Telford and Wrekin Safeguarding PARTNERSHIP

Safeguarding Adults Board Annual Report

April 2025 - March 2026

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Introduction from the Chair

Hello

This is the last Annual Report for me as Independent Chair of the Safeguarding Adult's Board. I will be leaving at the end of March 2026, but I am very proud of the work the Board has achieved in the last twelve months, and since I took on the role in 2024.

To provide some context, The Care Act 2014 says that we must have a Safeguarding Adults Board (SAB), to help safeguard people who have care and support needs from abuse and prevent harm happening to them. My role as Independent Chair has been to ensure that happens; that the appropriate agencies provide adequate assurance, take the right action and where they don't, hold them to account.

By law, three core members make up the Telford and Wrekin Safeguarding Partnership (TWSP), Telford & Wrekin Council, West Mercia Police and the Integrated Care System but we endeavour to put the people of Telford and Wrekin at the centre of all our discussions and decision making.

We published our Strategy in March 2025, which outlined our future priorities. However, we always intended it to be a living strategy; monitored and amended, as circumstances and people's needs changed. Therefore this year, where we were satisfied with the action being taken by agencies, we have consolidated some of our original priorities and placed more emphasis on others, for example self-neglect, which has sadly become a theme locally and nationally. We still believe in the importance of good communication with our communities in Telford and Wrekin and while some good progress has been made, we know this is something we need to work much harder on, especially the diverse groups who do not naturally engage with the work we do. We are pleased there has been some progress in sharing, understanding, and using the data each member of TWSP holds.

This year we have continued to review more cases, which sadly reached the threshold for a Safeguarding Adult's Review. It is our responsibility to ensure that when things have gone wrong, and abuse has occurred to people with care and support needs, genuine lessons are learnt and changes to practice made by the agencies involved.

Where we identified areas for learning and action, we shared that learning with the people working across Telford and Wrekin Partnership to ensure the people of Telford and Wrekin remain free and safe from harm.

Legally the SAB has three core duties::

- develop and publish a strategic plan setting out our objectives, how we will meet them and how the board members and our partner agencies will contribute;
- ensure Safeguarding Adult Reviews take place for any cases which meet the criteria; and
- publish an annual report like this one, which details how we have fulfilled our statutory obligations.

I would like to take this opportunity to thank all of those people and agencies who continue to work tirelessly in Telford and Wrekin, to make it a safer place for those adults who need our support and extra protection.

Sue Howard

Independent Chair of Telford and Wrekin Safeguarding Partnership

Who makes up the Telford & Wrekin Safeguarding Adults Board and what does it do?

Telford & Wrekin Council, West Mercia Police and Shropshire, Telford & Wrekin Integrated Care Board ICB have a statutory duty to put in place multi-agency safeguarding arrangements to protect and safeguard vulnerable adults. This responsibility is driven by the Telford & Wrekin Safeguarding Adults Board which is funded, equally, by the three statutory partners.

Membership of the Board is drawn from:

- Shropshire Community Health NHS Trust
- Shrewsbury and Telford NHS Hospital Trust
- Midlands Partnership NHS Foundation Trust
- Partners in Care
- Making it Real Board
- Healthwatch
- Chief Officers Group

The Board has agreed its core focus as:

- put the person who has been harmed or at risk at the centre of everything that we do and listen to their views about what we can do to improve the safety of people;
- hold members to account – are we/they doing enough to keep people safe;
- collect and share information about how well we are keeping people safe and what more we could do;
- make sure our workers and volunteers get the training they need to provide safe services and share concerns if they think a person is being hurt or abused;
- review our policies and guidance to make sure we are constantly improving; and
- raise awareness of safeguarding issues and what to do.

How the Board does things is as important as what it does. To shape how it delivers its role, the Board has adopted the following principles and values::

- **Empowerment** – presumption of person led decisions and informed consent;
- **Prevention** – it's better to take action before harm occurs;
- **Proportionality** – proportionate and least intrusive response appropriate to the risk presented;
- **Protection** – support and representation for those in greatest need;
- **Partnership** – local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting abuse and neglect; and
- **Accountability** – accountability and transparency in delivering safeguarding.

