



Annual Report

2016 / 2017

Foreword

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

Work has continued across 2016/17 to embed safeguarding principles and practice across our combined workforces. The report also provides a further opportunity for the Board to provide information as to the needs of adults at risk of abuse and neglect within the Borough and how Member Agencies have worked in partnership to address these needs.

All adults in Wigan have a right to live in a borough where systems that safeguard and protect their wellbeing work together effectively.

2016/17 saw further financial strains across all services that make up the WSAB. As always within the Borough of Wigan, these challenges continued to be met with a firm belief and passion across all agencies that the transformational change required must be innovative, and that new approaches needed to result in an improved service offer for service users, customers, families and communities. Under the overarching Deal for Wigan and the Deal for Adult Social Care further work was undertaken that focused on forging new relationships with and within communities, as well as further work that explored and tested how services integrate and collaborate to provide a simplified and improved service for those in need.

Many of these innovative programmes of change are linked directly to improved outcomes for those in need of safeguarding, and the Board has helped shape and support many of these such as the Deal for Adult Social Care and further development of a Multi-Agency Safeguarding Hub (MASH) which within 2016/17 included the integration of Adult Social Care within it. The MASH also provided an opportunity for the Board to test out supporting different cohorts of vulnerable adults following the interim review of the Care Act. A new multi-agency approach to supporting victims of financial abuse is now key process within the MASH.

One of the key challenges for any safeguarding board is developing meaningful connections, conversations and collaboration across individuals, professionals and communities. 2016/17 saw WSAB:

- Conduct a full review of the current training offer regarding adult safeguarding and the development of a joint (with Wigan Safeguarding Children's Board) Workforce Development and Training Strategy.
- Further develop relationships with community and voluntary organisations across the Borough through engagement events and through holding Board meetings in localities
- Improve how we use social media to engage in different ways with communities, individuals and the organisations that support them

But we can and will go further to establish the voice of the vulnerable adult at the centre of the Boards objectives. We continue to develop this through wider consultation with adults at risk who experience a safeguarding enquiry, the roll out of early intervention Safeguarding Tier Model for a wider set of providers and community and voluntary sector groups and developing out training database to provide consultation, engagement and participation opportunities.

It has been a year of new ways of working for WSAB following the significant changes that 2015/16 brought, and without the enthusiasm and commitment from the partnership these would have failed. I am grateful for the strength of the partnership that has met these challenges with a commitment that bodes well for the coming year and beyond.

Dr Paul Kingston
Independent Chair

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Section 1 Executive Summary:

Purpose

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

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

Achievements and Work Programme

In our 2015/16 report we identified several key challenges to address. WSAB has continued to make progress in these areas in 2016/17:

1. **The Communications and Engagement work of the board will continue to develop.** – This is central to the work of the Board. Engagement and consultation with both internal and external groups, professionals, individuals and organisations will further develop safe and effective policies, processes and practice for all adults at risk of neglect or abuse. In 2016/17 the WSAB:
 - Attended and promoted the WSAB at 23 external and 4 internal events and engaged face to face with **1825** individuals across the Borough communities
 - Held its 4 annual board meetings within communities across the Borough and engaged with **20** individual community and voluntary based organisations that provide services to adults at risk of abuse or neglect in the place.
 - Further developed its social media presence through Twitter with **551** followers to date (a mix of organisations and individuals)
 - Held a successful third Annual Safeguarding Conference that was attended by over **200** front line professionals from across the Health and Social Care, Criminal Justice and Community and Voluntary Sector.
 - PMMD / Adult Safeguarding Team engaged and trained **450** individuals across **18** Safeguarding Tier Training sessions to embed it's preventative 5 Tier Safeguarding Model across both health and social care and community / voluntary organisations.
 - Delivered wider face to face training to **434** professionals across a wide range of subjects such as Preventing Violent Extremism, Adult Safeguarding awareness and Multi-Agency Public Protection Arrangements
 - Facilitated **1129** individuals to access further safeguarding e-learning training covering such subjects as Mental Capacity Act, Safeguarding Awareness courses and Information Sharing for Safeguarding.

2. **A review of the structures and the synergy between WSAB and Wigan Safeguarding Children's Board. Co-ordination of Children's Board and Adults Board processes** – this

has progressed in 2016/17 including a full restructure of the Safeguarding Team to ensure a life course approach to the partnership of the boards underpins a revised delivery model. It identified key life course priorities (such as transition and domestic abuse) that will continue to be jointly developed and owned by both Boards.

3. **A review of the current offer regarding adult safeguarding training products** – in 2016/17 we developed a joint (with Children’s Board) Workforce Development and Training Strategy. The delivery group also reviewed the current training offer and recommissioned its core Section 42 Skills and Practice course. It replaced the basic awareness and foundation course with the 5 Tier Safeguarding Model and began to roll out both the early intervention model and training to a wider set of organisations including within the community and voluntary sector. It also reviewed and quality assured its online course portfolio regarding adult safeguarding themes and practice and published its online training prospectus.
4. **Embed the principles and practice regarding Making Safeguarding Personal (MSP)** – the new Adult Social Care case management system MOSAIC went live in 2016/17. Within the safeguarding pathway MSP was built into the process and will enable further analysis of outcomes for individuals who undergo a safeguarding enquiry.
5. **Developing and trialling a self-neglect policy and process** – this continued across 2016/17 with a review of the policy pilot to be undertaken in 17/18.
6. **Develop and implement a Multi-Agency Safeguarding Hub** - this continued to evolve over 2016/17, including a pilot with Adult Social Care regarding integrated triaging of safeguarding concerns reported to the Police. The pilot resulted in more appropriate referrals made to social care regarding section 42 enquiries, with wider social support operating from the MASH for those cases that whilst not hitting Care Act eligibility for safeguarding enquiry, nevertheless require agency intervention. The MASH also developed other processes to support adults at risk of neglect or abuse around the themes of Missing Adults, Financial Scams and suicide prevention (more information on this can be found within the main body of this report
7. **Develop and embed a learning culture within the Board and across organisations and communities**– the Board undertook one Serious Adult Review and two local case reviews with action plans to be developed and implemented across 2017/18 to ensure that lessons learned inform future frontline practice and positively impact directly on service users.

Our Learning and Improvement approach was further enhanced through the development of a scorecard / performance reporting process for adult safeguarding that improved the Board’s insight into key thematic areas of work. A programme of “deep dive” audits specifically on section 42 outcomes and practice was also developed, and

that was collaboratively delivered between adult social care and the safeguarding team; this helped identify areas where support for safeguarding practice was required.

Wigan Borough CCG was recognised by NHS England regarding the development and implementation of a strengthened quality assurance model for health providers

Wider Partnership Work That Contributes to Safeguarding Outcomes

In addition to the core work of the Board, they continue to support and scrutinise key activity that partners have undertaken. Work continues to be developed and reported back into the Board across a wide range of agencies and partnerships that positively impact on safeguarding outcomes, they include:

- Further development and embedding of an asset based approach to health and social care through The Wigan Deal for Adult Social.
- Wider programmes of transformation work include developing an integrated health and social care community service through the Integrated Care Organisation, and implementation of the Innovation Fund for Care Homes that saw £1 million of funds being offered for ideas that would positively impact on people's experience of residential and nursing care.
- Local Authority Quality Surveillance Group which oversees a programme and quality assurance framework for care sector providers
- Wigan Suicide Prevention Group which has in place an action plan to raise awareness of early help for individuals and families
- Wigan's Palliative Care Steering Group which in 16/17 has developed an end of life pathway
- Wigan Place Based Steering Group which oversees the roll-out of integrated working across seven newly defined service delivery footprints. This group also oversees key transformation programmes including the Live Well / Complex Dependency Team. In 16/17 the group began plans for wider expansion of this innovative service that focusses on supporting clients high risk / non engaging vulnerable clients
- Wigan's Building Stronger Community Partnership (BSCP) which in 16/17 focused on key safeguarding themes. This included joint production of a Serious and Organised Crime Profile for the borough which identified key issues in relation to human trafficking / modern day slavery. The Serious and Organised Crime Partnership Group developed an overarching action plan following this profile which included building intelligence links between public health and police regarding modern day slavery / trafficking.
- The BSCP Tactical Group provided further focus and work across 16/17 on key safeguarding themes; for example on hate crime where a successful awareness week was held across the Borough. It also began to explore embedding the response of hate crime as a constituent part of the MASH
- Domestic Violence Steering Group – in 16/17 the group further developed the co-ordinated community response model through a review of its Integrated

Safeguarding and Public Protection team and process, piloting a response for all domestic abuse police reported cases through Operation Strive and began piloting a dedicated hospital based Independent Domestic Violence Advocate.

Future Challenges and Work for 2017/18

Whilst 2016/17 saw WSAB consolidate and build on the work achieved over 2016/17 and previous years, significant work is still required to fully realise our overall ambitions, they include

- Creating more opportunities for adults and their families to tell us what they think of the safeguarding process they experienced. In 2017/18 we'll explore with new partners how we can expand these opportunities and use this insight to further improve safeguarding practice.
- Launch of the joint Children's and Adults Deal for Safeguarding and wider roll out of connections into and across communities. In 2017/18 we'll begin piloting an Eyes and Ears programme of work that provides community intelligence regarding adults potentially at risk of abuse or neglect. We'll ensure the Deal for Safeguarding is embedded within all consultation, engagement and training / workforce development processes.
- Commissioning and rolling out the Section 42 workforce development training and programme to address consistency of practice in core safeguarding processes. This training will also connect the asset based approaches of the Deal for Adult Social Care with Making Safeguarding Personal principles and practice and ensure that a person centred approach is at the heart of all safeguarding processes whilst still managing risk.
- Further development of our learning and improvement framework which will include wider quality assurance work regarding section 42 processes and development of a performance framework against individual safeguarding thematic areas
- Further development and quality assurance work around our training offer including the implementation of an evaluation framework for those courses delivered / facilitated by the WSAB.
- Reviewing and refreshing our training database into one which can target both training and key safeguarding information / messages at the workforce. We'll also develop adult safeguarding virtual locality briefings
- Further work with Children's Board on key overlapping thematic and practice areas and to consolidate a life course approach to safeguarding.
- Undertake an LGA Peer Review to test our current position on both Section 42 practice and outcomes and the embedding of making safeguarding
- Review our Adult Safeguarding Policy and procedures to ensure they provide a robust focus on person centred processes and outcomes
- Roll out the Safeguarding 5 Tier Model to more community and voluntary sector groups and support them to embed a preventative approach to safeguarding.

