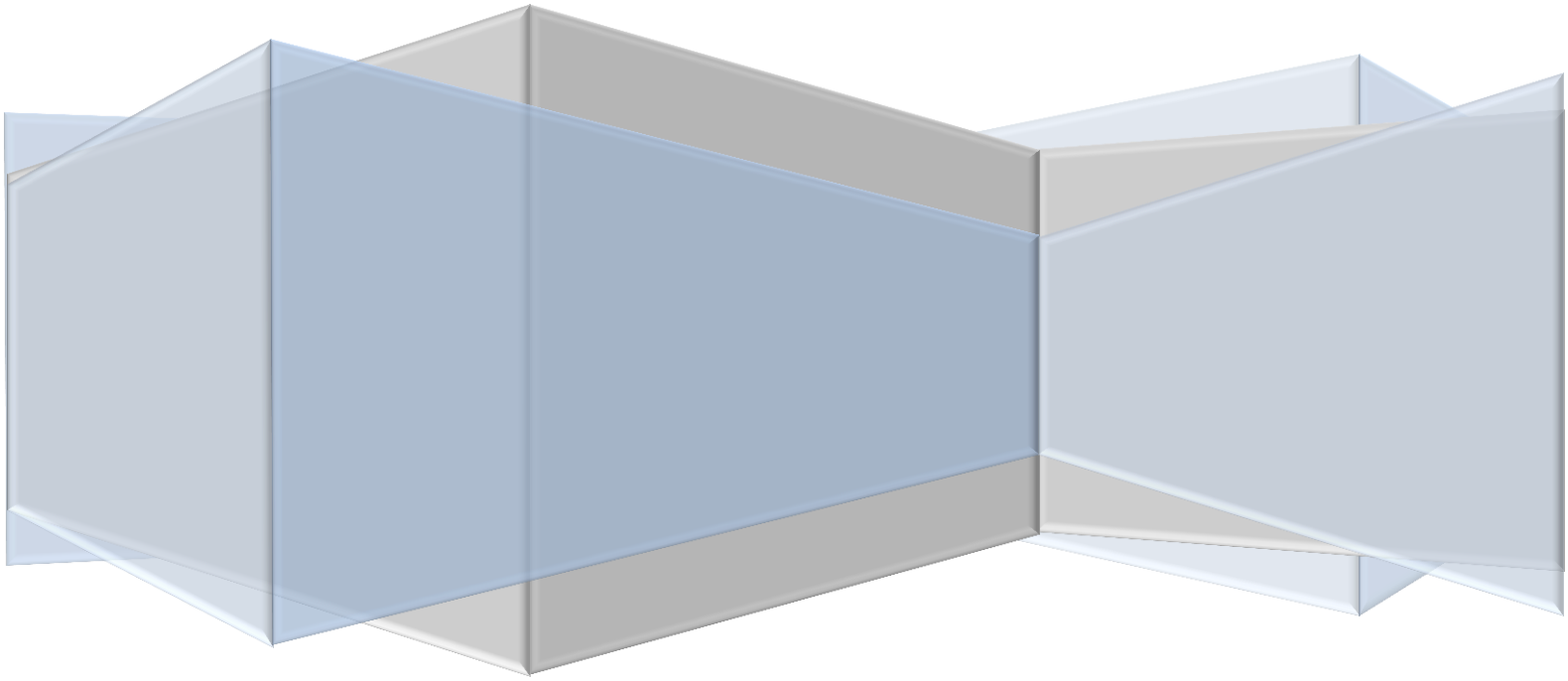
Halton Safeguarding Adults Board

Annual Report 2014-15



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FOREWORD

Halton's Safeguarding Adults Board believes that the safeguarding of vulnerable people is everybody's business, with all communities playing a part in preventing, detecting and reporting neglect and abuse. Although safeguarding adults is a complex and challenging area of work, effective measures are in place locally to protect those least able to protect themselves. As Chair of the multi-agency Safeguarding Adults Board, I am pleased to present this Annual Report which describes how organisations and individuals across all sectors, are working together to safeguard vulnerable people.

As well as reporting on its work over the past year, the Annual Report explains the national context in which we all operate and lists our priorities for the coming year. Some of the key highlights from the past year include working towards implementation of the Care Act from April 2014; continuation of the Safe in Town scheme in Halton; addressing key areas of safeguarding such as the increase in financial abuse and working with our partners in order to raise awareness of safeguarding across our various organisations and ensuring staff members have received appropriate training

I want to assure local people and partner agencies of our continuing commitment to this work, which is essential to the quality of life and experience of people whose circumstances make them vulnerable and take the opportunity to thank all those involved for their vital contribution to this essential area of activity. I am grateful to all those managers and practitioners who seek to ensure that adults at risk are safeguarded and who uphold the highest standards of care and support. I hope that you find the Annual Report both informative and reassuring.

From September 2015, the role of Chair of Halton Safeguarding Adults Board will be undertaken by an Independent Chair – Audrey Williamson and I wish the new Chair all the very best in their future work with the Board.

Dwayne Johnson

Chair of Halton Safeguarding Adults Board
Strategic Director – Communities
Halton Borough Council

1. OVERVIEW OF HALTON SAFEGUARDING ADULTS BOARD

The purpose of Halton's Safeguarding Adults Board is to:

- **Act as a multi-agency partnership board of lead officers and key representatives, which takes strategic decisions aimed at safeguarding vulnerable adults in Halton**
- **Determine and implement policy, co-ordinate activity between agencies, facilitate training and monitor, review and evaluate the safeguarding of adults**
- **Promote inter-agency cooperation activity between agencies**
- **Develop and sustain a high level of commitment to the protection of vulnerable adults**
- **Ensure the development of services to support people from hard to reach groups**

The HSAB has four main priorities, which underpin the work of the Board and its annual plan ensures all members are actively engaged/involved in supporting these priorities:

Priority 1: To promote awareness of abuse and of all individuals' right to be safe and be afforded dignity, particularly amongst people who are "vulnerable" or at risk and others, including the wider community, staff and volunteers

Priority 2: To increase the contribution from service users and carers and wider communities, by seeking to ensure that the views and experience inform the Board's work and service developments and by ensuring that personalised services are available in a way that keeps people safe but enables them to make informed decisions about risk

Priority 3: To ensure there is a strong multi-agency approach to assuring the safety, wellbeing and dignity of vulnerable adults

Priority 4: To equip employees with the necessary tools to both safeguard vulnerable adults and ensure their dignity is respected.

2. CURRENT PICTURE IN HALTON

From taking a closer look at the data collated for the statutory statistical Safeguarding Adults Return in 2014/15, we can start to build a profile of who are the most vulnerable to potential abuse in Halton and start to focus the work of the Board around addressing the needs of the community, in order to help keep people safe in Halton.

The 2014/15 data indicated that the most potentially vulnerable in our community were females, aged 65 and over, have an ethnicity of white british and who primarily require support for their physical needs from adult social care. The most prominent type of alleged abuse in Halton is physical abuse, followed by neglect / acts of omission. This year also saw an increased in referrals regarding alleged financial / material abuse, which was also identified as a trend nationally. The alleged abuse is most likely to occur in the person's own home and by someone who is known to the individual, for example a relative or a care worker.

By using this data, the following information highlights the work that has been undertaken by the Halton Safeguarding Adults Board in order to keep the people of Halton safe from potential abuse or neglect.

3. HOW HAS HALTON SAFEGUARDING ADULTS BOARD HELPED TO KEEP PEOPLE SAFE?

The Safeguarding Adults Inter-Agency Policy, Procedure and Good Practice Guidance has been updated for Halton, in terms of our safeguarding referral process and the new statutory requirements for safeguarding adults in light of the implementation of the Care Act 2014. The policy was agreed by members of the Halton Safeguarding Adults Board and the policy has now been circulated to all agencies for implementation. The policy is also available to view on the Halton Borough Council website at www.halton.gov.uk/safeguardingadults

A Multi-Agency Domestic Abuse and Sexual Violence Strategy 2014-17 has been developed. The purpose of the strategy is to set out what Halton intends to do over the next 3 years, to tackle the issue of domestic abuse and sexual violence within our communities. Halton Domestic Abuse Forum as a partnership will aim to create equality for all our residents through reducing fear and harm experienced from this form of violence and abuse. The strategy will seek to improve the risk identification, assessment and management processes and to target educational and support services effectively. No single agency can adequately deal with domestic abuse and sexual violence. The issue needs to be addressed by joint working and multi-agency strategies.

