Bury Safeguarding Adults Board

Annual Report

2023 – 2024

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Foreword from the Bury Safeguarding Adults Board Independent Chair

I am pleased to introduce the annual report of the Bury Safeguarding Adults Board (BSAB) which covers the period April 2023 to March 2024. Having been appointed as the Independent Chair in August 2024, I have reflected on the work of the BSAB over the reporting period, and I would like to thank my predecessor for establishing the new governance arrangements which have strengthened how agencies work together to ensure that vulnerable adults are safe and that their welfare is promoted.

This is the final year of our three-year strategic plan. The annual report celebrates our achievements, highlights our challenges and provides updates on progress made against our strategic priorities.

I am pleased to report that good progress has been made against these strategic priorities, delivered through a planned programme of work ensuring that we continue to meet our statutory duties.

Safeguarding adults does not begin and end at the start and finish of financial years and whilst the report covers the reporting period of 1 April 2023 up to 31 March 2024, the report recognises some of the work beyond this period which had already started, and which continued into the next reporting year.

I would like to give my personal thanks to practitioners and managers across all agencies who are working so hard to make a difference to safeguarding adults in Bury.

Frances Millar
Independent Chair

Introduction

What is adult safeguarding?

The Care Act 2014 statutory guidance describes adult safeguarding as:

"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, while at the same time, making sure that the adult's wellbeing is promoted including where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances."

Who does safeguarding apply to?

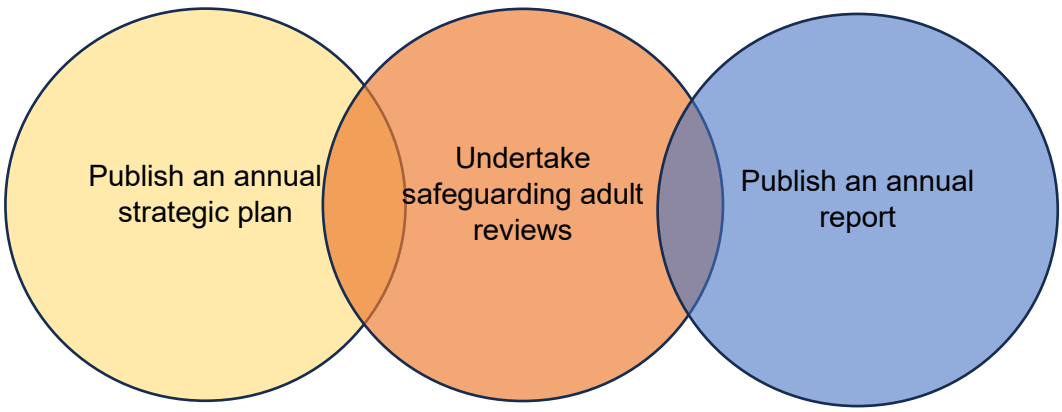
Safeguarding is everyone's responsibility, and the Bury Safeguarding Adults Board has a role to play in assuring our community that 'adults at risk' are safeguarded from abuse or neglect. An adult at risk can be anyone aged 18 or over who:

- Has care and support needs (even if no agency is involved in meeting those needs) and;
- Is experiencing, or at risk of, abuse or neglect; and/ or
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experiences of abuse or neglect.

Background

The Care Act 2014 requires Safeguarding Adults Boards to ensure that vulnerable adults are safe, and that agencies work together to promote their welfare. The Act sets out a legal framework for how local authorities and other organisations should protect adults at risk of abuse or neglect.

The board has three core duties:



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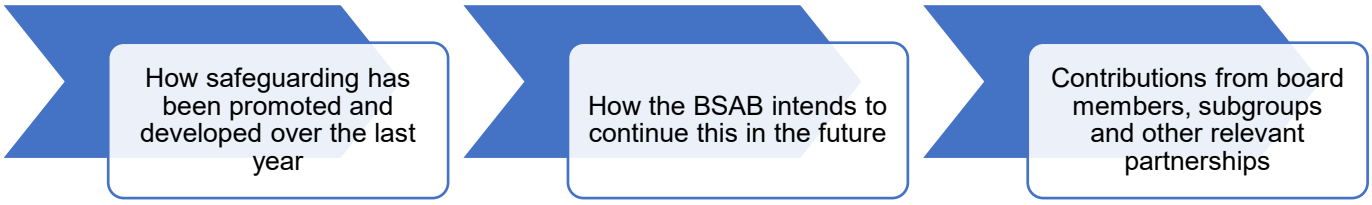


Safeguarding adults' performance data 2023-2024

This section presents data and information for 2023-24 in relation to safeguarding adults. It gives an overview of the number of safeguarding concerns that have been received, and the number and type of enquiries (investigations) that have been concluded. The Council in its lead role for safeguarding, has an overview of all safeguarding concerns received within Bury. As such, data from the Council's case management system has been used to inform this section.

2022/2023	2023/2024	
1862	1984	Individuals involved in safeguarding concerns
735	665	Individuals involved in Section 42 Enquiry[1]
28	18	Individuals involved in other safeguarding enquiry
168	107	Number of individuals involved with more than one Section 42 enquiry
9	1	Number of safeguarding adult reviews commenced in the reporting year

[1] Definition of Section 42 Enquiry in the Care Act 2014

Vision of the Bury Safeguarding Adults Board

We will all work together to enable people in Bury to live a life free from fear, harm and abuse.

