Wigan Safeguarding Adults Board Annual Report

Reporting Period
April 2023 – March 2024

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Foreword

Dr Suzanne Smith, Independent Chair, Wigan Safeguarding Adults Board

It gives me great pleasure to present the Wigan Safeguarding Adults Board (WSAB) Annual Report for 23/24, and the second annual report for me as Independent Chair. It's been a busy year for all partners around the Safeguarding Board, with lots to celebrate, and lots of challenges that we continue to work together on and support each other to solve and address.

It was a busy year for me as Independent Chair, and also a real pleasure as I continued to work with colleagues in the partnership beyond just the Board level. This has demonstrated even more, what an honour and a privilege it is to work with such a focused, passionate, professional and collaborative partnership. It is truly refreshing to see the work and outcomes generated by this Board and their determination to improve the lives and prevent abuse of adults at risk in Wigan.

2023/24 saw the partnership refresh its core Adult Safeguarding Procedures that underpin our overarching Policy. When we looked at the refreshed procedures, it was clear that the thought and work that had gone into reviewing our existing approach benefitted from being developed by a wider set of partners outside of just the local authority; co-production isn't just a term in Wigan, it's valued, and it happens.

On that note, one of the most exciting developments we had the pleasure to support and be part of at a Board level (and another example of true co-production) was the launch of the What's Up Champion Network. There's more on this in the report, but I was honoured to be asked by the champion network to come and help them celebrate their launch in October.

It was genuinely inspiring to hear from all the champions about why they wanted to be a part of the safeguarding partnership family and champion safeguarding in their own services. I know they'll go from strength to strength, and we're all committed from the Board level to help them achieve their aims. I'm really excited about how the group will help us review, refresh and develop new policies, processes and interventions shaped and influenced by them. I couldn't resist putting a photo from the day in, of partners with all our champions.

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We continued to learn from both our quality data analysis and case reviews where we've got issues in the safeguarding system that need addressing. You'll see within the report that self-neglect is both the highest thematic safeguarding type that's reported to the local authority, and that the complexity of cases is something we need to help practitioners address in new ways. Whilst we continued to develop policy and pathways in 23/24, we'll need to think creatively about how we continue to address this area into 24/25. Piloting new ways of working will be key and the report details what some of these will look like.

We continued across 23/24 to provide an assurance role at Board level, whilst some of this entailed asking partners to present updates and issues that may affect how services keep people safe, we always do so in a supportive and collaborative way, with a view to mutual problem solving. The report details what some of those were and my commitment to continue to support partners in addressing these issues continues.

Finally, the report details work we'll undertake across 24/25, I'd just point out some key ones that are important to me in addition to the self-neglect challenge highlighted above.

I'm committed to embedding and formalising our approach to quality assurance, and we've started doing some key things in 23/24 that we'll continue to expand on into 24/25. Making sure we get the voice of the service user at Board level is something that we've started to do, initially through the lens of good practice stories, and when we do, it's powerful. I'm committed to continuing to do this, as we formalise our "floor to board" framework about where partner data and assurance can help us understand both how we're achieving outcomes for people, as well as common issues that we can address together.

In April 24 we all came together as a partnership to discuss how we embed a culture of safeguarding all the way across our health and social care settings, and how the PRISIM model can help address some common themes we're seeing at Board around safer employment.

That is a small snapshot of the collaborative work that is included in this report. We are constantly horizon scanning and developing our focus in this ever-changing safeguarding landscape to ensure we are providing the best safeguarding services to our population as we possibly can. It's been a busy year, and I suspect next year will be the same as we strive to improve outcomes for adults at risk.

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Dr Suzanne Smith PhD
WSAB Independent Chair

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About the Wigan Safeguarding Adults Board

The Wigan Safeguarding Adults Board (WSAB) is made up of a partnership that agrees on how different services and professional groups will work together to safeguard adults at risk of abuse or neglect across the borough.

The Board oversees all organisations in Wigan and Leigh that work with adults at risk and have a responsibility to ensure the safeguarding system works well to protect them.

WSAB Statutory Duties under the Care Act 2014

- It must publish an evidence based strategic plan for each financial year that sets out how it will meet the above objective and what each member will do to achieve this.
- It must publish an annual report detailing what the Safeguarding Adult's Board (SAB) and each member has done during the year to achieve the above objective and implement the strategic plan and detail the findings of any Safeguarding Adults Reviews that have taken place.
- It must conduct any Safeguarding Adults Reviews under Section 44 of the Act.

Our Vision

That residents of the Wigan Borough can live safely, free from harm, and abuse or the fear of abuse, in communities which:

- Have a culture that does not tolerate abuse.
- Work together to prevent abuse.
- Know what to do when abuse happens.
- Are confident that the WSAB is making a difference.

Principles of Safeguarding Adults

The six principles of safeguarding adults that the WSAB work to are empowerment, prevention, proportionality, accountability, protection and partnership.

The six principles of Safeguarding Adults are:

1. **Empowerment**

'People being supported and encouraged to make their own decisions and informed consent.'

2. **Prevention**

'It is better to take action before harm occurs.'

3. **Proportionality**

'The least intrusive response appropriate to the risk presented.'

4. **Protection**

'Support and representation for those in greatest need.'

5. **Partnership**

'Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.'

6. **Accountability**

'Accountability and transparency in safeguarding practice.'

Our Strategic Priorities, Objectives and Delivery Framework

By default, new tables in the document will have this style applied:

Priority	Objective
Accountability, Assurance & Leadership	"Wigan has an effective Safeguarding Adults Board which fulfils its statutory responsibilities, has strong leadership and governance arrangements, and promotes a culture of collective accountability, respectful challenge and continuous learning"

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Quality Practice, Learning & Improvement	"Services & staff are learning and improving in their safeguarding practice and adult safeguarding risk is better understood by WSAB and appropriately assessed by partners."
Policies, Strategies & Procedures	"Our partners work within a framework of policies and procedures that keep people safe."
Early Intervention and Prevention	"Adults at risk are identified early and have their needs met promptly and effectively

We deliver an annual plan of activity through our agreed delivery and governance framework, and you can read a copy by clicking here or on the full URL below.

https://www.wigansafeguardingadults.org/The-Board/Strategic-plan.aspx

For this reporting period our plan was 2022-2024.

Achievements 2023/2024 – Future Work 2024/2025

Strategic Priority 1 - Accountability, Assurance & Leadership –

Ambition - Wigan has an effective Safeguarding Adults Board which fulfils its statutory responsibilities, has strong leadership and governance arrangements, and promotes a culture of collective accountability, respectful challenge, and continuous learning.

Key Delivery Groups – WSAB Board, Executive Group and Delivery Group Framework Plans

We planned and undertook a peer review with colleagues from Norfolk Safeguarding Adults Board. The review was developed to provide key feedback on strengths and areas for development based on a methodology set out below.

June 2023	'Long list' of potential areas for review exchanged
July 2023	'Short list' of review topic agreed: • Board effectiveness • Identification and management of risk • Board engagement
October & November 2023	Self-assessment completed & exchanged.
November 2023 to April 2024	• Peer review activity: Observations of meetings (operational & strategic) • Structured / Semi Structures interviews with both strategic leaders and frontline • Desktop review of policies • Sharing of key documents regarding learning and improvement products / process 5 cases peer audit / tracking S42 / multi-agency / tracking methodology)

The peer review results were presented back to the Board just outside the 23/24 reporting period of this report, the outcomes will be used to refresh the WSAB overarching strategy in Autumn 2024 as this finishes at the end of 2024. Appendix 5 summarises the results of the peer review.

The board continued to provide an overarching governance function regarding partner progress and activity through discussing and signing off strategies, annual reports, risk issues highlighted and individual agency results from regulatory inspections. This included:

- NHS Greater Manchester Annual Safeguarding Report
- Northwest Ambulance Service Annual Safeguarding Report
- Learning from Lives and Deaths, people with a learning disability and autistic people (LEDER) Annual Report
- Key findings from the NHS Independent Review of Greater Manchester Mental Health (GMMH) Trust
- Wigan Borough Suicide Prevention Strategy

Work to update our Learning Outcomes Framework continued and in 23/24 this gave us the ability to identify thematic areas across multiple case reviews that require assurance at the Board level. In November we undertook assurance around how the Mental Health Transformation Board is addressing mental health crisis interventions in the community through the Live Well pilot, introduction of crisis cafes and I the introduction of a mental health streaming pathway for people attending A+E with a mental health crisis. Work will continue to keep using the framework to account for larger scale system change actions from case reviews across 24/25.

The Business Unit underwent a review and from March 2024 will be fully staffed with new posts in place. Additionally, the Business Unit took on management of the adult's customer relations function, across 24/25 connecting this work to the Board will be key.

The Business Unit implemented new governance and accountability pathways regarding partners use of the escalation policy; within the new framework, all resolution issues notified to the Business Unit will be reported into the Executive Group to ensure that the issues have been dealt with, and that any learning to avoid future repetition of the same issue is avoided.

Managing Identified Areas of High Risk to Vulnerable Adults

The partnership continued to develop and strengthen its Risk Management Framework to enable the WSAB and Independent Chair to identify, manage and where required work collectively and supportively to address safeguarding adult risk issues.

