Halton Safeguarding Adults Board

Annual Report 2018-2019

HALTON
SAFEGUARDING
ADULTS
BOARD

Who are the Partners of the Board?

HALTON BOROUGH COUNCIL

The Council

Cheshire Constabulary

The Police

CHESHIRE FIRE AUTHORITY

Cheshire Fire Service

Halton NHS
Clinical Commissioning Group

Halton CCG

Mid Mersey age UK

Mid Mersey Age UK

National Probation Service

National Probation Service

Public Health England
myhalton living life well

Public Health

healthwatch Halton

Healthwatch

Bridgewater Community Healthcare NHS
NHS Foundation Trust

Bridgewater Community Services

SHAP

SHAP

HALTON Safeguarding Children Board

Children and Young People Partnership Board

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MESSAGE FROM THE CHAIR

As the Independent Chair of Halton Safeguarding Adult Board I am very pleased to present the annual report 2018/19. All Safeguarding Adults Boards are required to publish an annual report and analyse the effectiveness of the work across agencies to safeguard those adults who require additional support and care. I hope you find the report informative and useful.

During 2018/19 Halton saw a slight decrease in the number of safeguarding concerns raised. Older adults (75 plus) remain the largest group to require support with safeguarding and if living at home, can be vulnerable to experiencing neglect or acts of omission.

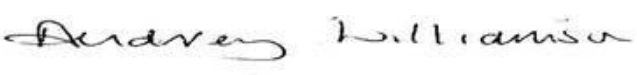
The Integrated Adults Safeguarding Unit remains a key strength in Halton and ensures that there is a prompt and consistent response to safeguarding concerns in the Borough. Work with care homes has also continued, with those homes that required improvement being a priority.

This year the Safeguarding Adults Partnership Forum has focused on self-neglect and hoarding; these are areas that staff across all professions were keen to learn about and improve their practice. This work has culminated in a recent relaunch of the Halton Self-Neglect Panel and the Forum chose to hold our annual event on these subjects. Merseyside Fire and Rescue service were particularly helpful in raising awareness of the potential high risks of hoarding by individuals and gave a very informative presentation.

Partnership working in Halton has continued with support for the Safeguarding Adult Board from the three key agencies, Cheshire Police, Halton Clinical Commissioning Group and the Local Authority. In addition, the work of the sub groups have contributed to developing an accurate reflection of safeguarding activity in Halton and to develop and support work in the community. The Faith Sector sub group has been particularly supportive in this work. Safeguarding Adults work in Halton continues to be a key priority, despite the demand on limited resources.

Challenges remain; we still wish to strengthen the voice of those who require services and ensure they influence services and how they are delivered.

I would like to take this opportunity to thank all those who have worked hard this complex area and for the support provided to both the Board and myself over the last twelve months. It has been a very positive year and I'm confident that the commitment and work will continue.



Audrey Williamson – Independent Chair, **Halton Safeguarding Adults Board**

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SECTION 1: OUR VISION

Everyone deserves to live a safe and happy life and we have a duty to care for those people who may need more support to enable them to live a safe and happy life too.

Safeguarding Adults is managed well in Halton and Halton Safeguarding Adults Board has shown a continuous strive for improvement in fulfilling it's statutory duties and a dedication to seeking and providing the best possible care and support to protect those members of our community that need it. This report provides a brief summary of the activities for the year 2018/19.

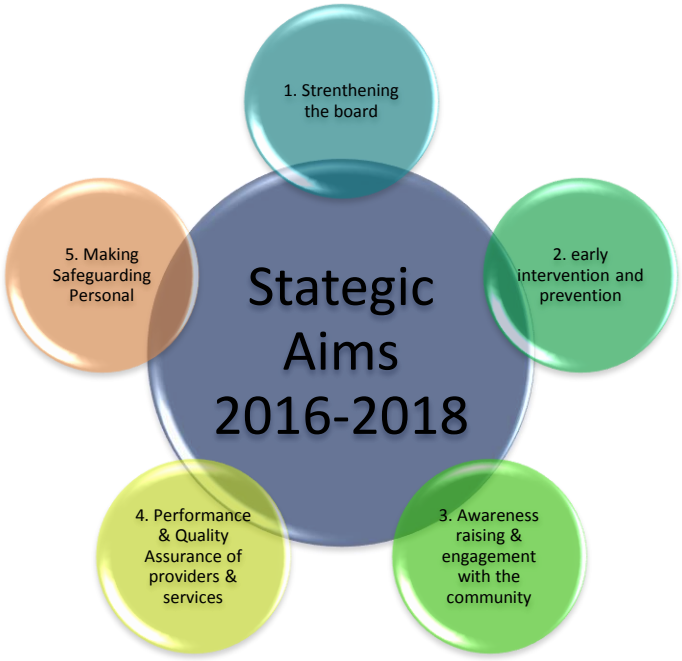
Definition of adult safeguarding

The Care Act 2014 defines adult safeguarding as protecting an adult's right to live in safety, free from abuse and neglect. It's about organisations and people working in partnership and everyone taking responsibility for learning about what abuse is and what to do if abuse happens. Safeguarding balances the right to be safe with the right to make informed choices.

Six key principles that underpin all adult safeguarding work

EMPOWERMENT	People being supported and encouraged to make their own decisions and informed consent. “I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens”
PREVENTION	It is better to take action before harm occurs. “I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help”
PROPORTIONALITY	The least intrusive response appropriate to the risk presented. “I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.”
PROTECTION	Support and representation for those in greatest need. “I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.”
ACCOUNTABILITY	Accountability and transparency in delivering safeguarding. “I understand the role of everyone involved in my life and so do they”
PARTNERSHIP	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. “I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me”

Halton Safeguarding Adult Board Strategic Aims for 2016-2018



Duties of Safeguarding Adults Boards

As stated in the Care Act 2014 (chapter 14), the main objective of a Safeguarding Adult Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults in it's area who meet the criteria set out; ie. the safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or at risk of, abuse or neglect
- As a result of those care and support needs is unable to protect themselves from either the risk of, or experience of abuse or neglect

The Care Act states that Safeguarding Adults Boards have three core duties:

- Develop and publish a Strategic Plan setting out how they will meet their objectives and how member and partner agencies will contribute
- Publish an Annual Report detailing how effective their work has been
- Commission Safeguarding Adults Reviews for any cases which meet the criteria

Halton Safeguarding Adults Board (HSAB) membership consists of representatives from each of the following:

- Halton Safeguarding Adults Partnership Forum Chair
- Elected member responsible for adult health and social care

Accountability and Assurance

The Care Act 2014 states every SAB must send a copy of its report to:

- The Chief Executive and leader of the Local Authority;
- The Local Policing Body;
- The Local Healthwatch;
- The Chair of the Health and Wellbeing Board.

HSAB is also committed to recommendations from Department of Health Care and Support Statutory Guidance (issued under the Care Act 2014) which recommends using: *'Local Health and Wellbeing Boards to provide leadership to the local health and wellbeing system; ensure strong partnership working between local government and the local NHS; and ensure that the needs and views of local communities are represented. HWBs can therefore play a key role in assurance and accountability of SABs and local safeguarding measures'.*

HSAB provides updates including the Annual Report to Halton Health and Wellbeing Board. HSAB communicates with sub-groups, partner groups and forums, service users and wider population. This year has seen continued growth in partnership building and establishing links across service providers and increased levels of engagement across the borough.

This year also saw the formation of a new subgroup for HSAB, the Safeguarding Adults Review (SAR) Group. This subgroup will enable HSAB to effectively and efficiently address any referals for a SAR, ensure timely completion of Reviews, oversee implemention of action plans from recommendations of the Reviews and provide assurance to HSAB that duties and activities have been fulfiled.

Halton Safeguarding Adults Board sub groups are:

HSAB continues to recieve data and intelligence from the following partner forums:

- Provider Forums (Care Homes and Supported Living)
- Halton Domestic Abuse Forum
- Safeguarding Champions Network
- Halton Safeguarding Children's Board

Figure 1: Structure of Halton Safeguarding Adults Boards subgroups and partners

* Joint subgroup with Halton Safeguarding Children's Board

SECTION 2: WHAT THE STATISTICS TELL US

Personalisation

54 per cent of individuals or their representatives were asked what their desired outcomes were and outcomes expressed

29 per cent were either fuly or partially achieved

Prevention

67 per cent of Frontline Staff have had Safeguarding Training during 2018/19 which is 6 percent higher than last year.

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Protection

There has been a 1.6 per cent decrease in the total number of concerns received. Of the concerns received, 47 per cent of those were dealt with under the section 42 safeguarding criteria; this is a decrease of 25 per cent from 2017/18.

Partnership

Working with partner agencies, stakeholders to achieve stratgeic priorities.

establishment of SAB Sub Groups and key agencies in attendance

The Safeguarding Adults Collection

The Safeguarding Adults Collection (SAC) records details about safeguarding activity for adults aged 18 and over in England, reported to, or identified by, Councils with Adult Social Services Responsibilities (CASSRs or councils). The collection includes demographic information about the adults at risk and details of the incidents that have been alleged.

Safeguarding concerns and safeguarding enquiries

Safeguarding Concerns (Alerts / Referral) is a sign of suspected abuse or neglect that is reported to the council or identified by the council. The collection captures information about concerns that were raised during the reporting year, that is, the date the concern was raised with the council falls within the reporting year, regardless of the date the incident took place.

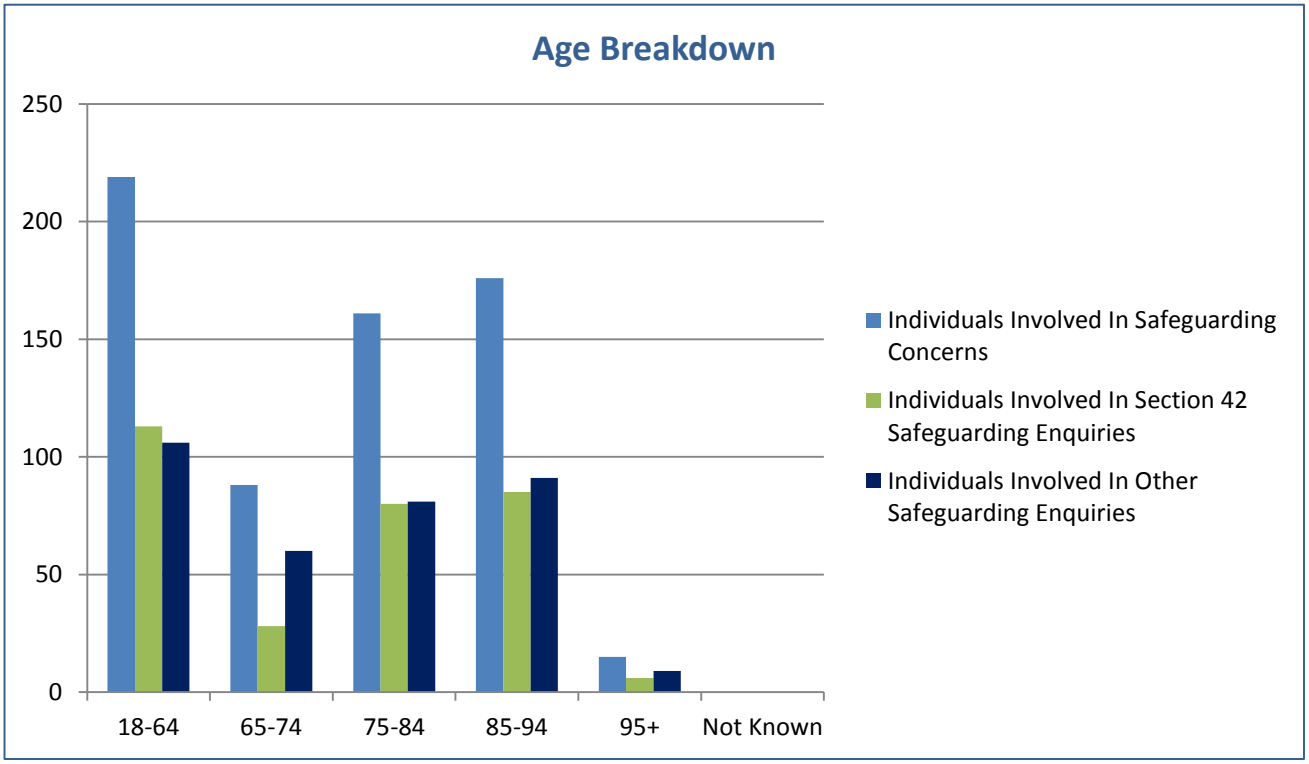
Safeguarding Enquiries (Strategy Discussion / Investigation) is the action taken or instigated by the Local Authority in response to a concern that abuse or neglect may be taking place. An enquiry

