Wigan Safeguarding Adults Board

Annual Report

Reporting Period April 2024 to March 2025

Our Mission:

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

Wigan Safeguarding Adults Board

NHS Greater Manchester Mental Health NHS Foundation Trust
NHS Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust
healthwatch Wigan and Leigh
NHS Greater Manchester
Greater Manchester Police
Probation Service Greater Manchester
Greater Manchester Fire and Rescue Service
Wigan Council

Contents

Foreword

Reflecting on this Annual Report reminds me how much Wigan Safeguarding Adults Board has achieved in 24/25 and I am proud to be presenting this as part of our statutory duty.

The story of 24/25 is one about refreshing our focus, engaging our partners and people we are here to serve and ensuring and demonstrating our effectiveness in protecting adults at risk in Wigan.

Our refreshed strategy completed in collaboration with all partners, aligns our approach to that of Progress with Unity ensuring a coherent direction of travel throughout the Borough.

We have refreshed our subgroup structure and sharpened the function and relationship between Wigan Safeguarding Executive and Board. In order to sustain and develop the ethos of openness and transparency we have introduced a series of 'keeping in touch' meetings with all Board members and are continuing to develop how we present and interrogate data from across the partnership. Our new Quality Assurance Framework introduced this year will enhance our ability to do this and demonstrate our effectiveness.

Our learning from reviews continues to inform our education and improvement agenda. An example from this year is the development and the launch of a new Section 140 policy. This is a significant collaborative achievement that is bringing consistency to accessing urgent mental health placements.

Our focus on preventing harm has been strengthened this year with the development of a collaborative pilot which identifies and responds to early intervention needs drawn from adult social care referral where the criteria for s42 intervention is not met. I am looking forward to reporting progress in next year's report.

How we empower participation and engagement with those who use our services is central to the work of Wigan Safeguarding Adults Board. This Annual Report shows how our 'Whatsup' Champions and Ambassadors network has continued to develop and we have shared some powerful accounts of how our passionate and dedicated workforce, across all our partner agencies, have made a difference of the lives of adults at risk.

I have highlighted a very small snapshot of the work done this year and this report gives many more that show how we meet our statutory obligations as a Board and how the protection of adults at risk remains at the heart of all that we do.

Dr. Suzanne Smith PhD Independent Chair, Wigan Safeguarding Adults Board

What is the role of Wigan Safeguarding Adults Board?

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

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

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

Our board values and behaviours can be found within Appendix 1

Principles of Safeguarding Adults

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

1. **Empowerment** - People being supported and encouraged to make their own decisions and informed consent.

2. **Prevention** – It is better to take action before harm occurs.

3. **Proportionality** - The least intrusive response appropriate to the risk presented.

4. **Protection –** Support and representation for those in greatest need.

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

6. **Accountability** - Accountability and transparency in safeguarding practice

Our Structure 24/25

Links to other Strategic Boards e.g.

Wigan Borough Community Safety Partnership

Mental Health Transformation Board

Domestic Abuse Strategic Oversight Board

Family Safeguarding Strategic Board

Wigan Safeguarding Adults Board

Wigan Safeguarding Adults Executive

Links to other Strategic Boards e.g.

Wigan Safeguarding Children's Partnership

Reducing re-offending board

Carers strategic Partnership Board

Care home support & Development Board

Learning & Quality Delivery Group

Organisational Safeguarding Delivery Group

MCA / DoLS* & Self Neglect Delivery Group

Task and Finish Groups Aligned to key work

**Mental Capacity Act / Deprivation of Liberty Safeguards*

Our Membership

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

What's Up Champions

The Safeguarding What's Up Champion Project continues to thrive. We now have 45 What's Up Champions across our provider services within the Wigan Borough and the project is continuing to expand. During this reporting period, we continued to hold the What's Up Champion Network Meetings every quarter. As part of our commitment and renewed focus 'Progress with Unity', The Champions were invited to co-produce some key information. This included; the redesign of the Wigan Safeguarding Adult's Board (WSAB) website; the What's Up Champions logo; What's Up Champions posters; their own role descriptor; and they have provided feedback on the UMAY Safer Places App.

Guest Speakers were invited to come and deliver talks to the Champions about topics which included Healthy Living and Advocacy.

During this time the What's Up Champions have supported in the launch of the What's Up Champion Packs which contain a logbook, confidentiality and consent statement and a management agreement, all of which the Champions helped to co-design. The Champions record any concerns they may come across within their setting in their logbooks and bring them along to the network meetings where they are invited to discuss how concerns were resolved.

Annual Report covering the period April 2024 to March 2025

Achievements against our Priorities

Please see below some highlights of our achievements during the above reporting period under each of our priorities.

Accountability, Assurance & Leadership

At each board meeting all partners are invited to contribute with updates in relation to safeguarding activity. These reports often focus on positive case studies, audits, risks identified and points for learning. Below is a non-exhaustive selection of evidence brought before board for assurance and discussion in 2024/25.

Board Resolutions / Advice

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

Of the referrals received 3 escalations resulted in the commissioning of Brief Learning Reviews to review further learning around the cases.

Other notable work undertaken due to escalations is summarised briefly as follows:

- WSAB updated its Modern Day Slavery advice page to include further information around the National Referral Mechanism (NRM)
- WSAB worked closely with the ICB, and a letter was sent to all primary care settings in the Borough stressing the importance of information sharing and participation in Risk Management Responses
- WSAB Safeguarding Referral Training was updated with learning identified around the disclosure of sexual assaults
- WSAB worked closely with adult social care to develop a reporting mechanism around attendance / non-attendance at Strategy meetings

Other escalations resulted in the WSAB Business Unit bringing together key partners to share learning, and actions were subsequently tracked by subgroups.

Probation Greater Manchester Reset Strategy

Following a discussion at the May 2024 Board meeting a paper was presented from Greater Manchester Probation explaining the strategy outlining the resetting the remit of rehabilitation. This work included the work being undertaken around the short notice early release of prisoners. This was discussed by the membership with full engagement from partners and all agreed to commit to supporting Probation colleagues with the implementation of the strategy.

Greater Manchester Police Adult Safeguarding Unit

Partners from Greater Manchester Police presented to Board in February 2025 around the restructure of existing Adult Safeguarding Units in the district. GMP presented that Wigan now had a dedicated Domestic Abuse Team. Information around outcome rates for convictions and out of court disposals were presented to partners, along with an update around Domestic Abuse Protection Orders (DAPO). Of note Wigan has been selected as a pilot area for the DAPOs as part of wider a wider GM pilot on behalf of the Home Office. Partners agreed to support the work and share details of DAPOs withing their work organisations, this will allow organisations to protect adults at risk of Domestic Abuse in the borough.

This presentation gave the Board assurances around the ongoing work and the chance to ask questions.

Merseycare NHS Foundation Trust

Following a presentation to both the WSAB Executive and Board members in February 2025 a presentation from Merseycare was shared . This presentation provided assurances back to the WSAB around recommendations highlighted in the Safeguarding Adult Review – Una. Of note during the review the care was delivered by NHS Northwest Boroughs Healthcare, and legacy legal cases had been transferred to Merseycare following a restructure.

Assurances covered the following areas:

- Managing allegations and Person in Position of trust (PIPOT) Policy and Procedure)
- NHS Patient Safety Incident Response Framework (PSIRF)
- Governance Reporting & Escalation around the above

The Board agreed they were assured by the work undertaken and this will lead to improvements from learning previously outlined for adults at risk.

His Majesty's Prison Hindley

At the August 2024 Board meeting an update regarding HMP Hindley was presented to Board members, Partners expressed positivity around the link between the prison and agencies. Within the presentation HMP Hindley outlined the role of a monthly safety committee and link to Board partners. Also outlined was the chaplaincy provision at the prison.

Northwest Association of Directors of Adult Social Services (ADASS) report 2023/2024

At the conclusion of the August 2024 Board the NW ADASS Annual Report was shared with the members. Focussing members on the report and its findings a quote from the report was read *"We are leading Adult Social Care in challenging times, but the beauty of Adult Social Care is we are helping people to live their best lives, whatever they are doing, and whatever they love…it's a beautiful job to do."* Partners agreed to share the findings of the report within their own organisations to further improve our offer to adults at risk.

Prevent / Channel Panel Update

At the November 2024 Board Wigan Council Community Safety Partnership leads presented to Board the findings of an independent review following the Manchester Arena Bombing. It was reported to Board that to date 34 of the 36 recommendations from the review to Government had been enacted with the remaining 2 in progress.

An update was also given around Operation Dovetail which had ended in Greater Manchester. During this meeting a brief overview of Wigan's Counter Terrorism Local profile was shared with members, with points that could be shared. An overview of Prevent referral data was also shared.

WSAB partners agreed to share the findings of this update within their own teams, and it was positive to see recommendations progressing. This in turn will lead to better outcomes for adults at risk of being exploited by extremists.

NHS GM Safeguarding Annual Report 2023 - 24 & GM NHS Quality Improvement Visit

At the February 2025 Board meeting colleagues from the Integrated Care Board (ICB) presented the 2023/24 NHS GM Safeguarding Annual Report. This allowed members of the Board to ask pertinent questions. The Board was informed of the formation of 3 new delivery groups – Systems Assurance, Statutory Safeguarding and Learning and Improvement.

Following on from this a Quality Improvement visit that had taken place at Atherleigh Park was presented to Board. During the visit which 4 NHS GM colleagues visited 4

wards speaking to both staff and service users. The visit focussed on quality and the presentation outlined to the Board the positives and learning from the visit with a plan moving forward.

With both presentations partners at Board were assured with the continued ongoing work, and agreed the visit enriched the assurance.

