OLDHAM SAFEGUARDING ADULTS BOARD

ANNUAL REPORT 2021-2022

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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 we?

By law, the Board's membership must include Oldham Council, Greater Manchester Police and Oldham Integrated Care Partnership (formerly NHS Oldham Clinical Commissioning Group).

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
- Oldham Integrated Care Partnership

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 a care setting.

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 2022/23 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 report a concern.

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 partners priorities for the coming year.

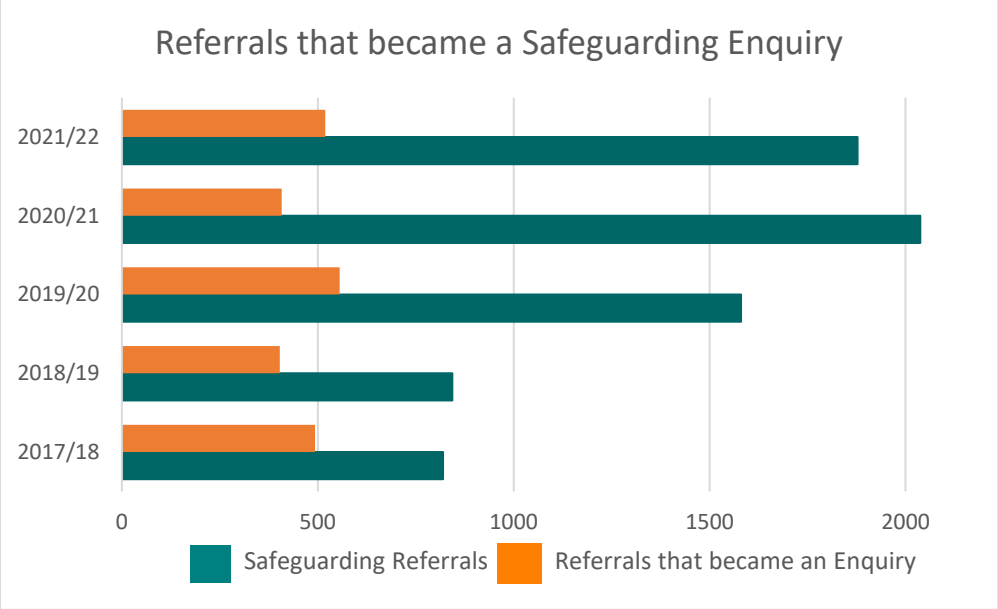
This Annual Report provides an overview of safeguarding trends in Oldham during 2021/22. It also provides information on the Safeguarding Adult Reviews commissioned by the Board and how the learning from these reviews has shaped and improved the way services work in Oldham.

Profile of abuse and neglect in Oldham

The following information shows the numbers and types of safeguarding abuse recorded for Oldham residents in 2021/22. 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 is investigated and if we believe that someone is at risk of serious abuse or neglect the referral becomes the subject of a formal safeguarding enquiry. The chart below shows the number of safeguarding referrals that have gone on to become formal safeguarding enquiries over the last five years.



During 2021/22, a total of 1,878 safeguarding referrals were received and of these, 519 (28%) became the subject of a formal safeguarding enquiry.

Whilst the number of safeguarding referrals in 2021/22 is lower than 2020/21, the number of safeguarding enquiries being investigated has increased by 22% compared to the previous year.

Sex, age and ethnic group of safeguarding referrals

Of the 1878 safeguarding referrals in 2021/22, 58% related to women and 42% related to men.

This is the same proportion as previous years and, as women make up 51% of the total adult population in Oldham, this means that the percentage of safeguarding cases per head of population in 2021/22 were slightly higher for women than for men.

safeguarding referrals were about women in 2021/22

safeguarding referrals were about men in 2021/22

Of the 1878 safeguarding referrals in 2021/22:

- 873 (47%) were 18-64 years old
- 226 (12%) were 65-74 years old
- 399 (21%) were 75-84 years old
- 380 (20%) were 85 years old or older

The breakdown by age group shows that over 50% of safeguarding referrals related to someone aged 65 or over. Whilst the percentage of people aged 85 years and over has increased slightly from 17% to 20% the breakdown by age group has remained consistent over the last three years, despite the impact of the Covid-19 pandemic.