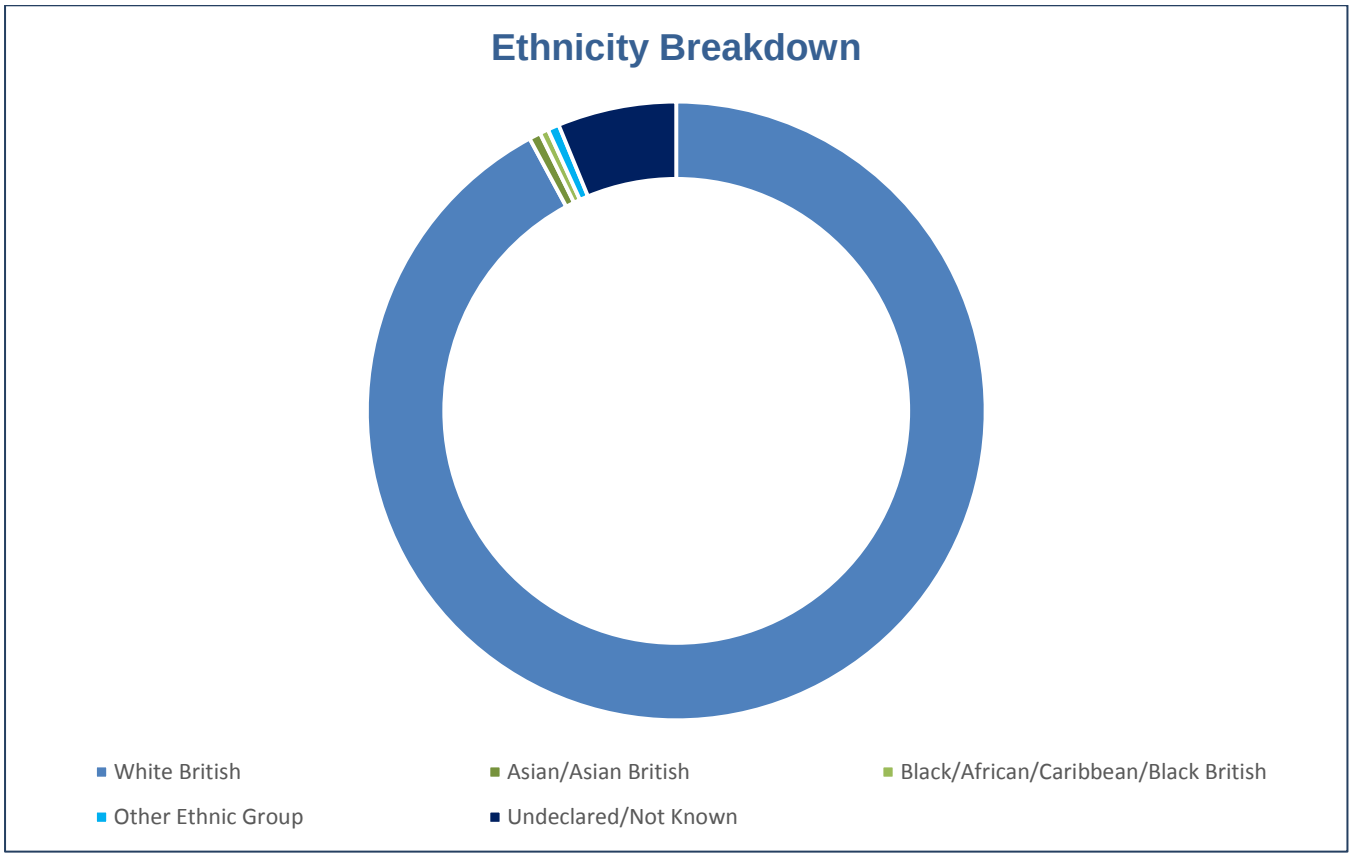
could range from a conversation with the adult to a more formal multi-agency plan or course of action.

Both Safeguarding Concerns and Safeguarding Enquiries can include cases of Domestic Abuse, Sexual Exploitation, Modern Slavery and Self-Neglect.

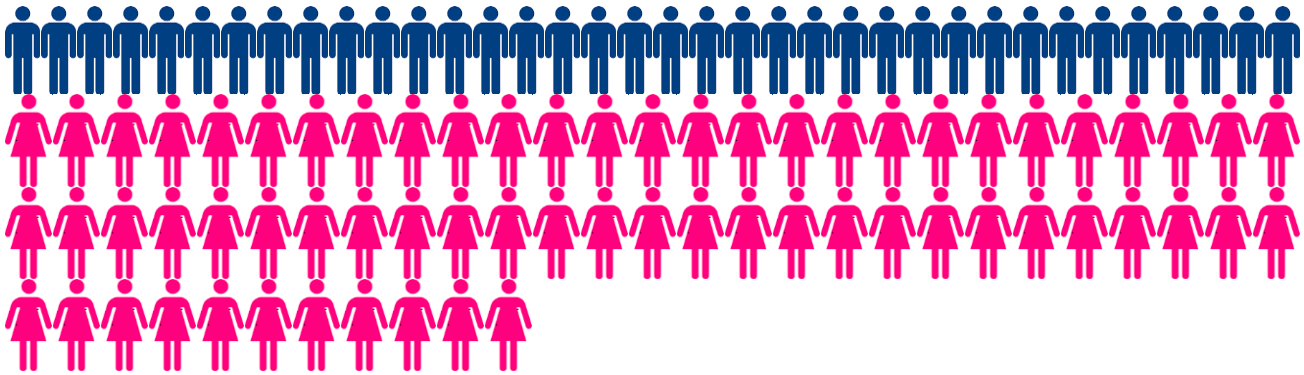
Profile of adults at risk

The population of Halton is approximately 127,595 with an adult population of around 99,200 of those 22,800 are aged 65 years and over, almost a quarter of the whole adult population. Halton has an increasingly ageing population with a projected 44% increase of adults aged 65+ by 2036.





Gender Breakdown



Mental Capacity - Completed Safeguarding Enquiries (Section 42)

40% lacked capacity

28% had capacity

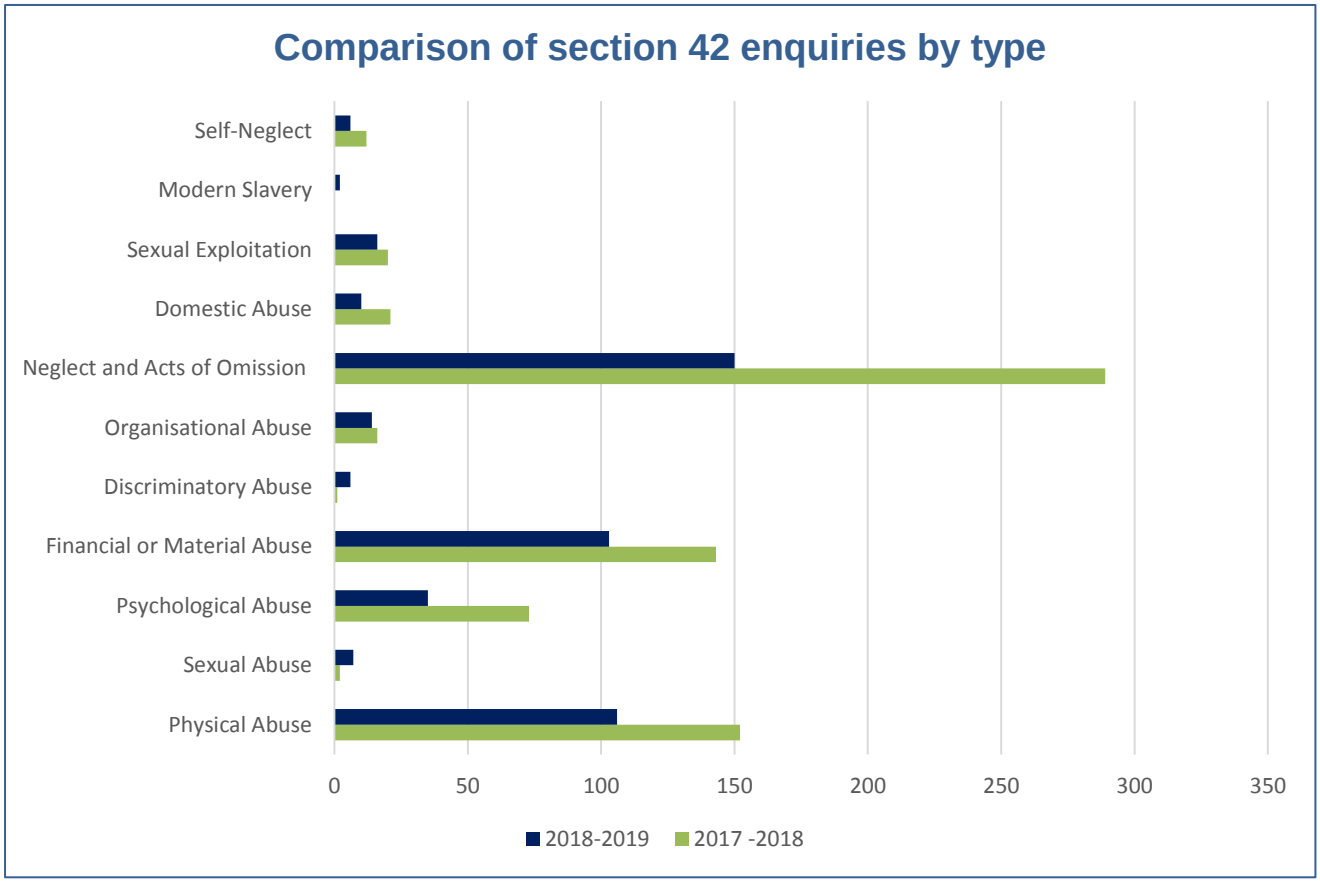
32% Unknown

What does this mean?
There has been a 1.6 per cent decrease in the total number of concerns received. Of the concerns received, 47 per cent of those were dealt with under the section 42 safeguarding criteria; this is a decrease of 25 per cent from 2017/18, this could be attributable to previous issues within and closure of care homes within the area.
What can we do?
To continue to work closely with provider services and stakeholders to ensure that services continue to get the appropriate support and training. The Integrated Adult Safeguarding Unit will complete the screenings/triage of Safeguarding Alerts to ensure that there is a consistent approach applied to determine when a Safeguarding Alert meets the thresholds for a Section 42 Enquiry.

What has been reported? ***NEEDS WORK***

Prevalence of section 42 enquiries by type of abuse / location /perpetrator / alerter

In 2018/19, the following summarise the significant changes which have occurred in reported safeguarding alerts in Halton.



Type of Abuse

There has been an increase on 1.2% in **Sexual Abuse**

There has been a 3% increase in **Psychological Abuse**

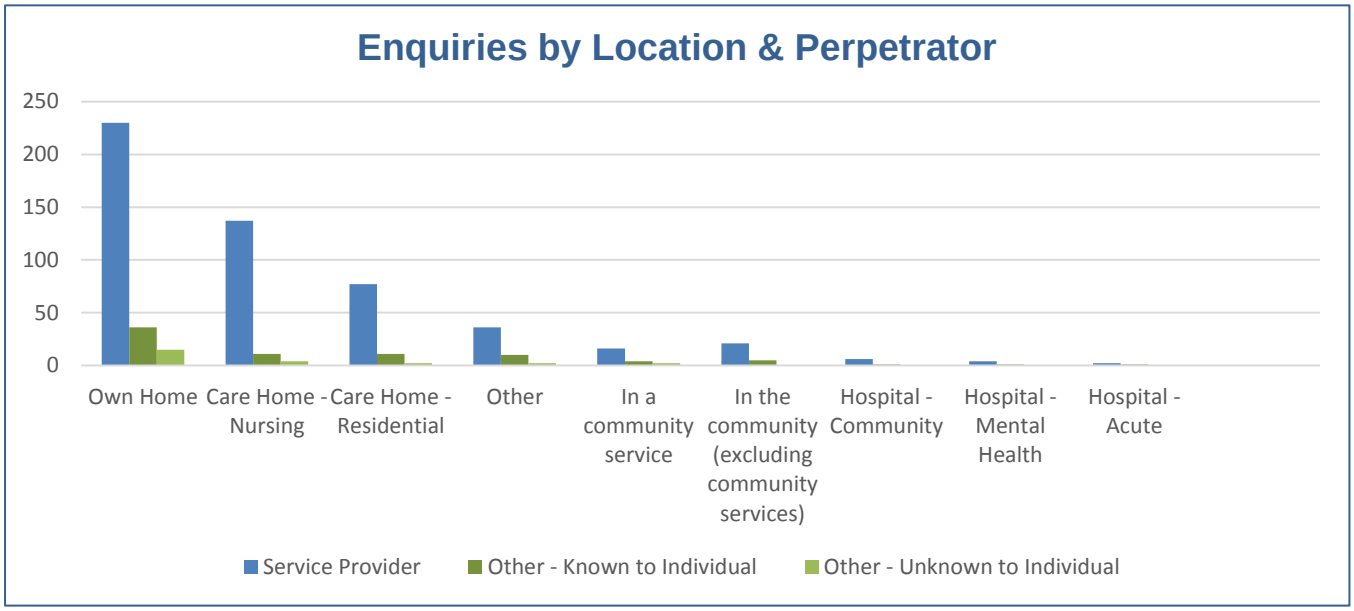
There has been a 13% decrease in **Neglect and Acts of Omission**

