Cheshire West and Chester Local Safeguarding Adults Board (LSAB)

Annual Report 2024-25

‘Our vision is to promote partnership working by working together to help people feel safe and free from abuse and neglect.’

‘Our mission is to put the adult at risk of abuse or neglect, at the heart of everything we do.’

www.cheshirewestandchesterlocal-safeguarding-adults-board

Welcome from our Chair – Ian Cardwell

As we reflect on the past year, it is clear that the challenges facing safeguarding services have continued to evolve. While the most acute pressures of the COVID-19 pandemic are now behind us, its lasting impact is still felt, and new issues have emerged which continue to test the resilience of both individuals and services. Rising financial hardship caused by the ongoing cost of living crisis, pressures across health and social care, and ongoing workforce challenges in recruitment and retention all present significant risks, particularly for those in our community who rely on care and support and who may be at greater risk of neglect or abuse.

Against this backdrop, the commitment and professionalism of our workforce, volunteers, and carers across Cheshire West remain remarkable. Their efforts have ensured that, even in the face of mounting pressures, adults in need of safeguarding continue to receive vital support, and the quality-of-service provision remains strong.

A central role of the Board is to ensure that safeguarding responsibilities are carried out effectively, despite the wider resource challenges partners face. This means not only overseeing the delivery of essential services but also holding partners accountable for their impact on individuals' lives. We have continued to champion the principles of Making Safeguarding Personal, keeping the voices and experiences of adults at the heart of safeguarding practice and decision-making.

Over the course of the year, the Board has also prioritised raising awareness of safeguarding within the wider community. Through campaigns, engagement work, and contributions to National Safeguarding Week, we have worked to make safeguarding everyone's responsibility. While progress has been made, the need to build public understanding and recognition of safeguarding risks remains a key focus for the year ahead.

The expertise and lived experience of our Service User Group has once again played a vital role in shaping how we work. Their contributions have helped us to make safeguarding information more accessible, including the production of easy-to-read versions of our key documents. This collaborative approach ensures that the voices of those most affected are central to our work.

This Report provides an overview of the Board's activity during 2024/25, highlighting both our achievements and the areas where further progress is needed. It includes our analysis of safeguarding data, findings from case reviews -including Safeguarding Adult Reviews- and the learning that will inform service improvements.

Looking forward, the Board will continue to work towards its three-year Strategic Priorities (2022–2025) and deliver on the Business Plan for the coming year.

Our focus will remain on strengthening safeguarding practice, building community awareness, and ensuring services are effective, accountable, and person-centred.

In closing, I would like to thank all members of the Board and, in particular, the Chairs of our sub-Groups for their ongoing leadership and commitment. My gratitude also goes to the Safeguarding Unit, whose support and hard work underpin everything we do.

Ian Cardwell - Independent Chair

The Board

Cheshire West and Chester Safeguarding Adults Board – Who we are

The overarching purpose of the Safeguarding Adults Board is to help and safeguard adults with care and support needs. It does this by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- assuring itself that safeguarding practice is person-centred and outcome-focused
- working collaboratively to prevent abuse and neglect where possible
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

The Safeguarding Adults Board must lead on adult safeguarding arrangements across Cheshire West and Chester and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. Under the provisions of the Care Act 2014, the Board is required to: -

- Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an Annual Report detailing how effective their work has been.
- Commission a Safeguarding Adult Review for any cases which meet the criteria for a review under section 44 of the Care Act 2014 and where there is opportunity for multi-agency learning.

The focus of the Safeguarding Adults Board is to ensure that in the borough safeguarding arrangements work effectively so that adults at risk can live their lives free from abuse or neglect.

An adult at risk is a person aged 18 or over who has needs for care and support and as a result of those needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect. In this report we will call an adult at risk the ‘adult’.

The Partners of Cheshire West and Chester Safeguarding Adults are made up of representatives of:-

Age UK Cheshire
Cheshire Police
Cheshire Fire and Rescue
Cheshire West and Chester Public Health
Cheshire West and Chester Adult Social Care
Cheshire West and Chester Elected Members
Cheshire West and Chester Children's Social Care
Cheshire West and Chester Community Safety Partnership
Cheshire West and Chester Domestic Abuse Board
Cheshire Wirral Partnership NHS
Countess of Chester Hospital NHS Foundation Trust
Cheshire and Merseyside Integrated Care Board
Disability Positive
HealthWatch Cheshire West
Mid Cheshire Hospitals NHS Foundation Trust
National Probation Service - Cheshire
North West Ambulance Service
NHS England
Weaver Vale Housing Trust

The purpose of the Board

Our overall purpose is to help and safeguard adults with care and support needs. The Board ensure that, locally, abuse is prevented and that, when it does occur, partners respond in line with the needs and wishes of the person experiencing harm.

A key role of the Board is to ensure that there is a partnership approach to safeguarding by promoting collaboration between all the partners for effective communication, information sharing and awareness raising.

Our aims

Working together and with adults at risk of abuse the Board aims to ensure people are: -

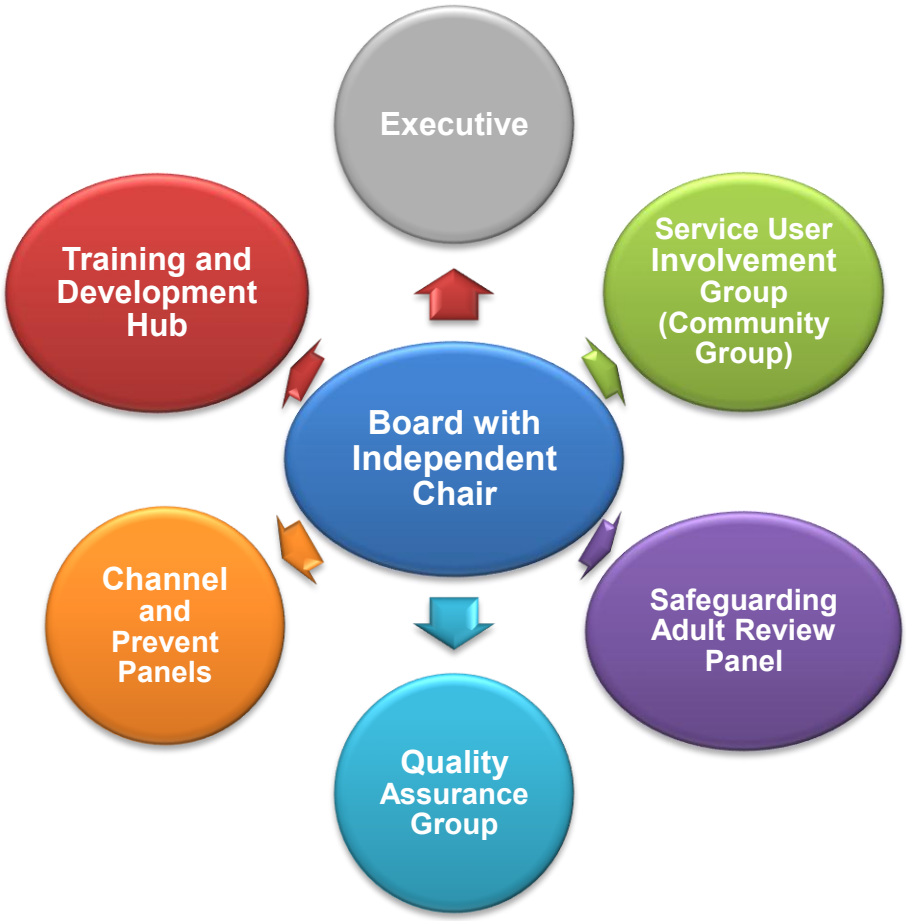
- safe and able to protect themselves from abuse and neglect
- treated fairly and with dignity and respect
- protected when they need to be
- able to easily get the support, protection and services that they need.

