Annual Report

2015 / 2016
Foreword

I am pleased to introduce the third annual report of the Wigan Safeguarding Adults Board (WSAB) since I became the Independent Chair of the Board.

From March 2015 the Board is now a statutory requirement as part of the Care Act 2014. We reported in last year’s report the work we undertook to get ready for this change, this work has continued across 2015/16 to embed safeguarding principles and practice across our combined workforces. The report also provides a further opportunity for the Board to provide information as to the needs of adults at risk of abuse and neglect within the Borough and how Member Agencies have worked in partnership to address these needs.

All adults in Wigan have a right to live in a borough where systems that safeguarding and protect their wellbeing work together effectively. This is the challenge that the WSAB sets itself, in a public sector environment that continues to be financially constrained. The partner organisations of WSAB have shown agility and crucially have shown a commitment to keeping the impact upon the child central to any decision making.

The Board and its delivery groups continue to strengthen our approach in taking evidence based decisions to improve how we undertake safeguarding practice, and local case reviews, audits and wider engagement and consultation with professionals and services have highlighted areas in which the Board and Partners need to learn and adapt practice. Through this we have continued to improve our understanding of how neglect and abuse can impact on vulnerable adults and their family’s lives. We will continue to identify and implement improvements around how disclosures of abuse are managed and understood and key learning for partners around communication and collaboration.

This is being taken forward in the ongoing training strategy; positive uptake of formal training and wider engagement opportunities with communities and service users themselves will enhance the skills and confidence of the local workforce in these areas of practice. In addition, the Board continued to oversee the review of protocols, policies and procedures to guide and support professionals. I am confident that the efforts of those within the wider workforce will produce the necessary service improvement.

Whilst I am pleased to note the above areas of progress and there are many others cited within the report, there is, as always, much still to be achieved. Connecting WSAB and its partners to these changes is a challenge that will have to be met. The board will also ensure that encouraging community engagement work that has already started continues and expands in the coming year, so that all key stakeholders in the community have a voice in how the Board works. Further development of the Live Well and Age Well delivery model for early intervention and prevention shows great promise as a system that will build resilience in all adults lives and, where service users and families need support and intervention, to reduce the factors that make them vulnerable. The inception of the Multi Agency Safeguarding Hub will ensure that the response is coordinated and targeted.

It has been a year of new ways of working for WSAB following the significant changes that 2015 brought, and without the enthusiasm and commitment from the partnership these would have failed. I am grateful for the strength of the partnership that has met these challenges with a child centred commitment that bodes well for the coming year.

Dr Paul Kingston
Independent Chair
Contents

Forward

1. Executive Summary 4
2. Context and Strategic Overview 5
3. Governance and Accountability Arrangements 7
4. Strategic Objectives 10
5. Progress against Strategic Objectives 11
6. Performance Update on Key Strategic Areas 14
7. Training and Development 25
8. Engagement and Consultation 28
10. Partner Updates 30
   - Bridgewater NHS FT 30
   - Wrightington, Wigan, And Leigh NHS FT 32
   - Wigan and Leigh Homes 35
   - Wigan Borough Clinical Commissioning Group 38
   - North West Ambulance Service 40
   - 5 Borough’s Partnership NHS Foundation Trust 42
   - Community Rehabilitation Company 44
   - National Probation Service 46
   - Greater Manchester Police 47

11. Towards 2016-2017 52
12. Appendix A – Membership of the Board 53
Section 1 Executive Summary:

Purpose

The Wigan Safeguarding Adult Board’s (WSAB) annual report aims to reflect the Board’s evaluation of its activity: where the board has achieved against the challenges it set itself and what impact the Board’s work is having on the safety and wellbeing of adults at risk of abuse, neglect and their families in Wigan.

2015/16 saw the Care Act become law and within it the clear statutory function and role of Safeguarding Adults Boards. Within this context, the WSAB set itself some robust milestones on the route to success for the last twelve month period. This work built on the previous year’s work that saw the Board prepare itself for the significant changes and responsibilities the Care Act brings around the Board’s function and role to safeguard adults (and which we reported in last year’s annual report).

Over 2015/2016, the Board committed to consolidating its approach including developing the subgroup delivery framework responsible for delivering the overall business plan, developing new resources and approaches to support its ambition to engage with the community, service users and across professional fields. Much of the work also focused on creating a consistent learning and improvement approach throughout all of its functions. This report goes into detail regarding the individual activities that have contributed to those broader objectives.

The Annual Report is also part of the requirements of the Board’s function in law, as defined in the Care Act as a requirement to report on the effectiveness of arrangements to promote safeguarding people at risk of neglect and abuse across the Borough.

The Report contains detail on the outcomes of work undertaken by the Sub Groups of WSAB, Governance, training activity and contributions from member organisations.

Achievements and Work Programme

WSAB has continued to make progress in a number of areas including its effectiveness around both the process and evidencing the outcome of safeguarding investigations (known in the Care Act as Section 42 Enquiries). There has also been further work undertaken regarding developing our training offer. The Board has also driven forward new innovative practice in the way it performs its statutory duties around Serious Adult Reviews and the process by which effective lesson learned plans are generated through this process.

Highlights of the Year have been:

- A highly successful second annual conference.
- Successfully rolled out a self-registration system for training.
- Developing and piloting a self-neglect policy and process
- Embedding a robust performance and insight framework at the Board level that highlights key areas for Board management and oversight
- Implementation of new adult safeguarding case management system.
Section 2: Context and Strategic Overview

The demographic of Wigan

Wigan is a town in Greater Manchester, England. It stands on the River Douglas, 7.9 miles southwest of Bolton, 10 miles north of Warrington and 16 miles west northwest of Manchester. Wigan is the largest settlement in the Metropolitan Borough of Wigan and is its administrative centre. The town of Wigan had a total population of 97,000 in 2011, whilst the wider borough has a population of 320,000

- Wigan is ranked 65th most deprived local authority in England.
- 2.7% from ethnic background other than White British.
- 1.8% speaking a first language other than English.
- A range of health providers including one Acute Trust, one Community Healthcare Trust and a Clinical Commissioning Group that oversees 63 GP practices.
- Mental health care is provided 5 Boroughs Partnership.
- Wigan's population is increasing (up % at the 2011 census) but at a slower rate than both England and the North West.
- 16% (around 50,000 people) of the Wigan population are aged 65 and over and 4% (11,000 people) are 80+ years of age.
- In comparison with the UK as a whole, the population of Wigan is ageing. By 2033, the proportion of older people in the population will increase, without much change in the numbers of people aged under 65 years; therefore there will be smaller proportions of younger, especially working age, people.
- The Borough is home to over 850 asylum seekers and refugees, with an increasing number who become resident in the area once leave to remain is granted by the Home Office.
- Wigan’s overall suicide rate at 10 per 100,000 population (PHOF 12-14) is slightly lower than the national average of 10.9 per 100,000.
- 22% of people, around 69,000 have a long term condition. Cardiovascular, Musculo-Skeletal and Mental Health conditions account for 70% of these.
WSAB Vision

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 values illustrate the approach the board will take in delivering its vision

- People have the right to live their lives free from violence, neglect and abuse
- Safeguarding adults is a shared responsibility of all agencies and agencies commit to holding each to account.
- The individual, family and community should be at the heart of safeguarding practice
- High quality multi-agency working is essential to good safeguarding
- We respect that adults have a right to take risks and that this will sometimes restrict our ability to act.
- There is a commitment to continuous improvement and learning across the partnership

The Government has set out six principles to govern the actions of Adult Safeguarding Boards:

- Empowerment – taking a person-centred approach, whereby users feel involved and informed.
- Protection – delivering support to victims to allow them to take action.
- Prevention – responding quickly to suspected cases.
- Proportionality – ensuring outcomes are appropriate for the individual.
- Partnership – information is shared appropriately and the individual is involved.
- Accountability – all agencies have a clear role.

The aims of WSAB is to co-ordinate and ensure the effectiveness of what’s done by each of the Board’s partners, individually and collectively for the purpose of safeguarding and promoting the wellbeing of adults at risk of abuse or neglect and their families in Wigan.

WSAB is aware that to meet the needs of these individuals that it serves, it has a crucial role in ensuring that anyone from the borough has equality of access to services that they need. Services must be active in identifying needs, and commit to continuous improvement that rigorously examines whether systems of support are accessible and meet vulnerable adults’ needs.

WSAB carries out statutory and non-statutory duties, but underpinning both is the commitment to evaluation of its practice and providing challenge and a collaborative model of working to guard against any adult in the borough experiencing preventable disadvantage or harm.
Section 3: Governance and Accountability Arrangements

What is the Wigan Safeguarding Adults Board?

The Care Act 2014 which became law in April 2015 required all Local Authority Areas to establish statutory Safeguarding Adults Boards (SABs).

Safeguarding is described as protecting adults and children from abuse and neglect. The Care Act is a response to the recognition that the law and practice around this issue had become complex and consumed. The Care Act has made the following changes in regard to safeguarding adults:

- Safeguarding Adults Boards are now statutory. The Board has an experienced independent chair and the statutory members are the Local Authority, the Police and the CCG. The board is required to have a safeguarding plan and will publish annual reports detailing what it has done during the year to achieve its main objectives and implement the strategic plan as well as detailed findings of any Safeguarding Adult Reviews (SAR) and subsequent actions.
- Safeguarding enquiries are a corporate duty for councils when they have reasonable cause to suspect that an adult in their area has a need of care or support is at risk of abuse or neglect and as a result of those care and support needs are unable to protect themselves.
- Formal Safeguarding Adult Reviews are mandatory if an adult at risk dies in circumstances where abuse or neglect is known or suspected. The review must identify lessons learned and apply those lessons to future cases.
- Relevant partners must co-operate with the local authority regard to supplying of information.
- Councils have a duty to fund and arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or a SAR where the adult has substantial difficulty in being involved in the process and where there is no other suitable person to represent them for people who have no one else to speak up for them.
- The Council’s power, under section 47 of the National Assistance Act, to remove people from insanitary conditions has been repealed.
- There is now a duty of candour on providers regarding failings in hospital and care settings.
- There is a new offence for providers – of supplying false or misleading information in the case of information they are legally obliged to provide.
- It re-enacts existing duties to protect people’s property when in residential care or hospital.

