



Cheshire West and Chester Local Safeguarding Adults Board (LSAB)

Annual Report 2025-26

‘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 – Celia Jeffreys

It is a privilege to introduce my first Annual Report as Independent Chair of the Cheshire West and Chester Local Safeguarding Adults Board. I took over the role from Ian Cardwell in November 2025 and would like to thank Ian for his leadership of the Board and for the support he provided during the handover. Since becoming Chair, I have been impressed by the commitment of partners, practitioners, volunteers and people with lived experience who work together to safeguard adults across the borough.

This report reflects both the progress made during 2025–26 and the continuing pressures facing adults, families and services. Increasing complexity, workforce and resource pressures, the cost of living and growing concerns about self-neglect, hoarding and mental capacity all reinforce the importance of effective prevention, early intervention and strong multi-agency working. Throughout the year, the Board has maintained its focus on Making Safeguarding Personal, ensuring that adults' wishes, rights and desired outcomes remain central to safeguarding practice.

There have been important achievements. Partners have strengthened joint working with the Safeguarding Children Partnership, Community Safety Partnership, Domestic Abuse Board and Pan-Cheshire colleagues; developed the Mental Capacity Act practitioner group; improved policies and guidance in response to learning from Safeguarding Adult Reviews; and continued to build workforce confidence through training, briefings and accessible online resources. Our Service User Group has also helped make key Board documents clearer and more accessible, including through easy-read versions.

A major focus since I became Chair has been the development of our new Strategic Plan for 2026–2029. We used our Board development day to reflect collectively on our impact, governance and future direction. The objectives were informed by local, regional and national evidence, including Safeguarding Adult Reviews, audits, performance information, Care Quality Commission findings and the experiences of adults, carers and communities. This work has enabled us to agree a clear three-year ambition, supported by stronger governance, measurable outcomes and shared accountability across the partnership.

Over the next three years, we have committed to four equally important objectives: prevention and early intervention; community voice and co-production; learning, culture and workforce effectiveness and partnership, assurance and system leadership. Together, these commitments will help us identify risk earlier, strengthen advocacy and Making Safeguarding Personal, improve practice under the Mental Capacity Act and Deprivation of Liberty Safeguards, promote professional curiosity and information sharing, and ensure that learning leads to measurable improvements in practice and outcomes.

Trauma-informed practice will underpin every priority rather than sit as a separate workstream. We recognise that trauma can affect how people engage with services, communicate, make decisions and build trust. Our commitment is therefore to work in ways that promote safety, trust, collaboration, empowerment, voice and choice; recognise strengths and resilience; respond to inequality and discrimination; and minimise the risk of re-traumatisation.

Delivery will be supported by aligned subgroup work plans, named leads, quarterly reporting, clear escalation of risks, audits, performance dashboards and tracking the impact of Safeguarding Adult Review learning. We will review the strategy annually so that it remains responsive to local needs. Crucially, we will judge our success not simply by the activity completed, but by the difference partnership makes to people's safety, wellbeing, rights and quality of life.

I would like to thank Board members, subgroup Chairs, the Safeguarding Unit and all our partners for their openness, constructive challenge and continued

commitment. I look forward to working with them, and with adults, carers and communities across Cheshire West and Chester, to deliver our shared ambition: that safeguarding is everyone's responsibility, prevention is prioritised and local voices shape how services improve.

Celia Jeffreys - 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 Safeguarding Adult Review (SARs) for any cases which meet the criteria for these 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 Domestic Abuse Board](#)

[Cheshire and Wirral Partnership NHS Foundation Trust](#)

[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](#)

[Weaver Vale Housing Trust](#)

[VoiceAbility Cheshire](#)

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:

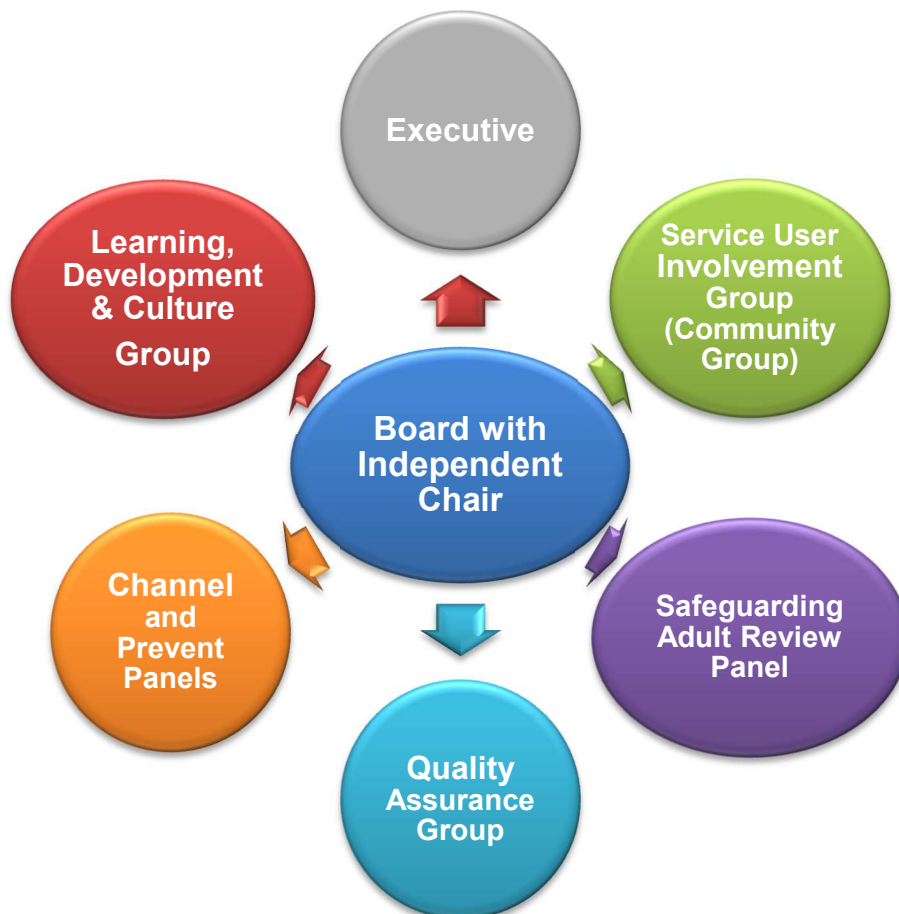
- safe and able to protect themselves from abuse and neglect
- treated fairly and with dignity and respect
- protected when they need to be
- able to easily get the support, protection and services that they need.

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 2025-26?

The Boards Strategic Plan sets out the priority areas over the next three years. To deliver those priorities several annual objectives are agreed. What we have done to achieve our objectives for 2025-26 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.

Our Impact –

Cheshire West and Chester SAB set up an MCA practitioner group to improve mental capacity practice across sectors and frontline services. Key areas of improvement include decision-specific capacity assessments, executive capacity, and clear Best Interest decision evidence and targeted training programmes to ensure sustainable, person-centred safeguarding practice. Regular policy reviews and improved multi-agency information sharing, especially regarding hospital discharge, were essential.

Our Service User group produced an easy read executive summary of our Annual Report and Strategic Plan.

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.

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 –

A key achievement during 2025–26 was the strengthening of collaborative working between the Safeguarding Adults Board and other strategic partnerships, notably the Safeguarding Children’s Partnership, the Community Safety Partnership, and the Domestic Abuse Board. Representatives from these partnerships attend LSAB, and a joint executive arrangement with children’s services has supported closer alignment of priorities, shared oversight, and coordinated responses to complex safeguarding risks that span adults, children, and families.

This integrated approach has delivered tangible benefits for service users. By maximising the impact of shared resources and reducing duplication of work, partners have been better able to identify risk, intervene earlier, and avoid missed opportunities. Joint working has supported a more holistic understanding of individuals’ circumstances, particularly where safeguarding concerns intersect with domestic abuse, exploitation, or community safety issues.

In addition, LSAB worked closely with Pan Cheshire colleagues to share learning from Safeguarding Adult Reviews and to undertake joint activities where common themes emerged. This regional collaboration enabled consistency of learning, avoided siloed responses, and ensured that good practice and innovation were shared beyond local boundaries. The value of this partnership approach was recognised during the LSAB development day, where joint working was highlighted as a key strength. Overall, enhanced collaboration has reinforced a cross-cutting safeguarding system focused on improved outcomes for adults at risk.

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. Training has strengthened collaboration among statutory and voluntary sectors reinforcing shared responsibility.

The training is supported by e-learning, bulletins, 7-minute briefings and updated web resources for wide workforce reach. The website continues to

be developed with revised policies and guidance updated, increased training opportunities and any safeguarding updates both locally and nationally. The highest number of views are in relation to the training page and the professional's area, where policies and procedures can be 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 –

The Board uses self-assessment, peer review, and benchmarking to enhance effectiveness and governance. Our annual board development day reviews impact, governance, and sets priorities for the upcoming year with all board partners. Our planning aligns with Care Act duties, focusing on measurable impact and community priorities. Progress on Safeguarding Adult Reviews and other reviews such as Domestic Homicide Reviews/Domestic Abuse Related Death Reviews, discretionary reviews and LeDeR reviews promote shared learning, challenge, and accountability.

