Stockport Safeguarding Adults Partnership

Annual Report 2024/25

Introduction and executive summary

Our annual report celebrates our achievements over the last 12 months and identifies where we will strengthen our partnership working over the next 12 months as we prepare to refresh our Business Plan. This year, we have continued our tradition of celebrating the achievements and improvements made under our 3-year business plan. This is the second report written under that plan before we refresh this with our partners in April 2026.

In last year's report we showed the work we had done with partners, and what we had identified for completion in the coming 12 months. The summary below shows the progress made since our last annual report.

What did we say we would do this year?

- Continue to deliver on our Business Plan priorities.
- Further refine the safeguarding thresholds tool and embed into multi-agency safeguarding practice.
- Work as a Partnership to ensure the right referrals are made to the right services, through initiatives including *Right Care Right Person* and the new multi-agency Risk Matrix and Safeguarding Thresholds tool.
- Refresh the Safeguarding Adults Partnership's Quality Assurance Framework.
- Progress with multi-agency work around transitional safeguarding and exploitation.
- Use our data analysis for SARs as well as multi-agency operational safeguarding data to better understand the demographics of the individuals who experience our services.

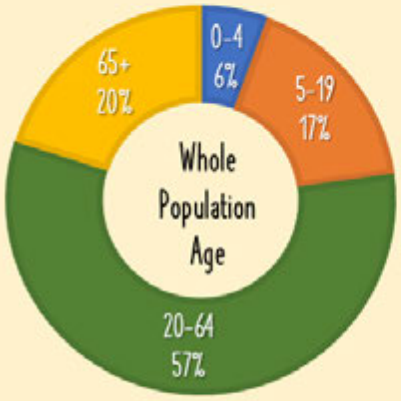
What difference have we seen?

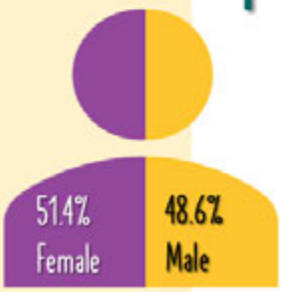
- Successful recruitment of an adult with lived experience to sit on the Executive Board & Quality Assurance Partnership, who has coproduced an easy read information leaflet on safeguarding processes.
- Our sub-groups have a more clearly defined focus on business plan priorities with the result that we can evidence areas of progress and any gaps or areas requiring escalation for completion.
- Successful delivery of multi-agency audits which have strengthened our SAR learning, particularly around self-neglect and substance misuse.
- We have stronger insight into how adults experience safeguarding pathways through consistently improved MSP conversations at the outset of enquiries, which are followed up at the point of closure. This is reflected in our data which shows 84% were asked about their desired outcomes, and only 4% were not satisfied with the outcome.

What do we need to do next year?

- Expand our engagement to hear more voices of individuals as well as practitioners, so the Partnership better understands the experiences of our residents and communities.
- Launch delivery of 'causing others to undertake enquiries' training, evaluating the impact.
- Launch the online multi-agency safeguarding policy and procedure resource.
- Seek assurance on partners' safeguarding training and competencies.
- Ensure partners fully embed the risk matrix and safeguarding thresholds tool in frontline practice.
- Work with partners to deliver multi-agency safeguarding training across the system.
- Encourage all partners to be more active in delivery of the Business Plan and other Partnership activities.

What do we know about Stockport's adults?





Stockport Safeguarding Adults Partnership

Population demographics taken from Nomis Web 2021 Census profile

25.9% registered disabled

87.3% White
7.3% Asian, Asian British or Asian Welsh
2.6% Mixed or Multiple
1.6% Other ethnic group
1.2% Black, Black British Caribbean or African

Safeguarding Intelligence

Gender split of S42 subjects

Age	Count
18-64	51.5%
65-74	9.8%
75-84	19.9%
85+	18.8%

70.2% White British 24.4% No ethnicity recorded

48.5% Lacked Mental Capacity

Introduction from Gail Hopper, Independent Chair and Scrutineer

This is the 4th annual report of the Stockport Safeguarding Adults Partnership it has been my pleasure to contribute to, since taking up the role of Independent Chair and Scrutineer in October 2021. Sadly, this will be my final contribution as I plan to retire later this year.

I have both read and influenced this report and completed some elements as the Independent Scrutineer. It reflects the journey travelled over the last four years and the significant progress made by the Partnership.

As a Scrutineer I am required to analyse the report and feedback on its accuracy. I am confident that the progress and changes that have happened over 2024 – 25 can be evidenced and demonstrated. This is an issue that over my time with the Partnership has shown continuous and significant improvement. The engagement of this Partnership and the shared ownership through its executive meetings, yearly conferences, training, multi- agency audits by partners have demonstrated that the experiences and outcomes for adults who need to be safeguarded is strong in Stockport.

This comment is not made from a perspective of complacency as there remain a number of challenges and many areas of work to complete, but it is helpful to remember where the board, as it was then, was in 2021 and where it is now. I believe it is a very different place.

This report shows progress made in engagement with those people who have or may need services in future. It has been a significant step forward to secure the engagement of Melanie Anderson on the Partnership. The support to her from the Business Manager and Principal Social Worker has been central to this.

Progress made in relation to learning, through Safeguarding Adult Reviews, scrutiny and multi-agency audits is a major achievement and having the opportunity to observe some of this work demonstrates the seriousness in commitment applied to this work. Partners respond well to change and challenge in Stockport, for example as evidenced from housing colleagues when we were required to address issues raised by Ministers early this year.

One of the questions we often ask ourselves in this Partnership is the “so what” question. How can we know what difference this makes? It is therefore positive to see that this report has improved on previous ones by being able to demonstrate impact. It is not yet in every area, but this work shows that it is a focus of the work undertaken and is becoming embedded in our thinking.

There remain challenges and in handing over to my successor in this role I will suggest that a priority is to continue to challenge each other about how the work of the Partnership, which is widely supported by Stockport leaders, reaches those practitioners at the front line. I am not yet assured that all the issues discussed and changes agreed by leaders, results in necessary changes and improvements in practice. Not all messages reach them, and quality assurance needs to measure this in each organisation. My successor will take up post in the wake of the separation from our Children’s Partnership, which I oversaw this year, and my message to them,

and to our partners and workforce, is to continue to share and collaborate, putting the people of Stockport at the heart of what we do.

I wish continued progress and success to the Partnership. It has been a privilege to serve the people of Stockport over the last four years and to work with such a committed group of leaders in the Partnership.