WSAB has undergone significant change over the last 12-18 months and has used this opportunity to develop robust governance, quality assurance and reporting mechanisms. The
Board brings together organisations from across the borough, who are committed to keeping adults at risk of neglect and abuse safe, to create a strong, mutual partnership where organisations can develop their practice and offer supportive challenge.

WSAB also offers a broad range of training across the partnership, accessible to all partners, and that is free of charge to community and voluntary sector organisations. The Training Offer from the Board addresses all aspects of the Board’s response to local and national learning, and allows timely dissemination of learning.

WSAB is committed to ensuring the effectiveness of the work undertaken by each partner organisation in relation to safeguarding and promoting the welfare of at risk adults in Wigan.

We aim to do this in two ways:

To co-ordinate local work by:

- Ensuring that policies and procedures related to safeguarding are appropriate for purpose, robust and accessible.
- To work in partnership with other key partnerships to participate in the planning of services for adults at risk of neglect and abuse in Wigan.
- Communicating the key messages about how everyone can promote the welfare of children, and explaining how this can be done.

In order to ensure the effectiveness of that work the Board:

- Monitors the work undertaken by partner organisations to safeguard and promote the welfare of at risk adults.
- Undertakes Serious Adult Reviews, Local Case Reviews and Single Agency Reviews, and sharing learning from these reviews.
- Collects and analysing information about adult safeguarding incidents.
- Publishes an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of the at risk adults of Wigan.
Key Roles

There are some key roles on Safeguarding Adults Boards (SABs), which are either laid down in the Care Act guidance or are locally determined. These are:

**Independent Chair**
It is expected that all SABs appoint an Independent Chair who can bring expertise and a clear guiding hand to the Board, to make sure that the WSAB fulfils its roles effectively. WSAB welcomed this role, as having an Independent Chair frees up all the members to participate on an equal footing, without any single agency having the added influence of chairing the Board.

**Director of Adult Services**
The Director of Adult Services is required to sit on the main Board of WSAB, as this is a pivotal role in the provision of adult and social care in Wigan Borough. This post is held by Stuart Cowley. The Director of Adults Services has a responsibility to make sure that the WSAB functions effectively and as such will liaise closely with the Independent Chair.

**Local Authority Chief Executive Officer**
The ultimate responsibility for the effectiveness of the WSAB rests with the Chief Executive of Wigan Borough, Donna Hall. The Director of Adults Services is answerable to the Chief Executive, who forms the final link in this chain of accountability.

**Lead member**
The elected councillor who has responsibility for Adult and Social Care, known as the Lead Member, sits on the board as a ‘participating observer’. This role is held by Councillor Keith Cunliffe. The Lead Member’s role is to scrutinise the WSAB and challenge it, if necessary from his political position, as a representative of the elected members and Wigan communities.

**Attendance**
The Board and its subgroups generally experiences good attendance and this is monitored. The chart below shows attendance at the Board in 2015/2016.
Section 4: Strategic Objectives

WSAB is committed to developing a strategy that is responsive first and foremost to the issues affecting the prevention of harm to vulnerable adults in the borough, and in order to do this the Board utilises a range of information including:

- Learning from Serious Case Reviews
- Learning from national reviews of practice
- Wigan’s performance data around key areas such as safeguarding enquiries under Section 42 of the Care act, serious incidents within the health sector, data from quality assurance frameworks regarding social care providers, information from police etc.

Each Strategic Objective was underpinned by a series of Key Objectives:

WSAB Key Priorities for 2015/2017

WSAB set key strategic priorities for 2015-2017 as set out below:

1. Ensure the board remains complaint with the Care Act.
2. Engage with individuals, families, communities and professionals.
3. Ensure a high quality workforce fully equipped to safeguard adults
4. Develop a performance management framework that will allow the board to demonstrate impact
5. Ensure high quality safeguarding through a robust quality assurance and case audit framework
6. Develop a strategy for Early Intervention and Prevention
7. Support the development of a Multi-Agency Safeguarding hub
Section 5: Progress against Strategic Objectives

The Board’s Sub Groups have provided reports into the Board regarding their activity in 2015/2016, and there is a review, at each board, of progress made and of areas that need the support of board partners to drive forward.

1. **Ensure the board remains complaint with the Care Act:**
   
   - Undertaking a review of board membership and sub groups, purpose and roles to ensure it is fit for purpose.
   - Undertake a review of subgroups role and function
   - Develop and embed key enabling policies and processes including an overarching Care Act Policy and Procedure, developing and piloting a self-neglect policy and procedure
   - Improve communication between partners, sub groups and practitioners.

2. **Engage with individuals, families, communities and professionals:**
   
   - Held a second successful Adult Safeguarding Conference in November 2015. This focused on key thematic areas such as Honour based Violence, Forced Genital Mutilation and Hate Crime amongst other key subject areas such as sense checking our approach to implementing the Care Act amongst multi-agency front line professionals
   - Developed a making safeguarding personal action plan closely linked to ‘The Deal’ and owned by Board partner organisations
   - Development work undertaken regarding a bespoke WSAB web site for professionals, service users, carers and families.
   - The Board invested in and appointed a WSAB Consultation and Engagement Officer to support delivering awareness of and engagement with communities, individuals and professionals and with lead responsibility for developing and implementing a strong and effective communication strategy
   - This role also focused on working with the community sector to develop new avenues for consultation and input on Safeguarding issues
   - Consolidated Board links with a wide range of other key partners such as Hindley Prison and Coroner’s Office.
   - WSAB remains an active partner in the regional and Greater Manchester safeguarding groups, and over 2015/2016 has contributed to policy and procedure updates around issues of Prevent, Female Genital Mutilation (FGM) and Human Trafficking
   - The Board has further strengthened its work with the other key strategic boards who have responsibilities for adults at risk including the Health and Well Being Board and the Building Stronger Communities Partnership

3. **Ensure a high quality workforce fully equipped to safeguard adults:**
   
   - Reviewed training plans and strategy to ensure they remain fit for purpose.
• Ensured there is clear guidance of expected levels of training – multi-agency, 3rd sector, community and volunteers.
• Monitored uptake of training by agency and challenge and support further uptake where deemed appropriate.
• Developed further evaluation of the impact of training on outcomes for vulnerable adults.
• Published a joint training brochure with Wigan Safeguarding Children Board with new thematic areas covered such as Preventing Violent Extremism.

4. Develop a performance management framework that will allow the board to demonstrate impact

• Ensured that learning from Serious Adult Reviews / Local Case Reviews / Case Audits etc. is captured and influences the transformation of services across the borough.
• Developed a performance reporting framework (including whole system performance and insight dashboard) and supporting data collection process
• Further developed the role and function of the learning and Improvement Sub Group including a holistic Learning and Improvement Action Plan
• This included inviting all agencies to consider their own data and how it might feed into a performance framework.
• Led by Adult Services, implemented a new case management and reporting system for adult social care and safeguarding that will allow for better data capture and analysis going forward

5. Ensure high quality safeguarding through a robust quality assurance and case audit framework

• Undertaken case file audits on key safeguarding themes identified from serious adult / local case reviews (safe hospital discharge, mental health, domestic abuse)
• Wider partners have contributed significantly to the overall wider quality assurance challenge and framework including
  ▪ Clinical Commissioning Group led review of safeguarding assurance framework and cycle for all health providers
  ▪ Provider Management and Market Development review and development of new framework for key aspects of social care

6. Develop a strategy for Early Intervention and Prevention

• Further expansion of the “Deal for Adult Social Care” across partner organisations and providers
• The Safeguarding Board has sought to develop a preventative response to themes that arise from Serious Adult Reviews / Local Case Reviews / Case Audits and has developed action plan that include early intervention / prevention opportunities across partner, services and processes

• The implementation locally of the Prevent strategy and Protocol, including increasing awareness across Board partner organisations through delivery of the Home Office Workshop to Raise Awareness of prevent to over one thousand front line staff

7. Support the development of a Multi-Agency Safeguarding hub

• The Board has supported the development of the Multi-Agency Safeguarding Hub, and been updated over the year on key thematic areas associated with this work stream including:
  ▪ The Domestic Abuse Steering Group has provided regular information to the Board as part of the performance and insight dashboard
  ▪ The needs assessment regarding Serious and Organised Crime produced jointly by GMP / Wigan Council has been scrutinised by the WSAB

• WSAB has supported the development of the Place Based Working initiative which has been very successful in the Platt Bridge area of the Borough. This is a project that is garnering national attention
Section 6: Performance Update on Key Strategic Areas

The WSAB has continued to work together as the key partnership to improve outcomes for the adults at risk of neglect and abuse and their families in the Wigan Borough. The Board continues to develop its oversight of performance, and has tasked its Learning and Improvement team to look at data held by partners to understand how it can evidence the impact of the Board’s work.

Currently, a range of specific outcomes are scrutinised on a regular basis, and these will be added to as data and intelligence becomes available.

- Improved outcomes regarding safeguarding investigations as specified by the Section 42 Duty to Enquire under the Care Act and delivered by Wigan Council’s Adults Social Care Team and their multi-agency partners.
- Ongoing monitoring of improvement plan progress made across wider social care providers (nursing and residential homes, domiciliary care providers etc.) led by Adult Services Provider Management and Market Development Team
- Clinical Commissioning Group led implementation of a refreshed and robust safeguarding Assurance Framework
- Individual inspections of partner agencies regarding safeguarding practice and processes.
- Regular reporting and scrutiny of outputs and outcomes regarding thematic interventions that contribute to the Boards objectives, examples include:
  - Multi Agency Public Protection Panels
  - Domestic Abuse interventions such as Operation Strive (that puts in place a response for all standard risk reported incidents, and that applies both a whole family and asset based approach to resolving low level domestic abuse)
- Oversight of Domestic Homicide Reviews and action plans

Social Care Outcomes
WSAB continues to work with Wigan Council on plans to improve outcomes for service users and their families engaged with Social Care. In 2015/16 we embarked on an ongoing programme of process and practice improvement that includes regular quality assurance audits and research. This has begun to highlight key improvement points for safeguarding including:

- Developing and implementing a response to self-neglect
- The need to update key training based on current practice issues within thematic areas including incorporating lessons from audits, case reviews etc.
- Development and implementation of a new social care case management system which incorporates a bespoke safeguarding process. This includes new options for social care practitioners to log and record decision making and outcomes within a specific “making safeguarding personal” work flow to assist with the challenge of embedding a person centred approach to safeguarding practice.
This new system was implemented in quarter four of 2015/16, and the Board contributed significantly to the safeguarding workflow and process.