What is Safeguarding?

Safeguarding means protecting people's health, wellbeing and human rights and enabling them to live free from harm, abuse and neglect.

The work of the Board is driven by its vision to promote partnership working by working together to help people feel safe and free from abuse and neglect.

The structure of the Board – how we work?



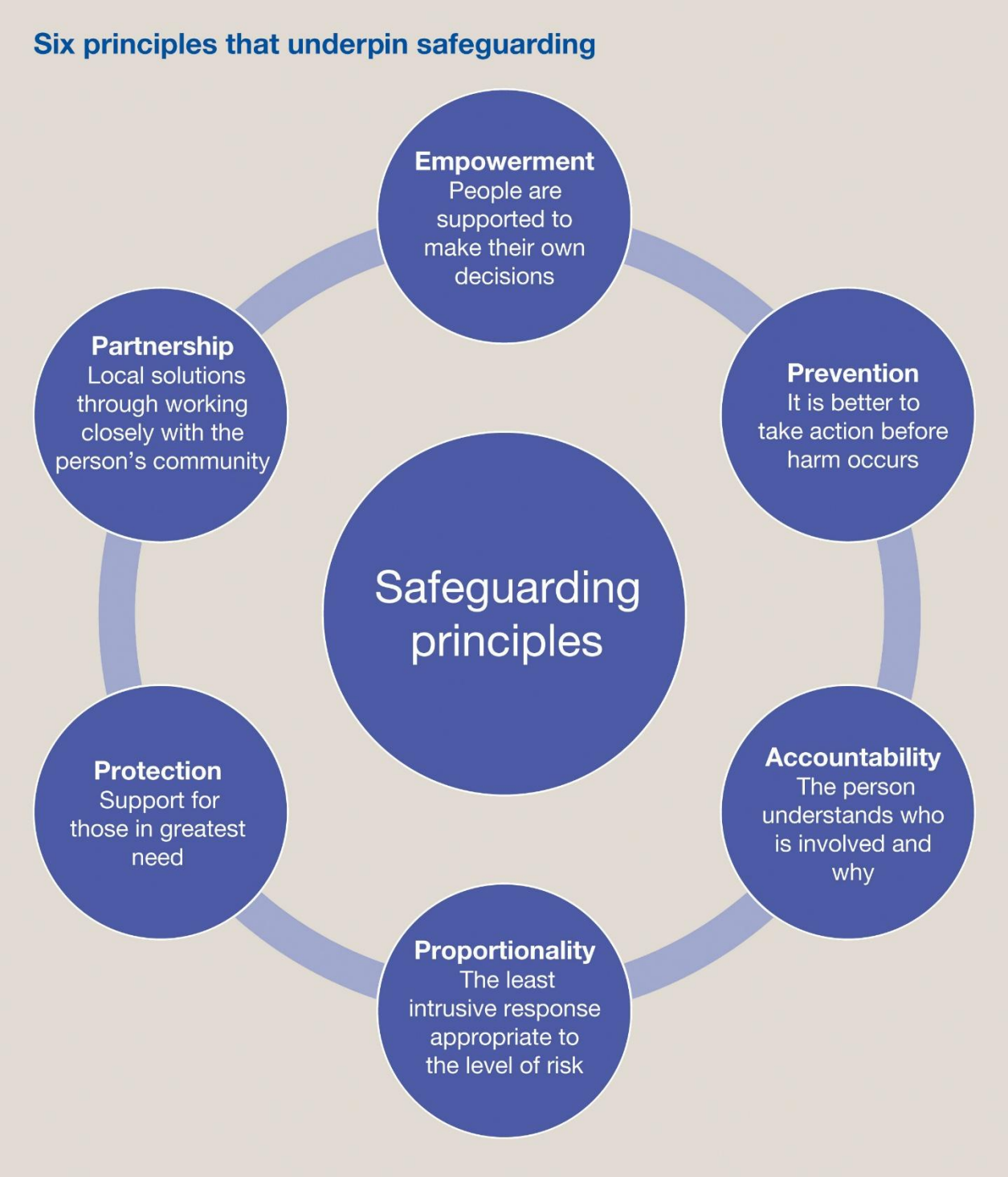
Each group has its own terms of reference and work plan based on the strategic priorities of the Board and the objectives in the Business Plan and provides quarterly updates to Board in respect of progress on these objectives. The Safeguarding Adult Review Panel convenes when a safeguarding adult review referral is received.

What impact did the Board make in 2024-25?

The Board's Strategic Plan 2022-25 sets out the priority areas over the next three years. To deliver those priorities, several annual objectives are agreed. What the board has done to achieve our objectives for 2024-25 are set out below:

Objective 1 – Ensure the delivery of effective safeguarding services, with a focus on Making Safeguarding Personal, informed by the voice of adults who are at risk of neglect and abuse.

Key to Making Safeguarding Personal is the six key principles of adult safeguarding. These are: Empowerment, Prevention, Proportionality, Protection, Partnership, and Accountability. These principles guide how individuals and organisations should approach safeguarding adults and children, ensuring their safety and well-being.



These six principles apply to all partners of the Safeguarding Adults Board. Partner agencies self-assessment provides assurance to the board that all partners are aware of the six principles of adult safeguarding and apply the principles throughout their safeguarding practice. Examples include the local authority adult social care recording system which is able to record individual Making Safeguarding Personal outcomes and whether individual outcomes have been fully, partially, or not achieved.

Our Impact – Self neglect audit Cheshire West and Chester Safeguarding Adults Board undertook an audit to understand more about self-neglect in Cheshire West and Chester. The audit was completed in Quarter 4, 2023-24, followed by two professionals' workshops in May and July 2024.
Recommendations from the audit include: -

1. Cheshire West and Chester Safeguarding Adults Board to undertake a multi-agency audit with the theme of mental capacity, to formulate recommendations from this audit and to use these recommendations to positively impact multi-agency practice.

2. Enabling professionals to have sufficient time to build a relationship with individuals experiencing self-neglect and/or hoarding.

3. The provision of longer-term interventions, specifically for adults experiencing self-neglect and/or hoarding, as opposed to time-limited interventions.

4. Cheshire West and Chester local authority and Safeguarding Adults Board partners to consider implementation of a multi-agency specialist team to support adults experiencing self-neglect and hoarding.

5. Cheshire West and Chester Safeguarding Adults Board partners to discuss how each organisation's communication systems and processes could be used more effectively to reduce duplication and ensure better multi-agency communication and information sharing within and between agencies.