The process involves identifying and then scoring against the impact the risks could have on people accessing or needing those services. Risks are identified through a mix of external partner inspection outcomes, WSAB learning and improvement activity (such as case reviews or quality audits) or a mix of both. Often a partner will bring an emerging issue that they are concerned about but want to highlight as needing a partnership response to address.

The WSAB Board itself manages those that score highly and support partners in identifying and implementing a risk mitigation or response plan.

Key areas of high risk identified and managed the Board and its partners across 23/24 are summarised here including a summary of action taken to reduce the risks.

Our risk description and effectiveness to mitigate risks as a partnership has enhanced in this reporting cycle.

Risk Areas	Response
If we have high waiting lists for assessment from the Deprivation of Liberty Safeguards (DOLs) service, there is a risk whereby we have people living without a legally authorised deprivation and lacking the appropriate safeguards for their current care or treatment. Impacting the Local Authority in the following way; 1. Reputational damage 2. Risk of Human Rights Claims being raised and potential Local Government Ombudsman (LGO) or financial punishment	To reduce the likelihood of this risk occurring the following actions have/will be taken; 1. Jan 24 Best Interest Assessor rota is back in place for locality BIAs 2. Increased the internal DoLS team to 4 Full time equivalent Best Interest Assessors plus 2 full time Advanced Practitioners. 3. Commissioned external agency to complete 300 assessments - completed in Sept 2024 4. Reviewing team processes to minimise short authorisations and unnecessary duplicate actions

3. Care Quality Commission (CQC) Inspection highlighting waiting list issues	
If S140 framework is not embedded there will be risks to the individual which include high level risks of self-harm and reputational risk to agencies responding to crisis. Impacting on the Local Authority and Greater Manchester Mental Health (GMMH) in the following way; 1. Reputational Damage 2. Risk to service users	To reduce the likelihood of this risk occurring the following actions have/will be taken; 1.S140 policy is now live as of 22/07/24 and provides consistent framework from bed identification, escalation of bed options and risk management / support plan in the community. 2. Monitoring is being collated by Adult Social Care (ASC) and fed into the Blue Light Delivery Group under the Mental Health Transformation Board.
If Section 117 of the Mental Health Act 1983 is not utilised vulnerable adults may miss vital after-care following being detained under s. 3 of the Act (or certain other provisions), and then discharged from hospital. Impacting on Local Authority and Integrated Care Boards (ICB's) in the following way; 1. Failure to comply with Statutory guidance 2. Risk to Vulnerable adults 3. Reputational Damage	To reduce the likelihood of this risk occurring the following actions have/will be taken; 1. S117 audit complete which has identified a number of areas for improvement and recommendations. 2. S117 policy has been adhered to and compliance will continue to be monitored. Further follow up audit in 6 months. 3.Local Authority (LA) training completed. GMMH / ICB training in planning stage. 4.S.117 Dashboard being developed. 5.Review of S.117 planned for 1st November 24.
If there is an increase in the number of referrals to the Wigan Attention Deficit Hyperactivity Disorder (ADHD) service, there will be risks that patients will not be able to access treatment and assessment within the 18 week target. Impacting on GMMH and Wrightington, Wigan and Leigh Teaching Hospitals	To reduce the likelihood of this risk occurring the following actions have/will be taken; 1. Waiting list management plan in place to ensure all patients referred to the Wigan ADHD service are aware of their referral status and how to contact the service.

NHS Foundation Trust (WWL) in the following way; 1.Patient care and safety 2.Increase in complaints 3.Reputational damage 4.Impact on staff well being	2. Staff supervision plan in place to ensure staff have access to regular management and clinical supervision every 8 weeks 3. Staff appraisal plan in place to ensure staff have access to an appraisal conversation every 12 months 4. All staff have a wellbeing action plan in place to support keeping well in work. 5. Job plans developed for clinical staff to support diary management. 6. Did not attend (DNA) management plan implemented to reduce the occurrence of appointments not attended. 7. DNA management plan implemented to ensure safe and appropriate plans are in place following appointment non-attendance. 8. Business continuity framework in place; initial assessments are not currently being offered while caseload work is prioritised. 9. Automatic email response is sent when an email is received into the ADHD inbox to provide assurance that a referral or query has been received and will be actioned. 10. 'Keeping Well' leaflet is sent to the patient with their welcome letter. 11. A welcome letter is sent to the patient to advise we have received their referral and they have been accepted to the ADHD service waiting list. 12. We are awaiting the Greater Manchester Strategic review on how

	this demand and capacity will be managed
Due to insufficient mental health inpatient bed capacity this could lead to risk of harm from patients needing inpatient care. Impacting on WWL and GMMH in the following way; 1.Failiure to provide timely access for mental health bed for the community and Royal Albert Edward Infirmary (RAEI).	To reduce the likelihood of this risk occurring the following actions have/will be taken; 1. Daily patient flow meeting to clinically review all admissions to hospital 2. 4hr response time to discharge a patient from mental health liaison that is in A&E 3. Up to twice daily safety huddles to review patient flow 4. Up to twice daily safety huddles to review patient flow 5. Requirement of 95% gatekeeping assessments to review requirement for an admission 6. Go Live of the interim mental health streaming area within RAEI 7. Weekly multi-agency discharge events 8. Work continues with system partners to review existing service specifications for mental health providers and identify opportunities to increase availability of supported accommodation based on need.
Ministerial changes to legislation relating to Standard Determinate Sentences (SDS), which would result in the overall amount of time spent in custody (eligible prisoners) reducing from 50% to 40%. Impacting on criminal justice and social care organisations in the following way; 1. For the initial Tranches possible risk of demand prior to Business as usual.	To reduce the likelihood of this risk occurring the following actions have/will be taken; 1. Numbers are managed by Probation who will work to ensure there is a robust resettlement plan in place, which initially will have shorter time scales but will result as Business as usual after the 2 tranches.

2. Risk to victims, however mitigated through National Probation Service (NPS) actions.	
If demand on services continues to significantly increase with higher numbers of homeless applications, homeless assessments, duty to accommodate and those requiring temporary accommodation as well as an increase in those entering drug and alcohol treatment and mental health support. Impacting on Local Authority, GMMH and We Are With You (WAWY) in the following way; 1. Increase in numbers rough sleeping or those living in unstable accommodation settings. 2. Individuals not receiving appropriate community support or access to inpatient provision to meet level of complexity. 3. Individuals bed blocking in hospitals as no suitable support and accommodation available at point of discharge	To reduce the likelihood of this risk occurring the following actions have/will be taken; 1. System capacity in place to support individuals requiring support and specialist provision. 2. System partners empowered to shift to early intervention and prevention support where possible.
If availability of accommodation across the system continues to be a challenge for the local authority and the wider partnerships, there is an ongoing risk that the increased demand and limited capacity for both general needs and commissioned supported and specialist accommodation will impact on the Local Authority, Greater Manchester Mental Health and We Are With You in the following ways; 1. Individuals not receiving appropriate support and accommodation to meet their needs in community. 2. Individuals bed blocking in hospitals as no suitable support and	To reduce the likelihood of this risk occurring the following actions have/will be taken; 1. Increase in supported accommodation options 2. Increase in private rented sector options 3. Recruitment to Specialist Accommodation Support Workers 4. Sustainable Temporary Accommodation Arrangements

accommodation available at point of discharge 3. Increase in numbers rough sleeping or those living in unstable accommodation settings.	

Forward Planning 2024/2025 –

- Focus on reviewing and refreshing those areas of work identified within the Norfolk Peer Review including:
    - Strengthening our risk register framework with a focus on thematic areas that require genuine partnership collaboration rather than single agency risk (whilst acknowledging that partners are still required to report those risks into the partnership).
    - Continue to compile a meaningful set of partner data that links to our overarching objectives or important areas of work identified in case reviews and wider learning and improvement activity.
    - Focus on improving core practice around re-occurring themes of the Mental Health Act assessments / capacity assessments, professional curiosity, self-neglect.
- Building on the work of the Mental Health Tier Pilot, Quality of Safeguarding Referral insights and the increasing number of safeguarding referrals that are reported to Adult Social Care / discharged at an early enquiry point, WSAB will pilot a new approach to managing risk and complexity from alert stage and regarding referrals to Adult Social Care that are described as “discretionary adult safeguarding enquiries” with Section 42 of the Care Act. Alongside this work.
- Capitalise on all our quality and assurance work and produce / agree an overarching Quality Assurance Framework for all partners to sign up to.
- Develop a meaningful partnership self-assessment as part of the quality assurance framework and that can inform the refreshed overarching WSAB Strategy and priority setting.
- Refresh our delivery group framework and ensure they are focused on the right priorities with accompanying deliverable action plans,

including reconfiguring our overarching strategy which finishes at the end of 2024.

- Further strengthen our Performance and Insights Framework to enable the Executive and Board to identify key areas of success or those that require further analysis from a wider set of partner data sets.

Strategic Priority 2 - Quality Practice, Learning & Improvement

Ambition - Services & staff are learning and improving in their safeguarding practice and adult safeguarding risk is better understood by WSAB and appropriately assessed by partners.

Key Delivery Groups: WSAB Executive Group and Learning / Quality Assurance Delivery Group / Wider Delivery Groups
Objectives:

- Consolidate existing learning and impact of actions taken from Brief Learning Reviews (BLRs)/ Serious Adult Reviews (SARs)
- Implement refreshed workforce development plan and impact on practice / safeguarding outcomes.

