

Annual Report 2025/26



Contents page

Welcome to this year's Annual Report for the Stockport Safeguarding Adults Partnership (SSAP).

Independent Chair and Scrutineers' Introduction	3
My year with the Safeguarding Partnership: Mel Anderson, Lived Experience Board Member	5
Introduction to Stockport	6
What we are proud of this year - highlights	7
How we work as a Partnership	8
Multi-agency safeguarding performance	10
Rough sleeping and homelessness	13
Delivering the Business Plan.....	14
Safeguarding Adult Reviews and System Learning	18
Scrutiny and Assurance.....	20
Learning and development	21
Our strategic plan for 2026-2029	22
Appendices	23
Appendix A: Glossary of terms	23
Appendix B: End notes and references	23

Independent Chair and Scrutineers' Introduction

This year's annual report includes commentary from both our previous Independent Chair and Scrutineer, who retired in December, and our new Independent Chair and Scrutineer, Brad Howe.

Gail Hopper, outgoing Independent Chair and Scrutineer

This will be my final input into Stockport Safeguarding Adults Partnership's Annual Report, following my retirement in December 2025. The final 9 months of my time in Stockport have been marked by some important and notable milestones including the Local Authority's first CQC Assurance inspection, the introduction of a Sub-Group Co-Chair as an individual with lived experience, and system-wide changes that I believe will have a lasting and positive impact on multi-agency safeguarding.

Throughout my tenure I have overseen completion of 3 Safeguarding Adult Reviews, 14 different scrutiny exercises, and service transformations across Adult Social Care, which included significant improvement around DoLS performance, the move from Stockport CCG to NHS Greater Manchester, and welcoming an adult with lived experience onto the Safeguarding Partnership Board as well as other colleagues who have joined and left us.

It has been a great privilege to chair and provide scrutiny to the work of this Partnership. Looking back over the last four years, I can see substantial evidence of the journey travelled, the part played by all partners to make progress and improvement in how adults living in Stockport are supported and protected from abuse and neglect. My final assurance comes from knowing how well partners responded to scrutiny and challenge, and then took responsibility for it, as part of their commitment to improve safeguarding systems for all residents.

Gail

Brad Howe, Independent Chair and Scrutineer

Welcome to this year's Annual Report from the Stockport Safeguarding Adults Partnership (SSAP). This report offers an important opportunity to reflect, celebrate what we are proud of achieving over the past year (2025/26) and share how the Partnership is continuing to further improve the way in which we protect adults at risk of abuse or neglect.

I was delighted to take on the role of Independent Chair and Scrutineer of the SSAP in January 2026, and I look forward to building upon the great work Gail oversaw, and to further strengthening the effectiveness of the Partnership in seeking assurance of safeguarding-related activity across Stockport.

This year's report is enriched by powerful case studies that reflect the real impact of our work, with our 'Stockport Stories' of individuals whose lives have been changed through coordinated,

multi-agency, person-centred support. This continues to build upon the progress we have made in capturing the voice of lived experience and the real value that Mel brings to the Partnership.

In addition to the assurance activity that has been undertaken this year, detailed within the report, we have reflected on the complex realities of safeguarding across Stockport and developed a strategic plan for 2026-2029.

The plan is cognisant of current impacts including social inequalities, homelessness and cross cutting themes impacting on families. The associated work programme has been shaped with a clear focus on preventing abuse and neglect, addressing the unique safeguarding needs of adults who are homeless, including those who are rough sleeping, developing multi-agency responses for young adults transitioning to adulthood and experiencing exploitation, and improving safeguarding practices and embedding learning.

I firmly believe we are moving in the right direction and I look forward to continuing to work with all our partners and communities to make safeguarding adults in Stockport more effective, accountable and person centred.

Finally, I want to extend my sincere thanks to all members of the Partnership for their tireless efforts on a daily basis, in delivering a significant amount of work to make a real difference to the lives of residents across Stockport.

My year with the Safeguarding Partnership: Mel Anderson, Lived Experience Board Member

My name is Mel and I work with the Safeguarding Board. This is our report that tells everyone what we have done.

I am still working on safeguarding in Stockport. This is important to me as I don't want the same thing that happened to me to happen to other people.

This year I have been working with YourGo to help people know about safeguarding. I get help and support with this.

I have helped to write an easy read leaflet on safeguarding with YourGo¹, so Social Workers can use these with people. I want to turn these into videos so people can watch these. In September I have to go and do a seminar with work colleagues and I'm thinking I can talk to student social workers about safeguarding.

I interviewed Brad and asked him questions about what safeguarding means to him and how he would help Stockport. I was nervous doing this but I was supported and helped to pick him.

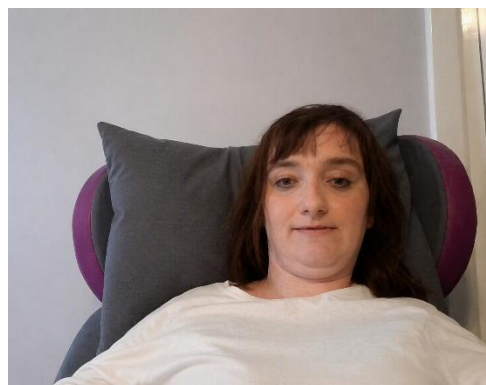
I am a Co-Chair of the Quality Assurance meeting, I enjoy doing this because I can get more experience of how to chair different meetings. I like hearing all the things people bring in to the meetings it gives me ideas to do more YourGo cards, and we have done some on going into hospital. I went to the hospital to talk about YourGo and they showed me how they help people with blue butterflies. They said they wanted to try YourGo cards to get feedback from people at hospital on safeguarding.

I spoke to CQC about how I work with the 'Making It Real Board' and Safeguarding. I told them about how we work on easy read information and what safeguarding means to me.

I want to do more YourGo cards to help Social Workers or anyone who works with adults who have disabilities to help make them feel supported and give them ways of communicating with us what disabilities they've got and what help they need. The Social Workers would then know who they are working with, and what kind of disability they've got, to help them.

I enjoy working with the Safeguarding Board and it has helped me to be more professional, and I enjoy how I can help other people who need safeguarding.

Mel



Introduction to Stockport

Stockport is a diverse, growing borough at the heart of Greater Manchester, home to around 300,000 residents. It combines strong communities, economic growth, transport links and green space, and through the One Stockport: One Future vision², partners are working together to help people live happy, healthy, connected and independent lives.

