SAFEGUARDING OLDHAM

OLDHAM SAFEGUARDING ADULTS BOARD

Annual Report & Single Agency Statements 2025-26

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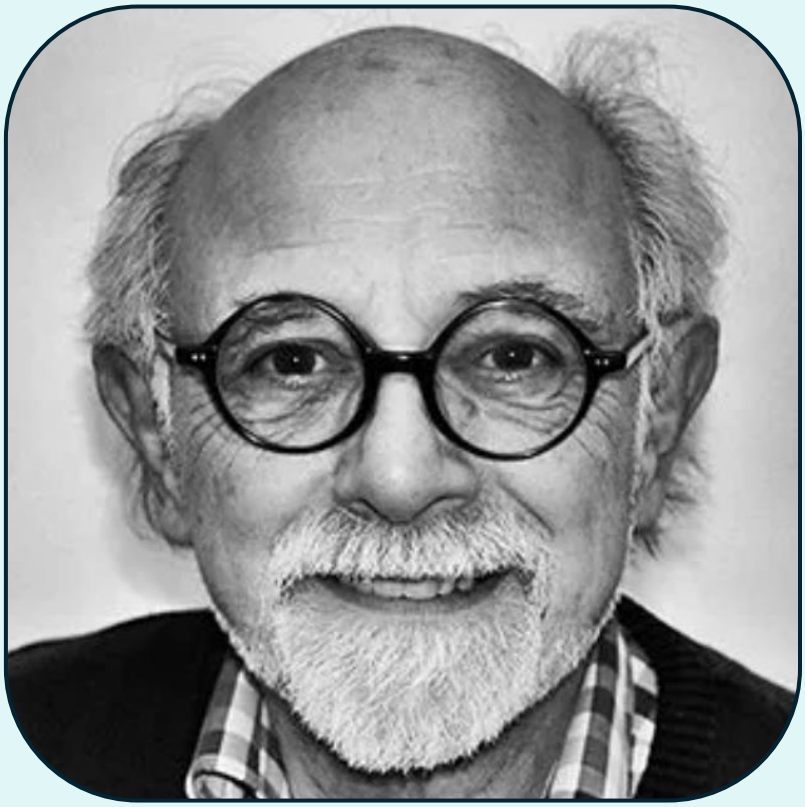


It is my pleasure to present the Oldham Safeguarding Adults Board (OSAB) Annual Report for 2025-26. This report reflects another year of strong partnership working, shared commitment and collective effort to help adults in Oldham live safely, free from abuse and neglect. As Independent Chair, I am continually impressed by the willingness of organisations across Oldham to work together, learn together and challenge themselves to improve outcomes for our most vulnerable residents.

This has been a year of significant achievement. One of the highlights was the introduction of Oldham's first Workforce Confidence Survey, which provided valuable insight into practitioner confidence across a range of safeguarding responsibilities, including recognising abuse, information sharing and the application of the Mental Capacity Act. The survey findings have already helped shape the Board's programme of work, ensuring that training, guidance and support are targeted where they can have the greatest impact.

The Board also continued its commitment to raising public awareness and engaging directly with communities. A particular success was the Freedom Bus visit to Oldham as part of Anti-Slavery Day. Working alongside partners, OSAB helped bring conversations about exploitation and modern slavery into the heart of the borough, encouraging residents to appreciate the important role everyone can play in safeguarding vulnerable people.

Another area of considerable success has been workforce development. During the year, OSAB delivered multi-agency training on key safeguarding topics to a large number of practitioners from more than 80 different organisations. Feedback from participants was overwhelmingly positive, highlighting the quality of delivery, the value of lived experience contributions and the opportunity to learn alongside colleagues from other agencies. Effective safeguarding depends on a skilled, confident and connected workforce, and these results demonstrate the strength of Oldham's commitment to continuous learning and improvement.

Alongside these successes, this report also highlights some important challenges. Safeguarding referrals increased during 2025-26, reflecting both growing awareness of safeguarding and the increasing pressures facing individuals, families and

communities. The complexity of vulnerability continues to evolve, with agencies reporting increasing presentations involving mental health difficulties, self-neglect, homelessness, exploitation, domestic abuse, trauma, substance misuse and social isolation. Many of these issues do not occur in isolation but overlap, creating situations that require coordinated and sustained multi-agency responses. The single-agency statements contained within this report provide compelling evidence of these challenges. Across housing, health, social care, policing, probation, voluntary sector and community services, organisations consistently report increasing demand, more complex risk profiles and growing numbers of people experiencing multiple disadvantages simultaneously. Whilst these pressures are significant, the statements also demonstrate the resilience, innovation and dedication of practitioners who continue to place people and communities at the centre of their work.

I am particularly encouraged by the ongoing commitment of partners to learn from Safeguarding Adult Reviews, strengthen professional curiosity, improve Mental Capacity Act practice and embed trauma-informed approaches. The positive feedback received through external scrutiny, including recognition of the strength of local safeguarding partnership arrangements as part of the Local Authority's assessment by the Care Quality Commission, provides further assurance that Oldham continues to build on solid foundations while remaining focused on improvement.

Finally, I would like to thank every practitioner, volunteer, manager, Board member and partner organisation for their contribution during the year. Safeguarding is truly everyone's business. The achievements described throughout this report are only possible because of the collective efforts of people across Oldham who remain committed to protecting the rights, dignity and wellbeing of others.

As we look ahead to 2026-27, we do so with confidence in our partnerships, determination to address emerging challenges, and an unwavering commitment to helping people live safely in Oldham.

Dr Henri Giller
Independent Chair
Oldham Safeguarding Adults Board

Helping People Live Safely in Oldham

What is Safeguarding?

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

- Care Act 2014

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

Who are the Safeguarding Adults Board?

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

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

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

- Voluntary sector organisations
- Healthwatch Oldham
- Probation Service
- Greater Manchester Police
- Pennine Care NHS Foundation Trust
- Northern Care Alliance NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Public Health
- Oldham Housing organisations
- Greater Manchester Fire and Rescue Service
- Oldham Council
- NHS Greater Manchester Integrated Care
- Mind
- Advocacy services
- Substance misuse services.

The Board is managed by an Independent Chair who is responsible for providing safeguarding leadership and oversight.

Through the work of the Board, the Chair seeks assurance from partner agencies that they are working together effectively to help keep people safe.

Safeguarding is Everyone's Business

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

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

The Board had three core duties:

1. Conduct a **Safeguarding Adult Review** where there is evidence to suggest that someone has experienced harm as a result of abuse or neglect.

2. Produce a **Strategic Plan** setting out the changes the Board wants to achieve and how organisations will work together to help keep people safe.

3. Publish an **Annual Report** setting out information on safeguarding trends locally, the actions of the Board over the last year, and priorities for the coming year.

This Annual Report provides an overview of safeguarding trends in Oldham during 2025-26. It also provides information on the Board's work and Safeguarding Adult Reviews commissioned by the Board and how the learning from these reviews has shaped and improved the way services work in Oldham throughout the period.

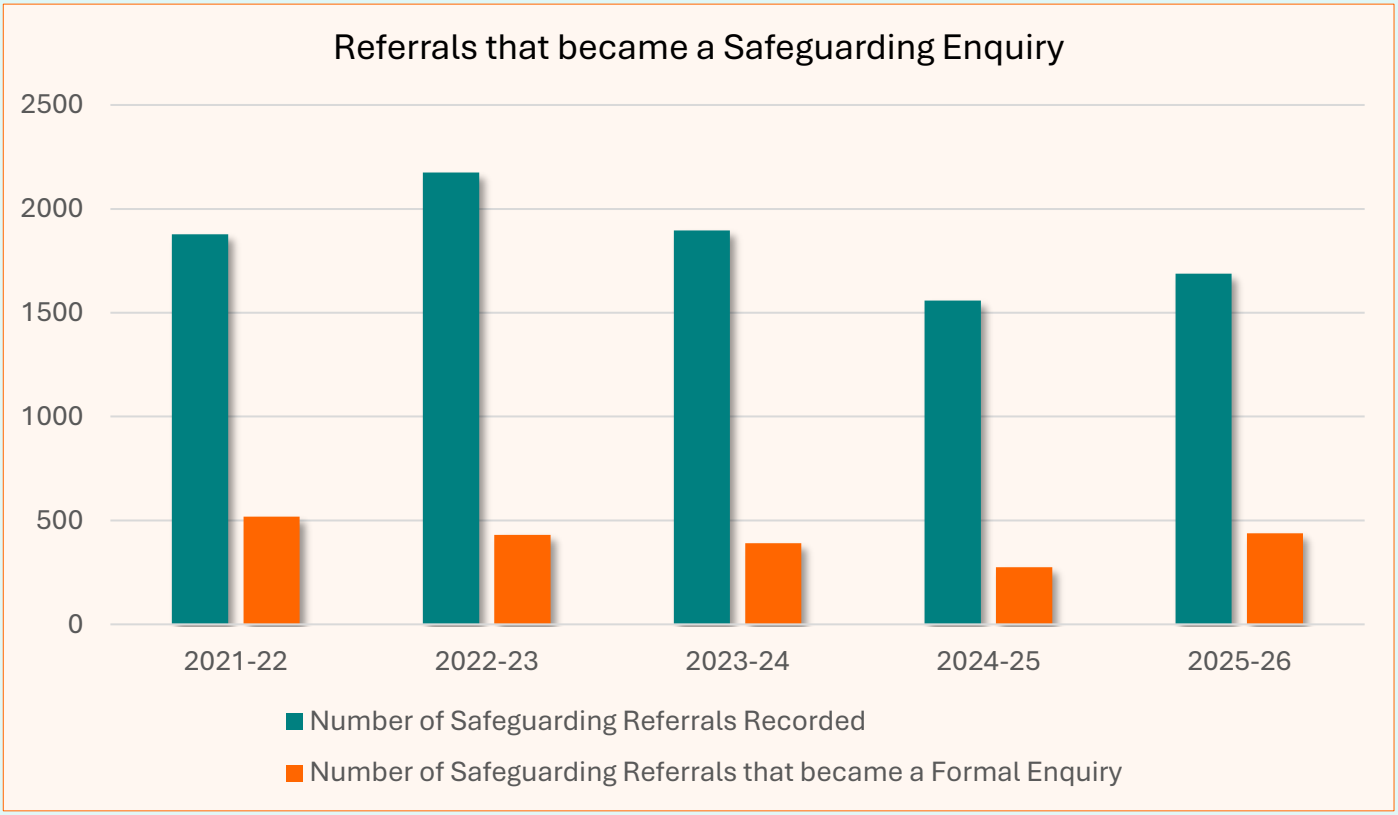
Profile of Abuse and Neglect in Oldham

The following information shows the numbers and types of safeguarding abuse recorded for Oldham residents in 2025-26. This data has been compared to the numbers and types of safeguarding abuse from previous years to help us understand any changes or new types of safeguarding concerns that need to be addressed.

Safeguarding referrals that became a formal safeguarding enquiry

Each safeguarding referral received is investigated and if we believe that an adult with care and support needs is at risk of serious abuse or neglect and is unable to protect themselves because of those needs, the referral becomes the subject of a formal safeguarding enquiry. The purpose of a formal safeguarding enquiry is to ensure that the referral is investigated, to gather more information, to collect the views of the adult at risk of serious abuse or neglect and the views of anyone else who may be relevant, and to prevent, or stop, abuse from occurring.

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



During 2025-26, a total of 1688 safeguarding referrals were received and of these, 438 became a formal safeguarding enquiry.

The number of safeguarding referrals received increased by 8% in 2025-26 compared to the previous year. Some of this increase may be due to safeguarding awareness campaigns designed to encourage the residents of Oldham to report their safeguarding concerns and training provided to professionals in Oldham about making safeguarding referrals.

The proportion of safeguarding referrals that led to formal safeguarding enquiries has increased from 18% in the previous year to 26% in 2025-26. The proportion that led to formal safeguarding enquiries has remained relatively consistent, averaging 22% over the last five years. The increase in 2025-26 is thought to be the result of messaging and training provided to professionals in Oldham about the criteria for formal safeguarding enquiries.

Safeguarding referrals by sex

Of the 1688 safeguarding referrals in 2025-26, 60% (1012) related to women and 40% (671) related to men. There were a further five safeguarding referrals where the sex was unknown. This is a similar split to previous years.

As women make up 52% of the total adult population in Oldham, this means that the percentage of safeguarding cases per head of population in 2025-26 were slightly higher for women than for men.

safeguarding referrals were concerning women in 2025-26

safeguarding referrals were concerning men in 2025-26

Safeguarding referrals by age

Of the 1688 safeguarding referrals in 2025-26:

- **162 (10%) were concerning 18-24 years olds**
- **650 (39%) were concerning 25-64 years olds**
- **218 (13%) were concerning 65-74 years olds**
- **333 (20%) were concerning 75-84 years olds**
- **325 (19%) were concerning 85 years olds or older adults**

Considering different age groups, during 2025-26, it was recorded that around 62% of all safeguarding referrals related to someone aged 65 or over.

Whilst the breakdown by age group has remained relatively consistent over the last few years, the percentage of people aged 18-24 years has increased to 10% from 5% in the previous year. It is thought that this increase could be the impact of work now taking place in relation to young people moving from children's services into adult services. Proactive partnership working, earlier identification of safeguarding risks, and stronger referral pathways for young adults with care and support needs may have contributed to a greater number of safeguarding referrals related to this age group.

Safeguarding referrals by ethnicity

Of the 1688 safeguarding referrals in 2025-26:

- **1354 (80%) were concerning White British adults**
- **163 (10%) were concerning Asian/British Asian adults**
- **107 (6%) were concerning adults where ethnicity was Unknown/Undeclared**
- **43 (3%) were concerning Black/African/Caribbean/ Black British adults**
- **21 (1%) were concerning adults of Mixed/Other Ethnicity**

Considering the ethnicity of Oldham residents, during 2025-26, it was recorded that 80% of all safeguarding referrals related to White British people. Whilst this has decreased by 5% compared to the previous year, the breakdown by ethnicity has remained relatively consistent over the last few years. As White British people make up 65% of the total adult population in Oldham, this means that the percentage of safeguarding cases per head of population in 2025-26 were slightly higher for White British people.

Overall, the 2025-26 figures suggest that White British people aged 65 years old and over were more likely to be the subject of a safeguarding referral compared to any other group.

Who reported the concerns

Of the 1688 safeguarding referrals in 2025-26:

- **25% were referred by a Professional**
- **23% were referred by Health services**
- **17% were referred by a service Provider**
- **10% were referred by 'Other'**
- **6% were referred by Someone Connected**
- **1% were self-referred**

For 19% the referrer was not recorded

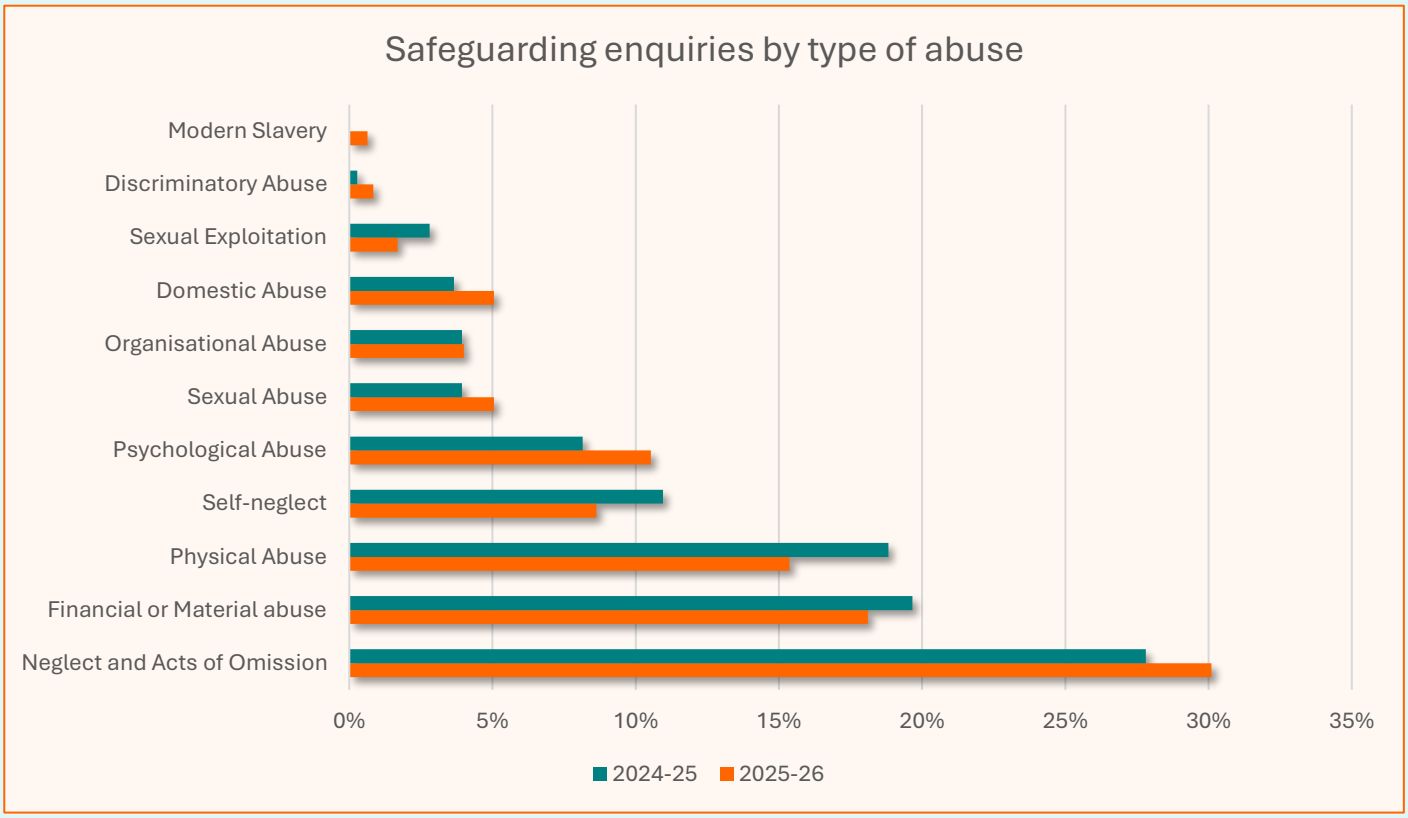
In 2025-26, most safeguarding referrals were made by local professionals. practitioners from health services, and local providers of care and support.

