

Wigan Safeguarding Adults Board

Annual Report

Reporting Period April 2025 to March 2026



Our Mission:

Working together with our communities,
helping people live safer, happier lives.



**Wigan
Safeguarding
Adults
Board**

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Chair's Foreword

I am pleased to present the Wigan Safeguarding Adults Board Annual Report for 2025/26, highlighting another year of strong partnership working and positive progress in our mission of **working together with our communities, helping people live safer, happier lives**.

This year has seen significant developments across the safeguarding partnership. We have embedded our new 2025–2027 Strategy, strengthened our Quality Assurance Framework, improved our use of partnership data and introduced more robust approaches to risk management and assurance. Together, these developments are helping us better understand risk, identify emerging themes and drive improvement across the system. I am also delighted that the strength of partnership working across Wigan was reflected in the recent **Outstanding** Care Quality Commission assessment of Adult Social Care, with several safeguarding initiatives recognised within the inspection findings.

A key achievement has been our growing focus on prevention and early intervention. Through initiatives such as the Prevention Hub, Complex Dependency Team and strengthened multi-agency working, we are increasingly supporting people before situations reach crisis point, ensuring that adults with complex needs receive coordinated and person-centred support.

I am particularly proud of the continued success of our **What's Up Champions** network and the launch of our inaugural Pride of Adult Safeguarding Awards, both of which demonstrate our commitment to involving communities, celebrating good practice and promoting safeguarding as everyone's responsibility.

The report also contains powerful examples of **Making Safeguarding Personal** in action, showing how professionals across Wigan have worked alongside individuals to achieve outcomes that matter to them. These stories remind us that safeguarding is about supporting people to live safer, more independent and fulfilling lives.

Learning continues to be at the heart of our work. We have embedded learning from Safeguarding Adult Reviews, audits and lived experience into new guidance, policies and training, including refreshed Section 42 training, safer employment resources and strengthened responses to self-neglect and exploitation.

I would like to thank all our Board members, partners, practitioners, volunteers, carers and community organisations for their commitment throughout the year.

While challenges remain, this report demonstrates a strong and ambitious partnership that continues to learn, improve and innovate. I look forward to building on these achievements in 2026/27.

Dr. Suzanne Smith PhD

Independent Chair

Wigan Safeguarding Adults Board

What is the role of Wigan Safeguarding Adults Board?



The Wigan Safeguarding Adults Board (WSAB) is made up of a partnership that agrees on how different services and professional groups will work together to safeguard adults at risk of abuse or neglect across the borough. The Board oversees all organisations in Wigan and Leigh that work with adults at risk and have a responsibility to ensure the safeguarding system works well to protect them. WSAB Statutory Duties under the Care Act 2014:

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

For more information about the board visit www.wigansafeguardingadults.org

Our board values and behaviours can be found within [Appendix 1](#)

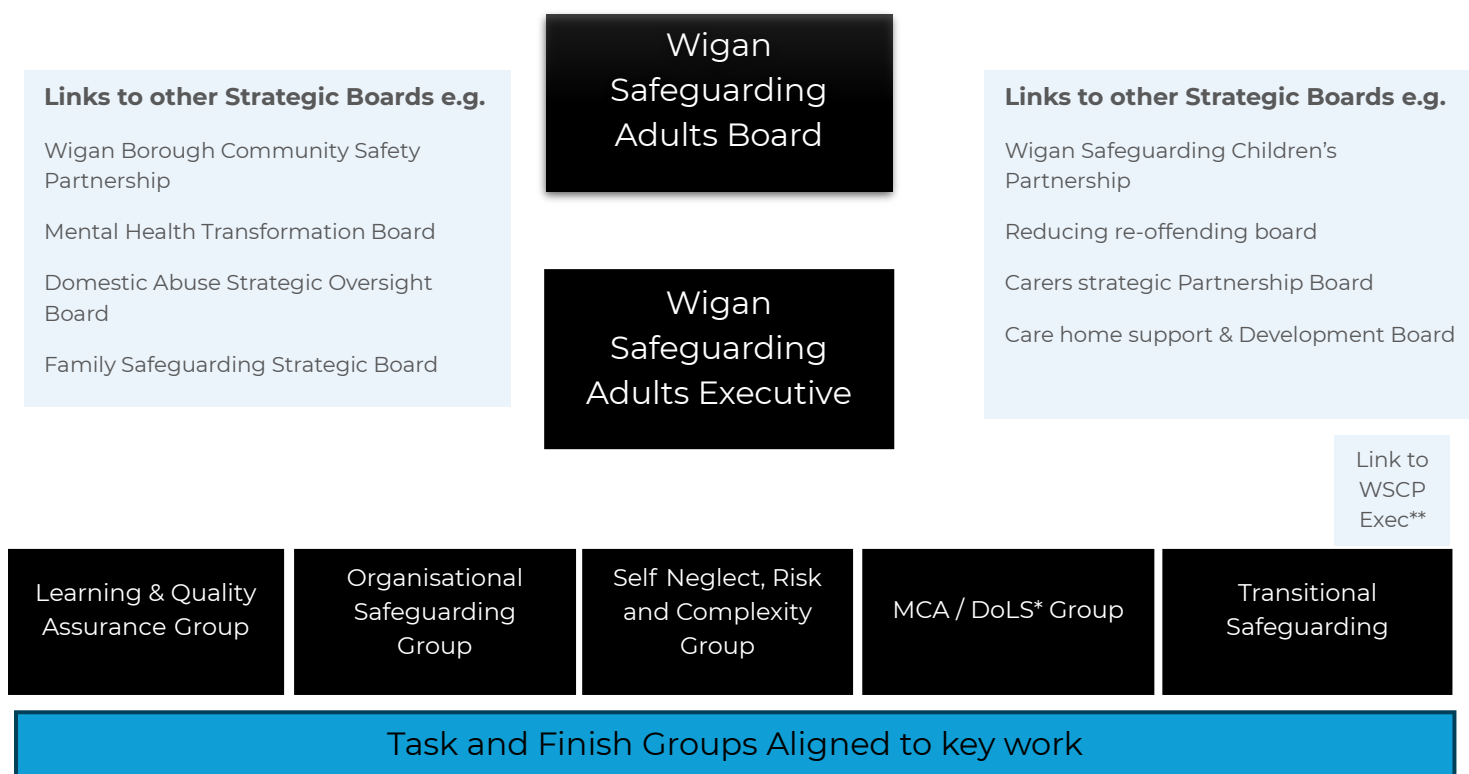
Principles of Safeguarding Adults

The six principles of safeguarding adults that the WSAB work to are:

1. **Empowerment** - People being supported and encouraged to make their own decisions and informed consent.
2. **Prevention** – It is better to take action before harm occurs.

3. **Proportionality** - The least intrusive response appropriate to the risk presented.
4. **Protection** – Support and representation for those in greatest need.
5. **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
6. **Accountability** - Accountability and transparency in safeguarding practice

Our Structure 25/26



*Mental Capacity Act / Deprivation of Liberty Safeguards

** Wigan Safeguarding Children's Partnership Executive

Our Membership

Position	Agency
Core Members	
Independent Chair	Independent
Chief Superintendent Wigan Division	Greater Manchester Police
Director of Adult Services	Wigan Council
Associate Director Quality	NHS GM Integrated Care Board
Portfolio Holder Adult Social Care	Wigan Council
Wider Membership	
Director Adult Social Care Practice	Wigan Council
Director of Social Care and Transformation	Wigan Council
Assistant Director Adult Safeguarding	NHS GM Integrated Care Board
Associate Director for Safeguarding, Wigan	Greater Manchester Mental Health Trust
Head of Probation, Wigan	Greater Manchester Probation Service
Prevention Manager, Wigan	Greater Manchester Fire and Rescue Service
Chief Officer	We Are with You (Drug and Alcohol Services)
Detective Superintendent (Vulnerability Lead) Wigan Division	Greater Manchester Police
Chief Nurse	Wrightington, Wigan & Leigh Teaching Hospital NHS Trust
Deputy Chief Nurse	Wrightington, Wigan & Leigh Teaching Hospital NHS Trust
Principal Social Worker (PSW Adults)	Wigan Council
Lawyer (Legal advisor to WSAB)	Wigan Council
Service Manager	Wigan Adults Safeguarding Board Business Unit
Chief Officer	Healthwatch Wigan & Leigh
Care Quality Commission (Wigan lead officer)	Care Quality Commission
Service Manager Adult Safeguarding	Wigan Council
Head of Safety	His Majesty's Prison Service Hindley
Service Manager Partnerships	Wigan Council
Prevent Lead	Wigan Council

What's Up Champions



The Safeguarding What's Up Champion Project continues to thrive, with approximately 50 Champions now active across provider services within the Wigan Borough. The project is continually promoted through attendance at care provider forums and visits to care settings, helping to raise awareness and encourage further engagement.

During this reporting period, quarterly What's Up Champion Network Meetings have continued to take place. These sessions have included a range of safeguarding-focused activities, alongside guest speakers delivering presentations on topics such as fraud and scams, and assistive technology. In response to feedback, the Champions' logbooks were replaced with a Microsoft Form to record concerns, to improve effectiveness

Champions have also played an active role in shaping wider Safeguarding Adults Board initiatives. They contributed to naming the WSAB awards, selecting 'The Pride of Adult Safeguarding Awards,' and were involved in choosing winners across each category from shortlisted nominations. A number of senior What's Up Champions attended and supported the awards evening itself.

In addition, Champions provided valuable feedback and suggestions to inform updates to the 'Making Safeguarding Personal' section of the safeguarding referral form. They also attended the WSAB Development Day, where they delivered an update on the What's Up Champion role, highlighting how it is working in practice and the positive impact it is making.

We are particularly pleased that the What's Up Champions were involved in speaking with the Care Quality Commission (CQC) as part of their recent inspection of Adult Social Care. Their contribution was recognised throughout the final report, where they were widely referenced. This recognition reflects the positive impact of the Champions' role and the strength of the project. We are extremely proud that, following the inspection, Adult Social Care was awarded an 'Outstanding' rating.

Achievements against our Priorities 2025/26

Please see below some highlights of our achievements during the above reporting period under each of our priorities. These are taken from items covered in both our Board and Executive meetings and further highlights of our work can be found under Subgroups later in this report.

The activity outlined below demonstrates how the Wigan Safeguarding Adults Board [Quality Assurance Framework](#) is being used to provide assurance, drive learning and improve practice across the partnership.

By triangulating data, assurance reports, lived experience, audits and case studies, the Board is able to understand risk, challenge effectiveness and support early, with a proportionate and person-centred response.

This approach aligns with the Care Act 2014 duties to promote wellbeing, prevent abuse and neglect, and ensure effective safeguarding arrangements, ultimately contributing to safer systems, strengthened prevention and improved outcomes for adults at risk in Wigan.

Prevention



Carers Support

In April, the WSAB Executive received an update on early identification and preventative support for unpaid carers, aligned to Progress with Unity and a strengths-based approach. Members welcomed efforts to raise awareness of often hidden caring roles and the development of accessible resources in community settings to support earlier identification.

The Exec noted recognition of carers as a protected characteristic and achievement of Carer Confident Ambassador status, highlighting the importance of employer support. Opportunities for wider partner engagement and shared learning were also identified.

In November, GMMH presented work to strengthen person-centred, co-productive approaches with carers, including engagement, learning from lived experience, and performance monitoring. The Board welcomed this, noting strong connections locally and the value of advocacy, feedback and partnership working to support carers' voices.

This work is making a positive difference for adults at risk in Wigan by ensuring unpaid carers are identified earlier, supported more effectively and genuinely involved as partners in care.

By raising awareness, improving access to information, strengthening advocacy and embedding co-production, carers are better able to maintain their own wellbeing and continue caring safely, helping sustain independence, stability and positive outcomes for the adults they support.

All Different, All Equal

As part of the board's commitment to reducing inequality through early intervention WSAB was pleased to receive a presentation from colleagues around All Different, All Equal at our May Board. The aim of this project is to co-design a new Wigan borough approach to address inequalities, celebrate diversity and promote inclusion.

The Board welcomed the presentation from Everything Human Rights, recognising its strong relevance to safeguarding through addressing inequality and promoting inclusion. Members valued the partnership approach and the intentional alignment with Progress with Unity, noting how the work connects local activity with sub-regional and national priorities.

The Board also highlighted the importance of innovative, participative methods of engagement that go beyond simply hearing voices to genuinely bringing people together. Overall, the work was seen as timely, relevant and impactful, with support for continued engagement and Board involvement in future activity.

This work is helping reduce risk for adults in Wigan by addressing inequality and exclusion early, recognising these as key factors that increase vulnerability to harm and poor outcomes.

By co-designing inclusive approaches and bringing people together meaningfully, the work strengthens safeguarding through greater belonging, access to support and communities that protect, value and empower individuals.

Prevention Hub & Complex Dependency Team Updates

In April, the WSAB Executive received an update on the Prevention Hub dashboard and Risk & Complexity pilot, designed to review cases below statutory thresholds where safeguarding concerns remain. Members noted improved oversight of vulnerable individuals who may previously have received no support and welcomed

the collaborative development of the dashboard, while recognising the need to improve data quality.

The Executive highlighted the importance of assessment led decision making and the value of the pilot in identifying appropriate preventative support where Section 42 thresholds are not met. Continued development of data, workforce training and referral pathways was supported to ensure risks are not missed.

In May, the Board noted the alignment of the Prevention Hub within the Adults Safeguarding Team and plans to develop an end-to-end safeguarding offer across Care Act and non-Care Act pathways, informed by a Key Worker and MASH-style multi-agency model to strengthen coordination and early intervention.

In December, further updates from the Prevention Hub and Complex Dependency Team demonstrated strong person-centred, multi-agency work supporting individuals with complex needs, including homelessness, substance misuse and mental health challenges. Members recognised these teams as key system strengths in preventing escalation, building trust and improving outcomes.

An audit of practice is underway led by WSAB Business Unit to identify good practice and areas for development.

This work supports adults at risk by strengthening early intervention, improving coordination, and ensuring timely, preventative support to reduce harm and avoid escalation. It enhances Care Act 2014 delivery by promoting proportionate responses and ensuring individuals do not fall through gaps when risks remain below statutory thresholds.

By embedding person-centred, assessment-led, multi-agency approaches across all pathways, it promotes wellbeing, addresses complex needs, and improves safety and outcomes for vulnerable residents.

GMMH Self Neglect Pathway

At the June WSAB Executive, Greater Manchester Mental Health Trust shared its model for supporting people experiencing self-neglect, focusing on early intervention and preventing crisis. The update covered local data, guidance and training, the internal self neglect panel, a case example, and future plans.

Members welcomed the approach, which emphasises identifying the right professional to build relationships, promoting early intervention, professional ownership, and reducing the need for escalation. The importance of person-centred, strengths-based practice, respectful language, and strong partnership working was highlighted.

This work supports the Care Act by focusing on prevention, wellbeing and safeguarding. It encourages early, person-centred support for people who may be self-neglecting, helping to reduce crises and avoid the need for more formal interventions for adults at risk in Wigan.

By strengthening professional responsibility, improving joint working with mental health services, and taking a strengths-based approach, it aims to help people stay safe, maintain their independence and dignity, and receive the right level of support when risks increase.

As part of the update presented to the Executive, a practitioner from Greater Manchester Mental Health (GMMH) shared a case study demonstrating the positive impact of the Panel. The practitioner highlighted concerns relating to a patient's personal hygiene and outlined how these issues had been identified through their ongoing work with the individual.

Through a collaborative, multi-disciplinary approach facilitated by the Panel, a coordinated action plan was implemented. This included engagement with the Community Learning Disability Team, a referral to Occupational Therapy, a comprehensive physical health assessment, and further consultation with a specialist consultant. As a result of these interventions, the patient experienced significant improvements in their ability to undertake and maintain personal hygiene tasks, demonstrating the value of integrated support.

Cuckooing

In November, the Board received new multiagency cuckooing guidance developed following a WSAB audit that identified gaps in information sharing and coordination. Produced between WSAB and the Community Safety Partnership and aligned with GMP, the guidance strengthens early identification, clarifies roles, and supports a preventative approach to tackling exploitation. It has since been approved and published. [Cuckooing and County Lines \(Exploitation\)](#)

Alongside this, WSAB and GMP introduced a monthly multiagency operation, bringing together Police, the Complex Dependency Team and Community Resilience Team to act on intelligence, engage those at risk, and disrupt criminal activity through targeted enforcement and support.

This work supports adults at risk by focusing on preventing abuse and neglect and promoting wellbeing. It improves early identification, better information sharing, and coordinated multi-agency responses to “cuckooing,” a form of exploitation that puts adults at risk in Wigan.

By combining clear guidance with proactive joint working, it helps ensure timely and proportionate safeguarding action. This supports people to stay safe in their own

homes while addressing criminal activity and providing supportive, person-centred help.

An example was presented to WSAB in March when Greater Manchester Police outlined a case involving a vulnerable adult who had been identified as a victim of Modern Slavery. Following the execution of a warrant linked to drug supply it became apparent the victim's home had been taken over by an organised crime group. Through partnership collaboration the victim was supported via the National Referral Mechanism (NRM) with partner agencies and relocated to ensure safety. Suspects have been charged with related offences under Modern Slavery and have been remanded to custody pending trial.