Section 2: Context and Strategic Overview

The demographic of Wigan

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

- Wigan is ranked 65th most deprived local authority in England.
- 2.7% from ethnic background other than White British.
- 1.8% speaking a first language other than English.
- A range of health providers including one Acute Trust, one Community Healthcare Trust and a Clinical Commissioning Group that oversees 63 GP practices.
- Mental health care is provided North West Boroughs Partnership.
- Wigan's population is increasing (up % at the 2011 census) but at a slower rate than both England and the North West.
- 16% (around 50,000 people) of the Wigan population are aged 65 and over and 4% (11,000 people) are 80+ years of age.
- In comparison with the UK as a whole, the population of Wigan is ageing. By 2033, the proportion of older people in the population will increase, without much change in the numbers of people aged less than 65 years; therefore there will be smaller proportions of younger, especially working age, people.
- The Borough is home to over 1000 asylum seekers and refugees, with an increasing number who become resident in the area once leave to remain is granted by the Home Office.
- Wigan's overall suicide rate at 10 per 100,000 population (PHOF 12-14) is slightly lower than the national average of 10.9 per 100,000.
- 22% of people, around 69,000 have a long term condition. Cardiovascular, Musculo-Skeletal and Mental Health conditions account for 70% of these.

Section 3: Progress against Strategic Objectives

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

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

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

The Board's Sub Groups have provided reports into the Board regarding their activity in 2016/2017, and there is a review, at each board, of progress made and of areas that need the support of board partners to drive forward.

1. Ensure the board remains complaint with the Care Act:

- Undertaking a review of Wigan Adult Safeguarding Policy and Procedure in line with interim Care Act review and update.
- Pilot a Self-Neglect Policy.
- Improve governance and scrutiny role of the Board and Executive through developing section 42 quality assurance process / further developing performance and insight reporting
- Improve communication between partners, sub groups and practitioners.

2. Engage with individuals, families, communities and professionals:

- Held a third successful Adult Safeguarding Conference in December 2016. This focused on engaging with front line practitioners regarding safeguarding and public service reform programmes as well as co-producing an overarching Deal for Safeguarding
- Developed further the Boards engagement programme across communities and at key events. The Safeguarding Communication and Engagement Officer role also focused on working with the community sector to develop new avenues for consultation and input on Safeguarding issues
- Development work undertaken regarding a bespoke WSAB web site for professionals, service users, carers and families.
- Full review and restructure of the Safeguarding Team which involved investment in a joint Children's and Adults Board Workforce Development and Engagement Team.

3. Ensure a high quality workforce fully equipped to safeguard adults:

- Reviewed training plans and produced a joint Children’s and Adults Board Workforce Development and Training Strategy and action plan.
- Ensured there is clear guidance of expected levels of training – multi-agency, 3rd sector, community and volunteers.
- Monitored uptake of training by agency and challenge and support further uptake where deemed appropriate.
- Quality assured and updated all adult based e-learning packages available through the Boards training web site.
- Updated and publicised training courses on offer through its online joint training brochure with Wigan Safeguarding Children Board.

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

- Ensured that learning from Serious Adult Reviews / Local Case Reviews / Case Audits etc. is captured and influences the transformation of services across the borough.
- Further developed a performance reporting framework (including whole system performance and insight dashboard) and supporting data collection process
- Further developed the role and function of the learning and Improvement Sub Group including a holistic Learning and Improvement Action Plan
- This included inviting all agencies to consider their own data and how it might feed into a performance framework.

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

- Developed a methodology for undertaking deep dive quality assurance audits into section 42 processes and outcomes that involved a peer review element through inclusion of adult social care team managers. The focus of these audits included appropriate use of advocates, cases that ended in unsubstantiated “No Further Action” and wider no further action samples.
- Undertaken case file audits on key safeguarding themes identified from serious adult / local case reviews (safe hospital discharge, mental health, domestic abuse)
- Wider partners have contributed significantly to the overall wider quality assurance challenge and framework including
 - Clinical Commissioning Group led review of safeguarding assurance framework and cycle for all health providers which has been recognised regionally by NHS England.
 - Provider Management and Market Development (PMMD) review and development of new framework for key aspects of care sector provision. This team also developed and implemented an Equality Framework for domiciliary care providers.

6. Develop a strategy for Early Intervention and Prevention

- Wider partners led by PMMD further embedded the Safeguarding Tier System across care providers and wider agencies including those in the community voluntary sector.
- The Safeguarding Board has sought to develop a preventative response to themes that arise from Serious Adult Reviews / Local Case Reviews / Case Audits and has developed action plan that include early intervention / prevention opportunities across partner, services and processes

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

- In October 2016 a MASH team was formed, located at Wigan police station and consisting of two key workers, 2 dual diagnosis nurses a representative from adult social care, a police officer from the public sector investigation unit and a worker from housing. The team began with no set framework and the sole aim of identifying high levels of repeat demand and trialing new approaches to removing the demand from the public sector while providing a better outcome for the person. A number of work streams were identified and tested as a starting position in terms of forming a PSR/MASH function.
- This includes two Adult Social Care workers based full time in the MASH. It is the responsibility of these officers to triage all of the adult safeguarding alerts for the Wigan borough. The alerts received by ASC that were deemed not at a safeguarding level would traditionally be allocated through to the social care locality teams. A process has now been implemented that allows for these cases now to enter the MASH function as described previously to identify the root cause for the presenting issue. The benefit to this process is that either the person receives a more appropriate intervention or the social care locality team receive a more informed handover utilising all information available.
- The MASH also began piloting work on other key safeguarding thematic areas including adult missing cases, multi agency support for vulnerable adults at risk of financial scams and support for potential suicide attempts. Further information on the MASH is provided within Greater Manchester Police's contribution to this report in Section 10.

Section 4: Update on Key Thematic Areas

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

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

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

Social Care Outcomes

WSAB continues to work with Wigan Council on plans to improve outcomes for service users and their families engaged with Social Care. In 2016/17 we embarked on an ongoing programme of process and practice improvement that includes regular quality assurance audits and research. This has begun to highlight key improvement points for safeguarding including:

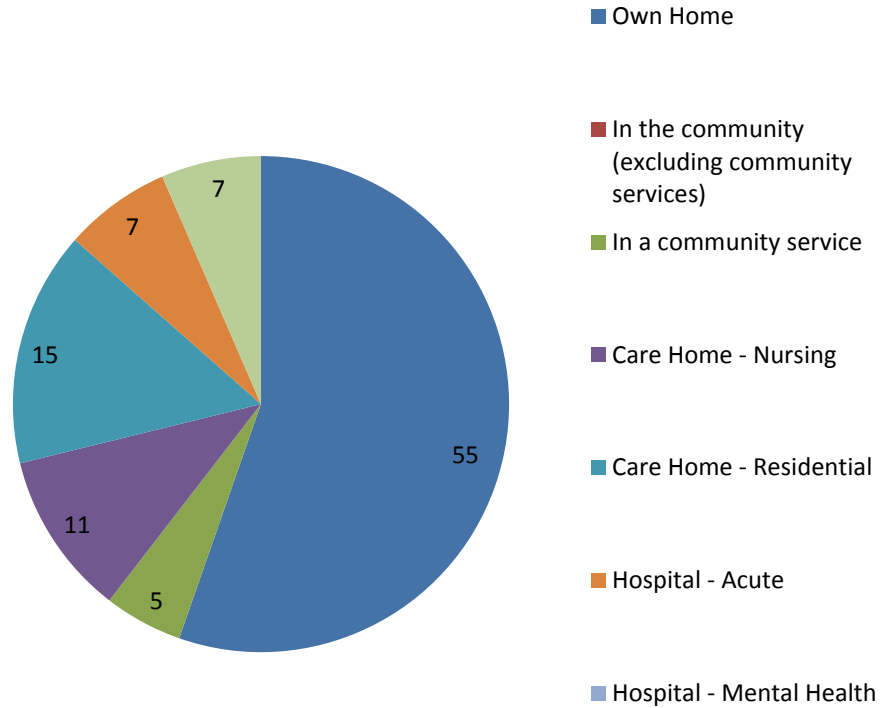
- Developing and implementing a response to self-neglect
- The need to update key training based on current practice issues within thematic areas including incorporating lessons from audits, case reviews etc.
- Further development and implementation of a new social care case management system which incorporates a bespoke safeguarding process.

In 2016/2017, there were **835** individuals who underwent a total of **1170** Section 42 Safeguarding Enquiries undertaken by Adult Social Care and involving wider partners. These were generated by a total of **1985** safeguarding concerns flagged to Adult Social Care; therefore 59% of concerns were converted to enquiry (England average 41%).