Outcomes

- Confidence in multi-agency safeguarding responses, with people being safeguarded from abuse and neglect.
- Our partners work within a framework of policies and procedures that keep people safe.
- Confidence that services are learning and improving in their safeguarding practice and adult safeguarding risk is better understood by the SAB and appropriately assessed by partners.
- Adults at risk are identified early and have their needs met promptly and effectively.
- Individuals feel empowered and for their voices to be heard in safeguarding practice and policy development.
- Individuals are supported by a skilled and competent workforce.

Priorities

The priorities in the strategic plan for 2022-24 are based on concerns and issues facing at risk adults in Bury, their families and our practitioners, and are backed up by evidence from data, auditing and inspection, and themes identified in our local Safeguarding Adult Reviews.

The delivery plan is the key mechanism for the BSAB in achieving its priorities within the strategic plan.

The priorities for 2022-2024, were agreed by the BASB, and were as follows:

Strategic Aim 1: **SAB Priority**:	**Accountability, Assurance & Leadership** Ensure the BSAB provides strategic leadership to embed the principles of safeguarding across agencies and contribute to the prevention of abuse and neglect.
Strategic Aim 2: **SAB Priority**:	**Policies, Strategies & Procedures** To be assured that multi-agency safeguarding strategies, policies and procedures are regularly reviewed to ensure currency, reflecting emerging legislation, policy and/or learning, and that these are easily accessible to frontline staff and used effectively.
Strategic Aim 3: **SAB Priority**:	**Learning from SAR's – Performance, Quality and Audit** Assure learning from SAR's is effectively distributed and embedded into practice across agencies, implement quality assurance mechanisms, and refocus safeguarding data to define SAB priority areas.
Strategic Aim 4: **SAB Priority**:	**Prevention & Early Intervention** Ensure the SAB has a focus on prevention that clearly identifies how it will aim to reduce incidence of abuse and neglect (including self-neglect) in Bury.
Strategic Aim 5: **SAB Priority**:	**Making Safeguarding Personal** To ensure the work of the BSAB and safeguarding responses are person centered.
Strategic Aim 6: **SAB Priority**:	**Learning and Development** Ensure the workforce is equipped to support adults appropriately where abuse including neglect is suspected.

Update on achievements

An important part of this report is to update you on what we said we would do and what we have achieved during the last 12 months.

Strategic objective one – accountability, assurance and leadership

We said we would:

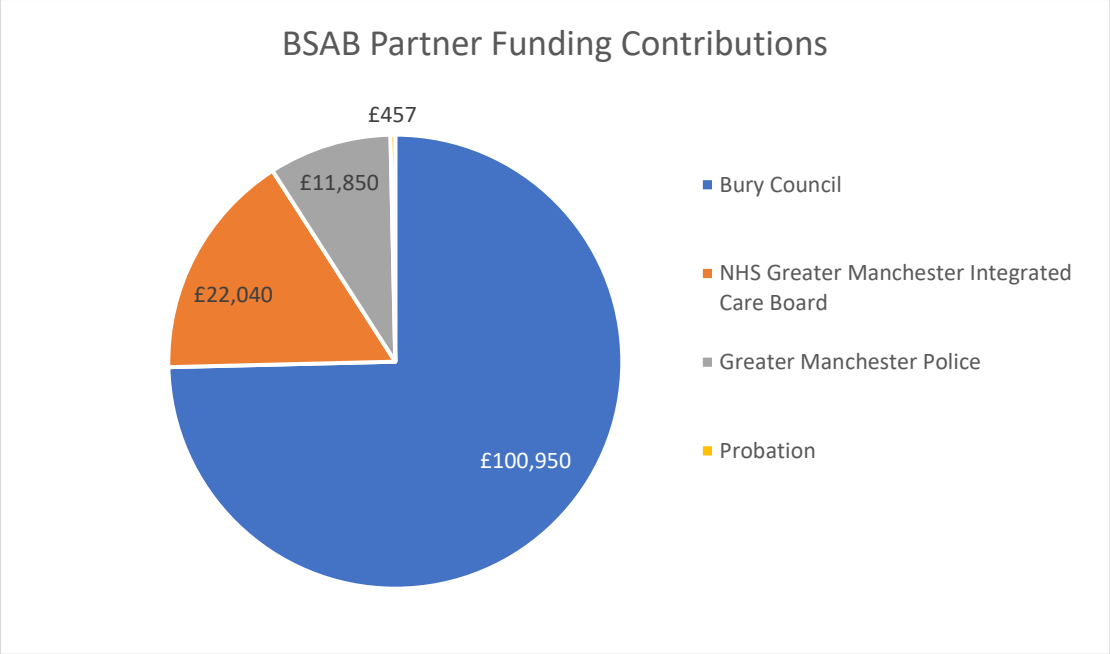
- Ensure clear and transparent annual budget plans are in place for all BSAB activities.
- Develop the BSAB and broader governance arrangements.
- Escalate and influence commissioning arrangements for the borough, considering the ICB development, key transformation programmes and commissioning plans.
- Provide regular briefings for partnership boards (Health and Wellbeing Board, Community Safety Partnership Board) on the progress of the BSAB.
- Continually strive to develop arrangements to be responsive and adapt to emerging safeguarding themes, based on available performance data.

