

**Wigan Safeguarding Adults Board**  
**Annual Report 2022/23**





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## 1. Foreword – Dr Suzanne Smith, Independent Chair, Wigan Safeguarding Adults Board

It gives me great pleasure to present the Wigan Safeguarding Adult Board Annual Report for 22/23.

I started as Independent Chair of the Board in August 22 and can honestly say, reflecting back over the last 12+ months, what an honour and a privilege it is to work with such a focused, passionate, professional and collaborative partnership. It is truly refreshing to see the work and outcomes generated by this Board and their determination to improve the lives and prevent abuse of adults at risk in Wigan.

We have done a lot of work on policies and procedures to ensure they are relevant to today's society and the risks that it presents. Our new Safeguarding Adults Policy incorporates, for the first time, our safeguarding Tier Model to ensure our Section 42 legal responsibilities are connected to our preventative / early intervention model.

We learned from Safeguarding Adult Reviews that we needed to simplify our self-neglect policy and pathway for practitioners. We have done this and also delivered training to increase overall awareness across the workforce.

One of the most important activities we undertake is the engagement and participation with those who use our services. We commissioned a new approach to how we achieve this in a meaningful way and have introduced the 'What's Up Champions' model. The fresh and vibrant approach is around working with clients from various settings and empowering them to become safeguarding champions. Early feedback is that it promises to be an exciting and successful way to ensure we engage effectively with those we are here to serve.

We have strengthened our risk management framework to ensure that risk areas are seen through a partnership lens rather than separate organisational views and that the risks are mitigated using that same partnership approach.

In February we met for the first time since I started in person for a Leaders Summit. This was a busy and dynamic event giving us the head space to refresh our resolve and approach to genuinely collaborating together and defining our priority work areas. These include an agreed focus on confidence in effective capacity assessments, meaningful engagement with stakeholders, enhancing our understanding of partners contributions through wider collection of partnership outcome data.

Our pace around Safeguarding Adult Reviews (SAR) and Brief Learning Reviews (BLR) has been steady, giving us the opportunity to ensure practitioners have the best chance to learn from the findings. In total we signed off 2 SARs and 13 BLRs.

Organisational change is a time when risk to vulnerable groups can escalate. Across the partnership, it is clear everyone has kept their eyes on the safeguarding ball at the same time as accommodating change. Examples of work across the partnership include:

- The introduction of new legislation to disestablish CCGs and create new Integrated Commissioning Boards. The Safeguarding Board has supported colleagues through this change whilst actively engaging at the GM level to ensure that safeguarding remains a key focus.

- Adult Social care have been working on their transformation plans called back to the Future. This re-energises social care workforce principles of person-centred work through named Social Worker work theme, and new collaborative models of hospital discharge through establishing a new Transfer of Care Hub.
- The Board supported and signed off on work led by Colleagues in our Domestic Abuse partnership to develop a simple tool around receiving a Domestic Abuse disclosure for all frontline staff. Initial meetings held with WBDAS, Adult Social Care and Wigan Council DA Leads to develop a short training Package around the model this has been rolled out with Lunch and Learn sessions.
- The Board supported and were provided oversight of the work of colleagues in Drug and Alcohol Commissioning Team achieved in the recommissioning of drug and alcohol treatment service for adults and young people.
- Colleagues in GMP came to our leadership summit in February with a new framework for our refreshed Adult MASH team building on the success of pre-covid co-location and collaboration principles. A refreshed Multi agency team and framework will triage and respond to daily safeguarding demand and work and the Board was happy to include this is a key objective for 23/24 and beyond.

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

Regards

*Sue*

Dr Suzanne Smith PhD

WSAB Independent Chair

## 2. About the Wigan Safeguarding Adults Board

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

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

WSAB Statutory Duties under the Care Act 2014

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

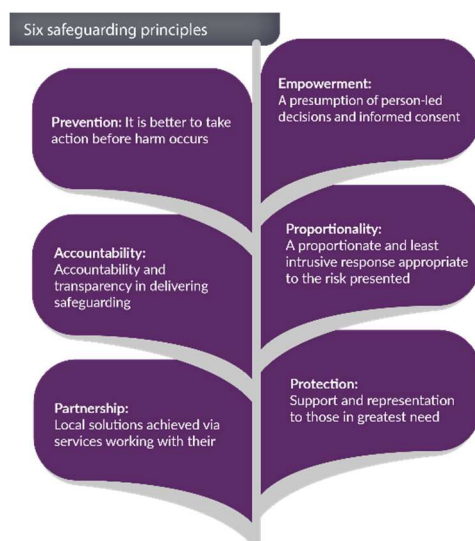
## 3. Our Vision

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

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

## 4. Principles of Safeguarding Adults

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



## 5. Our Strategic Priorities, Objectives and Delivery Framework

<b>Priority</b>	<b>Objective</b>
<b>1. Accountability, Assurance &amp; Leadership</b>	“Wigan has an effective Safeguarding Adults Board which fulfils its statutory responsibilities, has strong leadership and governance arrangements, and promotes a culture of collective accountability, respectful challenge and continuous learning “
<b>2.</b>	
<b>3. Quality Practice, Learning &amp; Improvement</b>	“Services & staff are learning and improving in their safeguarding practice and adult safeguarding risk is better understood by WSAB and appropriately assessed by partners.”
<b>4. Policies, Strategies &amp; Procedures</b>	“Our partners work within a framework of policies and procedures that keep people safe”.

We deliver an annual plan of activity through our agreed delivery and governance framework, and you can read a copy here.

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

## 6. Achievements 2021/2022 – Future Work 2022/2023

### **Strategic Priority 1 - Accountability, Assurance & Leadership –**

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

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

- The WSAB said goodbye and thank you to our outgoing Independent Chair Professor Paul Kingston after 9 years of hard work and dedication to safeguarding adults across the borough, and we welcomed our new Independent Chair Dr Suzanne Smith to her new role.

She met with senior leaders from around the Board in her induction period and led her first Leader Summit in February 2023 (see below). You can read more about Suzanne on her forward above.

- In February 2023, the WSAB refreshed its overall priorities and strategy and held a Leaders Summit. The workshop ensured that our overarching strategy and action plans remain focused on key areas highlighted through our Learning and Improvement activity (from case reviews, quality audits etc.) and how groups within our delivery framework will deliver our key objectives. You can download and read our plan on a page from the link in Appendix One and here.
- The partnership refreshed its overall Safeguarding Adult's Policy which for the first time incorporated key areas of early intervention and prevention by embedding the Safeguarding Tier System approach. Work began on working to develop and corresponding set of procedures to support the policy which will be implemented in 23/24
- We strengthened our overarching Resolution Policy and Process. As part of this process the Business Unit began reporting all resolution policy incidents into the Executive Group to ensure multi agency ownership of solutions where practitioners disagreed or differed on their view of how cases needed to be managed to reduce safeguarding risks to adults. The key thinking behind doing this more formally is to ensure that an early response to policy and practice issues is owned agreed by the WSAB before they become problematic or repeat issues. We'll be able to report next year on those issues as the process beds in across 23/24.
- Work on connecting the key objectives of the WSAB to other strategic partnerships included highlighting key work that will address key findings from case reviews with the following partnerships and strategic forums:
  - *Mental Health Programme Board –*
    - development and implementation of new response to crisis in the community through development of the new Live Well Model.
    - a new streaming process for people who access the acute hospitals emergency department in an acute mental health crisis (due to be operationalised 23/24)
    - Identifying a key work stream regarding where operationally issues regarding learning disability and mental health require new ways of working and new pathways (work to be undertaken 23/24)
  - *Wigan Place and Community Safety Partnership / Domestic Abuse Partnership:*