Whilst reporting from this system is not possible for 15/16, data has been migrated from old systems and combined with new system outputs and has enabled data for the year to be compiled under the new Safeguarding Adults Collection (which is overseen by NHS Digital on behalf of the Department Of Health the ministry responsible for government collection of this data). This data replaces the previous national Safeguarding Adults Return framework. Due to the new way in which this data is collected, comparison with previous year’s returns is not possible.

In 2015/2016, there were 692 Section 42 Safeguarding Enquiries undertaken by Adult Social Care and involving wider partners, this involved a total of 597 victims.

- 32% of alleged victims were aged 18-64 years of age and 68% were 65 years old and over.
- 39% of alleged victims were male and 61% were female
- 96% of alleged victims were white.
- In terms of alleged victims primary reason for needing support:
  - 42% had a physical disability, frailty and / or sensory impairment.
  - 34% had a known mental health issue
  - 15% had a learning disability.
- In terms of the 692 investigations and enquiries, at their conclusion:
  - 25% of cases involved physical abuse
  - 32% involved neglect of acts omission (where an individual of service providing care to an individual/s failed in some aspect of their caring responsibilities)
  - 16% involved financial or material abuse
  - 11% involved psychological abuse
  - 4% involved sexual abuse
  - 6% involved discriminatory or organisational abuse
- Regarding the source of risk, 44% of cases involved some aspect social care support, 43% of the sources of risk were known to the individual and 9% were unknown to the victim.
- Further data is presented overleaf.
Safeguarding Enquiries by Location (%)

- Own Home: 50%
- Community Service: 5%
- Care Home: 5%
- Hospital: 2%
- Other: 38%

Safeguarding Enquiries - Adult Assessed as Lacking Capacity?

- Yes
- No
- Don't Know
- Not recorded

Safeguarding Enquiries - Type of Abuse (%)

- Physical Abuse
- Sexual Abuse
- Psychological Abuse
- Financial or Material Abuse
Safeguarding Alerts and Investigations

Further information is presented here detailing the total number of safeguarding alerts received by the Local Authority in 2015/16. Please note data for 2015/16 is generated from old AIS systems, a new case management and reporting system is now in place.

<table>
<thead>
<tr>
<th>Breakdown of Safeguarding Process 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of safeguarding alerts</td>
</tr>
<tr>
<td>Number of safeguarding strategy meetings</td>
</tr>
<tr>
<td>Number of case conferences held</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2015-16 Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of alerts that progressed to strategy meeting</td>
</tr>
<tr>
<td>Percentage of alerts that are agreed as no further action</td>
</tr>
<tr>
<td>Percentage of alerts that progress to case conference</td>
</tr>
<tr>
<td>Percentage of strategy meetings that progressed to case conferences</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes from Case Conferences 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partially substantiated</td>
</tr>
<tr>
<td>Fully substantiated</td>
</tr>
<tr>
<td>Findings inconclusive</td>
</tr>
</tbody>
</table>

Please note that there can be more than one finding at a case conference and that for the 86 case conferences held in 2013/2014 there were 171 findings.
Wigan Borough Clinical Commissioning Group

Wigan Borough CCG has in place robust systems for monitoring safeguarding issues across all primary and secondary health services via provider contracts. Within 2015/16, this involved using the NHS Provider Safeguarding Audit Tool to Monitor Standards based on CQC Essential Standards, 17 compliance standards relate directly to Adult Safeguarding. A table reflecting Quarter 4 of 2014/15 and the end of Quarter 4 2015/16 is presented overleaf.

Within 2016/17, CCG will review and implement a refreshed framework regarding safeguarding assurance for health providers and ensure regular reporting within the WSAB performance and insight dashboard
There is a board lead for safeguarding children and vulnerable adults

The organisation is linked into the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adult Board (LSAB)

There is a named lead for safeguarding children and a named lead for vulnerable adults.

The Provider Board regularly reviews safeguarding across the organisation.

An adverse incident reporting system is in place which identifies circumstances/incidents which have compromised the safety and welfare of children and or vulnerable adults

A programme of internal audit and review is in place that enables the organisation to evidence the learning from review, incidents and inspections

Staff at all levels, have easy access to safeguarding policies and procedures. These policies and procedures must be consistent with statutory, national and local guidance. (policies as per Appendix 1)

There is clear guidance on managing allegations against staff and volunteers working with children and or vulnerable adults in line with those of the LSCB and LSAB.

There is a process for ensuring that patients are routinely asked about dependents such as children, or about any caring responsibilities

All staff have access to clear policy, procedures and documentation to support implementation of the Mental Capacity Act (2005) which incorporate, when appropriate, the management of patients under The Deprivation of Liberty Safeguards (2009).

There are agreed systems, standards and protocols for sharing information within the service and between agencies in accordance with national and local guidance.

The organisation works with partners to protect children and vulnerable adults and participates in reviews as set out in statutory, national and local guidance

Safeguarding responsibilities are reflected in all job descriptions relevant to role and responsibilities

Staff working directly with children and vulnerable adults have access to advice support and supervision. This includes clinical and safeguarding supervision as per the organisations safeguarding supervision policy

Named professionals seek advice and access regular formal supervision from designated professionals for complex issues or where concerns may have to be escalated.

There is a training strategy for safeguarding

All staff who are required to work within the legislation associated with the Mental Capacity Act receive sufficient training to enable implementation. When appropriate this will incorporate training in relation to the use of physical intervention.
Hate Crime and Incidents

Within 2015/16, 10,546 hate crimes and incidents were reported to Greater Manchester Police across the whole of the region. Within Wigan for the same time period, 760 hate crimes and incidents were reported (an increase of 40% compared with 2014/15 – GMP have worked to increase the number of reports through internal awareness raising amongst front line police officers to improve recording, plus have worked to increase the number of third party reporting opportunities for victims). The table shows both the Wigan and Greater Manchester totals broken down by hate motivation and for the previous year (14/15).

<table>
<thead>
<tr>
<th></th>
<th>Wigan 14/15</th>
<th>Wigan 15/16</th>
<th>GM 14/15</th>
<th>GM 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hate motivations</td>
<td>263</td>
<td>360</td>
<td>3914</td>
<td>4849</td>
</tr>
<tr>
<td>Alternative Subculture</td>
<td>1</td>
<td>12</td>
<td>13</td>
<td>30</td>
</tr>
<tr>
<td>Disability</td>
<td>19</td>
<td>33</td>
<td>161</td>
<td>233</td>
</tr>
<tr>
<td>Race</td>
<td>191</td>
<td>243</td>
<td>3203</td>
<td>3967</td>
</tr>
<tr>
<td>Religion</td>
<td>8</td>
<td>18</td>
<td>287</td>
<td>433</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>45</td>
<td>67</td>
<td>423</td>
<td>492</td>
</tr>
<tr>
<td>Transgender</td>
<td>9</td>
<td>6</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>No Motivation Listed</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sex/Gender (obsolete)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anti-Semitic</td>
<td>0</td>
<td>2</td>
<td>173</td>
<td>155</td>
</tr>
<tr>
<td>Asylum Seeker/Refugee</td>
<td>0</td>
<td>3</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Gypsy Traveller</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Islamophobic</td>
<td>6</td>
<td>13</td>
<td>167</td>
<td>315</td>
</tr>
<tr>
<td>Migrant Worker</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

- The highest hate motivation across Greater Manchester and within Wigan was race based. This reflects the focus over the past few years on hate crime between minority ethnic types.
- There were increases in all of the monitored hate crime strands (race, religion, sexual orientation, disability and transgender identity) between 2014/15 and 2015/16.
- Further work is planned by the Building Stronger Communities Partnership across 2016/17 regarding piloting new approaches within the broader work stream of developing a multi-agency safeguarding hub, as well as piloting a new advocacy service with targeted groups (disability etc.) to increase reporting and outcomes for victims.
- This supports the view of the WSAB that hate crime is vastly under-reported, particularly within the motivation of disability.
Domestic Abuse

### Domestic Abuse Incidents (GMP Monthly Performance Bulletin)

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMP</td>
<td>67069</td>
<td>64130</td>
</tr>
<tr>
<td>Wigan</td>
<td>7246</td>
<td>7062</td>
</tr>
</tbody>
</table>

### Domestic Abuse Crimes (GMP Monthly Performance Bulletin)

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMP</td>
<td>19619</td>
<td>18717</td>
</tr>
<tr>
<td>Wigan</td>
<td>2033</td>
<td>1940</td>
</tr>
</tbody>
</table>

### Domestic Abuse Repeat Crimes

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>454</td>
</tr>
<tr>
<td>2015/16</td>
<td>465</td>
</tr>
</tbody>
</table>

- Reported domestic abuse decreased slightly between 14/15 and 15/16. This is in line with Greater Manchester and national trends.
- Within 2015/16, the Building Stronger Communities Partnership continued to embed the coordinated community response model for domestic abuse, at the heart of which is the multi-disciplinary co-located Integrated Safeguarding and Public Protection (ISAPP) Team.
- The ISAPP Team consists of Children’s and Adults Senior Social Workers, Housing Officers, Independent Domestic Violence Advocates, Young Person’s Domestic Abuse Advocate, Greater Manchester Fire and Rescue Service Officers, Substance Misuse Outreach Workers alongside all of Greater Manchester Police’s Public Investigation Unit officers. Through effective sharing of partnership data and whole system risk assessment, MARACs are held three times a week with effective case management care plans developed within meetings. Appropriate agencies are identified as lead agency for all medium and high-risk crimes (around a third of all reported crimes form the tables above) reported to the Police, and case management plans are effectively implemented by the team. Health agencies and National Probation Service / Community Rehabilitation Company are also an integral part of the process and attend MARAC meetings as well as provide information relating to their management of individual cases.
- In addition to the ISAPP team, 2015/16 saw the introduction of a pilot, Operation Strive to support victims who were risk assessed as standard (and weren’t therefore currently being supported by ISAPP – for context this involves around 85% of all reported crimes). Delivered by GMP officers in 2015/16, all standard crimes are now followed up and through root cause analysis and different conversations, victims, offenders and their families are offered appropriate support. Data from GMP at the regional level suggest this is having a significant impact on repeat presentations (analysis from May 2016 looking back at around 9 months of
delivery suggested that post incident revisits were reducing overall repeat presentations by 50%.