Stockport's population is growing and becoming more diverse, with an older age profile than Greater Manchester and England. More than 20% of residents are aged 65 and over, and the number aged over 85 continues to rise. Around 18% of residents are disabled, more than 3,000 live with serious mental illness, and around 1,700 have a learning disability. 4,131 adults aged 65+ live with dementia and this is projected to rise to over 5,700 by 2030³. This is likely to increase the prevalence of frailty, dementia, cognitive impairment, social isolation, falls and care needs, all of which can increase the demand for care and support.



There are 66 care homes across Stockport providing residential, nursing, and specialist dementia care.

Stockport continues to be an area with significant inequalities; some neighbourhoods are among the most affluent in Greater Manchester, while others rank within the most deprived nationally. These inequalities affect health, wellbeing and life expectancy, with residents in the most deprived areas living around ten years less than those in the least deprived communities.

Wider determinants of health also influence vulnerability to abuse and neglect. Around one-third of households experience deprivation in at least one domain⁴, more than 53,500 residents live with a disability, thousands provide unpaid care, and many people face poverty, housing insecurity, poor health or isolation.

For the Safeguarding Adults Partnership, these changes highlight the need to focus on prevention, early intervention, community resilience and reducing inequalities. Safeguarding adults means responding to abuse and neglect, while also working together to address the wider conditions that place people at risk.

What we are proud of this year - highlights

2025/26 was a year of transition, consolidation and strengthening partnership delivery. We refreshed our leadership, expanded co-production, increased learning activity across the system, and used our SAR and scrutiny learning to shape the next phase of our safeguarding priorities.

The Partnership has taken a significant step forward in how people with direct experience of safeguarding influence our work in Stockport. Their insight has informed practice guidance and easy read documentation, contributed to recruitment and Business Plan development, and strengthened scrutiny activity. We want to continue building on this progress into 2026 and beyond.

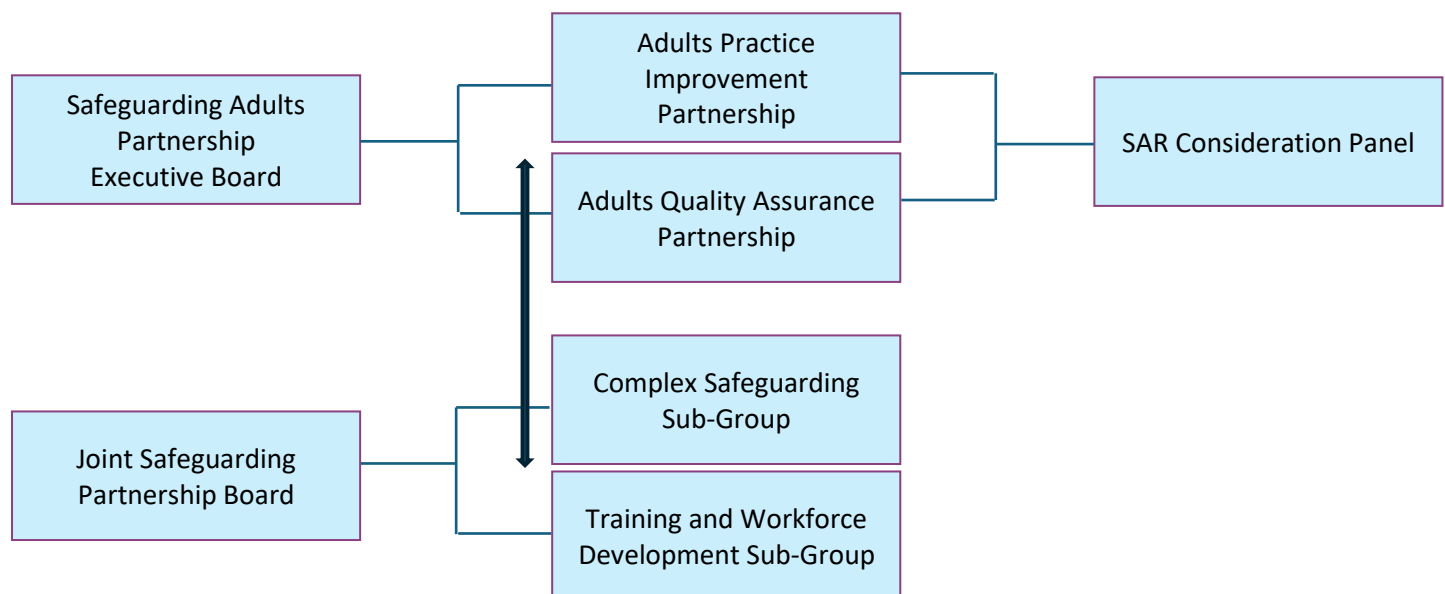
Theme	Why we are proud
Learning and development	339 practitioners and leaders attended Safeguarding Adults Week 2025, the Partnership's highest level of engagement, with seven online events and an 83% increase on the previous year.
Scrutiny and quality assurance	195 individual records were audited through deep-dive and multi-agency audit activity, showing a substantial programme of scrutiny across the year.
Co-production	The Partnership developed easy read safeguarding information and YourGo cards with adults with lived experience, supporting people to understand safeguarding enquiries and prepare for conversations about their wishes and views.
System recognition	The Local Authority's CQC Assurance visit resulted in an overall 'Good' rating, with 'Good' in the safeguarding domain. This provides important external assurance about the strength of local safeguarding arrangements, while also reinforcing the need for continued system-wide improvement through the 2026-2029 Business Plan.
SAR learning	Four SARs were commissioned in 2025/26 compared with none in the previous year, indicating that the Partnership is identifying and progressing learning opportunities. Our increase in SAR activity represents the system-wide commitment to learning through appropriate identification and transparency of response to improve multi-agency safeguarding practice.
Making Safeguarding Personal	Our Making Safeguarding Personal performance continues to be a strength across the Stockport system, with 84.9% of individuals asked about desired outcomes and 96% of enquiry outcomes either fully or partially achieved. Adults with lived experience continue to directly influence how we work and shape our safeguarding responses to meet their needs.