- Responding to audit findings regarding referrals to the Borough’s Multi Agency Risk Assessment Conference (MARAC) from adult social care, colleagues in DIAS (Community based support for victims of Domestic abuse), Partnerships and Domestic Abuse, Safeguarding Adults Team and the WSAB Business Unit developed a new awareness raising product and model to ensure all staff across health, social care, criminal justice and the comm / voluntary sector are confident in identifying and supporting disclosures of domestic abuse. The SAVED model began to be rolled out across 22/23 and will continue across 23/24.
- *Suicide Prevention Group / Wider Contribution*
  - The WSAB Business Unit continued to undertake brief learning reviews for all suicides where there were multiple service contacts and both task and co-ordinate multi-agency actions and update the group with relevant findings and trends / themes. Key responses to learning reviews included the implementation of a We are With You (Drug and Alcohol Services) / Greater Manchester Mental Health Trust weekly dual diagnosis triage meeting to ensure clients with dual needs are prioritised and across both services.
  - work with Public Health aligned our trauma responsive training offer with key mental health training offers including Connect 5 package. Adult Services also assisted the group to refresh its overarching Suicide Prevention Plan
- *Wigan Safeguarding Children’s Partnership*
  - The WSAB continued to hold joint leadership meetings with the Wigan Safeguarding Children’s Partnership in June 22. It considered and agreed prioritised areas for shared work including a proposed Wigan Transition Strategy which was co-ordinated by colleagues in Adult Services with key learning incorporated from case reviews.
- WE continued to receive updates on our partners regulated inspections and assurances that a response to those processes were in place. Crucially this included key conversations on how we might work together as a partnership to assist them in addressing key findings. Within 22/23 this included
  - HMIC PEEL Inspection of Greater Manchester Police (received in March 22)
  - Greater Manchester Mental Health Trusts overall trust wide inspection by CQC

Whilst the inspections highlighted key areas of work for those organisations, discussions with key partners highlighted where partnership collaboration was critical to addressing inspection outcome issues. In addition to single agency responses and action plans, the WSAB through its risk management framework identified key areas where this high level of risk could be addressed and is reported below.

#### ***Managing Identified Areas of High Risk to Vulnerable Adults***

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



- The process involves identifying and then scoring against the impact the risks could have on people accessing or needing those services. Risks are identified through a mix of external partner inspection outcomes, WSAB learning and improvement activity (such as case reviews or quality audits) or a mix of both. Often a partner will bring an emerging issue that they are concerned about but want to highlight as needing a partnership response to address.
- The WSAB Board itself manages those that score highly and support partners in identifying and implementing a risk mitigation or response plan.
- Key areas of high risk identified and managed the Board and its partners across 22/23 are summarised here including a summary of action taken to reduce the risks.

Risk Areas	Response
<p><b>Domestic Abuse</b> - High levels of repeat presentations of domestic abuse victims and at the Multi Agency Risk Assessment Conference meeting which is a multi-agency response to supporting people who are suffering domestic abuse</p>	<p>Colleagues in the domestic abuse partnership identified the need to identify resources and a framework to enable more interventions regarding offenders. A new MATAAC Officer and process was put in place in early 2022. MATAAC refers to the Multi-Agency Tasking and Coordination process of identifying and tackling serial perpetrators of domestic abuse perpetrators.</p> <p>The overarching objectives of the MATAAC are to safeguard adults and children at risk of domestic abuse and to reduce the offending of domestic abuse perpetrators</p>
<p><b>Mental Health Act Risk</b></p> <ul style="list-style-type: none"> <li>- local Section 117 Discharge and Care Plan to ensure a joined-up plan is in place when patients are discharged from mental health inpatient settings. This was also identified within local safeguarding case reviews and through subsequent audit and quality assurance activity by the WSAB.</li> <li>- local Section 140 policy required to address a patient safety risk concerning patient flow when admission to a mental health bed is required due to demand of those requiring admission and reduced capacity due to delays in discharges from inpatient beds. This is impacted on the reduced number of suitable specialists, rehabilitation placement and supported accommodation across the Wigan division. policy and pathway (in the case of Section 140 in response to pressure in the mental health system regarding lack of acute</li> </ul>	<p>Section 117 - A dual framework between GMMH and Wigan Adult Social Care was produced to ensure an effective care plan is in place for individuals who are being discharged from mental health provision.</p> <p>Patient Safety when admission is required:</p> <ul style="list-style-type: none"> <li>- local Section 140 policy required to ensure a safe process in place for people requiring inpatient bed and to be implemented 23/24</li> <li>- Daily patient flow meeting to clinically review all admissions to hospital.</li> <li>- 3 x time weekly Multi Agency Discharge Events</li> </ul> <p>Work on the above and other mitigation plan actions started in 22/23 and will</p>

mental health beds when people require them)	continue to be monitored by the WSAB across 23/24
<b>Mental Health Services</b> - increase in demand and complexity	Our mental health trust (Greater Manchester Mental Health Trust) highlighted this risk and identified new transformation service plans regarding addressing crisis need in the community. In particular the Living Well Community model began to be piloted for upscaling in 2023/24.
<b>Deprivation Of Liberty Safeguards (DOLS)</b> delay in assessment and authorisation	The Adult safeguarding Team implemented a range of actions including adopting the evidence based ADASS Decision Making / Prioritisation Tool. It focused staff and resources on addressing the waiting list which also included re-introducing a wider staffed Best Interests Assessor role) and worked to streamline referrals with colleagues in our acute trust at the hospital. The WSAB ensured that the issue was incorporated into the regular performance management framework and continues to monitor outcomes.

- Wider and lower score risks are managed by the WSAB Executive Group and Delivery Group framework.