Of the 1878 safeguarding referrals in 2021/22:

- 80% were White British
- 7% were Asian/Asian British
- 2% were Black/African/Caribbean
- 3% were Mixed/Other Ethnicity
- 11% were Unknown/refused information

Overall these figures suggest that White British people aged 65 and over were more likely to be the subject of a safeguarding concern in 2021/22, compared to any other group.

Number of closed safeguarding referrals and enquiries

During 2021/22, a total of 2253 safeguarding referrals and enquiries were closed which is more than the 1878 safeguarding referrals received in the year. This is due to a push by the Strategic Safeguarding Service to increase the number of timely closure of referrals and enquiries and includes the closure of outstanding cases from 2020/21.

Also, the 2021/22 figures include a higher proportion of complex safeguarding cases compared to 2020/21 with **40%** of the 2253 closed enquiries involving people who lacked capacity to make their own decisions.

Safeguarding – what does good look like?

When we report on safeguarding data we often focus on safeguarding enquiries, because this is a statutory responsibility for Adult Social Care. But this is only part of the picture. In 2021/22 Oldham's Safeguarding Hub (MASH) dealt with a further 1,359 safeguarding concerns that did not meet the criteria, but still involved a great deal of work to keep people safe and well.

In Norma's case a concern was raised about her wellbeing. Norma, who is in her 90s is very independent and had declined several previous offers of support from Adult Social Care. Instead, she organised her own support but staff were concerned that she wasn't taking her medication and were worried about her mental welling. The MASH team were able to use the safeguarding process to strike up a different type of conversation. Through gentle persistence the worker was able to build a relationship by getting to know Norma, rather than offering to assess her needs, and found out that Norma had experienced a lot of close personal loss and was going through a difficult time reflecting on her experiences.

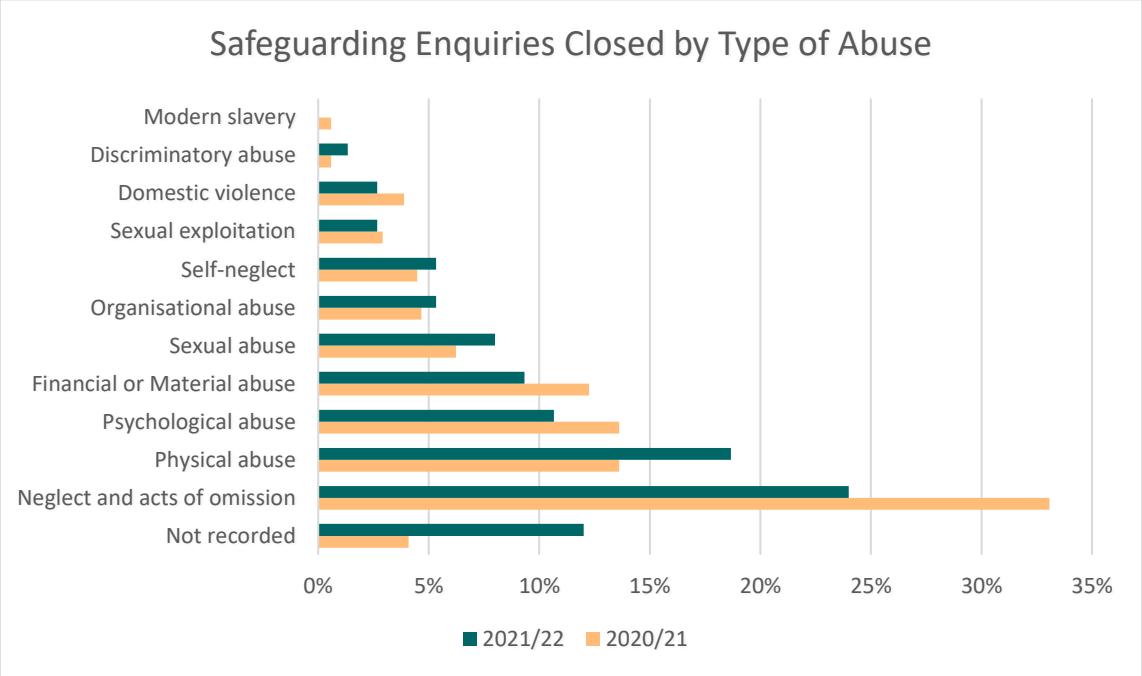
It was important for Norma to remain in control and feel independent. So, whilst she recognised that some extra help would be useful, she once again refused any social care or mental health support. Norma did however continue to accept support from the MASH worker who helped her think about the support she wanted and how to commission this herself - keeping her in control. By gradually building trust, Norma also agreed to the idea of talking about her past and experiences through life story work offered by Age UK Oldham.