How we work as a Partnership

This year we worked alongside our Safeguarding Children's Partnership to separate out respective arrangements, meeting statutory requirements under The Care Act (2014) and Working Together to Safeguard Children 2023⁵. In practice this meant appointing a separate Independent Chair and Scrutineer to the Children's Partnership. All system partners were included in the planning and process to ensure that this did not result in separation of our joint working or collaboration as we continue to 'think family' in Stockport. As part of this implementation, we will review and test our shared oversight and governance arrangements through a review of our Joint Partnership arrangements.

We welcomed our new Independent Chair and Scrutineer in December 2025, following a recruitment process that involved our lived experience Board Member.

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. Greater Manchester Police continue to hold a key role in our SAR decision making process and panel meetings. All system partners remain represented and included in our governance structures, which support our continued strong ethos of partnership working.



All partners provide 'Stockport Stories' which are used at sub-groups and our Board meetings to keep adults' voices and experiences central to our discussions.

The Safeguarding Partnership is funded by the three statutory safeguarding partners. The Partnership continues to operate at a deficit and the budget position for 2025/26 is shown below. This has been escalated to statutory partners to address in 2026/27.

	£	£
Stockport MBC contribution	72,573	
Greater Manchester Police contribution	15,769	
NHS Greater Manchester contribution	38,000	
Total income	126,342	
Staffing expenses		153,142
Safeguarding Adult Reviews costs		16,200
Total expenditure		169,342

There is much to celebrate within the Stockport Safeguarding Adults Partnership, which was recognised when CQC completed their Local Authority Assurance visit in November 2025 and awarded a 'Good' rating overall, with 'Good' in the Safeguarding Domain⁶. The report recognises some further work needed as part of the One Stockport system to further improve our safe systems approach, and this forms a key piece of work within our 2026-2029 Business Plan.

Ongoing developments involving NHS Greater Manchester have been shared at our Joint Partnership Board, ensuring both adults and children's colleagues have been kept informed about the change, and impact, on safeguarding.

Partners have also been briefed on Probation Service reform and the safeguarding implications for children, adults and families this will have across our system.

George's story

George is a man in his 80s and lives alone in his own home. He enjoys gardening and accessing his local community. George had a number of falls at home and missed some health appointments. He feared loss of control and separation from his home. His Social Worker took time to build a trusting relationship with him, and led a multi-disciplinary team meeting to safely keep George supported in his own home with technology-enabled care.

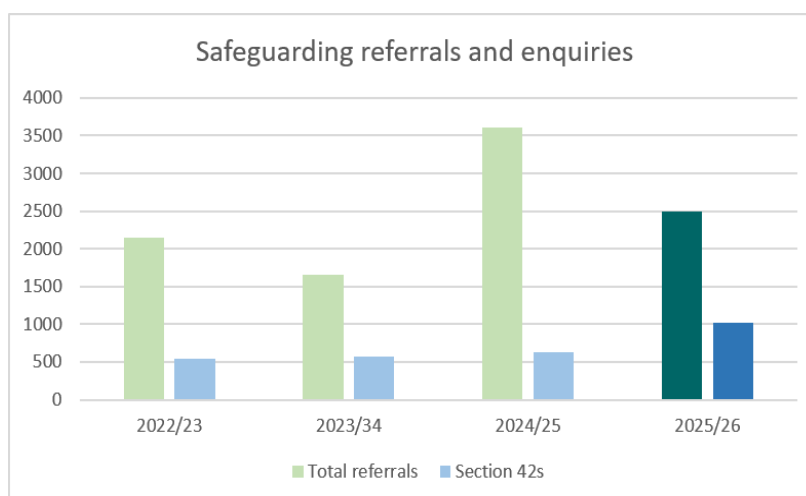
<https://youtu.be/UlkYDVofjZ4>

Multi-agency safeguarding performance

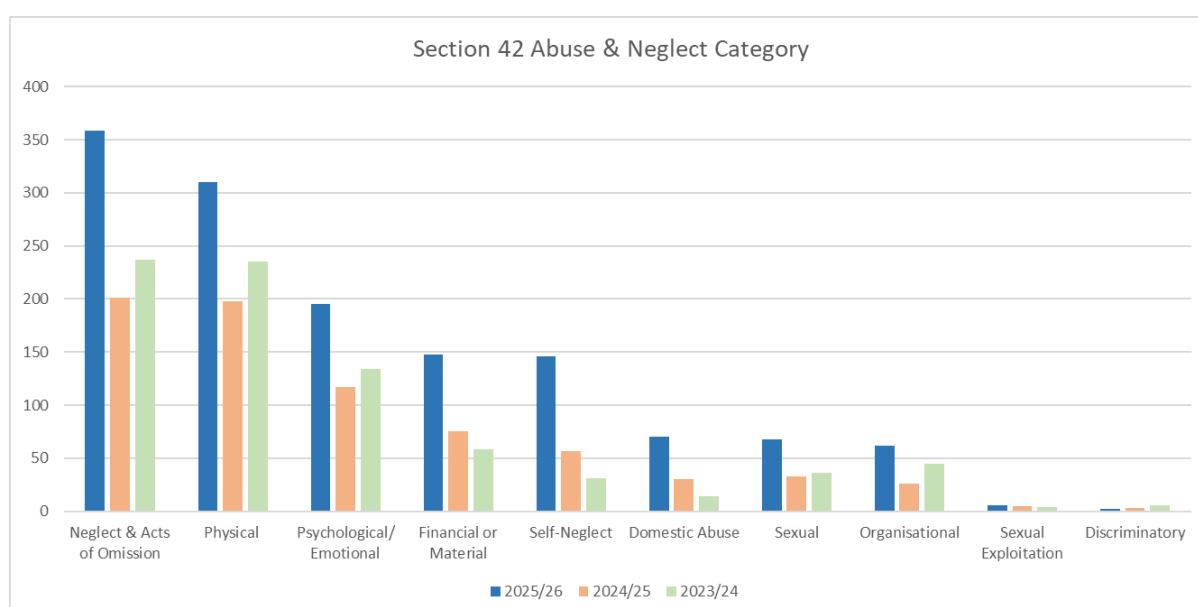
The Quality Assurance Partnership (QAP) has continued to oversee multi-agency safeguarding data through a performance dashboard. We know that our dashboard needs to improve and contain all relevant multi-agency data. This forms a key action within our 2026-2029 Business Plan.