This year has also seen the implementation of Domestic Violence Prevention Notices (DVPNs) and Domestic Violence Protection Orders (DVPOs). The implementation is legislated through the provisions of the Crime and Security Act 2010. DVPOs were designed to provide immediate protection for victim-survivors following a domestic violence incident in circumstances where, in the view of the Police, there are no other enforceable restrictions that can be placed upon the perpetrator. DVPOs aim to give victim-survivors time, space and support to consider their options by placing conditions on perpetrators, including restricting/removing perpetrators from households and preventing contact with, or molestation of, victim-survivors. Cheshire Police have committed to appoint dedicated resources to support this work. A newly developed role of DVPO Coordinator/Court Presentation Officer has been established. From Monday 2nd June 2014 – Friday 19th December 2014, there has been a total of 48 Domestic Violence Protection Notices issued. All notices were taken to court within the time limit of 48 hours. Of the 48 applications, 8 were contested by the offender at court and 3 orders were not granted by magistrates. The impementation of DVPNs and DVPOs has provided an opportunity to build upon established multi-agency working and strategies to intervene in

domestic abuse by providing additional measures to safeguard victims and their children. Effective multi-agency working is critical to ensuring the success of these orders.

A summary of the Independent Inquiry into child sexual exploitation (CSE) in Rotherham was presented to Halton Safeguarding Adults Board in October 2014. An Independent Inquiry into Rotherham Borough Council's internal processes and procedures, as well as its work alongside partners, in responding to historical cases of child sexual exploitation during the period 1997-2013 was undertaken. The inquiry was commissioned by the Council's Cabinet in September 2013 and was carried out by Alexis Jay OBE. No one knows the true scale of child sexual exploitation in Rotherham over the years. A conservative estimate is that 14,000 children were sexually exploited during 1997-2013. The abuse is not confined to the past, but still continues to this day. In May 2014, the caseload of the Specialist Child Exploitation Team was 51, with more CSE cases being held by other Children's Social Care Teams. In 2013, the Police received 157 reports concerning child sexual exploitation in Rotherham.

Following the publication of the Alexis Jay report, David Parr – Chief Executive of Halton Borough Council, wrote to all 23 North West Local Authorities requesting they all consider a review in light of the report's findings. Gerald Meehan, Strategic Director People & Economy - Halton Borough Council, is chairing a multi-agency group to agree a Terms of Reference to be used by partners across Cheshire and to report to Local Safeguarding Children Boards. A Pan-Cheshire Missing From Home and Child Sexual Exploitation Group has been established by the Police. This group has produced a Pan-Cheshire Strategy and Protocol which each Local Safeguarding Children Board has approved and an action plan developed.

A presentation was delivered to Halton Safeguarding Adults Board in March 2015, in regards to the establishment of a Child Sexual Exploitation Team within Halton. It was agreed that regular updates would be presented to both the Children and Adult Safeguarding Boards.

In January 2015, a report was presented to the Board regarding reporting financial abuse incidents during July-December 2014, due to an identified increase in the number of safeguarding referrals relating to alleged financial / material abuse. In the Care Act 2014, it states that financial abuse includes:

- Having money or property stolen
- Being defrauded
- Being put under pressure in relation to money or other property
- Having money or other property misused

Many types of financial crime can go unnoticed and factors, such as the economy, technology and social change are diversifying the threat. In 2008, Help the Aged reported that 60 - 80% of financial abuse against older people takes place in their own home and 15 - 20% in residential care. Research suggests that financial abuse is most frequently perpetrated by a person acting in a trusted capacity, for example, a family member or friends, neighbours or care workers/other professionals.

In order to address the local and national increase in financial abuse incidents, it was agreed by Halton Safeguarding Adults Board to establish a Task and Finish Group to develop a Financial Abuse Toolkit. The purpose of the toolkit is to raise awareness of both professionals and members of the public, in recognising the potential indicators of financial abuse and what support and services are available to help prevent such abuse occurring in the future. The toolkit has now been drafted and is in its final stages of development.

A launch event is being considered in order to help raise awareness of this type of abuse and to provide training to professionals to help support potential victims of financial abuse.

The Safe in Town Scheme has been running in Halton since 2012, to provide a safe haven for people who may feel vulnerable when out in the community. Once individuals enter a shop which has the Safe in Town logo sticker displayed and declare themselves as part of the scheme by showing their laminated card, one of the staff members would phone a dedicated number for the individual and a family member or carer would come to collect them. The Halton scheme has widened the range of beneficiaries and now includes adults and young people (aged 14 years plus) who have a learning or physical disability and anyone over 60 years of age. The logo for the scheme was designed and agreed by the Halton People's Cabinet and is now being used by Cheshire Police to roll out the scheme across the whole geographical footprint. Easy read comic books, which were produced for both individuals and organisations, to ensure the scheme's guidelines and safeguarding messages were consistent when shared with participants, have also been used by the Police, with thanks given to Halton Speak Out who produced the comic books.

As at November 2014:

- 504 people have signed up to the scheme
- 31 venues in Runcorn Shopping Centre are now Safe in Town havens
- 22 venues in Runcorn Old Town are now in Safe in Town havens
- 18 venues in Widnes Town Centre are now Safe in Town havens
- 10 local shops on housing estates throughout Halton are Safe in Town havens

- 3 Community Centres are Safe in Town havens
- 2 Health Centres are Safe in Town havens

It was anticipated that by the end of March 2015, the numbers would have further increased, with targeted activity to sign up more local shops, non-commercial premises and in particular, health centres and GP surgeries. Widnes Vikings Rugby Team are in discussions to put the Safe in Town logo on the t-shirts of their younger players and the scheme has been included as part of the Bright Sparks Kitemark and the purple handbook for people experiencing Alzheimer's and other forms of dementia.

A report was presented in March 2015 to the Board regarding reported medication errors, as it was identified that an increased number of safeguarding referrals were relating to medication errors in both domiciliary and residential care. The National Patient Safety Agency (NPSA) defines a medication error as an error which occurs in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred. Care providers who are commissioned to provide any medication administration service within a care plan are responsible for ensuring that people using the service, will have their medicines at the times they need them and in a safe way. The statutory requirements of care providers around medication errors requires that the registered person must protect service users against risks associated with the unsafe use and management of medicines, by means of appropriate arrangements for the obtaining; recording; handling; using; safe keeping; dispensing; safe administration and disposal of medicines used for the purposes of regulated activity. All medication errors should be reported in line with care provider's Management of Incidents policy, as soon as possible after the incident. Medication incidents have a number of causes, such as lack of knowledge; failure to adhere to systems and protocol; interruptions, staff competency; poor handwriting and instruction and poor communication. The National Patient Safety Agency has divided definitions of medication errors into the following areas:

- Prescribing errors
- Dispensing errors
- Preparation and Administration errors
- Monitoring errors
- Other errors (including poor or inadequate communication and recording etc.)

In Halton, in line with the NPSA definitions, local data suggests the majority of reported medication errors involve poor administration by care providers; this includes administration of the wrong medication or dose, administering medication too early or late and that the administration or medication has been recorded incorrectly or not recorded at all. Where medication errors are reported action is required by the provider service to protect the adult at risk from harm and to ensure that no other adults are put at risk. In many cases, the safeguarding investigation identifies that the worker needs more training and where this occurs, the worker is supported to deliver safe care. The Care Home Support Team is now well established in Halton with a dedicated Pharmacist, who provides support and advice to the care homes. All data regarding medication errors are shared with the NHS Halton Clinical Commissioning Group Medicines Management Team, so that trends, themes and ongoing support can be identified.

Halton Borough Council's Human Resources & Development Manager has chaired the Safeguarding Learning and Development Sub Group and has implemented Learning and Development Strategies that give a framework that contributes to helping to keep people safe. Core programmes for Adults and Children's

Safeguarding Training has been delivered, covering a wide range of subjects, such as:

- Alerter Workshops (0.5 days)
- Safeguarding Adults Basic Awareness (e-learning)
- Safeguarding Adults Safer Recruitment (e-learning)
- Safeguarding Children Basic Awareness (0.5 days)
- Safeguarding Adults Referrers Training (1 day)
- Safeguarding Adults Investigators Training (2 days)
- Safeguarding Adults Chairing Skills (1 day)

The chair of the Safeguarding Learning & Development Sub Group has worked closely with Halton's Safeguarding Children Business Manager, to ensure that:

- Quality assurance arrangements are in place in respect of safeguarding training delivered or commissioned by partners, agencies or the Boards
- Recording, monitoring, analysing and reporting on the volume, profile and impact of the training delivered under the direction of the Board
- A range of Learning & Development opportunities and to implement them as appropriate
- Promotion of key safeguarding messages through the organisation at workshops/events and engaging in local and national campaigns
- Engage a range of stakeholders in safeguarding development activity
- Links are esablished with other groups in order to ensure that safeguarding knowledge and practice is embedded in strategies and priorities

During the year, training packages from Halton Borough Council, Schools, Youth Federation and Early Years and Day Care providers have gone through a training validation process to ensure the quality of training is meeting the expectations of the Board. Each year the Safeguarding Learning & Development Sub Group undertake a Training Needs Analysis to establish emerging training requirements and to ensure appropriate levels of training are available.

Disclosure and Barring Service requirements are well established within Halton Borough Council and work is ongoing into the implementation of an online registration process that will ensure efficient processing of applications.