Formation of new subgroups / Keep in Touch Meetings

At the February 2025 Board meeting partners received an update of the new subgroup structure for the Board. This included refreshed membership for both WSAB and the Executive. New subgroups had been formed following learning and common themes from the Learning Outcomes Framework. Each of the new subgroups and Executive had been given new Terms of Reference with key aims for the year ahead. For more information, please see Our Structure 25/26

Also discussed was the creation of new keep in touch meetings. These meetings have been scheduled with Board members frequently throughout the year and is a chance for partnership leads to meet with the WSAB Business Unit. These meetings will allow for updates to be shared between Board meetings and pertinent pieces of work to be easily identified that can be brought to Board, along with opportunities for the business unit to support key work.

This new structure has created more clarity and transparency for board with outstanding learning outcomes framework actions which will result in less drift in actions and provides assurance that learning is being disseminated and operationalised.

Wigan Safeguarding Adults Board – Development Day 2024

In November 2024 the board was pleased to invite all our members to a development day hosted at Wigan & Leigh Hospice. The day focussed on the collective development of the following:

- Role of WSAB and leading partners

- Refresh of 2023/2024 high level priorities
- Governance and Assurance
- Board structure and subgroups
- Learning Outcomes Framework themes and sub themes
- Progress with Unity
- Future strategic priorities
- Self-evaluation returns

Through collaborating, the Board was able to reflect on the previous year and set the foundations for our future 3-year strategy and structure. Partners contributed fully to the session resulting in a new strategy to drive the work of the board forward.

Quality Practice, Learning & Improvement

Training figures: Reporting Period April 24 to March 25.

Based on number of professionals trained

- Best Practice Hoarding =12
- DASH/MARAC Training =171
- Hoarding Awareness =23
- Understanding Hoarding =9
- Level 3 Safeguarding Adult's =209
- SAVED Model of Domestic Abuse/ Coercive Control =157
- Predatory Marriage =47
- Professional Curiosity =68
- Provider Managers Tier Overview = 104
- Trauma and Resilience Level 2 =96
- Violent Resistance/Suicide Timeline Webinar =85

- Eyes and Ears Safeguarding Training =235
- Tier Reporting Safeguarding Training =507
- Lunch and Learn: Advocacy =34
- Lunch and Learn: An Introduction to the Asylum and Refugee World =140
- Lunch and Learn: Caring for Unpaid Carers When a Loved One is Dying =16
- Lunch and Learn: Caring for Yourself When Working with Someone Who is Palliative =5
- Lunch and Learn: Loss, Grief and Bereavement =28
- Lunch and Learn: Trauma Informed Care at End of Life=27
- Lunch and Learn: Making Safeguarding Personal =21
- Lunch and Learn: Pressure Ulcers =55
- Lunch and Learn: Resolution Protocol =12
- Lunch and Learn: SAVED Model of Domestic Abuse =20
- Lunch and Learn: Self-Neglect =9
- Lunch and Learn: Stalking and Harassment =25
- Lunch and Learn: Supporting Carers in the Wigan Borough =55

Total Number of Professionals Trained =2,170

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

Quality Assurance Framework

This year Wigan Safeguarding Adults Board signed off on its new Quality Assurance Framework (QAF). The QAF is designed to draw together data and information from a variety of sources across organisations. This will allow the Board to triangulate a variety of information both about quality and assurance and evaluate the effectiveness of its arrangements.

Further information about the Quality Assurance Framework can be found on the following link: QAF

Suicide Prevention Strategy – deaths on railways

At the May 2024 WSAB a presentation was given by Greater Manchester Mental Health Trust on the Thematic Review of confirmed suicide cases on railway tracks within the Borough.

The briefing provided a demographic profile of cases along with contributory factors and areas of focus.

WSAB contributed to the key areas on the thematic review and partners agreed to share the findings of the report with their own organisations, and the Suicide Prevention Group would utilise the key areas outlined to develop further work.

Peer Review Feedback

At the May 2024 Board 2 presentations were shared with members. This followed a comprehensive peer review exercise with Norfolk Safeguarding Adults Board. The Board welcomed feedback and findings from Norfolk and thanked them for their support. A presentation was also shown highlighting the findings of Wigan's peer review of Norfolk. This peer review has led to a renewed structure for WSAB including clear distinction between the role of WSAB and executive.

Safer Employment

A Safer Employment workshop was hosted by WSAB in May 2024. The Organisational Safeguarding Subgroup led on driving forward the development of a programme of learning and workforce development within this area. As a result of this work, there is now a partnership training offer that includes a 1-day training session designed for Recruiting Managers, HR Advisors, Registered Managers and QPO's. Bitesize sessions will be available for senior staff and voluntary and community groups. The training explores the key recommendations from SAR Una and includes the following:

- Understand legal and best-practice requirements in safer recruitment
- Prevent unsuitable individuals from gaining access to vulnerable groups
- Learn how to manage concerns, disclosures, and references effectively
- Create a safer organisational culture from the point of hire
- Practical resources to ensure that employers move from compliance to curiosity.
- Information, resources and advice on safer employment is also available on the WSAB website.

Learning from lives and Deaths of People with a Learning disability and autistic People (LeDeR) Action Plan

In September 2024 WSAB Executive was presented with the Greater Manchester LeDeR programme 2023-2024 Wigan Locality report along with the action plan. The report presented a thematic analysis of reported deaths along with a comprehensive action plan linked to key themes and workstreams.

Group members welcomed the report and agreed to share the learning within their respective agencies.

For more information re LeDeR visit: NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)

Policies, Strategies & Procedures

Case Review Process

This year WSAB updated its overarching Policy and Process in relation to case reviews. This followed consultation with partners and feedback. The new process recognises the importance of brief learning reviews whilst refocussing on the Safeguarding Adult Review (SAR) thresholds to ensure we prioritise learning.

Under the new process the Learning and Quality Assurance Subgroup will be fundamental in gathering information and assessing if a SAR referral has met the criteria with the final decision being made by WSAB and the Independent Chair.

In cases that do not meet SAR criteria the group can elect to hold a Brief Learning Review to quickly and efficiently establish learning to share back to the WSAB.

For more information about out Case Review Process click here.

Family Safeguarding Model

At the August 2024 Board Wigan Council Children's social care presented the introduction of the Family Safeguarding Model in Wigan. This replaces the Signs of Safety Model. The model includes adult services from across the partnership forming part of a team around families in need.

The presentation gave an opportunity for partners to be familiar with the changes and discuss how the Board can support implementation. More details can be found about the model on the Wigan Safeguarding Children Partnership website using the following link Family Safeguarding - Wigan Safeguarding Children's Partnership

Acronym Glossary

The Learning and Quality Assurance Subgroup worked together this year to create an updated glossary of commonly used Acronyms. Albeit it is encouraged to avoid the use of agency specific acronyms where possible, the glossary was produced to help new members to Wigan. Link: Acronym Glossary

S140 MHA Policy

In 2024 inconsistent access to urgent mental health placements was recognised, resulting in a number of strategic actions being implemented across the partnership. Central to this was the launch of the Section 140 policy, which went live on 22 July 2024. The policy provides a consistent framework for bed identification, escalation of bed options and the development of risk management and support plans within the community. It aims to reduce variability in practice and improve the timeliness and appropriateness of responses for individuals in crisis.

Monitoring of Section 140 activity is now being led by Adult Social Care (ASC), with data being fed into both the Mental Health Law Forum and the Mental Health Transformation Board to support system-wide oversight and continuous improvement. A formal review of the policy has been requested through the Mental Health Law Forum to ensure it remains responsive to operational needs and aligned with best practice.

In addition, the Integrated Care Board (ICB) and Greater Manchester Mental Health (GMMH) are working collaboratively to establish a commissioning approach for Section 140 placements. This will support consistency across the region and strengthen alignment between policy and commissioning decisions. A scheduled review of the

policy will further ensure it continues to meet the needs of service users and professionals alike.

Case Recording and Use of Appropriate Language

A key development has been the introduction and endorsement of new guidance on case recording and the use of appropriate language in safeguarding practice. This guidance was developed in response to learning from safeguarding adult reviews and customer feedback, which highlighted the profound impact that language can have on individuals' experiences of care and protection. It encourages professionals to write with kindness, clarity, and respect, ensuring that records reflect not only factual accuracy but also compassion and dignity.

To support implementation, practical examples have been shared with staff across the partnership, illustrating how thoughtful language can positively shape outcomes and relationships. The Board has asked all partners to provide assurance of adoption or evidence of similar policies in place, reinforcing our collective commitment to respectful and person-centred practice.

This initiative reflects our shared values and the belief that safeguarding is not only about protection but also about how we communicate, listen, and respond. By integrating customer voice and promoting kindness in our language, we continue to build a culture of care that is both safe and empowering for adults across Wigan.

Early Intervention and Prevention

Risk and Complexity Pilot

This year a new pilot was launched, created collaboratively by the WSAB, the process was aimed at early intervention and prevention from Adult Safeguarding Alerts. The pilot focusses on cases that do not meet s.42 Care Act Criteria following triage, but it is concluded that through a key worker approach tangible outcome around early intervention and prevention could be achieved to delay or prevent future need. A new pathway was created between Adult Social Care and the Prevention Hub. A team of key workers complete multi-agency checks and progress the case with a view to supporting individuals in need.

Within the reporting period 335 Alerts have been referred to the Prevention Hub of these reports 65% of cases had successful contact and input. An example case of this pilot is summarised below:

D was referred to Adult Social Care via a safeguarding route from a family member living abroad. Concerns raised had been around the condition of the property D resided in and the risk of losing their tenancy through eviction. The case was referred to the Prevention Hub.