Scrutiny

The role of Independent Scrutineer provides an external perspective on the work of the partnership to assist, when seeking assurance through approaches such as

- monitoring areas of performance that raise questions from data shared
- observing Partnership activities from the perspective of quality, focus and effectiveness
- exploring those areas that may not be highlighted by partners, to examine what is happening,
- reviewing progress and actions that are shared in the Partnership for assurance,
- testing out and challenging perceptions against evidence and data.

A number of audit and scrutiny activities have taken place in the last year, demonstrating this is an area that is important to the Partnership. Some have been single agency, that were shared with the Partnership, such as DoLS waiting list and improvement actions and Sexual Abuse referrals in Adult Social Care, to multi-agency audits of approaches to issues such as approaches to risk assessments and responses to self-neglect.

I have introduced and observed two sessions that demonstrated a strong multi-agency approach to auditing practice and was impressed by the quality of the approach, the wide engagement and involvement of partners, the focus on learning and the support shown to the practitioners whose work was exposed and shared. The feedback was strong from those participating.

It was great to meet partner colleagues

Audit was a brilliant tool that was helpful in understanding the needs of the service user

The Partnership can be assured that from the ownership and engagement shown, this approach to understanding quality of practice is now embedded and serves as a real strength, as long as this practice continues.

The three main areas of scrutiny that I have undertaken stretch across a range of areas.

In summer / autumn of 2024, alongside the Business Manager, I undertook some follow up audits and scrutiny of referrals to the front door of Adult Social Care, which was followed up by a substantial review of safeguarding referrals that did not progress.

The first element was to monitor progress made from an audit undertaken the previous year into referrals into the front door – to measure progress made and identify any areas that remained a cause for concern. Some areas of progress were evident, and some areas remained as issues for focus and improvement. It is a reflection of the progress made by the Partnership that the

response to the findings of the follow up work were positively received, and more so than in 2023, but partners also agreed that future follow up work should rest with them, and they need to take responsibility for this area of work in future.

The second element was aimed at examining the quality of decision making when high numbers of safeguarding contacts resulted in no further action. There remains a concern that when safeguarding contacts are made, some are the result of practitioners being unsure of the response required, that results in a handoff to Adult Social Care. This remains an area for further attention. A major enabler would be a wider understanding and expectation across the Partnership that the agreed risk matrix and safeguarding threshold tool is implemented. At present the Partnership cannot be assured that this is fully supported by partners.

An unexpected finding from the audit was that case recording deficits in adult social care meant that some adults were listed as closed cases in respect of safeguarding enquiries, when in reality casework was continuing, some of which involved other partner agencies and reflected a strong safeguarding approach. There was a sense of action and the person's voice in case files that is not reflected in the data.

Another scrutiny exercise focused on information sharing has taken place this year, as this was a joint priority in the current Business Plan. This was carried out through observation of the work of the Practice Improvement Partnership sub group, demonstrating that sub-group focus is on addressing the Business Plan priorities as part of their work.

Other areas of scrutiny have included monitoring of decision making in consideration panels, where the appropriateness or otherwise of undertaking SARs is considered. Following this, the progress and delay around completion of SARs has been undertaken. Stockport has been responsible for leading a complex SAR during the last year, involving 3 other SABs. This has been very challenging and scrutiny of progress, support and challenge when necessary has been a key issue and continues at the time of writing. Overall, it is a positive picture in Stockport in that a Safeguarding Partnership meeting rarely takes place without a specific scrutiny and / or audit exercise and the outcome of such work being presented to partners. This bodes well for the future, as it has become another area that is now embedded in Partnership activity.

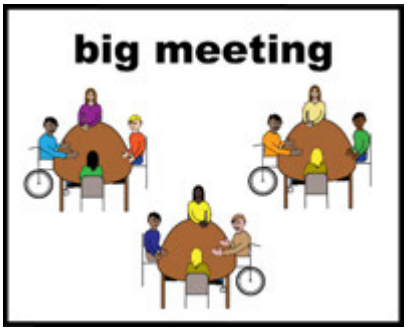
Gail Hopper

Independent Chair and Scrutineer

Introduction from Melanie Anderson, lived experience representative

My name is Mel. I started in September. It has felt quick. I enjoy the safeguarding work and coming to meetings. This year I have written an easy read leaflet on safeguarding with some help from Richard. I presented this in March and found it nerve-wracking, but I did it and want to do it again. It gives me a sense of purpose and something to focus on. I meet with Gail, and she helps me feel less nervous. I also get help from other people like Richard, Julia and Jonathan. I prefer seeing people and doing meetings in person. At the meetings we talk about people who need safeguarding, how the NHS and social workers help them. I told the safeguarding board about my own social worker and how they helped me.

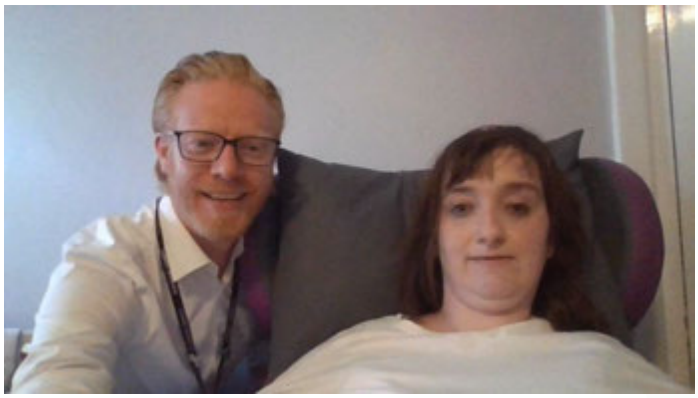
I like hearing about the people at each meeting and how they get help. It makes it real that I am helping people.



We have had 4 big meetings this year where we talked about safeguarding.

People tell us about what they have done. This year we have talked about mental health, communities, housing, care homes and my easy read leaflet.

Next year I want to share more about my leaflet and tell more people about safeguarding. I enjoy doing this and it gives me opportunities that are open to me now that I didn't have before.



