

HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

Day: Thursday
Date: 11 January 2024
Time: 6.00 pm
Place: Committee Room 1 - Tameside One

Item No.	AGENDA	Page No
1.	APOLOGIES FOR ABSENCE	
2.	DECLARATIONS OF INTEREST To receive any declarations of interest from members of the Scrutiny Panel.	
3.	MINUTES To approve as a correct record, the Minutes of the proceedings of the Health and Adult Social Care Scrutiny Panel held on 9 November 2023.	1-4
4.	ANNUAL REPORT - TAMESIDE ADULT SAFEGUARDING PARTNERSHIP BOARD The Panel to meet Jane Timson, Independent Chair, Tameside Adult Safeguarding Partnership Board; and Anna Jenkins, Head of Safeguarding, Quality and Practice, to receive the annual report.	5-60
5.	HEALTHWATCH TAMESIDE The Panel to meet Alex Leach, Manager of Healthwatch Tameside, to receive the annual report and to discuss opportunities regarding insight and information sharing, forward plans and the learning available by effectively capturing the voice and experience of patients and service users.	61-82
6.	CHAIR'S UPDATE The Chair to provide a verbal update on activity and future priorities for the Panel.	
7.	DATE OF NEXT MEETING To note that the next meeting of the Health and Adult Social Care Scrutiny Panel will take place on Thursday 7 March 2024.	
8.	URGENT ITEMS To consider any additional items the Chair is of the opinion shall be dealt with as a matter of urgency.	

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Paul Radcliffe, Policy and Strategy Lead, to whom any apologies for absence should be notified.

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Health and Adult Social Care Scrutiny Panel 9 November 2023

Commenced: 6.00pm

Terminated: 7.45pm

Present: Councillors Sharif (Chair), Owen (Deputy), Axford, Beardmore, Bowden, Drennan, Patel

Apologies: Councillors B Holland, Tillbrook, Warrington

20. DECLARATIONS OF INTEREST

The Chair declared a personal interest in connection to Item 4 of the Agenda. Councillor Naila Sharif informed panel members and attendees that she is currently employed by Pennine Care NHS Foundation Trust, in a capacity that is not senior or decision making. This will not impact her role as Chair given the nature and purpose in which the Scrutiny Panel will receive the information.

21. MINUTES

The minutes of the meeting of the Health and Adult Social Care Scrutiny Panel held on 14 September 2023 were approved as a correct record.

22. TAMESIDE MENTAL HEALTH PROVISION

The Panel welcomed Simon Sandhu, Medical Director, Pennine Care NHS Foundation Trust; Trish Cavanagh, Deputy Place Based Lead; and Lynzi Shepherd, Head of Mental Health, Learning Disabilities and Autism (Tameside), to receive an update on mental health priorities for Tameside and an overview of services and support delivered by Pennine Care.

Information was provided on regional planning and the Tameside Joint Health and Wellbeing Strategy and Locality Plan, the work that is ongoing and aspects relating to all age mental health and wellbeing.

It was reported that mental health priorities for Tameside include: –

- Improving mental health outcomes and understanding future needs (whole system approach)
- Mental health community transformation programme
- Mental health urgent and emergency care
- Continued development and implementation of the 'No Wrong Door' approach to all mental health care
- Prevention and crisis management/pathways (complex and varied need)
- Partnerships including VCSE

The Panel received a detailed update on the services provided by Pennine Care NHS Foundation Trust, with a summary and breakdown of service provision, resources and demand. This included chronology, key milestones and strategy relating to the improvement journey since the 2018 CQC inspection.

National benchmarking has shown local variances regarding resourcing and cost pressures. Spend on community services is considerably below the national average. It has also shown a

higher use of adult acute beds over the last 3 years, which can be attributed to a lack of community alternatives.

With reference to child and adolescent mental health services (CAMHS), local services are in the lowest quartile for costs per contact. There are significant gaps in CAMHS capacity due to baseline levels and increased demand.

Other areas of variation include:

- Inconsistent alternatives to admission services and availability of crisis beds
- Significant gaps in commissioned neurodevelopment pathways (Autism/ADHD) – long waits
- Funding and models across memory assessment services
- Disparity in commissioning levels for NHS Talking Therapies
- Interface issues transition from secondary to primary care

Panel members received a detailed breakdown and summary of quality metrics for Pennine Care. The areas covered:

- Patient safety
- Experience of care
- Workforce data and challenges
- Community mental health – access and crisis
- Aspects of specialist mental health provision
- Inpatients and bed occupancy, length of stay, out of area placements, delayed transfers and readmission

The current position and challenges for CAMHS in Tameside include significant increases in waiting times for neurodevelopment. Tameside has experienced the most significant increases across Pennine areas. It was reported that referrals and demand in other areas referrals and is picked up by paediatrics and recorded outside of the current method used locally.

The officers responded to a number of questions from the panel on:

- Complexity of demand and variation in needs of individuals – prevention and crisis
- Workforce planning and the challenges to be addressed
- Access, pathways and waiting lists
- Funding challenges
- The changing nature of the way young people display distress and concerns relating to high referral rates to CAMHS – managing risk and improvement priorities.
- Transitional support and variations age 18 to 25
- Specialist mental health provision - out of area placements, delayed transfers and readmissions
- Importance of partnerships, including VCSE

23. CHAIR'S UPDATE

The Chair advised members of upcoming Scrutiny reports to be tabled at the meeting of Overview Panel on 21 November 2023.

The second meeting of the Domestic Abuse working group will take place at 1pm on 11 December 2023. Members of the working group have received notice and details of the meeting.

24. DATE OF NEXT MEETING

To note that the next meeting of the Health and Adult Social Care Scrutiny Panel will take place on Thursday 11 January 2024.

25. URGENT ITEMS

The Chair reported that there were no urgent items for consideration at this meeting.

CHAIR

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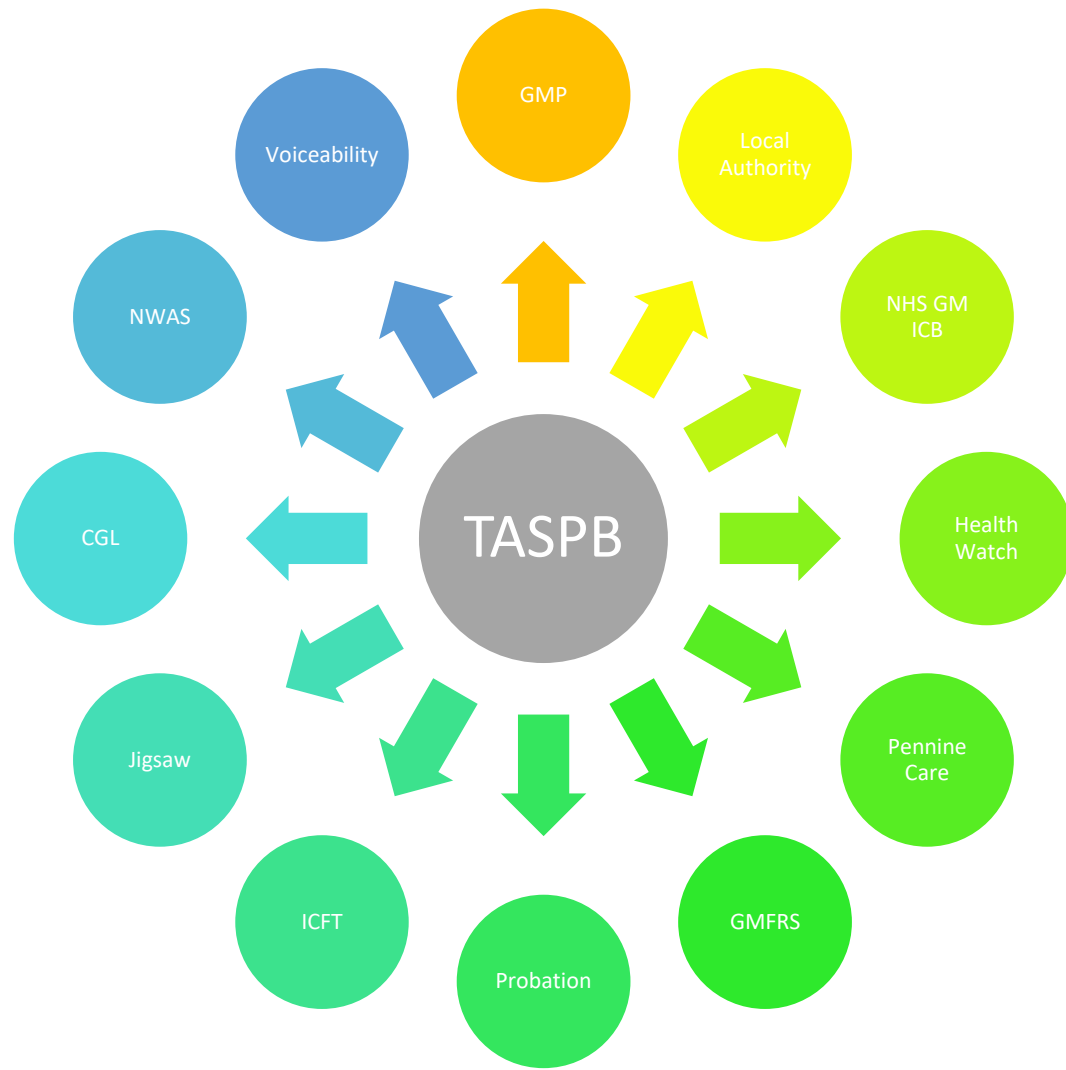
TASPB Annual Report

Jane Timson – Independent Chair TASPB

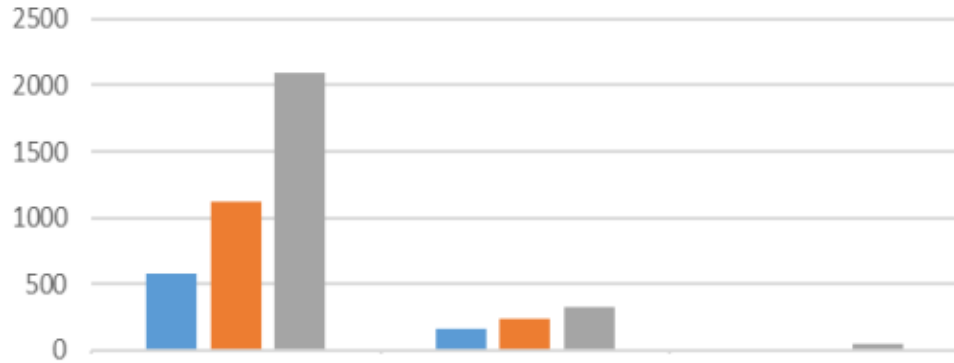
Anna Jenkins – Head of Safeguarding, Quality and Practice

TASPB Strategy Priorities 2022-25




- Self Neglect
- Multiple disadvantage
- Neglect
- Domestic Abuse



Total Number of Safeguarding Concerns



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		Total number of Safeguarding concerns	Total Number of Section 42 Safeguarding Enquiries	Total Number of Other Safeguarding Enquiries
	2021	581	156	0
	2022	1116	232	0
	2023	2089	331	51

- Number of concerns has increased bringing us inline with regional averages.
- Due to changes in Safeguarding Policy and Procedure changes in Feb 2022.
- Results also reflect national trends following a drop in referrals during the pandemic.
- Conversion rate is low work taking place to explore this.

Safeguarding Adult Reviews 2022/23

3 SARS were published during 22/23.

Gaynor

Erik

Demetria

Multiagency approach to Risk

Team Around the Adult Policy

Review Information Sharing Arrangements

Consider 'Think Family' and 'Professional Curiosity'

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Raising Awareness

- 15th June World Elder Abuse Awareness Day – Focus on cascading information on supporting older adults at risk of abuse and neglect and support carers.
- 21st November - 26th November National Adult Safeguarding Week – Online Conference for professionals re: Domestic Abuse
- TASPb Newsletter circulated to all Partner Organisations, promotes the work of TASPb

Organisations attending training 22/23	Number of Attendees
Active Tameside	4
Advocacy Services	3
Adults Social Care	11
Integrated Care Organisation	2
Change Grow Live	1
ICFT	12
Independent Commissioned Care Agencies	68
Jigsaw Housing	6
Pennine Care NHS Foundation Trust	27
GMP	1
St Peters Partnership	8
Tameside Education and Arts	2

Achievements 2022/23

- Ongoing development and embedding of new policy and procedures.
- Joint Learning Sessions between ASC, Jigsaw and CGL to share knowledge and learning in relation to multiple disadvantage and Hoarding
- Tiered Risk Assessment Model Developed with support of Oldham SAB.
- Improved pathways for accessing GMP support in Safeguarding Enquiries.
- Training for multiagency partners.

