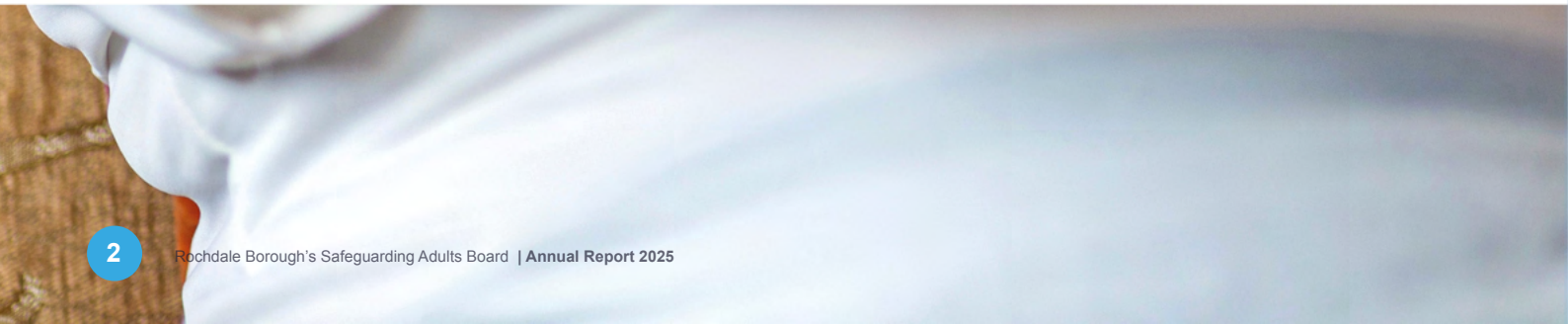
Rochdale Borough's Safeguarding Adults Board

Annual Report 2024 - 2025

RBSAB
ROCHDALE BOROUGH
SAFEGUARDING ADULTS BOARD

Contents



Independent Chair's Introduction

I am delighted to present this Annual Report from the Rochdale Borough Safeguarding Adults Board for 2024-2025, which reflects the continuing hard work and dedication of the many professionals, volunteers, carers and members of our community who ensure that adults across the Borough are protected from harm and abuse and supported when it does occur.

This report serves as a reference document for the residents of Rochdale Borough who need to know who, what, where and how adults at risk are protected. It gives highlights of the actions and work undertaken by the Board and partner agencies in delivering safeguarding related activity and details our plans for 2025-26.

2024-25 has been a transitional year for the Board following a Local Government Association review, which identified areas for improvement. I am happy to say that these have been addressed, and significant achievements include the development of a new vision, production of a three-year strategy for 2025-28 with a supporting plan of activity, new governance arrangements, including the creation of new sub-groups to achieve our strategic priorities, and strengthened representation on the Board which truly reflects our diverse community.

Our strategy has been devised using a range of information sources, however we recognise the need to have more effective multi-agency performance information to support analysis to identify changes, trends and areas for focus. We have also identified the need to strengthen the voice of adults with lived experience to influence our practice, policies and procedures through first-hand knowledge to truly understand the impacts and emotions.

Brad Howe - Independent Chair

These two key areas of focus will be progressed in late 2025.

This report also provides an opportunity to reflect on our achievements, and significantly I feel we have strengthened our collective ownership and responsibility in seeking assurance as to the effectiveness of safeguarding related activity across the Borough. This is most evident within the development of our quality assurance and performance framework which features heavily within our plans for 2025/26. The achievements represented in this report are due to board members' commitment and dedication, and I therefore want to thank them all on behalf of the residents of Rochdale Borough.

As a multi-agency partnership Board, we continue to be ambitious in the priorities we set ourselves for the year ahead, many of which will be taken forward by our hard-working sub-groups. Whether it is coordinating Safeguarding Adults Reviews (SARs), delivering a multi-agency training programme, engaging with seldom heard groups or developing preventative approaches to self-neglect, they are a vital component of our partnership.

Looking ahead for 2025/26 this report outlines our intentions as a Board for the coming twelve months and I would encourage anyone who reads this report to do so together with our strategy for 2025-28, which details the journey we are on. The programme of work whilst challenging is achievable against a backdrop of increasing demand, continuing austerity and significant changes within the public sector, most notably Health.

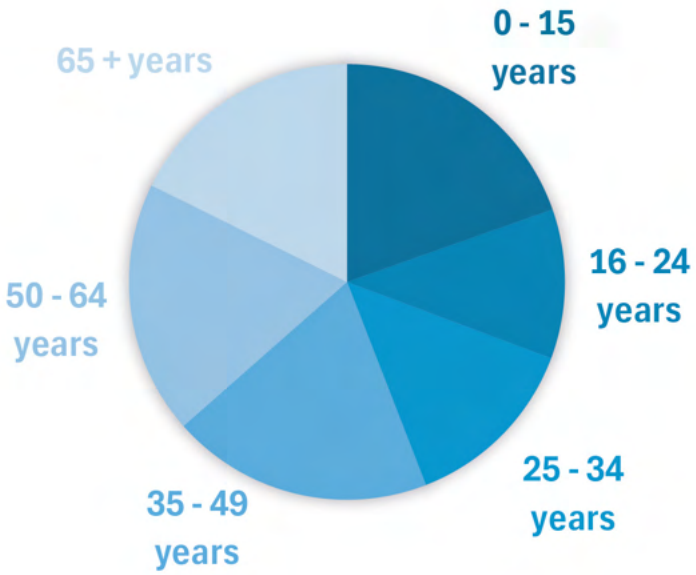
Lastly, I would like to thank the Business Unit which supports the Board. They are a small team, yet their commitment and dedication is clear for all to see.

Welcome to the Borough of Rochdale.

Rochdale is a borough characterised by its strong community values, inclusivity, and commitment to supporting adults from all walks of life. The local culture is rooted in respect, dignity, and a shared responsibility for the wellbeing of every resident. Rochdale's recently refurbished Town Hall showcases the boroughs aspirations, and proud heritage as the birthplace of the Co-operative Movement continues to influence its approach to partnership working, and mutual support. All of this alongside beautiful green space, and abundant scenery makes Rochdale a great place to live.

Total number of adults residents in Rochdale: 175,161.

Age breakdown by category:



% population Country of Birth

The borough benefits from a vibrant voluntary sector, active community groups, and a range of accessible services that empower adults to live independently and participate fully in community life. Voluntary sector /organisations are members of the RBSAB.

As of 21 March 2021, Rochdale had 223,800 residents. Rochdale had a higher proportion of residents aged 65 to 74 years (9.5%) compared to 7.9% in 2011, indicating an ageing population. The median age remained stable at 38 years, which is younger than both the North West and England (each at 40 years). Residents aged 65 years and over accounted for approximately 16.5% of Rochdale's population.

In 2021, 74.0% of Rochdale residents were of White ethnicity, which is lower than England (81.0%). The next largest ethnic group was Asian, Asian British or Asian Welsh, accounting for 18.5% of the population. Rochdale had 3.5% Black, Black British, Black Welsh, Caribbean or African residents.

In 2021, 77.9% of Rochdale residents rated their general health as good or very good (44.1% "very good" and 33.8% "good"). This is slightly lower than England (81.7%). 5.5% of Rochdale residents considered their health to be 'bad' or 'very bad'. 19% of Rochdale residents were recognised as disabled under the Equality Act (2010). This includes those whose impairments are long-term and substantially affect their ability to carry out day-to-day activities.

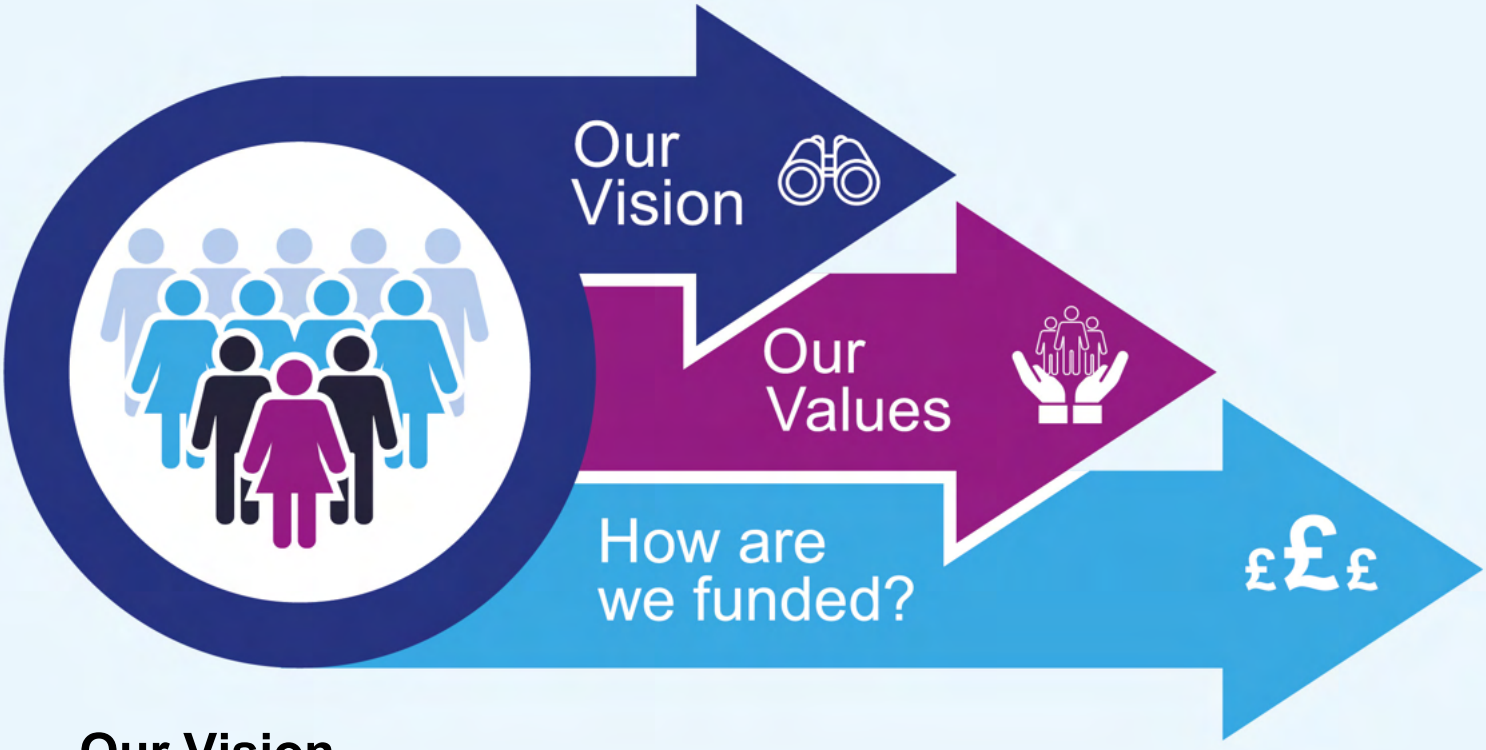
Rochdale Borough Safeguarding Adults Board (RBSAB)