Our Service User group produced an easy read executive summary of our Annual Report and updated the safeguarding booklet with additional forms of abuse which improves practice by ensuring we are providing people with information about safeguarding in an accessible format so that they can understand forms of abuse and what they can do.

The partners provide evidence of Making Safeguarding Personal via the Data Scorecard submitted to our Quality Assurance group. This is also evidenced by case studies submitted to the board, for example in the annual report. Other examples are Cheshire Police and the Domestic Abuse Board Regular

Facebook seminars, which allow the public to understand Domestic Abuse in more detail, where to go for support and assistance and these seminars usually attract approximately 2,000 views per seminar.

Objective 2 – Maximise the impact of delivering safeguarding services, in collaboration with other key partners (including the Safeguarding Children's Partnership), to develop a cross-cutting approach to safeguarding adults, children and families at risk of neglect and abuse.

Our Impact - We work closely with the Safeguarding Children's Partnership, Community Safety Partnership and the Domestic Abuse Board with representatives attending the Board and a joint executive with children's which has led to effective collaboration between partners which has resulted in improved outcomes for service users through maximising the impact of resources and reduced duplication of work or missed opportunities.
We have also worked with our Pan Cheshire colleagues to share learning from Safeguarding Adult Reviews and joint activities as part of National Adult Safeguarding Week in November.

Objective 3 – Raise awareness of safeguarding adults during the cost-of-living crisis and the increasing demands of service providers.

Our Impact – We offer a range of safeguarding training courses which has led to increased skills and knowledge for partners resulting in more effective safeguarding services and improved outcomes for service users, this has been demonstrated due to the number of increased safeguarding concerns.

We continued to produce regular e-bulletins to ensure people understand the impact of the work of Board partners, who provide content for the e-bulletin. In addition, we produce a quarterly training bulletin for partners so that people know what training is on offer and are appraised regarding any learning updates or changes.

The board website continues to be developed with revised policies and updated guidance, increased training opportunities and local, regional, and national safeguarding updates. The greatest number of page views are in relation to the training page and the professionals' area, where policies and procedures are located.

Objective 4 – To continuously improve the effectiveness and culture of the Board, through a range of development tools, including self-assessment, peer review and benchmarking.

Our Impact – We held our annual board development day in January 2024; the focus of the day was to look at making an impact in 2024/25 – setting our

strategic priorities and annual objectives. The first part of our Development Day related to the commencement of an important part of our governance function - our business planning year for 2024/25. The Development Day represents a key part of that process as it represents the first 'formal' consultation event of the annual planning cycle, with Board members and partners helping to identify the key priorities for the coming year and what actions we can take to achieve them, so that they have the maximum impact for service users, safeguarding professionals and the wider community of Cheshire West and Chester.

As well as providing focus for the Board's activities, we also carry out this process as part of our statutory requirements, set out in the Care Act 2014. The board is required to set 3-year Strategic Priorities and, in order to deliver those Priorities, develop a number of Annual Objectives to deliver those priorities in the following 12 months - monitored through our Annual Business Plan which is presented at our Board meetings.

The second part of the annual Development Day focused on a self-assessment exercise as part of preparing for the Care Quality Commission assurance visit. The Care Quality Commission announced in 2023, following implementation of the Health and Care Act 2022, that they would be undertaking assessments of local authorities, including how the local authority works with the safeguarding adults board, to provide independent assurance to people regarding the quality of care in their local area and to assess how local authorities meet their duties under Part 1 of the Care Act 2014. The impact of the day allowed us to identify what we are doing well, what else do we need to do and what do we need to improve on for the future Care Quality Commission inspection which formed part of the board's ongoing business plan.

National Safeguarding Adults Week

We took part in the National Safeguarding Adults Week which ran from the 18th to the 22nd of November 2024. The theme for the week was **'Working in Partnership'.** We believe that working in partnership with our partners, stakeholders and people with lived experience enables us to share our knowledge of safeguarding, learn from others and ultimately create safer cultures within our workplaces and communities. National Safeguarding Adults Week was a time for organisations to come together to raise awareness of important safeguarding issues. The aim was to highlight key safeguarding issues, facilitate conversations and raise awareness of safeguarding best practice. Partners undertook a range of activities within their settings and a variety of events and useful resources were promoted which included webinars focusing on various forms of abuse and exploitation.

Training and Development

The board is committed to a culture of continuous learning and improvement. There are large numbers of people working with adults both in paid employment and employed as volunteers, and it is important that they are sufficiently skilled to spot the signs of abuse and understand safeguarding issues. We need to know who in the workforce needs to be trained, hold their organisations to account to ensure that they receive appropriate training and to seek evidence that the training and learning opportunities have made a positive difference to safeguarding practice.

The importance of multi-agency training is reinforced through research and reinstated through local and national case reviews. Effective safeguarding is underpinned by robust multi-agency working and professionals understanding and acting upon their respective roles and responsibilities in relation to safeguarding adults.

In addition to the range of e-learning courses available we also provided training in Safeguarding Adults for Providers and Managers, Basic Awareness for Safeguarding Adults, Prevent and Far Right Extremism and Domestic Abuse training. We have seen an increase in safeguarding referrals and quality concerns and attribute some of that to an increase in awareness as a result of attending training, which is positive.

Policies and Procedures

The following safeguarding policies have been either produced in 2024-25 or revised to keep people informed of what they are expected to do.

- Adult Safeguarding Procedures
- Multi agency guidance on prevention and early intervention in adult safeguarding
- Quality Assurance Framework
- Safeguarding Adult Reviews Procedure
- Strategic Plan
- Victim Referral Pathway

Safeguarding Adult Reviews

Safeguarding Adult Reviews are a multi-agency process that considers whether serious harm experienced by an adult at risk of abuse or neglect could have been predicted or prevented. The purpose of Safeguarding Adult Reviews is set out in the statutory guidance, (Section 44) within the Care Act 2014. Safeguarding Adult reviews seek to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. The aim is that lessons can be learned from the case(s) and for those lessons to be applied to future cases to prevent similar harm re-occurring. The purpose of a Safeguarding Adult Review is not to hold any individual or organisation to account as other processes exist for that purpose, but to share learning to enhance practice and safeguarding knowledge.

During this period, the Safeguarding Adult Review panel received seven referrals of which three met the criteria for a Safeguarding Adult Review. One involved a person who was cuckooed and then physically and financially abused. The second one involved a family and as a result an adult with learning disabilities nearly died as a result of neglect. The third one involved a person who experienced self-neglect and as a result died. All the published reviews can be found on our website Professional area | Cheshire West and Chester Council

Performance Activity

There continues to be an increase in safeguarding concerns reported to the Local Authority: from 1270 in 2021/2022 to 2500 in 2022/23, representing an increase of 97%. Analysis of safeguarding concerns evidence that this increase was due to improved recording on the adult social care recording system and changes to local safeguarding processes. There was a minimal decrease in the number of safeguarding concerns received in 2024/25 with a total of 2471, a 1% decrease compared with the previous year. Notwithstanding, from 2021/2022 to 2024/2025 the overall increase in the number of safeguarding concerns received is 95%. The volume is increasing as a result of changes to recording practices that are now more aligned with other local authorities that share similar demographics. There exists a debate regarding whether a rise in safeguarding concerns is positive or negative. Generally, a rise indicates that safeguarding training and awareness raising is having an impact on the number of safeguarding concerns received. This means that the Safeguarding Adults Board is

meeting its core objective in ensuring that safeguarding truly is everybody's business, as more people are aware of what adult safeguarding is, and how to report safeguarding concerns.

