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ADULTS SOCIAL CARE AND HEALTH SCRUTINY BOARD
Overview & Scrutiny Committee
Agenda

Date	Tuesday 25 November 2025
Time	6.00 pm
Venue	J R Clynes Second Floor Room 2 - The JR Clynes Building
Notes	1. DECLARATIONS OF INTEREST- If a Member requires advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Alex Bougatef or Constitutional Services at least 24 hours in advance of the meeting.

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

3. PUBLIC QUESTIONS - Any Member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the contact officer by 12 noon on Friday, 21 November 2025.

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

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

MEMBERSHIP OF THE ADULTS SOCIAL CARE AND HEALTH SCRUTINY BOARD
Councillors Adams, Davis, Hamblett, Hurley, J. Hussain, Ibrahim, Iqbal, Kouser, McLaren (Vice-Chair), Rustidge (Chair) and Sharp

Item No

1 Apologies For Absence

2 Urgent Business

Urgent business, if any, introduced by the Chair

3 Declarations of Interest

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

4 Public Question Time

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

5 Minutes of Previous Adults Social Care and Health Scrutiny Board Meeting (Pages 3 - 6)

The Minutes of the Adults Social Care and Health Scrutiny Board held on 7th October 2025 are attached for approval.

6 Greater Manchester Joint Health Scrutiny Committee update (Pages 7 - 18)

The minutes of the Greater Manchester Joint Health Scrutiny Committee meeting on 14th October 2025 are attached.

7 Performance Assurance Report 2025/26 Q1+Q2 (Pages 19 - 44)

Report detailing the corporate performance indicators for the first and second quarters of 2025/26.

8 Oldham Safeguarding Adults Board Annual Report 2024/25 (Pages 45 - 92)

To note the Oldham Safeguarding Adults Board Annual Report 2024/25.

9 Adults Social Care Workforce Strategy (Pages 93 - 102)

10 Work Programme (Pages 103 - 104)

To note the 2025/26 Scrutiny Board work programme.

11 Key Decision Document (Pages 105 - 114)

12 Rule 13 and 14

To consider any rule 13 or 14 decisions taken since the previous meeting.

ADULTS SOCIAL CARE AND HEALTH SCRUTINY BOARD
07/10/2025 at 6.00 pm

Present: Councillor Rustidge (Chair)
Councillors Adams, Hamblett, Hurley, J. Hussain, Ibrahim, Iqbal, McLaren (Vice-Chair) and Sharp

Also in Attendance:

Mike Barker	Oldham MBC
Barbara Brownridge	Cabinet Member for Adults, Health and Wellbeing
Gary Flanagan	NHS
Jack Grennan	Constitutional Services
Claire Hooley	Joint Commissioining for People (Health & Social Care)
Jayne Ratcliffe	Director of Adult Social Services
Gerard Taylor	Assistant Director of Operations
Cliff Wilson	NHS

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Davis.

2 **URGENT BUSINESS**

There were no items of urgent business received.

3 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

4 **PUBLIC QUESTION TIME**

There were no public questions received.

5 **MINUTES OF PREVIOUS ADULTS SOCIAL CARE AND HEALTH SCRUTINY BOARD MEETING**

RESOLVED that the minutes of the meeting held on 29th July 2025 be approved as a correct record.

6 **GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE UPDATE**

Members noted the minutes, and it was requested that any questions about the minutes be passed to Councillor McLaren as a member of the Greater Manchester Joint Health Scrutiny Committee. Some members noted their unhappiness with the timeliness of the item being received.

7 **NHS MENTAL HEALTH SERVICES UPDATE**

Some members noted their unhappiness with the timeliness of papers received for the item.
Members were provided with an update on the report, particularly around the Greater Manchester Move On Project, CAMHS, GM Triage Services and Mental Health Mapping and Pathway redesign. It was noted that weekly bed management was being developed with partners and that Oldham's target for Clinically Ready for Discharge patients was 5.2 patients. It was noted that monies saved through this management could be

reinvested into other services. Long wait times were noted and it was advised that this was due to an increased number of referrals and the percentage of referrals accepted increasing.
It was noted that CAMHS provision was being expanded to 16-18 year olds with funding. It was highlighted that Optimise would be the new contracted provider for ASD and ADHD work, which had not had a contracted service until recently.
Members queried whether this learning was being passed onto other authorities and were advised that it was, with the work being presented as success stories to other local authorities and partners.
Members queried whether contact numbers could be provided and where Care Point were based. It was noted that contact information would be shared with the committee and that the Care Point offices in Oldham were on Randolph Street. It was also noted that Neural Developmental pathway facilities would be based in POINT, and that work would be done joining up with local authorities. Members also queried where Optimise was based, and it was noted that they had offices in Oldham meaning that services would not just be online, which was both responsible commissioning and a cost saving measure.
Members queried peer support and what this meant. It was noted that this would be linking people up with others to support them. Members also queried how big the Optimise backlog would be, and it was advised that there was no backlog but that work was ongoing to work to identify and support those with the most need.
Members queried the budget for this and were advised that the spend on ADHD was large and that £400k was being used in each locality which it was highlighted wouldn't be enough, but that those with the highest needs were being supported.
Members queried that under the proposals of moving navigators up front, what could they signpost. It was based on need, with the most appropriate support being referred to through initial triaging, but the full process was still being worked out.
Members also queried what the difference was between navigators and the GM triage system, and were advised that GM triage was just for ADHD and was more clinical, whereas navigators were for CAMHS.
Members noted the use of acronyms and requested that a glossary or definition be provided for each going forward.
Members also highlighted the lack of reference to the voluntary sector and what support and training could be provided. It was noted that more could be done on prevention, Live Well and Voluntary, Community and Social Enterprises.
Members noted the Riding the Rapids programme, noting that anecdotal evidence suggests the work is positive, especially around burnouts. It was queried what the outcome of the pilot was, and it was noted the pilot was still ongoing but was receiving positive feedback and that there was an element for teachers within the programme too.
Members requested more information on the percentage of autism referrals that are diagnosed and given support, referrals broken down by age group and the location data by school, and it was advised that this information could be provided to the board.

Members queried why there had been a 200% increase in CAMHS referrals, and were advised that there were a number of reasons including social media, more awareness and the work of mental health practitioners.
RESOLVED: That the report be noted.

8 **TRANSITIONS**

Claire Hooley and Gerard Taylor presented the item, noting that it had come from a request by members at the previous meeting. It was noted that this would be a process that takes time, and that the service was seeing increasingly complex cases which were causing a pressure on the budget. Transitions were described as the period of change in a young person's life when they move between childhood and adulthood. It was noted that the service was moving away from using the term 'transitions', instead using 'preparing for adulthood'.
It was highlighted that transitions were a key priority for the Oldham Safeguarding Adults Board (OSAB) in 2022/23 and an area of improvement in the Children's SEND inspection in 2023. A key aim of the service was to improve systems and governance as well as ensuring a better service for children and young adults.
Previous phases of the Transitions Project were discussed, particularly phase 1 (2022-23) and phase 2 (2024). It was also noted that the 2023 OSAB Preparing for Adulthood Policy was being updated to reflect the current position across the partnership. It was highlighted that the process starts for young people at age 14.
The Transitions Hub was highlighted, a joint team between Children's Social Care and Adult's Social Care specifically for transitions cases, and the team structure of the Hub, the transitions process and wider themes of the transitions work were also noted.
It was highlighted that in the upcoming CQC visit, transitions was a key strength of the service. It was noted that although lots of work had been done in the last 12-18 months, there was more to do.
Members queried why the age for starting the process was 14. It was noted that many of the cases involved complex needs and that when thinking about the next four years, the young people will be clear on what their education, aspirations and career ideas will be. It was also noted that this process would replicate a stable family life and in preparing for life, the young people would be treated the same as everyone else. It was highlighted that 14 years old was a national recommendation and regarded as good practice, as well as giving young people and parents a chance to prepare. It was also noted that not every child in the social care system will transition into the adult services.
Members queried whether a monthly review of cases was practical and whether the service could achieve this. It was noted that it was the plan to do this and to start the process at an early age for continual support. It was highlighted that these monthly reviews would depend on individual circumstances and that it was an aspiration as it was an ongoing issue. It was noted that the policy was being reviewed. Members queried how far

the service was from that frequency and it was noted that the review time varies by person but that they are fairly frequent. Members noted the 175 transitions cases and asked how many of these were Adult Social Care cases and the annual cost and budget mitigations for these. Pressures of the budget were noted and it was highlighted that work was being done to address projected spends. It was noted that funding demands were unpredictable.

Members noted that the governance felt complex to manage a small team and queried whether data and information could be lost within the governance structure. It was noted that governance was not just about the transitions team, but was a component of it, and that work was being done to look at whole system working as this was a complex service area. It was highlighted that there was also oversight of the safeguarding boards and lots of coproduction, with residents and feedback forming an important part of the system.

Members queried how determinations were made and whether there were criteria to transitions. It was noted that children's services would identify those who might need support, although it wasn't always clear, and that care act assessments would also take place. It was highlighted that children could be added later.

Resolved: That the report be noted and request an update be brought during the next municipal year.

9 **WORK PROGRAMME**

The Board noted and approved the draft work programme for 2025/26.

10 **KEY DECISION DOCUMENT**

The Board reviewed the Key Decision Document.

11 **RULE 13 AND 14**

Members noted the Rule 14 decision on the report of the Director of Public Health, entitled Young People's Sexual Health and Substance Misuse service – Contract Extension.

The meeting started at 6.00 pm and ended at 8.00 pm

Minutes of the Meeting of the Greater Manchester Joint Health Scrutiny Committee held on 14 October 2025 at 10.00 am at Transport for Greater Manchester, 2 Piccadilly Place, Manchester, M1 3BG

Present:

Councillor Elizabeth FitzGerald	Bury Council (Chair)
Councillor Colin McLaren	Oldham Council
Councillor Pat Dale	Rochdale Council
Councillor Wendy Wild	Stockport Council
Councillor Irfan Syed	Salford City Council
Councillor Emma Hirst	Trafford Council
Councillor Ron Conway	Wigan Council

Members in Attendance

Councillor Sean Fielding	Partner Member for Local Authorities, Integrated Care Board (ICB), NHS GM
Councillor Joseph Turrell	Derbyshire County Council

Officers in Attendance:

Claire Connor	Director of Communications and Engagement, NHS Greater Manchester
Jenny Hollamby	Senior Governance & Scrutiny Officer, GMCA
Paul Lynch	Director of Strategy, NHS Greater Manchester
Jo Street	Programme Director, NHS Reform and Transition · NHS Greater Manchester
Nicola Ward	GMCA Statutory Scrutiny Officer & Deputy Head of Governance

JHSC/41/25 Welcome & Apologies

The Chair opened the meeting and welcomed everyone present. Apologies for absence were received and noted from Councillor Ayyub Patel and Councillor Sangita Patel.

JHSC/42/25 Chair's Announcements and Urgent Business

It was noted that Warren Hepolette had been seconded to the GMCA to lead the delivery of the Prevention Demonstrator. On behalf of the Committee, the Chair expressed sincere thanks for his invaluable support to the Committee.

JHSC/43/25 Declarations of Interest

Councillor Liz FitzGerald declared a personal interest in Item 7 – Monthly Service Reconfiguration Report and Forward Look.

JHSC/44/25 To approve the minutes of the last meeting held on 16 September 2025

Resolved/-

That the minutes of the meeting held on 16 September 2025 be approved as a correct record.

JHSC/45/25 10 Year Health Plan and Greater Manchester Strategy (GMS) Next Steps for NHS Greater Manchester

Paul Lynch, Director of Strategy, NHS Greater Manchester introduced the report to Members and explained that it updated the Committee on how NHS Greater Manchester was developing its plans to respond to the Government's 10 Year Health Plan and Greater Manchester Strategy (GMS).

The Director of Strategy updated the Committee on changes to the Integrated Care Board (ICB) and following the publication of the 10 Year Health Plan, outlining Greater Manchester's required response. The Committee acknowledged the last decade of work building on prevention and the importance of partnership with Local Authorities (LAs), GMCA, and the Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector. Greater Manchester now had a unique opportunity to pursue a distinctive approach through the Prevention Demonstrator and Live Well programme, maintaining a focus on health inequalities.

Key areas from the report were summarised, , recommended three strategic shifts: hospital to home, treatment to prevention, and analogue to digital. Members recognised Greater Manchester's progress in these areas, supported by the new GMS. Highlighted was NHS Greater Manchester's role in regional success and the need for a collective approach to wider determinants of health.

The Live Well programme was cited as a means of empowering communities and promoting prevention, with all ten LA neighbourhoods developing implementation plans. NHS Greater Manchester and the GMCA worked closely to support the ten localities, with Stockport and Rochdale selected as pilot sites for the National NHS Neighbourhood Programme. The Committee noted the importance of a unified approach across all localities through shared learning and experience.

Greater Manchester had been confirmed as the UK's first Prevention Demonstrator andthe Committee acknowledged the early stages of the programme and its ambition to demonstrate the effectiveness of prevention, supported by robust data.

Concerns had been raised regarding the announcement to abolish Healthwatch by both Members and the public. NHS Greater Manchester intended to write to the Secretary of State about this, sharing correspondence with the NHS Greater Manchester's Board for review.

The ICB and GMS response to the 10 Year Health Plan was a focus on strengthening the role of LAs. Delivery was to be improved at place level, as illustrated in diagram 5.5 (page 29 of the agenda pack), which showed how these

elements worked together to deliver neighbourhood health and Live Well objectives. The intention was to ensure place partnerships were equipped to deliver effectively within their local contexts.

In response to a question on prevention, Members noted the establishment of the Greater Manchester Prevention Demonstrator and agreed that further updates on progress and outcomes would be brought back to the Committee.

A Member asked about the neighbourhood programme's duration and sharing learning with other LAs. It was confirmed the programme had just begun and would run long enough to establish strong foundations. A group chaired by Wigan Council's Chief Executive had been set up to bring together all ten localities, share best practice, and disseminate learning.

Shifting from sickness to prevention was noted as essential. A Member raised concerns about maintaining focus and funding for existing services. The commitment to timely, accessible services was confirmed, referencing the new Five-Year Strategy and Sustainability Plan, and emphasising the need to design services to meet future demand from an ageing population and chronic conditions.

A query was expressed regarding limited funding and training for the voluntary sector, noting it was often seen as the poor relation. The Director acknowledged the sector's vital role and confirmed that NHS Greater Manchester and GMCA had invested £10m in Live Well, with 50% allocated to the voluntary sector as a first step. Emphasised was the need for sustainable, long-term support and greater collaboration, with efforts underway to raise awareness and improve engagement across all ten localities.

It was acknowledged that overarching voluntary sector organisations, also lacked funding. In response, it was clarified that as the prevention demonstrator progressed, new investment and support for both prevention and services would be considered in future budgeting.

As a way forward, to support by Members to better understand the VCFSE sector, their role and potential funding challenges, it was agreed that a presentation would be provided to the Committee at a future date. Subsequently, representatives from the VCFSE sector would be invited to future meetings to share their experiences.

A Member asked how local delivery would be funded and supported. It was explained that the neighbourhood plan was the best approach, aiming for continual improvement and strong partnerships across health, housing, and employment. It was noted all plans and strategies would be reviewed by the ICB Board and LAs to ensure the right balance of local and Greater Manchester level support.

Members noted concerns across Greater Manchester regarding the announcement to abolish Healthwatch and the importance of retaining the patient and resident voice. The Integrated Care Partnership Board (ICPB) discussed the issue with Healthwatch present, leading to further discussions and a forthcoming meeting with the Greater Manchester Mayor. A is planned would be drafted for Government, with content reviewed by Members at the ICPB meeting on 7 November 2025. Locality boards would review changes to ensure LAs remained engaged and informed.

The challenges of reaching vulnerable groups as services shifted from analogue to digital were discussed, noting concerns about digital exclusion among those with limited access. Ongoing work at a Greater Manchester and local levels would ensure inclusivity, including quality impact assessments and targeted communications. The Director of Communications and Engagement added that her team used a range of engagement methods beyond digital to reduce the risk that anyone was excluded. Members found this approach reassuring.

The Chair requested that Officers ensure future report updates included health inequalities, prevention, timelines, outcomes of any changes, and budgets as ongoing threads of interest to Members.

Resolved/-

1. That Prevention Demonstrator updates be provided to the Committee in a

timely matter with the next update being provided in six months' time.

2. That the VCFSE sector, provide a presentation at a future meeting on their view of the greatest health issues in GM. Subsequently, representatives from the VCFSE sector be invited to future meetings.
3. That Officers ensure all future report updates include health inequalities, prevention, timelines, and budgets as ongoing threads of interest to Members.

JHSC/46/25 NHS Greater Manchester's Operating Model in Response To the National Integrated Care Board (ICB) Reforms

The item on NHS Greater Manchester's Operating Model in response to National ICB reforms was partly deferred to the 11 November 2025 meeting. However, members received a verbal update from Jo Street, Programme Director, NHS Reform and Transition, and Claire Connor, Director of Communications and Engagement, NHS Greater Manchester, outlining progress, priorities, and next steps.

The main points referred:

- The update explained how NHS reform enabled integration of health and care in Greater Manchester.
- Clarified were direction, priorities, and next steps for NHS Greater Manchester in response to national reforms, building on local ambitions and a history of integration.
- The NHS reform programme set out that some responsibilities would gradually shift to providers, regional, or national teams, with changes requiring time and, in some cases, legislative action.
- ICBs were now intended to have a maximum operating cost of £19 per head, which for NHS Greater Manchester would mean a 39% reduction in operating costs. ICBs were expected to reduce operating costs, but no national approval for a redundancy scheme had been received.
- NHS Greater Manchester remained aligned with the GMCA footprint, with no plans to merge with other ICBs.

- The vision and six missions for Greater Manchester ICB remained unchanged, with accountability for £9 billion of health spend.
- The new Operating Model aimed to strengthen place partnerships, challenge silo working, and had been supported by two years of organisational development.

The Director of Communications and Engagement added:

- From the end of October 2025 and throughout November 2025, an engagement exercise for staff and stakeholders was scheduled.
- The exercise aimed to provide a comprehensive update on the new Operating Model and its implications.
- Staff had experienced significant uncertainty, and the engagement was intended to clarify what was known and unknown, including redundancies, timelines, and consultations.
- Staff were invited to give feedback and discuss how they wished to be supported during the transition.
- Members across the system were asked to facilitate conversations within their networks.
- A slide pack and supporting materials were to be provided for Members to aid their discussions.

A Member asked whether the £19 per head for operating costs was fixed or subject to change and also asked when the slide pack would be available. It was clarified that the ambition to move to £19 per head remained, but the timeline to achieve this was uncertain and could now span a number of years. The £19 per head referred only to the ICB's operating costs, primarily staff, and did not affect healthcare delivery funding. The stakeholder slide pack was expected to be available at the beginning of November 2025, and Members were advised to review the presentation when it was provided at the next meeting 11 November before sharing locally.

The Committee expressed concern about the uncertainty surrounding the reforms, noting that potentially 600 staff members and their families could be affected. Members discussed how best to support staff and their families during this period.

The Chair highlighted the importance of addressing uncertainty and questioned the lack of information regarding any potential redundancies. The Programme Director acknowledged the challenge, emphasised the leadership team's commitment to openness and transparency, and described efforts to provide as much information as known and wellbeing support. It was noted that the timeline for any potential redundancy scheme remained unclear and could extend into the next financial year. Messages of support from stakeholders had been received and shared with staff to help alleviate anxiety.

The Chair expressed that concern for staff was a key priority for the Committee and it was agreed that a letter would be written to them explaining the Committee supported them. A letter would also be written to government expressing the Committee's focus on the workforce and how staff needed clarity of timelines, delivery and potential funding. The Statutory Scrutiny Officer and Deputy Head of Governance and Scrutiny would draft the correspondence as soon as possible, which would be shared with Members.

Councillor Fielding added that the ICP Members expressed concern and disappointment about learning of Healthwatch and ICB changes through the press, describing it as inappropriate and frustrating. The uncertainty surrounding any redundancy scheme remained a worry, but ICP Members continued to lobby for clarity. It had been reported that staff members were reassured by the ICB's proactive communication and support, and it was noted that every effort had been made in Greater Manchester to comfort and reassure affected employees and their families.

The Committee discussed integrating funding into public health budgets across ten LAs from 2026/27 to strengthen LA approaches. It was confirmed that the shared footprint with the GMCA and the ten localities provided opportunities to improve efficiency in wider public spending. Within the reform programme, NHS Greater Manchester had reviewed 20 functions through appraisals to deliver differently and was exploring joined-up leadership and financial resources. It was advised that further details on operational arrangements and delivery for improved health outcomes would be provided at the next meeting. Members noted the timescale for

implementing the new Operating Model by the end of the 2026/27 financial year. It was reported that some elements might take longer, over two years, but a material impact was expected within the current year.

A Member asked about the impact of 600 potential redundancies and any evidence of staff leaving already and the impact on service provision. Officers responded that reducing 1,600 staff by 39% would potentially affect around 600 colleagues. It was confirmed actions were underway to minimise redundancies and create other employment opportunities. At the time, turnover, sickness, and absence remained static, which suggested staff commitment remained strong. Morale was acknowledged as low but monitored through leadership briefings.

Resolved:

1. That the update be received and noted.
2. That an agenda item on the Operating Model be considered at the next meeting.
3. That a slide deck and supporting materials be prepared for Members to aid their local and wider discussions.
4. That suitable letters be prepared by the Statutory Scrutiny Officer as soon as possible and shared with Members.

JHSC/47/25 Monthly Service Reconfiguration Report and Forward Look

This report was presented by Claire Connor, Director of Communications and Engagement, NHS Greater Manchester, which provided an overview of the Greater Manchester wide service redesign projects currently progressing through for engagement and/or consultation and wider engagement projects that were supporting strategy development or listening exercises.

The following projects had been added to the report:

- Ophthalmology – Over the summer, NHS Greater Manchester spoke to 300 people across the region to gather experiences of ophthalmology services, informing the new strategy developed by the Clinical Reference Group.
- Interpretation and Translation Service - In recent months, 418 people were engaged, including 117 British Sign Language (BSL) users. Insights from both exercises were used to shape service specifications and ensure they reflected service user needs.
- ME (Myalgic Encephalomyelitis), CFS (Chronic Fatigue Syndrome) and Long Covid – NHS Greater Manchester was creating a new service that was fit for purpose and ensured the patient voice was embedded throughout its design.

The Chair asked about monitoring the implementation of services and how results needed feeding back to the Committee. It was confirmed that once engagement had concluded implementation moved to separate teams but agreed future reports would include updates on progress and outcomes as a result of consultation and engagement.

A Member asked whether patient and public engagement, particularly with seldom-heard communities, had genuinely been reached and had influenced final decisions. It was confirmed that engagement had been meaningful and previous consultations as evidence were sited. It was agreed that future reports would include evidence of reaching hard to reach groups and how engagement influence decisions.

Resolved/-

1. That report authors would be encouraged to include updates on service progress and outcomes of consultations in future reports.
2. That the Director of Engagement and Communications would ensure that future reconfiguration reports included evidence of reaching hard to reach groups and how engagement had influenced decisions.

JHSC/48/25 Work Programme for the 2024/25 Municipal Year

Consideration was given to a report presented by Nicola Ward, Statutory Scrutiny Officer and Deputy Head of Governance and Scrutiny, GMCA that provided Members with a draft Committee Work Programme for the 2025/26 municipal year.

Items for the next meeting were noted as:

1. Reconfiguration Progress Report and Forward Look
2. Major Trauma Review
3. NHS Greater Manchester's Operating Model
4. Adult ADHD Consultation Results
5. Diabetes and Cardio Vascular Disease Prevention (Deep Dive Presentation)

Given the extensive agenda for the next meeting, the Committee agreed to extend the meeting by 30 minutes if required.

The Chair reminded report authors that they must ensure future report updates included health inequalities, prevention, timelines, outcomes of any changes, and budgets as ongoing threads of interest to Members.

Resolved/-

That the meeting on 11 November 2025 be extended by 30 minutes if required.

JHSC/49/25 Date and Time of Next Meeting

Tuesday 11 November 2025 at 10.00 am to 12.30 pm, Transport for Greater Manchester (TfGM), 2 Piccadilly Place, Manchester M1 2BG.

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Report to Adults Social Care & Health Scrutiny Board

Performance Assurance Report 2025/26 Q1 (1st April to 30th June 2025) and Q2 (1st July to 30th September 2025)

Portfolio Holder (Performance): Cllr Arooj Shah, Leader & Cabinet Member for Growth

Report Owner: Mike Barker, Deputy Chief Executive (Health & Care)

Officer Contact: Steve Hughes, Assistant Director Strategy & Transformation

Overview Report Author: Gail M. Stott, Performance Improvement Lead, Strategy & Performance

PAR collated by: Performance Improvement Team and Data & Intelligence Service, Strategy & Performance

Contact: StrategyandPerformance@oldham.gov.uk

Date: 25.11.2025

Reason for decision

The Council's Performance Management Framework (PMF) underpins how we measure progress and monitor the impact of the Corporate Plan objectives. It is aligned to our Medium-Term Financial Strategy, and the outcomes will increasingly become the focus for our budget, Directorate and Service Plans.

The Framework provides measurable evidence of progress against objectives as part of a systematic process of robust corporate performance reporting to provide assurance that:

- services are aligned to corporate priorities and the needs of our residents
- our services are good, or are on track to good
- any services that are not on track, or have identified risks, are being supported or challenged appropriately
- any demand indicators or resource pressures are noted, and service provision is being re-assessed accordingly.

Report summary:

The purpose of this report is to provide an overview of directorate performance against agreed service plan measures and in the context of related reports and open (public) data. The intent is to support the scrutiny process through open and transparent discussion and challenge.

The reporting format is being developed as various overarching frameworks (national, regional and local) and digital reporting and data storytelling options emerge. The aim is to achieve a level of consistency of reporting, however, there will be some nuances in how and when we implement the framework and reporting styles used in each of the four scrutiny boards.