"Normally we would close a case if someone refused support, but with safeguarding we can be more creative. In this case, it meant Norma could manage her own wellbeing without going through a formal assessment. Our hope is that this connection is just the start and will open up even more opportunities." MASH worker

Types of safeguarding abuse

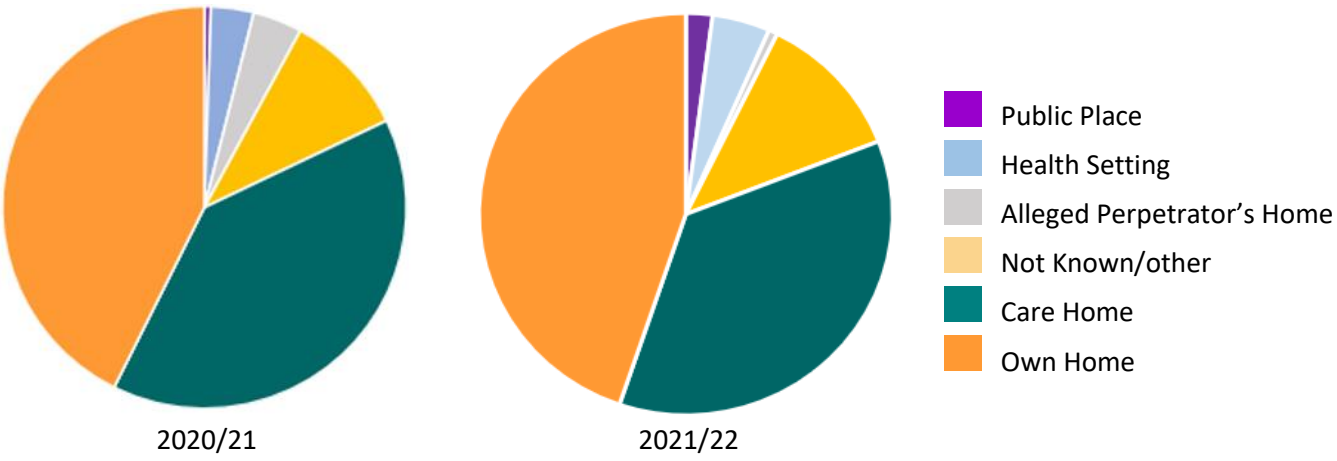
The chart below shows a breakdown of the **types of safeguarding** abuse investigated in 2021/22 compared to 2020/21. The most common form of abuse in 2021/22 relates to neglect and acts of omission. These are cases where a person who is responsible for the support of an adult at risk has failed to provide adequate care or essentials such as medicines, nutrition, heating etc. Despite this being the most common form of abuse, levels have come down from 33% in 2020/21 to 24% of cases investigated in 2021/22. Conversely there has been a slight increase in the percentage of physical and sexual abuse cases investigated in the last year.

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. As part of Oldham's safeguarding processes, new requirements have been introduced for 2021/22 to ensure the recording of the category of abuse is a mandatory part of the recording process.



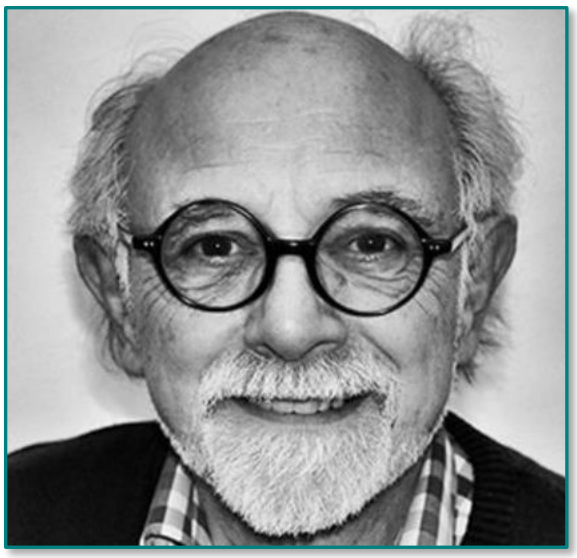
Where the abuse took place

The charts below show that for both 2020/21 and 2021/22 the most common places where the reported abuse or neglect took place was within the person's own home or within a care home/residential setting.