- Across 2023/24 we focused our quality assurance work on key areas such as quality and appropriateness of adult safeguarding referrals. This was identified as a key area following findings in both previous audits and case reviews that highlighted.
    - A high percentage of closures at early stage of Section 42 enquiry were due to either lack of appropriate information,
    - lack of eligibility regarding Care Act (noting that provision within the act itself regarding “discretionary enquiries”) and
    - lack of a preventative approach in referring agencies (and reliance on Section 42 processes to facilitate and co-ordinate safeguarding enquiries.
- The audit took place over a series of meetings with a focus on a single agency each time, led by a senior manager from that agency. The audit identified key actions from both a single agency and partnership perspective and a resulting action plan which is now complete.
- The audit also strengthened the rationale for continuing to pilot the Safeguarding Mental Health Tier Pilot (on both an acute ward and the Late Life and Memory Service (LLAMS) within Greater Manchester Mental Health Trust). The underpinning principles that address the point above regarding an early intervention approach within single agencies to manage low level quality / safeguarding issues and to stop further escalation (please see forward planning section for work scheduled to take place in 24/25 regarding this)

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- Our work continued ensuring that our newly developed Learning Outcomes Framework (LOF) both drove accountability regarding completing learning actions from case reviews and could identify common areas of learning, with themes and outcomes being analysable to inform the prioritised work of the WSAB and framework.
- From November 23 we therefore began to ensure the Board directly undertook a governance role regarding the actions contained within the LOF (and throughout the delivery framework). This began with governance and assurance around GMMH's new community service / pilot Live Well Service as it appeared in two Safeguarding Adult Reviews as a key transformational action. The Board were provided with an overview and assurance that the pilot would be modelled across the borough across the next eighteen months and will receive more outcomes assurance as this key service develops.
- We continued to embed our workforce development offer across the partnership and refreshed out overarching workforce development strategy and offer which you can read here:

Learning and development (wigansafeguardingadults.org)

- Based on Key findings from case reviews and audit activity our evidence – based training offer continued to be rolled out. We continue to provide a blended mix of training (Face to Face and virtual) including expanding our lunch and learn sessions for practitioners. Below are those courses delivered in 23/24.

  ✓ Understanding Hoarding = 41

  ✓ Best Practice Hoarding = 50

  ✓ Hoarding Awareness = 180

  ✓ Level 3 Safeguarding Adult's = 199

  ✓ Professional Curiosity = 101

  ✓ Trauma and Resilience Level 2 = 118

  ✓ Section 42 Training = 39

  ✓ Tier Training = 560

  ✓ Eyes and Ears Training = 192

  ✓ Lunch and Learn: Carers and Safeguarding = 9

- ✓ Lunch and Learn: An Introduction to the SAVED Model of Domestic Abuse = 124
- ✓ Lunch and Learn: Hoarding/Clutter Toolkit = 56
- ✓ Lunch and Learn: Hoarding Awareness = 52
- ✓ Lunch and Learn: Predatory Marriage = 101
- ✓ Lunch and Learn: Resolution Protocol = 127
- ✓ Lunch and Learn: Self-Neglect = 204
- ✓ Lunch and Learn: Stop Loan Sharks and Financial Crime = 43
- ✓ Lunch and Learn: What is the Victim Really Saying? = 14
- ✓ Overall Total number of Attendees = 2,210

Forward Planning 2024/2025 –

- Further work to ensure all case reviews and wider learning and improvement activity is captured within our developing Learning Outcomes Framework
- Develop and implement our overarching Quality Assurance Framework which in 24/25 will include a framework for partners to assure the Board that they have in place effective safe policies' practice and systems regarding adults at risk of neglect or abuse, as well as a culture of safeguarding rooted in person centred approaches.
- Work on developing a broader performance outcomes framework that incorporates partner data and outcome intelligence.

Strategic Priority 3 - Policies, Strategies & Procedures

Ambition - Our partners work within a framework of policies and procedures that keep people safe.

Key Delivery Groups – WSAB Board, Executive Group, Self-Neglect and Mental Capacity Act (MCA) / DOLS Delivery Group, Organisational Safeguarding Work Stream,

- The WSAB developed, agreed and implemented a refreshed set of overarching Adult Safeguarding procedures to strengthen practice within the partnership regarding statutory safeguarding enquiries as set out within the Care Act. (WSAB Safeguarding Adults Procedure (wigansafeguardingadults.org))
- The procedures were developed with consultation and participation of core Board partners at WSAB Executive and Learning and Quality Assurance Group, but also with wider health and social care providers through newly established Safeguarding Provider Forums (extra care, domiciliary care, residential and care homes). For the first time the policy and procedures incorporate the Wigan Safeguarding Tier Framework to ensure that our prevention process better and seamlessly connects with our statutory responsibilities under Section 42 of the care Act.
- The Organisational Safeguarding Delivery Group continued work on completing a system wide set of guidance and tools for all organisations regarding preventing, managing and reporting pressure ulcers. They also continued to oversee performance reporting around the Falls Strategy signed off in the previous year.

- The Self Neglect / MCA / DOLS group refreshed the partnerships Hoarding toolkit and began a refreshed series of training sessions to raise awareness and build confidence in professionals identifying it and supporting individuals.
- The Business Unit undertook a series of lunch and learn sessions in order that a wider set of professionals were aware of and confident in raising concerns about the care, support and safeguarding of individuals through our refreshed resolution protocol.
- The Vulnerable Adult Risk Management pathway continued to be embedded within the Multi Agency Public Protection Team (that sits within Adult Social Care's Safeguarding Team). Within 23/24 work also began on planning a broader partnership response to risk and complexity with colleagues from the Partnership Prevention Hub and the broader partnership. The objective is to design and implement a tiered pathway for people who are referred under Section 42 but are not "eligible under the Care Act" but still require support (these are described as discretionary safeguarding enquiries within the Care Act).

Forward Planning 2024/2025 –

The Organisational Delivery, in addition to its core work of embedding actions from case reviews and wider learning and improvement activity has identified the following key priorities and work streams for 24/25:

- Continue to establish and embed a whole system Pressure Ulcer pathway and process and establish a quality assurance and outcomes framework in order to measure impact.
- Oversee further embedding of the WSAB Safeguarding Tier System including refreshing tier guidance.
- Establish an overview and scrutiny function regarding Tier System feedback from private mental health establishments in the borough.
- Establish a Quality Assurance timetable regarding use of the tier system across care settings and for the purposes of identifying practice, policy and process areas for improvement.
- Develop a shared policy on accompaniment from community to acute settings (A+E Protocol)

Strategic Priority 4 – Early Intervention and Prevention

Ambition - Adults at risk are identified early and have their needs met promptly and effectively.

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Key Delivery Groups – WSAB Board, Executive Group, Self-Neglect and MCA / DOLS Delivery Group, Organisational Safeguarding Work Stream,

- The Safeguarding Tier System continued to be implemented across all health and social care settings within Care Homes, Domiciliary Care, Extra care and Supported Accommodation.
- Colleagues in Provider Management and Market Development set up safeguarding forums for each of the sectors above with attendance from both the WSAB Business Unit and the local authority Safeguarding Team.
- The forums provided an informal way to work collaboratively with care organisations, and they helped develop the refreshed adult safeguarding procedure mentioned in this annual report. We also facilitated guests from the wider partnership to join the forums to discuss key issues identified from case reviews and wider learning and improvement activity. In October Greater Manchester Fire and Rescue Service (GMFRS) came to the forums to talk about the newly implemented fire awareness training offer, why the partnership wanted the providers to attend from case reviews undertaken.
- In October 23, the partnership formally launched the What's Up Champion network. The What's Up Champions are people that use services, but they also support other individuals to have a voice. The Champions help people to have the confidence in talking about any worries they may have about their safety, or about something that may be upsetting them. The champions also come together to work on co-production projects to improve services.
- The aim is to have open conversations around safeguarding that focus on guarding people to be safe and improving services. Below is a link to the new space on the WSAB website that they helped create, as well videos providing more information from the launch day itself.

What's up Champions

We continued to roll out our Eyes and Ears Training to a wide range of organisations across the voluntary and community sector. The Eyes and Ears programme aims to provide basic awareness of safeguarding, and what to do when something doesn't feel right regarding something they've seen or heard. This is provided to external partners across the community and voluntary sector, but also to internal staff in the council who can easily report their concerns, with feedback as to what was positively done with the information to support people,

Forward Planning 2024/2025 –

- Develop and implement an outcomes framework for the Vulnerable Adult Risk Management Process (VARM) / Multi-agency Public Protection Team (MAPPT).
- Develop and test new pathways for people who don't hit Care Act threshold but still require support to stay safe and be safeguarded.
- With colleagues in Place Directorate refresh our approach to the Eyes and Ears programme.
- Supporting the development of the What's Up Champion network, including opportunities for the group to shape and participate in designing policies and interventions.
- Launch and embed the updated Tier System guidance across all health and social care participants.
- Organisational Group to take a lead on developing and implementing a safer employment model (PRISIM), which will include an initial partnership workshop to identify local opportunities for implementation.

Learning Lessons: Safeguarding Adult Reviews (SARs) and Wider Case Review Work

WSAB continue to undertake both statutory (Safeguarding Adult Reviews) and discretionary reviews (Brief Learning Reviews) within its case review framework. As of writing this annual report there are currently 9 Active BLRs and an additional 9 BLRs pending completions of parallel processes (criminal investigations, Section 42 Enquiries etc.)