#### *Forward Planning 2023/2024 –*

- Plan and implement a peer review with Norfolk Safeguarding Adults Board
- Capitalise on all our quality and assurance work and produce / agree an overarching Quality Assurance Framework for all partner to sign up to
- Refresh our delivery group framework and ensure they are focused on the right priorities with accompanying deliverable action plans.
- Further strengthen our Performance and Insights Framework to enable the Executive and Board to identify key areas of success or those that require further analysis from a wider set of partner data sets.
- Develop and launch our new Safeguarding Adult Procedures

## **Strategic Priority 2 - Quality Practice, Learning & Improvement**

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

**Key Delivery Groups** – WSAB Executive Group and Learning / Quality Assurance Delivery Group / Wider Delivery Groups

### **Objectives** –

- *Consolidate existing learning and impact of actions from taken Brief learning Reviews / Serious Adult Reviews*
- *Implement refreshed workforce development plan and impact on practice / safeguarding outcomes.*
- The partnership continued to develop and embed a performance and insights framework to ensure that core Section 42 Safeguarding Enquiry were reported to Executive Group and Board. This framework enables the Board to understand where strengths and areas for development are within the safeguarding framework and pathways.
- Through our Learning and Quality Assurance Delivery group, quality audit work continued to be focused on those areas that require further assurance or investigation. We delivered both single agency and multi-agency quality assurance work including multi agency case file audits as directed by learning and improvement activity / caser review findings. Of note were:
  - Safeguarding Tier System (Tier 2 level) audit with colleagues in Provider Management and Market Development (who lead on developing our safeguarding Tier System with our care sector) highlighted key learning regarding the need to ensure that escalation processes to tier 3 level could be adequately captured on case management systems.
  - Deep Dive Audit regarding Adult Safeguarding Enquiries and when cases are moved to a risk management response.
  - Quality of Referral Audit Cycle – Our major focus for multi-agency audits focusing on quality of adult safeguarding alerts from partner agencies began towards the end of 22/23. Each audit was led by a partner agency and focused on alters generated from their staff. This audit cycle will continue into 23/24
- We consolidated the learning from case reviews and quality assurance work and produced new minimum standards for safeguarding practice that was both published in a tool format on the WSAB web site and incorporated within core training products offered by the WSAB Business Unit (Section 42 Core Training and Adult Safeguarding Level Three). They are available here if you want to read them:  
<https://www.wigansafeguardingadults.org/Docs/Professionals/Wigan-Safeguarding-Adults-Practice-Standards.pdf>
- We started work on redeveloping our action tracker tool into a more robust Learning Outcome Framework that can easily group thematic learning together, more easily task partners with key actions from case reviews and worked on describing those actions in a way that more easily translates into capturing improved outcomes for people. We started on our

Safeguarding Adult Reviews first and the work will be completed in 2023/24, with further work next year to focus on Brief Learning Reviews.

- We continued to embed our workforce development offer across the partnership and refreshed out overarching workforce development strategy and offer which you can read here:

<https://www.wigansafeguardingadults.org/Professionals/Professional-training.aspx>

- Based on key findings from case reviews and audit activity our evidence-based training offer continued to be rolled out. We continued to provide a blended mix of training (face to face and virtual) including expanding our lunch learn sessions for practitioners. Below are those courses we delivered in 22/23.

- ✓ Hoarding Awareness Half Day = 39
- ✓ ABC Trauma = 20
- ✓ Financial Crime: Illegal Money Lending Awareness = 83
- ✓ Harmful Gambling = 74
- ✓ Level 3 Safeguarding Adult's = 170
- ✓ Lunch and Learn: Domestic Abuse – An Introduction to the S.A.V.E.D Model = 198
- ✓ Lunch and Learn: Domestic Homicide Review = 2
- ✓ Lunch and Learn: Forced Marriage = 149
- ✓ Lunch and Learn: Hoarding Awareness = 66
- ✓ Lunch and Learn: Predatory Marriage = 161
- ✓ Lunch and Learn: Self-Neglect = 34
- ✓ Lunch and Learn: Supporting Criminal Investigations = 15
- ✓ Lunch and Learn: Trauma and Resilience = 14
- ✓ Lunch and Learn: Stop Loan Sharks and Financial Crime = 72
- ✓ Multi- Agency Public Protection Arrangements = 32
- ✓ Trauma and resilience Level 2 = 122
- ✓ Section 42 Training = 108
- ✓ Tier Training = 651
- ✓ Eyes and Ears Training = 151
- ✓ **Overall total number of attendees = 2,161**

- Agencies within the partnership continued to deliver training which we promoted via our training brochure available to read here -

<https://www.wigansafeguardingadults.org/Professionals/Professional-training.aspx>

- The WSAB Business Unit also undertook support work with colleagues in Community Services (Adult Social Care) and with the newly appointed Principal Social Worker on key areas of work that will have a positive impact on safeguarding outcomes. This included developing and launching a new supervision framework for all social care staff that embeds the principles of safeguarding within the Crae Act and is person centred / strength based.



### *Forward Planning 2022/2023 –*

- Further work with Adult Services to develop and embed key safeguarding improvements within the Back to the Future transformation plan (see their agency update in the report below)
- Further work to ensure all case reviews and wider learning and improvement activity is captured within our developing Learning Outcomes Framework
- Develop and implement our overarching Quality Assurance Framework which in 23/24 will include a framework for partners to assure the Board that they have in place safe policies' practice and systems regarding adults at risk of neglect or abuse.
- Work on developing a broader performance outcomes framework that incorporates partner data and outcome intelligence.

### **Strategic Priority 3 - Policies, Strategies & Procedures**

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

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

- Self-Neglect / MCA / DOLS – The delivery group undertook work in 22/23 on refreshing the overarching Self Neglect Policy and Pathway to ensure it is effective in providing a risk management approach for people with capacity who choose to make unwise decisions. This is a key function and review work given the prominence of safeguarding alerts regarding self-neglect.
- A connected element of this work involves developing new responses to cohorts of adults who are experiencing / involved in acute or chronic high-risk behaviour that threatens their safety or wellbeing, and the need to work with them in a more intense way through multi-agency work. The new Vulnerable Adult Risk Management process and framework was developed in 22/23 by Community Services Adult Safeguarding Team; a new team was also put in place and the Multi-Agency Public Protection Team went live in late 22/23.
- Organisational Safeguarding – the delivery group focused on embedding the learning from the Care Home Self-Assessment exercise. The self-assessment was based on published guidelines by NICE. This exercise was designed to be a co-produced benchmark exercise regarding current practice and culture within the care and residential home sector. It provided key information and trends back to the group regarding common areas of work that require further support.
- The WSAB signed off an overarching Falls Strategy and Pathway and in 23/24 will be a key focus for the Organisational Safeguarding Delivery Group, with a focus on developing an outcomes framework for reporting back through the Board.
- Colleagues in Greater Manchester Mental Health Trust worked with officers in the WSAB Business Unit and began to pilot our Safeguarding Tier System in both acute and community

settings (Sovereign Ward in Atherleigh Park and Late Life and Memory Service or LLAMS). The pilot highlighted the work undertaken to safeguard individuals by the trust and established a robust escalation process for Tier 3 (Care Act Safeguarding alerts), whilst ensuring that these were appropriate and at the right level. Further work to expand the process trust wide will take place in 23/24.

- We worked with colleagues in Drug and Alcohol Commissioning Team and provider services to set up a new Drug and Alcohol Related Deaths Panel, making sure that the framework linked to the WSAB Case Review process.
- In response to key learning from case reviews and audits, we also published a new approach to non-engagement that re-positions the issue within a trauma informed approach. The toolkit challenges professionals to re-consider how non-engagement should be viewed from the experience of clients and not just an organisational perspective, what the impact of non-engagement is and how to address it within service offers and approach. We'll continue to roll out the approach within our training offer across 23/24. The toolkit is available to read here:

<https://www.wigansafeguardingadults.org/Docs/Professionals/Understanding-non-engagement-with-services.pdf>

#### *Forward Planning 2022/2023 –*

- The Organisational Delivery, in addition to the falls work above have identified the following key priorities and work streams:
  - Establish and embed a whole system Pressure Ulcer pathway and process and establish a quality assurance and outcomes framework in order to measure impact.
  - Oversee further embedding of the WSAB Safeguarding Tier System including.
  - Oversee and implement expansion of the GMMH Tier system pilot across further acute and community settings.
  - Establish an overview and scrutiny function regarding tier system feedback from private mental health establishments in the borough.
  - Develop a shared policy on accompaniment from community to acute settings.
- The WSAB will oversee a local plan and approach in response the national Right Care, Right Person scheme which aims to establish clearer pathways and appropriate service response when individuals go missing from health and social care settings.