What we have done

Budget and Resources

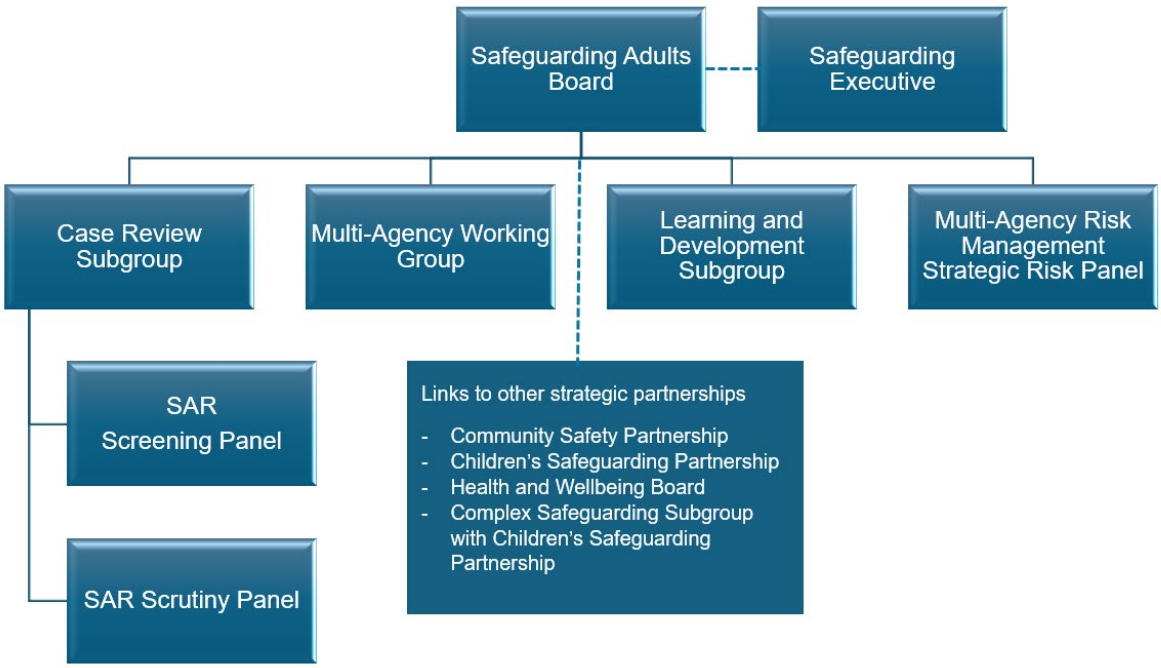
Each of the statutory partners, and some relevant agencies contribute to the Bury Safeguarding Adults Board budget, and all partners offer their time and expertise to the activities of the Board. These activities include participating in meetings, safeguarding adults reviews, delivering training and ensuring the roll out of key learning and messages. The commitment, contribution and engagement of partners in supporting adult safeguarding in Bury is acknowledged and valued.

The funding contributions are essential and support the BSAB to have a business unit that can effectively co-ordinate all multi agency safeguarding activity, including management of Safeguarding Adult Reviews (SARs) and the commissioning of independent reviewers where appropriate, analysis of themes from SARs, performance reporting, governance support, learning and development, policy and strategy development, audit work, partnership website, performance reporting, implementing legislative changes, horizon scanning for national reforms to be implemented, co-ordinating action tracking, and developing the strategic plan. In comparison to some safeguarding partnerships across Greater Manchester, Bury has a small business unit (5 FTE) covering both the safeguarding adults board and safeguarding children partnership.



Effective Arrangements

The BSAB has a robust governance structure, and there is continual commitment from all partners in supporting the work of the BSAB and the subgroups.



The BSAB has continued to build strong links with partnerships. Reciprocal reporting arrangements and attendance at Community Safety Partnership (CSP) meetings are in place, so that there is an opportunity for joint responses to safeguarding matters. An example of this approach is the sharing of learning from a SAR with the CSP, where domestic abuse had been a theme, to improve recognition and understanding of the circumstances in which adult safeguarding and domestic abuse overlap.

The BSAB also has a rhythm of reporting on its progress to the Health and Wellbeing Board, submitting its annual report for consideration.

Members of the BSAB and the Bury Safeguarding Children Partnership come together as the Complex Safeguarding Subgroup where connections are made regarding young people transitioning to adults.

Performance Data

The BSAB has developed a dataset to strengthen oversight of safeguarding adults in Bury. This will further evolve in 2024/2025 and a schedule of performance reporting to the BSAB will be on a quarterly basis.

The BSAB also supports the completion of the Safeguarding Adults Collection (SAC) data published by NHS Digital. This reports on the statutory duties of local authorities under the Care Act to safeguard adults at risk of abuse or neglect and enables the BSAB to undertake comparative analysis on safeguarding activity.

A SAR dashboard has also been developed in this reporting year, which informed the analysis of the types of abuse or neglect featured in SARs in Bury. This information, alongside the National SAR analysis, supports the BSAB to be responsive and adapt to emerging safeguarding themes, based on available performance data.

Strategic objective two – policies, strategies and procedures

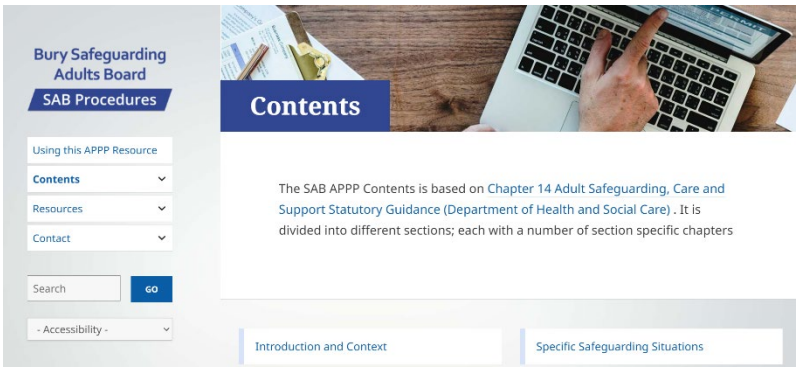
We said we would:

- Ensure the publication of the BSAB strategy and review every 12 months.
- Launch a suite of Safeguarding Policies and Procedures to support frontline practitioners.
- Develop arrangements to manage allegations against People in a Position of Trust (PIPOT)
- Review the Safeguarding Adults Review (SAR) protocol.
- Ensure the publication of the BSAB annual report.