Recommendations

Scrutiny Board members are asked to:

- note the directorate outcomes identified
- celebrate areas of good or improved performance
- consider areas for review (good or poor) that would produce organisational learning.

Contextual considerations include:

- the interconnection between key projects and ongoing activities in other portfolio and Scrutiny Board areas
- the Council's performance reporting in the public domain – in particular the LG Inform App and Draft Local Government Outcomes Framework for Oldham
- the importance of viewing performance in the context of our borough by utilising published district profiles and the Oldham JSNA.

1. Context

1.1 Directorate service / business plans include a range of performance metrics to monitor progress in achieving the Corporate Plan objectives, statutory duties and putting our residents first.

1.2 Ongoing monitoring is important because services can be impacted by a range of internal and external factors, including changes in demand, resources, legislation or policies.

1.3 It is essential that performance is viewed in the context of our borough - the published district profiles and the Oldham JSNA provide more detail and these statistics and projections need to be considered when reviewing current and projected service levels and demands.

1.4 Performance management systems that generate data are utilised at all levels; good governance processes support a transparent performance reporting cycle.

1.5 As part of our performance management framework, each directorate has regular opportunities to review their performance at a service level and more holistically; and to raise issues or concerns or take necessary actions to improve or maintain it. Data scrutinised at this level will be more detailed and focused on the service or function.

1.6 The Performance Assurance Reports (PAR) enables key (high-level) data to be scrutinised to provide reassurance, whilst also allowing space for discussion. The format of these reports is evolving as the council navigates its digital journey. The aspiration is to offer a balance between data, insight and contextual narrative.

1.7 A standardised 'one size fits all' approach to performance monitoring and reporting is not feasible across the range and complexity of services the council provides. Some services produce data that is qualitative and readily benchmarked against milestones. To remain relevant, they need to be set in an appropriate timeframe – for example education services data needs to be reported termly, as opposed to in financial year quarters. Similarly, some strategic programmes, such as public health initiatives, will only show meaningful results over several years.

1.8 Many core services provide a supporting role so performance within their functions cannot be measured quantitively and success is identified by the performance of the services they support. To avoid repetitive or inaccurate reporting for these services, performance reporting may only occur at the beginning and the close of the year when major milestones can be effectively and accurately reflected on.

Appendices:

Health & Care Directorate Data pack and narrative:

- **Adult Social Care**
- **Public Health**

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Performance Assurance Report: Adult Social Care & Public Health

Quarter 1 – 1st April to 30th June & Quarter 2 – 1st July to 30th September 2025

Portfolio holder (Performance): *Cllr Arooj Shah, Leader of the Council*

Cabinet Member for Adults, Health and Wellbeing: *Cllr Barbara Brownridge*

Report owner: *Mike Barker, Executive Director, Health & Care*

Officer contact: *Steve Hughes, Assistant Director of Strategy & Transformation*

Report to Adult Social Care & Health Scrutiny Board: 25th November 2025

Oldham Council

Directorate overview

The Council is split into four key executive directorate areas; Place, Resources, Children & Families and **Health & Care**.

The Health & Care directorate is overseen by **Mike Barker, Executive Director, Health & Care** and consists of two directorates:

- Adult Social Care overseen by **Jayne Ratcliffe, Director of Adult Social Care (DASS)**
- Public Health overseen by **Rebecca Fletcher, Director of Public Health**
- *The Strategy & Transformation service, overseen by Steve Hughes, Assistant Director of Strategy & Transformation is also within this directorate, but performance is reported to the Governance, Strategy & Resources Scrutiny Board*

Quarter 2 introduction: Mike Barker, Executive Director, Heath & Care

This report provides a comprehensive overview of the Adult Social Care and Public Health directorates' performance for Q1 and Q2 of 2025.

It reflects a directorate that is ambitious, committed to improvement, and focused on delivering high-quality services and outcomes for residents.

There is a clear drive towards raising standards, promoting independence, and reducing reliance on long-term care, which is both beneficial for individuals and more sustainable for the system.

Quarter 2 introduction: Mike Barker, Executive Director, Heath & Care

Overall, the report paints a picture of a directorate striving for excellence and transformation, with clear strengths in ambition, partnership, and some areas of operational improvement.

However, there are persistent challenges, particularly in workforce wellbeing, information governance, and the timely resolution of complaints.

Addressing these issues, alongside filling data gaps and clarifying incomplete sections, will be crucial for sustaining progress and delivering on the directorate's ambitions.

Quarter 2 introduction: Mike Barker, Executive Director, Heath & Care

Positives

- Strong ambition and commitment to improvement.
- Increased compliments and engagement in public health programmes.
- Reduced agency spend and improved staff turnover.
- FOI response rates close to target.

Negatives

- Decline in timely complaint responses and increase in overdue complaints.
- High and rising sickness absence rate.
- SAR response rates and some disclosure requests well below target.

Balanced scorecard metrics

Customer Experience | *Workforce* | *Finance* | *Access to information*

Customer Experience

Complaints Metrics	Oldham Council Q1 Complaints	Oldham Council Q2 Complaints	Adult's & Health Q1 Complaints	Adult's & Health Q2 Complaints
Received	133	168	29	39
Completed within Target	59.8%	70.4%	66.7%	59.3%
Overdue (Open/Late)	19	13	2	6
Compliments Metrics	**Oldham Council Q1 Compliments**	**Oldham Council Q2 Compliments**	**Adult's & Health Q1 Compliments**	**Adult's & Health Q2 Compliments**
Number of Compliments*	52	66	4	9

* Not all compliments can be logged by Directorate due to lack of information so individual directorate figures will not equal overall compliment figure

Complaints – Adult Social Care

ASC complaints responded to within timescales

59.3%

Q1: 66.7%

Target: 75%

Workforce

Workforce Metric	Oldham Council Q1	Oldham Council Q2	Adults & health Q1	Adults & health Q2
Headcount*	2595	2618	236	244
Sickness Absence %	6.2%	5.04%	9.6%	12.8%
Turnover rolling 12 month %	12.9%	12.7%	13.4%	12.8%
Agency Spend Year to Date M4	£4,229,708	4.02m	£1,893,148	0.42m
Appraisals/Let's Talk	N/A	75.9%	N/A	64.2%

*Overall Headcount is measured on distinct posts, so removes numbers of people with multiple roles. Hence this number is lower than the sum of Directorate headcount

Access to information

Governance Metrics	Target	Oldham Council Q1 Overall	Oldham Council Q2 Overall	Adults Health and Care Q1	Adult Health and Care Q2
Number of Freedom of Information (FOI) requests received		401	387	36	24
FOIs answered within statutory time period	90%	357 (89%)	70	31 (86%)	16 (67%)
Number of Subject Access Requests (SARs) received		108	96	11	16
SARs answered within statutory time period	80%	40 (62.5%)	37	1 (20%)	2 (25%)
Number of Requests for Disclosure received		244	257	19	23
Number of Requests for Disclosure responded to within Target time period	80%	217 (89%)	217	13 (68%)	16 (70%)

Adult Social Care directorate

Commissioning & Market Management, Operations, Social Work, Business Strategy, Assurance & Improvement

Introduction: Director of Adult Social Care

Adult Social Care has been transforming and improving services, focusing on working with residents in a strength-based way to maximise their independence and reduce reliance on long term services.

Adult Social Care have strived to respond to complaints in a timely way. Unfortunately, during quarter two the number of complaints Adult Social Care received increased in comparison to quarter one. This has had an impact on the timely response to complaints being resolved.

The directorate continues to monitor the complaints received and identifies themes and service improvements via the Learning and Improvement board which is led by the Adult Social Care Principal Social Worker (PSW).

Adult Social Care have developed a co-production charter which underpins the newly formed Adult Social Care resident experience group. Monthly meetings and will support the directorate to develop system and service improvements aligned to resident experience.

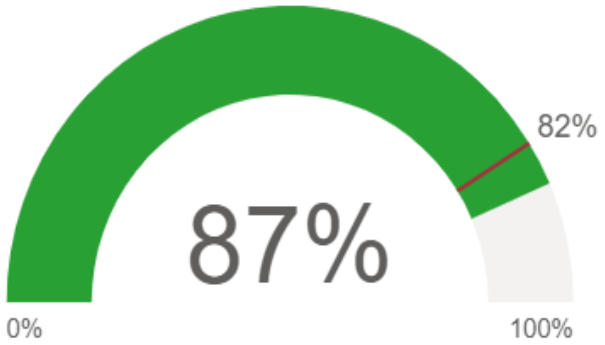
In relation to workforce Adult Social Care are undertaking targeted recruitment to support the reduction of the number of agency staff within the service and increase the continuity of permanent social worker. In turn Adult Social Care's workforce clearly defines the commitment to apprenticeships, including training and developing of staff.

Jayne Ratcliffe

Adults Social Care key metrics (target where set)

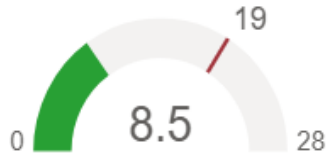
The proportion of people who received short-term services during the year - who previously were not receiving services – where no further request was ma...

Quarterly Target



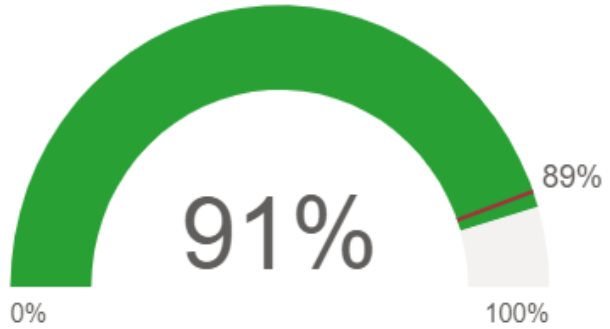
The number of adults aged 18 to 64 whose long-term support needs are met by admission to residential and nursing care homes (per 100,000 population)

Annual Target



The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital

Quarterly Target

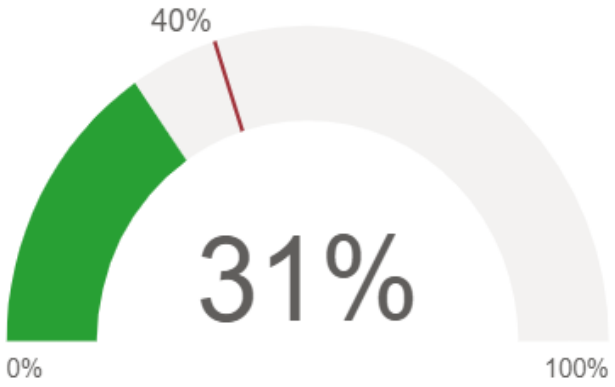


The number of adults aged 65 and over whose long-term support needs are met by admission to residential and nursing care homes (per 100,000 pop...

Annual Target

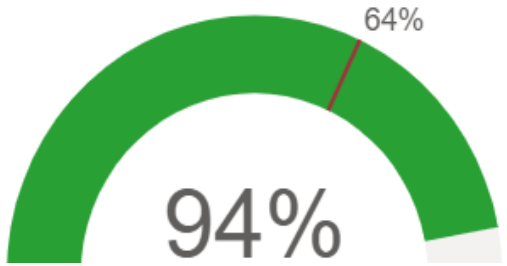
The proportion of people who use services who receive direct payments

Quarterly Target



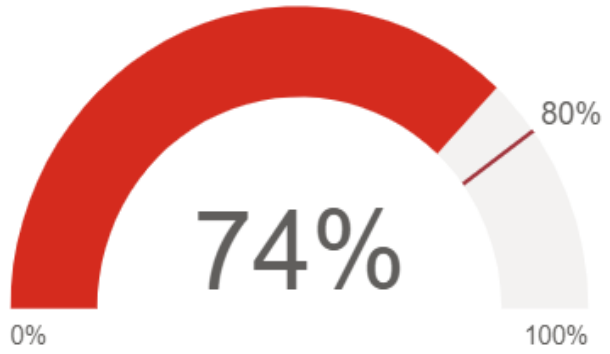
The proportion of section 42 safeguarding enquiries where a risk was identified, and the reported outcome was that this risk was reduced or removed

Quarterly Target



The percentage of adult social care providers rated good or outstanding by CQC

Quarterly Target



Adults Social Care key metrics (target where set)

The key metrics have been met for the following areas:

- proportion of people who received short term services during the year
- low number of adults in residential/nursing care
- number of people who have remained at home 91 days after being discharges from hospital
- number of people who are in receipt of direct payments - Oldham is the 5th best performer nationally in this area
- proportion of adults who when a safeguarding concern has taken place risk was removed
- in relation to the number of good/outstanding care homes, these homes are awaiting a re-inspection from CQC - in the interim, our quality monitoring team are undertaking an Oldham quality approach with the care homes to determine the level of care being provided.

Reflections from Cabinet Member

I am pleased Adult Social Care continue to meet 6 out of the 7 performance metrics. The performance metric in relation to care homes rated good or outstanding is dependent on the Care Quality Commission (CQC) inspection and several care homes in Oldham are awaiting to be re-inspected by CQC. We continues to work with care homes to support and oversee the quality of care they are providing.

There has been a slight increase in complaints during quarter 2, which has impacted on timely responses. The service is striving to be proactive in reducing complaints with a newly established oversight group to address complaint themes. The service is also undertaking targeted recruitment for those statutory social work posts to reduce the number of agency social workers.

Councillor Barbara Brownridge

Cabinet Member for Adults, Health & Wellbeing

3rd November 2025

Public Health directorate

Public Health

Sport, Leisure & Wellbeing

Introduction from the Director of Public Health

Social Prescribing referrals have increased compared with Q2 last year. There were 912 referrals in Q2 25/26, compared with 633 the previous year. The most common referral routes are Primary Care, followed by the Adult Social Care front door. In addition to referrals into the service the Social Prescribing link worker based in ARCC provided advice or guidance on a further 138 cases, supporting management of demand at the front door. Loneliness and social isolation remains the most common reason for referral into the service, with more than 50% of clients experiencing this. Overall, the proportion of clients seeing an increase in their wellbeing (measured by SWEMWBS) following intervention remains high, at 82%.

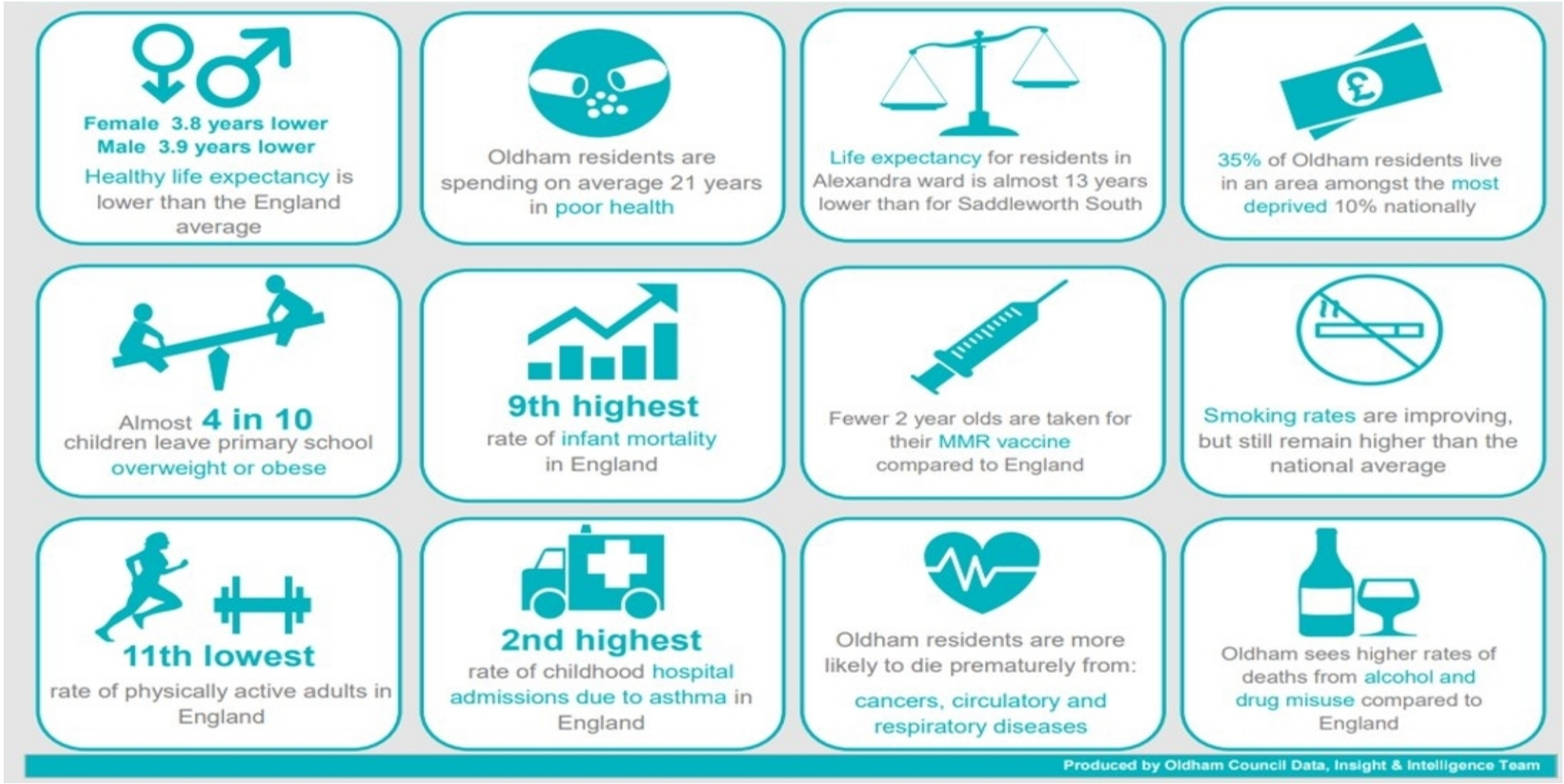
Our specialist weight management service is provided by ABL as part of the Your Health Oldham service. This continues to see extremely high referrals and has a waiting list. For those who complete the intervention, 80% achieve some weight loss.

Improving access and quality of NHS Health Checks continues to be a priority. These are cardiovascular disease (CVD) health checks for those aged over 40 who currently do not have a long-term condition. We have seen a significant increase in provision, and an increase in the proportion that include at least 8 of the 10 elements of the check. This is an important strand of our work on tackling CVD.

Over the last twelve months we have increased the numbers of residents accessing drug and alcohol treatment and overall we are sustaining that increase. Last quarter we saw a small decrease in clients accessing support for non-opiate substances. We will work with the provider on this.

Rebecca Fletcher

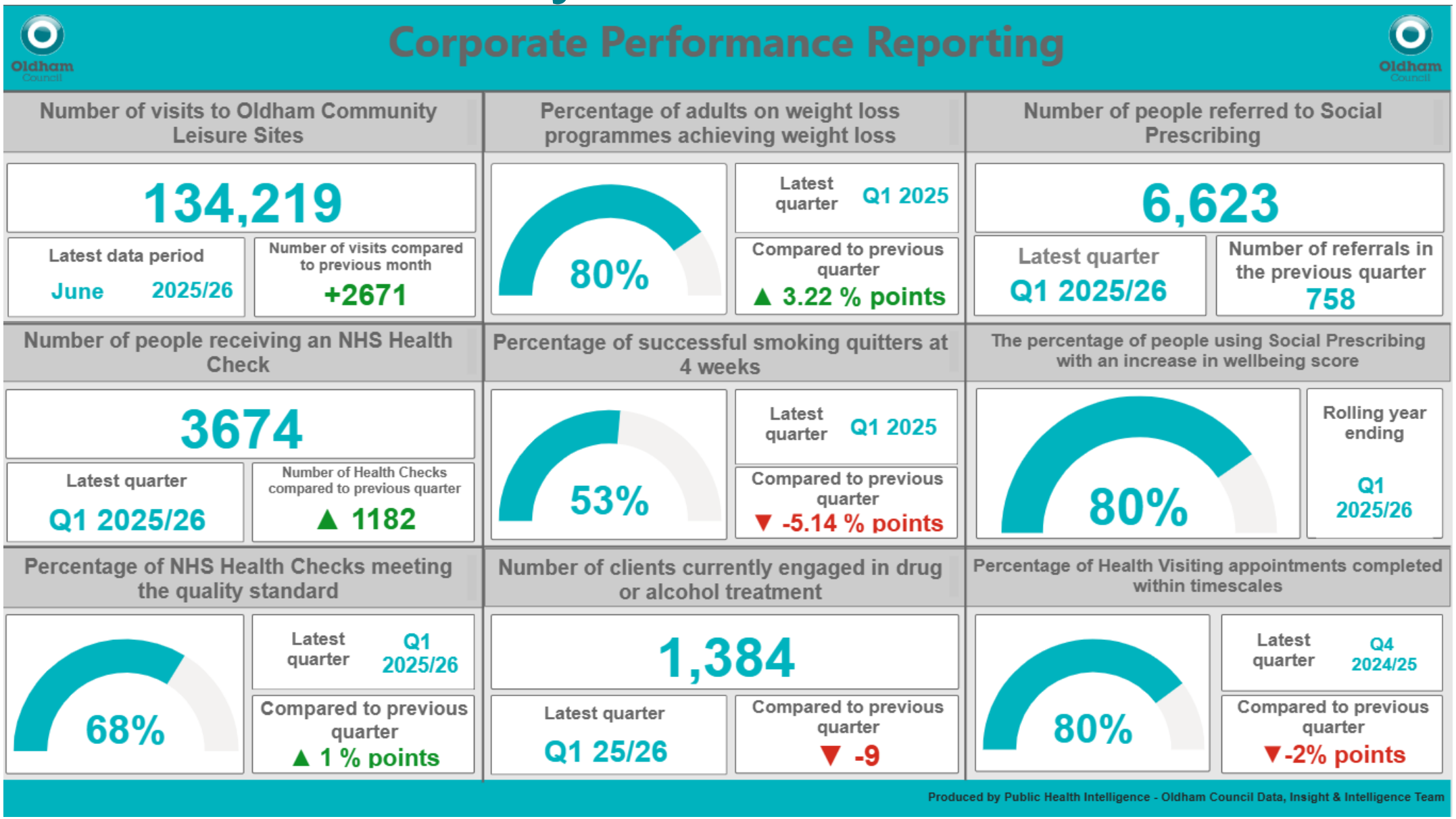
Oldham's Health in context



Public Health key metrics

Number of visits to Oldham Community Leisure Sites	Percentage of adults on weight loss programmes achieving weight loss	Number of people referred to Social Prescribing
The number of people who have visited Oldham Community Leisure sites over the past month. This measure relates to the number of visits, not distinct visitors. Data is extracted from provider systems and reported to the Council from Oldham Community Leisure on a monthly basis.	The percentage of adults completing weight loss programmes achieving weight loss in the quarter. Data is extracted from provider systems and reported a quarter in arrears due to data processing and validation by the provider and by Council Public Health Intelligence.	The number of people referred into social prescribing during the quarter. Data is extracted from provider systems and reported in arrears due to data processing and validation by the provider and by Council Public Health Intelligence.
Number of people receiving an NHS Health Check	**Percentage of successful smoking quitters at 4 weeks**	**The percentage of people using Social Prescribing with an increase in wellbeing score**
The number of eligible patients (aged between 40 and 74, not had a check in the previous 5 years and not exempt as a result of an existing condition) who have attended an NHS Health Check in the quarter. Data for this measure is a quarter in arrears due to the processing and validation of the data that is required before it can be reported. The data is extracted from GP systems (EMIS) and processed by both GM ICB and Council Public Health Intelligence.	The percentage of adults who report they have not smoked for 4 weeks from the start date of their programme. Data is extracted from provider systems and reported a quarter in arrears due to data processing and validation by the provider and by Council Public Health Intelligence.	The percentage of people who have improved their wellbeing score whilst receiving assistance from the social prescribing service as measured by the Short Warwick and Edinburgh Mental Wellbeing Scale (SWEMWEBS). Reporting for this measure is currently undergoing review and may be more delayed than usual. Data is presented as a rolling 12 months rather than an individual quarter to make this measure more robust.
Percentage of NHS Health Checks meeting the quality standard	**Number of clients currently engaged in drug or alcohol treatment**	**Percentage of Health Visiting appointments completed within timescales**
The percentage of completed NHS Health Checks that meet the Council's minimum criteria for completeness (at least 8 out of 10 elements to include Q-Risk score). Data for this measure is a quarter in arrears due to the processing and validation of the data that is required before it can be reported. The data is extracted from GP systems (EMIS) and processed by both GM ICB and Council Public Health Intelligence.	The number of Oldham clients currently engaged in drug or alcohol treatment during the quarter. Data is extracted from provider systems and reported a quarter in arrears due to data processing and validation by the provider and by Council Public Health Intelligence.	The percentage of health visiting appointments completed within target timescales during the quarter. This includes visits for 14 days, 6-8 weeks, 12 months and 2-2.5 years. Data is extracted from provider systems and reported up to two quarters in arrears due to data processing and validation by the provider and by Council Public Health Intelligence.

Public Health key metrics



Reflections from Cabinet Member

The work in improving the uptake and quality of NHS Health Checks has clearly made a real difference. This is an important way to prevent and identify heart disease early. Our GPs provide this service, and it is positive to see how many more checks they have carried out.

There has been an increase in referrals into health improvement services and increase in diagnoses.

If we continue to provide effective early intervention and prevention on heart disease, we will see fewer heart attacks and strokes happening in our communities.