- Within 2016/17 and beyond, revisits will be delivered by volunteers who are trained to engage with victims, offenders and families. The Building Stronger Communities Partnership will continue to develop this approach and report back to WSAB.
- The Independent Violence Advocate Service also began working in a dedicated way within the Royal Albert Edward Hospital, with one full time IDVA attached in per week. Working on a whole hospital approach, this is starting to provide support through early disclosure for victims. Work is underway to provide a full cost benefit analysis of this approach in 2016/17.
- Within 2016/17, and building on the success of the ISAPP model, the WSAB will continue to support the development of a Multi-Agency Safeguarding Hub through the Public Service Reform Programme Board.

Serious and Organised Crime

Serious and organised crime costs the United Kingdom at least £24 billion a year. It is estimated that there are around 5,600 active organised crime groups operating against the UK, compromising of about 39,000 people. The illustration below shows the estimated social and economic costs of different types of organised crime¹.

![Cost of Organised Crime](image)

In October 2013 the Government’s Serious and Organised Crime Strategy was launched. It covers four core themes:

¹ Source: Home Office ‘Serious and Organised Crime Strategy’, published October 2013. NB While costs do vary across the different crime types, differences in how the various estimates were calculated means they are not directly comparable.
Pursue: prosecuting and disrupting people engaged in serious and organised crime;
Prevent: preventing people from engaging in serious and organised crime;
Protect: increasing protection against serious and organised crime;
Prepare: reducing the impact of this criminality where it takes place.

The WSAB recognise the disproportionate impact that key forms of serious and organised crime have on vulnerable adults, and have scrutinised a jointly produced (between GMP / Wigan Council) Local Profile. The next sections details findings from this report on key thematic areas.

**Human Trafficking / Modern Day Slavery**

In order to develop a consistent and coordinated response GMP have a dedicated Modern Slavery Coordination Unit (MSCU) within the Organised Crime Coordination Unit (OCCU). This is a multi-agency team which includes Home Office Immigration, Police, Probation, Local Authority and Gang Masters Licensing Authority. The stated purpose of the unit is to provide specialist operational support, partnership review of investigations, development and the delivery of training to front line staff.

According to GMP’s Organised Crime Co-ordination Unit (OCCU) there were 198 separate intelligence reports, crimes and incidents relating to Human Trafficking and Modern Slavery in GMP between March-October 2015\(^2\). It is important to note that these are not confirmed crimes, but a collection of all these sources. Of this number, reports within Wigan are low with only 10 intelligence reports recorded (5%).

Only 3 intelligence reports were made about Human Trafficking in Wigan between April 2014 to May 2015. Several of these intelligence reports have since been investigated with enquiries ruling out any actual offences.

Although significantly lower than other intelligence topics, the content of the intelligence reported to Police in Wigan poses a substantial risk to the safety and well-being of individuals. Each of the reports received during these periods mention named individuals who are suspected of being trafficked into the UK and forced to conduct manual labour.

**Honour Based Violence**

- The term ‘honour based crime’ covers any criminal offence that is driven by a mistaken desire to protect the cultural or traditional beliefs of a family or community. It may or may not involve violence. It can include:
  - Personal attacks of any kind, including physical and sexual violence.
  - Forced marriage.

\(^2\) As above.
- Forced repatriation (sending someone back to a country from which they originate without their consent).
- Written or verbal threats or insults.
- Threatening or abusive phone calls, emails and instant messages.

- Honour Based Violence can be distinguished from other forms of violence, as it is often committed with some degree of approval and/or collusion from family and/or community members.
- National data indicates that many of these issues remain unreported for many reasons including fear of reprisals, becoming ostracized from families and communities, as well as acceptance and tolerance given that many of the offences have been instilled within communities for many years.
- Within 2015/16, the WSAB worked with partners to begin to examine the issue in more detail, including assessing the extent and nature of local risks regarding this issue, and the issue was highlighted at the November 2015 Conference.
- Work progresses to establish this within WSAB training products, to raise awareness across front line staff.
Section 7: Training and development

The Training and Development Sub Group oversee the training provided by the Board. The Sub Group is chaired by the Assistant Director for Safeguarding from Wigan Borough Clinical Commissioning Group.

Safeguarding training offered by the Board is continually reviewed and updated as a result of learning from reviews and case audits. For 2015, the WSAB training programme has been made available via a website rather than published. This is to ensure it is easily accessible to a wider audience and is regularly updated with regards to course availability and venue. The table below provides an overview of 2015/16 training provided.

<table>
<thead>
<tr>
<th>Training Topic</th>
<th>Internal</th>
<th>External</th>
<th>Sum:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults - Basic Awareness</td>
<td>123</td>
<td>294</td>
<td>417</td>
</tr>
<tr>
<td>Safeguarding Adults - Bespoke</td>
<td>17</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults - Foundation</td>
<td>93</td>
<td>100</td>
<td>193</td>
</tr>
<tr>
<td>Safeguarding Adults - Managing Initial Concerns of Abuse</td>
<td>13</td>
<td>38</td>
<td>51</td>
</tr>
<tr>
<td>Safeguarding Adults - S42 Investigative Practice</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Safeguarding Adults - S42 Investigator Training</td>
<td>25</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Sum:</td>
<td>278</td>
<td>434</td>
<td>712</td>
</tr>
</tbody>
</table>

Whilst the Care Act places no responsibility on SABs to provide safeguarding training, it is clear that the role of the Board should be to

- To understand the training needs of the workforce.
- To monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children and adults at risk of abuse.
- To evaluate the impact of training upon practice to improve outcomes for adults at risk and their families.

The current challenge for WSAB has been to discharge their multi-agency training and staff development role during a period of organisational instability ensuring that training provides value for money as budgets come under increasing pressure across the public sector and meeting the aspirations of the Board to deliver high quality and safe services to vulnerable adults.

Achievements to date

The training and development sub group has continued the partnership with e-Academy to develop an innovative e-learning solution to enhance the learning process for those who work within our Borough. We have additional modules available to meet the learning needs of the
workforce. Our partnership with the virtual college enables us to disaggregate data, compile and run reports to provide up to date information. Each learning and development activity has been regularly reviewed and redesigned to ensure that it presents up to date, relevant, localised information. During 2015/16 WSAB took steps to align all parts of the system to financial years. This has made reporting more difficult for this year’s report as previously reports ran from September to August.

**Commissioned Training - Zoe Lodrick**

Following her presentation at the WSAB conference in 2014, Zoe Lodrick was invited to deliver four very successful sessions on “Working with Victims of Sexual Violence” commissioned by GMP in partnership with WSAB. 444 delegates attended, 75% of these completed an evaluation. An evaluation report was completed and a number of comments referred to Zoe's knowledge and skills in putting that knowledge across and "making complex issues easy to understand and relate to practice". 100% of delegates stated they had better understanding of why victims behave as they do. "It has explained how victims think and form relationships to people and the relevance of those relationships", "mind boggling- it all makes perfect sense now". Many references were made to the use of analogies or metaphors, for example "Evian water" "broken biscuits". The impact of this is clear and through the use of stories served to link theory to the impact on victims and practice. 98% said their practice would change as a result of the training.

**Operation Challenger**

47 staff attended training by GMP regarding serious and organised crime. Feedback demonstrated increased understanding of the issues and guidance regarding reporting. The multiagency attendees reported more confidence in reporting to GMP their concerns.

**Disability Awareness training to taxi drivers**

In partnership with the Licensing department, training has been offered to 900 taxi drivers and 750 attended in 2015/16. Although some drivers were resistant and anxious about attending, feedback on the day from several of the drivers was positive. Following one of the sessions a driver made a referral to social care about a child. He reported this was a direct result of the training as through the training he was aware of his responsibilities to act on his concerns, knew who to contact and was confident to do this. Further training sessions are planned in 2016/17 until all 1250 drivers are trained. The course was quality assured by an external trainer and was highly recommended. Wigan has led the way across Greater Manchester and the presentation has been shared across the North West.
Training sub group

The training sub group has met regularly throughout the year, combining with the Children's Board during the year. The terms of reference have been revised and a standardised presentation with agreed slides to be used across all courses has been agreed. The training strategy and plan is being developed. All training packages are to be ratified by the training sub group.
Section 8 - Engagement and Consultation

Engagement with Professionals

Annual Conference

The 2015 WSAB Annual Conference was attended by over 200 professionals and gave the Board an opportunity to increase awareness around Honour Based Violence / Forced Marriage, Hate Crime, and Forced Genital Mutilation. Presentations were also delivered by legal experts regarding issues such as Inherent Jurisdiction of the High Court.

Delegates heard about the impact of local services such as the Live Well Team who address complex dependency in adults from an asset based perspective. This also involved hearing from a Live Well Team service user who had benefitted from this approach.

Delegates were also given the opportunity to take part in a workshop presented by Aftathought, which posed a series of challenging questions and explored professionals practice around safeguarding vulnerable adults.

Engagement with the Community

In 2015/16, WSAB resourced and appointed a Communications and Engagement Officer. Within 2016/17, this post will develop an increased social media presence through Twitter, and implement the WSAB web site. They will embed engagement and consultation with service users and their families through creating key partnership links with agencies such Healthwatch and wider community voluntary groups, and critically through specific actions identified with Serious Adult / Local Case Reviews and audit processes.