Mel

How we work as a Partnership

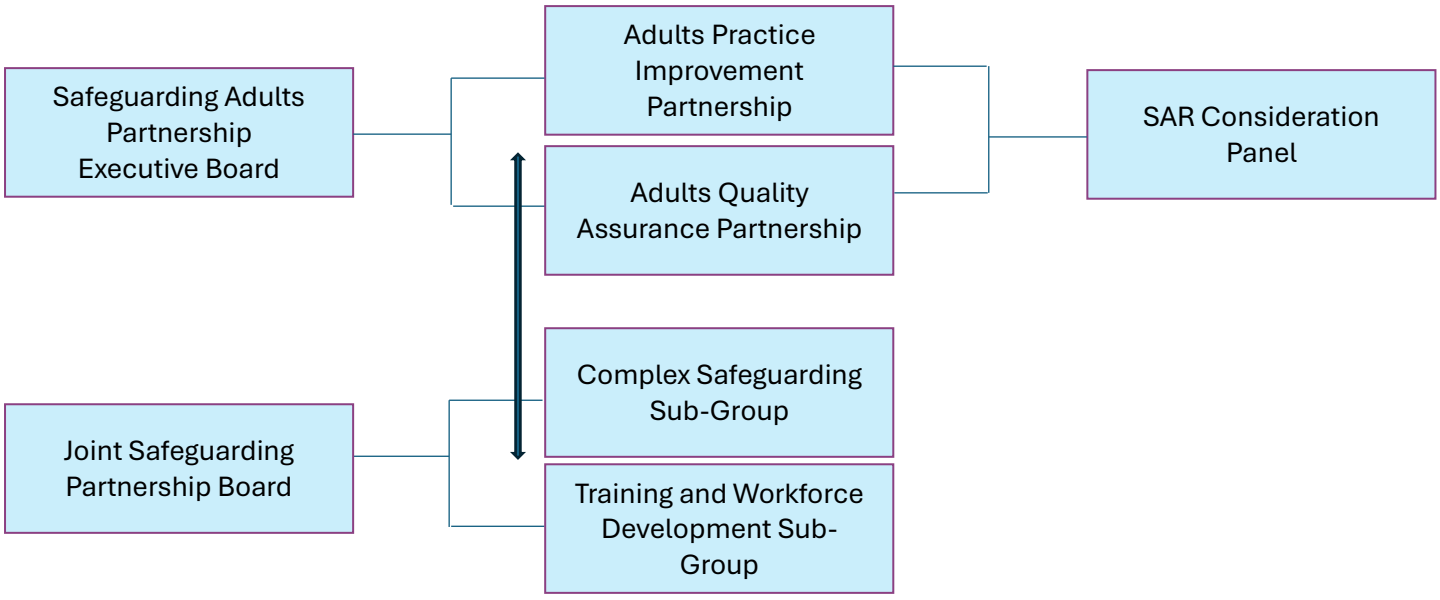
Following publication of Working Together to Safeguard Children 2023[1], we carefully considered the wider system implications with Partners to ensure continuation of our strong ethos of partnership working in Stockport. This was to ensure that when the Children's Partnership no longer required an Independent Chair, we did not lose any partnership links with our 3 Joint Priorities nor the Joint Board or joint sub-groups.

The current governance structure is set out below, which is unchanged from last year's report. Chairing (and vice-chair) arrangements for our sub-groups include partnership representation from Stockport Council, NHS Greater Manchester, and Stockport NHS Foundation Trust.

The Care Act 2014 sets out the statutory functions of our Safeguarding Adults Partnership as below.

Statutory function	Our position
Develop a business plan	Our Joint Business Plan was launched in 2023 and is in effect for a further 12 months. Each of priority area was selected by partners based on evidence from our performance, feedback, and statutory reviews.
Produce an annual report	We use the annual report as an opportunity to reflect honestly and transparently on our position, rather than simply summarise our actions at the Executive Meetings held.
Conduct Safeguarding Adult Reviews	We have published 2 SARs this year and have another ongoing at the year-end. Details of our SAR activity are provided in this report.

Our current governance structure is shown below.



Safeguarding Adult Reviews and System Learning

This year we received fewer SAR referrals than in previous years. 7 adults were referred to the Partnership compared to 15 in the previous year. 1 referral was under consideration at the end of March 2024.

	2022/23	2023/24	2024/25
Individuals referred for a SAR	2	15	**7**
Mandatory SAR commissioned	0	*5**	**0**
Discretionary SAR commissioned	0	0	**0**
Did not meet S44 criteria	2	7	**5**
Inappropriate	0	3	**2**

Breakdown of SAR Referrals and outcomes between April 2022 and March 2025

**this figure relates to individual adults and not SARs, in addition to Josie and Martin below, 3 adults were progressed to a single thematic SAR.*

The inappropriate referrals noted above were where information was shared using a SAR referral form that should have been a cause for concern to the local authority. In both instances, feedback was provided to the referrer to ensure that the safeguarding cause for concern was not lost.

In response to one of the referrals received, the Partnership held detailed conversations regarding whether a discretionary SAR was required. At the time of writing the report, learning had been identified by 3 health trusts and additional work was being led by the ICB.

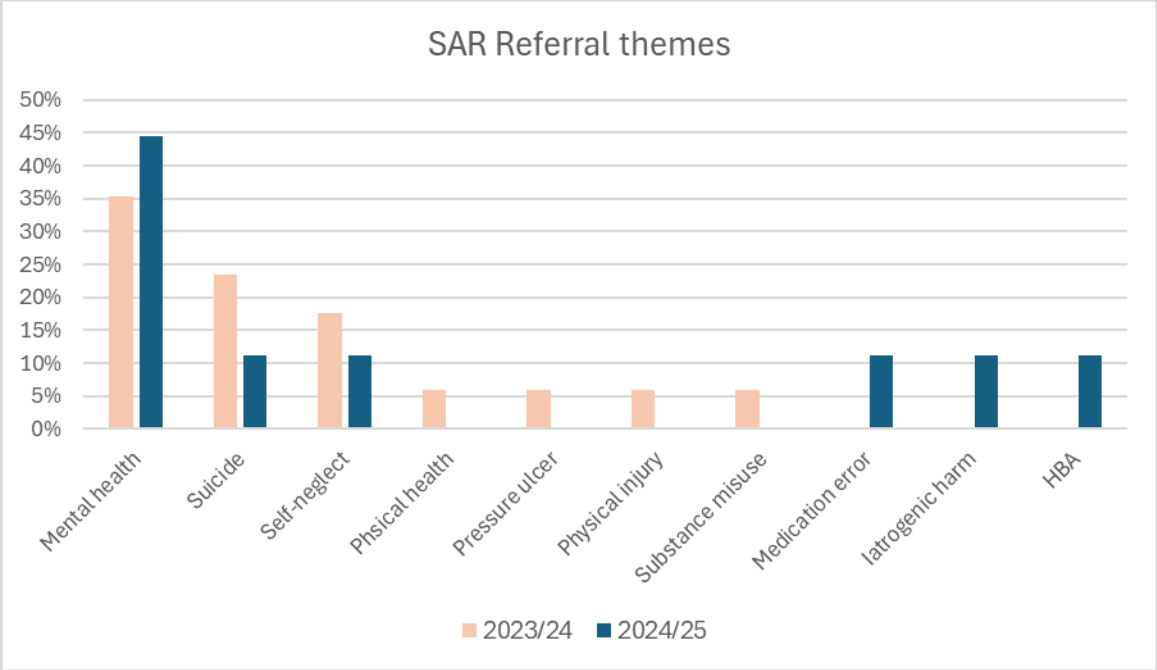
We published 2 SARs this year, for **Josie** and **Martin**.