Councillor Barbara Brownridge

Cabinet Member for Adults, Health & Wellbeing

5th November 2025

Oldham Council

OLDHAM SAFEGUARDING ADULTS BOARD

Annual Report & Single-Agency Statements 2024-25

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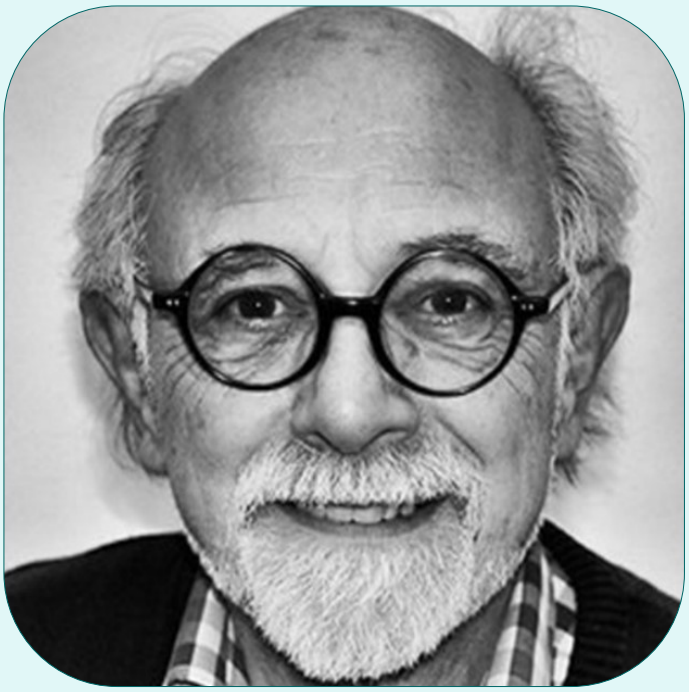
Foreword from the OSAB Independent Chair



This annual report of the Oldham Safeguarding Adults Board for 2024-25 overviews the activities undertaken by the local safeguarding partners under the new three-year safeguarding strategy for Oldham (which commenced in April 2024). Under this strategy the Board will seek to advance four strategic objectives:

- Prevention and early intervention
- Strengthening system assurance
- Listening and learning
- Embedding improvement and shaping future practice.

How these objectives were progressed in 2024-25 can be seen in the actions captured on pages 14 to 18 of this report.

The partners to the Oldham Safeguarding Adults Board are committed to the following aims:

- Engaging with local communities to understand safeguarding priorities
- Listening to the lived experience of those with safeguarding need
- Ensuring practitioners have confidence in making safeguarding personal for the individuals concerned.

We anticipate significant advances in meeting these strategic aims during the 2025-26 period.

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.

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

Who are the Safeguarding Board?

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

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

- Voluntary sector organisations
- Healthwatch Oldham
- Probation Service
- Greater Manchester Police
- Pennine Care NHS Foundation Trust
- Northern Care Alliance NHS Foundation Trust
- 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, 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 2024-25. It also provides information on the Safeguarding Adult Reviews commissioned by the Board and how the learning from these reviews has shaped and improved the way services work in Oldham.

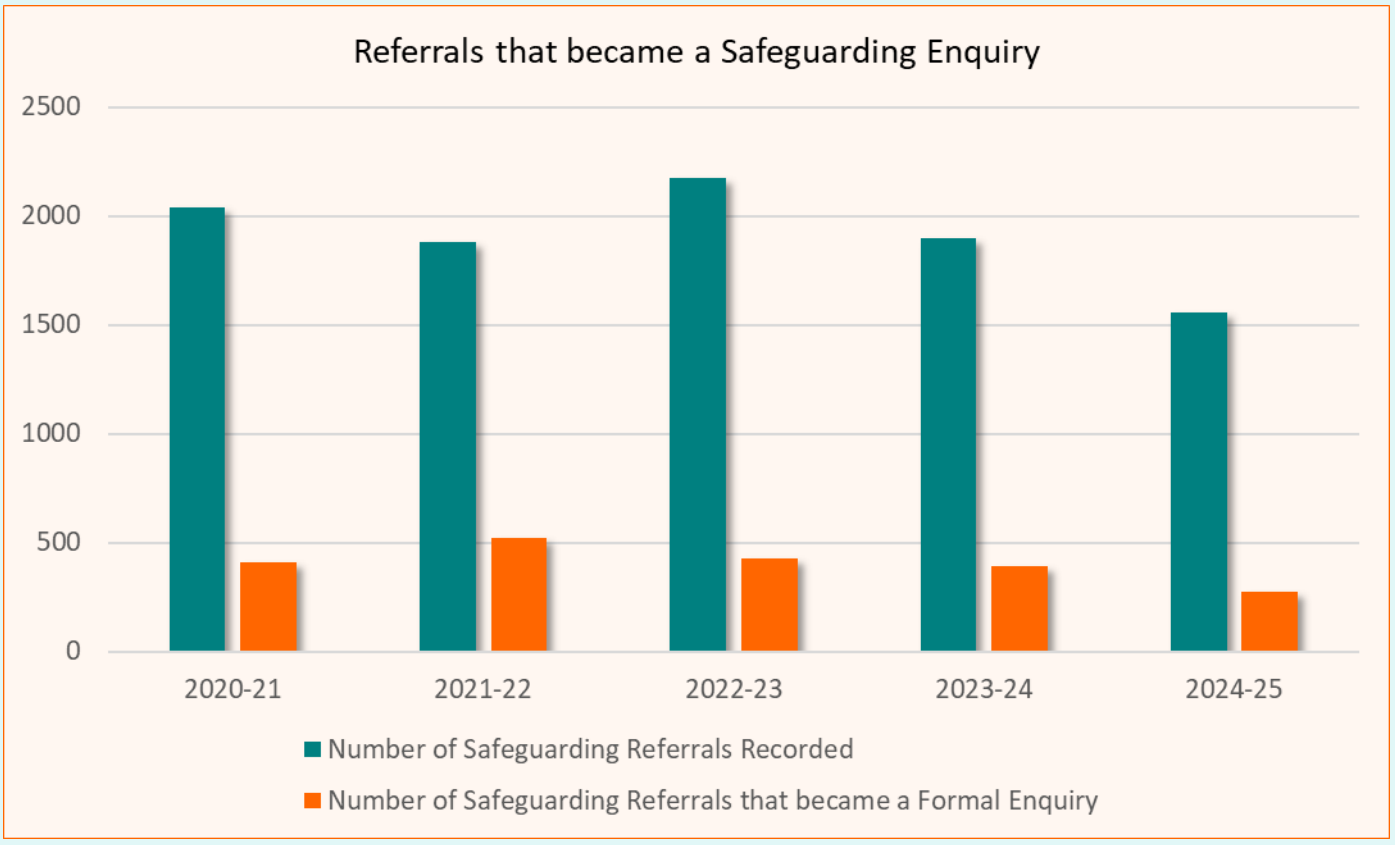
Profile of abuse and neglect in Oldham

The following information shows the numbers and types of safeguarding abuse recorded for Oldham residents in 2024-25. 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 2024-25, a total of 1559 safeguarding referrals were received and of these, 275 became a formal safeguarding enquiry. The number of safeguarding referrals decreased by 18% in 2024-25 compared to the previous year. The decrease is thought to be a result of awareness raising activity and training provided by the partnership in relation to the criteria for a formal safeguarding enquiry and alternative safeguarding pathways such as referrals to the Independent Domestic Violence Advisory (IDVA) Service and the Changing Futures team who support adults with multiple and complex dependencies. Practitioners are also utilising the OSAB Tiered Risk Assessment and Management (TRAM) Protocol which is designed to support people who are at risk of serious harm or death.

Whilst the number of overall referrals has decreased, the proportion of those that have led to formal safeguarding enquiries has remained relatively consistent, averaging at 20% over the last three years.

Sex, age, and ethnic group of safeguarding referrals

Of the 1559 safeguarding referrals in 2024-25, 57% (888) related to women and 43% (670) related to men. There was a further safeguarding referral 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 2024-25 were slightly higher for women than for men.

safeguarding referrals were concerning women in 2024-25

safeguarding referrals were concerning men in 2024-25

Of the 1559 safeguarding referrals in 2024-25:

- **79 (5%) were concerning 18-25 years olds**
- **297 (32%) were concerning 26-64 years olds**
- **240 (15%) were concerning 65-74 years olds**
- **386 (25%) were concerning 75-84 years olds**
- **357 (23%) were concerning 85 years olds or older adults**

Considering different age groups, during 2024-25, it was recorded that around 63% of all safeguarding referrals related to someone aged 65 or over. Whilst the percentage of people aged 75 years and over has decreased slightly from 51% last year to 48%, the breakdown by age group has remained relatively consistent over the last few years.

Of the 1559 safeguarding referrals in 2024-25:

- **1331 (85%) were concerning White British adults**
- **110 (7%) were concerning Asian/British Asian adults**
- **71 (5%) were concerning adults where ethnicity was Unknown/Undeclared**
- **34 (2%) were concerning Black/African/Caribbean/Black British adults**
- **13 (1%) were concerning adults of Mixed/Other Ethnicity**

Considering the ethnicity of Oldham residents, during 2024-25, it was recorded that 85% of all safeguarding referrals related to White British people. This is largely the same proportion as previous 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 2024-25 were slightly higher for White British people.

Overall, the 2024-25 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 1559 safeguarding referrals in 2024-25:

- **29% were referred by Health services**
- **28% were referred by a service Provider**
- **21% were referred by a Professional**
- **12% were referred by 'Other'**
- **8% were referred by Someone Connected**
- **1% were self-referred**

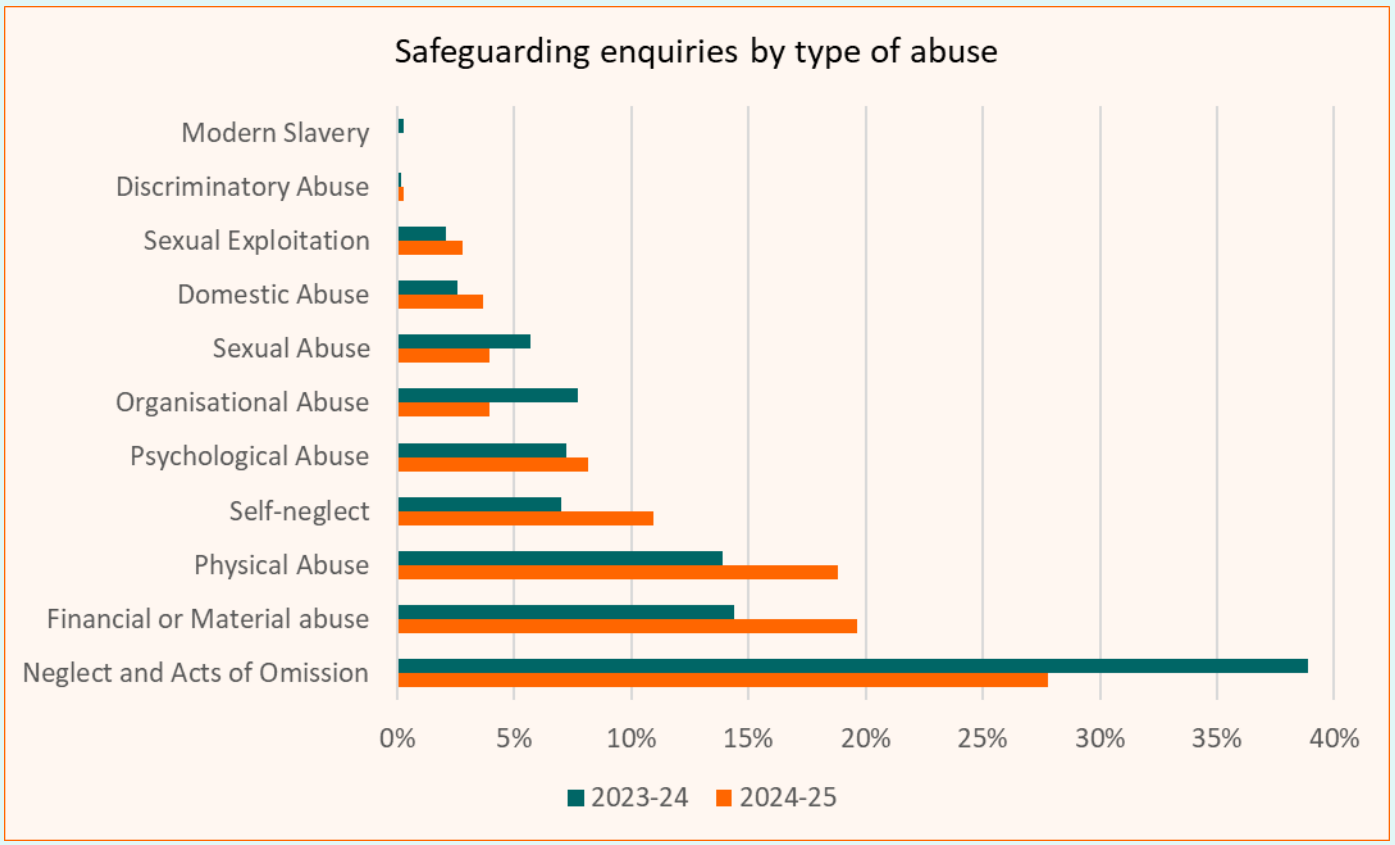
In 2024-25, most safeguarding referrals were made by practitioners from health services, local providers of care and support and local professionals.

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 2024-25 figures include a high proportion of complex safeguarding enquiry cases, with 44% of the closed safeguarding enquiries involving people who lacked capacity to make their own decisions. This has stayed relatively consistent as in 2023-24 the proportion was 43%.

Types of safeguarding abuse

The chart below shows a breakdown of the types of safeguarding abuse investigated in 2024-25 compared to 2023-24. 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.



Financial Abuse is theft, fraud, internet scamming, or coercion in relation to an adult's financial affairs or arrangements. Self-Neglect covers a wide range of behaviour to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. Sexual Exploitation involves exploitative situations and relationships where people receive 'something' as a result of them performing, or others performing on them, sexual activities.

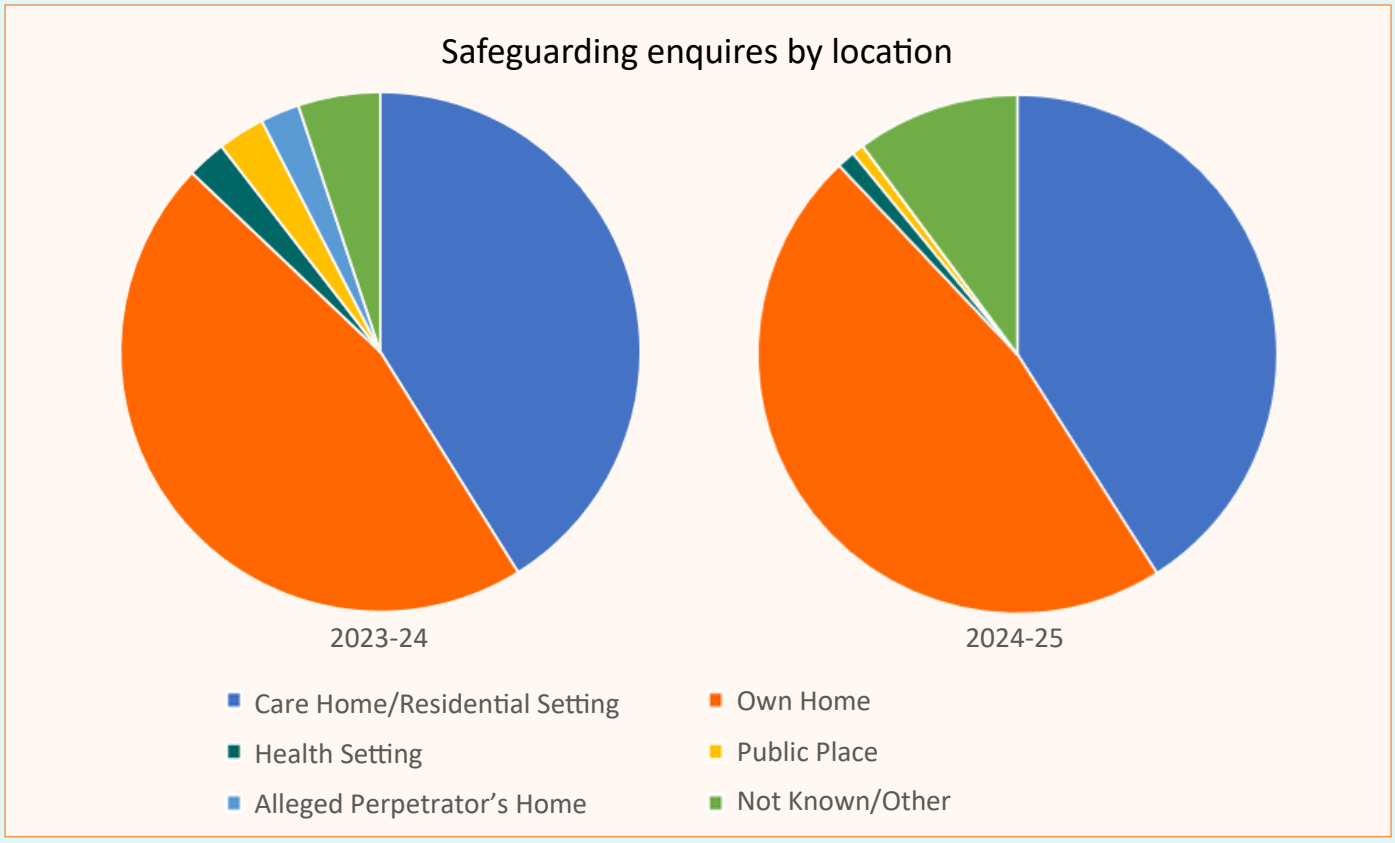
The proportion of safeguarding enquiries undertaken in 2024-25 in relation to Financial Abuse, Self-Neglect, and Sexual Exploitation increased compared to the previous year. Throughout the year, local professionals were encouraged to recognise the signs of these types of abuse and neglect through multi-agency training, practitioner guidance and briefings that the Board introduced throughout 2023-24 and 2024-25.

Although the proportion reduced compared to the previous year, the most common form of abuse in 2024-25 related to Neglect and Acts of Omission. These are cases where a person who is responsible for the support of an adult at risk has failed to provide adequate care or essentials such as medicines, nutrition, heating etc. Neglect and Acts of Omission has consistently been the most common form of abuse over the last six years.

Modern Slavery is an umbrella term for all forms of slavery, human trafficking, and exploitation. In 2024-25, there was one safeguarding referral received related to Modern Slavery ; this did not progress to a safeguarding enquiry, as it is often the case that the potential victims do not have care and support needs. These cases are usually responded to through alternative processes. Local professionals are encouraged to recognise the signs and provided with the details of the alternative processes that can be used to respond to concerns through multi-agency training, practitioner guidance and briefings that the Board introduced throughout 2024-25.

Where the abuse took place

The charts below show that for both 2023-24 and 2024-25 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

During 2024-25, a total of 1572 safeguarding referrals and enquiries were closed which is fewer than the 2569 closed during the previous year. This is consistent with the fewer number of referrals received. The 1572 closed is more than the 1559 referrals received in the year, this is due to a drive by Oldham's Strategic Safeguarding Service to increase the number of timely closures of referrals and enquiries and includes the closure of outstanding cases from 2023-24.

OSAB regularly review partnership safeguarding data. In 2024-25, 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 on safeguarding data, the focus is often on safeguarding enquiries, because this is a statutory responsibility. But this is only part of the picture. In 2024-25, Adult Social Care worked with other partner agencies to respond to a further 1284 safeguarding referrals that did not meet the criteria for a safeguarding enquiry, but often involved a great deal of work to keep people safe and well.

In Tim's case a referral was made about self-neglect and hoarding. Tim's story involves a number of agencies and is provided to demonstrate what we have learnt to date, what has been making a difference to safeguarding practice and to outcomes for individuals, and where we are experiencing challenges.

Tim

Adult Social Care received a referral in relation to Tim and enlisted the support of Age UK Oldham to respond. Tim felt really embarrassed about the way he was living; he felt like he was living a double life. He explained that he was a hoarder, and he had let his home get into a 'complete state' due to poor health and the passing of his mother. After initially stating that he felt ashamed to let people in due to the condition of his home, Tim agreed to a visit from Age UK Oldham to discuss any support they could offer him.

The property was very cold and packed with various items including clothes, furniture and a fridge freezer blocking a door. There was very little floor space to move around. Tim explained that he had not had heating or hot water for over seven years and was showering at the local sports centre. Tim told Age UK Oldham that a leak in an upstairs toilet had created a hole in the kitchen ceiling and as there was no electricity upstairs, trip hazards had been created because lighting was poor and he had an extension lead running up the stairs.

Tim explained that an infestation of bugs was eating away at the carpet, and an infestation of rats was also creating problems. Tim's kitchen was considered to be unsafe and unhygienic; he was using an air fryer to cook all of his meals.

Tim explained that he was receiving benefits and had very little funds to get the property to a habitable state. Tim was very emotional and explained that the condition of the property was having an impact on his mental health.

Utilising the Tiered Risk Assessment and Management (TRAM) Protocol, Age UK Oldham led a Team Around the Adult made up of Tim's social worker, the safeguarding team, Environmental Health, and Mind. Risk assessments and risk action plans were developed. Environmental health visited the property. A deep clean and electrical testing were arranged. Age UK Oldham supported Tim with roofing issues as well as some insurance issues, seeking Citizen's Advice support with an insurance claim. There was contact with the Local Energy Advice Partnership for support with a new boiler and kitchen appliances. Referrals were made to Mind, the Age UK Oldham meals delivery and shopping service, and also to Greater Manchester Fire and Rescue Service for a Home Fire Safety Assessment. The Age UK Oldham Navigator supported Tim by being present with him at the property when other agencies visited.

Tim is now living in much better conditions. He has a new boiler and has access to hot water and heating and is able to use his own facilities at home. He is no longer experiencing any issues with rat infestations. Following the deep clean, many of the rooms are now clutter free, safe and hygienic. The electricity is now safe, and his kitchen ceiling is repaired and watertight.

Tim's mental health has improved significantly due to the dedicated support that was provided by the Age UK Oldham Navigator and their work with partner agencies. Tim has said: "*The support I have received from the Age UK Oldham Navigator has been amazing and I am not sure where I would be now without the support that was provided.*"

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.

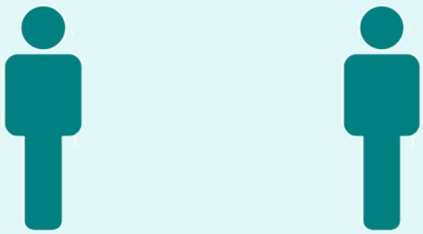
Central to the process is the involvement of the individual if they are still alive, or the family. This ensures that the Board captures the experiences of people who use services and use this insight to inform any changes.

SARs Concluded in 2024-25

During 2024-25, the Board received seven SAR referrals in total. All of which were screened by a multi-agency panel to determine if the criteria defined in the Care Act had been met. Four of the referrals met the criteria for a Mandatory SAR as all statutory criteria had been met.

The information below shows the increase in the number of SARs completed in 2024-25 compared to the previous year.

2023-24 2 Safeguarding Adult Reviews



2024-25 3 Safeguarding Adult Reviews

Common learning themes emerging from the three SARs completed in 2024-25 involved the assessment of an individual's mental capacity in line with the Mental Capacity Act (MCA); multi-agency management of risk and sharing of safeguarding information; Complex Safeguarding and exploitation; defensible decision making; adoption of a 'Think Family' approach, the practice of considering the entire family unit when working with an individual; and ensuring the use of reasonable adjustments, which are changes or modifications to services to ensure individuals can access and benefit from them as easily as everybody else, learning included the need for measures to enable appropriate adjustment of workloads that allow particular professionals more time to support some individuals.

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. On 31 March 2025 the status of each was as follows:

Completed/Implemented Recommendations:

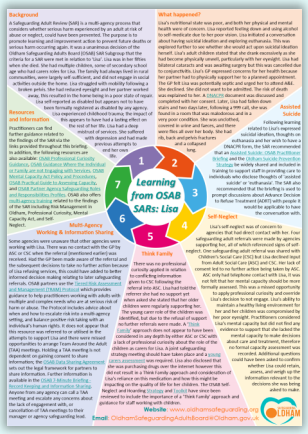
- OSAB should satisfy itself as to whether local policies and protocols are sufficiently clear about the duty to make safeguarding referrals without delay and the use of strategy meetings to plan the conduct of enquiries and interviews that take account of additional factors including learning disability, mental capacity and mental illness.
- Children's and Adult Social Care should provide OSAB with assurances about the effectiveness of current transitional arrangements for children and young people with learning disability and consider further areas for development.
- OSAB should publish a practice briefing rather than the full SAR report.

Recommendations where further assurance was required regarding completion or implementation:

- 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.
- The OSAB should refer the report to the appropriate subgroups to examine further how specific areas of learning from the SAR could be taken forward.
- Children's Social Care should provide OSAB with assurances about the implementation of the National 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.

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. On 31 March 2025 the status of each was as follows:

Completed/Implemented Recommendations:

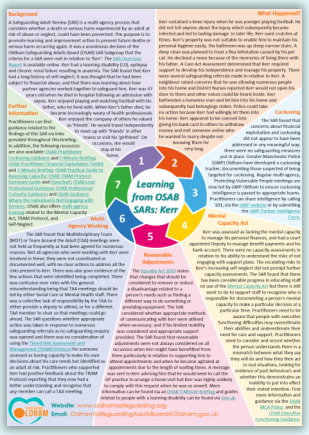
- OSAB have sought assurance and feedback from partner agencies concerning the embedding of the cultural change that the Tiered Risk Assessment and Management (TRAM) Protocol represents. OSAB should progress the findings of this exercise and
  - → seek assurance from agencies that an appropriate escalation/advice champion model is agreed internally and that this is subject to an internal communication strategy for all agencies.
  - → support further awareness raising via the development of the new workforce development resources including podcasts and single-agency role and responsibilities profiles.
- That OSAB, Oldham Safeguarding Children Partnership (OSCP) and partner agencies work together to embed the 'Think Family' approach to safeguarding ensuring that practitioners are aware that a refusal of services or a lack of consent to share information does not preclude the sharing of relevant information with appropriate professional colleagues. This is to enable the assessment of the risk of harm within a family and possible steps to mitigate that harm from occurring.
- OSAB should work with partner agencies to develop the 'Think Family' approach in all safeguarding work to ensure the voice of the adult and the voice of the child is heard and responded to.
- That OSAB receives assurances from partner agencies that further steps to embed professional curiosity will be taken to allow better understanding and recording of the lived experiences of those known to be at risk of abuse and harm is documented to allow the risk to be evaluated.
- That OSAB raise awareness across Oldham about when information can be shared in a safeguarding context to include when consent must be overridden.
- OSAB should review the Multi-Agency Policy and Procedures and consider inclusion of highlighting when it would be good practice for Adult Social Care to inform other agencies when a safeguarding concern has been raised (even if the outcome is no further action) for example if they were the referrer, if they needed to be informed as part of prevention via monitoring as risk that has the potential to recur, or if they were part of ongoing risk management plans.
- OSAB should seek assurance that partner agency policies and processes related to individuals who are not attending appointments/visits, are not engaging with a service, or are non-concordant with treatment, care and support, are person-centred and demonstrate supportive and trauma informed approaches.