Mental Capacity

A person lacks mental capacity if their mind is impaired or disturbed in some way, which means they are unable to make a decision at that time as they cannot understand the information relevant to the decision; retain that information; or use or weigh up that information as part of the process of making the decision. Examples of how a person's brain or mind may be impaired include mental health conditions, dementia and intoxication caused by drugs or alcohol misuse. The 2025-26 figures include a high proportion of complex safeguarding enquiry cases, with 40% of the closed safeguarding enquiries involving people who lacked capacity to make their own decisions. This has stayed relatively consistent as in 2024-25 the proportion was 44%.

Types of safeguarding abuse

The chart below shows a breakdown of the types of safeguarding abuse investigated in 2025-26 compared to 2024-25. Some safeguarding investigations can involve the recording of more than one category of abuse for the same person and these are the cases that often involve multiple agencies working together to ensure those involved are safe.



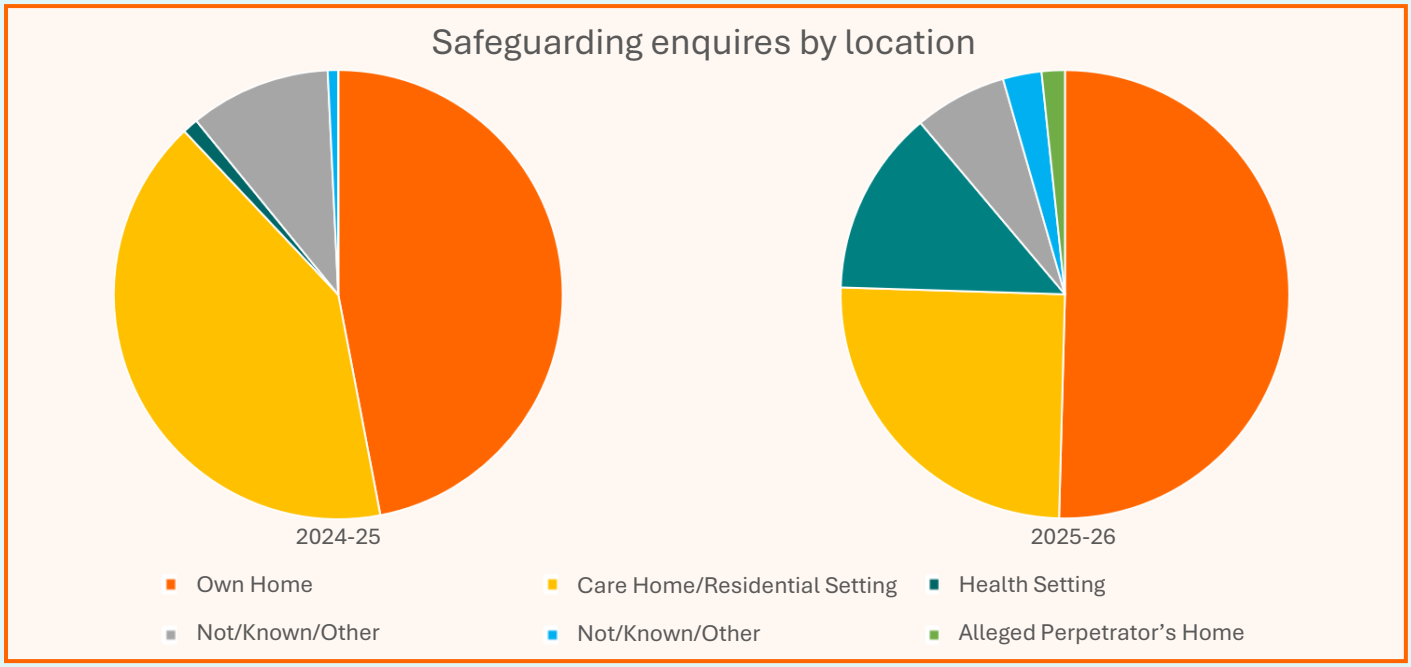
Domestic Abuse is abusive behaviour or a pattern of abusive behaviour between two people aged 16 years or older that are personally connected to each other; behaviour is abusive if it consists of physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; psychological, emotional or other abuse. Modern Slavery is an umbrella term for all forms of slavery, human trafficking, and exploitation. Sexual Abuse includes rape and sexual assault or sexual acts to which the adult at risk has not consented or could not consent or was pressured into consenting.

The proportion of safeguarding enquiries undertaken in 2025-26 in relation to Domestic Abuse, Modern Slavery, and Sexual Abuse increased compared to the previous year. Throughout the year, local professionals were encouraged to recognise the signs of these types of abuse and neglect through multi-agency training, practitioner guidance and briefings.

The proportion of safeguarding enquiries in relation to Neglect and Acts of Omission also increased in 2025-26. These are cases where a person who is responsible for the support of an adult at risk has failed to provide adequate care or essentials such as medicines, nutrition, heating etc. This has consistently been the most common form of abuse over the last seven years.

Where the abuse took place

The charts below show that for both 2024-25 and 2025-26 the most common places where the reported abuse or neglect took place was within a care home/residential setting or the person's own home.



Number of closed safeguarding referrals and enquiries

1572 safeguarding referrals and enquiries closed in 2024-25

1665 safeguarding referrals and enquiries closed in 2025-26

During 2025-26, a total of 1665 safeguarding referrals and enquiries were closed which is more than the 1572 closed during the previous year. This is consistent with the increased number of referrals received. The 1665 closed includes the closure of outstanding cases from 2024-25.

OSAB regularly review partnership safeguarding data. In 2025-26, the Board oversaw further development of a detailed data 'dashboard'. The insights from this are used to prioritise development of safeguarding resources such as training and guidance and where appropriate, adjust the way services work together to keep people safe.

Safeguarding - What does good look like?

When Oldham Safeguarding Adults Board report about safeguarding, the focus is often on safeguarding enquiries, because this is a statutory responsibility. But this is only part of the picture. In 2025-26, Adult Social Care worked with partner agencies to respond to a further 1230 safeguarding referrals that did not meet the criteria for an enquiry but often involved a great deal of work to keep people safe and well. The complex case detailed below involved safeguarding referrals raised for multiple adults experiencing financial exploitation, coercion and control, modern slavery, and neglect. It demonstrates how Oldham's safeguarding procedures, risk management processes, escalation mechanisms, professional challenge, and multi-agency information-sharing arrangements have supported effective partnership working and positive outcomes for adults at risk. The case highlights key learning, areas of effective practice, and ongoing challenges across the local safeguarding system.

Safeguarding concerns regarding an unregistered landlord exploiting adults were raised by Drug and Alcohol Services. The concerns of financial exploitation, coercion and control, modern slavery and neglect were initially responded to via Care Act Safeguarding. The first multi-agency safeguarding approach was led by Police and Adult Social Care supported by Drug and Alcohol Services, Focused Care and Housing partners. Initial outcomes were:

- An older male with care and support needs left the abusive situation, accessed safe accommodation in 24-hour care, regained control of his finances and received the wellbeing support he required.
- An older male was supported with safety planning, connected with prevention services, and a Team Around the Adult was built to support resilience – this then led to further recognition of different safeguarding concerns and responses.
- A working age female who did not have care and support needs was suspected to be experiencing modern slavery and financial exploitation. She was supported with safety planning.

Due to the levels of risk whilst still living in their accommodation, no one felt able to disclose abuse by the landlord.

Plans were made to secure a place of safety for the working age female to provide the opportunity for disclosure. A Police visit took place in advance of the place of safety being secured and she withdrew contact with all services. At this stage, there were no disclosures amounting to criminal offences, partners submitted intelligence to Police to support a disruption approach, and the Care Act safeguarding response was closed. The Drug and Alcohol Team and Focused Care remained concerned and persisted in attempting to contact the female. They also received new information from three further adults that they too were being financially exploited by the landlord and their associates. The OSAB Escalation Protocol was successfully used to request reconsideration of the risks to the working age female and the other adults at risk.

Through effective information sharing using the OSAB Tiered Risk Assessment and Management (TRAM) Protocol, it was identified that none of the adults had care and support needs but did have trauma histories and multiple complex dependencies. A multi-agency risk management response followed.

Partners including Drug and Alcohol Services, Changing Futures, Focused Care, Police, Independent Domestic Abuse Advocates, and Housing worked together to understand the risks and respond. Adult Social Care acted in an advisory capacity under Care Act Prevention and Delay duties. Further outcomes included:

- The working age female re-engaged and built trusted relationships with a team around her. Work to support her safety continues.
- A working age female who was being financially exploited; and physically, psychologically and domestically abused, was supported to leave the abusive situation, and secure a place of safety. There is an ongoing professional network to support her recovery.
- A working age female and a working age male who were being financially exploited; and physically and psychologically abused, were supported to secure safe accommodation and continue to work with the services supporting them in recovery.

All concerns were taken to the local Adult Exploitation Intelligence meeting, which supported a dedicated Police response to be implemented and all potential victims to be spoken to in places of safety. The adults at risk remain fearful and to date no disclosures have been made which would support criminal investigations, but this has not prevented multi-agency working from removing the risk for five adults, reducing the risks to two adults, and continuing attempts to identify and respond to other potential victims. Ongoing intelligence sharing in support of disruption and evidence gathering regarding criminality also continues.

Safeguarding Adult Reviews

What are Safeguarding Adult Reviews?

The Board has a legal duty to carry out a Safeguarding Adult Review (SAR) if it believes someone with needs for care and support has died as a result of, or experienced, serious abuse or neglect and there is reasonable cause for concern about how effectively partner agencies worked together to protect them.

The aim of a SAR is to review the way agencies worked together to safeguard the person. Learning from SARs is shared across agencies and used by the Board to review the way services operate in order to prevent a similar situation occurring again.

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

SAR Referrals and SARs Undertaken by OSAB

During 2025-26, the Board received six SAR referrals in total (there were seven received in the previous year). All referrals were screened by multi-agency partners to determine if the criteria defined in the Care Act had been met. Two of the referrals met all the criteria for a Mandatory SAR (two referrals met the criteria in the previous year).

The information below illustrates the number of SARs completed in 2025-26 compared to the previous year.

2024-25 3 Safeguarding Adult Reviews

2025-26 2 Safeguarding Adult Reviews

Aleina

The Board approved the Overview Report in relation to Aleina (a pseudonym) on 29 July 2024. A 7-Minute Briefing is available summarising the key findings and learning. The SAR made nine recommendations. Three of these were completed or implemented in 2024-25. On 31 March 2026, the status of each of the remaining six was as follows.

Completed/Implemented Recommendations:

- OSAB should seek assurances from all hospital trusts that are stakeholders in the SAR about arrangements for their clinical staff to have access to effective timely safeguarding expertise and the arrangements for escalating safeguarding concerns
- OSAB should seek assurances from the ICB about progress in improving the operation of the GP registers of patients with a learning disability.
- OSAB should consider what measures will improve the identification and multi-agency response to so called honour-based abuse including forced marriage.
- Children's Social Care should provide OSAB with assurances about the implementation of the Mental Capacity Act competency framework.
- OSAB should seek assurance from partner agencies about their reasonable adjustment policies and procedures and how they might have been applied to the circumstances of this SAR. This includes whether policies stipulate for example that some service users may need more time allocated for services such as social care, adjustment of workload measures that give more time to particular professionals, the development of Child in Need or enhanced access to services for children caring for or living with parents who have a cognitive condition such as a learning disability.

Recommendation where further assurance was required regarding completion or implementation:

- OSAB should refer the report to the appropriate subgroups to examine further how specific areas of learning from the SAR could be taken forward.

Lisa

The Board also approved the Overview Report in relation to Lisa (a pseudonym) on 29 July 2024. A 7-Minute Briefing is available summarising the key findings and learning. The SAR made eleven recommendations. Seven of these were completed or implemented in 2024-25.
On 31 March 2026, the status of each of the remaining four was as follows.

Completed/Implemented Recommendations:
• OSAB should complete a further review of the Self Neglect and Hoarding Strategy and Toolkit and consider how they might be strengthened following the circumstances and findings from this SAR and findings from the second National Analysis of Safeguarding Adult Reviews.
• OSAB should seek assurance from ASC and CSC that staff are aware of when a young carers assessment is required and how to access them.
• OSAB should seek assurance that the Assisted Suicide: OSAB Safeguarding Briefing for Practitioners has been shared by partner agencies and is included in training to support staff in providing care to individuals who disclose their thoughts of 'assisted suicide' or 'euthanasia'. This document should also be used to prompt discussions about Advance Decision to Refuse Treatment with people it would be applicable to have the conversation with. And, that the findings from this SAR should be shared with the Oldham Suicide Prevention Partnership and practitioners to be aware of the Oldham Suicide Prevention Strategy when someone they are working with discloses suicidal ideation.

Recommendation where further assurance was required regarding completion or implementation:
• That the Review Panel members that have identified learning for their agency as a result of this SAR provide OSAB with assurance that the necessary actions are complete within a mutually agreed timeframe.

Kerr

The Board approved the Overview Report in relation to Kerr (a pseudonym) on 4 November 2024. The Overview Report was published and a 7-Minute Briefing was made available summarising the key findings and learning.

The SAR made six recommendations. Three of these were completed or implemented in 2024-25. On 31 March 2026, the status of each of the remaining three was as follows.

Completed/Implemented Recommendations:
• OSAB continue to take steps to respond to learning from previous SARs and improve legal literacy around the Mental Capacity Act via extensive practitioner guidance, training and seeking assurance from partner agencies. It is recommended that OSAB
→ Continue to endorse and promote single-agency use of the National MCA Competency Framework.
→ Promote existing practitioner guidance further.
→ Continue to offer multi-agency MCA training.
→ Work with neighbouring SABs to embed learning concerning the MCA found in SARs.
→ Encourage practitioners to evidence if capacity of the person to understand the abuse/neglect has been considered in their safeguarding referrals.
• That OSAB ensures its multi-agency training includes clear consideration of:
→ Executive function in relation to the assessed persons' capacity
→ Where risk of serious harm/death is a possible outcome that there is clear documentation evidencing the reasons why capacity has not been formally assessed
In addition, that OSAB receives assurance that single agency mental capacity training also includes these important elements.
• That Adult Social Care consider whether an audit of safeguarding practice is required because of the findings in this review to determine if the findings are specific to the management of Kerr or an indication of the potential for wider system failure. If an audit is agreed, then the OSAB and their partners will be informed of the audit findings and any necessary action plan.

John

The Board approved the Overview Report in relation to John (a pseudonym) on 8 August 2025. The Overview Report was published, and a 7-Minute Briefing was made available summarising the key findings and learning. The SAR made six recommendations.
On 31 March 2026, the status of each was as follows.

Completed/Implemented Recommendations:
• OSAB to raise awareness of the importance of including adequate information about the vulnerabilities of the person they are referring when

making referrals to other agencies, such as, in John's case Age UK Oldham and Mind.
• OSAB to produce a 7-Minute Briefing about key considerations for practitioners when discharging a vulnerable person to HMO (Houses in Multiple Occupation).

Recommendations where further assurance was required regarding completion or implementation:
• Adult Social Care to make the triaging/decision making process more transparent so that partners understand how ASC have made the decision.
• Adult Social Care to consider whether repeat referrals for the same person should then lead to a Care Act needs assessment e.g. in this case three referrals resulted in a prevention response.
• Adult Social Care to audit cases that have resulted in 'No Further Action' or prevention responses to ensure that decision making is robust.
• Health and Social Care partners that are stakeholders in this SAR to consider the SAR findings and undertake a review of:

a) how the 'system' gathers relevant information about a person's vulnerabilities (clinical needs and safeguarding concerns) and any after care when planning hospital discharges and
b) how this information is shared appropriately with Primary Care, relevant ASC teams, and all members of the Team Around the Adult at the point of discharge

to decide what action/s can be taken to strengthen existing processes. Assurances to be provided to OSAB following completion of this action.

Joe

The Board approved the Overview Report in relation to Joe (a pseudonym) on 2 February 2026. The Overview Report was published, and two 7-Minute Briefings were made available summarising the key findings and learning. The SAR made sixteen recommendations. On 31 March 2026, the status of each was as follows.