National Safeguarding Adults Week



We took part in the National Safeguarding Adults Week which ran from the 17th to the 21st of November 2025. The theme for the week was **'Prevention: Act before Abuse'**. The week is a time for organisations to come together to raise awareness of important safeguarding issues. The aim is 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 including webinars was promoted.



Training and Development

LSAB continued to prioritise workforce development during 2025–26, recognising that effective safeguarding depends on skilled, confident, and knowledgeable professionals. A total of 210 professionals attended 13 safeguarding courses delivered directly by the Board during the year. Courses covered a wide range of topics, including Safeguarding Adults for Providers and Managers, Basic Awareness of Safeguarding Adults, Prevent and Far Right Extremism, and Domestic Abuse. These sessions were complemented by a suite of e-learning opportunities available across partner organisations.

Training delivery was reinforced through regular e-bulletins, a quarterly training bulletin, and ongoing development of the LSAB website. Updated policies, guidance, and learning from SARs were made easily accessible, with training and professional pages consistently attracting the highest levels of engagement. This multi-channel approach ensured that learning reached a broad and diverse workforce, including staff and volunteers across statutory and voluntary sectors.

The impact of training was evidenced through increased awareness and improved safeguarding responses. LSAB reported a rise in safeguarding concerns, which was interpreted positively as an indication that professionals were more confident in recognising and reporting abuse and neglect. Feedback and case evidence demonstrated that training contributed to stronger professional curiosity, more timely interventions, and improved outcomes for adults at risk. Overall, safeguarding training in 2025/26 played a critical role in embedding learning, strengthening multi-agency practice, and reinforcing the message that safeguarding is everybody's responsibility.



Policies and Procedures

During the reporting period, LSAB reviewed, updated, and produced a range of safeguarding policies and procedures to ensure that learning from Safeguarding Adult Reviews was translated into practice. Key documents included the Self-Neglect Policy, Procedure and Toolkit, the Quality Assurance Framework, the Safeguarding Adults Review Procedure, and Seldom Heard Guidance. These updates reflected recurring SAR themes such as self-neglect, hoarding, mental capacity, coercive and controlling behaviour, and the need to engage effectively with individuals whose voices are often marginalised.

The revised policies were designed to provide clearer guidance for practitioners and managers, support consistent decision-making, and promote person-centred practice. Particular emphasis was placed on aligning Mental Capacity Act policies with current legal and practice

expectations, responding directly to audit findings and national SAR analysis that highlighted gaps in capacity assessment and recording.

All updated policies and procedures were published through the LSAB website, ensuring accessibility for professionals across partner agencies. By embedding SAR learning into formal guidance, LSAB strengthened assurance that practice improvements are sustained over time. This work demonstrated the Board's commitment to continuous improvement and to ensuring that lessons from serious cases lead to tangible changes that enhance safeguarding outcomes.

Safeguarding Adult Review (SAR)

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. The 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 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.

During this period the Safeguarding Adult Review panel received eight referrals of which one met the criteria for a SAR and one met the criteria for a discretionary SAR. Themes included hoarding, self-neglect, mental capacity, information sharing and harmful use of alcohol.

We published two reports during this period, which can be found on our website. Case one was around quality of care provided to the individual in the community and to support their discharges from hospital. Case two looked at the ways in which services respond to adults experiencing hoarding, the response to potential coercive and controlling behaviour, how services work with people who are seldom heard, and how professionals work with the Mental Capacity Act and take account of executive functioning.

New initiatives shaped by SAR themes include: -

Hoarding Alliance Partnership

The Hoarding Alliance unites professionals from a wide range of disciplines including (but not limited to) housing, fire, health, mental health, and social care professionals for coordinated support.

Impact of Coordinated Support

Long-term, coordinated support reduces fire risk, improves health, and enhances living environments for individuals.

Dependent Drinkers Forum

The forum improves coordination around alcohol-related safeguarding risks through community-focused initiatives.



Performance Activity

There continues to be an increase in safeguarding concerns reported to the Local Authority: from 1270 in 2021/2022 to 3981 in 2025/26, representing an increase of 213%. 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. Between 2024/25 and 2025/26, safeguarding concerns increased by 61%. 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 987 in 2025/26, although this is not insignificant, representing a percentage increase of 45%. In 2025/26, safeguarding enquiries accounted for 25% of all adult safeguarding concerns received.