Recommendations 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.
- 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.
- That 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.

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. On 31 March 2025 the status of each was as follows:

Completed/Implemented Recommendations:

- That OSAB receives assurance from partner agencies that the OSAB Cuckooing Guidance and 7-Minute Briefing guide on cuckooing continues to be embedded across Oldham and that any concern by agencies that someone they are working with is suspected of being vulnerable to cuckooing is shared with GMP Oldham District to allow efficient use of their fortnightly multi-agency Protecting Vulnerable People meetings in assessing risk and implementing safety plans.
- That OSAB promotes that agencies evidence that reasonable adjustments are made for people who would require these so that they have equal access to services in line with the Equality Act 2010. And, that OSAB considers whether a briefing paper should be produced reminding all agencies of the need to consider reasonable adjustments particularly with LD who have multiple needs.
- Partner agencies of the OSAB should consider what further action is required to provide assurance to the Board that the learning from SAR 'Derek' is embedded in respect of multi-agency working and escalation; single agency escalation; professional curiosity; and risk assessment.

Recommendations where further assurance was required regarding completion or implementation:

- 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.

SARs Started in 2024-25

Adult 1

An older male with mental and physical health needs including challenges with his mobility. It was recognised that there had been missed opportunities for partner agencies to manage and monitor his needs more effectively; and although a natural cause of death was found, it was suspected that self-neglect and neglect may have been contributing factors.

Adult 2

A young male with mental health needs. There were concerns around cuckooing, financial abuse and self-neglect. It was recognised that there had been some positive interventions and some intense work undertaken with the male by multiple agencies over a number of years but a coordinated approach was not seen, and a Team Around the Adult approach had been needed earlier.

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. In addition, Oldham has an ethnically diverse population and areas with high levels of poverty. We are committed to working together to make sure that safeguarding is everyone's business, and we are committed 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 2024-25, 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 and there is more to do to improve how we engage with adults as a partnership.

Sadiqa - An Empowering Story of Hope

Following the success of the Eggshells short film in 2022, OSAB built on its collaborative relationship with Made by Mortals, a participatory arts organisation who work closely with communities to understand their lived experience and transform this into creative resources to change practice, policy and create wider, deeper understanding. An exciting new training package was launched in 2024-25; 'Sadiqa' is an audio story that allows the listener to walk in the shoes of a woman from the South Asian community who has experienced domestic and honour-based abuse and has left the abusive situation. Sadiqa is a fictional character devised by women, using their skills, imagination and lived experience as inspiration. Sadiqa's story contains the voices of 'real people', speaking in English and community languages.

The training package enables organisations to run workshops on domestic and so-called honour based abuse, and explore community support. At the May 2024 OSAB Development Event, senior representatives from partner agencies donned blindfolds and audio headsets to fully engage with Sadiqa's Story. The session received overwhelmingly positive feedback and was followed by a reflective discussion about local practice. Subsequently, key multi-agency actions were agreed to improve local responses to so -called honour based abuse including full day training sessions for Oldham practitioners.

In July 2024, OSAB concluded a SAR in relation to 'Aleina' which provided significant learning about so-called honour-based abuse including forced marriage. As a result, further actions were agreed which will be finalised in 2025-26, including providing practitioners with the opportunity to participate in the immersive Sadiqa's Story workshop and the development of two new procedure and guidance documents covering so-called honour based abuse and forced marriage.

Working in Partnership in 2024-25

The role of the Board is to ensure that agencies work together to help adults live safely. To provide clear direction, the Board produces a three-year strategic plan. 2024-25 represented the first year of the 2024-27 Three-Year 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 2024-25 Business Plan was published at the start of the year. The timeline below sets out just some of the headline achievements during 2024-25 as partner agencies worked towards achieving their annual plan.

April 2024

OSAB Making Safeguarding Personal Audit Findings

Findings from a 2023-24 **audit concerning application of the Making Safeguarding Personal (MSP) principles** were presented to OSAB Board in April, who subsequently agreed to **positive actions in response** including awareness raising with practitioners in relation to MSP and recording keeping, and advocacy, and development of Partner Agency Safeguarding Roles Responsibilities Profiles designed to improve understanding of each other.

June 2024

Embedding Learning from SARs

The completion of SARs in relation to Aleina, Lisa, and Kerr in 2024-25 involved OSAB determining 26 new actions to be undertaken in response. **Exceptional multi-agency effort saw almost 60% of all outstanding actions derived from SARs reach conclusions.** This included assurances provided by partner agencies concerning key areas of practice including engagement, visibility to community and supervision arrangements being approved by the Safeguarding Review Subgroup in June.

August 2024

Mental Capacity Assessments Guidance: What Questions Should I Ask?

Following a multi-agency audit, feedback from agencies, and SAR learning, **partner agency representatives collated example questions to support staff to complete robust mental capacity assessments** related to some common decisions. The new practitioner guidance was published in August.

DID YOU KNOW?

In 2025-26, OSAB offered multi-agency training courses about **ten** different safeguarding topics on a number of occasions and also hosted **three** different learning events. These were attended by **more than 600** practitioners and managers representing **more than 50** different services from the statutory and voluntary sectors!

May 2024

OSAB Practitioner Briefings

OSAB produced **eighteen grab guides and seven-minute briefings** in 2024-25, including in May, a briefing covering what the response should be when assisted suicide is raised by adults practitioners work with. This was then utilised by Safeguarding Adults Boards nationally. Briefings covered key topics ranging from essential learning from SARs and gaining access to support an adult, to reasonable adjustments and safeguarding individuals with pressure ulceration.

July 2024

Assurances

OSAB accepted **timely assurance in July regarding 'Right Care, Right Person' implementation** and associated partnership actions. In 2024-25, assurances were also provided in relation to the local response to measures to manage a national prison capacity crisis, development of transitions processes, support for survivors of non-recent Child Sexual Exploitation, risks identified in Learning Disability services, and preparedness for external assessment.

DID YOU KNOW?

OSAB and Oldham Domestic Abuse Partnership launched a new practitioner guide to supporting individuals suffering domestic abuse, detailing questions to ask and local support pathways.

DID YOU KNOW?

The 'Think Family' approach was promoted by OSAB via new OSAB Safeguarding Supervision Guidance in April, a refresh of the OSAB Self-Neglect and Hoarding Strategy and Toolkit in June and a new OSAB 7-Minute Briefing in March.

September 2024

Adult Complex Safeguarding & Exploitation Strategy 2024-27

Launched in September, the 2024-27 strategy was developed as a joint initiative between the Children's and Adults Safeguarding Boards and Oldham's Community Safety Partnership. **The strategy sets out multi-agency commitments and explains how partners will tackle the constantly evolving landscape of exploitation** through the sharing of intelligence; listening to the views of victims and survivors; and working collectively beyond traditional age, statutory and geographical boundaries, to ensure a whole system response.

October 2024

Tri-Borough Mental Capacity Act (MCA) Learning Hub Event

Following feedback from HM Coroner, OSAB worked with Bury and Rochdale colleagues to host **an event focused on complexities experienced by practitioners related to the MCA**. 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**.

November 2024

National Safeguarding Adults Week

New Resource Launch

New resources to support practitioners with multi-agency risk management were launched alongside new Greater Manchester Fire and Rescue Service Hoarding Safety Tips and details of forthcoming changes to the OSAB adult safeguarding policy and procedures.

Opportunities for Practitioners

Practitioners were invited to attend training about Hoarding, How to Make a Safeguarding Adult Referral, Responding to Domestic Abuse in Later Life and the TRAM Protocol.

OSAB 'We Need to Talk About Hoarding' Conference

92 strategic and frontline practitioners attended a conference which included the voice of an Oldham resident with lived experience; shared examples of local cases and learning; and included the psychiatric perspective and details of the local Peer Support Group. The keynote speaker shared their thoughts on hoarding, views about responses nationally and provided examples of responses in other areas. Attendees were asked to provide their thoughts and feedback about the local response and the results were used to shape the ongoing work of the Hoarding Improvement Partnership (HIP).

December 2024

'The OSAB Gab': OSAB Podcast Launch

The launch of 'The OSAB Gab', a series of podcasts about different topical safeguarding issues, on all podcast platforms including Spotify, Amazon Music, Apple Podcasts, and RSS.com was well received. Following practitioner feedback and in line with OSAB priorities, the first episode focuses on 'Practice Informed by Trauma' and the second on 'Chairing Multi-Agency Safeguarding Meetings'. **These two episodes were listened to by more than 70 practitioners in the first six months.** The third episode covering Team Around the Adult and the TRAM Protocol will be released in 2025-26.

DID YOU KNOW?

From November onwards, **OSAB expanded its Data Dashboard to include quarterly updates concerning Modern Slavery** from Greater Manchester Police colleagues from the Programme Challenger team, Greater Manchester's partnership response to serious and organised crime. This includes regional and local data allowing partners to interrogate and analyse data to understand local activity, identify trends, and provide strategic multi-agency responses.

OSAB.org.uk, @SafeguardOldham and the Oldham Safeguarding Bulletin

During 2024-25, the OSAB website was visited more than **17,000** times (an increase of 3,000 compared to the previous year)! The most visited page was 'News and Events' where all new policies, guidance, and learning opportunities are promoted with 7-Minute Briefings proving most popular. The busiest periods were undoubtedly when details of Safeguarding Adults Week were released and during the week itself.

During 2024-25, tweets by @SafeguardOldham were seen more than **9,000** times!

There are now more than **1,500** subscribers to the fortnightly Oldham Safeguarding Bulletin!

Eggshells - OSAB Short Film

The **Eggshells short film** was designed to help everyone recognise the signs and promote an understanding of escalating domestic abuse over time, particularly coercive and controlling aspects. It was co-produced with a team of professional artists, partners from health and social care and a group of women from Oldham who courageously shared their lived experience as a way of helping others going through the same experiences.

Since its launch two years ago, Eggshells has been watched more than **1,050,000** times, and received more than **31,000** likes and more than **2,700** comments from people all over the world! The short film also won the Semi-Finalist Award at the Lonely Wolf International Film Festival!

January 2025

Cuckooing, County Lines and Beyond: Multi-Agency Learning Session and Q&A

In January, University of Manchester and North West Regional Organised Crime Unit representatives facilitated a fantastic event drawing on operational examples and combining them with an academic perspective to explore the challenges of defining and responding to cuckooing. **More than 60 practitioners benefitted** from Adult Social Care, Education, First Choice Homes Oldham, Focused Care, ForHousing, Jigsaw Homes, NHS Integrated Care Board, MioCare, Northern Care Alliance, Pennine Care, Positive Steps, Guinness Partnership and Turning Point.

OSAB supported a **Greater Manchester Modern Day Slavery Week of Action** by inviting practitioners from across Greater Manchester to join a police led 'Understanding Modern Slavery and Human Trafficking' webinar.

DID YOU KNOW?

February 2025

First Annual Workforce Confidence Survey

The first annual workforce confidence survey launched in February. Although originally planned to only cover mental capacity, it was agreed that the survey was an opportunity to provide evidence that the overall work of OSAB is having an impact on safeguarding practice locally. **100+ responses were received from across every OSAB partner agency**.

March 2025

Learning From Lives and Deaths (LeDeR) Programme

In March, **the pertinent learning and identified positive practice from the Greater Manchester LeDeR Annual Report was shared** with the OSAB Statutory Leadership Group. LeDeR is the service improvement programme for adults aged eighteen and over with a Learning Disability or a clinical diagnosis of autism. There was a focus on the learning themes seen in Oldham cases and how these were being addressed. The processes linking LeDeR reviews and OSAB SARs and the scoring system used by the LeDeR programme were also clarified.

DID YOU KNOW?

OSAB are supporting a three-year **Safeguarding Adults For Empowerment (SAFE) research project**, led by the University of Sunderland, to improve safeguarding for older adults by addressing gaps in the understanding and implementation of 'making safeguarding personal'. **The first stage, involving older Oldham residents discussing their views on safety and safeguarding during an arts-based workshop, was completed in December**. This will influence the next stages involving interviews with people who have been subject to a safeguarding enquiry and family member advocates. The project will lead to findings, events and resources designed to improve practice in Oldham and nationally.

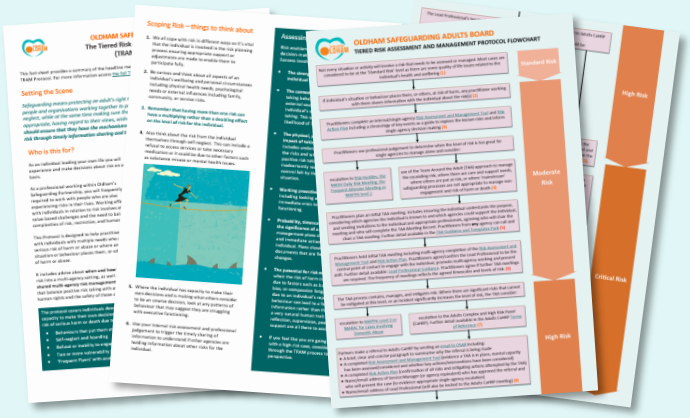
Embedding the TRAM Protocol in Oldham

What is the TRAM Protocol?

The OSAB Tiered Risk Assessment and Management (TRAM) Protocol sets out a shared commitment across agencies in Oldham to working with risk. It provides guidance to help practitioners working with adults with multiple and complex needs who are at serious risk of harm or abuse. It includes advice about when and how to escalate risk into a multi-agency setting, as well as how to run shared risk management processes that balance positive risk taking with an individual's human rights.

The TRAM Protocol was developed by OSAB based on learning from SARs, professional experience and academic research. The TRAM Protocol is specifically designed to support professionals working with adults deemed to have capacity to make their own decisions, but who are at risk of serious harm or death due to:

- Behaviours that put them at risk
- Self-neglect and hoarding
- Refusal or inability to engage
- Two or more vulnerability factors
- 'Frequent Flyers' from acute service.



Culture Change

The Protocol was launched in February 2022. At that time, it was recognised that the Protocol represented a significant culture change in local safeguarding practice. For this reason, the embedding of the Protocol has featured on the OSAB Business Plans each year since. The processes the Protocol put in place and associated training have been regularly adapted as lessons have been learnt from practice and feedback has been received. In order to support the embedding of the Protocol, OSAB created a short TRAM Protocol Summary Guide and a two-page TRAM Protocol Flowchart (shown above) and offered regular multi-agency training: 'Risk Management in Oldham: Team Around the Adult and the TRAM Protocol'.

Single-Agency Assurance

Learning from SARs highlighted the need for OSAB to seek assurance from partner agencies that the Protocol was being effectively embedded in their frontline practice. Senior representatives from each OSAB partner agency were asked to initiate conversations with practitioners and use their knowledge of current practice to provide some feedback and assurance about the Protocol.

Agencies provided some clear assurances of their commitment to the cultural change that the Protocol represents and clear assurance that the Protocol was becoming increasing embedded. Some examples of excellent practice were also highlighted. Simultaneously, some responses indicated a need for further achievable single-agency and multi-agency actions to support as many practitioners as possible to be fully aware of and confident with utilising the Protocol.

Actions Taken in 2024-25

Throughout 2024-25, the multi-agency OSAB Policy, Procedure and Workforce Development Subgroup, who developed the Protocol, took a number of actions based on all the single-agency assurance and feedback received from practitioners and senior leaders to ensure further successful embedding of the Protocol. Some of their work is highlighted below.

Improvements to Confidence to take Lead Professional Role and Chair Meetings:

The Team Around the Adult (TAA) Guidance and Templates Pack within the Protocol was reviewed to ensure all resources were appropriate for use by all agencies and to support the Lead Professional role. Multi-agency Safeguarding Supervision Guidance was launched including 'Working with Complexity' as a key consideration during reflective supervision and highlighting details about the Protocol. A new episode of the OSAB Gab Podcast was released as a supportive resource for practitioners chairing any multi-agency adult safeguarding meeting in Oldham.

Reflective Discussions:
Arrangements were put in place so that practitioners are now given the opportunity to share their experiences, feedback and any queries about the processes as part of every multi-agency training session. The Protocol also includes a section offering practitioners this opportunity via the OSAB Business Unit. Practitioners are now also encouraged to share their thoughts and feedback with their agency Safeguarding Lead; all challenges, concerns and suggestions are then raised for discussion at the Subgroup every eight weeks.

Supporting with Limited Experience of Using the Protocol:
Practitioners are given an opportunity to attend multi-agency training at least once every twelve weeks. A one-page poster/flyer template about risk escalation, including links to Protocol, training, and space for agencies to include their own appropriate escalation/advice/champion contact, was provided and single-agency assurance sought that this was subject to an internal communication strategy.

Improvements to Agency Accountability for Participating in TAAs and Completing Actions:
The OSAB Independent Chair contacted all agency lead representatives about the multi-agency agreements in place around attending TAAs and included a reminder of escalation routes. Agency expectations of each other were made clear within the TAA guidance encouraging achievable actions to be set in meetings with realistic timescales for completion.

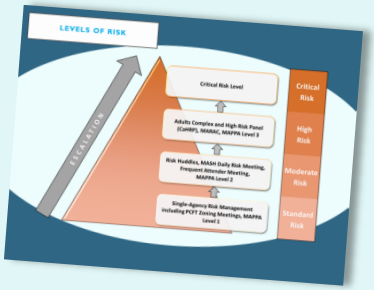
Practitioner Understanding of Different Processes:
The Protocol was updated to include both a clear definition of MARAC (Multi-Agency Risk Assessment Conference in relation to Domestic Abuse), and an explanation of MAPPA (Multi-Agency Public Protection Arrangements concerning violent and sexual offenders living in the community) through a new 7-Minute Briefing, to avoid any duplication with the TAA process.

Resolving Challenges with Duplication of Documentation Required:
The requirement for TAAs to develop the risk assessment and risk management plan for the person they are supporting using only the templates provided in the Protocol was relaxed. In some cases, TAAs can refer a case to the Adults Complex and High Risk Panel (CaHRP) using established single-agency versions of the templates.

Practitioners Understanding of Each Other's Roles and Responsibilities:
Each agency provided a profile with the aim of improving multi-agency understanding of each other's safeguarding roles and responsibilities and avoiding any delays in delivering person-centred safeguarding responses. Each profile also includes some common misconceptions about what each agency can provide support with, as well as basic information about how to access their service(s). These were published as Partner Agency Safeguarding Roles and Responsibilities Profiles and were widely promoted.

Removing Practitioner Expectation that the Lead Professional Role will Always be Taken by a Statutory Agency:
The OSAB Lead Professional Guidance was promoted highlighting that many practitioners in the adults workforce can take on the Lead Professional role, as the skills, competence and knowledge required to carry it out are similar regardless of professional background or role.

Improvements to Training and Training Rollout:
New case studies were added to the multi-agency training to ensure these covered a wide range of safeguarding practice areas and were therefore relevant to attendees from all partner agencies. Training attendance data was shared with agencies to support targeted promotion across the partnership.



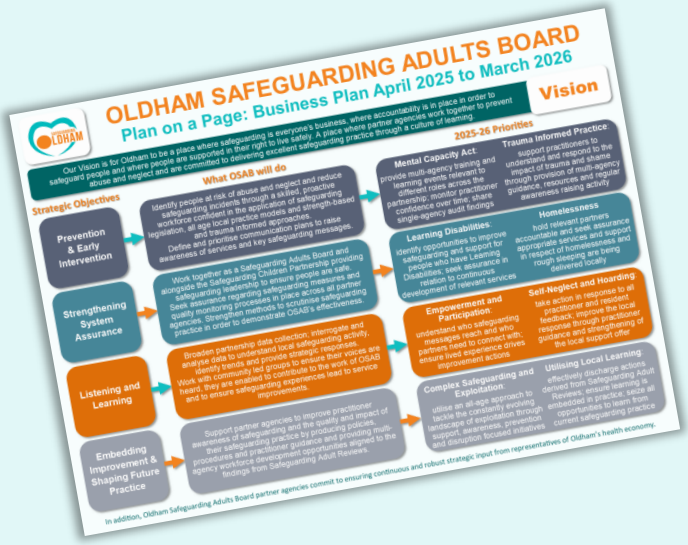
Continuous Improvement

OSAB recognise the embedding of the cultural change as an ongoing task, particularly as new practitioners regularly join Oldham. There is a shared commitment to continuous development of the Protocol as lessons are learnt through experience in practice and regular feedback.

Plans for 2025-26

2024-25 was the first year of the Board's Three-Year Strategy which set out its strategic aims from April 2024 to March 2027 by identifying the partnership's shared vision and direction for safeguarding adults within Oldham. The Board made significant progress throughout 2024-25. Progress against the year's priorities and potential new priorities for the partnership were considered at a Development Event held in April 2025. This resulted in partner agencies developing their plans for 2025-26 under 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 2025-26 follow.

The Board will:

- review the findings of the first annual **Workforce Confidence Survey** and undertake a second survey to monitor progress in key practice areas, particularly practitioner confidence in applying the **Mental Capacity Act**, following supportive actions that will be taken throughout the year including the offer of multi-agency training sessions and a chance for further practitioners to benefit from the Tri-Borough Learning Event.
- continue to ensure all actions derived from **Safeguarding Adult Reviews** are effectively discharged in a timely manner to ensure learning is embedded in practice.
- focus on further development of **trauma informed practice** through the commissioning of awareness raising training from both motivational speakers with lived experience and academics specialising in shame competency.
- review and formalise the **quality assurance** mechanisms in place to confirm the Board is sufficiently assured that partner agencies have effective systems, structures, processes, and practices in place to improve outcomes and experiences in the context of safeguarding adults at risk.
- take action in response to all practitioner and resident feedback obtained at the 2023-24 'We Need to Talk About **Hoarding**' Conference and improve the local response through improved practitioner guidance and strengthening of the local support offer.
- build on the work undertaken to improve safeguarding practice in relation to **complex safeguarding and exploitation** by focusing on the roll out of an all-age multi-agency training offer; seeking assurance about the offer of intervention for perpetrators of exploitation; and raising awareness of exploitation with Oldham residents, including how to spot the signs and report concerns.
- receive assurance appropriate services and support in respect of **homelessness and rough sleeping** are being delivered locally and strengthen the links between safeguarding and homelessness services to enable positive outcomes for local people.
- provide robust responses to new and emerging risks in relation to safeguarding adults at risk considering those risks associated with agency's core business and effective multi-agency working including the identification of opportunities to improve safeguarding and support for people who have **Learning Disabilities**.

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 2024-25 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 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.

Action Together hosts Healthwatch Oldham (HWO), the consumer champion for health and social care in Oldham. 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. HWO plays a key role engaging with hard to reach and vulnerable groups across Oldham.

Safeguarding and Action Together

Safeguarding runs through everything we do within the organisation. Our approach is to ensure that all our staff and volunteers have awareness and training at the right level for their role with us. This means that all our staff and volunteers, including our emergency response volunteers, undertake a safeguarding awareness training session that covers both safeguarding children and safeguarding adults at risk.

Our Social Prescribing teams receive further detailed training as part of their induction and ongoing Continuing Professional Development.

We deliver Safeguarding Children and Adults at Risk awareness training to anyone in Oldham who works or volunteers in the VCFSE as part of our regular training programme.

We also support VCFSE organisations to achieve our Quality in Action Award, the locally recognised quality assurance award for VCFSE groups and organisations. One of the modules in the framework focuses on safeguarding and ensures that groups and organisations have appropriate safeguarding policies, procedures, and training in place for their staff and volunteers, and also focuses on safer recruitment practices for staff and volunteers.

Safeguarding in 2024-25

The key adult safeguarding themes for Action Together in 2024-25 continued to be risk of suicide or self-neglect, closely connected with housing issues and the need for a multi-agency approach between substance misuse services, mental health services and approaches to support people who experience hoarding.

As the local infrastructure organisation for the VCFSE sector, one of our key functions is capacity building for volunteers and staff in the sector. To this end, we deliver a regular programme of Safeguarding Adults at Risk Training. In 2024-25, we reviewed and updated our training materials to reflect recent Safeguarding Adult Review learning.

Within the Social Prescribing Service, one of our top achievements has been working closely with the Adult Referral Contact Centre (ARCC) to embed a Social Prescribing Link Worker into the integrated ARCC team. This has ensured that an informed multidisciplinary team approach can be implemented at the earliest possible point and that people who come through the ARCC, but who do not need a statutory service, receive the appropriate level of support in a timely manner. Social Prescribing has attended and been an active member in many Team Around the Adult (TAA) meetings which has had some positive results for individuals.

Successful Multi-Agency Safeguarding Work

In 2024-25, we continued to embed our recently transformed Social Prescribing delivery model which enabled us to place a worker within the ARCC team. This was a key development to ensure that the step-up and step-down pathway between Adult Social Care and Social Prescribing continues to be person -centred and timely allowing the right staff to support when needed.

We worked with external partners to mitigate the reduction of local services for people, allowing us to build on a robust triage process enabling Social Prescribing to direct resource and workforce where needed in Oldham.

We attended numerous safeguarding meetings in Oldham focused on Workforce Development and Hoarding Improvement, and ensured staff within our Social Prescribing teams are appropriately skilled and trained to support safeguarding improvements. We embedded SAR learning onto our case management systems, where possible recording outcomes for cases and regularly held support sessions for staff in accessing training delivered by OSAB and Oldham Safeguarding Children Partnership.

During 2024-25, we received a referral from ARCC for a gentleman who was an alcoholic and had housing and financial issues. He had lost his most recent relationship and employment in a short period of time and was struggling with his mental health. Due to his struggles, he became homeless and disconnected from family. He was admitted to hospital a number of times and safeguarded by Social Prescribing, hospital staff and social care.