1 active SAR is pending completion.

The Learning Outcome Framework (LOF) captures/tracks all actions/learning from BLR's and SAR's within WSAB. To date (30.10.24) 106 Actions have been completed within the LOF. This changes daily and is a weekly focus of the WSAB business to ensure actions are being progressed effectively. As well as new actions being added on account of new learning.

A Dashboard has been created to provide a helicopter view of BLR/SAR action summary (BRAG) summary, Governance summary and Theme summary. Current top 4 themes within LOF are;

1. Mental Health

2. Legislation (MCA, Section 117 etc)

3. Self-neglect

4. Information sharing

The LOF Dashboard not only facilitates the tracking of actions but also is used to determine our Learning and Improvement and Workforce Development activity as well as key focus of the Boards various subgroups.

Published Reviews we completed are available here:

Case Reviews (wigansafeguardingadults.org)

Case Studies:

1 Vulnerable Adult Risk Management (VARM) case study- Shannon:

Shannon was referred to VARM in October 2023 due to high risks related to domestic abuse and mental health, including self-harming and suicidal behaviours. As a care leaver with a traumatic childhood, Shannon struggled to engage with services, feeling unheard and judged, especially by mental health professionals.

Initially, Shannon did not engage with the VARM process. However, after multiple attempts, a consistent approach helped establish a positive relationship between Shannon, the Local Authority, and an Independent Domestic Violence Advocate (IDVA). This improved understanding of her risks and support needs.

Shannon's mental health crises often led to emergency service interventions, which did not provide therapeutic support and reinforced barriers to her seeking help. A multi-agency approach under VARM, involving mental health services and the police, implemented a risk assessment to avoid unnecessary emergency responses, which helped reduce her crisis.

Ongoing engagement revealed patterns in Shannon's behaviour, leading to criminal charges for false allegations of domestic abuse and enabling support for victims of such allegations. Shannon remained under VARM until July, when she was transferred to the Locality team for continued support under Section 42 risk management.

Throughout her time under VARM, multiple meetings and professional collaborations ensured timely escalation of concerns and effective risk management. Shannon continues to work with key professionals towards a safety plan.

Positive outcomes achieved:

A consistent and persistent approach has enabled positive relationship building and improvement in engagement with services, this has evidenced that a consistent approach works in improving engagement, this has been shared with partner agencies with recommendations of this to be implemented from their respective services.

Shannon's views were obtained and shared with multi-disciplinary team to inform action planning in line with her outcomes.

Continued GMMH involvement in Multi-disciplinary Team (MDT) working despite Shannon being closed to Mental Health services for non-engagement.

Shannon being transferred to Locality Social Work Team for ongoing support under S42 risk management.

Identified patterns of behaviour and allegations against others which has enabled measures to be taken to protect potential victims of false allegations from Shannon.

Reduced demand on emergency services.

Effective information sharing and multi-agency working with partner agencies in Health, Police, North West Ambulance Service (NWAS), GMMH, Approved Mental Health Professional (AMHP) services, Social Care.

Continued engagement with ASC.

2. Hoarding Support

Introduction

'Belongings' is Wigan's Hoarding & Clutter Peer Support Groups.

Sally first came to the support group in December 2022 with her mum. She had seen the advert posted on Facebook by the Wigan & Leigh Carers Centre and she had come along to find out more. She is one of the few people that have just turned up to group, most people tend to ring or text to find out more information first.

This first meeting set the tone for the work we have done together. Sally is very pro-active, once she makes her mind up about something she hits things head on. If Sally says she is going to do something, she does it.

She is a very valued member of the group, she has really helped to push us forward and she is always keen to share her experiences with others.

Sally owns her own home, and generally speaking offering support to people in this position can be the most difficult. Private rented, council and housing association tenants do have to engage up to a certain point. But I would like to offer an additional note that this additional pressure does not often translate into more successful outcomes for people. Quite the opposite in most cases. More pressure generally means more hoarding.

Multi-agency approach

The group is facilitated by staff from both Wigan Council and the NHS. without key staff form both organisations the group couldn't take place. They are both fantastic people. The commitment from their services to support them as Hoarding Champions is essential to the groups continuing success. Hoarding Disorder is a much mis-understood mental health condition. It has only been a diagnosis in the UK since 2018. Getting staff on board with a very different way of working has and continues to be very challenging. We are very fortunate that both Wigan Council and the NHS work together as one organisation and that we share the passion of supporting people in a strengths-based way.

The support from Greater Manchester Fire and Rescue Service (GMFRS) has also been outstanding in supporting Sally. Good links between GMFRS and the council are long established. Our local fire station attends the peer support group a few times each year and they promote the Home Fire Safety Risk Assessments (HFSRA). Sally was keen to take up this support offer but very nervous about letting people into her home. Time was taken to explain the process and on the home visit the Firefighters were very kind and supportive. The safety information and advice they gave Sally was very useful. The risk of a fire in Sally's property is now reduced. She has gone on to talk to other members of the group about the HFSRA as being a very positive experience for her and this in turn helps others.

Undertaking a joint visit with GMFRS for the Fire Risk assessment was key to supporting Sally. When people are nervous it is very difficult to take in and process the safety information given. I was able to be there to support Sally by making a note of their recommendations and using this information to plan the next goals to work on. This took a very small amount of my time as a worker but I see this as a good investment in supporting Sally. Our best practice guidance WSAB Hoarding & Clutter Toolkit recommends that all staff undertake a joint visit with GMFRS, not to just refer on as we recognise the value of this joint working.

Positive outcomes

The peer support group has given Sally additional motivation and skills to reduce the amount of belongings in her home. It has also given her confidence to talk about this issue, she is no longer ashamed and embarrassed for people to come into her home. She has started to socialise at Northern Soul events and has met a partner after living on her own for

many years. Sally's partner has attended events with the support group and he has inspired a Family & Friends leaflet that has been produced. All members of the group had input into this information leaflet.

Sally has attended community marketplace events to promote the group, and she is confident to speak to people about her issue. There are huge amounts of stigma around hoarding and there really doesn't need to be.

Supporting people who have lots of belongings has to be person not possession focussed. The large number of belongings are generally a symptom of something else. Asking staff to switch their focus from de-cluttering is a hard sell. As a local authority we do have statutory duties such as dealing with environmental health concerns which must be addressed but we are trying to make enforcement action a last resort when all other avenues have been exhausted. Moving away from funding deep cleans and thinking about how we can support people longer term is the approach we are advocating for.

Partnership Activity 2023/2024

WSAB is a partnership, and without the hard work and dedication of our partners around the table and at every level, would not be able to achieve its objectives and ambitions.

In addition to the work described through the annual report, below is a summary of the wider work undertaken by our partners that link to improved outcomes for adults at risk of abuse or neglect. Many of the work areas have been brought to Board within 23/24 or worked up within our delivery group framework.

Provider Management and Market Development (PMMD) Wigan Council

Area of Work	Activity Undertaken 2023 – 2024	Activity Ongoing / Planned 24/25
Safe use of Bed Rails within Care Home settings	- Developed pathway for the safe and lawful introduction of bed rails in a care home setting. - Presented to the care home market in partnership with Safeguarding leads and shared electronically also. - This has ensured care homes are operating safely with its use of bed rail supported by the pathway from initial query regarding the safe introduction through to installation including capacity and all other risk reducing, least restrictive measures.	- Continuous monitoring of the application of the pathway via Quality Performance Officers (QPOs).
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Safeguarding people from financial abuse	- Developed a draft financial audit tool to quality assure systems and processes within supported living	- To work with colleagues in the appointee team to map our toolkit

	environments in respect of recording of tenant expenditure. - Ensuring that tenants residing in supported accommodation and have their expenditure managed robustly and that staff working within these services have a framework and auditing process that supported them in their role.	against their audit tools to ensure best practice sits across both.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Provider Forums	- Quarterly provider forums held with each market area that PMMD work with, Care Homes, Home Care, Extra Care and Supported accommodation. - Forum brings together leaders of services to share best practice, share challenges experiences and seek input as to how peers have overcome similar circumstance. - Guest speakers present at the provider forums, sharing best practice, providing updates on legislation, policy and processes. - By facilitating these forums PMMD ensures providers are delivering services in line with current guidelines, frameworks and best practice safeguarding people from harm, abuse, acts of omission or neglect. - PMMD are often seen as the conduit between providers and many in reaching services linking with medicines management, Infection prevention control, safeguarding, Community Learning Disability Teams, Wigan and Leigh Hospice, GMMH and Continuing HealthCare (CHC) colleagues to name but a few. Developing those relationships between professionals. - Guest speakers and topics at the forums have included Safeguarding Leads, Infection Prevention Control Team,	- Continue to be proactive in our role in ensuring best practice is evident in each aspect of service delivery within the local market via nurturing the relationships between providers and supporting teams / professionals.