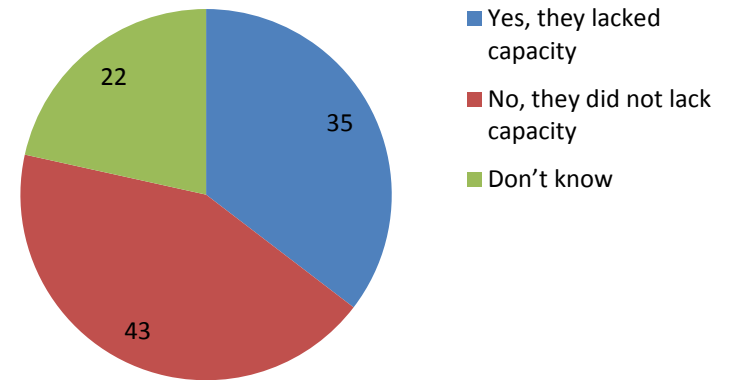
- **40%** (n=335) of alleged victims were aged 18-64 years of age and **60%** (n=500) were 65 years old and over.
- **38%** (n=320) of alleged victims were male and **62%** (n=515) were female
- **91%** (n=760) of alleged victims were white.
- In terms of alleged victims primary reason for needing support:
 - **48%** (n=395) had a physical disability, sensory impairment or required support with memory or cognition
 - **33%** (n=270) had a mental health issue (this primary reason seems to be an outlier compared to the England average of 12% and will require further analysis)
 - **14%** (n=120) had a learning disability.
- In terms of the Section 42 Safeguarding Enquiries, at their conclusion:
 - **22%** of cases involved physical abuse
 - **32%** involved neglect of acts omission (where an individual of service providing care to an individual/s failed in some aspect of their caring responsibilities)
 - **23%** involved financial or material abuse
 - **13%** involved psychological abuse
 - **5%** involved sexual abuse
 - **4%** involved organisational abuse
 - **1%** involved discriminatory abuse
- Regarding the source of risk, **31%** of cases involved a service provider (England average 31%), **63%** of the sources of risk were known to the individual (England average 51%) and **7%** were unknown to the victim.

Further data is presented overleaf.

Safeguarding Enquiry By Location (%)



For each enquiry, was the adult at risk lacking capacity to make decisions related to the safeguarding enquiry?



Wigan Borough Clinical Commissioning Group

Within 2016/17, CCG reviewed and implemented a refreshed framework regarding safeguarding assurance for health providers and provided regular reporting within the WSAB performance and insight dashboard.

It puts in place a robust system for monitoring safeguarding issues across all primary and secondary health services via provider contracts. Within 2016/17, this involved using the NHS Provider Safeguarding Audit Tool to Monitor Standards based on CQC Essential Standards, 17 compliance standards relate directly to Adult Safeguarding. A table reflecting the end of Quarter 4 2016/17 is presented overleaf.

NHS PROVIDER SAFEGUARDING AUDIT TOOL					
Not Applicable		Non-Compliant		Partial Compliance	Full Compliance
SAFEGUARDING STANDARD		5BP	BCHFT	WWLFT	
1	There is a Board lead for safeguarding children and adults at risk.				
2	The organisation is linked into the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adult Board (LSAB).				
3	Identification of a named doctor and named nurse (and named midwife if the organisation provides maternity services) for safeguarding children. In the case of out of hours services, ambulance trusts and independent providers, this could be a named professional from any relevant health or social care background.				
4	There is a named lead for safeguarding children, a named lead for adults at risk and a named lead for MCA. This must include the statutory role for managing adult safeguarding allegations against staff.				
5	The Provider Board regularly reviews safeguarding across the organisation.				
6	An adverse incident reporting system is in place which identifies circumstances/instances which have compromised the safety and welfare of children and/or adults at risk.				
7	A programme of internal audit and review is in place that enables the organisation to evidence the learning from review, incidents and inspections.				
8	Staff at all levels, have easy access to safeguarding policies and procedures. These policies and procedures must be consistent with statutory, national and local guidance.				
9	There is clear guidance on managing allegations against staff and volunteers working with children and/or adults at risk in line with those of the LSCB and LSAB.				
10	There is a process for ensuring that patients are routinely asked about dependents such as children, or about any caring responsibilities.				
11	There are agreed systems, standards and protocols for sharing information within the service and between agencies in accordance with national and local guidance.				
12	The organisation works with partners to protect children and adults at risk and participates in reviews as set out in statutory, national and local guidance.				
13	Safeguarding responsibilities are reflected in all job descriptions relevant to role and responsibilities.				
14	Staff working directly with children and adults at risk have access to advice, support and supervision. This includes clinical and safeguarding supervision as per the organisation's safeguarding supervision policy. Named professionals seek advice and access regular formal supervision from designated professionals for complex issues or where concerns may have to be escalated.				
15	There is a training strategy for safeguarding.				
16	Staff are trained to the appropriate levels in accordance with the current safeguarding children intercollegiate document and the anticipated adults intercollegiate document.				
17	There is a process for following up children who do not attend appointments.				
18	There is a system for flagging children for whom there are safeguarding concerns.				
19	When it is known that a child is not accessing education a referral will be made to the Local Authority in which the child lives.				
20	There is clear guidance as to the discharge of children for whom there are child protection concerns.				
21	The child's GP and health visitor/school nurse is notified of admissions/discharges.				
22	All attendances for children under 18 years to A&E, ambulatory care units, walk-in centres and minor injury units should be notified to the child's GP. Attendances at A&E will also be copied to the health visitor and/or school nurse depending on the age of the child.				

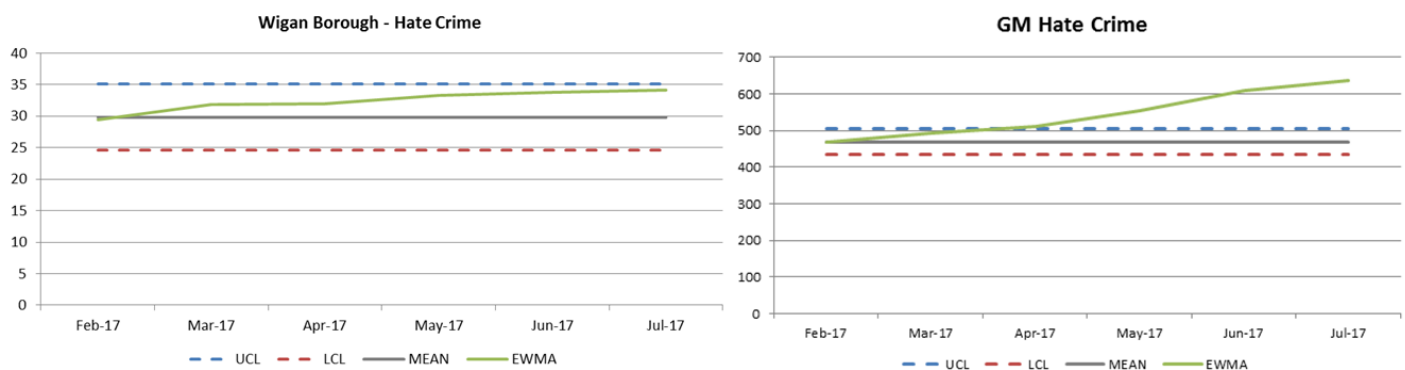
Overview:

The CCG have 22 performance standards which directly relate to Adult Safeguarding / are applicable to both children's and adults safeguarding. Providers self audit these standards on a bi-monthly schedule following an annual validation provided by CCG to quality assure compliance. The standards have been updated in order to provide focus to what is required by each standard and as such the standards cannot be compared to previous year returns. The standards are set at a Greater Manchester level and recent changes have observed a more robust validation process. CCG monitor the standards on a bi-monthly basis until compliance is achieved. Action plans are submitted against non compliant standards, and providers identify non-compliant standards within their corporate risk register.

Hate Crime and Incidents

In the 12 months to July 2017 there were 392 recorded crimes with a hate motivation in Wigan, an increase of 6% on the previous 12 months when there were 371 hate motivated crimes. Relative to the GM picture this appears to represent positive performance, with recorded hate crimes across the sub-region rising 42% in the 12 months to July 2017.

The statistical control charts below illustrate hate crime performance across Wigan and GM between February and July 2017. The Wigan chart indicates there was no statistically significant change in hate crime locally. Conversely the GM chart highlights a statistically significant change in the recorded hate crime.

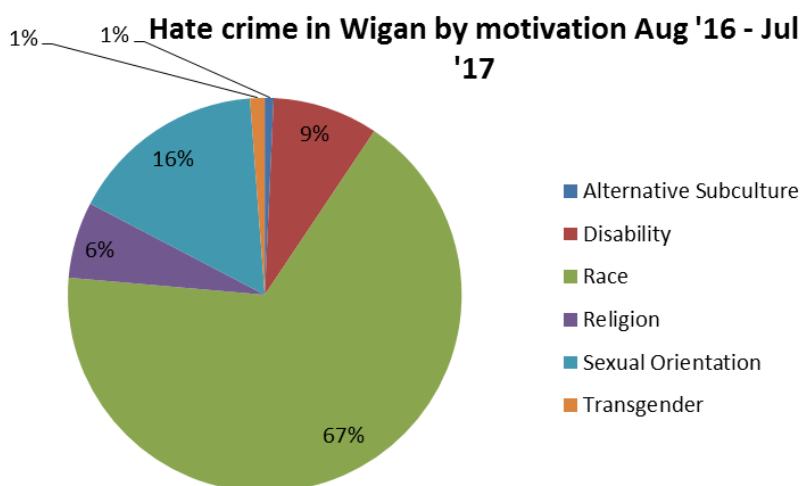


Source: GMP Hate Crime Bulletin (Statistical control charts contain data between Apr-14 – Jul-17)

Although the contrast in performance appears to show the borough in a positive light, consideration should be given to the approach in recording hate crime. Action taken by police forces to improve their compliance with the National Crime Recording Standard (NCRS) has led to improved recording of hate crime. Discussions with GMP performance officers suggest Wigan's reporting approach is good both in terms of compliance and relative to other divisions within GM.

Breakdown of Hate Crime in Wigan

GMP's Hate Crime Bulletin suggests hate crime in the borough is largely racially motivated with 67% of a recorded crimes coming under this category. Sexual orientation makes up 16% of all hate crimes, with disability making up a further 9%. Religion, Transgender and Alternative Subculture make up the remaining 8%.