Plans for 2023/24

- Redesign of TASPb Team
- Implement Tiered risk Assessment Model – embed Team Around the Adult.
- Review the Self Neglect Strategy and Tool Kit
- Develop a new approach to hoarding.
- Review arrangements in place for data sharing and financial sustainability.
- Recruit a new Independent Chair of the Board.
- Develop Integrated Dashboard
- Review the Public Website

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TASP B

**Tameside Adult Safeguarding
Partnership Board**

Tameside Adults Safeguarding Partnership Board (TASP B)

Annual Report 2022/23

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Foreword

Welcome to TASPB Annual Report 2022/23, where the Board reports on their Safeguarding Activity over the last 12 months.

There is much to celebrate regarding the work, which is evident through the Partnership working. The conclusion of the TASPB strategy 2019-2022 demonstrates this. We have successfully responded to priorities of Making Safeguarding Personal, Prevention and Quality assurance, to such an extent whilst these will remain a core focus for the Board they are now embedded as practice across the Partner Organisations. We acknowledge that Partnership working in Tameside has been the key to the success of the strategy and are assured all Partners are committed to Adult Safeguarding in Tameside. This work provided the platform to continue to respond to the safeguarding agenda as it evolved during 2022/23.

It is acknowledged a wealth of work will continue across Partner Organisations in Tameside to inform this safeguarding agenda and the revision of the TASPB strategy 2022-25 begins to address this as you will read in the report.

TASPB constantly seeks assurance from partners that adult safeguarding is a priority for all their staff. Despite the impact of the many challenges faced on working practices, this Annual Report will provide an insight of the ongoing commitment from organisations to this agenda and how working in Partnership we strive for good outcomes for every person.

Led by the TASPB Independent Chair, Andrew Searle, during 22/23, TASPB Partners have been challenged and held to account encouraged in collective working to tackle the issues of abuse and neglect involving adults with care and support needs in Tameside. TASPB would like to thank Andrew for his commitment to this role and as we begin a new chapter and move into another 12-month cycle of business TASPB would like to welcome Jane Timson as the Independent Chair of the Board.



Stephanie Butterworth
Director of Adult Services

Introduction

TASPB have a statutory requirement to publish a report every year telling you what we've been doing to improve the safety of adults in Tameside and to explain what progress we have made in response to the TASPB Strategy 2022-25

The Annual Report includes information to demonstrate: -

- TASPB activity during 2022/23 to achieve the TASPB strategic priorities and response to the Safeguarding Adult Reviews.
- Outcomes of the Safeguarding Adult Work in Tameside.
- Partner Organisations contributions during the past 12 months to support the Adult Safeguarding Agenda in Tameside.
- Our priorities for TASPB 23/24.

TASPB 2022/23

The main focus for TASPB during 22/23 was the conclusion of the TASPB strategy 2019-22 and the refresh of this to continue to progress TASPB business. [TASPB-Strategy-2022-25.pdf \(tameside.gov.uk\)](#) The work also included the review of the TASPB membership and TASPB are pleased to welcome, Change, Grow, Live, (CGL) Jigsaw and Voiceability.

Partner Organisations represented at TASPB: -

Statutory Agencies:-

- Local Authority
- Greater Manchester Police
- NHS GM Integrated Care Organisation

Partner Agencies:-

- Healthwatch
- Greater Manchester Fire and Rescue Service
- Probation
- Tameside and Glossop Integrated Care NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- Jigsaw
- Change Grow Live
- Northwest Ambulance Service
- Care Quality Commission
- VoiceAbility

And Elected Member:-

- Cllr John Taylor

Safeguarding Adults in Tameside 2022/23

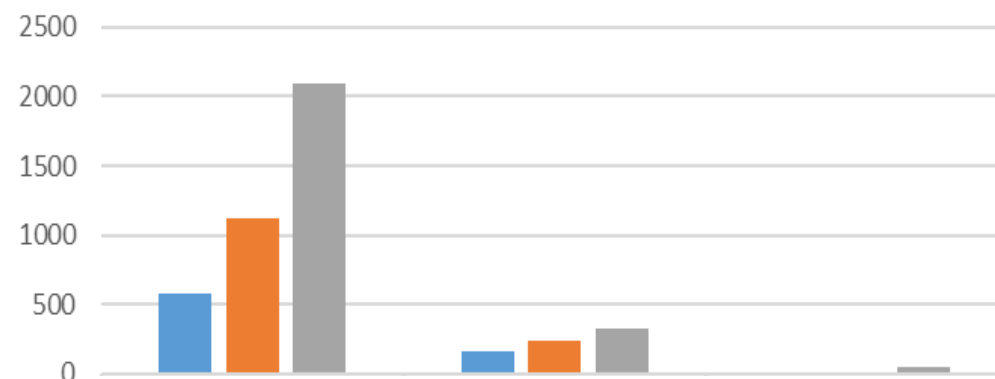
Partner organisations are pro-active in their response where there is reasonable cause to suspect that an adult who has care and support needs, is at risk of or experiencing abuse and neglect. These Enquiries are led by the Local Authority working in Partnership with Organisations across Tameside to prevent Adult Abuse.




During 22/23 the number of concerns has increased. This has been due to the change in the approach to recording the Adults Safeguarding Concerns and Enquiries. This has been an outcome of the changes to the TASPb Policy and Procedures introduced in February 2022. In addition, as the increase is mirrored nationally, it is felt that this is also an outcome of the COVID restrictions ending. Potentially, the increase in the number of enquiries where the location of abuse is in one's own home is evidence of this perception.

TASPb have continued their work to raise awareness of Adult Abuse and ensure Safeguarding is everybody's business, and the surge in concerns is also evidence of the impact of this work. The report later discusses the work in World Elder Abuse Awareness Day and the focus on Domestic Abuse. This data demonstrates an increase in this theme, which is an example of the effect of the TASPb work in response to this area.

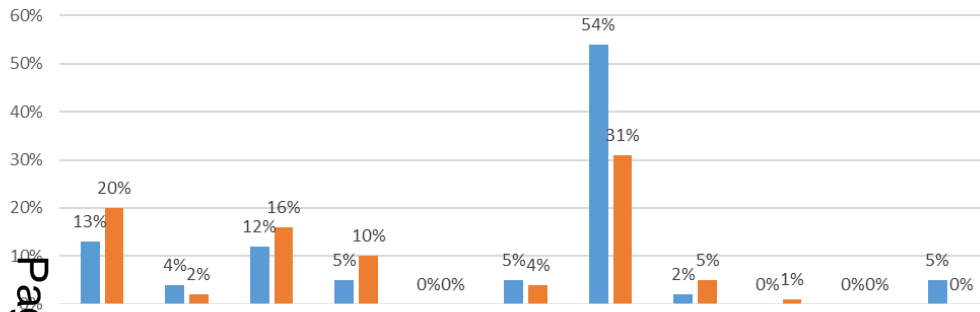
TASPb have also had a focus on the most prevalent type of abuse being neglect and acts of omission. Partner Organisations have worked together to understand the detail of these concerns to provide assurance to TASPb that these enquires are proportionate and appropriate. Consequently, there has been a reduction in enquiries for this area of abuse and work with partners to look at the quality of care in the context of neglect and address through commissioning arrangements.

Total Number of Safeguarding Concerns



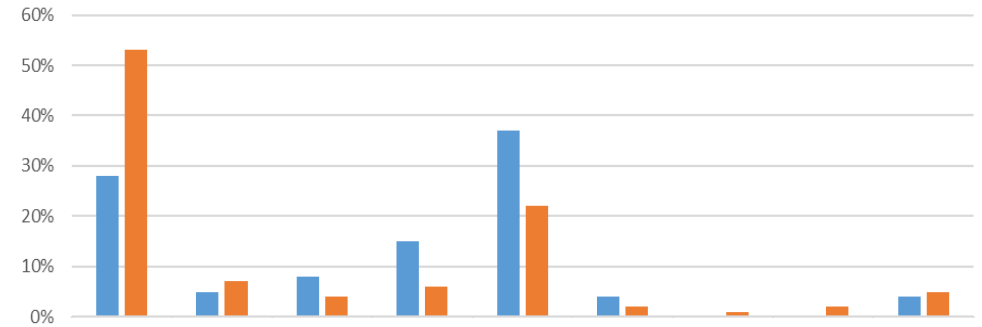
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Type of Risk - Section 42



	Physical Abuse	Sexual Abuse	Psychological Abuse	Financial or Material Abuse	Discriminatory Abuse	Organisational Abuse	Neglect and Acts of Omission	Domestic Abuse	Sexual Exploitation	Modern Slavery	Self-Neglect
2022	13%	4%	12%	5%	0%	5%	54%	2%	0%	0%	5%
2023	20%	2%	16%	10%	0%	4%	31%	5%	1%	0%	0%

Location of Risk - Section 42



	Own Home	In the Community (Excluding Community Service)	In a Community Service	Care Home - Nursing	Care Home - Residential	Hospital - Acute	Hospital - Mental Health	Hospital Community	Other
2022	28%	5%	8%	15%	37%	4%	0%	0%	4%
2023	53%	7%	4%	6%	22%	2%	1%	2%	5%

Outcomes for Safeguarding Adults in Tameside 2022/23

Safeguarding Adult Reviews (SAR)

Safeguarding Adults Reviews (SARs) are a statutory requirement for all Safeguarding Adults Boards.

To respond to barriers to good practice and review what is supporting Safeguarding Adult practice so we can adopt best practice and improve, to protect Adults from abuse, the findings from SAR's are used to inform this work.

TASPB ensure that SARs are shared to maximise the value of their learning. In addition to the SAR Report, 7-minute briefs are also shared to aid discussion across organisations.

TASPB are keen to develop this area of work to ensure it is effective as possible. Consequently, once again TASPB have revised their guidance for staff for the SAR process and will continue to respond to this as a working document as new methods and systems are adopted.

TASPB publish [Safeguarding Adult Reviews](#) on the TASPB website. The Board have a process in place to respond to action plans for the Safeguarding Adult Reviews: -

Safeguarding Adult Review (SAR) Review of Action Plans Sub Group Chair: Tracey Hurst Designated Nurse Adult Safeguarding NHS Greater Manchester Integrated Care

The SAR Review of Action Plans Sub Group was set up in 2022/23 to monitor progress of action plans that have been developed in response to the recommendations from Safeguarding Adult Reviews (SARs).

The purpose of the group is:

- To develop action plans and monitor progress in response to recommendations as defined in Safeguarding Adult Reviews (SAR)
- To have oversight of Publication of SAR's in the National Repository and consider carefully how best to manage the impact of the publication on family members, practitioners and others closely affected by the case.
- To update the Tameside Adult Safeguarding Partnership Board (TASPB) regarding progress of action plans and publication
- To present a report to the TASPB for final sign off of completed Action Plans

The Sub Group is represented by key Statutory and Non-Statutory partners who have worked collaboratively to agree the Terms of Reference and develop the work plan for 2022/23.

The group continues to monitor the progress and implementation of Action plans developed from three completed and published SARs in 2022/23, [Demetria](#), [Erik & Gaynor](#).

The group links in to TASP Learning and Development Sub Group and TASP Quality Assurance Sub Group providing assurance and information on learning themes which inform safeguarding practice improvement initiatives.

One of the main priorities to respond to the learning in these SAR's has been the development of the Team around the Adult Model (TRAM). This is a Protocol for Supporting Practitioners working with Adults at Risk including adults with multiple complex needs or cumulative risks. It enables a co-ordinated and collaborative multi agency approach to risk which acknowledges that complex cases are often long term and entrenched behaviours that requires multi-agency commitment for a longer-term solution-based approach. It is anticipated that the TRAM will be launched in November 23.