The Rochdale Borough 'Safer Lives Together' Safeguarding Adults Board (RBSAB) is a multi-agency strategic partnership established under the Care Act 2014. Its purpose includes:

- seeking assurance of effective safeguarding adults activity
- working together to prevent abuse and neglect, promoting a culture of improvement through evidence from Safeguarding Adults Reviews, national and regional good practice and influenced by the voice of the adult
- promoting awareness and understanding of safeguarding adults issues and concerns

RBSAB's statutory duties are:

- to publish a strategic plan for each financial year that sets how we will meet our main objectives and what our members will do to achieve this;
- to publish an annual report which sets out how the RBSAB has worked to achieve the objectives described within its Strategic Plan; details of any Safeguarding Adults Reviews (SARs) which are ongoing or have concluded in the past year, and what work has taken place to implement recommendations from those reviews; the performance of member agencies and how effective partnership working is in safeguarding adults across the borough;
- to commission any Safeguarding Adults Review in accordance with Section 44 of the Care Act 2014.



Our Vision

Together we will be outstanding in ensuring that adults across Rochdale Borough with care and support needs live safely, free from harm and abuse, and are able to make their own choices.

Our Values

Collaborative in our approach. We will work collectively with partners and local people to deliver the best outcomes for adults with care and support needs across Rochdale Borough.

Determined to make a difference. We will promote a culture of continuous improvement by learning from mistakes and identifying good practice to influence future service delivery.

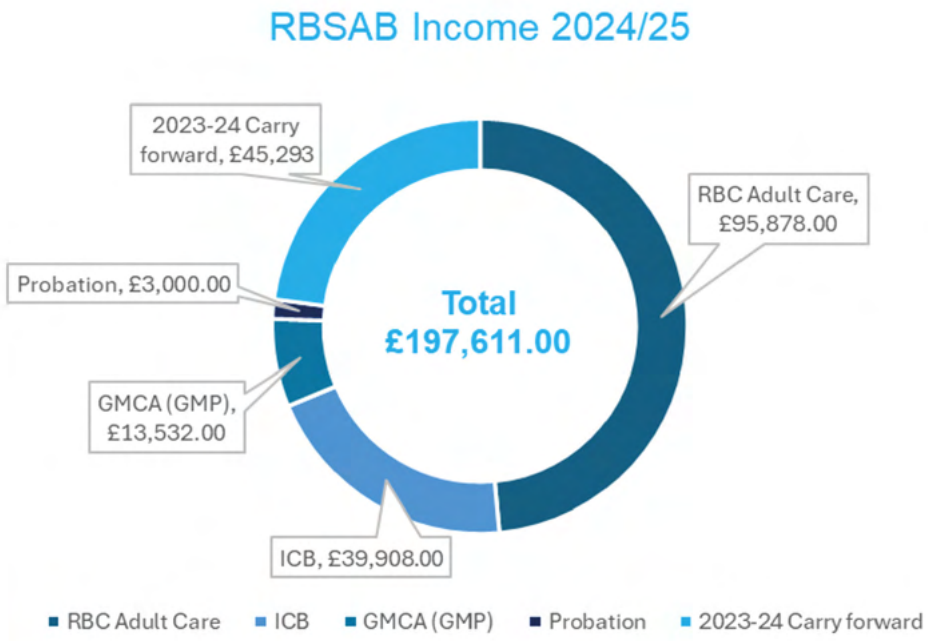
Compassionate in our support. We will act with empathy and understanding when supporting adults with care and support needs to ensure their voice is heard.

Accountable for our actions. We will be open and transparent in our decision-making, taking responsibility to ensure we support adults with care and support needs, and achieve our objectives.

The co-development and embedding of these values has supported members to feel a strong sense of ownership of the RBSAB, its subgroups and work programme. The RBSAB has benefited from this as a wider number of professionals are contributing to assurance of safeguarding-related activity.

How are we funded?

The information below describes income and expenditure of RBSAB in 2024/25

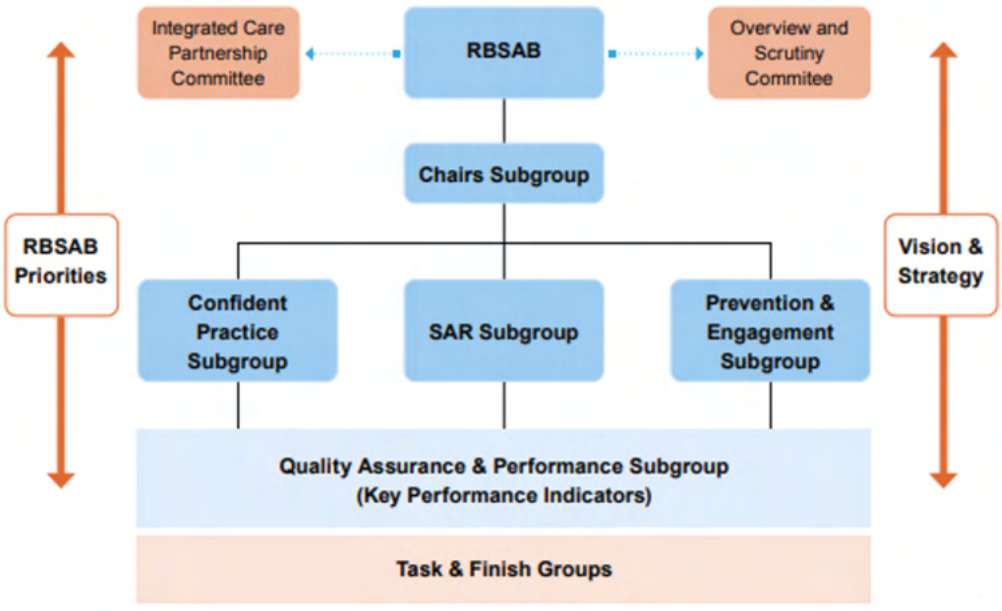


The main areas of expenditure were:

- **£29,165** on professional fees such as Independent Chair and Safeguarding Adult Review activity.
- **£15,298** on training and other learning & development associated costs.
- The remaining budget was used for support staff costs and carry forward.

How are we structured?

The RBSAB governance model is one of equal co-operation and equal contribution to RBSAB activity. When attending Board meetings, it is senior roles who attend and represent their organisations, share information, and ensure safeguarding knowledge and practices are embedded across the multi-agency system. Attendees are expected to act with candor and identify resources, when required, for assurance activities.



Our Board Members

Statutory Members:

- Adult Social Care, Rochdale Borough Council
- Integrated Care NHS Greater Manchester
- Greater Manchester Police

Other Member Agencies include senior representatives of Children's Services, Commissioning, Community Safety Partnership, Public Health, Strategic Housing, Rochdale Boroughwide Housing, Northern Care Alliance NHS Trusts, Pennine Care NHS Foundation Trust, HMP Buckley Hall, Probation Service, North West Ambulance Service, Greater Manchester Fire & Rescue, Rochdale Mind, Turning Point, Action Together, Healthwatch, Caring & Sharing Rochdale, Rochdale Council of Mosques and Advocacy Together.

RBSAB ensures delivery against strategic priorities via four subgroups, and task and finish groups where required:

Quality Assurance & Performance Subgroup:

The Quality Assurance subgroup will reflect upon, identify, develop and ultimately seek assurance of partner agencies safeguarding quality systems. The aim of the quality systems are to ensure RBSAB understand and are assured on the effectiveness of local multi-agency safeguarding. This subgroup underpins all subgroups and is chaired by Rochdale Borough Adult Social Care's Principal Social Worker and Strategic Safeguarding Lead.