Section 42 and Other Enquiries

Section 42 and discretionary safeguarding enquiries (commonly referred to as "other" safeguarding enquiries) have seen a smaller increase; from 680 in 2022/2023 to 1273 in 2024/25, although this is not insignificant, representing a percentage increase of 87%. In 2023/24, safeguarding enquiries accounted for 41% of all adult safeguarding concerns received, this increased to 52% in 2024/25.

Consistent with trends identified over the last four years, Neglect and Acts of Omission and Physical Abuse continue to be the most reported categories of abuse in Section 42 and discretionary adult safeguarding enquiries, accounting for 47% of concluded cases in 2024/2025 (Neglect and Acts of Omission 28%, Physical Abuse 19%). Neglect encompasses many factors, including failing to provide access to appropriate health, social care or educational services, ignoring medical or physical care needs and withholding the necessities of life such as medication, adequate nutrition and heating. It is important to note that this trend is not unique to Cheshire West and Chester and is reflected in regional and national data trends, including those local authorities that are most similar to Cheshire West and Chester in terms of demographics. Physical abuse encompasses hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions. In 2024/2025, Psychological abuse (also known as Emotional abuse) was the third most reported category of abuse, accounting for 14% of safeguarding enquiries concluded within the year. Psychological abuse encompasses emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or support networks. This is consistent with trends identified in the previous year. More than one category of abuse can be reported for each safeguarding concern or enquiry.

The most reported location of abuse is the individual's own home, recorded in 52% of concluded safeguarding enquiries. This is consistent with trends identified over the last four years. A slight increase in abuse reported in a person's own home has been noted, from 44% of concluded safeguarding enquiries in 2021/2022 to 52% of concluded safeguarding enquiries in 2024/2025. This is consistent with regional and national trends. Care homes were the second most reported location of abuse in 2024/2025, accounting for 30% of concluded safeguarding enquiries which is consistent with regional and national trends. More adults are receiving services in

their own home, and there are increasing numbers of people being cared for in residential and nursing care homes which might explain the reasons why a person's own home and care homes are the most reported locations of abuse. For the first time in the last four years, there has been a very small number of reported incidents taking place in services in the community, accounting for 1% of concluded safeguarding enquiries. Community services include community centres, day care centres, leisure centres, libraries, schools, GP surgeries and dental surgeries.

Making Safeguarding Personal

Making Safeguarding Personal is about having conversations with people about how to respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. The *Care Act* 2014 advocates a person-centred rather than process driven approach to safeguarding. The individual or their representative are asked their wishes as part of the safeguarding enquiry. The number of people who expressed their wishes at the outset of the safeguarding enquiry was 76%, which is a 3% decrease when compared with the previous year. Of these, 95% had their outcome fully or partially achieved, a 1% decrease when compared with the previous year. 493 people were asked how satisfied they were with the safeguarding process, an increase of 4% compared with the previous year. 474 people (96%) said that they were satisfied with the safeguarding process which is consistent with trends identified over the last two years. Making Safeguarding Personal is central to the support provided by the Safeguarding Adults Board Partnership.

Cohort of Gender and Age

Females continue to account for the highest ratio of clients subject to Section 42 and discretionary enquiries, although the proportion has decreased slightly this year, from 63% in 2022/2023 to 57% in 2024/25. The most reported age group continues to be working age individuals aged 18-64 (35%) which is consistent with the previous two years, although represents a 1% decrease in percentage terms. The second most reported age group in 2024/2025 is adults aged 75-84 which is consistent with the previous year.

Findings from Audits

Self-Neglect

Cheshire West and Chester Safeguarding Adults Board undertook an audit to understand more regarding use of the Cheshire West and Chester Safeguarding Adults Board self-neglect policy, procedure, and toolkit; barriers to working with people experiencing self-neglect; what is working well; and what can be done to improve practice. Discretionary safeguarding enquiries and safeguarding enquiries undertaken under section 42 of the *Care Act* 2014 where self-neglect was recorded increased by 290% between 2021-22 and 2023-24. An increase in self-neglect is also reflected nationally in referrals for Safeguarding Adults Reviews under section 44 of the *Care Act* 2014.

OVERARCHING THEMES

1. Differing professional opinions regarding an individual's mental capacity or the circumstances in which a mental capacity assessment would be undertaken.

2. A general lack of longer-term, specific interventions for people experiencing self-neglect, as the majority of offers of intervention is time limited.

3. Lack of time was a concern for professionals. This underpins the other emerging themes as professionals reported that individuals with co-morbidities such as poor mental health or use of drugs and alcohol often required more time to build up relationships and professionals also felt that they needed more time to understand situations which are frequently highly complex. Several people who experience self-neglect having experienced earlier life trauma. Time and a sensitive approach are required to understand a person's history, to gain their trust and to build a positive working relationship.

4. Linked with theme number three, operational professionals discussed that front line practice was increasingly busy and cases were increasingly complex. The ability to respond to cases in a timely way or to provider longer-term support is impacted by resources, the main issue being the number of staff and their existing caseloads.

5. Professionals discussed that a specific, multi-agency team for people experiencing self-neglect and hoarding would be of immense benefit; not only to professionals but to people experiencing self-neglect and hoarding, as this

would enable longer-term intervention and the time required to build professionals relationships.

6. Multi-agency communication, specifically knowing the correct professional(s) to contact, being in possession of up-to-date and accurate contact details and access to external systems to enable information to be shared in a timely manner and to reduce duplication.

There are common themes with regional and national Safeguarding Adult Review recommendations: effective multi-agency communication, mental capacity, resource implications and a lack of tailored support. A number of these themes are also reflected in local Safeguarding Adult Reviews, including those that have been undertaken in Cheshire West and Chester.

OVERARCHING RECOMMENDATIONS

1. Cheshire West and Chester Safeguarding Adults Board to undertake a multi-agency audit with the theme of mental capacity, to formulate recommendations from this audit and to use these recommendations to positively impact multi-agency practice.

2. Enabling professionals to have sufficient time to build a relationship with individuals experiencing self-neglect and/or hoarding.

3. The provision of longer-term interventions, specifically for adults experiencing self-neglect and/or hoarding, as opposed to time-limited interventions.

4. Cheshire West and Chester local authority and Safeguarding Adults Board partners to consider implementation of a multi-agency specialist team to support adults experiencing self-neglect and hoarding.