Work is also in place to develop an audit process to provide assurance that organisations have adopted the learning. This will be further developed during 23/24.

Making Safeguarding Personal (MSP)

TASPB strategy 2019-2022 successfully responded to the TASPB priority of Making Safeguarding Personal, to such an extent whilst this will remain a core focus for the Board it is now considered to be embedded as practice across the Partner Organisations. The initial work in response to MSP provided the platform and the work has continued to evolve to promote a person centred, outcome focused and strength-based approach to safeguarding adults.

Adult Safeguarding Lead in Adult Social Care has been particularly proactive in working in Partnership with TASPB to develop a survey and leaflets for the Adults at Risk and their Carers to promote MSP. This work will continue during 23/24 and will contribute to TASPB assurance that this work is integral to daily Safeguarding Business.

World Elder Abuse Awareness Day & National Adult Safeguarding Week

WEEAD this year would see TASPb working to promote the need to protect vulnerable adults, carrying the work from WEAAD on to National Safeguarding Week in November of the same year.

Elder abuse is any act that causes psychological and/or physical harm to an older person and is carried out by someone they know and trust, such as family, friends, or carers. TASPb provided a booklet with the support of colleagues from other organisations to offer advice and guidance relating to this.

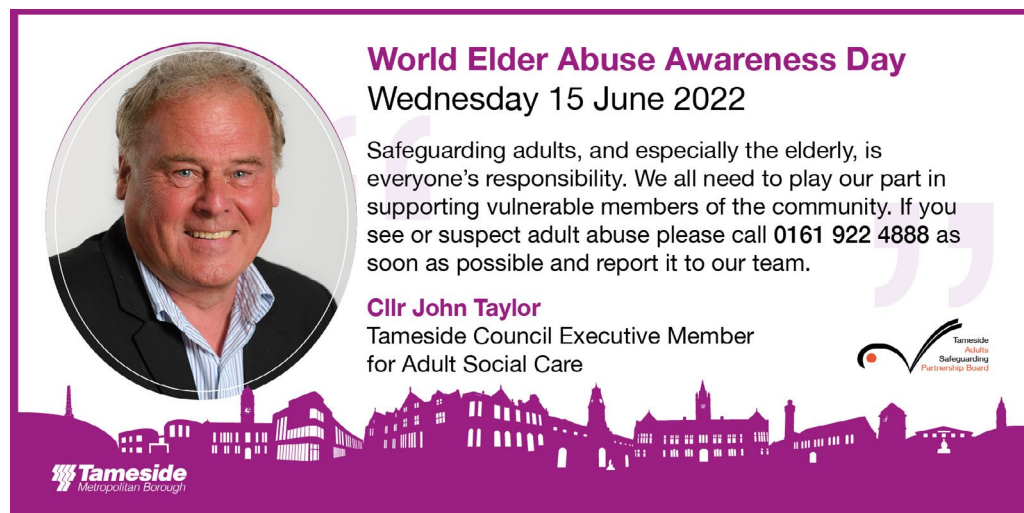
The booklet was forwarded to colleagues across organisations and shared by Tameside communications team. This included two virtual sessions on Recognising Carer Stress which were designed to equip staff with skills, knowledge and give an insight into recognising carer stress with the use of professional curiosity to help keep people safe.

<https://www.tameside.gov.uk/TamesideMBC/media/adultservices/WEAAD-Flyer.docx>

Once again Dukinfield Town hall shone purple lights for the week.

All the events were supported by Tameside Communications Team sharing the information on the staff portal, the staff magazine “THE WIRE” and the Chief Executives weekly briefing.

The information was also shared with the public via Twitter, Facebook, and local media.



World Elder Abuse Awareness Day
Wednesday 15 June 2022

Safeguarding adults, and especially the elderly, is everyone's responsibility. We all need to play our part in supporting vulnerable members of the community. If you see or suspect adult abuse please call **0161 922 4888** as soon as possible and report it to our team.

Cllr John Taylor
Tameside Council Executive Member
for Adult Social Care

Tameside Adults Safeguarding Partnership Board

Tameside Metropolitan Borough

Following on from WEAAD TASPb continued the theme into National Adult Safeguarding week with the launch of two flyers one for professionals and one for the public which were distributed across many organisations to provide useful information and contacts for support around Domestic Abuse.

Many organisations supported the week with events such as the learning Lunches, sharing of podcasts and promotion of the week within their own teams.

Pennine Care NHS Foundation Trust

[Safeguarding-Adults-Week-2022-Newsletter-PCFT.](#)

Adult social care spent the week visiting the social care teams that have implemented the new Safeguarding Adult's Policy and whose roles changed to the enquiry officer.



Two further development sessions took place providing an opportunity for Practitioners to consider the overlaps between safeguarding and domestic abuse. The Safeguarding Development session gave Practitioners an opportunity to explore the different forms of Domestic Abuse and the tools to understand and respond effectively to domestic abuse in the context of Adult Safeguarding.

TASPB continued to provide updates in relation to Safeguarding in the TASPB quarterly newsletter which is shared with colleagues in partner organisations.

Shared Priorities

TASPB reviewed the Business Unit offer during 22/23 and concluded that the option in 21/22 to merge with the Tameside Safeguarding Children's Partnership TSCP Business Unit was counterproductive. It was agreed to continue to enhance the work to focus on the Shared Priorities the more appropriate and effective approach, was to separate the Business Units and have a dedicated Business Manager to support the Adults Board.

This approach will be implemented in 23/24 and the Board will continue to work in Partnership with:

- Tameside Safeguarding Children Partnership
- Community Safety Partnership
- Health & Wellbeing Board
- Domestic Abuse Steering Group

The focus on the shared priorities work will continue to progress and align shared priorities, such as the response to domestic abuse and transition.

Learning and Development

In response to the refreshed TASPB Strategy the governance arrangements identified the requirement for a Learning and Development Sub-Group. TASPB agreed that the Learning and Accountability group had been productive to respond to 2019-22 strategy and felt that this group would be an evolution of the work to date. The purpose of this Learning and Development group is to identify the activity to respond to the TASPB Strategy.

The sub-group work is primarily focused on ensuring the TASPB Safeguarding Adult Policy and Procedures are fit for purpose and that learning from Safeguarding Adult Reviews informs future practice. The sub-group will also inform the development and review of the TASPB Learning Framework.

The first meeting of this group took place in February 2023 and the initial focus was to identify the systems and engagement of partner organisations to address communication and the priorities for TASPB and training to address the refresh of the learning framework. It was agreed that a priority to take forward for this meeting during 23/24 will be the TASPB website.

Training for Partner Organisations

In addition to the development sessions for staff to compliment the work of WEADD and National Adult Safeguarding Week. During 22/23, TASPb have continued to host Safeguarding Adults Training. The training provides an overview of Adult Safeguarding in the context of the Care Act 2014. The content will build on Practitioners existing knowledge of the Care Act and the Mental Capacity Act (MCA) 2005.

The training provides an opportunity to focus on key themes and learning identified in recent Safeguarding Adult Reviews in Tameside. The legislative framework to support Safeguarding Adults is explored. A particular focus is on exploring importance of capacity and consent in safeguarding and looking at how Practitioners work with people who have capacity but choose to take risks. The training also offers a summary of the Board and Partner Organisations Roles in Adult Safeguarding and the application of the TASPb Safeguarding Adult Procedures.

The course is a blend of presentations, discussion, and group work in a multi-agency environment. This enables Practitioners to consider their approach to Adult Safeguarding in their organisations and working in Partnership and the tools to support them in their role, Safeguarding Adults from abuse. The training also provides support and guidance to Practitioners to lead on an enquiry.

Organisations attending training 22/23	Number of Attendees
Active Tameside	4
Advocacy Services	3
Adults Social Care	11
Integrated Care Organisation	2
Change Grow Live	1
ICFT	12
Independent Commissioned Care Agencies	68
Jigsaw Housing	6
Pennine Care NHS Foundation Trust	27
GMP	1
St Peters Partnership	8
Tameside Education and Arts	2

This training has been well received by Practitioners. Comments received from these participants are used to inform the update of the training: -

Areas that delegates felt really helpful: -

- I thought all parts to me were helpful because other training courses just tend to just go through the basics of what is abuse and you helped me with the escalation of forms and procedures which in honesty, I have been a little unsure because of a lack of expertise.
- The scenarios were personable and realistic. I liked how the sessions were split in two and there was opportunity for discussions and tasks but didn't feel like too much was being asked from us.
- Sharing the knowledge from the other folk taking part in the training was very valuable. I'm dyslexic so it was easier to discuss procedures and policies as I struggled to retain some of the information. But overall, I found it very informative and will tailor to my various work with vulnerable adults and school children.
- Interactive, excellent tutors
- Both sessions were really helpful to bring me back up to speed with Safeguarding. I have been away from the role for about 3 years and so was a little rusty. Also, the role of SAM had changed to the provider led model so this was really good to know and learn. Also, to be able to look at the new Policy that came in in February 2022.
- This training was a good refresher and was very informative. Prefer class room based as I can find it easy to be distracted but it was still very engaging.

- General awareness of how the adult safeguarding process works has been improved massively. I now know where to raise concerns if I have any for people I come into contact with and more importantly how to raise them and how the process works...

Quality Assurance Subgroup

In response to the refresh of the TASP B Strategy, TASP B, also identified that a Quality Assurance Subgroup is required to support TASP B to respond to the Annual Priorities to progress the TASP B Strategic Plan and Annual Business Plan. During the initial part of the financial year this work had been progressed via a Dashboard sub group and the work undertaken by this meeting informed the Terms of Reference for the Quality Assurance Sub Group: -

To develop a data set and approach to collate this, that can support TASP B to build a picture of the outcomes of safeguarding activity in Tamworth to provide assurance that safeguarding arrangements are in place to inform: -

- best practice
- policy development
- service development, planning and improvement.
- business cases
- identify any immediate priorities/areas for concern.

Evaluate the effectiveness and impact of the findings and recommendations from reviews, performance management activity and multi-agency learning.

Ensure the Voice of the Adult/ feedback from services is integral to safeguarding activity and that this drives service improvement.

The group should act as a critical friend and in collaboration with those agencies and partnership groups will have a clear line of sight on practice.

The initial meetings identified Key Performance Indicators and agreed a dashboard which TASP B will embed into practice during 23/24 and have made recommendations to TASP B to: -

1. The Board agree the mechanism for data capture and sharing.
2. The Board approve the information Sharing Agreement on behalf of their agencies.
3. The Board approve the dashboard design and the resources required to routinely deliver it.

Individual Organisations Contribution

Tameside Adult Services	18
Greater Manchester Police Tameside District	21
Intergrated Care Board (ICB)	27
Pennine Care NHS Foundation Trust	30
Healthwatch Tameside	33
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Tameside Adult Services

Priority Self - Neglect

- We have continued to develop and strengthen our knowledge in relation to working with adults who self-neglect. During 2022/23 we have focused on working with adults who hoard.
- We have had regular attendance at the Greater Manchester Hoarding Improvement Partnership, and we have worked in partnership locally with Jigsaw Housing and Pioneer homes with support from Ian Porter a leading expert in this area to begin the first Peer Support Group for adults experiencing hoarding in Tameside 'Hoarders Helping Hoarders'
- A Safeguarding Forum took place focussing on approaches to hoarding, it was well attended by staff in Adult Services and Pennine Care NHS Foundation Trust.
- We have also delivered a joint learning workshop to staff from Adult Services and Jigsaw Housing strengthening the relationships between our staff and developing staff knowledge on responding to hoarding.
- Adult Services have chaired the Tameside Adult Safeguarding Partnership Board (TASPB) task and finish group on Hoarding and supported the work on the Multiagency Guidance.
- Self-Neglect continues to feature in the Safeguarding training provided to Adult Services staff and managers and following learning from internal learning reviews our procedures have been strengthened to support case transfer between teams when self-neglect is a risk.

What impact has this work had?