The Board is chaired by an Independent Chair appointed by the three statutory partners with the objective of providing independent challenge and scrutiny. As part of our arrangements for external challenge, the Chair presents the Board's annual report to the Health & Wellbeing Board.

To drive delivery of its objectives, the Board has a series of groups which feed into its work as set out below:

Telford and Wrekin – the place

Telford and Wrekin is a Borough of contrasts. At its heart is Telford, a New Town created in 1968 that has grown around long established communities such as Wellington, Oakengates, Dawley and Madeley. Along the River Severn sits Ironbridge, the birthplace of the Industrial Revolution and now a UNESCO World Heritage Site. Beyond the main town is a wide rural area, which makes up more than two thirds of the Borough.

Our changing population – Telford and Wrekin continues to grow quickly. Between mid 2021 and mid 2022, the population increased by just over **3,000 people (1.6%)**, making it one of the fastest growing areas in England and Wales, with a **5.4% rise** between 2021 and 2024 [telford-live.com]. The Borough's **older population is increasing particularly quickly**, growing faster than the national average. Between 2011 and 2021, Telford and Wrekin saw one of the largest rises in older residents in the country [telford.gov.uk].

Why this matters for safeguarding – As more residents grow older, we are seeing changes in the types and complexity of safeguarding concerns. These include:

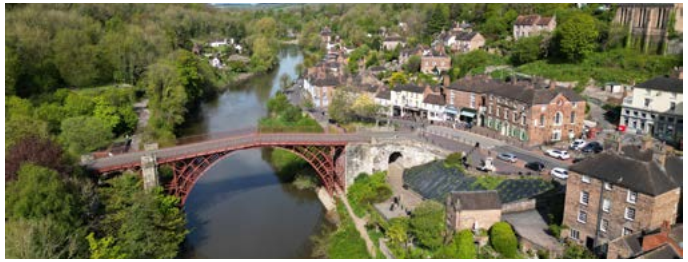
Growing age related risks

- Self neglect
- Financial scams or exploitation
- Dementia and other conditions affecting memory and decision making
- Abuse or neglect involving carers

More need for joined up support – People may require help from several services at the same time, including:

- Health services (especially for frailty, falls and dementia)
- Housing support
- Emergency services

More complex safeguarding enquiries - Older adults may face multiple overlapping challenges, such as physical health needs, mental health difficulties, loneliness and barriers to accessing care. Together, these can make safeguarding concerns more complicated and require stronger partnership working.



What have we achieved in the last 12 months against our priorities?

As a SAB we identified that the following workstreams would form the basis of our priorities:

- **Priority One:** Understand better the levels of exploitation amongst our communities and ensure the right action is taken.
- **Priority Two:** Understand better the levels of intra familial abuse of older people in our community and ensure the right action is taken.
- **Priority Three:** Understand better the levels of self-neglect in our communities and ensure the right action is taken.
- **Priority Four:** Improve the experience of people needing to transition between the services in our community.
- **Priority Five:** Reduce the time it takes to complete a s.42 (safeguarding) enquiry – *this was achieved in the previous financial year with ongoing monitoring of timescales taking place within the Adults Review, Learning and Training subgroup.*
- **Priority Six:** Improve the way we work with and listen to people representative of all our communities to ensure our work is fully inclusive and reflective of their views and experiences
- **Priority Seven:** Ensure we are using data to its full potential to inform our decisions and target support.
- **Priority Eight:** Learn from local and national Safeguarding Adults Reviews to inform local actions and ensure lessons are learnt the first time

An essential objective of this report is to demonstrate the impact of the Board and the multi-agency safeguarding arrangements that it has put in place. The following part of the report takes a look at the work and activities which have taken place to address these priorities and ensure safeguarding continues to strengthen.