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 41% of concluded cases in 2025/2026 (Neglect and Acts of Omission 41%; Physical Abuse 34%, Emotional & Psychological Abuse 24%). 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 2025/2026, Psychological abuse (also known as Emotional abuse) was the third most reported category of abuse, accounting for 24% 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 62% of concluded safeguarding enquiries. This is consistent with trends identified over the last four years. An increase in abuse reported in a

person's own home has been noted, with a 10% increase compared with the previous year. This is consistent with regional and national trends. Care homes were the second most reported location of abuse in 2025/2026, accounting for 35% 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. Analogous with the previous year, 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 84%, which is an 8% increase when compared with the previous year. Of these, 95% had their outcome fully or partially achieved, the same proportion as the previous year. 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. The proportion has increased slightly this year, from 57% in 2024/25 to 59% in 2025/26. The most reported age group continues to be working age individuals aged 18-64 (38%) which is consistent with the previous two years and represents a 3% increase 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

Quality Assurance and Multi-Agency Audit

The Cheshire West and Chester Local Safeguarding Adults Board uses multi-agency audit to understand how safeguarding arrangements operate in practice, identify areas for improvement, and provide assurance that learning is leading to better outcomes for adults at risk. During 2025/26, the Board's Quality Assurance Subgroup continued to strengthen its approach to audit and developed a draft forward programme designed to examine key areas of safeguarding practice across partner organisations.

The proposed programme is structured around one multi-agency audit per quarter from Quarter 3 of 2026/27. Each audit will involve at least two statutory Safeguarding Adults Board partners and will test whether learning from local and national Safeguarding Adults Reviews is evident in frontline practice.

Current audit actions

The Board's current quality assurance activity is focused on developing a consistent and evidence-based approach to multi-agency audit. This includes establishing common assurance criteria that can be applied across different audit themes, enabling the Board to identify recurring strengths, risks, and barriers.

A central priority is to ensure that safeguarding risk is clearly understood and owned. Audits will examine whether there is a named lead agency or, where responsibility is shared, a clear multi-agency risk management plan. They will also consider whether information is shared in a timely and

proportionate way, and whether decisions and actions are appropriately recorded.

Mental capacity will be a core consideration across the audit programme, particularly when an adult is declining support or when there are concerns about executive functioning. Audit activity will consider whether capacity assessments are decision-specific, timely and clearly recorded, and whether best interests' processes, advocacy and escalation are used appropriately when risks remain high.

The Board will continue to test how effectively agencies recognise and respond to self-neglect. This includes examining professional curiosity, persistence in engagement and the use of escalation or multi-agency risk management arrangements where an adult's circumstances remain unsafe. The Making Safeguarding Personal approach will also be central to this work. Audits will seek evidence that the adult's views, desired outcomes, and involvement in safety planning have informed the safeguarding response.

An important feature of the strengthened approach is the emphasis on impact. The Quality Assurance Subgroup will look beyond whether actions have been marked as complete and will seek evidence that they have resulted in meaningful and sustained improvements in practice. Previous audit actions and recommendations will therefore be revisited to establish whether learning has been embedded and whether changes have improved multi-agency responses and outcomes for adults.

The draft reporting cycle supports this approach. It proposes that audit scope, case samples and tools are agreed in the first month of each quarterly cycle, followed by audit activity and multi-agency moderation in the second month. Findings and actions would then be presented during the third month. Urgent actions and barriers would be monitored through an exception report in the following quarter, with a further impact review undertaken six months later.

Future planned audits

The first proposed audit will examine safeguarding responses involving dependent drinkers. Linked to the Cheshire West and Chester Dependent Drinkers Forum, it will consider risk assessment, escalation, information

sharing, mental capacity, self-neglect, repeat referrals, hospital discharge, and engagement with specialist alcohol services. Adult Social Care, NHS and Integrated Care Board partners, and the Police where relevant, will contribute to the audit.

Furthermore, the audit programme will focus on hoarding and safeguarding practice. This audit will review how agencies respond when hoarding is associated with safeguarding, fire safety, housing, health, or self-neglect concerns. It will explore shared risk management, the use of relevant pathways or panels, engagement with the adult, executive capacity, environmental risk, and outcomes. The proposed partner involvement reflects the multi-dimensional nature of hoarding and will involve core partners including Adult Social Care, Fire and Rescue, NHS and Integrated Care Board partners, Housing, and the Police where relevant.