Persons in a Position of Trust Guidance (PiPoT)

In March 26 the Board considered updated PiPoT guidance brought forward for sign-off, noting that representatives from partner agencies had contributed through sub-group discussions and that further feedback had since been received, this work was undertaken by our organisational safeguarding subgroup. Members emphasised the need for consistency, alignment with existing organisational policies and procedures, and the development of a supporting training offer to aid implementation, including practical tools such as a checklist to promote a shared approach across statutory and voluntary sector partners.

The Board acknowledged that responsibility for PiPoT cases does not rest solely with the Local Authority and highlighted the importance of effective liaison and oversight arrangements across agencies. Members welcomed plans for a coordinated roll-out alongside training and peer support opportunities. Work remains ongoing through the subgroup and into the new financial year with planned sign off in May.

This work strengthens delivery of the Care Act 2014 by supporting effective safeguarding arrangements and shared responsibility for abuse prevention (Sections 1 and 42), ensuring PiPoT concerns are managed consistently and proportionately across agencies.

By introducing aligned guidance that places a clear focus on managing allegations of abuse within employment settings, training and practical tools, it improves early identification, information-sharing and professional accountability, promotes safer recruitment and employment reducing risk and promoting the safety, dignity and wellbeing of adults at risk in Wigan.

Quality Assurance



S.42 Data

In April, the WSAB Executive reviewed safeguarding data for Q1–3, noting a reduction in Section 42 enquiries followed by an increase in December. While the cause is unclear, this will be monitored and may reflect greater complexity and improved front-door triage. Plans to develop a safeguarding and equality dashboard were welcomed to strengthen oversight and shared understanding. Members highlighted the need to better understand referral sources, ensure proportionate responses, and improve data quality, audit activity and targeted training.

In December, annual data showed an increase in safeguarding concerns in line with national trends, with conversion rates to Section 42 enquiries consistent at 31%. Higher volumes than the regional average were seen as reflecting strong awareness and confidence in safeguarding processes. Neglect and self-neglect remained the most common risks, with financial abuse emerging, and most cases occurring in individuals' own homes. While risk reduction remained high, fewer cases fully removed risk, reflecting increased complexity and positive risk-taking.

Overall trends were comparable with peer authorities when considered proportionately, providing reassurance while highlighting areas for continued system improvement and assurance activity. This insight fed into WSAB training products such as s.42 training (as seen in a later section in this report) and our Level 3 Safeguarding offer.

This work improves how safeguarding risks are understood and responded to across Wigan by strengthening shared oversight, intelligence and partnership decision-making.

Better use of data supports proportionate, timely responses to neglect, self-neglect and emerging risks, helping adults remain safe while respecting personal choice and improving the consistency and quality of safeguarding outcomes.

Working in partnership with SERCO

At the May Board, partners received a safeguarding update from Serco, who deliver housing support for asylum seekers. The report covered safeguarding processes, service user demographics, local referral data, and key contacts to strengthen partnership working.

The Board welcomed the update, recognising the scale of preventative safeguarding work and its links to equality, diversity and inclusion. Members noted the complexity of supporting individuals with mental health and substance misuse needs, highlighting challenges around engagement and information-sharing, and supported stronger multi-agency collaboration. Positive partnerships with the Resettlement Team, health services and the Home Office were acknowledged, alongside improved local connections facilitated by WSAB.

The Board also agreed actions to strengthen data quality around nationality and location to support prevention and assurance and welcomed continued engagement and future updates from Serco.

Wigan Council Resettlement Team has developed a strong and effective working relationship with Serco, which supports early intervention and improved outcomes for newly granted refugees in Wigan. Serco provides the Resettlement Team with regular direct notifications of individuals or families who have recently been granted Leave to Remain and are transitioning from asylum accommodation. This timely information enables the Resettlement Team to make early contact, assess needs, and provide support around housing, welfare, health, employment, and integration.

In addition, monthly multi-agency meetings are now in place and are attended by representatives from Serco, the Resettlement Team, Greater Manchester Police (GMP), health services, education services, and voluntary sector organisations supporting this cohort. These meetings provide a valuable forum for information-sharing, coordinated planning, and partnership working. They facilitate the early identification and management of safeguarding concerns, enable agencies to discuss emerging risks and vulnerabilities, and ensure that individuals receive a joined-up and holistic response from services.

This collaborative approach has strengthened professional relationships and communication pathways between partner agencies. It has promoted a joined-up approach to supporting refugees as they transition into local communities. Serco's proactive engagement and commitment to partnership working have been instrumental to the success of the multi-agency engagement and strengthening support for some of Wigan's most vulnerable residents

GMP Domestic Abuse Team, MARAC and DAPO Pilot

At the May Board, GMP reported positive early impact from district restructures and the new Domestic Abuse Team, with performance targets exceeded, strong investigative outcomes, and improved safeguarding responses. The Domestic Abuse Protection Order (DAPO) pilot is also showing positive results, alongside ongoing support for high-demand vulnerable adults through the Prevention Hub and strong partnership work with Housing.

In June, the WSAB Executive reviewed the Multi-Agency Risk Assessment Conference (MARAC) audit and improvement plan. Progress is underway, supported by a new Delivery and Improvement Group, though training uptake remains inconsistent and will be strengthened through further benchmarking and promotion. Members highlighted the importance of high-quality, person-centred recording and consistent safeguarding practice.

A refreshed Domestic Abuse Strategy was also welcomed, with a stronger focus on prevention, early intervention and co-production with people with lived experience. In August, the Board noted further improvements to multi-agency arrangements and received learning from a Domestic Homicide Review, highlighting key issues such as familial abuse and recognising caring roles in complex situations.

Overall, the Board expressed growing confidence in the effectiveness and innovation of the local response.

This work is making a clear difference for adults at risk in Wigan by strengthening the effectiveness, consistency and confidence of the local domestic abuse response, ensuring victims receive timely protection, coordinated support and improved outcomes.

As a result of these changes Greater Manchester Police reported to the board in March a large reduction in both identified (1694 fewer) and repeat victims (1,136 fewer) from last year. At this time over 170 DAPO's had been obtained across the borough.

Through focused strategies, strong multi-agency arrangements and learning shaped by lived experience, the approach reduces repeat harm, supports safer choices, and promotes long-term stability and wellbeing for adults affected by domestic abuse.

Case Study - A client was supported by an Independent Domestic Violence Advocate (IDVA) to apply for a DAPO. They had been known to the domestic abuse team since 2022, with a significant history of abuse from ex-partner, including threats to kill, stalking, harassment, economic abuse, and coercive behaviour. Although assessed as high risk, the client had not engaged with support services for over 16 months, believing existing protective measures were sufficient.

with the service and requested support to obtain further legal protection. A DAPO application was submitted, and support was provided throughout the court process. Following the interim order, the perpetrator continued the abuse, and delays occurred due to difficulties serving the order and locating the offender.

The stalking continued while criminal investigations progressed, and further charges were brought against the perpetrator. Following subsequent hearings, a 12-month DAPO was granted. Since the order was made, there have been no further reports of abuse, and the client reports feeling safer and more able to focus on her future and family. This case demonstrates the value of specialist IDVA support working in partnership with Greater Manchester Police, and the effectiveness of DAPOs in managing high-risk domestic abuse cases.

Greater Manchester Mental Health Assurance and Shanley Report Update

In April, the WSAB Executive received an update on progress in embedding learning from the Shanley Report, focusing on leadership, culture, workforce wellbeing and quality improvement within mental health services. Members welcomed strengthened leadership, improved governance, and enhanced staff support, noting these changes are helping build a more open, resilient and safety-focused culture.

At the May Board, GMMH provided further assurance on actions taken to address cultural issues, embedding accountability and transparency, and responding to previous SAR findings. The Board recognised clear progress, strong leadership, effective oversight, and positive partnership working, with safeguarding embedded in quality systems. Improvements in workforce morale and stability were also noted, alongside consistent evidence that learning is being sustained in practice.

In March 2026, the Board received an update on improvements at Riverside, including enhanced safeguarding arrangements, improved staff morale, exit from the national recovery programme, and improved CQC ratings. Members welcomed the progress and highlighted the importance of strengthening learning from LeDeR reviews in future reporting.

This work supports adults at risk by strengthening leadership, governance and culture within mental health services, improving safety, early risk identification, and the delivery of consistent, person-centred care.

A more open, accountable culture and sustained learning from reviews increases confidence that risks are identified earlier, practice is safer, and people receive respectful, person-centred care that supports recovery, dignity and long-term stability.

Provider Marker Quality Improvement and Safeguarding Report

At the May Board, the Council's Provider Market Oversight Team presented a report on their work to improve quality and strengthen safeguarding across care providers. This included updates on the market, improvements in CQC ratings, the quality improvement model, team activity, and key achievements.

The Board welcomed the progress, highlighting strong partnership working, renewed focus and capacity, and a clear shared ambition to improve outcomes. The collaborative approach was seen as impactful and reassuring, particularly in the context of national challenges, and a strong example of whole-system working.

Members also recognised alignment with local priorities and welcomed plans to further capture lived experience to support learning and improvement.

This work supports adults at risk by proactively improving care quality, strengthening safeguarding practice, and preventing harm, while building confidence in responsive, person-centred services through partnership working and continuous improvement.

An example of this work is provided later in the report under [Wigan Council Provider Management & Market Development](#)

Prevent Assurance Updates

At the May Board, partners received a Prevent update from the Community Safety Partnership, covering benchmarking, local referral data and demographics, staff training, and the national Channel Panel evaluation. Significant improvement was noted, with 5 of 7 Home Office benchmarking areas exceeding expectations.

The Board welcomed the update, emphasising the importance of strong Channel Panel membership, consistent partner attendance and effective intelligence sharing to support early identification of risk. Members highlighted the need for workforce awareness and robust, proportionate decision-making.

In November, the Board also reviewed the Counter Terrorism Local Profile 2025, noting increased Prevent referrals alongside low overall CT activity, reflecting improved awareness and early identification across partners. Discussion focused on ensuring appropriate targeting of Prevent alongside its role within wider safeguarding and violence reduction.

Overall, the Board emphasised strong partnership working, shared intelligence and continuous learning to support proportionate early intervention.

This work supports safeguarding by strengthening Prevent duty delivery through effective partnership working, workforce awareness and intelligence-led

decision-making, helping to identify vulnerability early and reduce the risk of harm to individuals and communities in Wigan.

Housing Assurance

In August, the WSAB received a safeguarding-focused housing update covering risk register progress, local homelessness demand, key challenges, priority groups, and the Homelessness and Rough Sleeping Strategy 2025–30, alongside a safeguarding case study.

The Board welcomed the update, reaffirming housing as a key multi-agency safeguarding issue and praising the Homeless Team's commitment in supporting vulnerable residents. Members highlighted strong partnership working between Housing and Adult Social Care, transparency around risks, and proactive approaches to managing complex challenges.

Wider partnership activity to improve safety for people experiencing homelessness was noted, including Rough Sleeper Fire Safety guidance and strengthened collaboration between Fire and Rescue, outreach teams and housing partners. The focus on prevention, continuity of support, and Home Fire Safety referrals was also welcomed.

This work supports adults at risk by strengthening coordinated, preventative responses to homelessness and housing insecurity, reducing harm, improving safety, and promoting more stable and supported transitions into accommodation.

A case example to support this work is as follows.

X has experienced repeated placement and tenancy breakdowns over the past seven years due to a combination of property damage, fire-setting, substance misuse, cuckooing, anti-social behaviour, and significant physical health needs, including lower limb amputations.

A range of partner agencies, including Homeless Services, Adult Social Care, Health Services, Probation, Complex Dependency Services, Safeguarding, and Police, have worked together to reduce risks and improve outcomes. Through coordinated multi-agency planning, alternative accommodation has been secured when placements have ended, properties have been adapted to meet X's mobility needs, and ongoing care, support, welfare, and rehabilitation interventions have been provided.

X now has a resettlement package focused on sustaining a tenancy, supported by regular welfare visits and practical assistance with daily living and tenancy responsibilities. Ongoing collaboration through multi-disciplinary meetings, case reviews, and strategy discussions continues to promote stability, reduce the risk of exploitation, and support X's long-term wellbeing.

Quality Assurance Framework and Resolution Policy Changes

At the August Board revised versions of the QAF and Resolution policies were shared with partners. Key changes included the adoption of progress with unity key principles as our shared board values and behaviours in line with our 3 year strategy.

Also within the resolution policy was a new way to report resolved concerns that do not need board oversight to Board as part of continuous learning.

These changes support adults at risk in Wigan by embedding shared values and consistent behaviours across the partnership, helping ensure safeguarding concerns are managed fairly, proportionately and with a strong focus on learning.

Clearer resolution processes strengthen confidence that issues are addressed at the right level, enabling continuous improvement in practice and safer, more responsive support for adults.

One example of a matter brought to the Wigan Safeguarding Adults Board (WSAB) involved an allegation of sexual abuse between two vulnerable adults within a care setting in the borough. A review of the case identified valuable learning opportunities and highlighted areas where processes could be strengthened, particularly in relation to safer and healthy relationships policies, procedures for managing disclosures, and the preservation of evidence to minimise the risk of cross-contamination.

In response, WSAB partners worked collaboratively to review practice and implement improvements. This coordinated effort involved:

- Greater Manchester Police
- Wigan Council Adult Social Care Safeguarding Team
- Wigan Council In-House Services
- Wigan Council Independent Domestic Violence Advocates (IDVAs)
- Wrightington, Wigan and Leigh NHS Foundation Trust Independent Sexual Violence Adviser (ISVA) Team
- Greater Manchester Mental Health NHS Foundation Trust Domestic Abuse Leads

As a result of this partnership approach, several key developments were achieved:

- The development of a new Safer Relationships Policy and Procedure for Wigan Council In-House Services, created in collaboration with WSAB partners and shared as an example of good practice for wider adoption across partner agencies.
- The design and delivery of a multi-agency training package to improve understanding of how to respond appropriately to disclosures of sexual abuse, including guidance on the preservation of evidence.

- The inclusion of a dedicated section within the [WSAB Sexual Exploitation Guidance](#) to support practitioners in managing disclosures effectively and consistently.

This work demonstrates the Board's commitment to learning from safeguarding concerns, strengthening multi-agency practice, and improving outcomes for adults at risk across the borough.

Some further examples of this in action can be found under [WSAB Advice and Escalations](#)

WWL Annual Safeguarding Report

At the October WSAB Executive, Wrightington, Wigan and Leigh NHS Trust presented their annual safeguarding report, covering the previous year's activity, key achievements, patient demographics, staffing, partnership work, performance, and next steps.

Members welcomed the report's person-centred approach and its focus on improving experiences and outcomes, particularly for people with learning disabilities, while noting areas for further development.

This work supports adults at risk by strengthening person-centred safeguarding in health services, improving outcomes, and ensuring safer, more responsive care through strong partnership working and performance oversight.

MAPPA Update

In November, Probation provided an update on MAPPA, outlining its purpose, offender classification framework, information-sharing principles, and local demographics.

The Board welcomed the update, noting strong assurance from effective partnership working and robust oversight. Members highlighted low levels of serious re-offending, supported by proactive risk management, low recall thresholds and clear multi-agency scrutiny, while acknowledging national challenges within the prison system.

The importance of consistent partner engagement and the statutory duty to cooperate was emphasised, alongside the value of senior-level involvement in Level 2 and 3 meetings. Training opportunities were welcomed to strengthen understanding and accountability across agencies.

This work protects adults at risk by ensuring individuals who pose serious harm are effectively managed through coordinated multi-agency oversight, reducing re-offending and improving community safety through consistent partnership working.

HMP Hindley

In November, the Board received an update on the complex challenges within the prison setting, particularly for a young and vulnerable population affected by trauma, substance misuse, self-harm and violence. Members noted performance following inspection, with earlier improvements in violence reduction impacted by staffing pressures, contraband, gang dynamics and restricted regimes.

The Board recognised proactive measures, including incentives, mentoring, staff training and scrutiny of incidents, alongside continued focus on reducing self-harm and supporting vulnerable individuals. Members welcomed strong multi-disciplinary and preventative work, including partnership working, peer support, mental health input and innovative wellbeing initiatives.

Positive feedback was given on structured MDTs, action planning and continuity of care, with reassurance around effective handovers. The Board acknowledged both the challenges of the custodial environment and the commitment of staff to support rehabilitation and positive change.

This work supports adults at risk by strengthening coordinated responses within custodial settings, proactively managing risks, reducing harm, and improving longer-term safety, rehabilitation and wellbeing outcomes for individuals and the wider community.

Public Health Assurance

At the November Board, Public Health partners delivered a comprehensive update covering their current work, including the new Public Health approach in Wigan, the 2024 Joint Strategic Needs Assessment, commissioned services, links to safeguarding, and the wider determinants of health. Examples of good practice and alignment with WSAB priorities were also highlighted.

The Board welcomed the presentation, recognising the breadth and impact of commissioned services and the opportunities they offer beyond traditional interventions. Members noted strong alignment with local approaches, particularly Progress with Unity, as a key vehicle for addressing inequality and adverse experiences.

The Board was reassured by the effectiveness of services and the strong partnership working in place, while emphasising the importance of maintaining a long-term focus on wider determinants of health.

This work supports adults at risk through preventative, community-based approaches that address root causes of harm, reduce risk early, and improve long-term safety and wellbeing outcomes.