By working closely with a key worker, it was established that an eviction notice issued to D was not legal. Further work from the key worker with the housing standards team indicated that property was unsafe, and that the landlord had not been fulfilling their duties as a private landlord, which was dealt with.

The key worker worked with D to secure an alternative property. As part of this work the key worker and fellow prevention hub staff facilitated moving all of D's belongings to a new tenancy. In the new property D received ongoing support from the key worker and tenancy support teams. Multiple household goods were sourced from charities and external organisations. D is now living in the new tenancy independently and happily. A video with the key workers and D was presented to WSAB showing the remarkable transformation in living conditions. D commented in the video that the key worker "had helped a lot and doesn't know how much help she had been over the last few months". D further commented if not for the intervention they would have been out on the streets.

Further work around the pathway will continue into 2025.

Integration of customer relations to board

The Customer Relations Team (Adults), responsible for managing feedback across adult social care, formally integrated into the Wigan Safeguarding Adults Board. This strategic alignment reflects our commitment to embedding the voice of residents at the heart of safeguarding practice. By linking key learning from compliments, complaints, and concerns directly into safeguarding discussions, we've strengthened our ability to drive service improvements and promote a culture of continuous learning. The integration has enabled us to celebrate impactful case studies, share best practice, and enhance partnership working across agencies. Together, we are ensuring that feedback not only informs but transforms the way we protect and support adults at risk in Wigan

Dashboards created including self-neglect

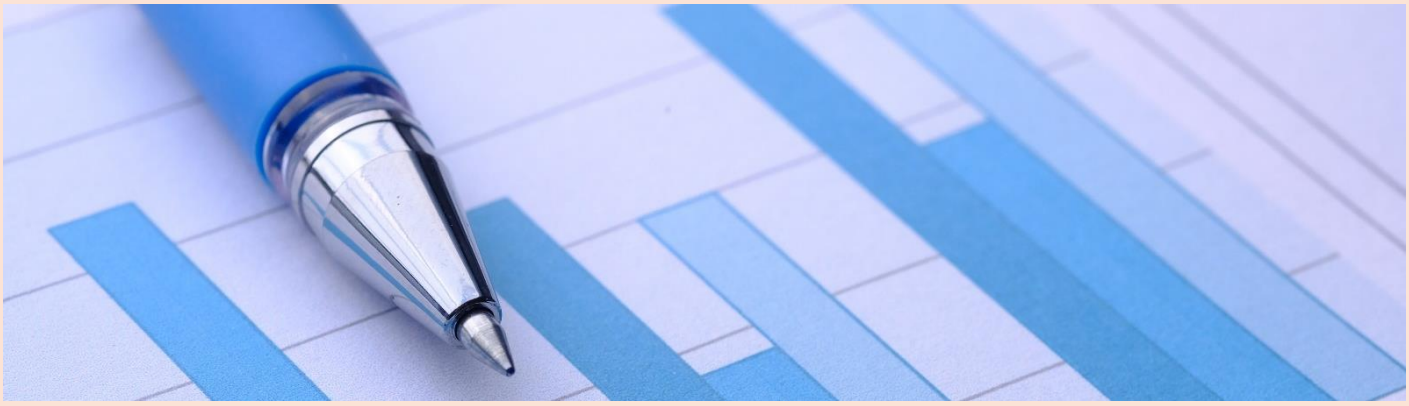
In collaboration with Wigan Council's Performance Insight Unit, the Wigan Safeguarding Adults Board (WSAB) has developed a suite of Safeguarding Dashboards to strengthen strategic oversight and operational delivery across the safeguarding partnership.

These dashboards offer a comprehensive, single-view representation of the Adult Social Care safeguarding pathway—from the initial alert through to case closure. They enable detailed performance monitoring and data-driven analysis, supporting a more informed understanding of safeguarding activity and outcomes.

Importantly, the dashboards allow users to drill down into specific areas of focus, such as abuse categories and repeat safeguarding concerns. This capability enhances the

partnership's ability to identify emerging trends, target interventions, and continuously improve safeguarding practice.

Crucially, the insights generated are aligned with the broader safeguarding partnership, fostering a more integrated and responsive approach to safeguarding adults across the borough.



Risk Management

The Wigan Safeguarding Adults Board (WSAB) Risk Register outlines key strategic and operational risks currently live across the safeguarding partnership. Each risk is assessed in terms of its impact, likelihood, and mitigation status, with ownership clearly assigned across relevant agencies.

The register reflects a complex landscape of interdependent risks requiring coordinated multi-agency responses. It highlights the importance of:

- Integrated planning and commissioning
- Robust governance and oversight
- Proactive workforce and capacity management
- Data-informed decision-making

Safeguarding Adult Reviews

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

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

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

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

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

Why do we conduct case review?

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

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

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

Within the reporting period of April 2024 to March 2025 we concluded 1 Safeguarding Adult Review. Additionally, is a link to SAR Una which concluded late March 2024.

Links for both can be found below:

SAR - Jayne

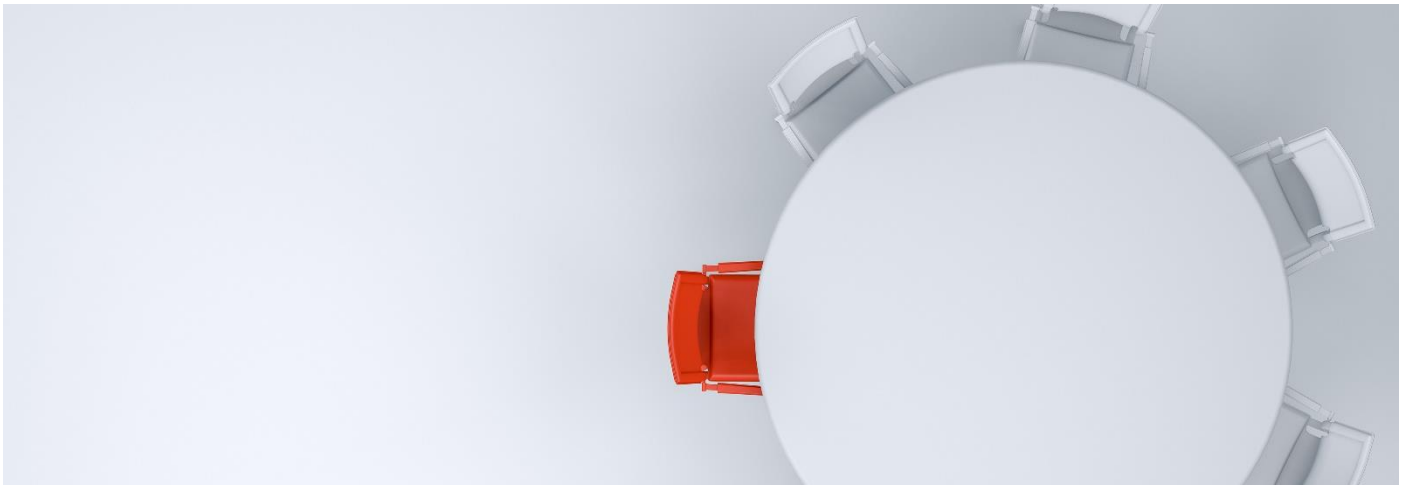
SAR - Una

Within the reporting period of April 2024 to March 2025 we concluded 2 Baseline Learning Review's (BLRs).

Both **BLR Action Plans** highlight a strategic shift towards more proactive, person-centred safeguarding through improved multi-agency collaboration, professional curiosity, and trauma-informed practice. A key theme is the importance of early identification—whether through flagging repeat safeguarding alerts, monitoring missed prescriptions, or encouraging staff to explore underlying causes of disengagement. This is supported by refreshed training and system changes, such as mandatory referral fields and strengthened MDT coordination.

Practice has already evolved in tangible ways: for example, safeguarding forms now require consideration of fire risk referrals in hoarding cases, and pharmacy-GP links are

being used to identify potential self-neglect. These changes reflect a growing emphasis on consistency, curiosity, and shared responsibility across agencies, ultimately leading to safer and more responsive care.



Partnership Activity

As part of our commitment to transparency, accountability, and continuous improvement, the Wigan Safeguarding Adults Board (WSAB) asked partners to report back activity for our Annual Report period April 1st 2024 - March 31st 2025.

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

Please see Appendix 3 for full details of these returns

Data

Please see appendix 4

Financial Contributions

Agency	Amount
Greater Manchester Police – GMCA Funded	£16,038
Wrightington, Wigan & Leigh NHS Foundation Trust	£15,000
Greater Manchester Mental Health Trust	£12,000
Greater Manchester Integrated Care Partnership	£52,000
Wigan Council	£260,588
TOTAL	**£355,626**

Looking ahead to 2025 - 2026

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

Strategy & Priorities

We are proud to introduce the Wigan Safeguarding Adults Board (WSAB) three-year Strategic Plan 2025 to 2027 —developed in close collaboration with our Board partners and shaped by the progress we've made together. This plan sets a clear direction for the future, building on our shared commitment to safeguarding and strengthening our communities.

At the heart of our approach is a renewed emphasis on working together captured in our guiding theme, Progress with Unity. Through this lens, we have introduced a robust Quality Assurance Framework (QAF) to monitor progress, inform decision-making, and ensure transparency through regular updates to the Board.

Our refreshed mission, values, and behaviours reaffirm our dedication to person-centred, community-led safeguarding. We continue to adopt an outcome-focused and asset-based approach, ensuring that our work reflects the strengths and needs of the people we serve.

Each year, we will report on our strategic priorities through this annual report, using the QAF to demonstrate impact and guide any necessary adjustments. Our strategy

remains flexible and responsive—ready to incorporate emerging local and national developments, legislative changes, and best practices.