The central Wigan Safeguarding Board staff has also donated their volunteer days, supported by Wigan Council, to support local initiatives at Haigh Hall and an allotment project.

<table>
<thead>
<tr>
<th>Income</th>
<th>2015/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transferred from 2014/2015</td>
<td>£104,270</td>
</tr>
<tr>
<td>Wigan Council</td>
<td>£50,000</td>
</tr>
<tr>
<td>Wigan Borough CCG</td>
<td>£50,000</td>
</tr>
<tr>
<td>5 Boroughs Partnership NHS Foundation Trust</td>
<td>£15,000</td>
</tr>
<tr>
<td>Bridgewater Community Healthcare Trust</td>
<td>£15,000</td>
</tr>
<tr>
<td>Wrightington, Wigan and Leigh NHS Foundation Trust</td>
<td>£15,000</td>
</tr>
<tr>
<td>Training income</td>
<td>£2,250</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£251,520</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>2015/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Chair</td>
<td>£9,711</td>
</tr>
<tr>
<td>Salaries and Sundries</td>
<td>£64,015</td>
</tr>
<tr>
<td>Conference, training and publicity</td>
<td>£19,516</td>
</tr>
<tr>
<td>IT, Room Hire, sundries</td>
<td>£5,234</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£98,476</td>
</tr>
</tbody>
</table>

| Carried Forward to 2014/2015               | £153,044  |

In 2014/2015, WSAB undertook a review of partner contributions and agreed a formula for contributions. Partners contribute financially and additionally they offer staff time and resources.

During 2015/2016, there were a number of staff vacancies that took some time to fill, leading to a significant underspend on salaries. Vacancies will be filled within 2016/17 and salaries are expected to be on budget in 2016/2017. Additionally, there is a restructure underway that will review the capacity within the team given the increase demand around case reviews, audits and training.

A number of case reviews are underway and reserves are retained to fund independent chairs.
10. Partner Updates

Bridgewater NHS Community Healthcare Foundation Trust

During 2015/16, Bridgewater Community Healthcare NHS Foundation Trust have contributed to work as part of the multiagency work of the Safeguarding Boards including

A new Named Nurse for Safeguarding Adults commenced with the trust in March 2016. New robust processes and flow charts have been put in place for staff to access with the updating of the adult safeguarding pages on the staff intranet (Hub). This now includes guidance for staff on ‘what to do if you have a safeguarding concern’, who to contact with a concern (internal, Local authorities, CCG’s and/or police if required), updated safeguarding policies and procedures and links to the local safeguarding Adults boards. There are also Individual guidance pages on Mental capacity, Deprivation of Liberty Safeguards, Prevent, training, Domestic Abuse, information on self-neglect, modern day slavery and transitioning from children’s to adult services.

If a staff member has a potential or actual safeguarding concern, they can access their manager, a safeguarding champion or contact, via phone or email, the named nurse for safeguarding adults for verbal advice and further discussion. All safeguarding adult incidents are logged on the Trust’s incident reporting system so a record of concerns can be logged, saved and audited. Staff are also encouraged to access the out of hours manager or the adults local authority for those concerns outside of Monday to Friday office hours for further support or advice to prevent any delay in reporting a concern.

All staff are asked to ensure any adult at risk is supported and encouraged to make their own decisions. Staff are encouraged to ask the adult what they want to happen about the situation they are in and does the adult consent to reporting the incident to other agencies. If an adult at risk does not consent for information being shared, staff are encouraged to ensure other support services are offered and they continue supporting the adult if necessary at their next visit. It is important that sometimes sharing information without consent can be legitimate where there is the wider public interest, mental capacity issues or a crime has been committed but is also important to recognise the adult at risk wishes and needs are personalised and documented and they are kept fully informed on who information is going to be shared with if require.

We have worked in partnership with all agencies in relation to the local and serious case reviews that have been undertaken by the Wigan Borough Safeguarding board and contribute positively to the process.

Challenges 2016/17

There is currently only one named nurse for adults in the adult safeguarding team and this gives constraints for a day to day operational and from a strategic point of view
The statutory and mandatory training offer across the Trust has been reviewed with the aim of improving the quality of provision. The new offer commenced on 1st May 2016 and has been mapped to the National Core Skills Framework (which we have now aligned to) and the Care Quality Commission (CQC) Standards. TheNamed Nurses have reviewed the content of the eLearning programmes and have found them to be suitable to meet the training needs of staff.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Clinical Staff</th>
<th>Non-clinical Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once</td>
<td>Wrap 3 face-to-face</td>
<td></td>
</tr>
<tr>
<td>2 Yearly</td>
<td>Safeguarding Adults Level 2 eLearning</td>
<td>Safeguarding Adults Level 2 eLearning</td>
</tr>
<tr>
<td>3 Yearly</td>
<td>Mental Capacity Act &amp; Deprivation of Liberty Safeguards eLearning Prevent eLearning Safeguarding Adults Level 3</td>
<td>Prevent eLearning</td>
</tr>
</tbody>
</table>

The Named Nurse for Safeguarding Adults has undertaken a review of the training available. MCA and DoLS were identified as a priority for the inpatient units and a face-to-face training package was developed and commenced in June 2016. This is in addition to the eLearning that is a mandatory 3 year requirement. A Level 3 adult safeguarding training package, in line with the Bournemouth competencies, is currently being developed to deliver to all relevant identified staff.

A robust adult safeguarding audit plan needs to be developed in line with previous audits.
Wrightington, Wigan and Leigh NHS Foundation Trust

The Safeguarding of all our patients remains a priority for Wrightington, Wigan & Leigh NHS FT and is a fundamental component of all care delivered.

All staff within WWL has a responsibility to help prevent abuse / harm to adults at risk, ensuring that where abuse is suspected, it is acted upon quickly and proportionately to protect the adult at risk.

In line with previous years, the increase in referrals / concerns raised in respect of adult safeguarding within WWL NHS FT continued throughout 2015/16. There were a total of 438 concerns/ referrals raised, with the continued trend of increase in applications for Deprivation of Liberty Safeguards (DoLS), 128 for the reporting period.

We have also seen an increase of concerns raised in respect of the acute hospital, 33 in total for the reporting period. The source and nature of these referrals are varied, 4 were raised by hospital staff. Each concern raised has been investigated and addressed. WWL continues to work collaboratively with partner agencies in local case reviews as and when required.

<table>
<thead>
<tr>
<th>Total</th>
<th>Hospital</th>
<th>Concern For Welfare</th>
<th>Carer</th>
<th>Domestic Abuse</th>
<th>Care Home</th>
<th>DoLS</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>56</td>
<td>90</td>
<td>21</td>
<td>62</td>
<td>48</td>
<td>128</td>
<td></td>
</tr>
</tbody>
</table>

Safeguarding Referrals/Concerns - 2015/16
The main challenge faced in 2014/15 was the roll out of the e mandatory training on Mental Capacity Act & Deprivation of liberty Safeguards (MCA / DoLS).

Following the successful trial of the e learning course with a group of multi-agency staff, this training was rolled out across the organisation at the beginning of September 2015.

Compliance rate with the training stood at 92.6% at the end of March 2016.

Compliance monitoring continues and, in addition, face to face training sessions continue to be delivered monthly.

Challenges 2016/17

There are a number of Safeguarding challenges that the acute trust will face in the coming year, the challenge to ensure Safeguarding is made personal is ongoing, and the continued close working with all stakeholders to ensure the principles of safeguarding are embedded in practice to achieve this is paramount.

In addition, there are the following key challenges:

- Year on year increase in referrals / concerns raised to WWL adult safeguarding team
- Increase of involvement in local and serious case reviews

Delivering the domestic abuse agenda that includes awareness /advice and information on FGM; Modern Day Slavery & Honour Based Violence

Case Study

The following case study demonstrates how WWL NHS FT have worked with partners to ensure that safe effective and equality of care is delivered to all who use services within the acute Trust and that all patients receive the best possible experience.

WWL is committed to integrated working with the hospital liaison team for Learning Disabilities, (LD), to ensure safe and effective care delivery for individuals with a learning disability who access any of our services.

Hospital tours of individuals with an LD, of A&E and TLC outpatient department, have been running for a couple of years. The aim of the tours is not only to show the
individual with a learning disability, what they can expect should they ever have to attend hospital either in emergency (A&E), or at outpatients, but also to raise the awareness and understanding of the staff who deliver the care, of the specific needs and requirements for this group of patients and the potential complexities that may arise.

Lloyd is a young man who has been attending the tours from the very beginning.

He has a fear of needles and petrified of attending hospital. Each tour that Lloyd attended, the team managed to get him a step further in the process of the journey through A&E. Following an accident Lloyd required a tetanus injection, Staff Nurse form A & E, who leads the tours, was contacted, this meant that she was familiar to Lloyd, and managed to get Lloyd to accept her giving him the injection and he watched it all. As you can see below, this was a huge breakthrough and demonstrates that the smallest of actions can have the biggest and most effective impact.
Wigan and Leigh Homes

Wigan and Leigh Homes, as the largest manager of social housing within the borough is committed to its responsibilities with regard to safeguarding adults at risk across the borough.

Many Wigan and Leigh Homes staff and our partner contractors meet with customers in their own homes on a day to day basis for various reasons and as such have a privileged insight to customers’ lives that other agencies and professionals may not.

Building Communities is a strategic priority for WALH where a culture of prevention rather than reaction is being developed. With this in mind, identifying vulnerable customers and supporting them through the principles of The Wigan Deal is integral to our daily business as well as working closely with all partners and agencies.

