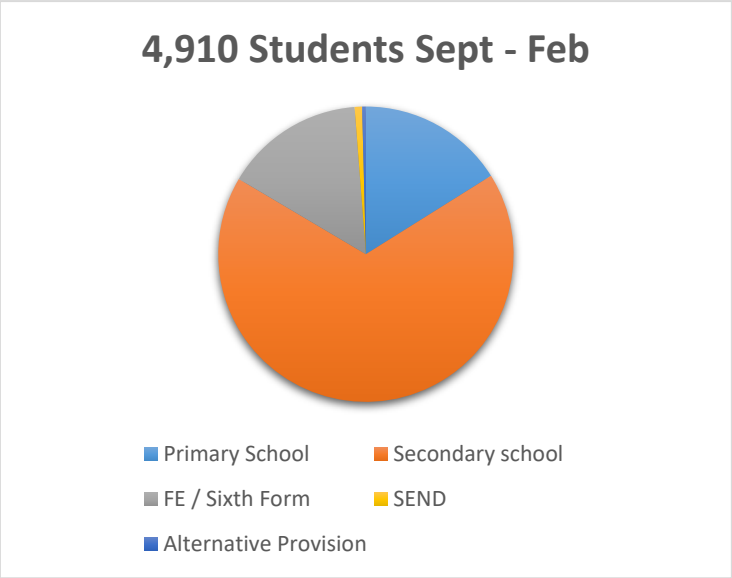
Whole school foundation safeguarding training sessions were provided to 13 primary schools and academies and 2 secondary schools.

Having assurance around safeguarding is a core responsibility for any school governing body, and six training sessions were delivered to school governors over the year equipping them with the safeguarding knowledge to underpin their role.

Termly network meetings for Designated Safeguarding Leads have been coordinated and chaired by the Safeguarding Lead for Education. In the year 2022/23 attendees have received updates on DfE statutory safeguarding guidance such as Keeping Children Safe in Education, and changes to local procedures and practice. Guest speakers are invited to these network meetings included NSPCC, Talk Listen Change, Early Break Service, MASH and the Complex Safeguarding Team.

The work of the Partnership in reaching young people with preventative and educational input on issues of relationships and sex education over 2022-2023 was a particular area of strength and progression.

Over the first 5 months of the academic year (Sept 2022-Feb 2023) the Training Officer for Children and Young People delivered sessions to a total of 4,910 students across the borough:



Alongside the work with children and young people, this offer from the Partnership also impacts education professionals, is offered to professionals from other agencies and to parents and carers. In this same period of September to February sessions were delivered to:

245 Education Staff

250 Professionals from non-education agencies

160 Parents and Carers

The contribution that this makes to supporting children to recognise that they or a friend is experiencing harm or abuse, and in developing their knowledge for the future is an area of strength for Oldham Safeguarding Children Partnership, Community Safety Partnership, Health and wellbeing strategy and more.

SCRUTINIZING THE SAFEGUARDING CHILDREN PARTNERSHIP IN OLDHAM (APRIL 2022 TO MARCH 2023) – Dr Henri Giller, Independent Chair of the Oldham Safeguarding Children Partnership

The new safeguarding arrangements, introduced by the Children and Social Work Act 2017 and Working Together to Safeguard Children 2018, require that they include provision for the scrutiny by an independent person of the effectiveness of the arrangements. This section of the report provides the scrutiny of the Independent Chair of the Oldham Partnership of the third working year of the new partnership arrangements. The criteria for scrutiny is that contained in the report "Six Steps for Independent Scrutiny" as updated by the national survey of what is currently being scrutinised, by who and how (Pearce, Stratton, Parker & Thorpe,2022).

LSCP Leadership

LSCP Partner Leads are clearly identified and accountable for LSCP activities safeguarding children. In addition to their participation in the Partnership Executive meetings, the Partner leads meet as a leadership group with the Independent Chair and the Partnership business manager, to consider on-going strategic safeguarding priorities and operational matters arising that may impact upon those priorities. During this period the leadership group met on a monthly basis, rather than fortnightly as was the practice during the Covid period. The leadership group continues to oversee the development of the agenda for quarterly Executive meetings. The Partnership leads are represented at allied partnerships (the safeguarding adult board, community safety partnership and the health and wellbeing board) and attend quarterly accountability meetings with the local authority chief executive and key elected members. In this period the Council established an all-party member group to oversee safeguarding activity around sexual exploitation. The safeguarding leads were fully engaged in this initiative. Delegated representatives of the three statutory partners continue to actively participate in relevant sub- groups and working groups of the Partnership.

Engagement of Relevant Agencies

All relevant agencies are engaged with the safeguarding children partnership, are aware of local information sharing protocols and training initiatives and participate in partnership development events and reviews of strategic priorities. New members to the partnership are provided with induction materials by the business manager and a safeguarding newsletter is regularly circulated to representatives of relevant agencies informing them of local and national reviews and research and training and workforce development opportunities.

Oldham, along with the other areas of the greater Manchester conurbation, continued to experience significant staffing difficulties across the partner agencies during this period. These difficulties related to both the shortage of suitable staff and the skills levels that they were able to deploy. This has had significant impacted on the quoracy of safeguarding meetings, the timeliness of case conferences and reviews and the delivery of appointments for safeguarding services. The statutory partners continued to oversee the pattern of disruption caused by staff shortages in safeguarding agencies and to initiate preventive or remedial actions as appropriate. While the partners are undoubtedly willing to redress this situation, the timelines involved in resolving staff shortage means that quick fixes are not possible.

Outcomes for Children and Young People

Significant consultation events involving children and young people were undertaken during the course of this year providing substantial opportunities for their views to influence the development of service priorities. Safeguarding concerns around hate crimes, bullying, sexual exploitation and other complex safeguarding needs were identified, and proposals developed for service enhancements. Presentation of the findings from this work by young people was widely shared with the partnership representatives throughout 2022-23. Work on enhancing the experience of young people transitioning from children's services to adult services was likewise progressed in the period.

Quality Assurance & Information Sharing

Performance data on safeguarding activity continues to be gathered and shared across the partnership with initiatives ongoing to ensure a better representation of data from a wider range of relevant agencies. Quarterly data feedback is a standing item on the Partnership Executive agenda. This year the introduction of the multi-agency case audit (MACE) has been a significant development in both engaging partner agencies in quality assurance initiatives but also enabling the enhancement of good practice to be facilitated. The MACE activity around early help has led to significant changes in how this strategy will be delivered in the future.

Learning from Local & National Reviews & Research

Local reviews of critical cases were undertaken in the period, both on an individual case-specific basis and thematically. Significant findings on the need for improved cross-agency case management information sharing and case co-ordination were identified by both methods. These requirements continue to be monitored and followed up into 2022-23

The period also saw follow-on work arising from the independent review of cases of non-recent child sexual exploitation (CSE) and a continuing focus on current practice in CSE and complex safeguarding to ensure that the lessons from the past are clearly learned. Evaluation of the extent of change reflected in current practice will be the subject of a further GMCA review in 2023-24.

National research findings continue to be circulated and promoted through the partnership newsletter and inform the content of the partnership training programme.

Multi-Agency Safeguarding Training & Workforce Development

The commitment to a multi-agency training strategy continues to be a strength of the Oldham partnership. A substantial number of staff from across relevant agencies have engaged with the training opportunities available in the period. The availability of a variety of training delivery mechanisms was sustained in the period 2022-23.

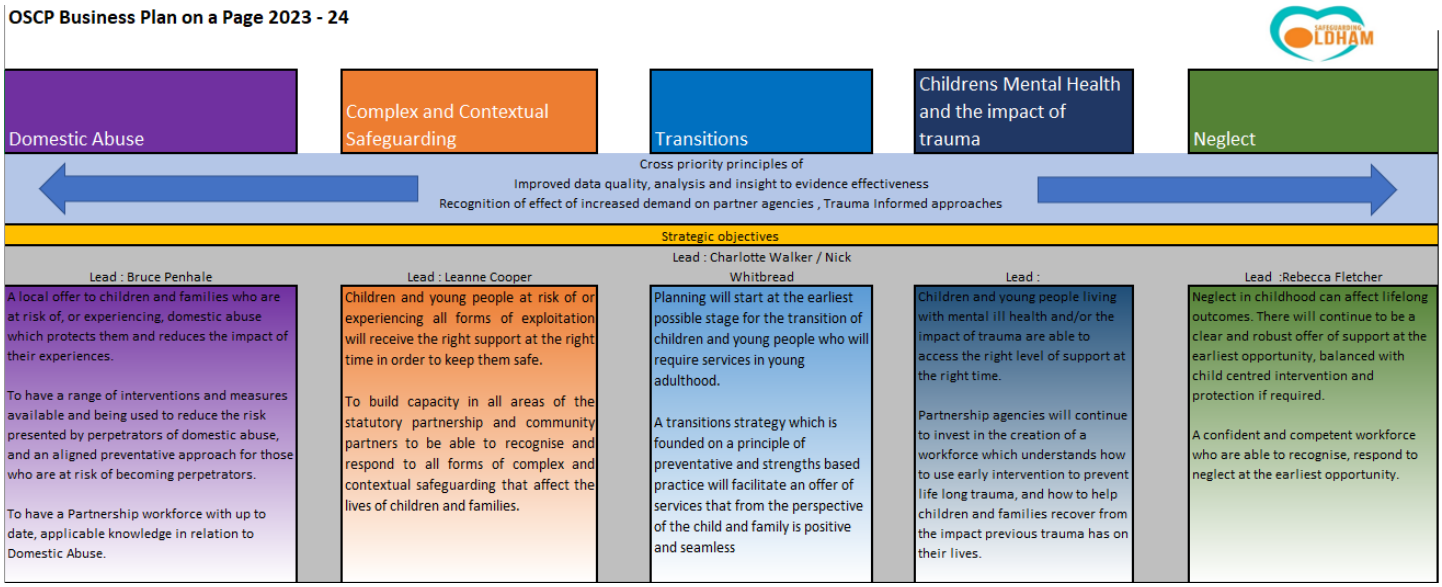
The training programme continues to be closely linked to the priority safeguarding concerns identified in the partnership annual business plan. This year the programme reflects the themes of complex safeguarding, domestic abuse and the assessment of neglect.

The challenge of having an adequate workforce to undertake safeguarding activities continues across all relevant agencies, and Oldham inevitably competes with the nine other GM boroughs to fill staffing vacancies. Initiatives to "grow one's own" skilled workforce continue to be forcefully progressed.

The engagement of local schools in safeguarding training initiatives continues to be a hallmark of the Oldham partnership with substantial numbers of pupils and students being engaged by dedicated staff from the partnership business unit.

Dr Henri Giller – Independent Chair

Our plan for 2023-2024



Appendix 1 - Statements from Oldham Safeguarding Children Partnership agencies.

In addition to the Oldham Safeguarding Children Partnership's Annual Report setting out information on safeguarding trends locally, the actions of the Partnership over the last year, and priorities for the coming year, agencies are invited to provide highlights of their own safeguarding work for publication as Single-Agency Statements.

Single Agency Report final 22-23.d

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Oldham Suicide Prevention Strategy

September 2023

Oldham Council

Foreword

A death by suicide can affect anyone. Sadly, 1 in 20 people will attempt suicide at some point in their life. But deaths by suicide are not always inevitable, and with the right support we can help people to recover from crisis, or better still, prevent people from reaching a crisis in the first place.

Living through the COVID-19 pandemic has left few people unscathed, the health, social and economic impacts, as well as loss and bereavement, have been experienced by many individuals and communities. Whilst we emerge from the pandemic, hardships continue for many Oldham residents as the cost of living rises, and people struggle in these times of financial crisis and uncertainty. Although fortunately, there is currently no evidence to suggest a rise in the rate of suicide, these significant stresses will undoubtably take their toll on individuals mental health and wellbeing, causing a significant amount of distress, that can leave some people feeling unable to cope. It is essential that we do everything that we can to support Oldham residents through these difficult times, protect against the risk of suicide, and prevent as many deaths as possible.

Suicide prevention is a national responsibility, and local authorities have a statutory duty to deliver and act on a suicide prevention strategy and action plan. To date, Oldham has an established Suicide Prevention Partnership, made up of a multidisciplinary team, who drive this agenda forward. The partnership reports to the health and wellbeing board and the integrated care board, and is accountable to Oldham residents.

This Suicide Prevention Plan has been written collaboratively by the Suicide Prevention Partnership, and with the help of people who live and work across the borough, including insight from young people. We must be mindful that this is not a service improvement plan, but rather an approach that strives for Oldham to become a suicide prevention town. It is about taking a collective responsibility to create an environment that supports positive mental health and wellbeing, and breaking down the stigma around mental health, suicide and self harm to enable residents to feel confident to talk openly with each other. After all, suicide prevention does not lie with one service or team, but is everyone's responsibility.

Each life lost to suicide is one too many. By using the data and evidence to inform our actions we seek to have the biggest impact on the greatest amount of people across our neighbourhoods and communities.

Cllr Barbara Brownridge
Cabinet Member for Health and Social Care

Suicide affects all
(SPS Consultation)

"My ideal would be that nobody reached the point where they felt like this was their only option"
(SPS Consultation)

Everyone matters
(SPS Consultation)

Throughout the document we have included quotes from the Suicide Prevention Strategy Consultation 2022 (SPS Consultation)

In England in 2020:

- The overall suicide rate in England is 10.0 per 100,000, This is a 7.4% decrease in rate compared to 2019
- 4912 people died by suicide, this is 404 less than in 2019. Part of this reduction may be due to delays in deaths being registered as a consequence of the pandemic.
- More than 1 in 20 people will attempt suicide at some point in their life
- 75% of deaths by suicide occurred in males, a rate of 15.3 per 100,000. 3682 deaths.
- 25% of deaths by suicide occurred in females, a rate of 4.9 per 100,000, 1230 deaths.
- The age groups with highest suicide rate are:
  - Males aged 45-49 years, 23.8 deaths per 100,000.
  - Females aged 45 – 54 years, 7.1 deaths per 100,000.
- Males are 3.1 times more likely to die by suicide in England than females.
- The suicide rate in the North West is similar to the national rate at 10.1 per 100,000.
- In Greater Manchester, more than 200 people die by suicide each year.
- The overall suicide rate in Oldham (2018-2020) is 7.1 per 100,000.
- For every death by suicide there are many more people who have attempted to end their life, or who are struggling with suicidal thoughts.
- Every death by suicide is a tragedy which has a profound and devasting effect on many.

Introduction

The World Health Organisation states that globally, over 700,000 people die by suicide each year. In England in 2020, 4912 people tragically took their own lives. Behind each number there is an individual who has lost their life too soon. Yet these figures only represent the tip of the iceberg, and for every recorded death by suicide, there will be many more people who have made attempts on their life, or who are struggling with harmful thoughts. Many deaths by suicide can be prevented and we believe that no one should ever be left to feel that suicide is their only option.

A suicide prevention plan would be incomplete without the inclusion of self-harm, which can cause significant harm in its own right. Self-harm is often used as a way of coping with distress, but in some cases can precede suicide attempts. Whether self-harm is with or without suicidal intent, there is a considerable risk of harm and even death, therefore preventing self-harm and supporting those who do, is a key part of this suicide prevention plan.

The COVID-19 pandemic has had a profound and ongoing impact on people's lives, and existing risk factors for suicide, such as loneliness and poverty have been exacerbated for many. Whilst there is no evidence for an increase in suicide risk, or self-harm, it is too early to know the full extent of the long-term health, social and economic effects. Whilst COVID-19 has brought hardship upon all of our community, we must be mindful of the disproportionate effects on the most vulnerable, those who may already be struggling. Suicide and self-harm can affect anyone, at any age, but there are avoidable and unfair health inequalities, meaning that certain groups are more vulnerable than others. Community mental health and wellbeing and strengthening community resilience, will be crucial going forward.

To prevent deaths by suicide, communities must come together to make suicide prevention everyone's responsibility. Only a third of deaths by suicide occur in people who have access to mental health services, highlighting the need for a system wide, public health approach. Local authority public health teams are uniquely positioned to bring together services for a blend of approaches, to combine expertise and resources and facilitate collaborative working.

We believe that every death by suicide is one too many, and we strive to ensure that the support and protection is in place to prevent further deaths by suicide in Oldham. This Suicide Prevention Plan sets out an ambitious 10 year plan, building on existing work across the borough, to create a suicide safer community.

The Nine Pillars of Suicide Prevention

Oldham's Suicide Prevention Plan is modelled around the Nine Pillars of Suicide Prevention for Suicide-Safer Communities. This is an international, evidence-based approach to suicide prevention, that recognises the importance of taking a multi-agency and community approach. By achieving the Nine Pillars of suicide prevention a town can become an accredited suicide safer community. The Nine Pillars form the strategic base of our strategy with supports our primary aims and enables our vision.

The Nine Pillars are:

Leadership
Evidence and Data
Suicide Prevention Awareness
Suicide Intervention and Clinical Support
Bereavement Support
Capacity Building
Mental Health and Wellness Promotion
Training
Evaluation

Our Vision

Oldham as a Suicide Safer Town

- We will strengthen community resilience and wellbeing, to enable Oldham residents to cope with life stresses and adversities
- Our plan is people powered and designed for the people of Oldham, by the people of Oldham
- By structuring our suicide prevention plan and actions around the Nine Pillars of Suicide Prevention we strive towards achieving Suicide Safer Communities Accreditation
- A place-based approach will enable an individual community focus to tailor suicide prevention to local needs

Suicide is Everyone's Business

- We want to shift the focus to recognise that suicide is not just related to poor mental health, it can affect anyone, and should be tackled across our services and community
- We want to empower Oldham's workforce and residents to contribute to preventing suicide through increased awareness and training
- We seek to reduce stigma to ensure that our residents feel that it is ok to talk about suicide and self-harm, to be able to offer, or ask for help

Help is always on hand for people who are struggling

- No one should feel that suicide is the solution to their problems. We want to help people before they reach crisis point through prevention and early intervention
- We seek to support people who self-harm to access help and support and to keep people safe from harm in times of distress
- We will continue to ensure that when people are in crisis and struggling to cope, there is help and support available in a variety of forms, that recognises varying needs and is accessible and inclusive to all Oldham residents
- Raising awareness of the support that is on offer will support people to know where to access help

Suicide affects everyone
(SPS Consultation)

Every public health/suicide prevention team or those working to prevent suicide should work to the Nine Pillars of suicide prevention.
(SPS Consultation)

Building and Sustainability

Making Suicide Everybody's Business

Our plan is powered by the people, for the people of Oldham and makes suicide prevention everybody's business.