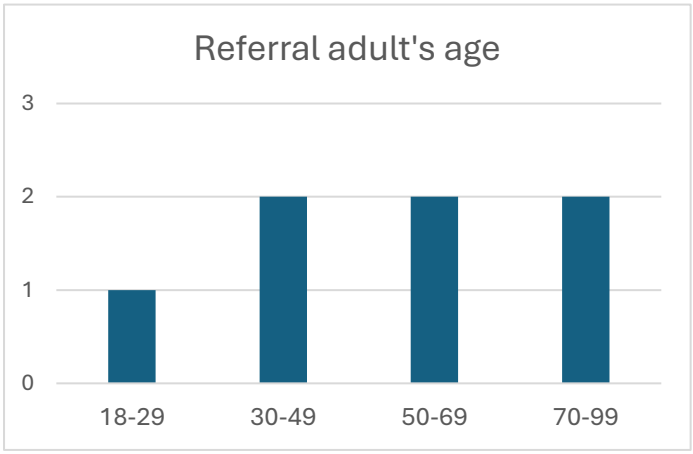
Who they were	What we learned	What we've done
Josie was 79 years old when she died following deterioration of a pressure ulcer. Authored by an Independent author.	Improved information sharing between care homes and District Nursing. Improved information for families on safeguarding processes.	Developed 'meet the team' posters to be displayed in all care homes. Shared SAR learning at provider forums with District Nursing in attendance to strengthen working relationships.
Martin was 49 years old when he died from alcoholic liver disease as a result of self-neglect and alcohol consumption. Authored by SSAP Business Manager.	How well partners are aware of support for adults with LD. How we include family members in safeguarding processes. The importance of putting self-neglect concerns through S42 processes.	Changed practice in Adult Social Care so all self-neglect concerns are progressed under Section 42 until the point of an initial protection plan. Improved use of hospital passports within Stockport NHS FT. Developed an easy read safeguarding leaflet and encouraged partners to do the same.

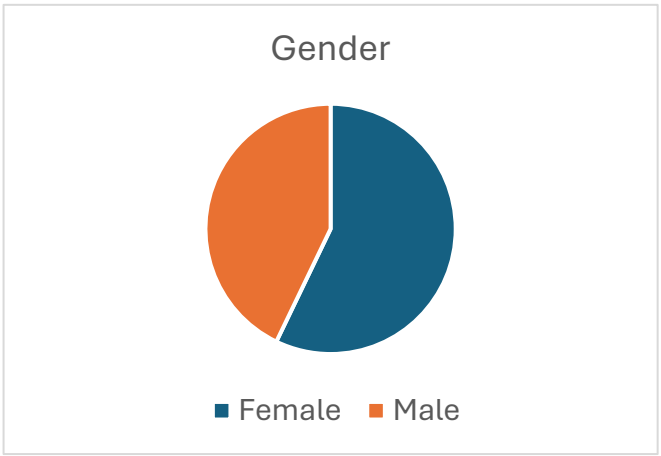
There is one SAR ongoing at the end of the year which involves 3 adults placed in a private hospital from other national SAB areas. We anticipate this review concluding later in 2025.

Hearing the voice of Martin's parents makes it real and reminds you that you're dealing with a person, not a case.

Mental health continues to be a common theme in most SAR referrals, with suicide and self-neglect presenting as common themes as well compared to the previous year.







Scrutiny and assurance

We continued to deliver a programme of multi-agency audits this year to ensure we are capturing all learning opportunities available to us.

July 2024 – visit to front door and safeguarding team

The Independent Chair and Scrutineer, and Business Manager, visited the ASC Front Door and Safeguarding Teams as a follow-up to a 2023 visit. Learning found the risk matrix and safeguarding thresholds tool is not fully embedded, there are a high number of inappropriate referrals made, and partners' confidence in holding and managing risk needs to be increased.

August 2024 – self-neglect and hoarding multi-agency audit

This multi-agency audit focused on self-neglect and hoarding whilst we were waiting to publish Martin's SAR. We learned that the current self-neglect policy and toolkit needs to be refined and shortened to be accessible and user friendly. Adult Social Care and GM Fire and Rescue are now working together to ensure all eligible adults receive a home fire safety assessment.

October 2024 – Safeguarding referrals

This audit of 25 cases recorded as 'no further action' was completed as a follow-up to the front door visit in July, and also in response to high numbers of NFA contacts reported to the Executive Board. Again, we found that partners were not using the risk matrix and safeguarding thresholds tool as part of decision making, but rather making safeguarding referrals to the local authority as a 'hand-off'. This audit also identified learning in Adult Social Care recording, as some cases listed as closed, were actually receiving high quality safeguarding support.

November 2024 – sexual abuse deep-dive

This work was completed in response to analysis of NW ADASS data that showed high levels of sexual abuse locally. The audit found that the majority of safeguarding enquiries were for adults with learning disabilities, and that providers would benefit from training in safe relationships. For more serious instances of sexual abuse, the audit found good evidence of co-working between the local authority and GMP, and use of PIPOT procedures where appropriate.

January 2025 – Making Safeguarding Personal

This audit explored how well partners understand and practice the principles of *making safeguarding personal*. Learning was that partners have the correct policies and procedures, however there is more work to do to ensure this is fully embedded in front-line practice. Further work is planned in 2025/26 to engage with practitioners and increase adults' voices.