What we have done

In the last quarter of the reporting period, the BSAB reviewed its strategic plan in response to themes from SARs and performance data, so that a new three-year plan could be adopted for 2024-2027.

An operational delivery plan underpins the BSAB's strategic priorities and is driven by the subgroups. A range of multi-agency policies and procedures have been developed in the reporting year, with a dedicated website available to support frontline practitioners.



Following the review of the SAR procedures at the start of the reporting period, these have been well-embedded throughout the year and are in line with the procedures used across Greater Manchester.

In the previous reporting year, some partners in the BSAB undertook the SAR in rapid time training delivered by the Social Care Institute for Excellence (SCIE). The SAR in rapid time approach was used for one SAR in the reporting period, as this was proportionate to the scale, complexity, and impact of the abuse or neglect being examined.

The challenge of capacity across the BSAB continues in terms of authoring of SARs, and external commissioners are utilised for those SARs which are complex in nature.

The BSAB continues to be guided by the North West Policy for managing concerns around people in positions of trust with adults who have care and support needs. Local guidance will be developed during 2024/2025 by the Multi Agency Working Group to provide clarity on the management of risk so that actions are transparent and consistent.

Strategic objective three – learning from safeguarding adult reviews – performance, quality and audit

We said we would:

- Complete SAR processes, including publication of review and development of SAR action plan.
- Ensure the SAB has robust multi-agency safeguarding performance data.
- Assure a culture of openness and transparency is adopted for learning and recognising success.
- Develop a quality assurance framework which will robustly evaluate quality assurance process.
- Conduct multi-agency quality assurance audits, with the aim to providing an analytical overview of safeguarding across individual agencies and as a partnership.

What we have done

The SAR procedures were reviewed at the start of the reporting period. This included seeking more information as part of the referral process so as not to require detailed chronologies and summary information from agencies, unless the threshold for a SAR was met.

The three statutory safeguarding partners continue to screen SARs to consider whether the criterion for a SAR is met. A SAR dashboard has been introduced which tracks SAR referrals and those progressing to either a mandatory or discretionary SAR, together with learning themes from SARs, and completion of action plans.

An important focus in all SARs is how we work with the individual, or the person's next of kin or wider family. All families have wanted to contribute to the SARs, so that they can share their family members' experiences and help services get a better understanding of what life was like for their relative. This has given the BSAB a much richer insight into practice, and families have provided feedback to the BSAB stating how they have felt genuinely listened to, and reassured that lessons were being learnt.

To strengthen action planning, the case review subgroup and the learning and development subgroup now work more closely, so that the learning from the SARs forms part of the programme of learning for the SAB.

There has been increased focus on developing the performance data for the BSAB; as a consequence, there has been limited progress with the multi-agency quality assurance work, however, single agency audit and quality assurance has continued.

Strategic objective four – prevention and early intervention

We said we would

- Improve the website for the Partnership and review annually.
- Seek assurance regarding the quality-of-care provision within Bury and develop a mechanism where system assurance can be gained.

What we have done

Prevention and early intervention is a core strand of all work of the BSAB including a focus on multi-agency training and workforce development to enable people to recognise various forms of abuse and know what action to take.

The new website launched at the end of the last reporting period, and content has continued to be developed. All published SARs and learning is available for practitioners to access.

The Multi Agency Risk Management (MARM) framework has been reviewed to support anyone working with an adult where there is a high level of risk and the circumstances sit outside the statutory adult safeguarding framework, but where a multi-agency approach would be beneficial. The roll-out of the MARM Strategic Risk Panel will be early in 2024/2025 to enable a proactive approach which helps to identify and respond to risks before crisis point is reached.

Strategic objective five – making safeguarding personal

We said we would:

- Quality assure activity to gauge whether safeguarding practice is person-centred and outcome-focused.

What we have done

The Care Act says that adult safeguarding is about protecting individuals, but people are all different. So, when we are worried about the safety of a person, we should talk to them to find out their views and wishes. Then we should respond to their situation in a way that involves the individual as much as possible, enabling them to have choice and control over what happens in their life, so they can achieve an improved quality of life, wellbeing, and safety. This is referred to as Making Safeguarding Personal (MSP).

The BSAB have oversight of adult social care data related to MSP. An improving position can be noted in relation to more people being asked about their outcomes, and of those asked, more than 90% consistently say their outcomes are being fully or partially achieved. This will continue to be monitored by the BSAB.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
% of people that were asked about their outcomes	64%	56%	63%	63%	68%	75%	87%	80%	88%	79%	81%	90%
of those asked their outcomes, % of asked that had their Outcomes Fully or Partially Achieved	91%	96%	100%	97%	93%	90%	98%	91%	94%	91%	96%	95%

The BSAB continues to be committed to ensuring the adult is central to everything we do. During Safeguarding Adult Reviews, we work closely with either the individual or the family to get a good understanding of how safeguarding practices have affected the person at the subject of the SAR, and that their experiences shape the report and any recommendations to improve practice. Of the 11 SARs that concluded in 2023/2024 all the families wanted to work with us to inform the review, and the BSAB wishes to thank families for their engagement.