All Oldham residents have the ability to save a life, by helping someone that is struggling with self-harm or suicidal thoughts. Knowledge is power, and knowing what help is available and how to talk about self-harm and suicide, is crucial to empower residents to play a suicide prevention role. Through training and awareness raising we seek to start and maintain conversations to break down the stigma and taboo, which sadly so often enshrouds suicide and self-harm.

A People Powered Suicide Prevention Plan

We delivered a concise and time limited piece of engagement work to contribute the choices of Oldham's residents and experts by experience to the suicide prevention plan. We consulted as widely as possible, to ensure that the suicide prevention strategy, and accompanying action plan, reflect local needs to make a meaningful difference. We engaged with people who live and work across the borough, including people who use our services, who have lived experience of suicide and self-harm, or have been bereaved or affected by suicide.

The Nine Pillars of Suicide Prevention form a stable foundation to help us to achieve our strategic vision.

Each pillar has an important role to play both independently and in supporting and linking to one another. This overlap between each strand of work strengthens the strategic base, recognising that for meaningful and sustainable change, we must work together in our approach.

Whilst the pillars form the foundations of the strategy, capacity building runs through all of the pillars and everything we do. We understand capacity building to mean that Oldham residents' are at the heart of the plan, and we strive to build on existing strengths to help communities to help themselves.

Suicide affects all ages, our approach must consider different age groups who will have different needs

(SPS Consultation)

Family and friends of the vulnerable is the most important aspect in suicide prevention. They are the ones in need of support to identify and report

(SPS Consultation)

Consulting with Oldham residents and employees (Suicide Prevention Strategy Consultation 2022)

We delivered a concise and time limited piece of engagement work to contribute the voices of Oldham's residents and experts by experience to Oldham's suicide prevention plan. It was important that information was collected in a sensitive and empathetic manner to avoid being triggering or upsetting. We developed a questionnaire, which took into account a range of views including mental health and social care colleagues, research engagement and consultation team and Greater Manchester colleagues. TOG Mind staff sense checked the questionnaire before it was made available on Oldham Council's website site and social media platforms as well as in the staff newsletter. All the suicide prevention partnership members were encouraged to share the questionnaire with their staff.

The information gathered has been used to inform the suicide prevention work across Oldham

The results are based on the responses of over 80 participants

- 47% of respondents used at least one mental health or wellbeing service including: Healthy Minds, Positive Steps, TOG Mind, Healthy Young Minds (now CAMHS)
- 72% of respondents worked, some or all of the time, with people who at risk of or affected by suicide or self harm
- 54% work with adults
- 35% work with all ages
- 11% work with children and young people
- 89% of participants agree that the Nine Pillars of Suicide Prevention are a suitable framework for our plan

Percentage of participants who agree with the six priorities

Self-harm	83%
Legal, illegal and prescribed drugs and alcohol misuse	83%
Loneliness	90%
Age targeted approach	84%
Males	81%
Preventing access to means of suicide and high frequency locations	64%

Participants employment

Oldham Council	39%
Health and Social care	25%
None	15%
Voluntary sector	14%
Student	3%
Other	3%
Education	1%

A sample of quotes from the survey have been shared throughout the plan.

Insight gathering with children and young people (Young People Insight Gathering 2022)

Suicide and self-harm can affect all ages, but the challenges and experiences of individuals and the help that is required will differ with age. There are unique factors that are often present in the deaths of children and young people including problems at school, bullying, social media and internet use and neurodevelopmental conditions. In the UK suicide rates in children and young people are rising, particularly in girls and young women. Whilst fortunately rates of child suicide are low, one death is one too many, and more could be done to prevent future tragedies.

In writing our strategy it was therefore critical to capture the voices and needs of children and young people in Oldham.

Gathering Insight

The public health team and youth service worked together to develop a series of conversation prompts to capture information around young peoples experiences, and their thoughts on how things can be improved around suicide and self harm support and prevention. When it was safe to do so, young people who were well known were invited to take part by youth workers who have the training and expertise to facilitate difficult conversations and were known and trusted by the participants. The exercise was entirely voluntary and each conversation was tailored to the needs of the individual to ensure that each young person was safe and comfortable. This insight gathering was intentionally small scale and focused, recognising the complexity around the subject matter and the intensive approach and support that was required. A number of young people shared rich, powerful and invaluable insight with the team, which have helped shape our plan to cater to young peoples' needs, and for which we are very grateful.

Themes:

- Information and support should be available from any 'trusted adult'
- Suicide Prevention and Self-harm training is needed for all trusted adults
- Young people wish to be able to access help and support in a range of ways
- A safe space is discreet, comfortable, colourful, but not overstimulating, clean, and most importantly has friendly and welcoming staff
- 'make sure that reliable websites to find out more information are widely known to young people and adults'
- 'It should be a comfortable place to talk to someone that is accessible and personalised but not over stimulating but not too bare or stark. If it's a space in school, it should be discreet'
- 'It's the people that counts.'
- Schools focus more on mental health and less on suicide and self-harm
- The young people felt confident in accessing help and support

YP Insight Gathering 2022 continued

Toxic Positivity should be avoided

'Tik Tok especially spreads misinformation. It should be called Tik-toxic'

'You hear things like you're not depressed it's just a bad day – feels like they don't take it seriously.'

'A barrier is also it being too obvious that you are going to a specific place to get help like having to knock on the door or wait outside'

'I think young people are more at ease talking about mental health, but a barrier is the adults aren't – when you speak to some adults they are obviously uncomfortable.'

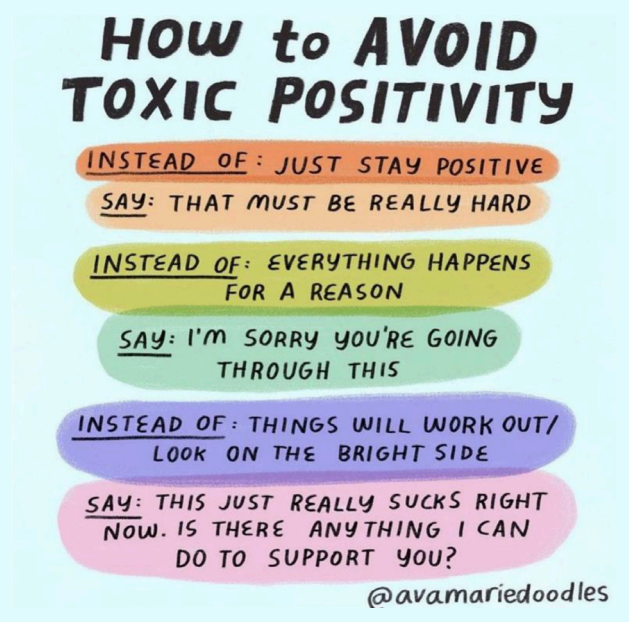
Social media can have both positive and negative content, but Tik-Tok can be particularly harmful

Barriers to accessing help include a lack of discretion, adults who struggle to talk about suicide and self-harm, not knowing where to access support, stigma and stereotypes

When someone is in distress, saying the right thing can be difficult. Toxic positive comments can be overly positive towards a difficult situation and make the recipient feel that their difficulties have been rejected.

These things are often said when people don't know what to say, and can be unintentionally harmful. This theme came up on several occasions during the young persons consultation, explicitly and inexplicitly, but this can occur in all ages particularly older generations.

Training is essential to support trusted adults, friends and family to know what to say to when someone is struggling and intergenerational work and learning may support all ages to think and talk differently about suicide and self harm prevention.



What does an adult trained in suicide prevention look like?

What young people said

- They stay calm
- Good eye contact
- They treat you how you prefer to be treated. They keep you safe.
- They are comforting and they listen, they are knowledgeable and provide advice.
- It's about them listening and working through the situation with us not for us.
- Knowledgeable but doesn't have to know everything.
- They are confident

The Nine Pillars of Suicide Prevention in Oldham

Leadership

Oldham's Suicide Prevention Partnership

In view of the complex factors that lead to a person ending their life, there is no single agency that can prevent suicide alone. In Oldham, the suicide prevention partnership facilitates and promotes collaborative working at a strategic and operational level, to prevent self-harm and deaths by suicide in Oldham residents. The partnership was established in 2016 and is chaired by Oldham's Director of Public Health, with the local authority public health team driving the agenda. This strategic group meets bimonthly to share knowledge and identify and agree improvements for the prevention of suicides in all ages and lead on the suicide prevention agenda.

Leadership The Oldham Suicide Prevention Partnership lead on the suicide prevention agenda in Oldham

Governance The Suicide Prevention Partnership reports to the Health and Wellbeing Board and the Integrated Care Board who hold the partnership accountable on behalf of Oldham residents.

Accountability Ultimately, the Suicide Prevention Partnership is accountable to Oldham's residents.

Oldham's Suicide Prevention Partnership members:

Action Together

Child and adolescent mental health services

Greater Manchester Police

NHS Oldham Integrated Care Board

Oldham Council

OPAL Advocacy Service

Positive Steps

Probation Service

SWAN bereavement

Your Health Oldham

Adult mental health services

First Choice Homes

Jigsaw Housing Support

North West Ambulance Service

Onward Support Services

Papyrus

Primary Care

Samaritans

Tameside Oldham and Glossop (TOG) Mind

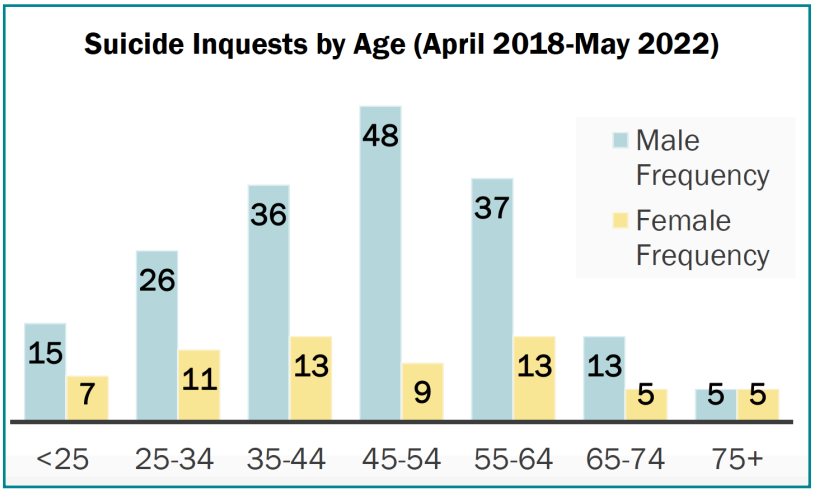
Turning Point Drugs and Alcohol Service

Evidence and Data
(Oldham, Rochdale and Bury (ORB) Suicide Audit April 2018-May 2022)

A range of challenges were experienced by the 243 people who died by suicide or misadventure between April 2018 and May 2022:

Relationship concerns	44%
Mental Health input	39%
Challenges around drugs	36%
Physical health problems	31%
Challenges around alcohol	27%
Financial concerns	25%
Employment concerns	25%
Affected by grief	23%
Made a previous suicide attempt	21%
Experienced known physical/mental abuse	10%
Under police investigation	10%
Non UK National	6%
Ex Service people	5%
Faced challenges around social media	3%
Carers	3%

Coronial data is collected from across the coronial footprint of Oldham, Rochdale and Bury and shared with the suicide prevention partnership monthly.



The local authority is notified of deaths by suicide or misadventure by the coroner following the inquest. Whilst there is something to be learnt from every individual story, exploring themes over a larger footprint can provide estimates of patterns and themes, to help identify where action is required to reduce deaths by suicide at a population level. This information helps us to understand local need and tailor our suicide plan and interventions accordingly.

There have been 243 coroner ruled deaths by suicide or misadventure in Oldham, Rochdale and Bury between April 2018 and May 2022.

60 of these deaths were Oldham residents.

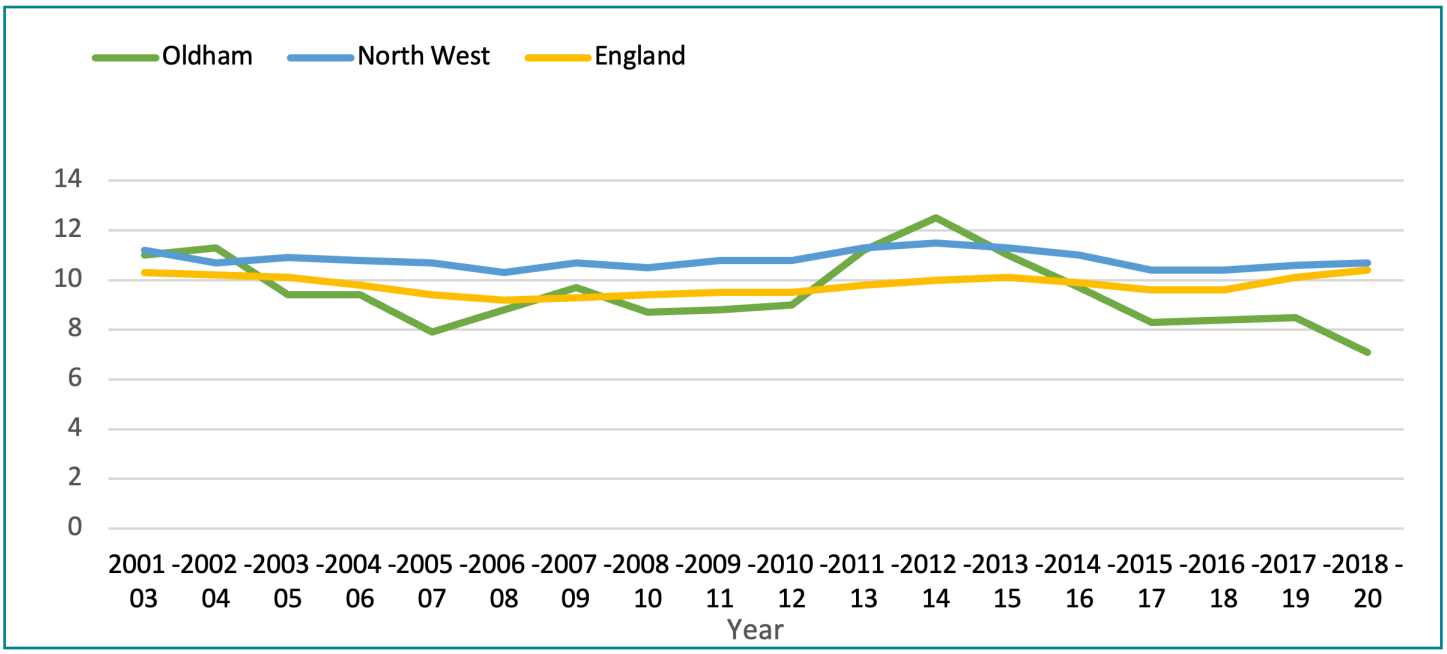
In 2021, there were 83 coronial inquests with a conclusion of suicide or misadventure across ORB. The corresponding deaths may have occurred in the same year or the year proceeding.

Numbers can only tell part of the story. There will be some individuals whose deaths were not recorded as suicide, who actively or intentionally contributed to their deaths. There are many others who continue to struggle. And behind each number there is an individual life lost and family and loved ones who are bereaved.

The average age of death between April 2018-May 2022 was **46 years** in males and females.

Females 26% Males 74%

Despite the fluctuations seen in the graph, the suicide rate in Oldham has been statistically similar to the national average from 2001 until 2018-2020 when it has dropped to significantly lower.



Mental Health and Wellbeing Promotion

Individual Wellbeing

The reasons for suicide are complex, sometimes suicide is seen as a solution to a crisis and often there are a many of factors that contribute to someone ending their life. But these factors do not automatically put an individual at an increased risk, and it will depend on a number of things including the support available to enable individuals to cope with adverse life events. Similarly, the absence of risk factors does not mean the absence of risk.

Five Ways to Wellbeing

Wellbeing, feeling good and functioning well, are important factors when we consider suicide prevention. If people are well, they are less likely to become mentally and physically ill. The Five Ways to Wellbeing suggests five simple ways in which individuals and communities can boost their wellbeing. They are things that anyone can do in some shape or form, it is not necessarily about achieving all five, or finding a new hobby, but about carving out space in our lives to do the things that bring joy, and allow us to enjoy a moment of pleasure.

An Environment for Wellbeing

If communities are healthy and well, they are less likely to turn to suicide and self-harm as a way of coping with adversity. We strive to provide the conditions required for resilient communities with positive mental health and wellbeing, recognising that this will look different for different people. To enable all individuals to have the opportunity to incorporate ways of wellbeing into their lives, the conducive environment must be created in schools, workplaces, homes and neighbourhoods. To achieve this our strategy links with other strands of work across Oldham to recognise the role of health inequalities and the social determinants of health in societal wellbeing, to facilitate the living conditions that will enable Oldham residents to adopt healthy lifestyles.

Protective Factors can help to increase peoples' resilience, mental health and wellbeing and reduce the population suicide risk. Some of these are:

- Effective coping and problem-solving skills
- Presence of reasons for living, hopefulness and optimism
- Being in control of behaviour, thoughts and emotions
- High self-efficacy
- Physical activity and sports
- Family connectiveness
- Supportive schools
- Religious belief and traditions

> ***A variety of vehicles to support people to connect with themselves, the world and each other.***
>
> (SPS Consultation)

What would an environment that supports children and young peoples' mental health look like? (YP Insight Gathering 2022)

- A place where you have positive relationships with adults you can trust
- A place where you are respected and treated as an equal
- Discreet
- A rest space
- It's the people that counts

> ***Any trusted adult. It might be a parent or youth worker or teacher or even sports coach. These are the people we go to so they need to have some training even if it's just to support to go to MH service.***
>
> (YP Insight Gathering 2022)

Suicide Prevention Awareness

Through campaigns and media engagement, we hope to raise awareness, change attitudes, and encourage conversation around suicide and self-harm. We hope to empower individuals to recognise and respond to suicide risk, by engaging local communities in a way that is culturally sensitive and aware.

Suicide Prevention Awareness can:

- Start and sustain conversations so that our communities feel that it is ok to talk about suicide and self-harm, and to ask for help.
- Break down the stigma and taboo associated with suicide and self-harm
- Raise awareness for the help and support, signposting people to the appropriate services or someone to talk to (eg. School setting). Click here for mental heath support.
- Empower individuals who are in a trusted positions, to have conversations with people at risk, to listen, support, signpost and escalate as appropriate.