In September 2014, the Halton Borough Council Trading Standards Team began a Scams Project to raise awareness of mass marketing fraud, after they became aware that at least 190 people in Halton had been targeted. The team have been trained in clean questioning and coaching skills for behaviour change. Trading Standards work with individuals to understand what scams they respond to, why they respond and work with them to find alternatives to fill the gap. The individual often feels a sense of belonging/friendship or purpose from responding to these scams. The team will also try to assist with the resolution of other problems that the individual may be experiencing, by referring to other agencies if necessary. As part of this work, the team have been raising awareness of this form of financial abuse with other Council services and agencies, as well as giving talks to community groups. For the purposes of the Scams Project, Trading Standards shared information with Adult Social Care, developing links with various teams. The team have also liaised with the Police and gathered information about services provided by local agencies and organisations that may be useful to the people they work wih.

Some members of the Trading Standards Team have also received Dementia Awareness training and all have been trained in clean questioning techniques to improve their ability to communicate with vulnerable people.

Case Example

Mr E is a 97 year old victim who has lost approximately £6,000 to scam mail but is reluctant to stop spending money. He is now receiving approximately 20 letters per day and numerous phone calls. Adult Social Care is involved and reported to Trading Standards that in a week Mr E's bank balance had gone from £60 credit to £220 overdrawn. The victim had no money for food and he had stopped paying his care bills.

Adult Social Care have worked with Mr E and his bank and arranged for him to have a new card as his current account is being drained by a series of direct debits that he has set up to the scam companies. The victim has agreed to have his mail redirected to Trading Standards so that the team can filter out any scam mail.

Mr E walks with the aid of sticks and the team was concerned that he was receiving a lot of scam and nuisance phone calls and his eagerness to reach the phone was likely to result in a fall. Trading Standards have provided him with a call blocker device, which should stop all of the scam and nuisance calls that he is receiving.

Working with Adult Social Care, Trading Standards have been able to remove the risk of continued financial abuse for this vulnerable person.

NORTH WEST AMBULANCE SERVICE

The North West Ambulance Service NHS Trust has a legal duty to protect patients, staff and the public from harm. This includes harm from others as well as avoidable harm to patients. The Clinical Safety and Safeguarding Team have worked hard during the year to identify patients at risk and have focused the following work streams to ensure patients and the public receive appropriate care and protection when required. The following summarises some of the achievements for the Trust over the last financial year: The Trust took part in the Care Quality Commission pilot assessments of Ambulance Service NHS Trusts. The result is that a number of standards have been developed for Ambulance Services and good assurance was received in relation to safeguarding arrangements. The Trust has a named contact for each of the 46 Safeguarding Adults Boards across the North West. This strengthens working together and information sharing relationships and is reflected in the increased number of Serious Case Reviews/Safeguarding Adult Revews and Domestic Homicide Reviews. Staff also access multi-agency training and share learning and expertise with their peers. The Safeguarding and Frequent Caller Teams are regularly identifying and sharing information, to enable a joined up approach to ensure vulnerable people are afforded the assessment and care they require, in accordance with their wishes. When appropriate they are protected from harm of abuse and a significant amount of patient data is now shared to ensure the best outcomes for these patients. This also includes sharing concerns in relation to nursing and care homes. A significant amount of work has been done to update the policy and associated procedures. These now include the principles of adult safeguarding and pathways are included for victims of Child Sexual Exploitation, Female Genital Mutilation and the radicalisation of vulnerable people. Over 75% of all North West Ambulance Staff have received WRAP 3 training, which is the “Workshop to Raise Awareness of Prevent” – part of the Government’s Anti-Terrorism Strategy. WRAP is included within mandatory training for all staff and compliance with this national requirement continues to increase monthly.

The following summarises some of the proposed developments for the Trust in 2015-16: The Electonic Information Sharing System (ERISS) is a bespoke web-based system used by the Trust for sharing safeguarding referral information with Children's and Adult Social Care. This system has the functionality to place warning flags, to alert the attending crew about child or adult protection issues. The application will be piloted over the forthcoming year. The current position of staff raising alerts with the Trust Safeguarding Team remains in place. The Trust is continuing to develop processes in relation to Domestic Abuse. Following the success of the pilot last year, a referral form for domestic abuse will be developed with provision for enhanced information sharing which links to the national guidance (NICE). The Trust Safeguarding Team is in the process of developing links with all the Child Sexual Exploitation Teams in the North West, to enable efficient and timely information sharing in relation to child sexual exploitation. This is over and above the current safeguarding procedures already in place. There is also a process to capture data relating to female genital mutilation, which has been communicated to all staff and this will be monitored during the year. The Trust is working with partners to help tackle issues relating to Slavery and Trafficking of children and adults. This work is in the initial scoping phase and any identified actions will be added to the safeguarding work plan for the year and progress monitored.

NHS ENGLAND NORTH (CHESHIRE & MERSEYSIDE)

NHS
North West

The following provides a summary of the activities and initiatives which have been undertaken by NHS England North in order to help keep people safe in 2014/15:

- Baseline Safeguarding Audit undertaken across all GP surgeries
- Safeguarding Training Assurance discussed at annual GP appraisal

- All NHS England Merseyside staff have undertaken Level 1, 2 or 3 training dependent on position held
- Second National Safeguarding Conference held in October 2014 hosted in Merseyside
- Safeguarding Report is presented to the Merseyside Quality Surveillance Group bi-annually
- All Clinical Commissioning Groups in Merseyside are assured for Safeguarding Service accountability
- A robust Serious Untoward Incident System and process is in place to monitor child deaths, Serious Case Reviews/Safeguarding Adult Reviews and Domestic Homicide Reviews
- NHS England North are members of all Local Safeguarding Children and Adults Boards
- A Merseyside Safeguarding Forum has been established for Designated Professionals
- Additional funding for Mental Capacity Act/Deprivation of Liberty Safeguards has been secured for training independent contractors (GPs, Dentists, Optometrists and Pharmacists)

NHS England North have identified the following as priorities for 2015/16:

- NHS England Assurance and Accountability implementation
- Review of Health Key Performance Indicator framework for all NHS contracted services
- Implementation of the Care Act 2014 in relation to adult safeguarding
- Develop in partnership with Clinical Commissioning Groups and Local Authorities – Mental Capacity Act/Deprivation of Liberty Safeguards awareness training
- Focus on PREVENT
- Implementation of Female Genital Mutilation mandatory recording for GPs

- Implementation of key recommendations from the Lampard Report 2015

WARRINGTON & HALTON HOSPITALS NHS FOUNDATION TRUST

Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust have participated in promoting public awareness by holding 'Safeguarding Events' in the main foyer of the hospital, providing the general public with up to date information on 'what is safeguarding?' and 'what to do if you have a concern or need to report abuse?'. Further engagement has taken place with partner agencies on National World Elder Abuse Day, Learning Disability Week and Domestic Violence Week, which has included promotional posters for Polish speaking families in the various departments across the hospital. Additional information resources have been added to the Patient Information HUB at the main entrance, which includes contact names and numbers for internal and external safeguarding teams. The Trust has also established a network of Safeguarding Champions in clinical areas to promote safeguarding and dignity standards. The Safeguarding Team within the Trust are triangulated with the Trust DATIX reporting system and Complaints Department. This allows for any incident that is reported and has a safeguarding element to it, to be reviewed by the Safeguarding Team to ensure correct investigation, referrals and processes have been undertaken. For example, investigation of any internal allegations made by patients or families against members of staff. The outcome of any internal investigations are shared with the Clinical Commissioning Group lead and Local Authorities. The Safeguarding Team are also participating members of the Trust Patient Experience Committee, Equality and Diversity Group and Learning Disability Group which all have third sector representation and patient representatives to allow for feedback. The Safeguarding Team have worked closely with other professional groups to allow for risks to be identified and plans put in place to, wherever possible, allow patients to continue to maintain their right to a family life.

Case Example

Mrs S lived alone and had a history of falls and of being alcohol dependent. She had a private carer who she paid to do her shopping and washing. She was admitted to hospital following a fall whist intoxicated. Her paid carer would supply the alcohol if requested to. Her daughter raised concerns with the staff that she felt her mother needed to go into a Care Home as she could no longer take care of herself.

A referral was made to the hospital Safeguarding Team to ask for help and support. The team along with the clinical staff, completed a mental capacity assessment on Mrs S regarding her wishes and choice of home. It was apparent that when not under the influence of alcohol, Mrs S had capacity to determine her own choices and wished to remain at home for as long as possible.

Along with the Discharge Planning Team, Mrs S was supported to understand the risks she was putting herself at by asking the paid carer to buy her alcohol and not providing her with appropriate nutritional needs. Mrs S agreed that her paid carer was not supporting her correctly and agreed to a package of care and to not have a private carer. Her daughter was also supportive of the new arrangements and Mrs S remained in her own home.