Recommendations where further assurance was required regarding completion or implementation:
• That OSAB reviews the criteria by which it is decided to support adults through the TRAM process to ensure there is clarity over eligibility, whilst retaining room for professionals to use their judgement, and that eligibility criteria do not inadvertently exclude some vulnerable adults.
• That OSAB works with partner agencies to adopt a co-ordinated multi-agency approach to improving the quality of safeguarding referrals including making use of the good practice which already exists in pockets of the whole system.
• That OSAB requests a report on the effectiveness of 'step up step down' arrangements between the Adult Referral Contact Centre (ARCC) and the Multi-Agency Safeguarding Hub (MASH), with a specific focus on the process by which requests for support are screened by the ARCC and the extent to which the ARCC has a robust process to identify any safeguarding concerns within requests for support.
• That OSAB ensures that TRAM training is targeted on line management and more senior management in order to raise managerial awareness of the TRAM process and to emphasise the importance of managerial support and encouragement to practitioners to fulfil the TAA lead professional role.
• That Oldham Integrated Care Partnership shares the revised DNA policy adopted by Joe's GP practice in response to the learning from this SAR with all Oldham GP practices and encourage them to adopt a similar approach where they have commissioned Focused Care and enhance professional enquiry into the circumstances of patients with mental illness and social and economic complexities where the GP practice does not have commissioned Focused Care.
• That PCFT review the process by which patients are discharged from mental health services to ensure that early contact is made with the patient's GP if it is known that agencies are experiencing difficulties in engaging with that patient.
• That PCFT review the process by which patients who are discharged from the Early Intervention Service on the grounds that their psychosis is drug induced, and they decline support from substance use services. In particular, Pennine Care are requested to ensure that practitioners explore what may lie behind any refusal of substance use support and that practitioners consider whether patients have the mental capacity to understand the risks they may be exposing themselves to if their drug induced psychosis goes untreated.
• That the Sanctuary Trust review their policy for formally raising concerns when an adult they support becomes isolated from services and, as a result, the risks to that adult escalate markedly.
• That Northern Care Alliance NHS Foundation Trust (NCA) and Pennine Care NHS Foundation Trust (PCFT) consider what action it is proportionate to take when a patient is repeatedly presenting at the Royal Oldham Hospital (ROH) A&E and repeatedly being assessed by the Liaison Mental Health Team (LMHT) and letters to the patient's GP are being returned because the patient is no longer registered with that GP practice.
• That PCFT review the ROH LMHT responses to Joe and consider why safeguarding referrals were not made and implement any necessary changes to

professional practice and advise OSAB of the outcome.

• That the Probation Service review their responses to Joe's unscheduled visits to Probation on 11 and 18 July 2024 and consider why safeguarding referrals were not made and implement any necessary changes to professional practice and advise OSAB of the outcome.

• That when OSAB disseminates the learning from this SAR, the need to consider formal Mental Capacity Assessments when a person refuses essential support or disengages, especially where there is evidence of impaired executive functioning is highlighted.

• That OSAB requests partner agencies to review their policies for the management of people who they support who present as angry, violent or aggressive in order that practitioners are trained to explore the underlying causes of the person's presentation, whilst embedding clear safeguards to prioritise practitioner safety, that practitioners are supported through structured reflective supervision frameworks to reflect on this challenging area of work and that consistent organisational learning is promoted.

• That OSAB shares the learning from this SAR with those responsible for the Oldham Suicide Prevention Strategy, particularly

→ The need for practitioners to reframe violent and aggressive behaviour as a defensive or protective response to past Adverse Childhood Experiences (ACEs), trauma and feelings of shame.

→ The need for practitioners to respond to indirect indications of suicide risk, especially where individuals have complex needs.

→ The need for practitioners to be supported to confidently approach discussions about suicide risk, which can often be anxiety provoking.

And, that OSAB should be formally consulted on the safeguarding aspects arising from the implementation of Staying Safe from Suicide.

• That OSAB considers the further steps required to build on the programme of work already underway to raise professional awareness of complex safeguarding and exploitation including cuckooing across the range of partner agencies who may become aware of the sometimes quite subtle indications of these categories of abuse.

• That OSAB arranges to bring the absence of any consideration of the psychological impact of the stabbing of Joe to the attention of Manchester University NHS Foundation Trust. (as the hospital trust at which Joe was treated) and Oldham Integrated Care Partnership (GP practices in Oldham) in order that both bodies may reflect on the response to the 2020 stabbing of Joe and advise of any steps they plan to take to disseminate learning and enhance service provision.

SARs Started in 2025-26

The Board began three statutory SARs during 2025-26 which are expected to be completed during 2026-27. Brief overviews are provided below.

Michael

A working age male who experienced multiple physical/medical and mental health crises in the year before he sadly passed away. There was reasonable cause to believe that Michael (a pseudonym) may have experienced abuse or neglect, including acts of omission by services, before his death. These considerations resulted in a SAR being commissioned, particularly with a view to understanding how Michael's co-occurring acute mental and physical health challenges and his wider vulnerabilities were supported and coordinated by services at a system level.

Ruth

A working age female who had a complex range of comorbid physical and mental health conditions, Ruth (a pseudonym) sadly died following an intentional overdose of prescription medication. A SAR was commissioned as it was acknowledged that there were acts of omission by involved agencies and weaknesses in the system around care coordination, medication management and collaborative support of people with complex mental and physical health needs, that contributed towards Ruth's death.

Keith

A SAR was commissioned in relation to an older male who sadly died following a significant period of self-neglect. Keith (a pseudonym) had care and support needs as he had a documented diagnosis of mild cognitive impairment, there was known chronic self-neglect and environmental neglect, and there was reasonable cause for concern about how agencies worked together to assess, escalate and respond to the risks he faced. The SAR is considering Keith's cognitive decline, previous safeguarding involvement, and the development of risk over time.

Listening to Lived Experience

Capturing the voice and experiences of the adult

The Care Act describes how agencies need to work together to help individuals and families live free from abuse, harm, and neglect. The Board recognises that whilst anyone can become a victim of abuse there are some who, due to their situation or the environmental factors around them, are at greater risk of experiencing harm. We are committed to working together to make sure that safeguarding is everyone's business, and to working with local communities to listen to and understand their experiences.

Capturing the voice and experiences of those at the centre of Safeguarding Adult Reviews is vital to help us make effective improvements to front line services and recovery pathways for those who have experienced abuse or neglect. Whilst the feedback from these reviews has helped to shape and inform the strategy and business plans of the Board and in turn, the training and practitioner resources produced throughout 2025-26, the Board recognises that capturing the voices and first-hand experiences of those who have accessed help and support is a key area for development.

Ensuring Experience Deepens Understanding

Strengthening the local support offer and local responses to self-neglect and hoarding and consequently, improving outcomes for adults was an important Board priority in 2025-26.

OSAB Support Tool

Through feedback, local residents and multi-agency practitioners asked for a specific assessment for practitioners to use with people with hoarding behaviours. The OSAB Hoarding Support Tool was developed with extensive input from adults with lived experience to help practitioners build a clearer understanding of how hoarding is affecting an adult's safety, wellbeing, and daily life, and to support consistent, person-centred risk management over time. The importance of respectful language was a crucial consideration and led to the resource being called a 'support tool' instead of an 'assessment' to promote a supportive and proportionate approach.

"My name's James. I'm a member of KeyRing. I've made slow but steady progress. It has taken me time, so the way in which my property is now, although it's not the best example of how things could be, it's a vast improvement. The amount of stuff that I'd gathered over the time, it's unbelievable."

OSAB Gab Podcast Episode

With fantastic support from Board partner agencies Positive Steps and KeyRing, the 'Hoarding Lived Experience' episode of the OSAB Gab Podcast was also released with the aim of raising awareness and shaping better practice. In the episode, we hear directly from Lesley and James, two people from Oldham who generously share their lived experiences of hoarding.

"I'm Lesley, and I'm in the 60s and I am a hoarder. It's not something that I wear as a badge. Some people think it's a badge of shame, but It's very easy to become a hoarder, and very hard to let go of certain possessions. Some people call themselves collectors, I'm definitely a hoarder."

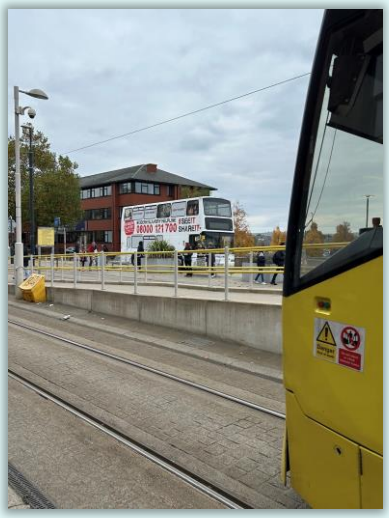
Their personal stories bring the realities of hoarding behaviours to life in a way that only lived experience can, offering insight and a deeper understanding that goes far beyond theory. Representatives from partner agencies reflect on the powerful themes raised by Lesley and James and explore why it is so important to understand a person's life history and circumstances, and how these may connect to their hoarding behaviours. The episode highlights the importance of practical, compassionate approaches such as using the same language the individual uses to describe their belongings and working alongside them at their own pace to build trust, relationships, and long-term progress. The honest, insightful conversations show how lived experience can remind practitioners of the humanity at the heart of hoarding support. The episode can be found via Apple Podcasts, Spotify, and Amazon Music or by searching for 'OSAB Gab' wherever you get your podcasts. Clips of Lesley and James sharing their experiences are now being shared as part of regular multi-agency self-neglect and hoarding training.

Opening Conversations, Raising Awareness, Protecting Communities: The Freedom Bus in Oldham

Anti-Slavery Day provides an important opportunity to highlight the scale of modern slavery both nationally and internationally. Established through the Anti-Slavery Day Act, the day aims to increase public awareness, encourage action and promote greater understanding of the steps everyone can take to help identify and prevent exploitation.

To mark Anti-Slavery Day on 18 October 2025, OSAB worked in partnership with a range of local and regional organisations to bring the Freedom Bus to Oldham. For two hours on a busy Saturday morning, the distinctive double-decker bus was stationed at Oldham Central Tram Stop, providing a high-profile and accessible focal point for awareness-raising activities within the town centre.

Hosted by the Pan-Lancashire Modern Slavery Partnership, the Freedom Bus is specially branded with anti-slavery messaging and the Modern Slavery and Exploitation Helpline number. Its purpose is to encourage conversations about modern slavery and human trafficking, helping communities recognise that exploitation can take place in any area, including within local neighbourhoods and businesses. The bus provided a visible and engaging platform which attracted residents and visitors, creating opportunities to discuss an issue that often remains hidden from public view.

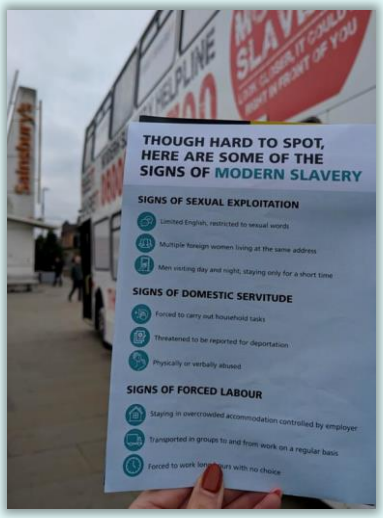


Throughout the event, representatives from OSAB and partner agencies used the bus as a community engagement base, speaking directly with members of the public about the realities of modern slavery and exploitation. Conversations on helping people understand the different forms exploitation can take, including criminal exploitation, labour exploitation and sexual exploitation, as well as the signs and indicators that someone may be experiencing abuse, coercion or control. Particular emphasis was placed on building confidence among local residents to recognise concerns, start conversations, share information appropriately and understand how and where to report concerns safely.

The impact of the Freedom Bus visit extended beyond those who attended in person. Key messages about exploitation and the importance of reporting concerns were amplified through coverage in the local press, helping to reach a much wider audience across Oldham. This additional publicity reinforced the awareness-raising objectives of Anti-Slavery Day.

The Freedom Bus visit was particularly relevant given the prevalence of modern slavery concerns within Greater Manchester. Data from Greater Manchester Police shows that between March 2024 and April 2025, there were 50 enquiries relating to potential modern slavery and human trafficking in Oldham.

The Freedom Bus visit demonstrated the value of partnership working in tackling modern slavery and exploitation. By bringing information and support directly into the community, partners successfully raised awareness of the issue, and encouraged residents to play an active role in safeguarding vulnerable people. The event reinforced the message that recognising the signs of exploitation and reporting concerns can make a significant difference in identifying victims and preventing harm, contributing to Oldham's ongoing commitment to protecting adults, children and communities.



Working in Partnership

The Board's role is to ensure that agencies work together to help adults live safely. To ensure clear direction, a three-year strategic plan is agreed. 2025-26 represented the second year of the 2024-27 Strategy. An annual business plan translates the Board's agreed ambitions into a programme of work shaped by learning from SARs and feedback about experiences of accessing services; the 2025-26 Plan was published early in the year. The timeline below sets out just some of the headline achievements during 2025-26 as partner agencies worked towards achieving their annual plan.

April 2025

A Stronger Safeguarding Response to Homelessness

Recognising the complexities of achieving effective engagement between practitioners and people experiencing homelessness where care and support needs may be present, OSAB worked closely with the Housing Options team from Oldham Council to develop **new practitioner guidance** in April raising awareness of the importance of partnership working in reducing risks and the responsibilities of housing authorities and social housing providers in the context of preventing and relieving homelessness. This was followed by the launch of **new multi-agency training sessions** which continue on a regular basis.

June 2025

Improving Trauma Informed Practice: Resources and Training

Throughout the year, OSAB promoted **Trauma Informed Practice Guidance** and the OSAB Gab Podcast episode '**Practice Informed by Trauma**'. OSAB also offered new multi-agency training opportunities to build practitioner confidence, starting with Trauma Informed Practice training in June, and followed by a session where **Lads Like Us** spoke about their lived experience and linked this to trauma attuned practice and professional curiosity, and the life changing difference they can make. The **Shame Lab** led two well received **Introduction to Shame Competency** sessions. 222 Oldham practitioners attended these four sessions.

August 2025

First Annual Workforce Confidence Survey

OSAB welcomed the encouraging results of the first **workforce confidence survey** in August. Completed by practitioners from every OSAB partner agency, the survey was broad ranging covering, for example, confidence recognising abuse, sharing information, and undertaking mental capacity assessments. The findings were used to shape the work of the partnership throughout the year.

DID YOU KNOW?

OSAB offered **15** multi-agency training courses about different safeguarding topics on a number of occasions in 2025-26. These were attended by **674** practitioners and managers representing **more than 80** different agencies from the statutory and voluntary sectors! See attendee feedback on page 20.

May 2025

Driving Confident Practice in Hoarding and Self-Neglect

During Hoarding Awareness Week in May, OSAB delivered awareness training and launched two linked resources: **Self-Neglect Policy, Procedures and Guidance** and **Responding to Hoarding Guidance** providing definitions, indicators, key practice principles to consider, the procedures to follow, and the statutory responsibilities of key agencies. The **Self-Neglect Toolkit** was also refreshed as a collection of tools, hints and tips designed to support defensible decision making and provide suggestions about what to do in difficult situations. A **new Hoarding 7-Minute Briefing** was released which is designed to act as a gateway to the three main documents.

July 2025

Embedding Risk Management in Oldham: the TRAM Protocol

The **OSAB TRAM Protocol** is designed to help practitioners work with people with multiple needs who are at serious risk of harm or abuse by explaining when and how to escalate risk into a multi-agency setting and how to run shared multi-agency risk management processes. **Multi-agency training** designed to embed the protocol was made available throughout the year. In July, agency management and safeguarding leads attended 'Train the Trainer' sessions to enable them to deliver the training to their teams.

DID YOU KNOW?

As part of a thematic SAR, an event for practitioners and managers from all local partner agencies was held to explore the learning for the Oldham system as a whole by listening to their open and honest reflections on key learning themes.

OSAB developed and rolled out a new **Quality Assurance Framework** to provide assurance that OSAB and its constituent partner agencies have effective systems, processes, and practices in place to improve outcomes and experiences in the context of safeguarding adults at risk.

DID YOU KNOW?

October 2025

Strengthening the Response to Exploitation

To mark Anti-Slavery Day, partner agencies across Greater Manchester coordinated a **programme of events and campaigns** in October. OSAB worked with key partners to arrange for the **Freedom Bus to visit Oldham** (see page 16) and offered an Understanding Modern Slavery and Human Trafficking webinar to practitioners across the region. Following recognition as "the gold standard", OSAB representatives were offered the opportunity to present Oldham's **Exploitation Strategy** including support pathway and the local tools that make it work, at the Greater Manchester Starting with the Survivor: Tackling Modern Slavery and Human Trafficking conference. OSAB received great feedback from attendees.

December 2025

Essential Assurances

OSAB accepted timely assurance in December regarding continuous development of agencies' Learning Disability and Autism services. In 2025-26, assurances were also provided in relation to the delivery of appropriate services and support in respect of homelessness and rough sleeping; local hospital discharges; the development of transitions processes; the local response to measures to manage a national prison capacity crisis; actions taken in response to demand for mental health beds; and agency preparedness for external assessment.

On White Ribbon Day, OSAB, OSCP and Made By Mortals, hosted a well received Learning Hub Event: **Walking on Eggshells – Ending Male Violence Against Women**. Through a collection of audio stories and short films co-produced by community groups, the conference challenged practitioners to walk in the shoes of characters with experience of domestic abuse. An audio story about '**Sadiqa**', a woman from the South Asian community who has experienced So-Called Honour-Based Abuse prompted much discussion.

At the event, OSAB launched new **So-Called Honour-Based Violence and Abuse Procedure and Guidance** and **Forced Marriage Procedure and Guidance** resources; both are titled 'One Chance Rule' as a practitioner may only have One Chance to speak to a potential victim and have One Chance to save a life.

DID YOU KNOW?

September 2025

Embedding Learning from Safeguarding Adult Reviews

At the beginning of 2025-26, OSAB had 28 actions derived from SARs to discharge. The addition of actions from SARs completed during the year in relation to 'John' and 'Joe', took the number of outstanding actions to 50. Exceptional multi-agency effort has seen this number reduce to 27. In September, the Safeguarding Review Subgroup approved multi-agency assurances regarding key areas of practice highlighted by SARs including reporting of cuckooing concerns, awareness of carer stress and burnout, engagement with adults, reasonable adjustment policies, and Mental Capacity Act training.