Location of Abuse

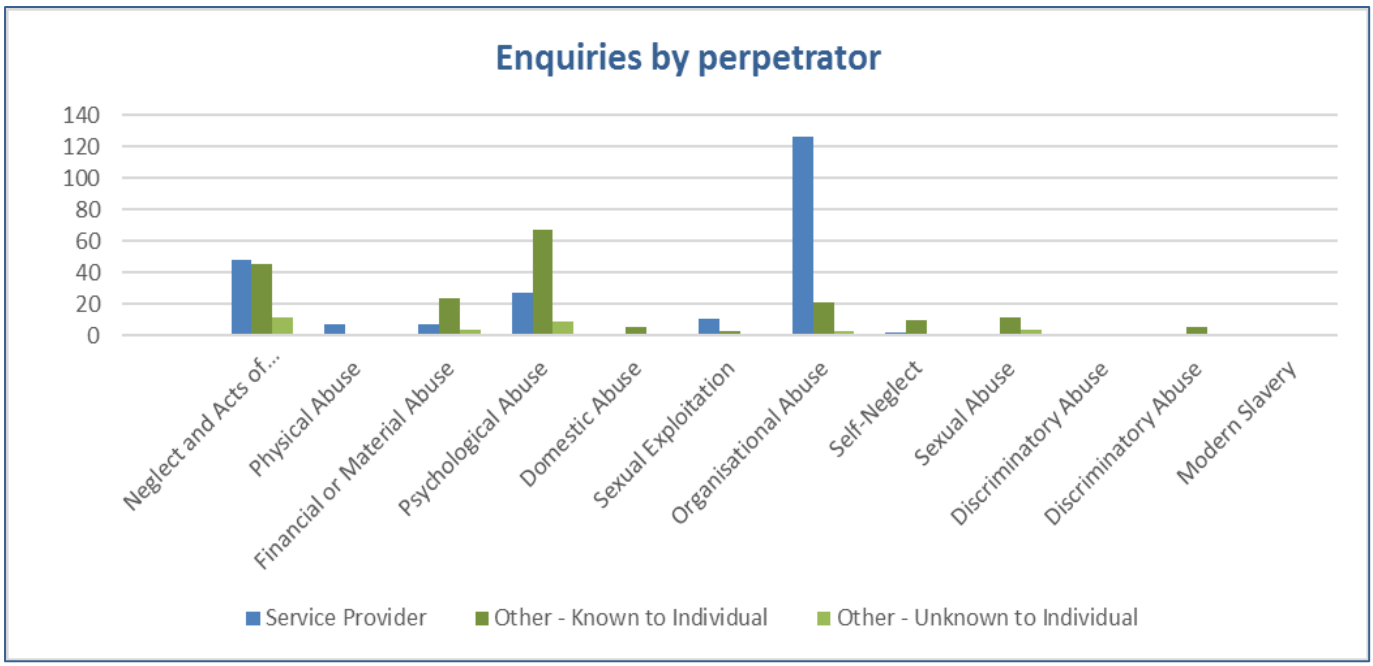
There has been a 9% decrease in abuse occurring in a person's **own home**

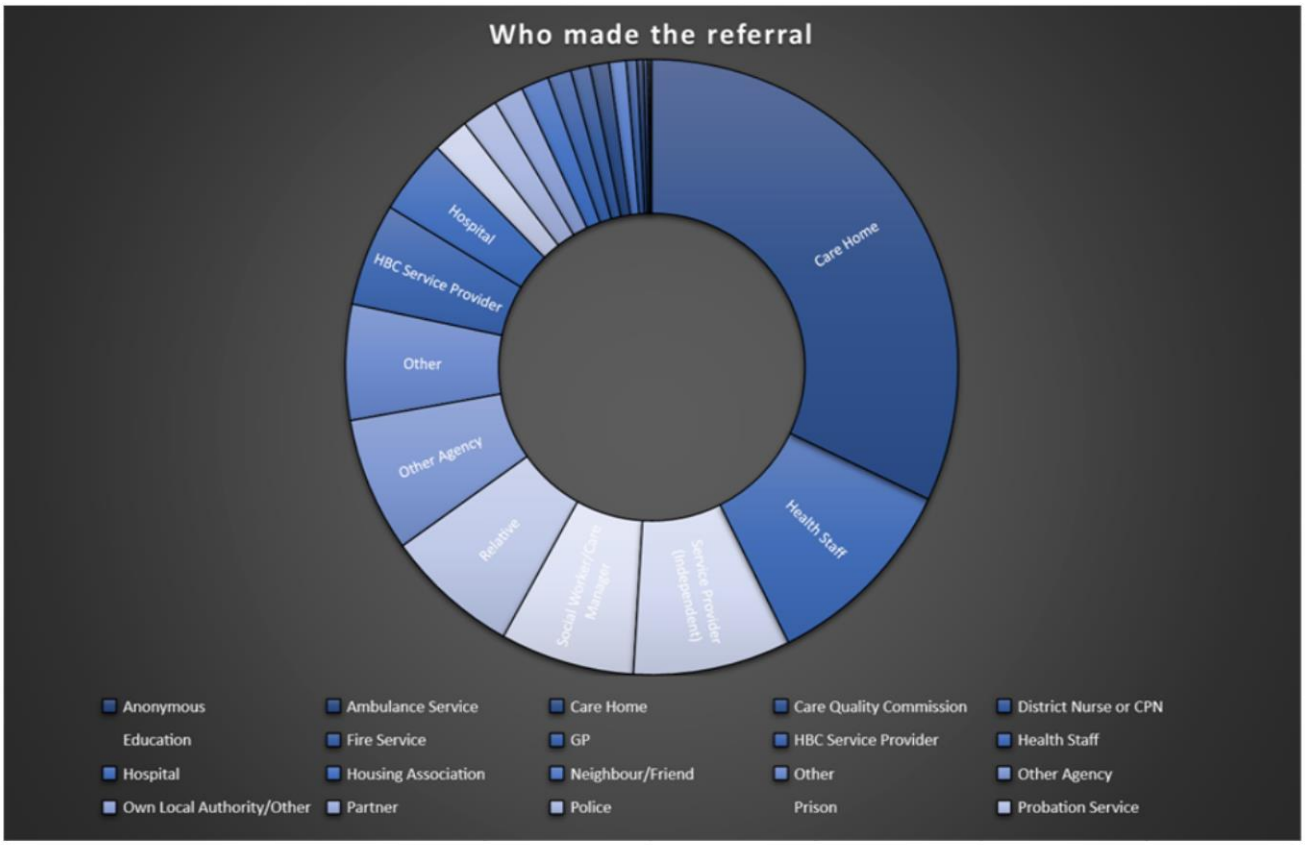
There has been a 15% increase in the number of alerts raised in **residential care** settings

There has been an 8% decrease in the number of abuse alerts occurring within a **nursing care** setting

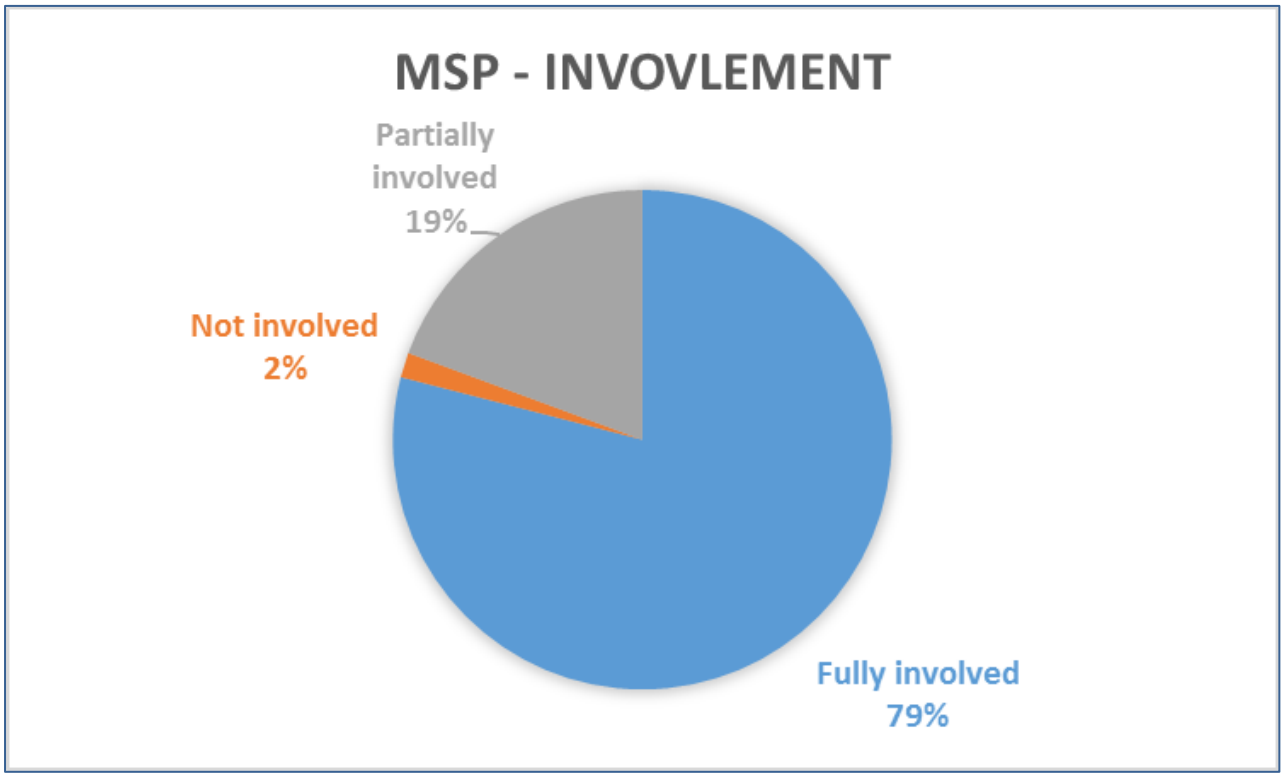


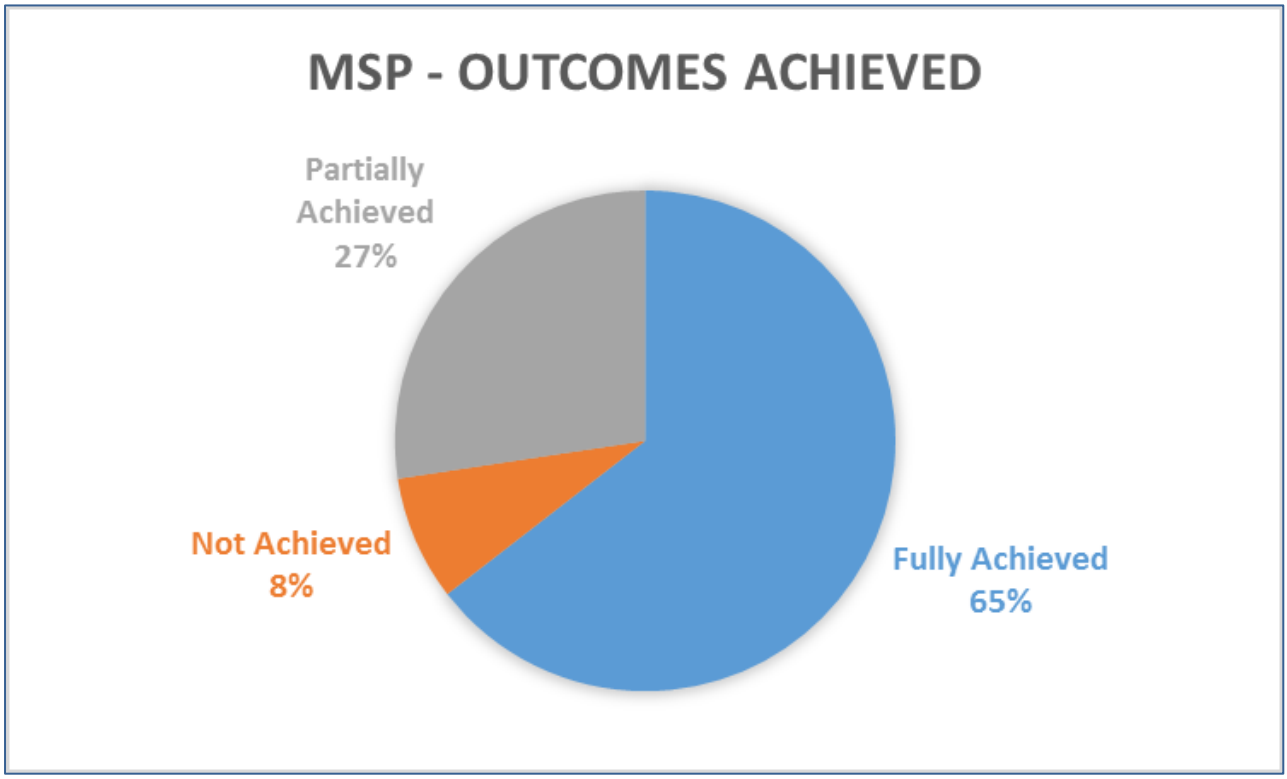
In 2017/18 in Halton, there was a significant increase in the number alerts relating to neglect and acts of omission. This increase was attributed to issues with care homes experienced at that time. This year, we have seen a significant decrease in alerts for neglect and acts of omission, and in alerts occurring within nursing care settings and a person's own home.