Our Key Messages:

- It is ok to talk about suicide and self-harm
- Compassion is essential
- Asking someone about suicide does not increase their risk
- Help is available to anyone that needs it
- Suicide is not inevitable and can be prevented
- Anyone has the power to recognise and respond to suicide risk

> ***More business to be involved in helping staff with mental health too many people choose to ignore it.***
>
> (SPS Consultation)

Everyone needs an awareness to have the power to help others, a key part of raising awareness is through appropriate training.

Training

We believe that with the right training anyone can be empowered to help reduce the risk of suicide. With the appropriate support, families, carers, friends, colleagues and employees can be equipped with skills that can help to keep people safe. In Oldham, we plan to develop the skills and knowledge of community members and professionals.

We recognise that there is a critical need for training across the borough, and advocate for training to be embedded within workplaces and made routinely available across Oldham. This is important for all organisations, not just within mental health spheres, and a key component of making suicide prevention everybody's business.

Whilst we respond to training needs directly, by providing training whenever we can, our primary role is to advocate that all organisations take responsibility for training their workforce. Recognising that this can be challenging, and in many settings will have never been done before, the Suicide Prevention Partnership are available to offer guidance and assistance for any organisation in Oldham who would like to develop their training approach.

Who should be trained to help support young people around suicide and self-harm? (YP Insight Gathering 2022)

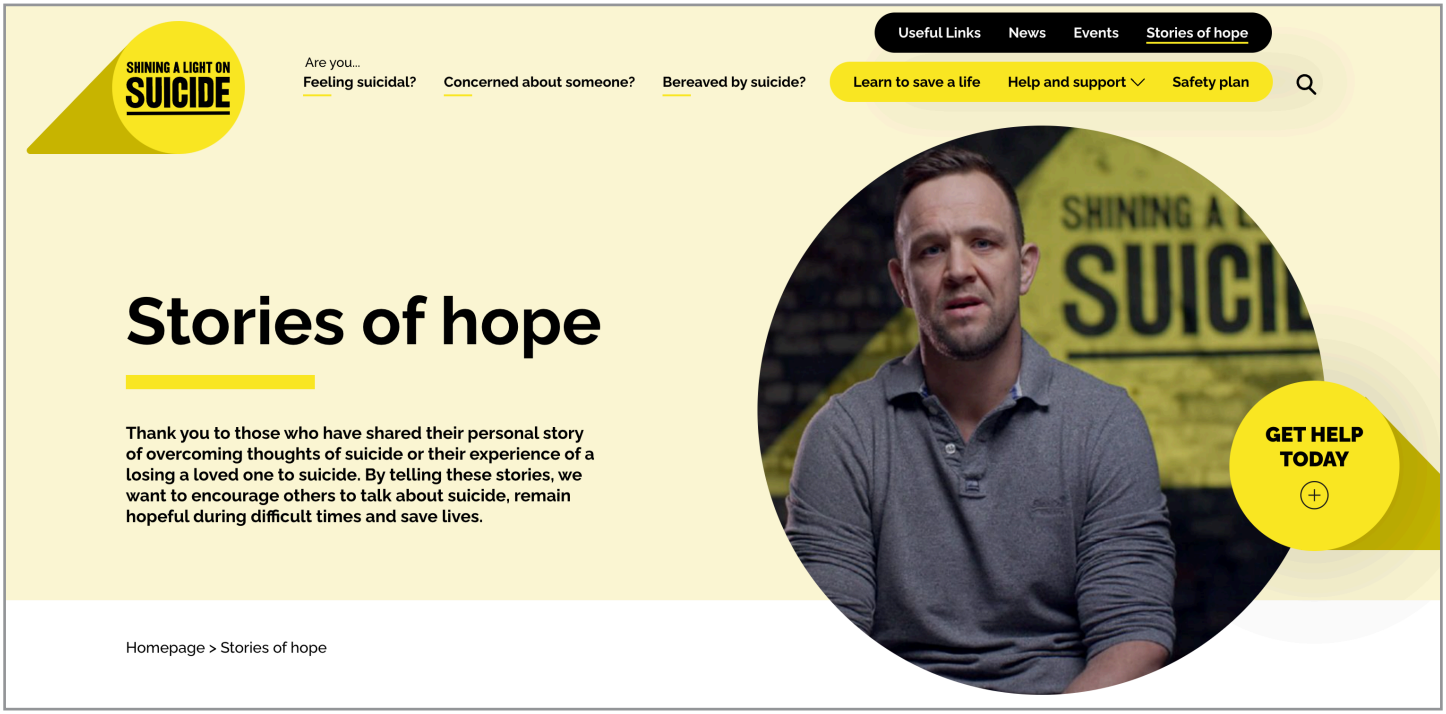
Friends
All school staff
Doctors and nurses
Specialist mental health people
Youth workers
Teachers
All adults in roles of responsibility with young people
The government
Parents

Training is available on a spectrum

- Suicide First Aid offers more detailed training to teach applied skills in suicide prevention and is aimed at professionals who manage and support people who are actively suicidal
- Self Harm Awareness training raise awareness and teach to have conversations
- Suicide Awareness Training offers approaches for raising awareness having conversations
- Free online training by Zero Suicide Alliance - From brief advice to support with applied skills, with something suitable for everyone's skills.

Shinning a Light on Suicide

Greater Manchester's campaign to bring suicide out of the dark offers further reading, free training and free resources such as training plans.



Suicide Intervention… is everyone's responsibility

Two thirds of people who die by suicide are not in contact with mental health services. Whilst some people may seek help from their GP, or other settings such as A&E, many others who are struggling are unknown to services. Some may look for help from someone they trust, such a teacher in a school setting, or show signs of distress perhaps when seeking financial advice or visiting their hairdresser. There are others who are struggling in silence who risk slipping under the radar.

When thinking about who may need help and support, we can split the population into three groups: general population, children and adults receiving safeguarding support and those under the care of mental health services. Instinctively, when we think about how we can prevent suicides we presume that the responsibility lies with mental health services. In reality, they are a crucial piece of the jigsaw. People under the care of safeguarding and mental health service teams are just some of the people who are vulnerable, and in fact there are many more people who we may not know about. Intervening to prevent a suicide is therefore everyone's responsibility. A suicide intervention can range from signposting someone who is struggling to services, providing a listening ear, a helpline poster or strategic responses to reduce access to means or increase training. No matter how big or small we all have a role to play.

Suicide Prevention and Mental Health

Mental health problems are common, with one in four adults experiencing at least one diagnosable mental health illness in any year . Throughout the pandemic, existing mental health problems have been exacerbated and new ones have developed. One third of deaths by suicide occur in people who have access to mental health services, meaning that adult's and children's mental health services have a critical role to play in suicide prevention.

Suicide Prevention and Safeguarding

The Oldham Safeguarding Adults Board and Oldham Safeguarding Children Partnership ensure that adults and children who are vulnerable to, at risk of or experiencing abuse and neglect, receive care and protection. Some children and adults who receive safeguarding support will be under the care of mental health services, but many others will not. However, all will have a level of vulnerability that means they may require additional help and support.

Suicide Prevention Partnership

The suicide prevention board sits in the middle and leads and champions the role of suicide prevention across all organisations in Oldham. We work closely with mental health and safeguarding partners to share learning and advocate suicide safety across the borough.

> ***'Not all those who complete suicide have mental health issues. Better sign posting to other services would help'***
>
> (SPS Consultation)

…and Ongoing Clinical and Support Services

With a range of voluntary and clinical support services available, no one should be left to struggle alone. Anyone who is in need of help, should be able to access a service that meet their needs, regardless of their social, cultural and religious norms, physical and mental illness and disability. Clinical and other support services must be connected, and work seamlessly to provide various access routes to help. Services and teams working within all three circles must work together to keep people safe, the suicide prevention partnership can support this.

We take an advocacy and coordination role to bang the drum for suicide prevention in all strategies and work strands.

This plan compliments and supports the priorities of other strategies to give a clear and consistent message. By ensuring that different strategies fit together, we broaden our scope, strengthen our response and avoid duplication, to make the most impact.

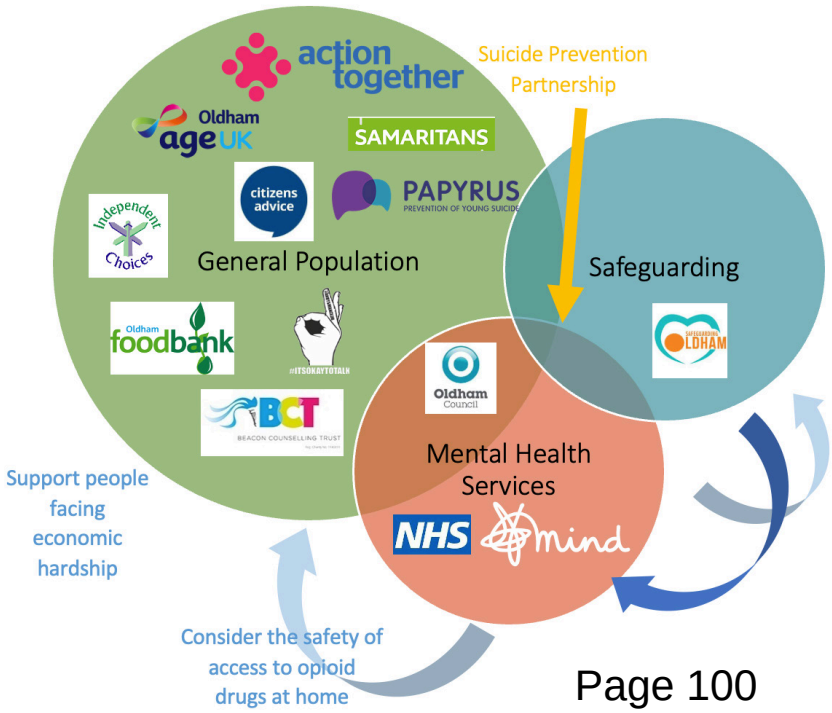
Whilst the suicide prevention partnership is not responsible for service provision, we act as a link between different teams to facilitate the sharing of information and learning in both directions.

Some of the other strategies, services and teams we link into are:

Domestic violence
Learning disabilities
Community Mental Health Transformation
Domestic Violence
Health Inequalities Plan
Public Health Annual Report Strategy
Carers
Autism
Drugs and Alcohol
Mental Health Strategy
Safeguarding
Thriving Communities
Asylum Seekers and Refugees strategy

We will work towards:

- Supporting people facing economic hardship
- Working with Oldham residents to improve services (Living well collaborative)
- Considering domestic violence and suicide risk
- Considering the safety of access to opioid drugs at home
- Considering ways to work together to support people with dual diagnoses and complex needs



A joined up approach with seamless transition between services that is easy to navigate by service users and other agencies.

(SPS Consultation)

That in someone's greatest hour of need - they can access good quality, compassionate support

(SPS Consultation)

Bereavement Support

The death of a family member, friend, colleague or neighbour will touch the lives of many and cause pain, sadness and suffering. Whilst grief is a normal reaction, sometimes help and support is required to manage these emotions. People who are bereaved, especially by suicide, will often experience acute distress and difficulty, and are at higher risk of suicide themselves.

A death by suicide can leave the bereaved feeling isolated and with lots of unanswered questions, stigma can make it particularly hard for people to talk and prevent people from seeking help and others from offering support. Whilst any loss has the potential to cause distress, evidence shows that bereavement by suicide can be particularly difficult. It is essential that people know where to turn to access help and that immediate information is available, including signposting to services. Everyone's experience of grief is unique and we must recognise this, by providing a personalised approach that meets individual's needs, whether that be now or later, face to face, online or via social media. If people have access to tailored bereavement support, their personal risk of suicide can be reduced.

The Ripple Effect

The grief caused by suicide can act like ripples in a pond extending much further than close family and friends. People can be affected by the death of something less well known, however the effect this may have on someone cannot be underestimated.

Support and advice

The following links have support and advice from trusted sources.

NHS Bereavement Helpline

Survivors of Bereavement By Suicide

SWAN Bereavement

Greater Manchester Bereavement Service

Oldham Community Crisis Support Line – Ghazali Trust

Breathe Parent and Carer Support Group

Child Bereavement UK

Healthwatch Online Support

Good Grief Trust

What would good support for children and young people bereaved and affected by suicide look like?

YP Insight Gathering 2022

It should be very specialist support because it's more than just being bereaved – its even harder to comprehend and the person may need help with guilt or blame feelings they are having...

It should be trauma support not just bereavement support – losing someone to suicide must be so traumatic

Evaluation

The most important part of this strategy is the action it evokes across all nine suicide prevention pillars.

The action plan that supports this strategy is iterative, live and responsive to changing needs.

Evaluation is vital to track our progress and ensure that our approach is under continual review.

Evaluation will be embedded throughout all nine pillars, to continually scrutinise our approach through regular review of our progress against the action plan, to which we are held accountable.

Local data will also form an important part of evaluation, and there will be a commitment to regularly review and share coronial data with the Suicide Prevention Partnership and other stakeholders. This will enable us to observe for a change in trends.

We will also listen to our Suicide Prevention partners who can share information of emerging trends observed by the services and organisations across the borough.

We will make a commitment to work with multidisciplinary team members such as North West Ambulance Service and Greater Manchester Police, to strengthen our use of their rich data sources and information, to further understand their insights and observed patterns.

When evaluating and reviewing changes in trends, it is important to be mindful that an increase in demand on services, or people presenting in distress, may not reflect an increase in need, but rather an increase in willingness to seek help. A combination of data and information sources will therefore be used to obtain a complete picture.

The Suicide Prevention Partnership's Role across the Nine Pillars

1. **A leadership group:** Oldham's Suicide Prevention Partnership **leads and** coordinate suicide prevention activity across the borough.

2. **Evidence and Data:** We utilise a range of local and national data sources and work closely with the coroner to help us to understand the scope of the problem within Oldham. **This information helps us to understand local need and tailor our suicide plan and interventions accordingly.**

3. **Mental Health and Wellbeing Promotion:** We want to create an environment that supports mental health and wellbeing and enables people to lead healthy lifestyles by advocating for healthy environments and the Five Ways to Wellbeing and Connect 5 across the borough.

4. **Suicide prevention awareness:** We raise awareness, to educate and reduce stigma, to help Oldham residents to feel safe to talk about suicide and self-harm.

5. **Training:** We want to develop the skills and confidence of community members and professionals in preventing deaths by suicide **by advocating that all organisations take responsibility for training their workforce and offering guidance and assistance for any organisation in Oldham who would like to develop their training approach.**

6. **Suicide intervention and clinical support services: We take an advocacy and coordination role to bang the drum for suicide prevention in all strategies and work strands. By ensuring that different strategies fit together, we broaden our scope, strengthen our response and avoid duplication, to make the most impact.**

7. **Suicide bereavement support: We want to ensure that all Oldham residents who have been bereaved have access to a support service that suits their needs.**

8. **Evaluation and data collection:** We will continue to gather data and information to ensure that **we follow trends and understand changes to local needs. Our activity and impact is under regular through the review of our progress against the action plan**.

9. **Capacity building within communities: Intertwined across all of the eight other pillars, we seek to make suicide prevention everyone's business to involve the people that this plan will impact, make the biggest impact and increase the sustainability of our plan and actions.**

Initial Areas of Focus

Oldham's Suicide Prevention Plan is designed to prevent as many deaths as possible in the population of Oldham. When it comes to the risk of suicide, we know that there is not a level playing field and some individual characteristics or social factors can make certain groups of people more vulnerable than others. To have the greatest impact, for the first year of the plan, we will direct a greater proportion of resources to the groups in our society who are disproportionately affected by suicide. Six initial areas of focus will be prioritised simultaneously to enable us to develop a focused action plan that recognises and works within our capabilities.

The initial areas of focus have been identified using local data and consultation with Oldham residents to reflect some of the key issues locally. Although we recognise these areas as potential vulnerabilities, this does not mean to say that all people who relate to these groups are vulnerable. Every death by suicide marks the devastating loss of an individual, with their own unique story and factors that contributed to their death.

Whilst this approach offers a starting point for more targeted action, we will continue to ensure that our actions have universal benefits across the borough, excluding no one, and the focus areas will be under regular review.

Our focus areas for years 1 and 2 will be:

- Self-harm
- Legal, illegal and prescribed drugs and alcohol misuse
- Loneliness
- Age targeted approach
- Males
- Preventing access to means of suicide and high frequency locations

A population based approach will hit the groups that are at higher risk, however there is a risk that resources may be stretched too thin.

(SPS Consultation)

I'm sure making services available to all would help, people don't have to fit into a category to have suicidal thoughts but having a focus on the most at risk groups helps.

(SPS Consultation)

Self-harm

Self-harm is complex and can occur with or without suicidal intent. It can be associated with a mental health condition or adopted as a coping mechanism in response to serious emotional distress. Whilst most people who self-harm will not go on to take their own lives, self-harm is a known risk factor for suicide and certain groups are at greater risk of fatal consequences. Self-harm presentations can provide an opportunity for intervention, and the detection and treatment of self-harm is paramount. Oldham has a foundation of existing work, particularly in schools, that we can build on.

Why is self harm important?

- Self harm is damaging and is an important issue in its own right.
- It is a known risk factor for suicide. Approximately 50% of people who die by suicide have previously self harmed.
- Self harm can lead to accidental harm and death.

We recognise that a preventative approach is needed to avoid a reliance on self harm and stop people resorting to self harm in the first place.

Support for people who self harm is needed to find alternative coping mechanisms and reduce harm.

Where concerning trends in behaviour are identified services must come together to understand what is driving it and what can be done to reduce the risks.

The suicide prevention partnership raise awareness of self harm across the life course and provides support for staff to know what do through each of the nine pillars.

Self-harm in all ages

Whilst self-harm is the most prevalent in young adults, with the highest rates in young girls and women, levels continue to rise in men and women of all ages.

Certain behaviours or demographics may mean that self-harm is less easily identified in some groups. For example, harmful behaviours in older adults such as self-neglect, may not be recognised as self-harm. It is important to make a distinction between self-harm in different groups to determine how it is managed. Whilst less common in older adults, suicide completion rates following self-harm are significantly higher in older adults. Self harm must therefore be recognised and managed effectively across all ages.

The true scale of the problem is not known as many people who self harm do not seek help from services.