Confident Practice Subgroup:

The purpose of the sub-group is to provide leadership for the multi-agency safeguarding training offer and gather assurance on behalf of the Board to ensure that safeguarding training, both multi-agency and single agency assists practitioners to deliver effective services.

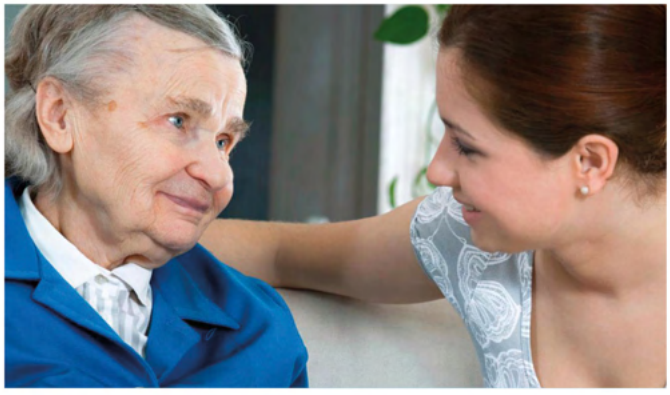
To ensure the RBSAB Multi - Agency Policy, procedures, protocols and guidance documents are accurate, regularly updated and relevant and meet legislative requirements, and to ensure they promote good practice across all partner agencies. The sub-group is chaired by GM NHS ICB Designated Professional for Adults.

Safeguarding Adult Review (SAR) Subgroup:

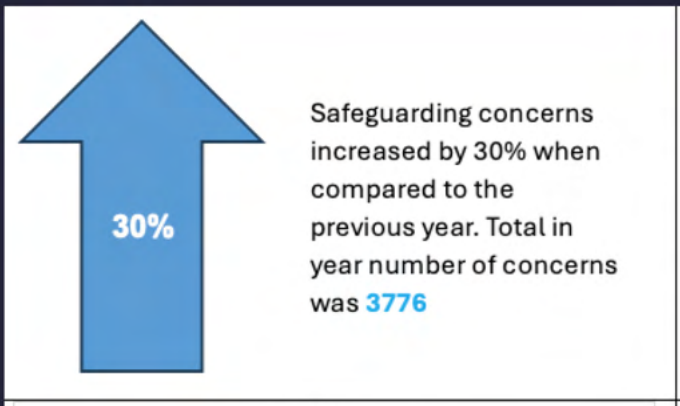
The purpose of the group is to enable and support the RBSAB to undertake statutory reviews in line with criteria set out within the Care Act 2014. The group also provides a mechanism for the SAB to ensure that learning from reviews is embedded into practice to improve outcomes for individuals, their carers and their families. The sub-group also communicates learning gained with children, families and practitioners and ensures engagement with communications is effective. Chaired by GMP Rochdale District Detective Superintendent

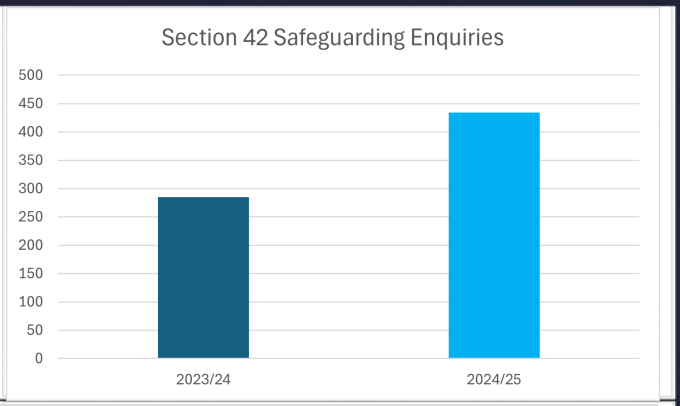
Prevention and Engagement Subgroup:

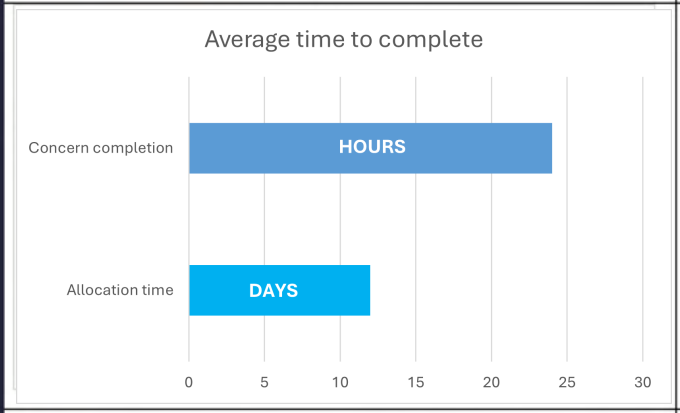
The sub-group brings partners together to understand themes, issues and risks relating to adult safeguarding to develop preventative responses that can be deployed across the partnership to keep people safe and free from harm and abuse. The group will also bring the voice of adults with lived experience, communities, colleagues and practitioners together to be heard with a focus on influencing practice, policy and procedure aimed at safeguarding adults from harm and abuse. It is chaired by the Rochdale Boroughwide Housing Chief Executive.

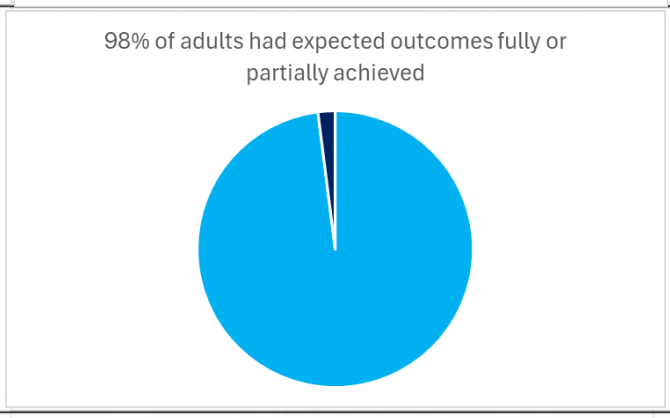


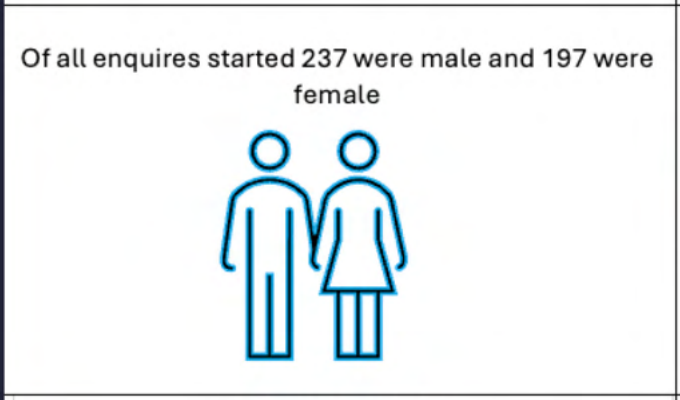
Key Safeguarding Facts 2024/25

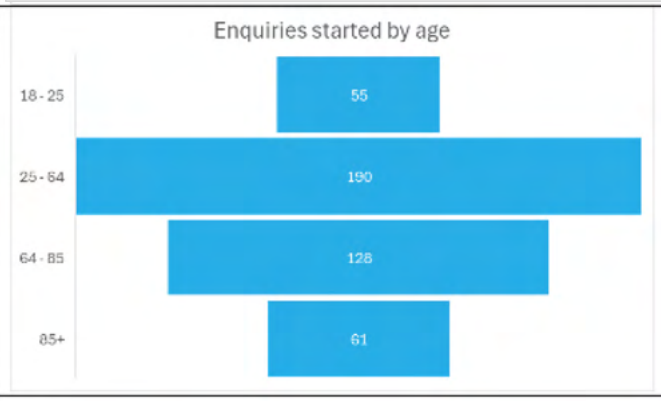


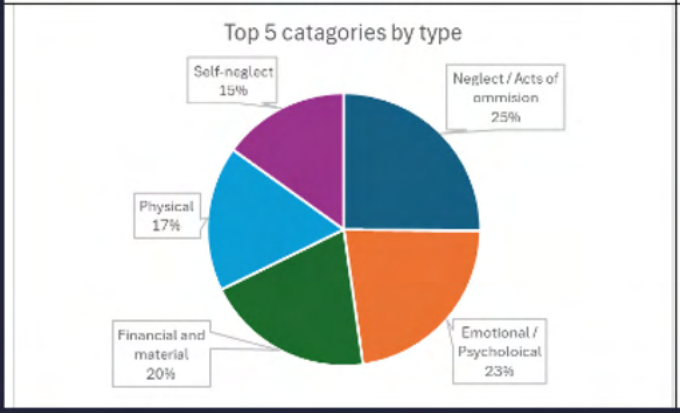












Compared to the previous year, safeguarding concerns increased by 30% and safeguarding enquiries rose by 52%, culminating in 434 enquiries involving 403 individuals - the highest in five years. This trend is a reflection of Adult Social Care activities undertaken to strengthen safeguarding systems following a noted decline in enquiry completions. These were targeted interventions such as the introduction of a “safeguarding front door” and multiple audits of concerns received and their outcomes.

A 98% achievement rate of service users' desired outcomes provided RBSAB with assurance of the service's commitment to making safeguarding personal.

A sampling audit revealed that initial reviews of safeguarding concerns were completed within 24 hours. The average waiting time for case allocation was 12 days which provided RBSAB of Adult Social Cares timely responses.