The Trust is represented at both the Halton Safeguarding Adults Board and the Safeguarding Childrens Board and subsequent sub groups. The Trust also has a representative at the Domestic Abuse Partnership and Multi Agency Risk Assessment Conference (MARAC). The Safeguarding Team cooperate with partner agencies to develop and agree protocols and policies that all staff can adhere to. The Trust have in place an agreed Information Sharing Protocol with partner agencies, which allow for the passing of information that is in the best interests of the patient. All requests for safeguarding information is channelled through the Safeguarding Team, where a record of the request for information and the information provided in response, is logged. This year the Safeguarding Team have

agreed a change of process with the Local Authority regarding the reporting of patients who have undergone a DoLS assessment. The Local Authority now informs the Safeguarding Team if a DoLS request has been made to them from the clinical areas. This allows for the team to provide additional support to the ward and the Local Authority, to ensure the correct process is being followed and patients' reviews are monitored. This has allowed for less duplication and errors in the process. This year has also seen the introduction of an Independent Domestic Violence Advocate (IDVA) service 2 days per week. This allows staff to refer any patient who discloses domestic violence to this service for guidance and support and provides a confidential service for low and medium risk clients, therefore, supporting prevention to the high risk category. There are a number of robust policy and procedures in place, that are accessible to all staff. These policies reflect local and national guidance. These include the process, procedure and guidance for Safeguarding Children and Adults; Domestic Violence; Mental Capacity Act and Deprivation of Liberty Safeguards; Prevent Agent; Clinical Holding and Restraint of Patients and are all widely promoted through the governance structure and available to all staff by the internal electronic intranet, known as the HUB.

The Trust views Safeguarding Adult training as a priority and is a mandatory requirement for all staff. Safeguarding Training Level 1 includes all clinical and non-clinical staff and is delivered in all Trust induction programmes. This programme is also delivered to all volunteers who join the Trust. Level 2 training is delivered by e-learning and twice monthly a 2.5hr session is delivered face to face to clinical staff. Bespoke one to one training is provided on request and to support action plans from internal investigations. Training has expanded to include Child Sexual Exploitation, Honour Based Violence including Female Genital Mutilation, Human Trafficking and the PREVENT agenda. There is a 3 yearly update session that all consultants have to undertake. The latest has been running since October 2014 and this will continue to run through to September 2015. Safeguarding Champion Days have taken place twice in the last twelve months, which is a multi-agency event to share learning and embed good practice. Each year we participate in the Halton audit of training evaluation and review the programme of training that staff require in accordance with national and local policy. The Safeguarding Team participated in the Crucial Crew Education Forum held at Select Security Stadium, which was in partnership with the Halton Safeguarding Adult Board's Learning & Development Sub Group. It is an

annual event that aims to offer Year 5 students across Halton advice regarding how to keep safe across a range of areas. The event received excellent feedback from all those who attended the event.

ST HELENS & KNOWSLEY HOSPITALS NHS TRUST

The following summarises the work undertaken by St Helens & Knowsley Hospitals Trust over the last year, in regards to helping keep people safe in Halton. The Trust has reviewed and ratified its Safeguarding Adults Policy to take account of the Care Act and statutory guidance. Safeguarding Adult activity issues are reported on a monthly basis to the Patient Safety Council supported by a Trust Safeguarding Adult Steering Group. The Trust has a Safeguarding Adult Work Plan which details all outstanding actions and progress is monitored through a Steering Group. The Trust has an Integrated Performance Report which includes a range of safeguarding metrics which is reported on a monthly basis to Trust Board level. The Trust reports on a quarterly basis to its commissioners on a range of Safeguarding Key Performance Indicators and is currently judged as providing reasonable assurance in respect of its safeguarding adult processes. On 26th June 2014, the Trust hosted a Care and Compassion Conference which was held at Whiston Hospital and attended by over 120 delegates, with internationally renowned speakers focusing upon creating a high quality care environment. The Trust Governance Process includes Patient Safety and Patient Experience Councils, both of which include representation from two local HealthWatch and parent carers. The Trust has a Learning Disability Pathway Group which includes representation from the local community disability services, advocacy groups and parent carers. The Trust has a number of Carer Focus Groups involving the on site Carer Support Team.

In January 2015, the Trust successfully bid for funding to develop and implement a single standardised pathway to enable adults who lack capacity and who may be resistant, phobic and challenging and who require acute care, to obtain that care through consistent best interest decision making and pathway planning. The aim is to deliver this in September 2015. The Trust ensures that it is well represented at all multi-agency meetings from Board to individual case level and achieved a 90% attendance in the period. The Trust has implemented the Halton Multi-Agency Procedures and has a good record of making appropriate safeguarding referrals, which are progressed through to an outcome. The Trust has signed up to the Crisis Care Concordat and is working with its partners in implementing its Local Action Plan.

The trust has a well established Dignity Champions Network which was reviewed and relaunched in 2015, leading to a much wider representation which includes both HealthWatch members and care providers. The Trust has a Safeguarding Adult Training Needs Analysis which supports four levels of training. Level 1 compliance is 97%, Level 3 is 80% and Level 2 compliance has been achieved in line with the trajectories agreed with the Trust's commissioners. The Trust has a range of policies and procedures which support safer workforce initiatives, identifies allegations made against professionals, makes safeguarding referrals to the local authority and collaborates with the investigative process. The Trust has a central reporting system known as DATIX, which generates reports and which feeds into the process of learning from such incidents. The Trust Safeguarding Team provides guidance to all areas of the Trust and provides quarterly reports on all activity, demonstrating that all areas of the Trust now raise safeguarding adult concerns at an increasing rate for advice and guidance, but the proportion referred on formally to the local authority continues to be consistent. The Trust has maintained a regular level of review of its processes relating to identifying and managing Deprivation of Liberty Safeguards over the period and is reviewing its Mental Capacity Act/DoLS policies. The Trust has adopted NICE Guidance in respect of managing incidents of Domestic Abuse and has achieved good progress against full compliance.

HALTON CLINICAL COMMISSIONING GROUP

NHS Halton Clinical Commissioning Group

NHS Halton Clinical Commissioning Group (CCG) requires that all its commissoned services, Governing Body Members, Member Practice staff and Clinical Commissioning Group staff are appropriately trained to ensure that they are aware of

abuse and the right to a safe and dignified life. The NHS Halton CCG through its contracts require that all providers evidence appropriate policies and procedures. Providers are required to evidence that their policies and procedures are in line with those approved at the Halton Safeguarding Adults Board. The NHS Halton CCG has developed and approved appropriate policies and procedures for staff to have completed appropriate training and this is monitored internally. All commissioned providers are required to assure the NHS Halton CCG of their compliance with staff training trajectories and to evidence how they are ensuring that staff are aware of risks of abuse and mitigate against these. The Designated Nurse for Safeguarding Adults has worked to support the development and review of a number of policies and procedures in relation to prevention on behalf of the NHS Halton CCG. One of the key functions for NHS Halton CCG is engagement and involvement of local people, on all areas of work undertaken. During 2014/15, NHS Halton CCG was involved in a large number of patient and service user engagement events obtaining views on commissioning plans and service delivery. NHS Halton CCG requires all providers to evidence how they enable and encourage service users and carers to share their views to influence service delivery and change. This information is shared with the Board to inform them of its work. Individualised care is a requirement in all health provision and currently providers are providing evidence of 'I Statements' from patients to evidence the level of involvement in care planning, the level of understanding of care planning and delivery and how confident patients feel of their ability to influence what happens to them. The NHS Halton CCG received regular reports from all providers in relation to comments, compliments and complaints which includes evidence of how this has led to service changes. Whilst this does not relate specifically to safeguarding, it will impact on the care of adults at risk. The NHS Halton CCG has supported and facilitated a string of multi-agency approaches to safety, wellbeing and dignity across all care areas. It provides a wellbeing service to all practices, which all local people can access. The development of a Multi Disciplinary Team around practices and patients has improved our ability to support vulnerable people to facilitate and encourage safety, dignity and independence. NHS Halton CCG in collaboration with all local stakeholders have enabled the development of person-centred planning to enable self care and independence whilst ensuring vulnerable people are protecting themselves from harm.

CHESHIRE CONSTABULARY

The following summarises some of the key work undertaken by Cheshire Constabulary during 2014/15 to help keep people safe in Halton:

- Active use of social media to promote all aspects of safeguarding, including Force Twitter, Neighbourhood Twitter accounts and Public Protection Unit Twitter accounts

- Reviewed and implemented the Force Adult at Risk procedure in line with the Care Act 2014

- Worked with all four Local Authorities and Safeguarding Adult Boards to develop a new Adult at Risk procedure

- Delivered training to all front line officers as part of regular monthly training days. Training focused on Adults at Risk in April to coincide with the launch of the new Force procedure

- The Force have committed to the delivery of regular safeguarding training across the whole workforce, as safeguarding is identified as a priority for the Force

- Training also includes other specific vulnerable groups - Domestic Violence and Stalking and Harassment

- Developed revised system to record concerns around vulnerable people through the new reporting system – Vulnerable Persons Assessment (VPA). This replaces the older IT system CAVA.