NHS England data shows that national demand for adult safeguarding has increased dramatically over the last 10 years, rising from 364,065 in 2016/17 to 640,240 in 2024/25⁷. This trend has also been seen locally with concerns increasing from 1,748 in 2020/21 (23.9% conversion rate) to 2,498 at the end of March 2026 (40.8% conversion rate, which is higher than the North West average of 32.0%)⁸.

39.4% of all S42 enquiries were for adults aged 18-64, accounting for the largest age group in this year's data. The majority of safeguarding enquiries were for White British adults, with only 1.6% for adults mixed / multiple groups, 1.2% for Black British, and 2.7% for Asian adults. There is a need for the Partnership to further understand the safeguarding needs of adults who are not White British.



The top 3 most prevalent abuse and neglect categories this year were Neglect and Acts of Omission (32.0%), Physical Abuse (27.7%) and Psychological & Emotional Abuse (17.4%). There has been a significant increase in the number of Section 42 enquiries for self-neglect, following a process change introduced after Martin's SAR (13.0% of all S42 enquiries this year).



Incidents in an individual's own home (30.3%) and care homes (28.5%) continue to be the most commonly reported locations for Section 42 enquiries. 161 individuals developed pressure ulcers whilst under the care of Stockport NHS Foundation Trust community services, and 199 incidents were reported in the community this year⁹. Over 100 incidents were in the person's own home, showing the increasing levels of individuals being supported by partners at home with high levels of need. This shows that there is more work to do to ensure learning from Josie's SAR is fully embedded and influencing strong, multi-agency safeguarding practice.

Targeted awareness raising work will take place under the 2026-2029 Business Plan to support early intervention initiatives, and accessible information dissemination to ensure preventable abuse and neglect in all locations is avoided wherever possible.

The latest North West comparative data¹⁰ shows that we remain higher than the North West and Greater Manchester averages for physical abuse, neglect and omission, and psychological abuse. Previous audit work has shown that this data is inclusive of incidents in provider settings that could be managed under quality concern processes, rather than being investigated under safeguarding, however as the data remains high for Stockport this is an area we will continue to monitor and explore over the next year.

Abuse / neglect category	Rates per 100,000 population as at end December 2025		
	Stockport	Greater Manchester Average	North West Average
Neglect & Omission	151.0	93.2	124.8
Physical Abuse	125.5	66.6	82.5
Psychological Abuse	93.7	50.4	68.8
Financial Abuse	65.7	50.7	70.3
Self-Neglect	64.4	58.6	59.5
Sexual Abuse	29.7	14.1	19.0
Domestic Abuse	26.4	23.6	37.7
Organisational Abuse	22.6	14.3	15.5
Sexual Exploitation	3.8	2.9	3.8
Discriminatory Abuse	1.7	1.9	3.2
Modern Slavery	0.4	1.4	2.1

North West ADASS Safeguarding Benchmarking Data, as at 31st December 2025

Greater Manchester Fire and Rescue Service (GMFRS) reported two fire deaths this year. In response to both incidents, GMFRS developed and delivered targeted post-incident reassurance campaigns to provide safety advice and to support the local communities.

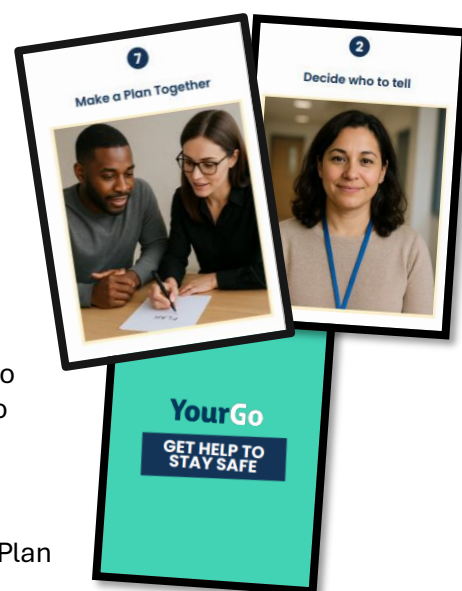
Making Safeguarding Personal

The Safeguarding Partnership and Local Authority have prioritised making safeguarding personal this year and we can see the impact of this work on how individuals experience safeguarding processes. Making Safeguarding Personal performance data has improved again, with 84.9% of individuals asked about their desired outcomes this year, compared to 83.9% last year. Of these, 96% of all enquiry outcomes were either fully or partially achieved. We understand that strong and effective practice in this area requires more measurement than the statutory performance indicators.

We have continued to share individuals' stories, under our Stockport Stories format, at sub-groups and each Partnership Board meeting, ensuring that all meeting agendas and

conversations keep a person-centred approach. George, Doris, and A & K were presented and are included in this Annual Report. A big focus this year has been on developing our ethos of co-production and engagement to ensure that information from the Safeguarding Adults Partnership is understood and shared beyond the boardroom through Key Messages and a Partnership Newsletter shared after each Partnership Board meeting. This approach, putting individuals stories and experiences at the heart of our work, was recognised as good practice by CQC during their local authority inspection.

The local authority's easy read safeguarding leaflet was co-produced with adults with lived experience, explaining what a safeguarding enquiry is, what may happen, and recording who that person's lead practitioner will be. This was further developed to include a 7-step process card which helps individuals, particularly those with learning disabilities, to prepare for a safeguarding enquiry, their meeting, and raising their views and wishes as part of a making safeguarding personal conversation. Our thanks go to YourGo¹¹ for working with the Safeguarding Adults Partnership, and our lived experience Board Member, and helping to develop these important resources. In 2026 and beyond we want to develop more of these cards and resources for use across the Partnership.



This work will form the foundation of our new 2026-2029 Business Plan as we embed principles around co-production and engagement as core operating values within the Safeguarding Adults Partnership.

Why we are proud

Our Making Safeguarding Personal performance continues to be a strength across the Stockport system, with adults with lived experience continuing to directly influence how we work and shape our safeguarding responses to meet their needs.

We are strengthening our approach to genuine co-production through developing more easy read and easily-accessible safeguarding information.

A & K's Story

A and K were brother and sister, both in their 70's, and living together. Their property was extremely cluttered and professionals raised concerns around environmental hazards including a broken gas main. The local authority (including Environmental Health), GMP, GMFRS and Stockport NHS FT worked together to safely remove A and K from the property, declutter and repair the home, and source alternative temporary accommodation.