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

- WSAB continue to undertake both statutory (safeguarding Adult Reviews) and discretionary reviews (Brief Learning Reviews) within its case review framework. As of writing this annual

report there are currently 19 Active BLRs, 12 pending completions of parallel processes (criminal investigations, Section 42 Enquiries etc.)

- Within 22/23 the WSAB will work with individual partners to address those themes that re-occur across our case review activity and develop Workforce Improvement Plans to address those issues. We've described the work we did on developing our Learning Outcomes Framework above.
- Our published Reviews we completed are available here:

<https://www.wigansafeguardingadults.org/Professionals/Adult-case-reviews.aspx>

## 8. Partnership Activity 2022/2022

- WSAB is a partnership, and without the hard work and dedication of our partners around the table and at every level, would not be able to achieve its objectives and ambitions.
- In addition to the work described through the annual report, below is a summary of the wider work undertaken by our partners that link to improved outcomes for adults at risk of abuse or neglect. Many of the work areas have been brought to Board within 22/23 or worked up within our delivery group framework.

### *Provider Management and Market Development (Wigan Council)*

Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
<b>Care Home Quality</b>	Quarterly in person care home provider forums resumed following covid. Wider colleagues and teams have been invited to reach in for support.	Further embed the approach across wider provider market areas.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>General Engagement of Markets / Thematic Areas -</b>	Mature reciprocal relationship with provider market which ensures openness and transparency around safeguarding and wellbeing.	Further work to embed the approach.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Falls in Care Homes Policy</b>	The policy has been signed off. Training sessions have taken place. Attendance at the provider forums.	Further work to embed the approach.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Bed Rail Policy</b>	Introduced and shared across the market areas and in response to key SAR findings / learning	Continued key focus within organisational safeguarding delivery group.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>CQC Ratings</b>	Highest rated NW local authority for Care Home CQC ratings.	Ongoing work to improve the position and continue the collaborative work.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Every Visit Counts – Damp and Mould Training</b>	Work with supported living landlords to improve the response to dealing with damp and mould. Link shared to report as a professional with external providers/landlords.	Continue to respond to emerging care setting crisis as and when required.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Rolling Blackout Contingency plans</b>	Relates to the ongoing energy crisis.	Further work to respond to the ongoing energy crisis.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Health Inequalities</b>	Health inequalities survey has been sent to all providers re health screening, access numbers for those registered with a learning disability. If they are experiencing barriers, we have asked to be	Further work to embed the approach.



	informed and so we can feed back to the subgroup from the LD Partnership Board.	
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Work with We are with you</b>	A piece of work is ongoing for people with a learning disability who misuse substances and alcohol. An easy read is being created to make it accessible. This has been shared with all providers to share with those they support.	Further work to embed the approach.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Community Mental Health Service and Provision</b>	Homecare providers are connected with GMMH and have commissioned a training package. When discharged from a MH hospital to receive homecare. Linked up to provide the correct training for those who may need support. Working towards prevention of safeguarding. Homecare colleagues are invited to the wards to present what home care is and isn't and to promote that virtual visits are available.	Further work to embed the approach.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Virtual Dom Care</b>	Developed a virtual offer, available to anyone. Bespoke service and person centre to keep people safe.	Further work to embed the approach.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Safe Places</b>	Inclusive Tennis were commissioned to roll out Safe Places in Wigan between 2022- 23, leading on business engagement, training, and quality assurance. 81 locations have been set up and are listed on the app.	Funding has been secured and UMay have recently signed the contract to build on the work done under Safe Places. UMay are a French company who run safety schemes across London and are looking at branching out in the Northwest – they are keen to work in Wigan. Additional features on the contract will include training offers for businesses, annual reviews and access to real time data.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Engagement work with APB, Autism Friends</b>	Our engagement group feeds into the autism strategy work areas, and meet monthly to discuss challenges faced, good practice seen, improvements to services and also have an opportunity to meet new people and socialise. Colleagues from Supported Employment, Community Groups, Support Providers and Department for Work and Pensions have attended to introduce themselves as well as offer further opportunities to engage. Engagement Leads from SEND and GM ICO are also linked in to ensure feedback is shared with all relevant service areas.	The group have been looking at improving our Autism Friendly Borough webpages – updating content, styles, layout and sections included. It will also have a section to find out more about our APB and Autism Strategy. This will be an ongoing action throughout the year as we improve information sharing and signposting.  Another area that we have been looking at is reducing social isolation. We have looked at Our Town and how to navigate

	<p>Some of the themes discussed in 2022 include the development of the Autism Strategy, Education, Health (impact of late diagnosis, access to health services, reasonable adjustments), and Post 16 offers and employment support.</p> <p>When asked the autism engagement group what their thoughts were on their involvement in the strategy development work and the Autism Partnership Board, and the following comments were made.</p> <ul style="list-style-type: none"> <li>• “Able to help with the decisions”.</li> <li>• “Can contribute to making a better society, for future generations too”.</li> <li>• “Engagement group is relaxed, feel listened to and can get things off my chest”.</li> <li>• “We feel listened to and that we can make a difference.”</li> <li>• “Voice of the people is good, but we do need to involve more people with lived experience, and the parent/carers too”.</li> <li>• “Feel more involved”.</li> <li>• “Need to continually look at how we encourage more people with lived experience to contribute”.</li> <li>• “Not everyone is the same and cannot assume things are important for all – we need to do better to attract more voices”.</li> </ul>	<p>the directory to find out more about groups and activities across the Borough and how we can improve how people find out information if they have limited access to online pages. Conversations ongoing regarding increasing the number of community boards across the Borough and other accessible means to promote services and events.</p> <p>The group have been focusing on developing our inclusive community and create a process to check accessibility. The group will look at inclusive groups and activities promoted on Our Town Online Directory and see if there are any suggestions or support to improve offers or highlight gaps in provision. This will offer a little reassurance to autistic people.</p> <p>We will also be involved the in a self-assessment of the Autism Strategy 18 months on from its development – looking at progress to date, celebrate success stories, challenge where required and be part of conversations to look at areas to focus on moving forward.</p>
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Financial Fraud</b>	Worked with all providers around vigilance and the review of financial safeguarding procedures. This may be more prevalent due to the cost-of-living crisis. Piece of work has taken place using Kathryn Leigh’s expertise.	Further work to embed the approach.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Based on I statement</b>	A deeper understanding of how safe people feel in relation to the care they receive.	Further work to embed the approach.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Trade Union Meetings</b>	Insight can be shared from Trade Union colleagues to provide an additional layer of insight around quality of care.	Meetings to continue.