The difference this has made	Our scrutiny tells us we have more work to do to fully embed the risk matrix and safeguarding thresholds tool. Our audit, scrutiny, and learning activity has increased this year giving our Partnership more meaningful insight into the impact and effectiveness of our interventions. Challenge has increased. We want to continue to build on this progress next year.
Next steps	We want to invite NHS Greater Manchester colleagues to share their learning and intelligence with the wider Partnership so recurring health themes from SARs (and DHRs and CSPRs) are shared with partners to help the Safeguarding Adults Partnership discharge its statutory functions around learning and improvement.

Delivering the Business Plan

This is the 2nd Annual Report that reviews progress of the 2023-2026 Business Plan. We remain committed as a Partnership to deliver meaningful change to safeguarding systems as part of our Business Plan.

<table>
<tr><th colspan="2">Priority: Improve partnership working and information sharing</th></tr>
<tr><td colspan="2">Where are we at the end of this year?</td></tr>
<tr><td colspan="2">The 2 published SARs this year highlighted information sharing as a continuing priority area for improvement across the Partnership. The Quality Assurance Partnership continues to facilitate senior leader peer-visits across the system, and we plan to expand this to include more frontline practitioners. The multi-agency MAARS panel[2] continues to bring partners together to support individuals through non-statutory safeguarding processes. Our plan for 2025/26 is to strengthen this process. Partners report strong compliance with safeguarding training attendance, and we are exploring how to strengthen links so partners share more of their own training offers across our system.</td></tr>
<tr><td colspan="2">How can we measure our effectiveness?</td></tr>
<tr><td colspan="2">Information sharing and communication were learning themes in both of our SARs published this year.
We received just less than half the SAR referrals this year compared to last year.
The conversion rate from contact to S42 enquiry has improved from last year with 30.8% of contacts progressing to an enquiry[3] - a change in recording practice meant the rate decreased in the final 3 months of the year and we will continue to monitor this next year.
The number of referrals received for MAARS panel has remained constant with 174 referrals this year compared with 166 last year. The most common abuse and neglect categories are mental health (77.1%), ASB (35.7%) and housing (20.7%), which broadly match last year.
Multi-agency attendance at MARAC, MAARS and strategy meetings continues to be a strength, as reported in our audit findings and partnership front-line visits.</td></tr>
<tr><td>What have we delivered?</td><td>What do we still need to do?</td></tr>
<tr><td>Josie and Martin were published alongside a series of well-attended learning circles, co-delivered by partners.
Partnership-led development day in December 2024.
A staff awareness session was co-delivered to Adult Social Care in November 2024’s Practice Week which included input from the Safeguarding Partnership and ICB.</td><td>Ensure all partners understand SAR referral criteria to ensure learning opportunities are not lost.
Test how well SAR learning is embedded in frontline practice.
Roll-out of the ‘causing others’ multi-agency training.</td></tr>
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We work hand in hand with health, housing, and community teams to ensure no one falls through the cracks.

Team Manager, Community Learning Disability Team

Priority: Effective transitions from childhood to adulthood

Where are we at the end of this year?

The multi-agency audit on transitions and exploitation completed in 2023/24 has been central to the work of the Complex Safeguarding Sub-Group. The work of that sub-group has been reviewed and refreshed, with a new Terms of Reference agreed, and additional governance and oversight of operational practice. We have also worked to strengthen representation from the Adults Partnership in this work.

Greater Manchester Combined Authority Complex Safeguarding Hub visited all 10 local authority areas as part of an assurance exercise. Feedback from the visit to Stockport in January 2025 commended the inclusion of Adult Services and SSAP colleagues in the discussions, which was the first area they had seen with this attendance. CAMHS services in Pennine Care NHS Foundation Trust have developed Cared for Children services, which are designed to ensure there are no gaps for care leavers during transitions.

How can we measure our effectiveness?

- The proportion of MAARS referrals for 18–25-year-olds remained consistent with 12.0% this year compared to 10.8% last year.
- There has been a reduction in the proportion of individuals experiencing exploitation referred to MAARS, from 30% last year to 16% this year[4].

What have we delivered?	What do we still need to do?
• The Complex Safeguarding Sub-Group has been refreshed and now includes a monthly operational meeting in its reporting structure. • Preparations for Making Every Adult Matter (MEAM) to support adults who experience multiple disadvantage[5]. • The local authority attends a GM community of practice group to share learning and identify opportunities.	• Agree and implement a Partnership data set for this priority area to better understand the cohort and design the right support offer. • Support colleagues in SSCP with a GMCA complex safeguarding peer-review. • Support our workforce with Mental Capacity Act training in 2025/26.

Young adults referred in to us mainly need mental health support or are struggling with substance use.

Priority: Understanding complex trauma and assessing risk

Where are we at the end of this year?

Learning from our scrutiny activities this year tells us that our risk matrix and safeguarding thresholds tool is not yet fully embedded in frontline multi-agency safeguarding practice. This means that we continue to see high levels of inappropriate referrals made to the local authority, and as a result some Stockport adults are not yet receiving the right service at the earliest opportunity.

We facilitated a *Trauma Conference* in November 2024 which was supported through funding from Trauma Responsive Greater Manchester[6]. After launching the multi-agency risk matrix and safeguarding thresholds tool last year, we are seeking assurance that it is having a positive impact on safeguarding practice and will explore this in 2025/26. Stockport NHS FT implemented safeguarding supervision for complex cases this year with enhanced reflective practice and risk assessment quality.

The launch of the Making Every Adult Matter (MEAM) work strengthens support to adults with multiple vulnerabilities, but introduces potential duplication with MAARS processes, and we will resolve these in 2025/26.

In March we started to plan a multi-agency audit on risk assessment approaches and will complete this work in the first quarter of next year.

How can we measure our effectiveness?

- There has been a sharp decrease in the proportion of individuals with multiple vulnerabilities referred to MAARS, with 16% compared to 30% of all referrals last year.

What have we delivered?	What do we still need to do?
• Embedded the Making Every Adult Matter (MEAM) pathway within Adult Social Care. • Multi-agency trauma conference held in November 2024 attended by over 185 professionals.	• Finalise multi-agency audit on risk assessment approaches in early 2025/26. • Launch 7-minute-briefing on trauma informed practice. • Seek assurance on use of the risk matrix and safeguarding thresholds tool in practice. • Review MAARS processes and relaunch with refreshed purpose, scope, and criteria.