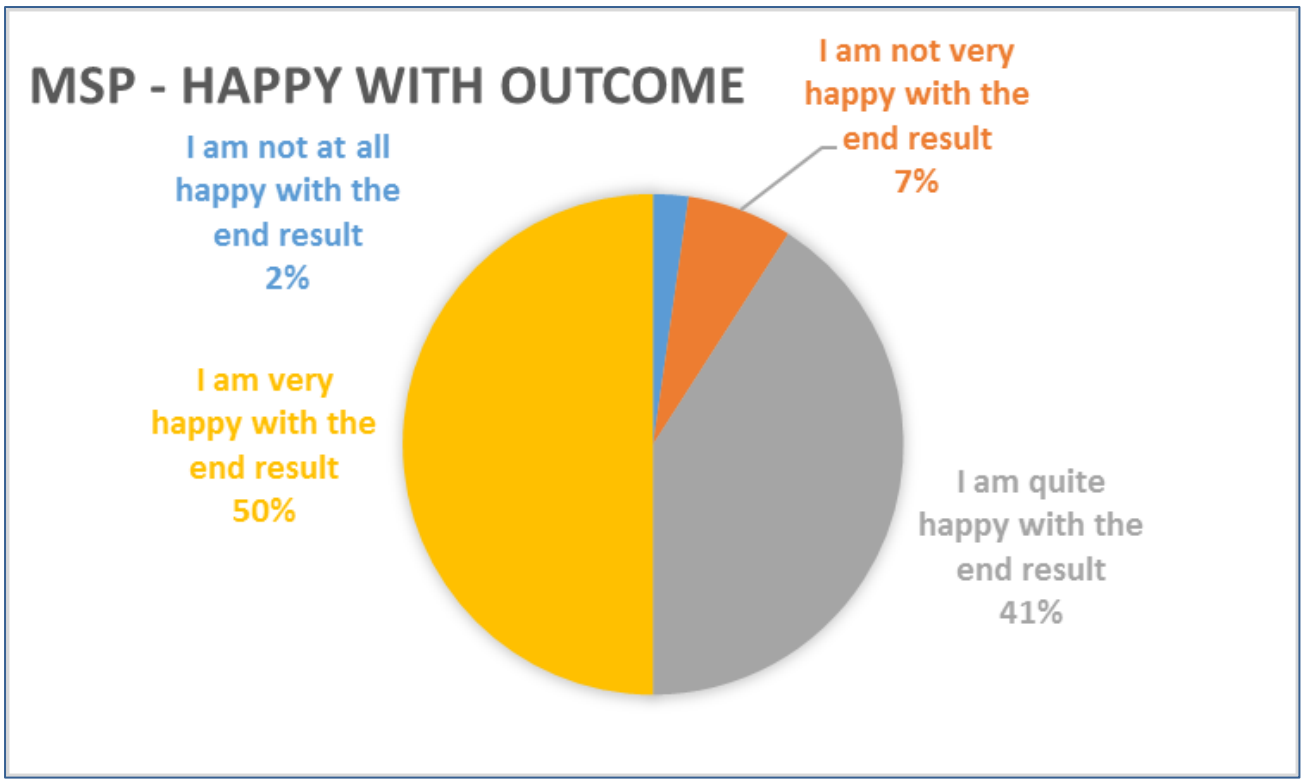

Enquiries by perpetrator
140
120
100
80
60
40
20
0
Neglect and Acts of...
Physical Abuse
Financial or Material Abuse
Psychological Abuse
Domestic Abuse
Sexual Exploitation
Organisational Abuse
Self-Neglect
Sexual Abuse
Discriminatory Abuse
Discriminatory Abuse
Modern Slavery
Service Provider
Other - Known to Individual
Other - Unknown to Individual

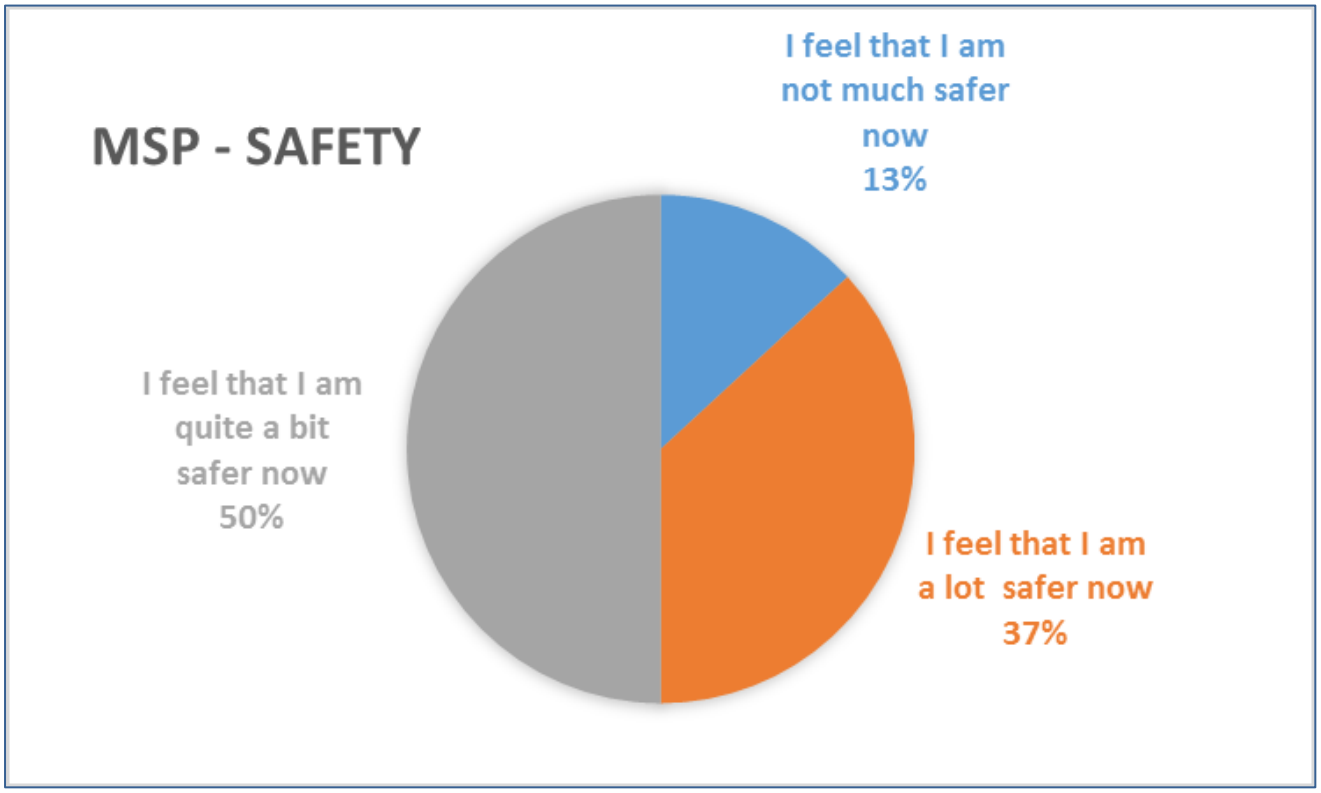

Who made the referral
Care Home
Health Staff
Service Provider (Independent)
Social Worker/Care Manager
Relative
Other Agency
Other
HBC Service Provider
Hospital
Anonymous
Education
Hospital
Own Local Authority/Other
Ambulance Service
Fire Service
Housing Association
Partner
Care Home
GP
Neighbour/Friend
Police
Care Quality Commission
HBC Service Provider
Other
Prison
District Nurse or CPN
Health Staff
Other Agency
Probation Service

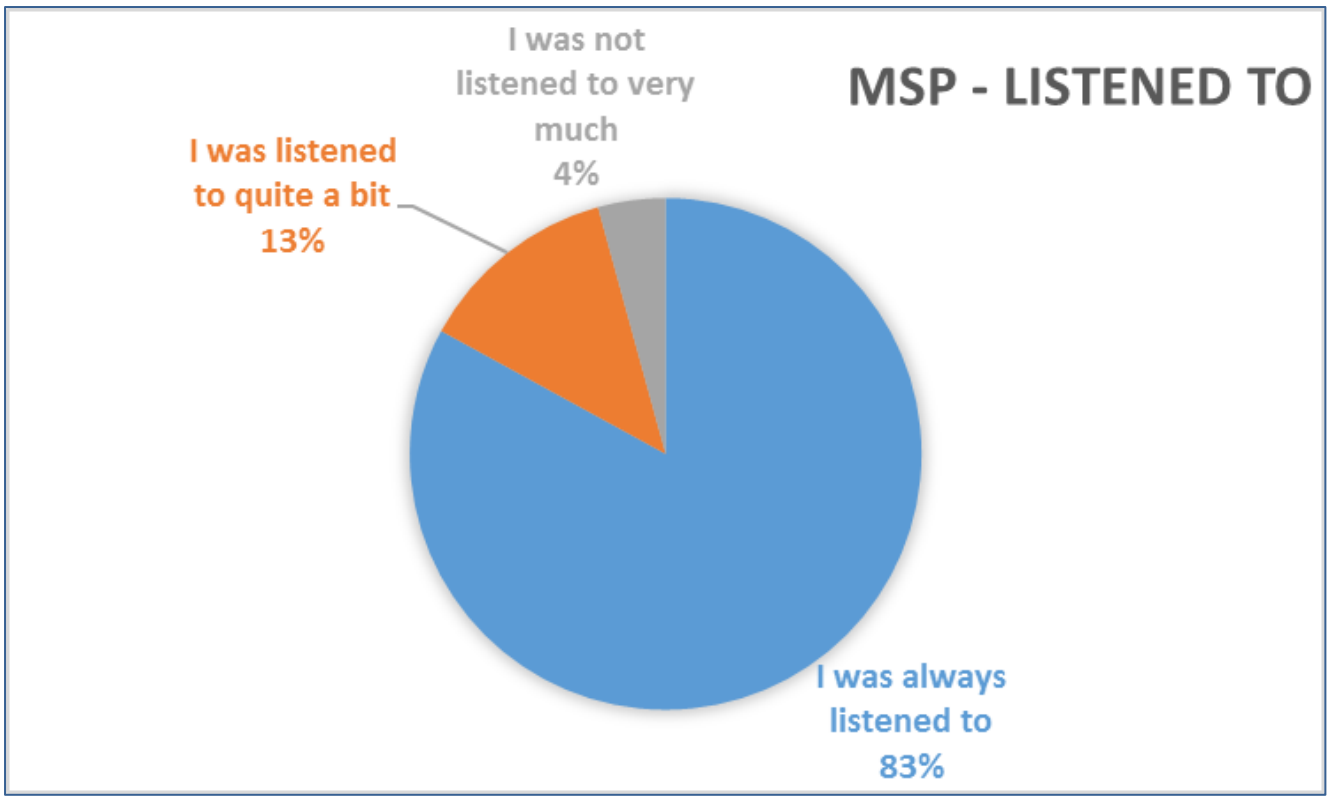
Making Safeguarding Personal

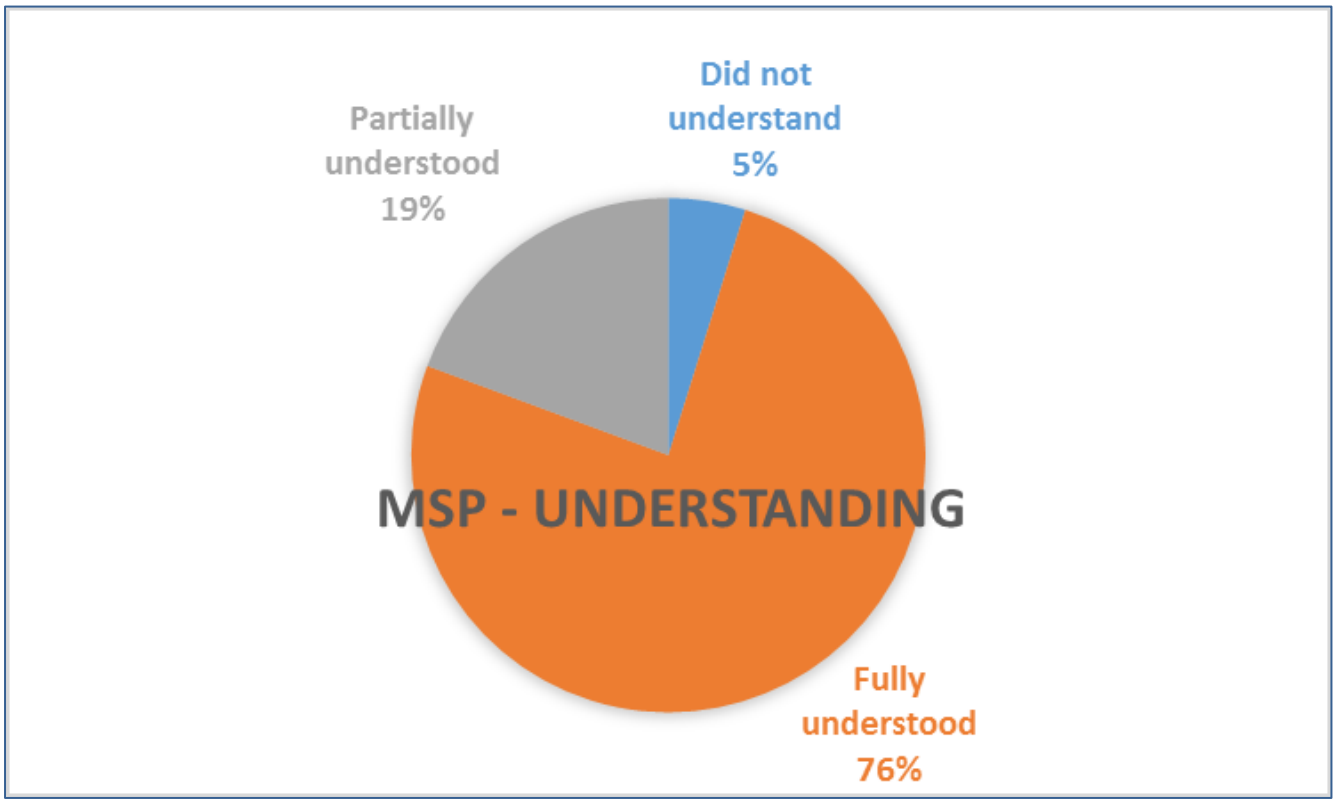





MSP - HAPPY WITH OUTCOME
I am not very happy with the end result 7%
I am not at all happy with the end result 2%
I am very happy with the end result 50%
I am quite happy with the end result 41%


MSP - SAFETY
I feel that I am not much safer now 13%
I feel that I am quite a bit safer now 50%
I feel that I am a lot safer now 37%


MSP - LISTENED TO
I was not listened to very much 4%
I was listened to quite a bit 13%
I was always listened to 83%


Did not understand 5%
Partially understood 19%
MSP - UNDERSTANDING
Fully understood 76%

What does this mean?