After careful consideration and discussion amongst partners over the last year, the SAB has been able to consolidate its original priorities for 2025-2026 due to identifying work streams already in place across the partnership to address priorities one, two and four detailed above. It is felt that by targeting our priorities in this way it will allow a renewed focus upon the remaining areas.

Priority Three: Understand better the levels of self-neglect in our communities and ensure the right action is taken.

The SAB has identified the action needed to recognise and respond to the risk of self-neglect. Self-neglect can include the following[1]:

- lack of self-care to an extent that it threatens personal health and safety;
- neglecting to care for one's personal hygiene, health or surroundings;
- inability to avoid harm as a result of self-neglect;
- failure to seek help or access services to meet health and social care needs;
- inability or unwillingness to manage one's personal affairs.

[1] Social Care Institute for Excellence 2024. https://www.scie.org.uk/self-neglect/at-a-glance/

The SAB have recognised that this is both a local and national issue. A National review has identified that across the country 60% of all Safeguarding Adult Reviews have involved self-neglect[2] and as such the SAB has created a priority group to address this trend locally. The group has met on four occasions since its creation in September with its focus being to address the following key factors from the national learning:

- home conditions not quantified, or deterioration understood;
- person's views or desired outcomes not featured;
- executive function not considered;
- lifestyle/unwise decision reason for lack of assessments;
- significance of medical conditions not understood;
- alcohol and drug use not deemed to be self-neglect;
- self-neglect not seen as a care and support eligible need;
- lack of awareness about Section 11 of the Care Act;
- need to grade level of self-neglect.

Membership of the group consists of ICB (who acts as chair for the group), principle social worker, safeguarding strategic lead and safeguarding team manager and representation from the independent sector via Partners in Care who have brought key subject matter expertise. The learning from the 2nd National SAR analysis highlighted the need for local processes and guidance to be in place and this is actively being addressed within Telford, based on sharing best practice and resources from elsewhere in creating comprehensive guidance that provides a manual to meet all the above points. The group have also considered the self-neglect themed SARs following the deaths of two men who had complex problems which reinforces the importance of this work. These have yet to be published so updates will be provided in next years annual report

[2] Second National SAR Analysis

Priority Six: Improve the way we work with and listen to people representative of all our communities to ensure our work is fully inclusive and reflective of their views and experiences.

This priority has been the golden thread running through all aspects of our work this year. We have continued work on the new Communication and Engagement strategy with support from lived experience and neurodiversity groups. The strategy will detail how we will communicate and consult with all communities across Telford throughout the year and an action plan to achieve this consistently is currently being formulated. We look forward to publishing this new document in the near future.

We have developed new QR stickers to allow feedback to be shared from safeguarding lived experience clients.

A new safeguarding animation was launched on the TWSP website which covers the topics of neglect, exploitation and domestic abuse in a short easy to understand manner, the animation can be viewed here LLR Safeguarding.

A key event which took place this year was the Coproduction conference, which was attended by multiple members of the SAB, including the independent chair, who also delivered a presentation.

We continued to grow our support for the annual Safeguarding Adults Week campaign through a week long timetable of learning events for safeguarding workers including a face-to-face drop in day at the town centre. This resulted in 52 direct engagements with members of the public, including direct interventions with people requiring mental health support. Arriva buses kindly displayed our safeguarding poster in their bus fleet during November to help spread safeguarding resources and support throughout communities.

Finally, the Telford and Wrekin Safeguarding Partnership website is currently being revamped to make it easier to navigate and locate information for both professionals and members of the public. This is being done in partnership with the Making It Real Board to include input from lived experience and neurodiverse user groups to ensure content is accessible to all.

Priority Seven: Ensure we are using data to its full potential to inform our decisions and target support.

The Board's data subgroup has improved how information is collected and shared so that we can better understand safeguarding concerns across Telford & Wrekin. This year, we introduced a new set of data specifically focused on Safeguarding Adults Reviews. This helps us identify important themes and patterns, so we can target learning and awareness where it is most needed. A similar approach is now being developed for Domestic Homicide Reviews.

We are also working on making our data easier to understand by improving how it is visually presented, helping it tell a clearer story about people's real experiences.