Adult Social Care Team Changes

In March the Board was presented on significant developments within Adult Social Care, including strengthened safeguarding leadership and a structural review of statutory safeguarding functions informed by learning from reviews, audits and customer feedback.

A new, centralised safeguarding team was established to improve consistency, quality and oversight across safeguarding activity. Members welcomed the continued emphasis on prevention and early identification, recognising safeguarding as a proactive, system-wide responsibility rather than solely a response to crisis.

Early evidence demonstrates the positive impact of this approach in practice. For example, the safeguarding team worked collaboratively with health colleagues to support an adult with complex needs who had previously been viewed as difficult to engage. Through a person-centred approach, skilled communication and coordinated multi-agency working, professionals were able to build trust, improve engagement and put the right support in place during a particularly vulnerable period. Partner agencies provided highly positive feedback regarding the professionalism of the safeguarding response, the reassurance gained through effective multi-agency coordination, and the quality of support available within the community.

This work is improving outcomes for adults at risk in Wigan by strengthening safeguarding leadership, consistency and oversight, helping ensure concerns are identified and addressed earlier and more effectively. By centralising expertise and embedding learning from practice and lived experience, safeguarding is becoming more proactive, prevention-focused and reliable, reducing risk and improving the quality and timeliness of support.

Response to Concerns raised

In March, the Board received an update on safeguarding and quality assurance activity across commissioned health services. This included discussion of concerns that had been identified in relation to a mental health ward. Members noted that a multi-agency inspection and walk-round is planned, alongside an internal review and increased senior leadership oversight to support improvement.

The Board reflected on commissioning arrangements and the importance of maintaining robust and proactive assurance processes across the system. Members emphasised the value of timely responses and early resolution of issues.

The Board also highlighted the importance of consistent and effective information-sharing with Adult Social Care and agreed that strengthened collective

assurance will be beneficial. It was agreed that further joint activity, including a walk-round and a more detailed presentation at a future meeting, will help to enhance oversight and shared understanding of the actions being taken to address the concerns identified.

This work helps protect adults at risk in Wigan by strengthening oversight, accountability and partnership assurance within commissioned health services when concerns are identified. Prompt multi-agency scrutiny, clearer information-sharing and stronger commissioning leadership support timely action to reduce risk, improve care quality and ensure people receive safe, responsive and well-coordinated support.

Making Safeguarding Personal (MSP)



Case Recording and Use of Appropriate Language

In April the WSAB Executive received and endorsed refreshed guidance on case recording and the use of appropriate, respectful language developed by members of the WSAB Business Unit with safeguarding partners. The guidance was developed in response to patterns identified in case notes, learning from Safeguarding Adult Reviews, and feedback highlighting the impact of language on people's experiences. Members welcomed assurance that the guidance had been positively reviewed by Information Governance and external partners, reinforcing its credibility and relevance.

The Board supported the aim of raising professional standards and expectations, emphasising that accurate, kind and non-judgemental recording is central to good safeguarding practice. Members welcomed plans to embed the guidance through supervision, quality assurance activity and learning opportunities, including Lunch and Learn sessions. The importance of reflective practice was highlighted, with recognition that words matter and that how records are written reflects organisational culture, professionalism and respect for individuals and families' recording and Use of Appropriate Language. More details can be found on the following webpage [Case Recording and Use of Appropriate Language](#)

This work supports adults at risk in Wigan by improving the quality, accuracy and compassion of safeguarding records, helping ensure people's experiences, wishes and risks are understood and responded to appropriately.

Using respectful, non-judgemental language strengthens trust, promotes dignity, and supports better-informed decision-making, contributing to safer, more person-centred safeguarding practice across the partnership.

Refreshed Practice Standards

At WSAB executive in September Members were updated on the refreshed Practice Standards, which have been aligned with Progress with Unity, linking to a person-centred approach to safeguarding and ultimately MSP. The Standards are underpinned by the competency framework and informed by learning from reviews, national guidance and legislation. They provide a clear and consistent baseline for good practice and are available through WSAB published policies and procedures.

The discussion highlighted the importance of embedding the Standards across the wider partnership, with promotion and visibility seen as key to supporting cultural change. The Standards include person-centred "I statements" and link to self-assessment, enabling partners to reflect on practice and identify development needs. Members noted that the framework also offers a strong foundation for further multi-agency training and continuous improvement activity.

This work supports adults at risk in Wigan by setting a clear, shared standard for person-centred safeguarding practice that keeps people's voice, wishes and outcomes at the heart of decision-making.

By embedding consistent expectations, reflective self-assessment and continuous learning across the partnership, it strengthens the quality of practice, improves experiences, and helps ensure safeguarding interventions are respectful, proportionate and effective.

An example of an agency who have utilised the practice standards can be found below from With You:

With You have embedded the principles of Progress with Unity by communicating the key missions and ingredients to the wider team. As a national charity that supports people affected by substance use we do offer a person-centred approach that is trauma lead.

The examples below demonstrate the service's commitment to strengthening safeguarding practices for the adults we support. Through the use of audits, feedback, and learning from incidents, we continuously review, develop, and enhance our

safeguarding arrangements to ensure the highest standards of care and protection within the service.

See the Person-We ensure safeguarding is truly personalised by placing trauma informed practice at the centre of everything we do. Our focus is on preventing harm by recognising people's strengths, celebrating their successes, and building self esteem so they feel empowered, valued, and safe. IPS - Individual placement supports adults in recovery by building resilience, self-esteem and entire clients are employment ready.

Listen deeply - We pride ourselves on being active members of the Safeguarding Partnership Board, we recognise the importance of daily support for staff supporting adults and offer a Concerned Others Worker to provide guidance and preparation for family members caring for a relative affected by addiction. Suicidality training is completed by all staff annually. This year has seen the relaunch of the client forum, influencing service delivery ensuring the adults we work with are a key part of shaping our future.

Know this place - Contextualising safeguarding is vital to our service. We discuss any places, spaces, or people of risk during daily meetings to help identify patterns of risk. Staff also attend CEDAM meetings to share intelligence with the police, and the service participates in the WASP panel to address exploitation affecting adolescents and young adults. The service has recently become involved in the cuckooing tactical meeting to ensure we can support adults where drugs and alcohol are increasing the risk of exploitation.

Additionally, we work closely with partners, to identify trends for example a recent contaminated drug supply resulted in 5 adults in Wigan requiring hospitalisation, this information was shared with the adults we work with and naloxone was re-disrupted for harm reduction. With You have satellite services across the neighbourhoods ensuring that services are accessible for all people across Wigan and Leigh

Show our pride and love - Staff are trained in professional curiosity to deepen understanding of people's experiences. Learning from brief reviews is shared with clear actions to improve practice. The team also completes regular adult safeguarding training, including courses from the local Safeguarding Adults Board. With you are active part of the training offer for the board helping to deliver section 42 and soon the MCA and Dols training alongside helping to create learning labs to provide interactive rationing response to BLR's for the Wigan workforce.

Do the right thing - The six principles of safeguarding are reflected upon and embedded throughout all of our safeguarding training. These principles guide our decision making, shape our culture, and ensure that every interaction prioritises safety, dignity, and empowerment. We use clear service agreements to support effective

information sharing with our partners, ensuring expectations are transparent and aligned. Staff also follow the seven golden rules of information sharing, enabling a robust, lawful, and ethical approach that protects individuals while supporting collaborative safeguarding practice. This year With has created a multiagency group to develop a pathway for adults suspected of having alcohol-related brain injury to ensure support is consistent and timely.

Connect with the neighbourhood - With You ensure that we are working in various locations within the community to reduce any potential barriers for adult access support from the service by seeing people in the community where they live. A visible presence at events helps to break down stigma about accessing support and ensure the service is part of the communities we support. and that our teams are in regular contact to ensure literature is in each service and that our training offer is available to all.

A Copy of the standards can be found here: [Practice Standards](#)

Story of Making Safeguarding Personal in action

At our November board a key worker from the Prevention Hub presented a case study to board members. Case studies play a vital role in Board agendas, grounding strategic leadership in lived experience and bringing our shared principles and ways of working to life.

This case demonstrated a person-centred safeguarding response focused on preventing homelessness and improving quality of life. Following concerns raised by a family member overseas, a s.42 referral identified that D was at immediate risk of eviction, living in unsafe conditions, and socially isolated, with limited access to digital resources or local support. Although the case did not meet the criteria for a s.42 enquiry the case was allocated to a key worker in the aligned prevention hub.

Through early triage and a prevention-led approach, the allocated Key Worker worked collaboratively with D to understand what mattered to him and advocate on his behalf. This included challenging an illegal eviction notice, completing a homelessness assessment, supporting housing applications, and coordinating with housing and environmental health partners.

As a result, D was safely rehoused in a council bungalow with ongoing tenancy support, received practical assistance to furnish and settle into his new home, and is now living independently in safe accommodation. Wider safeguarding outcomes were also achieved, with enforcement action taken against the landlord to address unsafe housing conditions.

This outcome reflects MSP principles by ensuring D's voice was heard, risks were addressed proportionately, and support was tailored to achieve meaningful, person-defined outcomes.

Feedback from the Board strongly endorsed the case as an excellent example of the Progress with Unity and Key Worker way of working in practice. Members highlighted that the service enabled the right action to be taken at the right time, preventing homelessness and supporting the individual to build resilience and independence, which may not have been achieved through traditional threshold-based approaches. The Key Worker model was praised for wrapping services around the individual, providing navigation, advocacy and a trusted point of contact, and demonstrating Wigan behaviours.

The discussion also identified a practical learning point around the challenge of accessing and storing donated household furniture, with agreement that this issue should be explored further through the WSAB Self-neglect, Risk & Complexity sub-group. Overall, the work received a resounding endorsement from the Board.

This work shows how a prevention-led, person-centred safeguarding response can make a real difference for adults at risk in Wigan by acting early to prevent homelessness, reduce isolation and improve quality of life.

By focusing on what mattered to the individual, providing advocacy and coordinated support, the Key Worker approach delivered timely, proportionate help that promoted safety, independence and resilience without reliance on threshold-driven escalation.

Adult Social Care Customer Relations Case Story

In August, the Board welcomed a positive case study demonstrating compassionate, person-centred practice.

A, a 60-year-old man with mental health needs and a learning disability, was referred due to self-neglect and unsuitable living conditions. Practitioners used a strengths-based approach, recognising his independence and protective factors, including his connection to nature and his pets.

When a Mental Health Act assessment was considered, effective advocacy and multi-agency working challenged the need for hospital admission, avoiding detention and supporting A to remain in the community with appropriate mental health support. Further work improved his living situation, leading to acceptance into supported accommodation while maintaining his independence and local connections.

Members were pleased to see the passion and commitment demonstrated, commenting that examples such as this help to bring the work to life and remind

partners what the Board aims to achieve. The presentation was described as powerful, heartfelt and genuine, highlighting the real impact of seeing the person, understanding their circumstances and responding in the right way at the right time.

Board members reflected that the case strongly exemplified the local culture and ways of working, demonstrating how applying shared principles can prevent unnecessary escalation, such as avoidable hospital admission, and support people to achieve better life outcomes and maintain independence. The value of encouraging and sharing positive case studies was recognised, both as a learning tool and as evidence of how the local approach supports better experiences and outcomes for residents.

This work demonstrates how compassionate, person-centred practice can make a tangible difference for adults at risk in Wigan by responding to individual circumstances early and in the right way. By focusing on understanding the person and applying shared values in practice, it helps prevent unnecessary escalation, supports independence, and leads to better life outcomes and experiences for residents.

Transition into Adulthood



Transitional Safeguarding Summit

WSAB undertook some early work in conjunction with Wigan Safeguarding Children's Partnership in December. This began with a joint session commissioned by both partnerships with research in Practice. This followed an earlier session plotting our transitional safeguarding picture across Wigan.

The session was attended by teams from across Children's and Adult partnerships and covered the following topics:

- An overview of transitional Safeguarding
- Some reflections on the local strengths Wigan can build on
- Some reflections on challenges of system innovation
- An opportunity to move forward collectively

Strengthening Cross Service Safeguarding

In February 2026 a joint presentation during Social Work week was given to practitioners across Adults and Children's social work practitioners. The presentation focussed on:

- Why transitional safeguarding matters
- Why the system can feel disjointed
- Areas where our worlds overlap and what shared goals we have
- Progress with unity as an anchor for forward planning
- Our 6 ways of working and links to safeguarding
- Transitional safeguarding as a mindset shift not an intervention
- Links between SAR learning key themes and early life precursors
- A case study to bring to life the work
- Shared learning opportunities across both partnerships

Further work will continue into 2026 with Research in Practice using Human learning to advance our commitment to system wide exploration of opportunities to improve transitional Safeguarding

This joint work between the WSAB and Wigan Safeguarding Children's Partnership strengthens the journey for adults at risk by promoting a more joined-up, transitional safeguarding approach in line with the Care Act 2014. By bringing together children's and adult services to reflect on strengths, challenges, and system innovation, the partnership is better able to ensure continuity of support as young people move into adulthood, reducing gaps in protection and improving early identification of risk. This collaborative, person-centred approach supports the Care Act principles of prevention, partnership working, and safeguarding that is proportionate and responsive, helping adults at risk in Wigan experience smoother transitions and more coordinated, effective safeguarding responses.

Digital



Digital transformation in Social Care

In August, the Board received an update on digital transformation in Adult Social Care, recognising its positive impact on practice, productivity and early intervention. The programme focuses on digital priorities, inclusion, technology-enabled care, digital planning and the use of AI.

Members welcomed the focus on reducing administrative burden to enable more person-centred work. Tools such as conversation-to-assessment and rapid case audit were praised for improving efficiency and recording quality whilst not losing crucial professional judgment, with positive staff feedback.

The Board also emphasised the importance of maintaining professional judgement and oversight alongside innovation, noting strong governance arrangements and the potential of digital developments to support sustainable, high-quality practice. This work is improving outcomes for adults at risk in Wigan by enabling practitioners to identify needs earlier, record information more accurately and spend more time on meaningful, person-centred practice.

Digital tools that support professional judgement and early intervention help ensure safeguarding responses are timely, proportionate and focused on what matters most to people, while supporting safe, sustainable services for the future.

Use of tech in the WSAB Business Unit

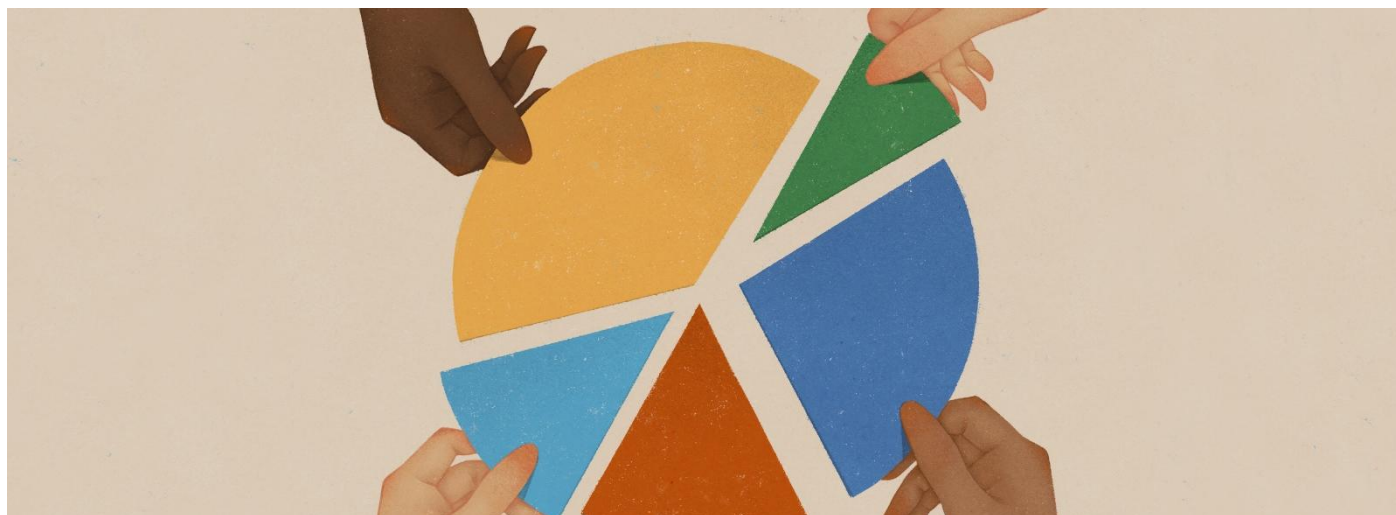
WSAB has increasingly embedded the use of digital tools and data-driven approaches to strengthen how it understands learning, impact, risk and workforce development across the system. Through the development of integrated dashboards and shared data platforms, including Microsoft 365 applications such as Lists, Power Automate and Power BI, the Board has transformed the Learning Outcomes Framework from a largely retrospective process into a dynamic, insight-led model. This enables real-time tracking of themes emerging from Safeguarding Adult Reviews, Brief Learning Reviews, customer feedback and wider practice activity, ensuring that learning is not only captured but actively translated into system improvement. By aligning datasets across these areas, WSAB is better able to identify patterns, triangulate evidence and provide robust assurance on the effectiveness of multi-agency safeguarding arrangements. This, in turn, supports WSAB subgroups to drive focused activity and provides clear assurance to the Board that learning is being systematically shared and embedded across the partnership.