- We have seen an increased use of the Managing the Risk Protocol in Adult Services which shows a greater understanding of the issues associated with self-neglect and a greater awareness of the structures in place to manage risk.
- We have seen an increased awareness of person centered approaches to hoarding and some creative approaches utilising direct payments and partnership working to achieve positive outcomes for adults who experience hoarding.
- We have observed through cases presented at a "Legal Gateway" that staff and managers are more confident in applying legal frameworks and local policy to support adults who self-neglect.

Multi-disadvantage

- We have continued to strengthen our relationship with Change Grow Live, this has involved delivering shared learning events to our staff. One session focussed on the roles and responsibilities of our teams and consideration of partnership approaches when working adults who affected by substance misuses. The second session focused on Trauma Informed Practice. We are contributing to the drug related death panel and considering the learning for our services.
- We have made positive links with the homelessness service, the Integrated Urgent Care Team have attended and supported the complex case meeting to strengthen our multiagency response to adults affected by multi-disadvantage.

- We are regularly attending Multiagency meetings with the Organised Crime Unit in the Police to share intelligence; the group aim to strengthen safeguarding adults' pathways for adults at risk of criminal exploitation.
- Adult Services have a good track record of attendance at Multi-agency public protection arrangements (MAPPA) Meetings through our Neighbourhood Teams and Mental Health Forensic Social Worker. Plans are in place for a joint learning event in 2023 for adult services and probation staff to further strengthen relationships and knowledge of adult safeguarding for our staff.
- We have engaged in a Greater Manchester (GM) wide workshop sharing the learning from the Changing Futures Programme and local initiatives to working with adults affected by multi-disadvantaged.

What Impact has this work had?

- Staff feel more confident in understanding the complexities of working with adults with affected by multi-disadvantages. We have seen increased number of cases shared at Legal Gateway of involving people affected this illustrates the increased awareness of staff and confidence in relation to legal literacy in this area of practice. We have also seen an increased use of the Managing the Risk Protocol.

Priority – Neglect

- Neglect is featured in all Safeguarding training delivered to adult services staff and managers. Learning from safeguarding adult reviews has been cascaded through learning events and 7-minute briefings to staff.

- We conducted a deep dive into Safeguarding Data in relation to the police involvement with safeguarding activity. The learning from this has been shared and it has resulted in a Single Point of Contact being identified in the Police for consultation on safeguarding referrals and enquiries. Work has taken place across Adult Services to raise awareness of the Police's role in Safeguarding enquiries. This has supported to embed consistent approach and increased police involvement.
- A joint learning event with Children Social Care took place to consider share knowledge of one another's services, roles, and responsibilities. Learning in relation to neglect and self-neglect was considered in the context of 'Think Family.' Further work is planned in 23/24 to continue to strengthen our partnership working and knowledge in this area.

What impact has this work had?

- We have seen positive outcomes for individuals and families through strengthened partnership working with Children Social Care. Staff and Managers have easy access to police advice and support in relation to Safeguarding Work.

Domestic Abuse

- Domestic Abuse is featured in all Safeguarding Training delivered to adult services staff and managers. The Safeguarding Lead at Adult Services contributed to and delivered sessions during National Safeguarding Adults week focusing on Domestic Abuse.

- Through the implementation of the domestic abuse strategy for Tameside, staff have also attended specialist training on working with perpetrators.
- Managers from the Neighbourhood Team regularly attend Multi-Agency Risk Assessment Conference (MARAC). Adult Services have been regular panel members at Domestic Homicide Reviews and will be active parties in implementing the learning from these.

What impact has this work had?

- Due to awareness raising with staff we have seen domestic abuse being recorded in the categories of abuse increase. There is an increased awareness of staff of the issues associated with domestic abuse and the prevalence in Tameside.
- Through legal gateway we have seen a number of complex cases that have required legal intervention to protect individuals from harm as result of domestic abuse. This is evidence of the recognition of the role that Adult Services can play in certain circumstances.
- We have also seen an increased number of non-statutory enquiries taking place, an analysis of this shows this has often been in relation to domestic abuse experienced by carers. Again, the increased recognition of adult services role in these situations is positive and shows the impact of the awareness raising and training that has been taking place.



Greater Manchester Police (Tameside Division)

Priority – Self-Neglect

Activity in your organisation in response to priority.

One of the core roles of the officers within the MASH is to triage any child or vulnerable adult concern recorded as a Care Plan (CAP) generated from incidents, external referrals, intelligence reported to Police and will include cases of self-neglect. The MASH officers will review the full circumstances of the CAP authored by the frontline attending officers (usually from the 24/7/365 Response Team) and review the overall history for the persons involved including previous CAPs recorded. This will include Toxic trio and RARA (Remove/Avoid/Reduce/Accept) and other risk factors such as history of mental health, suicidal tendencies and missing from home episodes.

This assists the MASH officer with making a risk assessment and creating an investigation plan; checking that appropriate safeguarding has been implemented for the child, vulnerable person, or family; and appropriate markers have been placed on the persons and associated addresses involved on GMP's record management system PoliceWorks. The MASH officer will assess whether referrals to other agencies are required and will share via email as per the local information sharing protocol in place.

Tameside Senior Leadership Team (SLT) have invested in a vulnerable adults SPOC within the MASH for partner agencies to undertake discussions, information sharing and seek professional guidance. This provides a consistent approach to adults at risk and ensures the most appropriate response is embedded at the earliest opportunity. A weekly

meeting takes place between GMP and Adult services with a tiered risk assessment process in place to recognise prevention and early identification of risk. The high-risk complex case panel meets every six weeks, again with a dedicated representative from GMP in attendance.

All new officers receive safeguarding training when they undertake training centrally including recognising and responding to adult safeguarding concerns and mental health. Additionally at Tameside, new recruits enrol on a further 15-week bespoke programme where they spend dedicated time with the MASH team to increase their knowledge in safeguarding procedures and practices and the early help offer available.

7-minute briefings are regularly circulated with staff to enhance learning. Additionally, the Public Protection Governance Unit centrally has provided a number of online to up training sessions over the last 12 months available to all staff to expand their safeguarding knowledge.

The partnership is providing training events in September/October 23 on 'Hoarding and self-neglect' that Police representatives from Tameside are attending.

GMP's Investigation and Safeguarding Review Team (ISRT) based centrally attends all Safeguarding Adult Review (SAR) panels that acts as an audit process. The SAR panel considers the involvement of partners in adult safeguarding concerns and whether this was in line with expectations. Feedback and learning take place, and this may include the views of the adult as part of each agency's interaction with that vulnerable person and/or family.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

The work within the MASH ensures GMP has a dedicated response to safeguarding adults at risk at the earliest opportunity with appropriate referrals made to partners for effective intervention and support. The dedicated vulnerable adults' spoc within the team encourages collaboration and strengthens working relationships with partners that results in the best outcomes for adults at risk within Tameside.

As indicated training of police staff is a priority for GMP and is being embedded through bespoke training programmes, briefings, CPD and partnership events to enhance knowledge and learning to apply to their practice and improve safeguarding of adults at risk of abuse in Tameside.

GMP's central Review team provides consistency and impartiality to Reviews, to enable identification of wider themes, learning and development opportunities, and the ability to work more closely with the Public Protection Governance Unit (PPGU) and People and Development Branch to implement recommendations arising from statutory reviews.

Priority - Neglect **Activity in your organisation in response to this priority**

As indicated one of the core roles of the officers within the MASH is to triage any child or vulnerable adult concern recorded as a Care Plan (CAP) generated from incidents, external referrals, intelligence reported to Police and will include cases of neglect.

The MASH officers will review the full circumstances of the CAP authored by the frontline attending officers (usually from the 24/7/365 Response Team) and review the overall history for the persons involved including previous CAPs recorded. This will include Toxic trio and RARA (Remove/Avoid/Reduce/Accept) and other risk factors such as history of mental health, suicidal tendencies and missing from home episodes.

This assists the MASH officer with making a risk assessment and creating an investigation plan; checking that appropriate safeguarding has been implemented for the child, vulnerable person, or family; and appropriate markers have been placed on the persons and associated addresses involved on GMP's record management system PoliceWorks. The MASH officer will assess whether referrals to other agencies are required and will share via email as per the local information sharing protocol in place.

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GMP's central Review team provides consistency and impartiality to Reviews, to enable identification of wider themes, learning and development opportunities, and the ability to work more closely with the Public Protection Governance Unit (PPGU) and People and Development Branch to implement recommendations arising from statutory reviews.

Priority - Adults experiencing Multi-disadvantage. Activity in your organisation in response to this priority

As previously mentioned, one of the core roles of the officers within the MASH is to triage any child or vulnerable adult concern recorded as a Care Plan (CAP) generated from incidents, external referrals, intelligence reported to Police and will include cases of adults experiencing multi-disadvantage. The MASH officers will review the full circumstances of the CAP authored by the frontline attending officers (usually from the 24/7/365 Response Team) and review the overall history for the persons involved including previous CAPs recorded.

This will include Toxic trio and RARA (Remove/Avoid/Reduce/Accept) and other risk factors such as history of mental health, suicidal tendencies and missing from home episodes.

This assists the MASH officer with making a risk assessment and creating an investigation plan; checking that appropriate safeguarding has been implemented for the child, vulnerable person, or family; and appropriate markers have been placed on the persons and associated addresses involved on GMP's record management system PoliceWorks. The MASH officer will assess whether referrals to other agencies are required and will share via email as per the local information sharing protocol in place.

Tameside SLT have invested in a vulnerable adults SPOC within the MASH for partner agencies to undertake discussions, information sharing and seek professional guidance. This provides a consistent approach to adults at risk and ensures the most appropriate response is embedded at the earliest opportunity. A weekly meeting takes place between GMP and Adult services with a tiered risk assessment process in place to recognise prevention and early identification of risk. The high-risk complex case panel meets every six weeks, again with a dedicated representative from GMP in attendance.

All new officers receive safeguarding training when they undertake training centrally including recognising and responding to adult safeguarding concerns and mental health. Additionally at Tameside, new recruits enrol on a further 15-week bespoke programme where they spend dedicated time with the MASH team to increase their knowledge in safeguarding procedures and practices and the early help offer available. 7-minute briefings are regularly circulated with staff to enhance learning. Additionally, the Public Protection Governance Unit centrally has provided a number of online to up training sessions over the last 12 months available to all staff to expand their safeguarding knowledge.

GMP's Investigation and Safeguarding Review Team (ISRT) based centrally attends all Safeguarding Adult Review (SAR) panels that acts as an audit process. The SAR panel considers the involvement of partners in adult safeguarding concerns and whether this was in line with expectations. Feedback and learning take place, and this may include the views of the adult as part of each agency's interaction with that vulnerable person and/or family.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

The work within the MASH ensures GMP has a dedicated response to safeguarding adults at risk at the earliest opportunity with appropriate referrals made to partners for effective intervention and support. The dedicated vulnerable adult's spoc within the team encourages collaboration and strengthens working relationships with partners that results in the best outcomes for adults at risk within Tameside.

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GMP's central Review team provides consistency and impartiality to Reviews, to enable identification of wider themes, learning and development opportunities, and the ability to work more closely with the Public Protection Governance Unit (PPGU) and People and Development Branch to implement recommendations arising from statutory reviews.

Priority – Domestic Abuse

Activity in your organisation in response to this priority

Front line staff and MASH Police officers regularly receive training on themes and topics such as 'Voice of a child' and toxic trio supporting informed decision making to improve outcomes for our children and families of Tameside. This includes 7-minute briefings and features in our new bespoke 15-week training programme known as the 'Tameside Academy' for Police recruits at Tameside. This ensures all opportunities for learning, coaching, and mentoring on effective safeguarding policing response across the district. Additionally, the Public Protection Governance Unit are regularly providing online CPD events for all officers to improve their knowledge of the powers and procedures available to them including Police Protection Powers, Claire's, and Sarah's Laws. A 'DA Matters' 1 day training course has been provided to all officers and staff within GMP with mandatory attendance to improve our response to Domestic Abuse aligned with our force priorities.