**Please highlight any additional work you have planned for 2023/24**

- Extending and embedding wider provider forums to include Care Homes, SAS, Homecare and Extra Care. In response to internal peer review.
- Care Home Quality – provider forums and engagement.
- Be a voice for care.
- Reintroduction of the quality surveillance framework and process
- What’s up champions.
- Service user engagements – home care surveys and drop inn for SAS families and individuals around personal experiences. Based on I statements.

*Greater Manchester Police – Wigan Division*

Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
<b>RE-instating Adult safeguarding / Domestic Abuse Adult Safeguarding Unit</b>	Standalone unit re-instated back end of 21.22, 22/23 saw the new team embed the approach with multi-agency support e.g., three times per week meetings with ASC Adult safeguarding Team in new triage process which reduced inappropriate referrals and streamlined quality section 42 referrals	Further embedding of the work and approach across 23/24
Area of Work	Activity Undertaken 2022 – 2023	Activity Ongoing / Planned 23/24
<b>Prevention Hub</b>	Reviewed and refreshed approach to multi-agency working building on the success of pre-covid PSR Hub principles. Multi agency team and framework to triage and respond to daily safeguarding demand and work. WSAB support via GMP presentation at WSAB summit Feb 23	Further work to embed across 23/24

**Please highlight any additional work you have planned for 2023/24**

- Redesign and implementation of a partnership framework to tackle and manage Organised Crime in the borough.

## Housing (Wigan Council)

Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
<b>New Housing Model</b>	<ul style="list-style-type: none"> <li>Housing is now in Places Directorate and 22/23 saw a period of consolidation regarding refreshing strategic approach.</li> <li>Redesign / service transformation of core housing offer to ensure service is able to provide the right support to communities attenuated per community and the need each one requires.</li> <li>Housing continued in 22/23 to maintain strategic links.</li> <li>Response to Rochdale case of mould in priorities led to system wide approach and new monitoring / response fort all housing, health and social care staff in Every Visit Counts framework.</li> </ul>	<ul style="list-style-type: none"> <li>Further consultation and development of new rough sleeper and homelessness strategy across 23/24</li> <li>Refresh approach to Housing Needs Assessment</li> </ul>
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Workforce Development Safeguarding</b>	<ul style="list-style-type: none"> <li>Continued to roll out both the Eyes and Ears and Trauma Informed Approach from WSAB workforce development offer.</li> <li>Autism training for all staff ongoing across 22/23 (and into 23/24).</li> </ul>	<ul style="list-style-type: none"> <li>Continue to embed safeguarding training offer with a particular focus on new induction programme for new staff.</li> </ul>
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Commissioning</b>	<ul style="list-style-type: none"> <li>22/23 saw continuation of commissioning around safe accommodation agenda including Mercure emergency accommodation.</li> <li>Rough Sleeper Accommodation - new accommodation built and developed including recruitment and onboarding of trained support staff</li> </ul>	<ul style="list-style-type: none"> <li>Re-Commissioning of domestic abuse refuge supported accommodation service.</li> <li>Further properties and support to go live 23/24</li> </ul>
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Transition</b>	<ul style="list-style-type: none"> <li>16/17 and Care Leavers protocol to establish offer to ensure joint working and delivery of co-ordinated local offer</li> </ul>	<ul style="list-style-type: none"> <li>Review of protocols through continued membership of Corporate Parenting Board</li> </ul>
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Sheltered Accommodation</b>	<ul style="list-style-type: none"> <li>Wharfedale provision handed over and new care provider commissioned.</li> </ul>	<ul style="list-style-type: none"> <li>New provision to be handed over in 23/24 and new build in Shevington to be completed</li> </ul>

**Please highlight any additional work you have planned for 2023/24**

- Mainstream approach to Hoarding and establish Hoarding Officer role.
- Preparing for new housing Inspection Framework



## Domestic Abuse and Sexual Violence / Prevention Hub

Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
<b>MARAC (multi-agency risk Assessment Conference)</b>	MARAC continued to be held daily via MS Teams providing quick multi-agency support and planning to those in need.	MARAC has changed from Daily meetings to Monday, Wednesday and Friday and the format has been changed to be far more risk focussed in line with Safe Lives recommendations. This change allows for more time for IDVA contact prior to meetings and conversations to take place to look at referrals in to ensure we have the correct cases being discussed Continue to review MARAC through DA governance arrangements. Undertake work to review the repeat definition at MARAC and understand our repeat rate.
<b>MATAC (multi- agency task and co-ordination group)</b>	Met with other areas in UK to look at MATAC models to address the needs and proactive enforcement and disruption to high repeat/serial perpetrators of Domestic Abuse	MATAC has now been set up and Wigan protocol in place identifying through risk assessment out top 10 repeat risk perpetrators. Prevention Hub key Workers work closely with GMP and partners to offer intervention to lower the risk / demand and offer a breathing space for victims to engage. We will continue to evaluate this response and work with GM around similar models across the areas.
<b>Operation Encompass</b>	Operation Encompass continues to remain a strong commitment in Wigan with a dedicated Police resource sending notifications leading to many more disclosures to schools and settings	A review of Op Encompass took place in May with consultations with schools to explore how the Domestic Abuse disclosure is utilised to safeguard children and families. This review will form part of a task and finish group to share good practice and continue to review the effectiveness of Op Encompass
<b>SAVED Model</b>	Worked with partner agencies to develop a simple tool around receiving a Domestic Abuse disclosure for all frontline staff. Initial meetings held with WBDAS, Adult Social Care and Wigan Council DA Leads to develop a short training Package around the model this has been rolled out with Lunch and Learn sessions	Embed the SAVED model into various partner agency training offers and ensure new events are planned through the WSAB training brochure.
<b>Domestic Abuse Community Offer</b>	The community offer delivered by Wigan Borough Domestic Abuse remains strong. We have continued to ensure we have a dedicated DA	Recommissioning now complete of the service to continue to deliver a comprehensive Domestic Abuse community offer.

	Borough helpline for residents, families, concerned others and Professionals alongside drops ins, counselling, support groups and Healthy relationship sessions in schools.	This followed a thorough partnership consultation. Continue to work with the provider (WBDAS/DIAS/Well Women) to ensure our offer in Wigan remains strong.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Specialist Domestic Abuse Nurse sat in Primary Care</b>	Initial work undertaken to scope how we incorporate primary care information into MARAC and provide a feedback/action loop back to primary care around high-risk Domestic Abuse	Specialist nurse now in post and linked into every MARAC meeting. Primary care information is shared between MARAC and surgeries. Continue to explore data integration to make the best use of the role with IG and utilise the role to provide awareness and training to primary care.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Experts by Experience Group</b>	On the back of the 'love is not abuse' campaign we met with various survivors of Domestic Abuse and formed an expert by experience group to meet and influence current policies, practice, and direction to the Domestic Abuse governance structure.	The group have already met with CYPS to co-design an agreement given to families experiencing domestic abuse between families and CYPS. The group have also met with a local MP and justice minister to offer views around domestic abuse and national policies. The group have provided videos that will be used to train GMP staff around victim's experiences to improve practice. The group plan to continue to provide feedback to the governance structure around policies concerning Domestic abuse. The group have been trained to co-facilitate Trauma Approach training to frontline staff that will be rolled out.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Love is Not Abuse Campaign</b>	Campaign continues to be successfully rolled out across the borough aimed at identifying the red flags that indicate domestic Abuse and how to get help early.	Develop the campaign to look at engaging perpetrators and bystanders to recognise abusive behaviours and actively and safely challenge this and seek support.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Prevention Hub</b>	Work has continued to address repeat demand across services through the work of the PSR Hub and a key worker, holistic and trauma informed approach. This is now known as the prevention hub and works alongside the GMP Prevention hub to integrate Police demand with partnership demand to ensure we have comprehensive regular data around repeat demand across services and offer interventions to problem solve demand and reduce this. Workstreams have continued around repeat Adult missing from homes, repeat vulnerable adult referrals, repeat A&E demand, Repeat NWS demand amongst others.	Continue to enhance the offer and look at new workstreams around repeat demand both for individuals and places. Work with mental health colleagues to understand and offer support around repeat acute and community MH demand.