5. Cheshire West and Chester Safeguarding Adults Board partners to discuss how each organisation's communication systems and processes could be used more effectively to reduce duplication and ensure better multi-agency communication and information sharing within and between agencies,

6. Cheshire West and Chester Safeguarding Adults Board to relaunch the self-neglect policy, procedure, and toolkit during Adult Safeguarding Week 2024 (18th – 22nd November 2024) to raise awareness of the toolkit with partners and encourage use of the self-neglect policy, procedure, and toolkit.

Mental Capacity Act

Professional understanding and application of the *Mental Capacity Act* 2005 is a common theme in recommendations from Safeguarding Adults Reviews. In May 2024, the second National Analysis of Safeguarding Adults Reviews was published by the Local Government Association. This study analysed the findings of 652 Safeguarding Adult Reviews completed over a 4-year period, drawing out common learning themes. The most commonly noted practice included shortcomings in mental capacity assessment, which was found in 58% of cases analysed. Findings on the wider systemic factors that impact upon direct practice highlight a lack of relevant guidance for practitioners. Mental Capacity Act policies were identified as a specific area where relevant guidance was lacking. The *Mental Capacity Act* 2005 was an overarching theme throughout two Safeguarding Adults Reviews commissioned by Cheshire West and Chester Safeguarding Adults Board under s.44 *Care Act* 2014. Furthermore, the *Mental Capacity Act* 2005 was identified as the top training priority across all sectors responding to a training survey facilitated by Cheshire West and Chester Safeguarding Adults Board and Cheshire West and Chester Safeguarding Children Partnership. For this reason, Cheshire West and Chester Safeguarding Adults Board undertook an audit to understand more about professionals' understanding and application of the *Mental Capacity Act* 2005.

Audits were completed by Cheshire West and Chester Council, Cheshire Constabulary, Cheshire and Wirral Partnership NHS Trust, Mid Cheshire Hospitals NHS Foundation Trust, Countess of Chester Hospital NHS Foundation Trust, Cheshire and Merseyside Integrated Care Board and Weaver Vale Housing Trust.

OVERARCHING THEMES

- Lack of formal Mental Capacity Act assessment.
- Lack of decision-specific Mental Capacity Act assessment.
- Mental Capacity assessments to include executive capacity.
- The individual not provided with the relevant information, meaning that the Mental Capacity Act assessment does not stand up to legal scrutiny.
- Lack of Best Interest decisions recorded, or lack of involvement of the person.
- Lack of referrals to statutory advocacy services.

- Multi-agency information sharing needs to improve, specifically around hospital discharge.

- Need to ensure that the person's voice is central to the assessment, and to include the views of family carers as appropriate.

- To improve practitioner confidence in completing Mental Capacity Act assessments, working with Best Interests, case recording and making advocacy referrals.

OVERARCHING RECOMMENDATIONS

- Cheshire West and Chester Safeguarding Adults Board to set up a Mental Capacity Act subgroup to consider the multi-agency recommendations, particularly around training.

- Train the trainer model used to deliver Mental Capacity Act training – option for this to be free at the point of delivery.

- Targeted multi-agency training on Mental Capacity Act to include the interface with other legislation such as the Mental Health Act and *Care Act*.

- Mental Capacity assessment checklist for adult social care managers prior to approval of assessment.

- Improved recording in relation to defensible decision making, and record of actions. To be monitored via audit led by practice development leads and Mental Capacity Act/Deprivation of Liberty safeguarding practice manager. Assurance in respect of partner agencies to be led by the Safeguarding Adults Board.

- Improvements in understanding around recording of Best Interest meetings and decisions. For the local authority, to be monitored via audit led by practice development leads and Mental Capacity Act/Deprivation of Liberty Safeguards practice manager. Assurance in respect of partner agencies to be led by the Safeguarding Adults Board.

- Capacity assessments to be decision-specific and formally recorded and to include a record of executive capacity.

- A personalised approach to supporting the person, based on their needs rather than their diagnosed health conditions.

- The individual's views and wishes to be captured and recorded at each assessment.

- The individual to be provided with the relevant information, to ensure that the assessment stands up to legal scrutiny.

- All partners to clearly evidence that the individual has been involved in decision making, with use of an advocate where necessary.

- Referrals to advocacy to be made in a timely manner to ensure that advocates are involved at the right time.

- All partners to ensure that Best Interest processes are followed and Best Interest decisions clearly recorded.

- Mental Capacity Act policies and procedures to be reviewed regularly to ensure relevance to current practice.

- Use of information sharing agreements to ensure that multi-agency information sharing is effective, with particular reference to hospital discharge.

Case Studies

Countess of Chester Hospital

Patient story

A 20-year-old female care leaver, placed out of area into a domestic abuse refuge in Cheshire West and Chester, was admitted to the Countess of Chester Hospital following an overdose. Due to a deterioration in her mental health, the refuge could no longer support her, prompting safeguarding concerns. The patient, with a complex history including Section 136 admissions, a diagnosis of emerging Unstable Personality Disorder, had no safe discharge destination, resulting in a prolonged hospital stay. The Countess of Chester Hospital played a pivotal role in escalating concerns, coordinating with Cheshire West and Chester Council and out of area local authority, and ensuring the patient's safety, particularly considering her significant vulnerability to sexual exploitation. Weekly multi-agency meetings were held, and the Trust's safeguarding team supported both the patient and ward staff throughout. Ultimately, following a Mental Health Act assessment, a suitable placement was secured, and the patient was safely discharged with safeguarding measures in place

In 2024/25, the Countess of Chester Hospital made significant progress in embedding safeguarding into operational practice, enhancing strategic

collaboration, and increasing visibility across sites. Key achievements included updated safeguarding policies, daily involvement from the Trust's safeguarding team in discharge planning, strengthened partnerships with housing and homelessness services, and active participation in multi-agency audits and Safeguarding Adult Reviews. The Trust also achieved contractual compliance for safeguarding adult training at all levels, reflecting a strong commitment to workforce development and improved staff confidence. Safeguarding referrals rose, with self-neglect emerging as a key theme and priority for 2025/26. Additionally, the Trust enhanced its approach to pressure ulcer management by embedding the Adult Safeguarding Decision Tool into their incident reporting framework and working closely with Tissue Viability Nurses and the Integrated Care Board quality team, ensuring a consistent and proactive safeguarding response.

Disability Positive

Our key Adult Safeguarding achievements:

- Mandatory annual safeguarding training delivered internally for all Disability Positive staff.
- Safeguarding Officer in place to support staff to complete and process records of concern.
- Two referrals made to Cheshire West Adults Safeguarding Team.
- Chairing the Safeguarding Adults Board service user involvement group to ensure the voice of people with lived experience drives the work of the Board.

Highlights of some of the work we have done during the year to support safeguarding:

- Annual safeguarding training delivered for all Disability Positive staff which includes how to recognise the signs of abuse.
- The Chief Executive Officer is a member of the Safeguarding Adults Board and attended board meetings.
- The Safeguarding Adults Board service user involvement group met during the year, and we heard from service users and carers about their lived experience which was fed back to the Board.
- We promoted Adult Safeguarding Week in November via posts on social media.