Source: GMP Hate Crime Bulletin

Under-reporting

In 2015-16, police forces in England and Wales recorded 62,518 hate crimes. But the Crime Survey for England and Wales, which provides an alternative measure, estimated that 222,000 hate crimes took place in the same period. Under-reporting varies significantly between different strands: recent figures in England suggest one in two racist hate crimes are reported to the police; this drops to one in four for homophobic crimes, one in 10 for religiously motivated hate crimes, and one in 19 for disability hate crimes.

Research indicates that victims do not report hate crime for fear the Police and authorities will not believe them. The Equality and Human Rights Commission's Hidden in Plain Sight report suggests disabled victims are also likely to fear the consequences of reporting the crime. The BSCP will continue to explore opportunities to increase reporting rates for this area of work.

Domestic Abuse

Domestic Abuse Incidents (GMP Monthly Performance Bulletin)			
	2014-15	2015-16	2016-17
GMP	67069	64130	64231
Wigan	7246	7062	7172

Domestic Abuse Crimes (GMP Monthly Performance Bulletin)			
	2014-15	2015-16	2016-17
GMP	19619	18717	22715
Wigan	2033	1940	2735

NB – please note that GMP introduced tighter recording and investigation processes under Home Office National Crime Recording Standards recording rules within 2016/17 regarding

reported incidents. The changes ensured that all incidents must be recorded as a crime and then downgraded to incident following investigation (rather than the other way round previously). This was to ensure that victims were accorded the necessary investigation and to improve on the overall forces conversion of incidents to crimes through that investigation.

- Reported domestic abuse increased slightly between 15/16 and 16/17. This is in line with Greater Manchester and national trends.
- Within 2016/17, the Building Stronger Communities Partnership continued to embed the coordinated community response model for domestic abuse, at the heart of which is the multi-disciplinary co-located Integrated Safeguarding and Public Protection (ISAPP) Team.
- The ISAPP Team consists of Children's and Adults Senior Social Workers, Housing Officers, Independent Domestic Violence Advocates, Young Person's Domestic Abuse Advocate, Greater Manchester Fire and Rescue Service Officers, Substance Misuse Outreach Workers alongside all of Greater Manchester Police's Public Investigation Unit officers. Through effective sharing of partnership data and whole system risk assessment, MARACs are held three times a week with effective case management care plans developed within meetings. Appropriate agencies are identified as lead agency for all medium and high-risk crimes (around a third of all reported crimes from the tables above) reported to the Police, and case management plans are effectively implemented by the team. Health agencies and National Probation Service / Community Rehabilitation Company are also an integral part of the process and attend MARAC meetings as well as provide information relating to their management of individual cases
- In addition to the ISAPP team, 2016/17 saw the continuation of Operation Strive to support victims who were risk assessed as standard (and weren't therefore currently being supported by ISAPP) – for context this involves around 85% of all reported crimes). Delivered by GMP officers in 2015/16, all standard crimes are now followed up and through root cause analysis and different conversations, victims, offenders and their families are offered appropriate support. Data from GMP at the regional level suggest this is having a significant impact on repeat presentations (analysis from May 2016 looking back at around 9 months of delivery suggested that post incident revisits were reducing overall repeat presentations by 50%).
- Within 2016/17 and beyond, revisits were delivered by volunteers who are trained to engage with victims, offenders and families. The Building Stronger Communities Partnership will continue to develop this approach and report back to WSAB.
- The Independent Violence Advocate Service also began working in a dedicated way within the Royal Albert Edward Hospital, with one full time IDVA attached in per week. Working on a whole hospital approach, this is starting to provide support through early disclosure for victims.
- Within 2016/17, and building on the success of the ISAPP model, the WSAB continued to support the development of a Multi-Agency Safeguarding Hub through the Public Service Reform Programme Board.

Serious and Organised Crime

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



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

- Pursue:** prosecuting and disrupting people engaged in serious and organised crime;
- Prevent:** preventing people from engaging in serious and organised crime;
- Protect:** increasing protection against serious and organised crime;
- Prepare:** reducing the impact of this criminality where it takes place.

The WSAB recognise the disproportionate impact that key forms of serious and organised crime have on vulnerable adults, and have scrutinised a jointly produced (between GMP / Wigan Council) Local Profile. The following section updates overall figures for Wigan across 2016/17 for key thematic areas.

Human Trafficking / Modern Day Slavery

In order to develop a consistent and coordinated response GMP have a dedicated Modern Slavery Coordination Unit (MSCU) within the Organised Crime Coordination Unit (OCCU). This is

¹ Source: Home Office 'Serious and Organised Crime Strategy', published October 2013. NB While costs do vary across the different crime types, differences in how the various estimates were calculated means they are not directly comparable.

a multi-agency team which includes Home Office Immigration, Police, Probation, Local Authority and Gang Masters Licensing Authority. The stated purpose of the unit is to provide specialist operational support, partnership review of investigations, development and the delivery of training to front line staff.

Although there were no crimes recorded in Wigan regarding Human Trafficking / Modern Day Slavery intelligence reports continue to be investigated. Although significantly lower than other Greater Manchester areas, the content of the intelligence reported to Police in Wigan poses a substantial risk to the safety and well-being of individuals.

The Building Stronger Communities Partnership continued in 2016/17 to raise awareness of the issue through GMP led force weeks of action focussing on this thematic area, and the Serious and Organised Crime Partnership group continue to lead activity regarding this area of work.

Forced Marriage / Honour Based Violence

- The term 'honour based crime' covers any criminal offence that is driven by a mistaken desire to protect the cultural or traditional beliefs of a family or community. It may or may not involve violence. It can include:
 - Personal attacks of any kind, including physical and sexual violence.
 - Forced marriage.
 - Forced repatriation (sending someone back to a country from which they originate without their consent).
 - Written or verbal threats or insults.
 - Threatening or abusive phone calls, emails and instant messages.
- Honour Based Violence can be distinguished from other forms of violence, as it is often committed with some degree of approval and/or collusion from family and / or community members.
- National data indicates that many of these issues remain unreported for many reasons including fear of reprisals, becoming ostracized from families and communities, as well as acceptance and tolerance given that many of the offences have been instilled within communities for many years.
- Although there were no honour based crimes reported within 2016/17 within the Borough, the WSAB continue to raise awareness of the issue through its training offer and the issue was highlighted at the November 2015 Conference.

Complex Dependency / Live Well Team Update

In 2014 a gap in public service systems in Wigan was highlighted by partners relating to working age adults who failed to meet thresholds for specialist services / legislative thresholds or criteria but created demand across services. Initial analysis identified a significant cohort of individuals, generally aged between 24-49 with no parental responsibility, who presented with a complex set of relationships with public services due to the a range of issues. Extensive research and modelling of systems changes to address this gap was undertaken using the methodology described in the Lankelly Chase reports “*Hard Edges*”, “*The Complexity of Severe and Multiple Disadvantage*” and “*Breaking Boundaries*”.

The central aim of *Hard Edges* was to “establish a statistical profile of the extent and nature of [...] severe and multiple disadvantage (SMD) in England”. The authors defined their cohort as those in the extreme margins of social disadvantage and looked at the “multiplicity and interlocking nature” of the issues of offending behaviours/ ASB, substance misuse, homelessness, or poor mental health.

The conclusions of the report included that “SMD seems to result from a combination of structural, systemic, family and personal disorders” and that “support systems struggle to deliver positive outcomes in more complex cases”.

The follow up study “*The Complexity of Severe and Multiple Disadvantage*” makes the case for development of a personal support worker workforce to address. Wigan’s Complex Dependency team of keyworkers was established and would test this hypothesis.

Analysis

Impact is measured using chaos indicators and an outcomes framework. This is now recorded on the Adult Services CRM, Mosaic, allowing for improved monitoring, analysis and evaluation. The process of recording has been iteratively improved and going forward will allow for accurate measurement against performance metrics.

Due to the various changes in scope and collection of information there are some gaps in recording, though it is possible to draw sound conclusions from the data as follows:

- 455 referrals recorded on Mosaic between April '16 and October '17 from 385 individuals (24 per month)
- 130 repeat referrals – 28% of all cases – from 60 individuals (some individuals repeated more than once).
- The highest proportion of cases came from the SDF of Leigh (24%), with Scholes, Hindley, Abram, Platt Bridge and Ince (21%), Wigan Central (14%) and Tyldesley and Atherton (14%) also accounting for significant number of cases
- 51% of cases were referred to Live Well via GMP, 14% via Place Based / INT, 5% from the MASH. Together these 3 services made up 70% of all referrals
- Of those presenting with specific Lankelly Chase issues:

- 7% of cases recorded 4 presenting issues;
- 20% of cases recorded 3 presenting issues;
- 22% of cases recorded 2 presenting issues;
- 26% of cases recorded 1 presenting issue
- (25% no Lankelly Chase presenting issues)

At the time the team was set up Lankelly Chase suggested that there were 3820 people in Wigan Borough who had a combination of offending behaviour, substance misuse and homelessness and a further 1695 people with these factors plus mental health (total of 5515 people).

In addition to the data recorded by the team, a cost benefit analysis was carried out by New Economy which showed that for every £1 spent the Complex Dependency programme generates a financial return on investment of £2.65.

The Deal for Adult Social Care

The Deal for Adult Social Care and Health (DASCH) results in people living rich and valued lives, connected to their local communities, increasing individual resilience and independence. This reduces dependence on formal health and social care services, making a significant contribution to financial sustainability.

All staff within the service and wider partners have been trained to adopt the asset based approach by having different conversations with service users, residents, carers and families. This approach also involves the workforce knowing what resources are available within our communities and to connect individuals to these resources, promoting self-reliance and resilience. Central to this approach are our Deal behaviours which all staff are expected and supported to display;

- **Be Positive**- taking pride in what you do where you work and the service you offer to our customers.
- **Be Accountable** - how we deliver our services, how we can work with partners and colleagues in a smarter way and ways which we can make a commitment to making improvements
- **Be Courageous** is all about being open to doing things differently, positive risk taking.