We are confident that this renewed focus on collective action will drive meaningful and lasting improvements. Together, we aim to break down barriers that contribute to financial, health, educational, and environmental inequalities—ensuring fair and equitable opportunities for all.

As we look ahead, the Wigan Safeguarding Adults Board remains committed to its mission:

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

For full details of our Strategy and our Quality Assurance Framework click the following link Strategic plan

Please see appendix 2 for our priorities on a page

Future Structure & Initiatives

Our Structure 25/26

Links to other Strategic Boards e.g.

Wigan Borough Community Safety Partnership

Mental Health Transformation Board

Domestic Abuse Strategic Oversight Board

Family Safeguarding Strategic Board

Wigan Safeguarding Adults Board

Wigan Safeguarding Adults Executive

Links to other Strategic Boards e.g.

Wigan Safeguarding Children's Partnership

Reducing re-offending board

Carers strategic Partnership Board

Care home support & Development Board

Link to WSCP Exec**

Learning & Quality Assurance Group | Organisational Safeguarding Group | Self-Neglect, Risk and Complexity Group | MCA / DoLS* Group | Transitional Safeguarding

Task and Finish Groups Aligned to key work

**Mental Capacity Act / Deprivation of Liberty Safeguards*
*** Wigan Safeguarding Children's Partnership Executive*

Data

Following the inception of the Partnership Data Group, our future ambition is to build a more integrated, intelligence-led approach to data across the Adult Safeguarding Partnership. We aim to strengthen collaboration between partners by developing shared data standards, improving interoperability, and embedding a culture of proactive insight generation. This will enable us to move beyond reactive reporting and towards proactive insights that inform strategic decision-making, drive service improvement, and ultimately enhance outcomes for adults at risk in Wigan. By aligning our data efforts, we will create a more transparent, responsive, and person-centred system that supports continuous learning and innovation.

Pride of Adults Safeguarding Awards

Wigan Safeguarding Adults Board recognise that working together with our communities and helping people live safer and happier lives is key to improving outcomes. As a Board in line with Progress with Unity we have a unique and genuine commitment to work together as a collective for the good of the borough.

In line with Progress with Unity we have created an awards process that creates a new multi-agency award for practice, initiatives and community involvement that recognises excellent work that demonstrate tangible outcomes.

There will be six annual awards in line with the six key principles that underpin all adult safeguarding work. In addition, we are pleased to also recognise work undertaken on a more regular basis with a special recognition award. You will be asked to confirm which awards you are submitting your nomination for within the nomination process.

Award categories

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership

- Accountability
- Special Recognition.

You can find further information about the Pride of Adult Safeguarding Awards including the award categories and how to nominate by clicking the following link Pride of Adult Safeguarding Awards

What's Up Network

Following on from our fantastic year developing our What's Up Champions we aim to develop the network with the introduction of What's Up Ambassadors. In line with our commitment to early intervention and raising the awareness of safeguarding adults we will develop a new training and awareness offer to staff and leaders within community settings. This network will look to create new ways to raise awareness around Safeguarding adult topics and create a feedback loop back to WSAB.

Appendix 1 – Our Values and Behaviours

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

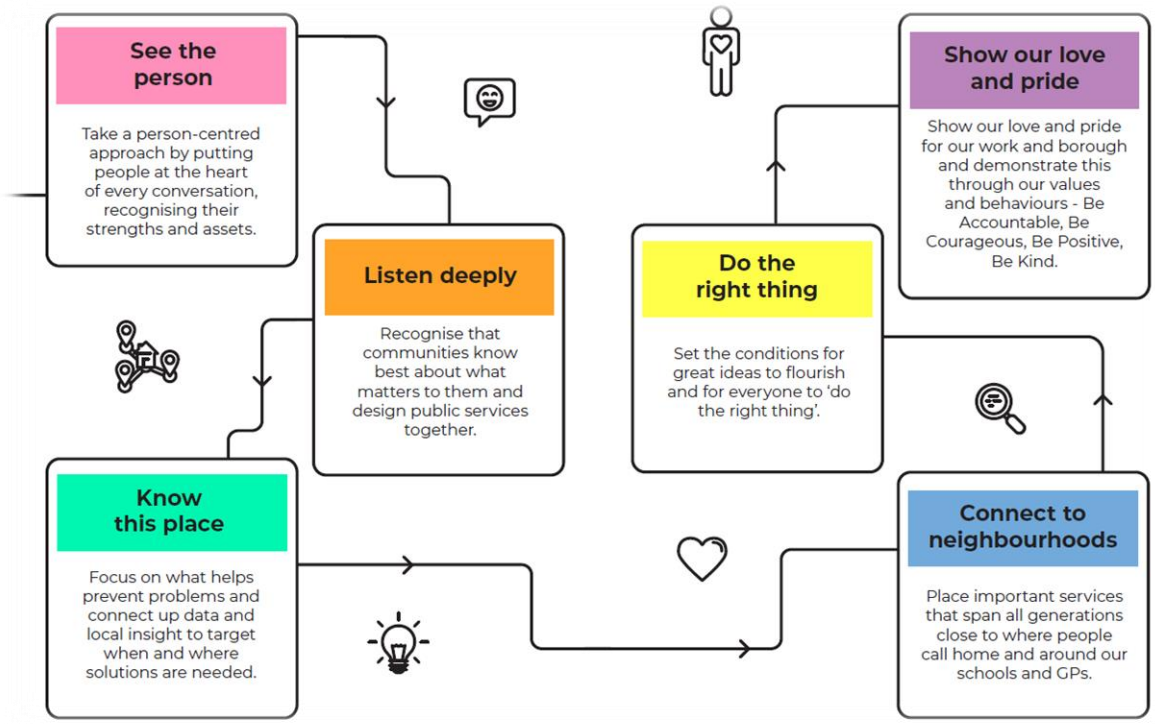
Listen Deeply
Recognise that communities know best about what matters to them and design public services together.

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

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

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

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



Appendix 2 – 2025 to 2027 Priorities on a Page

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

Appendix 3 – Partnership Activity

Greater Manchester Integrated Care Partnership (NHS GM)

Area of Work	Activity Undertaken (2024–2025)	Outcomes / Impact	Planned Activity (2025–2026)
Workforce Development	Training materials (PowerPoint Presentation) regarding the assessment of capacity has been developed and shared with Primary Care. The purpose of the training materials is to inform and improve the assessment of capacity including reference to the two-stage test.	A better understanding of the Mental Capacity Act and improved assessment of capacity.	Examples of real-life mental capacity assessments (case studies) to be shared across Primary Care to help inform future cases where the assessment of capacity is necessary.
Policy & Procedure Updates	Guidance re: Supporting Victims of Domestic Abuse drafted in conjunction with DIAS and shared with Primary Care to improve the current offer to victims of domestic abuse.	GPs better informed and delivering an improved and more robust response to victims of domestic abuse.	To revisit and update the Domestic Abuse Champions project by offering further training dates.
Multi-agency Working	The Hoarding Toolkit was shared across Primary Care to improve the response to people who display this behaviour and in doing so ensure a multi-agency approach to meeting their complex health needs.	A better understanding of hoarding and how best to respond to the same.	The Hoarding Toolkit is to be presented at the GP Safeguarding Leads Forum including a case study to facilitate discussion.
Learning from Reviews	The learning from Safeguarding Adult Reviews (SARs) in terms of key themes has been shared with Primary Care.	GPs better informed about the learning to emerge from SARs which in turn informs and improves practice.	The learning from SARs and DHRs is to be presented at the GP Safeguarding Leads Forum.
Community Engagement	Although not a patient facing organisation, NHS GM does have contact with members of the community via Section 42 Enquiries and the Complaints Procedure. Both processes provide opportunities to learn and improve practice.	This past year has seen significant learning emerge from both processes in respect of self-neglect and care of the elderly respectively. The impact of the learning is that increased efforts have been made to better engage Primary Care in both processes.	An audit to be undertaken regarding Primary Care's contribution to self-neglect cases with findings to be presented to WSAB.

Greater Manchester Police (GMP)

Area of Work	Activity Undertaken (2024–2025)	Outcomes / Impact	Planned Activity (2025–2026)
Workforce Development	Introduction of the Domestic Abuse Team (DAT) DAT are responsible for processing prisoners and continued investigation of high risk DA incidents. DAT introduced in November 2024 Additional training delivered to all staff dealing with DA around the use of evidence led investigations where victims do not support a criminal investigation but there is sufficient evidence to pursue a prosecution. DAT has contributed to improved outcomes for DA abuse at Wigan. Current YTD outcomes for DA are 16.4% which is second highest in GMP and above target KPI of 15.5%. DA outcomes for high-risk DA investigated by DAT at Wigan are 48%.	Impact – 84 DAPO's have been granted at Wigan since launch. Currently 51 Live DAPO's at Wigan These provide valuable safeguarding to victim's of DA. Number of breaches have resulted in custodial sentences for offenders and extension of DAPO's. Positive feedback from victims, GMNP currently rolling out to other Districts	Further training around the use of evidence led prosecutions. Training regarding identifying signs of cuckooing, particularly around vulnerable adults and care leavers.
Policy & Procedure Updates	Review of local procedure around DVDS (Clare's law). DI Preston has completed a review and introduced a new process to ensure applications are progressed efficiently and in line with force policy. Introduction of DAPO's as part of GMP pilot. DAPO's launched November 2024 as part of GMP Pilot. Wigan second District to 'Go live'. Reintroduction of the DA Delivery improvement subgroup to review processes around DA to ensure they are effective and fit for purpose.	Impact – timely progression, currently meeting target of disclosure being given within 28 days of application being received. 84 DAPO's granted by courts at Wigan. Currently 51 live DAPO's. There have been a number of suspected prosecuted for breaching DAPO's which has resulted in custodial sentences. Positive feedback from victims. GMP rolling out DAPO to other Districts based on success.	Continue to review processes to ensure they are efficient and in line with current policy.