<https://youtu.be/9isqRltFh7E>

Rough sleeping and homelessness

All Safeguarding Adults Boards received a letter from the Minister for Housing and Homelessness, and the Minister for Social Care in 2024 with four recommendations to support local areas to address rough sleeping and homelessness, including strengthening oversight and assurance of performance and learning¹².

Performance data on homelessness and rough sleeping is presented to our Sub-Groups and Executive Board, and in February a detailed annual report showed that Stockport has the second highest rough sleeping levels across Greater Manchester with an average of 32 individuals rough sleeping at the end of December 2025. In response, the Safeguarding Partnership has:

- Commenced with quarterly reporting at each meeting of the Partnership Board.
- Provided input into the Local Authority's Homelessness Prevention Strategy.
- Included actions regarding safeguarding oversight and scrutiny of rough sleeping and homelessness in our 2026-2029 Business Plan.
- Planned an audit exercise to review the rough sleeping cohort against the Making Every Adult Matter (MEAM) workstream to seek assurance around multi-agency support.

We will continue to seek assurance regarding rough sleeping and homelessness and support delivery of the local Homelessness Prevention Strategy.

Delivering the Business Plan

This is the final year of our 2023-2026 Joint Business Plan¹³ and we used our sub-groups (including joint sub-groups with the Children's Partnership) and Executive Board meetings in March to reflect and review our progress against our priorities, and work that needs to be carried over to our new Business Plan.

Joint Priority: Improve partnership working and information sharing
What did we want to do this year?
This year we wanted to raise awareness of the SAR referral criteria, and seek assurance SAR learning was having a positive impact on safeguarding practice, streamline our processes, and launch 'causing others to undertake enquiries' training.
What have we delivered?
We revised and relaunched our SAR process to ensure it was streamlined and information requests were proportionate. The new process is supported with good practice examples of a SAR referral and completed information request report¹⁴. Partners have continued to strengthen how they collaborate and come together. • Adult Social Care and Greater Manchester Fire and Rescue collaborated to promote Home Fire Safety Assessments. • Making Every Adult Matter (MEAM) implementation brings together system-wide partners for adults experiencing multiple vulnerabilities. • Stockport Homes implemented a Safeguarding Champions Network to help embed learning from the Safeguarding Partnership, audits and SARs. • A standardised 'causing others to undertake enquiries' training package was launched across care providers, Stockport NHS FT and Pennine Care NHS FT. • Safeguarding Adults Week saw our highest levels of engagement from all partners. • We launched our staff engagement focus groups giving direct lines of communication between the Independent Chair and Business Manager, and frontline practitioners. • We worked across Greater Manchester to implement a regional self-assessment supporting Partners who work across more than one locality in Greater Manchester.
How can we measure our effectiveness?
• Our SAR referral rates (12) almost doubled on the previous year (7). 4 SARs were commissioned this year compared with none the previous year. • The conversion rate from safeguarding referral to enquiry increased to 40.8% which suggests that safeguarding thresholds are being more consistently applied however this will require more audit work to gain greater assurance. • 7 online events were held in Safeguarding Adults Week 2025, with 339 attendees across the week, an increase of 83% on last year.
What do we still need to do?
• Revise our audit schedule for 2026/27 to include revisiting previous SAR learning. • We will build on the success of Safeguarding Adults Week and will implement an annual series of bitesize learning events and opportunities. • Continue to deliver our programme of frontline peer visits. • Review our 2022 Information Sharing Agreement to ensure it supports effective information sharing and addresses emerging risks from the increased use of Artificial Intelligence.

Joint Priority: Effective transitions from childhood to adulthood

What did we want to do this year?

Actions were focused around strengthening our oversight of transitional and complex safeguarding delivery, supporting delivery of the GMCA peer review action plan and upskilling our workforce around MCA application.

What have we delivered?

Developments have been led by the Complex Safeguarding Sub-Group with activity delivered as below.

- The Sub-Group has strong oversight of exploitation and transitional safeguarding activity through a new Monthly Governance Meeting.
- Stockport completed the Tackling Child Exploitation GMCA Peer Review programme, and was recognised as being the first area the GMCA team visited that included the Safeguarding Adults Partnership in the process.
- Partners have been able to explore and understand system-wide support offers and pathways that extend beyond safeguarding concerns, for example addressing housing and employment needs of vulnerable young adults. The Prevention Alliance have ensured priority allocation for young people who transition to adult services.
- Greater Manchester Police have an established post in the MASH¹⁵ that specialises in vulnerable adults, supporting a proactive approach to adult exploitation and builds on identification and disruption activities.
- We understand there is still more work to do to develop a fully defined system-wide offer regarding transitional safeguarding, with particular reference to housing and exploitation-linked vulnerabilities. In response, Stockport Homes have developed a joint protocol with Children's Social Care for care leavers and homelessness, and have implemented a pathfinder project supporting 18-25-year olds.
- Our multi-agency audit on transitional safeguarding pathways this year identified where there is more work to be done and what other governance systems outside of safeguarding need to be involved.
- The sub-group has overseen development and initial delivery of an improvement plan following the GMCA Peer Review. Work on this will continue into 2026/27.

How can we measure our effectiveness?

- Because of the focus of this priority and sub-group work, we have identified an increase both in sexual offences, and bicycle-enabled crime that is cross-border in nature. The cohort includes those from age 14, reinforcing the need for early identification of issues and pro-active support.
- As a result of prioritising this area, we now have a better understanding of children who are open to the local authority's Complex Safeguarding Service. The majority of young people were supported for a period of 0-6 months (76%), with 7% for 6-12 months and 11% for 1-2 years and none for longer than 2 years. Almost 50% of all referrals were for concerns around criminal exploitation and just over one-third pertaining to sexual exploitation, with 8% covering both types of exploitation¹⁶.

What do we still need to do?

- Co-produce an all-age Transitional and Complex Safeguarding Strategy.
- Develop a strategic data-set for this cohort to support the work of the Complex Safeguarding Sub-Group.

There is still more work to do under this priority therefore it will be carried over into our 2026-2029 Business Plan

Joint Priority: Understanding complex trauma and assessing risk

What did we want to do this year?

We wanted to complete a multi-agency audit on risk assessments, and launch updated practice guidance and resources to ensure there were appropriate tools and meeting spaces to support effective multi-agency safeguarding practice.

What have we delivered?