Locally Tameside district SLT have devised an improvement plan for DA that correlates with our business plan for 2023/2024. The three key priorities focus on

1. Building performance momentum
2. Instilling pride and effectiveness in our work
3. Overcoming inexperience with a learning environment

The objectives include improving officers' understanding that rapid response and primary investigation increases the chances of positive outcomes through evidence led collection and victim confidence with prioritised arrests. Additionally, GMP are currently working with the

partnership to develop the Domestic-Abuse-Tactical-And-Coordination (DATAC) meeting to embed a coordinated response to repeat victims and serial perpetrators to provide effective interventions and support to prevent further DA instances.

As indicated the core role of the officers within the MASH is to triage any child or vulnerable adult concern recorded as a Care Plan (CAP) or high/medium risk domestic recorded as a Domestic Abuse Care Plan (DAB) generated from incidents, external referrals, intelligence reported to Police. The MASH officers will review the full circumstances of the CAP/DAB authored by the frontline attending officers (usually from the 24/7/365 Response Team) and review the overall history for the persons involved including previous CAPs/DABs recorded. This will include Toxic trio and RARA (Remove/Avoid/Reduce/Accept the risk) This assists the MASH officer with making a risk assessment and creating an investigation plan; checking that appropriate safeguarding has been implemented for the child, vulnerable person, or family; and appropriate markers have been placed on the persons and associated addresses involved on GMP's record management system PoliceWorks. The MASH officer will assess whether referrals to other agencies are required and will share via email as per the local information sharing protocol in place.

In January 23, a Specific, Measurable, Achievable, Realistic, Timeframe (SMART) action plan was formed by GMP with objectives to improve the quality of referrals into the front door including training of frontline staff and MASH officers, joint triaging and adopting the conversational model as a multiagency. Joint discussions of referrals are tracked by police that have indicated a considerable improvement in the number of appropriate contacts being referred and a reduction in referrals being declined. Multiagency audits are now completed regularly allowing

partners to have a greater understanding of repeat referrals, influxes, reductions, and outcomes.

For high-risk cases of domestic abuse, daily risk management meetings are held by the partnership to address immediate safeguarding actions and the case will be discussed again at the next Multi-Agency Risk Assessment Conference (MARAC) meeting. MARAC meetings are held every fortnight to assess risk, actions taken, and longer-term work required. GMP are currently working with the TMBC to improve the effectiveness of the MARAC process and train all partners to share responsibility as chair. This will develop agencies understanding and the need to work in partnership to effectively problem solve.

Nationally, there is a drive to improve the police's response to Violence Against Women and Girls (VAWG) and GMP has rightly embedded this as a force priority to tackle. Locally, Tameside are delivering a VAWG plan with emphasis on changing culture and mind-set ingrained in the approach to VAWG offences, victims, and offenders. Strategic priorities include creating safer spaces, pursuing perpetrators, improving trust and confidence, communication, and awareness. The organisational approach focuses on combating and preventing inappropriate behaviour of any nature, ensuring staff feel safe, empowered, and confident in 'calling out' such behaviour.

To drive cultural change and increase people's voice, expectations and standards of behaviours set are aligned with GMPs Codes of Ethics, Plan on a Page (POAP) and policing values. Communication is vital and is delivered through regular briefings, CPD, posters, emails and one to ones. As part of GMP's VAWG Strategy, to prevent offending and educate children on spotting the signs of domestic abuse, exploitation and misogyny, the partnership leads locally including GMP consulted

a local youth council to capture their views on how best to deliver key messages through a play aimed at Year 6 pupils. The play will be delivered to primary schools in Oct/Nov 23 and has been commissioned by Tameside's Senior Leadership Team.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

The collocation of Police Officers within the MASH at Tameside One has had a positive impact for our children and families, by improving the quality of our referrals into the front door resulting from joint triaging and understanding thresholds of children services. As previously mentioned, joint discussions of referrals are tracked by police that have indicated a considerable improvement in the number of appropriate contacts being referred and a reduction in referrals being declined. Multiagency audits are now completed regularly allowing partners to have a greater understanding of repeat referrals, influxes, reductions, and outcomes. The MASH would be keen to see the investment of adult services within the team to develop the same approach with vulnerable adults.

As indicated training of front-line staff, MASH and child protection officers is a priority for GMP and is being embedded through bespoke training programmes, briefings, CPD and partnership events to enhance knowledge and learning to apply to their practice and improve safeguarding of adults at risk of abuse in Tameside.

The new DATAC process will support with problem solving for repeat victims of abuse and serial perpetrators to ensure effective interventions and support are provided at the earliest opportunity to safeguard and reduce demand.

Intergrated Care Board (ICB)

Priority – Self-Neglect

Activity in your organisation in response to this priority

Self-Neglect is included within Mandatory Safeguarding Training which is aligned with Job Role in accordance to the intercollegiate document [adult safeguarding: roles and competencies for healthcare staff](#)

Designated Nurse for Adult Safeguarding and Continuing Health Care (CHC) team members continue to be fully engaged in Tameside Adult Safeguarding Partnership Board (TASPB) work on Self Neglect and Hoarding Strategy.

Designated Nurse for Adult Safeguarding and CHC team fully engaged with TASPB Managing Adult at Risk Policy including ongoing work reviewing this guidance.

Named General Practitioner (GP) for Adult Safeguarding represents at Local Drug Related Death Panel and cascades learning.

Safeguarding Awareness is ongoing via the following mechanisms:

- Learning from Safeguarding Adult Reviews (SAR) 7-minute brief
- Safeguarding Snippet Sessions for Primary Care
- Safeguarding Newsletter
- Safeguarding Facebook Page.

Commissioning:

- Safeguarding Assurance for providers with and National Health Service (NHS) contract is monitored via Greater Manchester Contractual Standards.
- The Big Life Group, Introduction of Safe Tameside a safe place for mental health support, an alternative to Accident & Emergency (A&E).
- Living Well Plus Service has been developed to complement existing services to support some of the most vulnerable individuals within our communities. The focus of the work will include identification and early intervention of a rolling cohort of people who are heavily relying on unscheduled services for their health care.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

The Adult with Care and Support needs who self neglects feels safer as a result of being supported by multi-agency safeguarding procedures and approaches to managing risks.

Priority - Neglect

Activity in your organisation in response to this priority

Neglect is included within Mandatory Safeguarding Training which is aligned with Job Role in accordance to the intercollegiate document [adult safeguarding: roles and competencies for healthcare staff](#)

- Participation in Practitioner learning events.
- 7-minute Briefings learning from Safeguarding Adult Reviews cascaded.
- Continued Engagement with TASPB Learning and Development Group.
- Continued work with commissioned providers to seek assurance on quality and safety of services via Quality Assurance Processes and GM Safeguarding Contractual Standards.

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What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

- Raised Awareness helps all staff across the organisation including Primary Care understand and recognise the risks and signs of abuse including signs of neglect.
- Health professionals will know how to respond and how to refer safeguarding concerns.
- Adults with care and support needs feel supported through Multi-agency safeguarding processes.

Priority - Adults experiencing Multi-disadvantage
Activity in your organisation in response to this priority

Designated Nurse for Adult Safeguarding has led a Multi-Agency Task and Finish Group developing a Tiered Risk Assessment Model (TRAM).

TRAM is a protocol which supports practitioners across the system when working with adults with capacity at risk including adults with multiple complex needs and cumulative risks.

Central to the protocol is:

- Team Around the Adult
- Proactive and timely sharing of information on risk
- The voice of the adult
- Holistic person-centred assessments that recognise individual strengths
- Shared multi-agency decision making and risk management.
- Multi-agency risk review processes
- Improved outcomes for the adult at risk
- Adults Complex and High-Risk Panel
- High Risk and Critical Risk Register

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

TRAM - Supportive Framework for practitioners which will improve culture of proactive and timely multi-agency risk assessment and management for people living with multi-disadvantages and increasing risks.

Adults with care and support needs feel supported through the TRAM Model and their voice is heard.

Priority – Domestic Abuse

Activity in your organisation in response to this priority

Domestic abuse is included within Mandatory Safeguarding Training which is aligned with Job Role in accordance to the intercollegiate document [adult safeguarding: roles and competencies for healthcare staff](#)

Contribution to Raising Awareness about Domestic Abuse during National Adult Safeguarding Week November 2022. This included raising awareness of Domestic Abuse amongst male victims and older people.

Raising awareness about Domestic Abuse including briefings on Coercive and Controlling behaviours to Primary Care via Safeguarding Snippet Sessions, Safeguarding Facebook Page, and Safeguarding Newsletter.

There is health safeguarding representation and support to the Deaths from Substances Panel so that learning from such reviews considers impact on all family including children.

NHS GM Tameside have supported the work of the domestic abuse strategic plan. We have contributed to the strategic and operational groups to ensure health partners support the work to improve Domestic Abuse (DA) services in Tameside. We have contributed to the DA workforce training offer and workforce.

We have worked with commissioned providers to ensure procedures are in place to recognise and respond to support victims of domestic abuse.

The Identification and Referrals to Improve Safety (IRIS) Programme has been commissioned and implementation steering group established with the aim of supporting victims of domestic abuse in general practice. The offer of service is for both male and female victims. Further work is intended to review service provision to perpetrators of violence.

Designated Nurse fully engaged with Community Safety Partnership in completing reports for Domestic Homicide Reviews and sharing the learning from those reviews across the health economy in Tameside.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

- Strategic representation has influenced the decision to commission IRIS to support Primary Care.
- Representation at Domestic Homicide Panels ensures learning from reviews is shared across health.
- Raised Awareness helps all organisations understand and recognise the risks and signs of Domestic Abuse.
- Health Professionals will know how to respond and will feel more confident identifying risks and making onward referrals.
- Adults with Care and Support needs who are experiencing domestic abuse feel safer as a result of multi-agency safeguarding procedures.

Pennine Care NHS Foundation Trust

Priority – Self-Neglect

Activity in your organisation in response to priority

Making Safeguarding Personal is integral to our safeguarding families' policy, which has just been updated. Staff across PCFT can access the safeguarding team, through our helpline, Monday-Friday 9am-4.30pm. Safeguarding consultations are offered which support frontline staff to follow the values of MSP. Engagement with this has increased by 39%.

Safeguarding supervision is offered in children's services and is currently being audited. The safeguarding team are trialling the offer of group supervision to some adult sectors. This supports staff to think about MSP.

Level 1 adult safeguarding training is mandatory to all staff roles, this incorporates MSP. Compliance with this in Tameside is: 92.8%, which equates to 380 staff.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

Any learning that the safeguarding team present to the trust staff is to a good standard and been developed in consultation with Safeguarding Adult Boards within the Trust footprint, this brings learning and development for all areas of practice. For example, the Tiered Risk Management protocol, which is for people with multiple complex needs, which can include self-neglect.

This was developed in Oldham; however, the Trust has been involved in developing this further with support and guidance to Tameside Adult Safeguarding Partnership Board (TASPB) to implement a similar approach.

To ensure that learning is embedded into practice, the team are starting to follow up on all participants of training, with a questionnaire to fully explore the impact on training, to support the transformation of our learning.

Priority – Neglect

Activity in your organisation in response to priority

The Trust has a Safeguarding Families policy in place which includes how the Trust will ensure the staff are trained and developed in safeguarding, including neglect. The Trust's level 3 Safeguarding training is based on the intercollegiate adult safeguarding roles and competences. In addition, it meets our contractual standards. Our training is monitored by the ICB.

All staff within the Trust can all contact the safeguarding team via our duty system for advice support and guidance in connection with neglect. In addition, the Trust's Safeguarding team have oversight on all incidents with a neglect cause code or other indicator, ensuring that Neglect can be recognised, and advice given to ensure patient safety.

To ensure that learning is embedded into practice, the team are starting to follow up on all participants of training, with a questionnaire to fully explore the impact on training, to support the transformation of our learning.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

Any learning that the safeguarding team present to the trust staff is to a good standard and been developed in consultation with Safeguarding Adult Boards within the Trust footprint, this brings learning and development for all areas of practice.

PCFT are compliant with training and therefore equipped to safeguarding adults at risk of abuse within Tameside, this is supported with the advice given by the safeguarding team, which ensures the detection and action for those at risk of Neglect.