		Review completed for MARAC and action plan created to ensure process is improved in line with MARAC audit recommendations.	
Multi-agency Working	Introduction of joint governance for suspected victims' of cuckooing. Initial review meeting identified gaps around service for victim's of cuckooing. This has led to a new process being drafted across the partnership to ensure consistent information sharing and proactive approach to address concerns around vulnerable adults being cuckooed. GMP have introduced 'cuckooing car' to provide multi agency support to suspected victim's and to put safeguarding measures in place.	Impact – Victim's of cuckooing are being identified through information sharing and proactive approach taken to safeguarding.	Further work at strategic level to introduce new cuckooing policy for the partnership.
Community Engagement	DA week of action has seen engagement with hairdressers and gym's in repeat locations for Stalking. Training provided by DAIS and joint visits completed with police PCSO's attendance at drop in sessions at family hubs to offer advice and support.	Increased awareness of stalking behaviours and how to report to police.	Increased focus on addressing violence against women and girls and safer spaces. Increased visibility in hotspot areas which include Town centre with focus being on Nighttime economy. Increased use of cuckooing car to engage with potential victim's

Greater Manchester Mental Health (GMMH)

Area of Work	Activity Undertaken (2024–2025)	Outcomes / Impact	Planned Activity (2025–2026)
Workforce Development	The Corporate Safeguarding Team delivered the following training sessions in 2024-25: • Level 3 Safeguarding Adults • Level 3 Safeguarding Children • Chairs training – Section 42 • Section 42 Enquiry • Mental Capacity Act • Historical Disclosures of Abuse	Increased knowledge and staff awareness of safeguarding. Staff have access to resources to support their learning and response to safeguarding concerns. Immediate access to learning in response to new and emerging themes.	Development of a Trust wide Safeguarding newsletter. Increase in bitesize learning sessions available to staff. Review of the Trust wide Level 3 Safeguarding Adults Training to ensure continued alignment to the Intercollegiate document and single/multi-agency learning. Development of a safeguarding resource pack for all staff.

- Parental Mental Health and the Impact on Children (delivered to multi-agency partners)

In addition to the L3, S42 and Enquiry Chair Training, in Q3 2024-25 new Bitesize training sessions launched in response to key themes from learning:

- Wilful Neglect – legalities/roles/responsibilities
- Safeguarding Children - including the safeguarding response, professional curiosity, think family and recording processes
- Domestic Abuse Policy re-launch module
- Section 117

The following briefings have been completed during 2024-25 in response to key learning and themes emerging from internal and external multi-agency reviews:

- Self-Neglect and MCA
- Care Leavers
- Prevent and radicalisation
- Domestic Abuse – policy and resources
- Professional Curiosity
- Private Fostering
- The National CSPR Report on child sexual abuse in the family environment
- Serious Youth Violence
- Distressed Behaviours

'Let's Talk about Domestic Abuse' - training developed and delivered. This training is available via the GMMH Recovery Academy and was co-developed and co-delivered by an adult

Quarterly Impact of Training audits.

	with lived experience and the Corporate Safeguarding Team. It is available for both staff and service users. In response to Learning, the Corporate Safeguarding Team co-developed and co-delivered an event in relation to Professional Curiosity during Q4 2024-25. New network established for identified Champions, facilitated by the Corporate Safeguarding Team; and Champion role supported by 'Champion Role Descriptor.' The safeguarding intranet pages were refreshed and updated during Q2 2024-25. Safeguarding is now more visible on the homepage and links are now available to the local authority safeguarding pages for referrals, advice and support.		
Policy & Procedure Updates	The Trust has a comprehensive suite of safeguarding policies, procedures, and practice guidance, alongside the multi-agency procedures, which support staff to identify and respond to safeguarding concerns. These are accessible on the staff intranet. A total of **6** Trust policies reviewed and ratified in 2024-25, **5** of which are owned by the Corporate Safeguarding Team. The remaining 3 policies owned by the Corporate Safeguarding Team were ratified in 2021 and 2023 and remain in date.	Staff have access to policies and procedures which are current and in line with national legislation and local procedures and guidance.	Ongoing review of policies and procedures and the Trust intranet page which is accessible to all staff.
Multi-agency Working	GMMH is an established provider and partner across the existing multi-agency safeguarding system. We are represented at Safeguarding Partnerships, Boards and their sub-groups across **6** Local Authority areas. We participate in Rapid Reviews, Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, and Domestic Homicide Reviews across the GMMH footprint, and disseminate lessons learnt which are integrated into our safeguarding training, briefings and guidance. During 2024-25 the Trust has contributed to the following:	The Trust is an active partner and contributes to multi-agency partnership working. The Trust is able to provide assurance/identify areas for improvement.	Further mapping of GMMH representation across the partnership Board and sub-groups. Ongoing engagement in partnership working.

	Engagement with the newly established Multi-Agency Risk Panels across the localities • Engagement with the 6 local Safeguarding Health Collaboratives • Safeguarding Board/Partnerships Annual Reports • Section 11 Children Audits in all required localities • Self-assessment tools in relation to the effectiveness of our safeguarding arrangements • 'True to Us' work in relation to Serious Youth Violence • Spotlight Reports in response to safeguarding themes and learning • Delivered multi-agency Parental Mental Health training across the Safeguarding Partnerships • Delivered presentations to Safeguarding Boards in relation to the Trusts Improvement Plan and our safeguarding improvements and developments		
Learning from Reviews	During 2024/25, The Trust developed a module for all Multi-agency Safeguarding Reviews (SAR's, DHR's and CSPR's) and associated action plans. This will enable a central system, Trust wide and locality dashboards to be developed which will show review activity and progress against actions/identified learning. It will also help aid the triangulation of themes and hotspots. In Q4 2024-25, the Trust were engaged in **31** active Multi-agency Safeguarding Reviews. In response to learning from reviews the Trust has initiated the following to support the embedding of learning: • Safeguarding briefings • Bitesize learning sessions • Safeguarding contributions to the Trusts Patient Safety newsletter. • Updated safeguarding training packages to include new and emerging themes and learning.	The Trust has oversight of all multi-agency safeguarding activity and learning.	The development of dashboards which will support multi-agency review activity oversight and reporting to the Divisions/Care Groups. To continue to develop the content within the Learning from Reviews Report.

	Development of a quarterly Learning from Reviews Report which is presented to the Safeguarding Assurance Group which includes all multi-agency review activity and learning.		
Community Engagement	The Trust Service User and Carer Experience Team have responsibility for developing, implementing and monitoring our Trust strategies and for the operational policies that underpin them. The team are also responsible for supporting operational services to develop, implement and monitor their own local action plans to help the Trust achieve its strategic aims. The **Recovery Academy** is just one way we engage with service users and carers at GMMH. It is based at our purpose-built education centre, The Curve, on our Prestwich site. It offers educational resources about mental health, addiction, and recovery including self-help materials; self-help videos; e-learning packages and webinars/seminars. All our resources are co-produced and co-delivered between professionals with expertise in the relevant subject, and people with lived experience. The emphasis is on shared learning to reduce the stigma associated with mental health and learn about different conditions, coping strategies and interventions that promote recovery. The Trust actively encourages service-users and carers to provide feedback on their experiences.	Engagement with service-users and carers which informs Trust strategies and policies and supports recovery.	Ongoing improvements to be made in response to service user and carer feedback.

Greater Manchester Fire & Resue Service (GMFRS)

Area of Work	Activity Undertaken (2024–2025)	Outcomes / Impact	Planned Activity (2025–2026)
Workforce Development	Corporate support for the introduction of two new roles, Safeguarding Learning and Quality Assurance Officers to assist Prevention Managers in quality assuring, safeguarding activity and enhancing learning and development activity.	To be measured across 25/26	Support Wigan SAB's Multi-Agency Training on Section 42 Assessment. Development and delivery of awareness campaigns across GMFRS.

			Introduction of regular 'Safeguarding Learning Briefs' and forums to disseminate learning from reviews via station-based workshops etc. Introduce scenario-based face to face learning sessions tailored to fire service contexts (hoarding, self-neglect, exploitation).
Policy & Procedure Updates	Embedded safeguarding in GMFRS Operational Frameworks through inclusion in Standard Operating Procedures (SOP) for the following incident types: Attending Incidents - Safeguarding (Operational Information Card) • Safe Working at Height SOP • Person in Crisis Operational Guidance • Missing Person SOP	To be measured across 25/26	Monitor number of safeguarding referrals relating to each incident type. See feedback from Firefighters on effectiveness of inclusion in SOP i.e. has this made a difference to hand over meetings etc.
Multi-agency Working/ Learning from Reviews	Following a fatal incident in Wigan in 2023 involving an individual with care and support needs, Reg Dempster, Prevention Manager worked with Wigan Adult Social Care lead and Safeguarding Board to increase awareness of fire safety training. This developed into an initiative to ensure domiciliary providers attend fire safety in the home training with the view of preventing future incidents within these settings. The activity took place across 2024-5 and continues.	Increase representation of domiciliary care providers attending GMFRS training	GMFRS will continue to promote our training offer and the importance of fire safety in the home to relevant organisations.
Community Engagement	GMFRS lead a targeted campaign to raise awareness of child exploitation focused on young people/adults engaged in complex safeguarding provision at the GMFRS Training and Safety Centre in Bury. The project was called 'The Takeover'.	Increased referrals into Catch 22 County Lines Rescue Team; improved awareness of GMFRS prevention offer. Continued engagement.	Continue to develop content and delivery of The Takeover in line with trends and feedback from social/youth workers and the community.