Safeguarding data is reviewed monthly by the Board's Statutory Leadership Group. In 2020/21, the Board oversaw the development of the first phase of a more detailed data 'dashboard'. The insights from this are used by the Board and Statutory Leadership Group to review safeguarding resources and where appropriate, adjust the way services work together to keep people safe in Oldham.

Message from the Independent Chair

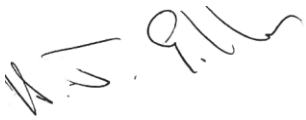


In the foreword to last year's annual report from the Oldham Safeguarding Adult Board I wrote about the challenges facing the Board in Oldham and how the local partners will need to review their working practices to meet new and emergent needs. I asked, "How relevant are traditional working practices to meet these emergent trends? How can we more effectively work together to make an impact on safeguarding need? How can we incorporate the perspectives of service users and their carers in safeguarding plans and outcomes?" The report for the year 2021-22 illustrates that significant developments have been made by the local partnership to meet the continuing challenges of safeguarding and adapt working practices to the meet the complexity of current safeguarding need.

The evidence of significant safeguarding challenge can be seen throughout the report – social isolation, compromised mental capacity, dual diagnosis of mental and physical vulnerability, living conditions threatened by violence (such as with domestic abuse) and homelessness. Moreover, this evidence has been recurrent both in our safeguarding adult reviews and in our learning reviews.

The response to these messages from our partners has been clear and decisive – we must listen to people's experiences of the challenge of safeguarding, we must challenge traditional working practice, we must innovate, we must work more closely and interchangeably to ensure that services are responsive and seamless. The Tiered Risk Assessment and Management (TRAM) Protocol, the progress of the Board's training programme and the closer collaborative working with people with a dual diagnosis are all good examples of this willingness of partners to creatively change.

The year ahead in 2022-23 is likely to prove more of the same sorts of challenge. The shadow of Covid continues to be cast over vulnerable people and those seeking to provide them with support. The changed governance landscape of the NHS will need to settle in the period and demonstrate that it will continue to champion safeguarding issues. The publication of the review of historic sexual abuse in Oldham will cause people to seek assurance that services have changed over the past 20 years and are now more responsive and inclusive. The partners are aware of these challenges and will use the safeguarding adults partnership constructively to ensure that they are met.



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.

Where cases do not meet the legal requirements for a mandatory SAR, but the Board feels there are lessons to be learnt, it can carry out a **Learning Review**. The following information shows the number of reviews commissioned by the Board in 2020/21 and 2021/22.

2020/21 — **4 Safeguarding Adult Reviews**
5 Learning Reviews

2021/22 — **2 Safeguarding Adult Reviews**

A common theme emerging from both the Learning Reviews and SARs involves dual diagnosis, where an adult has a mental health condition combined with an alcohol or substance misuse disorder. This can be further complicated when the adult also has a diagnosis of autism or Attention Deficit / Hyperactivity Disorder (ADHD). The following findings come from two learning reviews commissioned in 2020/22.

Anna and Maya

Anna was in her early 20's when she was taken to hospital with serious wounds following an alleged assault. She had a history of self-harm, mental health issues and alcohol use and as a child was diagnosed with ADHD and Emotionally unstable personality disorder (EUPD).

Anna was known to, and well supported by children's mental health services but on reaching 18 she was not eligible for adult's mental health services. Her family said that she used alcohol to manage the effects of both her social anxiety and ADHD symptoms, but her use of alcohol made it hard for services to assess her mental health needs. As a young adult, she was regularly missing from home and often found drinking with strangers, which left her open to abuse.

Anna's parents really struggled to keep their daughter safe, especially when she turned 16, as services saw her an adult, able to make decisions that others may feel are unwise.

Maya was brought up by her adoptive parents until the age of 14 years old. She had a medical diagnosis of Asperger's Syndrome, Oppositional Defiant Disorder, Emerging Borderline Personality Disorder and Anorexia Nervosa; she had a history of alcohol misuse, domestic abuse, self-neglect, and attempted suicide.

Over a two-year period, Maya repeatedly drank to excess, called out emergency services due to physical health problems or attempted suicide, but would then refuse to attend A and E. At its height she called out emergency services more than 25 times in two days. Maya also refused help from mental health and alcohol support services despite her family's belief that she drank alcohol to manage her anxiety and mental health symptoms.