- Introduction of new reporting system was supported by training provided to all officers and staff about identification of vulnerability, local problem solving and escalation through submission of a Vulnerable Persons Asssessment

- A dedicated Adult at Risk Officer has been appointed by the Force

- The Force has supported a number of Domestic Homicide Reviews across the county. Learning from these reviews is coordinated through the Strategic Public Protection Unit

NATIONAL PROBATION SERVICE - CHESHIRE

The National Probation Service which was established as a separate entity by the Government in June 2014, has a dual responsibility to offenders (some of whom are at risk and vulnerable) and to their victims who can at times be exploited/abused by offenders and who indeed may target such victims. Victims of serious crimes have been advised over the last year of their right to have some protection written into offender's prison licenses on release, via no contact clauses and exclusion zones where the offender may not pass through or visit. They are also given support and advice and guidance linked into Independent Domestic Violence Advocates/Adult Social Care/Police as relevant and with their permission and active participation wherever possible.

The main multi-agency partnerships that the National Probation Service link into, in order to ensure safety and dignity of both victims and offenders are Multi- Agency Public Protection Arrangements (MAPPA) for our dangerous offenders and Multi-Agency Risk Assessment Conference (MARAC) and Domestic Violence Forums for domestic violence victims, where our offenders are the perpetrators and similarly in child safeguarding and in particular the developing strategy over 2014/15 of Child Sexual Exploitation. MAPPA meetings are primarily concerned with the past and potential victims of dangerous offenders and links are made with agencies that can assist in the protection of those who are vulnerable and they are invited to the meetings to contribute to the risk of management plans of the offender. All potential victims are tracked and constraints as well as therapeutic interventions are placed on offenders including, where necessary, proportionate disclosure to new partners/families etc.

The National Probation Service undertake victim feedback audits each year, which the Victim Contact Service have been in contact. An Offender Survey is also analysed and working practices altered where indicated. The offenders responding to the last survey indicated that they felt treated with respect in the way they were responded to; waiting times; interventions and transparency of the service they received. Feedback both positive and negative, as well as learning from reviews and

investigations and complaints from service users, are responded to by the management of the service.

Service User Forums are held in most of the offender management units. These are active and lively forums, which also contribute to the development of policy and practice. One of the biggest strengths/skills a Probation Officer requires, is their ability to be transparent with service users about the danger they are seen to represent to others more vulnerable than themselves, whilst at the same time supporting and respecting the needs of the offender who may also be vulnerable to others. They understand that often the best way of reducing the risks that an offender represents, is to meet their needs that have often been neglected in the past. It is well recognised that many offenders have mental health needs that can, if untreated, influence their negative behaviour to others.

CARE QUALITY COMMISSION

As a regulator, the main responsibility of the Care Quality Commission (CQC) is to ensure that all health and adult social care providers have clear and robust systems in place to keep people who use their services safe and employ staff that are suitable skills and supported. The role and overarching objective of the CQC in safeguarding is to protect people's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. As a regulator, CQC are keen to work with local safeguarding teams and to establish effective working relationships. These relationships help to keep people safe.

CQC commit to representation to a Halton Safeguarding Adults Board meeting as least once per year. Local agreements should be in place to ensure that local CQC Inspection Managers receive minutes from all Board meetings. As a partner, as opposed to a member of the Board and a national regulator, the focus of our local inspection teams is on inspecting regulated services against their five key questions of safe, effective,caring, responsive and well-led. In doing this, CQC work in partnership with Local Authorities and local Clinical Commissioning Groups, to highlight areas of concern within regulated services. CQC will take regulatory action as appropriate.

CQC has implemented a specialist approach to the inspection of health and social care services, informed by intelligent monitoring. This informs when and how they inspect health and social care services and with the use of real time data, results in appropriate and timely action to safeguarding concerns. The CQC's position with

regard to working with Local Authorities does not change under the implementation of the Care Act 2014 and therefore CQC will not be implementing a Designated Adult Safeguarding Manager for each Local Authority across England. CQC have two National Advisors for safeguarding, who work across all Directorates and offer advice and support to staff and who work with national bodies, such as the Department of Health. All CQC staff are offered role appropriate safeguarding training. CQC has, and continues to, raise awareness amongst the general public about their role. Safeguarding concerns raised with CQC come from members of the public or from community organisations. People who use services and their carers are involved as partners in inspections. CQC is continually working to forge closer links with local organisations.

5 BOROUGHS PARTNERSHIP

Over the reporting year the Trust has introduced the Duty of Candour into our delivery of services as a key recommendation of the Mid Staffs enquiry. This places a duty on us, as a health provider, to be open with patients when things go wrong. The safeguarding service are working with partners to ensure that our Duty of Candour is embedded into the culture of the organisation and works alongside ither agendas such as Making Safeguarding Personal.

The Safeguarding Team in the Trust continue to provide advice and support to all our services. Practitioners reporting concerns to the team are guided to asking the individual concerned what they want to happen in the first instance, are they aware of safeguarding and what this means t them and more importantly what they don't want to happen.

Safeguarding Adults training is mandatory for all clinical staff who have patient facing contact. This training highlights what abuse is, the effects abuse has on an individual and how to report it. Safeguarding Adults training has undergone an extensive review over the reporting year and the Trust will now commence embedding the National Competency Model (Bournemouth) into training provision. This will seek to further embed the key knowledge and training expected of all staff in the Trust in relation to Adults at Risk.

The Trust continues to support the work of the Board and to implement the changes in safeguarding practice in line with the requirements of the Care Act which came

into force in April 2014. One of the key challenges for our staff is the process of "making an enquiry" on behalf of the Board. This will continue to be driven by the safeguarding process and advice sought from our Local Authority partner in the first instance as to how much involvement is needed by our staff.

The Trust has reviewed its Consent Policy and the Safeguarding Team are heavily involved with the review of how this works in practice Trust wide across all of our busines streams. This seeks to ensyre that service users are fully informed of the care and treatment being provided to them and when concerns are raised what happens next. This has been run in conjunction with a series of Mental Capacity Act workshops looking at how to complete assessments and maximise an individual's ability to make decisions for themselves.

The Safeguarding Team in the Trust continue to provide advice and support to all our staff. Safeguarding concerns are communicated to the team on an electronic form as well as telephone advice being available in working hours. The team will quality assure all safeguarding activity across the Trust to continually improve practice and maintain a safe, effective service. This involves support being given to practitioners who are working with complex cases and managing high levels of risk.

The Trust has "what to do" flowcharts in all clinical areas that guide staff through the reporting process of reporting abuse. The presence of the flowcharts are checked within our Internal Quality Review process to ensure staff have easy and quick access to the appropriate contact numbers and advice. Both the Trusts internal safeguarding team and the Local Authority Contact Centre details are on the flowchart.

The Trust has a robust Information Governance procedure that guides staff through the handling of sensitive information. We are also signed up to Information Sharing agreements across our partner agencies for processes such as MARAC. Training is mandatory for staff and advice available from our Information Governance Lead.

Trust staff are aware that information must only be shared on a need to know basis and that consent should always be sought to disclose information unless inappropriate to do so. This is covered in existing safeguarding training with case examples being used to highlight the scenarios staff may face when out in practice.

Under the Care Programme Approach, service users who are classed as "CPA" will have a care plan which clearly documents the roles and responsibilities of all those involved. Care plans are subject to rigorous audits to ensure they are of high quality and meaningful to the individual in receipt of the service. For those service users who are not meeting the threshold of CPA, in that their needs/presentation is not as complex, there is a statement of care provided. Again, this will outline what service is being provided and by whom.

The Trust runs regular inspection of services which we call Internal Quality Reviews. These involve a team of "experts" who visit a service/team over the course of a day looking at standards of care and the patient experience. Within the reviewing team will be service user/carer representatives who will lead on speaking to other service users/carers on their experience of services and how we can improve as an organisation. This will include asking about the care plan/statement of care and if they are happy with this.

4. KEY ISSUES WHICH HAVE HAD AN IMPACT ON THE BOARD

Deprivation of Liberty Safeguards: The Deprivation of Liberty Safeguards (DoLS) is one aspect of the Mental Capacity Act 2005. The safeguards are to ensure that people in care homes and hospitals are cared for in a way that does not inappropriately restrict their freedom and, if necessary, restrictions are only applied in a safe and correct way and is only done when it is in the best interests of the person and there is no other way to provide appropriate care.

On 19th March 2014, the Supreme Court made a judgement, which is significant in determining whether arrangements made for the care and/or treatment of an individual, lacking capacity to consent to those arrangements, amount to a deprivation of their liberty.

There are a number of implications for Local Authorities as a result of this judgement:

- There is likely to be an increased number of applications for DoLS authorisations, which will inevitable place pressue on the Best Interest Assessors across the Council and other agencies

- There is likely to be a need to revisit previous decision making and address it in some cases. There is a need to scope settings outside of residential care homes and hospitals and proceed with those that need authorising

- Communication and guidance will be required for all stakeholders

An initial scoping exercise has been completed to estimate the number of assessments that may be required and a risk assessment undertaken. In addition to the Best Interest Assessors, there is a requirement for a Mental Capacity Assessment to be completed by an appropriately qualified Doctor. NHS England are to address the increased need for Doctors qualified in this area.