This priority area has demonstrated one of the most significant areas of improvement for our Partnership over the previous 3 years.

- The *Risk Assessments* multi-agency audit and corresponding action plan was completed via the Quality Assurance Partnership. This learning has informed the development of our Risk and Escalation Process (REP)¹⁷.
- Adult Social Care and Greater Manchester Police began work on developing a bespoke risk assessment tool to support GMP making the right referrals to Adult Social Care.
- We launched our updated Joint Partnership Modern Slavery Strategy¹⁸.
- Pennine Care NHS FT's training programme includes dedicated sessions on high risk protocols and risk assessment tools, and Adult Social Care have commissioned bespoke trauma-informed training, as have GMFRS (which also includes reference to ACES).
- Stockport Homes have achieved Domestic Abuse Housing Alliance Accreditation, meaning they are able to better support tenants who are at risk of, or experiencing, Domestic Abuse.
- Our new Self-Neglect and Hoarding policy was written through a 'think family' lens and made explicit links to the 2025 Safeguarding Children's Partnership Neglect Strategy.

How can we measure our effectiveness?

- The Quality Assurance Partnership has prioritised learning through reviewing a total of 195 cases that have been audited across the year. Additional single-agency audit learning has also been shared.
- The learning from Martin's SAR to recognise, refer, and address self-neglect through a process change in the local authority has continued to increase self-neglect in local safeguarding data over the last 2 years; Section 42 enquiry data increased 256% compared to the previous year.
- Adult Social Care have introduced an automatic Home Fire Safety Assessment (HFSA) referral to Greater Manchester Fire and Rescue Service within their assessment process, resulting in more assessments being completed this year. In total 3,410 HFSA's were completed across Stockport, compared to 3,248 in 2024/25.

What do we still need to do?

- Hold a multi-agency launch event for REP to bring system leaders together to oversee critical risk scenarios.
- Continue to oversee delivery of Making Every Adult Matter (MEAM) in the local authority to understand system-wide impact of these interventions.

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

What did we want to do this year?

We wanted to ensure practitioners were supported to work together, as a safe system, to put individuals at the heart of all safeguarding interventions.

What have we delivered?

Multi-agency practice guidance and resources have been developed to support person-centred safeguarding across our system.

- All multi-agency safeguarding policy and procedure is now live on our Tri-X website¹⁹. The multi-agency self-neglect and hoarding policy²⁰ was streamlined and launched this year.
- Our accessible information library has continued to grow through the launch of our substance misuse easy read information leaflet²¹, and more accessible 'Your Go' cards to support adults with learning disabilities through safeguarding processes. Our co-production approach has been led by Adult Social Care who have continued to utilise the Making It Real Board to engage with individuals. The Risk Matrix and Safeguarding Thresholds tool²² has been updated and is embedded into some safeguarding training.
- Our Stockport Stories continue to be promoted with [George](#) and [A&K](#) shared through accessible video format.

How can we measure our effectiveness?

- A total of 84.9% of individuals were asked about their Making Safeguarding Personal (MSP)²³ outcomes this year. Performance in provider-led enquiries has significantly increased from 65.6% last year to 81.6% this year.
- The conversion rate from referral to S42 enquiry increased slightly from 35% at March 2025 to 40.8% at March 2026. 92% of safeguarding enquiries resulted in risk being reduced or removed. We recognise this rate is high and expect this to drop next year as work continues on our safeguarding thresholds, decision making, and referral quality.
- The number of Home Fire Safety Assessments arising following a Care Act Assessment increased from 100 in 2024/25 to 211 in 2025/26²⁴.
- Because of our focus on pressure care following Josie's SAR, we now have greater awareness of the prevalence across Stockport. 77% of individuals who developed a pressure ulcer this year were receiving support from Stockport NHS FT and at least one other partner. Pressure care was a feature in 3 of the 12 SAR referrals received this year.

What do we still need to do?

- Develop safeguarding specific feedback mechanisms to understand how adults experienced safeguarding pathways in Stockport.
- Continue to promote use of the Risk Matrix and Safeguarding Thresholds Tool and develop a bespoke triage tool for use by GMP.
- Explore additional training and practice guidance to support with effective pressure care management.

Doris' story

Doris is an 82 year old woman who lives alone with support from a care package twice per day. Following a fall Doris was taken to hospital and discharged home with additional support from District Nursing. Her GP raised concern that Doris has spent too long sat in her chair and District Nursing completes a pressure ulcer assessment, and information and advice is given along with a referral to Steady In Stockport. A potential pressure ulcer is prevented and Doris is supported to safely mobilise.

Safeguarding Adult Reviews and System Learning

A Safeguarding Adult Review (SAR) is a multi-agency learning process that must be completed under Section 44 of The Care Act (2014). These reviews must take place following either the death or serious injury of an adult with care and support needs, as a result of abuse or neglect, and where there are concerns regarding multi-agency safeguarding practice.

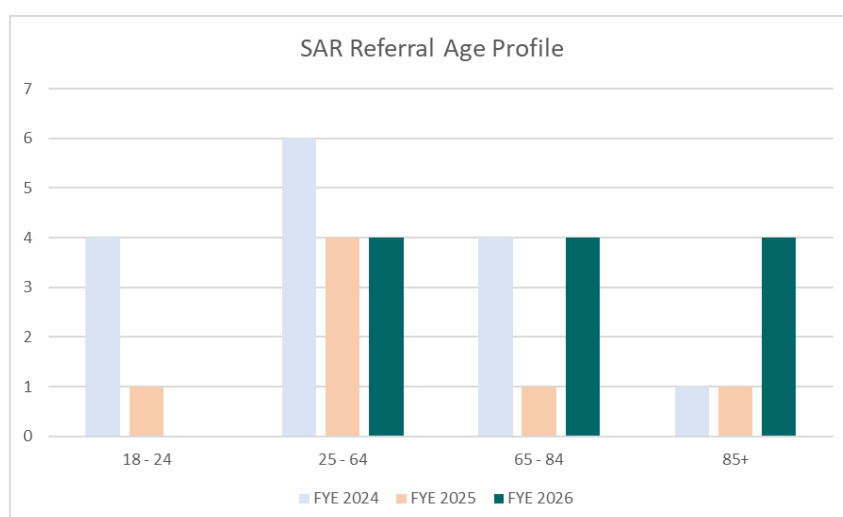
Stockport has always had fluctuations in SAR referral levels. While referral numbers are important, our primary focus is always on the quality and appropriateness of referrals, and whether the Partnership is identifying the learning needed to strengthen safeguarding practice. This year, we received almost double the number of referrals as we did the year before, bringing us closer to the position in 2023/24 where numbers significantly increased following a review of our processes and refresher training delivered by the Business Manager. Inappropriate referrals are those which should have been causes for concern shared with the local authority.