Maya was diagnosed with chronic liver disease and told that if she continued to drink at her current levels she would die. At one point she told ambulance services that she felt very lonely. Maya was assessed under the Mental Capacity Act and professionals judged that she had the capacity to make decisions that others may feel are unwise. Maya died aged 24 from liver disease and after discharging herself from hospital.

Listening to lived experience

The Board carried out a Learning Review to explore the events leading up to the death of Maya and spoke to Anna's family about their experiences of accessing services.

The findings were shared through two multi-agency Learning Hub events in June and November 2021. The Learning Hub events identified the following Issues which have been used to change the way services are provided:

- **Transitions** – As children, both Anna and Maya were supported by Mental Health and Learning Disability Teams. However, the different criteria for adults' services meant that this support did not continue when they transitioned from Children's to Adults services between the ages of 16 and 18.

- **Dual Diagnosis** – In each case, it was reported that Anna and Maya used alcohol to manage both their mental health conditions and ADHD or Asperger's symptoms. However, the combination of alcohol dependency and ADHD/Asperger's made it hard to assess any mental health needs. As a result, they did not access services that could have supported their mental wellbeing.

- **Executive Functioning** – Services felt that both Anna and Maya had the capacity to make their own decisions. However, it was not clear if professionals considered the potential impact that their ADHD/ Asperger's and mental health issues might have had on their understanding of risk and how this might affect the decisions they made.

- **Known to Multiple Services** – Anna and Maya were known to multiple services and whilst services did work well together at some points, this was not sufficient to manage the risks.

- **Social Isolation** – Both Anna and Maya experienced social isolation and social anxiety. These were key factors that contributed to their use of alcohol, which in turn increased Anna's vulnerability and for Maya, often resulted in violent and aggressive behaviour, even to the professionals she called out to help her. As a result, the GP stopped home visits, ambulance call outs were stopped, and the police were frequently called to attend. Agencies focused on managing distressed behaviour rather than working collectively to understand their needs and wishes.

Anna: the family's experience

"Anna is really intelligent, meeting her you would assume she doesn't have autism…it is only when you start talking to her and see the difficulties she has in social situations. [When she was young] she received a lot of support so when she was 16 it was like falling off a cliff, from having a service once or twice a week…very intensive, thorough, and helpful then hit at sixteen with nothing.

Her condition became gradually worse as she became involved in the adult world. There would be an incident and firefighting and then another incident, rather than having any sort of pre-emptive intervention. It felt that we were passed on, each time they would say "that isn't our problem". I would go to appointments and have to repeat and repeat, say what is going on over and over again, going over all the bad things, it was pure torture. There are things that happen in life so for you to cope while waiting for the right mental health services to kick, this other problem starts to grow because you cope with your mental health by drinking. She has so many complex issues it isn't just autism there is an eating disorder, mental health issues, alcohol. They are all kind of interrelated and impact on each other. I sent email after email saying can't you get someone to manage her case and bring all these services in?

We got a call from [a community mental health worker], she introduced herself and what she did. I can only describe it as the clouds parting and the sun shone down, the relief of knowing that you were finally going to have this person to support Anna, and by God she is brilliant. We have gone from being in the wilderness to having all this support pulled together…we have a social worker who acts as the central hub and brings police, mental health, social work, drink support people. They meet regularly, updating each other, they are all on the ball.

The support has totally changed in terms of managing and coming up with a plan to pre-empt situations. Since being involved with [a Turning Point worker], he is just fantastic, he connects with Anna. She connects in return, so you get somewhere with her. The key to the improvement is getting them together so they can reflect and discuss what they are each doing to help …it's a much more cohesive arrangement. I would like to see more people with complex needs having someone who project manages their case rather than it just being mental health or passed to your GP, it's more of a coordinated approach."

Working in Partnership in 2021/22

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 three-year ambitions 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 2021/22 include:

- **Multi-Agency Team Around the Adult Arrangements** – in response to learning from SARs and feedback from families such as Anna's, agencies have adopted a new Tiered Risk Assessment and Management (TRAM) Protocol. For cases involving complex issues and risk, the Protocol helps agencies to identify a lead professional and coordinate support effectively through regular Team Around the Adult meetings. This approach brings together relevant statutory, voluntary, and independent services and works by sharing insight and resources and working with the individual and family to come up with solutions.