In 2021/22 there were 320 referrals to Child and Adolescent Mental Health Service (CAMHS) for concerns of self harm.

Whilst there is no national evidence to suggest that self-harm rates have increased due to the pandemic, it is important to note that the picture is unclear due to limited data, and the effects will not be the same across different groups.

A lot of damage is done through self harm - mentally and physically

(SPS Consultation)

if we get this right it will drastically reduce the pressures on other services such as ambulance, A&E, CAMHS, Police

(SPS Consultation)

Self harm is an indicator of potential suicide and needs to be responded to in a positive way

(SPS Consultation)

Legal, illegal and prescribing drugs and alcohol misuse

In June 2021, 1441 people were receiving treatment within the Oldham branch of Turning Point

4% of the people in treatment had recently attempted suicide
17% have attempted suicide in the past
10% have current suicidal ideation
23% have experienced suicidal ideation in the past
15% have high levels of distress
21% have experienced high levels of distress in the past
6% reported self harm behaviour
13% report past self harm behaviour

The use, escalating use and misuse of alcohol and legal, illegal and prescribed medications is commonly seen in people who die by suicide in the UK. Drug related challenges is one of the most common related challenges noted by the local coroner in relation to deaths by suicide in Oldham, Rochdale and Bury. A large number of serious adult reviews by Oldham Adults Safeguarding Board indicated that many vulnerable adults who have died by suicide had a dual diagnosis and used substances to manage mental health conditions.

Oldham's integrated Drugs and Alcohol service, Turning Point, have seen an increase in their clients presenting with crisis, self-harm and suicidal ideation and attempts. Other services have seen a rise in people experiencing challenges around alcohol and drug use, particularly since the pandemic.

Turning Points are seeing strong links between suicidal ideation and alcohol misuse, with alcohol a factor in two thirds of incidents. Staff observed that factors impacting clients mental state included isolation, traumatic events, unhealthy or abusive relationships, all of which had been exacerbated by the pandemic.

Trauma

Trauma can occur at any age, past or present, and affects everyone differently. The effects of a traumatic event or ongoing stress, can be long term and cause difficulties in daily life. Trauma is childhood is often termed Adverse Childhood Experiences (ACEs) and can be associated with physical and mental illness in later life. Some people misuse drugs and alcohol, or self harm, as a means to cope with difficult memories or emotions. A trauma informed approach can help support people who have experienced trauma.

Dual Diagnosis

When people have co-occurring drug and/or alcohol conditions alongside a mental health illness it is known as dual diagnosis and is associated with an increased risk of suicide ideation and suicide.

Criminal Justice System

People who are struggling with drug and alcohol conditions are more likely to be involved in crime, therefore links with the criminal Justice system, including the police and probation services are required. People in contact with prisons, probation and court can be more vulnerable to suicide, particularly at transition points, into, within and out of the system.

Lockdown caused many new drug and alcohol problems.
(SPS Consultation)

When people are struggling with drugs/alcohol there is usually underlying trauma in their life, which may then lead them to suicide
(SPS Consultation)

Loneliness

Anyone can feel lonely. People typically feel lonely when their need for social contacts and relationships are not met, this is not necessarily the same as being alone. Whilst some people can feel content without much social contact, others will experience loneliness. We can all feel lonely at some point in our lives, but when feelings of loneliness become persistent, it can be associated with a range of physical and mental health conditions, and people who are lonely may be less able to cope with adversity and life stressors.

Loneliness is also a risk factor for suicide. Whilst loneliness is a risk factor for suicide in all ages, a recent review found that loneliness affects young people and older adults the most significantly, perhaps due to significant life events, transitions, and changes in social status. Loneliness is a also significant risk factor for middle-aged men who need opportunities to strengthen their social relationships. People who were already feeling lonely, or were vulnerable to loneliness due to health, income, ethnicity or sexuality, were more likely to be affected by covid-19 restrictions. And although now restrictions have eased, and many people have returned to normality, people who face barriers, such as mental and physical health problems, or unemployment, continue to be affected.

Feeling lonely can be hard to talk about, and sometimes difficult to recognise in ourselves. Those who work with people vulnerable to loneliness, must feel comfortable asking the question, and inviting people to talk about how they are feeling. Our role is to ensure that the people who work with those who are vulnerable to feeling lonely, feel comfortable recognising the signs of someone who may be having thoughts of suicide or self-harm and be able to have conversations to support those individuals to access help.

Before the pandemic one in five people living in the UK felt lonely often or always, and numbers are likely to have increased since then due to reduced social contact.

Loneliness is one of the worst things and covers all ages.
(SPS Consultation)

Isolation can be a strong influencing factor on people having suicidal thoughts.
(SPS Consultation)

Misconceptions of what loneliness actually is requires addressing. People can be lonely whilst surrounded by others, for instance, work colleagues, family and friends. However, these relationships can be superficial or abusive, resulting in an experience of loneliness.
(SPS Consultation)

Loneliness is not just someone being 'alone'. Anyone can feel lonely.
(SPS Consultation)

Know that loneliness heightens all the other anxieties and self doubts.
(SPS Consultation)

This has a big impact and most people can experience this at some point, especially people who are vulnerable due to disability issues.
(SPS Consultation)

Age Targeted Approach

Suicide affects all ages. Many vulnerabilities are established in childhood and adolescents particularly through the impact of poverty, chaotic family lives, family break-ups and problems with education. Changing things in early life can have an impact through to adulthood.

We have prioritised an age targeted approach that recognises that whilst suicide affects people of all ages, there is no one size fits all, and the risks and needs of individuals will vary depending on age and stage in life.

We recognise that age groups are not discrete, and transition periods can cause difficulties. This aligns with GM Strategy's all ages approach.

We also wish to take an intergenerational approach to understand how different ages groups can help, support and learn from one another, for example how young people can take what they learn in schools to support older generations within their family and community.

Suicide risk is often cumulative, and rather than being caused by one thing, it is secondary to a build-up of trauma in early life, adversity and stressful events. These early experiences shape individual's futures, so reducing trauma and adversity in childhood, can mitigate the risk for today's children and young people, and tomorrow's adults. Different stressors are experienced at different ages, for example academic pressures and bullying in young people under 20 years whilst housing, finance and workplace problems more likely later in life.

Adults, over 65 years, who died by suicide were more likely to be a carer, have physical health problems, have experienced physical or mental abuse. (ORB Suicide Audit April 2018-May 2022)

Top five mental health challenges facing young people in Oldham
(Young People 2017 MH:2K Report)

Families and relationships
Stigma
Self-harm
The environment and culture of schools
Professional practise

The following factors were recorded as having been presented in child deaths by suicide. These are taken from coroner's inquest reports April 2019 - March 2020:

Household functioning
Mental health needs of the child
Conflict within key relationships
Abuse and neglect
Bullying
Drug and alcohol misuse by the child
Neurodevelopmental conditions
Problems with the law
Loss of key relationships
Risk-taking behaviour
Problems with service provision
Problems at school
Medical condition in the child
Social media and internet use
Sexual orientation/identify and gender identity

All ages can experience loneliness, all ages can have problems with alcohol dependency, all ages can use various ways to self harm. But all this will only differ in the ways it shows according to their age.
(SPS Consultation)

I think you miss a lot of the older generations as they won't ask for help and have the stiff upper lip of the older generation yet behind closed doors they are in a mess.
(SPS Consultation)

Males

On average, one man takes his own life every two hours in the UK. Middle-aged men are more likely to die by suicide than any other age group. Men in the lowest social class, or living in the most deprived areas are at the greatest risk of all, highlighting the health inequalities associated with suicide.

Typically, men are less likely to speak up, talk openly about their feelings or ask for help compared to women. Stigma can contribute to a sense of shame and weakness, and some men can feel that confiding their struggles does not align with the masculine ideal and societal expectations. The research shows that financial crisis, unemployment and relationship breakdowns, can also contribute to the distress that men feel.

Factors which play a role in Suicide Risk for middle aged men:

- Loneliness
- Unemployment and job loss
- Recessions
- Relationship breakdown
- Socio-economic factors
- Masculinity
- Challenges of midlife
- Emotional illiteracy

Building services that support men to engage without it being focused on mental health may be the answer

(SPS Consultation)

'You don't Need to Man Up, Just Speak Up' –Andy's Man Club

Andy's Man Club is a talking group for men, which provides a safe space for men to open up and talk about their experiences. They spread the message that #ItsOkayToTalk and challenge the stigma around male mental health. With weekly meets across the country, including in Oldham, Andy's Man Club provides a confidential, free, peer support group for men aged over 18.

The 2021 National Confidential Inquiry into Suicide and Safety in Mental Health, based on suicide deaths in middle aged men in 2017, identified that 91% of the men who died by suicide had actually been in contact with at least one front line services, most often primary care, 82%.

GPs need support to improve the recognition of distress in men and suicide risk, to ensure that men's needs are being met. It is vital that these opportunities to help a man in crisis

Building services that support men to engage without it being focused on mental health may be the answer

(SPS Consultation)

Men are less likely to seek support when struggling with mental health and more likely to resort to unhelpful coping mechanisms such as substance misuse, which then increases risk of domestic violence.

(SPS Consultation)

Males generally do not speak out due to stigma.

(SPS Consultation)

Statistics show that men are greatly effected however the focus needs to show involvement for females.

(SPS Consultation)

Preventing access to means of suicide and high frequency locations

"these are among the most practical things that local suicide prevention groups can do"
Preventing Suicide in Public Places, 2015

Putting measures in place that make it more difficult for people to put themselves in danger, can help people to pause, think through their actions and discourage suicide. The person will not necessarily go elsewhere or try again.

Around a third of all suicides take place in a public location. They can attract harmful media attention as well as having significant psychological consequences for those, including children, who witness them or discover a body. Suicides outside the home may also directly involve another person, such as a train driver.

Sometimes, individual locations become known locally because they are frequently used. It is important that we make these high-risk locations safer to prevent further deaths through restricting access, increasing opportunity for last minute intervention and by changing perceptions.

The Evidence

Since 2005, the evidence for restricting access to means in the prevention of suicide has strengthened. This is especially with regard to:

1. the control of analgesics
2. the implementation of structural interventions at high-risk locations for suicide by jumping.

Nationally, this approach has seen an overall reduction in deaths of 86% with little evidence of major substitution to other potential sites.

Making Places Safer

We work closely with the Greater Manchester Suicide Prevention team towards the GM approach, which supports the work of regional colleagues to take action at high frequency locations. The Greater Manchester Strategy follow the approach suggested by the evidence-based resource, Preventing Suicide in Public Places to take several effective steps:

Step 1. Identify locations used for suicide and prioritise on the basis of frequency through systematic collection and analysis of local data.

Step 2. Plan and take action at priority locations. This involves engaging stakeholders, assessing the site and drawing up and implementing an action plan.

Step 3. Apply the same thinking to similar locations. This pre-emptive approach should enable local authorities to prevent the emergence of frequently used locations.

Step 4. Evaluate and reflect.

Many suicidal crises are fleeting, by reducing the lethality of the chosen method or access to it lives can be saved.

The higher fences over motorway bridges and other prevention measures help as if someone is deterred from acting on instinct they have time to reflect and it gives time for them to reach out or others to intervene.

The less opportunity there is, hopefully the less deaths by suicide will occur.

Developing our Plan

Shared Goals	Oldham's suicide prevention plan aligns with the National and Greater Manchester Suicide Prevention Strategies. Working congruously with Greater Manchester acknowledges the fluidity of place and that Oldham residents move across the region for work and pleasure.
Guided by evidence	We have taken account of local, national and international approaches that have a proven track record in reducing the number of suicides in locations and/or populations. Our strategy has been guided and our action plan will be further developed following these principles and approaches.
Informed by data	Local data has been analysed to understand the needs locally
Local voices	Listening and responding to local voices
Synergising	This plan compliments and supports the priorities of other strategies to give a clear and consistent message, strengthen our response and avoid duplication.
Collaboration	Written collaboratively with suicide prevention board members
A dynamic action plan	Meaningful actions are under continual review to reflect changing needs across the borough
Accountability	The suicide prevention board members are responsible for overseeing the progress of actions

Shared Goals

- National Suicide Prevention Strategy 2012
- The National Strategy 5th Progress Report of the cross-government outcomes strategy to save lives
- The Five Year Forward View For Mental Health
- NHS Long Term Plan
- Greater Manchester Suicide Prevention Strategy
- Evidence and Guidance
- Nine Pillars of Suicide Prevention evidence based framework
- NICE Quality Standards: Suicide Prevention
- NICE Guidance (Get name)
- Samaritans – Local Suicide Prevention Planning in England
- Public Health England- Guidance for Developing a local suicide prevention action plan
- National Suicide Prevention Alliance Strategic Framework
- PHE literature review (get the name of this)
- Local government association suicide prevention guide for local authorities

Data

- Public Health Outcomes Framework
- Coronial Department's Suicide Audit April 2018 -March 2021
- Themes observed by the Coronial Bereavement Nurse Referrals

Turning Points Data on suicide and self-harm in people receiving treatment within the Oldham's Drug and Alcohol Services

- NWAS
- Adult and Children Serious Incident Reports
- TOG Mind Service Data

Local Voices

- Expert led workshop with key stakeholder in Feb 2020 with Bury, Oldham and Rochdale exploring what a good future strategy would look like
- 2019 workshop
- MH: 2K Oldham -A youth-led approach to exploring mental health
- Our Minds, Our Voices Survey Oldham -Youth-led research to explore what emotional health and wellbeing currently looks like in schools
- Engagement piece of work

Please find below a reading list, for further information and support if required

https://media.samaritans.org/documents/Suicide_Stats_England_2020_FINAL_eONhYYF.pdf

https://www.who.int/news-room/fact-sheets/detail/suicide

https://www.samaritans.org/about-samaritans/media-guidelines/suicide-facts-journalists/

https://www.who.int/news-room/fact-sheets/detail/suicide

https://www.bmj.com/content/371/bmj.m4352

https://documents.manchester.ac.uk/display.aspx?DocID=51861

https://media.samaritans.org/documents/Samaritans_Covid_1YearOn_Report_2021_BJCM8rI.pdf

https://media.samaritans.org/documents/Samaritans_Covid_1YearOn_Report_2021_BJCM8rI.pd

https://www.samaritans.org/about-samaritans/research-policy/understanding-our-callers-during-covid-19-pandemic/what-do-we-know-about-coronavirus-and-suicide-risk/

https://www.nice.org.uk/guidance/qs189/chapter/Quality-statement-1-Multi-agency-suicide-prevention-partnerships

https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/3/gid/1938132828/pat/6/par/E12000002/ati/102/are/E08000004/iid/41001/age/285/sex/4/cid/4/tbm/1

https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/3/gid/1938132828/pat/6/par/E12000002/ati/102/are/E08000004/iid/41001/age/285/sex/4/cid/4/tbm/1

https://media.samaritans.org/documents/Samaritans_-_Pushed_from_pillar_to_post_web.pdf

https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b6fdf395_10

The Five Year Forward View for Mental Health (england.nhs.uk)

Suicide Prevention in Oldham

Rebecca Fletcher, Interim DpH
Vicki Gould,
Senior Public Health Strategy and Commissioning Manager

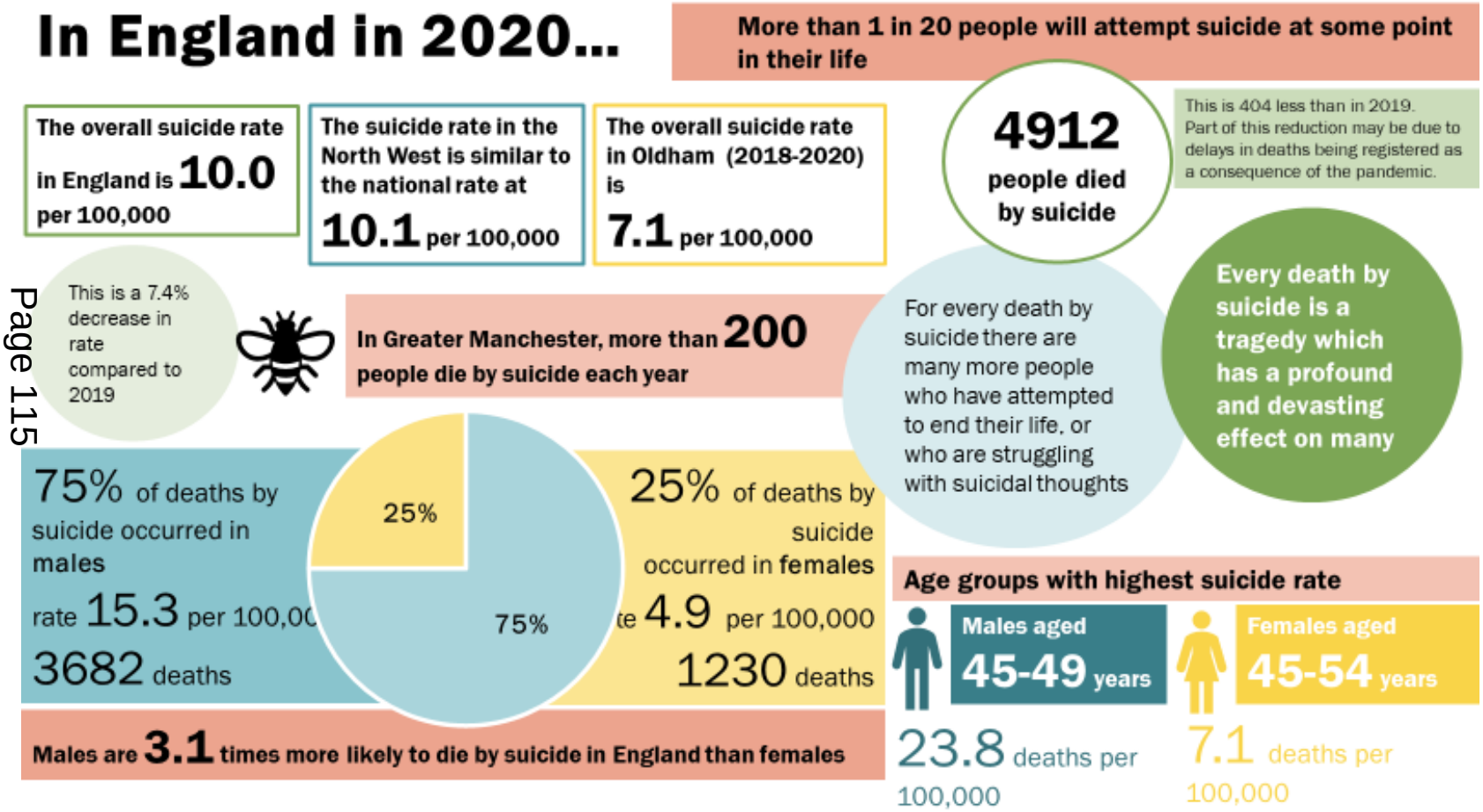
Oldham Council

Why Suicide Prevention?