A further audit will examine PREVENT, safeguarding and risk ownership. Led through the Quality Assurance Subgroup with Community Safety and PREVENT colleagues, it will review referral pathways and the interface between PREVENT and adult safeguarding. Particular attention will be given to risk ownership, information sharing, escalation, multi-agency decision-making and, where relevant, oversight of online risk.

The Board will revisit previous self-neglect audit actions and recommendations. The audit will test whether learning has been embedded, including learning about professional curiosity, Making Safeguarding Personal, multi-agency risk meetings, escalation, and sustained engagement when adults decline support. This will be followed by an audit of Mental Capacity Act practice in complex safeguarding. The work will consider decision-specific assessments, executive and fluctuating capacity, best interests decision-making, recording, advocacy, legal literacy, and escalation in high-risk cases.

The proposed audit programme will conclude with a thematic Safeguarding Adults Review learning assurance audit. This will bring together learning from local and national reviews and from earlier work on self-neglect, mental capacity, dependent drinkers, and hoarding. Its purpose will be to establish whether actions have produced measurable improvements, rather than solely confirming that action plans have been completed.

Through this programme, the Board intends to strengthen collective accountability, support reflective multi-agency learning and maintain a clear focus on the experiences and outcomes of adults with care and support needs.

Case Studies

Disability Positive

The individual was in receipt of Direct Payments and had an allocated Direct Payments Advisor providing ongoing support. The individual's son contacted the service following concerns raised by neighbours, who had reported that the individual had been walking the streets at night and searching through bins. The son also reported a noticeable decline in the individual's ability to manage daily living tasks, including preparing meals, laundering clothing, and maintaining personal wellbeing. He explained that the individual was eating cold food because they were struggling to use kitchen appliances safely. The son advised that previous discussions with Adult Social Care regarding additional support had indicated that funding was not available to increase the existing care package.

Following the concerns raised, a safeguarding referral was made to Adult Social Care. Subsequent liaison with Adult Social Care confirmed that contact had been made with both the individual's son and GP. The Community Team became actively involved and arranged a home visit to undertake an assessment of the individual's needs and circumstances.

The concerns were successfully escalated to the appropriate statutory services, ensuring that the individual received a multi-agency assessment and that potential risks associated with self-neglect and deteriorating wellbeing were appropriately considered and addressed. This intervention helped ensure that the individual's changing needs were identified and reviewed through the appropriate safeguarding and care management processes.

Age UK Cheshire

Marie, in her 60s, lives with poor mobility and spends much of her time at home. Although she has family nearby, she experienced periods of loneliness and enjoyed connecting with other animal lovers through social media. Fraudsters exploited these circumstances after seeing photographs of her pets on Facebook, gradually building a friendly and personal relationship with her and gaining her trust. They then began asking her to purchase gift cards supposedly to support animal shelters. The requests increased until Marie was struggling financially. When she could no longer afford to help, contact stopped and she realised she had been manipulated.

Feeling ashamed and blaming herself, she initially kept what had happened from her family.

Following a referral from a Social Prescriber, Age UK Cheshire's Scams Awareness & Aftercare Project provided regular one-to-one support in Marie's home. Taking a person-centred and holistic approach, we helped Marie understand how the fraudsters had gained her trust, strengthened her online security and reassured her that she was not to blame. We also supported her to reconnect with her community through other Age UK services and local activities, helping to reduce her isolation and rebuild her confidence.

As a result, Marie has gained the confidence to tell her family what happened, strengthened her online safety and begun rebuilding her trust in herself. She now wants to use her experience to help protect others, saying: *"If someone else could read my story and take it in, it may save them from being scammed."* This case demonstrates the importance of recognising fraud as a safeguarding issue and of partnership working to address both the immediate risk of financial exploitation and the underlying factors contributing to vulnerability.

Hoarding Alliance

A referral was made in relation to an adult experiencing significant self-neglect and hoarding behaviours within their home environment. Concerns had been raised by partner agencies regarding the accumulation of items, restricted access throughout the property, increased fire risks, and the impact on the individual's health, wellbeing, and quality of life.

The allocated Social Worker adopted a person-centred and strengths-based approach, recognising that building trust and maintaining a positive relationship would be beneficial to achieving meaningful change, rather than focusing solely on the environmental risks. Time was invested in understanding the person's history, circumstances, and the reasons behind their hoarding behaviours. The case was presented at the Hoarding Alliance, where agencies including Adult Social Care, Housing, Fire and Rescue Service, and Commissioning worked together to develop a coordinated support plan.