Social Prescribing led the TAA and escalated to Adults CaHRP when needed. Working with his Link Worker, he began to engage with local support services, such as Turning Point, and completed a detox stay and attended rehab to remain sober. Working with partners in social care, we were able to safeguard his finances as, due to his previous drinking, he was vulnerable to exploitation. He was able to find private rented accommodation and furnish the home himself. With support from Social Prescribing he was able to rebuild relationships with family who provided a social support network for him to build on.

Safeguarding Priorities in 2025-26

Our key adult safeguarding priorities for 2025-26 will be:

- To further develop the workforce development offer for the VCFSE sector around adult safeguarding key themes.
- To continue the Social Prescribing team contribution to the development of place-based integration to ensure multidisciplinary team and integrated working improve outcomes for residents.
- To further develop the relationship between Social Prescribing, Adult Social Care, Children's Social Care and Early Help to strengthen the whole family, whole household approach.

Key Challenges

Challenges continue to be demand and the complexity of cases, this is made more difficult because of the waiting lists in other services meaning individuals stay with Social Prescribing longer.

With reductions in local services, and complexities around housing and financial issues for people in Oldham, we will ensure workforce development is a priority to ensure staff are able to support and connect people with complex issues to support services appropriate to their needs.

Adult Social Care, Oldham Council

Adult Social Care is an Oldham Council service which supports Oldham residents to be independent, healthy, safe and well. Adult Social Care 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, health 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.

Adult Social Care 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 are deprived of their liberty in a hospital or care home settings, to determine if the care restrictions in place are necessary, proportionate and in their best interests, and to make recommendations regarding less restrictive care, where appropriate.

Adult Social Care 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 and Adult Social Care

Safeguarding is the top priority for Adult Social Care and for Oldham Council. We work both preventatively and responsively to ensure that adults with care and support needs can live safely free from the risk or experience of abuse. Adult Social Care have a statutory duty to make safeguarding enquiries under section 42 of the Care Act 2014 when there is reasonable cause to suspect that an adult in Oldham (whether or not they ordinarily reside there):

- has needs for care and support (whether or not the authority is meeting any of those needs)
- is experiencing, or is at risk of, abuse or neglect and
- as a result of those needs, is unable to protect himself or herself against the abuse or neglect or the risk of it.

Adult Social Care also has the power (at its discretion) to decide whether to make non-statutory safeguarding enquiries.

Our approach to working with adults is to make safeguarding personal. We do this by:

- Promoting wellbeing and safety through empowering conversations which are person centred, trauma informed, strengths and rights based.
- Working preventatively to help adults with care and support needs to build an understanding of what abuse is, how to recognise the signs, and where to seek help.
- Working proportionately alongside adults with care and support needs who are experiencing or at risk of abuse and neglect in a person centred, outcomes focused way that is meaningful to them and supports them to lead decisions about their safety.
- Working in the best interests of adults at risk who lack the capacity to make decisions about their safety, ensuring that their voice and previous wishes and feelings are represented through advocacy, and that they are protected from the risk or experience of abuse.
- Using approaches which support recovery for people who have experienced abuse and trauma.
- Being accountable for our practice.

Our approach also involves recognising when others, including children, adults who do not have care and support needs, and the public may be at risk of abuse or harm, and reporting our concerns to our safeguarding partners. We work in partnership with other services and organisations to effectively:

- Respond to safeguarding concerns.
- Contribute to multi-agency safeguarding forums.
- Contribute to, develop and implement safeguarding strategy.
- Learn from when things have gone wrong and implement change.

We are accountable for our practice and our approach seeks to recognise:

- Our strengths
- Our challenges
- Our opportunities for ongoing development.

Safeguarding in 2024-25

Themes and trends emerging in 2024-25 included those related to prevention, Complex and Contextual Safeguarding, and Modern Slavery in Care Home Settings.

Prevention: During 2024-25, Adult Social Care received a total of 1,559 new Safeguarding Concerns. This represented a 17.8% decrease on the previous year when we received 1,896. Of the Safeguarding Concerns received this year, 275 had an outcome of Safeguarding Enquiry. Of these, 248 were section 42 enquiries with the remaining 27 being non-statutory enquiries.

This year, the Concern to Enquiry conversion rate was 17.6%, a decrease on the 20.6% rate in 2023-24. 266 Safeguarding Enquiries were completed. The consistent trend of decreased safeguarding demand is attributed to the impact of Adult Social Care and the full safeguarding partnership's prevention strategies.

The impact of effective partnership working in ARCC and the work of Changing Futures, Social Prescribing, Focused Care, and the voluntary, community, faith, and social enterprise sector is now embedded in Oldham's approach. This, alongside the impact of systematic multi-agency forums such as the Making Every Adult Matter (MEAM) Panel and the Adults CaHRP has resulted in more Oldham residents being supported to safeguard themselves through preventative safeguarding approaches that had not been possible in previous years.

Adult Social Care has also supported professionals to understand which safeguarding pathway is most suitable to protect the individuals who are experiencing abuse, by assisting with the delivery of multi-agency training about making a Care Act section 42 referral throughout 2024-25.

Complex and Contextual Safeguarding: For a fourth year running we have continued to see a trend in safeguarding concerns for adults at risk of criminal and sexual exploitation. Our understanding of and approach to working with individuals who are at risk of or experiencing complex and contextual abuse has also continued to grow. We now have both a response and emergent recovery model in development.

Our response model is multi-agency, trauma attuned, strengths-based and rooted in effective multi-agency risk assessment and management, underpinned by appropriate legal frameworks.

Our recovery model builds on the response model, working to reduce risk and restrictions consecutively, placing the person's voice at the centre of all practice, and providing safe conditions for independence, wellbeing and strengths to thrive, and for trauma recovery to commence.

Modern Slavery in Care Home Settings: In 2024-25 we have continued to respond to concerns of modern slavery, forced labour and labour abuse for care staff in care settings. We have worked with the Safeguarding Adults Board, our local, Greater Manchester, North West, and national partners to develop and deliver effective approaches to these types of concern.

This has enabled us to act preventatively and respond effectively to notification of suspension of sponsorship licences for commissioned providers and to work effectively with local and central agencies when protection responses are required.

We are acutely aware of and responsive to both the risks to the care workforce and those posed to resident safety by this trend. We welcome central government reform which will strengthen the rights of sponsored care workers, and we will continue to contribute to the development of regional and local strategy to tackle modern slavery.

The key adult safeguarding achievements for Adult Social Care in 2024-25 were:

- Our high-level contribution to Oldham's multi-agency safeguarding offer: Adult Social Care is an active member of Oldham Safeguarding Adults Board. Our proactive contribution includes chairing board subgroups and Adults CaHRP; contributing to the creation of policy, procedure, guidance and training packages; delivering training to the safeguarding partnership; and delivering against SAR action plans. We also support our partners operationally by providing advice and guidance on our safeguarding networks and in relation to the TAA approach.
- Recognising our strengths and areas for continuous improvement: In preparing for assessment by the Care Quality Commission (CQC), Adult Social Care has recognised adult safeguarding as one of our areas of strength. Effective partnership working for both statutory safeguarding responses and multi-agency risk management via the TRAM Protocol, alongside leading the OSAB Business Unit, consistently enhances the safety and wellbeing of Oldham residents. Our continuous improvement approach has allowed us to know ourselves better and to understand where we now need to target further safeguarding strategy to achieve operational consistency in safeguarding.
- Transitional safeguarding: Great progress has been made in progressing the joint Adult Social Care and Children's Social Cares transition strategy at a local level in 2024-25. Key activity has included an updated referral process in our electronic recording system, Mosaic; practice guidance for a new transitions team has been completed, including a standard operating procedure; recruitment to the transitions team has commenced; a young person's guide in terms of preparing for adulthood is being devised working with barrier breakers; performance data reports for transitions are being devised; Transitions has been included in the Adult Social Care commissioning delivery plans to ensure young people are able to have their specialist needs met within the borough; a transitions board is established, chaired by the Director of Adult Social Care (DASS) and the Director of Children's Services (DCS), supported by subgroups to ensure alignment across the partnership to achieve the best outcomes for young people in Oldham. These positive actions all align to our early intervention and prevention approach at Oldham Council. In addition, Adult Social Care have worked at a Greater Manchester level to focus on and develop strategy regarding our local response to transitional safeguarding. We have also contributed at a regional level towards outlining the need for a Pan Greater Manchester approach for transitional safeguarding. We look forward to working with our colleagues across Greater Manchester to develop and deliver this approach in 2025-26.

Making Safeguarding Personal

Our Safeguarding Lead has led a consistent promotions campaign in relation to making safeguarding personal in Adult Social Care throughout 2024-25. As a result, we have consistently ensured we are performing above target in asking the individuals we work with about their making safeguarding personal outcomes.

In addition, we have contributed to the review of Oldham's Multi-Agency Adult Safeguarding Policy and Procedures, advocating for making safeguarding personal to be the focus of the revised policy and procedures which will be rolled out in 2025-26. We have also reviewed and revised our own safeguarding recording workflows to ensure making safeguarding personal is the focus of our safeguarding activity and supports practitioners to work in partnership with individuals towards personalised safety outcomes.

Successful Multi-Agency Safeguarding Work

One of the most successful multi-agency initiatives Adult Social Care have been involved in in 2024-25 is the ongoing updating and delivery of mental capacity theory to practice training to the multi-agency workforce, as this a consistent theme in our local SAR learning. Sharing our knowledge and expertise in this area of practice is supporting the whole partnership to work more effectively to safeguard adults through consideration of mental capacity decisions.

Safeguarding Priorities in 2025-26

Our key adult safeguarding priorities for 2025-26 will be:

Meeting our statutory duties effectively: We will meet the statutory duties of Adult Social Care 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: We will enhance our approach to the Mental Capacity Act by delivering theory to practice training to Adult Social Care and Children's Social Care, and the multi-agency workforce and ensuring full Adult Social Care service compliance with this training offer by March 2026. We will also update the Mental Capacity Act recording workflow in Adult Social Care to support high quality practice. We will deliver a trauma informed practice comms campaign. We will work with the Oldham safeguarding partnership to ensure the Adult Social Care and partnership workforce understand and engage with the trauma informed practice offer and can apply this in the context of prevention and delay duties and in the transitional safeguarding and complex and contextual space.

Ensuring safety: We will enhance our safeguarding data and data informed approach, delivering an improved safeguarding recording workflow which will effectively inform an enhanced safeguarding data dashboard. This will include key local safeguarding data including Adult Social Care, provider and partnership performance markers, and enable us to capture trends more effectively and effectively inform where future strategy is targeted and deployed. We will deliver safeguarding quality assurance by launching and embedding the updated OSAB Multi-Agency Safeguarding Adults Policy and Procedures and align this to the roll out of the revised safeguarding recording workflow and practice changes in Adult Social Care. In addition, we will consistently complete safeguarding audits and deliver improvement strategy to ensure policy compliance.

Listening and Learning: We will take action to continuously improve our service based on learning from our CQC self-assessment and the results of CQC assessment, ensuring safe, high quality services are consistently provided by Adult Social Care through strategic analysis, planning and delivery in response to regulatory, partnership and resident feedback. We will proactively scan for and engage with national, regional and local agendas influencing adult safeguarding including the Casey review, National Care Service plans, the National Safeguarding Chairs Network, North West Association of Directors of Adult Social Services (ADASS), Greater Manchester Living Well, local independent review into non-recent Child Sexual Exploitation, Safeguarding Adult Review learning, Domestic Homicide Review learning, the voice of lived experience, and transitional safeguarding.

Embedding Improvement and shaping future practice: We will support Adult Social Care practitioners and the wider safeguarding partnership to achieve consistently high-quality safeguarding practice by providing advice, guidance and support, sharing local learning, creating and delivering continuous improvement plans rooted in local safeguarding learning. We will enhance our safeguarding communication strategy, to ensure dispersed leadership can provide the bridge to delivery for safeguarding strategy within Adult Social Care. We will do this by creating and delivering a communication strategy for the workforce which clearly articulates local safeguarding learning, sets expectations of operational leaders and empowers them to deliver these.

Transformation and sustainability: We will continue to review our services and to restructure to ensure that we are fit for purpose. We will work within our existing budget and saving requirements ensuring good financial management practice is in place throughout the service.

Key Challenges

The key challenges for Adult Social Care Oldham have now remained consistent over a number of years.

Oldham Council continues to operate in a challenging financial climate where the rising costs of care provision and sustained increased demand for services result in highly challenging operating conditions. A strategic approach to continuous transformation ensures our workforce can continue to meet our statutory safeguarding duties and ensure the financial stability of Oldham Council.

Workforce capacity remains a key challenge for Adult Social Care. A dedicated workforce strategy is in place to address national and local workforce challenges and ensure that we have the right workforce in place to delivery high quality safeguarding prevention and protection to our residents.

Age UK Oldham

Age UK Oldham aims to provide opportunities for the entire spectrum of older people in the local area. At its inception, traditional services were targeted towards more dependent older people but the charity has now expanded its role to include preventative projects and we aim to improve the physical and emotional health of older people in the community and to foster asset-based community development.

We have a wide and varied portfolio of activities delivered both in-house and in numerous neighbourhood buildings and offer both close and arms-length support in the community helping to reduce social isolation which has a positive impact on those older people living with physical and mental health conditions.

Safeguarding and Age UK Oldham

Safeguarding is fundamental to the work we do and is everyone's responsibility. Training of all staff, volunteers and contractors who meet with older people routinely is essential, ensuring they recognise any potential issues, instilling confidence in them to assist. Equally important is our prevention strategy, both in taking a person-centred approach to individuals and ensuring our services are designed to help people to live safely and independently for as long as possible.

Safeguarding in 2024-25

During 2024-25, once again, rising prices have affected pensioners on a fixed income and for some, led to an increase in referrals relating to the following:

- Financial difficulties for older people continue to impact on their ability to maintain a safe and liveable home environment e.g. Heating bills leading to damp, unsanitary and unhealthy conditions, home repairs, white goods replacement, bedding and household supplies are all major factors.
- Hunger and malnutrition are also a concern – we are often in the position of supplying basic groceries and emergency meal packs as a temporary measure whilst our Community Service team can support and refer to relevant services and also source advice and support with benefits checks, claims, and applications.
- Hoarding has emerged as a concern for older people who have become anxious and isolated in later life and often leads to self-neglect and poor health. Taking time to grow relationships whilst slowly helping to declutter their homes in a non-judgemental way is how we at Age UK Oldham gain trust and slowly introduce other agencies/services/ activities to augment their support network and prevent reoccurrence.
- Becoming victims of scams has become more prevalent in this age group. Living alone without support leaves householders open to doorstep, phone, mail and online criminals who are adept at recognising signs of potential vulnerability. Older people are more susceptible to financial abuse when they become lonely or isolated and most of our services delivered in the local community focus on prevention and inclusion to ensure that people have the confidence to approach our staff with their concerns.
- In the community, continued reduction in home visits and face to face appointments has meant rising isolation for vulnerable people, many of whom are reluctant to ask for help and can be unaware of the support available. Memory loss, confusion and ill-health also leads to "hidden" self-neglect, gradual deterioration and high risk situations in the home which are not always apparent during phone contact and result in crises.

We continue to take advantage of the Oldham Safeguarding Adults Board's wide variety of training offers (including 7-minute briefings) with the online sessions being particularly valuable and accessible. This means that we are able to reach every level of our workforce and have great examples of safeguarding alerts from staff who come into contact with the general public.

We have undertaken training sessions/group discussions focusing on the 7-minute briefings circulated to staff which have been a great success and led to valuable sharing of experiences and practical examples of approach.

From our experience, the development of ARCC and our growing relationship with their staff has enabled closer working relationships. It has given us greater opportunities to discuss possible safeguarding issues informally to agree the best routes forward.

We have numerous examples of Safeguarding Prevention whereby staff, delivery drivers, shop staff, outreach activities practitioners, our Handyman service, and our trusted contractors (electricians, plumbers, gardeners etc.) whom we engage with on behalf of older people, alert us to concerns for older people when carrying out tasks in their homes. When adding them to our approved list, we carry out the necessary checks and ensure that they are made aware of circumstances and situations they may encounter and give them the confidence and reassurance in reporting any concerns (however trivial) that we will respond to.

Successful Multi-Agency Safeguarding Work

In 2024-25, we responded to a referral from the Occupational Therapy team for the fitting of a toilet raiser. Our handyman trusted assessor reported his concerns regarding the insanitary conditions and general cleanliness. Following contact with the Adult Social Care Memory Assessment team, and relatives, an ultimation was proposed that the lady would be admitted into permanent residential care if conditions did not improve in two weeks as the older person did not have mental capacity. We worked together with social care, Occupational Therapists, a Home Care agency, and the family and conditions vastly improved. Household goods were purchased and additional adaptations and strategies were devised with Home Care staff when the service user was confused and uncooperative. A pleasant routine was achieved and admission to care averted in less than two weeks. A shining example of a multi-agency, flexible initiative that gave an older person comfortable living and independence in their own home.

Safeguarding Priorities in 2025-26

Although time consuming and resource heavy, home visits remain a priority for all of our support services.

Door to door transport is also highly labour intensive and costly (especially for a small charity). Older people with mobility issues/living with dementia etc. often need to be assisted and escorted whilst travelling but we remain committed to providing equal opportunity for socialisation which also affords.

A priority will also be our staff maintaining close contact and being a watchful eye on vulnerable older people in the community. This is a significant factor in reducing deterioration, crisis, safeguarding risks and unnecessary hospital admissions. It is a priority for Age UK Oldham to continue to support older people face-to-face wherever possible, be that in their own homes, at our day care and through our range of other services which often include home delivery.

A further priority will be increasing our reach into health establishments which gives us extra focus to offer practical services in the home, aiming to facilitate speedier discharge and gain further insight into the difficulties and risks some older people encounter on discharge such as adjusting to living independently with increasing health and mobility challenges.

Key Challenges

2025-26 brings major challenges in our delivery of Preventative Services which has always been our key goal and the bedrock of our service offer. Our concern is the dwindling resources of organisations such as ours to provide low level support for those people who are not totally independent, but neither are they eligible for assessed care needs packages. There have been dwindling resources and cuts in funding contracts for valuable preventative services for vulnerable older people. Our services and projects at this level contribute to the prevention of:

- Failed hospital discharges where practical measures ensure a safe discharge environment; advice and support to access home support; and residential care and low-level continued support in the community.
- Carer breakdown e.g. Day Care provision and carer support.
- Costly and premature admission to residential care.
- Crisis interventions.

Our presence in the Hospital Discharge hub commissioned by and working with Northern Care Alliance NHS Foundation Trust on both the Home First, Urgent Care Emergency Discharge, and Dementia Front Runner Discharge service has been increasingly successful. Working alongside hospital staff and carrying out joint visits, we are able to offer our very practical services in the homes of discharged patients. Also, providing Day Care to newly discharged patients gives daily respite to family carers and a 'breathing space' to enable services, adaptations and support routines to be set up in the home. This intervention averts potential crises and readmissions and 'deconditioning' in dementia patients that a longer hospital stay can cause.

In the past we have subsidised our preventative services (in 2022-23 we contributed £405,056 from our independent income) but the financial climate of contract funding cuts and reduced income from our independent income generation has led to workforce reductions and loss of essential services, for example, the Safe at Home and Shopping Service has been just one casualty. The challenge is to continue to reach out to those 'hidden', vulnerable, older people and ensure their safety and wellbeing. Another example is the loss of our Luncheon Club funding whereby each week over 300 people in eight neighbourhoods came together to enjoy a hot three course meal and social activities. Staffed by Age UK Oldham, these social gatherings for older people who lived independently gave them a focus to meet with their peers and allowed us a watchful eye when their health, circumstances or disposition needed support.

We have now worked hard to reconfigure the service to ensure the socialisation and support continue. Fewer staff and venues, limited catering and funding from some generous local councillors meant that the clubs survived and thrived. Consequently, a number of safeguarding alerts relating to attendees and implementation of timely preventative measures pay testament to the efficacy of this approach. One example involves a long-standing volunteer at a luncheon club who was always offered a free cooked meal and would ask to take home any leftovers each week. When the meals were discontinued, over the following weeks she appeared to have lost weight and became forgetful. Contacting her sheltered accommodation provider manager, it transpired that she had been living off savings from an inheritance for many years during which time her memory had deteriorated. Her flat was in disarray and there was evidently no food or provisions. She was not claiming her benefit entitlements and had clearly been existing from handouts.

Doctor Kershaw's Hospice

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

Safeguarding and Dr Kershaw's Hospice

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

Safeguarding in 2024-25

The Hospice dealt with one Safeguarding Adult concern in relation to a patient being cared for by our domiciliary care service in the community at the end of life. Staff arrived for their visit and found the brother of the patient about to administer injectable anticipatory medication via syringe orally. They stopped him, and observed him dispose of the medication. They advised him not to give any of the medication, and that they would contact the Specialist Palliative Care Nurse team (SPCN) for advice. They informed the Continuing Health Care Duty Manager. An investigation by the SPCN team revealed miscommunication between the doctor and the family regarding administration of regular pain medication. They gave the family additional support and training and they were assured that the family now understood what had gone wrong and they were now able to identify the correct medication and administer the oral pain medication as prescribed. The issue was resolved with no harm.

During 2024-25, the hospice:

- had proactive membership within the OSAB Board governance structure.
- has tried and tested systems in place for reporting safeguarding incidents and concerns. Safeguarding incidents at the Hospice are rare but processes are in place to manage these. The hospice has an ethos and a culture of proactive and reflective learning. Any incident or safeguarding concern is seen as an opportunity to drive quality and improve systems.
- has promoted all aspects of safeguarding training in a bespoke manner. The Hospice provides safeguarding training on adults and children and also includes Prevent and Restraint training. All of which are well evaluated.
- ensured that it adhered to the six principles of safeguarding and this is referred to throughout the core mandatory training and delivered in line with Royal College of Nursing intercollegiate document recommendations.
- ensured that the safeguarding lead and safeguarding deputy lead have attended level 5 training and attended the OSAB Development Event.
- achieved compliance for safeguarding adults training at 98% for staff. The compliance for Prevent is 98%. Compliance for Mental Capacity Act, Deprivation of Liberty Safeguards and Restraint training is 98%. Compliance for Learning Disability, Autism, and Mental Health Awareness training is 100%.

Making Safeguarding Personal

Dr Kershaw's Hospice has utilised the Making Safeguarding Personal Toolkit when dealing with any Safeguarding concerns, ensuring that the person (adult at risk) and/or their advocate, are fully engaged and consulted throughout and that their wishes and views are central to the final outcomes as far as is possible.

The safeguarding concern that was shared above highlighted the collaborative working between professionals and the patient seeing them as an expert in their own life, so that they felt they had been fully involved and were satisfied by the outcome, as far as was possible. The patient wanted to maintain some control over their life by not having health professionals attending twice daily to administer medication, and instead having their brother administer this medication. Services worked with the patient and their family to ensure these wishes could be fulfilled safely, with support on hand, if and when required.

Safeguarding Priorities in 2025-26

Our safeguarding priorities in 2024-25 will be:

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

Key Challenges

Our key challenges in 2025-26 will be:

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

Greater Manchester Fire & 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.

Find out more about us via the GMFRS website.

Safeguarding and GMFRS

Safeguarding is a strategic responsibility of the organisation which is centrally managed through the Safeguarding Policy and Practitioners Group, chaired by the lead safeguarding officer. All internal safeguarding processes are aligned to the organisation safeguarding policy, which was most recently reviewed and revised in 2025. The approach to safeguarding throughout the organisation is policy driven and systematically structured. Effective compliance monitoring of performance and practice is undertaken at an individual borough level and at an organisation wide level.

Safeguarding in 2024-25

The key adult safeguarding trends identified in 2024-25 by GMFRS were related to Self-Neglect; Hoarding; Mental Health; Substance Misuse; and Care and Support Needs.

Our top adult safeguarding achievements in 2024-25 were:

- Level 3 accredited training and supervision support sessions for designated safeguarding officers.
- Revision of the safeguarding policy and procedure.
- Introduction of a new UK GDPR compliant internal safeguarding reporting system.
- Continued utilisation of our case management system to ensure all safeguarding concerns are effectively recorded and managed as required.
- Internal performance and compliance monitoring for safeguarding referrals.
- Introduction of Safeguarding Learning and Quality Assurance roles.

In 2024–25, GMFRS has:

- Enhanced person-centred home fire safety visits by incorporating wellbeing conversations that identify safeguarding concerns and promote independence.
- Used SAR learning to improve multi-agency collaboration, particularly in cases involving self-neglect, hoarding, and mental health. Staff are trained to recognise indicators and escalate concerns appropriately.
- Implemented reflective practice sessions following safeguarding referrals, allowing teams to consider how their actions aligned with making safeguarding personal principles and what could be improved if needed
- Updated safeguarding training to include real-life scenarios from SARs, helping staff understand the impact of professional curiosity, communication, and timely intervention.

Making Safeguarding Personal

GMFRS continues to embed the principles of Making Safeguarding Personal by focusing on person-centred outcomes in all safeguarding interactions. Our prevention teams work closely with individuals to understand their unique circumstances, preferences, and desired outcomes, ensuring that safeguarding interventions are tailored and empowering.

Successful Multi-Agency Adult Safeguarding Work

Throughout 2023-24, GMFRS supported safeguarding professionals meetings.

GMFRS also supported and contributed to the OSAB Policy, Procedure and Workforce Development Subgroup and the OSAB Hoarding Improvement Partnership and provided hoarding awareness training to partner agencies.

Safeguarding Priorities in 2025-26

GMFRS will continue to strengthen its safeguarding work in 2025–26 with a focus on:

- Improving data sharing and multi-agency collaboration - Enhancing systems and protocols to support timely and effective information sharing with partners, especially in cases involving self-neglect, hoarding, and domestic abuse.
- Safeguarding Through Prevention - Expanding the scope of Home Fire Safety Assessments to include broader health and wellbeing checks, identifying safeguarding risks early and referring appropriately.