- Every suicide is a personal tragedy and the impacts are wide reaching
- Some people in our communities are at particularly high risk
- People may become vulnerable at certain times / events
- Suicide among young people often leaves particularly devastating consequences / knock on effects

- Suicide is preventable, not inevitable

Suicide data



Where are we now?

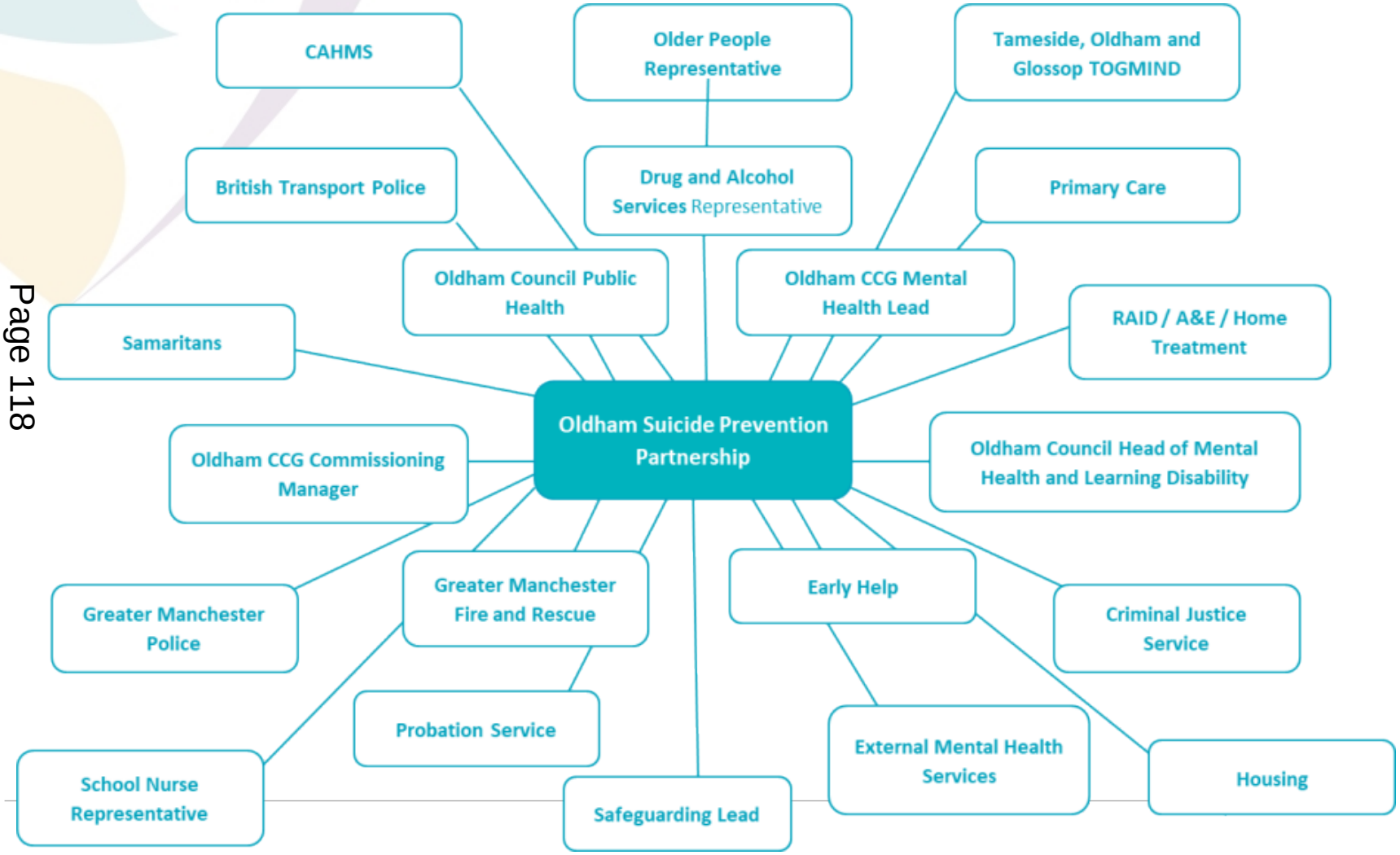
Oldham Council

Work to date in Oldham

1. First Suicide Prevention Strategy for the borough was launched in 2017

1. Brought together a partnership board for the first time

Stakeholder map – partnership group as of 2020



Work to date in Oldham …

- ✓ First Suicide Prevention Strategy for the borough was launched in 2017
- ✓ Brought together a partnership board for the first time

1. Many successes achieved by that board – i.e. integration into the GM approach, links into the Coroners court, embedded into safeguarding approaches (all ages)
2. Three year strategy. Should have been re-written for 2020…
3. Began work in early 2021 on a new strategy and action plan for the borough

In June 2021 we agreed…

- ✓ To use the 9 Pillars to structure the suicide prevention strategy
- ✓ To align with Greater Manchester and National Strategy
- To **use the evidence base to inform the strategy**
- To choose focus areas to concentrate our attention within the strategy

The next step was to…

…To choose the strategies focus areas or groups

The 9 Pillars of Suicide Prevention

A **leadership**/steering committee

A robust **background summary** of the local area to support goal setting

Suicide Prevention **Awareness raising**

Mental Health and **Wellness promotion**

Training

Suicide **intervention** and ongoing **clinical support** services

Suicide **bereavement** support and resources

Evaluation measures including data collection and **evaluation** system

Capacity building/**sustainability** within communities

Oldham Risk Factors (Data)	National Priorities	NICE Quality Standards	NICE recognised risk factors	PHE strategic Recommendations	GM Priorities
Men Middle age Physical Illness Grief Drugs & Alcohol Mental Health services Employment Concerns Financial Concerns Previous Suicide Attempts Relationship Concerns	1. Reduce risk of suicide in high risk groups -Men -mental health services -self harm -criminal justice system -Occupational groups 2. Improve mental health in specific groups 3. Reduce access to means of suicide 4. Bereavement support 5. Media support 6. Research, data collection and monitoring	1. Multi-agency suicide prevention partnership 2. Reducing access to methods of suicide 3. Media Reporting 4. Involving family, carers and friends 5. People bereaved or affected by suspected suicide	1. Men 2. Self harm 3. Drug & Alcohol Physical illness 4. Older adults 5. LGBT Community 6. Autism 7. Criminal justice system 8. Specific occupational groups 9. Mental health services 10. Bereaved	1. Men 2. Self-harm 3. Children and young people 4. High frequency locations 5. Isolation 6. Bereaved 7. Treatment of depression in primary care 8. Mental Health Services	1. Men 2. Self-harm 3. Children, young people 4. Women during pregnancy and postnatally 5. Tackling high frequency locations 6. loneliness 7. Bereavement support 8. Treating depression in primary care 9. Mental health care setting

...As you can see there were many similarities across the board

We invited members of the Suicide Prevention Board to share their thoughts…

"Please complete the questionnaire with you views and the views of your organisation"

Questions asked of the board:

1. Do these areas align with your views? If not, then why not?

2. Which of these areas do you think are the most important?

3. Or are there other areas that you think should be prioritised?

4. Is your organisation already doing work in this area?

Areas of Focus that emerged

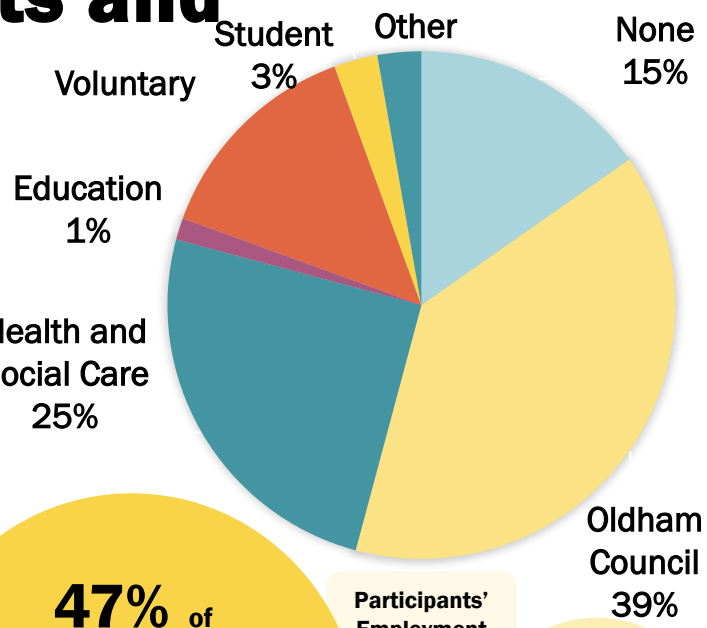
- Self Harm
- Legal, illegal and prescribed drugs and alcohol use
- Loneliness
- Age Targeted Approach
- Males
- Preventing access to means of suicide and high frequency locations

Next step was to consult more widely on the proposed areas of focus …

Oldham Council

Consulting with Oldham residents and employees (SP Consultation 2022)

The information gathered has been used to inform the suicide prevention work across Oldham



Participants' Employment

The percentage of participants who agree with the 6 priorities

- 83% **Self-Harm**
- 83% **Legal, illegal and prescribed drugs and alcohol misuse**
- 80% **Loneliness**
- 84% **Age Targeted Approach**
- 81% **Males**
- 64% **Preventing access to means of suicide and high frequency locations**

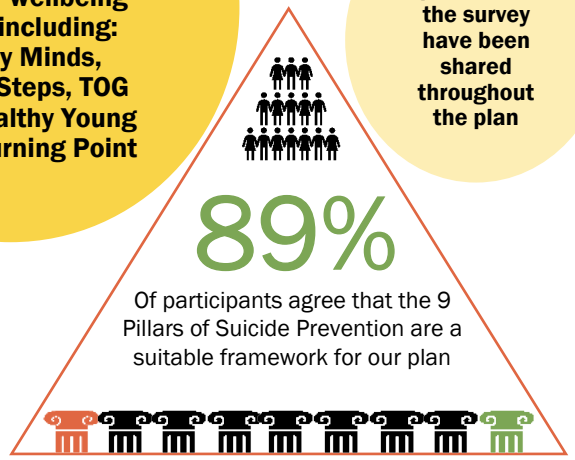
47% of **respondents used at least one mental health or wellbeing service including: Healthy Minds, Positive Steps, TOG Mind, Healthy Young Minds, Turning Point**

A sample of quotes from the survey have been shared throughout the plan

72% **of respondents worked, some or all of the time, with people who at risk of or affected by suicide or self harm**

- 54% work with adults
- 35% work with all ages
- 11% work with children and young people

We delivered a concise and time limited piece of engagement work to contribute the voices of Oldham's residents and experts by experience to Oldham's suicide prevention plan. It was important that information was collected in a sensitive and empathetic manner to avoid being triggering or upsetting. We developed a questionnaire, taking into account a range of views including mental health and social care colleagues, research engagement and consultation team and Greater Manchester colleagues. TOG Mind staff sense checked the questionnaire before it was made available on Oldham Council's website site and social media platforms, staff newsletter. All the suicide prevention partnership members were encouraged to share the questionnaire with their staff and clients in a way that was safe and suitable.



We also conducted insight gathering with children and young people ...

Oldham Council

Insight Gathering with Children and Young People

YP Insight Gathering 2022

Suicide and self-harm can affect all ages, but the challenges and experiences of individuals and the help that is required will differ with age. There are unique factors that are often present in the deaths of children and young people including problems at school, bullying, social media and internet use and neurodevelopmental conditions. In the UK suicide rates in children and young people are rising, particularly in girls and young women. Whilst fortunately rates of child suicide are low, one death is one too many, and more could be done to prevent future tragedies.

In writing our strategy it was therefore critical to capture the voices and needs of children and young people in Oldham.

Gathering Insight

The public health team and youth service worked together to develop a series of conversation prompts to capture information around young peoples experiences, and their thoughts on how things can be improved around suicide and self harm support and prevention. When it was safe to do so, young people who were well known were invited to take part by Youth workers who have the training and expertise to facilitate difficult conversations and were known and trusted by the participants. The exercise was entirely voluntary and each conversation was tailored to the needs of the individual to ensure that each young person was safe and comfortable. This insight gathering was intentionally small scale and focused, recognising the complexity around the subject matter and the intensive approach and support that was required. Five young people shared rich, powerful and invaluable insight with the team, which have helped shape our plan to cater to young peoples' needs, and for which we are very grateful.

Themes

'Information and support should be available from any trusted adult'

Suicide Prevention and Self-harm training is needed for all trusted adults

Young people wish to be able to access help and support in a range of ways

'make sure that reliable websites to find out more information are widely known to young people and adults'

A safe space is discreet, comfortable, colourful, but not overstimulating, clean, and most importantly has friendly and welcoming staff

'It should be a comfortable place to talk to someone that is accessible and personalised but not over stimulating but not too bare or stark. If it's a space in school, it should be discreet'

Schools focus more on mental health and less on suicide and self-harm

'It's the people that counts.'

The young people felt confident in accessing help and support

Themes YP Insight Gathering 2022

Toxic Positivity should be avoided

'Tik tok especially spreads misinformation. It should be called tic-toxic'

'I think young people are more at ease talking about mental health, but a barrier is the adults aren't – when you speak to some adults they are obviously uncomfortable.'

'you hear things like you're not depressed it's just a bad day – feels like they don't take is seriously.'

Social media can have both positive and negative content, but tic-toc can be particularly harmful

'A barrier is also it being too obvious that you are going to a specific place to get help like having to knock on the door or wait outside'

Barriers to accessing help include a lack of discretion, adults who struggle to talk about suicide and self-harm, not knowing where to access support, stigma and stereotypes

When someone is in distress, saying the right thing can be difficult. Toxic positive comments can be overly positive towards a difficult situation and make the recipient feel that their difficulties have been rejected. These things are often said when people don't know what to say, and can be unintentionally harmful. These theme came up on several occasions during the young persons consultation, explicitly and inexplicitly, but this can occur in all ages particularly older generations. Training is essential to support trusted adults, friends and family to know what to say to when someone is struggling and intergenerational work and learning may support all ages to think and talk differently about suicide and self harm prevention.

It's sad to think that the older generations like myself were always fobbed off when younger (S P Consultation 2022)

Oldham's Strategy was launched on World Suicide Prevention Day 2023

Oldham Council

Developing Oldham's action plan

15th June 2023 – Action Planning Day

Oldham Council

What we did on the day…

Exercise 1: -

Working on tables, we looked at the previous action plan and decided:

- *What had been completed*
- *What needed revising and adding to a new action plan*
- *What hadn't been started/completed (but is correct in its current format) and needed bringing forward*

Oldham Council

What we did on the day continued…

Exercise 2:-

Spent time deciding our objectives /actions **and** ownership

Oldham Council

ACTION PLAN 2023-25

Oldham Suicide Prevention Partnership

Core Membership: tbc

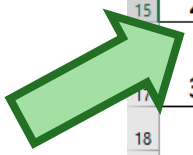
Chair: tbc

Purpose: tbc

Format of the plan:

1. The below is a list of the 6 priority areas of focus their overarching objectives
2. The tabs represent the 9 pillars of suicide prevention and the strategic framework against which this plan is set
3. All of the priority areas have focused actions that aim to support the board in achieving the 9 pillars of suicide prevention
4. Each action has timescales, lead officers and progress updates

Priority areas	
1	Self Harm
2	Legal, illegal and prescribed drugs and alcohol use
3	Lonliness
4	Age Targeted Approach
5	Men
6	Preventing access to means of suicide and high frequency locations



Action Plan - Introduction | Leadership | Summary evidence | Awareness raising | Wellness promotion | Training | Intervention & clinical support

Ready Accessibility: Investigate

Where we are now – current work

- Public Health collated all the information received at the action planning day and begun populating it into the agreed structure
- Ownership of most actions was agreed
- Finalised action plan was signed off in November meeting - this is a two year plan from November 2023 and will sit alongside our strategy
- Action plan is iterative and responsive – it will be reviewed throughout the next 2 year period and adapted / updated as needed
- A new action plan (still sitting within the 2023 strategy) will be written in time and **in line with changing needs and the emerging evidence base**

Any questions?

vicki.gould@oldham.gov.uk

Oldham Council

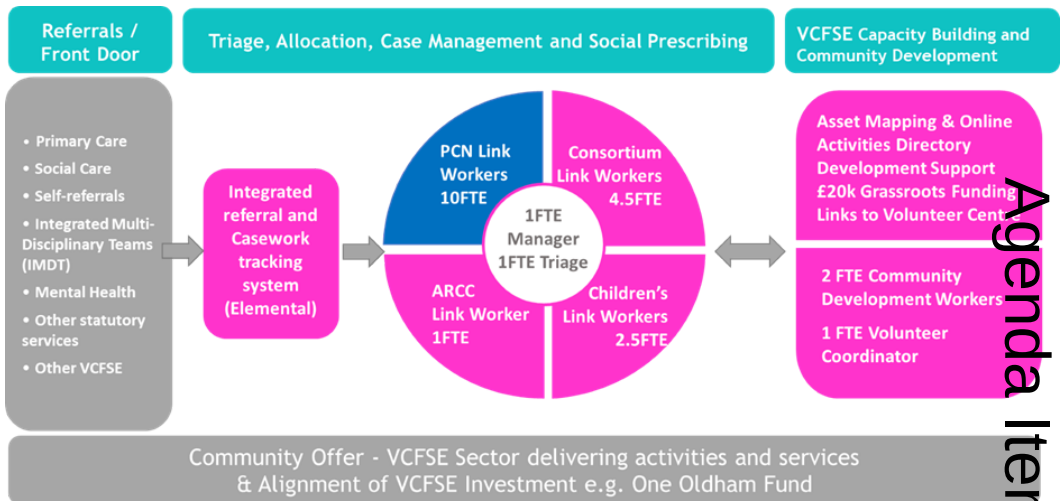
Oldham Social Prescribing

Emotional Wellbeing and Mental Health Support

About Oldham Social Prescribing

Oldham Social Prescribing Service is delivered by a consortium of Oldham Charities including; Age UK Oldham, Positive Steps and Tameside, Oldham and Glossop Mind, led by Action Together. Since 2019 the service has been co-designed by these Charities with stakeholders from across Oldham's Health and Care System.
The model brings together the three essential elements for successful People and Community Centred Approaches to care:

- Strength based, personalised care delivered via Social Prescribing Link Workers
- Asset Based Community Development and Capacity Building in the VCFSE Sector
- Grant Investment in the VCFSE to enable the delivery of community-led activities and support



Oldham Social Prescribing Innovation Partnership Impact Report

Year to Date 2023-24

Year to Date Headlines

Year to date headlines include:

- Embedding a Social Prescribing Link Worker full-time with ASC ARCC team and the difference it's making (p11)
- Social Prescribing and integrated working (p11)
- The outcomes of engaging with those who have worked alongside Social Prescribing to understand how it has benefitted them (p17)
- Working with the Family Hubs development team to integrate the CYPF Link Workers to the Family hubs approach (p8)
- The impact on improving Oldham residents health and wellbeing through wellbeing scores data (p8/9) and case studies (p13/14/15/16)

Year to Date in Numbers

- **2097** Referrals (Apr-Nov)
  - **52%** for loneliness and isolation
  - **48%** for mental health
  - **33%** for physical health / long term condition
  - **26%** for welfare and money management
- **635** Active Cases (avg each month Apr-Nov)
- **20,844** Contacts with clients or other professionals on behalf of clients
- **1,178** Social Prescriptions
- **75.4%** Increase in Wellbeing Outcomes (ONS4),
- **77%** increase in Wellbeing Outcomes (SWEMWEBS)

Year to Date Data

Fig 1 Social Prescribing Unique Referrals

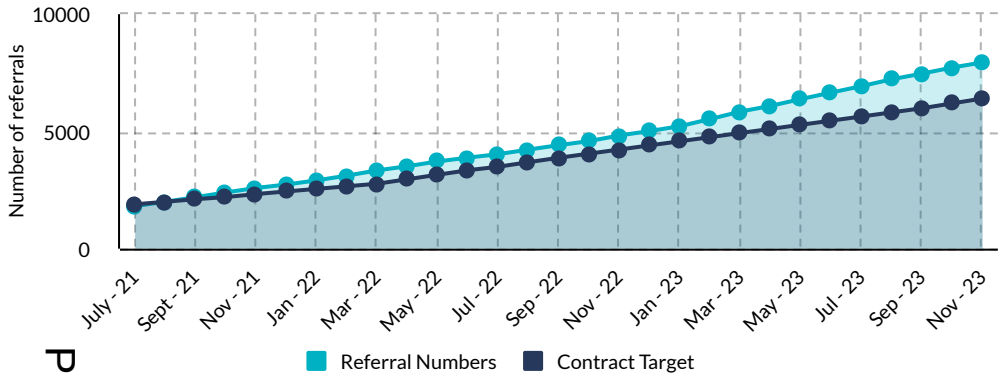


Fig 2 Social Prescribing Unique Referrals Comparison by Year

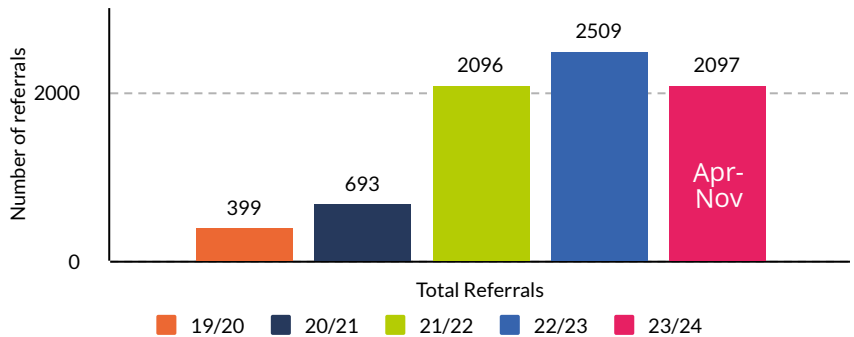
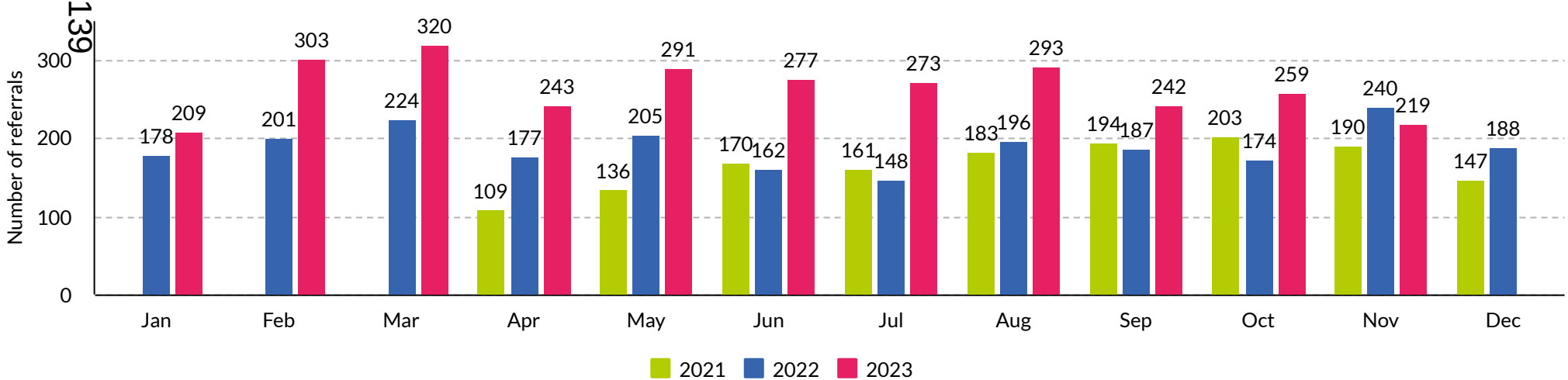


Fig 3 Social Prescribing Referrals Comparison by Month



Year to Date Data

Fig 4 % Referrals by PCN Area Q3

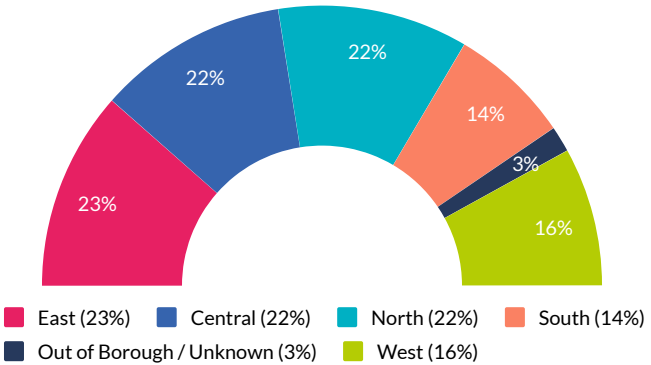


Fig 5 Referral Source Q3

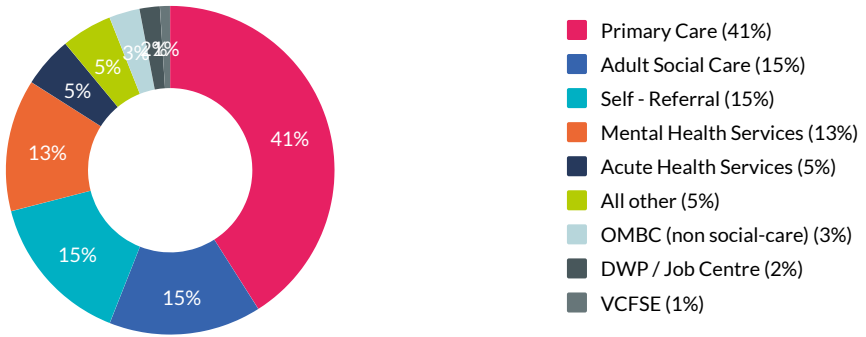


Fig 6 % Referrals by PCN Area Total Cohort

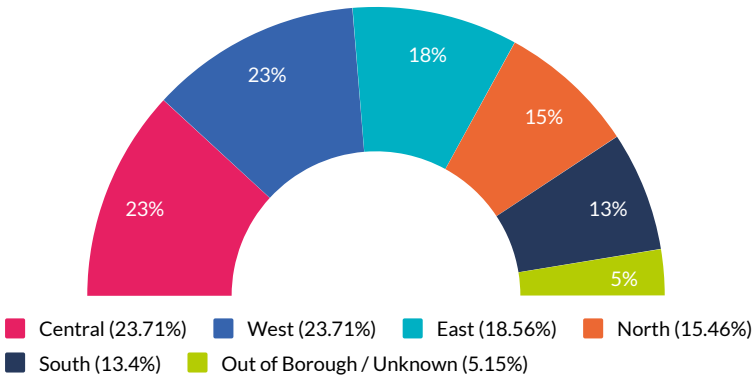
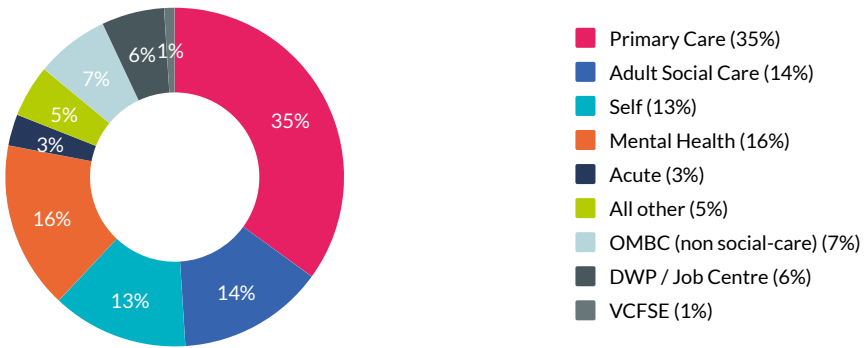


Fig 7 Referral Source Total Cohort



Year to Date Data

Fig 8 Primary Reason for Referral Q3

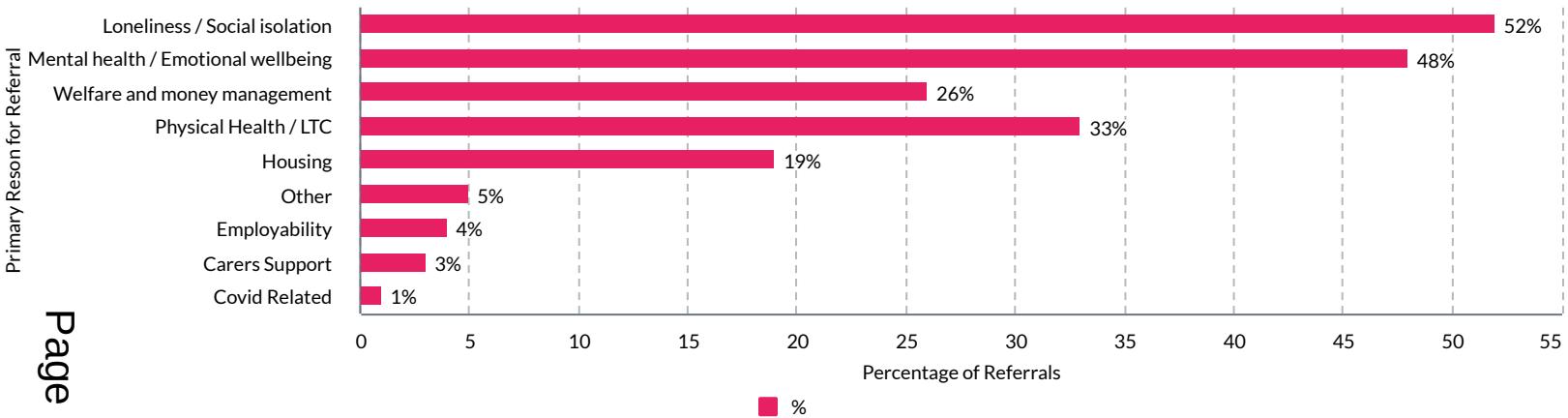


Figure 8 shows that there is an increased trend for people being referred for loneliness and social isolation

Fig 9 Primary Reason for Referral 2021-Present

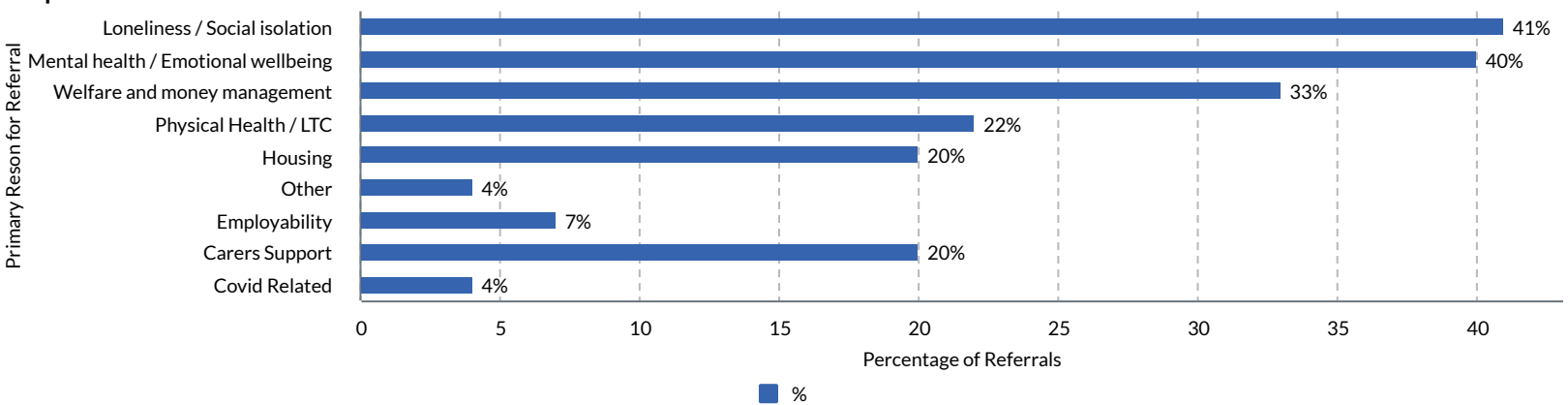


Figure 9 Since moving to Elemental we are unable to report soley on the primary reason for referral, but now we can report on multiple reasons for referral per case. This means that the percentages will not add up to 100% as 1 referral case may have 2 or 3 reasons for referral. Eg, 43% of referrals had mental health as a reason for referral.

Year to Date Data

Fig 10 Number of Active Cases (635 average per month 23-24)

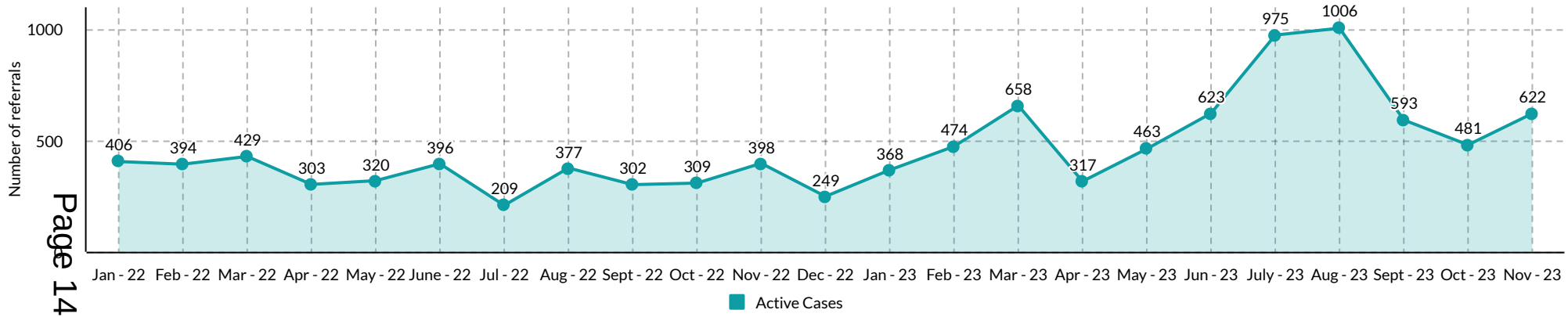
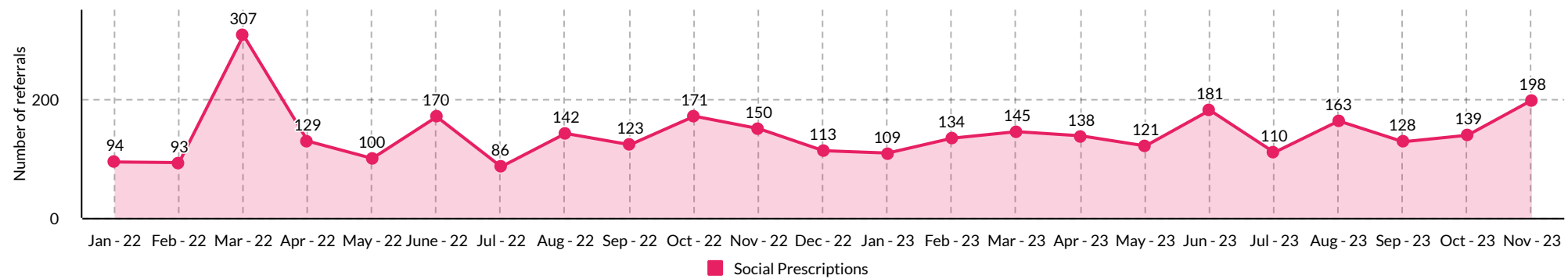


Fig 10 shows the numbers of people who are actively receiving support each month from social prescribing. In this quarter there was an average of 858 people per month actively receiving support.