The highest safeguarding concern category type is neglect and acts of omission. This will be subject of further exploration in 2025/26 so that we can better understand it and develop preventative approaches.

Summary of Delivery in 2024/25

The annual report for 2024/25 provides an overview of the Board's achievements against the RBSAB's strategic plan for 2022-2025.

1.0 Prevention and Early Intervention

Priority Focus:

Safeguarding transitions to adult services; All-age safeguarding offer; Effective response to self-neglect.

Key Activities & Achievements:

- Ensured the joint safeguarding website promoted 'Think Family' approach to both children and adult partners
- Promoted an extended range of self-neglect knowledge with regards to bariatric patients via SAR Adult M activity
- Self-neglect polices, guidance and tool kits updated and delivered to a multi-agency audience
- Development of rough sleeping data to allow analysis

Impact:

- Shared knowledge consistent across children and adult practitioners
- Increased availability of current self-neglect training material that is relevant to professionals and the adults they support
- Identification of challenges faced by rough sleepers

2.0 Complex and Contextual Safeguarding

Priority Focus:

Addressing vulnerabilities holistically; Embedding trauma-informed practice; Raising awareness of financial abuse.

Key Activities & Achievements:

- Trauma-informed content added to provide specific examples in multi-agency training
- Dedicated resource webpage created to help standardise where professionals can find information
- Development of financial abuse 7-minute briefing for adults and practitioners
- RBSAB delivery of a Greater Manchester Honour Based Abuse Conference
- Delivered a voice of experience presentation from Men from Hare Hill House with regards to alternative support systems

Impact:

- Broader understanding of trauma, ACEs and its implications in safeguarding
- Improved understanding of Financial Abuse
- Enabled all partners to understand about holistic approaches to vulnerability via direct voice activities

3.0 Quality Assurance and Learning Shaping Practice

Priority Focus:

Embedding SAR learning; Promoting Making Safeguarding Personal (MSP); Auditing responses to self-neglect

Key Activities & Achievements:

- SAR subgroup developed QA checklists, bespoke training templates, and 6-month review processes
- Development of the Rochdale Performance Information Dashboard
- Safeguarding practitioners informing strategic direction
- An improved SAR checklist procedure to support an effective process

Impact:

- Improved additional guidance of making safeguarding personal to ensure all agencies are aware of the expected RBSAB standards.
- Improved understanding of how to use data to make informed decisions
- Ensuring voice of professionals and adults inform strategic safeguarding
- SAR checklist ensured RBSAB can evidence and effective SAR process

Rochdale Borough Adult Social Care

Adult Social Care have carried out a number of deep-dive audits throughout the year including the following:

- Safeguarding Strategy Meeting Audit: In 80% of enquiries, multi-agency meetings were held, promoting shared risk management and accountability. 87% used the correct agenda, and 90% evidenced good practice in capturing service users' views—hallmarks of a person-centred approach.
- Self-Neglect Audit: A 55% increase in safeguarding enquiries related to self-neglect signals improved recognition and response. 86% of cases involved multi-disciplinary meetings, with many showing formal capacity assessments or documented consideration of decision-making ability. This reflects embedded partnership working and adherence to safeguarding frameworks.
- Quarterly Quality Assurance Audits: Across the year, 61% of cases were rated "Good" or "Excellent", with strengths noted in risk recording, safeguarding principles, and user involvement. These audits not only identify best practice but also drive continuous improvement through direct feedback and team forums.
- In response to the above findings the following has been implemented:
  - A redesigned Training, Assurance and Safeguarding (TAS) resource hub.
  - Targeted training for Community Mental Health Team (CMHT) practitioners.
  - A new Safeguarding and Practice Forum for non-qualified staff.
  - A joint working group with care home providers to refine referral pathways and reduce inappropriate safeguarding referrals.

Additionally, the partnership with Pennine Care Foundation Trust has led to the development of a new integrated care model, launching in July 2025. This aims to enhance social work practice, improve data recording, and ensure statutory duties are met.

Rochdale Adult Social Care's safeguarding performance in 2024/2025 reflects a culture of accountability, responsiveness, and learning. Through rigorous audits, data intelligence, and strategic collaboration, the service has not only addressed previous challenges but set a benchmark for safeguarding excellence.

Integrated Care NHS Greater Manchester

NHS GM as with all NHS Organisations, has a requirement to safely discharge its statutory duties in relation to the safeguarding of both children, young people and adults as outlined in national guidance.

NHS GM has continued to discharge our statutory safeguarding duties throughout 2024-25. The responsibility for Safeguarding within the ICB is delegated to the Chief Nursing Officer supported by the Deputy Chief Nurse and Associate Director of Safeguarding supporting governance and assurance structures. Statutory safeguarding delivery is overseen via Associate Directors of Quality and Safety in each of the GM localities and undertaken by the locality Designated Teams.

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

The ICB has submitted quarterly Safeguarding Assurance Self-Assessment to provide assurance of its arrangements to NHSE, this includes our oversight of the NHSE self-assessment audits from our GM commissioned providers. In addition, NHS GM submits statutory self-assessments to the Adult Safeguarding Boards. An overview of our detailed activity will be provided the Annual Safeguarding Report 2024-25 which will be published in quarter 2 of the financial year 2025-26.

NHS GM safeguarding team has established infrastructures to support learning from Adult Safeguarding Reviews, this supports embedding system learning when significant incidents occur. System assurance demonstrating the impact from learning remains a key area of focus for the team in 2025/26.

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

NHS GM works with wider Integrated Care System partner representatives to ensure there are representatives across the NHS GM committees and boards including, NHS providers, Healthwatch and VCSE. Our partner representatives are key to ensuring effective community and citizen participation in the work of the wider Integrated Care System to safeguarding our residents across Greater Manchester.

Greater Manchester Police

Key achievement(s) during year:

- Right Care Right Person was implemented Monday 30th September 2024. The impact is continually reviewed by the force Prevention hub, through which, recommendations, learning and coronial regulation 28 are assessed and where appropriate changes are made in conjunction with partners. RCRP has seen a reduction of the overall demand picture for GMP.
- The Multi-Agency Tasking and coordination (MATAC) offer has been established with a monthly cohort of suspect being identified, which affords both suspects and victims the opportunity and identified will be managed via the Neighbourhoods and the specialist domestic abuse teams.
- Since the HMIC Inspection within Greater Manchester Police, there is daily local and force weekly governance in respect of DVD's and those over 28 days old. Rochdale have continued to maintain disclosure within the timeframes, whilst using technology (RVR) to make the disclosures more effectively, ensuring that potential victims and victims are signposted or are able to safeguard themselves and their families.
- The force Stalking Triage Centre (STC) has been funded by GMCA, the STC consists of two Investigative Support Officers. They are a support hub, offering advice on evidential opportunities, suspect strategies, safeguarding and victim engagement. This is being supported by Rochdale's stalking and harassment 4P plan, with the intention of better understanding the nature of stalking in Rochdale as it is one of the highest contributor in GMP and how to reduce the impact.
- Continual professional development (CPD) is delivered monthly with tailored training in respect of Cuckooing, DA and vulnerable adults. The CPD is recorded on individual officers' personal records to ensure officers and supervisors are current with internal / external changes as well as changes to the law.
- Attendance at RBSAB meetings is assured through the nomination of specific leads and deputies which has been reflected in the quarterly returns. The district commander and detective superintendent both take to the lead or chair boards or sub-groups to have multiagency involvement and influence the delivery of objectives and priorities within their thematic areas.
- The District Operating Model has been embedded throughout GMP since November 2024. The specialist Domestic Abuse Teams (DAT) have realised a increase in positive outcomes, with a focus on evidence led prosecutions. The DAT also support the district investigation teams, which have also seen the increase in the use of CARA pathway and DVPN's to safeguard both victims and suspects.

Pennine Care Foundation Trust

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

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

The safeguarding team has seen an increase in workforce in 2024/25 with the addition of a Named Nurse for Safeguarding Looked After Children role and a Mental Capacity Act lead role being introduced to the team. The workforce in the team continued to be fully staffed and this has allowed the team to drive the priorities, training and supervision offer across the Trust.

PCFT worked towards achieving its 2024/25 safeguarding priorities with many successes being seen:

- Enhance work within the Trust in relation to the Mental Capacity Act to ensure knowledge, compliance, and governance.
- Continue to promote and develop Safeguarding supervision in the Trust, expanding our offer and embedding the new LMS recording system in relation to engagement and attendance with safeguarding supervision and evaluate effectiveness and compliance.
- Use digital recording to understand and audit safeguarding referrals and activity (work as done) within the Trust.
- Enhance work within the Trust in relation to domestic abuse awareness, prevention and support for both staff and patients/service users.
- Continue to enhance the additional safeguarding training offer, developing how we embed and promote additional learning and development in safeguarding.
- Work with inpatient services and quality teams to enhance the safeguarding knowledge and awareness to ensure safeguarding practices are robust and offer high levels of care.
- Develop work and training on transitions within safeguarding.

PCFT has been a regular contributor to RBSAB in 2024/25. They have supported with inspections, case file audits, safeguarding reviews, subgroup deputy chair responsibilities and a range of learning & development.

Northern Care Alliance NHS Trust

The NCA are one of the largest providers of health care for both acute and community in the country.