November 2025

National Safeguarding Adults Week

New Resources Launched

Throughout the week, resources to support practitioners with risk management, responding to self-neglect and hoarding, and understanding executive functioning were promoted, alongside new **Cultural Competence in Safeguarding - Practice Guidance** designed to provide practitioners with a framework of best practice and support which can be deployed when working in circumstances where there are concerns that cultural factors may be influencing patterns of risk.

Learning Opportunities

Practitioners were invited to attend training about the TRAM Protocol, How to Make a Safeguarding Adult Referral, Hoarding, and Homelessness Awareness.

Tri-Borough Mental Capacity Act Learning Hub Event

Following feedback from HM Coroner, OSAB worked with Bury and Rochdale colleagues to host a **second event focused on complexities related to the Mental Capacity Act** experienced by practitioners working with both adults and children including the interfaces between mental health, mental capacity and the Children's Act, and the impact of alcohol and drugs. The event opened with details of the lived experience of three people including 'Robert' who was subject of an Oldham SAR. The keynote presentation and Q&A session with Neil Allen, Senior Lecturer at University of Manchester and Barrister, used the cases to discuss best practice and strengthen the local approach. Attendee feedback was overwhelmingly positive.

OSAB.org.uk, @SafeguardOldham, Safeguarding Bulletin, and Eggshells

During 2025-26, the **OSAB website** was visited more than **22,500** times (an increase of 5,500 compared to the previous year)! The most visited page was 'News and Events' where all new guidance, policies, briefings and learning opportunities are promoted.

During 2025-26, **@SafeguardOldham** reached more than **700** followers on X and there are now more than **1,600** subscribers to the fortnightly **Oldham Safeguarding Bulletin**!

The OSAB short film '**Eggshells**', promoting an understanding of escalating domestic abuse over time, has been viewed more than **1,200,000** times! The film has also received more than **34,000** likes and more than **2,900** comments from people all over the world!

New Communications Strategy

OSAB and OSCP are committed to the effective safeguarding of children, young people and adults who may be unable to protect themselves.

Recognising that in order to fulfil our objectives, we need to raise awareness about how everybody can contribute to the safeguarding agenda, a new **Oldham Safeguarding Communications Strategy** was devised and published with the aim of articulating our plan of action for improving and strengthening communication to and from partner agencies and Oldham residents. This involves active listening to and consulting with participants, volunteers, and staff, and ensuring their views and opinions are taken into account in the planning and delivering of safeguarding support.

January 2026

Driving More Effective Safeguarding Practice

Important changes to the local overarching **Multi-Agency Safeguarding Adults Policy and Procedures** came into effect from January, including an amended outcomes framework for the safeguarding process. The changes were agreed to allow the process to be enacted more efficiently and effectively ensuring workforce capacity for new safeguarding concerns; to place renewed focused on Making Safeguarding Personal; and to enhance local safeguarding data collection and analysis. Additional benefits include improved accountability by evidencing how partners keep people safe more effectively and allowing outcomes to be available to survivors and families earlier.

OSAB are supporting a three-year **Safeguarding Adults For Empowerment (SAFE)** research project to improve safeguarding for older adults. Interviews with Oldham residents who have been subject to a safeguarding enquiry and family member advocates took place throughout 2025-26.

DID YOU KNOW?

February 2026

Endorsement of Partnership Safeguarding

The Care Quality Commission (CQC) assessed how the local authority meet their duties under the Care Act. This included assessment of local safeguarding partnership arrangements which were praised by CQC in the **assessment report** in February, highlighting strong leadership oversight, effective systems and a well-coordinated multi-agency approach to keeping people safe. Partnership working was identified as a key strength, with the local authority commended for working closely with health services, care providers and community organisations to deliver joined up, coordinated support. Oldham was rated as '**Good**'; the score placed us in the top third of all areas assessed!

March 2026

Sharing Key Messages

7-Minute Briefings are based on research which suggests that seven minutes is an ideal time span in which to concentrate and learn. Learning for 7 minutes is manageable in most services and often more memorable as it is necessarily brief and not clouded by other issues and pressures. These short, safeguarding snapshots can be a helpful way to support team learning. Teams are asked to discuss briefings and send a short feedback form to OSAB. OSAB produced ten new seven-minute briefings and grab guides in 2025-26, including a briefing all about **Supporting People who are Deaf, have Hearing Loss or Tinnitus** in March. This was part of a series focused on supporting people with a range of access needs which also included a briefing around **interpretation support and services**. Other briefings covered key topics ranging from **essential learning from SARs** and **defensible decision making**, to **Young Carers Assessments** and **potential risks to consider when working with adults living in Houses in Multiple Occupation (HMOs)**.

DID YOU KNOW?

OSAB and OSCP partners completed a Self-Assessment Audit covering practice during 2024-26. The report concerning the findings was welcomed by OSAB Board. The audit provided a robust and comprehensive evaluation of safeguarding arrangements across Oldham's statutory and voluntary sector agencies and organisations.

The findings demonstrated a strong commitment to safeguarding and promoting the welfare of children, young people, and adults at risk, with high levels of compliance observed across the majority of the audit standards.

Multi-Agency Training and Feedback

Effective safeguarding depends on staff and volunteers across all agencies having a clear understanding of their individual roles and responsibilities. This includes the ability to recognise when an adult at risk may require safeguarding as well as the knowledge and skills to respond effectively. The Board has committed to ensuring that its partner agencies provide training for their staff and volunteers on legislation, policies, procedures, and professional practices that reflect the local safeguarding adult arrangements.

"There should be a culture of continuous learning and improvement across organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice."

- Care Act 2014

The Care Act states that SABs must promote multi-agency training, consider any specialist training that may be required, and consider any scope to jointly commission training. OSAB provides multi-agency training in recognition of the value of working collaboratively and valuing different roles, knowledge, and skills. Throughout 2025-26, the following multi-agency training opportunities were offered:

- Risk Management in Oldham: Team Around the Adult and the TRAM Protocol Training
- Self-Neglect and Hoarding Training
- Hoarding Awareness Training
- Learning Hub Event: Walking on Eggshells – Ending Male Violence Against Women
- Professional Curiosity and Unconscious Bias Training
- Homelessness Awareness Training
- How to Make a Safeguarding Adult Referral Training
- Trauma Informed Practice Training
- Training Opportunity: Lads Like Us – A Million Pieces
- Introduction to Shame Competence Training
- Introduction to Multi Agency Public Protection Arrangements (MAPPA) Training
- Mental Capacity Act Training
- Tri-Borough Mental Capacity Act Learning Event
- All-Age Understanding Exploitation Training
- Understanding Modern Slavery and Human Trafficking Training

A selection of participant feedback from these sessions is provided below:

How to Make a Safeguarding Adult Referral:

"This has helped me clarify and validate rationale for referral. I learnt different pathways/ devices to support adults in need"

Hoarding Awareness Training:

"I will be better at spotting signs of hoarding and also feel more confident at delivering support for people going through this"

Tri-Borough Mental Capacity Learning Event:

"Loved the barrister guest speaker - excellent! I really enjoyed the training, and the relaxed and friendly delivery and atmosphere"

"I found the session very informative and gave a great insight into the challenges faced by services to provide accommodation for service users. It also taught me ways in which to manage expectations of both myself and people I work with"

Homelessness Awareness Training:

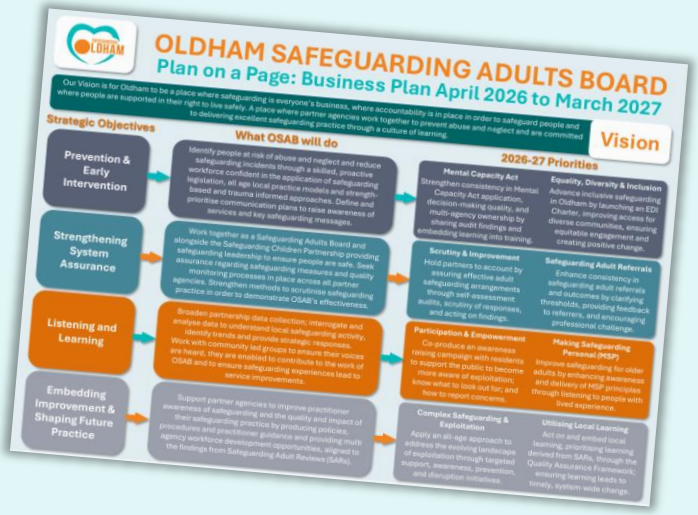
"This has been an amazing experience. The participatory focus was perfect and so engaging. I loved it, the whole thing was my kind of learning. Thank you to everyone who shared their lived experiences. So grateful I got to come"

Walking on Eggshells – Ending Male Violence Against Women:

Plans for 2026-27

2025-26 was the second year of the Board's Three-Year Strategy, which sets out its strategic ambitions for the period April 2024 to March 2027. The strategy identifies the partnership's shared vision and priorities for safeguarding adults in Oldham and provides a clear framework for collaborative working. Significant progress was made during 2025-26 in delivering the Board's objectives. At the Development Event held in April 2026, partners reviewed progress against 2025-26 priorities and considered emerging issues and potential new areas of focus. This discussion informed the development of partner agency plans for 2026-27, aligned to the Board's current Strategic Objectives:

- **Prevention and Early Intervention**
- **Strengthening System Assurance**
- **Listening and Learning**
- **Embedding Improvement and Shaping Future Practice**



These plans were published as the annual OSAB Business 'Plan on a Page' (shown above). Highlights of the key plans for 2026-27 follow.

The Board will:

- Review the findings of a second annual **Workforce Confidence Survey** and compare the results to the previous year to monitor progress in key practice areas, particularly practitioner confidence in applying the Mental Capacity Act.
- Strengthen the consistency and effectiveness of **Mental Capacity Act** practice across partner agencies by sharing audit findings, improving the quality of decision-making, and promoting collective multi-agency ownership. Embed lessons learned into workforce development and training programmes to support practitioners in applying the Mental Capacity Act confidently, lawfully, and consistently across all settings.
- Continue to ensure all actions derived from **Safeguarding Adult Reviews** are effectively discharged in a timely manner to ensure learning is embedded in practice.
- Enhance consistency and quality in **safeguarding adult referrals** and outcomes by promoting a shared understanding of referral thresholds across partner agencies. Strengthen decision-making through timely feedback to referrers, support practitioners to reflect on and improve practice, and foster a culture of constructive professional challenge to ensure safeguarding concerns are identified, escalated, and responded to appropriately.
- Improve public awareness and engagement in safeguarding by gathering feedback from residents and community groups to better understand current levels of awareness, **strengthen communication activity**, and ensure key safeguarding messages reach a wider audience. Use findings to inform future awareness campaigns, enhance community engagement, and support people to recognise concerns and access help when needed.
- Advance **equality, diversity and inclusion** (EDI) across safeguarding practice by implementing an EDI Charter that promotes fairness, accessibility and inclusive approaches across all partner agencies and leads to improved engagement with diverse and underrepresented communities.
- Strengthen accountability across the partnership by undertaking a comprehensive **Self-Assessment Audit** of safeguarding arrangements and practice. Audit findings will be reported to the Board, providing assurance of compliance, identifying areas for improvement, and highlighting effective practice.

Single-Agency Statements

In addition to the Oldham Safeguarding Adults Board's Annual Report setting out information on safeguarding trends locally, the actions of the Board over the last year, and priorities for the coming year, partner agencies are asked to provide highlights of their own safeguarding work in 2025-26 to be published as Single-Agency Statements. The following pages contain the statements from Oldham Safeguarding Adults Board partner agencies.

Action Together

Action Together CIO (Charitable Incorporated Organisation) is the local infrastructure organisation for the voluntary, community, faith and social enterprise (VCFSE) sector in Oldham, Rochdale, and Tameside. We deliver Safeguarding Children and Adults at Risk awareness training to anyone in Oldham who works or volunteers in the VCFSE sector as part of our regular training programme. We connect people with what's happening in their community, develop community ideas into action, strengthen local organisations, and provide strategic influence for the charity and voluntary sector. Action Together also leads a partnership of charities that deliver the Oldham Social Prescribing Service, and hosts Healthwatch Oldham (HWO), the role of HWO is to gather the views of local people to help shape the way services are provided, understand what is important to service users, and hold services to account.

Safeguarding in 2025-26

The main emerging safeguarding themes have been around self-neglect and suicide concerns.

Safeguarding Achievements

Improving our Training Offer: Over the past twelve months, 190 people have completed the Level 1 Adult Safeguarding training. Strengthening the adult safeguarding workforce development offer for the VCFSE sector was a key priority for 2025-26, therefore training was reviewed in February 2026. The training had previously been delivered online, but participation in group discussions was limited and trainers were not always able to offer one-to-one support when needed. In response, the programmes were adapted so they could be delivered face to face on a monthly basis. This approach is more closely aligned with safeguarding training best practice and has improved the quality of delivery. Group discussion is now more detailed and interactive. Participants have more opportunities to ask questions and clarify information. Feedback indicates stronger engagement and improved knowledge among participants.

Complexity of Need Within Volunteering Pathways: Over the past twelve months, we have identified an increased complexity of needs of volunteers within our volunteering pathways. With individuals often presenting with multiple vulnerabilities (e.g., isolation, trauma, and financial hardship). Through Trailblazer and Refugee Welcome investment in trusted community organisations with expertise in delivery of trauma-informed and holistic approaches for vulnerable cohorts, we have been able to embed support within our volunteering pathway that meets the needs of these cohorts, e.g., economically inactive and sanctuary seekers. This is an important safeguarding achievement for Action Together because the focus is on engaging vulnerable individuals with wrap-around support whilst also developing their skills, experience and confidence within a volunteering capacity.

Services Stretched Across System: Action Together's Social Prescribing service has seen an increase in the complexity of cases referred to the team. Despite stretched resources and a changing system landscape, the team have achieved a flexible, responsive service that meets a wide range of needs. This has been possible because the service offers several pathways, including support for older people, employment support through Trailblazer and WorkWell, and support for young people and families. The Social Prescribing model

allows for cases to be kept open for as long as needed, allowing Link Workers to work at the client's pace and provide support while people are waiting for other services, significantly reducing the risk of safeguarding concerns going unrecognised. This helps fill gaps in provision and ensures support is available when it might otherwise be limited. The Social Prescribing model also includes a strong triage process, so Link Workers receive relevant background information and levels of engagement when a case is allocated. This supports quick escalation to the Adult Referral Contact Centre (ARCC) where needed and timely referrals to other services, such as foodbanks or welfare rights.

Lived Experience Advisors: The Lived Experience Advisors are a diverse group of Oldham residents with personal experience of poverty, systemic trauma and social injustice. They use their insight and skills to help drive positive change and improve systems. We consider this network a safeguarding achievement for Action Together in 2025-26 because advisors have been supported to develop in their roles while safeguarding best practice has been maintained. A lived experience coach has worked closely with the group, providing one-to-one pastoral support and signposting to relevant services to ensure wrap-around support where complex needs or multiple disadvantages are identified. Action Together and Tameside Oldham Glossop Stockport Mind have also agreed a clear pathway for identifying and escalating safeguarding concerns, improving the timeliness, transparency and accountability of safeguarding responses. A flexible approach to the role has also been adopted to meet advisors' needs, including open conversations about payments or vouchers where substance misuse is a factor, and the option to step away from the role and re-engage when appropriate.

Safeguarding Priorities in 2026-27

Improved partnership working through the development of Live Well: Our key safeguarding priority is to utilise our involvement in and the development of Live Well to improve multi-agency working

Managing growing case complexity and number of referrals against resources available: Within our Social Prescribing team, we want to focus on mitigating the stretched capacity of service through place-based integration (e.g., Link Worker in ARCC), and effective escalation through integrated working within our volunteering pathway, we aim to introduce a structured case review model to reflect the needs of our growing caseload complexity to support early identification and management of safeguarding concerns.

Identification of learning and training opportunities for VCSE delivery partners: i.e. De-Escalation training for Refugee Welcome partners. As a membership organisation, it is our role to support VCFSE groups, which extends to safeguarding. As mentioned, we deliver our own level 1 safeguarding training, but a priority for 2026-27 is to advance the work we are already doing to identify appropriate training for our members.

Key Challenges and Opportunities

Challenges:

- Case complexity and number of referrals
- Timely access to support
- Where we have concerns for welfare, but the person does not have care and support needs – much focus on social prescribing

Opportunities:

- Increased integrated neighbourhood working through Live Well
- Increasing the capacity of the VCFSE sector to deliver community-led approaches to support health and wellbeing, which enables a prevention ecosystem to increase its ability to proactively support residents at an early point.

Adult Social Care, Oldham Council

Adult Social Care (ASC) is an Oldham Council service which supports Oldham residents to be independent, healthy, safe and well. ASC facilitate this by working in a person centred and strengths-based way to enable residents to:

- Identify where prevention and self-help opportunities can assist residents to stay independent, healthy, safe and well.
- Support residents to access information and advice and work to ensure residents can find out about local support and other services to help people to look after themselves in local communities and make informed choices about care and support.
- Support residents to recover and be enabled to be as independent as they can with the help of friends, family, and the community.

ASC also:

- Work with residents who need care and support to have an assessment and receive services that support them to live as independently as possible.
- Support residents who need care and support to protect themselves from the risk or experience of abuse to safety plan when they are unable to do so independently due to care and support needs.
- Support carers for people with care and support needs to have an assessment of their own needs as a carer and to receive advice, guidance and support which helps them to stay healthy, safe and well.
- Assess residents who need statutory assessment under the Mental Health Act 1983.
- Assess residents who lack capacity to make decisions regarding accommodation, care and treatment and may deprived of their liberty in a hospital or care home settings to determine if deprivation of liberty safeguards are required.

ASC work in partnership with people with care and support needs, other council services, the local community, carers, social care provider organisations and safeguarding partnership organisations, to prevent and delay the appearance of care and support needs, promote wellbeing and safety, promote human rights, and ensure that people with care and support needs can live safely free from the risk or experience of abuse.