Recommendations from the panel were implemented at a pace that the individual felt able to manage, ensuring they remained in control of decisions affecting their home and daily life. Through ongoing engagement and regular reviews, the individual gradually began clearing areas of the property, resulting in improved access, reduced risks, and an increase in their ability to safely use living spaces within the home. Partner agencies provided

practical support and advice, helping to create sustainable change rather than a short-term solution.

Six months later, the case was reviewed by the Hoarding Alliance and positive progress had been maintained, risks had significantly reduced, and the individual reported feeling more confident and optimistic about their living environment. The case demonstrated the value of effective multi-agency working, early intervention, and relationship-based practice when supporting adults experiencing self-neglect and hoarding. It also highlighted the importance of balancing safeguarding responsibilities with respect for individual choice, control, and independence. We felt the key learning from this case included: -

- Building trust and working at the person's pace can lead to more sustainable outcomes.
- Multi-agency collaboration is essential in addressing the complex risks associated with hoarding and self-neglect.
- Positive risk management can support individuals to make lasting changes while maintaining their autonomy.
- Regular review and oversight through specialist panels can help sustain progress and evidence outcomes.

Adult Social Care

KJ was referred to Support to Change Outreach due to significant welfare, safeguarding, and health concerns linked to long-term alcohol dependence. At the point of referral, she was consuming up to eight bottles of wine per day, experiencing frequent falls, repeated hospital admissions for detoxification, and severe self-neglect. She had been removed from the waiting list for a much-needed hip replacement due to ongoing alcohol use.

Following multiple bereavements, the loss of employment, and a breakdown in family support, KJ became increasingly isolated and overwhelmed. Her home environment had deteriorated significantly, with extensive clutter, poor hygiene, broken essential appliances, mounting debts, and disengagement from correspondence, services, and healthcare appointments. Family members feared for her safety and believed she was at risk of drinking herself to death.

Despite a long history of disengagement from services, Support to Change adopted a persistent, relationship-based outreach approach focused on building trust, reducing immediate risks, and addressing practical barriers to recovery. Through regular engagement and hands-on support, KJ reconnected with alcohol treatment services, completing a reduced drinking programme before progressing to an abstinence group. She was supported to address financial issues, engage with Citizens Advice, manage her post

independently, attend healthcare appointments, and begin preparing for a re-referral for hip replacement surgery.

Outreach also worked with KJ to improve her living conditions, securing a replacement fridge/freezer, supporting a boiler replacement grant application, arranging essential mobility equipment, and helping to declutter and organise her home. Alongside these practical interventions, support focused on rebuilding daily routines, confidence, and independence.

The intervention has resulted in significant and sustained positive change. KJ has now achieved nine weeks of abstinence, is actively engaged with recovery services, and has had no emergency service call-outs or hospital admissions since February. She is attending healthcare appointments consistently and is progressing towards hip replacement surgery.

Her physical health has improved considerably, with normal liver function, resolved incontinence, improved nutrition, and increased mobility through the use of a wheelchair and perching stool. Her home environment is safer and better maintained, relationships with care staff have improved, and she is independently managing appointments, daily routines, and personal care.

KJ has also rebuilt her relationship with her daughter and is beginning to reconnect with other family members. While she remains vulnerable, she is more resilient, optimistic about the future, and focused on goals including reducing her care needs, improving her home, rebuilding social connections, becoming financially stable, and returning to meaningful activities and employment. The intervention has not only improved KJ's quality of life but has also significantly reduced demand on emergency health and social care services.

Domestic Abuse Intervention Prevention Service

Lucy (not her real name) was referred to the Domestic Abuse Intervention and Prevention Service (DAIPS) following a high-risk referral from the police concerning suspected honour-based abuse within her family. At the time of referral, Lucy was under the age of 18 and living in circumstances that placed her at significant risk of harm. Initial engagement proved challenging. Lucy questioned the involvement of the police and Children's Social Care and was reluctant to engage with assessments or disclose the full extent of her experiences.

Recognising the complexity and sensitivity of the situation, DAIPS adopted a patient, trauma-informed approach that prioritised trust-building and safety. Due to the risks associated with contact at home, the Independent Domestic Violence Adviser (IDVA) established regular meetings with Lucy at her college. These multi-agency meetings involved the college safeguarding

lead, tutor, and a specialist honour-based abuse charity that was also supporting Lucy. Over time, Lucy's confidence in professionals grew, and she became increasingly willing to discuss her circumstances and engage with support.