- **Dual Diagnosis** – Oldham SARs have seen an increase in cases involving adults living with a 'dual diagnosis'. This means that the adult has a diagnosed mental illness combined with substance or alcohol misuse. Many adults with a dual diagnosis also experience homelessness. In response to the increase in cases and SAR learning, Oldham Housing Options, Turning Point and Pennine Care mental health services have joined forces to recruit a dual diagnosis worker as part of a new Homeless Addiction Treatment Support Service (HATSS), for those sleeping rough or at risk of homelessness. The post will be co-located with Turning Point and adults will be supported through mental health assertive outreach workers.

- **Training and Awareness** – As a result of the Board's new Workforce Development Strategy launched in 2021/22, a total of 366 professionals from 23 different services have received training in a range of topics including Self-Neglect, Hoarding, Trauma Informed Practice, and the Mental Capacity Act. The Board has also been part of six 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.

- **Listening to people's experiences** – In partnership with Age UK Oldham, Healthwatch and Oldham's Domestic Abuse Partnership, the Board has carried 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, 26 adults shared their stories; with experiences ranging from long standing abuse by an intimate partner to abuse from wider family members. Our research found that abuse can be triggered by life changing situations such as retirement, disability or taking on an informal caring role. Feedback will be 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.

- **Hoarding Taskforce** – In 2020, the Board published a range of multi-agency hoarding and self-neglect resources. As a result, there has been a growing recognition and awareness of cases in Oldham and calls from practitioners to set up a Hoarding Taskforce to provide a practical forum to bring services together to discuss complex cases and identify solutions. Set up as a joint initiative between Royton District Centre Partnership and the Board, the Taskforce has been instrumental in the production of a new training resource and guidance on the use of standard 'clutter ratings' to help assess risk.

Each year, partner agencies provide a summary of their own safeguarding work for publication in the Board's **2021/22 Single-Agency Reports**. The following pages provide summaries from Oldham Council, NHS Oldham CCG and Greater Manchester Police as the three lead agencies on the Board.

Partner Contributions: 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 delivers these statutory responsibilities as part of Oldham and 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 themes in 2021/22

The Covid-19 pandemic continues to impact through increased demand on services and reduced capacity due to staff sickness. Other key challenges have been:

- **Increase in reports of abuse to Adult Social Care.** We have responded to the significant increase in reported safeguarding concerns by reconfiguring the ASC access point designed to speed up the screening of new referrals.
- **Increase levels of complexity.** We have responded to the increase in complexity of cases, particularly involving exploitation, domestic abuse, hoarding and self-neglect, through the creation of the Complex and High Risk Panel which brings together safeguarding leads to help problem solve cases involving multiple issues.
- **Increase in requests for Deprivation of Liberty Safeguards.** We responded to the increase in demand by increasing the pool of people authorised as Best Interest Assessors. In addition, appointing a dedicated manager has resulted in streamlining processes and strengthened the operating model for the service.

Our major successes include:

- **National Recognition –** Oldham Council was recognised nationally in the Insight Report for outstanding Safeguarding Adult responses during the Covid-19 pandemic.
- **Safeguarding Data Collection** – Adult Social Care has traditionally provided data on how it responds to safeguarding enquiries. Last year, this was expanded through a new Partnership Data Dashboard to collect data on who is reporting safeguarding concerns so we can identify gaps and target our information campaigns and training.
- **Complex Safeguarding** – We have provided a lead role on behalf of the Association of Directors of Adult Social Services (ADASS), working with partners across Greater Manchester to understand what constitutes and causes complex safeguarding and how we respond effectively to adults experiencing exploitation.

Our Priorities for 2022/23

Key challenges for the coming year will be the ongoing impact of the Covid-19 pandemic combined with cost-of-living increases. Both are expected to disproportionately impact on Oldham's poorer communities and adults at risk of abuse and neglect. Our priorities will be:

- **Capacity and Demand:** We will continue to balance the increasing demand from safeguarding referrals with reduced staffing capacity. Key to this will be a focus on the recruitment and retention of staff within Oldham.
- **Place Based Working:** We will focus resources on working at the local level with communities both to promote people's understanding and awareness of safeguarding and build on local networks of support to help keep people safe.
- **Safeguarding Prevention Strategy:** Priority will be given to the production of a safeguarding prevention strategy aimed at refocusing resources on the early identification and intervention to prevent abuse or neglect. This will be developed in partnership with local communities and service user groups.