Priority - Adults experiencing Multi-disadvantage Activity in your organisation in response to this priority

The Trust has a Safeguarding Families policy in place which includes how the Trust will ensure the staff are trained and developed in safeguarding, including neglect.

The Trust's level 3 Safeguarding training is based on the intercollegiate adult safeguarding roles and competences. In addition, it meets our contractual standards. Our training is monitored by the ICB.

In addition, PCFT contributes to multiple working groups aimed at decreasing health inequalities for adults experiencing multiple disadvantages.

The level 3 training includes working with people with multiple disadvantages and the managing the risk process in the Tameside areas, the named professional is working with the Tameside Adult Partnership sub group, to support partners update the policy.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

Any learning that the safeguarding team present to the trust staff is to a good standard and been developed in consultation with Safeguarding Adult Boards within the Trust footprint, this brings learning and development for all areas of practice.

It is hoped that the work PCFT are completing towards the workstreams will reduce health inequalities and safeguarding adults experiencing multiple disadvantages.

Priority – Domestic Abuse Activity in your organisation in response to this priority

The Trust L3 Training encompasses domestic abuse, and the Domestic Abuse Stalking Harassment and Honour Based Abuse Risk Indicator checklist (DASH), Multi-Agency Risk Assessment Conference (MARAC) Process. In addition, the team have developed a standalone domestic abuse training.

This is currently being refreshed by one of the safeguarding practitioners. We are currently formulating a new lunch and learn session on how to complete a DASH risk assessment.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

The standalone domestic abuse training is part of the team's responsibility to ensure our workforce is well training and knowledgeable about people who experience domestic abuse.

Healthwatch Tameside

Healthwatch Tameside are a committed partner to the Tameside Adults Safeguarding Partnership Board (TASPB) including its subgroups.

Our contribution to the partnership is primarily to utilise our expertise to be a critical friend sharing key insights on patient engagement and co-production but also to champion the lived experience of those who use health and care services in Tameside.

We continue to promote the role of safeguarding in our functions and ensure communications are shared with the public through our website and our engagement with communities.

We have robust governance, policies, procedures, and training in place which demonstrate our proactive arrangements at keeping adults at risk safe. As a service safeguarding is maintained as a high priority and we will continue to support the work of TASPB in the year ahead.

Tameside & Glossop Intergrated Care NHS Foundation Trust

Priority – Self-Neglect

Activity in your organisation in response to priority.

The integrated safeguarding team continues to offer a daily duty service, support, guidance, and advice and be proactive, reactive, and visible in supporting staff to safeguard.

The TASP Managing the Risk Protocol is actively promoted by the safeguarding team.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

Staff working directly with adults at risk have access to advice, support, and supervision and therefore adults at risk continue to be recognised and responded to at the earliest opportunity. The impact being- prevention, early intervention and creating safer cultures.

Self-Neglect is the third highest reported abuse by the Trust in this annual report year.

Priority - Neglect

Activity in your organisation in response to this priority

The Trust continues to be responsive to meeting its statutory responsibilities, as outlined in the Care Act 2014.

The Trust successfully hosted their Inaugural Integrated Safeguarding

Conference in November 2022, focused on Safeguarding as ‘Our Everyday Business’. Attended by operational staff, system partners, and a number of Non-Executive Director colleagues were also able to join the event. The conference was attended by the National Associate Director of Safeguarding NHS England, and nationally acclaimed guest speakers who delivered thought provoking and engaging presentations on exploitation, adverse childhood experiences and predatory marriage. Presentations from local partners were also shared and recognition awards presented to Safeguarding Stars.

The day also included the premier of a play by Pluto Play Productions and commissioned by the Deputy Director of Nursing for Professional Standards, Safeguarding and Assurance on behalf of the Trust, called “Everyone Matters.” This play was commissioned in response to the learning from a complex patient story and lived experience following an inquest, comprehensive investigation and subsequent Domestic Homicide Review that included lines of enquiry for a Safeguarding Adult Review. This provided a unique and impactful way of sharing learning based on a patient’s experience and ‘neglect.’

The Trust also developed a short film of this patients experience and case as an alternative approach to sharing learning in the Trust. This film was presented to TASP.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

The conference provided time and a space to reflect and focus on safeguarding, supporting, and enabling staff to understand how to make safeguarding their everyday business and consistently discharge their

safeguarding responsibilities. Excellent feedback was received, and the conference evaluated extremely positive.

“Listen to people with lived experience.”

“Become a Safeguarding Champion”

“How important Professional curiosity is.”

“Absolutely an Excellent day, powerful and thought provoking. The voice of the person came through loud and clear and the work that is going on to support both children young people and adults at risk in our community is inspirational.”

“Such an important event – Thank you”

The play functioned as a vehicle for sharing learning, encouraging professional curiosity, which echoed themes explored during conference.

Priority - Adults experiencing Multi-disadvantage Activity in your organisation in response to this priority

Since November 2022, the Integrated Safeguarding portfolio has included mental health, dementia, learning disabilities and Neurodiversity. Strategic Objective: To drive and develop an enhanced offer of Mental Health, Mental Capacity Act, Admiral Nursing support, advice and expertise to hospital and community-based services.

“As specialist nurses we are here to professionally challenge and address health inequalities in Mental Health (MH) and Dementia” with a view to

maximising people’s potential for better outcomes and quality of care provided.

Ambitions: To improve service delivery, in line with statutory legislation, progress seamless pathways, improve partnership working to ensure parity of esteem, increasing better health outcomes & quality of care. The Lead Nurse for Mental Health is aiming to ensure appropriate oversight is in place and offer support to review incidents, contribute to relevant investigations and provide appropriate challenge where/if necessary to trust services.

A focused development session was held with the quality & governance committee in December 2022 on Mental Health and ‘vulnerabilities’.

The Lead Nurse for Mental Health who commenced in post on 19th September 2022, presented her work to date at this session and has been engaging with a wide range of colleagues across the system. Collaboration and relationships with colleagues at Pennine Care NHS Foundation Trust (PCFT) are areas that require particular focus. A scoping exercise is underway in relation to the background of mental health within the Trust, with an aim to develop a vision & strategy, ensuring clear priorities are set.

The lead nurse for MH is the Co-Chair for the Urgent and Emergency Care Workstream relating to the system wide Mental Health, Learning Disabilities and Autism (MHLDA) offer, and although in its infancy reports to the boards relating to the development of structures that support meaningful engagement and reduce duplication across the system. To ensure there is a collective understanding of what provision is currently hard to reach for some of our population to ensure inclusivity for all

minority and underrepresented groups this is in conjunction with other organisations across Tameside in which an alliance agreement across all partners will be formulated.

It is hoped that this will improve a strengthened approach in relation to health outcomes for adults experiencing multi disadvantage that are responsive, able to meet the needs and provide seamless journeys for the people of Tameside.

The system wide Key priorities for Tameside are to focus on outcome measures that will support:

1. The Development of an all-age Mental health and wellbeing strategy for the borough with a relentless focus on reducing health inequalities.
2. Transformation and service development to achieve our Starting Well, Living Well and Aging Well ambitions and delivery of the National Health Service (NHS) Long Term Plan.
3. Reducing Health Inequalities for individuals with a Learning Disability and Autistic People.

The Trust has continued to promote, create, and ensure safeguarding is our everyday business, culture and whole organisational approach that is firmly embedded within the wider duties and all areas and activities of the Trust.

The Integrated Safeguarding Team continue to triage incidents daily, effective collaboration with Mental Health professionals sat within the team has proved positive, contact is frequent with professionals in neighbouring organisations where patients are known which is supporting to develop seamless, timely interventions to the population served with the hope of better outcomes.

Supported National Safeguarding Adult Week 2022 that aimed to create a time where we could all focus on the importance of safeguarding adults.

Supported World Elder Abuse Day

A Spotlight on Safeguarding Month- Each week throughout November 2022, our aim was to create a time to focus on the safeguarding life course, by raising awareness and providing opportunities for learning to support and promote a culture and organisational approach, that safeguarding is 'Our Everyday Business'

Embedded safeguarding at the daily sight huddle, providing key messages, updates, and informing management of risks, incidents, and concerns. This continues to generate useful conversations where actions and learning is identified and shared, when relevant.

The Safeguarding Champions Model was launched at our Integrated Safeguarding Conference. This pivotal role will help the safeguarding team expand its reach, visibility, and promotion of safeguarding across the Trust. The safeguarding champion role will be central to a 'back to basics and back to practice' approach, where the champions will act as a focal point in passing on key messages, learning from incidents, investigations & safeguarding case reviews.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

Ensuring a continued focus on those with multi disadvantages and staff working directly with adults at risk continue to have access to advice,

support, and supervision and therefore adults at risk have continued to be recognised and responded to at the earliest opportunity. The impact being- prevention, early intervention and creating safer cultures.

The aim is to develop and improve system working to support the prevention agenda and a reduction in health inequalities.

To ensure collaborative, improved working relationships to promote responsive, well led provision, improvements in coordination across organisation sin Tameside.

To ensure meaningful alternatives to the emergency department are available for those with multi disadvantages to reduce People facing barriers in accessing help at a time of crisis.

Priority – Domestic Abuse **Activity in your organisation in response to this priority**

Activity in your organisation in response to this priority
The Trust continues to prioritise adult safeguarding and is core to its business and value, with a continued focus on developing its approach to Domestic Abuse.

The Trust is represented at the fortnightly Multi-Agency Risk Assessment Conference (MARAC) and contributes through facilitating information sharing, risk assessment and safety planning. There is daily contribution to the multi-agency risk assessment of high-risk domestic abuse incidents in the MASH.

The Trust is represented and contributes to the Domestic Abuse Operational and Steering Groups, supporting the implementation of

Tameside Domestic Abuse Strategy.

The Trust has contributed to Domestic Homicide Review processes and ensured lessons were learned from Domestic Homicide Reviews (DHRs) as well as serious incidents (SIs), and Safeguarding Adults Reviews (SARs) and continued to fulfil the Trust’s statutory duty in attendance at the Adult Safeguarding Board and subgroups.

The Trust Integrated Safeguarding team, managers and occupational health team have reported an increase in cases of domestic abuse where our staff are the victims. Over 80% of the Trusts employees living in Tameside, with over 70% of employees being women. Work has therefore progressed on developing a Domestic Abuse policy for its staff.

The Independent Domestic Violence Advocate (IDVA) fixed term funded role was extended and continues to work in the Trusts Emergency Department and Maternity Services.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

The hospital IDVA role aims to; Improve identification of victims of interpersonal violence; provide an effective, consistent presence in Accident& Emergency(A&E) to advocate for the service and improve the response to victims of interpersonal violence, by supporting, empowering and training clinical staff to identify signs of abuse and ask screening questions; work collectively as a team with our staff, to offer a safe space where support is provided and choices are offered for immediate safeguarding and provide on-the-spot advice, support and safety planning to victims of abuse and violence at the point of crisis.

Hospital based IDVAs are in the right place at the right time when co-located with the ability to have an immediate response.

Promotes domestic abuse in the trust/raises awareness this is a priority. Thus, sending the crucial message that health professionals are cognisant of abuse's prevalence and do not consider it to be acceptable or unimportant.

Safe space for disclosures created permanently and embedded in the service offer, aligned to strategic priorities.

Helps improve victim safety and health by increasing referral and access to wider services.

Help safeguard adults and children.

Could reduce future health costs.

Greater Manchester Fire and Rescue Service (GMFRS)

Priority – Self-Neglect

Activity in your organisation in response to priority.

GMFRS interventions such as Home Fire Safety Assessments, Prevention Education Programmes, FireSmart and Atlas (the children and adult fire setting programmes) all consider personal risk factors to identify and manage fire risk. Referrals for those who identify with self-neglect are made into the relevant services.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

GMFRS has attended and supported the Tameside Hoarding Task and Finish Group and committed to attend the Tameside Hoarding Peer Support Group (commenced in 2023). Involvement in these forums demonstrates GMFRS commitment to raising awareness and providing support where possible to those identified with self-neglect or affected by clutter and/or hoarding.