Given the level of risk identified, Lucy was referred to the Multi-Agency Risk Assessment Conference (MARAC). The MARAC process enabled partner agencies to share information and coordinate safeguarding actions, including measures specifically relating to honour-based abuse. Through this process, the IDVA gained a fuller understanding of the risks posed by wider family members and worked with Lucy to develop comprehensive and dynamic safety plans. Importantly, Lucy began engaging with the police, a significant milestone given her initial reluctance to do so. Discussions also took place around civil protective orders, although Lucy initially felt unable to pursue these while she remained living at home.

A key aspect of the case was respecting Lucy's wishes whilst carefully managing risk. Although professionals identified an urgent need for her to leave the family home, Lucy wanted any departure to happen on her own terms and at a time she felt able to manage. Several months later, when Lucy fled to a friend's address, DAIPS was able to respond quickly, implementing additional safeguarding measures including the provision of a new mobile phone, requesting police markers, and reviewing safety arrangements. The IDVA then supported a referral to refuge accommodation, and Lucy was successfully placed in a refuge within her preferred area, enabling her to maintain contact with positive support networks and continue her education.

Alongside addressing immediate safety concerns, the support focused on helping Lucy establish independence and recover from the impact of abuse. The abuse she experienced included financial control, with restrictions placed on her ability to work or access her own income. Following her move into refuge, the IDVA supported applications for benefits and helped her access financial support. Lucy subsequently secured her own employment while also successfully completing her college qualification. Once she was safely accommodated, she felt able to engage with Children's Social Care and disclosed further details about her experiences within the family home.

Throughout the intervention, the IDVA maintained regular communication with key partners, including the college, police, Children's Social Care, and the specialist honour-based abuse service. This collaborative approach ensured risks were continually monitored and that swift action could be taken when concerns arose, including supporting college staff with safety planning when Lucy unexpectedly failed to attend lessons.

As Lucy's situation stabilised and she became supported by refuge services, the DAIPS case was initially closed. However, shortly afterwards partner agencies requested further assistance in relation to a court hearing for a non-molestation order. DAIPS provided practical and emotional support, helping to arrange safe transport to court and ensuring special measures, including separate waiting areas and protective screens, were in place. The application was successful, and the non-molestation order was granted immediately before the review of police bail conditions, ensuring Lucy remained protected through both civil and criminal justice processes.

Lucy has since continued to rebuild her life. She is living in safe accommodation, has completed her college studies, secured employment, and is accessing her own income and benefits. She has obtained legal protection through civil orders, continues to engage with the police investigation, and is receiving housing support to secure longer-term independent accommodation. Most importantly, she is now able to make choices about her own future free from the control and abuse she experienced within the family home.



Our Strategic objectives and priorities 2026-2029

This year we 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.

The revised Strategic Plan explains the work we will do over the next three years. We will check it every year so that it continues to respond to local needs. We will focus on four equally important objectives. We will work with our partners to make progress on these objectives by 2029. We chose them by looking at local, regional and national information, including learning from Safeguarding Adult Reviews, audits, performance data and Care Quality Commission findings.

Prevention and Early Intervention

Strategic Objective 1: To strengthen early identification, prevention and intervention through coordinated multi-agency working, helping to identify risks earlier and improve outcomes.

Outcome

People receive the right support at the earliest opportunity, reducing risk and preventing escalation into crisis.

Priorities

- Embed a prevention-first safeguarding approach.
- Improve pathways and processes that support earlier intervention.
- Promote awareness of safeguarding across communities.
- Improve understanding of thresholds and access to support.
- Strengthen integrated neighbourhood working.
- Use horizon scanning to identify emerging risks and opportunities.
- Reduce future demand through effective prevention activities.
- Improved partnership working

Success Measures

- Reduction in crisis interventions.
- Earlier identification of safeguarding concerns.
- Improved outcomes for individuals and families.
- Increased community awareness of safeguarding.
- Reduced demand for reactive services.

Community Voice and Co-production

Strategic Objective 2: To embed co-production and lived experience across all safeguarding activity, ensuring that communities, service users, carers and under-represented groups influence planning, delivery and evaluation.

Outcome

People with lived experience and communities actively shape safeguarding priorities, services and system improvements.

Priorities

- Embed co-production in planning, commissioning and service delivery.
- Actively seek and use lived experience.
- Increase community participation and engagement.
- Improve accessibility and inclusion.
- Reduce stigma through effective communication and language.
- Build community resilience and social connectedness.