- Staff Development and Confidence - Continuing to build staff confidence in identifying safeguarding concerns and making referrals, with updated training and access to safeguarding champions.
- Learning from SARs - Embedding SAR learning into operational practice, with regular updates to training and guidance based on local and national review findings.
- Digital Inclusion and Accessibility - Ensuring safeguarding messaging and services are accessible to all, including those with cognitive impairments, language barriers, or limited digital access.

Key Challenges

Staffing levels within the prevention teams are as such that attendance at all professionals' meetings is not possible. However, demand is managed through focused prioritisation to ensure all actions required from the organisation are carried out to support vulnerable individuals within the community.

Greater Manchester Police, Oldham

Oldham Police District is part of Greater Manchester Police (GMP) and is responsible for delivering local policing services across the borough of 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 and Greater Manchester Police

Safeguarding is a core function within Oldham Police District and is embedded across all aspects of our operational and strategic activity. It is not confined to specialist teams but is recognised as a shared responsibility across the entire workforce. All officers and staff are expected to identify, respond to, and escalate safeguarding concerns appropriately, regardless of their role.

Our safeguarding responsibilities are delivered through a combination of:

- Dedicated teams such as Domestic Abuse, Child and Adult Exploitation, and Missing from Home.
- Neighbourhood Policing Teams, who play a vital role in early identification and community engagement.
- Multi-Agency Safeguarding Hub (MASH), where we work alongside partners to assess and respond to risk in a timely and coordinated manner.

We adopt a whole-system, victim-centred approach to safeguarding, underpinned by the following principles:

- Prevention: We work proactively with partners and communities to identify vulnerabilities early and reduce the risk of harm.
- Protection: We ensure that individuals at risk are safeguarded through timely intervention, robust risk assessment, and appropriate support.
- Partnership: We are committed to multi-agency working, recognising that effective safeguarding requires strong collaboration, information sharing, and joint decision-making.
- Accountability and Learning: We continuously review our safeguarding practices through internal audits, case reviews, and reflective learning to improve outcomes and ensure high standards.
- Safeguarding is a standing priority within our district's leadership structure, with regular oversight through internal governance and contribution to the wider safeguarding partnership arrangements across Oldham.

Safeguarding in 2024-25

In 2024–25, Oldham Police District observed several key adult safeguarding themes and trends, reflecting both local intelligence and wider regional priorities across Greater Manchester:

- Transitional Safeguarding and Young Adults (18–25): There has been a growing recognition of the vulnerabilities faced by young adults transitioning from children's to adult services. Many individuals in this age group remain at risk of exploitation, coercion, and harm, particularly those with care experience or complex needs. Our approach has increasingly focused on bridging this gap through trauma-informed, age-appropriate safeguarding responses.
- Exploitation and Extra-Familial Harm: Adult victims of Criminal, Sexual, and Financial exploitation, particularly those with learning disabilities, mental health issues, or substance misuse vulnerabilities, have remained a significant concern. We have worked closely with partners to disrupt perpetrators and safeguard victims through multi-agency interventions.

- Mental Capacity and Coercive Control: Cases involving adults who may lack capacity or are subject to coercive control have become more prominent. This includes victims of domestic abuse, modern slavery, and financial abuse. Officers have received additional training to better identify and respond to these complex dynamics.
- Increased Complexity of Risk: Many safeguarding cases now involve multiple overlapping risk factors, including homelessness, substance misuse, and mental ill-health. This has reinforced the need for coordinated, multi-agency responses and early intervention strategies.
- Learning from Reviews and Lived Experience. Themes emerging from SARs and lived experience feedback have informed our practice, particularly around improving information sharing, professional curiosity, and the need for consistent safeguarding responses across agencies.

These trends have shaped our operational priorities and informed our contribution to the Greater Manchester Complex Safeguarding Strategy, which emphasises early intervention, partnership working, and a contextual understanding of harm.

Oldham Police district continues to improve on our domestic abuse outcomes. We are currently achieving 13% year to date. This is an improvement from 12% the previous year, and 11% the year preceding that.

Arrests are up 3% from the previous year, which had seen a percentage increase from the year that preceded that.

Oldham continue to be the district which responds faster to emergency calls then anywhere else in GMP.

Making Safeguarding Personal

In 2024–25, Oldham Police District embedded a more outcomes-focused approach to safeguarding through the adoption of Making Safeguarding Personal (MSP) principles. Officers have had inputs to engage more meaningfully with adults at risk, ensuring their views, wishes, and desired outcomes were central to safeguarding decisions. This included:

- Using trauma-informed communication techniques during safeguarding interviews.
- Involving individuals in safety planning and risk management discussions.
- Ensuring that safeguarding interventions were proportionate, person-led, and aimed at improving long-term wellbeing - not just immediate risk reduction.

Safeguarding Priorities in 2025-26

Our safeguarding priorities in 2024-25 will be:

- Improving identification and disruption of adult exploitation, tackling criminal, sexual, and financial exploitation of vulnerable adults remains a priority. We will enhance our use of intelligence, community engagement, and partnership disruption activity to identify and safeguard victims, particularly in cases of cuckooing, modern slavery, and coercive control.
- Embedding learning from SARs. We will ensure that learning from recent SARs is fully embedded into operational practice, with a focus on improving professional curiosity, information sharing, and multi-agency coordination.
- Promoting a person-centred, outcomes-focused approaches In line with Making Safeguarding Personal. We will continue to train and support officers to place the voice and wishes of the adult at the centre of safeguarding interventions, ensuring that outcomes are meaningful and tailored to individual needs.
- Enhancing workforce development. We will support the delivery of the OSAB Workforce Development Strategy by prioritising training in trauma-informed practice, shame competence, and mental capacity awareness for officers and staff.
- Strengthening multi-agency safeguarding governance. We will continue to contribute to the effectiveness of the MASH and other partnership forums, ensuring timely, coordinated responses to safeguarding concerns.

Key Challenges

Our key challenges in 2025-26 will be:

- Increasing Complexity of Risk and Demand: Safeguarding cases are becoming more complex, often involving overlapping issues such as mental ill-health, substance misuse, homelessness, and exploitation. Managing this complexity within existing resources will remain a challenge. Response: We will continue to invest in multi-agency working, early intervention, and trauma-informed practice to ensure proportionate and effective safeguarding responses.
- Sustaining Capacity and Workforce Resilience: Like many public services, we face pressures around staffing, wellbeing, and maintaining specialist knowledge in safeguarding roles. Response: We are prioritising workforce development, reflective supervision, and cross-training to build resilience and ensure continuity of safeguarding expertise.
- Information Sharing and System Integration: Timely and effective information sharing remains a challenge, particularly in fast-moving or high risk cases. Response: We will work with partners to improve digital systems, streamline referral pathways, and promote a culture of professional curiosity and shared responsibility.
- Embedding Learning into Practice: Translating learning from SARs and audits into consistent frontline practice remains a system-wide challenge. Response: We will continue to embed learning through briefings, scenario-based training, and internal governance processes.

Healthwatch Oldham

Healthwatch Oldham (HWO) is the consumer champion for health and social care in Oldham. 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. HWO plays a key role engaging with hard to reach and vulnerable groups across Oldham.

Safeguarding and Healthwatch Oldham

HWO is hosted by Action Together and thus our broad approach is embedded in Action Together's. In line with this, we ensure that our small team and volunteers have awareness and training to respond to safeguarding concerns effectively. This means that the HWO staff undertake regular safeguarding awareness training that covers both safeguarding children and adults at risk. The HWO team have access to Action Together's Designated Safeguarding Officer to give individual advice on cases when the need arises. The HWO team also have access to Healthwatch England's resources, advice and training on safeguarding, which the team access on an annual basis.

Residents across Oldham will often contact Healthwatch Oldham with non-formal complaints or 'have your says'. We also conduct engagement events and focus groups across both the statutory and voluntary sector. It is often within these interactions that we can identify safeguarding concerns. Therefore, there are often a small number that we receive each year, but the team are trained on identifying concerns within these environments.

Safeguarding in 2024-25

The key adult safeguarding themes for HWO in 2024-2025 were relating to mental health issues, self-neglect and reported organisational abuse.

HWO traditionally receive few safeguarding concerns each year, but over the years our relationship with social care has improved, meaning that safeguarding concerns are responded to quickly and appropriately. We would note this as our primary achievement for 2024-25.

We have been able to develop a good working relationship with social services for the few safeguarding concerns we have received. Often, those who contact us are already known to social services, and so we are able to put together an action plan to address concerns raised relatively quickly.

Safeguarding Priorities in 2025-26

Our safeguarding priorities are naturally embedded within our workplan priorities; by engaging with Oldham residents on issues that are important to them, we have historically been more likely to identify previously unidentified safeguarding concerns relating to that area of work, for example, understanding refugee experiences in temporary accommodation in Oldham. In terms of disadvantaged groups, our workplan priorities relate to better understanding the experience of the elderly Asian community and Youth Carers.

Other than this, our top priorities are to:

- continuously develop safeguarding understanding within our team by attending relevant training held by Action Together and Healthwatch England.
- empowering our staff to respond to complicated safeguarding concerns.
- continue to attend all OSAB Board meetings and make contributions to all relevant subgroups.

KeyRing Living Support Network

KeyRing is a charity that provides 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 and KeyRing

- As a national adult social care provider providing services to adults at risk, safeguarding is a core element to the work we do and the support we deliver on the ground. We work with very complex individuals who are classed in the main, as on the 'edge of care' or 'not eligible' for care and support under the Care Act. This means the Members we work with have often 'fallen through the net' or have had multiple interventions over their lifetime with no positive or effective outcome in their lives. This leaves a legacy of distrust, non-engagement and poor outcomes in the very services that are there to support individuals in times of greatest need. This means that relationship building and trust is vital, along with providing the resources and giving the 'right support at the right time'. This is also the case with Members we support who are eligible for support

under the Care Act and multi-agency working is vital and core to supporting the individual.

Area managers have local teams that provide frontline support and raise any safeguarding concerns both internally and externally. Mandatory safeguarding training is implemented for all staff and volunteers and additional training is sought where there are gaps identified in knowledge or identified trends that are occurring in an area or nationally. A national Safeguarding Reference Group meets quarterly which the Oldham manager attends. The group takes learning, experiences and best practice examples and resources from around the country to improve safeguarding practice. This is led by the Safeguarding and Practice Development Lead who has full oversight of all safeguarding logs that come through the organisation.

We have a named trustee who oversees safeguarding and who also attends the quarterly Safeguarding Reference Group sessions to offer insight and challenge to safeguarding practice across the organisation.

Safeguarding in 2024-25

Our Oldham services logged 23 individual safeguarding alerts in 2024, eight of those showed a concern for the welfare of the individual member (35%). This reflects our national trend where 53% of all alerts were connected with welfare concerns. Some alerts were recorded against more than one category, for example a domestic violence alert may also be recorded as financial abuse and physical abuse. KeyRing capture this as multiple alerts. In 2024, 32 abuse categories were recorded.

In 2024, KeyRing introduced a new learning system nationally. All staff received comprehensive safeguarding training using the new system. We reinforced that operational staff who are not up to date with their safeguarding training will not be allowed to work with Members directly.

KeyRing prides itself on being a learning organisation. We ask what learning, both organisationally and personally has come from each safeguarding concern. This is required on each concern we complete.

The key adult safeguarding achievements for KeyRing in 2024-25 were as follows:

- Following an analysis of our internal safeguarding figures in 2023-24, we had a focus on self-neglect and hoarding with the teams with a bitesize session being created and resources identified to use alongside the bitesize session. These were shared with all area managers across the country and disseminated to their teams in team meetings.
- Our National Safeguarding Reference Group continued to meet quarterly and is made up of all levels of the organisation with representation from across England. The group gives an opportunity for managers to learn from each other, which enables any change in practice to be identified and implemented.
- The Oldham managers attended the group and shared the OSAB 7-minute briefings that are produced with the rest of the group. These are then shared across the organisation. One of the Oldham managers is a member of the OSAB Policy, Procedure and Workforce Development Subgroup and shared learning and reflections from Oldham SARs and other OSAB resources that have influenced our Safeguarding Reference Group discussion topics.
- The group took the learning from the national safeguarding logs each quarter and managers talked through case studies and examples from the teams themselves with specific themes to build knowledge and confidence. Themes covered throughout 2024-25 included Professional Curiosity; Strengths based approaches to engagement; Digital Abuse learning set, case studies and resources; Members as perpetrators, KeyRing action learning set and case studies; Supporting Members on probation; Hoarding and Self neglect bitesize session and resources; OSAB Presentation showcase; KeyRing Safeguarding audit for Oldham; and Safeguarding Adults Week. We recognise Safeguarding Adults Week every year and put out special briefings. We also support and encourage teams to do themed sessions with members sharing information and resources pulled together.

In addition to the above, we also delivered Oldham specific support sessions focused on support for the Oldham team. Topics included safeguarding being covered in supervision sessions and learning from Oldham SARs following cases we were involved in. We also provided:

- Decompression and resilience training session for all operational staff in Oldham.
- Regular check-ups and debriefs with staff following a traumatic event/death involving Members.
- Separate support and wellbeing sessions with staff who experienced trauma in their work.

We continue to go through OSAB 7-minute briefings at team meetings when they were published and feedback to OSAB. These briefings have generated some really good feedback and discussion.

Successful Multi-Agency Safeguarding Work

KeyRing have continued to be involved in many TAA meetings over the past twelve months. We are currently attending one or two each week.

We have also worked with the team around improving their knowledge and confidence in attending TAA meetings. The Oldham team have attended the TRAM Protocol training.

Safeguarding Priorities in 2025-26

In 2025-26 our priorities will be to:

- Improve our recording of Members desired outcomes and following up that these have been achieved.
- Improve our recording of any learning from safeguarding concerns raised and any gaps in our knowledge that require additional discussion or training.
- Improve assurance that what is discussed at the Safeguarding Reference Group is disseminated to local teams and ensure representation from all areas.
- Work with Members to build resilience and empower them to keep safe, particularly in the areas where most abuse occurs. These areas are financial abuse, self-harm and welfare concerns.

Due to the complex nature of Oldham's intensive and preventative services and the individuals we support in Oldham, we have been involved in SARs, LeDeR reviews, inquests and complaints. It is vital that we take the learning and reflections that come out of all of these and use it to look at current practice and any changes for the organisation that need to happen as a result. Any learning is used in our training and policies and procedure reviews.

Learning & Reflection from logs: Building on the above example, we will continue to raise awareness of safeguarding themes and topics that are coming through our internal logs affecting our Members and change practice where identified as part of the Safeguaridng Reference Group. We will continue to ensure this is shared with teams and Members.

We plan to incorporate the OSAB safeguarding supervision minimum standards into team/group supervision sessions around Safeguarding. This will tie in with work around trauma support for teams.

Key Challenges

Due to reductions in KeyRing funding and moving to a one-to-one service, we have lost some of the flexibility in how we deliver support. As a result, we have had to make many experienced staff redundant. We have had to reduce our management team by over half. The challenge for us this year will be building the service and team back up and ensuring we are delivering support in a safe way and ensuring quality.

We work with a high number of complex people and therefore there are many TAAs in place with regular TAA meetings. We are currently supporting the team to feel fully confident in attending and feeding into TAA meetings. It will not be possible for someone from the management team to be present at them all.

Mind (Tameside, Oldham & Glossop)

Tameside, Oldham and Glossop (TOG) 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. We are commissioned by NHS Greater Manchester Integrated Care and the Local Authorities to provide services, as well as subcontracted by other organisations. We have grant funding and fundraise in order to support the communities we reach.

Safeguarding and TOG Mind

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

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

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

As a charity, we record safeguarding incidents on an internal system and provide repotts to our Board of Trustees as well as commissioners.

Safeguarding in 2024-25

For our Oldham adult services in 2024-25, 3811 risk and safeguarding incidents were internally reported on our system. Of these incidents, 3037 were related to adults experiencing suicidal ideation/planning, and 306 were related to self-harming behaviours. These would not be unusual presentations with the services we provide. However, our internal matrix ensures we capture all risks associated with adults. Due to the introduction of the NHS Patient Safety Incident Response Framework (PSIRF), we will be redeveloping our risk matrix accordingly in 2025-26.

During 2024-25, we increased partnership working with Pennine Care NHS Foundation Trust and secondary care services, especially through the Oldham Living Well model that went live in July 2024, meaning that we are an established partner within the weekly huddles and cross-organisational multidisciplinary teams. Alongside our Listening Space service, which is an alternative to A&E, we expected to see a rise in incident reporting.

As always, there was an increase in the complexity of cases and co-morbidity/co-occurring conditions alongside complex social issues in presentations.

Our top adult safeguarding achievements in 2024-25 included:

- New Risk and Safety planning training – A new training session was developed around risk and safety planning. This session focuses on increasing confidence in exploring risk and have meaningful conversations; safety planning collaboratively; ensuring accurate record keeping; and a message of hope.
- Involvement in hoarding partnerships, and working closely with a hoarding specialist to create a peer support hoarding group with positive steps in Oldham. This has involved staff receiving intensive training and attending Greater Manchester groups with other facilitators.
- Peer group supervision for supervisors was established to enhance reflective practice across management teams.

Making Safeguarding Personal

We have developed an outcomes focus to safeguarding work by embedding a more robust duty management rota at all times of our open operating hours, whereby service (project) managers in the building are always available to respond to immediate duty needs, with an enhanced senior and safeguarding manager system for any internal escalation needs.

In addition, Level 3 safeguarding training has been reviewed and rewritten. This now takes place over two days. Feedback has been positive, with comments around the benefit of it being over two days which allows for reflection in between; the value of discussions; and acknowledgement of the complexities of safeguarding, making safeguarding personal, and learning through each other.

Following internal reviews we developed risk and safety planning training for all front line workers.

Successful Multi-Agency Safeguarding Work

TOG Mind initiated multi-agency working with Positive Steps to create a hoarding peer support group in Oldham, as part of the OSAB Hoarding Improvement Partnership initiative.

TOG Mind also have presence on subgroup meetings such as, but not limited to, OSAB Policy, Procedure and Workforce Development Subgroup and the Greater Manchester Voluntary, Community and Social Enterprise (VCSE) Crisis Alternative initiatives.

Safeguarding Priorities in 2025-26

Our key adult safeguarding priorities for 2025-26 will be:

- Embedding enhanced safer recruitment practices.
- Progression of getting access to Learning from Patient Safety events to explore system reporting and application to TOG Mind. Collaboration with other VCSE organisations to explore understanding of PSIRF expectations. Further discussions with commissioners to highlight limited clarity on application to community organisations.
- Redesigning our incident reporting system.
- Embedding the new risk and safety planning training in accordance with National Institute for Health and Care Excellence (NICE) guidelines.

Key Challenges

In 2025-26, our Listening Space is expanding and will be opening an additional 21 hours per week. We expect to see a significant rise in complex social needs, suicidal presentations and self-harming behaviours, as well as vulnerable adults disclosing that they may be at risk. This will be managed through our new duty management rota system. We also expect a need for more training for front line workers for capacity assessments.

MioCare Group

The MioCare Group is a Council owned company providing a range of services to adults with Autism and/or Learning Disabilities and older people who require support outside of hospital; we do this with the aim of supporting people to maintain their independence and to live in their own homes for as long as possible.

Safeguarding and MioCare Group

Safeguarding is a priority for the Group and features in all elements of our operational activity, leadership and governance. We ensure that all employees are equipped with the skills, knowledge and support required in order to identify and act upon any concerns.

Safeguarding training is mandatory for all roles across the Group, reiterating that all employees have a role to play in ensuring that people are safeguarded and that the safety of the people we support is never compromised.

Safeguarding in 2024-25

In 2024-25, we had six safeguarding incidents which were reported as medium or high. Four of these were 'physical abuse' relating to unexplained bruising or allegations of assault by a person we support against another person in the same service. Each incident is thoroughly investigated and reported in line with policy and procedure, with appropriate actions taken and a thorough review and 'lessons learned' process followed in each case.

We work collaboratively with partners and colleagues and continue to report low level concerns via the Council's procedure; when looking at themes and trends, the majority of these are low level medication errors and behaviour related incidents.

In 2023, we undertook a major refresh of our organisational Safeguarding Policy and have focused this year on embedding this policy at every level of the organisation, through our quarterly service spotlight process, Safeguarding Champions meetings, managers meetings, team meetings and briefings. Similarly, we updated and relaunched our Safeguarding Plan in 2024 which is aligned to the Care Quality Commission Single Assessment Framework. This focuses on four key areas: Safeguarding Leadership; Prevention and Early Intervention; Listening/Learning/Acting; and Safeguarding Excellence.

We have revised a number of processes to increase scrutiny and oversight at all levels of the organisation and continue to roll out our digital platform across services which provides increased speed of reporting, visibility and scrutiny. The implementation of changes such as digital recording of medication (EMAR) in some services has seen a significant reduction in medication recording errors for example, and these changes continue to enhance our internal assurance processes.

Successful Multi-Agency Safeguarding Work

In March 2025, our residential reablement service cared for a person who had been discharged from Royal Oldham Hospital. Due to a range of mental health and behavioural issues, a number of which were logged as medium and high level safeguarding incidents, the person needed to be discharged from the service. This proved to be problematic despite regular multidisciplinary team meetings involving all stakeholders, although it was eventually achieved through partnership working. As this was a significant event across the hospital and intermediate care system, MioCare has requested a full review of the case to scrutinise all partners responsibilities to ensure we identify any areas of learning and embed these into future practice.

Safeguarding Priorities in 2025-26

As well as continuing to embed our Safeguarding policy approach, we will focus on the following areas in 2025-26:

- Revision and dissemination of our 'Supporting People to Manage Their Finances Policy' and associated procedures.
- Roll out of updated investigation training for managers.
- Building and introducing digitised safeguarding audit tools at service and organisation levels.
- Further refinement of our reporting and analysis tools.
- Formal collaboration with people we support to help drive our safeguarding aims.

Key Challenges

Budgetary and resource constraints remain a constant challenge and we are working closely with the Local Authority and other partners to help address this and to plan for future changes and efficiencies. Further challenges will include:

- Recruitment and retention. We are looking at more innovative ways to attract, recruit and retain staff.
- The increasing complexity and acuity of people we support in all our services.
- Embedding process changes such as incident sharing with NCA partners and other external stakeholders.

NHS Greater Manchester Integrated Care

NHS Greater Manchester (NHS GM) is the Integrated Care Board (ICB) responsible for making decisions about health services across Greater Manchester. NHS GM works in collaboration with partner agencies including health, police, local authorities and education to keep all those living in our communities safe.

Safeguarding and NHS Greater Manchester Integrated Care

Safeguarding remains within the overarching NHS GM quality governance structure which supports an integrated model for the delivery of the safeguarding functions across the organisation and with system partners. This also provides the opportunity for system learning and improvement and safeguarding oversight and assurance across the localities within NHS GM.

NHS GM as with all NHS Organisations, has a requirement to safely discharge its statutory duties in relation to the safeguarding of children, young people and adults as outlined in national guidance. NHS GM has continued to discharge our statutory safeguarding duties throughout 2024-25. The responsibility for safeguarding within the ICB is delegated to the Chief Nursing Officer supported by the Deputy Chief Nurse and Associate Director of Safeguarding supporting governance and assurance structures. Statutory safeguarding delivery is overseen via Associate Directors of Quality and Safety in each of the GM localities and undertaken by the locality Designated Teams.

The NHS England Safeguarding and Accountability and Assurance Framework (SAAF 2024) provides the strategic framework for ensuring strategic system oversight of our safeguarding priorities. Assurance and oversight of these duties is maintained via the NHS GM governance structures. The ICB Quality Committee receives regular safeguarding reports to ensure that it is fully sighted on safeguarding assurance, activity, risks, and the plans to mitigate as required.

The ICB has submitted quarterly Safeguarding Assurance Self-Assessments to provide assurance of its arrangements to NHS England, this includes our oversight of the NHS England self-assessment audits from our Greater Manchester commissioned providers. In addition, NHS GM submits statutory self-assessments to the Safeguarding Children's Partnerships and Adult Safeguarding Boards. An overview of our detailed activity will be provided via the Annual Safeguarding Report 2024-25 which will be published in 2025-26.

NHS GM has maintained statutory duties across the Greater Manchester Safeguarding Adult Boards as a statutory partner. The safeguarding team continues to promote effective joint working across the Integrated Care System. NHS GM has representation on other statutory partnerships including Child Death Overview Panels, Corporate Parenting Boards, Channel Panels, Multi-Agency Public Protection Arrangements Boards, Domestic Abuse Partnership Boards and Community Safety Partnerships.

NHS GM continues their work with our Safeguarding Adult Boards to develop their offer to support health, wellbeing and opportunities for the future and to understand the improvements required to strengthen our safeguarding offer across our communities. NHS GM works with wider Integrated Care System partner representatives to ensure there are representatives across the NHS GM committees and boards including, NHS providers, Healthwatch and the Voluntary, Community and Social Enterprise sector. Our partner representatives are key to ensuring effective community and citizen participation in the work of the wider Integrated Care System to safeguarding our residents across Greater Manchester.

NHS GM has a statutory responsibility for ensuring safe systems of care are delivered and to ensure that all health providers whom they commission, discharge their functions regarding safeguarding and the promotion of welfare of children, young people and adults at risk. The statutory safeguarding assurance processes set out in the SAAF have been adhered too.

NHS GM Safeguarding Children, Young People and Adults at Risk Contractual Standards provide the safeguarding audit framework used to monitor all NHS and Non-NHS providers of health care and ensure safeguarding arrangements are in place to provide oversight of provider annual safeguarding assurance. Assurance of ICBs is overseen by NHS England. Assurance reviews are carried out quarterly via the Safeguarding Commissioning Assurance Toolkit (SCAT), completion of self-assessment heatmaps, and monitoring through the NHS Safeguarding Case Review Tracker (SCRT) and NHS Safeguarding Integrated Data Dashboards.

Safeguarding in 2024-25

In collaboration across the ten Greater Manchester localities, the Safeguarding Children Partnerships, Safeguarding Adult Boards and Community Safety Partnerships, Designated Safeguarding Professionals from NHS GM, maintain oversight of learning and recommendations from all statutory safeguarding reviews.