Technology has also enhanced the Board's approach to risk management and workforce development. The WSAB Risk Register is now supported by live data feeds and improved visualisation, enabling risks to be monitored, escalated and mitigated more proactively at both operational and strategic levels. In parallel, the Workforce

Development Dashboard and associated evaluation tools have strengthened the Board's ability to assess both training activity and impact. This includes tracking participation and training hours delivered, alongside the influence of learning on safeguarding practice. Feedback loops now directly link training to changes in practitioner behaviour and areas for improvement. This integrated, intelligence-led approach ensures that investment in workforce development is evidence-based, targeted and demonstrably contributes to improved outcomes for adults with care and support needs.

The WSAB Business Unit was happy to pioneer this new use of technology around Risk Management which has now been adopted elsewhere within the local authority, upon sharing our learning journey.

Subgroups



Learning & Quality Assurance Group

I am the Service Manager of Wigan Safeguarding Adults Board Business Unit and I am extremely proud to Co-Chair of the Learning & Quality Assurance (L&QA) Subgroup the WSAB Workforce Development Lead.

Over the past year, the L&QA Subgroup has progressed several key areas of work. A highlight summary of our activity is outlined below:

- Developed and implemented a range of multi-agency guidance and frameworks, including case recording standards, appropriate language use, meeting etiquette, and a shared training and competency framework, with alignment achieved across SAB partner organisations.
- Strengthened safeguarding practice through the design, delivery, and quality assurance of training provision, including multi-agency Section 42 training,

alongside commissioning innovative learning resources such as safeguarding guidance videos in partnership with a local college.

- Enhanced partnership working to improve outcomes for residents, including collaboration with GMMH and With You to establish substance misuse and harm minimisation pathways, and with Primary Care to produce guidance addressing repeated non-collection of prescriptions.
- Improved system assurance and oversight by monitoring SAR and BLR referrals, ensuring timely access to advocacy for individuals detained under mental health legislation, and reviewing cross-agency awareness of advocacy and carer support services.
- Supported the development and adoption of key safeguarding policies and initiatives, including Wigan Council's in-house ligature policy and its promotion across partner agencies, as well as contributing to the successful delivery of the inaugural Pride of Adult Safeguarding Awards.
- Maintained effective communication and engagement across the partnership through oversight of regular WSAB newsletters and ongoing promotion of best practice.

The work undertaken by the L&QA Subgroup over the past year has strengthened the quality, consistency and effectiveness of safeguarding practice across Wigan, leading to improved outcomes for adults at risk. By embedding shared standards for recording, language and training, practitioners are better equipped to recognise, respond to and manage safeguarding concerns in a timely and person-centred way. Enhanced pathways for substance misuse, advocacy and mental health support have improved access to critical services, ensuring individuals receive the right support at the right time. Increased multi-agency collaboration, clearer guidance and improved system oversight have reduced gaps in practice and promoted more coordinated responses to risk.

Collectively, these developments have contributed to safer, more informed and more responsive services, empowering adults at risk to be heard, supported and protected more effectively.

Organisational Safeguarding Group

I am the Age Well Service Lead at Wigan Council, I co-chair the Organisational Safeguarding Subgroup alongside the WWL Safeguarding Lead, Amy Booth. Over the past year, the Organisational Safeguarding Subgroup has progressed several key areas of work. A highlight summary of our activity is outlined below:

- Co-produced and endorsed Multi-Agency Guidance for managing allegations relating to People in Positions of Trust (PiPoT). Partners will now embed the guidance within their own organisations, supported by coordinated bite-sized

learning sessions to build awareness, consistency, and shared understanding across the system

- Shared and reflected on key system learning arising from provider failure, highlighting how partners worked collectively to safeguard individuals and strengthen resilience. This has informed a more proactive, learning-focused approach to continuous improvement across agencies
- Advanced discussions on safer employment practices, including opportunities for system-wide approaches to induction for temporary and agency staff, and a more aligned disciplinary framework. This will support the development of a shared information repository, enabling partners to access and utilise consistent intelligence across organisational boundaries
- Agreed and operationalised a Pressure Ulcer pathway, strengthening joint working between providers and WWL to ensure more consistent, preventative, and coordinated care and safeguarding approaches

Overall, this programme of work reflects a strong, shared commitment to strengthening organisational safeguarding through greater collaboration and collective learning across partners. By co-producing and embedding joint guidance, sharing learning from system challenges, progressing aligned safer employment practices and formalising integrated care pathways, partners are building a more connected and resilient system.

The Organisational Safeguarding Group is supporting improved information sharing, more consistent practice and developing a culture of continuous improvement, ultimately enhancing the effectiveness of safeguarding to benefits people living in our borough.

Self-Neglect, Risk and Complexity Group

I am the Service Manager for hospital Social Work, MH Professional Lead & Deputy Principal Social Worker and Chair of the WSAB Self-neglect, Risk & Complexity Group. The Co-Chair is the Safeguarding manager at With You.

Over the past year, the Self- Neglect, Risk and Complexity Subgroup has progressed several key areas of work. A highlight summary of our activity is outlined below:

- Data shared from the Prevention Hub (April 2025) highlights a clear disparity between the high number of referrals received and the low conversion rate to Section 42 enquiries. The subgroup has identified the need to undertake focused work on Section 42 training.
- An action arising from the Safeguarding Adult Review for Adult 27 highlighted the need for improved consistency in responding to self-neglect. GMMH shared examples of good practice in managing self-neglect. This approach has since

been replicated within With You and the hospital social work team to ensure a consistent response for adults in Wigan experiencing self-neglect.

- We have developed and will shortly implement a strategic risk management process to replace Vulnerable Adult Risk Management (VARM), ensuring that actions and monitoring sit with the most appropriate agency. This process promotes the use of MDT's to ensure the system responds in a timely manner to situations where .42 or other statutory criteria are not met.
- The group reviewed the exploitation guidance linked to SAR learning, and guidance around cuckooing and sexual exploitation have since been approved and published. Feedback from a dip sample of six cuckooing cases highlighted the need to strengthen the cuckooing process. In response, the process was reviewed, developed, and distributed across the partnership, with supportive training offered to ensure consistent understanding and practice.

In summary the SNR&C subgroup has undertaken significant work to strengthen safeguarding responses for adults in Wigan. Updated exploitation guidance developed and distribution of an improved cuckooing process, supported by training to ensure consistent practice and timely intervention for those adults being exploited by organised crime.

The revised GMMH self-neglect pathway has been shared and replicated across With You and the hospital social work team, promoting a unified approach to managing self-neglect, ensuring staff are supported to explore all options for adults they work with to prevent over reliance on statutory social care.

In addition, a new strategic risk management process has been implemented to replace VARM, ensuring adults in the borough are supported by professionals they know. An additional overnight contingency plan will allow any challenges or drift to be addressed quickly.

Collectively, these developments enhance the partnership's ability to provide proportionate, coordinated, and effective support for adults across Wigan

Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS) Subgroup

As Designated Practitioner Safeguarding Adults, I am delighted and proud to co-chair the MCA/DoLS subgroup alongside the Service Manager – Safeguarding and DoLS.

During the past year, the subgroup has met regularly to discuss and progress key areas of work as summarised below:

- The MCA/DoLS subgroup is underpinned by comprehensive audit activity to ensure that when assessing capacity, practitioners act in compliance with the Mental Capacity Act 2005. Audits undertaken by WWLFT, GMMHFT and Primary

Care have helped identify training needs, informed the development of new training materials and improved the quality of capacity assessments undertaken by practitioners.

- The sharing of good practice has been a cornerstone of the subgroup and is best illustrated by example. A presentation regarding the assessment of capacity was delivered to the GP Safeguarding Leads Forum at their request and was well received generating rich discussion. The presentation related to the assessment of capacity in complex cases and included clear reference to the two-stage test used to legally determine if someone can make a specific decision. The impact of the presentation is that GPs are better informed as to assessing capacity in complex cases which in turn delivers the right outcome for patients.
- Recognising the importance of having a knowledgeable and informed workforce in respect of issues relating to MCA and DoLS, training is a standard agenda item of the subgroup. An MCA Training Group has been established and informed by audit findings has developed a comprehensive multi-agency training package titled Mental Capacity Act and DoLS. The training package has been reviewed by the wider subgroup with comments and observations reflected in the final draft. A robust roll out program has been agreed with partner agencies from health, social care and the Third Sector encouraged to attend as a matter of priority. The expected impact of the training package is that practitioners will adhere to the Mental Capacity Act (2005), be better informed as to matters relating to MCA and DoLS and deliver improved outcomes for patients and service users.

In summary, the MCA/DoLS subgroup provides several key benefits including improved legal compliance, consistent best-practice standards, expert guidance for practitioners, targeted training, and error reduction in terms of lowering the risk of incorrect capacity assessments.

Training Developments & Figures



Safer Employment

This year the Safer Employment training and supporting resources were developed in direct response to the learning from Safeguarding Adult Review (SAR) Una, with a clear focus on strengthening safer employment practices to prevent abuse by people in positions of trust. While grounded in the specific findings from SAR Una, the work was deliberately designed to have wider relevance across multi-agency organisations and the VCFS sector. The training and materials explore and apply the PRISM model, supporting organisations to embed a safeguarding mindset throughout the full employment lifecycle—from recruitment and induction to supervision, monitoring, and managing leavers—moving beyond compliance to curiosity and vigilance.

To support consistent implementation, a dedicated Safe Employment webpage has been created on the WSAB website, bringing together the training, resources, and practical supporting documents to help organisations review, strengthen, and evidence safer employment practice.

This work helps protect adults at risk in Wigan by strengthening safer employment practices that reduce the likelihood of abuse by people in positions of trust.

By embedding a consistent safeguarding mindset across recruitment, supervision and workforce management, organisations are better equipped to identify risk early, promote accountability, and create safer services that prioritise dignity, trust and protection for adults.

s.42 Training

This year the Wigan Safeguarding Adults Board has undertaken a comprehensive refresh of the Section 42 safeguarding training to ensure it is robust, consistent, and responsive to emerging practice issues for a multi-agency audience across Wigan. The refreshed content was shaped by national and local learning, safeguarding adults reviews, quality assurance audits, and practitioner feedback, and was co-produced through a task and finish group made up of advanced practitioners from across Adult Social Care.

This collaborative approach ensured the training reflects real practice challenges, strengthens legal literacy, professional curiosity, and defensible decision-making, and reinforces Making Safeguarding Personal. The training is delivered bi-monthly and rolled out through a multi-agency training pool, with practitioners from partner organisations facilitating sessions, modelling shared ownership and reinforcing safeguarding as a collective responsibility.

This work is improving outcomes for adults at risk in Wigan by strengthening the quality, consistency and confidence of safeguarding decision-making across the partnership.

By grounding the refreshed Section 42 training in real practice learning and shared ownership, practitioners are better equipped to identify risk, apply professional judgement and deliver person-centred safeguarding responses that are timely, lawful and focused on what matters to individuals.

Training figures: Reporting Period April 25 to March 26

Based on number of professionals trained

- An Introduction to the Asylum and Refugee World =14
- Armed Forces Awareness = 50
- Best Practice for Hoarding = 24
- Best Practice in Customer Service and Managing Challenging Behaviour= 49
- Care Provider Interim Safeguarding training =76
- Case Recording and Use of Appropriate Language = 290
- Cuckooing Guidance = 84
- DASH/MARAC training = 64
- Eyes and Ears Training =571
- Healing from Trauma and Building Resilience = 85
- Hoarding Awareness = 58
- How to Make a Good Safeguarding Referral = 252
- Independent Domestic Violence Adviser Awareness = 61
- Initial Response to Sexual Assault = 117
- Level 3 Safeguarding Adults = 176
- Modern Slavery Tier 2 = 64
- Provider Managers Tier Overview Training = 116
- Receiving, Investigating and Responding to Complaints = 19
- Responding to and Safeguarding Our Homeless Community = 63
- Safer Employment = 53
- SAVED Model of Domestic Abuse & Coercive Control = 28
- Section 42 Training = 94
- Subject Access Requests = 22
- Tier Training =331
- Understanding Hoarding = 8

Total number of professionals trained = 2,769

A total of 360 hours of training was delivered. That's an average of nearly 1.5 hrs per working day over the period.

WSABs commitment to training ensures we continue to drive forward improvements and packages are regularly refreshed with new learning.

Risk Management



WSAB has strengthened its approach to partnership risk management through the development of a dynamic, system-wide WSAB Risk Register that provides clear oversight of emerging and ongoing safeguarding risks. The register brings together shared partnership risks, enabling the Board to maintain a comprehensive view of risk at both organisational and partnership levels. This structured approach ensures that risks are clearly articulated, ownership is defined, and their wider impact is understood through a multi-agency lens rather than within individual organisations alone. Mitigating actions are clearly identified, supporting greater transparency, accountability and assurance in how safeguarding risks are managed across the partnership.

To support this, the Board has embedded a programme of regular monthly risk review meetings, strengthening oversight and responsiveness. These meetings bring together key partners to review live risks, assess the effectiveness of mitigation plans and identify any escalation required at Board level. This more frequent and structured approach is improving the timeliness and quality of risk discussions, enabling earlier identification of emerging issues and a more proactive, coordinated response. It also provides a consistent mechanism for challenge, shared ownership and collective decision-making.

Together, the enhanced Risk Register and monthly review process ensure that WSAB maintains a clear line of sight from operational risk through to strategic oversight. This approach supports a more agile and intelligence-led system, where risks are not only monitored but actively managed, and where learning is continuously fed back into strategic planning and service improvement. As these arrangements continue to embed, they are strengthening the Board's ability to provide robust assurance on the effectiveness of safeguarding arrangements and the partnership's capacity to respond to an evolving risk landscape.

Safeguarding Adult Reviews



Wigan Safeguarding Adults Board (WSAB) is required under section 44 of the Care Act to consider undertaking case reviews to establish whether there are lessons to be learnt from the circumstances of a specific case. Our approach is made of both:

- Discretionary case reviews or Brief Learning Reviews (BLRs)
- Statutory reviews or Safeguarding Adult Reviews (SARs) (as defined within the Care Act 2014).

Case reviews are undertaken to establish key learning, and most importantly any actions required to improve policy, process or practice. Approaches that are based on the most appropriate methodology required and may include;

- reflective learning principles.
- whole system approach.
- Root cause analysis.
- Thematic Analysis.
- Specific quality assurance activity.

All reviews involve multi-agency participation to determine what individuals and agencies could have done differently that may have prevented neglect, abuse, harm or a death from taking place.

Why do we conduct case review?

The purpose of a case review is not to apportion blame, it is to promote effective learning and improvement to prevent similar issues occurring again.

A case review highlights key recommendations for system, practice, policy or process changes and actions are managed within the WSAB delivery group framework. These are analysed from both a local, regional and national perspective to establish key areas for local improvement, training or service delivery; these in turn inform the WSAB overarching strategy.

All of our published case reviews along with how to refer and our policy are available using the following link [Case Reviews](#)

Within the reporting period of April 2025 to March 2026 we concluded 1 Brief learning review. As of this report we have 1 SAR in progress and 2 pending referrals.

It should be noted that the 2025/26 reporting year represents an anomalous period in relation to case review activity. The number and nature of reviews concluded during the year are not considered reflective. In particular, a number of referrals and review processes remain active and will progress into the next reporting cycle. As these reviews conclude and associated learning is analysed, the Board anticipates being able to provide a more comprehensive assessment of emerging themes, practice developments and system-wide learning within the 2026/27 Annual Report

Within the reporting period of April 2025 to March 2026 we concluded 1 Brief Learning Review (BLRs).

The Wigan Safeguarding Adults Board (WSAB) has utilised the Brief Learning Review (BLR) process to strengthen system learning and drive targeted improvement across the partnership. The review of Ben's case highlighted the complexity of supporting adults with multiple and intersecting needs, including homelessness, substance misuse, mental ill-health and self-neglect. Learning identified key systemic themes, including inconsistent multi-agency coordination, limited use of structured risk management approaches, gaps in information sharing, and the impact of perceived disengagement on safeguarding responses. The review reinforced the importance of professional curiosity, trauma-informed practice, and the need to better understand the impact of addiction and mental health on decision-making and capacity

In response, WSAB has developed a comprehensive, partnership-owned action plan to ensure that learning is translated into measurable system change. Key priorities include strengthening multi-agency working through the development of a clearer MDT framework, embedding the use of Vulnerable Adult Risk Management (VARM) approaches for individuals experiencing self-neglect and complexity, and promoting earlier and more consistent safeguarding referrals. The partnership is also progressing a programme of workforce development focused on trauma-informed practice, dynamic risk assessment, and improving recognition of self-neglect and homelessness as safeguarding concerns.

The action plan also places a strong emphasis on improving practice in relation to mental capacity, particularly where substance misuse may impact executive functioning, and ensuring that risk is not understated where individuals disengage from services. Alongside this, work is underway to strengthen system pathways, including reviewing accommodation models for people experiencing homelessness and improving escalation processes for outreach and non-clinical staff. Governance arrangements through WSAB subgroups ensure clear ownership, oversight and

accountability for delivery, with progress monitored through regular reporting mechanisms.

Collectively, this work demonstrates WSAB's commitment to learning from complex cases and embedding change at a system level. By aligning learning, workforce development and partnership practice, the Board is strengthening its ability to respond to adults at risk of harm with more coordinated, proactive and person-centred safeguarding arrangements.