Period	DoLS Applications 2014-15	DoLS Applications 2013-14
Quarter 1	38	10
Quarter 2	51	12
Quarter 3	53	5
Quarter 4	48	6

Care Act 2014

Care Act 2014: The Care Act come into effect from 1st April 2015. Regular updates regarding the implementation of the Care Act and the statutory requirements for Safeguarding Adults Boards, have been presented to Halton Safeguarding Adults Board. A Care Act Compliance Checklist has been developed in order to monitor if the Board is meeting all of its statutory requirements. Updates in relation to this checklist will be presented to the Board at regular intervals.

In relation to the North West Ambulance Service, the implementation of the new Care Act 2014 provides a legal framework for the assessment and protection of adults including those at risk with an emphasis on the wellbeing of the patient. This may account in part, for the noticeable rise in safeguarding adult activity over the year, which includes concern for the welfare of vulnerable adults requiring assessment. Likewise, safeguarding children activity steadily increased across the trust, particularly within the Paramedic Emergency Service, but at a slower rate than for adults. A number of high profile national investigations have resulted in an update to safeguarding procedures and training, to ensure that adults and children who are at risk or victims of exploitation and radicalisation are also safeguarded.

The National Probation Service – Cheshire: The service has managed vulnerable offenders over the last 12 months. Elderly sexual offenders or those serving life for other serious crimes have to be assessed for release when their risk to others is deemed to have been reduced to a safe enough level or where they have reached a determinate release date whatever their risk levels. Such offenders can be quite frail and in need of care and support to live in the community. At times they have become dependent on the prison regime and their ability to look after themselves is severely diminished. Advocating for their needs to be met can be very challenging for their Probation Officers. Such needs are taken account of in the Service's Vulnerable Adults Practice Guidelines, where needs of the service users need to be balanced with the risks that they may still pose to others.

Case Example

A Probation Officer had to find appropriate care for an elderly male who had been convicted of serious child and adult sexual offences. He needed residential care and was released from prison at the end of a determinate prison sentence. As he still presented some risk and this may have increased with the onset of early dementia, the Probation Officer had to ensure that sufficient safeguards were present in any residential setting for both visitors/fellow residents and staff, that was being investigated, but that his needs could still be met and that only those who needed to know about his background were informed and that he was still treated with dignity and respect.

This was very challenging for the Probation Officer simply to have him accepted anywhere and the safeguards and needs met, but this was achieved and the officer worked very closely with the management of the residential setting that was accepting and respecting of him.

The Care Act now includes those in the National Probatin Service, who reside temporarily in their Approved Premises. These house, in the main, those offenders who are deemed to still present a significant risk to others. As above, the responsibility for those offenders who may be vulnerable to the exploitation of others because of their physical and mental health needs, has to be combined with ensuring that meeting their needs and wishes does not present a risk to others. The main challenge in relation to communities that abound our Approved Premises, is getting across that if such offenders were not housed in this facility, they would be subject to much less oversight and monitoring if they were out in the community and that they too have rights and needs and can be vulnerable and need assistance themselves, to live a worthwhile life post prison. The Probation Service work through multi-agency partnerships such as Multi Agency Public Protection (MAPPA), to try and achieve the balance of protecting the public, whilst meeting the needs of the individual offender to allow them to live as independent a life as possible in the community.

2014/15 has been a very turbulent year for the Probation Service as the Government legislated that the high risk offenders would be dealt with by a National Probation Service and the others managed by a private company, generically known as a Community Rehabilitation Company. This split took place in June 2014 and created much disruption to both staff and clients for a considerable period and hampered innovation in all areas of work. Currently policies and practice guidelines are all being reworked, as the National Probation Service has developed the necessary management and infrastructure to allow the basics to be in place. In the interim, the Probation Service has continued to use the Probation Trusts' previous policies, with amendments as required. Workshops and events around both child and adult safeguarding are planned for the summer months covering all the offender management units.

Despite the disruption, the adult safeguarding concernsfor both victims and offenders have been uphelad via forums, such as MAPPA, and in individual supervisions sessions of Probation Officers managing offenders and those staff whose primary role is victim contact and support. The service has also developed reflective practice sessions in particular for those offenders with Personality Disorders, often presenting a high risk of harm to others whose own needs have not been met by established systems. There is a well established complement of psychology staff, advising Probation Officers as to how best to combine both risk and need management. This has been an invaluable resource and has aided Probation Officers to work more effectively with that complex dynamic.

5. PERFORMANCE

The Safeguarding Adults Return is based on a data collection from 1st April 2014 - 31st March 2015. This is a mandatory collection which records information about individuals for whom safeguarding referrals were made during the reporting period.

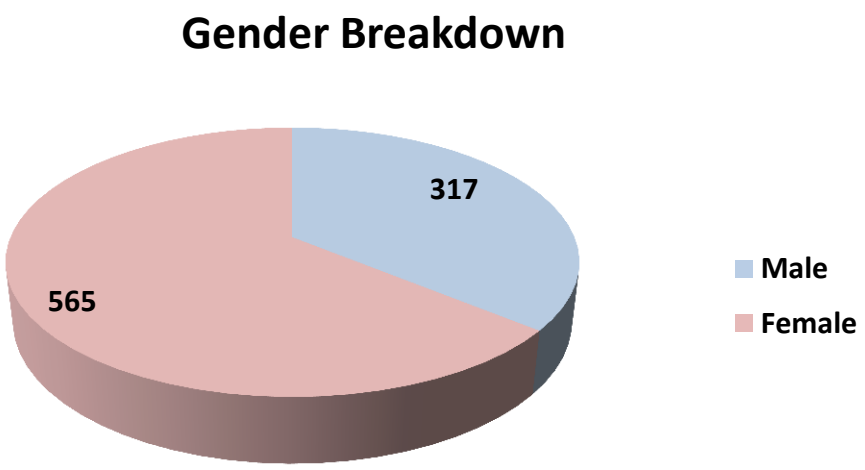
A safeguarding referral is where a concern is raised about a risk of abuse and this instigates an investigation under the safeguarding process. A referral can involve more than one location of abuse, type of abuse or more than one person alleged to have caused harm.

An adult at risk is the person who is alleged to have suffered the abuse. The adults at risk included in the Safeguarding Adults Return are aged 18 and over and have some level of care and support needs.

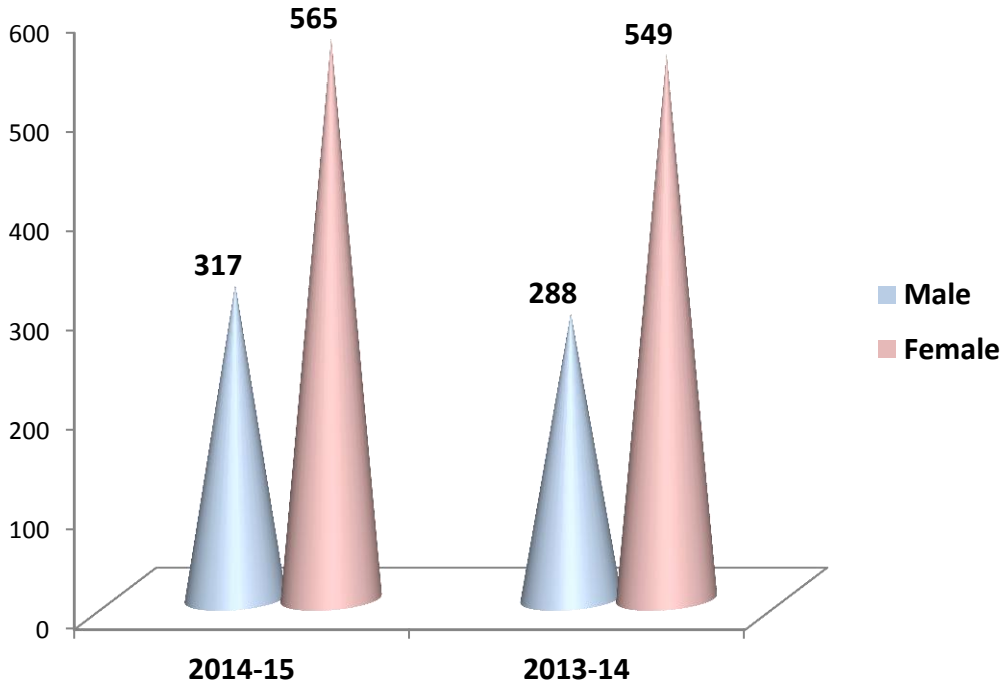
Please find below a summary of the findings from the Safeguarding Adults Return and a comparison of figures between 2013/14 and 2014/15, where applicable.

The total number of safeguarding referrals received during 2014/15 was **882**. This compares to **837** safeguarding referrals received in 2013/14.