	Person in Position of Trust (PIPOT) leads, Hoarding Pathway Leads, Greater Manchester Fire and Rescue.	
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Safer Recruitment	- Alongside service providers attended a Safer Recruitment workshop ensuing that best practice in regard to recruitment of staff is instilled within local practices including the necessary buy in for authentic and honest references.	- Through Partnership meetings and QPO ongoing engagement will ensure that providers continue to buy into the safer recruitment for all via monitoring of and challenges to recruitment processes.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Fire Safety	- Worked in partnership with WSAB and Greater Manchester Fire and Rescue to ensure fire training is seen as a mandatory course for all staff working within adult social care services. Promoting a two tier training offer of online training and face to face.	- Continue to promote take up of the training through partnership meetings and QPO support visits

Greater Manchester Police – Wigan Division

Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Frontline Policing/ Domestic Abuse	Domestic Abuse (DA) is a force and District priority. There has been implementation of a governance structure to monitor outcomes for victims of Domestic Abuse. We recognise that not all outcomes are quantifiable and a positive outcome for victims may not be a Police prosecution however this is a means of tracking police activity.	There are plans to implement a Domestic Abuse Team (DAT) from November. This will be an investigative team who will be responsible for investigating high risk reports of Domestic Abuse. The team will be given additional training with a view to improving their knowledge of trauma

	There is now increased data to track outcomes for victims of Domestic Abuse which supports supervisors to have increased scrutiny and offer challenge to ensure the best outcomes for victims. The DA target is 15% positive outcomes for DA. Currently Wigan have Year to date outcome rate of 12.5% however there have been consistent improvements over recent months and we continue to work towards our targets.	informed approach and improving outcomes for victims.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Multi-Agency Safeguarding Service / Adult Safeguarding Unit	Adult care plans are consistently triaged within a short timescale to ensure that where police have contact with vulnerable adults the information is shared in a timely manner to ensure appropriate support at the earliest opportunity.	From November the Adult Safeguarding Unit and Child protection triage team will merge to become a Multi-Agency Safeguarding Service. This will enable increased triage coverage which will cover weekend to prevent a delay in triage times and increase the timeliness of information sharing.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Domestic Abuse	Implementation of Multi-agency Tasking and Coordination (MATAC). Wigan were the first area within Greater Manchester Police (GMP) to implement MATAC – which aims to reduce the	In August 2024 Wigan District piloted the RVR (Rapid Video Review) process which allows victim's of Domestic abuse to have an immediate video link when reporting Domestic Abuse.

	number of repeats incidents and harm to victims of Domestic abuse. MATAC is now well embedded within Wigan who are supporting other Districts across GMP to implement a similar process. Wigan MATAC has shown a reduction in DA abuse re-offending within the identified cohorts.	Feedback from Victims of DA has been positive and further work is ongoing to explore other ways of increasing outcomes for victims of DA. Review of the Domestic Violence Disclosure Scheme (Claire's Law) process to maximise opportunities to identify risk and prevent further harm. Increased use of Civil Orders e.g., Stalking Prevention Orders (SPO's) and Domestic Abuse Prevention Orders (DAPO's) to safeguard victim's and reduce further harm.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Prevention Hub	Use of police data to identify vulnerable people who are regularly coming to the attention of police. - Demand reduction of Care Plan submissions via Key Worker interventions for all reports of concern for	In the process of the Adult Social Care Pathway pilot, which will hopefully see a reduction of inappropriate Care Plans and Domestic Abuse Event being sent to ASC front door (we will see some

	welfare logs whereby Mental Health (MH), substance misuse, general vulnerabilities etc are prevalent. - Demand reduction of missing from home (MFH) submissions via Key Worker interventions (this includes education to hospital settings, residential and nursing homes etc, on what constitutes a MFH report to GMP). Officers within the Prevention hub will scan police handovers for any mention of vulnerable adults to identify what support they can offer at the earliest opportunity.	real success from this once the daily multi-agency triage meetings are implemented).

Greater Manchester Mental Health Trust (GMMH)

Area of Work	Activity Undertaken 2023 – 2024	Activity Ongoing / Planned 24/25
Trust Improvement Plan	The Trust's Improvement Plan was developed following the identification of serious failings across our services and concerns being raised about our organisational culture and leadership. We are also required by the Care Quality Commission (CQC) and others, to take action to improve the quality and safety of our services and how we run the Trust. Our Plan includes several immediate actions to tackle the most urgent quality and safety issues, alongside a comprehensive set of long-term ambitions to improve everything we do at the Trust, grouped into five themes:	Our Plan is being progressed in tandem with existing change programmes, such as the ongoing work to transform community services and the delivery of our digital strategy. Work is ongoing in relation to the safeguarding aspects of the Improvement Plan which are aligned to the Patient Safety workstream. Progress is being made in relation to a review of the

	• **Patient Safety** • **Clinical Strategy and Professional Standards** • **An Empowered and Thriving Workforce** • **An Open and Listening Organisation** • **A Well-Governed and Well-Led Trust**	safeguarding system, training compliance, policies and guidance to support staff to effectively safeguard, and the response to safeguarding referrals.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Edenfield Centre	During 2023/24 the Trust has continued to work closely with safeguarding partners to address the safeguarding concerns raised at the Edenfield Centre following the Panorama documentary. We have also strengthened our safeguarding arrangements within the service, increased the safeguarding training offer, and introduced more robust oversight and assurance mechanisms.	Ongoing improvement work, aligned to the Trusts improvement plan.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Safeguarding Staffing Establishment	In February 2024, the Trust welcomed our Associate Director for Safeguarding which is a newly established post within the organisation. Adult Safeguarding and Deputy Lead posts were created and appointed to in Wigan to support the safeguarding agenda. The postholders work proactively alongside the existing Advanced Practitioner for Domestic Abuse.	Ongoing review of the safeguarding staffing establishment across the Trust.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**

Safeguarding Governance and Accountability	During 2023/24, the Terms of Reference and membership of the Trusts Joint Safeguarding Group were reviewed, and the group was re-launched as the GMMH Strategic Safeguarding Sub-Committee (SSSC), this being chaired by the Executive Lead for Safeguarding. An Operational Safeguarding Group (OSG) was also established, alongside a refresh of the Terms of Reference for the locality Safeguarding Groups. A Quarterly Safeguarding Report has been developed during this reporting period to provide both internal and external updates and assurance in relation to safeguarding activity and developments to the Trust Board via the Quality Assurance Committee. This ensures that the Board are fully cited on the effectiveness of the arrangements in place across the Trust to safeguard children, young people and adults at risk, and provides assurance ad information around highlights, emerging risks and challenges. The terms of reference for the Wigan locality safeguarding meeting have been reviewed and updated. This has resulted in enhanced membership and an increase in frequency of the meetings.	Establishment of additional safeguarding groups to further improvement oversight of safeguarding activity and outcomes across the Trust. This will include the development of a Safeguarding Effectiveness Group and a Learning from Reviews Group.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**

Safeguarding Strategy's	During the reporting period the Trust has published the following Strategy's: - Safeguarding Strategy on a Page 2023-26 - Domestic Abuse Strategy on a Page 2024-27.	
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Self-neglect	GMMH Wigan have established a new 'Self-Neglect Panel' consisting of multi-disciplinary team members from across the services. The panel was established to support practitioners to navigate this complex and challenging area of work, and to promote safe and effective outcomes for service-users.	Ongoing review of the outcomes and outputs from this panel.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Safeguarding Training	Training has been delivered across the Wigan Division in response to lessons learnt by the Adult and Deputy Safeguarding Leads. This has included self-neglect lunch and learns and a Prevent refresher module. The Trust commissioned legal training in response to learning identified in relation to MCA and self-neglect, with a particular focus on our in-patient areas. The Corporate Safeguarding Team have also worked in partnership with the Recovery Academy to co-produce and co-deliver a 'Let's Talk about Domestic Abuse' - training	Further training sessions to be developed and delivered in relation to: - Self-neglect and physical health - Neglect and acts of omission - Professional curiosity - S117

	module with an adult with lived experience and the Corporate Safeguarding Team. This is available to service users and staff.	
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Safeguarding processes and associated guidance.	The following guidance was developed and issued to our staff in the Wigan Division: - Safeguarding thresholds guidance and safety planning - Safeguarding recording processes guidance - Quick Guide to Self-neglect	Policies and guidance review.

Adult Social Care

Area of Work	Activity Undertaken 2023 – 2024	Activity Ongoing / Planned 24/25
Back to the future transformation plan	The Transfer of Care Hub (TOCH) started. Named social care worker model started. Refreshed supervision framework in place. ABC conversations in place.	TOCH still being developed and new Urgent and Emergency Care (UEC) pilot to be implemented. Named social care worker not fully implemented. Refreshed supervision framework is still being embedded.

		ABC asset-based training rolled back out and evidenced with Supported Self-Assessment / Safety Plans
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Self-neglect refresh	Audits Training has been rolled out. Advanced Practitioner forum has been used to cover this area. The policy and process were refreshed.	Section 42 training being refreshed, inc self-neglect. Widening multi agency involvement and learning regarding self-neglect. Embedding learning from Safeguarding Adult Reviews and Brief Learning Reviews. Fire safety training encouraged, with partner agencies also.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Complexity and risk group has commenced.	Early discussions with partners about this happening.	Pilot commenced in May 2024 to provide early intervention and prevention to reduce risks and escalation into sec 42. It started with Social Workers and the Prevention Hub Widening agency involvement via screening days including partners. Ongoing reviews of pilot. WSAB commencing complexity and risk subgroup.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**

Establishing Vulnerable Adult Risk Management (VARM) framework.	We established a policy and process to assist us in supporting vulnerable and high risk people that do not meet the s42 criteria.	To further embed this process and to have more partners acting as lead agency.