Making Safeguarding Personal (MSP) is embedded within the Care Act 2014 and is an approach to Adult Social Care which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. It is about engaging with people about the outcomes they want at the beginning and middle of working with them, and then ascertaining the extent to which those outcomes were realised at the end.

MSP seeks to achieve:

- A personalised approach that enables safeguarding to be done with, not to, people
- Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'
- An approach that utilises social work skills rather than just 'putting people through a process'
- An approach that enables practitioners, families, teams and SABs to know what difference has been made

During 2018-2019, Halton Adult Social Care piloted a new MSP Framework developed by ADASS, which aimed to measure how Halton were ensuring MSP remained at the heart of Safeguarding interventions.

In terms of **involvement**,

- **79%** of Adults at Risk were fully involved in the process.
- 19% of Adults at Risk were partially involved, with **2%** of Adults at Risk not being involved. This would be for a range of reasons, including lacking capacity, determination in health or involvement would be with a representative either family or advocacy.

In terms of **Outcomes** being achieved,

- **65%** of Adults at Risk had their outcomes fully achieved
- 27% of Adults at Risk had their outcomes partially achieved, with **8%** of Adults at Risk not having their outcomes achieved. An example of why outcomes were not achieved could be due to police led investigations where there is not enough evidence to pursue, or outcomes may not have been achieved through the safeguarding process.

In terms of Adults at Risk being **happy** with their outcomes,

- **91%** of Adults at Risk were happy with their outcomes
- **9%** of Adults at Risk were either not happy or not very happy with their outcomes.

In terms of Adults at Risk feeling **safer** as a result of their enquiry,

- **37%** of Adults at Risk feel a lot safer, following their enquiry
- **50%** of Adults at Risk felt quite a bit safer, whereas **13%** of Adults at Risk feel not much safer as a result of their enquiry. In terms of safeguarding, enquiries can be closed at times where the risk towards the Adults at Risk remains. Examples of this could be Self Neglect cases, civil matters or if enquiries are not able to substantiate evidence of abuse.

In terms of Adults at Risk feeling **listened to,**

- **96%** of Adults at Risk felt either always listened to, or quite a bit listened to.
- **4%** of Adults at Risk felt they were not listened to much.

In terms of Adults at Risk **understanding** the process,

- **76%** of Adults at Risk fully understood the process
- 19% of Adults at Risk partially understood, whereas **5%** of Adults at Risk did not understand.

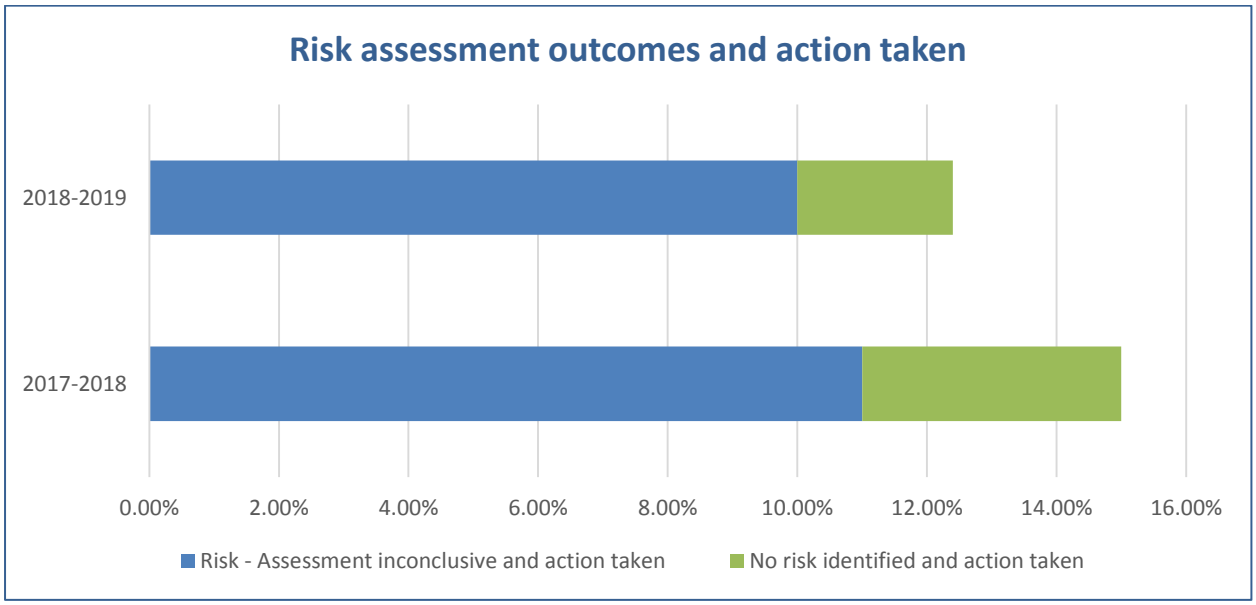
What can we do?

Adult Social Care will continue to develop the culture of Making Safeguarding Personal across services. This includes

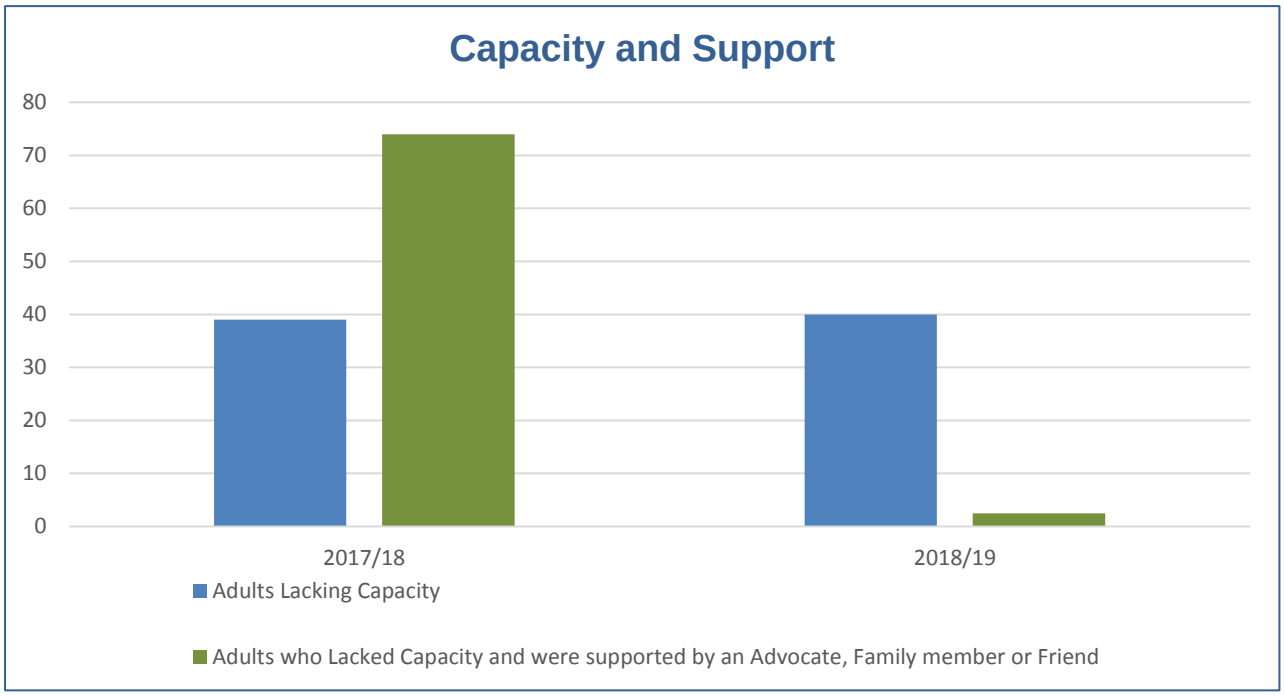
- Continuation of the MSP Practitioner Group Meetings
- Quality Assurance and Audits continue to capture MSP within the framework
- Halton and HSAB training schedules to continue to develop professionals understanding of MSP
- HSAB to ensure that the voice of Adults at Risk are heard and listened to, to further develop practice.

Profile of risk assessment outcomes and support

Risk assessment outcomes / mental capacity and advocacy and support



There are clear discrepancies between the figures for 2017/18 and 2018/19, this could be due to



reporting, and this is being investigated by our performance team, who will implement training should this be the case.

What does this mean?
The figures above suggest a decline in the number of people who lacked capacity and received support for this, however this could be a reporting issue and is being investigated by our performance team.
What can we do?
If this is a reporting issue, our performance team will implement training for all staff involved in completing safeguarding enquiries. Adult Social Care will continue to develop the culture of Making Safeguarding Personal across services. This includes • Continuation of the MSP Practitioner Group Meetings • Quality Assurance and Audits continue to capture MSP within the framework • Halton and HSAB training schedules to continue to develop professionals understanding of MSP • HSAB to ensure that the voice of Adults at Risk are heard and listened to, to further develop practice.

SECTION 3: CASE STUDIES

Case Study 1

Mrs A. An Older Person living within a 24 hour Residential Setting. Mrs A had physical health problems and needed support to maintain her level of independence.

A Safeguarding Alert was raised by the lady's allocated Social Worker within a care management team, following the identification of a substantial amount of money withdrawn from Mrs A's bank account, it appeared from the care manager that this was by Mrs A's daughter who may have taken the money.

It was considered by the care manager that Mrs A lacked capacity to decide how her funds are managed and she was advised that the referral was going to be made. Mrs A was reluctant for the referral to be made as she was concerned about her daughter being reported to the Police. However, due to the concerns raised, the care manager made a Safeguarding Alert to refer the case to the Police. Consent was gained although this was reluctantly.

In the interim, the bank fraud team put a block on the account so that telephone and internet banking could not be set up. It was arranged so that only Mrs A was able to access any funds from her bank account. All of the advisors in the local branch were to direct Mrs A's Daughter to a designated person if she did try to withdraw funds from her bank account.

A visit was made to Mrs A's to assess her mental capacity in regards to a Police investigation. The visit was a joint visit with social services and the police. It was established that Mrs A did have capacity to decide not have Police involvement.

Mrs A confirmed that she still did not want Police involvement as she didn't want to get anyone in trouble specifically her daughter

Was Desired Outcome achieved?

Yes the case was closed as per Mrs A's wishes. Various visits were made to the lady to build a rapport. On the final visit the lady confirmed that she still didn't want Police involvement as she didn't want to get anyone in trouble specifically her daughter. It was confirmed with Mrs A that she now felt that her finances were safe, she was pleased with the outcome.

Impact of our work with the adult at risk

This case evidences Making Safeguarding Personal. The lady acknowledged that her daughter had been taking money from her bank account however she also stated that despite this she is her daughter who she loves. The lady has agreed to measures put in place to ensure her money is safe however she did not want any action taken against her which was respected. The impact was positive. Support was also offered to the daughter, regarding her housing and financial affairs, in an aim to evidence preventative and proportionate approaches to Safeguarding. This case highlighted good multi-disciplinary team working between Adult Social Care, the Bank, the Police and the care provider.

What does this mean?

- This case evidences Making Safeguarding Personal and application of the Mental Capacity Act 2005, supporting the Adult At Risk to make informed decisions regarding her welfare.
- This case evidences that the rights of the Adult at Risk have been protected and adhered to
- The case highlights that having time to follow and apply Making Safeguarding Personal to Section 42 enquiries can achieve positive outcomes for people
-

What can we do?

- Ensure that Making Safeguarding Personal, updates and case law is discussed at the Provider Forum and Champions Forum
- SAB training schedule for Provider Services is free and will cover Safeguarding Awareness and Making Safeguarding Personal
- IASU will continue to complete Audits/Quality Assurance of Safeguarding cases internally, which aims to provide feedback on good practice and any areas for improvement
- MSP Practitioner Group is established and has attendance from Advanced Practitioners from each team internally, which reviews cases, allows for challenge and reflects on approaches to safeguarding
- SW Matters forum is established and allows for the sharing of good practice
- Safeguarding Training which includes Making Safeguarding Personal is mandatory for Adult Social Care Staff internally
- Halton BC staff are able to access additional resources through Ripfa
- Stakeholders to continue to ensure that Making Safeguarding Personal is at the heart of any approach

Case Study 2

Mr S is a young man with a physical disability, living in his own home with support from a provider service

A Safeguarding Alert was received from the manager of a domiciliary support agency. Mr S had disclosed that a member of his support team has been providing sexual relief to him for several months, in exchange for additional shifts (as Mr S manages his own rota) takeaway food and expensive gifts. The original alert was quite brief in nature and it was unclear at this stage whether Mr S had consented. There are no concerns around Mr S's ability to make decisions for himself.