**Please highlight any additional work you have planned for 2023/24**

**UMAY App – An app to report street level concerns and harassment linked to the GM Gender Based Violence strategy. The app directs concerned individuals to safe places and makes available data around hotspot areas of concern.**

**Whole Family Approach – An IDVA will be working with Childrens Social Care locality teams to further enhance our whole family approach. They will be available for support, advice, and case management of cases when children are at risk of being placed into care when Domestic Abuse is a factor.**

**Greater Manchester Mental Health Trust (GMMH)**

<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
Edenfield Centre	<ul style="list-style-type: none"> <li>- NHS England placed GMMH into Segment 4 of the System Oversight Framework and enrolled the Trust into the National Recovery Support Programme,</li> <li>- An Improvement Board was established.</li> <li>- A single Improvement Plan was developed.</li> <li>- A Rapid Quality Review was completed.</li> <li>- Greater Manchester Police (GMP) set up Operation Crawton to investigate any potential criminal acts.</li> <li>- Bury Local Authority commenced safeguarding enquiries.</li> <li>- An independent Review has been commissioned.</li> <li>- CQC undertook several unannounced inspections across the Trust.</li> </ul>	<p>Our Improvement Plan includes several immediate actions to tackle the most urgent quality and safety issues, alongside a comprehensive set of long-term ambitions to improve everything we do at the Trust, grouped into five themes:</p> <ul style="list-style-type: none"> <li>• Patient Safety</li> <li>• Clinical Strategy and Professional Standards</li> <li>• An Empowered and Thriving Workforce</li> <li>• An Open and Listening Organisation</li> <li>• A Well-Governed and Well-Led Trust</li> </ul>
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
GMMH Safeguarding Governance and Oversight Arrangements	Review of the Trusts safeguarding arrangements undertaken by external ICB lead.	Report and recommendations to be considered at Board level to inform the future delivery and staffing model both at a strategic and operational level.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
Safeguarding Training	Impact of training audits developed and completed to measure the impact of training on knowledge, skills and practice.	To be completed on an annual basis.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>

Deprivation of Liberty Safeguards Compliance	Sept 2022 Mersey Internal Audit completed a review of the Trusts compliance with DoLS which included a review of clinical records, systems, processes and the training offer. The outcome was 'Substantial Assurance' was provided.	Ongoing development and review of processes as required.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
MCA Legal Training	<p>Groundwork funding approved for the delivery of training on key aspects of law by solicitors experienced in the MHA/MCA field. To ensure relevance and links with clinical practice, sessions were identified from Datix actions, 3-day reviews, complex cases and common learning requests from GMMH Staff.</p> <p>The training sessions available which are relevant to the application of the MCA are as follows:</p> <ul style="list-style-type: none"> <li>• Assessing capacity and causative nexus</li> <li>• Section 49 (MCA) Reports</li> <li>• MHA/MCA Interface</li> <li>• Section 21A Challenges and DoLS</li> </ul>	Ongoing delivery of training during 2023/24.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
Training Needs	Development of a child to parent abuse training module for CAMHS staff in Wigan, in response to themes/learning identified.	Ongoing delivery of training during 2023/24.
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
Patient Flow	System improvements and integrated delivery board reporting in relation to patient flow leading to a reduction in out of area placements and length of stay	Ongoing system improvement work
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
Multi- Agency Discharge Events (MADE)	System wide approach to supporting safe and effective discharges and ensuring capacity for admissions.	Ongoing system improvement work

**Please highlight any additional work you have planned for 2023/24**

- **Implementation of the new GMMH safeguarding governance arrangements which includes the GMMH Strategic Safeguarding Sub-Committee and Operational Safeguarding Group – refresh of membership and TOR.**

- The development of a GMMH Safeguarding Strategy which will set out our strategic vision and approach to strengthen our safeguarding arrangements for the next 3 years and beyond.
- To ensure that there is sufficient staffing capacity across the organisation to ensure that we meet our statutory safeguarding duties and responsibilities.
- Introduction of a new Associate Director for Safeguarding post.
- To develop an annual safeguarding audit calendar which will report into the Operational Safeguarding Group to enable routine review of our safeguarding practices.
- To develop a dataset in relation to protected characteristics e.g., to understand the prevalence of and implications for those from minority ethnic backgrounds.
- To continue the development or safeguarding dashboards via Power-BI.
- Workforce Development Officer for Safeguarding to be introduced.

### Adult Social Care

Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
<b>Establishing Vulnerable Adult Risk Management (VARM) Framework</b>	Establishing a policy and process and securing resources for new Multi-Agency Public Protection Team and VARM framework to address rising complexity and risk in adults safeguarding cases, and to ensure a response to cases who are at extreme risk / no identifiable care and support needs	Embed the approach within a broader connected system response
Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
<b>Back to The Future Transformation Plan</b>	Comprising of specific thematic areas, transformation plan elements will also ensure improved responses to safeguarding. <ul style="list-style-type: none"> <li>• Transfer Of Care Hub (Acute and Mental Health Settings)</li> <li>• Named Social Worker</li> <li>• Refreshed Supervision Framework</li> <li>• ABC Conversations</li> </ul>	
Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
<b>Self-Neglect Refresh</b>	Policy and process was refreshed in 22/23 and rolled out via Self-Neglect / MCA / DOLS Delivery Group	Continue to embed approach

**Please highlight any additional work you have planned for 2023/24**

- Principal Social Worker refreshed action plan.
- CQC inspection preparation
- Refreshed approach to the Deal for Adult Social Care
- PiPoT Refresh
- Re-focus on improving system response to existing guidance and legislation re DOLS.