Strategic objective six – learning and development

We said we would:

- Develop a training strategy which includes mechanisms to review the impact and effectiveness of training.
- Explore opportunities for multi-agency training delivery, across statutory and voluntary sector services.
- Gain assurance from individual agencies regarding internal training opportunities.

What we have done

Six practitioner events were held during the year to provide an opportunity for those directly involved with the individual who was the subject of the SAR to share their experiences and learn from them.

The Learning and Development Subgroup reviewed the themes from SARs to inform the training programme for the year. It was agreed that a learning day was required to disseminate the learning in an effective and efficient manner from previous SARs.

The agreed themes were:

Theme	Found in SAR
Eating Disorders	SAR Jennifer (K21) SAR Lisa (O22) SAR Emily (H23)
Confident Decision Making / Professional Curiosity	SAR Michael (I21 and themes from M21 and N21) SAR Jennifer (K21) SAR Walter (O21) SAR Jacob (A22) SAR Alice (C22) SAR Penelope (N22)
Mental Health	SAR Michael (I21 and themes from M21 and N21) SAR Penelope (N22) SAR Robert (M22)
Mental Capacity Act	SAR Michael (I21 and themes from M21 and N21) SAR Walter (O21) SAR Alice (C22) SAR Lisa (O22) SAR Ann (C23) SAR Stuart (E23) SAR Emily (H23)

An impact toolkit has been developed and will be rolled out in 2024/2025 to evidence the effectiveness of the training, and its impact on supporting adults with care and support needs.

Safeguarding Adult Reviews

The purpose of a SAR is not to hold any individual or organisation to account but to learn lessons when an adult in its area dies as a result of abuse or neglect, whether known or suspected; and

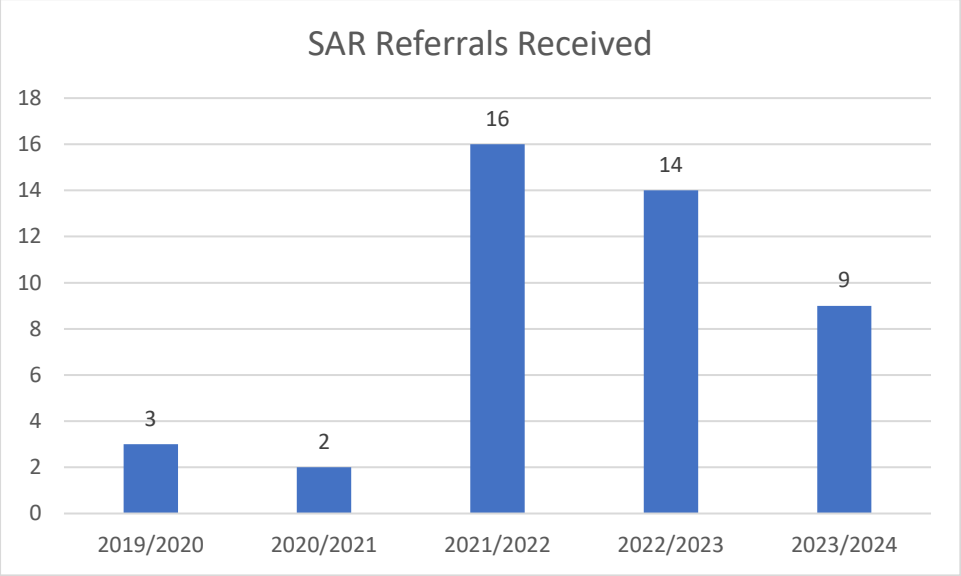
- There is concern that partner agencies could have worked more effectively to protect the adult.