Capturing the voice of Service Users and carers:

- Disability Positive is a representative organisation of people with lived experience of disability, long-term conditions and caring responsibility: 100% of our members have lived experience and we are majority governed and staffed by people with lived experience. By its very nature, we are driven by the needs and aspirations of people with lived experience of disability and long-term conditions.

- We have a robust review process for all services delivered which captures the wishes and feelings of the service user.
- Service users are asked to complete benchmarks of outcomes at point of access to a service which are then reviewed on a quarterly basis, to measure customer journey.
- All referrals made to the local authority include the service users requested outcome.
- We complete a record of concern before any referral made to the local authority; this record includes the wishes and feelings of the service user.
- Safeguarding referral process includes the requirement to follow up all referrals and outcomes shared with the individual at potential risks.

Our Adult Safeguarding objectives for 2025/26:

- Maintain the Cheshire West Safeguarding Service User/Carer Involvement Group to drive forward the workplan of the Board and ensure the voice of people of adults at risk continue to be heard; to meet the Board Strategic Objective around Making Safeguarding Personal.
- Continue to ensure all Disability Positive staff have access to annual safeguarding training.
- Continue to ensure all internal referrals processes are fit for purpose.
- Ensure the Safeguarding Officer is up to date with Safeguarding Adults training.
- Continue to support the voice of Service Users/Carers.
- Continue to support the work of the Safeguarding Adults Board.

Disability Positive case studies:

Case Study 1 – Safeguarding Referral

The Challenge

An adult who attends our social group reached out to us feeling anxious and unsure about what to do. They were worried about their transport arrangements to college, sharing that their driver had fallen asleep at the wheel on several occasions and regularly used their phone while driving. Understandably, this made the adult feel unsafe and heightened their anxiety. We were already aware that this individual has a co-existing diagnosis and takes daily medication to manage their anxiety. We also knew how important their college placement was: something they had worked hard to secure after challenging the local authority to ensure they were in the right setting. Any disruption to their attendance could have a serious impact on both their emotional and physical wellbeing.

The Solution
With the adult's consent, we immediately referred the concern to the adult safeguarding team and notified the Transport Team to let them know the referral had been made. We wanted to ensure the adult's safety was prioritised and that their voice was heard. The response was swift. On the same day, the Transport Team confirmed that a new driver had been allocated with immediate effect. This new driver would be taking the adult home from college that very day. We contacted the adult straight away to explain the outcome, so they were aware of the change in advance and could feel reassured that their concern had been taken seriously and acted upon.

The Outcome
The adult was relieved and grateful to know that their safety had been prioritised and that they would no longer have to travel with the previous driver. Their anxiety was eased, and they felt empowered knowing that speaking up had led to a positive change.

Case Study 2 – Support

The Challenge
An adult who regularly attends our social group reached out to us feeling deeply concerned and upset. They had been told that their transport arrangements were being withdrawn, which meant they might no longer be able to attend the group or other community activities they enjoy. Understandably, they were worried about losing contact with their friends and feeling increasingly isolated.

They shared that they felt ignored and unheard, especially after a recent experience where overnight staff had been removed from their residential setting without their input. That decision had left them feeling frightened and powerless, and now they feared the same thing was happening again with transport. They just wanted someone to listen and help make sure their voice mattered.

The Solution
With the adult's consent, we contacted their residential setting to better understand the situation. We learned that a social care review was underway, and while transport was still in place for the time being, its continuation would depend on the outcome of that review. We shared the adult's concerns with the setting, especially their feeling of not being heard. We also discussed the possibility of referring the adult to Voiceability for advocacy support, so someone who could help ensure their views were represented during the review process. The residential setting acknowledged our concerns and

agreed to keep us informed. They also said they would reach out if transport was not approved so we could work together to explore alternative options.

The Outcome

Following the social care review, the residential setting let us know that a request had been made for transport to continue and they were awaiting a decision from the panel. Shortly after, the adult happily told us, “I still have transport and can still come to the group,” and thanked us for helping them feel heard and supported. This outcome meant they could continue attending the group, stay connected with their friends, and feel reassured that their voice truly mattered.

Regulatory Services

“The Age UK Scams Awareness and Aftercare Project began in January 2025 with Cheshire West and Chester Council, after being successfully implemented in Cheshire East since 2020. The team provide intensive victim support, group fraud awareness sessions, a monthly newsletter and information packs to older people across Cheshire West. The project has provided 68 intensive one-to-one victim support sessions and delivered 23 group awareness sessions provided to 420 people. The project has also spoken to 178 people at Wellbeing Hubs and partnership working with Cheshire Police at events in Tarvin, Kelsall and Delamere. In total, Age UK estimate that the project has directly benefited over 600 older people in Cheshire West.

Their work was recently summed up in a case study written by a project worker about her dealings with an elderly, vulnerable resident in Cheshire West. The lady has poor mobility so doesn’t leave the house unless she is assisted, which can be frustrating for her as she is very sociable. The lady has a Facebook account where she shares her photographs, this mainly consists of her beloved pets. She was approached on Facebook from someone she believed was a friend. They targeted her due to the animal photographs and started the conversation of their love for animals. She enjoyed the compliments, being showered with love and affection. It made her feel good but sucked her into the scam, and parting with money she did not have to give away. Small amounts of money were asked for at first in the form of gift cards. She did not feel that this was a problem at the time, as she was helping with the care of animals. She did not feel the need to tell her family about it as it was only a small amount of money. The contact increased and more money was requested. The lady was sending the gift cards but was now struggling with her finances. It was coming up to Christmas and she was struggling to buy gifts for her family, which she wanted to do. She advised that she could no longer donate any money, and all contact stopped. The lady was referred to Age UK Cheshire by a social prescriber and Age UK Cheshire arranged a 1:1 visit. During this visit, they discussed how the

fraudsters had used her love of animals, love bombing and coercive language to draw her in and obtain money from her. They spoke about other ways fraudsters can make contact. Online safety, privacy settings, password protection and being careful not to change platforms when talking to someone. Support phone calls have continued, and she has been given ideas and details of activities and clubs in her area that she may want to join. The lady has had the confidence to confide in her family and open up about the situation. Her daughters have shored up her social media accounts. She feels better that she can talk about this to her family and says, 'What a silly beggar I was'. 'I gave myself a good talking to.' 'If someone else could read my story and take it in, it may save them from being scammed.'

Age UK Cheshire

Age UK Cheshire benefit from being a Voluntary Community and Social Enterprise representative on the Adult Safeguarding Board. The priority of safeguarding is a thread that runs throughout our charity in every interaction we have. The safety of the older people we exist to support is paramount. The additional exposure to multi-agency working, Safeguarding Adult Reviews learning, shared training and shared best practice escalates our thinking and ensures our practice and strategic governance is as strong as possible. We welcome the opportunity to share our learnings with partners through our collaborative and supportive partnership.

Cheshire Police

During the end of 2024, the Safeguarding Governance Unit, who oversee and govern all statutory reviews and subsequent learning, implemented a vulnerability learning tracker. The tracker is designed to keep records of all live, and closed statutory reviews, and includes a tracking tool relating to both statutory and non-statutory learning recommendations and actions. The tracker is managed on a day-to-day level by the Serious Case Review Team inclusive of a Detective Sergeant and two Detective Constables, and overall governance is managed at a senior level.