*PMMD In-House Services*

Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
<b>Positive Behavioural Support (PBS)</b>	Following identification of the approach through WSAB BLR, Work continued across 22/23 including expanding the approach and workforce development activity to cover mental health where that is a facet of in-house provision. Developing bespoke training to learning disability that have seen a reduction in incidents in in-house services and improving independent living for individuals.	PBS roll out to continue and include respite / day care settings. Bid in place to fund PBS Practitioner / Train the Trainer model. Also included in induction for new staff going forward (also to include WSAB training regarding tier training)
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Trauma Responsive approach</b>	90% of the mental health workforce attended the trauma awareness courses. Managers and staff have started to apply the approach from building layout redesign to and general case support / risk management	Continue roll out across 23/24
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Carers Strategic Forum</b>	22/23 saw a whole system action plan developed and signed off. The new forum has	Support the work and identify additional resource for 23/24
<b>Area of Work</b>	<b>Activity Undertaken 2022 - 2023</b>	<b>Activity Ongoing / Planned 23/24</b>
<b>Health Inequalities Work</b>	Work across the service to ensure that people with a learning disability and where they require services where possible receive this in current provision. Service is committed to flex the support which in some cases results in higher costs but improved life chances. A good example is the input of health improvement officers has seen improved outcomes within client cohort. Approach incorporates issues such as healthy eating that has seen benefits to both staff and the people they support. The approach is person centred and modelled around the wants of the individual (in line with public health, “upstream” working, with health improving in the community as a result and less hospital admissions.	Continue to roll out 23/24



Please highlight any additional work you have planned for 2023/24 you would like to see included in next year's annual report.

- In addition to the service leading a system wide response and development of a Respite Strategy, further develop an in-house response to respite including taking on Highfield / Billinge bungalows increasing capacity from 4 to possible 13, important given the volume and complexity of people requiring a service. This is in line with responding to service wide demand increase for people who require a service that can support increasing complex presentation from both a mental and physical health perspective.
- Respite Strategy will also cover emergency respite and what a positive offer might contain regarding the mix of physical / mental health needs.
- Work on developing Heathside plan for respite beds.
- Workforce development approach to engaging younger / school – college leaver workforce and a career in social care /provision.
- Underpinning awareness and response to Prevent (training) and membership of the Channel Panel. Also, in-house service response to new pathways including VARM / MAPPT.

### Drugs and Alcohol Commissioning (DAAT) Team

Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
Drugs and Alcohol	Implementation of GM Co-Occurring Needs standards and principles at locality level. Facilitated sign-off of co-occurring needs staff policy at GMMH through co-occurring needs transformation group. Continued membership of GM Working Group – Co-occurring needs.	Continued strategic role to influence.
Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
Drugs and Alcohol	Ongoing review of Drug and Alcohol Related Deaths (DARD) Panel system and processes.	Commitment to invest and continue DARD System for 23/24. GM review of DARD panel approach across all localities. Continue to align work to WSAB BLR processes.
Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
Drugs and Alcohol	Test and Learn approach to Complex Social Work remit as part of the Rough Sleeper Drug and Alcohol Treatment Grant	Review work to commence on effectiveness of role, including a review of cases supported in first year with lessons learnt.
Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
Drugs and Alcohol	Secured grant funding for the following: Rough Sleepers, Housing Support, Employment Support for D&A until March 2024.	Detailed activity plans and outcomes in place to track progress against nationally set targets. Focus on increasing numbers in treatment – adults and young people, reducing drug and alcohol related deaths, increase number of residential rehab placements and maintain engagement in treatment services.

Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
Drugs and Alcohol	Recommissioning of drug and alcohol treatment service for adults and young people completed.	New contract in place with implementation of new model underway.

### *We Are With You (Drug and Alcohol Services Wigan)*

Area of Work	Activity Undertaken 2022 - 2023	Activity Ongoing / Planned 23/24
Drugs and Alcohol	Implementation of co-occurring needs drop in and advice clinics in service to support clients with unmet mental health need. Recruitment of 2x advanced practitioners to lead on mental health. Expansion of safety huddle to partner agencies to support multi-agency approach to co-occurring needs	Continued monthly clinics and ongoing review of effectiveness. Implementation of advanced practitioner roles to support service users with co-occurring needs and to support workforce development
Drugs and Alcohol	Ongoing participation and review of DARD Panel system and processes. Participation in GM DARD Panel operational group Attendance at BLRs to support multi-agency learning from service user deaths. Weekly internal incident review meetings to ensure any themes and learnings are quickly identified to support service delivery	Recruitment of a dedicated safeguarding manager (social worker)
Drugs and Alcohol	Recruitment and implementation of family worker offer providing a whole family approach to substance misuse	Co-location within social care settings Roll out of Triple P parenting programme. Embedding the offer and pathway in service and in local safeguarding teams
Drugs and Alcohol	Increased assessment capacity to provide faster access to service	Focus on increasing numbers in treatment – adults and young people, reducing drug and alcohol related deaths, and maintain engagement in treatment services.
Drugs and Alcohol	Recruitment of naloxone peers to support peer to peer naloxone distribution and training to support reduction in drug related deaths	Expand peer to peer delivery to include hepatitis C, harm reduction and needle and syringe provision
Drugs and Alcohol	Planning for future community model	Establishing community / neighbourhood teams to be embedded in local neighbourhoods to increase community offer

Area of work	Activity undertaken 2022-2023	Planned 23-24
<p><b>NHS GM invested in Domestic abuse workforce in primary care</b></p>	<p>Primary Care Domestic Abuse Specialist Nurse commenced her post in Spring 2023 and has increased the quality of GP contributions to MARAC, and offers professional expertise to Primary Care and the partnership</p>	<p>Planned improvements to accessibility of primary care information to aid timely receipt of information.</p> <p>Focus on impact of role on residents and professionals.</p> <p>Development of domestic abuse champions in primary care settings.</p>
<p><b>Quality improvement activity in intermediate care and mental health independent hospitals</b></p>	<p>The NHS GM Wigan locality safeguarding team supported Ashwood Court and Alexandra Court to improve the care provided to people following the identification of poor-quality care by CQC or local intelligence.</p>	<p>Nursing and quality team focus in 2023-2024 is to be visible and speak to residents and staff to shine a light on service user experience and the impact of partnership working on the frontline workforce.</p>
<p><b>NHS GM Safeguarding Team are attending meetings in respect of the different NHS GM Service Delivery Transformation Groups (Safeguarding System Assurance; Statutory Safeguarding Responsibilities &amp; Partnerships; and Learning and Improvement).</b></p>	<p>System assurance group are developing NHS GM policies, reviewing assurance activity and processes, 1 GM section 11 process, establishing sound NHS GM governance, and developing the new NHS E LAC dataset.</p> <p>Statutory safeguarding group consider inspection outcomes, MCA, PREVENT, ICON and statutory safeguarding agenda items where there are areas that can be managed at scale and to reduce variation.</p> <p>Learning and improvement subgroup seek to review learning across GM and use information to prioritise themes across NHS GM and work at scale more efficiently to improve practice.</p>	<p>Continued transformation in each workstream.</p>
<p><b>Supporting the management of complex cases</b></p>	<p>The team have supported the progression of complex mental capacity assessments, provided professional expertise, supported health providers with cases requiring escalation to resolve blocks, and worked with partners to support the provision of high-quality safe care for adults at risk.</p>	<p>Continued support and partnership working.</p>