My Social Worker has been brilliant – so involved in the whole case. He has been very approachable and I have been able to speak to him and ask for advice during a very difficult situation. I have regular contact and he is always very informative and brilliant. He picks up other issues with other commissioned care company when we have raised these, and makes sure he gets updates from us as required.

Priority: Working with adults to manage risk effectively and make safeguarding personal

Where are we at the end of this year?

People in Stockport who require a DoLS are still waiting too long. However, Adult Social Care have had a focussed improvement plan that is resulting in greater compliance. In order to support this work, they have implemented a monthly *Safeguarding and DoLS Assurance meeting* which provides scrutiny and oversight of operational practice. This in turn feeds escalation and assurance reporting to the Safeguarding Partnership, The Quality Collaborative, and the Local Authority Chief Executive and Leader with regular reporting on the DoLS waiting list and performance improvements. The Partnership has seen audit findings on specific areas of abuse and neglect which include self-neglect, and sexual abuse. Partners have made progress in DoLS delivery, Stockport NHS FT developed a standard operating procedure for DoLS and Pennine Care NHS FT recruited to a Mental Capacity Act and DoLS Lead. We hope these developments will support improved multi-agency practice and individuals' experiences. Importantly we have recruited an adult with lived experience of safeguarding as a member of the Executive Board and Quality Assurance Partnership sub-group.

How can we measure our effectiveness?

- Longest DoLS wait time was reduced by 601 days from 1350 to 845[7].
- 83.9% of adults subject to a Section 42 enquiry last year (led by the local authority) were asked their desired outcomes and expressed these. Conversely 65.6% of enquiries led by other agencies had MSP outcomes asked and expressed[8]. Only 3.9% of all individuals with completed enquiries reported they were not satisfied with the outcome.
- Self-neglect cases referred to MAARS reduced from 25.3% last year to 8.0% this year, with a 274% increase in S42 for self-neglect in Adult Social Care comparing Q4 this year to last year, demonstrating impact of learning from Martin's SAR.

What have we delivered?	What do we still need to do?
• Change in safeguarding practice around self-neglect in the local authority. • Training package for 'causing others to undertake enquiries' agreed by our Executive Board.	• Launch our new Tri-X online multi-agency policy and procedure resource. • Increase MSP performance for S42 enquiries led by other agencies. • Revise and launch self-neglect & toolkit.

The Social Worker explained the safeguarding process, giving reassurance that the concerns raised would be investigated. I gave my views, which she understood, and let me know what would happen next. She was very helpful and during the conversation they started to discuss other aspects of care and I was told where I could find other support available.

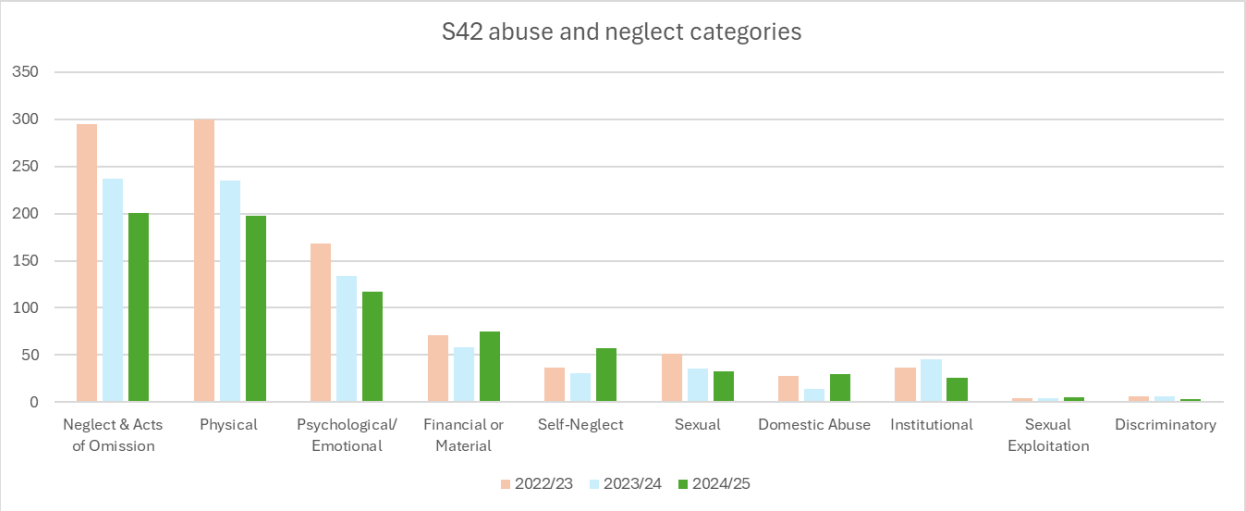
Multi-agency safeguarding performance

We collect and analyse multi-agency safeguarding performance each quarter through our Quality Assurance Partnership. A summary of our performance this year is provided below.

We have seen an increase in the proportion of adults referred to the local authority as a safeguarding concern, and we continue to see high levels of referrals that do not meet statutory safeguarding thresholds, so no action is taken. This remains a concern and an area of focus as we are confident from our audit work that many of these people could have been supported and signposted more effectively.

Learning from Martin's SAR is having a positive impact and we have seen a significant increase in the numbers of individuals referred for self-neglect than in previous years. We have also seen a corresponding increase in *own home* as a location of abuse this year, which is mainly due to the increase of self-neglect enquiries.

For the first 9 months of 2024/25 we saw relatively even numbers of males (49.7%) and females (50.3%) as the subjects of Section 42 enquiries. 49.3% of these were for individuals aged 18-64, with 23.2% aged over 85[9].



The most common abuse and neglect categories that individuals experienced this year were neglect and acts of omission (27.0%) physical abuse (26.6%), and psychological abuse (15.7%). Multi-agency data identified areas for further scrutiny and assurance; one area that was higher than regional comparators was our sexual abuse cases. By working with the local authority in November 2024 to better understand this we learned that some enquiries were for adults with learning disabilities who required support around managing safe relationships. These findings were shared with provider managers, and we plan to continue this approach by looking at physical abuse.

The latest comparator information for abuse and neglect in concluded Section 42 enquiries is show below, taken from NW ADASS reporting at the end of September 2024.