At the same time, we recognise that numbers alone do not give the full picture. The data subgroup will therefore be looking at how we can include more personal, qualitative information and compare our findings with other Safeguarding Adults Boards nationally, to help us keep learning and improving.

Priority Eight: Learn from all our Safeguarding Adults Reviews to inform local actions and ensure lessons are learnt the first time.

The Safeguarding Adult Review subgroup and the Adult Review, Learning and Training (ARLT) subgroup work closely together to promote how we ensure the lessons from case reviews do make a difference. Telford and Shropshire has now launched a new reflective learning toolkit which allows practitioners time and space to reflect on the individual cases and discuss how this has changed practice. This toolkit will enable the SAB to understand how learning is implemented, from the work of the SAR Panel, within partner agencies.

All local review themes and trends from across Safeguarding Adults Reviews, Domestic Homicide Reviews and Childrens Safeguarding Practice Reviews are captured in a thematic spreadsheet. This ensures that where learning is identified from one Board which can be useful to another Board it is shared at the earliest opportunity and ensures that key learning can be brought together to avoid duplication and ensure common areas of concern are addressed.

The SAB also takes a proactive approach when it comes to national emerging themes and trends by utilising learning and developments from SAR's in other areas. Regular attendance at national meetings allows for the free flow of information to take place and best practice to be shared, an example of this is current work taking place to adapt guidance around bariatric care and support.

Safeguarding Adult Reviews (SAR's) and Domestic Homicide Reviews (DHR's)

The purpose of the **SAR Panel** is to meet the statutory requirements of the Care Act 2014, the Local Safeguarding Adult Board[3] has a responsibility to conduct Safeguarding Adult Reviews (SARs). This Sub-group has delegated authority to undertake this activity to promote a culture of continuous learning and improvement across the organisations by using learning from case reviews to drive improvements in practice and is made up of representatives from Adults Social Care, the Integrated Care Board (ICB), Shropshire and Telford Hospitals Trust (SaTH), Shropshire Community Health Trust (SCHT), Midlands Partnership Foundation NHS Trust (MPFT) and West Mercia Police.

[3] This is now known locally as Telford and Wrekin Safeguarding Partnership

We have not received any SAR referrals this year, however, have continued work on the previous reviews resulting in the publication of the three SAR's detailed below.

Lou's SAR – published June 2025

This case review considered the death of a 40-year-old person who resided within supported accommodation. They received full-time care due to having disabilities and underlying health conditions including severe epilepsy which was eased with the use of a Vagus Nerve Stimulation (VNS). The following recommendations were made following the independent review:

- Assurance should be sought around procedures reinforcing the need for a single multi agency plan to be developed in complex cases. If single agency reviews have taken place these should be shared with other agencies involved with the person. This should be audited regularly to ensure this is happening.
- Assurance should be sought that the outcomes and recommendations from Section 42 enquiries are being shared at the earliest opportunity with all relevant organisations, including care providers.
- Social Care should ensure that all guidance and templates address the issue of suitability of the care plan, taking into account identified risks such as fire or medical emergency.
- The CQC and Social Care should use the findings of this review for future quality assurance of Home farm trusts provision Telford.
- The assistive technology team should ensure clarity on roles and responsibilities of provision and maintenance of the equipment in cases where the care providers have their own technical support team, along with ensuring there is a contingency plan in place in case of equipment failure.

- Assurance should be sought that all care providers and community based professionals are aware of the ‘acid test’ in relation to DoL’s criteria and the process to follow for identified cases.
- Telford and Wrekin Safeguarding Partnership should remind care providers and agencies not to initiate any investigation following a death where there is police involvement.

Click here to access the full report.
Click here to access the learning briefing.