On the day that the alert was received by Halton, an Initial visit is carried out to identify desired outcomes. Mr S had consented to the visit. Mr S demonstrated a good understanding of the situation and was happy for safeguarding enquiries to be made, however did not wish for police involvement. The support worker involved is suspended pending further enquiries

Mr S no longer wanted this particular agency to provide his package of support, he has requested a Personal Health Budget (as he is fully Continuing Health Care funded).

Mr S was also worried that the particular support worker may in the future, work with somebody who does not have a full understanding of what may be happening. Even though Mr S knows what is happening is wrong, he feels that he had some control as he is free to disclose.

Upon learning of the disclosure from Mr S, his mother called the police and alleges that her son has been sexually abused. Mr S states that although he told his mother of the disclosure, he did not want her to report to the police.

The Police made contact with safeguarding social worker to ask for more detail, which resulted in the police requesting a joint home visit with safeguarding to clarify that no crime has been committed. Mr S agreed to this.

A joint visit between safeguarding team and police was completed. Mr S assured officers that he was in agreement with the arrangement between himself and the support worker. The police were satisfied that there is no criminal investigation needed.

Mr S's desired outcomes were relayed to allocated care manager, who worked alongside a Continuing Health Care nurse to explore a Personal Health Budget. This was agreed and notice was served to the agency, meaning that Mr S in now in receipt of a Personal Health Budget.

Following an internal hearing, the support worker is dismissed from his role and the DBS was made aware of the dismissal.

Was Desired Outcome achieved?

Mr S was very happy with the outcomes and stated that he would feel confident in raising any issues regarding his care in the future.

Impact of our work with the adult at risk

Mr S had reported that as the issue that he disclosed was one of a sensitive nature, he was happy that it wasn't his allocated case worker who was making enquiries as this would have been embarrassing for him.

Mr S stated that he felt that his disclosure was taken very seriously and his views have been taken forward until his desired outcome has been achieved.

Mr S also felt that he may have had a part in being able to protect other people who may be supported by the particular support worker in the future.

What does this mean?

- The adult at risk made a serious disclosure regarding the conduct of a staff member
- The service provider acted swiftly to mitigate risks and met ASC expectations
- Making Safeguarding Personal was at the heart of the enquiry, reviewing and re-negotiating a desired outcome, to which the adult at risk was happy about and felt involved throughout
- In order to achieve a person's desired outcome, it is key to have knowledge of a range of service provision, and how to access this
- This enquiry evidences good Multi-Disciplinary working between health and social care teams to ensure Desired Outcomes can be achieved fully.

What can we do?

- To continue to have a collaborative approach to safeguarding adults across stakeholders, ensuring that Making Safeguarding Personal remains at the heart of any approach
- To share this case an example of good practice
- Continue to embed Making Safeguarding Personal within Section 42 Enquiries
- For health and social care to continue to promote and implement Personal Health Budgets and Personalisation, which gives people who use services more control, freedom and flexibility over their care provision

SECTION 4: LEARNING FROM REVIEWS

Under the Care Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews. Halton SAB commissioned a Safeguarding Adult Review (SAR) and Halton CCG commissioned a Multi-Agency Review (MAR) during 2018/19 with resulting Action Plans derived to address the recommendations within these reviews. SABs also hold responsibility to manage and monitor the progress of Action Plans from all safeguarding reviews.

Halton SAB also oversees the local reviews from the Learning Disabilities Mortality Review (LeDeR) Programme.

What does this mean?
Information is shared within Halton CCG regarding LeDeR, which includes findings, outcomes and recommendations following LeDeR's Halton CCG informs SAB of any learning identified within reviews, to actions can be set and any learnings shared within SAB Members, SAB Sub Groups and across health and social care
What can we do?
Ensure that any learnings identified continue to be shared within appropriate forums, so that any actions can be measured and monitored to improve the experiences of people with a Learning Disability. It is vital that people with a learning disability have the same level of care and treatment as everyone else. This means that any learning or gaps identified needs to be explored, actioned and monitored.

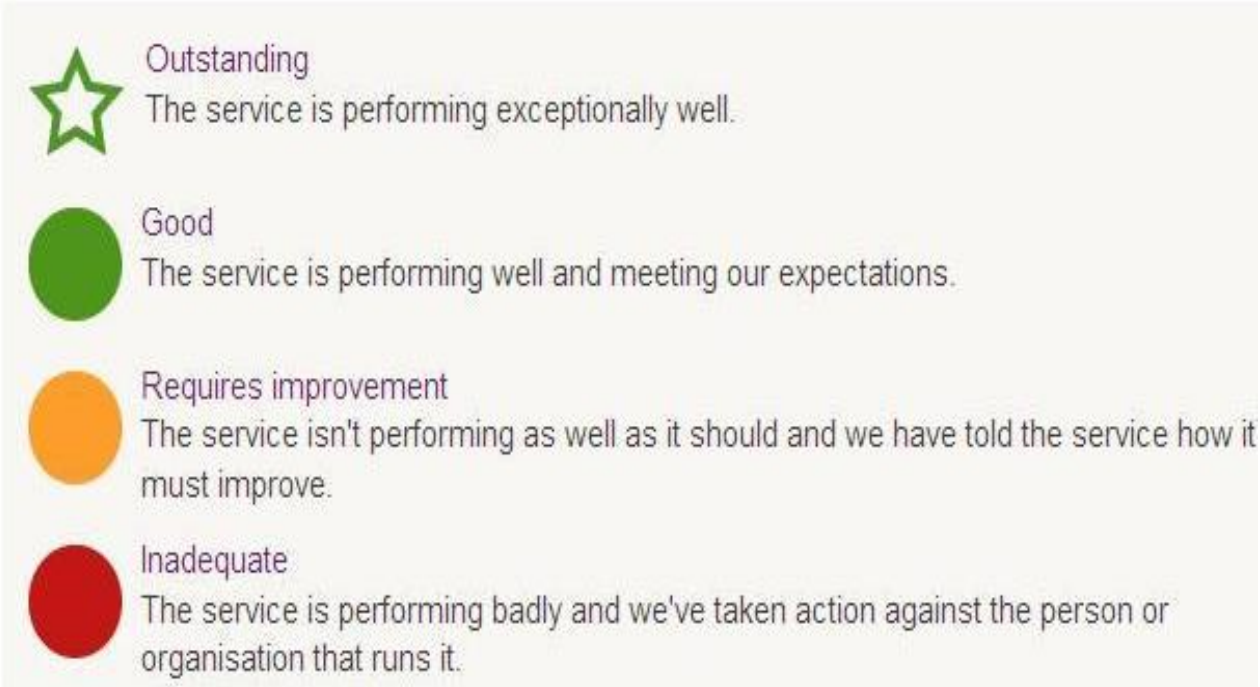
Safeguarding Adults Review and Multi-Agency Review

During 2018/19 there has been no referrals made to request a Safeguarding Adult Review or a Multi-Agency Review

The Safeguarding Adult Review Group (SARG) has been established, where health, Police, Local Authority and other Stakeholders are represented. This was a recommendation following the completion of the SAR and MAR in 2017, which is captured within the HSAB Annual Report of 2017-2018.

What does this mean?
• Within the SARG, major stakeholders meet on a quarterly basis to review any SAR or MAR referrals that have been made to the Local Authority and if applicable, review the decision made • The SARG accesses the national archive of SAR's which have been completed to identify and share any learnings with SAB. This can result in working groups to ensure that learnings are shared across health and social care • Learning events and action plans following the SAR and MAR of 2017-2018 have been completed
What can we do?
• To ensure the SARG to continue in its function • To ensure that Stakeholders continue to contribute to the SARG Group • To ensure that the SAR Policy is reviewed at review date, to ensure that approaches, methodology and practice continues to be contemporary and meets legal requirements

NHS Providers and Independent Hospitals (CQC ratings)



Good CareQuality Commission	➢ **Halton General Hospital** ➢ **North West Boroughs Healthcare NHS Foundation Trust** ➢ **Gateway Recovery Cente (independent Hospital)**
Inspected and rated Requires Improvement CareQuality Commission	➢ **Bridgewater Community Healthcare NHS Foundation Trust**

SECTION 5: PROGRESS AGAINST OUR PRIORITIES

Halton Safeguarding Adults Board and it's partners value the positive relationships that have been built which enable continued partnership working. This approach helps utilise existing community assets, addressing safeguarding issues from early identification and prevention through to improving specialist skills and services to address safeguarding issues raised. The sub-groups of the board have evidenced their dedicated commitment to assisting HSAB to fulfil it's statutory and moral duties for the benefit of Halton and in particular to improve the lives of adults at risk of harm.

As highlighted in last year's Annual Report, Halton Safeguarding Adults Board set out three key priorities for sub-group and partners to work towards. The priorities were set using data and information gathered through previous Safeguarding Adults Collection (SAC), local intelligence and consultations with service providers and service users, the Safeguarding Adults Review and Multi-Agency Review and Thematic Review findings and recommendations, along with recommendations from the Halton Adult Safeguarding Peer Review facilitated by St.Helen's Council.

The following is a snapshot of the work and activities from Halton Safeguarding Adults Board, it's sub-group and partners, that took place during 2018-2019

Priority 1: Creating a safer place to live for all adults living in Halton (Safeguarding Prevention)

This year saw the establishment of a dedicated Safeguarding Adults Review Group following the commission and completion of a Safeguarding Adult Review (SAR). This SAR linked closely to a Multi-Agency Review (MAR) which was conducted by Halton Clinical Commissioning group (CCG) and a Thematic Review that Pubic Health undertook during 2016-2017 which HSAB had oversight of.

HSAB has worked proactively towards developing effective coproduction and engagement opportunities in all its activities, including public and practitioner events, developing the training and marketing plan and resources, information sharing routes to and from HSAB to sub-group and partner groups and the public; ensuring inclusivity and accessibility in practice and implementation through its activities.

A Pan-Cheshire Modern Slavery Strategy and Pan-Cheshire Harmful Practice Strategy has been published. These and all other local, regional and national strategies and guidance are available on HSAB website: **www.haltonsafeguarding.co.uk**

Halton's Partnership Forum, chaired by CEO MM Age UK Mark Lunney has further established its forum, discussing and sharing relevant information to key stakeholders and providers. This includes developments in Housing and Homelessness, GDPR and Persons in Positions of Trust (PIPOT). There was also presentations completed by the Department of Work and Pensions to discuss the

impact of Universal Credit, as wll as the Principal Social Worker for Adult Social Care, Marie Lynch, sharing information and key issues within her role.

All safeguarding adults information and leaflets have been updated to ensure compliance with The Care Act, these have been disseminated to all partners and it is expected that partners will embed 6 principles of safeguarding and Making Safeguarding Personal approaches into their professional practice.

healthwatch Halton

Healthwatch Halton has a positive working relationship with the HBC Quality Assurance Team both prior to and following enter and view activities to care homes across the Halton. Healthwatch Halton Advocacy HUB includes a IMHA, IMCA, Care Act, DoLs and general advocate service who have undertaken continuous Safeguarding training provided by HBC which they strictly consider when appropriate when dealing with vulnerable adults and older people in the Halton Community, through working within the policy and legislative frameworks We are also in the process of ensuring that Staff and Volunteers undertake refresher Safeguarding Training with HBC. Several care concerns and appropriate Safeguarding referrals have been made through the appropriate policies procedures and legislative framework. Healthwatch Halton is in the process of developing a training matrix for Volunteers and staff.

Mid Mersey age UK

Age UK Mid Mersey_holds its own accredited internal quality framework as part of its national affiliation and in which has a significant focus on safeguarding vulnerable people. Age UK Mid Mersey has met all its standards for quality in this area and carried out a full audit review in late 2018. The model ensures we apply considerations for Making Every Adult Matter, Making Safeguarding Personal and applying Mental Capacity considerations when appropriate. All staff were asked to reflect on the content of the framework and to review this against Halton culture. Staff were encouraged to report any observations of this as part of consultation and were made aware of training opportunities available. Team meetings were asked to add this to their agenda.

Gateway Recovery Centre (GRC) reviews data which advises of themes, types of abuse, outcomes and lessons learnt. GRC promotes person centred care with each individual. At GRC every victim of abuse is spoken to, to gain their wishes and views. Individuals who lack capacity at GRC are assessed under the MCA followed by a Best Interest decision/ meeting and a least restrictive care plan is put into place.

Halton Housing Trust have a Safeguarding Policy that is provided to all new starters and mandatory training in safeguarding is provided. Our approach to cross sector partnerships is inclusive and the various groups where we are partners or within the groups we manage our partners include: community safety, the police, health professionals, we work with MH services other housing providers, local support agencies and substance misuse. Internally and locally we have developed and agreed a methodology to identify individuals facing multiple disadvantage and the information is quality checked to ensure that the person's needs, and risks are fully taking into account. We ensure that all agencies are aware of any adults that are at risk are being looked at and offered the correct support. We are very aware of the risk of modern slavery, CSE, signs of adult abuse and staff are provided with training that is quality assured to keep their skills up to date.