Success Measures

- Increased community participation.
- Demonstrable examples of co-produced services and initiatives.
- Improved service user satisfaction and experience.
- Greater diversity of voices influencing decision-making.
- Increased public confidence in safeguarding arrangements.
- Lived experience representation in governance and decision-making
- Engagement with seldom-heard communities
- Stronger community links and participation
- Increased awareness of advocacy and support services

Learning, Culture and Workforce Effectiveness

Strategic Objective 3: To create and sustain a positive culture that supports learning, continuous improvement, collaboration and effective use of resources.

Outcome

A skilled, confident and resilient workforce working within a culture of continuous learning, accountability and improvement.

Priorities

- Invest in workforce development and training.
- Strengthen recruitment, retention and succession planning.
- Support staff wellbeing and resilience.
- Promote a learning culture across the partnership.
- Capture and share learning from reviews, audits and practice.
- Ensure practitioners understand their safeguarding roles and responsibilities.
- Build confidence in professional challenge and accountability.

Success Measures

- Improved workforce satisfaction and retention.
- Increased training participation and competence.
- Reduced vacancies.
- Strong evidence of learning informing practice.
- Improved confidence in safeguarding responsibilities.
- Shared values and behaviours

- Effective communication and collaboration
- Resource and capacity management
- Improved documentation and knowledge management

Partnership, Assurance and System Leadership

Strategic Objective 4: To develop effective leadership, governance and accountability arrangements that support collaborative decision-making and shared ownership across partner organisations.

Outcome

Partners work effectively together, provide strong leadership, deliver robust governance and demonstrate measurable impact.

Priorities

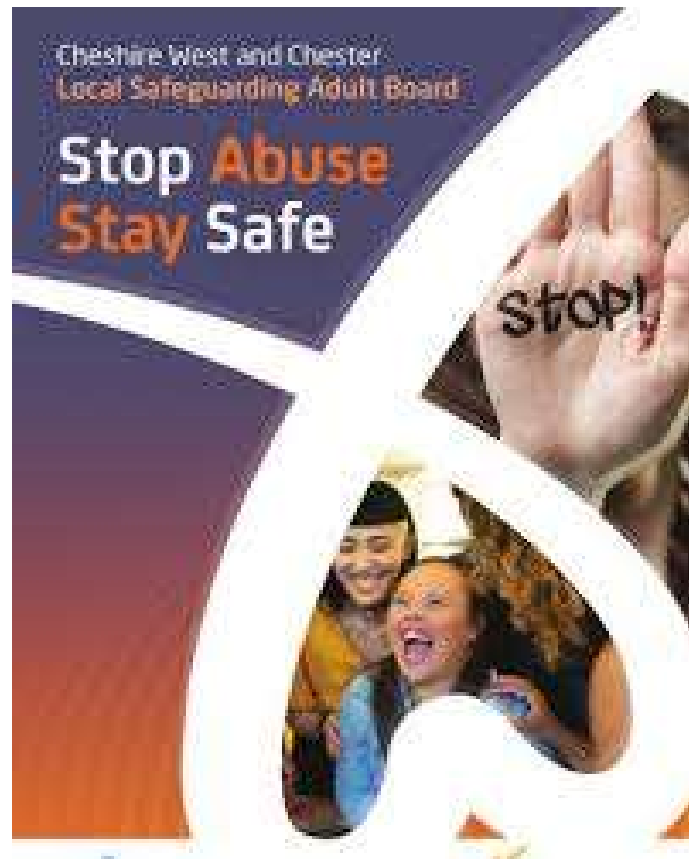
- Create clarity of purpose, roles and responsibilities.
- Strengthen relationships between boards, organisations and practitioners.
- Ensure the right partners are represented.
- Improve multi-agency information sharing.
- Review governance structures to reduce duplication.
- Strengthen assurance arrangements.
- Focus on outcomes and impact, not simply activity.
- Use evidence and intelligence to inform decision-making.
- Demonstrate effective system leadership across safeguarding arrangements.

Success Measures

- Stronger partnership effectiveness.
- Better information sharing.
- Evidence of impact and improved outcomes.
- Reduced duplication across partnership structures.
- Multi-agency systems and processes
- Clear governance structures and Terms of Reference
- Defined responsibilities and escalation routes
- Board-level leadership and strategic ownership
- Streamlined approvals and decision-making
- against priorities

Strategic Success Statement

By the end of the strategy period, partners, communities and people with lived experience will work together within a strong safeguarding culture that prioritises prevention, promotes learning, strengthens accountability and delivers measurable improvements in safety, wellbeing and quality of life for local people.



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

Author: Dawn Lewis
LSAB@cheshirewestandchester.gov.uk