Pride of Adult Safeguarding Awards



Wigan Safeguarding Adults Board recognise that working together with our communities and helping people live safer and happier lives is key to improving outcomes for our residents.

In line with Progress with Unity, we held our inaugural Pride of Adult Safeguarding Awards. These awards recognise individuals or teams who have achieved exceptional safeguarding outcomes, where they have gone the extra mile to help people feel safer, more valued and happier.

Hosted at Leigh Sports Village in January WSAB brought together board partners, local acts and of course finalist to a fantastic evening of celebration. This was the accumulation of over 12 months work which included:

- 52 Nominations
- 7 Special recognition awards issued
- Nominations from 12 different organisations
- Creation of a brand-new identity and image for the awards
- A name picked by our what's up champions

- Our what's up champions voting for the winners from 18 finalists
- A brand-new awards process built with board partners

We plan for the awards to return next year and will become an annual event. The awards both promote safeguarding adults and also celebrate practitioners and members of our community going above and beyond to support our most vulnerable adults. [Pride of Adult Safeguarding Awards](#)

Safeguarding Adults Week 2025



In November 2025 we marked Safeguarding Adults Week with an incredible programme of learning and collaboration across Wigan.

Over the course of the week, Wigan Safeguarding Adults Board with support from partners, hosted 12 learning events covering a wide range of safeguarding topics. Highlights included:

- Prevention Hub Team – Insight into their vital work, how professionals can make referrals, and real-life examples of support for vulnerable adults.
- Greater Manchester Fire and Rescue Service – Sharing fire safety resources and information on Home Fire Safety Assessments for professionals and vulnerable adults.
- With You Drug and Alcohol Service – Exploring the support available for those affected by alcohol and substance misuse.
- Additional sessions included How to Make a Good Safeguarding Referral, Safer Employment, Eyes and Ears Safeguarding Training, Independent Domestic Violence Adviser (IDVA) Awareness, and more.

A total of over 500 colleagues from across the partnership engaged with these events, demonstrating a strong commitment to safeguarding in Wigan. Beyond the sessions, we also connected with other Safeguarding Adults Boards, partners, and the Ann Craft

Trust via social media, helping to raise awareness of safeguarding issues and share key messages throughout the week.

This work strengthened safeguarding for adults at risk in Wigan by building workforce confidence, awareness and shared responsibility through wide-ranging learning focused on prevention, early help and effective response.

By engaging over 500 professionals and raising public awareness, Safeguarding Adults Week helped ensure risks are identified sooner, support is accessed more quickly, and safeguarding practice across the partnership is more consistent, informed and person-centred.

WSAB Development Afternoon 2026



The Board held a development afternoon in March at the Edge, Wigan. During the event we had a packed agenda which looked at our last 12 months reflectively. We then looked at where we are now followed by plans moving forward.

Topics discussed where:

- Snapshot of the previous 12 months
- An update from our What's Up Champions
- A reflection on our first Pride of Adult Safeguarding Awards
- Self-assessment summary of findings and cross cutting themes
- An overview of our strategy and a chance to adjust
- Practice standards linked to Progress with Unity
- Staff links to our vision and behaviours
- What's ahead and final thoughts

CQC Result



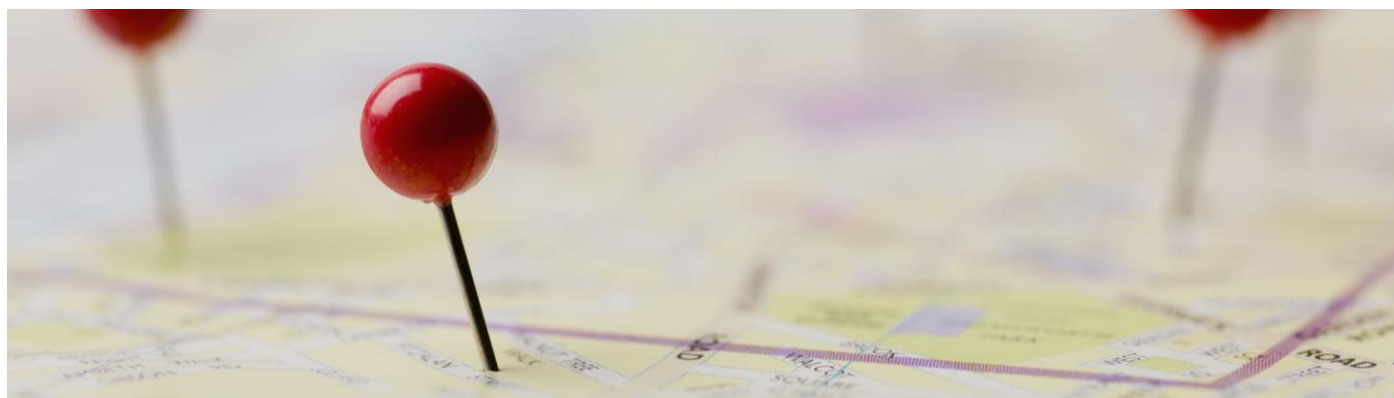
Wigan Safeguarding Adults Board were hugely proud that one of statutory partners receive the findings of a CQC inspection from CQC undertaken in December and published in March this year. The inspection was an assessment of how the local authority undertake their functions in respect of part 1 of the Care Act 2014.

Wigan Council scored 95 out of 100 and has been rated as outstanding.

WSAB was proud to read within the report some of the board multiagency achievements being recognised such as our What's Up Champions, Eyes and Ears initiative, our tier care provider offers amongst others.

The full report can be read here: [CQC rates Wigan's adult social care provision as outstanding - Care Quality Commission](#)

Partnership Activity



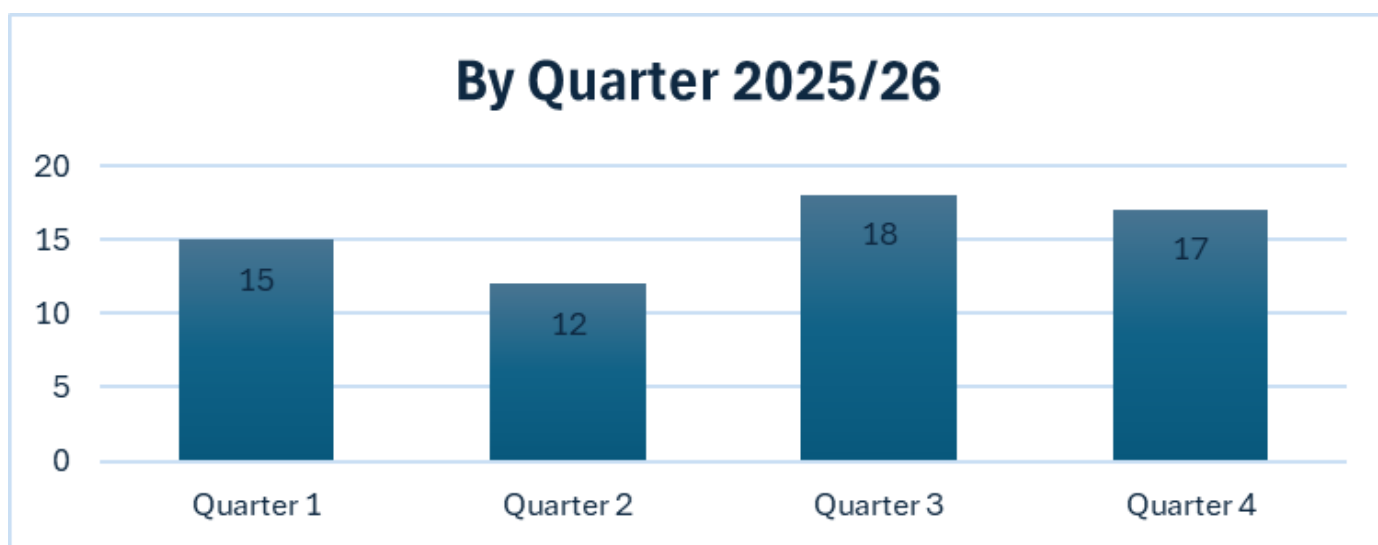
As part of our commitment to transparency, accountability, and continuous improvement, the Wigan Safeguarding Adults Board (WSAB) asked partners to report back activity for our Annual Report period April 1st 2025 - March 31st 2026.

We invited all WSAB member organisations to contribute a short summary of their safeguarding activity over the past year.

Please see [Appendix 3](#) for full details of these returns

WSAB Advice and Escalations

Below is a summary of the number per quarter of Board resolutions and escalations for advice brought to the attention of the WSAB Business Unit in the reporting period.

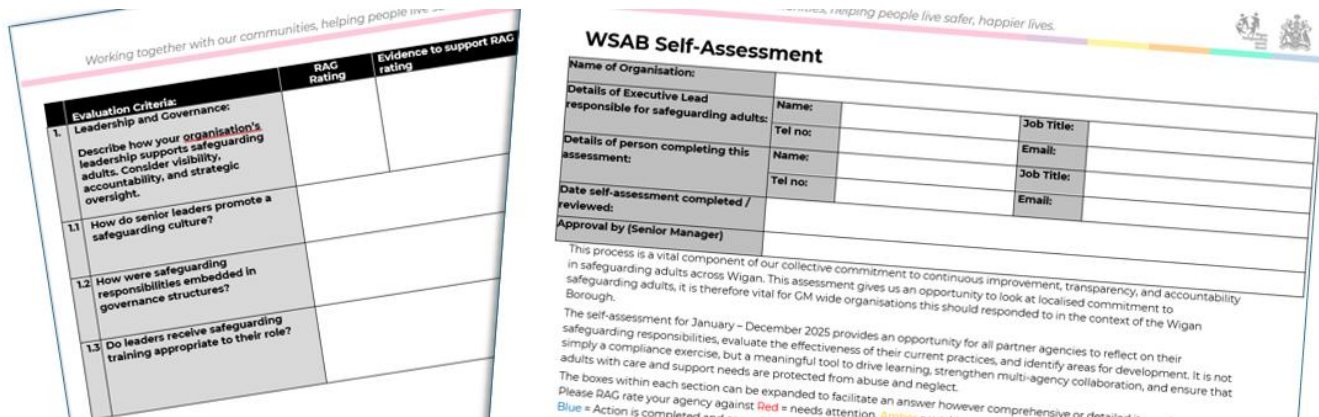


Key Themes Identified from Escalations and Resulting Actions:

- Three cases progressed through the PiPoT process.
- Multi-agency work (GMP, Community Safety Partnership, providers) improved perceptions of safety.
- ICB issued guidance to GPs on involvement in Section 42 processes.
- Learning informed a briefing on discharge planning following detox.
- Collaboration improved between NNAS and care providers, including DNACPR processes.
- Stronger links established between Adult Social Care and Police on disclosure in Court of Protection and PiPoT cases.
- Concerns about an unregulated group entering care homes were escalated for action.
- HR teams were supported in managing safeguarding concerns.
- Escalations informed the risk register and Board oversight.
- Support provided on Right Care, Right Person implementation.
- Learning contributed to a new policy and training on sexual assault disclosures.
- Multi-agency work addressed concerns around CIC companies and regulatory oversight.

- Issues with the Wigan Safe Places app informed redesign and recommissioning.
- A meeting etiquette guide was developed to improve confidentiality and professional standards.

2026 Self-Assessment



Evaluation Criteria:	RAG Rating	Evidence to support RAG rating
1. Describe how your organisation's leadership supports safeguarding adults. Consider visibility, accountability, and strategic oversight.		
1.1 How do senior leaders promote a safeguarding culture?		
1.2 How were safeguarding responsibilities embedded in governance structures?		
1.3 Do leaders receive safeguarding training appropriate to their role?		

WSAB Self-Assessment

Name of Organisation: _____

Details of Executive Lead responsible for safeguarding adults:

Name:	_____	Job Title:	_____
Tel no:	_____	Email:	_____

Details of person completing this assessment:

Name:	_____	Job Title:	_____
Tel no:	_____	Email:	_____

Date self-assessment completed / reviewed: _____

Approval by (Senior Manager): _____

This process is a vital component of our collective commitment to continuous improvement, transparency, and accountability in safeguarding adults across Wigan. This assessment gives us an opportunity to look at localised commitment to safeguarding adults, it is therefore vital for GM wide organisations this should responded to in the context of the Wigan Borough.

The self-assessment for January – December 2025 provides an opportunity for all partner agencies to reflect on their safeguarding responsibilities, evaluate the effectiveness of their current practices, and identify areas for development. It is not simply a compliance exercise, but a meaningful tool to drive learning, strengthen multi-agency collaboration, and ensure that adults with care and support needs are protected from abuse and neglect.

The boxes within each section can be expanded to facilitate an answer however comprehensive or detailed.

Please RAG rate your agency against **Red** = needs attention, **Amber** = needs improvement, **Green** = good practice.

Blue = Action is completed

This process is a vital component of our collective commitment to continuous improvement, transparency, and accountability in safeguarding adults across Wigan. This assessment gives us an opportunity to look at localised commitment to safeguarding adults,

The self-assessment for January – December 2025 provided an opportunity for all partner agencies to reflect on their safeguarding responsibilities, evaluate the effectiveness of their current practices, and identify areas for development. It is not simply a compliance exercise, but a meaningful tool to drive learning, strengthen multi-agency collaboration, and ensure that adults with care and support needs are protected from abuse and neglect. This data was used to shape our [board development afternoon](#) in March.

Early in 2026 we received 9 completed assessments from WSAB agencies giving us key insights into:

- **Leadership, governance, and culture** (including embedded responsibilities and WSAB alignment)
- **Workforce awareness, learning and communication** (training and how priorities are shared)
- **Learning, improvement, and impact** (capturing activity, sharing learning, and demonstrating outcomes)
- **Voice, outcomes, and success** (lived experience, carer voice, and celebrating what works)
- **Risk, partnership, and future focus** (risk management, joint working, strengths, development areas, WSAB)

At the Board development session, cross-cutting themes were identified to inform reflection and shape priorities for 2026.

Strengths

- Visible leadership and strong governance
- Effective multi-agency working
- Growing culture of learning
- Embedding trauma-informed and MSP approaches
- Strong focus on prevention and early help

Areas for Development

- Strengthening outcome measurement and evidencing impact
- Greater consistency in complex safeguarding practice
- Improving MCA application, recording and least-restrictive practice
- Ensuring a consistent focus on the voice of the adult
- Aligning risk and assurance processes
- Managing capacity and demand pressures

Priorities for 2026

- Develop shared frameworks for complex safeguarding
- Improve outcomes and intelligence
- Strengthen the voice of the adult
- Deliver an MCA and least-restrictive practice improvement programme
- Enhance multi-agency workforce development
- Review pathways under pressure

Data



Safeguarding Adults Collection (SAC) data can be found using the following link once published annually. [Safeguarding Adults Data England - Interactive Report](#)

Financial Contributions



Agency	Amount
Greater Manchester Police – GMCA Funded	£16,455
Wrightington, Wigan & Leigh NHS Foundation Trust	£15,000
Greater Manchester Mental Health Trust	£12,000
Greater Manchester Integrated Care Partnership	£52,000
Wigan Council	£241,055
TOTAL	£336,510

Looking ahead to 2026 - 2027



Below is a brief look at the coming year for Wigan Safeguarding Adults Board with some exciting new directions for the Board.

Strategy & Priorities

We are proud to continue delivering the Wigan Safeguarding Adults Board (WSAB) Strategic Plan 2025–2027, developed with partners and building on our shared progress. It sets a clear direction for safeguarding and strengthening communities.

Central to this is our theme, Progress with Unity, supported by a robust Quality Assurance Framework to track progress, inform decisions and ensure transparency.

Our refreshed mission, values and behaviours reinforce a person-centred, asset-based approach focused on outcomes. Progress against priorities will be reported annually, with flexibility to respond to emerging developments and best practice.

Through collective action, we aim to reduce inequalities and improve opportunities for all.