GMFRS continue to train staff and Designated Safeguarding Officers on the various themes of abuse and harm and are committed to promoting priority areas raised from emerging themes identified internally and via partners in Tameside and across GM.

This partnership approach and focus on development will ensure GMFRS staff are equipped to identify and support adults at risk in Tameside and other areas of Greater Manchester (GM).

Priority - Neglect

Activity in your organisation in response to this priority

GMFRS routinely share the outcomes of Safeguarding Adult Reviews across the cadre of Designated Safeguarding Officers. We recognise that we need to strengthen our approach to sharing learning across the organisation and have committed to improve this area in our Safeguarding Self-Assessment documents and corresponding Action Plans (Section 11, National Fire Council Chiefs Self-Assessment Toolkit and Fire Standards Board – Safeguarding Standard).

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

The intention of improving the services' approach to sharing information on emerging themes and outcomes from Safeguarding Adult Reviews is to raise the profile of prevalent or even hidden issues and best practice.

Again, this will assist GMFRS in continually improving our approach to safeguarding adults.

Priority - Adults experiencing Multi-disadvantage

Activity in your organisation in response to priority.

GMFRS interventions such as Home Fire Safety Assessments, Prevention Education Programmes, FireSmart and Atlas (the children and adult fire setting programmes) all consider personal risk factors to identify and manage fire risk. Referrals for those who identify with self-neglect are made into the relevant services.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

GMFRS continue to train staff and Designated Safeguarding Officers on the various themes of abuse and harm and are committed to promoting priority areas raised from emerging themes identified internally and via partners in Tameside and across GM.

Ensuring GMFRS staff have an awareness of the range of safeguarding issues and the heightened risk created through Multi-Disadvantage should mean that more individuals are identified and supported appropriately.

Priority – Domestic Abuse Activity in your organisation in response to this priority

GMFRS is proactive in raising awareness of the issue of Domestic Abuse through support for campaigns such as White Ribbon Campaign etc. As such we do see referrals from our staff, submitted to Social Care Teams and sometimes Police, relating to Domestic Abuse (DA).

In 2022 has joined the GM Domestic Abuse Steering Group.

In 2022, GMFRS launched a DA E-Learning pack for staff.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

Through greater promotion and public commitment to addressing DA, GMFRS staff should be alert and equipped to recognise and respond to DA appropriately and support adults at risk when they are identified.



North West Ambulance Service (NWAS)

NWAS Safeguarding-Annual-Report-2022-23

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Change Grow Live

Priority – Self-Neglect

Activity in your organisation in response to priority

CGL have been joint working with Adult Social Care and Adult Safeguarding to upskill staff across both services in both drugs and alcohol and adult care and to build relationships across the teams. We have liaised around individual cases, jointly care planning. CGL and Partners have attended and contributed to the Drug Related Death panel and have identified learning around self-neglect.

CGL have contributed to SAR's.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

Relationships and partnership working has significantly improved.

Processes are more streamlined with Multi-Disciplinary Team (MDT) meetings taking place and with queries and escalations being responded to.

CGL have supported people not in treatment, by providing information and advice in relation to substance misuse, to partners.

Priority - Neglect

Activity in your organisation in response to this priority

CGL have contributed to SARs.

CGL have led on the Drug Related Death panel with Liverpool John Moores University (LJMU) and partners.

CGL have implemented an internal Safeguarding Multi-disciplinary Team (MDT) for the team to raise concerns and to improve learning.

CGL have Contributed to learning around specific issues – cuckooing (raising awareness) within the team.

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

Joint sessions have enabled staff to identify neglect more readily. Concerns are being raised by staff.

Learning has been generated.

Priority - Adults experiencing Multi-disadvantage **Activity in your organisation in response to this priority**

We have an MDT approach to multi-disadvantage.

The Drug Related Death panel highlights multi-disadvantage and encourages a partnerships approach to learning and improvements.

We have attended meetings to contribute to the Vulnerable Adult Multi Agency Safeguarding Hub (MASH) and tiered system.

Priority – Domestic Abuse

Activity in your organisation in response to this priority

CGL attend Multi-Agency Risk Assessment Conference (MARAC) and contribute to information sharing.

We have contributed to the Domestic Abuse and Violence needs assessment and the perpetrator task and finish group.

CGL have attended initial Domestic Abuse Task and Coordination panel (DATN) meeting and will continue to attend. We have given our commitment to continue with this.

We have advocated to support people to access support from Independent Domestic Violence Advocate (IDVA) and partner agencies where needed (safer option).

What impact has this work had or likely to have on Safeguarding Adults at risk of abuse in Tameside?

Continued to contribute to a partnership approach to recognition of DAV.

Using MARAC to manage risk.

Summary

A wealth of work has continued during 2022/23 to respond to TASP B Statutory responsibilities and progress the TASP B Strategic Plan. The Board are assured that Partnership work is pro-active in Tameside in response to the Adult Safeguarding Agenda. This year we have seen how the outcome of the introduction of the revised TASP B Policy and Procedures has been instrumental in responding to the increase in the number of safeguarding concerns.

The governance arrangements and representation at Board also strengthen the approach in Tameside, to ensure Safeguarding Adults is everybody's business. It is evident TASP B continuously strive to improve Adult Safeguarding Practice and good initial progress has been made to implement the revised **2022-25 Strategy** and defined priorities.

- **Self-Neglect** - this type of abuse is included as a category under the Care Act. We recognise that this is an emerging theme of abuse in Tameside. Whilst the number of concerns are low, they appear to be increasing in Tameside. TASP B, are pro-active in their response to the Safeguarding Prevention Principle and we will strive to have assurance that Partner organisations provide a Person Centred approach to empower individuals to make choices and support for them to manage risks.
- **Neglect** - Strategies for the prevention of abuse and neglect are a core responsibility of TASP B. Recent local Safeguarding Adult Reviews have identified neglect as a pertinent theme. We acknowledge there is further work to complete to promote the signs and symptoms of neglect and support a multi-agency approach to protect Adults with care and support needs who are experiencing or at risk of this form of abuse.

- **Adults experiencing Multi-disadvantage** – There is a strong commitment from TASP B to raise awareness, strengthen an integrated approach and improve knowledge and understanding of Adults experiencing Multi-disadvantage. We will seek assurance that there are strong cross-sector partnerships to respond to tackling multiple disadvantage and improving outcomes to prevent Adult Abuse in this cohort of people
- **Domestic Abuse** - Many circumstances are both safeguarding situations and domestic abuse. Whilst Organisations will respond and support individuals in these circumstances we are keen to enhance the support and want to be assured Partner Organisations have a workforce who are competent in demonstrating and understanding of the signs and symptoms of Domestic Abuse and the knowledge of pathways available to respond in the context of section 42 enquiries.

The key to this work is Partnership and during 23/24 the Board focus will be to continue to strengthen this approach to prevent abuse and neglect and help and protect people with care and support needs at risk of abuse and neglect.

Glossary

CAP	Care Plan
CGL	Change, Grow, Live
CHC	Continuing Health Care
CPD	Continuing Professional Development
DA	Domestic Abuse
DAB	Domestic Abuse Care Plan
DASH	Domestic Abuse Stalking Harassment and Honour Based Abuse Risk Indicator checklist
DATA C	Domestic Abuse – Tactical and Coordination
DATN	Domestic Abuse Task and Coordination panel
DAVA	Domestic Abuse and Violence
DHR	Domestic Homicide Review
GMFRS	Greater Manchester Fire & Rescue Service
GM	Greater Manchester
GMP	Greater Manchester Police
GP	General Practitioner
ICB	Intergrated Care Board
IDVA	Independent Domestic Violence Advocate
IRIS	The Identification and Referrals to Improve Safety
ISRT	Investigation & Safeguarding Review Team
LMIU	Liverpool John Moores University
MAPPA	Multi-agency public protection arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MDT	Multi-disciplinary Team
MH	Mental Health
MHLDA	Mental Health, Learning Disabilities & Autism

MSP	Making Safeguarding Personal
NHS	National Health Service
PCFT	Pennine Care NHS Foundation Trust
POAP	Plan on a Page
PPUG	Public Protection Governance Unit
RARA	Remove/Avoid/Reduce/Accept
SAR	Safeguarding Adult Review
SI	Serious Incident
SLT	Senior Leadership Team
SMART	Specific, Measurable, Achievable, Realistic, and Timeframe
SPOC	Single Point of Contact
TASPB	Tameside Adult Safeguarding Partnership Board
TMBC	Tameside Metropolitan Borough Council
TRAM	Tiered Risk Assessment Model
VAWG	Violence Against Women & Girls
WEAAD	World Elder Abuse Awareness Day



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Together

we're making health
and social care better

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healthwatch
Tameside

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“

"In the last ten years, the health and social care landscape has changed dramatically, but the dedication of local Healthwatch hasn't. Your local Healthwatch has worked tirelessly to make sure the views of local people are heard, and NHS and social care leaders use your feedback to make care better."

Louise Ansari, Healthwatch England National Director

Message from our Chair

Welcome to the 2022/23 Annual Report from Healthwatch Tameside. I present this report confident that Healthwatch Tameside's work remains strong and respected amongst our local partners.

Over the course of the year we have:

- Welcomed Alex Leach as the new Healthwatch Manager.
- Assessed our compliance with the Healthwatch England Quality Framework standards and implemented action for improvement.
- Published 4 reports, and shared feedback on 'what matters' to our local community with commissioners and providers of services.
- Maintained our focus on digital inclusion and ensuring the widest possible access through the use of the telephone and hard copy materials.
- Prepared the ground work for 2023/24 with a new business plan and an agreement to hold our board meetings in public.



Tracey McErlain-Burns
Healthwatch Tameside Chair

About us

Healthwatch Tameside is your local health and social care champion.

We make sure NHS leaders and decision makers hear your voice and use your feedback to improve care. We can also help you to find reliable and trustworthy information and advice.



Our vision

A world where we can all get the health and care we need.



Our mission

To make sure people's experiences help make health and care better.

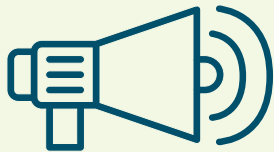


Our values are:

- **Listening** to people and making sure their voices are heard.
- **Including** everyone in the conversation – especially those who don't always have their voices heard.
- **Analysing** different people's experiences to learn how to improve care.
- **Acting** on feedback and driving change.
- **Partnering** with care providers, Government, and the voluntary sector – serving as the public's independent advocate.

Year in review

Reaching out



765 people

shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care.

221 people

came to us for clear advice and information about topics such as mental health and the cost-of-living crisis.

Making a difference to care

We published

4 reports

about the improvements people would like to see to health and social care services.



Health and care that works for you



We're lucky to have

8

outstanding volunteers who gave up their time to make care better for our community.

We're funded by our local authority. In 2022-23 we received

£135,806 in funding

which has remained the same to the previous year.

We currently employ

3.2 Full time equivalent staff

who help us carry out our work.

How we've made a difference this year

Spring



We launched our mental health survey, to be able to compare what we were told in 2017 with current feedback.



We published a report about 'Changes to the ways people access health and care services',

Summer



We published a report about 'Delays in non-urgent care, showing the impact on people's lives.



We supported the #BecauseWeAllCare campaign which saw people come forward to tell us about issues they faced with services.

Autumn



We worked with the other Healthwatch in Greater Manchester on a joint project about the Greater Manchester Integrated Care Partnership 5-year plan.



We re-started our regular outreach sessions at Tameside Hospital, talking to people about their experiences of care.

Winter



We launched our cost of living survey, in partnership with Action Together.



Our governance board approved our assessment on the quality assurance framework

10 years of improving care

This year marks a special milestone for Healthwatch. Over the last ten years, people have shared their experiences, good and bad, to help improve health and social care. A big thank you to all our Healthwatch Heroes that have stepped up and inspired change. Here are a few of our highlights:

How have we made care better, together?

Mental Health

Our research exploring mental health provision in Tameside has helped shape new projects and design new services.