To demonstrate our commitments to safeguarding adults at risk we:

- are active members of the Adult Safeguarding Board and its sub groups.
- ensure that awareness about safeguarding adults and children is maintained across the organisation. Our focus is to ensure that all staff in the organisation are able to recognise, respond and refer any potential risk they may come across within their work and proactively prevent harm in line with the Safeguarding Board’s Policies and procedures.
- have an ongoing training plan for all staff within the organisation. Safeguarding awareness is mandatory. We have also devised and delivered safeguarding awareness training to our partner contractors, board members and our tenants and residents groups.
- Domestic Abuse – Integrated Safeguarding and Public Protection Unit - We continue to have one of our Housing Advisors based within the Integrated Safeguarding and Public Protection unit dealing with all high risk victims and perpetrators of domestic abuse. Being part of this team allows for quick housing interventions to take place where the victim has requested them such as moving out of the property or help in applying for injunctions or amendments of tenancies. The advisor’s role is also to provide the victim with the right information and support to allow them to reach an informed choice.
- A WALH officer now works with the Council’s Initial Assessment Team. Any referral coming through where the reason is either unsuitable living conditions or inadequate housing is passed through to the housing officer to case manage and find resolutions with the aim the case being sent on to the social care locality team.
- To reduce delayed discharge and prevent un-necessary admissions at Wigan Infirmary, Wigan and Leigh Homes have appointed two Hospital Discharge Officers funded by the CCG. Over the last twelve months officers have dealt with 408 cases and made savings of £353,600 to the NHS alongside 550 bed days saved. The work of the Officers is having a significant impact on safeguarding individuals.
• We have a Financial Support Team that work in conjunction with the main rents service. Their role is to provide specialist budgeting and debt advice to those customers that need it the most. The team refers any suspected financial abuse or other abuse to appropriate agencies.

• Across sheltered housing schemes and on estates we look to support a wide range of community projects. We look to create opportunities and organise events to facilitate wellbeing, education, employment and tackle social isolation. To do this we work with volunteers and other partner agencies.

• Our Tenancy Sustainment Team has the capacity to support approximately 250 of the most vulnerable tenants and the primary focus of the service is to assist these households to establish and maintain a successful tenancy, maximise income and secure employment.

• During 2015/16 the Support Officers all attended a number of courses around the “Deal” including the Adult Deal and Different Conversation training. As a direct result of this training the Support Officers are now taking an asset based approach to their work, identifying peoples’ skills and attributes so as to develop a support plan with an outcome focused on enhancing an individual’s resilience, self-reliance and independence. The Support Officers now utilise the Community Connectors and increasingly use third sector organisations to complement their work in building successful communities and to reduce social isolation and loneliness within the client group.

During 2015/16, a total of 20 adult safeguarding referrals were made to the Initial Assessment Team by WALH

Our first challenge for last year was to ensure compliance with The Care Act 2014 Statutory guidance in relation to safeguarding, staff are undertaking E-learning which is still ongoing.

Secondly, we recognised a challenge would be as resources tighten to continue our commitment to effectively contribute as a partner to the Safeguarding Agenda within the Borough. This has been undertaken as a priority when any remodelling and restructuring of services has taken place.

**Challenges 2016/17**

To review the training plan for WALH staff, board members and partner contractors.

To continue to ensure safeguarding is embedded across the organisation.

**Case Study**

**Complex case to facilitate safe return home with support from the homeless prevention fund**

Mr. X is an elderly gentleman who lives in a WALH tenancy. He had been admitted to hospital after he had collapsed in his property. Mr. X also suffered with incontinence. Mr. X was not previously known to any services.

The ambulance service reported that his flat was in an extremely poor condition and reported to
the ward that he shouldn’t return home in its present condition.

The Hospital Discharge Worker and a Social Worker carried out a joint assessment. At this assessment Mr. X was adamant that he wanted to return home and didn’t want to be rehoused into Sheltered housing or Residential care.

The Hospital Discharge Worker and Social Worker visited the property to inspect its condition and noticed the following:

- All floor coverings were in a poor state and damp with urine.
- The flat was dirty and untidy.
- There was a lack of food in the fridge.

A joint decision was made that if Wigan and Leigh Homes funded a deep clean and replaced the floor coverings, then Social Care would commission a full package of support which included visits 4 times per day, Including personal care and meals daily.

This action meant that Mr. X could safely be discharged from hospital straight away. In addition to this he is now receiving the support he requires to make his tenancy sustainable and potentially cut down on repeat admissions to hospital.
Wigan Borough Clinical Commissioning Group

Wigan Borough Clinical Commissioning Group (WBCCG) continues to deliver the safeguarding agenda by ensuring that the services it commissions have the necessary systems, processes, policies and procedures to protect and safeguard adults at risk.

Empowerment

Supporting service users and/or their representatives to voice complaints regarding the care and treatment they receive from WBCCG funded services remains a key work stream. For example, this past year a number of service users have been personally supported by the Assistant Director of Safeguarding – Adults to complain about the treatment they have received from mental health services, care homes and sports clubs.

Protection

Protecting adults at risk by way of commissioner visits remains an important way of hearing about and understanding patient experiences of services. Such visits drive quality standards and the findings of visits are shared with colleagues from the Local Authority, Care Quality Commission and Healthwatch as appropriate to ensure a consistent approach to maintaining quality service provision. This past year, WBCCG has undertaken visits to the Royal Albert Edward Infirmary, Home Treatment Team (mental health) and Neurological Rehabilitation Unit (elderly). The visits have been a positive experience and have identified good practice across each of the services.

The Assistant Director of Safeguarding – Adults has delivered presentations/training to GPs across the Borough in respect of Female Genital Mutilation (FGM) including reporting and responding appropriately to suspected cases of FGM.

Prevention

Delivering the government counter terrorism agenda remains a key work stream for the Safeguarding Team. The Safeguarding Team supported by the Equality and Diversity lead continue to deliver training to General Practices and internally to WBCCG staff. The Assistant Director of Safeguarding – Adults continues to attend the Wigan Prevent Delivery Group and North West Regional Group in order to keep abreast of developments in this important field.

Presentations/training sessions regarding domestic abuse and the lessons emerging from Domestic Homicide Reviews have been delivered to GPs by the Assistant Director of Safeguarding – Adults in order to raise awareness and ensure an appropriate response when such behaviour is reported or suspected.

Partnership

The Assistant Director of Safeguarding continues to work in partnership with colleagues from the Local Authority, Acute Provider Trust and in some cases the Police to investigate concerns regarding the quality of pressure ulcer care within Care Homes across the Borough. This work
stream often identifies good practice which is shared as appropriate but also identifies areas for improvement which is also shared in order that learning is disseminated across the Borough. Crucially, this work often involves the families of service users and patients who are encouraged to contribute to investigations and case conferences in order that their loved one’s voice is heard.

WBCCG continues to work in partnership with colleagues from the three main providers of acute, community and mental health services, separately on a bi-monthly basis. The areas of assurance monitored include: responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards, monitoring against the NHS Provider Safeguarding Audit Tool, monitoring in relation to progress against Serious Case Review, Domestic Homicide Review and Local Case Review action plans and monitoring of the management of allegations against staff working within healthcare providers.

Challenges and work undertaken within 2015/16 include:

- The Safeguarding Vulnerable Adults Toolkit for General Practitioners was sent to all 63 practices across the Borough. By the end of March, 61 completed toolkits were returned with each practice self-assessing themselves against 18 safeguarding standards. To support the launch of the toolkit the safeguarding team re-established the GP Safeguarding Lead meetings.
- The Assistant Director of Safeguarding – Adults continues to deliver training, advice and support to care homes regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, a more targeted approach has been taken than in previous years with a focus on Care Homes where issues regarding MCA and DOLs have emerged via audit, safeguarding concerns etc.
- Prevent training remains a challenging agenda in terms of Providers and GP Practices meeting training compliance targets. The agenda is monitored closely via the Quality, Safety and Safeguarding Group Meetings held bi-monthly with each of the Providers.
- GP Practice Safeguarding Leads Meetings have been reintroduced this year to positive effect. To date, a number of important safeguarding agenda items have been presented and discussed including; Female Genital Mutilation, GP Toolkit, Domestic Homicide Reviews and training.

Challenges 2016/17

- Improve the oversight and governance in relation to performance against safeguarding contractual standards contracts with our smaller providers.
- Further develop the GP Safeguarding Lead Meetings and GP Safeguarding Assurance Tool.
- Develop a Safeguarding Adults at Risk Health collaborative.
- Continue to work in partnership with colleagues to improve the quality of Care Homes.
North West Ambulance Service

North West Ambulance Service NHS Trust is a regional service providing pre-hospital emergency care, Urgent Care and 111 services and Patient Transport Services.

Safeguarding activity has increased throughout the year which is reflected in the increase in the numbers of safeguarding concerns raised about adults at risk. The numbers are broken down into geographical area (GM=Greater Manchester, CM=Cheshire and Mersey and CL=Cumbria and Lancashire).

The implementation of the Care Act 2014 with its focus on personal choice and empowerment for patients has resulted in an increase in requests to be involved in Adult Reviews and Strategy Meetings. Senior Clinicians and Managers support staff with engagement in safeguarding processes and regularly represent the Trust at associated meetings.

Each month the NWAS safeguarding concerns rejected by Adult and Children’s Social Care are scrutinised to understand the themes and either re-allocated to the correct service or to the patients GP. Less than 6% of adult concerns are rejected. The rejections relate predominately to mental ill health for adults and the Trust is working towards developing referral pathways with partners to address the risks.

Quality Audits

Audits have been introduced to monitor the quality of safeguarding calls made by staff to the Trust Support Centre. This provides additional data relating to safeguarding knowledge and how the process has facilitated information sharing. Early indicators show that referral information is of a high quality and is captured and documented by the Support Centre Advisors accurately. Areas for improvement are highlighted and raised with the staff concerned for their learning.

PREVENT awareness and training

92% of all NWAS staff have now received WRAP 3 training which is the ‘workshop to raise awareness of PREVENT’ and part of the Government’s anti-terrorism strategy. Prevent is any terror related activity that takes place in the pre-criminal space. WRAP is included within mandatory training for all staff and compliance with this national requirement has increased during 2015/16.
The Trust will be updating its mandatory training relating to Human Trafficking, Modern Slavery and Domestic Abuse in the Next Year. Training in these subjects is currently available within the Trust Learning Zone and is accessible to all staff.
5 Borough’s Partnership (Mental Health Trust)

The Trust continues to promote the key principles of safeguarding, as determined by the Care Act 2014, across our footprint.

The Trust has an approved Safeguarding Strategy which sets out the Safeguarding Assurance Framework for the implementation of safeguarding arrangements within the organisation, the accountability structures and the methods of monitoring to provide assurance of delivery of safe working practices in line with Trust Safeguarding Policies.