Our mission remains:

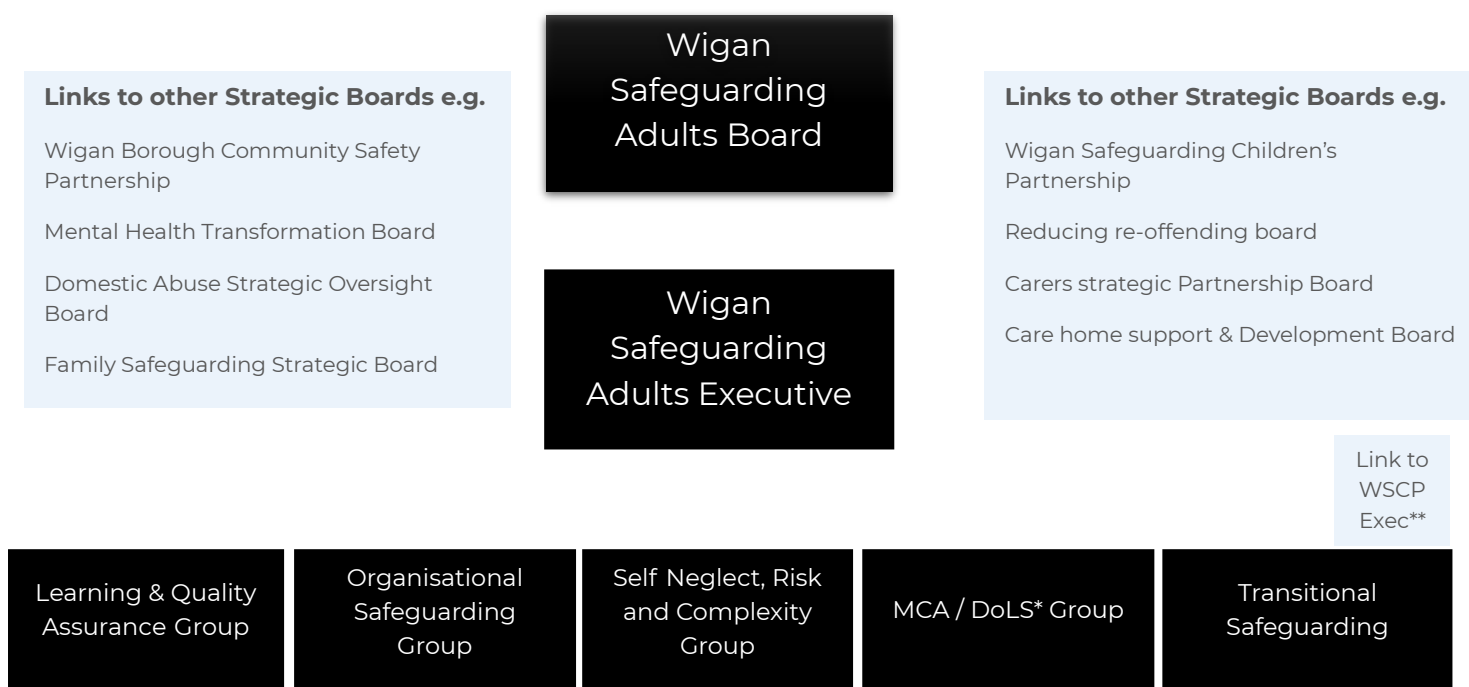
Working together with our communities, helping people live safer, happier lives

For full details of our Strategy and our Quality Assurance Framework click the following link [Strategic plan](#)

Please see [appendix 2](#) for our priorities on a page

Future Structure & Initiatives

Our Structure 26/27



Task and Finish Groups Aligned to key work

*Mental Capacity Act / Deprivation of Liberty Safeguards

** Wigan Safeguarding Children's Partnership Executive

Data Oversight

WSAB has begun to strengthen its use of partnership data to support system-wide assurance and informed decision-making. Drawing on intelligence submitted by partner agencies, the Board is starting to develop a more joined-up understanding of safeguarding activity, demand and emerging risks across Wigan. This evolving approach enables early identification of key themes, system pressures and areas for improvement, supporting a more proactive and intelligence-led response.

As this work develops, partnership data is increasingly being used to inform priority setting, highlight variation in practice and provide greater oversight of safeguarding performance across the system. While still emerging, this approach is helping to build a clearer, shared picture of safeguarding across agencies and strengthen the Board's ability to drive improvement, learning and accountability in line with its Care Act responsibilities.

Partnership Learning Lab

WSAB has begun to develop the Partnership Learning Lab as an innovative, multi-agency approach to embedding learning and strengthening safeguarding practice across the system. The Learning Lab provides an immersive environment where practitioners work through realistic safeguarding scenarios, with information introduced progressively to reflect how risk, evidence and understanding evolve in practice.

The model is being shaped by learning emerging from the Learning Outcomes Framework (LOF), ensuring that key themes and areas for improvement are translated directly into practice-based learning. This approach will also enable WSAB to better understand and evaluate the impact of learning once embedded across the partnership, strengthening the link between insight, workforce development and improved outcomes.

The Learning Lab supports partners to test decision-making in real time, strengthen multi-agency collaboration, and better understand how outcomes are influenced by timely information sharing and coordinated responses. The model has secured strong partnership buy-in and is currently in development, with a view to phased rollout from September 2026. As this work progresses, the Learning Lab is expected to build greater confidence, consistency and effectiveness in safeguarding practice across the partnership.

Mental Capacity Act & DoLS Guidance and Training

This multi-agency training and accompanying practitioner guidance have been developed to strengthen lawful, person-centred Mental Capacity Act (MCA) and DoLS practice across Wigan. The programme responds directly to learning from Safeguarding Adults Reviews (SARs), Brief Learning Reviews (BLRs), and findings from the local MCA audit, where gaps in understanding and application have contributed to risk, harm and missed safeguarding opportunities. It also addresses common themes such as self-neglect, substance use, executive dysfunction, and the importance of professional curiosity.

The training is designed to build workforce confidence, legal literacy and consistency across partner agencies, supporting practitioners to apply the MCA lawfully and

proportionately in complex situations. It focuses on balancing autonomy, risk and safeguarding, avoiding unnecessary restrictions, and upholding individuals' human rights through informed, defensible decision-making.

The programme is targeted at a wide multi-agency audience, including Adult Social Care, health professionals, care providers, housing, police, and voluntary sector partners involved in capacity assessments, best-interest decisions, safeguarding processes and DoLS referrals. Priority workforce groups will be targeted initially, with bi-monthly sessions delivered by trained facilitators.

This work strengthens safeguarding for adults at risk in Wigan by improving the confidence and consistency of professional practice. A clearer understanding and application of the MCA and DoLS helps ensure people are protected from harm without unnecessary restriction, promoting autonomy, dignity and proportionate, person-centred responses that lead to improved outcomes.

Self-Neglect Guidance and Toolkit refresh

The Wigan Safeguarding Adults Board (WSAB) Self-Neglect Guidance and Learning Refresh will be informed by both national evidence and local learning, including safeguarding adult reviews, audits, and practitioner feedback. To support this work, a task and finish group will attend specialist multi-agency training focused on self-neglect and hoarding, strengthening shared understanding, professional curiosity, and proportionate responses.

Learning from this training will inform the development of an updated learning refresh and practical resources, ensuring practitioners are equipped to identify, assess, and respond effectively to self-neglect through a coordinated, person-centred, and strengths based approach. Work on this will begin in April 2026 with an anticipated roll out from October 2026.

This work will help adults at risk in Wigan by improving how self-neglect is identified, understood and responded to, reducing the likelihood of harm through earlier, more coordinated and proportionate intervention.

By strengthening professional curiosity, shared understanding and person-centred practice across agencies, it supports safer decision-making that balances autonomy with protection and leads to more meaningful, sustainable outcomes for individuals experiencing self-neglect.

Appendix 1 – Our Values and Behaviours

See the person

Take a person-centred approach by putting people at the heart of every conversation, recognising their strengths and assets.

Listen Deeply

Recognise that communities know best about what matters to them and design public services together.

Know this place

Focus on what helps prevent problems and connect data and local insight to target when and where solutions are needed.

Connect to neighbourhoods

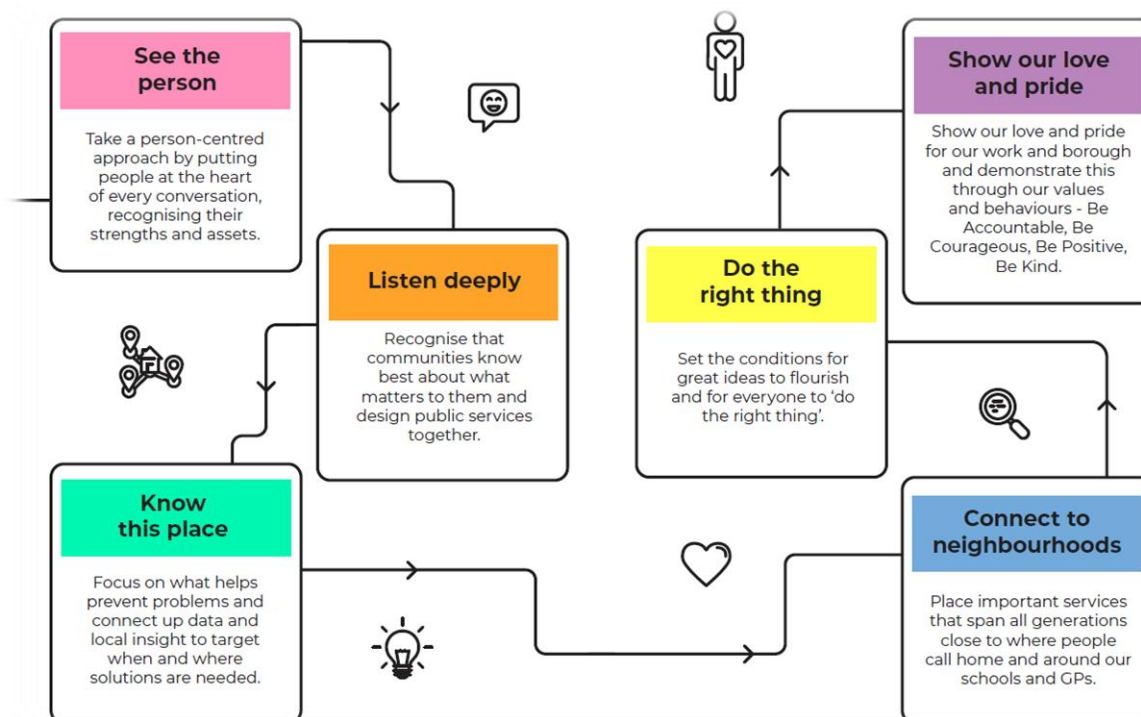
Place important services that span all generations close to where people call home and around our schools and GPs practices.

Do the right thing

Set the conditions for great ideas to flourish and for everyone to 'do the right thing'.

Show our love and pride

Show our love and pride for our work and borough and demonstrate this through our values and behaviours – be accountable, be courageous, be positive and be kind.



Appendix 2 – 2025 to 2027 Priorities on a Page

Prevention	Quality Assurance	Making Safeguarding Personal (MSP)	Transition into Adulthood
Reducing inequality and keeping people safer through early intervention before the situation reaches crisis	An effective Board with strong leadership and governance, promoting accountability and continuous learning within set policy and procedure to keep people safe	Listening deeply and utilising asset-based approaches to safeguarding practice- doing the right thing for individuals at the heart of our work	We will work together to have a seamless move into adult services
Our Strategic Objectives			
We will improve awareness of safeguarding across all communities, especially with those who are isolated, diverse and underrepresented by reviewing our communication approach and developing a measurable action plan. We will ensure there is “no wrong door” to raising concerns or accessing support. We will ensure strong connections are established with other key programs of work and boards which relate to safeguarding and a shared understanding of the interrelationships between them. We will continue to provide training for our Safeguarding Tier System and monitor its effectiveness. We will continue to provide training for our “Eyes and Ears” program and monitor its effectiveness. We will ensure through “Progress with Unity” there is a strong community presence, citizenship and connection reducing inequalities. We will ensure that services are in place to support people presenting with vulnerabilities and risk that don't “fit the box”.	We will work with other Strategic Boards on available data and intelligence to understand emerging safeguarding themes (both locally & nationally) We will further develop our partnership quality assurance framework. We will ensure that we Incorporate examples of best practice in our learning and improvement. We will ensure that learning from Safeguarding Adult Reviews and multi-agency audits is effectively embedded into practice and facilitating organisational change across agencies, leading to better outcomes for adults. We will ensure multi-agency safeguarding data shapes training, offers, awareness and practice, and affects change when required. We will undertake assurance activity to test compliance and effectiveness of implementation of local safeguarding and adult protection policy and procedure.	We will ensure our default position is to work with people, being open and honest throughout. We will promote that safeguarding will be understood as everyone's business. We will be open & honest, even when things go wrong. We will focus safeguarding on the person, not the process. We will use learning to inform future approaches. We will change policy to ensure that individuals, their families, friends or carers are involved in strategy meetings where appropriate- “No decision about me, without me”.	We will be part of the creation of a Transitional Safeguarding Policy. We will make sure children, young people and their networks know what support is available or what care they will receive when they turn 18. We will ensure that the transition from child to adult services is smooth addressing the full range of needs, including mental health, education, and social care, recognising that these needs do not change overnight with age. We will promote strong collaboration between children's and adult services to provide consistent and continuous support. Involving young people in decisions about their care and support, ensuring their voices are heard and respected. We will identify and address risks early to prevent issues from escalating as young people transition to adulthood.
Digital			
As a cross-cutting theme, we will ensure we harness the power of new, innovative and creative digital and artificial intelligence solutions and products			

Appendix 3 – Partnership Activity

Wigan Council Adult Social Care

Three Key Safeguarding Achievements:

- Successfully established a single, cohesive safeguarding function by bringing together additional Social Workers, Advanced Practitioners, the Prevention Hub and Complex Dependency Team, improving consistency, accountability and coordinated responses for adults at risk
- Strengthened partnership working with the Safeguarding Adults Board, improving communication and the dissemination of learning from Safeguarding Adult Reviews to frontline practitioners and managers, leading to clearer practice improvements
- Embedded a more proactive, support-first safeguarding approach focused on early intervention, reducing risk and promoting wellbeing through closer collaboration with individuals, families and providers



**Wigan[♥]
Council**

One Significant Learning, Risk, or Challenge:

A key challenge has been aligning a more proactive, support-first safeguarding approach with existing demand and system pressures, particularly where individuals do not meet Care Act thresholds but still present significant risk. The integration of teams highlighted gaps in pathways for people requiring consistent, lower-level intervention, creating pressure on safeguarding to respond where broader early-help solutions are still developing. This has reinforced the need for stronger system-wide ownership of prevention and clearer thresholds for intervention. Without this, there is a risk that safeguarding becomes a default route rather than a targeted protective function.

One key example to evidence of Partnership / MDT Working:

A clear example of effective partnership working has been the strengthened collaboration between Adult Social Care and the Wigan Safeguarding Adults Board, with regular “keep in touch” meetings between the Service Manager and the Principal Social Worker. This brought together ASC leadership, SAB partners and multi-agency subgroups to review learning from Safeguarding Adult Reviews and identify priority areas for audit and practice improvement. As a result, learning has been more consistently shared with frontline

practitioners and managers, improving practice responses and awareness of risk. This has mattered in ensuring safeguarding improvements are system-wide, rather than isolated within single agencies.

Voice of Adults and/or Carers:

Lived experience has been actively captured through feedback from adults and carers following safeguarding involvement, including follow-up conversations, case reviews and outcomes discussions. This feedback has focused on whether people felt involved, understood the process, and achieved what mattered most to them, with themes then analysed and shared with practitioners. As a result, practice has been strengthened to be more transparent, proportionate and person-centred, reinforcing a Making Safeguarding Personal approach. This has mattered in ensuring safeguarding decisions are shaped by people's real experiences, not just process or performance measures.

One Priority Where WSAB Can Help the System Improve:

A key system-wide priority is developing clearer multi-agency thresholds and pathways for individuals who present risk but do not meet Care Act eligibility. Current practice highlights that these cases can default into safeguarding, creating inconsistency and pressure across the system rather than a coordinated early-help response. The partnership should strengthen shared understanding, escalation routes, and ownership across agencies to ensure prevention and lower-level support are consistently applied. This would help safeguard remain a targeted protective function rather than a substitute for gaps in wider system provision.

Wigan Council Domestic Abuse Services

Three Key Safeguarding Achievements:

- **Strengthening Support Pathways for High- and Medium-Risk Victims**
This year has seen strengthened coordination between the IDVA service and the Wigan Borough Domestic Abuse (WBDA) community provision, improving the identification and safeguarding of both high- and standard/medium risk victims. Improved referral pathways and risk assessment processes (including consistent application of DASH) have enabled more timely interventions, reduced delays in support, and ensured that safeguarding responses are proportionate and responsive to risk. This has directly contributed to increased victim engagement and safer outcomes.
- **Enhancing Multi-Agency Working and Safeguarding Responses**
The IDVA team has continued to play a key role within MARAC and wider multi-agency safeguarding arrangements, ensuring that the voice of the victim is central to decision-making. Closer collaboration with police, housing, health, and adult social care has strengthened information sharing and joint risk management. This has supported more robust safety planning, particularly for individuals with complex needs, including those experiencing repeat victimisation, mental ill-health, or substance misuse.
- **Increasing Accessibility and Early Intervention through Community Provision**
The development and delivery of the community medium-risk domestic abuse service has expanded access to support at an earlier stage, preventing escalation to higher risk. This includes targeted outreach, flexible support offers, and improved accessibility for underrepresented groups. Early intervention has reduced harm, increased awareness of available safeguarding support, and contributed to a more preventative approach aligned with Care Act duties to promote wellbeing and reduce risk.



One Significant Learning, Risk, or Challenge:

A key learning this year has been the absence of a clearly defined governance framework for overseeing Domestic Homicide Review (DHR) action plans, which presents a risk to consistent oversight, accountability, and implementation of learning. This has highlighted the potential for actions to lack coordination or measurable impact across partners. In response, work has commenced to develop a joint DHR tracker and learning outcomes framework, designed to strengthen governance, improve monitoring, and ensure that learning is effectively

embedded into practice across the partnership. This will support greater assurance that DHR recommendations lead to meaningful system-wide change

One key example to evidence of Partnership / MDT Working:

A strong example of multi-agency working this year has been engagement with Public Health to support the Domestic Abuse Strategy priority on prevention, specifically around challenging attitudes, beliefs, and behaviours linked to domestic abuse. Through joint discussions, Public Health colleagues were brought on board to co-design and deliver a multi-agency workshop, involving partners from across safeguarding, health, and community services. The workshop created space to explore the role of Public Health approaches within the domestic abuse landscape and identify opportunities for early intervention and culture change. This has strengthened partnership alignment and laid the groundwork for embedding prevention-focused activity across the system.