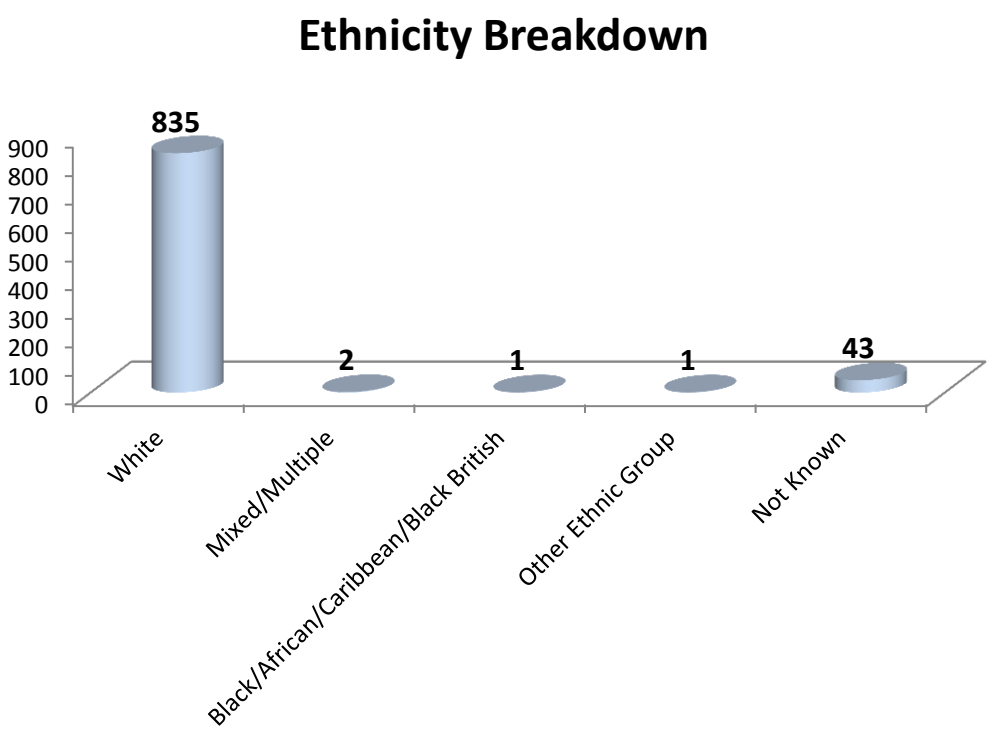
Gender	2014/15 Total
Male	317
Female	565



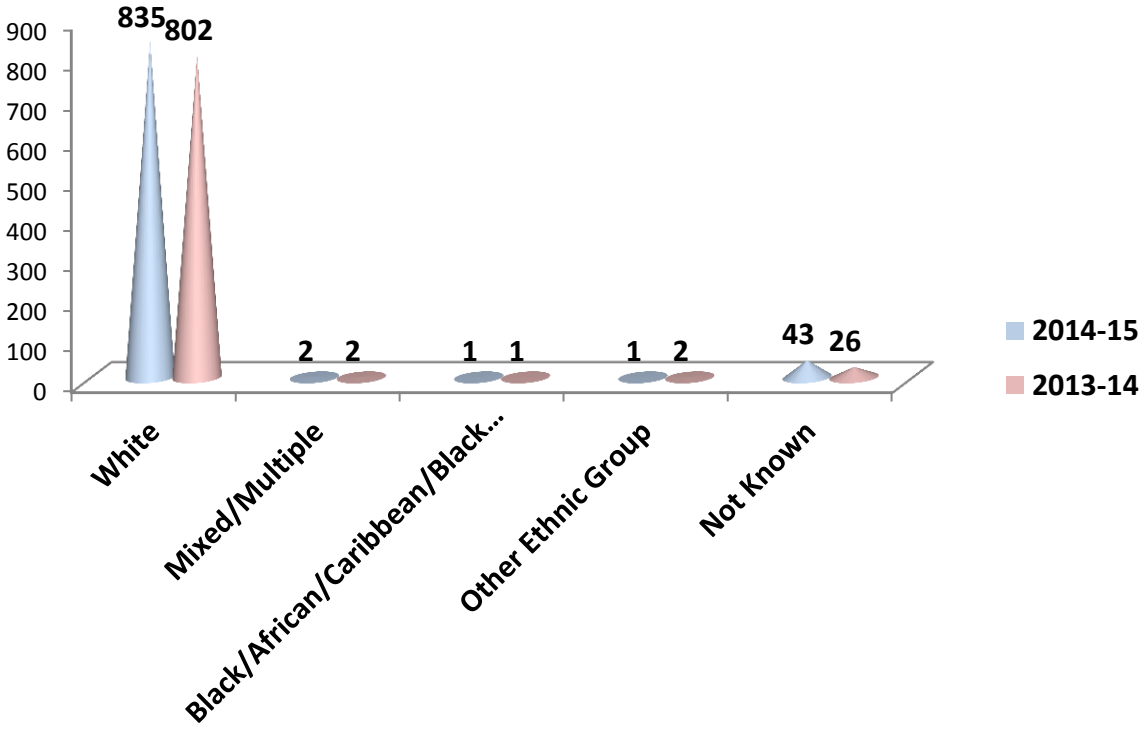
Gender	2014-15	2013-14
Male	317	288
Female	565	549



Ethnicity	2014/15 Total
White	835
Mixed/Multiple	2
Black/African/Caribbean/Black British	1
Other Ethnic Group	1
Not Known	43

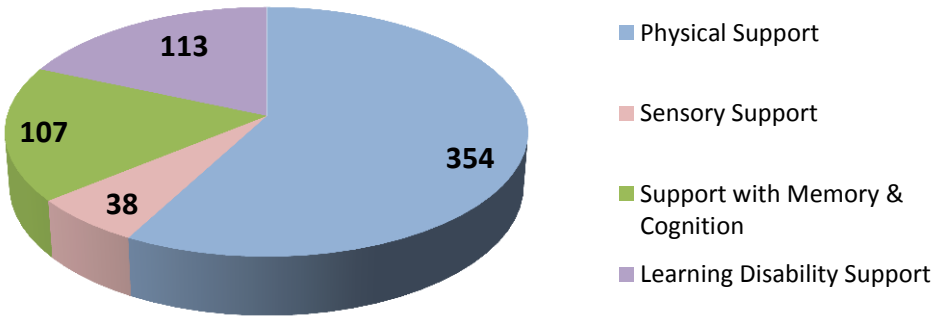


Ethnicity	2014-15	2013-14
White	835	802
Mixed/Multiple	2	2
Black/African/Caribbean/Black British	1	1
Other Ethnic Group	1	2
Not Known	43	26



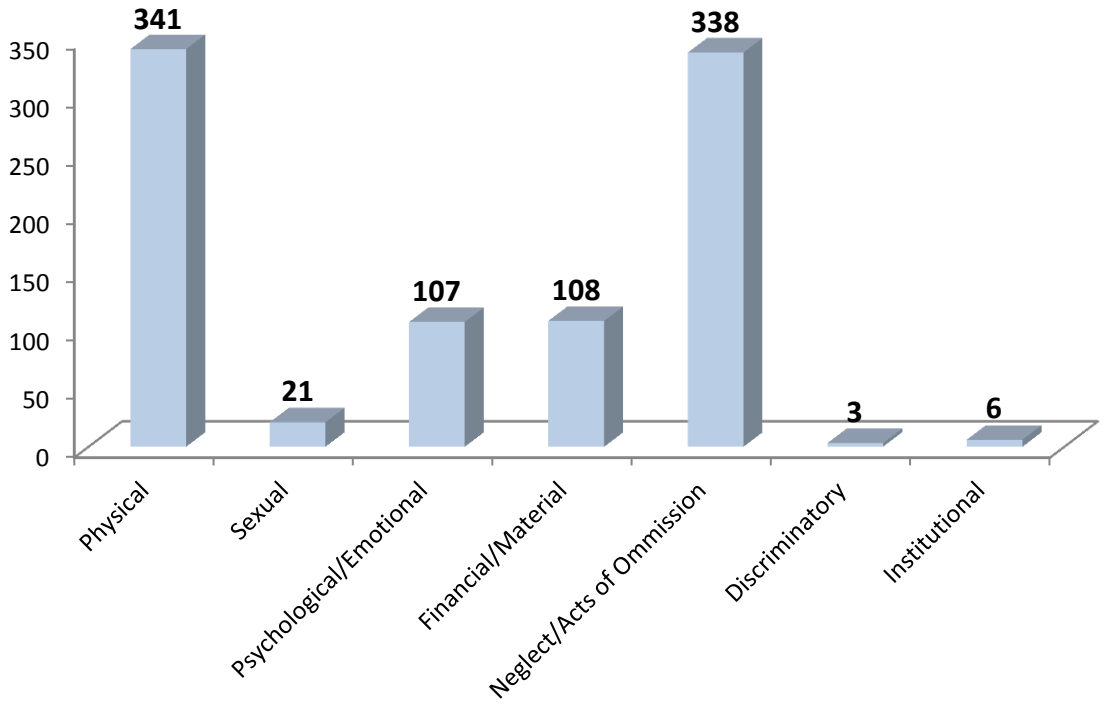
Primary Support Reason	2014/15 Total
Physical Support	354
Sensory Support	38
Support with Memory & Cognition	107
Learning Disability Support	113