ICB Greater Manchester (Wigan)

Area of Work	Activity Undertaken 2023 – 2024	Activity Ongoing / Planned 24/25
Senior Commissioner Visits	Visits have been undertaken to the Sovereign Unit and Psychiatric Intensive Care Unit (Atherleigh Park) and Ashwood Court (Independent Hospital). The purpose of Senior Commissioner Visits is to capture the voice and experience of service users and to ensure that services are safe and deliver good quality support. The findings of each of the visits has been shared with the respective services by way of a 'poster' which is displayed publicly for service users to view.	Moving forward, the focus of Senior Commissioner Visits will be Independent Hospitals with visits to be scheduled for Ashwood Court, Fir Trees, and the Spinney.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Section 42 Enquiries	The Assistant Director Safeguarding Adults has supported two Section 42 Enquiries both relating to concerns raised by families in respect of the care and support their loved ones received in local Care Homes. Both enquiries have been complex and required a multi-disciplinary approach to deliver the right outcomes for the adult at risk and their family. The impact of this work is that the voice of the vulnerable adult and their family was clearly heard which in turn delivered the right outcome to their safeguarding concern.	The Assistant Director of Safeguarding Adults will continue to support complex Section 42 Enquiries as appropriate.

Area of Work	Activity Undertaken 2023 – 2024	Activity Ongoing / Planned 24/25
Statutory Safeguarding Reviews	A key work stream of Greater Manchester ICB (Wigan) is that of meeting its statutory responsibilities in terms of contributing to Safeguarding Adult Reviews (SARs) and Domestic Abuse Related Reviews (DARRs) and sharing the learning to emerge from the same with Primary Care. To this end, 3 SARs and 1 DARR have been completed for the period. Key learning in respect of the following themes has been shared with Primary Care: professional curiosity, coercion and control, and exploitation. Sharing the learning to emerge from SARs lends itself to improving service delivery and clinical practice. In addition, sharing learning results in an informed workforce with a better understanding of safeguarding.	Work relating to statutory safeguarding reviews remains a priority for Greater Manchester ICB (Wigan) and will be undertaken as required.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Domestic Abuse Champions	The Champions Project has seen nominated staff from within Primary Care undertake a one-day training event delivered by the Specialist Nurse – Domestic Abuse (Primary Care) and DIAS Domestic Abuse Centre. The impact of the role and training thus far has been positive with Champions reporting timelier referrals to specialist domestic abuse services (DIAS).	To implement a quarterly Champions Forum to discuss issues pertaining to domestic abuse including how best to measure the impact of the Champions role.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Validation Visits	An important function of Greater Manchester ICB (Wigan) is to undertake validation visits to Wrightington, Wigan and Leigh Teaching Hospital NHS Foundation Trust (WWLFT) the purpose of which is to ensure that WWLFT safeguarding policy, procedure and practice is commensurate with the NHS Contractual Standards. The standards are set out in the	To continue to undertake validation visits to seek the assurance that WWLFT is meeting its safeguarding duties and responsibilities as outlined in the SAAF.

	Safeguarding Accountability and Assurance Framework (SAAF) and include compliance with legislation, roles and responsibilities, training, and statutory safeguarding activity for both children and adult safeguarding. Validation visits are an important part of the assurance process not only in terms of the commissioner/provider relationship but in evidencing that safeguarding duties and responsibilities are being met effectively.	
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
MARAC (Muti-agency Risk Assessment Conference)	The Specialist Nurse – Domestic Abuse (Primary Care) has supported the MARAC agenda acting as a conduit between MARAC and Primary Care in terms of information sharing, safety planning and bespoke support to individual cases.	Unfortunately, the Specialist Nurse – Domestic Abuse (Primary Care) post was a secondment which has now concluded. Moving forward, discussions are ongoing as to how best to continue to support the MARAC agenda and ensure a robust response to victims of domestic abuse from Primary Care.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Organisational Safeguarding Subgroup	The Assistant Director of Safeguarding Adults co-chaired this subgroup for a period and was involved in sharing the National Institute for Health and Care Excellence (NICE) Guidelines for Safeguarding with Care Homes across the Borough and asking them to assess themselves against the same. The result of this piece of work is that Care Homes are better informed regarding their safeguarding duties and responsibilities and can better evidence their safeguarding practice when inspected by the Care Quality Commission.	The Assistant Director of Safeguarding Adults to continue to support the work of WSAB in terms of attending and contributing to subgroups.
Area of Work	**Activity Undertaken 2023 - 2024**	**Activity Ongoing / Planned 24/25**

Mental Capacity Assessments	The Assistant Director of Safeguarding Adults has undertaken several mental capacity assessments at the request of the Local Authority. Each of the cases has had its own complexities but the commonality has been that the overarching themes has been self-neglect. This work stream has been impactful in the sense that undertaking the mental capacity assessments has ensured that the vulnerable adult has received the support most appropriate to their needs.	To continue to develop the capacity within Primary Care to undertake mental capacity assessments.

Wigan, Wrightington and Leigh Foundation Trust

Area of Work	Activity Undertaken 2023 – 2024	Activity Ongoing / Planned 24/25
Key Priority for the WWL Think Family Safeguarding Service was to develop a data system and dashboard that is able to articulate the breadth of safeguarding activity and intervention by all Divisions and Services across the Trust	Throughout 2023/24 a review of data collection and safeguarding notification processes was undertaken utilising Business Intelligence support to identify improvements in data integrity and influence future service development. Service level review has been completed with some transformation work commenced. A review of internal data has created the opportunity to focus on supporting links at Divisional and ward/service level to develop safeguarding pathways and improve patient level practice.	Additional support from Data Analytics and Clinical Informatics colleagues is required and very recently acquired to facilitate continued progress against this area of work. Wider sharing of safeguarding data internally and externally via various safeguarding and associated forums. Provision of data at NHS England and Greater Manchester Integrated Care Board level to be improved via improvement work linked to health record reporting.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Development and delivery of a rolling and continued programme of bitesize and	Review of safeguarding training offer to compliment mandated training.	Development of new Think Family Safeguarding Training offer that will promote and strengthen local and national learning from

full training packages committed to the establishment of a trauma informed workforce embedding 'lived experience' as central to safeguarding practice.	Targeted and bespoke packages developed and delivered in response to incidents/reviews to improve patient experience and practitioner competence and knowledge.	safeguarding reviews with key focus on 'Wigan Themes' such as self-neglect, Domestic Abuse with opportunities to engage wider with the WWL workforce on a practical level therefore increasing and improving exposure to adult practitioners regarding areas such as Trauma Informed Care, Exploitation and Transition agendas
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**
Ensure cross-population of learning from reviews, both internal and external, to support richer action plans to be shared and implemented on a wider organisational footprint.	Embedded into Divisional Patient Safety Activity with focus on new Patient Safety Incident Response Framework (PSIRF) process through a safeguarding lens. Revision and roll out of specialist training and education to embed 'lessons learnt' from reviews. Relaunch of Safeguarding Champions Forum as a mechanism to share good practice whilst learning from when things go wrong. Investment in After Action Review (AAR) training across the organisation to improve timeliness of review of incidents and accelerate learning from these. Continued roll out of Human Factors Training	Revision of associated policy and process such as 'Local Authority Alerts' to ensure timely, effective and standardised response to safeguarding concerns raised about the organisation. The introduction of monthly Safeguarding Operational Group will enable divisional level analysis and subsequent presentation of safeguarding activity to create greater depth of insight into emerging trends in safeguarding assisting in roll out of targeted responses to protect patients, services users and staff within Wrightington, Wigan & Leigh Teaching Hospitals.
Area of Work	**Activity Undertaken 2023 – 2024**	**Activity Ongoing / Planned 24/25**

All Think Family Safeguarding Service practitioners now trained in restorative supervision providing extended opportunities for access across the Trust; Supports in recognition, response and action around safeguarding issues.	Revised Safeguarding Supervision Offer developed and underpinned by a new policy. The introduction of tripartite and multiagency supervision with Local Authority partners has increased the successful management of safeguarding cases with increased complexity. Whilst these have invariably focused on 'children in need of protection' there has been improved responses to adult safeguarding concerns linked to maternity intervention and transition to adult services for individuals with additional needs such as Learning disabilities but also those with 'protected characteristics' such as Care Experience and veteran status and cases where self-neglect/neglect is a feature.	Increase in multi-professional and multiagency opportunities for supervision and case discussion. Build on improved governance and oversight of safeguarding via internal meeting structures, divisional processes and escalation pathways.

Appendix One – WSAB Strategy

(https://www.wigansafeguardingadults.org/Docs/About-us/WSAB-Strategy.pdf)

Wigan Safeguarding Adult Board Strategy on a Page 2022-2024

Our Strategic Statement

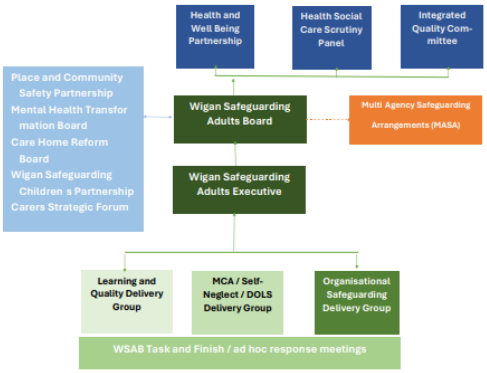
Our Vision is that residents of the Wigan Borough can live safely, free from harm, and abuse or the fear of abuse, in communities which:

Have a culture that does not tolerate abuse.
Work together to prevent abuse.
Know what to do when abuse happens.