Partner Contributions: NHS Oldham CCG

NHS Oldham Clinical Commissioning Group (CCG) is a member led organisation and every family doctor in Oldham is a member. The vision of NHS Oldham CCG is to improve health and healthcare for the people of Oldham by commissioning the highest quality healthcare services, provided near to the patient and that represent best value for money. As we move into the Greater Manchester Integrated Care System, we are committed to reducing health inequalities and improving outcomes for those in need.

Where does safeguarding fit?

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.

They are responsible for the provision of effective clinical, professional, and strategic leadership in regard to safeguarding adults, including the quality assurance of safeguarding through contracts with all provider organisations and agencies, including independent providers.

Safeguarding themes in 2021/22

Throughout 2021/22, Oldham CCG has worked with providers and partners to respond to new and emerging safeguarding concerns. Key challenges have included:

- **TRAM Protocol** – We have supported the development of multi-agency safeguarding policies, particularly the development of the Tiered Risk Assessment and Management (TRAM) Protocol, Allegation Management Protocol and Domestic Abuse Policy.
- **Safeguarding Assurance** – we have reintroduced the safeguarding Assurance Processes for Nursing Homes and reviewed safeguarding audits with GP Practices.
- **Covid Response** – we have continued to contend with the effects of the Covid Pandemic and support partnership working as we have moved into the next phase, with Covid becoming 'business as usual'. The impact of the last few years on our workforce across health and care is phenomenal and we continue to support staff through difficult challenges and emotive situations.

Our major successes include:

- **Managing Professional Allegations** - the Designated Nurse for Safeguarding Adults has worked to embed policies supporting staff to raise a safeguarding allegation about a person in a position of trust. Actions include ensuring compliance is included in Provider Contracts and including information in training resources.
- **Greater Manchester ICS** – Leading the development of an Integrated Care System model of safeguarding on behalf of partners across Greater Manchester. The changing landscape of health and social care means that, more than ever, it is essential that Oldham people have a voice and that we continue to work directly with the local community to improve outcomes and keep people safe. We have worked with safeguarding partners to review existing structures in Oldham to ensure robust governance processes for safeguarding remain central to any changes.

Our Priorities for 2022/23

Changes across health and care will provide challenges over the coming year but this also brings opportunities to work with Oldham partners to ensure that safeguarding remains a core component of our new governance arrangements. Our priorities will be:

- **Place Based Working** - Primary Care is at the core of our place-based approach and over the coming year we will support the growing maturity of primary care networks to solidify their contribution to safeguarding practice and embed the learning from Safeguarding Adult Reviews to improve outcomes for residents in Oldham.
- **Integrated Care System** – ensure the smooth transition to the new Greater Manchester structures including the transition of complex safeguarding and MASH Specialist Nurses to the Northern Care Alliance.
- **Compliance** – ensure the ICS is compliant with the new **Domestic Abuse Act 2021** assurance framework duties for health services and continue preparations for the implementation of the Liberty Protection Safeguards.

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. As a force, it is essential 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 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 themes in 2021/22

Key issues for GMP in 2021/22:

- **Month on month increase in Domestic Abuse** – This year has seen an increase in Domestic Abuse incidents which have included an increase in stalking, harassment, and domestic related sexual abuse. Possible reasons for this include an increase in public confidence to report as well as the drive around National Crime Recording Standards.

Our major successes include:

- **Investigative Safeguarding Review (ISR2)** - Implemented stage one of the ISR2, which moved officers into the specialist Child Protection Units. The Force is now preparing for stage two which will develop Adult Safeguarding Units, providing specialist officers dedicated to tackling Domestic Abuse and safeguarding vulnerable adults.
- **Domestic Abuse Learning Circles** – Learning from an audit carried out by The Public Protection Governance Unit has resulted in the creation of Domestic Abuse Learning Circles. This new initiative has been trialled in Oldham and is designed to encourage reflective practice as well as the chance for officers to comment on organisational barriers when dealing with Domestic incidents. The District also takes part in daily governance meeting where incidents from the previous 24 hours are reviewed and any concerns are swiftly addressed.
- A **Stalking, Harassment and Domestic Abuse Panel** took place in October 2021 made up of the Police, Crown Prosecution Service (CPS) and Victim Service Coordinators. The exercise found that the CPS were receiving more stalking cases from the Police compared to the previous year. The exercise also found some strong investigations and tenacity of officers and good evidence of joint working between the CPS and Police.