Greater Manchester Probation Service

Area of Work	Activity Undertaken (2024–2025)	Outcomes / Impact	Planned Activity (2025–2026)

Protect the public from serious harm	• During this business period GMPS has delivered improvements across both performance metrics and quality assurance and secured a place as best performing region nationally	Improved performance and delivery of service	Continue improvements in performance
	• GMPS has efficiently managed significant change in response to wider criminal justice initiatives and the prison population crisis. This including early release schemes, SDS40, Probation Re- set and PRARR	Safe and effective management of significant change including early release of prisoners	Continue effective change management that supports public and victim protection
	• GMPS has delivered a new Domestic Abuse and Safeguarding Information Team (DASIT) to focus on accurate and timely information and checks to support practitioners and protect victims	Streamlined and centralised DA and Safeguarding check system	Further establishment of the DASIT team
	• GMPS work with victims of violent and sexual offending who are assigned a Victim Liaison Officer who provide updates regarding the case. This service enables victims views and concerns to be reflected in sentence and risk management plans	Supports victim protection and voice in risk management	Continued delivery of the Victim Contact Scheme
Reduce Reoffending	• Maximised use of CAS3 accommodation with increased units made available via collaboration with local partners and improved performance across accommodation service level metrics	Increased individuals in suitable accommodation	Continued use of CAS3 accommodation and maintained links with local authority colleagues to support positive accommodation outcomes for cases
	• Greater Manchester Integrated Rehabilitation Service (GMIRS) co-commissioning has delivered excellent performance across accommodation, ETE, Dependency and Recovery, Wellbeing services and outcomes	Improved access for individuals to range of quality rehabilitation services Availability of new Accredited Programme	Continued high referral to range of commissioned services and new services added in accordance with need
	• Successful roll out of new Accredited Offending Behaviour Programme, Building Choices, with positive performance across compliance and completion measures		Increased volume of Accredited programme completions
Workforce development	• A national policy framework continues to inform all safeguarding work	Framework and for safeguarding practice Mandatory training in place	Continued adherence to safeguarding policy and process requirements Staff completion of mandatory Safeguarding training
	• Mandatory Adult Safeguarding and Domestic Ause training is completed by all staff on an annual basis		
	• All cases are subject to detailed and complex analysis to identify risks and needs, including to who, nature,	Improved risk assessment and risk management work	Staff audit and development work to improve quality

	imminence and impact. Risk management plans are formulated to manage risks, protect victims, co-ordinating the services of other agencies as required • Implementation of GMPS Quality and Assurance Team/Strategy with audit regime and focus on quality improvement	Increased focus on quality improvement	Continued audit and practice develop activities
Multi-agency working	• Probation lead on MAPPA arrangements that provide the formal structure for the multi-agency management of the most complex cases and includes contribution from adult safeguarding services. There were 71 MAPPA Level 2/3 meetings chaired by Wigan probation during this business period • Probation Practitioners and managers contribute to MARAC and MATAC processes and meetings • Greater Manchester Integrated Offender Management (IOM) is the highest performing region nationally. There have been over 4000 joint probation and police home visits with a 91% desistance rate and 76% compliance rate.	Effective multi agency management of complex cases presenting high levels of risk of harm Improved multi agency management of cases Effective management of IOM cohort	Continued chair of MAPPA meetings at Level 2 and 3 Contribution to the development of MARAC/MATAC process and attendance at meetings Continued development of IOM work

Wrightington Wigan and Leigh NHS Trust (WWL)

Area of Work	Activity Undertaken (2024–2025)	Outcomes / Impact	Planned Activity (2025–2026)
Workforce Development			
Safeguarding Operational Group (SOG)	The Safeguarding Operational Group (SOG) was established as a formal subgroup of the Safeguarding Effectiveness Group (SEG). This structure enhances organisational insight into emerging safeguarding trends, enabling more responsive and informed decision-making by improving safeguarding governance. SOG meetings are held monthly and chaired by the Named Nurses and Named Midwife.	Regular attendance at the Safeguarding Operational Group (SOG) provides a valuable opportunity to share monthly operational updates, identify emerging safeguarding themes, and promote early learning from incidents across the organisation.	There is a plan to complete a survey on the effectiveness of SOG. Data gathering will capture participant satisfaction while providing opportunity to influence future sessions. Further surveys will support evidence of information dissemination and provide assurance for equity and inclusion to the WWLTH workforce.

Least Restrictive Practice	A Trust-wide Least Restrictive Improvement Plan was developed and is being implemented by a least restrictive working group, with the WWL Think Family Safeguarding Service (TFSS) leading delivery of enhanced Crisis Prevention Intervention (CPI) training programme that now includes additional Mental Capacity Act and Medicines Management competencies. The rationale for this workstream was to promote safer, more dignified care by equipping staff with the knowledge and skills needed to apply least restrictive practices confidently and lawfully, while embedding learning from incidents and audits across WWLTH. Continued assurance in relation to Organisational Abuse not being the cultural norm within WWL is now able to be robustly provided.	The implementation of the Trust-wide Least Restrictive Improvement Plan, led by the newly established working group and supported by TFSS through enhanced CPI training, has had a positive impact across WWLTH. By embedding Mental Capacity Act and Medicines Management competencies into training, staff are now better equipped to deliver care that is both safe and respectful of patient autonomy. Development of associated policies and procedures have ensued offering consistency and quality of care provided.	This workstream will continue in 2025-2026. It has strengthened knowledge and legislation of least restrictive practices, while ensuring that learning from incidents and audits informs continuous improvement and promotes a culture of dignity and legal compliance.
Develop a Think Family Safeguarding Level 3 training program	Development of a joint Level 3 safeguarding training via a Think Family approach A Think Family approach is a preferred model of safeguarding training as it recognises the interconnectedness of children, adults, and families including those in care or with care experience. It supports staff in understanding how adult issues can affect children and vice versa promoting holistic, coordinated safeguarding that improves outcomes across the family unit encapsulating a trauma awareness and alertness response that translate to provision of trauma informed care and provision.	New Think Family Mandatory level 3 Safeguarding training was officially rolled out in July 2025 however the pilot sessions were delivered in November 2024. Feedback from the pilot sessions has been positive. Staff are finding real case scenarios impactful in supporting and empowering them to ensure application of the safeguarding duties. This delivery model creates wider opportunities to ensure learning from local reviews is embedded into every day practice creating change at a granular level to improve patient outcomes.	Compliance against the new delivery model needs careful review and oversight along with consideration of evidence of how training improves the skills, knowledge and competence of the WWLTH workforce. This will be captured through close monitoring of safeguarding activity.

Improving patient experience			
Care leavers maternity pathway	A multi-agency Maternity Pathway for Care Leavers was developed to provide coordinated, individualised support throughout pregnancy and early parenthood. This was implemented to ensure care leavers receive tailored, consistent support that addresses their unique vulnerabilities and promotes positive outcomes for both parent and child during the perinatal period.	In early stages therefore outcome and impact is difficult to measure however initial feedback has highlighted positive gains from ensuring professional collaboration to support individuals who have care experience whereby their acceptance of services maybe be reluctant due to negative prior involvement. This agenda promotes a Think Family and Trauma informed approach through collaboration that is considerate of the impact of transitions.	Use lived experience to develop our offer and improve our service to care leavers. Plans are already underway for Care leavers to speak at Safeguarding Champions, use their voice to deliver training and included on interview panels when recruiting new staff.
Alignment of governance processes to strengthen organisational safeguarding response	In alignment with the NHS Patient Safety Incident Response Framework (PSIRF), the Think Family Safeguarding Service (TFSS) conducted several After Action Reviews (AARs) to examine safeguarding-related incidents and identify areas for learning and improvement. The aim of this workstream, was to foster a positive safety culture by encouraging staff reflection, promoting shared learning, and strengthening safeguarding practice through open, constructive engagement.	Aligning governance processes with safeguarding processes ensures strategic oversight, accountability, and consistency within the organisation. This strengthens the organisations response to safeguarding incidents whilst facilitating wider reach of safeguarding consideration and intervention outside of direct activity completed by the safeguarding service.	Review of adherence to internal processes is planned to consider impact of change and provide assurance as to the Trust and wider partnership response to patient safety incidents that highlight harms and/or abuse in line with Care Act legislation.
Data collection			
Development of a data dashboard	Progress has been made in developing a Safeguarding Data Dashboard, with Datix now aligned to abuse categories and ongoing optimisation of SystmOne. An improvement proposal has also been endorsed by internal Safeguarding Effectiveness Group and accepted by the HIS advisory board.	This is required to enhance safeguarding data visibility and reporting accuracy across the organisation, addressing challenges posed by multiple IT systems and varied Electronic Patient Records (EPRs), and to support more informed decision-making and governance.	Completion of HIS optimisation to streamline safeguarding activity, whilst capturing the voice and lived experience of the patient. The work around HIS optimisation will be the foundation for the safeguarding data dashboard providing assurance of safeguarding recognition and response across WWLTH.