Seeking opportunities for co-location of teams and partners within a place is key, especially as the seven service development footprints develop.

Section 5: Training and development

The Joint Children’s and Adults Safeguarding Boards Workforce Development and Training Delivery Group oversee the training provided by the Board. The Sub Group is chaired by the Assistant Director for Safeguarding from Wigan Borough Clinical Commissioning Group.

Safeguarding training offered by the Board is continually reviewed and updated as a result of learning from reviews and case audits.

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

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

Within 2016/17 the WSAB conducted a fundamental review of its training offer. As a result, it will re-commission its current foundation level / level one adult safeguarding course based on the model developed by PMMD and Adult Safeguarding team. The current model is illustrated below, but will be adapted to allow supporting organisations to identify and manage low level safeguarding issues before the need arises for a formal section 42 process.

Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Managed within own organisation but monitored by PMMD team Quality Monitoring Systems	Referral passed to L.A. Provider Management and Market Development Team (PMMD) and enquires made within own organisation and outcome passed to PMMD	Alert Raised to the L.A. Initial Assessment Team (Formerly Central Duty Team) and enquires made in line with Wigan’s Multi Agency Policy and Procedures.	Alert Raised to LA Initial Assessment Team (Formerly known as Central Duty Team). Potential Crime and Investigation by Police (PPD) and Safeguarding Procedures in line with WSAB Policy and Procedures. S44 MCA to be kept in mind.	Indicates potential for Safeguarding Adults Review. Safeguarding Board Critical Case Meeting procedure and authorisation of the chair of the WASB required.

The model has already been adopted by care organisations, the roll out will include other statutory organisations and community / voluntary sector organisations and will involve investment in a dedicated officer to provide both the training and ongoing support / monitoring for organisations adopting the model.

A specific Section 42 Skills Course for the Adult Social Care workforce will be commissioned in 2017/18 to build up consistency of safeguarding practice across locality teams (which in Wigan is where the statutory function of Section 42 enquiry sits).

Within 2016/17, the delivery group also refreshed the online choice of courses and quality assured their content in partnership with Virtual College.

Overall Training Facilitated by the WSAB

The table below highlights training undertaken in 16/17.

E-Learning	Numbers
Safeguarding Adults	708
Mental Capacity Act	143
Domestic Abuse in Wigan: Your Responsibilities	101
Information Sharing Level 2	79
Safeguarding Everyone	98
Face to Face	
Safeguarding Adults - Foundation	60
Domestic Abuse (2 Day Course)	49
MAPPA	35
S42 Enquiries	21
S42 Enquiry Practice	14
Supervision Skills (2 Day course)	28
Workshop to Raise Awareness of Prevent	227
Total	1563

Section 6 - Engagement and Consultation

Engagement with Professionals

Annual Conference

The 2016 WSAB Annual Conference was attended by over 200 professionals and gave the Board an opportunity to increase awareness around local transformation programmes under the Wigan Deal and Deal for Adult Social care that should impact positively on adult safeguarding outcomes.

These included presentations on the Wigan Integrated Care Organisation, the Community Book which allows community and voluntary organisations to connect with service users requiring support within communities and an overview of the Innovation Fund for Care Homes which supports innovation and creativity across the market so care homes are a great place to live and work.

The afternoon saw Aftathought present a case study in drama form to highlight the principles and practice of Making Safeguarding Personal, which was then followed by a workshop to identify what the key principles and actions might be within an overarching Deal for Safeguarding.

Engagement with the Community

In 2015/16, WSAB resourced and appointed a Communications and Engagement Officer. Within 2016/17, this post developed an increased social media presence through Twitter, and implementation of the WSAB web site. .

The Board continued to hold meetings within the community, each Board meeting being preceded by an engagement lunch with local organisations that support adults at risk of neglect and abuse talking to Board members about pertinent safeguarding themes they deal with on a day to day basis.

An overview of engagement and consultation activity is presented below

- Numbers of External and Internal Events attended (Comms and Engagement):
- Total Number of External Events attended: 23
- Total number of internal events attended: 4
- Total number of individuals engaged from both: 1825(approx.)
- WSAB Engagement Lunches:
- Total: 4 Engagement lunches held
- Total: 33 individuals attended

- Number of organisations engaged via Engagement Lunches: 20 community organisations
- WSAB Social Media Channels:
- @WiganSAB Twitter Followers to date: 551
- WSAB Facebook page : Launched November 2018
- WSAB Instagram page: 58 Followers to date

Section 7 - Financial Report

Income	2016/2017
Local Authority	£50,000
CCG	£50,000
WWL	£15,000
Bridgewater	£15,000
5 Boroughs	£15,000
General Fund Contribution	£44,321
Total	£189,321
Expenditure	2016/2017
Salaries	£88,194
Car Mileage	£890
Printing WSAB postcards/banners etc.	£3,199
General Expenses stationery, equipment etc.	£824
Professional Fees (incl. Ind. Chair)	£13,168
Mobile Phone charges	£79
Conference/Hospitality / Room Hire etc.	£23,529
Total	£129,883
Carried Forward to 2017/18	£59,441

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

During 2016/2017, there were a number of staff vacancies whilst a restructure of the Safeguarding Team took place, leading to an under spend on salaries. Vacancies have been filled within 2017/18 and salaries are expected to be on budget by 2018.

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

Section 8 - Partner Updates

Bridgewater NHS Community Healthcare Foundation Trust

Bridgewater Community Healthcare NHS Foundation Trust - Individual Agency Report for Wigan Adult Safeguarding Board Annual Report 2016-2017

Section 1 - Activity

The Safeguarding Adult Named Nurse continues to ensure that Bridgewater Community Healthcare NHS Foundation Trust staff is equipped with the appropriate safeguarding knowledge and skills to enable them to effectively and proportionately safeguard adults at risk. This enables the organisation to fulfil its statutory duty to safeguard and promote the welfare of adults at risk in all areas of service provision.

The safeguarding team has enabled all staff to know what to do and how to protect service users if they suspect or identify abuse or neglect of an adult at risk by putting systems and processes in place for all staff to access. The Team encourages all staff to promote positive outcomes for adults at risk by working with service users, families and carers for the early identification of any concern whether it be care support or safeguarding issues. This enables staff to offer the appropriate support and referral to the relevant agencies to the service user

Our aim is to promote good outcomes for adults at risk by ensuring that when working with adults at risk, families, carers and multi-agency partners, the adults needs remain paramount and staff empowers our service users to ensure their wishes and feelings are heard and taken into account by all professionals.

The Safeguarding Adults team continues to work in partnership with the statutory and voluntary agencies across the Bridgewater Community Healthcare NHS Foundation Trust footprint to discharge its responsibilities in relation to the safeguarding of adults at risk. The Associate Director for Safeguarding sits on the WSAB and the Named Nurse attends the Wigan Executive meetings and various sub groups.

The Safeguarding Adult Team contributes to SAR and LCR processes with the Named Nurse Safeguarding Adults leading on the review on behalf of Bridgewater by undertaking panel member duties. The Named Nurse Safeguarding Adults also leads on action plans and provides updates to the Clinical Commissioning Group and the LSAB on the progress of the action plans. Ultimately progress is overseen by the LSAB SAR Board Panel and the Named Nurse Safeguarding Adults presents evidence to the Board Panel to demonstrate outcomes against the required action.

Section 2 – Comments / Updates / Progress on meeting Challenges set the previous year

The focus of work for the safeguarding adult team in the 2016/17 period has been to confirm that there are structures in place within the organisation, which ensure that practitioners

working with adults at risk are able to recognise and respond to concerns. Extensive work by the Named Nurse has been carried out to ensure that processes are integrated across the Trust. There has been additional focus to ensure that there is adequate support in place to help staff to carry out their safeguarding role.

The Named Nurse has worked closely with the Risk Management Team to clarify how members of staff are able to identify and report risk and the process for initiating safeguarding investigations about an adult at risk of harm and an improved Safeguarding recording system has been identified for use within the Safeguarding team which, when integrated into electronic patient records, is expected to improve the dataset collected by the team and documentation in general.

The Trust has introduced the Quality and Safety Sub Groups which provide a forum for the Named Nurse to discuss identified safeguarding issues and the senior teams provide further opportunity to address safeguarding and clinical practice and disseminate information for wider learning within our organisation.

The Safeguarding Assurance Group (SAG) was renamed Safeguarding Team Assurance Group (STAG) and the Terms of Reference reviewed. STAG is chaired by the Associate Director for Safeguarding and oversees the implementation of assurance processes for safeguarding children and adults at risk across the Trust and gives assurance to the CCG's (Clinical Commissioning Groups) on contractual issues. The Group provides a forum for safeguarding leads to work together to address safeguarding issues within the community setting and ensures that effective processes and policies are in place to safeguard children and adults at risk.

Adult Referrals

The Safeguarding Adult Team monitor and review all referrals made to Adult Social Care by Bridgewater staff. This review allows the Safeguarding Adult Team to ensure that the referrer has access to safeguarding supervision and support as required.

The Named Nurse Safeguarding Adults came into post in February 2016 and developed robust support systems, training, safeguarding supervision, policies and processes to enable all staff to recognise and respond to suspected, identified or disclosed abuse or neglect of an adult at risk. This has led to increased referrals to the adult safeguarding team over 2016/2017.

There were 39 safeguarding concerns raised to the safeguarding adult's team for adults living in Wigan and the main area of concern was for neglect and acts of omission.

2016 /17 Training

A comprehensive Training Strategy and Framework setting out the safeguarding training needs for all staff across the Trust has been established. This enables staff to identify the appropriate level of training, depending on their job role, and for managers to ensure compliance. Bespoke sessions are offered to specific staff groups to ensure the training is relevant to their sphere of work

The PREVENT strategy has been embedded within the organisation with support of the Safeguarding Team. The strategy ensures that staff are able to identify extremism and make appropriate referrals to Greater Manchester/Cheshire or Merseyside Police's Channel Team for comprehensive risk assessments.