We use the following documentation for customers in supported housing:

- Support plans or waivers
- PEEPs (Personal Emergency Evacuation Plans)
- Risk Assessments
- Person centred fire risk assessments

All customers are required to sign a GDPR/Information Sharing, which allows us to seek out the best support for that person Attend Professionals Meetings and \Multi-Agency Meetings as requested to ensure that all agencies are providing a person-centred approach when support is being discussed and checking that their consent and mental capacity when providing consent has

been checked. To provide quality assurance on being 'customer led' on any cases that we are asked to get involved with, internally we ensure that evaluation includes the impact on individuals, on local services and systems. We use Qualitative methods when reviewing referral, response and outcome processes and quantitative methods, resulting in a mix of data about wellbeing, customer experience, service use and cost. The teams work closely with Changing Lives in respect of Domestic Abuse, attend MARAC and deliver target hardening works were required, attend various Multi-Agency Meetings as requested, including, Tasking and Coordinating, MAM, iDAT and weekly Police Beat Meetings to ensure that all agencies are aware of any adults that are at risk are being looked at and offered the correct support. The Approach ensures the partnership has the right people involved who understand local need.

- Clear guidance on the organisation's approach to safeguarding
- Joined up approach, with support tailored to the individual

- Promotion of person-centred approach when providing the housing support service
- GDPR compliant.
- Link in with partner agencies.
- No duplication of work, so less impact on the client.
- Joined up approach, tailoring support to the needs of the client
- Ensures we are meeting the desired need of the client.

Halton Disability Partnership

Halton Disability Partnership provide Training for all staff. Have engaged with an external evaluator of new SA service (R.A.G.). New SA officers subject to performance management review and core objectives. Comprehensive register of PAs. Safeguarding review both registered and current clients by SA lead CEO. Clients have real choice and secure safety both in setting up care and clients and new referral's active follow up care.

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BOARD

Halton Safeguarding Faith Forum

- Discussions have taken place at Forum meetings regarding adult self-neglect, consent and how adults can be encouraged to accept support, utilising other service providers eg Fire and Rescue

- Several members attended the self-neglect and making safeguarding personal training sessions
- The C of E faith has just finished a national safeguarding audit
- A national safeguarding audit is underway in the Catholic faith
- A weekly drop-in safe space for refugees, asylum seekers and those who have been trafficked has been set up in Trinity Methodist Church, Widnes, run by volunteers, all of whom have been safely recruited, using processes and procedures based on good practice in the sector, in recognition of the changing demographics of the area and the wish to become more inclusive
- A safeguarding audit has been carried out at St Wilfrid's Church Parish, Widnes by the Liverpool Catholic Archdiocese, as part of the national one. Records have been updated and agreed as current. Attendance at the Archdiocese Safeguarding Reps' meeting in March which shared updates and good practice
- People are more aware of issues of consent and of how to engage other service providers. One specific case of self-neglect has been moved forwards. More people are aware of self-neglect and making safeguarding personal and know how to refer. A report has just been published into the findings
- Several people attend the drop-in weekly; food, clothes, cycles, toiletries and information are given out; partners e.g. Red Cross provide specialist information and support; English lessons are provided, and a simple lunch is eaten by attendees and volunteers. Attendees are made to feel very welcome and are treated with kindness and compassion.
- Updated database of who is doing what in the Parish and who has a DBS check is agreed good practice has been shared with the clergy to be actioned within the next few months

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To promote person centred approach across services within Halton. Safeguarding Adult Team have held weekly meetings with MH staff to ensure that they are recognising signs of abuse and neglect and supporting patients to make their own choices in line with Making Safeguarding Personal.

Making safeguarding personal audit completed

Within the next reporting year it is planned that we hold a Making Safeguarding Personal (MSP) workshop to support staff to utilise the MSP local Government national toolkit to ask Patients what their views are and what their desired outcomes are. To also support staff in recording patients outcomes within documentation

Bridgewater undertook a stocktake of our position in relation to Making Safeguarding Personal Audit and how mental capacity was considered and recorded by community nursing teams. Development of a proposal for enhanced, practical training in applying the MCA.

- Forum set in with LA to review retrospective referral data for safeguarding enquiries with a clinical element to help identify emerging themes and trends and enhance learning.
- Halton CCG contributed to an executive review the processes and learning from a SAR and MAR completed for Halton
- This event highlighted areas for improvement to strengthen the recognition of diversity and culture and its impact both in practice and in safeguarding reviews. This has been included as a quality marker in the SARG. Halton CCG is represented as a core panel member of SARG
- Regular audits provided to the sub group – this is a standing agenda item. Learning from audits is shared and subject to peer support by the group. Designated professionals have oversight of audit activity through the safeguarding assurance frame work in place with commissioned healthcare services
- HCCG safeguarding assurance framework assures providers have policy and training in place in respect of the mental capacity act and the effectiveness is reviewed regularly through audit activity

- Identified targeted areas for learning and improvement. Forum is on-going and evolving
- Quality framework in place to support and underpin future safeguarding adult reviews. This will ensure effective learning and improved outcomes for adults at risk
- Assurance of scrutiny of practice to ensure in line with legislation, policy and best practice
- Outcomes and voice of the adult/making safeguarding personal heard
- Best practice and learning shared across the whole health system.
- Effective application of the MCA and adults at risk supported in the least restrictive way.

Level one and two adult safeguarding training is delivered via e-Learning, it was realised that some staff groups had limited access to computers. Therefore Increased access to

Safeguarding adult level one and two training had been facilitated via face to face sessions late in the evenings.

A program of level three training has been put in place to upskill all band 7 and above staff to ensure they are confident and able to address safeguarding concerns and support junior members of staff. Slides and training session have been updated to include information about making safeguarding personal and ensuring staff are aware of how their care act their responsibilities apply to all patients they come into contact with. Level three training information is shared with staff following their attendance as an aide memoir.

MCA/DoLS training is facilitated on a face to face basis with a training aid to support staff in their practice after attending the sessions.

Greater awareness of safeguarding adults across the organisation is evident.

This is noted from the increased variety in the category of abuse of safeguarding notifications to the adult team and in where the information has come from. For example a member of the finance team who supports the trust with non EU patient charges, notified us of a patient she felt may have been trafficked, A/E staff had let the safeguarding team know however it was reassuring that non clinical staff had also picked this up. A further example came from a vigilant nurse who noticed clues regarding a possible honour based violence situation.

The adult team has noted a remarkable increase in adult safeguarding notifications of 34%.

Please observe the charts and information below for details of 17/18 and 18/19 activity and the types of abuse highlighted.

SHAP

All employees of Plus Dane (PD) are provided with safeguarding training.

We have a team of 12 Designated Safeguarding Leads across all areas of the organisation. Our approach is that safeguarding is the responsibility of all staff.

Increase in the number of safeguarding concerns being raised. Increased awareness/knowledge of safeguarding issues and how to deal with them across the organisation.

Cheshire Constabulary

Cheshire Constabulary fully recognise the importance of quality assurance. The Constabulary engage in all audits identified in the safeguarding board and ensures that good practice and learning is shared with its officers and staff.

Within Halton, we are co-located in Municipal building with the local authority. This means that referrals received in to the Police (both internally and externally) are reviewed quickly and with a person centred approach. Cheshire Constabulary share these referrals with adult social care as well as other agencies identified as being supportive to the needs of the person involved.

The Constabulary has recently undertaken training in relation to the Vulnerable Person Assessment (VPA) and has seen an improvement in the standards of those submitted. This allows the right agency to be identified at the earliest opportunity

Priority 2: Providing the skills and knowledge to enable genuine care and understanding for adults at risk of harm (Awareness-raising and Training)

The Training and Marketing Plan was completed, using a coproduction approach consulting with stakeholders. An awareness campaign concept was developed and designed with accessible language for the marketing campaign and free multi-agency training sessions based on demand, need and again accessibility to a wide audience was designed. Delivery of the training will be over the next 12 month with an evaluation at the end to identify further/ongoing support needed.

The website for Halton Safeguarding Adults Board has been successfully established. The website hosts free toolkits, access to information around safeguarding and support services; advice on abuse- with indicators, local and national policy and guidance as well as resources from external providers e.g. SCIE and RiPfA. The learning resources available include videos, tookits, and access to free ELearning for all HSAB partners and adults who provide care or support,

additionally there is free multi-agency training for all partners including volunteers and personal/family carers.

Following the success of HSAB's first Awareness Day Event in March 2018, the board have made a commitment to host annual Awareness Days and take more opportunities to raise the public profile of safeguarding adults and the work of the HSAB. In March 2019, the focus of the event was Self Neglect. This was well attended and feedback given was really positive. This has informed the SAB training schedule for the year ahead, where there is now free training regarding Self Neglect Awareness.

A marketing campaign was also developed in consultation with stakeholders across the community. The marketing campaign will address the top three most prevalant types of abuse for adults in Halton, will raise the general profile of adult safeguarding and help to inform people of potential risk indicators for safeguarding and how to respond to these.

All safeguarding adults information and leaflets have been updated to ensure compliance with The Care Act, these have been disseminated to all partners and it is expected that partners will embed 6 principles of safeguarding and Making Safeguarding Personal approaches into their professional practice.

In early 2019 and as part of the Good Neighbour Scheme, an offer of free Safeguaridng Adult awareness was offered to general public. Attendance was excellent and the feedback was positive. This initiate will aim to continue each year.

Within Adult Social Care, there is an established Safeguarding Champions forum, which reports to the board. This is led by the Integrated Adult Safeguarding Unit and provides a forum for

provider services to share learnings, good practice, raise issues and develops positive relationships.

The website address is: **www.haltonsafeguarding.co.uk**

Healthwatch Halton promotes a positive culture through promoting a duty of care for staff volunteers and Advocates. Healthwatch Halton therefore ensures access to Safeguarding Training is available through accessing HBC free training and resources to ensure personal awareness of any care concerns or safeguarding issues and risks in relation to vulnerable adults and older people, and to importantly ensure that that they are confident and compliant with safeguarding reporting. Healthwatch Halton is committed to continuous learning and Professional Development. Advocates and staff have undertaken Safeguarding Training which is due for renewal this year.

Four staff from Age UKMM attended refresher training on safeguarding in the period. Including the CEO. Staff are better equipped and aware of key responsibilities in the borough and how to use and communicate them.

All staff and volunteers access induction days that have safeguarding as a key module.

GRC continue to improve their skills and competencies. All practitioner at GRC have a duty of care and a responsibility to make themselves aware of safeguarding risks.

Halton Housing Trust has a comprehensive staff training programme which in 2018-19 included:

- Dementia friends (17 staff trained)
- Time to Talk Champions (20 trained staff)
- Mental health awareness (108 staff trained)
- Suicide prevention (86 staff trained)
- Self-harm awareness (10 staff trained)

The above is supported by a comprehensive e learning platform which includes the following modules:

- Safeguarding adults – care certificate
- Safeguarding children – care certificate
- Working in a person-centred way
- Trained and knowledge workforce who can identify and report suspected safeguarding cases and ensures we are up to date with legislation and our duty.

HDP whole team skills audit, SA training for all, Team support with 200 PAs.

All clients being followed up / reviewed by SA assessor, documented and intervention if required. One year into new service staff appraisals provide evidence of competence and commitment

Halton Safeguarding Faith Forum

- HSCB and HSAB training has been publicised in the weekly Parish newsletter
- A safeguarding refresher session, which included trafficking/modern slavery, financial and other types of abuse not commonly discussed in previous training, was delivered by P Ruth to members of the St Vincent de Paul Society, volunteers who visit vulnerable people in their homes

- Those who visit people in their own homes or in care/nursing homes were reminded of their duty to report appropriately anything that they deem to be a possible safeguarding concern
- A discussion has taken place on updating the Parish lettings policy and procedures to ensure safeguarding is more prominent in it
- A discussion has taken place on new procedures for children's liturgy
- Awareness has been raised and hopefully, those who attended have gained new/updated information
- Better trained staff and volunteers who put training into practice and share with others
- People are more aware of keeping themselves safe as well as those with whom they come into contact
- Awareness has been raised and information shared to ensure health and safety policies and procedures are up to date and being followed
- More knowledge was gained by attendees and a rich discussion took place on issues which are becoming more common/more highlighted
- Hopefully, concerns will be raised in an appropriate manner and will be dealt with to ensure people are safer and have their needs met more effectively
- The policy and procedures will be updated and circulated to those who hire premises
- The procedures will be re-written and rolled out during the next few months

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- Mental Capacity Act 2005 survey monkey short summary
- Following on from Mental Capacity Training delivered across the Trust, A survey Monkey was conducted to assess the requirements for future training and development
- 100 staff members completed the survey, the responses were across all adults services including Learning Disability/Mental Health and Community Services
- Based on the range of responses key themes emerged regarding future training needs including:
    - Applying the act practically
    - Recording mental capacity and best interests
    - Training needs to be specific to service types

- Mental Capacity Audit has identified the need for on-going support for staff in completing Mental Capacity Assessment and how to record decision specific information
- Identified staff need for specialist training which specific to their service needs
- Joint Mental Capacity Act Training to be delivered by Halton Borough Council Safeguarding Team and NWBH Adult Safeguarding Service. Dates to be arranged for later 2019. This training will support existing training available to staff within the Trust.