Fig 11 Number of Social Prescriptions (1,178 total 23-24)



Year to Date Data

Fig 12 Number of Contacts (20,844 23-24)

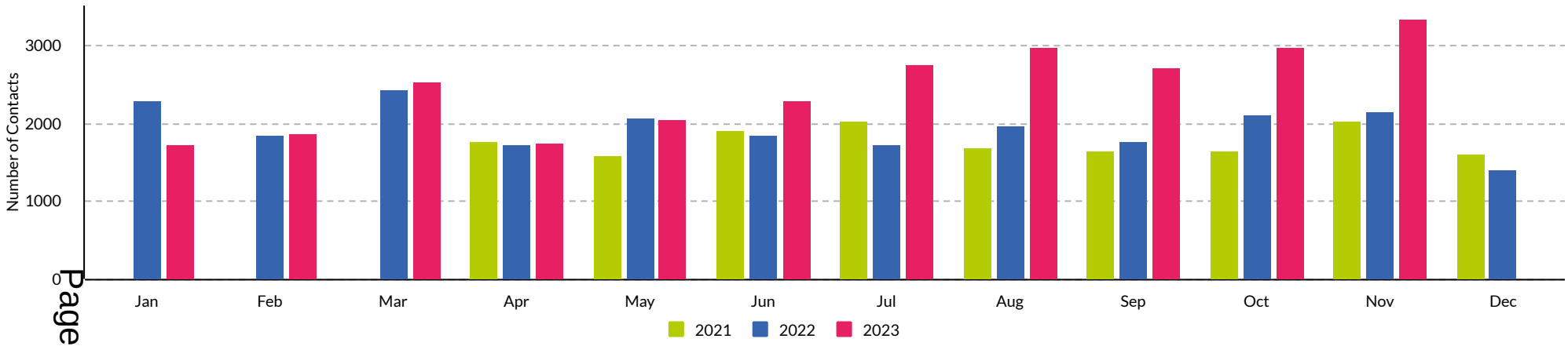
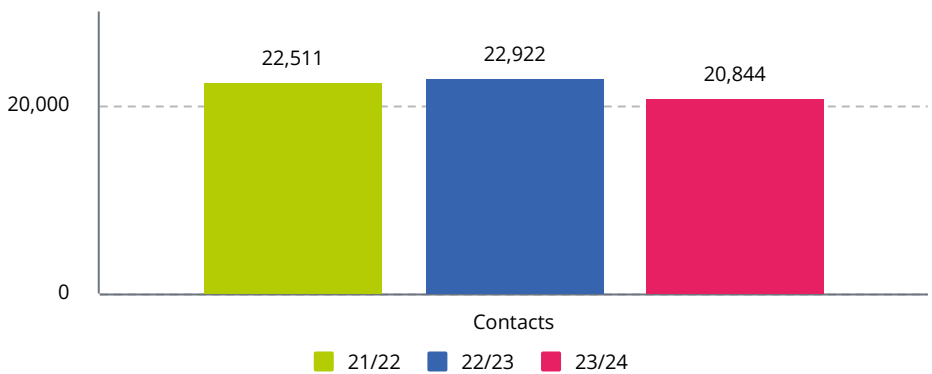


Fig 12 shows the numbers of contacts Link Workers had with the people they are working alongside and the number of contacts they had with other professionals and groups and organisations providing activities and support on their behalf.

Place Holder for Active Case Demographic Data

We collect demographic data and are waiting on the completion of a development from Elemental so that we can report on this data. As soon as this is available it will appear here!

Annual Contacts by Year



Year to Date - CYP

Fig 13 Children and Young People Social Prescribing Referrals

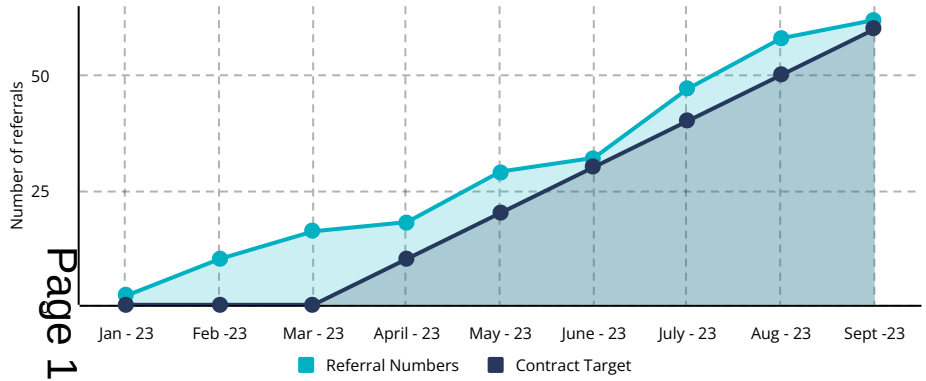


Fig 14 Referral Source Total Cohort

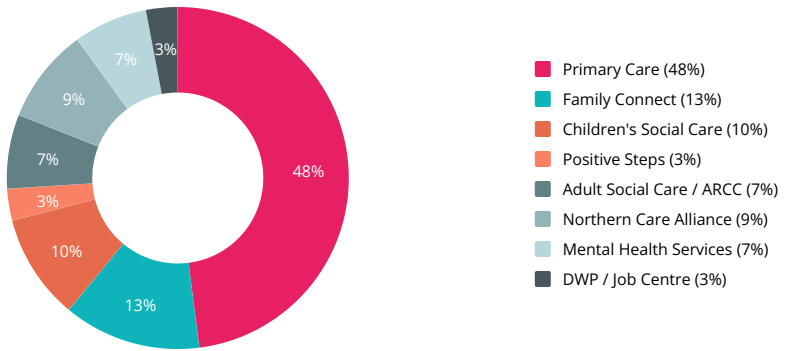


Fig 15 Children and Young People Social Prescribing Referrals Comparison by Month

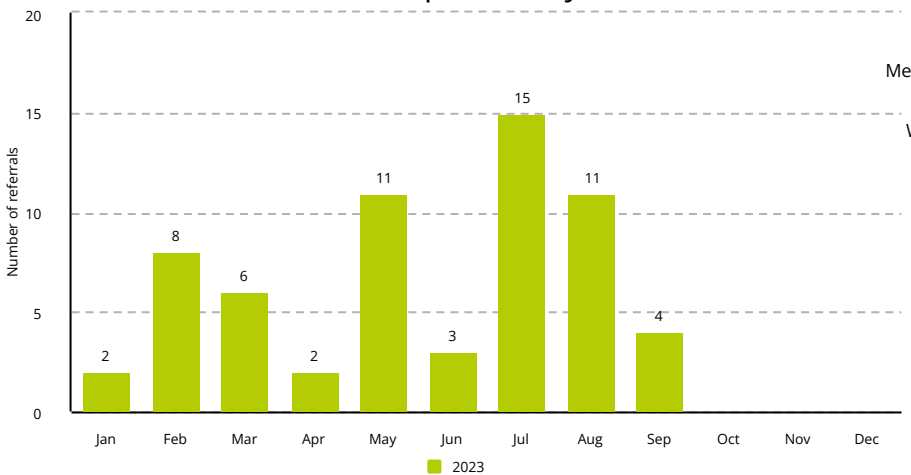
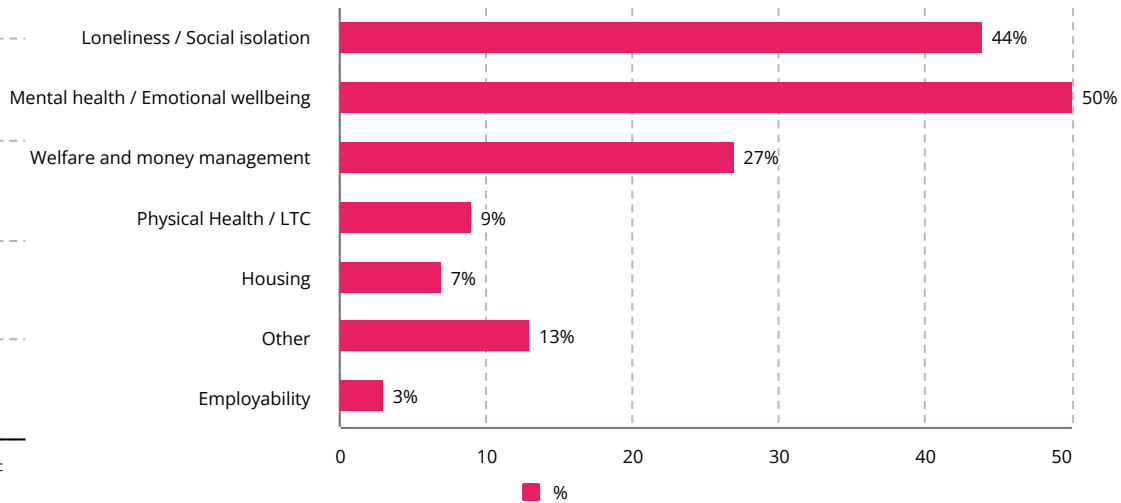


Fig 16 Reasons for Referral Total Cohort

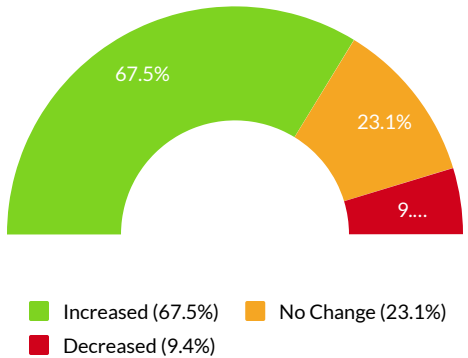


Impact - Wellbeing Scores ONS4

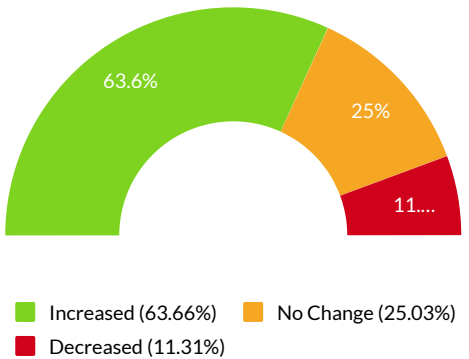
Personal well-being (PWB) is part of the wider Measuring National Well-being (MNW) Programme at the Office for National Statistics (ONS), which aims to provide accepted and trusted measures of the nation's well-being.

Personal well-being uses four measures (often referred to as the ONS4), which capture three types of well-being: evaluative, eudemonic and affective experience. Link workers use ONS 4 alongside SWEMWEBS at their initial contact, at 3 months and then at 6 months or the last contact.

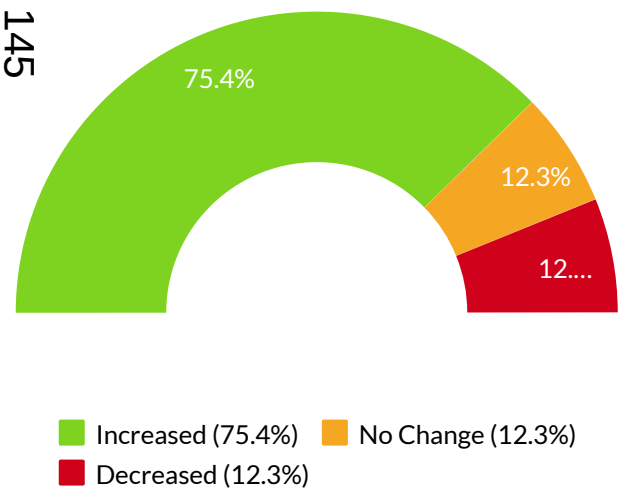
Satisfaction



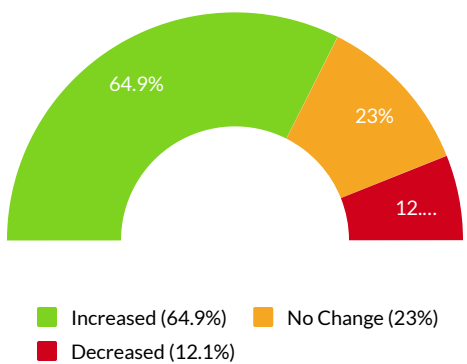
Worthwhile



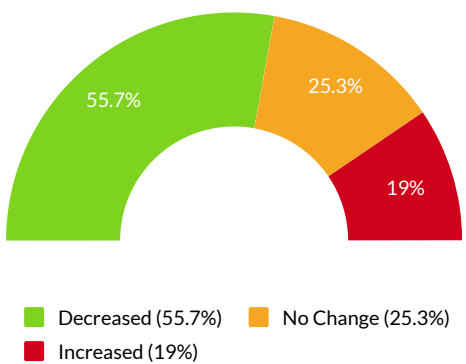
Overall Wellbeing ONS4



Happiness (ONS4)



Anxiety

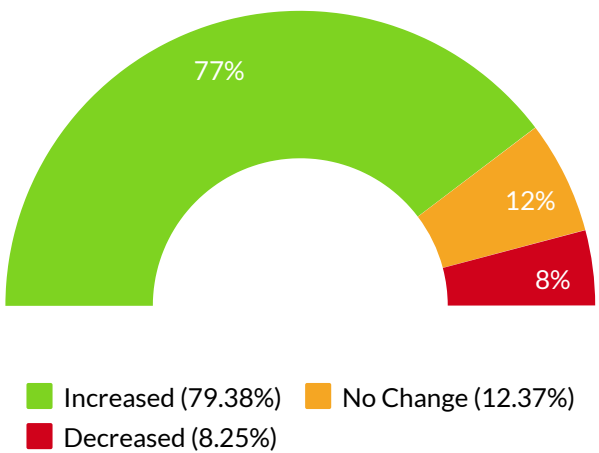


Impact - Wellbeing Scores SWEMWEBS

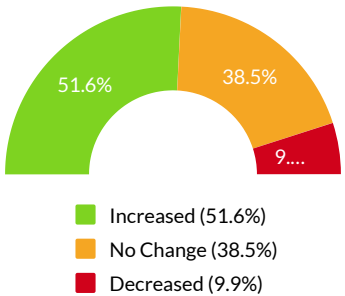
The Warwick-Edinburgh Mental Wellbeing Scales were developed to enable the measuring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. The 7-item scale SWEMWBS have 5 response categories, summed to provide a single score.

Link Workers use the shortened version (SWEMWEBS) which is a 7 item scale. We use the scale at the first appointment to get a baseline, then at 3 months as a review and then at 6 months or at the end of the Link Worker relationship.

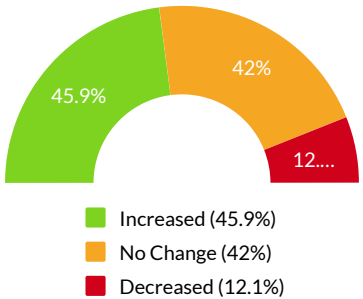
Overall Wellbeing SWEMWEBS



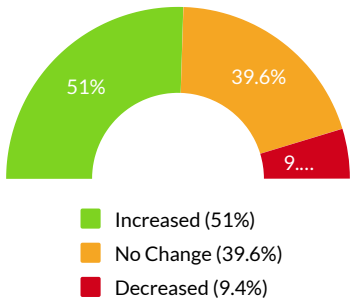
Feeling Optimistic



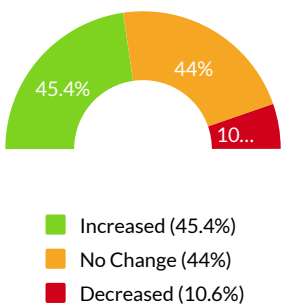
Feeling close to people



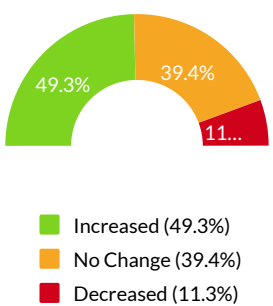
Dealing well with problems



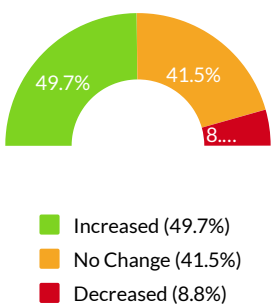
Make up own mind



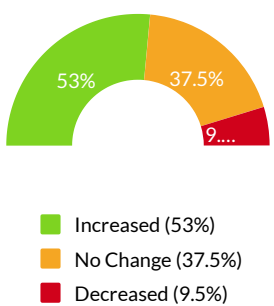
Thinking clearly



Feeling Useful



Feeling Relaxed



Social Prescribing Activity Highlights

Integrated Working

Quarter 1

Loneliness and isolation continues to be the main reason for referral in this quarter, followed closely by support needed for housing and anxiety and low mood. We've noted a slight increase this quarter in referrals for people in the age group 35-45 years. In addition to the case work, we have continued to be active partners in mulit-disciplinary team work this quarter including:

- Oldham Collaborative – Living Well
- Adult Complex and High-Risk Panel
- Making Every Adult Matter Hub
- Cost-of-living Response - Residents Requiring Repeat Support - Clean Room

In Q1 we have based a Link Worker full-time in the ARCC team. This is an additional post and has been recruited to internally to enable quick mobilisation and to provide continuity in the relationship development between Social Prescribing and the ARCC team. Having a link worker based with the Adult Social Care front door, will improve the speed in response and the experience for people who contact Adult Social Care when a more appropriate response to meet their need is a step down into Social Prescribing. We envisage that it will also improve the experience for people who may need to be stepped up from Social Prescribing into Adult Social Care.

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Quarter 2

In Q2 we continued to contribute to partnerships around integrated working highlighted above, and in addition this quarter have joined a collaborative looking at how Dove Stones can be better accessed by people working with Social Prescribing to improve their health and wellbeing.

Last quarter we saw the introduction of a Link Worker to the team at the ARCC (adult social work front door), this is proving to be very impactful, with the manager of the team reporting how it has supported with upskilling the ARCC team with the wider offer of community support and that it is having a positive effect on waiting lists and client experience. We have joint worked and taken direct referrals for 90 individuals.

Engagement and Outreach

Q1 We've supported two health and wellbeing enagagement events at the Honeywell centre and Failsworth Town Hall, on hand to talk to residents about what matters to them and what is available in their local community.

Q2 We've supported a health and wellbeing event at the Cotton Rooms for Adults with a Learning Disability and / or Autism

Social Prescribing Activity Highlights

Systems Change

We continue to be comitted to supporting system transformation in Oldham and across Q1 and Q2 have supported system change partnership work including:

- Suicide prevention planning work
- The multiple disadvantage and system change partnership day
- Multi-Agency Early Help Panel Planning Session
- Oldham Collaborative – Living Well
- What Drives Demand in Oldham Workshops

Workforce Development

Quarter 1

The team have continued to develop their skills and knowledge and have completed:

- Connect 5 Mental Health Training
- Practitioners training for encountering people with problematic drinking

We have launched The Active Travel and Social Prescribing Project (funded by TfGM) in Q1. The project will build capability and capacity within our Social Prescribing Network around active travel and physical activity, will strengthen the connections between this network and the active travel infrastructure, and will reduce inequalities that act as a barrier to active travel within communities.