Violet’s SAR – published January 2026

This case review considered the death of Violet, a 75-year-old woman, in May 2024. She lived in a Wrekin Housing Group bungalow with her son, supported by her daughter and a care package delivered by an external agency (2 calls daily). Violet attended a day centre and enjoyed social activities. Her health conditions included reduced mobility, right-side weakness from strokes, and ulcerated legs. She used a wheelchair and required support for personal care. Violet died in hospital on 15 May 2024 following admission with sepsis and pneumonia. The following recommendations were made following the independent review:

- All agencies to ensure staff have an increased awareness of the role of the MDT and ensure staff make relevant referrals that meet the safeguarding threshold.
- All agencies involved to ensure all staff are aware of escalation policies in their own agencies and utilise appropriately and also be aware that local authorities have their own escalation processes, should practitioners not agree with a decision that has been made.

Click here to access the full report.
Click here to access the learning briefing.

Patricia's SAR – published February 2026

This case review considered the death of Patricia, a 74-year-old woman who died in February 2024. Patricia was born in 1949 in South Africa. Her daughter Christine identified that Patricia had been in this country since 2016 and had been bedbound since 2020 due to multiple complex health conditions meaning she had full care and support needs in respect of personal care. The Review was commissioned because there was reasonable cause for concern about how agencies worked together to safeguard Patricia. Patricia's report highlights complex challenges of health, care, self-neglect, family responsibility, immigration status, and system response. The following recommendations were made following the independent review:

- All agencies to place a greater emphasis on professional curiosity. To revise the current face to face training programme updated training package to raise awareness about the value of exploring home circumstances/relationships further.
- All agencies to ensure staff have an increased awareness of the role of the MDT and ensure staff make relevant referrals that meet the safeguarding threshold.
- All agencies to ensure staff have easy access to information and assessment tools (such as self-neglect toolkit) this is vital as part of the ongoing support given to staff within all agencies working with adults at risk, to help them maintain their professional knowledge and understanding of complex safeguarding issues and where to go to get the help.
- The Home Office to consider a review of information that is available to health and care professionals and families when applying for and being granted an ancestry visa. (The panel also recommended an easy read version).

Click here to access the full report.
Click here to access the learning briefing.

A Safeguarding Adults Review Panel is in place to monitor delivery and improvement against these, and all recommendations coming from SAR's.

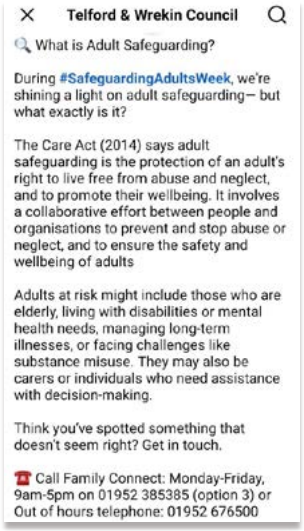
Members of the SAB offer their deepest sympathy to the families who have lost loved ones and we thank them for their bravery in contributing to the reviews and helping us make improvements.

Training and development

All partners have mandatory safeguarding training in place where compliance is monitored and considered as part of the Care Act audit and ongoing assurance work within the Adults, Review, Learning and Training sub group.

In addition to these mandatory courses the SAB offers a constant E-Learning training offer which is extended to all partners through the Telford and Wrekin Council online learning environment and can be accessed at a time to suit them. This site includes multitude of training packages including Exploitation and Vulnerability, Adult Safeguarding, The Care Act 2014, Deprivation of Liberty Safeguards (DoLS), Domestic Abuse Awareness and Hoarding to name but a few.

We have continued to work with the Council comms team in highlighting key messages through social media. This year we have created a number of social media post around domestic abuse (as part of the White Ribbon campaign) and also daily posts through Safeguarding Adults Week.