Bridgewater provided Level 2 Safeguarding Adult Training via e-Learning for all staff. Team leaders in clinical roles will also undertake Level 3 Training.

Group Supervision opportunities were provided to District Nurse and Urgent Treatment Centre staff to support the development of skills and competencies.

Whether arising from incident reports or by direct contact via telephone/email, there has been a significant increase in contacts from Trust teams who required Safeguarding Adult support and advice.

- Halton CCG seeks assurance from commissioned health care services that the workforce and volunteers are trained in respect of safeguarding in line with the intercollegiate guidance for healthcare staff- children and adults.
- Halton CCG has a training needs analysis in place and supports staff to access the appropriate safeguarding training.
- Halton CCG are a key partner in local safeguarding adult arrangements and have active input to the Safeguarding Board, and sub groups. These forums ae utilised to support and share learning and professional development.
- Halton CCG Designated Nurse- safeguarding adults, has engagement with the regional designated professionals network and supports system wide learning and leadership
- Designated professionals have taken action to raise awareness of safeguarding within PC through practice visits, training sessions, safeguarding forum meetings, and targeted support as required.

A program of level three training has been put in place. Slides and training session have been updated to include information about making safeguarding personal and ensuring staff are aware of how their care act their responsibilities apply to all patients they come into contact with.

MCA/DoLS training is facilitated on a face to face basis with a training aid to support staff in their practice after attending the sessions.

The safeguarding Adult team have attended SAB based training as well as access other relevant external courses to ensure knowledge and practice is kept up to date.

The Named Nurse safeguarding Adults has completed a Mary Seacole safeguarding adult leadership program and has gained 50 credits at level 7 Masters study in safeguarding related study, this has supported the Trust in delivering the safeguarding adults agenda.

All CBU leads receive learning from SAR and internal incidents where safeguarding has been identified; via Safeguarding Committee. Where actions arise from this learning, leads are asked to report progress via high level briefing papers and actions are monitored via the safeguarding committee work plan.

In instances where information from a SAR or internal incident requires sharing with and where no action is required CBU leads are asked to ensure that they take information back to their CBU meetings for dissemination across their areas.

Services are delivered by staff who are trained re safeguarding to deliver safe effective care and recognise and act upon any safeguarding concerns in line with legislation and local policy.

GP safeguarding lead in place in every practice. Referral pathways and safeguarding resource pack in place in every practice.

Training provided re:

- Coding safeguarding concerns
- FGM
- Neglect
- Domestic Abuse.

Attendance at safeguarding forum has doubled.

Calls for advice from designated professionals have increased.

Greater awareness of safeguarding adults across the organisation is evident.

This is noted from the increased variety in the category of abuse of safeguarding notifications to the adult team and in where the information has come from.

Increased knowledge and understanding of safeguarding within the safeguarding team has improved the quality of training and day to day advice/support provided across the Trust.

Domestic Abuse, adult only notifications continue to increase for the adult team with 125 cases reported in 17/18 and 18/19

Please see the tables below detailing the improvement in training compliance between 17/18 and 18/19

Cheshire Constabulary

Learning is a key focus of the Constabulary. We are currently delivering training around Domestic Abuse as well as other areas of vulnerability (both adult and children). The Constabulary recognises that the vast majority of demand is in relation to vulnerability and the safeguarding of adults within the Community.

Further to this, the Constabulary's Serious and Organised Crime Board has identified the prevalence of County Lines within Cheshire and the impact of those vulnerable adults who are being exploited in their own home.

National Probation Service

All NPS case holding staff and line managers are required to undertake Safeguarding Adult eLearning and two days classroom training.

Priority 3: Gaining a greater understanding of how mental health can impact adults at risk being protected and cared for in the best way possible (Mental Health)

Healthwatch made a commitment to work with Halton Safeguarding Adults Board to design a questionnare and information gathering process and disseminate to partners and the local population to help establish local needs and knowledge around safeguarding and mental health. The questionnaire is available to access and comment on via Healthwatch and HSAB websites.

The SAR and MAR reviews highlighted mental health as an issue and as a result of the recommendations revsion of local provision has taken place. Further details can be found in Section 4.

Healthwatch Halton works collaboratively with residents whose behalf they are working on. This is evidenced through documenting their feelings and wishes when working on their behalf, which is evidenced through advocacy services and various outreach and enter and view activities.

Healthwatch Halton works collaboratively with statutory health and social care organisations through representation and attendance at various strategic board meetings working collaboratively with statutory and voluntary sector organisations across the various sectors. To ensure that as a responsible organisation we meet the core duties of the SAB as required by The Care Act (2014). Engagement and Co-production is a key feature of Healthwatch Halton as an organisation and we will continue to do so using a wide range of tools and methods, to ensure compliance with our duties as a SAB member and safeguarding under the Care Act (2014).

The CEO is the current Chair of the HSAB Partnership forum and as a result fully collaborates with a wide range of stakeholders and key safeguarding teams across the local authority. Our organisations has Safeguarding at its highest possible level of involvement in its core strategic planning and development.

GRC collaborates and works together with partner agencies. E.g. HBC safeguarding teams, Cheshire Police, HBC Advocacy Services. Welfare services.

- Tenancy Services Manager has a place on the Adult Safeguarding Board
- Amethyst Living Manager and the Tenancy Services Manager have a place on the Safer Halton Partnership, o ensure all meetings are covered.
- Health and Wellbeing Officer has a place on the One Halton Population Health Board
- Halton Housing is a member of the Halton Dementia Action Alliance and regularly attends their conferences and training courses
- Halton Housing is a member of the Domestic Abuse Strategic Forum

Attend Professionals Meetings including MARAC and \Multi-Agency Meetings as requested to ensure that all agencies are providing a person-centred approach. Strong partnership relationship between Halton Housing and Halton Borough Council. Increased awareness of inter-agency arrangements. Joined up approach, with support tailored to the individual.

HDP founded on co – production. Liaison with client carer and volunteer based consultation group. More than 50% trustees have disability and vulnerability issues.

Lottery bid authorised investment to develop a Safeguarding Adults service which involved full consultation with group and was co-authored by C.E.O as Safeguarding Adults lead who regularly liaised with social work teams including individual assessment, complex care and mental health.

Halton Safeguarding Faith Forum

The existence of the Faith Forum is to enable inter-agency arrangements and to ensure the faith sector is carrying out its safeguarding responsibilities. This does involve cooperating with statutory partners in specific cases and discussions have taken place at meetings about considering adults' wishes and feelings in decision making

St Wilfrid's Catholic Parish, Widnes: As well as what is stated above, we are cooperating in the safe space drop-in with members of our Parish volunteering.

More recognition of the diversity of Widnes' population and the issues facing the attendees. More knowledge gained of asylum seeking processes and support available.

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Boroughs Healthcare
NHS Foundation Trust

Safeguarding Adult Named Professional is a member of Halton Safeguarding Adult Review Group. Together with the Designated Nurse for Safeguarding Adults regular discussions are held to ensure that information is shared and that we work collaboratively to support the SAB in fulfils its core duties

Advanced Practitioner for Safeguarding Adults has a close working relationship with Halton Borough Council Adult Safeguarding team. Regular discussions are held to ensure that safeguarding concerns are referred in a timely manner. Joint thresholds have been produced to ensure that NWBH staff are clear on what information needs to be shared.

Making safeguarding personal audit short summary:

The Care Act (2014) statutory guidance states that all safeguarding partners should "take a broad community approach to establishing safeguarding arrangements raised." Safeguarding "should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety."

The aim of the Evaluation was to ensure that NWBH patients who experience abuse or neglect need to be empowered to have their wishes and feelings recognised. The evaluation audited 20 patient

records to ensure that practitioners are recording patients views in relation to safeguarding concerns and what their desired outcomes are (Care Act Guidance 2014) The findings of this small evaluation were as follows:

- Good evidence of recording type of abuse/concern
- Good evidence of documentation regarding immediate action/protection plan
- Very little evidence of the views of the patient is recorded within documentation, however the patient records do state a conversation has been held with the person about the concerns but there is poor evidence of the patient's views being recorded.

Safeguarding Adults Training is delivered as part of all induction training. A range of specific topic based training has been developed including Domestic abuse/coercion and control/Mental Capacity and Advance Decision to Refuse Treatment/Self neglect/ financial exploitation.

NWBH provided level 1 training for all staff at induction and Level 2 Safeguarding Adult training via e-learning for clinical staff.

Group Supervision opportunities were provided to Mental Health Teams and in patient services to support the development of skills and competencies

NWBH Adult Safeguarding Named Professional attends Health Sub Group/SARL Group and SAR and Case Review Panels

Established a joint threshold model with Halton Local Authority to ensure that appropriate Safeguarding Adult concerns are referred onto Local Authority and that care concerns or complaints can be dealt with via other pathways. Halton North West Boroughs Healthcare in-patient wards historically have had a lower referral rate to both internal and Local Authority safeguarding team. Referrals to NWBH Adults Team have increased from 100 across 2017/18 to 147 across this report year 18/19.

The Advanced Practitioner is spending half day per week on the wards offering a drop in to assist staff in making decisions regarding safeguarding enquiries. This is being supported by Halton Local Authority safeguarding team.

SHAP

PDS are represented on a number of safeguarding boards across LCR and Cheshire East.

More effective multi –agency working. Positive relationship building with partner services. Increased knowledge of issues within the sector and how to address them.

One of the keys questions asked of the adult is what outcome they would like to see from the safeguarding disclosure.

Cheshire Constabulary

The Constabulary attends all Safeguarding adult boards within the Cheshire footprint.

DCI Williams chairs the Safeguarding Adult Review Group which reviews those incidents where an adult has come to harm within the Community. This is key in identifying any agency failings and to ensure best practice and learning is shared continually.

National Probation Service

All NPS OASYs assessments require a service user self-assessment to be completed.

SECTION 6: THE YEAR AHEAD – 2019/2020

For the year ahead, the following three priorities have been identified by the Safeguarding Adult Board

Quality Assurance

Quality Assurance has been identified as a key priority for the year ahead by the HSAB. It will involve ensuring that HSAB members and provider services have systematic monitoring and evaluation of the various aspects of safeguarding adults in place, to ensure that standards of quality are being met. This will include

- Ensuring internal quality assurance frameworks are in place
- Ensuring any identified learning is shared
- A review of the Safeguarding Adults audit processes within Halton
- Sharing of information across HSAB members and Provider Services

Learning and Professional Development

Learning and development has been identified by HSAB as a key priority for the year ahead. This will aim to further develop the work completed over the past few years in relation to the HSAB training schedule, as well as the introduction of the SAB annual event. In addition, other areas to consider will be the following

- Ensuring HSAB partner agencies have learning and professional development opportunities in place for their individual workforce
- Ensure there is a consistency and standardisation of Safeguarding practice across Halton
- Ensure all agencies promote a Making Safeguarding Personal (MSP) approach
- Ensure that there is effective communication of training opportunities shared within HSAB Members and Partner agencies.
- Support the development of good multi-agency practice, sharing best practice, lessons learned and have the confidence to challenge decision making.
- To support adults at risk, informal carers and families with Safeguarding and ensuring that they all feel supported within the Safeguarding process.

Coproduction and Engagement

Co-production involves working with people with care and support needs, their families and carers, along with Service Providers, voluntary organisations, statutory services and other stakeholders, on an equal footing, to design, influence, develop, deliver, monitor and review services. It is a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities.

The HSAB would like to work and have assurances regarding how safeguarding approaches are developed, ensuring that the following people and organisations are actively involved:

- Adult Social Care operational teams;
- Housing, Finance and Legal representatives;
- People with health and social care and support needs, carers and family members;
- Care and support Service Providers, relevant voluntary, user and other support organisations;
- Advocacy services
- Local communities

At the end of 2020, HSAB would like to ensure that the voice of people who use services are heard, are involved in developing policy and are at the centre of any health and social care intervention, Making Safeguarding Personal to the adult at risk and ensuring their rights, wishes and feelings are at the heart of the decision making process.

SECTION 7: APPENDICES

APPENDIX A: BOARD MEMBERS

Independent Chair – Audrey Williamson

Halton Borough Council - Sue Wallace-Bonner

Halton Borough Council – Tracey Coffey

Halton Borough Council – Helen Moir

NHS Halton Clinical Commissioning Group – Michelle Creed

Cheshire Constabulary – DCI Louise Cherrington (Previous rep Gareth Lee)

Cheshire Fire and Rescue – Emma Coxon

North West Ambulance Service - Andrea Edmonson (previous rep Vivienne Forster)

Probation Services (Cheshire CRC) - Jenny Archer-Power

Healthwatch - Elizabeth Learyod (previous rep Hitesh Patel)

Elected member responsible for adult health and social care - Cllr Tom McInerney (previously Cllr Marie Wright)

Halton Safeguarding Adults Partnership Forum Chair – Mark Lunney (Mark Weights deputising)

APPENDIX B: PARTNERS AND CONTRIBUTORS

APPENDIX C: CONTACT DETAILS

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Website: www.haltonsafeguarding.co.uk

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HALTON
SAFEGUARDING
ADULTS
BOARD