The Safeguarding Adults team provide advice, guidance and support to all Trust staff, as well as training and quality checking safeguarding adults’ activity in each of our 5 boroughs covering all of our services (Mental Health, Learning Disabilities, Later Life and Memory Services, Child and Adolescent Mental Health Services, Forensic and Community Health Services). Under the Making Safeguarding Personal agenda practitioners reporting concerns to the team are guided to asking the individual concerned what they want to happen, are they aware of safeguarding and what this means to them and more importantly what they don’t want to happen.

Following the Saville enquiry and the subsequent Lampard report (2015) the Trust has undertaken a wide scale review of its Involvement Scheme. The scheme is designed to provide a safe and efficient process to enable volunteers to become involved in all stages of designing, delivering and monitoring Trust services. The Trust is committed to involving patients, service users; carers and members of the public (volunteers) in a wide range of our business. We appreciate the unique contribution they make by sharing their experience of living with a health problem and using health services personally or in a caring role. The safeguarding team have worked closely with the Social Inclusion Service to address the issues raised in the Lampard report to ensure that the scheme continues to function in a safe and effective way.

The Safeguarding Adults team have been involved with a Trust wide review of the consent agenda to ensure that service users and their carer’s are fully involved in decisions regarding their care and treatment and that any decisions made, should the individual concerned lack the capacity to consent, are in their best interests.

This has been supported by a series of Mental Capacity Act workshops to equip frontline staff with the skills and knowledge to undertake capacity assessments and make best interest decisions.

The Prevent duty became effective as of 1st July 2015 which directs NHS Trusts to have due regard to the need to prevent people from being drawn into terrorism. The Safeguarding Adults team are working with all partner agencies, including Chanel, to ensure that all staff are aware of their duties under the new Counter Terrorism and Security Act 2015.

During 2015-16 the business of the Safeguarding Service was monitored by the quarterly Safeguarding Governance Committee (SGC). The SGC provides internal monitoring to ensure the continued delivery of the safeguarding agenda. The SGC monitors the progress to deliver the
actions, gives visibility to the high level risks, monitors training statistics and provides assurance
that audits have taken place as planned.

The Trust is commissioned by 5 Clinical Commissioning Groups (CCG’s) to provide a Safeguarding
Services across the organisation. The Trust Safeguarding Assurance Group is held on a quarterly
basis which invites the Designated Nurses to support the Trust with assuring compliance and
standards of safeguarding practice. The respective CCG’s monitor the Trust’s contractual
performance, quality, safety and safeguarding arrangements through a joint Clinical Quality and
Performance Group with 3 respective locality Quality, Safety and Safeguarding Monitoring
Groups.

During the past year the Trust has significantly developed the Lessons Learned Forum which
enables systematic analysis of a range of patient quality and safety information including the
outcomes of internal and external reviews following incidents in order to identify and improve
the quality of services. A series of lessons learned events have taken place across the Trust
during the past year involving practitioners aimed at the sharing of information and to improve
clinical practice.
Cheshire and Greater Manchester Community Rehabilitation Company

We are in the process of launching our new operating model, which is called ‘Interchange’. This is a strengths-based approach, which puts our Service Users at the heart of the model. Each SU who comes under our supervision will have a bespoke needs and risk assessment completed, and will be involved in setting what areas of work will be undertaken with them. We are also piloting a ‘personalised budget’ approach, which is very innovative in a Criminal Justice setting, and hasn’t been attempted before.

In addition, we are involving Service Users in every area of the business. Going forward we will develop:

- A Service Users council, chaired by the Chief Executive, which will give a voice to service users in terms of improving our delivery model, and our key strategies
- We will be employing Service Users mentors to work alongside our staff to deliver our services

We have refreshed our Equality and Diversity strategy, which will focus on the following key areas this year:

- Work alongside the National Autism Society, to develop a set of standards by which CRCs can be measured in terms of their work with SUs who have Autism. This will lead we hope to the CGM CRC being nationally accredited by the NAS
- We have developed a strategy for working with Veterans, who we know can be vulnerable members of our communities. We have established a project the Armed Forces to employ Veteran mentors who will work with ex-forces personnel who come under the supervision of the CRC.
- We have refreshed our female Service Users strategy, and are co-commissioning women’s provision in all Boroughs alongside the Justice and Rehabilitation Executive – chaired by the Police Crime Commissioner.
- We have reviewed our Partner Link Worker (PLW) scheme. This provides support to the female partners of those Service Users who are subject to our Domestic Violence programme. The PLWs ensure there is a safety plan in place for all female victims whilst their partners attend the programme.
- We are also implementing our strategy for working with Service Users who have learning or communication difficulties. This group of Service Users are estimated to make up approximately 20% of our caseload, so this is a key piece of work.
Challenges 2016/17

The main challenges for us this coming year are to:

- Train all staff to ensure they understand their responsibilities under the Care Act. This training will be scheduled for the Autumn.
- Be awarded NAS accreditation.
- Complete the development of our Personalised Budget approach.
National Probation Service

Across the key principles of safeguarding outlined by the Care Act:

- **Empowerment** – Within NPS a core part of our work is the sentence plan. Each client/offender we work with has one completed both in custody and the community. The work where possible is completed with the individual to ensure they own the objectives set. We have also piloted the Calderstones reflection tool to ensure we work with our offenders in a way that best suits their needs.
- **Protection** – NPS works under the Victim’s Charter. All cases that meet the criteria are offered a service from a named Victim Liaison Officer so that they are kept updated about the perpetrator’s sentence and have a voice in any parole hearings and conditions on the licence period in the community.
- **Prevention** - Our thresholds regarding risk/need are different within NPS/Adult Safeguarding which can creates some barriers.
- **Proportionality** – Within our entire decision making we ensure they are necessary and proportionate to the risk of serious harm they present to the community including risk to self.
- **Partnership** – NPS have largely a good working relationship supported by protocols regarding information sharing with Wigan adult safeguarding. We are looking forward to further investment in the hub and in place based approaches. We have also worked with colleagues to identify appropriate and robust risk management plans for service users released / discharged as part of the Winterbourne review.

**Challenges 2016/17**

- Ensuring that all NPS staff are trained / retrained in Safeguarding.
- Working in the hub.
- Working with partners to identify and resolve barriers for out ageing offender population.
- Understanding and being agile to the opportunities presenting under the devolution of Manchester agenda.
Greater Manchester Police

Operation Strive
The STRIVE project focuses on and targets Standard Risk victims and perpetrators of Domestic Abuse, through an Early Help Offer, encompassing families and children. It aims to address the gap in service provision within Wigan around early intervention with domestic abuse victims and perpetrators to prevent escalation of incidents to crisis point and reduce preventable demand for public services. One of the key aims of the project is to make re-visits to victims of Standard Risk domestic abuse, following a referral from the police. As part of the visit, an outcome-based assessment tool is undertaken and a subsequent action plan developed. This plan includes making contact with relevant agencies and services in order to explore further identified issues and seek resolution.

The Strive team revisits are aimed at exploring the victims perceptions of triggers for abuse i.e. alcohol, drugs, debt, mental health etc. and also what help they would like. The team consists of GMP officers, CAB and specially trained volunteer champions in order to build capacity within the community sector to maintain this service going forward. UCLAN have been commissioned as part of this project to independently evaluate the results and an initial evaluation report is now available. Early indications are suggesting that there is a reduction in the number of repeat callers from the sample cohort which if correct could result in up to 1,500 fewer low risk DVA per year in Wigan Borough.

Inner Strengths:
Aligned with Operation Strive and as part of the same successful GM application to the Innovation Fund, Wigan has also been successful in gaining support to pilot a voluntary perpetrator programme again aimed at early intervention and prevention. We are working with Forensic Psychological Solutions who from August 2016 will provide the Inner Strengths Behaviour Change Programme across the Borough for those identified at the earliest possible opportunity and before any statutory requirements are in place. The programme will be delivered over 12 x 2 hour sessions from community facilities and will be evaluated by Manchester University.

ISAPP:
The Integrated Safeguarding & Public Protection team continues to provide a robust multi-agency response to both high and medium risk domestic abuse victims, their children and linked offenders. The most recent cash benefit analysis work indicates a continuing reduction in repeat victimisation particularly in relation to crimes of wounding, common assault, robbery and criminal damage, as well as achieving broader success in reducing the re-presentation of medium- and high-risk victims of harassment and other non-physical forms of abuse. This continues to suggest a gross fiscal saving of approximately £500,000K per annum. The development of ISAPP to be part of the PSR Hub going forward will allow the continued growth of a joint timely response based on contextual need and not simply systematic response based on thematic area resulting in a further reduction in repeat victimisation and impact on families.
<table>
<thead>
<tr>
<th></th>
<th>No. of Meetings</th>
<th>Total Cases</th>
<th>High</th>
<th>Med + Crime</th>
<th>Male Victim</th>
<th>Female Victim</th>
<th>Repeat Yes</th>
<th>Repeat No</th>
<th>Children Yes</th>
<th>Children No</th>
<th>Total No. of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14/15 Total</strong></td>
<td>204</td>
<td>1044</td>
<td>291</td>
<td>753</td>
<td>85</td>
<td>959</td>
<td>225</td>
<td>819</td>
<td>649</td>
<td>395</td>
<td>1246</td>
</tr>
<tr>
<td><strong>15/16 Total</strong></td>
<td>147</td>
<td>1336</td>
<td>359</td>
<td>977</td>
<td>106</td>
<td>1230</td>
<td>523</td>
<td>812</td>
<td>861</td>
<td>475</td>
<td>1543</td>
</tr>
</tbody>
</table>

Although the total cases have decreased this can be attributed to the reduction in ISAPP to Monday, Wednesday and Friday’s. The number of male victims identified through ISAPP has increased by 32%.