To ensure recommendations and learning are driven, addressed and resolved in the most efficient and timely way possible, the team take part in a Bi-Monthly review of the tracker to assess progress of outstanding recommendations, identify actions plans, and to identify and allocate an appropriate owner, usually of a more senior rank.

<u>Safeguarding Adult Review cases/recommendations</u>

As a result of the above drive Cheshire Police currently have six live statutory recommendations relating to Safeguarding Adult Reviews across the county, and a total of three statutory recommendations resulting from Cheshire West Safeguarding Adult Reviews have been addressed.

Of those live recommendations, one relates to a Chesire West Safeguarding Adult Review and is specifically around ensuring Police Officers and Staff submit Vulnerable Person Assessments regardless of other agency involvement at an incident, to provide opportunity to share relevant and important information to our partners which may otherwise have been missed. This issue has been raised at least once more within a Warrington Thematic review this year, and so work is ongoing in the form of updated communication, training and guidance to provide the best chance of meeting the recommendation and ultimately better support those at risk.

In terms of closed statutory actions, the issue of sharing via Vulnerable Person Assessments again was presented in an earlier review, whereby information around an individual subject to self-neglect was not shared via the pathway. Although an individual issue within the case, it is recognised that this issue is in actual fact a theme. The issue of self-neglect is covered in the adult at risk procedure as well as available tool kits, and so it is widely communicated that Vulnerable Person Assessments be submitted in all safeguarding need cases. Local Authority based referral units also now sit within the Vulnerability Hub and are responsible for ensuring the sharing of Vulnerable Person Assessments to appropriate partners. Their work is frequently audited to ensure consistency. Work in relation to this area remains under review within the Vulnerability Hub.

Another area of learning identified via a Safeguarding Adut Review is the requirement of training around the Mental Capacity Act and carer abuse/carer stress and disguised compliance. The issues have now been included in force wide training delivered by the Serious Case Review Team, to promote awareness and offer guidance when dealing with adult at risk case.

Other Thematic Learning

Outside of Cheshire West cases, other thematic issues have been highlighted. One in particular is the requirement to strengthen the response both proactively and reactively to the risk of exploitation and complex risk. Not only is this an issue raised via the Safeguarding Adult Review process, but also commonly under children's safeguarding practices. Cheshire Police are addressing individual recommendations and learning locally, however addressing the matter with our partners via a Pan-Cheshire approach.

Cheshire and Wirral Partnership NHS Trust

The Safeguarding Team in collaboration with Cheshire and Wirral Partnership's Clinical Systems Team, have successfully launched a new

safeguarding screening tool and safeguarding templates for use on Electronic Patient Recording systems across the Trust. The template officially went live on 4th October 2024. To support the implementation of the new template, resources were developed that included a user guide, and recorded training sessions, which staff were able to access via the Safeguarding SharePoint site on the Trust intranet. The purpose of the new template is to assist practitioners in both identifying and managing safeguarding concerns effectively. It features direct links to facilitate referrals and to access multi-agency assessment tools and threshold documents via the Safeguarding SharePoint page and promotes a 'Think Family' approach, which encourages practitioners to consider 'Information Sharing' and liaison with other services and agencies, enhancing safeguarding practice.

A primary focus for the Trust in 2024-25 has been to enhance awareness and understanding of domestic abuse safeguards, ensuring staff have the necessary resources and support to protect individuals affected by or at risk of domestic abuse. All Cheshire and Wirral Partnership and multi-agency partnership resources are accessible on the Trust SharePoint system.

Coercion and Control within Domestic Abuse is covered in the Trust's Level 3 Think Family Training, and the Trust standalone Domestic Abuse Training package, which can be delivered in a classroom setting but is also accessible on the Virtual Academy.

In addition, there's also a recorded Domestic Abuse Briefing Session that's accessible on SharePoint along with multiple 7 Minute Briefings covering a variety of topics, which include but are not limited to Domestic Abuse:

- Coercion and Control
- Domestic Abuse and the Homicide Timeline
- Cheshire East Council: One Minute Guide - Professional Curiosity
- Cheshire East Domestic Homicide Review Emma
- Indicators of Domestic Abuse and Routine Enquiries

Cheshire Wirral Partnership Case Study

The patient is an 87-year-old female who is bed bound, has three care calls a day from a care agency, and her husband is responsible for all other aspects of her care. The Community Care Team became involved following a GP referral to the team for wound care.

During a routine visit with a district nurse and a student nurse, they observed the patient's demeanour visibly change when her husband entered the room. Having recognised this, the Community nurse acted quickly and made an impromptu decision to complete a full nursing assessment in order to create

an opportunity to remain present and explore the situation further. The husband remained present throughout the assessment and would notably speak on behalf of the patient preventing her from answering the questions herself, therefore preventing further exploration of the concerns.

In order to undertake safe routine enquiries with the patient, the community nurse asked to speak to the patient's husband in the garden as part of the assessment, allowing the student nurse to safely explore the situation further with the patient. Whilst both the district nurse and the husband were outside in the garden, the student nurse contacted the Cheshire Wirral Partnership Safeguarding Team for advice and support. On the advice of the safeguarding team, the student nurse completed a Domestic Abuse Stalking and Harassment Risk Indicator Checklist with the patient. The patient disclosed that she had not been physically hurt, however she felt unsafe at home. She shared that her husband made all the decisions for her, was extremely controlling and did not allow her to have a voice and refused to help her when she requested it. She also disclosed he would shout and raise his voice at her daily.

The Domestic Abuse Stalking and Harassment Risk Indicator Checklist met the criteria for a referral to the Multi-Agency Risk Assessment Conference, which was made in collaboration with the patient, a safety plan was completed which included close monitoring and support by the care agency who visited her three times a day. The patient clearly expressed that she did not want police involvement. However, she asked for her social worker to be informed and is actively receiving support to move into a care setting.

Cheshire West and Chester Domestic Abuse Board

The report outlines the continued implementation of the Domestic Abuse Strategy 2021–2025, which aims to ensure all residents of Cheshire West and Chester live free from domestic abuse. The strategy focuses on improving health and wellbeing, supporting disclosure and recovery, and challenging those who harm.

Key Service Areas and Achievements

- **Safe Accommodation**
  - Delivered 30 safe accommodation spaces and 69 Sanctuary Schemes, meeting statutory obligations.
  - Strategic Needs Assessment recommends increasing provision to 37 spaces.
  - Women's Housing Action Group commissioned for refuge and dispersed housing; the Domestic Abuse Intervention and Prevention Service provides Sanctuary Schemes.
  - Internal audit led to an action plan to improve compliance.
- **Support Services for Survivors**

    - **Gateway Recovery Programme**: 248 referrals (+29.8%), 92 completions (−20.7%).
    - **Hospital Independent Domestic Abuse Adviser**: 334 referrals (+83% since 2022/23); embedded in Countess of Chester Hospital.
    - **Open Access Groups**: 168 sessions, 546 women and 20 men attended (+54% and +53% respectively).
    - **IRIS Programme**: 175 GP referrals (+12%), 235 staff trained (+69%).
- **Domestic Abuse Intervention Prevention Service:**
    - 2,617 referrals (+2.2%); 39.1% high risk, 57.3% medium risk.
    - 40.4% repeat referrals; majority from police and self-referrals.
    - Highest referral area: Chester & Rural (33.1%).
- **MARAC (Multi-Agency Risk Assessment Conference)**
    - 626 high-risk cases heard (+32%); 32.6% were repeat cases.
    - Increased representation of BME (8.5%), male (7.3%), and LGBT (1.9%) victims.