	2022/23	2023/24	2024/25	2025/26
Individuals referred for a SAR	2	15	7	12
Mandatory SAR commissioned	0	5*	0	1
Discretionary SAR commissioned	0	0	0	3
Did not meet S44 criteria	2	7	5	6
Inappropriate	0	3	2	2

**this figure relates to individual adults and not SARs.*

We are seeing more SAR referrals for older adults compared with previous years, and have seen a sharp drop in SAR referrals for young adults over the last 3 years. Five referrals were for females and seven for males, and all individuals were White British. The two highest incident locations for SAR referrals this year were *own home* and *hospital setting*. The largest proportion of SAR referrals continues to be following the death of an adult with care and support needs as opposed to incidents involving injuries or significant harm.

The most common themes and abuse & neglect categories in our SAR referrals this year were neglect (42%), physical health concerns (25%) and domestic abuse (17%), self-neglect (17%) and substance misuse (17%).



No SARs have been published this year. The previous annual report gave progress on a SAR looking at the deaths of three women. This SAR has been a significant piece of work in Stockport, given the national learning implications that will arise. We expect to publish this review in 2026/27.

There are four Safeguarding Adult Reviews ongoing at the end of March 2026:

- **A mandatory SAR** looking at the deaths of three individuals who were placed in Stockport has been completed and approved however publication is delayed until 2026/27 whilst family engagement is concluded.
- **Joint Domestic Homicide Review and Discretionary SAR** is ongoing and likely to conclude later in 2026/27.
- **Discretionary SAR** which will be completed as a SAR in rapid time.
- **Mandatory SAR** which will be completed in 2026/27.

We completed two reviews this year. Amy's discretionary SAR was completed to look at learning around domestic abuse, trauma informed practice, and multi-agency support. The referral for S did not meet SAR criteria and the consideration process identified learning reviews happening across three NHS Foundation Trusts, so we facilitated a learning event attended by over 40 frontline professionals to ensure learning was not lost.

Who were they?	What did we learn?	What is the difference?
Amy ²⁵ was 51 when she died from bleeding and pneumonia. She had experienced significant previous trauma, domestic abuse and financial abuse.	The importance of multi-agency working with a clearly identified lead professional. This includes stepping down and then re-convening the MDT / TAA when the individual comes in and out of placements and other care settings.	Practitioners are aware of the need to include Stockport NHS FT Safeguarding Teams for multi-agency safeguarding meetings, especially when the individual is accessing community services, and not an in-patient.
S completed suicide shortly after giving birth. She was 34 and her baby was 12 weeks old.	The importance of full and complete information sharing and handovers when individuals move between teams and settings. Maintaining a focus on the parent when a young child is involved in safeguarding processes.	Pennine Care NHS FT, Stockport NHS FT, and Greater Manchester Mental Health NHS FT shared learning and improvements around lead practitioner responsibilities, and the importance of MDT working around discharge and transfer between settings.

S's learning has been shared across the Partnership, and was also presented at a learning circle for the Safeguarding Children's Partnership, signifying our ongoing commitment to always 'think family' and not lose important connections with system colleagues.

What is the impact on safeguarding practice?

Due to the high numbers of SAR referrals for neglect, and abuse in care settings, in 2026/27 we will be reviewing and updating our Risk Matrix and Safeguarding Thresholds guidance to include specific reference to provider settings around medication errors, slips trips and falls, resident-on-resident abuse and pressure care.

Three of the twelve SAR referrals this year have featured pressure sores, which was one of the main themes in Josie's SAR. We want to ensure partners and care providers are aware of how to safely identify and manage pressure care incidents, and will develop and launch updated safeguarding threshold guidance specifically for providers.

Scrutiny and Assurance

We continued to deliver our programme of multi-agency quality assurance this year with 4 deep-dive audits and 2 multi-agency audits completed. In total, 195 individuals' records were audited throughout the year.

Our multi-agency audit on **risk assessments** invited partners to come together and reflect on how risk is identified and managed across the Partnership. The findings from this audit exercise has informed development work around our new critical risk panel and process.

We completed a **physical abuse** deep dive to understand the increasing prevalence in local Section 42 data. The audit found that resident-on-resident abuse in care settings accounted for the majority of enquiries. Learning was shared with Adult Social Care to ensure particular provider settings were supported to respond to incidents.

A deep dive focusing on **neglect and acts of omission** found that triage decisions at the Adult Social Care Front Door could provide stronger feedback to referrers on where neglect should be explored under a Section 42 enquiry, and where there was not enough evidence to investigate.

We facilitated a **Transitional Safeguarding** multi-agency audit, building on findings from our 2023 audit. The audit recognised that this issue is broader than a safeguarding concern, which requires input from a wider response from other systems, for example around housing or employment needs.

We wanted to understand the experiences of individuals who had **multiple referrals to Adult Social Care**. The review found that in the majority of referrals, individuals were being supported to manage challenging behaviours and were receiving ongoing support, rather than safeguarding enquiries being ineffective. Subsequent referrals were made by partners in response to presentations or escalating concerns and were addressed through case management rather than multiple Section 42 enquiries.

In partnership with our colleagues across Greater Manchester Safeguarding Adult Boards, we standardised the self-assessment process. This process was launched in March 2026 and we will complete in May. We will use findings from this process to inform improvements to our self-assessment cycle, and will also seek to include individuals in this from next year.

As we prepare to publish our 2026-2029 Business Plan, our quality assurance programme will develop with new audit and scrutiny priorities. Audit activity that we want to complete next year will include:

- A multi-agency audit on physical abuse as levels continue to increase locally
- A multi-agency audit on self-neglect and hoarding to monitor impact of our new policy

Why we are proud

Scrutiny and learning continue to be a genuine strength with real commitment from all system partners to completing audit activity, and embedding learning from SARs, audit, and data interrogation. 195 records were audited this year demonstrating the scale of our commitment.