The project will focus on the communities within Central Primary Care Network and will enable us to further develop our volunteer/peer support model to support delivery. These roles have been successfully recruited to the coordinator started in June and the development worker will be with the team from July, this project will build on capacity in the team alongside the opportunities we are able to offer the individuals accessing Social Prescribing.

The Children, Young People and families link workers, employed by Positive Steps, are now fully established within the team and are actively supporting children, young people and their families, this work is developing alongside the Family Hub development.

Quarter 2

In Q2 we have hosted a student placement for the NHS graduate management training scheme, the student has been delivering a project to capture the voices of the individuals that have been accessing the service. The results being a co-produce piece of work that celebrates and raises awareness of Social Prescribing, while also using the opportunity through lived experience to capture successes and learning for the future. We have shared more details on the outcome of this work in the feedback section of this report.

We have have recruited 3 Link Workers this quarter to backfill for vacant posts. Using our inclusive recruitment processes we have successfully appointed a person who has lived experience of the refugee and assylum seeker system, whose skills and experience are an asset to the team.

Case Study

Hannah

Hannah was referred to Social prescribing for support with her mental health. Hannah had been the main carer for her mother, who passed away 2 years ago, Hannah lots her husband the year before her mother. Since her bereavement Hannah has really struggled. She feels disconnected socially and is struggling with her confidence. She has also got financial issues and debt problems, all of which were contributing to her anxiety and low mood. Hannah was referred to Social Prescribing by her GP at Chadderton Medical Practice.

The link worker contacted Hannah and arrange to meet with her, Hannah explained that she prefers to talk to people in person and so they arranged to meet at a local cafe. At their first meeting Hannah talked about her bereavement, about her emotional wellbeing, how isolated she feels and about her money worries.

The link worker helped Hannah with some of the immediate things at that first appointment. Hannah's money worries were so bad that she didnt have any food and hadnt eaten properly in two days. The link worker connected Hannah to the Foodbank and arranged for a food parcel to be delivered later that day, she also connected Hannah to the SIT team to help with Council Tax reduction, which later led to a £28 monthly reduction.

Hannah and her link worker arranged to meet weekly with a check in phone call in between, the link worker introduced Hannah to the Bread and Butter Thing, which meant that Hannah could get a weekly food shop at a much more affordable price, and wouldnt be reliant on the Foodbank. The link worker supported Hannah to complete a PIP application including the evidence required from her medical records to help her maximise her income. Hannah has many physical health issues that impact her quality of life. Hannah did not think she would be entitled to any help as she recieves a small amount of income from her late husband's pension.

The link worker introduced Hannah to TOG Mind's Listening Space, Hannah has found the support there incredibly helpful and is continuing to regularly attend the Listening Space. The Linkworker is currently helping Hannah to reduce her debt burden and set up affordable payment plans. The next goal on Hannah's wellebing plan is to try a local arts and crafts group and to join the local walking group.

Case Study

Robina

Robina arrived in the UK in 2015 with her husband and 3 children. Her husband had a suddenly passed away in February 2023. She lived with her mother-in-law in a private rented property. She had no other family in UK to support her. Robina was very distressed and had very low level of mental health. Her husband had been the sole earner of the family. She was finding it very difficult to cope with the everyday roles and responsibilities with her children. She was constantly worried about her finances as she was not entitled to benefits due to her immigration status.

She was referred to Social Prescribing for low level mood, bereavement, befriending and benefit advice and she is a patient at Kapur Family Practice. Robina met with her Link Worker who could talk to her in her first language and they agreed a wellbeing plan together including:

- Connecting Robina with relevant services for her mental health and wellbeing,
- The Link Worker worked closely with the Social Worker and Children's school, providing the language and emotional support for Robina and completing a referral to UKEFF for foodbank and financial assistance. A successful application was also made to Healthy Start Vouchers scheme.
- Robina's financial situation was a huge part of her worries so we completed a UC online application after obtaining confirmation of her immigration status. The Link worker supported Robina to be more involved at meetings, explaining things in her first language, she feels that language line only interprets and isnt able to explain some concepts and procedures as the link worker can. With UC in place she had more financial independence to fulfil her, and her children needs.
- Robina registered and enrolled on ESOL and IT courses and training to further develop her skills and confidence.
- We also helped her to register with Mind Matters counselling sessions at EIC Centre for bereavement support following the loss of her husband.
- Robina engaged with ARC art classes at Oldham Library and was also supported to attend BAME Connect for social groups and yoga classes.
- The Link Worker completed a referral for the digital device gifting scheme through Oldham Libraries for a laptop as the family had no digital device for children to use for homework. This was successful and had a positive impact on the whole family.

At the time of closing the work with Robina, she is attending Oldham Lifelong Learning for ESOL classes and engaging with Werneth & Freehold Community Development Project for peer support and IT classes. She feels confident to attend activities and classes on her own, she is now more outgoing and engaging with help and support.

Case Study

John

John was initially referred into social prescribing from his GP Practice for support with reducing isolation, feeling motivated and support for housing. John lives alone and has a limited support network. John expressed wanting to move house due to anti-social behaviour issues he was experiencing in his local area and with neighbours. He wanted to improve his mood and emotional wellbeing and look at ways of feeling purposeful. John also wanted to start to do some physical activity.

The link worker met with John at a community venue that was convenient for him and over the course of the next few weeks started to build a relationship, develop a wellbeing plan and work together to take the steps required to achieve John's goals. They also kept in touch via telephone in between appointments to progress actions.

John's link worker connected him to the Volunteer Centre for exploring volunteering opportunities, as way of becoming more engaged within the community, feeling more purposeful and building confidence and better mental health.

The link worker also supported John to complete a housing application ensuring that all the relevant supporting documents were submitted. The link worker was able to support with the application to make sure the forms were all filled in correctly meaning that the application wouldn't face any unnecessary delays.

The link worker connected John to Oldham Community Leisure's Exercise on Referral Programme as away to start to becoming more active, but with the additional encouragement and support that he felt he would need.

As a result, John's housing application is being processed currently. He has registered for volunteering and has applied to a number of roles. John has enrolled on the Exercise on Referral Programme and joined the gym at OCL. He is excited about going and looking forward to making some positive changes to improve their health.

John recently said "*I love going to the gym its brilliant, I've already been 5 times and it's getting me out of the house, thank you'.*

Case Study

Alice

Alice was referred to Social Prescribing by Adult Social Care. The referral asked for support for Alice to access OT services, to supporting with financial and budgeting issues and to support her with a PIP benefit renewal. On meeting Alice, she talked to the link worker about having a diagnosis of ADHD, MS and said that she was awaiting a diagnosis of Autism, she was experiencing low mood and anxiety.

Alice talked to the link worker about her past, she has a history of childhood abuse and neglect and has lived with an abusive partner and experienced domestic abuse. Alice is currently attending psychotherapy on a weekly basis and attends a college woodwork class, she is determined to set up her own up-cycling furniture business in the near future.

Alice has two adult daughters, one who is currently living with her. Alice told the link worker that she struggles to meet people in person, due to her ADHD, low mood and anxiety issues. The link worker arranged to have regular contact with Alice via phone, text and email and meet only when necessary. Alice and the link worker started to form a plan together, the plan included:

- Support to contact OT services for an assessment on her property, Alice has had a series of trips and falls at home due to the symptoms of MS.
- Support to deal with debt and budgeting, Alice is aware of her spending habits spiraling due to impulse buying, a symptom of her ADHD. The linkworker supported Alice to access Christians Against Poverty who helped her to deal with her debt.
- The link worker also supported Alice to look at her benefits and supported her to renew her PIP application.
- The OT assessment clarified that adaptations were required to Alice's property and installed an extra stair rail and grab rails were fitted to minimise the impact of trips and falls.
- Alice's autism assessment confirmed a diagnosis and the link worker supported her to renew a PiP benefit application due to the recent diagnoses.

Alice received a positive outcome of the PIP benefit tribunal, and received an increase of award granted and this was back dated from March 2023. This has significantly relieved Alice's financial situation. Alice continues to attend college and has recently set up a website to start her up-cycling business.

Feedback

Quarter 1

Text Message from Sue...

Social prescribing is an amazing service. We are so grateful. Gemma has helped us sort all our bills and mess for Angela. Years of no bill paying etc you can imagine the nightmare. Gem sorted it all and got carers back into Angela within a weekend. No job was to big or an inconvenience even supporting us just being at the end of the phone when losing our brother over the last few weeks. We are so grateful. Thank you.

Quarter 2

Email from Margaret ...

Laura just a little update, I have moved into my new flat, at Nelson Way. I cannot believe the difference I feel I have won the lottery, everything is lovely, and I can breath more easily, also still struggling with my grief, trying very hard to move forward, I need to thank you for your support and professional advice thanks again.

In Q2 we hosted a student placement for the NHS graduate management training scheme, the student has been delivering a project to capture the voices of the individuals that have been accessing the service. The results being a co-produce piece of work that celebrates and raises awareness of Social Prescribing, while also using the opportunity through lived experience to capture successes and learning for the future: Here's some of the headlines - with more at details on our website

91% of users were extremely satisfied and very satisfied with the Oldham Social Prescribing service

100% of users would recommend the Oldham Social Prescribing service to a family member or friend

100% of users noticed a significant or slight improvement to their wellbeing since accesses the Oldham Social Prescribing service

Good service, understanding and helpful! The team have worked miracles. Can't think of anything negative about the service at all."

""Thank you for all that you did , the time spent supporting us you have taken the pressure of our current situation so thank you much!"

"You have been great! I didn't know this service existed and now I feel it's essential, not just for knowing about social activities and support groups but by addressing loneliness... it has been so helpful."

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Tameside, Oldham and Glossop

Health and Wellbeing Board

Tameside, Oldham & Glossop Mind mental health offer - Oldham

MINDFUL EMPLOYER

TOG Mind Navigators

- People can be referred from any service in Oldham. Navigators spend their time in community hubs, GP surgeries, on ROH wards and within the ARCC team. We also take self-referrals upon an in-house initial discussion with the person on the support they feel they need.
- We provide navigation to the appropriate services for the person, led by the person. This is a warm handover that ensures the person is comfortable in the process and understands the services they are accessing and who is contacting them.
- We deliver joint appointments with other providers to facilitate wrap-around support and a team around the person e.g. Turning Point, Changing Futures etc.
- This improves relationships and communication with staff within the system leading to improved delivery of care for the person accessing these services.
- Navigators are able to provide brief guided self-help interventions, crisis support, and coaching using a strength-based approach.
- Between 4-12 weeks of support, but this has been extended where necessary.
- We measure progress using self-defined Goal Based Outcomes and SWEMWEBS.

Sheila’s story

Sheila was referred to the navigator team by her focused-care practitioner reporting long-standing depression, suicidal thoughts & attempts and PTSD from non-recent sexual and physical abuse

Each session with the navigator focused on:
Risk management – suicidal thoughts & attempts
Developing coping strategies
Exploring feelings around trauma and therapeutic readiness with a view for future counselling
Improving communication within relationships
Improving self-esteem, self-care and setting healthy boundaries

Sheila’s suicidal thoughts have reduced significantly since starting sessions with the navigator. Sheila states this is due to support from TOG Mind, including support around linking in with her GP to facilitate a medication review, coaching for improved communication with her partner through strategies discussed in session, and support linking in with housing to access a new flat so she can move out of supported accommodation.
Sheila was invited to Silvercloud during her time with TOG Mind as she was interested in CBT. Sheila said she has found this very helpful and frequently uses the app.
Sheila has now been referred to NHS Talking Therapies for counselling and feels the sessions with the navigator have supported her to feel ready to engage with therapies.

Rahul’s story

Rahul was referred via his GP surgery. At his first session, Rahul stated up to 3 weeks ago, he was alcohol dependent and sometimes this crossed over into the occasional use of cocaine. Rahul nearly lost his marriage through this so decided to quit everything in one go and because of this the client is now suffering with headaches. The navigator spoke to the GP to ensure they were aware and were monitoring this.

During his first session Rahul stated he had “tried to take their life a couple of times” stemming from working 7 days a week prior to the pandemic and when it hit, and the country went on lockdown he stated this “broke” him. Rahul stated he attempted to take his life during the lockdown and was seen by a doctor at this time but received no help after. Rahul stated he tried to “bury” how he felt deep down, and this led him to attempting a second time “two weeks ago”. Rahul stated they find it difficult talking about how they feel, and this is why he believes things have got so bad for him.

Rahul has not presented with any current risk since half-way through his sessions with the navigator. He is still alcohol and drug free and has sated he has absolutely no desire to take these up again as forms of coping techniques. Rahul reports he is maintaining positive and open communication with his spouse, instead of ‘burying things’ as he feels through sessions, he can open up and effectively express his feelings. Rahul has come to his own conclusion that his mental health had deteriorated because of his work and how this affected his home and work life balance. Through engage with person-centred coaching, he has advocated for himself, leading to appropriately informing his workplace and positive changes to his workload.

What can we offer?
Peer Support Worker

- ‘Experts by Experience’ of living with and overcoming ill mental health, using their own powerful experiences of recovery to support others.
- This approach gives clients a sense of hope and inspiration to work towards goals.
- PSWs use strengths-based coaching approaches to maintain recovery & wellbeing goals - identify own coping strategies/resources.
- Facilitate engagement with community support & resources, offering side-by-side support to build confidence until the person is ready to attend independently.

TOG Mind Peer Support Workers - Outcomes

- Identify and overcome barriers
- Empower - increase motivation and self-belief
- Improve problem-solving skills & coping strategies
- Increase self-compassion and acceptance
- Facilitate access to practical & financial support
- Engagement with social, peer & community groups/activities.
- The role provides opportunity for people with lived experience to develop skills & knowledge
- Share valued insight & perspective within Living Well MDT.

Mind Tameside, Oldham and Glossop

VCSE Partnership

Under Living Well, TOG Mind subcontracts to Positive Steps to provide a Senior Engagement Worker, and Age UK Oldham to provide a navigator for ages 55+.

This partnership working provides clients with wraparound, multidisciplinary support on wider issues such as benefits, housing, family support, and access to employment and education opportunities.

Positive Steps
Senior Engagement Worker

- Support clients who come through mental health pathways to improve their practical and socio-economic circumstances e.g., benefits support, relationship and parenting support, employment and education and housing support, which includes work with private landlords, environmental health and tenancy relations.

- Supports the TOG Mind Listening Space, supporting people who present in crisis on a walk-in basis with issues detailed above.

POSITIVE STEPS
SUPPORT | CHALLENGE | CHANGE

Age UK Oldham

- Support older Adults 55 + who have a mental health condition or a cognitive impairment to navigate services and support options.
- Link in with all Age UK Oldham services such as lunch clubs, befriending, day care, dementia support services, premade meal provision etc.
- Provide low level equipment and aids for around the home such as grab rails, keysafes, perching stools.
- Provide home visits and telephone appointments.

Client feedback

“With the dedicated support from the navigator, I now feel less isolated, and I have started to gain my confidence back and in turn this is helping me through the grieving process.”

“The support I have received from the Age UK Living Well Navigator has supported me when I have been feeling low in mood. It is nice to know that I can pick up the phone and have someone to talk to and offer reassurance.”

Clients' daughter said, "I feel the Age UK Oldham Living Well service has helped mum in many different ways especially with the information they have provided on services to keep mum living independently in her own home.”

“I feel positive about receiving support and I am thankful for the service. The sessions provided some consistency, and it was nice to know that people genuinely care about my wellbeing.”

Counselling

At TOG Mind we have offered our communities person-centred counselling for over 30 years. Additionally, we offer IAPT Counselling for Depression for residents of Oldham.

Our counselling service can support people with a range of mental health concerns including:

- Low mood or feelings of depression
- Anxiety
- Bereavement or loss
- Relationship difficulties
- Feelings of low self-esteem or low self confidence
- Work related stress
- Feelings of anger
- Self-understanding and self-development
- Difficult or traumatic life experiences
- Suicidal ideation

Supported Self-Help

Supported self-help is a 6-week guided programme. We give people the materials to understand and manage their feelings and call them regularly to provide support.

This is a one-to-one guided self-help service, not a counselling service. But our practitioners do use counselling-based skills in their support. It incorporates some Cognitive Behavioural Therapy (CBT) style tools but also provides other kinds of support.

We have the following pathways to choose from:

- Anxiety and panic attacks
- Coping with grief and loss
- Loneliness and feeling lonely
- Low self esteem
- Low mood and depression
- Managing anger
- Managing stress
- Understanding menopause

• The service was rated 9/10 by clients and nearly all would recommend it
• 84% of people said they had improvement in feelings of anxiety
• 85% felt improvement in feelings of depression
• 83% reported an improvement in their mental wellbeing

Immediate support

The Listening Space provides a service for people who feel they need immediate support in times of distress. People present with a range of difficulties, from relationship breakdowns and social stressors to long-standing mental health issues they just need some extra support with.

A space simply to have their voice heard and receive support and validation can make a powerful difference.

The Listening Space

"I felt lighter at the end of the session...I felt better after being able to speak freely"

"After the session I feel more comfortable, relaxed and know how to move forward now"

"The session was like a breath of fresh air. Thank you"

"After bringing my son to the Listening Space, what a difference it has made. Not only to him which these visits are all about but to myself, as the staff are asking me about things, and I am getting things off my chest that I didn't realise existed. So, thanks to all the lovely staff for helping us both really. I would highly recommend this place to anyone needing to talk. Thanks, with all my heart."

"I feel like I have a sense of direction after talking about my feelings"

"I felt better than I had hoped at end of session and now have relief from my stress and anxiousness"

Oldham Lived Experience Panel

If you come across any people with experience of the mental health system, we would love to hear from them.

TOG Mind currently host the Living Well Lived Experience Panel; a collaboration of people with valuable lived experience that they use to inform the system on improvements pertinent to them. They have opportunities to be involved in designing training, recruitment, communications, contributing to multi-disciplinary forums and more.

To join, they can reach out to our co-ordinator at:

- **LEP@togmind.org**

Accessing our services

All of our services have multiple pathways and roads into support, but all can be accessed via the below details. Following contact, a member of our team will book in an appointment with the person for an initial discussion about their support needs.

info@togmind.org

0161 330 9223

Or pop in at:

19-25 Union Street, Oldham OL1 1HA