Commissioned Services

- **Women's Housing Action Group**: 139 referrals; 83 accepted, with longer stays reflecting increased complexity.
- **TLC Behaviour Change Programme**: 68 referrals; 4 completions of 26-week course.
- **Healthbox Counselling**: 1,503 sessions delivered to 293 high-risk individuals.

Governance and Strategic Direction

- The Domestic Abuse Local Partnership Board oversees delivery and compliance.
- Strategy priorities include risk assessment, early intervention, support for victims and children, and perpetrator accountability.

The 2024/25 Annual Report demonstrates the continued commitment of Cheshire West and Chester to tackling domestic abuse through a partnership coordinated trauma-informed approach. With increased service engagement, expanded safe accommodation, and strengthened partnerships across health, housing, and community sectors, The Domestic Abuse Intervention and Prevention Service has made significant strides in supporting those harmed and challenging those who perpetrate abuse. As the service prepares to launch a refreshed strategy in autumn 2025, the focus remains on improving outcomes, enhancing accessibility, and ensuring that every resident can live free from domestic abuse.

- **Next Steps**:
    - Launch of a new Domestic Abuse Strategy in autumn 2025.
    - Review of Multi-Agency Risk Assessment Conference Operating Protocol.
    - Refresh of Board governance and membership.

Cheshire and Merseyside Integrated Care Board

The Named General Practitioners (GPs) for the Cheshire and Merseyside Integrated Care Board continue to use local and national reviews to disseminate learning to the safeguarding lead GPs across the Integrated Care Board. The most recent GP meeting used the Safeguarding Adults Review 'Tom' to identify the need for GPs to be cognisant of multi-agency information sharing, professional curiosity, referring for Care Act assessment and safeguarding concerns and the use of advocacy services. The GP meetings also ensure wider learning from the Integrated Care Board footprint and other reviews are also shared to embed the 'safeguarding is everyone's business' message. A further learning point was shared around the existence and operation of Multi Agency Risk Assessment Meeting or high risk panels which promotes multi-agency working and promotes that health services can be the referring agency when risks have escalated.
GPs are also provided with fortnightly webinars presented by multiple services. So far in 2025 there have been presentations on domestic abuse, county lines/cuckooing, Ketamine use and modern-day slavery. While sharing essential safeguarding education, these webinars also evidence the range of services that can support individuals and that health services may consider working with.

A very recent discretionary Safeguarding Adults Review for a family at risk has now been completed. The extremely high-risk circumstances the family were living in was highlighted by the death of one of the adult children. The hospital safeguarding team acted promptly to liaise with social care and secure or assure the safety of other members. Subsequent multi-agency meetings ensured all services shared information appropriately. Though joint working occurred the subsequent Safeguarding Adults Review has found potential learning which will be shared at future safeguarding lead GP forums in the continual cycle of learning from reviews.

Strategic Priorities 2022-25

This year, the board undertook a review of our governance and scrutiny procedures, resulting in the publication of revised Governance Arrangements. This work was done to ensure the Board is equipped to deliver its statutory and local commitments and to add value to partnership working in safeguarding adults through effective oversight and scrutiny.

It is important to add that, in setting revised Strategic Priorities and Annual Objectives, the key aspects of the previous year’s work have (where relevant)

been incorporated into the new priorities and objectives, so that good practice, learning and ongoing work is not 'lost' going forward.

It is proposed that the high-level Strategic Priorities for 2024/25 remain unchanged to continue to the progress we have made over the last 12 months. These Priorities remain relevant to the activity of the Board and represent a clear framework on which to assess progress. They form a comprehensive framework that captures all the key functions of the Board, focusing on three areas of equal importance; effective operational delivery; good governance; and active communication and community engagement.

Whilst the Strategic Priorities effectively remain the same, it is important to demonstrate that each has been thoroughly reviewed in the context of the current operating environment. Each priority is set out below together with the rationale for its selections.

Strategic Priority 1: People and Outcomes – Ensuring Safeguarding services are delivered effectively and professionally, with Making Safeguarding Personal at the heart of how those services are delivered. This priority continues to be relevant, so that the Board's focus on adult safeguarding remains firmly on the needs and expectations of the individual at risk.

Strategic Priority 2: Governance, Systems and Processes – Ensuring that there are effective governance, scrutiny, and business processes in place to ensure that the safety and well-being of adults who are subject to, or at risk of, abuse and neglect is at the heart of Board members organisational priorities. This includes ensuring that the findings from Safeguarding Adult Reviews published during 2024-25 and other key areas of Practice improvement are implemented. The Board will continue to develop and strengthen its governance arrangements; it is important to maintain the focus on systems and processes.

Strategic Priority 3: Partnerships and Community Engagement - We will promote safeguarding adults in the community by listening to their concerns and raising awareness to prevent neglect and abuse before it happens, with a focus on diverse, isolated, and under-represented communities. It is critical that effective communication and engagement with the community is maintained and that the concerns of adults at risk of abuse and neglect are listened to. We will also continue to work with other key groups, committees, and partners, to build on our effective partnerships. We will continue to deliver training and development in areas where awareness and understanding needs to be improved.

Our objectives for 2025-26

To deliver those Priorities, several annual objectives are proposed but will be reviewed at our next Boards Development Day to ensure we move towards delivering our Strategic Priorities, which are:-

Objective 1: Ensure the delivery of effective safeguarding services, with a focus on Making Safeguarding Personal, informed by the voice of adults who are at risk of neglect and abuse.

Objective 2: Maximise the impact of delivering safeguarding services, in collaboration with other key partners (including the Safeguarding Children's Partnership), to develop a cross-cutting approach to safeguarding adults, children and families at risk of neglect and abuse.

Objective 3: Raise awareness of safeguarding adults during the cost-of-living crisis and the increasing demands of service providers.

Objective 4: To continuously improve the effectiveness and culture of the Board, through a range of development tools, including self-assessment, peer review and benchmarking.

Stop Abuse
Stay Safe

Speak up if you are worried about something that is happening to you or someone else.

Don't just talk about it. Report it.

If you have a concern or need advice, contact the
Community Access Team

- Report a safeguarding concern
- Phone: 0300 1237034
- Out of hours phone: 01244 977277 (Emergency Duty Team)
- Alternatively call Cheshire Police: 101 for non-emergencies or 999 in an emergency.

If you are scared, tell someone you trust who can report it for you.

We must work together to make sure people feel safe and stay safe.

For information search online for the Adult Safeguarding Board at Local Safeguarding Adults Board

Responsible officer: Dawn Lewis
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