There a number of training courses available for staff to access via classroom learning or E-learning. These include:

Safeguarding Adults Level 2

Safeguarding Adults Level 3

Prevent Basic Awareness Training

Prevent WRAP-3 Training

Mental Capacity Act and Deprivation of Liberty Safeguards Training

Female Genital Mutilation Training

Human trafficking/modern day slavery

Staff can also access the WSAB and WSCB training which is advertised on the internal hub

Section 3 – Challenges for 2016-2017

Challenges in 2016-17

- Data needs to be captured to ensure that outcomes of referrals can be recorded
- Assurance is needed that patients who have compromised capacity to consent are being appropriately assessed as per requirements of the Mental Capacity Act (2005)
- Work is to be undertaken with other agencies to identify the criteria for which a safeguarding investigation has been initiated
- Assurance is needed that outcomes for adults at risk who have been notified to the Safeguarding Team can be measured
- The Named Nurse Safeguarding Adults covering Bridgewater with 1 part time (0.4 WTE) Specialist Nurse

Priorities for 2017/2018

- To explore opportunities to contribute to the Wigan Multi-Agency Safeguarding Hub (MASH)
- Review the part time band 6 specialist nurse role (who leaves the service in May 2017) and explore the need for a 0.8 wte band 6 post to support the Named Nurse Safeguarding Adults
- Re launch of the Adult Safeguarding Champion role and develop a specialist training programme to these staff to ensure full dissemination of adult safeguarding principles across the Trust
- The Safeguarding team and Education and Professional Development team to work with the Trust Assistant Directors and Clinical Service Managers to ensure there is on-going compliance with training requirements, monitoring of accessibility of training for appropriate staff groups and assessment of the content of training sessions as per requirements from Serious Adult Reviews
- Staff have access to de-brief sessions from complex adult safeguarding cases and learning is cascaded through the Trust and staff have regular briefings following SARs to disseminate the learning and actions that will have an impact on practice
- Continued work with WSAB to ensure that any service development at the Trust is reflective of multi-agency safeguarding practices both locally and nationally
- Work with the Risk Management Team to ensure that links between safety and safeguarding procedures are incorporated into the Trust's Risk Management Strategy. Work is on-going to establish a Safeguarding package within the Ulysses system
- Work with Wigan health service commissioners to ensure that the service remains responsive to changing population needs
- Monitoring, identification and implementation of changes within key legislation
- Continued monitoring and audit safeguarding activities within the organisation via the development of a comprehensive safeguarding audit calendar
- Formalise a dissemination process across the Trust for Safeguarding Adults Reviews/Serious Case Reviews and Domestic Homicide Reviews

Section 4 – Case Study

Occupational Therapist visited a patient after she called the service and asked for a home visit. Patient has no previous concerns around cognition. Patient had been referred to social services on the OT's last visit as the patient and OT felt she needed social support at home. On this visit the OT had a concern regarding patient's capacity and cognition as the patient could not recall two home visits with OT the previous week. OT completed a Mental Capacity Assessment to see if the patient could consent to the OT care and treatment and the patient could not understand, weigh up or retain the information given by the OT.

The patient had telephoned the service querying when she will be assessed although the OT had previously visited and spoke with her numerous times.

When the OT arrived there were concerns that the patient allowed the OT into her home and

did not know who she was or why she was there. Also there were concerns raised that the patient has leaving her front door open and back doors unlocked and the patient was telling people passing by to come in.

Actions taken by OT to safeguard the patient:

Contacted the patients GP for an urgent assessment and home visit as there were no previous concerns raised in regards to confusion or cognition

Spoke to patient and asked her if it was ok to contact her son to discuss the visit then liaised with the son regarding the concerns.

Referred patient to social services to raise new concerns

OT waited with patient until her son arrived to ensure her safety

The GP visited the patient and admitted her to hospital for investigation of the new onset of confusion. The patient's son was concerned that his mum had left all her doors unlocked and there was possible cash and jewellery missing from the house and reported the incident to the police. Patient was diagnosed with dementia and an infection. Social services arranged a meeting with the patient and family and it was agreed on discharge the patient would go home with the support of carers 4 times a day and a key safe at home

Wrightington, Wigan and Leigh NHS Foundation Trust

Individual Agency Report for Wigan Adult Safeguarding Board Annual Report 2016-2017

Wrightington, Wigan & Leigh NHSFT (WWLNHSFT)

Activity

Safeguarding Vulnerable Adults at Risk is everybody's business and everyone working in health care has a responsibility to help prevent abuse and to act quickly and proportionately to protect vulnerable adults where abuse is suspected.

The safeguarding of all our patients remains a priority for the Trust and safeguarding is a fundamental component of all care provided.

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

WWL, under the guidance and direction of WASB, continues to work with all partner agencies to ensure policies and procedures and the activity underlying these, are fit for purpose.

WWL's approach to safeguarding is about addressing inequalities, creating an environment where patients feel safe and where their dignity is respected, and, whatever their circumstances are free from discrimination.

The Director of Nursing remains the identified Executive lead for Safeguarding and the chair of the Trust Safeguarding Committee and is therefore responsible for reporting to the Trust Quality & Safety Committee.

The Trust Safeguarding Committee addresses both the adult and child/young person's safeguarding agenda's. The committee continues to meet on a bi monthly basis and receives adult safeguarding update reports from the Head of Adult Safeguarding at each meeting.

These reports identify the number and type of adult safeguarding concerns raised by staff across the organisation, and the wider health care community, highlighting any trends, together with updates from local case reviews, serious adult reviews, identifying any learning outcomes.

The reporting period of 2016/17 has continued to see an increase of acute Trust referrals in relation to Adult Safeguarding. A total of **744** potential safeguarding referrals were made, in the same period 2015 /16 there were **629** referrals.

The increase in concerns raised, can, in part, be attributed to both an increase in application for Deprivation of Liberty Safeguards (DoLS) and in pressure Ulcers grade 3 & 4 routinely being reported to Adult Safeguarding team. It should also be noted that there has been an increase in the complexities of referrals received within the last quarter of the reporting period, resulting in WWL Adult safeguarding team attendance required increasingly at strategy and case conference meetings.

Wigan Borough Clinical Commissioning Group

Individual Agency Report for Wigan Adult Safeguarding Board Annual Report 2016-2017

Section 1 - Activity

Empowerment

The Safeguarding Team has led on several complex Section 42 investigations the purpose of which has been to capture the voice of service users in respect of their various complaints and concerns. For example, a middle aged man with a diagnosis of severe and enduring mental health issues residing in a secure unit was supported to voice his concerns regarding the care and treatment he received in respect of him being restrained and having his movements restricted. The investigation was additionally complex in that the service user had communication difficulties. However, he was supported in his own time and at his own pace to

accurately capture his experience and ensure that he was able to participate at the case conference convened to hear the matter.

The Assistant Director of Safeguarding – Adults continues to work closely with the Local Authority Adult Safeguarding Team in respect of Strategy Meetings and Case Conferences in terms of capturing service user’s voice and ensuring that their experience of the safeguarding process is person centred.

Protection

A number of service users and their families have been supported to raise safeguarding alerts regarding the care and treatment they have received from a range of different health care services including General Practice, Hospital and Care Home. Typically, this support has been practical such as explaining the safeguarding process and/or talking them through how to make a safeguarding alert or complete the electronic pro forma on the Wigan Council website. However, it has also included clarification regarding clinical matters to help them better understand the care and treatment that has caused them concern.

Prevention

The Safeguarding Team continues to work closely with the Police and Probation in respect of the Multi Agency Public Protection Arrangements (MAPPA) agenda. This involves the gathering and sharing of information with GP colleagues as appropriate to provide a timely response to MAPPA concerns such as risk assessment.

Presentations/training sessions regarding Female Genital Mutilation and the associated Mandatory Reporting Duty have been delivered to GPs and Practice Nurses by the Director of Safeguarding – Adults in order to raise awareness and ensure an appropriate response when such cases are reported. Furthermore, a presentation regarding domestic abuse and the lessons emerging from Domestic Homicide Reviews has been delivered to Practice Managers in order to raise awareness of this key safeguarding agenda.

The Assistant Director of Safeguarding – Adults continues to work with Local Authority colleagues regarding Service Improvement Plans the purpose of which is to drive quality standards within Care Homes across the Borough.

Proportionality

The Safeguarding Team participates in Safeguarding Case Conferences the purpose of which is to determine whether abuse has occurred or not and if so to ensure that the adult at risk has a protection plan in situation to ensure their safety in future. Crucially, decision making in this process reflects a person centred approach that is respectful of the adult at risk wishes taking into account issues that might restrict opportunities for the individual such as mental capacity.

Partnership

The Safeguarding Team continues to support statutory processes such as Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews. Key to these processes is the

sharing of information with partner agencies particularly in respect of lessons learnt in order to improve service delivery and ensure that adults at risk are better protected and experience better outcomes.

The Assistant Director of Safeguarding – Adults continues to work in partnership with colleagues from the Police and Local Authority in respect of a case of alleged wilful neglect. This has included delivering a training session to colleagues in respect of the care and treatment of pressure ulcers.