Our Ambition is that the Safeguarding Adults Board works within a broader partnership to:

- Champion the interests and rights of adults at risk of abuse and neglect.
- Ensure there is an emphasis on outcomes for adults at risk of abuse and neglect.
- Provide independent and objective challenge and leadership that is essential to ensure the best outcomes for those in need of protection and safeguarding amidst competing priorities.
- Involve all partners, not just police, health and the local authority, with a clear platform and duty to co-operate.
- Scrutinise and improve practice - using a range of new practice and individual user led approaches and meaningful measures to provide accountable oversight and feedback on performance and outcomes, with a focus on before crisis and that incorporates early help across the life course.
- Learn from experience and evidence of what works well – creating workable strategic and operational arrangements that fit form to function and are proportionate, efficient, effective, and adequately resourced.
- Meet the leadership challenge of connecting multiple partners together and collaborate to achieve common goals and within new ways of working.

Wigan Safeguarding Adult Board Governance Arrangements



2023/24 High Level Priorities

WSAB / Exec
- Continue to develop and implement an overall response to management of risk within and across the partnership rooted in collaboration and partnership support

Develop and implement an overall response to positive information sharing across the system

Learning and Improvement / Quality Assurance
- Consolidate existing learning and impact of actions taken BLRs / SARs / LEDERS via our Learning Outcomes Framework (LOF)
- Focus on quality assurance activity that supports improvement in Safeguarding Enquiries

Organisational Safeguarding
- Review and refresh group priorities to include :

Pressure Ulcer Guidance and response
Extending the Safeguarding Tier System,
Falls Policy Outcomes Framework

Self-Neglect / MCA / DOLS
- Delivery group to develop and implement a system plan for self-neglect and outcomes framework
- Develop and implement a system wide plan for improvement in timeliness, focus and effectiveness of mental capacity assessments across all settings

Mental Health
- Develop and implement a local MOU / protocol regarding MHA Section 140 Policy

Develop and implement a local MOU / protocol regarding MHA Section 117 Policy
Deliver assurance on key MH transformation plans linked to case review recommendations.

Complex & Contextual Safeguarding
- Support the implementation of a Vulnerable Adults Risk Management Framework within a wider partnership response to people who present as complex / high risk

Domestic Abuse
- Work with DA Steering Group to embed effective response in S42 processes

The 6 Care Act & Safeguarding Principles:

- Empowerment
- Protection
- Proportionality
- Prevention
- Partnership
- Accountability

Our Behaviours

Be Positive
...take pride in all that you do

Be Accountable
...be responsible for making things better

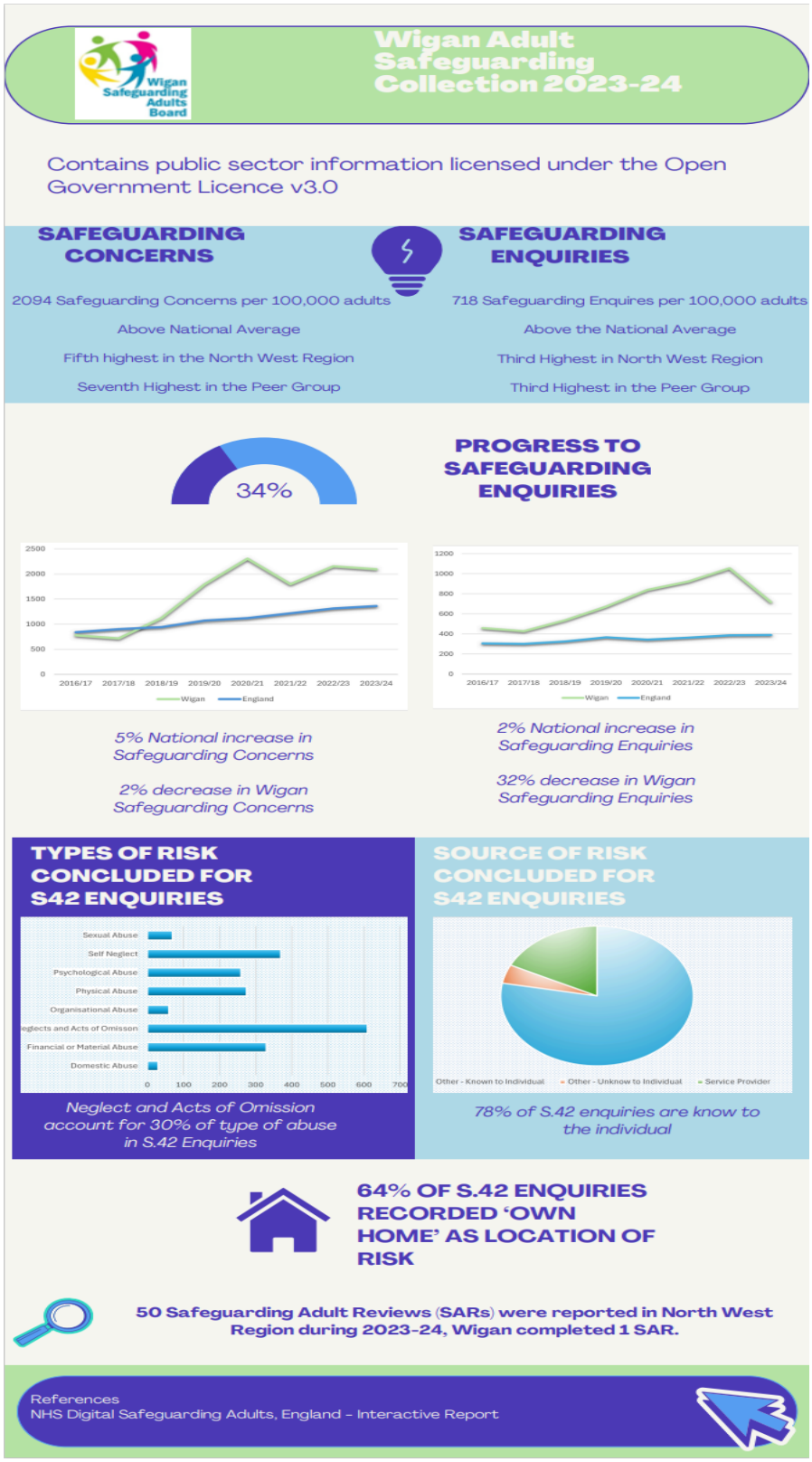
Be Courageous
...be open to doing things differently

Be Kind
...be helpful, generous and thoughtful towards others

Strategic Priorities

Accountability, Assurance & Leadership	Quality Practice, Learning & Improvement	Policies, Strategies & Procedures	Early Intervention and Prevention
"Wigan has an effective Safeguarding Adults Board which fulfils its statutory responsibilities, has strong leadership and governance arrangements, and promotes a culture of collective accountability, respectful challenge and continuous learning "	" Services & staff are learning and improving in their safeguarding practice and adult safeguarding risk is better understood by WSAB and appropriately assessed by partners."	"Our partners work within a framework of policies and procedures that keep people safe"	"Adults at risk are identified early and have their needs met promptly and effectively
Strategic Objectives Continue to develop the WSAB and broader governance arrangements Develop arrangements with other Strategic Boards to be responsive and adapt, based on available data and intelligence to emerging safeguarding themes (both locally & nationally) Undertake risk / horizon scanning and respond accordingly to any changes that may impact on the effectiveness and / or efficiency of Safeguarding in Wigan. Ensuring robust mechanisms are in place for partners to be held to account for their safeguarding practice. Develop a partnership outcome framework Develop an assurance framework to ensure and be assured that partners and services have in place a minimum standard set of policies, practice, capacity, and capability regarding safeguarding adults To raise awareness of the Safeguarding Adults Review (SAR) process, and ensure threshold decision making is consistent across Wigan.	**Strategic Objectives** Learning from Safeguarding Adult Reviews and multi-agency audits is effectively embedded into practice and facilitating organisational change across agencies, leading to better outcomes for adults. Variety of feedback mechanisms available across staff groups and organisations (learning forums, reflective supervisions, newsletters) Robust multi-agency safeguarding data to shape any multi-agency training offers, awareness and practice, and affect change when required. High-quality risk assessments, well documented and accessible to all The workforce is equipped to support adults appropriately where abuse and neglect are suspected through implementation of a robust workforce development and training strategy.	**Strategic Objectives** Our partners work within a framework of policies and procedures that keep people safe and can demonstrate this within the WSAB framework Multi-agency safeguarding strategies, policies and procedures are regularly reviewed to ensure currency, reflecting emerging legislation, policy and/or learning, and that these are easily accessible to frontline staff and used effectively Establishing robust feedback mechanisms to ensure safeguarding practice is in line with current best practice and the Care Act 2014. Undertaking assurance activity to test compliance and effectiveness of implementation of local safeguarding and adult protection policy and procedure. To raise awareness of safeguarding policy and procedure related to specific local safeguarding challenges.	**Strategic Objectives** We will improve awareness of safeguarding, including "complex" safeguarding, across all communities, especially with those who are isolated, diverse and underrepresented by reviewing our communication approach and developing a measurable action plan. There will be a "no wrong door" approach to raising concerns and / or accessing support. People will be able to raise concerns and access support in a timely manner and from wherever they seek There will be strong connections established with other key programmes of work which relate to safeguarding and a shared understanding of the interrelationships between them. This includes, but is not limited to; Mental Health, Suicide, Self-Neglect, Substance Misuse / Addiction, Domestic Violence & Homelessness Invest in our Safeguarding Tier System

Appendix 2 – Safeguarding Data



Summary

Appendix 3 –Board Membership

Board

Who is on the board?