They disseminate key learning from local, regional and national reviews via a range of mechanisms such as health collaboratives, supervision, contractual and relationship meetings and support the embedding of recommendations into practice and policy across the health economy, to ensure prevention of further harm to the most vulnerable children and adults who are at risk of abuse and neglect. Examples of this include:

- the development of a suite of learning sessions, planned to be delivered by Named GPs for Safeguarding during 2025-26 to GP Safeguarding leads, across ten GM localities, aligned to recurrent learning.
- liaison with NHS England to ensure that recruited nurses from abroad receive information on how to access antenatal care and pregnancy employment rights.

During 2024-25, the Delivery Group for System Learning and Improvement has led on the development of a Greater Manchester Statutory Review Dashboard which will provide data and analytics, supporting better understanding of recurrent learning, themes, and trends across the health system. This will influence and inform development of health services, and strategic commissioning to drive improvement in outcomes for our population. Key themes to arise from Adult Reviews across the health system include Mental Capacity Act implementation, multi-agency working and escalation, and self-neglect.

During 2024-25, the NHS GM Designated Safeguarding Team we have worked with senior leads across all localities to streamline our assurance processes whilst maintaining safeguarding quality improvement. We have a well-established central pan Greater Manchester assurance model to align and strengthen our system oversight, support early identification of safeguarding system risks and support improved safeguarding standards across NHS GM commissioned services. This aligns with the NHS GM Quality Oversight Framework and Quality Strategy.

We have co-ordinated safeguarding assurance within the NHS GM commissioning cycle, using subject matter expertise for the patient choice commissioning process.

We have established and audited locality health collaborative meetings to strengthen health system relationships and identification of potential system risk and embed good practice.

Successful Multi-Agency Safeguarding Work

The Oldham Designated Professional for Safeguarding Adults led the development of the Safeguarding Briefing for Practitioners concerning Assisted Suicide in response to learning emerging from SAR 'Lisa'. The guidance aims to support staff in providing care to individuals who disclose their thoughts of 'assisted suicide' or 'euthanasia'. This was published and promoted across agencies in December 2024.

In collaboration with the Safeguarding Adults Board and Children's Partnerships Learning and Development teams, the Designated Professional for Safeguarding Adults has supported the development of a comprehensive Complex Safeguarding training package that addresses both adult and children's safeguarding concerns in relation to exploitation and modern slavery. This multi-agency training aims to enhance understanding of overlapping risks, promote joint working, and embed consistent safeguarding practices across all sectors. The first session is to be delivered in early 2025-26.

As a commissioning organisation, we have embedded learning from recent SARs into our quality assurance processes, supporting both Designated Professionals and providers to improve early identification of safeguarding concerns and to deliver more personalised, outcomes-focused responses for adults at risk.

A key enabler has been the implementation of a secure web-based tracker developed by GM NHS, which allows Designated Safeguarding Professionals to update the status of statutory reviews and access review summaries for their locality. This tool provides live data, including the number of open and closed cases, incident themes, and learning from recommendations. The tracker supports consistent oversight and reporting across Greater Manchester NHS and enables cross-agency learning, helping to meet statutory safeguarding duties and drive continuous improvement across the system

Safeguarding Priorities in 2025-26

NHS GM will continue to address any newly acquired statutory responsibilities and reforms and development of our activity to continue to address the ICB duty to cooperate in line with the Serious Violence Duty (2022), the Domestic Abuse Act (2021) and the implementation of the Sexual Safety Charter in line with the Worker Protection Act 2023 (amendment of the Equality Act 2010).

The NHS GM Designated Safeguarding Team has established infrastructures to support learning from SARs, Children Safeguarding Practice Reviews and Domestic Homicide Reviews. This supports embedding system learning when significant incidents occur. System assurance demonstrating the impact from learning will remain a key area of focus for the team in 2025-26.

The Designated Professional for Safeguarding Adults leads the Modern Day Slavery and Human Trafficking (MDSHT) workstream across GM NHS and is involved in the creation of bite-sized learning events which will be introduced to help NHS staff better identify and respond to victims and survivors of MDSHT, particularly in the absence of statutory National Referral Mechanism (NRM) duties.

Key Challenges

The ongoing NHS reforms present a significant challenge to meeting safeguarding priorities within the ICB. Structural changes and evolving responsibilities introduce complexities in partnership working, communication, and resource allocation. These reforms require continuous adaptation to ensure safeguarding remains a central focus amid shifting organisational landscapes, while maintaining robust protection for vulnerable individuals across the system.

North West Ambulance Service NHS Trust

North West Ambulance Service NHS Trust (NWAS) provides 999 emergency pre-hospital care, Patient Transport Service for pre-booked journeys, and the North West Regional 111 service. NWAS serves the whole of the North West footprint - over 5400 square miles and has over 300 job roles.

Safeguarding and North West Ambulance Service NHS Trust

The NWAS Safeguarding Team provides representation for each of the NWAS service lines and the 3.6 Whole Time Equivalent Safeguarding Practitioners engage with statutory processes as well as internal and external demands. The Practitioners are supported by 1.8 Whole Time Equivalent administrators and sit within the wider NWAS Quality Directorate, managed by the Head of Safeguarding.

The Safeguarding Team aim to ensure that safeguarding expectations are well understood throughout all NWAS service lines and support all areas with safeguarding governance, such as the Patient Safety Incident Response Framework (PSIRF), training and complex incident support. Uniquely for a healthcare provider, the NWAS Safeguarding Team encompass both the adults and children's disciplines.

Safeguarding in 2024-25

NWAS makes safeguarding referrals to 27 Local Authorities within the geographical footprint. Referrals are made electronically via our Support Centre in Carlisle to the appropriate Local Authority. During 2024-25, we have seen a 19% increase in safeguarding and early help referrals made by NWAS staff. This is likely attributable to a Training Needs Analysis review which resulted in more staff now aligned to level 3 training and a subsequent increase in staff knowledge and confidence. We continue to closely monitor the rate of referral rejections by the Local Authorities. The rejection rate for 2024-25 is 1.95%, down from 2.73% in 2023-24, thus providing continued assurance that the safeguarding information shared by NWAS is of a high quality.

Safeguarding referrals continue to be made to our Support Centre Team who take telephone referrals from our crews and send them electronically to the relevant Local Authority. Assurance in relation to the quality of NWAS referrals is monitored closely by the Safeguarding Team. Approximately 10% of all referrals deemed not to meet the safeguarding threshold by the Support Centre are subsequently put on 'hold' and forwarded electronically to the Safeguarding Team for additional oversight, thus ensuring that the potential for missed safeguarding opportunities is minimised

Implementation of the NWAS Safeguarding Dashboard has allowed us to further examine referral activity data by service area, by geographical location and by Local Authority. As expected, the highest number of NWAS referrals have been generated by Paramedic Emergency Service (PES) staff: 78% of Early Help referrals and 64% of safeguarding referrals.

Safeguarding training compliance is monitored closely. At the end of 2024-25, the Learning and Development Team reported overall safeguarding training compliance (levels 1-3) to be above 90%.

Our key safeguarding achievements in 2024-25 included:

- Delivery of bespoke, participative safeguarding training for Integrated Contact Centre and Support Centre staff improved knowledge and confidence within this staff group, who by nature of their role, are safeguarding 'at a distance' over the telephone as opposed to face-to face with our patients.
- Restructure within the Safeguarding Team enhanced cross working and sharing of expertise between safeguarding and mental health staff.
- Development and implementation of the safeguarding dashboard which enhanced our reporting and assurance processes.
- Continued engagement with Integrated Care Boards to streamline assurance requirements and to provide a conduit to safeguarding boards/partnership boards.
- Continued development of easily accessible safeguarding resources for our workforce.

Safeguarding Adult Review Learning

During 2024-25, NWAS engaged in 171 statutory reviews consisting of 94 SARs, 42 Domestic Abuse-Related Death Reviews (DARDRs) and 35 Local Child Safeguarding Practice Reviews LCSPRs). Greater Manchester, our largest area, continues to generate the most safeguarding activity. Thematic learning from reviews is shared via the Green Room (our staff intranet) and via Safeguarding Practitioners attending their area Learning Forums. NWAS-specific learning is delivered directly to Sector Leads for immediate communication with the relevant staff and service areas.

The Trust Management Committee are apprised of the outcomes of all statutory reviews and any action plans subsequently formulated via the bi-monthly Reportable

Events paper. Risks identified during participation in a review are escalated as per Trust policy. There are currently no risks in relation to safeguarding on the Trust Risk Register.

Safeguarding Priorities in 2025-26

The safeguarding priorities for NWAS in 2025-26 will include:

- Embedding Safeguarding Supervision within the Trust appraisal process.
- Development of safeguarding champions/link staff within our Integrated Contact Centres.
- Ongoing delivery of bespoke, face-to-face, lightening learning sessions to our Integrated Contact and Support Centre Staff.

The Head of Safeguarding attends the National Ambulance Safeguarding Group (NASaG). Engagement with NASaG ensures the Trust are informed of any changes to national safeguarding policies, safeguarding standards, and regulatory framework. The group also facilitates collaboration with other ambulance trusts to share best practice and to work together in addressing challenges. The workplan for 2025-26 includes development of a safeguarding training suite that is bespoke to ambulance services following acknowledgement that examples within existing training packages do not adequately reflect pre-hospital care.

Key Challenges

NWAS engagement with system-wide safeguarding activity remains a challenge due to the large geographical area we cover. In order to make the most effective and equitable use of the resource within the Safeguarding Team, we are working closely with our ICBs to develop leaner ways of working and to ensure that our contributions are meaningful and proportionate. Each Safeguarding Board/Partnership Board is formally written to on an annual basis by the Head of Safeguarding to inform them of our commitment to engage with the Safeguarding Boards, and to establish good working relationships in each area. A copy of the Trust annual safeguarding report is also shared.

Northern Care Alliance NHS Foundation Trust

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 - our NCA family - deliver healthcare excellence 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 department, including a specialist one for children and offers a comprehensive range of acute, general surgical services and women's, children's and maternity services.

Safeguarding and Northern Care Alliance NHS Foundation Trust

To address the Oldham safeguarding adult agenda, responsibility and accountability is embodied at board level and is encompassed within the Group Chief Nurse role and responsibilities. The strategic and operational delivery of the Oldham safeguarding adult programme is led by the Assistant Director of Nursing for Safeguarding Adults under the leadership of the Royal Oldham Director of Nursing, NCA Group Associate Director of Safeguarding and the Deputy Chief Nurse for NCA.

The Care Act 2014 provides statutory legislation for adults at risk, it is expected health will cooperate with multi-agency partners to safeguard adults. To facilitate this statutory requirement the NCA provide full engagement to the safeguarding adult agenda under Oldham Safeguarding Adults Board.

Safeguarding in 2024-25

The NCA Safeguarding Adult Service are key health partners representative at the Complex Safeguarding and Safeguarding Adult Review subgroups of the OSAB. The themes emerging from these relate to:

- multi-agency working, information sharing and communication.
- impact of Domestic Abuse and coercion and control including in Older Adults.
- awareness of Mental Health concerns.
- application of the Mental Capacity Act (2005).
- non-adherence: where a person who has mental capacity is making unwise decisions with regards to their health and social care needs, which places them at significant risk of harm.
- self-neglect: challenges with self-care to an extent that it threatens personal health and safety.
- professional curiosity.

In terms of the above, NCA foster a culture of learning, on this basis all learning from SARs and complex cases progress through the NCA internal governance process emphasising a learning culture reflecting a floor to board approach.

Adult Safeguarding training is a mandated requirement across NCA; to date full compliance with regards to Adult Safeguarding Level 3 training threshold as outlined within the Greater Manchester Contractual Standards for Children, Young People and Adults at risk ,has been achieved with a full commitment from NCA to deliver this ongoing programme of training.

In terms of the Domestic Abuse Bill (2021) and the government recommendations to employ health based Independent Domestic Violence Advocates (IDVAs), NCA have supported the Domestic Abuse Specialist Nurses within the team to undertake the IDVA training; resulting in NCA having four health based IDVAs within the organisation offering support and advise to those requiring this service.

Safeguarding Adult Review Learning

Safeguarding is a priority for NCA. On this basis, the Safeguarding Service offer monthly champions meetings with safeguarding topics for discussion applicable to all levels of practitioners and senior leadership. Learning from SARs is high on the agenda with robust safeguarding and internal governance processes embedded ensuring a floor to board approach to learning.

Safeguarding Priorities in 2025-26

NCA aim to continue to work with both our workforce across the Alliance and in partnership with local health and social care colleagues to embed learning to keep children, young people and adults with a care and support need safe. This will be achieved by attendance at the relevant safeguarding committees, continuous delivery of the Safeguarding Adult Level 3 and Mental Capacity Act training programme across NCA, and the strengthening of the governance and reporting arrangements for SARs and Domestic Homicide, thus embedding the recommendations, and learning across NCA.

Key Challenges

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 every day practice.

Pennine Care NHS Foundation Trust

Pennine Care NHS Foundation Trust (PCFT) is proud to provide Mental Health and Learning Disability services to people across Greater Manchester and beyond. We serve a population of 1.3 million and our vision is a happier and more hopeful life for everyone in our communities. More than 4000 dedicated and skilled staff deliver care from 88 different locations in six boroughs.

Safeguarding and Pennine Care NHS Foundation Trust

PCFT has a statutory duty to promote the welfare of children and young people and to protect adults at risk of abuse. Safeguarding means protecting a citizen's health, wellbeing, and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care.

The PCFT vision for a happier and more hopeful life for everyone in our communities includes safeguarding practices and requires a 'Think Family' approach, as neither children, young people, adults, nor their families and carers exist in isolation.

The statutory accountability for safeguarding lies with the Executive Director of Quality, Nursing, and Healthcare Professionals. A safeguarding team support the Trust with safeguarding our patients, service users and carers; meeting statutory responsibilities, in line with the Safeguarding Accountability Framework; and take action to improve key areas of safeguarding practice.

The PCFT safeguarding team offers a daily (Monday to Friday) consultation system. A Safeguarding Families Specialist Practitioner responds to all colleagues who contact the team for safeguarding advice, support, and guidance. The system is supported by safeguarding administrators. The safeguarding consultation system is a robust system offering advice, support, and guidance to staff on the safeguarding agenda.

Safeguarding in 2024-25

The safeguarding team recorded 2382 consultations during 2024-25, an increase of 36% from 2023-24. This increase aligns with previous yearly increases and the overall increase in the number of colleagues, services, and patients that PCFT supports.

The most prevalent categories of abuse or themes were Domestic Abuse, historic (or non-recent) child sexual abuse, child emotional abuse and parental mental health and information sharing. These are consistent with themes from 2023-24, with a noted increase in concerns about the impact of parental mental health and safeguarding, for which the team is creating supportive resources. The data is regularly reviewed alongside network colleagues at the Central Safeguarding Assurance Group, and themes captured inform the training offer, support and communications from the safeguarding team.

The PCFT safeguarding team has seen an increase in workforce in 2024-25 with the addition of a Named Nurse for Safeguarding Looked After Children role and a Mental Capacity Act Lead role introduced to the team. The team continued to be fully staffed and this has allowed the team to drive the priorities, training and supervision offer across the Trust. The safeguarding team were nominated for a Greater Manchester Health and Social Care champions Award.

In 2024-25, the safeguarding team initiated a review of the governance and accountability of the safeguarding arrangements within the Trust, making this a priority for 2025-26. The Central Safeguarding Assurance Group meets bi-monthly and will be supported by the Statutory Safeguarding Delivery Group. A work plan is in place to strengthen the terms of reference and reporting from the team and networks, with the development of a dashboard to support this effort. This will be guided by a learning review which has been commissioned to review the current safeguarding service provision. The Central Safeguarding Assurance Group is chaired by the Executive Director of Nursing, Healthcare Professionals and Quality Governance and reports to the Central Safety Summit. The Quality Committee receives reports on a bi-annual basis.

Our Trust provides external assurance through a variety of methods but primarily via the Integrated Care Systems Safeguarding Children, Young People and Adults at Risk Contractual Standards.

During 2024-25, our top achievements in support of OSAB included:

- supporting to deliver TRAM Protocol training and to embed the processes across the care hub.
- presenting a psychiatric perspective at the OSAB 'We Need to Talk About Hoarding' conference.
- contributing to the OSAB Gab podcast recordings.
- delivering OSAB Mental Capacity Act Training
- chairing the OSAB Safeguarding Review, Audit and Quality Assurance Subgroup.
- continuous development of the OSAB Professional Curiosity and Unconscious Bias training package; now offered to practitioners from all PCFT areas.

In September 2024, the safeguarding team hosted their first safeguarding conference. The conference covered the lifespan of safeguarding and included topics such as child criminal exploitation, Domestic Abuse, and the lived experience of predatory marriage. The conference was attended by 112 colleagues, and feedback highlighted that the event was successful and valued by colleagues, with some providing suggestions for topics for next year.

Safeguarding Adult Review Learning

PCFT is committed to active involvement in local statutory multi-agency reviews. This process is led by the safeguarding team with the support of the service(s) who were involved with the individual or their family. In 2024-25 the safeguarding team received 56 requests to contribute to safeguarding reviews from our local boards and partnerships. Of these, the safeguarding team coordinated the PCFT contribution to 50 reviews in which the individual or family member were known to the Trust. The number of requests has seen a decrease of 28%. Eight referrals have been made by PCFT as part of our robust patient safety processes. Safeguarding team colleagues are members of all quality and safety panels throughout the Trust and can make recommendations about whether significant incidents are referred for statutory review. The safeguarding team discuss this with quality or senior leads, and the Head of Safeguarding signs off on any referrals being submitted.

It is crucial that learning from safeguarding reviews is disseminated and embedded into PCFT safeguarding practice. Learning from reviews is incorporated into safeguarding training updates, work plans and included in training strategies. We work with our multi-agency partners to offer assurance about learning and changes made following reviews. We capture this through Quality Walks and dip samples, the governance of which is captured through the Central Safeguarding Assurance Group.

Across the trust, themes from SARs have been understanding and application of the Mental Capacity Act; professional curiosity; cultural competency; communication and information sharing; dual diagnosis, and disengaging patients. The safeguarding team completes learning events about SAR learning themes. We have completed lunch and learn training sessions on professional curiosity and a 7-minute briefing about information sharing. The team have also supported the development of new PCFT policies, such as the domestic abuse policy and the 'Was Not Brought' policy.

Safeguarding Priorities in 2025-26

Our key adult safeguarding priorities for 2025-26 will be to:

- enhance work in relation to the Mental Capacity Act to ensure knowledge, compliance, and governance.
- develop a safeguarding champion/link model within the Trust.
- introduce new governance around safeguarding within the Trust, establishing an improved Central Safeguarding Assurance Group and a new learning from statutory safeguarding delivery group supported by the networks.
- Develop a safeguarding data dashboard to ensure data driven decision making and accountability across the Trust footprint.

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 and Positive Steps

Safeguarding is at the heart of all of the work within Positive Steps from the universal offer of the careers advice and guidance to working with vulnerable groups within the Youth Justice Service and Young Carers. Practice is guided by safeguarding policies and procedures across the organisation with specific departmental policies available where needed. All employees are required to undertake safeguarding training as part of their induction at a level that is appropriate to their role with requirement to refresh this training as required. Regular Continuing Professional Development is encouraged and promoted through wider training across the partnership. We also have an internal safeguarding log where all concerns are recorded with management oversight required.

Safeguarding in 2024-25

During 2024-25, we recognised trends in relation to:

- Social Housing - waiting lists, lack of provision, poor quality, overcrowding. This is a particular issue for single adult males, in particular those on probation or who are affected by substance dependency.
- Finances - debt, increase in cost of living, benefit entitlement, increase in numbers falling into poverty
- Mental health - hoarding and self-neglect, thresholds, access to services due to high waiting lists.

Further trends were related to substance use, social isolation and gambling.

We have renewed our focus on how we provide help, safeguarding and protection for those we support:

- We appointed a new Designated Safeguarding Lead who is also the Head of Service for Youth Justice and Missing from Home, having been at Positive Steps for twelve years.
- We reviewed our Safeguarding Policy, working with a consultant.
- All staff received a Safeguarding Induction by a qualified Social Worker or the Designated Safeguarding Lead within their first week of commencing employment.
- Minimum standards for safeguarding training were reviewed across all staff levels to ensure that these were relevant and proportionate to roles.
- We reviewed our internal safeguarding group, now the Positive Steps Safeguarding Assurance Group, which oversees and scrutinises all aspects of safeguarding across the organisation and feed this into the Leadership Group and the Board of Trustees on an annual basis.
- We are the lead facilitator for the Hoarding Peer Support group which feeds into the wider OSAB Hoarding Improvement Partnership.

Collaboration is one of the values of Positive Steps, reflected in the new Strategic Plan for 2025-28. We work alongside people, respecting their experience and expertise, which includes staff and service users. “People” is one of our four strategic pillars which serve as the guiding framework to deliver on our vision.

Making Safeguarding Personal

A risk framework has been developed by the Oldham Wellbeing Hub supporting people on probation, alongside our Positive Futures team who support our group sessions to ensure a robust risk measuring tool is in place for each session delivered. On the back of direct feedback from a client, we have developed a ‘working with me’ client document which enables safeguarding and individual needs to be at the forefront of our work.

Successful Multi-Agency Safeguarding Work

The Adults Team has played a pivotal role in the OSAB Hoarding Improvement Partnership, contributing significantly to raising awareness and enhancing professional understanding of hoarding behaviours. The team presented at the OSAB ‘We Need to Talk About Hoarding’ conference, collaborating with TOG Mind and a psychologist specialising in hoarding. This event aimed to educate professionals about the complex impact of hoarding on adults, children, and families.

In addition, the team have been the primary facilitators of the Hoarders Helping Hoarders peer support group. This initiative, which has been running successfully for several months, is designed to be voluntary and peer led. It provides a safe, non-judgmental space where individuals can explore the root causes of hoarding, share their experiences, and support one another in managing their anxieties and challenges. The group has five consistent attendees with positive promotion across networks steadily increasing numbers.

Safeguarding Priorities in 2025-26

Positive Steps safeguarding priorities for 2024-25 will be:

- to embed a new recording system for internal safeguarding concerns across all service areas. This has been trialled within one area of the organisation and is now being rolled out across all service areas. This allows all safeguarding activity to be recorded in one place and can therefore be

monitored for quality assurance and trends.

- to explore the development of a Safeguarding Dashboard to monitor and track activity in real time however this has not been developed as yet due to budget restraints.
- The leadership team will be completing safeguarding audits. These will quality assure the recordings through our internal safeguarding process. Managers will audit across other services, not their own, to allow the organisation to assure consistently of practice.
- to contribute to wider safeguarding partnership through attendance at appropriate subgroups and operational meetings, sharing appropriate information across the organisation.

Key Challenges

Our key challenges in 2025-26 will be:

- Implementing changes: embedding a new way of recording internal safeguarding and development of a dashboard – we will need to ensure consistency of practice across all services. Our internal Safeguarding Group will continue to monitor and lead on this work.
- Reduced capacity and funding: a significant budget cut to our adult provision in 2025-26 adds pressures on other parts of the system both internally and externally. We will continue to work with wider partners to streamline support, reduce duplication and actively maximise staff capacity whilst remaining person centred in our approach.

Probation Service

The Probation Service is a statutory criminal justice agency that supervises adults released from prison on licence and those on community sentences as imposed by criminal courts. The Probation Service additionally delivers accredited programs, unpaid work and the victim contact services. Our priorities are to protect the public by the effective rehabilitation of people on probation. We work closely with partners in the delivery of our objectives.

Safeguarding and the Probation Service

The role of the Probation Service is to protect the public. Safeguarding adults is a key priority within this; built into strategy, policy and operational procedure.

Safeguarding in 2024-25

Safeguarding victims of domestic abuse together with a high incidence of mental health issues and substance abuse, often underpinned by childhood trauma, continues to present high levels of safeguarding concern. Anecdotally, cuckooing appears to be a growing concern, potentially linked to substance dependence and vulnerability associated with this. Housing crisis and limited availability of suitable accommodation is being made more acute by a prison capacity crisis and adds to concerns regarding adult vulnerability.

Our top adult safeguarding achievements in 2024-25 included:

- Embedding Probation Practitioner Single Point of Contact (SPOC) alongside the victim liaison SPOC into Oldham MASH to improve information sharing and enhance partnership relationships.
- Agreeing a plan with Oldham Local Authority for a regional specialist Domestic Abuse and safeguarding team to complete safeguarding checks via access to electronic systems and agreeing a plan supported by an information sharing agreement and training. This will free the capacity of the duty and advice team to meet demand more effectively and will create a more effective and efficient process for ensuring checks are completed within Oldham Probation Delivery Unit.
- Improving our approach to monitoring and managing completion of Domestic Abuse and safeguarding checks, evidencing good practitioner compliance with organisational expectations.
- Enhancing focus on quality assurance at a local level including significant investment in an ongoing programme of local case audit, including assessment of compliance with safeguarding policies and setting actions to address any deficits in practice.

Safeguarding Priorities in 2025-26

Priorities in 2025-26 will be to:

- ensure all staff complete mandatory training in relation to Safeguarding Adults and Domestic Abuse.
- ensure HM Prison and Probation Service Safeguarding policy and practice is adhered to by practitioners; delivery of high quality of service in this respect will be evidenced by quality assurance mechanisms.
- improve practitioners understanding and effective engagement with Local Authority and Safeguarding Adult Board strategies and protocols.

Key Challenges

A key challenge will be the prison capacity crisis and measures to reduce demand on prisons resulting in increased demand on capacity of services in the community. There is a need for significant investment at a national and regional level to build capacity and make best use of the resources available via commissioning and partnership working.

Turning Point

Turning Point – Rochdale and Oldham Active Recovery (ROAR) 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 with the individual, psychosocial interventions, opiate substitute prescribing, health and wellbeing assessments, harm reduction sessions, health and wellbeing appointments and access to detox and rehab placements.