Section 2 – Comments / Updates / Progress on meeting Challenges set the previous year

- Good progress has been made regarding the oversight and governance in relation to performance against safeguarding contractual standards contracts with smaller providers. A significant program of work has been implemented to implement and measure progress against the Safeguarding Contractual Standards Audit Tool (a Collaborative Greater Manchester (GM) Document) for nursing homes across the Borough (20 in total). The document was developed by the Safeguarding Collaborative of the Greater Manchester Health and Social Care Partnership (GMHSCP). It provides clear service standards against which healthcare providers are monitored to ensure that service users are protected from abuse or the risk of abuse.
- The program consists of an annual cycle of audit against 11 safeguarding standards with providers rating themselves against the standards before having their submission validated by the Assistant Director of Safeguarding – Adults. All amber rated standards are underpinned by a clear action plan to ensure that appropriate remedial action is taken and in doing so to improve quality standards.
- The GP Safeguarding Leads Meetings have developed into a well-attended and established forum. The meetings provide the opportunity to share information and discuss key safeguarding agendas in an open and constructive manner. This past year the Safeguarding Team has presented regarding changes to the Mental Capacity Act 2005 in respect of the reporting of deaths for individuals in a supported in Care Homes or hospitals who do not have the capacity to agree their care and treatment and are subject to a Deprivation of Liberty Authorisation
- The Safeguarding Team continues to work in partnership with Local Authority colleagues to improve the quality of Care Homes. The Assistant Director of Safeguarding – Adults regularly contributes to Service Improvement Plans in focusing on the reporting of safeguarding concerns and issues pertaining to the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and pressure ulcer care. In addition, the Safeguarding Team continues to support the Police in cases of wilful neglect alleged to have occurred within Care Homes.

Section 3 – Challenges for 2016-2017

- Further progress the program of implementation regarding the Safeguarding Contractual Standards Audit Tool across the Borough to include Residential Homes and small mental health providers.

- Implement and co-ordinate the Learning Disabilities Mortality Review (LeDeR) Programme.
- Integrate current practice into the Wigan Multi Agency Safeguarding Hub (MASH).

Cheshire and Greater Manchester Community Rehabilitation Company

The Safeguarding of Adults remains a key priority for CGM CRC. We recognise that our service users are also members of the local communities against which their offences are often perpetrated and, on occasion, victims themselves. The CRC aims to balance both rehabilitation and public protection

This year has represented a period of significant transformational change for the structure and delivery of adult probation services. CGM CRC officially came under the ownership of Purple Futures, an Interserve led partnership consisting of P3, 3SC, Shelter and Interserve on 1st February 2015, and is one of 21 CRC's nationally. During 2016 the company went through a significant transformation programme to fully implement the Interchange Model. The theory underpinning the "Interchange Model" is strengths based, with a focus on rehabilitation and the fundamental building blocks for this are: desistance theory, the good lives model, and personalisation. The Interchange model is built around the principles of the SEEDS 'Skills for Effective Engagement and Development' model which includes desistance based approaches. The desired high-level outcomes for service users from the Interchange Model are: Hope and motivation; something to give; Healthy lifestyle; Place in society; Family and relationships; Positive identity.

Other key features of the new operating model, designed to maximise practitioner ability to work towards rehabilitation with offenders more effectively, include the following:

- **Improved technology and better use of IT:** In November 2016 all staff were issued with updated IT equipment. For front line practitioners this included mobile devices (laptops and phones) that now enable them to work more flexibly with service-users, in their homes and other locations in the community. Ideally, this will also enable CRC staff to co-locate more easily with key organisations that can contribute to the rehabilitation process and enhance service user compliance and engagement. In Wigan we are negotiating our contribution to placed based integrated teams (PSR Hubs) and working alongside partners to improve our ability to accurately assess and manage risks to adults and services provided
- **Integration of interventions and offender management:** There is no longer a split between interventions and case management with case managers having responsibility for both case holding and delivering group work interventions. Whilst it is relatively early days in testing out this model the aim is to ensure that all staff are fully tuned into the priority to reduce reoffending and enhance rehabilitation.
- **Introduction of a Directory of Services to improve offender manager access to interventions:** Whilst the completed Directory of Services won't be fully operational until later into 2017 the first phase has already been implemented and case managers now have access to an organisation wide directory which provides contact details and referral processes for providers across the rehabilitation pathways. Future releases will provide access for partner organisations.

CGM CRC has demonstrated an ongoing commitment to Safeguarding Adults during 2016 – 2017 by:

- Establishment of a Service User Council to ensure service user feedback is obtained and utilised to influence service delivery
- Implementation of a peer mentoring and volunteer scheme

- Refresh of the Working Effectively with Female Service Users Strategy and continued co-commissioning of bespoke women's services
- Establishment of the EFAN Ex-Forces Network to respond to the specific needs of ex veterans
- Implementation of an Integrated Health Liaison and Diversion Scheme, to support individuals who have been arrested and taken to police custody into community services
- Continued delivery of an Intensive Community Order that focuses on the specific needs of 18 – 25 year old service users
- Refresh and roll out of Safeguarding and Domestic Abuse Policies, Procedures and training
- Organisational drive to ensure that all new and existing staff have completed the required level of Domestic Abuse and Safeguarding Training
- Continued delivery of Accredited Programmes that address a range of service user risks and needs. This including the Building Better Relationships intervention for perpetrators of domestic abuse and a bespoke Partner Link Worker service for victims
- Implementation of a Risk Management and Review process that ensures management oversight and scrutiny of the most risky and complex cases
- CRC Contribution to Domestic Abuse, Child Sexual Exploitation, Prevent, Honour Based Violence and Modern-Day Slavery multi agency working groups and forums
- Refresh of local Integrated Offender Management Schemes and increased volumes

Challenges 2017/18

- Delivery of refreshed Public Protection, Safeguarding and Domestic Abuse Training to all staff
- Full implementation of the new Interchange Model
- Transition to alternative estates and delivery of a community based model

National Probation Service

Individual Agency Report for Wigan Adult Safeguarding Board Annual Report 2016-2017

Section 1 - Activity

Empowerment – Within NPS a core part of our work is the sentence plan. Each client/offender we work with has one completed both in custody and the community. The work where possible is completed with the individual to ensure they own the objectives set. We have also piloted the Calderstones reflection tool to ensure we work with our offenders in a way that best suits their needs.

☑ Protection – NPS works under the Victim’s Charter. All cases that meet the criteria are offered a service from a named Victim Liaison Officer so that they are kept updated about the perpetrator’s sentence and have a voice in any parole hearings and conditions on a the licence period in the community.

☑ Prevention - Our thresholds regarding risk/need are different within NPS/Adult Safeguarding which can create some barriers.

☑ Proportionality – Within our entire decision making we ensure they are necessary and proportionate to the risk of serious harm they present to the community including risk to self.

☑ Partnership – NPS have largely a good working relationship supported by protocols regarding information sharing with Wigan adult safeguarding. We are looking forward to further investment in the hub and in place based approaches. We have also worked with colleagues to identify appropriate and robust risk management plans for service users released / discharged as part of the Winterbourne review.

Section 2 – Comments / Updates / Progress on meeting Challenges set the previous year

Ensuring that all NPS staff are trained / retrained in Safeguarding.

The NOMS Safeguarding Policy and Action Plan clearly identifies minimum training requirements of all staff. It is a requirement that all staff complete Safeguarding Level 1 training and refreshed every 3 years and recorded in individual training plan. All non operational staff need to complete mandatory NOMS stage 1 e-learning course on child/adult protection and safeguarding. All practitioners are expected to complete and pass mandatory safeguarding and Domestic Violence E-learning events Thereafter they are required to complete a national two day class room based safeguarding event. There is also an expectation that practitioners attend the multi agency themed events in order to understand the local context and share valuable learning across the partnership. As part of their SPDR (Appraisals) there is an expectation alongside attending the mandatory in-house safeguarding events that also attend multi agency events/seminars.

All newly appointed Learner practitioners receive induction according to NPS Procedures which is available via “My Services” (on the MOJ website). They also receive safeguarding training as

part of their learning and development programme and required to complete the level 1 safeguarding training.

All managers are required to undertake a training needs analysis with practice staff and this requires safeguarding knowledge and skills to be reviewed and updated.

☑ Understanding and being agile to the opportunities presenting under the devolution of Manchester agenda.

In 2017 the NPS North West has appointed a designated senior manager with a lead for devolution who is heavily involved in the evolving agenda. The NPS presence in this arena gives us the opportunity to maximise our involvement in the best outcomes for the communities we serve and individuals we work with.

Section 3 – Challenges for 2016-2017

Identify the key safeguarding challenges for your organisation in the next year.

Our organisation is now managed under the umbrella of Her Majesty’s Prison and Probation Services so we are starting to embark on a further huge organisational change which will see the strategic framework being developed about how this will work operationally. The move is to a new model of “Offender Management in custody” where long term prisoners will be managed by Probation and Prison staff based in the local Prison establishment as opposed to their home area until 9 months before release and then transferred back to the community Probation teams.

In terms of Adult safeguarding we already have a challenge of Local Authorities taking ownership of the individual in the area they are imprisoned, so will continue to work with Las to ensure offenders do not become displaced and disadvantaged. As a National organisation our challenge is how we broker the National picture to a local one within our Safeguarding boards.

Section 4 – Case Study

Where possible (and appropriate) include an anonymised case study that demonstrates the impact of your activity and helps makes safeguarding real for readers of the report.

Senior Probation Officers approached the board about supporting a piece of work to look in to a case of a couple both with risks and vulnerabilities as Domestic Abuse perpetrator and victim. The aim was to scrutinise the work with this couple across the partnership from an Adult safeguarding perspective using the principles of a Domestic Homicide Review as professionals hold a genuine fear that this case could result in one of the individuals being killed.

A panel of agencies was coordinated and each SPOC completed a chronology that was discussed on a day event with healthy challenge from each other around the table. It was reassuring that agencies had fulfilled their obligations and highlighted some gaps in terms of understanding

capacity and deprivation of liberty that the NPS and other agencies needed to understand further and be supported with in terms of a training need.

Greater Manchester Police

Operation Strive:

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

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

ISAPP:

The Integrated Safeguarding & Public Protection team continues to provide a robust multi-agency response to both high and medium risk domestic abuse victims, their children and linked offenders. The most recent cash benefit analysis work indicates a continuing reduction in repeat victimisation particularly in relation to crimes of wounding, common assault, robbery and criminal damage, as well as achieving broader success in reducing the re-presentation of medium- and high-risk victims of harassment and other non-physical forms of abuse. This continues to suggest a gross fiscal saving of approximately £500,000K per annum. The development of ISAPP to be part of the PSR Hub going forward will allow the continued growth of a joint timely response based on contextual need and not simply systematic response based on thematic area resulting in a further reduction in repeat victimisation and impact on families.