The board is chaired by an independent chair, is supported by staff within the Partnerships and Safeguarding Team and is hosted by Wigan Council.

Name	Agency
Core Members	
Independent Chair Adults Safeguarding	Independent
Superintendent Wigan Division	Greater Manchester Police (GMP)
Director of Adult Services	Wigan Council
Associate Director Quality	NHS GM Integrated Care Board
Portfolio Holder Adult Social Care	Wigan Council
Director Community Services (Adult Services)	Wigan Council
Wider Membership	
Wigan Director Of Public Health	Wigan Council
Assistant Director Adult Safeguarding	NHS GM Integrated Care Board
Head of Operations, Wigan Division	Greater Manchester Mental Health Trust
Assistant Chief Officer	Probation Service Greater Manchester
Prevention Manager (Wigan)	Greater Manchester Fire and Rescue Service (GMFRS)

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Chief Officer	We Are With You (Drug and Alcohol Services)
Locality Manager	Wigan Healthwatch
Inspector (safeguarding) Wigan Division	GMP
Safeguarding Manager	North West Ambulance Service (NWAS)
Chief Nurse and Director of Infection Prevention and Control	Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL)
Deputy Chief Nurse (Corporate)	WWL
Assistant Director Provider Management and Market Development	Wigan Council
Service Manager & Principal Social Worker (Adults)	Wigan Council
Lawyer (Legal Adviser to WSAB)	Wigan Council
WSAB Service Manager	Wigan Safeguarding Adults Board (WSAB)
Service Manager (Domestic Abuse, Reform and Partnerships)	Wigan Council
Care Quality Commission (Wigan Lead Officer)	Care Quality Commission (CQC)
Adult Safeguarding Team Manager (Adult Services)	Wigan Council
CQC Locality Lead	CQC

Appendix 4 – WSAB Financial Contributions

Income	2023/2024
Local Authority	£192,219
NHS Greater Manchester (ICB)	£52,000
Wrightington, Wigan and Leigh Teaching Hospital NHS Foundation Trust	£15,000
Greater Manchester Mental Health NHS Trust	£12,000
Greater Manchester Police (through GMCA contribution)	£14,400
Total	**£285,619**

Appendix 5 – Summary of Norfolk Peer Review of WSAB

Board effectiveness	
Strengths	Areas for development
Ability to gather and present safeguarding data (predominantly Local Authority). Clear link shown through board data to activity. [SA / OM]	Build on the current process and gather partner data to support the understanding of safeguarding across other partner agencies – being clear on what questions you are asking? [SA]
Multi-agency audit activity gives clear support to board assurance. [SA]	If there are continuing risks around the ability to analyse data, consider include this in the risk register to maintain partner focus. [SA]
Plan on a page – rather than a longer document, busy picture. [SA]	Consider whether the structure of board not required on strategic plan. [SA]
Board agenda reflects the key areas of the board strategy. [SA / OM]	Strengthening how learning is embedded and the measure of impact – Learning Outcomes Framework. [SA]
Quality Assurance framework includes the "so what question?" reflecting the lived experience of people accessing the safeguarding services – have we made you safer? [SA]	Development of impact and performance measures – being careful not to overcrowd the landscape. [SA] [R]

Board effectiveness	
Strengths	Areas for development
Clear and consistent policy in relation to prevention of neglect and abuse through a Tiered Safeguarding Process understood by all partners. [SA]	Developing a way of holding agencies to account, so that accountability lies with the agencies. Shift of focus. [SA / FG]
Thinking wider than just strategic partners – 'eyes and ears' campaign & What's Up Champions. [SA]	To link with the boards ambition of an audit around advocacy consider advocacy rep onto board. [SA / FG]
Clear lines of accountability for identified work streams (Organisational Abuse Sub-group and Learning Quality delivery group). [SA / OM]	Consideration of a shorter audit tool for smaller organisations? [SA]
Sense that the board have embraced and developed trauma informed practice across the partnership e.g understanding and demonstrating this through the difficult to engage guidance. [SA]	Reliant on SAB BM. Always approachable and known as 'Mr SG' – does that reduce the opportunity for others to step forward, slows partner ability to strengthen their own safeguarding skills and participation. NOTE agenda for 7.2.24 – number of items attributable to Paul. [SA /OM / FG] [R]
Self-assessment audit tool good practice. [SA]	Voluntary sector / representation on board? [SA / OM]

Board effectiveness	
Strengths	Areas for development
Relationships are strong, supportive and appropriately challenging. In particular role of the elected member [OM]	Identifying the impact and difference is made – asking the question in the L&QA sub-group. Comment " We need to change from asking – show us your paperwork to show us your impact! [OM]
Strong collaborative relationships with other SABs evidenced (SAR – Bury SAB) and with other boards. [OM] Clear links with other boards processes e.g LeDeR and the LD Partnership Board. [OM]	Some agencies need to step forward – focus group comment and in self-assessment "same face syndrome" – maybe a direct approach to agencies is helpful to address this. [OM / FG]
Separate board meeting to receive and discuss a SAR – allowed plenty of time for discussion and questions. [OM]	Good process governance would suggest key actions are clearly articulated at the end of the meeting – SAR meeting. Could consider using the chat to show agreement and sign off by partners. [OM]
The representatives at the SAR meeting were from an appropriate range and mix of agencies and there was a good level of debate following the presentation. [OM]	Reflecting on SAR presentation – was 90 minutes sufficient to consider the large system issues such as Sec 117 aftercare. [OM]

Board effectiveness	
Strengths	Areas for development
The board showed an awareness and appreciative of parallel enquires eg, police/criminal and the impact of a Panorama programme relating to the provider involved. [OM]	Consideration of EDI in board activity, policies and workstreams (recognising the Whats Up Champions are being used to look at the S42 process) not observed during review. [SA / OM / FG] [R]
Voice of the family clearly heard through SAR and author returning to family for comments om final report. [OM]	How do they encourage other partners to bring and drive agenda items. [OM]
Openness and transparency around finance of board (Finance update). [OM]	
Coproduction development Safeguarding "Whats Up" champions is a relatively new concept. The SAB are involving Have them to develop website. [OM]	

Board effectiveness	
Strengths	Areas for development
Good initial, quick responses at the start, especially in crisis. Consistency of management oversight and decision-making. In 3 of the 4 cases relatives were actively involved in the enquiries. [CFA] All had outcomes met at the closure of the case. [CFA]	Re-occuring themes identified around professional curiosity, mental health act assessments and the importance of Making Safeguarding Personal – could signal either these are outliers or an indication of issues around quality. Suggest discuss for possible recommendation. [CFA]
All cases had outcomes recorded at some point in the process; most were from the family members involved. [CFA]	How do they encourage other partners to bring and drive agenda items. [OM]
One case showed good practice especially in the earlier stages, mobilising a multi-agency response to immediate concerns raised. [CFA]	Current S42 process & forms do not appear to be supporting good practice, practice being driven by the process [CFA] [R]

Identification and management of risk	
Strengths	Areas for development
Evidence that the board is able to identify both risks and issues that cut across the partners and that areas are considered in detail. E.g CoL crisis, DOLs. [SA / FG]]	Current risk register identifies risks and issues but does not identify any mitigating action, current activity and a direction of travel. [SA]
Board identified a key risk being the impact upon staff when the SAR was published and agreed some mitigating actions. [OM]	New risk and complexity delivery group to develop provides an opportunity to developed the risk and issues management process to identify all relevant risks and issues, allocate ownership and monitor movement. [SA] [R]
System risks as identified in the SAR are captured in the risk/issues log for further action e.g. sec 117 and system pressures. [OM]	Unclear how Exec Group manage risks scoring under 15. [OM]
Clear line between risk and NEW complexity delivery group and the board. [SA]	Consideration of a stronger distinction between the role & work of the SAB and the Exec Group - feel interchangeable - the agendas are very similar. What could be learned from Wigan's safeguarding children's arrangements. [OM / FG] [R]

Board engagement	
Strengths	Areas for development
'What's Up' champions and their future development to support the SAB in coproduction. [OM]	Service user story previous brought to board. Consider how these can be expanded / presented by other SAB members. [OM]
Communication to all partners via a system wide newsletter & social media. [OM]	Consideration of monitoring attendance, commitment to full meeting and publishing attendance data? [OM]
Yearly development session and good board engagement from members. [OM]	How to build in the voice of the person to board? Consider work to further clarify what effective community engagement looks like. [OM / FG]
BMs reach and connection in the system is outstanding. People spoke very proudly of Paul and his connections. Will proactively seek his advice and guidance. [OM]	Could the SGA principles as set out in Adult Social Care Practice Framework (draft) be positively used across the wider partnership (adapted appropriate to role) to underline engagement? [OM]
Lunch and learn concept. [OM]	