Abuse Type – per 100,000 population	Stockport	Greater Manchester Average	North-West Average
Physical	58.2	40.7	45.3
Neglect and Acts of Omission	57.4	66.3	76.4
Psychological	46.2	32.3	36.7
Financial or Material	26.5	34.5	40.6
Self-Neglect	16.7	29.4	29.3
Sexual	11.6	8.8	11.1
Domestic Abuse	10.3	16.1	18.7
Organisational	7.3	10.7	8.5
Sexual Exploitation	1.3	1.1	1.1
Discriminatory	0.9	1.0	1.1
Modern Slavery	0.9	0.3	0.8
ADASS comparator information as at September 2024 (latest available data)			

Adult Social Care have reported an increase in the proportion of adults who use advocacy services, and to help us understand this in more detail, input from advocacy services in our sub-groups workplan next year.

Greater Manchester Fire and Rescue Service (GMFRS) reported 3 fire deaths this year, which is consistent with last year. To ensure learning is captured from fire deaths, we invited GMFRS to present at our Partnership sub-group meetings.

We saw an increase in rough sleeping this year, and in response to this upward trend and a Ministerial letter to all SABs, we cemented homeless representation on the Partnership this year. The named lead also sits on the Homeless Prevention Board and has presented to the Partnership on their strategy and how this links with the work of the Safeguarding Partnership.

Making safeguarding personal and engaging with the workforce

In last year's annual report, we recognised that an improvement priority was to increase how we seek the views of adults with lived experience of safeguarding. This year we welcomed an individual with lived experience of a safeguarding pathway in Stockport to sit as a full member of the Safeguarding Adults Partnership, attending both the Executive Board and our Quality Assurance Partnership.

In March 2025 our lived experience Board Member presented at our Safeguarding Board to share an easy read leaflet that she coproduced with the local authority, which explains the safeguarding process. We want to build on this progress next year through developing more easy read information. We view this as the start of the next phase of our journey of co-production and engagement with adults with lived experience, to make sure that this becomes part of our Safeguarding Partnership culture.

We continue to begin each meeting of the Executive Board and sub-groups with a case study as a reminder of *why we are here*. During this year we reshaped this item into a new structure as *Stockport Safeguarding Stories*. The format has been well received by partners.

Our Trauma Conference in November 2024 coincided with Safeguarding Adults Week and was attended by over 185 professionals from both the Children and Adult Safeguarding Partnerships.

The event included guest speakers who gave invaluable lived experience of working with safeguarding partners in Stockport. Other topics covered included research on Adverse Childhood Experiences (ACEs), professional curiosity and the links between domestic abuse and trauma.

The Safeguarding Partnership continues to support partners' training and workforce development offers. The Business Manager has enjoyed spending a third year of presenting at monthly Level 3 Safeguarding Training sessions at Stockport NHS Foundation Trust. These sessions provide a great opportunity for the Partnership to hear directly from frontline practitioners. Next year we plan to facilitate more opportunities for practitioner engagement and have invited our lived experience Board Member in this work.

The Quality Assurance Partnership facilitates *frontline visits* which are short peer-review opportunities for partners to understand more about others' work. Since starting the programme, visits have taken place as below.

Visit by	Visit to
Greater Manchester Fire and Rescue Service	Adult Social Care Front Door
Adult Social Care and NHS Greater Manchester	Pennine Care NHS Foundation Trust
NHS Greater Manchester	Greater Manchester Police
Adult Social Care	Stockport NHS Foundation Trust
Adult Social Care	SSAP Business Unit

> The team were very welcoming bearing in mind how busy they are

> It was helpful to see how the recording system was being used – I've heard lots about it but never seen it or understood how it worked

> I hadn't realised the breadth of the training being offered to staff, and it made me think about our training offer or how we could share training opportunities

We have also used opportunities through the quarterly newsletter (jointly produced with the Safeguarding Children's Partnership) to share information on services across the Partnership. This year we have shared information on the Adult Social Care safeguarding team, Stockport NHS Foundation Trust's safeguarding team, and NHS Greater Manchester's Designated Nurse for Safeguarding Adults in Stockport. This has helped us address learning from Martin's SAR which told us that we could promote different services and pathways across the borough.

We heard a number of **Stockport Safeguarding Partnership Stories** this year, which give partners an insight into how our multi-agency practice is received at an individual level. Two examples are below:

"P" was the story of an individual who required an amputation and received person-centred care whilst an application was made to the Court of Protection in his best interests. The story highlighted how well staff at the Trust worked with P and partners to achieve a positive outcome.

"Phillip" was in his 40's and was being cuckooed. The local authority led a plan with partners to support Phillip to be rehoused, receive mental health and substance misuse support, as well as advice and support around his finances.

Strengths, Challenges and Opportunities

The Safeguarding Adults Partnership requires funding from our partners to deliver statutory functions. This year we had to escalate concerns regarding our financial position to partners.

The budget for 2024/25 is shown below.

Income	**£**	**£**
Base partnership budget from local authority	68,161	
GMP contribution	15,370	
NHS GM contribution	38,000	
Total income		**121,531**
Expenditure		
Staffing expenditure	166,385	
Safeguarding Adult Reviews	23,700	
Total expenditure		**190,085**

The training offer from the Partnership will be revised next year, as the Partnership's Training Manager moves to a new post. Unfortunately, the budget position means that we are unable to recruit to this vacancy. To ensure there continues to be effective learning and multi-agency training opportunities, we will work with partners to support more training and learning opportunities. The impact of this will be closely monitored through the Training and Workforce Development sub-group, and the Joint Safeguarding Board.

There is still more work for partners to do around embedding the risk matrix and safeguarding thresholds tool in frontline practice. This will remain a priority action within our current Business Plan (links with priorities 1 and 5) and this will be a continued scrutiny focus.

Recruitment for a new Independent Chair and Scrutineer will commence next year, and we will work with our partners to ensure there is minimal impact during the transition from current arrangements which are shared with our Safeguarding Children's Partnership.

National announcements regarding the future of NHS England, and ICBs, will undoubtedly have an impact on all Safeguarding Adults Boards nationally, and we want to work with our colleagues to understand and mitigate any potential risk for Stockport.