Voice of Adults and/or Carers:

Wigan's Experts by Experience domestic abuse group has played a significant role in shaping both local and Greater Manchester (GM) practice. Over the past 12 months, Wigan was the only area with an established lived experience group, and this insight was elevated to a GM platform through facilitating a member's engagement with GMCA via the Domestic Abuse Coordinators network. This directly contributed to the establishment of a GM-wide lived experience panel, which formally commenced on 12 May 2026, now including representation from Bolton, Tameside, Stockport and Rochdale.

Lived experience has influenced strategic and operational activity across GM, including informing plans for the upcoming GBV conference, contributing to the development of the GM GBV 3-year plan promotional materials, and shaping research into barriers to reporting domestic abuse to police. The panel has also begun influencing wider system work, including collaboration with Transport for Greater Manchester to support campaigns around defining and promoting what constitutes a "safe journey." This demonstrates how lived experience has directly informed system-wide priorities, strengthening victim-centred practice beyond Wigan.

One Priority Where WSAB Can Help the System Improve:

A key priority for WSAB is strengthening multi-agency governance and accountability in relation to Domestic Homicide Review (DHR) action plans. With domestic abuse explicitly recognised within the Care Act 2014 safeguarding framework, there is a clear role for WSAB in providing system-wide assurance that learning from DHRs is embedded across all partners. Current arrangements highlight inconsistency

in how agencies evidence completion and impact of their actions, limiting collective oversight. WSAB could support by establishing a more robust framework for monitoring, challenge, and escalation, ensuring agencies are accountable for delivering and evidencing their actions, and that DHR learning leads to sustained, measurable improvements across the safeguarding system.

Greater Manchester Mental Health Services

Three Key Safeguarding Achievements:

- During Q2 2025/26 Mersey Internal Audit completed a review of the Trusts safeguarding arrangements. An overall assurance opinion of Substantial Assurance was received.
- Development of safeguarding care documentation for adults and children which captures all safeguarding activity on the Trusts clinical record system in an auditable format.
- Safeguarding dashboards developed via Power BI. This development ensures improved data capture of all Trust safeguarding activity which will enable more effective oversight and assurance, alongside the identification of areas/services who may require additional focus and support.



**Greater Manchester
Mental Health**
NHS Foundation Trust

One Significant Learning, Risk, or Challenge:

In response to learning from reviews the Trust has commissioned a safeguarding campaign BELIEVE which will focus on #SAFE – Safeguard, Act now, Follow-up, Escalate.

One key example to evidence of Partnership / MDT Working:

Case Example:

X was referred to safeguarding due to ongoing self-neglect and a pattern of disengagement from services. Social care escalated the concerns to the Deputy Safeguarding Lead and requested involvement from mental health services due to X's deteriorating presentation. A safeguarding meeting was attended by the Deputy Safeguarding Lead to explore the issues, resulting in escalation to the Specialist Community Mental Health Team (SCMHT) clinical lead.

At the time, X was living in extremely poor conditions, and their own health was significantly impacted. Joint visits were arranged between the assistant practitioner and a social worker.

A placement was arranged which enabled X to receive coordinated support from district nurses and podiatry services and facilitated health assessments to address his physical health needs. Meanwhile, X's home underwent necessary repairs and a deep clean. Although X was offered supported accommodation, X declined, expressing a strong preference to return to their own home with a tailored care package. This package included support with cooking, cleaning, personal care, and medication management.

Throughout this process, multi-agency collaboration was key. Social care, healthcare providers (including district nurses, podiatry, and GP), mental health services, and care providers worked together to engage X, stabilise their situation and promote positive outcomes. This work and approach align to WSAB priorities of prevention and making safeguarding personal.

Voice of Adults and/or Carers:

The voice of the adult and their carers is captured during any interventions to support service users who have experienced or are at risk of abuse/neglect, in line with Making Safeguarding Personal. This is documented on the clinical record via the safeguarding care documentation.

Service users and carers across the Trust engage in the following:

- Providing views as a representative at a service improvement meeting or working group
- Involvement in the recruitment and selection process of staff
- Helping inspect our buildings for the purposes of audit or PLACE Inspection (Patient Led Assessment of the Care Environment)
- Co-deliver our training (as part of the Trust induction or as a Course Tutor for our Recovery Academy)
- Contributing to the development of policies or reviewing information

Trust Recovery Academy:

Offers educational resources about mental health, addiction, and recovery including self-help materials; self-help videos; e-learning packages and webinars/seminars. All of our resources are co-produced and co-delivered between professionals with expertise in the relevant subject, and people with lived experience.

Our service improvements are informed by the lived experiences of mental health and our services. The voice of the adult is captured via compliments, concerns and complaints, ward community meetings, local service user and carer forums and feedback from other organisations i.e. Healthwatch, VCSE. This influences our future approach and helps us to share learning and best practice.

One Priority Where WSAB Can Help the System Improve:

PIPOT remains a challenge requiring further consideration by safeguarding partners due to inconsistencies across local authority areas.

Greater Manchester Integrated Care Board

Three Key Safeguarding Achievements:

- During 2025-26 NHS GM continued to safely discharge its statutory duties in relation to the safeguarding adults as outlined in national guidance. The Chief Executive holds organisational safeguarding accountability and is supported by our Executive Lead who was the Chief Nursing Officer until 1st January 2026 when, as part of the ongoing NHS Reforms, this formally transferred to the Chief Clinical Officer. The organisational leads were supported by the Deputy Chief Nurse and the Associate Director of Safeguarding, who provided strategic system leadership and oversight of safeguarding assurance. Statutory safeguarding delivery continued to be supported through the locality Associate Directors of Quality and Safety and delivered by Designated Safeguarding Teams in each of the ten GM localities. NHS GM ICB continues to fulfil its statutory responsibilities by implementing effective safeguarding assurance arrangements for the NHS Standard Contract with providers. In addition, NHS GM ICB actively participates and contributes to Wigan Safeguarding Adult Board including its Delivery Groups as well as having direct involvement in statutory review processes such as Safeguarding Adult Reviews and Domestic Abuse Related Death Reviews. Furthermore, NHS GM ICB contributes to the development of system wide learning with an emphasis on preventing harm to adults at risk of abuse.



- NHS GM has established infrastructures to support learning from Safeguarding Adult Reviews, and Domestic Homicide Reviews and has continued to draw upon national learning, reviewing relevant findings from national panel reports, and independent inquiries. Key themes have been used to support system assurance and learning such as extra familial harm, neglect, sexual abuse and the impact of parental vulnerabilities. These have informed local safeguarding discussions and improvement actions with providers and partners. NHS GM supported system learning and improvement across partnership arrangements. The ongoing development and sharing of educational materials/updates for Primary Care in respect of key safeguarding work streams including self-neglect, hoarding, assessment of capacity and supporting victims of domestic abuse.
- NHS GM continued to embed and deliver the NHSE Safeguarding and Accountability and Assurance Framework (SAAF 2024) strengthening our approach to governance, assurance and improvement. SAAF implementation audits and the NHSE Safeguarding Clinical Audit Tool (SCAT) were routinely reviewed through internal governance structures and informed provider assurance, risk identification, strategic commissioning and improvement planning NHS GM ICB has undertaken an audit re: completion of uDNACPR within Care Homes with findings and learning presented to WSAB and shared across Primary Care.

One Significant Learning, Risk, or Challenge:

The assessment of capacity remains a priority training need for clinicians working within Primary Care. The training package and materials developed via the MCA/DoLS Delivery Group presents the opportunity to significantly improve the current training offer and in doing so improve the knowledge and skills of colleagues in Primary Care who in the course of their duties are required to assess the capacity of patients. This represents a significant challenge in terms of numbers and logistics but is being addressed via the formation of a coherent implementation plan by the MCA/DoLS Delivery Group.

One key example to evidence of Partnership / MDT Working:

NHS GM has maintained their statutory duties as an equal statutory safeguarding partner. We have supported the MCA/DoLS Delivery Group in a range of subjects and activity including the Assisted Dying Bill, Executive Functioning, audit of training compliance and the development of training materials. The Delivery Group comprises of colleagues from health, Adult Social Care, and the Third Sector and as such is genuinely multi-disciplinary in nature. The development of quality training materials to support the assessment of capacity has been a priority for the Delivery Group with good progress having been made this past year. The next phase of this work is to implement the training across the Borough and will be supported by the Delivery Group. This work matters not just because the assessment of capacity

remains a key safeguarding issue but because by colleagues being equipped with appropriate knowledge and skills to undertake high quality mental capacity assessments it ensures the best possible outcomes for patients and service users.

Voice of Adults and/or Carers:

NHS GM continue to advocate for person centred practice across our locality partnerships & boards. The Designated Nurses/Professional strives to influence policy, training as well as providing strategic leadership and case oversight. Requested to contribute to a Section 42 Enquiry, NHS GM ICB supported interventions with a family who lived in difficult circumstances characterised by self-neglect. Central to the enquiry was the assessment of capacity because there was professional disagreement as to whether family members had the capacity to make decisions regarding their health. By visiting the family and listening to their experience, a positive relationship was built and a better understanding of their lived experience developed. This resulted in the recognition that the family had difficulty attending GP appointments due to the distance involved and their lack of transport. The family have subsequently been supported to register with a new GP, nearer to their home, resulting in them being able to better meet their complex health needs.

Co-production is integral to this and throughout 2025-25 NHS GM has continued to build a culture where young people and adults shape commissioning decisions. A workshop 'Shaping Co-production Together' alongside a 'citizen engagement platform', has provided opportunities for direct contribution to the design of services, to join collaboration events, and to offer feedback on recent experiences in health settings.

One Priority Where WSAB Can Help the System Improve:

It is important that WSAB continue to support the review and roll out across the Borough of key safeguarding policies such as Self-Neglect, Hoarding, and PIPOT to ensure a robust and consistent approach to the same that delivers the right outcome for patients and service users.

Wigan Council Provider Management & Market Development

Three Key Safeguarding Achievements:

- Continued proactive provider quality assurance and safeguarding oversight, including engagement with providers through quality visits and targeted support to improve safeguarding practice.
- Embedded early identification and prevention approaches, supporting providers to recognise and respond to risks before they escalate.
- Improved multi-agency information sharing with care providers, ensuring timely escalation of concerns and more coordinated responses to safeguarding issues.



One Significant Learning, Risk, or Challenge:

Safeguarding received for a tenant at a local care provider. Key learning was that assistive technology alone cannot sufficiently mitigate risk where immediate physical intervention is required, particularly given X's rapid movement from lying to standing. Delays in sensor response (even a few seconds) highlighted the need to balance technology with proactive, staff-led early intervention.

This case demonstrated strong partnership working through close collaboration between Adult Social Care, the provider) Assistive Technology services, CHC, and health teams, including joint problem-solving, testing solutions (e.g. PIR sensor, revised bed sensor), and adapting plans based on shared learning. This multi-agency approach was critical in identifying safe, least restrictive options for X.

One key example to evidence of Partnership / MDT Working:

Partnership working with a local provider for client X, multi-agency working around fire evacuation

What happened

During risk assessments completed by a local care provider it was identified that X could not safely evacuate his home should there be a fire. X is paraplegic and the only exit from their bedroom was via through the rest of the house.

Fire safety referral to GMFRS to visit the property who agreed that the risk was high. Wigan council property and it was identified that if patio doors were installed in the bedroom X could safely evacuate.

Carers helped get the property ready on the day of installation and adjusted their call times, so he was up and ready before the workmen arrived.

Who was involved

A local care provider, GMFRS, Early Intervention and Occupational Therapy, CAF, Adaptations Team, Wigan and Leigh Housing

Why it mattered

Without this happening X would have been unable to stay in his home of 5 years where he was happy living with his wife. With the fitting of the patio doors X was reassured they could evacuate safely in the event of a fire and could remain in their own home.

Voice of Adults and/or Carers:

Feedback from adults and carers has been actively used through provider engagement and quality monitoring processes, including listening to lived experiences through regular client surveys, during visits and through reviews.

In the example above, safeguarding received for a tenant at a local care provider. X's lived experience directly shaped decision-making, as interventions were adapted or discontinued where they caused distress, confusion, or disengagement (e.g. mobility chair refusal, decision not to change bedroom door orientation). This ensured approaches remained person-centred and avoided increasing risk through restrictive or unsuitable measures.

One Priority Where WSAB Can Help the System Improve:

The safeguarding system underpins PMMD's quality improvement approach by providing robust intelligence, enabling early identification of risk and facilitating timely multi-agency responses. It supports a shift from reactive intervention to proactive prevention, strengthens our provider oversight through targeted quality assurance and improves information sharing.

Although we have feedback loops to share learning from safeguarding, this would be an area to further improve - sharing themes from across the whole system into provider forums, training and educational opportunities (like lunch-time learning sessions for provider partners) and contract monitoring (where appropriate).

Wigan Council in House Care Services

Three Key Safeguarding Achievements:

- Life- saving effort by the team at a local care provider for one of the staff who had heart attack on site. Use of local Defib and has led to successful installation of Defib on site, as well as saving staff members life.
- 1st engagement day for people who use inhouse services, which incorporated What'ss up champions and led to more people signing up to be a champion.
- Lived experience insights have fed into strategic plan for services.



One Significant Learning, Risk, or Challenge:

Supporting people with developing and maintaining personal and intimate relationships is an important area locally and nationally. The development of a policy around supporting people within services with safer relationships and sexuality has been taken forward by In House services, particularly focussing on the balance between capacity vs human rights and how to best safeguard people in services. This has been built on the learning from a significant safeguarding situation.

One key example to evidence of Partnership / MDT Working:

Development of the safer relationships policy is a key piece of partnership working to support preventative safeguarding, address a gap in service/knowledge and enable people to live their best lives. This was delivered via positive partnership between Inhouse services, WSAB, ASC leads and GMP.

This led from discussions between partners and sourcing of good practice nationwide. This also led to the development of training with GMP colleagues to improve practice in services when incidents are declared, which is being provided across the provider market.

Voice of Adults and/or Carers:

- Within our engagement day the voices of people using care and support was fully captured to ensure all our work is focussed on lived experience and feeds into our strategic development plans. Some people shared their experience of not always feeling safe in their environment due to external factors such as Anti-Social Behaviour (ASB) etc. This was incorporated into our strategic development plan as a priority and a team have been working with WSAB colleagues and wider networks to develop a number of approaches to build confidence in safety and socialise the issue. A safety checklist for buildings is in development for people in services to lead the assurance process on the safety aspects of the building i.e. lighting, security etc. In House customers are peer advocates and trainers with Happy Smiles (local user led organisation) and are developing information session for schools targeting areas where ASB is an issue.
- Within one service the team have supported a resident whose family member had power of attorney (POA) and control of finances and the resident wanted control of their own money. The team received a contact from a brother who X had not spoken to for years and she expressed that she wanted to see them, but sister was preventing this with evident issues of coercive control. Team worked with social worker to enable a full capacity assessment, and it was identified that this was the case and X now has full control over finances, contact with brother and family and is living a happier life.

One Priority Where WSAB Can Help the System Improve:

Concerns over the level of information services receive in situations where POA or Deprivation of liberties safeguard is in place. Only currently get notified that it is in place, not the full detail. Some issues where POA is in place for health and wellbeing and family are requesting that loved ones do not attend hospital following falls or medical emergencies. Within CQC registered services this is a challenge due to duties of registered service and clarity is needed to ensure persons wellbeing and best interests are supported.

Wigan Council Resettlement Team

Three Key Safeguarding Achievements:

- **Strengthening Safeguarding Responses for Newly Arrived and Vulnerable Cohorts**
The Resettlement Team has enhanced safeguarding arrangements for asylum seekers and resettled families through improved triage and early identification of vulnerabilities. A key development has been the delivery of twice-weekly joint drop-in sessions alongside the Homeless Team, supporting early intervention to reduce the risk of homelessness and enabling more effective identification of safeguarding concerns. In addition, the team offers home visits to all families, including those arriving through family reunion routes. This proactive approach has improved engagement, enabled earlier identification of safeguarding concerns, and created safer opportunities for individuals to disclose issues and access support. This has strengthened preventative safeguarding and improved access to timely interventions for individuals with care and support needs.
- **Embedding Multi-Agency Pathways to Reduce Risk and Promote Stability**
Significant progress has been made in strengthening partnership working through the establishment of monthly SERCO multi-agency meetings, bringing together housing providers, police, local authority services, and voluntary sector partners. These meetings provide a consistent forum to discuss safeguarding risks, emerging issues, and community cohesion, enabling coordinated responses and improved information sharing. This has supported a more joined-up, proactive approach to managing risk and reducing gaps in support for vulnerable individuals.
- **Improving Access to Support and Safeguarding Through Inclusive Services**
The Resettlement Team has further strengthened staff knowledge and practice in responding to domestic abuse, with a focus on the additional barriers faced by individuals with different immigration statuses (e.g. spousal visas and family reunion). Staff have also built strong links with local refuges and worked closely with Greater Manchester Immigration Aid Unit (GMIAU) at drop-in sessions to ensure individuals can access appropriate legal advice. This has enabled more informed, coordinated safeguarding responses and improved support for victims navigating complex legal and support systems.