		Improvements in data integrity will better identify emerging themes and trends on an individual and population level to illicit safeguarding intervention that is proactive not just reactive. Data will be able to link families along with attendance and service use as a collective picture of safeguarding incident and activity as opposed to current provision of standalone events.	
Policy & Procedure Updates			
Policy & Procedure Updates	A suite of safeguarding policies and Standard Operating Procedures (SOPs) were updated and ratified to reflect changes in national and regional guidance, providing clear expectations for staff. To ensure the workforce is equipped with consistent, up-to-date guidance on recognising and responding to specific safeguarding concerns, supporting safe and legally compliant practice across the organisation. Safeguarding specific policies along with generic ones that now have a stronger safeguarding content have been implemented, reviewed and ratified to promote a knowledgeable and competent workforce.	WWLTH has again been recognised across Greater Manchester (GM) as having the highest compliance achieved with the Integrated Care Board (ICB) Safeguarding Contractual Standards. Detailed review of our policies and procedures is standard within the assurance framework.	Review of key policies linked to national and local initiatives such as PREVENT and Right Care Right Person to ensure professional confidence with safeguarding intervention in relation to specific scenarios such as Radicalisation and Missing Patients (hospital walkouts).
Multi-agency Working			
Royal Bolton Hospital Collaboration	The WWLTH TFSS have established a positive professional relationship with the safeguarding team at Royal Bolton hospital. Safeguarding peer support with a neighbouring trust provides an opportunity to strengthen practice through shared learning, collaborative reflection, and consistent system-wide improvements.	This has been a valuable opportunity to facilitate shared learning and professional development through collaborative case reflections and cross-organisational supervision. Additional benefits to patients and service user who access both	Continued peer review will support assessment, monitoring and feedback about the quality of the information provided to our workforce. Constructive feedback will promote standards of care empowering colleagues and evoking change as needed. Additional external safeguarding supervision can be accessed within a safe space

		organisations from consistency of response and intervention.	
GMMH	Continuous and consistent review of shared policies and procedures alongside facilitation of learning events via After Action Review model to improve care pathways and patient experience for individuals accessing services within both organisations.	This collaboration has enhanced practitioner confidence, improved cross-organisational communication, and supported more timely interventions to those at risk of mental health crisis.	Ratification and implementation of Makerfield Suite Standard Operating Procedure to ensure consistency of support and care for those attending WWL A&E department when suffering mental health crisis. Additional liaison and communication to support WWL patients who are detained under MHA section.
WSAB/ Community Safety Partnership	Presence and engagement at WSAB and Community Safety Partnership Executive and sub-groups. Support and involvement with multi-agency audit, policy production and training has been maintained throughout the reporting period	Enhance the collective safeguarding response across all WSAB partner agencies to promote consistent, coordinated provision and ensure continuity of support throughout the borough.	Further engagement in Multi-agency training: Mental Capacity Act and Section 42
Learning from Reviews			
Brief Learning Review- Ava	Learning points from the *Ava* review have been encompassed in the new Level 3 think Family Safeguarding with topics such as: • Repeat victim of domestic abuse often having differing partners • Lack of professional curiosity • The complexities of alcohol dependency • Trauma informed approaches	Utilising learning from local reviews supports and promotes effective dissemination of information that provides a vehicle for improvements and changes in practice. WWL ensures that staff are 'connected' to the lived experiences of our patients and service users to promote empathy and compassion to facilitate person-centred decisions that make safeguarding personal.	Next year the TFSS want to develop a one stop resource platform accessible to all colleagues within WWLTH. This would allow staff to have access to up-to-date safeguarding resources including training, learning from reviews, new changes to legislation and priorities within local safeguarding partnerships. There are plans to build into this platform activity review which would provide assurance that staff are utilising the resources.
Domestic Abuse Related Review (DARR) 10	Three of the four DARR held in 2024-2025 were male victims of domestic abuse. Analysis of our data highlighted a 24% increase in male victims seeking support from domestic abuse. As a result, the service continues to promote a gender inclusive approach with safeguarding training encouraging practitioners to be alert to the signs of male victims, avoid gendered assumptions and to respond with diligence and empathy.	By recognising and addressing the rising number of male victims, the service is actively challenging gendered assumptions and ensuring that support is accessible and empathetic for all individuals.	

Community Engagement			
Care Leavers Hub	The WWL CiC Team and wider safeguarding service have developed stronger links with Wigan Council Leaving Care team; weekly visibility in the Care Leavers hub; in addition to monthly 'drop in' and a dedicated CiC Nurse as 'Care Leavers Champion'	Relationships between CiC Nurses and care leavers post 18 is strengthen ensuring the commissioned health advocacy role is fulfilled. Additional activity via engagement with Leaving Care PAs for young care experienced adults has seen a wide variety of social prescribing activity inclusive of wider emotional health and practical support being offered. Recognition of the impact of care leaver status has influence safeguarding responses by the WWL Adult Safeguarding Practitioners which in turn has enables education and insight to be provided to the wider workforce; its is acknowledged that a number of SARs & BLRs completed by WSAB in recent years sadly feature adults with care experience or whose children have entered the system impacting further trauma.	Enhanced and increased care leaver support from the TFSS in addition to that provided by the CiC Nursing Team. Consultation ongoing with care experienced adults in regard to 'flagging' health records with care leaver status and how this may support a 'tell it once' approach to accessing services with options to introduce fast track intervention based on the recognition of the needs of this cohort of individuals.

Wigan Council Adult Social Care

Area of Work	Activity Undertaken (2024–2025)	Outcomes / Impact	Planned Activity (2025–2026)
Monitoring our data to understand the needs of our communities.	Safeguarding Referrals Analysis –	We had a 14% increase in Safeguarding referrals/alerts from the previous year. Neglect & Acts of Omission is the most common type of abuse referred to us over the timeframe. Self-neglect is our fastest growing area of concern. Most abuse occurs in people's own homes. Our	To continue the upward trend of more people being asked their desired outcome when safeguarding referrals are received about them. Ideally all people should be asked what their outcome is. We will utilise s42 training to get this message out, as well as utilising our Advanced Practitioner Forums.

		numbers of people that have been asked what their desired outcomes are when a safeguarding referral has been received about them, has increased from the previous year to 71.5%. This fits with the Board's priority of making safeguarding personal.	
	Analysis of data re Deprivation of Liberty Safeguards (DoLS)	In the last year we received 2816 DoLS applications. We completed 2818 applications over the same period. Due to the volume of DoLS applications and that each one granted is temporary, this is an area of high demand, and we have a waiting list.	We are remodelling how we carry out this work and are moving to a model where we will utilise more external Independent Assessors. We recognise that there are many external providers that will be able to work with us.
Policy Updates	Our Principal Social Worker has worked with the Board to update the Safeguarding Adult Board Policy.	This was to ensure that wherever possible, we are involving people in meetings about them. The default position now is that people are involved in their own meetings and efforts made to support this.	N/A
Learning from Reviews, etc	Our Principal Social Worker has set up regular Reflective Learning forums within Adult Social Care.	It is asked that at least 1 person attends from each team, inc Public Health, and we discuss learning from Safeguarding Adult Reviews, Brief Learning Reviews, MAPPA cases and anything else as required. It's a safe, reflective space for learning.	To maintain this.
Community Work	Various workshops have been delivered about hoarding, and these have been open to a range of people from outside of the council	Awareness has been raised about hoarding and that it is a recognised mental health condition. The sessions have also been aimed at reducing stigma. The sessions have highlighted a gap in services available to sensitively work with people that need help with their belongings, and this has been raised with the council's commissioning manager of provider services for consideration.	To consider more opportunities for meaningful consultations and awareness sessions with the wider public. We wish to improve awareness of adult safeguarding across all communities; to enable people to have clear access to information about abuse and neglect and they are able to report it.
		Our Principal Social Worker is part of the Wigan Borough Inter Faith	To continue this.

		Network, with various faith leaders, which helps ensure that information about safeguarding is accessed more widely in our communities.	
	We have been promoting sessions about The Care Act, Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards that have been free and facilitated by a training company called Edge Training.	People have been able to access expertise, independent of the council.	To continue.
	We have started online information sessions about the Deprivation of Liberty Safeguards (DoLS) for loved ones of people affected by this legal framework.	This is a new offer and is too early to evaluate the impact.	To continue this and to gather evaluations of the information sessions.
Service Provider Links	We regularly have an experienced social worker attending Care Home Forums to keep updated with any updates or priorities for them, and to be on hand for any queries.	We continue to receive high numbers of applications under the Deprivation of Liberty Safeguards, suggesting that care homes are aware of their responsibilities in this area.	To continue this.
Transitional Safeguarding	There has been lots of close work between adults and children's safeguarding leads within the council working towards a transitional safeguarding policy. Our Adults Principal Social Worker and Children's Managers have carried out visits to schools to consult with young people.	Excellent relationships have been built between the Adults Principal Social Worker and Children's managers. We gained meaningful participation from young people that we can incorporate within a transitional safeguarding policy. We have a joint Children's and Adults Safeguarding Board Event in November hosted by Dez Holmes, Director of Research in Practice, to further help us in our development of this policy.	To continue progressing this, which is in line with our Board's strategic priorities.

Greater Manchester Fire and Rescue Service (GMFRS)

Key Achievement

- Partnership with domiciliary care providers led to over 300 staff trained in fire safety, improving multi-agency collaboration and reducing risk for vulnerable individuals.

Learning & Development

- Training content revised following internal audits and case reviews.
- New operational guidance introduced for responding to persons in crisis.
- Service-user feedback gathered through fire safety assessments and community projects.

Case Highlights

- Hoarding & Self-Neglect: Multi-agency intervention reduced fire and safeguarding risks.
- Financial Exploitation: Safeguarding referral led to protection and removal from harm.

Plans for 2025/26

- Launch 'Think Family' safeguarding campaigns.
- Strengthen audit and supervision processes.
- Expand multi-agency training opportunities.

Support requested from WSAB

- Feedback on referral outcomes.
- Continued promotion of GMFRS training.
- Inclusion in WSAB-led learning sessions.