Appendix A: Glossary of terms

Acronym	Definition
CAMHS	Child and adolescent mental health services
CSPR	Child Safeguarding Practice Review, *a multi-agency learning review following the death or serious incident involving a child or young person*.
DHR	Domestic Homicide Review, *a multi-agency learning review following the death of someone by a family member or intimate partner*.
DoLS	Deprivation of Liberty Safeguards. *DoLS are rules that protect people who cannot agree to their care or treatment in a hospital or care home, by making sure any restrictions on their freedom are in their best interests and legally checked*.
GMCA	Greater Manchester Combined Authority
GMP	Greater Manchester Police
HBA	So called honour-based abuse
NW ADASS	North West Association of Directors of Adult Social Services
PCFT	Pennine Care NHS Foundation Trust
PIPOT	Person in a position of trust. *A PIPOT is someone who works with adults with care and support needs, and if concerns are raised about their behaviour, it must be checked to make sure they are safe to work with vulnerable people*.
S42 / Section 42	A statutory safeguarding process completed in line with The Care Act 2014.
SAR	Safeguarding Adult Review. *A multi-agency learning review following the death or serious injury of an adult with care and support needs*.
SSAP	Stockport Safeguarding Adults Partnership
SSCP	Stockport Safeguarding Children's Partnership

Appendix B: Safeguarding Partnership Members

- Stockport Safeguarding Children and Adults Partnerships
- Age UK
- Greater Manchester Fire and Rescue Service
- Greater Manchester Police
- HealthWatch Stockport
- North West Ambulance Service
- Pennine Care NHS Foundation Trust
- Stockport Metropolitan Borough Council
- Stockport Homes Group
- NHS Greater Manchester
- Stockport NHS Foundation Trust
- Greater Manchester Probation Service

Appendix C: NHS Greater Manchester contribution to the Annual Report

Stockport Safeguarding Adults Partnership Annual Report NHS GM (Stockport) contributions:

NHS Greater Manchester (NHS GM) has continued to discharge our statutory safeguarding duties throughout 2024-25 in relation to safeguarding adults at risk.

The NHS GM Chief Nurse holds the statutory accountability for safeguarding and is supported by the Deputy Chief Nurse and Associate Director of Safeguarding. Statutory safeguarding responsibilities are delegated to the Associate Director of Quality and Safety in each of the GM localities and delivery of the statutory functions are undertaken by the locality Designated Teams.

NHS GM is able to demonstrate that there are appropriate safeguarding governance systems in place for discharging their statutory safeguarding duties and functions in line with the following key legislation:

- Human Rights Act 1998
- Mental Capacity Act 2005
- Care Act 2014
- Counter Terrorism Act 2015
- Serious Crime Act 2015
- Domestic Abuse Act 2021
- Health and Care Act 2022

NHS England (NHSE) Safeguarding and Accountability and Assurance Framework (SAAF 2024) provides the strategic framework for ensuring strategic system oversight of safeguarding priorities. Assurance and oversight of these duties is maintained via NHS GM governance and reporting.

Safeguarding assurance

NHS GM has a statutory responsibility for ensuring safe systems of care are delivered and to ensure that all health providers with whom they commission, discharge their functions regarding safeguarding and the promotion of welfare of children, young people and adults at risk. Effective safeguarding arrangements are in place to ensure oversight of provider safeguarding assurance via the annual 2024-25 Greater Manchester Safeguarding Children, Young People and Adults at Risk – Contractual Standards which provide the safeguarding audit framework used to monitor all NHS and Non-NHS providers of health care. The statutory assurance processes set out in the SAAF (2024) have been adhered too.

Safeguarding Partnerships and Boards

NHS GM has maintained the duties as a statutory partner for the Stockport Adult Safeguarding Partnership in 24/25. Full representation has been maintained at associated boards and subgroup meetings, to fulfil and discharge both commissioning and statutory safeguarding responsibilities. This has enabled NHS GM to work with its partners to ensure learning from local and national safeguarding reviews has influenced and strengthened practice across the Stockport system.

Safeguarding System and Partnership Work

In addition to its work through Safeguarding Partnership, NHS GM continues to engage with wider system partners to advance the safeguarding agenda. This is reflected in NHS GM's safeguarding and governance structures, including system groups and transformation workstreams, which are shaping the priorities, principles, and strategy for 2025–26.

During the last year the development of the Stockport Safeguarding Health Collaborative, led by the Designated Safeguarding Team, has brought together safeguarding leads from across the NHS, private healthcare, hospices, and community services in Stockport. Many of these professionals don't typically work together in the same space, but through this collaborative, they've built a strong, supportive community of practice.

Their work has led to:

- A shared voice for health in safeguarding boards and partnerships
- Reduced duplication and improved consistency across services
- Joint development of guidance, training, and learning
- Monitoring of inspections from a health perspective
- System-wide risk reporting and coordinated improvement efforts

While the Collaborative does not alter statutory responsibilities for individual providers, it fosters stronger alignment and cooperation across the health system.

The Stockport Quality Collaborative receives regular updates on safeguarding assurance from contracted health providers, the Stockport Health Collaborative, and health-specific learning from reviews via the Designated Team. These reports help ensure alignment with the broader safeguarding agenda and provide positive assurance around areas of development, risk management, and the promotion of a safe, system-wide approach to safeguarding.

As part of the NHS Greater Manchester (GM) System Learning and Improvement Delivery Group, a platform was developed during 2024–25 to collect and analyse data from safeguarding statutory reviews. This platform has enabled the group to identify recurring health themes and insights, for example data from reviews has directly informed the creation of monthly development sessions for GP Safeguarding Leads across GM. These sessions provide enhanced safeguarding knowledge, shaped by findings from statutory safeguarding reviews.
The Designated Nurse for Adult Safeguarding in Stockport is leading this initiative on behalf of GM and is collaborating with other localities to apply the learning in ways that strengthen safe systems within Stockport and GM.

NHS GM Contributions:

- Continue to deliver the core statutory functions as the statutory partner for health
- Initiating a review of Safeguarding Adult Review policy and procedures
- Supporting the development and redesign of core partnership plans, terms of references and areas of work
- Provide scrutiny and quality assurance of statutory reviews
- Undertake front line visits to services in Stockport
- Participate in multi-agency audit work and provide system wide health oversight

Appendix D: Endnotes and references

[1] Working together to safeguard children 2023: statutory guidance
[2] Multi-Agency Adults At Risk System (MAARS)
[3] April 2024 – December 2024 data reported to Quality Assurance Partnership 21.05.2025
[4] April 2024 – December 2024 data reported to Quality Assurance Partnership 21.05.2025
[5] Making Every Adult Matter (MEAM) - Stockport Council
[6] Trauma Responsive Greater Manchester
[7] Reported by Adult Social Care to Executive Board 19.03.2025
[8] Data taken from Local Authority tableau report 09.04.2025
[9] Reported in the Q4 2024/25 dashboard to Quality Assurance Partnership 21.05.2025