Our statutory duties derive form the Care Act 2014, the Mental Capacity Act 2005, the Mental Health Act 1983, and the Human rights Act 1998.

Safeguarding in 2025-26

Prevention and protection: During 2025-26, ASC received a total of 1688 new safeguarding concerns. This represented and 8.3% increase on the previous year when we received 1559 safeguarding concerns. Of the safeguarding concerns received this year, 438 had an outcome of safeguarding enquiry. Of these 361 (82.4%) were section 42 enquiries with the remaining 77 (17.6%) being none statutory enquiries. This year the concern to enquiry conversion rate was 25.9%, an increase on the 17.6% rate in 2024-25.

360 safeguarding enquiries were completed, with 92.6% achieving outcomes of risk reduced or removed (up from 89.3%) in 2024-25.

The increase in safeguarding demand seen in 2025-26 is attributed to the ongoing safeguarding partnerships strategy to raise awareness of safeguarding pathways. A positive increase in the conversion rate from safeguarding concern to section 42 enquiries has also occurred, meaning that partners are now referring more effectively for statutory Care Act safeguarding responses, and ASC are effectively recognising and responding when the section 42 duty is met.

ASC continued to work extensively in the preventative safeguarding space to respond to risk and vulnerability through both safeguarding concern responses, non-statutory safeguarding responses, Changing Futures, Making Every Adult Matters, and Oldham's local multi-agency risk management framework (TRAM Protocol).

ASC has also continued to supported professionals to understand which safeguarding pathway is most suitable to protect the individuals who are experiencing or at risk of abuse, by assisting with the delivery of multi-agency training on Making a Care Act section 42 referral throughout 2025-26.

Transitional safeguarding: Transitional safeguarding has emerged as a local theme both operationally and strategically in 2025-26. This trend is also reflected nationally and has been highlighted as an

area requiring national policy development in the Casey Review. Locally, ASC have identified that this trend is linked to the complex and contextual exploitation concerns for young people which have been highlighted in our previous single-agency statements.

ASC's operational response models to transitional safeguarding concerns have developed in 2025-26, with an understanding of how both preventative responses, which focus on vulnerability, and statutory wellbeing and safeguarding responses, which focus on Care Act eligible individuals, play a role in responding to transitional safeguarding concerns. Our response models at all levels are rooted in relational and least restrictive practice principles and delivered via the Making Every Adult Matters and Changing Futures approach, alongside the ongoing development of a local Easement Framework for individuals supported via statutory interventions.

Strategically, ASC actively engaged with the Greater Manchester (GM) Complex Safeguarding Hubs Transitional Safeguarding Community of Practice throughout 2025-26 and contributed to the development of GM Transitional Safeguarding principles. We have focused on creating enabling environments which support us to work jointly and creatively and pilot new ways of aligned working with young people at risk of abuse. We have also begun to consider how well the GM transitional safeguarding principles are embedded in our services and how we will implement and embed these further.

As part of our continuous improvement approach, Children's Social Care and ASC also jointly commissioned a thematic review relating to five young people and local responses to transitional safeguarding risks. The review is now complete and learning and recommendations will be taken forward via the Strategic Transitions Board in 2026-27 to ensure a continuous improvement approach to transition safeguarding.

Safeguarding Achievements

Care Quality Commission inspection outcome: ASC were inspected by the Care Quality Commission in October 2025. We received an overall rating of good, and a specific rating of good regarding our operational and strategic safeguarding work. The CQC report highlighted the following as strengths within ASC safeguarding services:

- Use of structured safeguarding procedures.
- A staff development focus.
- Making Safeguarding Personal (MSP).
- Effective partner collaboration.
- Identification and coordinated responses to specific safeguarding risks including exploitation, modern slavery, cuckooing, self-neglect, and hoarding.
- Use of risk management tools.
- Addressing system challenges.
- Continuous learning and early Intervention.

ASC are extremely proud of this achievement and the dedication of our workforce to supporting adults to live safely, free from abuse and neglect.

Safeguarding strategy and training: A dedicated communications strategy and training plan was implemented within ASC in 2025-26 to prepare the workforce for significant updates to the OSAB Multi-Agency Safeguarding Adults Policy and Procedures. The communications strategy and training plan engaged operational staff and leaders in preparing for and understanding the significant procedural changes, how these would benefit adults at risk, and how changes made to safeguarding documentation would support more effective safeguarding practice and assist in achieving better outcomes for adults at risk of or experiencing abuse. The new procedures and new safeguarding forms went live in January 2026. Early evidence shows that they are impacting positively on practice.

Safeguarding supervision: Dedicated group safeguarding supervision for Safeguarding Adults Managers was introduced in 2025-26. Focusing on systems and practice learning from SARs and learning and improvement sources. The supervision provides:

- A dedicated and protected space to share safeguarding knowledge and learning.
- A safe space for peer reflection and learning.
- A mechanism to agree how practice improvement and systems improvement actions will be delivered operationally.

and supports effective delegated leadership of safeguarding strategy.

Safeguarding Priorities in 2026-27

Meeting our statutory duties effectively: We will meet the statutory duties of ASC by delivering the Deprivation of Liberty Safeguards function, Mental Capacity Act Deputyship function, Allegation Management duty, and Care Act Section 42 and section 44 duties.

We will maintain a stable service via relational leadership and the consistent application of corporate and directorate policy including induction; supervision; appraisals; team, service and business planning meetings; provision of workforce development opportunities; prioritising staff wellbeing; effectively managing absence and performance; and undertaking timely recruitment.

Prevention and Early Intervention:
Enhancing our approach to the Mental Capacity Act (MCA) - We will create and deliver an MCA strategy which will include achieving full ASC MCA training compliance by March 2027; delivery of an updated MCA mosaic workflow to support high quality practice and provide reportable data; and the development of MCA practice guidance following the Supreme Court judgment (Attorney General for Northern Ireland (AGNI), which reshapes the legal framework for deprivation of liberty.

Ensuring safety:
Enhanced data and a data informed approach - We will develop an enhanced safeguarding data dashboard with key local safeguarding data including ASC, provider and partnership performance markers, capture trends and effectively inform where future strategy is targeted and deployed.

Safeguarding quality assurance - We will develop and launch thematic safeguarding audits to complement the existing ASC audit cycle and continuously utilise the findings to create targeted strategy to ensure high quality practice and policy compliance.

Listening and Learning:
CQC inspection response - We will work to ensure that our CQC inspection feedback and the CQC quality standards are embedded in our systems and practice.

We will proactively scan for and engage with national, regional and local agenda influencing adult safeguarding. This will include the Casey review, National Care Service, National Safeguarding Chairs agenda, North West Association of Directors of Adult Social Services (ADASS), GM, Live Well, National review into historic CSE, SAR learning, Domestic Homicide Review learning, and listening to the voice of lived experience.

Embedding Improvement and shaping future practice:
ASC will embed identified systemic SAR learning into strategic and operational plans and review and update our safeguarding practice guidance.

Transformation and sustainability:
We will review the ASC safeguarding operating model, safeguarding pathways within ASC and the Strategic Safeguarding Service in 2026-27 to ensure that we are able to continue to deliver safeguarding duties effectively.

Challenges and Opportunities

Financial sustainability: Oldham Council continues to operate in a challenging financial climate where the rising costs of care provision and sustained high demand for ASC result in highly challenging operating conditions. Financial sustainability is the highest-rated risk for Directors of ASC nationally. Directors report significant concerns regarding:

- Increasing complexity of need among working-age adults.
- High-cost transitions from children's services into adult services.
- Increasing complexity of need among older people.
- NHS funding pressures and reduced financial contributions.

Implications include significant risks of overspends, the introduction of emergency savings programmes, and a reduced ability to invest in prevention and early intervention.

Legal Duties and Care Act Compliance Risk:
Nationally there is growing concern about Councils' abilities to meet their statutory obligations with specific concerns from Directors of ASC regarding prevention, wellbeing and safeguarding duties emerging.

A strategic approach to continuous transformation is taken locally to support our workforce to continue to meet our statutory safeguarding duties. Taking the opportunity to transform collectively as a system and assessing agencies financial and strategic decision-making impact at systems level is now required to support all partners to continue to deliver effectively and mitigate against safeguarding failures locally.

Workforce capacity: Workforce capacity remains a key challenge for ASC. A dedicated workforce strategy continues to evolve and respond to national and local workforce challenges and ensure that we have the right workforce in place to deliver high quality safeguarding prevention and protection to our residents.

Doctor Kershaw's Hospice

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

Safeguarding in 2025-26

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

Safeguarding Achievements

The Hospice dealt with three Adult Safeguarding concerns in 2025-26. All three were completely different.

A patient attempted self-harm by placing a nurse call bell cord around their neck. The patient did not know why they had done it and did not disclose any thoughts or intentions of self-harm. The call bell cord was removed and replaced with a pendant call bell and a two-hourly comfort log was recorded for observation. No further concerns were expressed or noted or expressed.

Police attended the Hospice searching for an individual they believed to be visiting his dad. The individual was under a psychiatric section and was an individual of concern. A photograph identified that the individual had not visited the Hospice.

Staff found an individual standing outside the Hospice gate confused. After speaking with them, staff realised he lived across the road from the Hospice. Staff escorted him home and the individual's partner informed staff that the individual had Dementia, that they was struggling with them and that the individual had put their hands round their throat earlier that evening. With consent, staff contacted a family member of the individual to informed them. The individual's partner declined any further support from our team, and also declined police contact that evening but agreed to contact the next day. Hospice staff felt they were safe and able to make this decision, and the individual was calm and cooperative. Staff advised the individual's partner to contact 101 or 999 if there were any further episodes of concern or violence and they contacted police on their behalf to explain the situation. The police agreed to visit the following day and stated they would refer to the Multi-Agency Safeguarding Hub.

Safeguarding Priorities in 2026-27

Priorities:

- To be a proactive member in locality safeguarding groups.
- To be active participant in Greater Manchester Hospices Safeguarding forum.
- To continuously develop safeguarding training, optimise staff awareness and empower them to know how to respond to any safeguarding concerns.
- To update our current Safeguarding Adults and Children Policies with Persons in a Position of Trust (PiPoT) guidance.
- To embed Making Safeguarding Personal (MSP) in our safeguarding policy, procedures and practice.
- To monitor whistleblowing data to improve safeguarding.
- To develop secure, timely, and effective systems for sharing safeguarding information across partners, including for children, young people, and adults, in line with 'Think Family' principles and multi-agency working expectations.
- To promote alignment with children's safeguarding services, especially during transitions.
- To gather feedback from adults with lived experience and use this to improve safeguarding practices and service delivery.
- To provide information about services and safeguarding adults in accessible formats and different languages.

Challenges and Opportunities

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

First Choice Homes Oldham

First Choice Homes Oldham (FCHO) is a social housing provider managing homes and delivering customer, neighbourhood and community services across Oldham. The organisation also develops new homes and maintains its existing housing stock to ensure safe, good-quality homes for customers. As a landlord with daily contact with customers, we play a key role in identifying vulnerability, managing risk and working with partners to safeguard adults at risk.

Safeguarding in 2025-26

During 2025-26 we saw:

- A significant increase in safeguarding activity, with 315 alerts raised (up from 125 in 2024-25), reflecting both increased community vulnerability and a stronger internal safeguarding culture.
- A continued prevalence of domestic abuse as the most common safeguarding concern, alongside mental health, self-neglect, non-engagement and exploitation linked to criminality.
- An increasing complexity of cases.
- A greater need for persistent engagement approaches where customers are reluctant or unable to engage.

Safeguarding Achievements

- A strengthened safeguarding culture, with improved staff confidence leading to earlier identification and appropriate reporting of concerns.
- The introduction of Domestic Abuse Champions, improving frontline response, Multi-Agency Risk Assessment Conference (MARAC) engagement and risk management.
- 99.5% safeguarding training compliance, providing strong assurance on workforce capability.
- Embedded robust governance arrangements, including monthly safeguarding audits, capped caseloads for Designated Safeguarding Officers (DSOs), and cross-service safeguarding forums.
- Active participation in multi-agency safeguarding, including involvement in 125 cases with partner agencies and contribution to five SARs.
- Ongoing development of trauma-informed approaches, particularly in relation to domestic abuse, mental health and non-engagement.
- Introduction of a multi-disciplinary Complex Case Panel, providing structured oversight of high-risk and high-complexity cases, strengthening joint decision-making, improving coordinated responses and supporting sustained engagement with customers who are harder to reach.

Safeguarding Priorities in 2026-27

- Further embed trauma-informed and person-centred practice across all services.
- Strengthen engagement approaches for customers who are harder to reach or who present as non-engaging.
- Enhance information sharing and system alerts to improve risk visibility and coordination.
- Continue development of workforce capability, including targeted training informed by SAR learning.
- Undertake a review of the Customer and Communities directorate, including how services are structured and delivered to ensure we are effectively supporting and safeguarding customers in the context of significantly increased demand.
- Host FCHO's first annual safeguarding conference, open to all colleagues, providing specialist input, opportunities for shared learning and reflection, and celebrating good practice across the organisation.
- Maintain strong partnership working to respond to increasing complexity and system pressures.

Challenges and Opportunities

- Increasing complexity of safeguarding cases, often involving multiple and overlapping needs such as domestic abuse, mental health, self-neglect and non-engagement; this will be managed through continued multi-agency working, trauma-informed practice, training and strengthened professional curiosity.
- Significant growth in safeguarding demand, with higher numbers of alerts placing pressure on services; this will be managed through effective triage, clear thresholds, strong governance and prioritisation of high-risk cases and enhanced with our wider review.
- Maintaining strong safeguarding performance during a period of organisational change, including the review of the Customer and Communities directorate; this will be supported through clear leadership, robust oversight (including audits, regular leadership, committee and Board reporting and forums), and continued

investment in workforce capability.
- Impact on staff managing complex and often traumatic cases, recognising the emotional demands of safeguarding work; FCHO will continue to support staff wellbeing through access to counselling services and is exploring additional support for managers, including training in reflective debriefing to support teams effectively following challenging incidents.
- Balancing customer engagement with enforcement and practitioner safety, particularly where customers present as non-engaging or resistant; this will be addressed through persistent, coordinated and trauma-informed approaches.

Greater Manchester Fire and Rescue Service

Greater Manchester Fire and Rescue Service (GMFRS) is an emergency response service working to the following strategic priorities:

- Prevent emergencies, protecting people and places
- Deliver an outstanding emergency response
- To look after people and foster a culture of equality, inclusivity and excellent leadership
- To maximise public value through continuous improvement and sustainable use of resources.

Safeguarding in 2025-26

Adult safeguarding activity within GMFRS has continued to be characterised by consistently high levels of demand, underpinned by complex and multi-layered vulnerability among adults at risk. The predominant themes emerging reflect a strong prevalence of self-neglect and neglect, often presenting alongside hoarding and unsafe living environments, which continue to create significant fire risk within homes. These risks are frequently compounded by mental health needs, substance misuse, and a range of wider care and support needs, including mobility issues, physical disability and long-term health conditions. The safeguarding profile is therefore increasingly defined by individuals experiencing cumulative disadvantage, rather than isolated incidents, requiring a sustained, multi-agency response. This pattern reinforces the importance of early identification, information sharing, and partnership intervention, particularly in supporting older adults and those living alone, to reduce risk, improve living conditions and enhance overall wellbeing outcomes.

Safeguarding Achievements

We have made significant progress in strengthening safeguarding arrangements, underpinned by the development of a robust quality assurance framework and enhanced governance processes. This includes the introduction of dedicated safeguarding oversight functions, improved data reporting and compliance measures, and the implementation of corporate Key Performance Indicators (KPIs) to drive consistency and accountability. Workforce development has remained a key priority, with continued investment in safeguarding training and competency frameworks contributing to improved frontline confidence and increased identification of vulnerability. We have also strengthened our role within multi-agency partnerships, actively contributing to safeguarding boards, thematic groups and joint learning activity, particularly in relation to complex issues such as self-neglect and hoarding. Improvements to referral pathways, recording systems and information governance have supported more effective decision making and partnership working. In addition, learning from SARs and internal audits has been embedded through revised guidance, training and feedback mechanisms, reflecting a strong organisational commitment to continuous improvement. Collectively, these developments have enhanced our ability to identify, respond to and support adults at risk across Greater Manchester.

Safeguarding Priorities in 2026-27

We will prioritise strengthening safeguarding practice through a continued focus on quality assurance, workforce capability and partnership working. Key activity will include embedding robust audit and oversight arrangements to ensure safeguarding concerns are consistently recorded, reviewed and improved, alongside further development of safeguarding data systems to enhance performance monitoring and evidence-based decision making. Workforce development will remain a priority, with targeted training and awareness activity to build staff confidence in identifying and responding to complex vulnerability, supported by a strengthened competency framework and professional curiosity in practice. We will also continue to embed learning from SARs and thematic audits, ensuring this informs service delivery through updated guidance and practice. In partnership with OSAB and system partners, the

Service will focus on improving multi-agency working, strengthening referral pathways, and supporting earlier identification of risk through a preventative, person-centred approach.

Challenges and Opportunities

GMFRS recognises several key challenges, including increasing complexity of adult safeguarding need, variability in referral pathways, and the need to further strengthen data quality and workforce confidence. In response, we will focus on enhancing quality assurance arrangements, improving safeguarding data and performance oversight, and delivering targeted workforce development to support early identification and appropriate escalation of risk. We will also continue to embed learning from SARs and audits into operational practice. Alongside these challenges, there are clear opportunities to further develop a prevention-led approach, strengthen multi-agency partnership working, and utilise improved data and insight to better target risk. Collectively, this will support us to enhance our safeguarding contribution and improve outcomes for adults at risk across Greater Manchester.