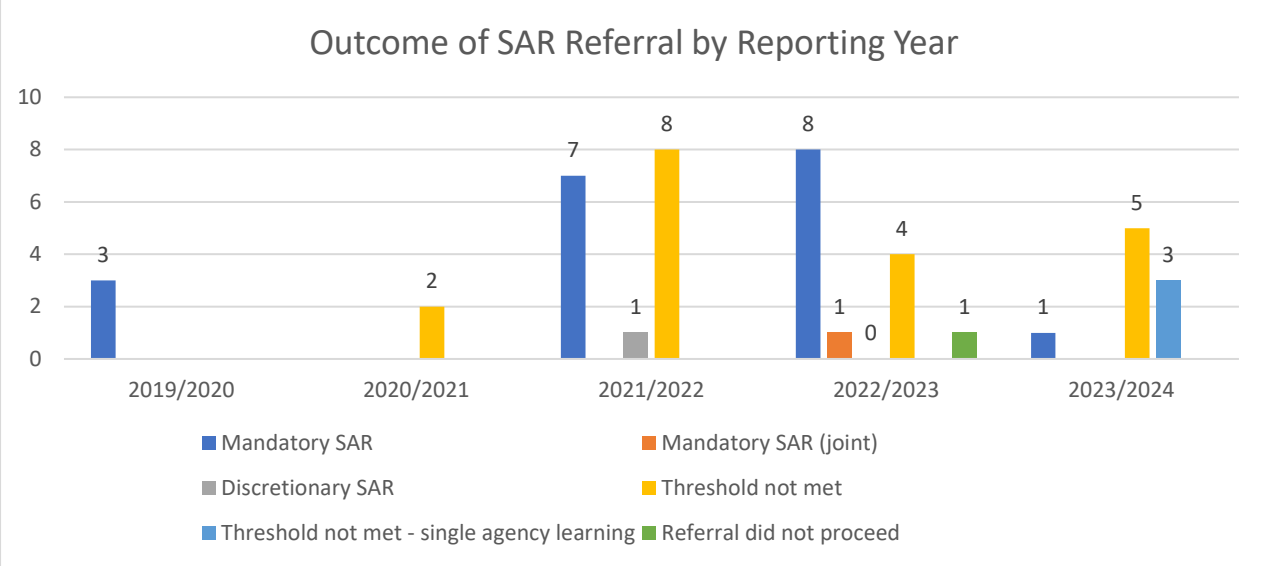
OR

- An adult in its area has not died, but the SAB know or suspects that the adult has experienced serious abuse or neglect.

Referrals for Safeguarding Adult Reviews (SARs)

During the reporting year, the Case Review Subgroup continued to see referrals being made, but a reduction from 14 in 2022/2023 to 9 referrals in 2023/2024. Of the 9 referrals, 1 met the criteria for a SAR (mandatory SAR), 5 did not meet the threshold for a SAR, and 3 referrals identified learning for single agencies.





Mandatory SAR - A SAR must be commissioned if there is a statutory requirement to do so when all the criteria and conditions have been met.

Discretionary SAR - A discretionary SAR may be needed where part of the criteria/conditions have been met and the panel feel there is multi agency learning.

Current SARs

All SARs within the current and previous reporting years were concluded in 2023/2024.

SARs completed during this reporting year

A total of 12 SARs concluded in 2023/2024, of which 11 were mandatory and 1 was discretionary, as detailed below (note the referral may have been received in the preceding years).

SAR Sam (L21 - Local Learning Review for Discretionary SAR)

Sam was 53 years old, and he had a diagnosis of multiple sclerosis. Sam's ability to care for himself had deteriorated over a period of time. Sam had 11 pressure ulcers at time of death and concerns had been raised regarding Sam not accepting advice or equipment to relieve his pressure areas.

Review themes include:

- Challenge to engage the person with services.
- Lack of consistent application of the Mental Capacity Act.
- Making Safeguarding Personal.
- Management of pressure ulcers.
- Risk assessment, risk management and escalation.

SAR Walter (O21)

Walter died in hospital at the age of 69 after he had been admitted following an unwitnessed fall at his Care Home. When Walter was around 18 months old, he had a choking incident, and it is thought this left Walter with an acquired brain injury.

Review themes include:

- Support for adults with learning disabilities.
- Confident Decision Making / Professional Curiosity.
- Mental Capacity Act assessment.
- Making Safeguarding Personal.
- Impact of Covid.
- Strengths based approach and person-centred language.

SAR Jacob (A22)

Jacob was 22 years old when he died in hospital following a suicide attempt. Jacob received a diagnosis of autism and dyslexia, and he wrote of feeling relieved that he had an explanation for a range of personality/behaviour traits that he had been aware of throughout his life.

Review themes include:

- Confident Decision Making / Professional Curiosity.
- Mental health.
- Suicide.
- Information sharing.
- Support available to adults with autism.
- Cultural understanding.

SAR Robert (M22)

Robert was 60 years old when he died. He had a learning disability and a diagnosis of schizophrenia. He resided in a care home and was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation as he was assessed to lack mental capacity to make decisions about where he resided.

Review themes include:

- Application of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Mental Health.
- Transfer between hospital and community.
- Person centred care.

SAR Penelope (N22)

Penelope was a young person in her late teens when she died. She spent much of her teenage years in mental health settings and was in a care home leading up to the time of her death. Concerns were raised about Penelope's self-harm behaviours which had escalated both in frequency and seriousness.

Review themes include:

- Confident Decision Making / Professional Curiosity.
- Mental Health.
- Risk factors when patients are being transitioned between services.
- Mental Capacity Act assessment.
- Self-harm.

SAR Lisa (O22) and **SAR Emily** (H23)

A desktop review commenced in relation to Lisa and Emily, both of whom were high risk due to their low BMI's, and neither had a diagnosed eating disorder.

Review themes include:

- Weight management.
- Professional curiosity and escalation.
- Disordered eating guidance.
- Self-neglect.
- Mental Capacity Act.
- Mental health support.
- Understanding and use of MARSIPAN/MEED guidelines.
- Transition and discharge points.
- Information sharing.
- Management of risk.
- Lack of assessment.

SAR Linda (B23)

Linda was 68 years old when she died. Linda had a number of health conditions and was in receipt of a package of care in her own home and lived relatively independently until eight months prior to her death due to her deteriorating health.

Review themes include:

- Roles and responsibilities across community teams.
- Self-neglect.
- Mental Capacity Act.
- Person Centred Care.
- Voice and daily lived experience.
- Impact of disability.
- Identification and safeguarding response to rapid deterioration.

SAR Ann (C23)

Ann was 66 years old when she died of hypothermia and pneumonia. She had a long history of contact with various public services, but most specifically Substance Misuse and Mental Health Services. Ann struggled during the covid lockdown and there were concerns for her welfare.

Review themes include:

- Use of Mental Capacity Act in the context of people with alcohol use disorders.
- Dual diagnosis of substance use and mental illness.
- Unconscious bias against people with alcohol and drug use disorders.
- Executive capacity and decisional capacity.
- Accurate recording of information.