## Wigan Safeguarding Adult Board Strategy on a Page 2022-2024



Our Strategic Statement	Wigan Safeguarding Adult Board Governance Arrangements	2023/24 High Level Priorities
<p><i>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:</i>  <b>Have a culture that does not tolerate abuse.</b>  <b>Work together to prevent abuse.</b>  <b>Know what to do when abuse happens.</b></p> <p><i>Our Ambition is that the Safeguarding Adults Board works within a broader partnership to:</i></p> <ul style="list-style-type: none"> <li>Champion the interests and rights of adults at risk of abuse and neglect.</li> <li>Ensure there is an emphasis on outcomes for adults at risk of abuse and neglect.</li> <li>Provide independent and objective challenge and leadership that is essential to ensure the best outcomes for those in need of protection and safeguarding amidst competing priorities.</li> <li>Involve all partners, not just police, health and the local authority, with a clear platform and duty to co-operate.</li> <li>Scrutinise and improve practice - using a range of new practice and individual user led approaches and meaningful measures to provide accountable oversight and feedback on performance and outcomes, with a focus on before crisis and that incorporates early help across the life course.</li> <li>Learn from experience and evidence of what works well – creating workable strategic and operational arrangements that fit form to function and are proportionate, efficient, effective, and adequately resourced.</li> <li>Meet the leadership challenge of connecting multiple partners together and collaborate to achieve common goals and within new ways of working.</li> </ul>		<p><b>WSAB / Exec</b></p> <ul style="list-style-type: none"> <li>Continue to develop and implement an overall response to management of risk within and across the partnership rooted in collaboration and partnership support</li> <li>Develop and implement an overall response to positive information sharing across the system</li> </ul> <hr/> <p><b>Learning and Improvement / Quality Assurance</b></p> <ul style="list-style-type: none"> <li>Consolidate existing learning and impact of actions taken BLRs / SARs / LEDERS via our Learning Outcomes Framework (LOF)</li> <li>Focus on quality assurance activity that supports improvement in Safeguarding Enquiries</li> </ul> <hr/> <p><b>Organisational Safeguarding</b></p> <ul style="list-style-type: none"> <li>Review and refresh group priorities to include :                      Pressure Ulcer Guidance and response                      Extending the Safeguarding Tier System,                      Falls Policy Outcomes Framework</li> </ul> <hr/> <p><b>Self-Neglect / MCA / DOLS</b></p> <ul style="list-style-type: none"> <li>Delivery group to develop and implement a system plan for self-neglect and outcomes framework</li> <li>Develop and implement a system wide plan for improvement in timeliness, focus and effectiveness of mental capacity assessments across all settings</li> </ul> <hr/> <p><b>Mental Health</b></p> <ul style="list-style-type: none"> <li>Develop and implement a local MOU / protocol regarding MHA Section 140 Policy</li> <li>Develop and implement a local MOU / protocol regarding MHA Section 117 Policy</li> <li>Deliver assurance on key MH transformation plans linked to case review recommendations.</li> </ul> <hr/> <p><b>Complex &amp; Contextual Safeguarding</b></p> <ul style="list-style-type: none"> <li>Support the implementation of a Vulnerable Adults Risk Management Framework within a wider partnership response to people who present as complex / high risk</li> </ul> <hr/> <p><b>Domestic Abuse</b></p> <ul style="list-style-type: none"> <li>Work with DA Steering Group to embed effective response in S42 processes</li> </ul>

### The 6 Care Act & Safeguarding Principles:

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

### Our Behaviours

- Be Positive**  
...take pride in all that you do
- Be Accountable**  
...be responsible for making things better
- Be Courageous**  
...be open to doing things differently
- Be Kind**  
...be helpful, generous and thoughtful towards others

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





# Wigan Safeguarding Adult Collection

## 2022-23

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SAFEGUARDING CONCERNS	SAFEGUARDING ENQUIRIES
2153 concerns per 100,000 population	1055 concerns per 100,000 population
Above National Average	Above National Average
Third highest in the North West region	Highest in the North West region
Third highest in the Peer Group	Highest in the Peer Group



1 in 2 Safeguarding concerns result in S.42 Enquiry



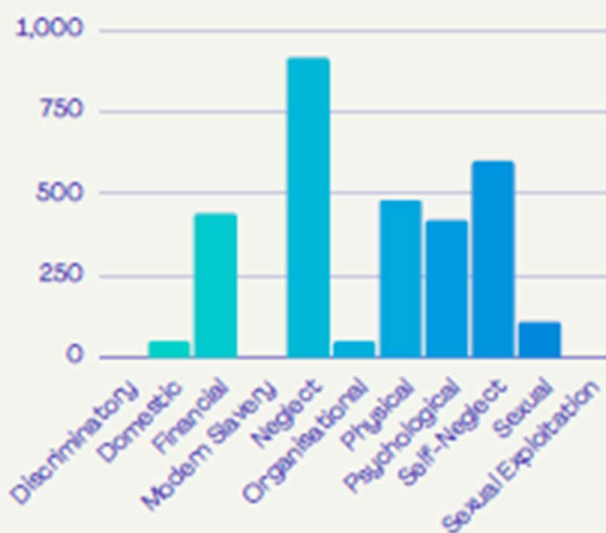
50 Safeguarding Adult Reviews (SARs) were reported in the North West region during 2022-23; Wigan completed 2 SARs.



The alleged source of risk is predominately somebody known to the individual at risk



65% of S.42 enquires recorded Home as the location of risk



Neglect and Acts of Omission account for 30% of type of abuse in S.42 enquiries

References  
NHS Digital Safeguarding Adults, England - Interactive Report





# Board

## Who is on the board?

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

Name	Agency
<b>Core Members</b>	
Independent Chair Adults Safeguarding	Independent
Superintendent Wigan Division	GMP
Director of Adult Services	Wigan Council
Associate Director Quality	NHS GM Integrated Care Board
Portfolio Holder Adult Social Care	Wigan Council
Director Community Services (Adult Services)	Wigan Council
<b>Wider Membership</b>	
Wigan Director Of Public Health	Wigan Council
Assistant Director Adult Safeguarding	NHS GM Integrated Care Board
Head of Operations, Wigan Division	Greater Manchester Mental Health Trust
Assistant Chief Officer	Probation Service Greater Manchester
Chief Officer (Wigan)	GMFRS
Chief Officer	We Are With You (Drug and Alcohol Services)
Locality Manager	Wigan Healthwatch
Inspector (safeguarding) Wigan Division	GMP
Safeguarding Manager	NWAS
Chief Nurse and Director of Infection Prevention and Control	WWL
Deputy Chief Nurse (Corporate)	WWL
Assistant Director Provider Management and Market Development	Wigan Council
Service Manager & Principal Social Worker (Adults)	Wigan Council
Lawyer (Legal Adviser to WSAB)	Wigan Council
WSAB Service Manager	WSP

Service Manager (Domestic Abuse, Reform and Partnerships)	Wigan Council
Care Quality Commission (Wigan Lead Officer)	CQC
Adult Safeguarding Team Manager (Adult Services)	Wigan Council
CQC Locality Lead	CQC

#### Appendix 4 – WSAB Financial Contributions

<b>Income</b>	<b>2021/2022</b>
Local Authority	£181,000
Wigan Borough Clinical Commissioning Group	£50,000
Wrightington, Wigan and Leigh Teaching Hospital NHS Foundation Trust	£15,000
Greater Manchester Mental Health NHS Trust	£12,000
Greater Manchester Police (through GMCA contribution)	£14,700
General Fund Contribution	£44,321
<b>Total</b>	<b>£317,021</b>