Greater Manchester Police, Oldham

Oldham Police District is part of Greater Manchester Police and is responsible for delivering local policing services across Oldham. Our core functions include preventing and investigating crime, protecting vulnerable people, maintaining public order, and working in partnership with local agencies to keep communities safe. We are committed to safeguarding as a central part of our duty to protect life and uphold the law.

Safeguarding in 2025-26

We have continued to see a rise in crime involving adult victims with complex needs. Domestic abuse is one of our volume crimes, which continues to present challenges both in terms of victim support and management of offenders. We have also seen a rise in complex crimes such as cuckooing, criminal exploitation, and county lines; crime types that mainly affect those who are vulnerable. Despite the introduction of Right Care, Right Person, we continue to see demand linked to mental health-related incidents and welfare concerns. Work is ongoing to reduce time spent waiting in hospitals. Oldham is not immune to the risks relating to online-enabled fraud and scams targeting elderly residents.

Safeguarding Achievements

We have continued to work on and improve our response to safeguarding adults. We have now embedded specialist Domestic Abuse (DA) teams in the district that are seeing positive outcomes for victims of around 33%. A Multi-Agency Tasking and Coordination (MATAC) Officer is now in place, who will help us to manage and disrupt serial and high harm perpetrators of domestic abuse. We went live with Domestic Abuse Protection Notices (DAPNs) , these will afford us with more powers to protect victims at risk of domestic abuse. We have continued to strive to achieve improved outcomes for DA victims throughout and have seen year on year improvements.

Safeguarding Priorities in 2026-27

Our focus will be on implementing and embedding a problem-solving approach to manage top offending perpetrators of crimes against vulnerable victims. With a recent change in the criteria, we aim to continue to support young adults transitioning into adulthood who are part of our complex cohort. We will continue to deliver and embed learning from SARs, through our own training and the 7-minute briefings provided by OSAB. We intend to improve our multi-agency approach around contextual safeguarding themes including modern day slavery, trafficking and cuckooing.

Challenges and Opportunities

A review of our KPIs has resulted in the introduction of Violence Against Women and Girls (VAWG) outcomes as a metric and a new stretch target for DA offences. These targets will be challenging to achieve but will be used to drive performance. The introduction of Domestic Abuse Protection Orders (DAPOs), with increased protection time for victims is resulting in a cohort of victims and offenders that are increasing exponentially. We are responsible for policing these orders and the rise in volume will become increasingly difficult to manage. The force is introducing a new risk assessment process which we hope will assist in managing the policing of these orders. Rape teams are being introduced force wide in 2026-27. It is unclear yet as to how these will be implemented and staffed and what impact they will have on both our rape investigations and other areas of business.

KeyRing Living Support Network

KeyRing is a national charity providing social care support across England. We work with anyone that needs support to live independently. Our support is adapted to the local area we work in, but every service is based around the key question "what do you want from life?".

Safeguarding in 2025-26

Following a review of our safeguarding form, policies, procedures and protocol, we said that we would focus on getting our safeguarding form right – ready for our new members system. This was completed. Our Safeguarding Reference Group (SRG) systematically went through the existing safeguarding form and looked at this alongside our safeguarding policy and procedure to ensure it was still meeting our needs.

We also said we would improve recording the desired outcomes for members and following up whether these have been achieved. The SRG, which is made up of frontline managers and support workers, received a presentation about making safeguarding personal where we looked at what we would expect to see in this section on our safeguarding form.

Guidance packs have been created for frontline support staff that can be accessed directly from our new member system. These follow a member's journey through KeyRing and detail best practice. They include useful and practical guidance for frontline workers and form part of the induction process. They were created alongside frontline workers, support coordinators, area managers and members of the leadership team from across the country. The guides were also created with members whose voice and feedback were taken from workshops throughout 2025. They reference best practice quality tools alongside national best practice initiatives such as Gloriously Ordinary Language and Making It Real. The packs contain top tips and links to additional reading and resources to support the work teams are doing with members.

We have worked with teams to improve the recording of what's been learnt from any concerns raised, and any gaps in our knowledge that require additional training and discussion.

We have developed checks to ensure we can provide assurance that what is discussed at SRGs is disseminated to local teams. We have also improved representation on the SRGs from all areas including Oldham.

We have supported members to build resilience around staying safe through individual and group work at hubs, particularly in the areas where most abuse occurred last year. These areas were financial abuse, self-harm and welfare concerns.

Safeguarding Achievements

Nationally:

- We undertook a listening exercise to get our safeguarding form ready for KeySupport (our new members system). This was a big task throughout the year.
- We have been out to teams, helping them to see the importance of good safeguarding practice. Recognising the importance of good accurate recording and reporting.
- We supported Oldham staff and other teams nationally to undertake decompression and resilience training sessions.
- We completed and used the annual OSAB audit and assurance documents to give an overview of KeyRing Safeguarding activity to the wider organisation highlighting our work with OSAB.
- We reviewed our annual safeguarding statistics, especially our learning and reflections for 2024 and 2025.
- We held self neglect and hoarding support discussions including making resources available nationally to teams across the country demonstrating good practice.
- We created bitesize safeguarding sessions for all teams on:
  - Digital safeguarding
  - Engagement & strengths-based approaches
  - Learning from Oldham SARs
  - Members as perpetrators - the role of probation
  - Professional curiosity
  - Safeguarding overview in KeyRing and the role of the safeguarding lead
  - Self-neglect & hoarding
  - The role of the OSAB (case study from Oldham)
- We reviewed 2024-25 national and regional safeguarding statistics and undertook an analysis of the learning, reflections and outcomes sections.

- We joined the Better Advice For All (BAFA) Network, a project run by UNLOCK which aims to improve the quality and accessibility of information, advice and support given to people with a criminal record who also face additional barriers. They offer training and capacity building; resource provision; ongoing support and collaboration; and referral pathways for complex cases.
- As part of national safeguarding week 2025 we ran a 'Prevention - Act before abuse' session with staff across the country and shared resources.
- We reviewed the role of the SRG and Safeguarding Lead asking for feedback on improvements and topics to cover.

Locally in Oldham:

- KeyRing have continued to be involved in many Team Around the Adult meetings over the twelve months.
- We have participated in SARs and completed all requests for documentation.
- We have implemented learning including ensuring more experienced staff support more complex people.
- We have attended several learning sessions via OSAB.
- We go through the 7-Minute Briefings at team meetings that are produced by OSAB; these are really well received and generate discussion and improve practice and learning.
- We have regular group and one-to-one supervision with the team.

Safeguarding Priorities in 2026-27

- *Safeguarding supervision:* Specific work to be completed with each team looking at learning from logs completed. This will be based on audits undertaken following alerts, looking at recording, reporting, and quality of information.
- *Making safeguarding personal (MSP):* Dedicated focus on looking at the outcomes of alerts for members and how members can feel more in control. There will be sessions with members using the MSP mandatory annual bitesize session accompanied by easy read guidance in our member handbook.
- *Consent:* Dedicated focus on consent in relation to safeguarding and the raising of concerns in relation to relationships, sexuality, choice and control.

Challenges and Opportunities

Key learning is particularly around staff raising concerns accurately and fully which is our biggest challenge. For example, most logs in 2025 stated 'no specific learning'. This reinforces a need for better reflective practice, risk recognition, multi-agency cooperation, and professional curiosity. Comments in logs also highlight gaps in follow up, unresolved risks, communication issues, and member disengagement. Again, the quality of alerts is a challenge that managers are continually addressing. Some examples of where recording could improve include where there are:

- only brief descriptions of alerts.
- a lack of professional curiosity. For example, a member's keyworker visited three times in twelve days and there was no answer at the member's door. There was also no answer from neighbouring flats in the building. The member had no working phone. There were known issues around spending and possible financial abuse. Nothing was raised about this initially other than in file notes. One log simply said, "member told me in a text that he is still very upset because of recent death of his mother and has been self-harming for last five days".

Getting the right training for staff is a challenge and we have identified some training needs for staff. Many safeguarding alerts will state, "staff require support around capacity, managing allegations, financial abuse signs, and emotional distress". This signifies specific training needs however, there are few actions added to the log to show how these needs have been met.

Mind (Tameside, Oldham, Glossop & Stockport)

Tameside, Oldham, Glossop and Stockport Mind (TOGS Mind) are a registered charity that provides a range of mental health and wellbeing services. The services we offer are available for children age 8 plus, young people, and adults of all ages. Interventions include crisis support, counselling, guided self-help, coaching, group-work, peer support and others. In Oldham, we work in partnership with other VCFSE organisations, the Local Authority and Pennine Care NHS Foundation Trust with numerous services.

Our Vision:
Enabling everyone in our communities to achieve better mental health

Our Mission:
To continue to provide the best quality local mental health services in prevention, early intervention and primary care; alongside empowering individuals and our communities to live well.

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

We are commissioned through different funding steams such as (but not limited to) Greater Manchester Integrated Care Board (GM ICB), Local Authority funding and grant funding. We also fundraise as an organisation to continue to be able to meet the needs of our community.

Safeguarding in 2025-26

For our adult services in 2025-26, 67% of adult related internal safeguarding reports were related to adults experiencing suicidal ideation/planning and 40% of incidents included self-harming behaviours. In 2025-26, our Listening Space expansion became fully operational, which is a service commissioned by the ICB to be a Crisis Alternative to A&E, so we expected and planned for suicidal ideation and planning, and self-harming to be a safeguarding theme within our organisation.

Through some of our other services such as Neighbourhood Mental Health Service (formerly Living Well), our MASH Link Worker Service working alongside ARCC, and our Guided Self-Help services with Turning Point and Probation, we have seen a rise in the need to coordinate and attend Team Around the Adult (TAA) meetings and Multidisciplinary Team meetings (MDTs) to support the best outcomes for our service users. With this, we have placed emphasis on our frontline workers attending the OSAB training around the TRAM Protocol and are currently working towards a train the trainer model to be able to deliver this training frequently to our workforce.

Safeguarding Achievements

- Safer Recruitment changes were launched in July 2025 and have been embedded into management team practice. Practices have now also been applied to our volunteer recruitment process. A guidance document has been created and amendments made to recruitment onboarding documentation to provide additional structure for managers completing and evidencing practice compliance.
- Internal training leads were established in the following areas:
  - Safeguarding Level 2 and Level 3 training.
  - Risk and Safety Planning Training - new version established in line with National Institute for Health and Care Excellence (NICE) guidelines regarding moving away from hierarchal risk stratification.
  - Clinical group supervision - renewed framework and peer supervision facilitation training has been established.
  - Trauma informed practice.
- Patient Safety Incident Response Framework (PSIRF) Policy developed and approved. Adults Director is leading a working group to revise the approach to risk/ safeguarding recording in line with NHS incident data reporting.
- Representation on further safeguarding meetings, such as the Adults

Complex and High Risk Panel (CaHRP) meetings, Pennine Care Suicide Prevention meetings, Oldham Suicide Prevention Board, OSAB Safeguarding Review, Audit and Quality Assurance Subgroup meetings, and OSAB Policy, Procedure and Workforce Development Subgroup meetings.

- As of March 2026, we now have four service managers who have joined the internal Safeguarding Steering Group. This is to support professional development, to incorporate operational experiences and to improve communication flow through the organisation.

Safeguarding Priorities in 2026-27

- Adult Safeguarding Policy to be reviewed, updated and approved.
- Patient Safety Incident Response Policy to be renewed.
- Recommendation put forward to consider approach to intruders following synagogue attack in Manchester.
- Reestablishing Task and Finish Group to redefine our approach and classification of what a risk/safeguarding 'incident' is versus business-as-usual practice.
- TRAM Protocol training to increase skills in working in partnership to safeguard adults.
- Continue to incorporate professional curiosity throughout our safeguarding training and case management.

Challenges and Opportunities

We have secured a GM ICB contract for 2026-27 in Mental Health Crisis work for 111 Mental Health option 2, and Mental Health Urgent Triage (MHUT) at the 999 NWAS call centre. A focus of VCSE investment is to support referrals into VCSE crisis spaces, reducing pressure on emergency services and A&E. Last year, we expected the expansion of the Listening Space hours to be a key challenge due to increased complexity in presentation, however, now that this is fully mobilised and operational, we view the 111 and MHUT contract as an opportunity to better utilise our Oldham Listening Space due to better ways of working between emergency services, the NHS Mental Health Trusts, and TOGS Mind. There is a robust clinical advice system in place for frontline workers, as well as weekly Senior Management Team meetings to discuss any key challenges that have arose that week, whether that is staffing, a service user presentation, or any challenges within the multi-agency approach.

A key challenge will be changes to the incident report system, considering what we report on and what system we report on from a data point of view and change management with frontline teams. This will be managed through new training, regular case auditing and case management, and regular reviews within our internal safeguarding and incident meetings.

MioCare Group

MioCare Group is a council-owned organisation dedicated to delivering high-quality support services for adults with autism, learning disabilities, and older people who need assistance beyond hospital care. Our focus is on empowering individuals to live as independently as possible, enabling them to remain in the comfort of their own homes for as long as they can.

Safeguarding in 2025-26

A range of medium and high safeguarding incidents were reported across services, highlighting several key themes and trends.

There were a total of twelve medium and five high level safeguarding incidents. The most prevalent theme was neglect/acts of omission, which was identified across supported living, extra care, residential reablement and community reablement services. This suggests a need to continue strengthening oversight, care delivery consistency, and recording practices.

Physical abuse incidents were also recorded across shared lives, supported living and extra care, although at a lower level. These were primarily managed through investigation, review and implementation of lessons learned, in line with safeguarding procedures.

There has been a notable presence of financial abuse and domestic abuse within supported living and extra care settings, indicating the importance of maintaining strong safeguarding awareness and partnership working, particularly in more independent living environments.

Additionally, self-neglect emerged as a theme within extra care services, reflecting the complexities of supporting individuals to maintain independence while managing risks.

As in previous years, all incidents have been appropriately reported, investigated and reviewed, with a continued focus on learning and improving practice. Low level concerns continue to relate primarily to medication errors and behaviour-related incidents, which are monitored and managed through established internal processes.

Overall, the themes identified indicate a need for continued focus on staff training, effective supervision, robust recording, and proactive risk management, alongside strong partnership working to ensure individuals are safeguarded effectively.

Safeguarding Achievements

Building on the refresh of our Safeguarding Policy and Safeguarding Plan in previous years, during 2025–26 we have focused on embedding these frameworks into day-to-day practice across all services.

A key area of progress has been the development of a co-production approach to safeguarding, including the introduction of a safeguarding group attended by people we support. This has strengthened engagement, increased awareness, and ensured that safeguarding practice is informed by the lived experiences of individuals.

We have also enhanced our information sharing and assurance processes with the Local Authority, with low-level concerns now submitted directly from the MioCare Quality Team. This provides additional oversight and supports the identification of any gaps or inconsistencies in incident reporting across services.

In addition, we have continued to strengthen our internal monitoring and oversight, supported by the ongoing use of our digital systems, improving the timeliness, visibility and scrutiny of safeguarding information.

Financial abuse emerged as a new safeguarding theme in 2025-26, with no incidents reported in the previous reporting period. Although the number of incidents remains low, the presence of both medium and high level concerns has increased organisational awareness of this risk area. In response, we have strengthened our focus on financial safeguarding, with plans to deliver targeted training and awareness throughout the year to support staff in identifying, preventing and responding to financial abuse more effectively.

Overall, this reflects a shift from policy development to embedded practice, alongside a more transparent, inclusive and quality-assured safeguarding approach.

Safeguarding Priorities in 2026-27

Our key safeguarding priorities for 2026-27 focus on strengthening consistency in practice, improving recording and assurance, and continuing to embed a proactive, person-centred safeguarding culture.

A key priority will be to improve the consistency and quality of Mental Capacity Assessments, ensuring that decision-specific assessments are completed, recorded appropriately, and supported by clear evidence of consent or best interest decision-making. This will include strengthening staff competence, leadership oversight, and audit processes.

We will also focus on strengthening the recording and management of safeguarding concerns across all levels (low, medium and high), ensuring consistent application of safeguarding policy and procedures. This will include improving the accuracy of categorisation and reporting through our digital systems, alongside enhanced oversight to ensure all incidents are appropriately identified, escalated and recorded. To support this, additional targeted training will be delivered to managers, with a focus on recognising safeguarding indicators, determining appropriate thresholds, and applying a refreshed Safeguarding Policy which provides greater clarity and guidance for consistent decision-making.

We will also introduce a revised audit framework, which is being piloted across services. This includes a new self-audit tool for Registered Managers to strengthen ownership and accountability at service level, alongside an audit summary report for Service Directors to provide oversight of key areas of performance. Safeguarding will form a core focus within the governance section of these audits, ensuring clear assurance that people we support are safe and that safeguarding practice is consistently applied across all services.

Another priority is to continue to develop our co-production approach to safeguarding, increasing the involvement of people we support in shaping safeguarding practice, promoting awareness, and ensuring that their voices remain central to service improvement.

We will continue to strengthen partnership working and quality assurance arrangements, including improved oversight of incident reporting and ongoing collaboration with the Local Authority to support transparency and shared learning.

Finally, we will continue to invest in workforce development, ensuring staff are trained and supported to recognise, respond to and report safeguarding concerns effectively, with a continued focus on person-centred and trauma-informed approaches.

Challenges and Opportunities

Many of the challenges identified previously remain relevant, particularly around recruitment and retention, increasing complexity of need, and resource pressures. However, these also present opportunities to further strengthen our approach to safeguarding and service delivery.