The following bespoke 'lunch and learn' sessions have taken place between April 2025 and March 2026 in collaboration with our partners and has allowed **over 149** professionals access to courses, seminars and learning material to develop their practice and expertise even further, to help protect the residents of Telford and Wrekin:

- **Understanding vulnerability in adults and spotting the signs of exploitation**
- **Modern Slavery Awareness**
- **Alcohol and drug services in Shropshire and Telford**
- **Adult Safeguarding – Prevention**

The following 7-minute briefings have been developed and circulated among partners to raise awareness and understanding:

- **Online Safety**
- **SAR Library and the Second National SAR Analysis Key Messages**
- **Trauma Informed Practice**
- **Professional Curiosity Learning Briefing**
- **Information sharing**
- **Non-fatal strangulation**
- **Gaining Access**

A new online SAR awareness package has been created and is available to staff across all agencies in Telford and Wrekin. A similar package is being designed in relation to Domestic Homicide Reviews. These online awareness packages will help prepare staff to be involved in any reviews and reinforce and assure those involved that any review process is not about apportioning blame but is to focus on learning and positive change.

Quality and performance

The purpose of the Adult Review, Learning and Training (ARLT) subgroup is to promote a culture of continuous multi-agency learning and improvement throughout the partnership.

The ARLT subgroup is made up of representatives from Adults Social Care, the Integrated Care Board (ICB), Shropshire and Telford Hospitals Trust (SaTH), Shropshire Community Health Trust (SCHT), Midlands Partnership Foundation NHS Trust (MPFT), Healthwatch, Partners in Care and West Mercia Police. The group meets quarterly and between April 2025 and March 2026 the subgroup has undertaken the following activities:

- Contributed to multiple online and in person events to mark Safeguarding Adults Week, including a town centre drop in for members of the public and professionals to seek advice.
- Completed all actions identified as part of the Care Act audit for 2023-2025 and undertaken a further audit for 2025-2027.
- Completed all actions identified as part of the ARLT Terms of Reference refresh and audit.
- Completed all actions identified within the ARLT Peer Review analysis work undertaken in 2024-2025.
- Undertaken a review of the Quality Assurance Framework and Standards. The purpose of this document provides assurance that safeguarding arrangements are effective in protecting adults from abuse and neglect. It acts as the mechanism for the SAB to hold partner agencies accountable for their safeguarding responsibilities and aligns safeguarding practice with the Care Act 2014 and Making Safeguarding Personal (MSP) principles. It ensures safeguarding practice is consistently monitored, evaluated, and improved across all agencies and supports a culture of continuous learning and improvement in safeguarding work.
- Undertaken a benchmarking exercise of Telford data using NHS data to understand themes and trends and identify any areas where we are outliers.

Another key area for both the SAR group and the Adult Review, Learning and Training is to ensure that the SAB supports front line teams in embedding the learning from case reviews. Nationally there is evidence from statutory case reviews of the repetition of some learning that suggests we need to improve how as a system we get messages to front line teams to reduce the need to repeat learning. Self-neglect would feature highly in that category.

The subgroup have developed and started to use a new template to promote whole team exploration of SAR recommendations which sets out evidence of how Teams have engaged with and applied the learning through a structured approach by going through five questions asking the team to think about the learning, then ask themselves could this happen hear before agreeing as a team how they can put some changes in place. Progress will be reviewed in next year's annual report.

Partner engagement

The Safeguarding Adults Board held four scheduled meetings during the year. These quarterly meetings are planned a year in advance to give partners as much notice as possible and support strong attendance. In addition, the Board held five extraordinary meetings. These are convened when urgent or emerging safeguarding issues need to be discussed, or when the Board must receive and agree the recommendations from Safeguarding Adults Reviews (SARs). Because extraordinary meetings are arranged at shorter notice, they can occasionally overlap with other safeguarding commitments across the partnership. When this happened, partners often provided written comments or updates beforehand so their views could still inform discussions and decision-making.

All quarterly meetings were quorate, ensuring the Board had the required representation to make decisions appropriately. It is also important to note that physical attendance alone does not reflect partners' overall involvement. Many continued to contribute actively between meetings, supporting the Board's work throughout the year.

A heartfelt thank you to...

- All the individuals and families who have taken the brave step to share their experiences and worked with us in pushing for change.
- The 100's of professionals up and down the borough who have continued to support the partnership, their colleagues and the residents of Telford and Wrekin.

To find out more about the Telford and Wrekin Safeguarding Partnership and access resources please visit **www.telfordsafeguardingpartnership.org.uk**