Adult safeguarding is embedded in practice within the healthcare setting; safeguarding training is a mandated requirement across the NCA. To date compliance in Adult Safeguarding Level 1,2 and 3 training thresholds, as outlined in the Greater Manchester Contractual Standards for Children, Young People and Adults at risk has been achieved, with full commitment from the NCA to deliver this ongoing programme of training.

The NCA, as a health provider representative within the Rochdale Borough Safeguarding Adult Board have engaged in the development days and the setting of agreed priorities for 2024/25 and the ongoing board priorities for 2025/26. During 2024/25 the NCA agreed worked to a number of organisational safeguarding priorities linked to those of all of our local Safeguarding boards and partnerships. A key priority was to improve the application of the Mental Capacity Act (2005) through a programme of training, ward /service level coaching and audit. The MCA audit has extended to include additional wards and departments inclusive of community services.

The aim of the extension was to strengthen and establish an understanding of the MCA application across the NCA as a whole system. This is an ongoing an evolving process.

Regarding the Domestic Abuse Bill (2021) and the government recommendations to employ health based Independent Domestic Violence Advocates (IDVA), the NCA has supported the Domestic Abuse Specialist Nurses to undertake the IDVA training. Successful completion of this training has resulted in the NCA having 2 health based IDVAs, to offer support and advise those requiring this service.

Developments supported by the delivery of NHS Safeguarding contractual standards 2024/25 have improved focus in the communication with GPs by district nursing services where there are safeguarding concerns, reducing gaps in information sharing and fostering effective safeguarding practice. This is to continue through 2025/26.

Rochdale and District Mind

MIND is an independent, local mental health charity who have been providing services to those within the Borough of Rochdale for 35 years!

We are focused on healing and recovery, and supporting people to lead happy, fulfilling lives through a range of services and group sessions.

During 2024/25 Mind increased their Safeguarding Team by appointment of a Deputy Safeguarding Lead. This allows for focus on analysing collected data to identify patterns of need and increase identification and reporting of safeguarding concerns. The safeguarding team have noted a rise of over 60% each year between 2022 and 2024.

In 2024, there was 118 completed forms related to ‘incidents’ and ‘safeguarding’ which represents an increase of approx. 27%. The type of forms now has a significant weighting of safeguarding concerns. No clear rationale has emerged for this shift in weighing of type of incident versus safeguarding concerns, but it is something that continues to be monitored and discussed with our partners.

All RBSAB meetings are attended by either the safeguarding lead or deputy safeguarding lead and Mind will continue to support these arrangements in the future.

Rochdale Council of Mosques

Rochdale Council of Mosques (RCM) has taken significant steps to strengthen safeguarding practice across the borough's Mosque network in line with local safeguarding objectives.

- Policy Development & Implementation
- Each Mosque has formally appointed a Designated Safeguarding Lead (DSL) and Deputy DSL, embedding accountability and clear lines of responsibility.
- Capacity Building through Training
- In June 2024, RCM launched a bespoke safeguarding training programme, tailored to the needs of Mosques and Madrassahs. Over 100 Imams, Madrassah teachers, and Mosque committee members participated in the seminar.
- Partnership & Strategic Engagement
- RCM continues to be a key stakeholder in the Rochdale Borough Safeguarding Adults Board (RBSAB), actively contributing to its strategy and action planning. This ensures the safeguarding needs and voices of Rochdale's Muslim community are represented, influencing borough-wide safeguarding priorities.

Working in partnership mean Rochdale now benefits from a more connected, culturally aware, and resilient safeguarding network, with faith communities actively contributing to the borough's safeguarding objectives.

Caring and Sharing Rochdale

At Caring and Sharing Rochdale, we believe in the transformative power of compassion and support.

We are dedicated to helping asylum seekers, refugees, and other marginalized individuals rebuild their lives with dignity and respect. Our approach is centred around understanding individual needs and providing tailored assistance that makes a real difference.

Caring & Sharing have strong safeguarding governance and systems in place. Our policies explicitly promote the dignity, choice and voice of adults at risk, aligning with the RBSAB's commitment to Making Safeguarding Personal.

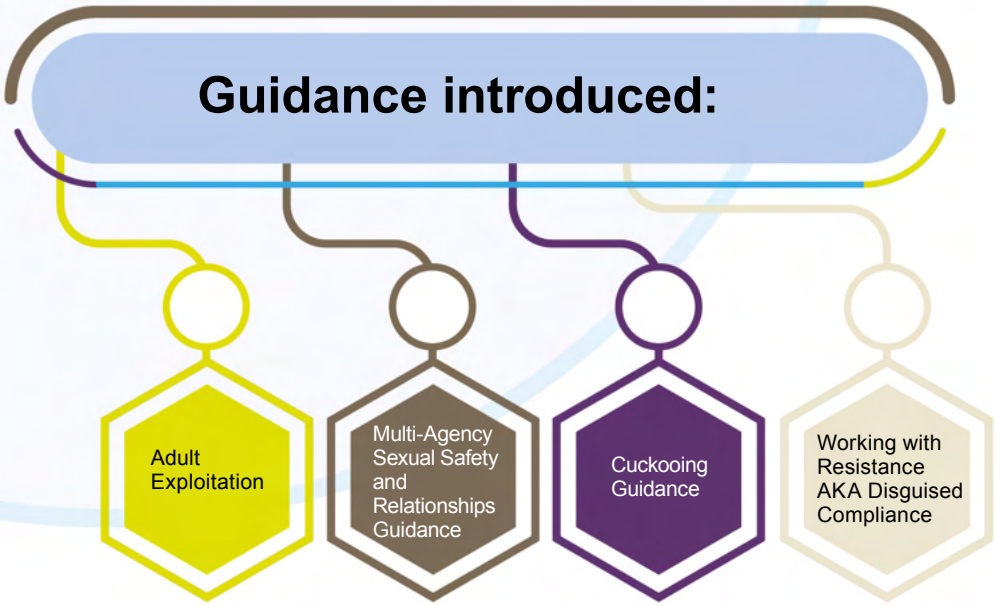
Caring and Sharing Rochdale contributes to the borough's safeguarding ecosystem by providing an additional layer of vigilance and support for 15 vulnerable adults (who have been enrolled into our "VIP Over 60 workshop sessions"), and over 70 children (during our "Holiday Activities for Kids" programme and "Friends of Shamwari" monthly socials) in our community. Our established policies and procedures ensure that concerns are identified early and responded to appropriately through proper channels.

Caring and sharing are a range of planned safeguarding activities for 2025 and 2026, all of which align to the new RBSAB safeguarding priorities.

Learning and Development

RBSAB Confident Practice Subgroup was newly formed in 2024. The new group is led by the Adult Safeguarding Designated Professional of GM NHS ICB. The subgroup has a wide range of agency representation from RBSABs membership. The group first met under new arrangements in November 2024.

The list below describes a number of L&D items developed in 2024/25



The Closed Cultures 7-minute briefing was prompted by learning from a complex abuse investigation focused on concerns relating to children, young people and adults living in the residential care, schools and other settings in Doncaster.

The investigation led to a National Review into safeguarding children and young adults with disabilities and complex health needs. The subsequent report showed a culture of abuse and harm, including evidence of physical abuse and violence, neglect, emotional abuse and sexual harm. There was also evidence that medication was misused and maladministered, an over-use of restraints, and unsafe and inappropriate use of temporary confinement. The children and young adults affected were placed at these homes from 55 local authorities across the country.

The 7-minute briefing was designed to increase practitioners understanding and recognition of organisational and closed culture abuse. It includes an explanation and definition of organisation abuse and information on encouraging best practice

Alongside the development of L&D material, RBSAB also provides free of charge training to any professional working in the Borough of Rochdale. The training offer is delivered thanks to a multi-agency training pool of around 35 experienced practitioners from partner agencies. These professionals generously contributed their time and expertise to deliver high-quality training courses.

The Train the Trainer model continued to flourish, empowering professionals within specialist agencies to deliver targeted training both internally and across the multi-agency programme. This approach expanded the training portfolio to include critical topics such as Violence Against Women and Girls, Intra-Familial Sexual Abuse, Loneliness Reduction, and Cultural Competency.

In 2024–25, the RBSB offered 35 distinct courses, delivered a total of 85 times, covering a wide spectrum of safeguarding themes. These included:

- Domestic Abuse Awareness (including twilight sessions for accessibility)
- Mental Health Briefings on self-harm and suicide ideation
- Substance Use Awareness (new courses on Ketamine, Nitrous Oxide, THC, and Synthetic Cannabinoids)
- Modern Slavery and Trafficking
- Cuckooing/Home Invasion
- County Lines
- Allegations Management
- Cultural Competency

These offerings reflect a responsive training strategy shaped by national and local initiatives, safeguarding reviews, partner feedback, and training needs analysis.

The programme saw 1,013 recorded attendances, with strong representation from:

- Early Help & Schools: 250 attendees
- Voluntary Sector Groups: 99 attendees
- Northern Care Alliance: 76 attendees
- Private Sector Providers: 64 attendees

This broad engagement underscores the programme's accessibility and relevance across sectors.

Mental Capacity Tri-Borough event – October 2024

In 2024, HM Coroner raised concern that issues of self-neglect and the refusal of services by adults were apparent in a number of inquests. More significantly was the importance of documenting detailed mental capacity assessments when an individual declines an intervention that could be potentially lifesaving, such as the decision to decline hospital admission.