Accessible information

We have worked with many different groups in the community to ensure that NHS services and information are accessible to everybody. Examples include helping ensure a group of Bangladeshi women had access to the LIPS interpreting service and help them get more involved with their local GP services; working with residents to produce a list of suggestions for providers on best practice for appointments with patients who may have a hearing impairment



NHS Complaints

Our NHS complaints service has grown year on year – we offer support through the NHS complaints process, and share feedback from these experiences to services so that they can make any appropriate changes.



NHS dentistry

We continue to voice public concerns that improvements to NHS dentistry are too slow, leaving thousands of people in pain.





Healthwatch Hero



Celebrating a hero in our local community.

Penny has been volunteering for Healthwatch Tameside for ten years, so our celebration of Healthwatch Tameside's anniversary would not be complete without her.

Penny, volunteer at Healthwatch Tameside said;

"When I heard about Healthwatch, it seemed a good fit as a volunteer opportunity for a retired nurse, so I approached them. I think it is genuinely important for people to have somewhere to tell their stories and get a response if possible. Sometimes it helps people just to feel listened to."

"I've been attending bi-monthly outreach sessions at Tameside Hospital to gather feedback on local health and care services, and I've renewed the monthly outreach sessions at Stalybridge Library. It's good to be back in contact with the public after all the upheaval of Covid restrictions and I really enjoy the interaction with the public."



Listening to your experiences

We use the feedback we collect to engage with providers and commissioners via our regular anonymous reports, and in meetings we attend. To be able to influence services, it is important that we hear your views, both positive and negative.

Access to NHS dentistry

We have been hearing a lot about people's attempts to access NHS dentistry since the pandemic started.

We are in regular contact with NHS dental commissioners and the Local Dental Committee (LDC) in Manchester about access to NHS dentistry. We also ask questions, and request updates on service provision. We have developed a good relationship with both organisations, who regularly respond with updates and information we can use as part of our information signposting service.



Here are some examples of queries we have assisted with:

- A care worker wanted to know how they could get NHS dental treatment for a young person in a children's home. The response told us about a scheme set up with local authorities to help find dental care for these children, and how to request a referral.
- We have asked questions about payments, NHS dental payment bandings and how these apply if someone is in receipt of benefits. We have responded to the individuals who asked us a question, with the responses received.
- We have asked for information, when people have been told by a hospital consultant, they must have a dental check-up before surgery or treatment can take place, and they have been unable to access the care required.

What difference will this make?

By building relationships with organisations, we are 'in the loop' when information is being made available. We have been told about plans being put into place to increase the number of NHS dental appointments across Greater Manchester during the 2023/24.

Three ways we have made a difference for the community

Throughout our work we gather information about health inequalities by speaking to people whose experiences aren't often heard.

Creating empathy by bringing experiences to life

Hearing personal experiences and the impact on people's lives provides them with a better understanding of the problems.



We were contacted by a member of the public who had not been registered with a GP for over a year. They were trying to register, but were being asked for photo ID which they didn't have. The NHS website states ID is not essential. We explained this to the person, and they were able to register with a practice. This was not the first time we had heard about this issue. We contacted the local primary care commissioners again, who agreed to send a reminder out to all Tameside GP practices that ID is not required to register with a GP Practice.

Getting services to involve the public

Services need to understand the benefits of involving local people to help improve care for everyone.



We meet regularly with Patient Experience staff from our local hospital and discuss anonymously the feedback themes we are hearing. Communication is often at the heart of issues, and we discuss ways improvements could be made. Changes have been made within the patient, advice and liaison team, with an emphasis on keeping people informed if they are waiting for information, or the outcome of a complaint.

Improving care over time

Change takes time. We often work behind the scenes with services to consistently raise issues and bring about change.



Digital access to care is increasing across all services. We regularly remind commissioners and providers that other methods of access are required for people who do not have, or do not want, access to online services. We are starting to see different options being included at the planning stage of new projects



Hearing from all communities

Over the past year we have worked hard to make sure we hear from everyone within our local area. We consider it important to reach out to the communities we hear from less frequently, to gather their feedback and make sure their voice is heard and services meet their needs.

This year we have reached different communities by:

- Having a stand at community events which include colleges, places of worship and libraries. An example of events we have attended include; Armed Forces Day, Tameside Men's Mental Health Conference and outreach events at Tameside College.
- We have worked with partner organisations to provide talk, listen and share events with a range of groups and services. For example, we have held sessions with Samuel Laycock School and Tameside Carers Centre.
- We have continued to develop our links with organisations which include the job centre and housing providers.



Advice and information

If you feel lost and don't know where to turn, Healthwatch Tameside is here for you. In times of worry or stress, we can provide confidential support and free information to help you understand your options and get the help you need. Whether it's finding an NHS dentist, how to make a complaint or choosing a good care home for a loved one – you can count on us.

This year we've helped 221 people by:

- Providing up to date information people can trust
- Helping people access the services they need
- Helping people access NHS dentistry and emergency treatment
- Supporting people through the NHS complaints process

Support with complaints

Healthwatch Tameside provides support to people living in Tameside to make NHS Complaints. We help people understand how the NHS complaints process works and support them where needed. Support is offered by telephone, online, and face-to-face in relation to any NHS service provision provided at hospitals, GP Practices, dentists, pharmacies, opticians, and nursing homes.

This year in Healthwatch Tameside:

Our complaints service received 92 new cases, a 15% increase from the previous year.

We have helped people write complaint letters, attended local resolution meetings and provided our Self Help Information Packs; empowering people to follow the complaints process themselves, but with clear guidance and expectations.

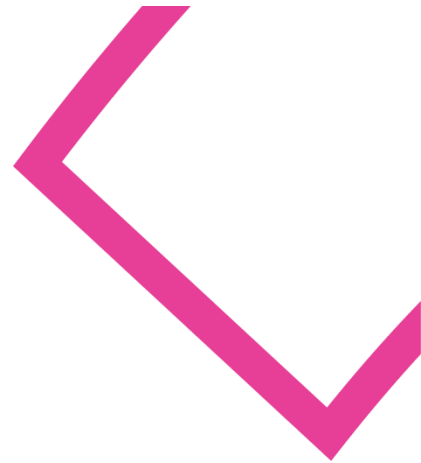
Comments from complaint clients

“Thank you so much for all your help yesterday, it really helped talking to you especially with you being so understanding”

“Thank you for your assistance and input over the last 6 weeks as I believe this had greatly assisted in me receiving a much higher quality response to the complaint”

“many thanks for your support at the local resolution meeting, it was greatly appreciated”

“The letter you drafted up is absolutely perfect. I could never have got my head around it. Thank you ever so much for taking the time to help me”




Concerns around hospital discharge

we often hear from people that are inpatients at hospital who are uncertain where to go for advice and information.

One enquirer contacted us as she was concerned around the discharge plan for her vulnerable family member. She felt that the plan was inadequate, and it didn't accommodate his needs when he got home.

Healthwatch Tameside talked through the concerns with her and helped her to make a list of the issues. We recommended that she speak to the ward manager with these concerns which she agreed to do and went to the hospital the same day. The concerns were addressed by the ward manager and a home assessment was done when her family member got home.


 "Special thank you to Healthwatch Tameside for listening to me and giving me the timely support I needed"

Helped mum get support for baby's feeding

A mother was referred to us by a social prescriber for support with making a complaint following a poor experience at a Children's Clinic.

After speaking to the mum, we explained that making a complaint can be a lengthy process and she needed urgent support around her baby's feeding.

With her permission we contacted the dietetic service and they agreed to contact the mum directly. She was happy with this outcome and was provided with a direct contact number for the dietetic service for future.

 "thank you for all your support with this case. Client is very happy to have had a call from dietician and she is now able to support her child better with the diet and weaning"
– Social Prescriber



Volunteering

We're supported by a team of amazing volunteers who are at the heart of what we do. Thanks to their efforts in the community, we're able to understand what is working and what needs improving.

This year our volunteers:

- Visited communities to promote their local Healthwatch and what we have to offer, this included our local hospital.
- Collected experiences and supported their communities to share their views
- Shared information with their communities about health and care
- Provided information to Healthwatch Tameside about local changes to services which impact the community

Finance and future priorities

To help us carry out our work we receive funding from our local authority under the Health and Social Care Act 2012.

Our income and expenditure

Income		Expenditure	
Annual grant from Government	£135,806	Salaries Expense	£102,922
Additional income	£816	Direct Delivery	£4819
		Overheads and Mgt	£30,000
Total income	£136,622	Total expenditure	£137,741

Next steps

In the ten years since Healthwatch was launched, we've demonstrated the power of public feedback in helping the health and care system understand what is working, spot issues and think about how things can be better in the future.

Services are currently facing unprecedented challenges and tackling the backlog needs to be a key priority for the NHS to ensure everyone gets the care they need. Over the next year we will continue our role in collecting feedback from everyone in our local community and giving them a voice to help shape improvements to services.

We will also continue our work to tackling inequalities that exist and work to reduce the barriers you face when accessing care, regardless of who you are or where in Tameside you live.

Top three priorities for 2023-24

1. We will conduct research projects on children and young people's mental health services
2. We will become enter and view ready
3. We will relaunch our volunteer programme including more ways for young people to be heard



Statutory statements

Healthwatch Tameside, 131 Katherine Street, Ashton-under-Lyne, OL6 7AW. Healthwatch Tameside is delivered by Action Together CIO (Registered Charity no: 1165512).

Healthwatch Tameside uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.

The way we work

Involvement of volunteers and lay people in our governance and decision-making

Healthwatch Tameside operates as part of Action Together, the voluntary sector infrastructure organisation in Tameside. Healthwatch Tameside has its own Board which sets our priorities and overall strategy. Our Healthwatch Board consists of **7** members who work on a voluntary basis to provide direction, oversight and scrutiny to our activities. Our Board ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local community. Throughout 2022/23 the Board met **6** times and made decisions on matters such as our quality assurance framework and our business plan for the year ahead.

We ensure wider public involvement in deciding our work priorities.

Methods and systems used across the year to obtain people's experiences

We use a wide range of approaches to ensure that as many people as possible have the opportunity to provide us with insight about their experience of using services. During 2022/23 we have been available by phone, email, provided a webform on our website and through social media, as well as attending meetings of community groups and forums.

We ensure that this annual report is made available to as many members of the public and partner organisations as possible. We will publish it on our website.

Taking people's experiences to decision makers

We ensure that people who can make decisions about services hear about the insight and experiences that have been shared with us.

In our local authority area for example, we share our insight to several committees and groups to support commissioners and providers with their decision making.

We also share our data with Healthwatch England to help address health and care issues at a national level.

Healthwatch representatives

Healthwatch Tameside is represented on the Tameside's Health and Wellbeing Board by Anna Hynes, Tameside Director, Action Together.

Healthwatch Tameside is represented on Tameside Strategic Partnership Board by Anna Hynes, Tameside Director, Action Together. and Tameside System Quality Group by Alex Leach, Manager, Healthwatch Tameside.

Healthwatch Tameside are also represented on Tameside Provider Partnership, Tameside General Practice Alliance, Tameside Adult Safeguarding Partnership Board, Primary Care Commissioning Committee, Integrated Medicines Optimisation Group, Tameside and Glossop Mental Health VCSE Network, Healthwatch in Greater Manchester Network, Pennine Care Foundation Trust Healthwatch Partnership Group, Tameside and Glossop Integrated Care Foundation Trust Patient Safety and Service User Experience Group.

These regular meetings enabled us to do a number of things on behalf of local people:

- Making sure that people leading our health and care systems understand the feedback we are given by local people.
- Asking questions based on things we know that local people have said to us before.
- Checking that the public engagement that informs decisions is balanced and not just based on the views of the people who are easiest to talk to.

Healthwatch in Greater Manchester Network

There are 10 local Healthwatch in Greater Manchester who have come together to work as a network. In 2022/23 the HW in GM network have achieved the following;

- Published an all-age strategy.
- Formalised a 3-year partnership agreement with Greater Manchester Integrated Care.
- Gather opinion from across our local communities to influence the Greater Manchester Integrated Care Strategy and the Greater Manchester Integrated Care Partnership Strategy.
- Contributed to the development of the Greater Manchester Integrated Care Quality Strategy.
- Delivered our commitment to continue raising concerns regarding access to NHS dentistry.



healthwatch
Tameside

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