SAR Stuart (E23)

Stuart was 54 years old at the time of his death from respiratory failure in 2022. He had long term mental illness and had been hospitalised for long periods of time throughout his life. He also had several long-term physical health conditions.

Review themes include:

- Mental Capacity Act.
- Care planning for physical health needs whilst in mental health settings.
- Person centred approaches.
- Self-neglect.
- Advocacy.
- Mental health.
- Information sharing.

SAR Ruby F23

A joint review with Wigan Safeguarding Adults Board commenced in relation to Ruby, following her death in 2022. Ruby had an extensive history of trauma throughout her childhood and early adult life. She was care experienced and had a history of poor mental health and substance misuse.

Review themes include:

- Assessment and treatment pathways for people with co-occurring conditions.
- Information sharing.
- Harm minimisation approaches being incorporated into risk management.
- Professional challenge.
- Escalation processes.
- Neglect.

SAR Rebecca (I23)

Rebecca died in 2022. She had been looked after by the local authority as a young person. Her life experience as a young person and young adult included substance misuse, domestic abuse, mental and behavioural disorder, and suicidal ideation, diabetes, exploitation and cuckooing and self-neglect.

Review themes include:

- Effectiveness of MARAC where adult safeguarding concerns are raised in parallel with domestic abuse.
- Information sharing.
- Cuckooing.
- Self-harm and suicide ideation.
- Self-neglect.
- Domestic abuse.
- Substance misuse.
- Mental health.
- Housing.
- Trauma informed practice.
- Quality of risk assessments and risk management.
- Mental Capacity Act assessment.

SAR Marie (P23)

Marie was 46 years old when she died. Partnership records evidence that she was the victim of sustained domestic abuse for more than 10 years preceding her death. This in turn led to continued issues with alcohol misuse and mental health difficulties.

Review themes include:

- Substance misuse.
- Mental Capacity Act.
- Long term trauma and its negative impact on executive functioning.
- Self-harm and suicidal ideation.
- Cumulative effect of loss to be a consideration of safety planning.
- Mental health.
- Potential risk to parents when children are removed from their care.
- Domestic abuse.
- Involvement of family in assessment and discharge plans.

Partner updates

The BSAB brings together the three safeguarding partners and relevant agencies whose involvement is required to help and safeguard adults with care and support needs. Agencies were invited to provide highlights of their own safeguarding work for publication within the annual report, and a summary is detailed below.

Adult Social Care

- Increase the number of people that we are asking their outcomes up from 53% to a month-on-month average of over 90%.
- Continue to ask people their outcomes while fully or partially meeting those outcomes.
- Peer review of adult social care.
- New safeguarding policy and procedure in ASC.
- Managed a complex organisational safeguarding and delivered good outcomes for the placement and residents in conjunction with commissioning colleagues.
- DoLS remains a strong area for Bury Council with no waiting list for authorisations outside of hospital applications.
- Dashboard provides good data which has allowed us to support staff in reducing the completion time of S.42 enquiries
- Audit safeguarding S.42 enquiries (and their associated safeguarding concerns on a monthly basis).

Housing

- Introduced Tenancy Support Strategy to support strength based working and trauma informed approaches.
- Providing training to communities and community leaders on safeguarding
- Eyes wide open training provided to all staff, which includes how to report concerns for safeguarding.
- Delivered training to students at Bury College covering domestic violence, safeguarding and hoarding within homes.
- Delivered cost of living workshops within our communities and provided 121 support to families.
- Supported 62 customers who are suffering with DV with target hardening.
- Training to all frontline staff to understand the risk and impact substance misuse have on families and those adults who also suffer with mental health conditions.

NHS Greater Manchester Integrated Care Board (NHS GM ICB) (Bury Locality)

- Training delivered to primary care regarding self-neglect and the Mental Capacity Act as these were areas where learning is required in reviews.
- Safeguarding team deliver Development Sessions to the Safeguarding Leads from each GP Practice.
- The NHS GM Bury Safeguarding Team provide case support and supervision to NHS provider safeguarding colleagues as well as practitioners within the Complex Care Team and Primary Care services.
- Suite of policies to support staff regarding safeguarding matters.
- Carries out assurance processes with providers on an annual basis for compliance with the safeguarding standards.
- NHS GM ICB Safeguarding team in Bury have delivered generic level 3 training to Primary Care practitioners.

Greater Manchester Police

- Rolled out updated and rigorous training modules for all officers and staff on adult safeguarding, focusing on identifying and responding to abuse and neglect effectively.
- Conducted successful joint operations resulting in the apprehension of perpetrators involved in cases of adult abuse and exploitation.
- Targeted campaigns to educate the public about signs of abuse and the importance of reporting concerns promptly and increased presence in local communities through outreach programmes.
- Numerous audits are completed throughout the year to ensure an effective safeguarding response is provided.
- Officers are trained in trauma-informed policing.
- Dedicated units focusing on adult protection and safeguarding provide expertise and focused resources for handling complex cases of abuse and neglect.
- Expanded victim support services, including specialised advocates for vulnerable adults.