Greater Manchester Mental Health NHS Foundation Trust (GMMH)

Key Achievements

- Established a Wigan Self-Neglect Panel to support complex cases and improve multi-agency responses.
- Strengthened safeguarding governance with new oversight groups and reporting cycles.

Learning & Development

- Training and resources updated in response to safeguarding reviews.
- Co-produced learning sessions and briefings, including lived experience contributions.
- Improved visibility and access to safeguarding tools via intranet updates.

Case Highlights

- Mr A – Self-Neglect & Multi-Agency Response: Coordinated support led to improved living conditions, health outcomes, and a personalised care package.

Challenges

- Capacity pressures due to increased multi-agency activity and duplicated requests.
- Mitigated through staffing increases and realignment of safeguarding leads.

Plans for 2025/26

- Align divisional safeguarding leads to the Corporate Safeguarding Team.
- Finalise a Trust-wide Safeguarding Dashboard.
- Review and refresh safeguarding training and care documentation.
- Support transition to new partnership arrangements.

Support requested from WSAB

- Continued collaboration on partnership transitions and governance.
- Shared learning and support with training compliance and development.

Greater Manchester Police (GMP)

Key Achievements

- Introduction of the Domestic Abuse Team (DAT) in Wigan, specialising in high-risk cases.
- Successful use of DAPOs and Evidence-Led Prosecution.
- High charge rates and improved victim safeguarding.

Learning & Development

- Police engagement with adults at risk through care planning and multi-agency support.
- Learning from SARs disseminated across GMP.
- Governance strengthened through active participation in WSAB groups.

Case Highlights

- Domestic Abuse Response: Multi-agency action led to arrest, charge, and remand of a high-risk perpetrator.
- MATAC Partnership Case: Coordinated response led to breach arrest and custodial sentence.
- Innovation: Launch of the Cuckooing Task & Finish Group and Cuckooing Car.

Challenges

- Resourcing pressures affecting response times and weekend coverage.
- Staffing limitations restrict expansion of specialist teams.

Plans for 2025/26

- Strengthen response to cuckooing and links with Wigan Adolescent Safeguarding Panel.
- Increase focus on violence against women and girls.

Support requested from WSAB

- Continued collaboration on exploitation risks and multi-agency safeguarding approaches.

Greater Manchester Probation Service (GMPS)

Key Achievements

- Established DASIT to improve safeguarding checks.
- Mandatory safeguarding and domestic abuse training for all staff.
- Chaired 71 MAPPA Level 2/3 meetings.

Learning & Development

- Audit work informed safeguarding improvements.
- Learning from Serious Further Offence Reviews improved risk management.
- Victim Liaison Scheme influenced planning and license conditions.

Case Highlights

- Case A: High-risk perpetrator monitored and arrested for breach. Multi-agency coordination ensured victim safety and future planning.

Challenges

- Organisational change and prison population pressures.
- Inconsistent senior-level attendance at MAPPA meetings.

Plans for 2025/26

- Continue training and audit regime.
- Embed review learning into practice.
- Strengthen multi-agency coordination and victim protection.

Support requested from WSAB

- Improved senior-level attendance and decision-making at MAPPA meetings.

NHS Greater Manchester (ICB – Wigan Locality)

Key Achievements

- Progress on Learning Outcomes Framework (LOF).
- Shared Domestic Abuse Guidance and Mental Capacity Act training with Primary Care.

Learning & Development

- Shared learning from SARs, DHRs, and complaints.
- Promoted professional curiosity and embedded safeguarding principles.
- Delivered safeguarding assurance across the system.

Case Highlights

- DARDR: Supported a complex case involving mental health risk, ensuring person-centred care and multi-agency safeguarding

Challenges

- Limited staffing capacity with one practitioner covering WSAB and ICB responsibilities.
- Effective safeguarding delivery maintained through strong partnership working.

Plans for 2025/26

- Share mental capacity case studies.
- Expand Domestic Abuse Champions project.
- Present Hoarding Toolkit and SAR/DHR learning.
- Conduct audits on self-neglect and DA Champion impact.

Support requested from WSAB

- Continued collaboration on audits, training, and embedding learning.

Wrightington, Wigan and Leigh NHS Trust (WWLTH)

Key Achievements

- Embedded Think Family Level 3 Training.
- Implemented Least Restrictive Practice Improvement Plan.
- Strengthened governance through policy updates and PSIRF alignment

Learning & Development

- Embedded learning from reviews into training.
- Empowered staff through real-life scenarios and lived experience.
- Developed Safeguarding Data Dashboard.

Case Highlights

- Mrs T: Multi-agency discharge planning led to safer arrangements and carer support.
- Tommy: Non-judgmental support and safe discharge planning for domestic abuse victim.

Challenges

- Cultural change needed for least restrictive practices.
- Increased demand due to Right Care Right Person changes.
- Navigating differing policies across partners.

Plans for 2025/26

- Evaluate Think Family training impact.
- Enhance peer review and collaboration.
- Optimise electronic records for safeguarding.
- Continue lived experience-centred improvements

Support requested from WSAB - Continued collaboration on training, policy alignment, and audits.

Wigan Council Adults Social Care (ASC)

Key Achievements

- Creating the in person Reflective Learning Forums
- Moving prevention workers into Safeguarding team to strengthen our prevention offer
- Principle Social worker collaboration with WSAB training and development offer
- Principle Social worker maintaining vital links with advocacy partners
- Principle Social worker developed key links with community faith leaders in the borough

Learning & Development

- Continue to develop the support offer and gaps in provision for those in need of support for hoarding.
- Learning from Serious Further Offence Reviews improved risk management.
- Victim Liaison Scheme influenced planning and license conditions.

Case Highlights

- Belongings Peer Support Group – Person gained confidence and reduced hoarding through peer support and multi-agency collaboration. They now advocate for others, contributing to research and community awareness.
- Complex Dependency – Person moved from high-risk homelessness to stable living through persistent, person-centred support. Their risk score dropped dramatically, improving both their life and family wellbeing.

Plans for 2025/26

- Continue to develop the transitional safeguarding policy
- Refreshed safeguarding team with increase in staffing
- Continue to work closely with the Mental Capacity and DoLs Subgroup to develop our offer

Support requested from WSAB

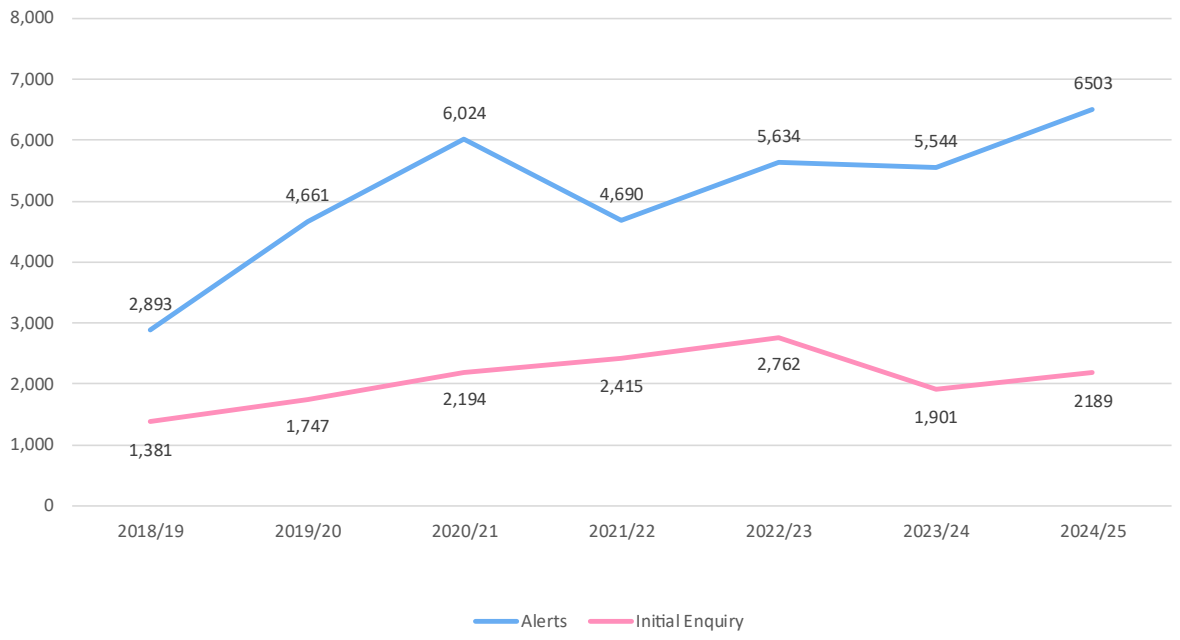
- Continued support with MCA/DoLs subgroup and transitional safeguarding policy

Appendix 4 – Safeguarding Data

Data Overview

- 17% increase in concerns raised
- 15% increase in Section 42 enquiries
- The conversion rate is 34%

Alerts and Initial Enquiries completed during the year



Key Observations

Type

- **Neglect and Acts of Omission** remain the **most common** type of abuse.
- **Self-Neglect** remains the has seen the **largest increase**, more than doubling since 2018/19.
- **Financial Abuse** has been **increasing** in recent years.
- **Psychological Abuse** and **Sexual Abuse** have **declined steadily**.
- **Modern Slavery, Discriminatory Abuse and Sexual Exploitation** are rare and declining.

Location

- **Own Home** consistently accounts for the location of abuse in the **majority of enquiries**, 62%.
- **Care Homes** account for **22%** of the location of abuse, 12% in residential, and 10% in nursing.

Source

- Source of Risk is predominately **Other – Known to the individual**