In response the Board and in partnership with Bury and Oldham hosted a tri-brough practitioner learning event in October 2024 which was attended by 180 practitioners.

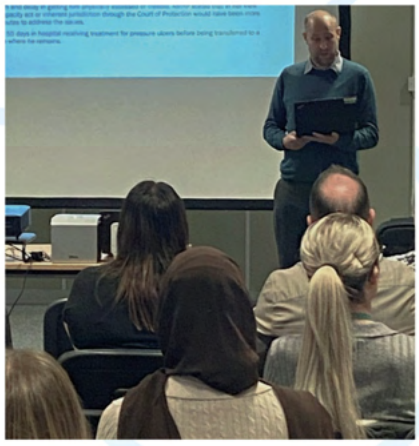
The main speaker was Neil Allen, (Senior Lecturer at the University of Manchester and Barrister) who explored the complexities of the Mental Capacity Act. This included the interface between mental health and mental capacity, the assessment of executive capacity (including impact of alcohol/ drugs on capacity), the level of detail required in the Mental Capacity Act assessments as they become more complex, and much more.

A senior officer from each borough presented a case study together with the identified. The Tri-Borough training was also supported with reference to the “Practical Guide to Assessing Capacity and Making Best Interests Decisions under the Mental Capacity Act (MCA)” which was introduced in August 2024 and “Executive Functioning Guidance” published in June 2025.

> “Excellent training session. Felt there was a lot to learn and carry forward.”
>
> “It’s amazing to have training in the application of MCA in safeguarding and not separate MCA and safeguarding training.”
>
> “I found the whole morning to be good evidence base practice, and the training will support and improve my current practice”

In terms of the impact of training for adults with care and support needs, attendees reported:

> This training has really made me think about considering dignity and giving people the space to make decisions. I will consider these in my assessment planning.
>
> I will be able to advise more confidently around executive dysfunction, and how this relates to mental capacity.



George Mark-Bell, Principal Social Worker and Head of Safeguarding in Rochdale, addresses the event.

Rough Sleeping and Homelessness

In 2024, The Department for Levelling Up, Housing and Communities made a several recommendations to Safeguarding Adults Board regarding rough sleeping. They centred upon SAB's taking a more active presence in system-wide discussions, ensuring that governance mechanisms could hold partners to account in seeking outcomes which promote the integration of experience informed practice into service standards.

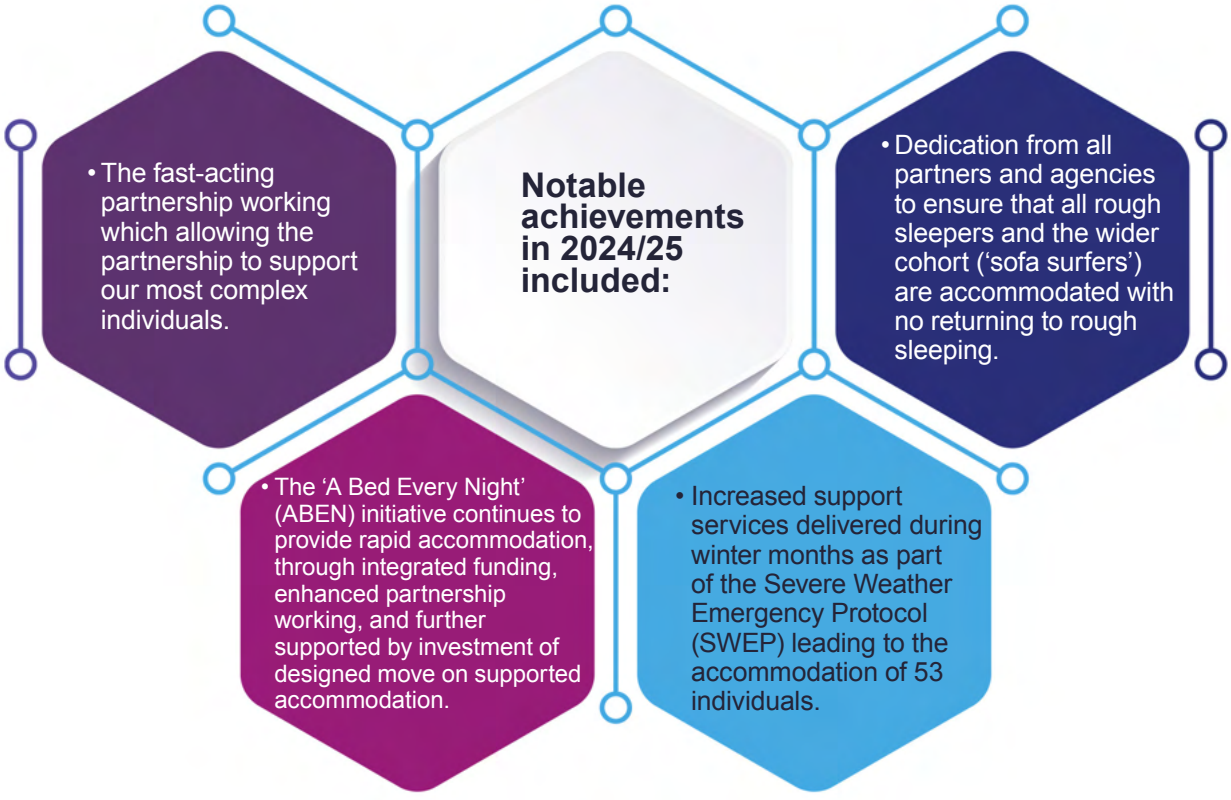
In response, the RBSAB appointed Rochdale Borough Council's Head of Strategic Housing, Hannah Courtney-Adamson, as the named board member to lead and update on the borough's approach to addressing rough sleeping within the wider context of homelessness.

Hannah presented to the RBSAB in March 2025, outlining that rough sleeper numbers fluctuate between 3 and 6 daily and are predominantly single males aged 25 and over. On average 80-90% have substance misuse issues with 60-70% having mental health issues and offending.

The reasons for households becoming homeless included where family / friends were no longer willing to accommodate, domestic abuse, end of a tenancy and leaving an institution with no accommodation available.

The RBSAB were appraised of the Rough Sleeper Strategy and action plan which aims to:

- ensure that no-one new to the streets sleeps rough for a second night
- minimise the flow of new rough sleepers onto the streets
- provide a rapid relief and consistent pathway into accommodation and support services
- ensure that no-one has to return to the streets
- prevent those at risk of rough sleeping
- maximise and maintain partnership working

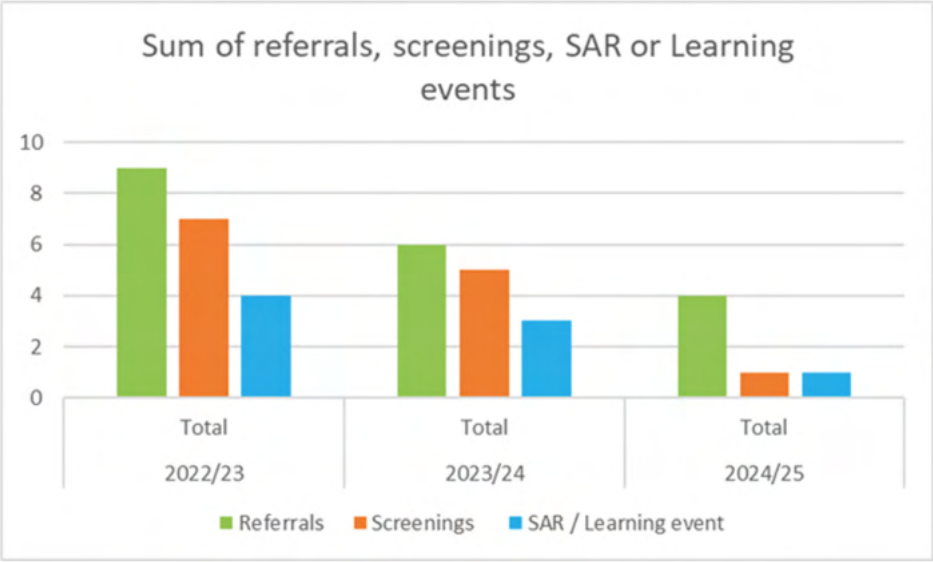


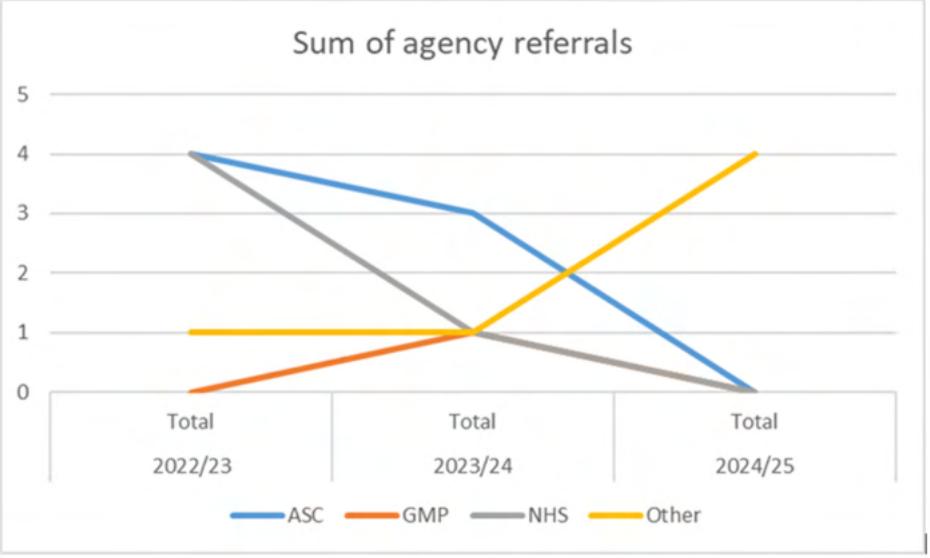
Whilst challenges remain in ensuring there is sufficient capacity and the necessary specialisms within accommodation and support provision to effectively engage with our most entrenched individuals and those faced with multiple disadvantage the RBSAB's focus throughout 2025/26 will be to embed a preventative approach at the earliest possible opportunity.