Ensuring consistency of safeguarding practice across all services remains a key challenge, particularly in relation to the identification, categorisation and recording of safeguarding concerns. We are addressing this through refreshed policies, targeted training for managers, and strengthened audit and oversight processes to drive greater consistency and assurance. The increasing complexity and acuity of people we support continues to require a skilled and responsive workforce. This presents an opportunity to further invest in training, supervision, and specialist support, ensuring staff are confident in managing risk, understanding behaviour, and applying person-centred and trauma-informed approaches. Recruitment and retention remains an ongoing challenge across the sector. We are continuing to explore innovative approaches to attract and retain staff, alongside strengthening workforce development to ensure colleagues feel supported, valued, and equipped to deliver safe care. We also recognise the importance of maintaining strong partnership working and information sharing, including embedding consistent processes for sharing safeguarding information with the Local Authority. Our improved use of digital systems supports this, enabling greater transparency, timeliness, and oversight. Finally, resource and budget pressures require continued collaborative working with the Local Authority and partners to ensure services remain sustainable while maintaining high standards of safeguarding. This creates an opportunity to further develop efficient, data-informed approaches to managing risk and improving outcomes.

Overall, by strengthening governance, workforce capability, and partnership working, we aim to manage these challenges effectively while continuing to improve safeguarding practice across MioCare.

NHS Greater Manchester Integrated Care

NHS Greater Manchester (NHS GM) is the Integrated Care Board (ICB) with statutory responsibility for planning, commissioning and assuring NHS-funded health services across Greater Manchester (GM). We work collaboratively with partner agencies including NHS providers, local authorities, police, education and the voluntary sector to support effective safeguarding arrangements and to help keep children, young people and adults at risk safe within our communities.

As a statutory safeguarding partner, we operate in accordance with the NHS England Safeguarding Accountability and Assurance Framework (SAAF), which sets out the responsibilities of ICBs for safeguarding leadership, oversight and assurance. The ICB's primary role is as a strategic commissioner, as set out in the NHS Long Term Plan and supporting national guidance. In this role, we provide assurance on the quality, effectiveness and safety of commissioned services, including oversight of safeguarding practice and governance, and seek assurance through robust contract management, quality surveillance, and system partnership arrangements, including engagement with local Safeguarding Adults Boards (SABs).

During 2025-26, we continued to safely discharge our statutory duties in relation to the safeguarding of children, young people and adults as outlined in national guidance. The Chief Executive holds organisational safeguarding accountability and is supported by our Executive Lead who was the Chief Nursing Officer until 1 January 2026 when, as part of the ongoing NHS Reforms, this formally transferred to the Chief Clinical Officer. The organisational leads were supported by the Deputy Chief Nurse and the Associate Director of Safeguarding, who provided strategic system leadership and oversight of safeguarding assurance. Statutory safeguarding delivery continued to be supported through the locality Associate Directors of Quality and Safety and delivered by Designated Safeguarding Teams in each of the ten GM localities.

Safeguarding in 2025-26

Analysis of statutory SARs across GM highlighted recurring themes of self neglect, mental health, and substance misuse, often cooccurring and contributing to increased vulnerability and risk of harm. In response, the NHS GM Designated Professionals for Safeguarding are undertaking a deep dive of all statutory safeguarding reviews where mental health and/or substance misuse have been a significant feature. The purpose of this work is to identify systemwide learning, themes impacting health services, and any commissioning or pathway gaps across the GM health footprint. Emerging learning to date indicates a need to:

- Strengthen professional understanding of adult exploitation, including criminal, sexual and county lines exploitation affecting adults with mental health and substance misuse needs.
- Improve recognition of how trauma informed responses (including disengagement, mistrust of services and perceived noncompliance) can present as barriers to effective safeguarding engagement.
- Learning from SARs and the deep dive work will inform commissioning discussions, improve pathway integration between mental health and substance misuse services, and strengthen safeguarding governance and assurance arrangements across commissioned services.

Safeguarding Achievements

During 2025-26, we continued to embed and deliver the SAAF, strengthening our approach to governance, assurance and improvement. SAAF implementation audits and the NHS England Safeguarding Clinical Audit Tool (SCAT) were routinely reviewed through internal governance structures and informed provider assurance, risk identification, strategic commissioning and improvement planning. We are a statutory partner for the SABs across our localities working with statutory partners to deliver our statutory safeguarding adult duties.

System learning and SARs:

- Led an NHS GM thematic review of SARs, supporting a more consistent and robust approach to identifying crosscutting learning, trends and health related system issues.
- Developed a GM SAR referral form in partnership with GM SABs to improve the quality, consistency and clarity of SAR referrals from health partners

and strengthening engagement with SABs across all localities.

Strengthening safeguarding leadership in primary care:

- Rolled out a GM wide GP Practice Safeguarding Leads Programme, delivered through the Named GP Safeguarding Network.
- Content included alignment with Royal College of General Practitioners (RCGP) Safeguarding Standards, practical application within general practice, and dissemination of key learning from statutory safeguarding reviews, supporting improved safeguarding assurance in primary care.

Modern slavery and adult exploitation:

- Acted as an integral partner during GM Modern Slavery Week of Action, with Designated Safeguarding expertise contributing to a Causeway webinar focused on best practice and the NHS role in the National Referral Mechanism (NRM).
- Provided keynote contribution at the Greater Manchester Combined Authority (GMCA) Modern Slavery Conference, incorporating a survivor perspective and sharing examples of effective protocols, policies and practice from the Oldham locality, strengthening system understanding of trauma informed responses and safeguarding pathways.

Trauma informed maternity services:
Progressed recommendations arising from survivor mothers' experiences of maternity services.

- To seek assurance from Named Midwives for Safeguarding during 2026-27 regarding how targeted, trauma informed support is provided to women with vulnerabilities linked to exploitation, abuse and complex trauma, supporting improvements in maternity safeguarding practice and equity of care.

Safeguarding vulnerable children in temporary accommodation:

- Developed and rolled out best practice guidance across the GM health footprint for identifying and responding to Unaccompanied Asylum-Seeking Children (UASC) placed within adult hotel accommodation, supporting staff who predominantly work with adults to recognise safeguarding risks, escalate concerns appropriately and work effectively with partners.

The ICB has maintained robust strategic, clinical and professional leadership during 2025-26 which has continued during the formal transition of the Executive Lead for Safeguarding from the Chief Nursing Officer to the Chief Clinical Officer in January 2026. NHS GM has upheld robust statutory safeguarding assurance processes across all commissioned and independent providers, monitored safeguarding risks through established governance structures and contributed proportionately to multi-agency safeguarding arrangements. This demonstrates that NHS GM continues to fulfil its statutory duties and support safe, effective and collaborative clinical safeguarding practice across the Integrated Care System.

Safeguarding Priorities in 2026-27

For 2026–27, our safeguarding priorities focus on strengthening statutory leadership, improving system assurance, and embedding learning and trauma informed practice across the GM health footprint.

Statutory leadership and partnership accountability:

- The ICB Chief Clinical Officer is the accountable executive lead for safeguarding across local and systemwide strategic partnership arrangements, including:
  - SABs
  - Multi-Agency Safeguarding Children Partnerships
  - Community Safety Partnerships
  - Violence Reduction Units
  - Corporate Parenting Boards
  - Domestic Abuse Partnership Boards.
- We will continue to ensure appropriate senior representation and engagement at each partnership, in line with statutory duties under the Care Act 2014 and Working Together to Safeguard Children 2026, with a focus on effective challenge, assurance and shared ownership of risk.

Strengthening safeguarding assurance and professional leadership:

- We will maintain and further develop its Designated Professional model, including Designated Professionals for Safeguarding Adults, Children, Children in Care, and a Named GP for Safeguarding, to support consistent implementation of safeguarding responsibilities across commissioned services.
- Priorities include strengthening safeguarding governance and escalation pathways; quality and performance assurance through contracts, reviews

and learning from incidents; and alignment between commissioning decisions and safeguarding risk.

Locality embedded safeguarding leadership:

- The Designated Safeguarding Team, will continue to provide:
  - strategic oversight and system leadership for adult safeguarding.
  - support and development of soft intelligence pathways, ensuring emerging risks, themes and concerns are identified and triangulated across providers and partners.
  - constructive professional challenge to commissioned services and system partners where safeguarding practice or assurance is incomplete.
  - a clear, proportionate assurance framework, supporting continuous learning, quality improvement and safer outcomes for adults at risk.

Learning, improvement and trauma informed practice:

- Building on learning from SARs and thematic system work, we will prioritise:
  - embedding trauma informed approaches across health services, particularly in relation to self-neglect, exploitation, mental health and substance misuse.
  - supporting providers to translate SAR learning into measurable improvements in frontline practice.
  - strengthening multi-agency collaboration where adults experience multiple, intersecting vulnerabilities.

Challenges and Opportunities

During quarter 1 of 2026–27, we anticipate a period of transition as the organisation operates under a business continuity model while moving towards a revised operating model following national NHS reform activity.

Key challenges:

- Ensuring continuity of effective safeguarding leadership, oversight and assurance during the transition period.
- Managing capacity pressures within safeguarding teams while maintaining statutory responsibilities and system engagement.
- Maintaining consistent safeguarding input and escalation during a period of organisational change.

How challenges will be managed:

- Safeguarding accountability will remain clearly retained within NHS GM, ensuring place leadership and system engagement are sustained.
- Our Safeguarding Leadership will retain oversight of statutory duties, partnership engagement and assurance processes during the transition.
- Existing business continuity arrangements will prioritise statutory safeguarding functions, SAB engagement, SAR activity, and escalation of risk.
- Clear communication will be maintained with SAB partners to provide reassurance regarding continuity, governance and decision-making arrangements.

Key opportunities:

- The transition provides an opportunity to:
  - Review and strengthen the role and function of Designated Nurses, Professionals and Named GPs.
  - Improve alignment between safeguarding leadership, commissioning assurance and system priorities.
  - Embed a more consistent and proportionate GM safeguarding assurance model that supports learning and improvement.

Next steps:

- Confirmation of the revised operating model for NHS Statutory Safeguarding.
- This will include clarity on roles, responsibilities, locality alignment and assurance workflows, supporting continued confidence from SABs that we are meeting its statutory safeguarding responsibilities.

Northern Care Alliance NHS Foundation Trust

The Northern Care Alliance NHS Foundation Trust (NCA) are one of the largest providers of health care for both acute and community services in the country. Our dedicated team of around 20,000 staff deliver hospital, community and maternity to over one million people across Salford, Oldham, Rochdale and Bury, as well as providing more specialist services to patients from Greater Manchester and beyond.

Royal Oldham Hospital has a full Accident and Emergency (A&E) department, including a specialist Childrens A&E and inpatient Paediatric ward and offers a comprehensive range of acute, general surgical services and women's, children's and maternity services.

Safeguarding in 2025-26

We are a key health partner in Oldham, with representatives participating in OSAB subgroups and multi-agency meetings including Team Around the Adult meetings. A thematic review of SAR learning themes for the NCA include:

- Effecting and improving Safe Discharge from hospital.
- Adults with co-occurring conditions i.e. frequent A&E attendance, substance/alcohol use/ homelessness.
- Professional curiosity.
- No Access/Did not attend/was not brought for adults at risk.
- Diagnostic overshadowing.
- Exploitation i.e. cuckooing and financial exploitation.
- Domestic abuse in older adults.
- Carer stress.
- Non-adherence / declining treatments.
- Effective application of the Mental Capacity Act.

Safeguarding Achievements

In 2025-26, we have reviewed our Safeguarding Governance and assurance arrangements to ensure the organisation recognises and understands safeguarding from 'floor to board' alongside wider organisational change. Representation across Safeguarding Boards and partnerships will be strengthened as a result. This includes:

- Development of a safeguarding performance report and safety profile.
- Improved oversight of training and completion of a full training needs analysis.
- Development of safeguarding supervision for staff working with adults at risk.
- Mental Capacity Act audits.
- Safeguarding team development.
- A focus on recognition of Domestic Abuse and Sexual violence.

Safeguarding Priorities in 2026-27

To embed learning from reviews into practice through development of safeguarding subgroups to the NCA safeguarding group including:

- Learning, Audit and Reviews.
- Mental health.
- Learning Disabilities and autism.
- Domestic abuse and sexual violence.
- Prevent and community safety.

The application of the Mental Capacity Act remains an organisational priority.

Challenges and Opportunities

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

A focus on the application of the Mental capacity Act will continue.

Oldham College

Oldham College is a further education provider delivering education, training and skills development to young people and adults across Oldham and Greater Manchester. We are committed to providing a safe, inclusive and supportive learning environment and work closely with statutory, voluntary and community partners to safeguard learners, including adults with care and support needs and those who may be vulnerable to abuse, neglect or exploitation.

Safeguarding in 2025-26

Key themes identified during 2025-26 included increasing mental health concerns, social isolation, domestic abuse, financial exploitation, online harm and vulnerability linked to substance misuse. We also saw continued safeguarding concerns relating to learners with neurodiverse needs, emotional wellbeing challenges and those requiring additional support to access services. There has been an increased focus on contextual safeguarding, professional curiosity and understanding the impact of trauma on behaviour and engagement.

Safeguarding Achievements

- Further embedding of a whole-college safeguarding culture through awareness campaigns, staff training and learner engagement.
- Strengthened multi-agency working with Adult Social Care, NHS services, Greater Manchester Police, the Violence Reduction Unit and specialist community organisations.
- Development of targeted wellbeing and mental health support, including access to therapeutic interventions.
- Improved safeguarding oversight through regular reporting to Senior Leadership and Governors.
- Enhanced approaches to vulnerable adults, ensuring person-centred and trauma-informed practice across support services.
- Increased staff confidence in recognising and responding to safeguarding concerns through ongoing professional development.

Safeguarding Priorities in 2026-27

- Continue embedding trauma-informed and person-centred safeguarding practice.
- Strengthen support for adults experiencing mental health difficulties.
- Improve identification and support for vulnerable adults experiencing exploitation, including financial, criminal and online exploitation.
- Increase awareness of the Mental Capacity Act and Making Safeguarding Personal principles.
- Enhance learner voice and involvement in safeguarding processes.
- Continue to strengthen partnership working across Oldham and Greater Manchester safeguarding networks.

Challenges and Opportunities

Challenges include increasing complexity of learner needs, rising mental health presentations and ongoing resource pressures across partner agencies.

Opportunities exist through stronger multi-agency collaboration, improved information sharing and expansion of preventative wellbeing initiatives. We will manage these challenges through workforce development, regular safeguarding supervision, robust governance arrangements, early intervention and continued partnership engagement.

Pennine Care NHS Foundation Trust

Pennine Care NHS Foundation Trust (PCFT) is proud to provide Mental Health, Learning Disability and autism services to people across Greater Manchester and beyond. We serve a population of 1.3 million. Our 4,700 dedicated and skilled staff deliver care from 88 different locations in six boroughs.

PCFT has a statutory duty to promote the welfare of children and young people and to protect adults at risk of abuse. Our Vision is for a happier and more hopeful life for everyone in our communities. This includes safeguarding practices and requires a 'Think Family' approach, as neither children, young people, adults, nor their families and carers exist in isolation.

Safeguarding is central to how we deliver safe, compassionate, and accountable care aligned with the Trust's values:

- *Kindness:* Evidenced through trauma informed, compassionate safeguarding practice that prioritises the wellbeing and dignity of children and adults at risk.
- *Fairness:* Demonstrated in our commitment to equitable, consistent safeguarding responses that uphold people's rights across all services.
- *Ingenuity:* Shown through ongoing improvements in data insight, governance, and partnership working to enhance safeguarding effectiveness.
- *Determination:* Reflected in the sustained focus on strengthening assurance, driving learning, and continually improving safeguarding standards across the Trust.

Safeguarding in 2025-26

Our safeguarding team recorded 2,182 consultations during 2025-26, a decrease of 9% from 2024/25. This is the first time that the safeguarding team have seen a decrease in the use of the service, since 2022, however, this aligns with the activity to train and empower colleagues to effectively safeguard such as ensuring training compliance, bitesize training offers, and improvements in the supervision offer. Furthermore, consultations have increased in complexity and length, often requiring the safeguarding team to offer additional follow-up conversations. The safeguarding team are effective in delivering a same-day response rate of 93%.

The most prevalent categories of abuse or themes continue to be domestic abuse, historic (or non-recent) child sexual abuse, child emotional abuse and parental mental health and information sharing/signposting. For adults, domestic abuse and non-recent child sexual abuse were the most frequently reported. These are consistent with themes from 2024-25.

Safeguarding Achievements

Safeguarding Champions: With support from the Quality and Improvement team, a Trust wide safeguarding champion model was introduced in 2025-26. The role of a safeguarding champion is to support the safeguarding team deliver key messages, share learning from national and local reviews, act as a resource for colleagues and promote best practice across the organisation. The project has gone from strength to strength and there are now 42 practitioners recruited as safeguarding champions working across children and adult inpatient and community services. The champions are invited to attend a safeguarding champion forum, facilitated by the safeguarding team on a quarterly basis. Each safeguarding champion forum has a topic that directly relates to learning identified from statutory reviews.

Safeguarding Conference: The annual safeguarding conference took place in November 2025 and focused on national, regional and local learning in relation to child sexual abuse, domestic abuse and the Mental Capacity Act (MCA). The conference was attended by over 100 practitioners and was used as an opportunity to strengthen practice in priority areas for PCFT. Domestic abuse and risk of suicide for children and adults was a topic of discussion and provided opportunity to share learning from a suicide thematic review completed by the patient safety team. Work has been ongoing since the conference to integrate safeguarding messages further in suicide prevention work and the journey to risk assessment task and finish group.

Mental Capacity Act: Significant progress has been made in strengthening the implementation, governance, and education of the MCA across the Trust. This has included improvements in training provision, documentation, digital infrastructure, partnership working, and practice support.