Learning and development

Each year we celebrate Safeguarding Adults Week to highlight all of the strong practice locally, and share developments or updates that will continue to strengthen our Partnership. This year we listened to our system workforce and changed how we deliver the week of action, moving to a series of online events rather than a single conference. As a result, we welcomed 339 practitioners and leaders across the week of events, delivered by a different partner each day. We want to learn from this level of engagement, and make sure that we continue to deliver learning opportunities in a way that all staff are able to access, ensuring that it supports their development, and puts individuals' voices and experiences at the forefront.

Give more case studies in training and comms to help make safeguarding real.
Stockport NHS FT Safeguarding Team

Our new self-neglect and hoarding guidance was launched through an online learning circle with representation from across the Partnership. The new guidance draws on direct learning from Martin's SAR and helps to embed partnership working.

In May 2025 we held our first staff focus group, giving frontline practitioners the opportunity to meet directly with the Independent Chair and Business Manager. The session gave valuable

The practice guides are really helpful to know where to make referrals to when I need to know now
Pennine Care NHS FT Community Team

insight into how our communications, events, and policy and procedures are used in practice and how accessible they are. We want to continue to deliver these sessions in future years to ensure there continues to be direct engagement with the practitioners who access our resources every day.

Learning continues to be routinely shared across the system, for example the Business Manager attends monthly Level 3 training days at Stockport NHS FT to present training on the Safeguarding Partnership. In November 2025 input on safeguarding adults experiencing

Domestic Abuse, and SAR and DHR learning was shared at the local multi-agency Domestic Abuse Conference.



Our strategic plan for 2026-2029

Next year we will launch our 2026-2029 Strategic Plan which details 5 key areas that we will prioritise with our partners, building on the success of our Safeguarding Partnership.

The five priorities are:

1. Prevention and wellbeing
Work as a partnership to prevent abuse and neglect from happening through a range of early intervention and prevention initiatives aimed at supporting wellbeing.
2. Rough sleeping and homelessness
Work with partners to address the unique safeguarding needs of adults who are homeless, in temporary accommodation and rough sleeping
3. Transitional and complex safeguarding
Work with partners to continue to develop our multi-agency response to young adults transitioning to adulthood, and experiencing exploitation, ensuring the right system response for them
4. Improving safeguarding practices and learning
Ensure all partners are able to consistently apply thresholds and effectively manage escalating safeguarding risk.
5. Strengthened governance, accountability and oversight.
The Safeguarding Partnership will work collaboratively to ensure safeguarding is inclusive of all communities and partners, and will measure and monitor effective delivery and impact of interventions.

A detailed strategic delivery plan has been developed with our partners and lived experience Partnership Board member. This sets out a work programme for our sub-groups. This will ensure that we hold ourselves accountable for progress and remain transparent in outlining what we have achieved.

As a Partnership we seek to strengthen our assurance as to the effectiveness of multi-agency safeguarding practice and we are excited by the impact our strategy will have over the next 3 years.

Appendices

Appendix A: Glossary of terms

Acronym	Definition
ACE / ACEs	Adverse Childhood Experiences
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DHR	Domestic Homicide Review
GMCA	Greater Manchester Combined Authority
GMFRS	Greater Manchester Fire and Rescue Service
GMP	Greater Manchester Police
HFSA	Home Fire Safety Assessment
MAARS	Multi-Agency Adults At Risk System
MDT	Multi-disciplinary team
MEAM	Making Every Adult Matter
MSP	Making Safeguarding Personal
NHS / NHS FT	National Health Service / National Health Service Foundation Trust
QAP	Quality Assurance Partnership
REP	Risk and Escalation Process
S42	A Section 42 Enquiry is a multi-agency safeguarding enquiry following abuse or neglect
SAR	Safeguarding Adult Review
SSAP	Stockport Safeguarding Adults Partnership
TAA	Team Around the Adult

Appendix B: End notes and references

¹ YourGo is a life-skills toolkit which helps people with learning disabilities communicate and develop important independent life skills <https://www.yourgo.org.uk/>

² [One Future Plan - One Stockport](#)

³ Taken from ONS population profile, Stockport JSNA and One Stockport data reporting

⁴ The English Indices of Deprivation measure deprivation across seven key domains, these are income, employment, education skills and training, health and disability, crime, barriers to housing, and living environment. [What are the English Indices of Deprivation? A beginner's guide to the IMD - OCSI](#)

⁵ [Working together to safeguard children 2023: statutory guidance](#)

⁶ [Stockport Metropolitan Borough Council: local authority assessment - Care Quality Commission](#)

⁷ [Cause for alarm: what can safeguarding data tell us about the challenges facing health and care services? | Nuffield Trust](#)

⁸ Reported in NW ADASS Safeguarding data collection to the end of December 2025.

⁹ Community acquired pressure ulcers data presentation, as at end of March 2026 presented to the Practice Improvement Partnership sub-group 20.05.2026

¹⁰ Data to the end of December 2025 as collated and published by North West ADASS <https://curator.gmtableau.nhs.uk/dashboard/safeguardingpg-typematrix>

¹¹ <https://www.yourgo.org.uk>

¹² [ministerial-recommendations-for-safeguarding-adult-boards.pdf](#)

¹³ [Business Plan 2023-2026](#)

¹⁴ [sar-policy-pack.docx](#)

¹⁵ Multi Agency Safeguarding Hub, a co-located multi-disciplinary team within Children's Services to receive and triage children's safeguarding referrals.

¹⁶ Data from the Monthly Complex Safeguarding Governance Meeting reported to Complex Safeguarding Sub-Group

¹⁷ Risk and Escalation Panel is a multi-agency senior leadership panel to oversee and respond to critical risk scenarios.

¹⁸ [Stockport Safeguarding Partnerships Modern Slavery Strategy](#)

¹⁹ [Welcome and Introduction](#)

²⁰ [ssap-self-neglect-policy-april-2026.pdf](#)

²¹ [alcohol-and-drugs-easy-read.pdf](#)

²² [risk-matrix-thresholds-document-v4.pdf](#)

²³ Making Safeguarding Personal means working with the person to understand their views, wishes and priorities, so safeguarding support is shaped around what matters to them. A set of statutory outcomes are reported on by the local authority.

²⁴ GMFRS data included in QAP dashboard up to the end of March 2026

²⁵ [amy-7-minute-briefing.pdf](#)