Safeguarding and Turning Point

Safeguarding is fundamental to all the work we do with service users. We work intensively with people to understand the impact of safeguarding issues such as the impact of substance use on children and loved ones, the potential for self-neglect, Domestic Abuse and self-harm or suicide.

For some service users, where there are associated severe physical and mental health issues, we work closely with social care and other partner agencies to identify appropriate care packages and ensure service users are allocated to our Focused Care Team to provide more intensive interventions.

We focus heavily on harm reduction to continually mitigate as much risk as possible, assessing risks for clients who have children, making referrals and liaising with Children's Social Care to ensure all information is shared. We also liaise with other partner agencies in relation to issues such as Domestic Violence, self-neglect, suicide prevention and risk management.

Within our case management recording system there is a specific area for recording safeguarding information where we can appropriately log the professionals involved with the individual, the meetings we have attended and the level of support which is in place.

We ensure that we are in attendance at regular professional meetings and where we are unable to do this we send a representative or provide updates via email.

We also offer regular safeguarding clinics for colleagues within our service so that staff can discuss their safeguarding concerns and these can be escalated via the appropriate protocols.

Safeguarding in 2024-25

The key themes for adult safeguarding have been:

- self-neglect in line with poly-drug use or dependent drinking.
- an increase in pregnancies in adults using substances with multiple complexities such as substance use, mental health needs, and domestic abuse concerns.
- care of elderly parents and vulnerable adults whilst experiencing substance use issues.
- unplanned hospital discharges.

Our top adult safeguarding achievements have included:

- A focused approach on pregnancy: Whilst this may fall under the remit of Children's Social Care, we are keen to acknowledge potential support needs required for both parents. Development of the 'Pregnancy Pathway' utilises the Recovery Worker and clinical roles to support both Mum and unborn baby. By expanding our clinical offer to pregnant services users, we now offer regular bespoke health and wellbeing assessments during each trimester; regular urine drug screens; and service users are breathalysed where appropriate. We continually encourage liaison and support via wider partner agencies.
- Continued work on increasing staff knowledge and understanding of self-neglect. Our training explores how self-neglect may present and can be recognised; developing confidence in being able to challenge; and how and where to complete appropriate referrals. ROAR have developed a twelve-week intensive rolling programme of face-to-face training for all staff to access, and the safeguarding theme features heavily in several modules. This learning is supported by a one-day training course specifically designed to support colleagues' knowledge of safeguarding policies and procedures in the local area.
- We regularly asked our clients about their caring responsibilities as we recognise this is an area of concern with our ageing population but also recognise that caring responsibilities are sometimes undertaken with a view to seek tenancy and how this can be counter-productive for the dependent and for the informal carer. This risk also appears evident in some of the SARs that have been raised whereby there is carer burnout.
- We continued to strengthen our relationships with local hospitals with our Hospital Liaison Worker. This ensures there is a strong continuity of care from hospital presentation and admissions right through to community engagement. This role aims to mitigate as much risk as possible by exploiting the relationships we have fostered with other professionals, so we have a clearer picture surrounding any safeguarding concerns.

Safeguarding Adult Review Learning

In 2024–25, our service continued to embed learning with a focus on widening the approach; ensuring that more colleagues are now involved in processes such as SARs and Service User Death Reviews. This means that all colleagues, including Recovery Workers, get to understand how and why conclusions surrounding learning are met, adopted and embedded into their day-to-day roles.

Adaptations to internal documents such as case note and supervision templates have ensured that learning from SAR outcomes are embedded within every stage of both service user treatment journeys and also recovery worker practice.

Making Safeguarding Personal

During 2024-25, there was further expansion of internal multidisciplinary team meetings and complex case reviews which support Recovery Workers in maintaining and strengthening their therapeutic relationships with service users. Stronger relationships with clients provide better outcomes with services users feeding back that they feel integral to their own care planning and safeguarding processes.

Safeguarding Priorities in 2025-26

Whilst continuing to build on last year's focus we will also be prioritising:

Women in treatment:

- Continuing to work alongside partner agencies to support vulnerable women including sex workers through MASH Van outreach.
- Building a referral pathway with partner agencies for long-acting contraception (LARC).
- Strengthen Pregnancy Pathways as Turning Point has now been approved to prescribe folic acid in early stages of pregnancy
- Continuing to strengthen professional relationships with midwifery teams.

Staff development:

- Implementing and embedding of the ROAR twelve-week rolling programme within the service has provided the opportunity to compliment Turning Point's mandatory training with a more bespoke and localised programme – this offer continues to expand, and we aim to offer external partners the opportunity to start facilitating sessions during 2025-26.
- Continuing to utilise Safeguarding 7-minute briefings. Ensuring they continue to be shared locally within service meetings and discussed within individual supervision sessions to provide a better understanding for all colleagues.
- Safeguarding Clinics have been set up to provide all colleagues with a designated space to discuss any concerns with either our Safeguarding Lead or one of our champions.

Key Challenges

Both nationally and locally, we are continually faced with emerging and changing drug trends and our challenge remains to be as adaptable, responsive and accessible as possible. The increased risk of contaminated drug supplies with Nitazenes remains a constant threat and we work closely with partner agencies to educate colleagues, service users and non-service users in harm reduction practice and overdose response.

Funding and increasing costs is an ongoing issue as we are heavily reliant on core, Drug and Alcohol Treatment, Recovery and Improvement Grant (DATRIG) and Dependency and Recovery monies. We have mitigated against it this year, but it has meant we have lost some key positions. Safeguarding wise, we managed to secure 0.5 Safeguarding Manager, to help with safeguarding practices in service. This will constantly be under review and have constant impact, but we share this with our commissioners.

We have seen an increase in more complex clients, which means we must prioritise who we send to detox and who we send to rehab. We have mitigated against this by speaking to commissioners and letting them know where we are, and on going talks with social care, and their funding for rehab placements.

What to do if you are worried about an adult

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

The Oldham **Adult Referral Contact Centre (ARCC)** has been set up to help adults and families looking for support 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 a safeguarding concern 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

Stay 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

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ASC Workforce Strategy 2025-27

Update to Health & Care Scrutiny
25th November 2025

Jayne Ratcliffe, Director of Adult Social Care (DASS)

Oldham Council

ASC Vision & Strategy

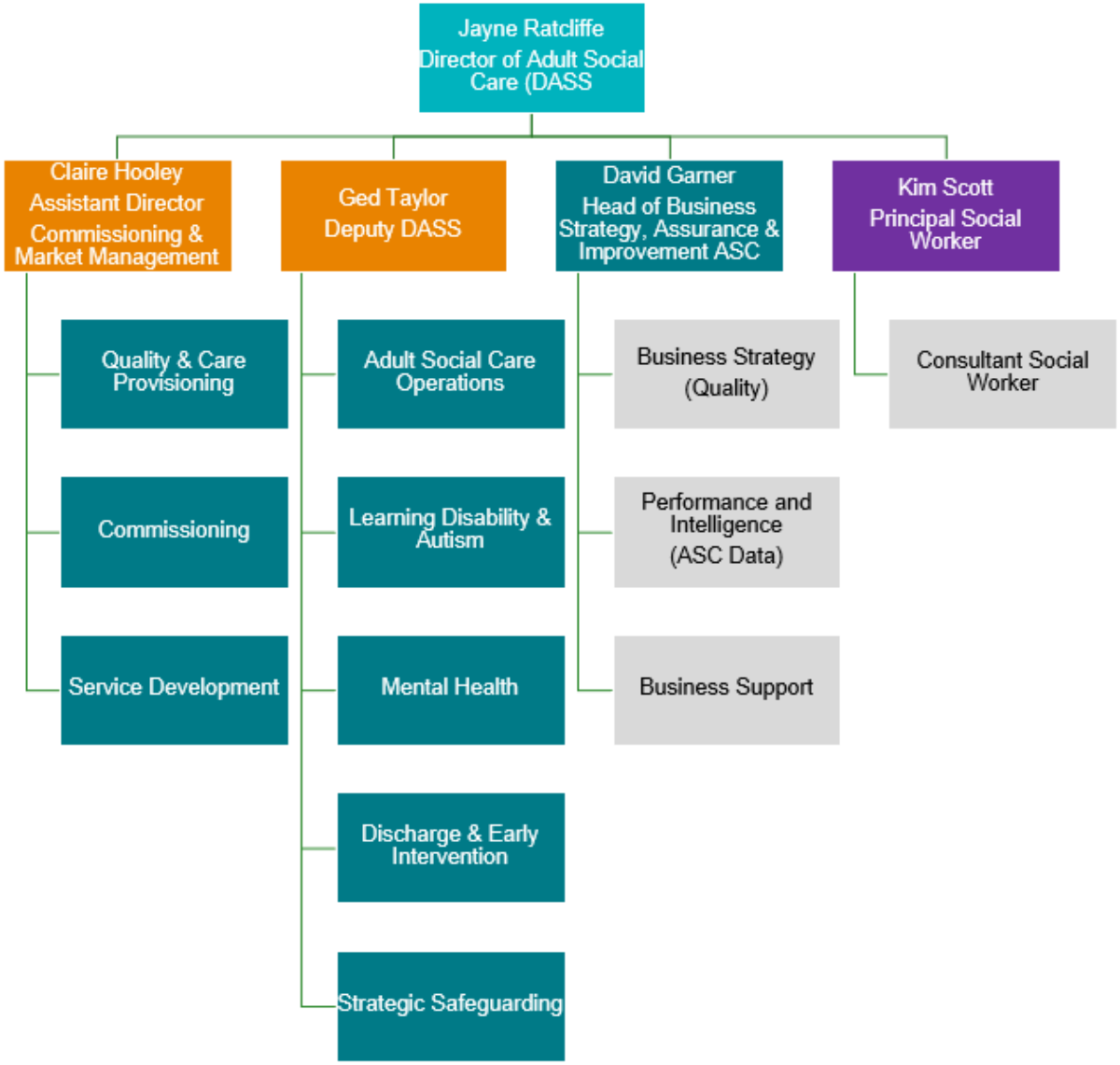
- The vision for ASC in Oldham is to **'Support residents to be independent, healthy, safe and well'** – this is underpinned by the Adult Social Care Strategy.

- The focus of the strategy is to enable residents to live as independently as possible, with minimal reliance on the Council, through early intervention, preventative services, and strengths-based ways of working.

- To do this we need to have a workforce at full capacity who feels valued, who are well trained and who want to remain working in Oldham. To do this we have prioritized **Recruitment Support**, **Training** and **Being Valued** within the ASC Workforce Strategy.

Adult Social Care Structure

- Number of established posts: **245**
- Number of vacancies: **36**
- Specialist roles are a struggle, and link to our areas of focus for the workforce strategy



Oldham's Adult Social Care Sector

- Skills for Care publish the ASC Workforce Data Set annually in Autumn which reflects data from the previous year (Oldham_Summary).

  It is reported that:

  - There are around 8,200 social care posts in Oldham, comprising of 300 vacancies.
  - The remaining 7,800 filled posts were split between LAs (3%), independent sector providers (74%), and posts working for direct payment recipients (23%).
  - It is estimated that the staff turnover rate in Oldham 15.7% which was lower than the regional average of 23.5% and lower than England at 23.7%.
  - Similarly, the vacancy rate in Oldham was 2.8%, which was lower than the regional average of 6.5% and lower than England at 6.8%

ASC Workforce Strategy - Key Priorities

Area	Our key priorities
Vision & Values	✓ Clearly define our vision, values and priorities of our workforce strategy aligned with the wider organisation's priorities. ✓ Take timely action to implement changes and new developments as part of our workforce strategy.
Roles	✓ Promote the variety of different roles available across adult social care sector. ✓ Clear define our career development and progression pathways. ✓ Continue to encourage and promote social work apprenticeship opportunities.
Recruitment	✓ Improve and streamline our recruitment and selection processes to ensure these are effective and easy to navigate. ✓ Explore opportunities for a values-based recruitment model which is aligned to our organisation values and culture.
Training & Development	✓ Implement a robust and attractive training programme that encourages and enables the continued professional development of our workforce. ✓ Embed a robust programme of supervision and annual appraisal in line with our professional supervision policy. ✓ Ensure detailed annual Training and Learning Needs Assessments are completed as part of supervisions and appraisals. ✓ Develop and grow our collaborative working arrangements with our partners e.g. education, social care providers, health partners and more. ✓ Continue to work with the GM social work academy and promote the available resources, forums and opportunities to our workforce.
Progession & Retention	✓ Implement our ASC career development framework and progression policy. ✓ Focus on 'growing our own' talent and supporting our existing workforce to maximise their capabilities and develop their careers with us in Oldham. ✓ Promote and embrace our partnership opportunities for leadership development via the GM leadership and Moving Up programme

Priority 1: Vision & Values

Our key priorities

- ✓ Clearly define our vision, values and priorities of our workforce strategy aligned with the wider organisation's priorities.
- ✓ Take timely action to implement changes and new developments as part of our workforce strategy.

Progress to date

- Workforce Strategy launched in May 2025 at ASC Staff Conference
- Engagement undertaken with staff to gather their views and feedback on what activities are needed to implement the workforce strategy.
- Feedback collated and analysed – key themes used to inform the development of ASC Workforce Delivery plan.
- Monthly ASC Workforce Group, chaired by Deputy DASS, provides oversight of progress against plan.

Priority 2: Roles

Our key priorities
✓ Promote the variety of different roles available across adult social care sector. ✓ Clear define our career development and progression pathways. ✓ Continue to encourage and promote social work apprenticeship opportunities.

Progress to date

- ASC landing page on Greater Jobs recruitment site reviewed and updated – further opportunity to include videos and case studies linked to recruitment campaign
- Next cohort of social work degree apprentices started

Planned activities to March-26

- Explore volunteering opportunities within ASC
- Develop work experience offer for ASC, MioCare & OTC
- Explore requirements for non-social work apprenticeships across ASC

Priority 3: Recruitment

Our key priorities
✓ Improve and streamline our recruitment and selection processes to ensure these are effective and easy to navigate.
✓ Explore opportunities for a values-based recruitment model which is aligned to our organisation values and culture.

Progress to date

- Review completed of current recruitment activities and practices and improvements made to tracking and monitoring processes.
- Engaging with corporate support teams to explore opportunities to streamline and further digitise recruitment processes.
- Commissioning an external agency to develop a recruitment campaign for hard to fill roles.
- Developing set of ASC values-based interview questions

Planned activities to March-26

- Deliver recruitment campaign for hard to fill roles
- Develop talent pipeline plan, to include colleges, universities, & partners

Priority 4: Training & Development

Our key priorities
✓ Implement a robust and attractive training programme that encourages and enables the continued professional development of our workforce.
✓ Embed a robust programme of supervision and annual appraisal in line with our professional supervision policy.
✓ Ensure detailed annual Training and Learning Needs Assessments are completed as part of supervisions and appraisals.
✓ Develop and grow our collaborative working arrangements with our partners e.g. education, social care providers, health partners and more.
✓ Continue to work with the GM social work academy and promote the available resources, forums and opportunities to our workforce.

Progress to date

- Workshops and staff survey held to gather views on current training offer and approach – results being collated and analysed.

Planned activities to March-26

- Undertake annual appraisals in line with wider council timeframes.
- Annual learning needs analysis and development of plan to address gaps in current training offer, particularly for non-social work roles.
- Develop SharePoint pages and communication to promote current training offer and available resources (internal & external) to workforce.

Priority 5: Progression & Retention

Our key priorities
✓ Implement our ASC career development framework and progression policy. ✓ Focus on 'growing our own' talent and supporting our existing workforce to maximise their capabilities and develop their careers with us in Oldham. ✓ Promote and embrace our partnership opportunities for leadership development via the GM leadership and Moving Up programme

Progress to date

- Social work progression policy updated and published
- Approach for social work registration fees being reviewed
- Themes and trends for leavers reviewed on a quarterly basis
- Two ASC staff selected for GM leadership programme

Planned activities to March-26

- Map progression pathways for non-social worker roles
- Produce ASC Career Development Framework

ADULT SOCIAL CARE AND HEALTH SCRUTINY BOARD

WORK PROGRAMME 2025/26

Agenda item	Purpose	Portfolio lead & officer lead	Method of scrutiny	Additional information
Tuesday 7th October 2025				
Transitions				
Mental Health services				As requested at Full Council 16th July 2025
Tuesday 25th November 2025				
Performance Assurance Report – 2025/26 Q1+Q2				
Safeguarding Adults Annual Report				
Adult Social Care Workforce Strategy				
Tuesday 27th January 2026				
MioCare Annual Report and Presentation				
CQC Inspection Action Plan				
Infant Mortality Action Plan				
Oral Health All Age Approach				
Tuesday 10th March 2026				
Corporate Performance Report – 2025/26 Q3				
MPS and Commissioning Delivery Plan				
Move More and the Place Approach				

Task and finish group deep dives:

Deep dive area:	Expanded proposal:

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KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 1 OCTOBER 2025

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
FCR-01-25	Transformation Partnership	Executive Director - Resources	20th October 2025	Cabinet
Description: To report on the Council's transformation partnership work. Proposed Report Title: Transformation Partnership Background Documents: Appendices Report to be considered in Public/Private: NOT FOR PUBLICATION by virtue of Paragraph 3 of Part 1 of Schedule 12A of the Local Government Act 1972 and it is not in the public interest to disclose the information because it relates to the financial or business affairs of the Council or a third party.				
EE-02-25	Oldham Community Leisure (OCL) Utilities	Director of Public Health	20th October 2025	Cabinet
Description: To report on the provision of utilities at sites across Oldham Community Leisure's (OCL) footprint. Proposed Report Title: Oldham Community Leisure (OCL) Utilities Background Documents: Appendices Report to be considered in Public/Private: NOT FOR PUBLICATION by virtue of Paragraph 3 of Part 1 of Schedule 12A of the Local Government Act 1972 and it is not in the public interest to disclose the information because it relates to the financial or business affairs of the Council or a third party.				
EE-03-25 **New!**	Oldham Active (OCL) - Agency Model	Director of Public Health	20th October 2025	Cabinet

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 1 OCTOBER 2025

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
Description: To report on the provision of an agency model for Oldham Active scheme, at leisure sites across Oldham Community Leisure's footprint. Proposed Report Title: Oldham Active (OCL) - Agency Model Background Documents: Appendices Report to be considered in Public/Private: NOT FOR PUBLICATION by virtue of Paragraph 3 of Part 1 of Schedule 12A of the Local Government Act 1972 and it is not in the public interest to disclose the information because it relates to the financial or business affairs of the Council or a third party.				
EDS-07-25	Speech, Language and Communication Needs Business Case	Director of Education, Skills & Early Years	20th October 2025	Cabinet
Description: To develop a borough-wide speech, language and communication needs business case Proposed Report Title: Speech, Language and Communication Needs Business Case Background Documents: Appendices – Various appendices attached to the report Document(s) to be considered in public or private: Public :				
EDS-11-25	Change Partnership Programme (CPP) delivery (inc. ELSEC/APST): grant requirements	Director of Education, Skills & Early Years	20th October 2025	Cabinet

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 1 OCTOBER 2025

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
Description: To highlight funding opportunities to the Council available from the Change Partnership Programme. Proposed Report Title: Change Partnership Programme (CPP) delivery (inc. ELSEC/APST): grant requirements Background Documents: Appendices – Various appendices attached to the report Document(s) to be considered in public or private: Public				
RBO-09-25	Sites of Biological Importance Update	Deputy Chief Executive - Place	20th October 2025	Cabinet
Description: The reason for this decision is to designate a new Site of Biological Importance (SBI) and adopt changes which have occurred to other SBI boundaries within the borough. Appendix 1 provides a map of the new SBI (Ladcastle Heath) and maps of the other SBI boundary changes (Medlock Headwater & Strinesdale, Moorgate Quarry and Armit Road Lodge). These changes are outlined in Appendix 2 and 3 alongside details of the other SBIs reviewed. Proposed Report Title: Sites of Biological Importance Update Background Documents: Appendices – Various appendices attached to the report Document(s) to be considered in public or private: Public				

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 1 OCTOBER 2025

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
HLO-04-25	Temporary Accommodation Procurement Exercises – Nightly-Paid and Emergency Accommodation	Director of Communities	20th October 2025	Cabinet
Description: The report provides an update on proposals regarding Temporary Accommodation Procurement Exercises – Nightly-Paid and Emergency Accommodation. Proposed Report Title: Temporary Accommodation Procurement Exercises – Nightly-Paid and Emergency Accommodation Background Documents: Appendices – Various Report to be considered in Public				
HLO-05-25	Extend the contract term for delivery of Accommodation Based Services for 12 months until 31st March 2027	Director of Communities	20th October 2025	Cabinet
Description: The report provides an update on the proposal to Extend the contract term for delivery of Accommodation Based Services for 12 months until 31st March 2027. Proposed Report Title: Extend the contract term for delivery of Accommodation Based Services for 12 months until 31st March 2027 Background Documents: Appendices – Various Report to be considered in Public				
FCR-08-25 **New!**	Revenue Monitor and Capital Investment Programme 2025/26 Month 5	Director of Finance	20th October 2025	Cabinet

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 1 OCTOBER 2025

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
Description: The report provides an update on the Council's 2025/26 forecast revenue budget position and the financial position of the capital programme as at the period ending 31 August 2025 (Month 5). Document(s) to be considered in public or private: Proposed Report Title: Revenue Monitor and Capital Investment Programme 2025/26 Month 5 Background Documents: Appendices – Various Report to be considered in Public				
HL-07-25 **New!**	Approval of Grant Funding Agreement with Greater Manchester Combined Authority for the provision of Community Accommodation Service Tier 3 Phase Three 2025/27	Director of Communities	20th October 2025	Cabinet
Description: The report seeks approval of Grant Funding Agreement with Greater Manchester Combined Authority for the provision of Community Accommodation Service Tier 3 Phase Three 2025/27 Proposed Report Title: Approval of Grant Funding Agreement with Greater Manchester Combined Authority for the provision of Community Accommodation Service Tier 3 Phase Three 2025/27 Background Documents: Appendices – Various Report to be considered in Public				

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 1 OCTOBER 2025

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
RBO-04-25	Approval to a) publish the Saddleworth Neighbourhood Plan for public consultation; and b) submit the Plan for independent examination	Deputy Chief Executive - Place	17th November 2025	Cabinet
Description: Approval to a) publish the Saddleworth Neighbourhood Plan for public consultation; and b) submit the Plan for independent examination Proposed Report Title: Saddleworth Neighbourhood Plan Background Documents: Appendices – Various Document(s) to be considered in public or private: Public				
EDS-12-25 **New!**	Approval to exercise the option to extend Short Breaks Play and Leisure Contract	Director of Education, Skills & Early Years	17th November 2025	Cabinet
Description: Cabinet is asked to approve an option to extend the existing short breaks, play and leisure contract. Proposed Report Title: Approval to exercise the option to extend Short Breaks Play and Leisure Contract Background Documents: Appendices – Various Document(s) to be considered in public or private: public				
HSC-14-25 **New!**	Section 75 Partnership Agreement with the NHS Northern Care Alliance	Director of Public Health	15th December 2025	Cabinet

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 1 OCTOBER 2025

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
Description: to seek approval for a Section 75 Partnership Agreement with the NHS Northern Care Alliance Proposed report Title: Section 75 Partnership Agreement with the NHS Northern Care Alliance Background Documents: Appendices – Various Document(s) to be considered in public or private: public				
NEI-09-25 **New!**	United Utilities Plc Partnership Agreement	Director of Environment	15th December 2025	Cabinet
Description approval for the Council to enter into a partnership agreement with United Utilities PLC. Proposed Report Title: United Utilities Plc Partnership Agreement Background Documents: Appendices – Various Document(s) to be considered in public or private: public				

Key:

New! - indicates an item that has been added this month

Notes:

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 1 OCTOBER 2025

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker

1. The procedure for requesting details of documents listed to be submitted to decision takers for consideration is to contact the Contact Officer contained within the Key Decision Sheet for that item. The contact address for documents is Oldham Council, Civic Centre, West Street, Oldham, OL1 1UH. Other documents relevant to those matters may be submitted to the decision maker.

2. Where on a Key Decision Sheet the Decision Taker is Cabinet, the list of its Members are as follows: Councillors Arooj Shah (Chair of Cabinet), Elaine Taylor, Abdul Jabbar MBE, Shaid Mushtaq, Mohon Ali, Barbara Brownridge, Chris Goodwin and Peter Dean.

3. Full Key Decision details (including documents to be submitted to the decision maker for consideration, specific contact officer details and notification on if a report if likely to be considered in private) can be found via the online published plan at: http://committees.oldham.gov.uk/mgListPlans.aspx?RPId=144&RD=0

Notice of Private Reports

(In accordance with Part 2 of the Local Authorities (Executive Arrangements) Meetings and Access to Information) (England) Regulations 2012)

Oldham Borough Council intends to hold a private meeting (or part thereof) of the Cabinet on Monday, 20th October 2025

Decision to be taken (Agenda Item) Decisions proposed to be taken in private at Cabinet on Monday, 20th October 2025:

a. **Transformation Partnership**

Reason:
The meeting (or part thereof) will be held in exempt session on the grounds that the reports and background papers will contain the likely disclosure of exempt information as defined in paragraph 3 of Schedule 12A of the Local Government Act 1972 (as amended) – information relating to the financial or business affairs of the Council and a third party.

b. **Oldham Community Leisure (OCL) Utilities Reason:**

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker

The meeting (or part thereof) will be held in exempt session on the grounds that the reports and background papers will contain the likely disclosure of exempt information as defined in paragraph 3 of Schedule 12A of the Local Government Act 1972 (as amended) – information relating to the financial or business affairs of the Council and a third party.

Oldham Active (OCL) - Agency Model
Reason:
The meeting (or part thereof) will be held in exempt session on the grounds that the reports and background papers will contain the likely disclosure of exempt information as defined in paragraph 3 of Schedule 12A of the Local Government Act 1972 (as amended) – information relating to the financial or business affairs of the Council and a third party.

Representations:
If you wish to make representations against the intention to hold a private meeting, please send these to Constitutional Services, JR Clynes Building, Cultural Quarter, Greaves Street, Oldham, OL1 1AT or email: constitutional.services@oldham.gov.uk

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