Our Priorities for 2022/23

Changes across health and care will provide challenges over the coming year but this also brings opportunities to work with Oldham partners to ensure that safeguarding remains a core component of work. Our priorities will be:

- **IRS2** - implementation of the Investigative Safeguarding Review unit (ISR2), improving our response to Adults with Complex Needs and reshaping the governance of Domestic Abuse Multi-Agency Risk Assessment Conferences (MARAC).
- **Adult Safeguarding Unit (ASU) –** implementation of the new ASU, providing an enhanced response to Adult Protection by triaging Adult Protection incidents to identify adults who are in need of support. Working closely with Adult Social Care, Mental Health services, drug and alcohol services and neighbourhood police officers, to ensure concerns are problem solved quickly, and by the most appropriate agency.
- We will continue to prioritise the emerging trends of complex safeguarding, Domestic Abuse, and neglect. We will explore options to contribute to the creation of a new all age Complex Safeguarding Team with partners moving forward.

Our Plans for 2022/23

The Oldham Safeguarding Adults Board has made significant progress over the last twelve to eighteen months, producing clear multi-agency safeguarding procedures, policies and training resources designed to translate the learning from serious safeguarding incidents into 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.

Despite this, the Board has a challenging year ahead. Our priority is to explore the findings set out in the Independent Greater Manchester Child Sexual Exploitation and Safeguarding Report to ensure that nothing like this can happen again. Through weekly multi-agency response meetings and a planned Learning Hub event in September 2022, partners will develop a forward plan for Oldham. This will provide assurance that systems and processes are changing, and that professionals across children's and adults' services are equipped with the skills and knowledge to respond effectively.

2022/23 will also see far reaching structural changes being developed in response to new legislation set out in the Health and Care Bill and the Mental Health Act White Paper. 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 a new Care Quality Commission inspection framework. The Inspection Framework will focus on how the Local Authority is delivering its 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's priorities for 2022/23:

In addition to the ongoing work to embed learning from Safeguarding Adult Reviews, the Board sets out its wider priorities in the annual Plan on a Page (available on the Board website or please click on the image).

The Key highlights for 2022/23 are to:

- **Improve the way services work together:** Working in partnership with the Association of Directors of Adult Social Services, the Board will continue to take a lead role in the development of an all-age Complex Safeguarding and Exploitation Strategy. This work will also be shaped by findings from the Greater Manchester Child Sexual Exploitation Report and developed in partnership with Oldham's Children's Safeguarding Partnership and Oldham's Community Safety and Cohesion Partnership.

- **Safeguarding Data:** Working as part of a Greater Manchester initiative, our priority is to complete phase 2 of the Data Dashboard designed to improve the collection and interrogation of partnership safeguarding data. This will help us to understand trends, direct multi-agency support and seek assurance from agencies on their safeguarding responses.

- **Quality Assurance:** Over the last eighteen months, the Board has focused on developing safeguarding procedures, policies and a programme of multi-agency training based on the learning from Safeguarding Adult Reviews. The focus for 2022/23 is to look at how well the learning and policy changes have been embedded into safeguarding practice. The Board will prioritise a programme of multi-agency audits and quality assurance reviews focusing on risk management, application of the Mental Capacity Act and Making Safeguarding Personal principles.

- **Be led by people's experiences:** We will continue to build on our existing work to capture the first-hand experiences of people using services. This insight will be used to produce a new safeguarding strategy designed to prevent future incidents. We recognise that local people are often contacted by multiple services to share their views so the Board is teaming up with Action Together, Oldham's voluntary sector umbrella organisation, to capture people's insight through a single mechanism. This will create a shared space to listen to, and learn from, local people and prevent agencies from asking people to repeat their stories.

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 Multi-Agency Safeguarding Hub (MASH) has been set up to help people who want to report a safeguarding concern:

0161 770 7777
or
Adult.Mash@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 them and their families and friends safe in Oldham:

@SafeguardOldham

Thank You from the Team

Oldham Council
Greater Manchester Police
NHS Pennine Care NHS Foundation Trust
NHS Northern Care Alliance NHS Foundation Trust
Oldham Integrated Care Partnership
Oldham age UK
healthwatch Oldham
Voice Ability
MioCare Group
Doctor Kershaw's Hospice
Probation Service
KeyRing ... We're Life Changing
OPAL
Greater Manchester Fire and Rescue Service
action together
Positive Steps
NHS North West Ambulance Service NHS Trust
Turning Point inspired by possibility