Safeguarding Adult Reviews

The purpose of a Safeguarding Adult Review is not to reinvestigate or apportion blame but to establish whether lessons can be learned from the circumstances of a case that may improve practice or the way in which agencies and professionals work together to safeguard vulnerable adults. The focus of Safeguarding Adult Reviews, in line with both multi-agency policy and national guidance, is to: learn from past experience and the specific event examined; improve future practice and outcomes by acting on learning identified by the review; improve multi-agency working and compliance with any other multiagency or single agency procedures.

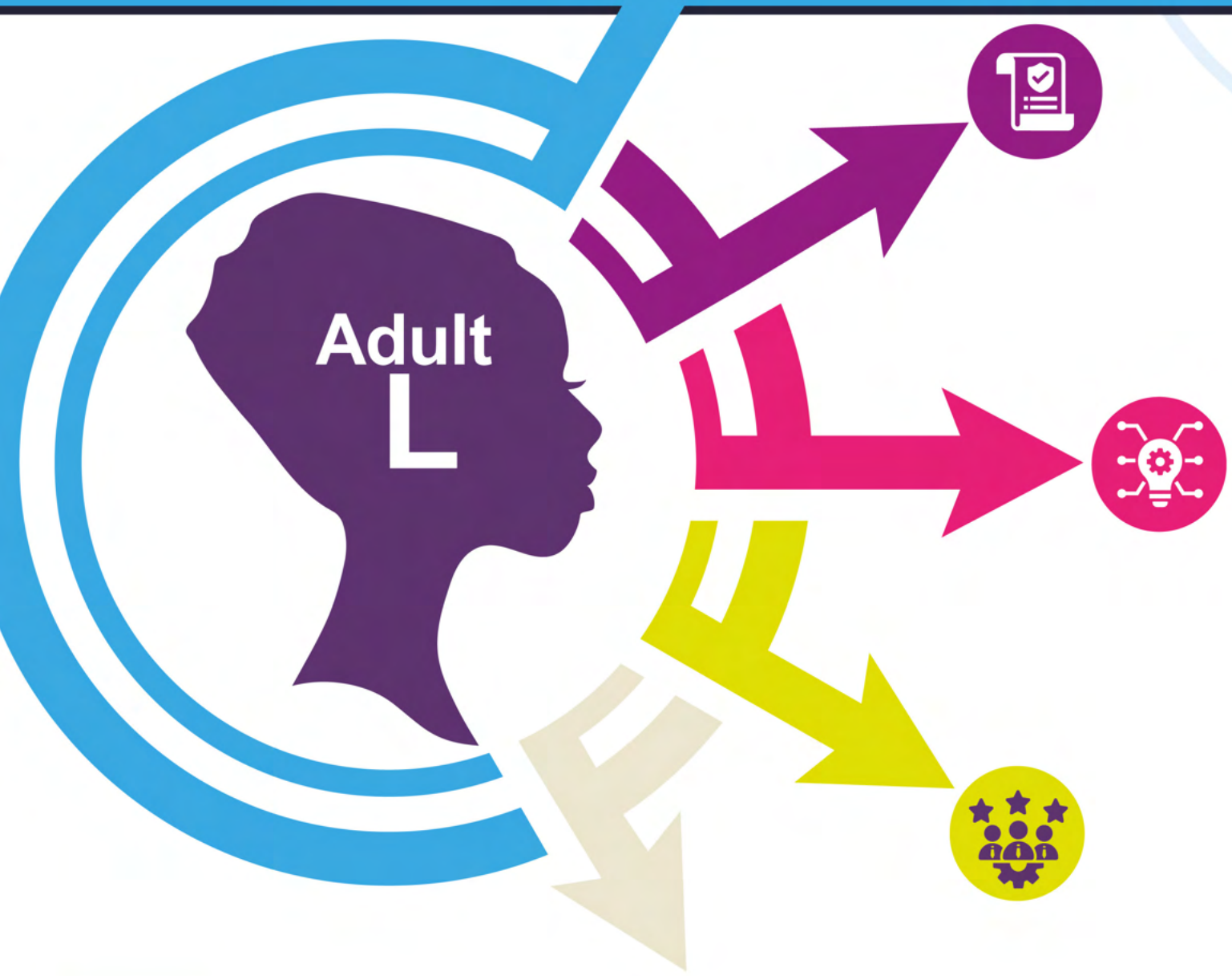
The SAR subgroup underwent significant changes early in 2024, resulting in a change of chairing arrangements. The refreshed subgroup met 5 times between April 2024 - March 2025. The group considered 4 referrals for potential SARs. The subgroup concluded that 3 of the referrals did not meet the SAR criteria, but one did which is titled Adult M. The decisions were ratified by the Independent Chair of the RBSAB.





The SAR subgroup underwent significant changes early in 2024, resulting in a change of chairing arrangements. The refreshed subgroup met 5 times between April 2024 - March 2025. The SAR screening panel considered 4 SAR referrals, concluding that 1 met the criteria (Adult M).

The RBSAB have published two SARs in the reporting year.



Adult L

Adult L came to the United Kingdom with her mother and siblings from Nigeria, to seek asylum when she was around 12 years old. Adult L lived with long standing issues with weight management, low mood and her home was found to be cluttered and untidy. Practitioners struggled to engage during periods of support but noted living conditions had deteriorated. Sadly, in September 2022, Adult L was found deceased in her bed.

Good practice found

- Mental capacity assessments were completed by the District Nurses.
- Rochdale Boroughwide Housing responded swiftly to concerns being raised and visited Adult L's home.
- When Adult L reported that she could not leave the house, a GP home visit was conducted the following day.
- District Nurses were persistent with their efforts to engage Adult L

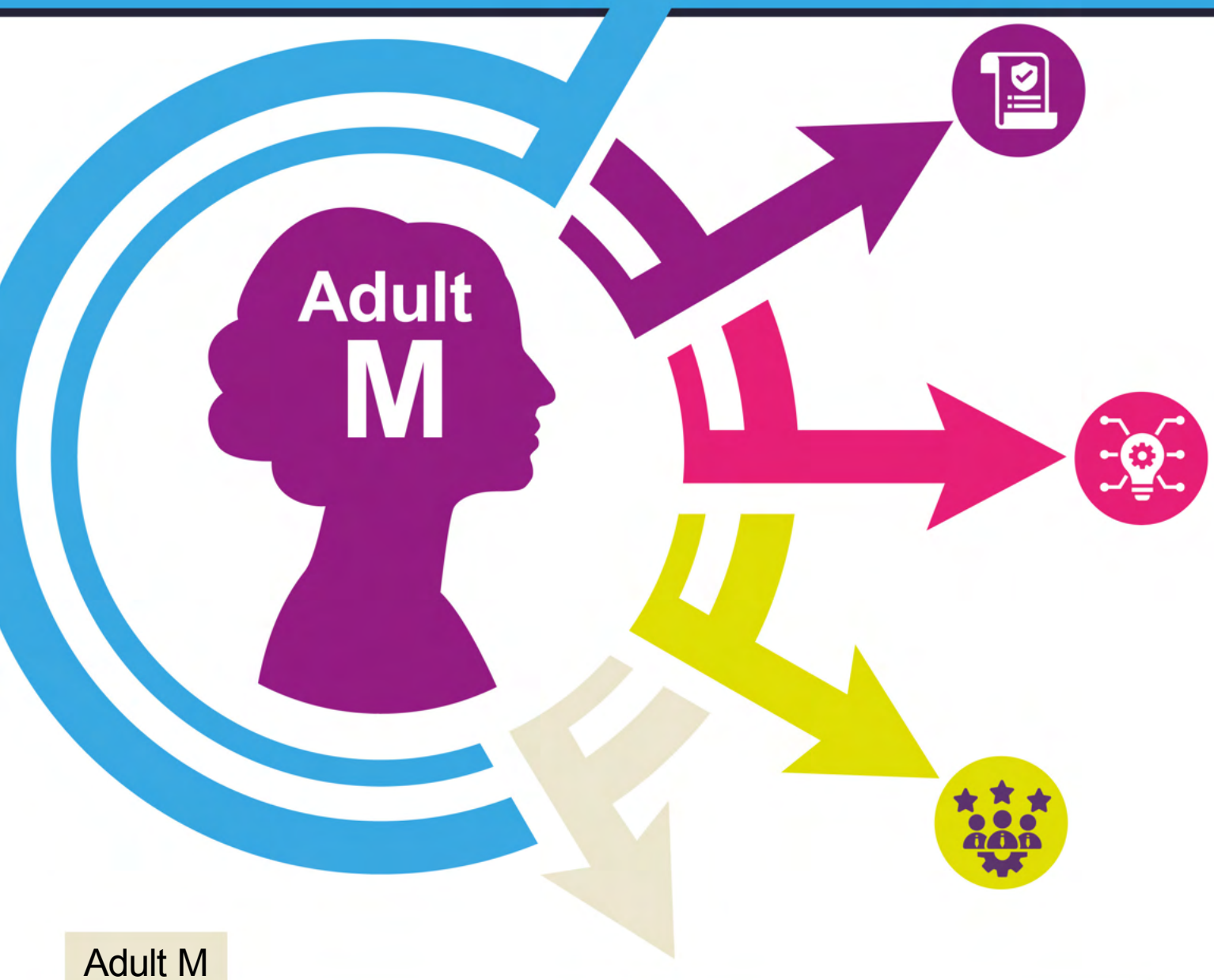
What did we learn?