Safeguarding Priorities in 2026-27

A thematic review of learning from statutory safeguarding reviews was undertaken in 2025-26 to

identify strategic priorities. A Trust wide strategic delivery plan was developed to identify strategic, operational and performance actions across key agendas. The adult strategic plan covers application of the MCA; recognition and response to domestic abuse; recognition and response to self neglect; and understanding, using and embedding high-risk protocols.

Challenges and Opportunities

Domestic abuse, as highlighted above, continues to represent a significant safeguarding risk. The Trust has an established Domestic Abuse Policy for people using services, supported by regular awareness training with strong uptake. Preparatory work is underway to support implementation of Domestic Abuse Protection Orders.

Self-neglect remains an increasing local and national concern. The Trust is assured that targeted workforce development is in place through bite-size learning sessions and contribution to multi-agency audits, with learning feeding directly into the adult safeguarding plan.

High-risk protocols remain an area for further development. The Safeguarding Team have developed a briefing to support staff in understanding how high-risk protocols operate within each locality. This includes clearer guidance on the role of the Lead Professional and responsibilities for coordinating a Team Around the Adult approach. Further work is planned to strengthen practitioner understanding and application of these protocols, ensuring effective safeguarding and support for adults who have been assessed as having capacity but continue to place themselves at risk of serious harm or death.

The application of the Mental Capacity Act is identified across reviews as a key area for improvement. This learning, supported by multi-agency insights and priorities set by Adult Safeguarding Boards, has shaped a focused approach to strengthening knowledge, decision-making, and practice across the Trust. The plan is further informed by themes emerging from MCA consultations with staff, ensuring that training and development are responsive to real practice challenges. In the wider health economy, the plan recognises the significant interface between MCA, physical health and the Mental Health Act. Training therefore aims to support clinicians in navigating complex decision-making across these areas, improving integrated, lawful, and person-centred care.

Positive Steps

Positive Steps is a charitable trust that delivers a range of targeted and integrated services for young people, adults and families that recognises the diversity of the people with whom we work.

We are a unique organisation delivering a combination of statutory, voluntary and traded services - funded through local authority and charitable trust grants, charitable donations, contracts based on payment by results, and income generated through our trading arm - where all profits fund our charitable activity.

Safeguarding in 2025-26

Housing issues, including social, private rented and homelessness was one of our key safeguarding concerns, particularly for single adult males. There has been an increasing risk in relation to 18–25-year-olds or those affected by substance dependency issues who are not a priority for social housing or emergency/temporary accommodation, and services have differing criteria or are at capacity.

Mental health, including self neglect, hoarding and suicidal ideation are also common themes. We have revisited training through Mind to ensure the teams are aware of how to complete effective suicide safety plans and have the confidence to provide support around them.

Our Hoarding Peer support group has its highest ever member numbers, which indicates that hoarding is still an emerging risk across Oldham. One of our challenges has been linking in with other professionals around this such as housing providers who do not have hoarding specialists in place to support their residents.

Gambling, exploitation, and substance misuse are all contributing factors to financial difficulties, which can have a significant impact on mental health. We are engaging with service users at an earlier stage to help prevent these issues from escalating, providing support with budgeting, and connecting individuals with specialised services to ensure they receive appropriate ongoing support.

Safeguarding Achievements

Internal Safeguarding Log: There has been continued development of the way in which we capture internal safeguarding activity, with a review of the categories/risk and vulnerabilities recorded to allow for increased oversight and analysis. This has enabled data and emerging themes to be reported and analysed through various mechanisms including Leadership and Managers Meetings and the Board of Trustees. This is ongoing work and auditing across the system will commence in 2026-27.

Hoarding Group development: We continue to lead on the delivery of the Hoarding Peer Support Group. This peer led group supports adults in a non-judgemental or stigmatising way where hoarding has been identified as a need. Attendance has steadily increased this year with a regular ten attendees now accessing the group.

Trustee Training: Safeguarding training has been delivered to all trustees this year by the organisational Designated Safeguarding Lead.

Safeguarding Practitioner Forums: Quarterly forums have been held for all staff within the organisation with a range of themes including OSAB and Oldham Safeguarding Children Partnership overviews from the relevant Business Managers.

TRAM Protocol Training: Our Operational Manager has completed the train the trainer for the TRAM Protocol and risk assessment training. They deliver this in house and across Oldham to other professionals. This training is delivered every six months and has been implemented as part of mandatory training for all new staff supporting adult service users, with a refresher required every two years for all staff.

MEAM Attendance: We started to attend Making Every Adult Matter meetings facilitated through the Changing Futures Team. Our Operational Manager attends and contributes each week both by using the service to escalate cases where complex safeguarding is required, or if a multi-agency approach is needed, and also to offer support and guidance to other professionals by providing early intervention and prevention support, including for those on Probation through the Oldham Wellbeing Hub.

Induction Review: As part of a wider review across the organisation the induction process has been strengthened. As a result, all new staff have an overview of the internal safeguarding process as part of their induction delivered by a Team Manager who is a Qualified Social Worker.

Introduction of a multi-disciplinary Complex Case Panel: providing structured oversight of high-risk and high-complexity cases, strengthening joint decision-making, improving coordinated responses and supporting sustained engagement with customers who are harder to reach.

Safeguarding Priorities in 2026-27

Improve auditing: The auditing of safeguarding concerns recorded on the internal log is planned to commence in 2026-27. This will ensure quality of recording and responses can be reviewed with findings and learning shaping development across services. This information will be shared with teams, leadership and Board of Trustees.

Participation and User voice: Two of the organisations strategic priorities this year are:

- To put our service users at the centre of everything we deliver, ensuring that they feel heard and have the opportunity to create change.
- To create a clear user voice strategy to allow our communities to shape and challenge our offer.

To support these priorities a participation working group has been established with members from across the organisation with clear aims and objectives to improve the collection and collation of user voice which will include responses to safeguarding, risk and vulnerabilities.

Challenges and Opportunities

Across all safeguarding issues, capacity and waiting lists from services are contributing to increase pressure to our service. Ensuring that we maintain support whilst we step down or escalate a service user to another relevant team is taking longer due to higher waiting times. We are seeing a higher complexity of needs and multiple disadvantages, which are also requiring additional support times and involvement from a wider range of services.

We are working on developing the monitoring of outcomes for our Hoarding Peer Support Group, which will provide us with some insight into how effective the group sessions are, and what improvements can be made. This will be captured both by reporting of data and gaining service user voices and will be fed back through the OSAB Hoarding Improvement Partnership.

Probation Service

The Probation Service is a statutory criminal justice agency responsible for supervising adults released from custody on licence and those subject to community sentences imposed by the courts. In addition, we deliver accredited programmes, Community Payback/Unpaid Work, and the Victim Contact Service. Our core purpose is to protect the public and support rehabilitation, working in close partnership with other agencies to achieve these outcomes.

Safeguarding in 2025-26

The continued high prevalence of domestic abuse remains a significant challenge in our efforts to protect the public. We work closely with partner agencies to develop robust risk management plans to minimise risk and support effective safeguarding.

Recognising and responding effectively to neglect has been an emerging theme. Contributing factors have included ongoing cost of living and housing pressures, together with substance misuse, elevated levels of mental health need, and the lasting impact of childhood trauma.

Safeguarding Achievements

GM Probation Service has established a specialist unit, Domestic Abuse and Safeguarding Information Team (DASIT). Since October 2025, DASIT has completed safeguarding checks for the Oldham Probation team, having direct access to the Oldham local authority recording system. This has enabled checks to be completed more efficiently without placing additional demand on MASH resources, improving operational efficiency and supporting increased capacity for local authority colleagues.

There has been collaborative work with Adult Safeguarding Services based on learning from SARs. Agreement was reached regarding the value of a collaboration to strengthen staff awareness of respective roles and responsibilities. Local authority colleagues contributed to a local Probation staff event with plans made for Probation managers to do likewise in return.

This work has provided a springboard to increase practitioner confidence to utilise the range of local pathways to meet safeguarding need.

GM Probation Service was the second highest performing region in England in 2025-26. In addition, quality assurance activity evidenced an improvement in the quality of risk assessments and risk management plans completed by practitioners over the course of 2025-26. This is evidenced both in local commencement audit activity and additionally via external audits.

Safeguarding Priorities in 2026-27

To ensure that our practitioners make effective use of local safeguarding pathways, including the TRAM Protocol, Changing Futures service, and Safeguarding Adult Referrals where the Care Act criteria are met.

To apply learning from quality assurance activity to further strengthen the quality of practitioner practice in relation to safeguarding victims of crime and vulnerable adults subject to Probation supervision.

Challenges and Opportunities

The Sentencing Act 2026 received Royal Assent in January 2026. This represents a massive shift for the Probation Service in England and Wales, moving focus away from short-term custody and amending the way Community Disposals are delivered. A very large change programme is currently under way with two large blocks of change coming into legislation in Spring 2026 and then again in Autumn 2026. Ensuring the change is effectively implemented is critical, requiring additional local governance and increased demand on staff resource at all levels.

HM Prison and Probation Service Our Future Probation Service (OFPS) is an eighteen-month digital and operational transformation programme designed to reduce staff workloads by 25% and increase resilience. As such, it represents a real opportunity to the organisation. One of the first measures to be introduced, Justice Transcribe, is an AI powered speech recognition tool developed by the Ministry of Justice to transcribe and summarise spoken records. This has been well received by practitioners in pilot areas. This, alongside other initiatives, will service to improve efficiency and effectiveness of practice.

Turning Point

Turning Point Oldham Active Recovery are the local drug and alcohol treatment service. We support individuals to make positive changes surrounding their drug and/or alcohol use. This is achieved by offering key working sessions, psychosocial interventions, opiate substitute prescribing, health and wellbeing assessments, harm reduction sessions, health and wellbeing appointments and access to detox and rehab placements.

Safeguarding in 2025-26

Safeguarding themes have been domestic abuse, mental health crisis and decline, sexual abuse, cuckooing and self-neglect. Most of which resulted in appropriate referrals to domestic abuse services, safeguarding and escalation to police or hospital.

We have been operating a weekly safeguarding clinic with our Safeguarding Manager and Safeguarding Champions to discuss several clients who do not require an immediate safeguarding referral or escalation to the police or A&E but to discuss what further support may be available and appropriate in the community. This can sometimes result in safeguarding referrals to social care.

Safeguarding Achievements

In 2025-26, our safeguarding clinics have become well established with many staff accessing these regularly to seek further support and guidance whilst case managing their clients.

We have also seen the pregnancy pathway flourish in the way in which it safeguards expectant mothers and their unborn children. This is a monthly MDT meeting where the Recovery Worker attends to discuss the expectant mother and their substance use, physical health, mental health, personal relationships, housing and engagement with professionals. It is a space in which we have open reviews of how treatment is managing the risks to mother and baby and agree further actions to risk mitigate. Attendees include the Safeguarding Manager, Deputy Clinical Services Manager, Independent Nurse Prescriber, Consultant Addiction Psychiatrist and Clinical Lead, Substance Use Nurses, Health Care Assistants, Advanced Recovery Practitioners and Recovery Workers. Several colleagues who do not have direct management of expectant mothers request to shadow this meeting so they can ensure learning is relayed to any clients whose pregnancy they may become of aware of throughout assessment or keyworking session.

As we have identified the need for the Pregnancy Pathway, we also recognised the importance of the Long-Acting Reversible Contraceptive (LARC) and how this would be beneficial to bring in house. We have a number of clients already engaging in treatment and support with MASH however we wanted something more widely available to our cohort of clients. We understand that clients often using substances are more likely to engage in unsafe sex practices and likely to have unplanned pregnancies. We also recognise there is a population that are sex working or engaging with the sex working community. We also understand there is a growing rate of STI transmission and often having the treatment and support all in one hub makes this more accessible as we recognise we are often a service with positive engagement rates compared to some of our statutory partners. We acknowledged that some of our clients find 'traditional' health care services inaccessible due to the times in which they must access appointments, we understand they may have faced stigma when seeking treatment and support and may have past trauma which makes engaging difficult.

We have seen increased use of the Domestic Abuse Stalking 'Honour' (DASH) assessment with our clients who are raising concerns in relation to their partners, family members and associates. These are then appropriately escalated to domestic abuse services and MARAC where they meet threshold.

Safeguarding Priorities in 2026-27

Domestic abuse is one of safeguarding priorities especially as it featured as one of our main safeguarding concerns. We have e-learning training available concerning domestic abuse but we will be offering in-house domestic abuse training as there is a need for colleagues to become more familiar and confident with the DASH assessment and the escalation pathways.
We know that colleagues are comfortable to

signpost to external agencies such as the Independent Domestic Violence Advisors (IDVA) service, Women's Aid and police, where appropriate, but we know that engagement is not always guaranteed so we need to ensure we are confident enough to mitigate the risks and have challenging conversations where clients are feeling hopeless or are normalising the abusive behaviours they are subject to.

Mental Health crisis and deterioration was also a theme when we reviewed our incidents as we know substance use can often lead to a further deterioration of mental health. We acknowledge that accessing mental health services whilst our clients are actively using substances is difficult. We are working collaboratively with partner agencies to address the substance use need and mental health needs in a way which mitigates the risks of self harm, suicidal ideation and attempts.

Self neglect will also be a theme in which we aim to respond to appropriately. Self neglect has remained a feature in the SARs. We frequently see self-neglect in our service and there is often the possibility it may be dismissed as part of a person's presentation or seen as a lesser need to address. We aim to address this and explore the reasoning behind the self neglect and determine whether it is appropriate for referrals to partner agencies to be considered.

Cuckooing will also remain on our agenda, we have many individuals who share accommodation or sofa-surf and this leads to difficult dynamics. Whilst the individuals might not consider this to be 'cuckooing', our staff need to be comfortable in challenging the tensions, living arrangements and some of the behaviours that are relayed to us and then escalate these concerns appropriately.

Challenges and Opportunities

One of the key challenges is staff participation in training. Mandatory e-learning training is completed in a timely manner and if not, this is appropriately challenged by team leaders. We are in the process of developing a training matrix to allow us to track some of our face-to-face learning offered to meet our specific needs and demands of the community. We do recognise we have a good number of staff who will continuously engage with our training opportunities and others who are more reluctant to do so advising they have limited time. This will be managed more effectively through our matrix, and we will also continue to encourage attendance at multi-agency OSAB training.

VoiceAbility

VoiceAbility is a third sector advocacy provider. We provide statutory and non-statutory advocacy independent advocacy for adults, children and young people depending upon the contract area.

Safeguarding in 2025-26

The key themes we recognised in 2025-26 were in relation to neglect and organisational abuse.

Safeguarding Achievements

- Utilising high-impact tools such as 7-minute briefings, piloting enhanced information-sharing protocols across selected regional teams to strengthen our internal knowledge-transfer and safeguarding culture.
- Increasing opportunities to support reflective practice in line with our safeguarding duties and responsibilities.
- Improvement programmes to embed good quality safeguarding referrals submitted to local authorities, evidencing how thresholds and criteria are met. This work resulted in more safeguarding referrals being accepted.
- Increased awareness and oversight of transitional safeguarding within the organisation and how we can ensure young people are accessing appropriate services and support with preparing for adulthood.
- Continuing to develop place-based safeguarding training into all learning plans.
- We also developed new organisational wide safeguarding policies and procedures.

Safeguarding Priorities in 2026-27

- Making Safeguarding Personal
- Transitional safeguarding
- Risk reduction as there is potential for 'siloed' working within the wider multi-agency safeguarding landscape which can lead to delays in critical information sharing.
- Continuing to strengthen our local communication channels ensuring that advocacy is integrated into safeguarding at the earliest possible stage.
- Streamlining safeguarding training and making best use of opportunities via partners for continuous learning and development.

Challenges and Opportunities

- Continuing system wide capacity pressures across statutory health and social care services.
- Internal pressures of balancing high volume operational delivery with the capacity for staff to engage in, and effectively embed, professional learning.
- Competing priorities within teams and pressures to meet rigorous key performance indicators (KPIs) can limit the time available for deep practice development. Active review of our internal meeting structures to better integrate learning opportunities.
- Highlighting the broader need for commissioning models that recognise and support the resource allocation required to maintain a highly skilled and developing workforce.

What to do if you are worried about an adult

Abuse and neglect can happen to anyone, anywhere, and may be carried out by people known to the individual or by strangers. They can take many forms, including physical, emotional, sexual, financial, organisational, discriminatory, and neglectful abuse. Adults with care and support needs can be particularly vulnerable and may be unable to recognise, report, or protect themselves from harm.

If you are experiencing abuse or neglect, or if you are concerned that someone you know is being abused, neglected, or is at risk of harm, it is important to speak up. Reporting concerns can help prevent further harm, ensure people receive the support they need, and enable agencies to take action to keep individuals safe. Safeguarding is everyone's responsibility, and no concern is too small to report.

The **Oldham Adult Referral Contact Centre (ARCC)** has been set up to help adults and families looking for support and can be contacted via the following email address: ARCC@oldham.gov.uk.

In addition, the **Adult Multi-Agency Safeguarding Hub (MASH)** has been set up to help people report safeguarding concerns and can be contacted via the following email address: Adult.Mash@oldham.gov.uk.

Both services can be contacted on the following number:

ARCC and MASH: 0161 770 7777

Keep in touch

If you have any queries about this Annual Report or would like more information, please contact the OSAB Business Unit at:

OldhamSafeguardingAdultsBoard@oldham.gov.uk

Oldham Safeguarding Bulletin is a way of keeping yourself up to date with news from Oldham Safeguarding Adults Board and Oldham Safeguarding Children Partnership partners across Oldham. To be sent the bulletin, complete the sign-up form on the OSAB website:

www.OSAB.org.uk/Bulletin

Please also follow us on X (formerly Twitter) and share our content to raise awareness of safeguarding and exploitation and what people can do to keep themselves and their families and friends safe in Oldham:

@SafeguardOldham

Thank you from the team