One Significant Learning, Risk, or Challenge:

A key challenge for the resettlement system is the complexity and fluidity of immigration status and accommodation pathways, which can create gaps in safeguarding oversight and continuity of support. Individuals may move between providers or settings (e.g. dispersal accommodation), increasing the risk of missed vulnerabilities, inconsistent information sharing, and disengagement from services. This highlights the need for stronger, system-wide coordination and clear safeguarding pathways across all partners involved in asylum and migration support. Addressing this will be critical to ensuring consistent, person-centred safeguarding responses for a highly transient and vulnerable cohort.

One key example to evidence of Partnership / MDT Working:

A key example of effective multi-agency working has been the utilisation of Greater Manchester Combined Authority (GMCA) Refugee Welcome Programme (RWP) funding to strengthen local infrastructure and partnership delivery. This enabled the development of a Wigan Refugee Alliance, coordinated by Rebuild with Hope, bringing together a wide range of voluntary, community, faith, and statutory providers to support resettlement and integration.

During 2025–26, this collaboration resulted in a significant expansion of provision tailored to asylum seekers and refugees, with partners delivering targeted support including: Rotary Club (ESOL and digital skills), Wigan Mosque (ESOL provision), Rebuild with Hope (digital skills and volunteering pathways), and Fitya (CV development and employability support). This coordinated approach improved access to skills, reduced isolation, and supported progression towards employment and independence. The partnership model, underpinned by RWP funding, has strengthened system-wide responses to resettlement by aligning services, reducing duplication, and embedding a more cohesive, community-led approach to safeguarding and wellbeing.

Voice of Adults and/or Carers:

Lived experience has directly informed the design and delivery of resettlement services through ongoing engagement at weekly drop-in sessions and community-based support offer, where asylum seekers and refugees regularly share feedback on barriers and needs. This feedback has shaped service delivery, including the introduction of on-site legal advice (GMIAU), health outreach provision, and targeted skills and employability support, ensuring services are accessible, relevant, and responsive.

In addition, the development of the Wigan Refugee Alliance has created further opportunities for individuals with lived experience to influence provision by informing partner organisations about what support is most needed to aid integration and independence. This has resulted in a more person-centred approach, where services are adapted in response to real-time insights from those accessing support, strengthening both safeguarding and wellbeing outcomes.

One Priority Where WSAB Can Help the System Improve:

A key priority for WSAB is strengthening system-wide awareness, identification, and response to safeguarding risks within migrant communities, particularly considering recent Domestic Homicide Review learning which highlighted an ‘unseen/unheard’ victim. This underscores the need for improved training and professional curiosity across agencies to recognise forms of abuse that may present differently, including so-called honour-based abuse and cultural or structural barriers to disclosure.

WSAB is well placed to support the development of consistent multi-agency training, guidance, and pathways to ensure practitioners are confident in identifying and responding to these risks. This would enhance early intervention, improve engagement with underrepresented groups, and reduce the likelihood of individuals remaining hidden from safeguarding systems.

Wrightington, Wigan and Leigh NHS Teaching Hospitals NHS Foundation Trust



**Wrightington, Wigan and
Leigh Teaching Hospitals**
NHS Foundation Trust

Three Key Safeguarding Achievements:

- Delivery of a Trust-wide Least Restrictive Practice improvement programme, reducing restrictive interventions and strengthening lawful, proportionate care for adults at risk.
- Continuation and further embedding of the Think Family safeguarding training model, strengthening workforce capability to recognise and respond to complex safeguarding risks across adults, families and wider systems.
- Evidence of improved Mental Capacity Act practice and decision-making, supported by audit activity and learning from reviews.

One Significant Learning, Risk, or Challenge:

While progress has been made, variability remains in the application of Mental Capacity Act and least restrictive practice in complex cases. Internal audits identified risks relating to proportionality, documentation and inconsistent staff understanding, alongside increasing demand and complexity. This highlights the need for continued focus on embedding consistent, legally compliant and trauma-informed practice.

One key example to evidence of Partnership / MDT Working:

WWLTH contributed to a multi-agency MCA/DoLS audit through the WSAB subgroup, alongside the Local Authority and partner agencies. Findings informed targeted improvement work led by the WSAB Business Unit, focused on strengthening the quality and consistency of Mental Capacity Act practice.

In response, WWLTH has supported delivery of internal MCA workshops to reinforce practitioner understanding and application of the Mental Capacity Act in practice alongside supporting multi-agency MCA training development and roll out. This collaborative approach has supported shared learning and improved consistency in MCA application across agencies.

Voice of Adults and/or Carers:

Lived experience is captured through compliments, complaints, incidents, patient feedback mechanisms and After Action Reviews (AARs), with themes used to identify gaps in safeguarding practice or build on what works well. This is supported by approaches including patient panels, advocacy access and safeguarding supervision, ensuring adults and carers can influence care and decision-making. Learning from these sources informs training, supervision and service improvement, particularly in strengthening trauma-informed and person-centred approaches.

This was demonstrated in the case of an adult with complex physical health needs, alcohol dependency, mental health difficulties and neurodiversity, who initially refused hospital treatment due to fear of detention and previous negative experiences. A coordinated multi-agency response involving Adult Social Care, WAWY, WWL community and acute health teams and safeguarding staff prioritised understanding his concerns and respected his initial decision by arranging community-based treatment. When his condition deteriorated and hospital admission became necessary, WWL Safeguarding Adult practitioners ensured continuity of support, enabling him to express his fears and preferences, which directly informed how care was delivered, including adapting communication and reducing distress. This approach enabled the individual to engage with treatment he had previously declined and resulted in a positive experience, with the individual reporting increased confidence in hospital care. This management further facilitated discussions with frontline staff around application of trauma informed care in real time whilst aiding opportunities for active, solution-focused supervision and education.

One Priority Where WSAB Can Help the System Improve:

A more defined and measurable system-wide approach to trauma-informed practice is required. While trauma-informed care is widely referenced across policies and practice, its application is often unclear and inconsistently understood across the workforce. Greater clarity is needed on what this looks like in practice, how it should be applied by practitioners, and how impact can be measured at both operational and strategic level. Aligning this with the level of clarity and assurance seen in Making Safeguarding Personal would support more consistent and effective implementation across the system.

Wigan Council Adult Social Care Early Intervention

Three Key Safeguarding Achievements:

- The Early Intervention Service continue to understand their important role in safeguarding, particularly as they work in people's homes and have direct insight into people's lived conditions and potential neglect, carer breakdown and abuse.
- Early Intervention staff act on their ability to identify situations early and to provide Prevention solutions to help prevent escalation.
- Where a Safeguarding referral is indicated Early Intervention staff feel confident in triggering timely referrals and are increasingly seeking multi agency information and advice to ensure the most appropriate response.



Wigan
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One Significant Learning, Risk, or Challenge:

Within the Early Intervention Service learning is ongoing to understand the impact of a person's level of capacity and ability to consent to decisions re Housing, adaptations and financial assessment for disabled facilities grant. For example, person A had mobility problems and dementia but lived independently in their own bungalow. Family lost a tenancy on their rented house, moved in with her and went on to sell her bungalow and purchase a house with the sale of her bungalow. Early Intervention staff raised a safeguarding referral as they were unclear of capacity and consent.

One key example to evidence of Partnership / MDT Working:

The Moving & Handling team were assessing a resident, and it became clear that the provider, though very caring, was using an unsafe method of lifting the person. This was raised with PMMD and a Safeguarding meeting ensued. The provider was fully involved, and the recommendation was to provide further Manual Handling training. The outcome was very positive, and the person was transferred with safe equipment and technique. This approach not only avoided harm to this person and any future customers but demonstrated a supportive approach to the provider.

Voice of Adults and/or Carers:

Early Intervention has led on the development of a Sensory Partnership Board to bring together key, systemwide partners and people with lived experience to improve the quality of life of residents with sensory loss in the borough. This was the result of feedback received at a community event for residents where their opinion was actively sought. Though early days, we have already begun to see some small, positive changes and key actions in place to make a real difference to people's lives. More generally, the Early Intervention Service actively seek feedback from adults and carers through quality monitoring strategies such as listening to people's experience, case studies, resident surveys and case audits.

One Priority Where WSAB Can Help the System Improve:

The system would value insight into how the WSAB works as a positive example of a great system wide partnership. Regular updates/information sharing / case studies would be beneficial as part of induction and ongoing learning.

Greater Manchester Police

Three Key Safeguarding Achievements:



- Delivery and embedding of Evidence Led Prosecution (ELP) training, resulting in increased domestic abuse charges and improved outcomes for victims who were unable or unwilling to support prosecutions.
- Successful implementation of the Domestic Abuse Protection Order (DAPO) pilot, with significant use of orders to provide ongoing protection for victims and hold offenders accountable.
- Establishment and embedding of the multi-agency cuckooing response model, including use of the Cuckooing Car, improving identification, safeguarding and support for vulnerable adults at risk of exploitation.

One Significant Learning, Risk, or Challenge:

A key challenge has been the sustained level of adult safeguarding and domestic abuse demand within Wigan, combined with workforce pressures arising from sickness, abstractions and limited resilience. This has created tension between demand and available resources,

impacting the ability to consistently meet statutory safeguarding responsibilities and agreed timescales. The experience reinforces the importance of effective partnership working, early intervention and proportionate demand management across the safeguarding system

One key example to evidence of Partnership / MDT Working:

A vulnerable adult repeatedly subjected to cuckooing was supported through a coordinated multi-agency response involving GMP, housing partners and intelligence teams. The individual received targeted safeguarding visits through the Cuckooing Car initiative, practical support, crime prevention advice and ongoing multi-agency oversight. Recognising that enforcement activity alone had not reduced risk, partners worked together to secure a move to safer accommodation, resulting in a longer-term safeguarding outcome and reduced vulnerability to exploitation.

Voice of Adults and/or Carers:

GMP's safeguarding approach is informed through direct engagement with vulnerable adults and their carers at the point of contact. Officers complete safeguarding assessments and care plans based on individual circumstances, ensuring support is tailored to lived experience and identified needs. The Cuckooing Car initiative further strengthens this approach by providing face-to-face engagement with vulnerable adults, helping shape multi-agency interventions and support plans around the individual's circumstances.

One Priority Where WSAB Can Help the System Improve:

Further development of multi-agency information sharing and integrated safeguarding arrangements would help partners identify vulnerability earlier, particularly for adults experiencing cumulative harm, exploitation and repeat victimisation. Consistent thresholds, improved information exchange and coordinated risk assessment processes would strengthen early intervention and improve outcomes across the safeguarding partnership.

Wigan Council Housing

Three Key Safeguarding Achievements:

- Targeted training sessions: Using examples directly experienced from Crisis Intervention and Prevention Housing Services (as opposed to care home/domiciliary settings) has helped embed safeguarding procedures more effectively.
- Partnership working with the Training team: Collaborated to develop service-specific training sessions, with practice based support from the Quality Performance Officer (QPO) on the day of training.
- Improved quality of tiers: A significant improvement in the quality of tiers has led to better outcomes for individuals, with risks and support needs being identified much earlier



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One Significant Learning, Risk, or Challenge:

Within Crisis Intervention services, we often work with highly vulnerable individuals who may be difficult to engage and often present with co-morbidities. Many have entrenched challenging routines or have a strong mistrust of services, which can act as a barrier to support. It is important that these individuals are approached with greater flexibility and understanding across all services. A strictly policy-driven approach can be ineffective; instead, a more tolerant and person-centred approach is needed to achieve positive engagement.

One key example to evidence of Partnership / MDT Working:

Over the last 12 months, we have worked in close partnership across multiple agencies, particularly in supporting the Target Priority Group (TPG) of long term rough sleepers. This collaborative approach has led to positive outcomes, including securing long-term housing for some of the most vulnerable individuals. This was achieved through coordinated input from Housing services, Health and Social Care professionals, and support teams, demonstrating the value of effective multi-agency working

Voice of Adults and/or Carers:

We routinely collect feedback from individuals who use the service. The feedback received has been positive and provides valuable insight into lived experiences. This feedback is used to inform and continuously improve our approach across the service, particularly in relation to our safeguarding responsibilities.

One Priority Where WSAB Can Help the System Improve:

New training sessions could be shared and discussed with wider services prior to rollout to ensure consistency and relevance across the session.

Response times and expectations should be clearly communicated to the person reporting the incident, to ensure transparency and provide realistic expectations.

Greater Manchester Fire and Rescue Service

Three Key Safeguarding Achievements:



- Improved GMFRS safeguarding digital recording arrangements, making it easier for staff to record concerns consistently, capture key information, evidence decision-making and support clearer oversight of safeguarding activity, referrals and follow-up actions for adults at risk.
- Continued to embed safeguarding within prevention activity, including the delivery of 3,356 Home Fire Safety Assessments, fitting 26,730 alarms and installing 634 deaf alarms. These visits and partner referrals helped identify and reduce risk for adults with care and support needs, particularly where fire risk is linked to vulnerability, mobility, health needs, self-neglect or unsafe living circumstances.
- Improved learning and assurance across GMFRS through case review activity, safeguarding training, practitioner support and stronger links with local safeguarding partners, helping staff to understand safeguarding thresholds, information-sharing expectations and the importance of timely and quality referrals.

One Significant Learning, Risk, or Challenge:

A significant learning point for GMFRS is the need to keep strengthening early identification of adults whose fire risk is linked to wider safeguarding concerns, including self-neglect, mental health, substance use, mobility issues, domestic abuse or caring arrangements.

Conversely, safeguarding concerns can also result in heightened fire risk, which is why it is important to continue promoting the offer of GMFRS Home Fire Safety Assessments to all partner agencies.

Operational and prevention staff are often well placed to notice risks within the home, but effective safeguarding depends on consistent recording, professional curiosity, timely referral and good information-sharing with and across partners.

A continued challenge is ensuring safeguarding is understood not only as a response to immediate harm, but also as a preventative approach that reduces risk before concerns escalate.

One key example to evidence of Partnership / MDT Working:

During the reporting period, GMFRS delivered 3,356 Home Fire Safety Assessments, fitted 26,730 alarms, installed 634 deaf alarms and made 860 onward referrals, including 113 referrals into Adult Social Care. This supported earlier identification of risk within the home and created opportunities for advice, referral and joined-up safeguarding responses.

GMFRS Safeguarding Learning and Quality Assurance Officers also supported WSAB in the delivery of Section 42 multi-agency training sessions, helping to strengthen shared understanding of safeguarding duties, thresholds, partner roles and the importance of timely, effective multi-agency working.

One Priority Where WSAB Can Help the System Improve:

A helpful system-wide priority for WSAB would be to further strengthen shared understanding of thresholds, referral pathways and information-sharing where fire risk is linked to adult safeguarding concerns. This should include continued partner awareness of GMFRS Home Fire Safety Assessment referrals, especially for adults with care and support needs, people who smoke, people with reduced mobility, those experiencing self-neglect, and people receiving domiciliary care. Clearer shared pathways would support earlier intervention, reduce duplication and help partners take a more consistent preventative approach.

Key Links

Below are some key links from the content of this year's Annual Report

- [All Different All Equal](#) –Wigan Borough Community First
- [Care Act 2014 - Role of a Safeguarding Adult Board](#) = SCIE
- [Care Act 2014 – S.42](#) – Legislation
- [Carers Centre](#) – Wigan & Leigh Carers Centre
- [Care Quality Commission \(CQC\) Wigan Report](#) – CQC report
- [Cuckooing](#) –WSAB Guidance
- [Domestic Abuse](#) –Wigan Council Domestic Abuse support page
- [GMP Report Link](#) – How to report to Greater Manchester Police
- [LeDeR Reviews](#) - Learning from lives and deaths NHS page
- [Making Safeguarding Personal](#) –SCIE
- [MAPPA](#) – .gov Multi-Agency Public Protection Guidance
- [PiPoT](#) - Persons in a Position of Trust WSAB Guidance
- [Practice Standards](#) –WSAB Practice Standards
- [Prevent](#) –Wigan Prevent Page
- [Pride of Adult Safeguarding Awards](#) – Awards page on WSAB website
- [Progress with Unity](#) – Progress with Unity Wigan Council page
- [Public Health JSNA](#) – Wigan Council Joint Strategic Needs Assessment
- [QAF](#) – WSAB Quality Assurance Framework
- [Report adult concern](#) – Wigan Council Webpage for reporting abuse or neglect for adults
- [Report Child Concern](#) – Wigan Council Webpage for reporting abuse or neglect for Children
- [Resolution Policy](#) – WSAB Resolution Policy
- [Safeguarding Adults Reviews](#) – WSAB Case review Policy and SARs
- [Safer Employment](#) – WSAB Safer Employment Page
- [Sexual Exploitation Guidance](#) – WSAB Sexual Exploration Guidance
- [Shanley Report](#) – Published report
- [Strategy](#) – WSAB Strategy
- [Training Brochure](#) – WSAB Training Brochure
- [Use of appropriate language](#) – WSAB Case Recording and Use of Appropriate Language guidance
- [What's Up Champions](#) – WSAB Champions Page

Sign Off and Publication

Date	Notes
May 2026	First Draft Completed
June 2026	Accessibility Checks Completed
August 2026	Signed off at Wigan Safeguarding Adults Board
September 2026	
September 2026	Published