MASH:

Greater Manchester Police remains committed to the MASH and the development of a Multi Agency Safeguarding Hub in the borough. Clear work streams have been identified and updates to some of these work streams as per the MASH report to Informal Leadership are as follows.

Adult missing from home reports - In the last 9 months MASH has recorded over 600 adult missing reports which have had a mini profile created allowing the keyworkers to make an informed decision. Of those, we have offered 1-2-1 support to 30% who present with the most vulnerable underlying risk but are not currently engaging with mainstream services. This

function has also been expanded to allow the initial safe and well to be conducted by a keyworker as opposed to the traditional approach of a police officer. This frees up a valuable front line resource and also allows the opportunity to engage in a different conversation to identify underlying need and support into appropriate services in a timely manner. At the start of this scoping pathway, there was a repeat rate of 51%. The current repeat rate is now only 10%. With the average cost of a missing person being £1,700 the monetary savings to this process are obvious.

Domestic Abuse – the MASH provides a focal point for the borough wide response to domestic abuse and work has been undertaken to build on the excellent ISAPP process and partnership and strengthen the capacity and capability of the Independent Domestic Violence Advocates. Particular “class leading” innovative practice like operation Encompass (the notification to schools the following day of children’s presence in domestic abuse incidents) have been well evaluated

Vulnerable adult – The vulnerable adult workflow is now embedded with many cases having been directed in to the MASH after triage. This followed a two week pilot study that demonstrated the potential for managing in a different way the requests from GMP for adult social care services assessment. Over the two week period the number of requests for assessment fell from 181 to 20. Even allowing for some subsequent regression, the added value was self evident. The additionality of Adult Services resources responsible for all adult safeguarding alerts for the Borough has allowed the MASH to proactively key work all those who do not meet the safeguarding threshold. This enables the correct support to be identified and prevents a direct referral to the locality teams if the support needs can be met elsewhere.

Organised crime (OCG) – MASH is first used as a safeguarding intelligence point for GMP staff so they can identify concerns, prior to further action being taken. Key workers will accompany police during the execution of warrants to provide support on a whole family approach and to identify ongoing needs. The pathway of support is then extended into the “place” to provide and co-ordinate longer term intervention and support with the aim to prevent the development of complex dependency at a later stage and also the generational cycle of crime.

Victim Hub – The newly created Victims Hub now sits within the remit of the MASH to allow appropriate information sharing and joint decision making and responsibility for each case focusing on those with additional vulnerabilities such as age, disability, gender etc. Utilising community assets and with investment through the CIF, the pathway of support includes organisations such as Victim Support and Citizens Advice as well as highly trained volunteers. A dedicated victim co-ordinator funded through GMCA will enable real co-ordination to this area of work, dedicated oversight to ensure the correct targeting of resources and true evaluation for future development. Priority victimology includes domestic abuse and hate crime

Vulnerable Children – the MASH is located in the same building as the CSE team, which itself will soon be joined by the missing children hub. In addition a number of test weeks have been held to establish the relationship between the opportunity of the MASH and wider children’s services but the outcomes have not been conclusive. Further work is required in this area,

particularly understanding a whole family perspective on vulnerable adults with children. Further work is also required in understanding the opportunity of the of the MASH to the implementation of the North Yorkshire model for looked after children

Appendix A: Governance and Accountability Arrangements

What is the Wigan Safeguarding Adults Board?

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

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

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

WSAB has undergone significant change over the last 12-18 months and has used this opportunity to develop robust governance, quality assurance and reporting mechanisms. The Board brings together organisations from across the borough, which are committed to keeping

adults at risk of neglect and abuse safe, to create a strong, mutual partnership where organisations can develop their practice and offer supportive challenge.

In 2016/17, WSAB conducted a full review of its adult safeguarding training offer and developed a new Workforce Development and Training Strategy. This ensures that a broad range of training across the partnership, accessible to all partners, and that is free of charge to community and voluntary sector organisations are in place. The Training Offer from the Board addresses all aspects of the Board's response to local and national learning, and allows timely dissemination of learning.

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

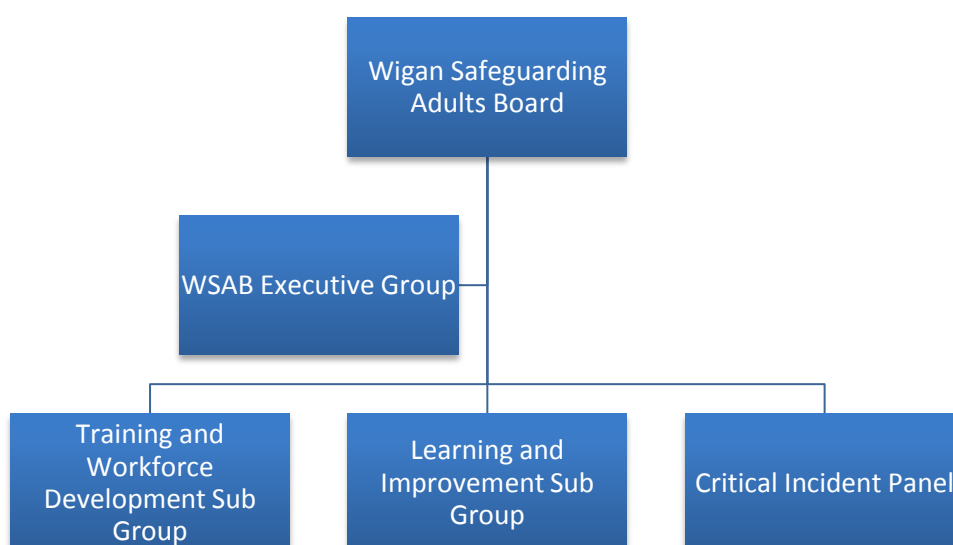
We aim to do this in two ways:

To co-ordinate local work by:

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

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

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



In addition to the key delivery groups of the Board, connections into key groups responsible for delivery of wider safeguarding outcomes are in place, and include:

- Local Authority Quality Surveillance Group which oversees a programme and quality assurance framework for care sector providers
- Wigan Suicide Prevention Group
- Multi-Agency Safeguarding Hub Steering Group
- Wigan's Palliative Care Steering Group which in 16/17 has developed an end of life pathway
- Wigan Place Based Steering Group which oversees the roll-out of integrated working across seven newly defined service delivery footprints. This group also oversees key transformation programmes including the Live Well / Complex Dependency Team. In 16/17 the group began plans for wider expansion of this innovative service that focusses on supporting clients high risk / non engaging vulnerable clients
- Wigan's Building Stronger Community Partnership (BSCP) which in 16/17 focused on key safeguarding themes. This included joint production of a Serious and Organised Crime Profile for the borough which identified key issues in relation to human trafficking / modern day slavery. The Serious and Organised Crime Partnership Group developed an overarching action plan following this profile which included building intelligence links between public health and police regarding modern day slavery / trafficking.
- The BSCP Tactical Group provided further focus and work across 16/17 on key safeguarding themes; for example
- Domestic Violence Steering Group – in 16/17 the group further developed the co-ordinated community response model through a review of its Integrated Safeguarding and Public Protection team and process, piloting a response for all domestic abuse police reported cases through Operation Strive and began piloting a dedicated hospital based Independent Domestic Violence Advocate.

All programmes and groups report appropriately back into the WSAB regarding key work streams.

Key Roles

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

Independent Chair

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

Director of Adult Services

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

Local Authority Chief Executive Officer

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

Lead member

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

Appendix B WSAB Vision and Principles

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

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

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

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

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

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

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

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

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

Appendix C - Membership of the Board

Job title	Agency	Status
Independent Chair	Independent	Full
Director of Adult Social Care and Health	Wigan Council	Full
Wigan Council - Cabinet Portfolio Holder – Adult Social Care	Wigan Council	Full
Chief Officer	Wigan Borough CCG	Full
Director of Nursing	Wrightington, Wigan and Leigh NHS Foundation Trust	Full
Director of Nursing	5 Boroughs Partnership NHS Foundation Trust	Full
Chief Executive Officer	Bridgewater NHS Foundation Trust	Full
Superintendent	Greater Manchester Police	Full
Community Safety Manager	Greater Manchester Fire and Rescue Service	Full
Assistant Chief Officer,	GM Probation Trust	Full
Community Director	Greater Manchester and Cheshire Community Rehabilitation Company	Full
Director of Tenancy Service	Wigan and Leigh Homes	Full
HM Coroner's First Officer	HM Coroner's Office	Full
Head of Safer Prisons and Equality	HMP Hindley	Full
CEO	Healthwatch	Full
Assistant Director Adult Social Care	Wigan Council	Advisor to the Board
Service Manager, Safeguarding	Wigan Council	Advisor to the Board
Service Manager, Support & Safeguarding	Wigan Council	Advisor to the Board

Assistant Director, Provider Management & Market Development	Wigan Council	Advisor to the Board
Director of Quality and Safety, Safeguarding	Wigan Borough CCG	Advisor to the Board
Assistant Director for Adult Safeguarding	Wigan Borough CCG	Advisor to the Board
Director of Public Health	Wigan Council	Advisor to the Board
Inspection Manager	Care Quality Commission	Advisor to the Board
Head of Public Health Commissioning	NHS England	Advisor to the Board
Learning and Improvement Officer (WSAB)	Wigan Council	Advisor to the Board
Senior Solicitor	Wigan Council	Advisor to the Board
Business Manager, WSAB	Wigan Council	Advisor to the Board
Media Officer	Wigan Council	Advisor to the Board
Business Support Officer, WSAB	Wigan Council	Admin Support