- As a result of agencies not seeking further information when it became clear that they were struggling to engage Adult L effectively with support, no professional or agency gained a vital understanding of Adult L.
- Practitioners did not consistently apply professional curiosity to practice and as a result no single professional gained a greater understanding of Adult L. This impacted on the level of support offered to Adult L.
- The learning objective of Safeguarding Adult Reviews is hindered if key frontline decision-making professionals do not attend learning events.
- It is important to listen to, educate and possibly challenge patients with extreme obesity who decline services and advice on the importance of weight intervention whist simultaneously respecting their autonomy.
- The Multi-Agency Risk Management Protocol is not being routinely used by professionals, and this is preventing effective multi-agency risk identification and management.

What has changed?

1. RBSAB assured that agencies are incorporating multi-agency meetings into practice to drive best decision-making, particularly with those practitioners are struggling to engage with.
2. RBSAB assured that agencies recognise the importance of enabling practitioners to attend learning events.
3. Rochdale's Public Health's Healthy Weight Steering Group is attended by many agencies and has an effective role in promoting advice and support to agencies to distribute to their practitioners.

The RBSAB have published two SARs in the reporting year.



Adult M

Adult M was an 83-year-old woman of white British ethnicity who lived in the UK. She was diagnosed with cancer in 2013, and her three adult children supported her wish to remain in her own home. Her care was managed by the nutrition and dietetics team, and in 2019 she received a gastrostomy tube.

In June 2022, signs of cancer progression led to her being placed on a palliative care pathway, with regular reviews addressing her complex needs. In November 2022, she was admitted to hospital due to diarrhoea and vomiting, and her feeding regime was incorrectly documented, resulting in a nutritional deficit.

Adult M was discharged to a local nursing home instead of her preferred intermediate care placement. The discharge process had missing and incorrect documentation about her feeding regime. Despite efforts from a CHC nurse and concerns raised by her daughter, the nursing home did not act promptly to correct the feeding plan. Adult M experienced multiple falls and a noticeable decline in health, eventually being readmitted to hospital, where she was found to be dehydrated and in kidney failure. Safeguarding referrals were made but closed without formal investigation. Despite receiving treatment, Adult M's condition deteriorated, and she sadly passed away 17 days after her readmission.

Good practice found

- Staff referred to the Abbott Nurse Team when there were issues with the feeding tube, these are specialist staff who provide education and support for carers with the management of feeding tubes.

What did we learn?

- Some staff on the hospital ward did follow the community regime rather than the EMPA when administering feeds however this ongoing error in the prescription was not communicated effectively to allow it to be corrected during this inpatient episode.
- Co-ordination of the hospital discharge was poor with the wrong feeding regime being sent with Adult M on her transfer to the nursing home. There was poor communication between the ward staff and the Transfer of Care Team over discharge planning.
- The hospital has undertaken a serious incident investigation following the discharge of Adult M to the Nursing Home. Several actions have been identified as a result which include a review of dieticians checking feeding regimes are correct as part of discharge planning, and a review of how the Transfer of Care Team co-ordinate hospital discharges and communicate with CHC and ward staff.
- The feeding regime was posted out to the nursing home but didn't appear to arrive. Agencies to agree a process that allows for e-mail transfer of information securely between hospitals and Care Homes that is GDPR compliant to prevent future delays in communication.
- There was a lack of clear leadership and communication in the Nursing Home, the failure to follow up the lack of receipt of the correct feeding regime from the hospital should have been addressed in the first 24 hours following transfer.
- Staff at the home appeared not to be familiar with the management of the gastrostomy tube and the requirement for water flushes pre and post feed.
- Framework is quality assured and to identify if there are any other Nursing Homes that report staff requiring training in the management of enteral feeds.
- ASC did not report back to the referrers what the outcome of their safeguarding referrals were.

What has changed?

1. Since the incident NCA has created a Quick Reference Guide (QRG) for Enteral Feeding via Gastrostomy & it's Prescription at Rochdale Infirmary (ME60 V1). Acute Link Nutrition Nurse Forums have been established, which take place quarterly, providing a forum to discuss governance and training including that relating to enteral tube feeding at Rochdale Infirmary.
2. ASC has daily discharge meetings with NCA, Hospital Discharge Team consider CHC funding and CHC alerted for all CHC funded patients being discharged. As well as links with hospital discharge teams, ASC has a Brokerage Team to lead on placements with improved communications with providers.
3. Following Serious Incident investigation, a root cause analysis of the contributory factors has been addressed with an action to reduce the likelihood of the issues recurring, this has been input into a Trust action plan.
4. Dedicated hospital discharge hub in place to ensure consistency in approach to discharge planning and communication. Assessments owned by the hospital hub with support of the brokerage team to source appropriate placements.
5. Employment of permanent member of staff in ASC Commissioning 'Care Market Training Coordinator' to signpost and guide.

Thematic Review of SARs

Also in 2024, the RBSAB commissioned a thematic review of SARs. The purpose of the review was to understand the causation of persistent repetition within recommendations of local Safeguarding Adult Reviews. The thematic review consisted of a 4-year snapshot which considered both completed SARs and new referrals.

A key finding of the report was local professionals were not always aware of the resources available to them which assist in navigating assessment, planning and associated risk management of adults with identified support needs. This is predominantly agencies “working in silos” and not with partners under agreed RBSAB policies and process.

The sub-themes of key finding were:

- Lack of resource usage in Mental Capacity, Executive Capacity and Mental Health.
- Lack of knowledge of local, multi-agency, risk mitigation processes such as Escalation, MDT and MRM.
- Lack of considering an individual’s unique experiences in assessment rooted in an absence of adult voice, involving wider family members or finding engagement difficult.
- An emerging lack of cultural competence when considering rising incidences of non-white British SARs.
- Missing evidence of advocacy.

It is important to consider as part of this report that good practice within many of the themes identified did take place to a high professional standard. Good multi-agency working was often found.

Post the review, RBSAB has undertaken activities to address the findings. The activities range from agreeing a refresh pathway for MRM / MDT processes via multi-agency policy review. Agreeing a set of multi-agency principles to ensure all local partners work in a “Team around the Adult” way, which ensure making safeguarding personal is the expected standard of all practice. Creation of documents that highlight the resources available in one place to ensure simplicity of access for multi-agency professionals. Also, L&D development of promotion of training and learning within the topics of Professional Curiosity and Cultural Competence.

The RBSAB activities from the Thematic Review of SARs will continue in 2025/26.



Strategic Plan 2025-28

Our strategic plan for the next 12 months and beyond is the most ambitious work programme the Board has ever had. It reflects our vision to be outstanding and is routed in ensuring that adults with care and support needs and lived experience influence our activity as well as practice, policy and procedure.

In doing so, we recognise the value in truly understanding their journey, the impact of harm and abuse on them and more importantly the hidden cost. We are excited about the impact the Board can have over the next 12 months and look forward to working with adults, carers, staff, practitioners and the wider community across Rochdale Borough.

Long Term Vision

Together we will be outstanding in ensuring that adults across Rochdale Borough with care and support needs live safely, free from harm and abuse, and are able to make their own choices.

Long Term Strategic Priorities

Prevention

We will work our partners to ensure we understand the key themes, issues and risks relating to adult safeguarding across Rochdale Borough developing preventative responses and early intervention.

Engagement

We will ensure the voice of our customers, staff, and wider communities is heard and influences how we safeguard adults at risk of abuse and neglect across Rochdale Borough.

Confident Practice

We will learn from experience to ensure our staff are knowledgeable and confident in their adult safeguarding roles and responsibilities.

In line with the above three strategic priorities there are a total of 32 actions that are planned for 2025-28. This will include: developing the voice of those adults with lived experience, engaging with seldom-heard groups, effective delivery of prevention campaigns to raise awareness of adult safeguarding themes and issues and strengthened assurance of safeguarding related activity by partners.

We will also review our multi-agency training offer for staff and practitioners to ensure it remains and a relevant and accessible. This will be underpinned by our new quality assurance and evaluation system introduced in 2025. We will focus on areas including cultural competency, financial abuse and Achieving Best Evidence ensuring that our training offer aligns more closely with strategic safeguarding objectives.



Worried about an adult

Please call 0300 303 8886 to speak to someone in Rochdale's Adult Social Care about your concerns or email adult@rochdale.gov.uk

If you feel an adult is in immediate danger please call the Police on 999

RBSAB
ROCHDALE BOROUGH
SAFEGUARDING ADULTS BOARD