NHS Northern Care Alliance

- Summary of reviews and learning themes is shared at the Bury Care Organisation Steering Group on a bi-monthly basis.
- Compliance with mandatory safeguarding training is above 90% for levels 1, 2 & 3.
- To ensure Adult Safeguarding measures are embedded in everyday practice, Senior Management and Safeguarding Assurance visits across wards and departments are scheduled on a 2-weekly basis.
- New Standard Operating Procedure was developed to triangulate internal safeguarding governance and inquest reporting arrangements.
- The NCA Safeguarding Team relaunched the Safeguarding Champions meeting and introduced a NCA wide Safeguarding Newsletter.
- The NCA encompass a Nursing Assessment Accreditation System (NAAS) inclusive of community services and theatres. This provides a programme of audit which includes the safeguarding standards.

Pennine Care

- Safeguarding families policy in place.
- Updated domestic abuse policy with a new training package.
- Variety of ways to distribute learning form SARs including lunch and learns, specific learning events and a monthly quality update.
- Programme of deep dives to provide assurance as part of the contractual standards with the ICB.
- Safeguarding team have trained 984 colleagues and delivered 10 face to face sessions.
- Our Safeguarding Team offers a weekday consultation system. A Safeguarding Families Specialist Practitioner will respond to all staff who contact the team for safeguarding advice, support, and guidance. During 2023/24 there were a total of 372 consultations recorded by our Safeguarding Team in the Bury area.

Greater Manchester Mental Health

- Following the immediate response to the issues exposed at the Edenfield Centre, GMMH developed a comprehensive Improvement Plan
- Implementation of a new GMMH safeguarding governance arrangements.
- GMMH Together Strategy to co-produce and co-deliver services.
- Establishment of Patient Safety Incident Groups at a Trust, Care Group and Locality level.
- GMMH suite of policies, procedures, and guidance available to support staff.
- Impact of training audits developed and completed post Level 3 training attendance, to measure the impact of training on knowledge, skills, and practice.
- Ongoing delivery of safeguarding training across the organisation and impact of training audits developed and completed to measure the impact of training on knowledge, skills, and practice.
- SAR's and learning shared at Operational and Strategic safeguarding groups and via the locality leadership teams.
- Patient Advice and Liaison Service established.
- New Freedom to Speak Up Guardian and over 50 Champions appointed.

Probation

- Implementing the family safeguarding model and having co-located practitioner staff – whilst there is a child focus to this, perpetrator work is undertaken by probation practitioners in this team with a focus on domestic abuse.
- Implementation of probation reset which has required effective safety planning.
- Mandatory home visits in line with refreshed policy – risks to other vulnerable persons, as well as the person on probation themselves is central to purposeful home visiting.
- Court mandated checks are now necessary for safeguarding and domestic abuse - a home detention curfew no longer being able to be imposed without information pertaining to the home circumstances being available from Social Care and Police to the Courts.
- All cases coming through to Probation via Courts have to have safeguarding checks completed, in relation to domestic abuse and adult/child safeguarding
- HMIP inspection December 2023 – the focus of which was on management of our 18-25 cohort of cases.

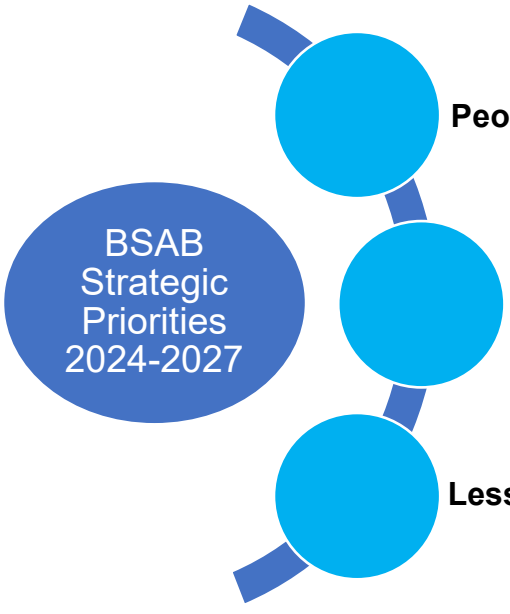
Bury Voluntary, Community and Faith Alliance (VCFA)

- Violence Reduction Programme: continue to strengthen relationships with social care and GMP through the VRU Alliance Programme.
- Disseminated partnership safeguarding messages to the VCSE sector through ebulletin and social media.
- Essential Trustee and Volunteer Management training contains input around trustee eligibility and disclosure and barring.
- Organisational health checks provide diagnostic assessment on groups' needs – and this includes safeguarding.
- All staff and Bury VCFA volunteers undertake mandatory online safeguarding training.
- Continued to champion the voice and role of the VCSE sector in the development and shaping of local services and sharing of insights at strategic level.

GM Fire and Rescue Service

- All staff are trained to Level 1 which includes, how to identify safeguarding concerns, how to report and record.
- Promoted and developed the Home Fire Safety Assessment focusing on the most vulnerable individuals within the community.
- Prevention Team have supported support all safeguarding professionals' processes throughout Bury.
- Alerting appropriate support at earliest opportunity to the identified need of vulnerable persons.
- Training plans are in place for staff whose role involves more in-depth contact with children and/or adults at risk and training records are maintained and can be monitored/audited.

Strategic Priorities for 2024-2027



People and Outcomes

We will ensure that safeguarding services are delivered effectively and professionally and put the adult at the heart of how those services are delivered.

Safeguarding Effectiveness

Building on the previous work, the BSAB will ensure it continues to provide strategic leadership and improvements to identify weaknesses and respond to any opportunities.

Lessons learnt and shaping future practice

Understanding that there are many priorities regarding learning, the BSAB will undertake two thematic learning areas as part of this plan to support prevention of abuse and neglect and to identify weaknesses and respond to opportunities.