**Data**

Domestic abuse reported incidents to police codes:
D61 (juvenile present), D62 (between adults), D65 (DV disclosure scheme)

2014-2015 Wigan 7015 Bolton 6600
2015-2016 Wigan 6708 Bolton 6548

Domestic abuse crimes reported to police:

2014-2015 Wigan 2026 Bolton 3740
2015-2016 Wigan 1864 Bolton 2111

Vulnerable adult reported incidents to police codes:
G16 (concern for safety for adult) or G 17 (mental health concern)

2014-2015 Wigan 3931 Bolton 3909
2015-2016 Wigan 3938 Bolton 3617

Wigan have a reduction of 307 domestic abuse incidents from 2014-15 to 2015-2016.

Although Wigan has more reported incidents than Bolton, Wigan has significantly less incidents that result in a crime being submitted.

Significant increases in the use of domestic abuse disclosure scheme and domestic violence protection orders to safeguard victims of abuse on division from this time last year.

Police received 46 domestic abuse disclosure scheme applications for 2015-2016, and successfully applied for 102 domestic violence protection orders from court.
Honour Based Abuse (HBA) / Female Genital Mutilation (FGM)

Wigan Public Protection Investigation Unit (PPIU) investigated 4 cases of HBA and 1 FGM for 2015-2016 compared to 20 and 7 respectively at Bolton. This can be attributed to the diverse population of Bolton.

Case Study 1

- Mother and adult son reside at an address in Leigh. Both parties present with extensive domestic violence history fuelled by alcohol issues and underlying learning difficulties for son.
- Son has warning markers for mental, firearms, violent and weapon.
- Both parties featured on the IOM Top 15 for perpetrator and victim.
- Son is shown as perpetrator on 7 crimes between 12th July 2015 and 12th February 2016. All crimes are for physical violence. Only one resulted in a charge due to mother refusing to provide a statement.

There have been 17 Police call outs to the home address since August 2015 with 13 for Domestic Abuse and 4 for concerns for welfare. Mother is shown as the victim on 33 Public Protection Incident’s with the majority involving son as the perpetrator.

They have been discussed at ISAPP on six occasions in the last twelve months due to both medium and high risk domestic abuse incidents.

- Victim states the abuse is getting worse due to the perpetrator’s drinking
- Victim states perpetrator has previously threatened to kill her (police called)
- Victim does not support prosecution
- Alcohol abuse by both parties
- Perpetrator has threatened suicide in the past.

At ISAPP the following actions were taken:

- To support victim with specialist domestic violence service WHAG (Women’s Housing Action Group) looking at 1 to 1 work, civil remedies.
- Greater Manchester West to complete risk assessment for both re substance misuse.
- GMFRS to conducted safe and well check as both are alcohol risks for fire.
- Allocation to Livewell Complex Needs keyworker
- Referral to Adult Social care re vulnerability concerns for the perpetrator
- To be discussed as part of IOM top 15 cohort for additional support

Results

- The client is safely accommodated
- Perpetrator is engaging with alcohol services
- Number of callouts re domestic abuse incidents have reduced dramatically
• No further incidents at ISAPP since 15/2/16.
• Perpetrator has been referred to specialist targeted support re LD and historical significant issues
• Perpetrator now has allocated Adult Social Care worker
• Victim is engaging with alcohol services
• Complex needs now exiting from both victim and perpetrator as specialist services are addressing needs.
• To be discussed at the next IOM meeting to look at removing from the cohort.
• Reduction in agency involvement.

Case study 2

The female victim resided with her husband and 2 yr. old child in the Wigan area.

Police received information from a close family member stating that they believed they had grave concerns for the female. The informant believed that she was being “tortured daily” and that recently the perpetrator has assaulted her and “hung her out of a bedroom window”. The female had fled the address to her mothers and it was felt that she would not disclose incidents to police. The informant wished to remain anonymous as they were currently supporting victim. Joint decision by police and local authority to pass information to IDVA service to obtain information and discuss options rather than police.

The IDVA completed a home visit the same day of receiving the referral from police. After some initial reluctance to engage the victim agreed to us carrying out a CAADA DASH Risk assessment. She scored 21 which identified her as a person who could be at significant risk of harm from Domestic abuse.

Risks Identified from visit:
• Physical injury – The female had extensive bruising over her body, visible to professionals on visit
• Scared of further violence especially if he is drinking and if he became aware of her speaking to professionals
• Victim had been to see the GP having felt suicidal recently
• Has tried to separate 5 times previously.
• Controlling behaviour, fears he will use the child to control her and make her come back to him
• They have a baby - 17months old
• Previous violence from alleged perpetrator to others including victims step dad
• Jealous behaviour from alleged perpetrator
• Threats to Kill
• Drug and alcohol use by alleged perpetrator
• Attempted strangulation
- Sexual abuse
- Financial abuse
- Alleged perpetrator has made suicide threats in past (held a knife against his throat and threatened to kill himself if she left him, possible mental health issues)
- Housing needs, joint tenancy and not enough room for victim and child to continue to stay at Mums long term

Following completion of the assessment, the victim agreed to a MARAC referral. It was explained that police and social care would be informed but that police would take into consideration her choices/wishes prior to action. At that stage she did not wish for any police action due to fear. Husband had been imprisoned in 2010 for 42 months for violence against a male.

Case heard at ISAPP and multi-agency action plan was agreed and implemented which included:
- A Non molestation order applied for and granted at Wigan Magistrates court.
- Joint visit conducted by IDVA with Children’s social care. A Section 47 being undertaken by social care. Child to have no contact with alleged perpetrator until this is completed.
- Joint visit with IDVA and housing. Secure accommodation arranged for victim and child.
- IDVA attended Bamfurlong police station with victim to support her whilst complaint was discussed. A video interview was agreed although cancelled by victim a short time afterwards as she didn’t feel ready for the judicial process.

Results
- Female has not returned to the relationship.
- Female is accessing private counselling for depression.
- She has enrolled onto a program recovery tool with support from IDVA service.
- Continues to be supported by IDVA service.
- No further reported incidents.

Although the victim has not at this time provided an evidential account to police she has taken positive action to protect herself and child from further abuse. She was suffering in silence and the action taken by family had a positive influence on the outcome.
11. Towards 2016 / 2017

WSAB is dynamic and already progressing against the business plan that will see the next 12 months being transformational in how the board performs its functions for the children and young people of Wigan.

There are several key strategic actions for the Board over 2016 /2017

1. A review of the structures and the synergy between WSAB and Wigan Safeguarding Children’s Board. Co-ordination of SCB and SAB processes has progressed in 2016 to date, and further development of a life course approach to the partnership of the boards will underpin the revised delivery model.

2. A review of the current offer regarding adult training products including development of a workforce development approach to embedding (and evidencing) effective practice across all partner agencies.

3. Developing and trialling a self-neglect policy and process.

4. The Multi Agency Safeguarding Hub will continue to evolve over 2016, and the Board is a key forum for the development of the strategy and delivery decisions that will be made.

5. The Communications and Engagement work of the board will continue to develop, looking towards establishing even stronger across communities and community / voluntary sector groups, active involvement of service users and their families / advocates in Board work.

6. The Board will review all strategies that sit under the board partner agencies.

7. Further development of an evidenced base regarding impact of safeguarding processes and interventions across thematic areas and services.
## Appendix A - Membership of the Board

<table>
<thead>
<tr>
<th>Job title</th>
<th>Agency</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Chair</td>
<td></td>
<td>Full</td>
</tr>
<tr>
<td>Director of Adult Social Care and Health</td>
<td>Wigan Council</td>
<td>Full</td>
</tr>
<tr>
<td>Wigan Council - Cabinet Portfolio Holder – Adult and Social Care</td>
<td>Wigan Council</td>
<td>Full</td>
</tr>
<tr>
<td>Chief Officer</td>
<td>Wigan Borough CCG</td>
<td>Full</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>Wrightington, Wigan and Leigh NHS Foundation Trust</td>
<td>Full</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>5 Boroughs Partnership NHS Foundation Trust</td>
<td>Full</td>
</tr>
<tr>
<td>Chief Executive Officer</td>
<td>Bridgewater NHS Foundation Trust</td>
<td>Full</td>
</tr>
<tr>
<td>Superintendent</td>
<td>Greater Manchester Police</td>
<td>Full</td>
</tr>
<tr>
<td>Community Safety Manager</td>
<td>Greater Manchester Fire and Rescue Service</td>
<td>Full</td>
</tr>
<tr>
<td>Assistant Chief Officer,</td>
<td>GM Probation Trust</td>
<td>Full</td>
</tr>
<tr>
<td>Community Director</td>
<td>Greater Manchester and Cheshire Community Rehabilitation Company</td>
<td>Full</td>
</tr>
<tr>
<td>Director of Tenancy Service</td>
<td>Wigan and Leigh Homes</td>
<td>Full</td>
</tr>
<tr>
<td>HM Coroner’s First Officer</td>
<td>HM Coroner’s Office</td>
<td>Full</td>
</tr>
<tr>
<td>Head of Safer Prisons and Equality</td>
<td>HMP Hindley</td>
<td>Full</td>
</tr>
<tr>
<td>CEO</td>
<td>Healthwatch</td>
<td>Full</td>
</tr>
<tr>
<td>Assistant Director Adult Social Care</td>
<td>Wigan Council</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Service Manager, Safeguarding</td>
<td>Wigan Council</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Service Manager, Support &amp; Safeguarding</td>
<td>Wigan Council</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Role</td>
<td>Organization</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Assistant Director, Provider Management &amp; Market Development</td>
<td>Wigan Council</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Director of Quality and Safety</td>
<td>Wigan Borough CCG</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Assistant Director for Adult Safeguarding</td>
<td>Wigan Borough CCG</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Director of Public Health</td>
<td>Wigan Council</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Inspection Manager</td>
<td>Care Quality Commission</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Head of Public Health Commissioning</td>
<td>NHS England</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Learning and Improvement Officer (WSAB)</td>
<td>Wigan Council</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Senior Solicitor</td>
<td>Wigan Council</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Business Manager, WSAB</td>
<td>Wigan Council</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Media Officer</td>
<td>Wigan Council</td>
<td>Advisor to the Board</td>
</tr>
<tr>
<td>Business Support Officer, WSAB</td>
<td>Wigan Council</td>
<td>Admin Support</td>
</tr>
</tbody>
</table>