Primary Support Reason Breakdown



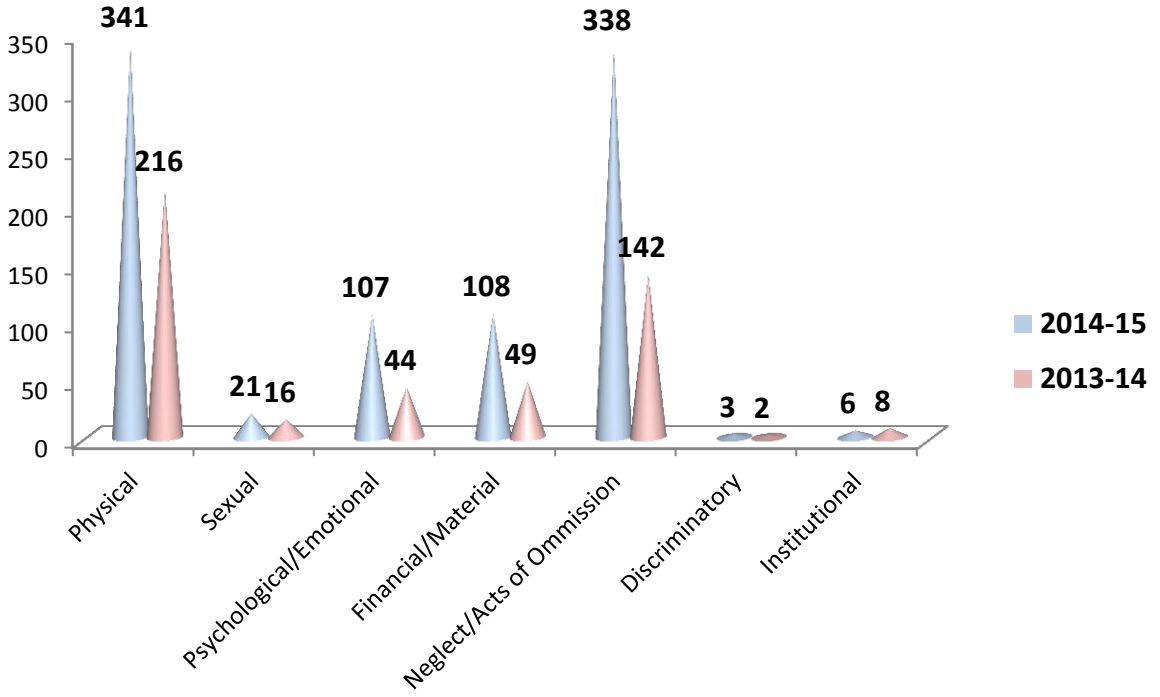
Type of Abuse	2014/15 Total
Physical	341
Sexual	21
Psychological/Emotional	107
Financial/Material	108
Neglect/Acts of Omission	338
Discriminatory	3
Institutional	6

Type of Abuse Breakdown



**please note the figures above exceed the total number of safeguarding referrals received, as some allegations involve more than one type of abuse*

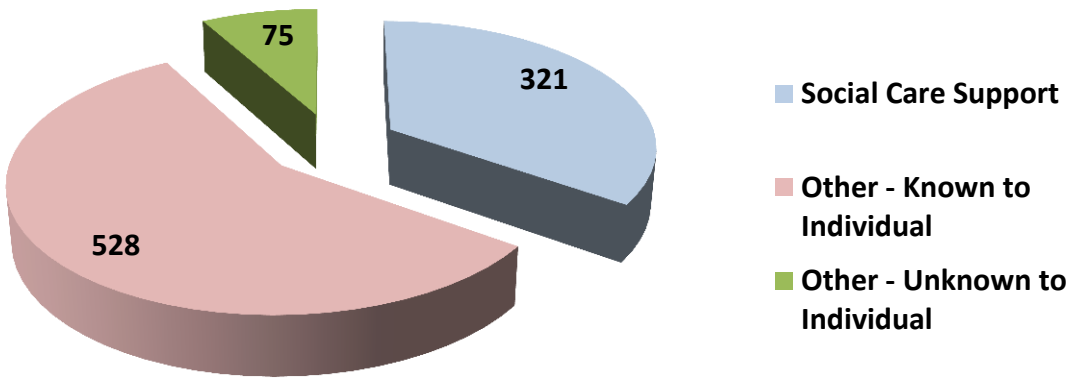
Type of Abuse	2014-15	2013-14
Physical	341	216
Sexual	21	16
Psychological/Emotional	107	44
Financial/Material	108	49
Neglect/Acts of Omission	338	142
Discriminatory	3	2
Institutional	6	8



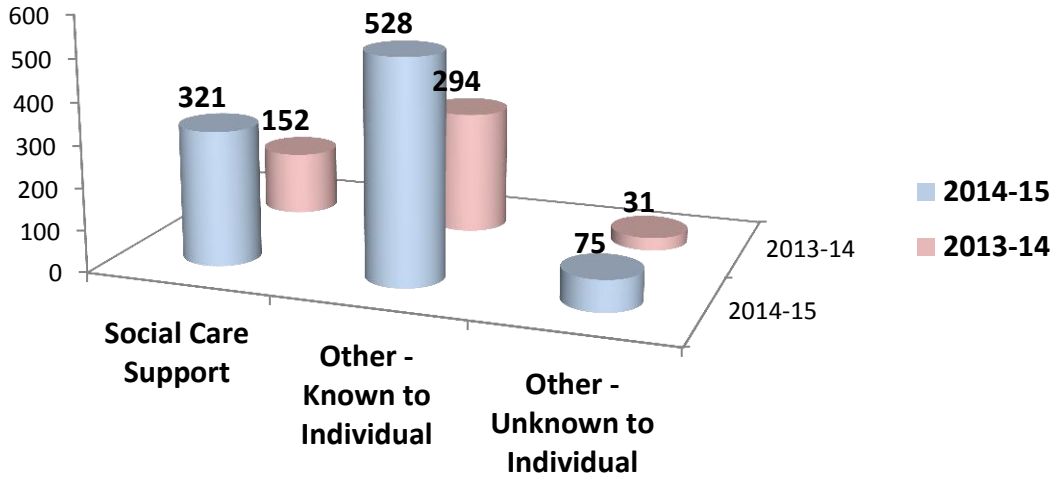
Source of Risk	2014/15 Total
Social Care Support	321
Other - Known to Individual	528
Other - Unknown to Individual	75

*please note the figures above exceed the total number of safeguarding referrals received, as some allegations involve more than one person alleged to have caused harm

Source of Risk Breakdown

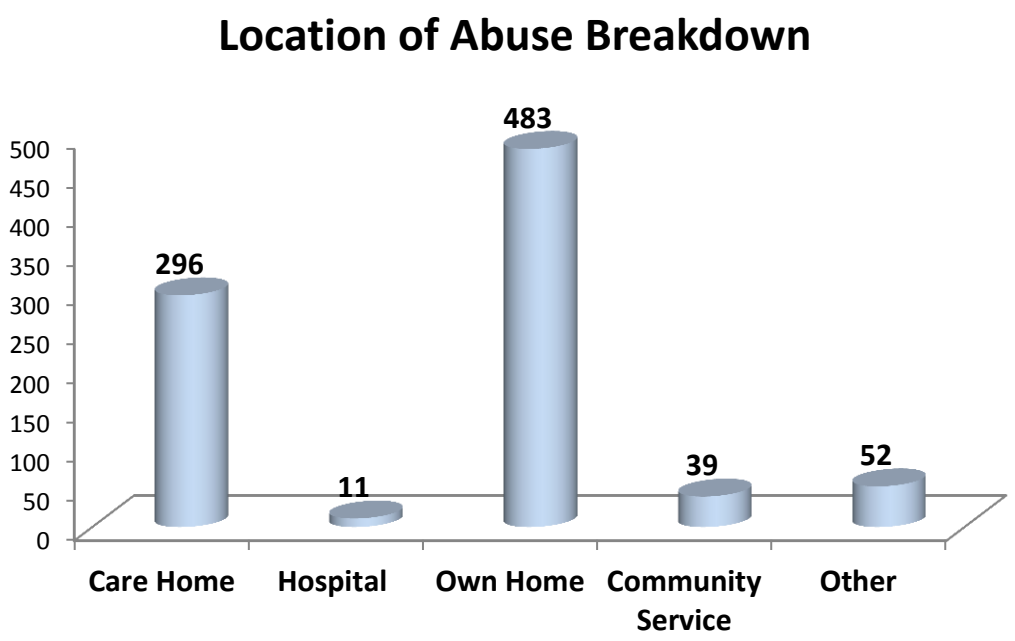


Source of Risk	2014-15	2013-14
Social Care Support	321	152
Other - Known to Individual	528	294
Other - Unknown to Individual	75	31

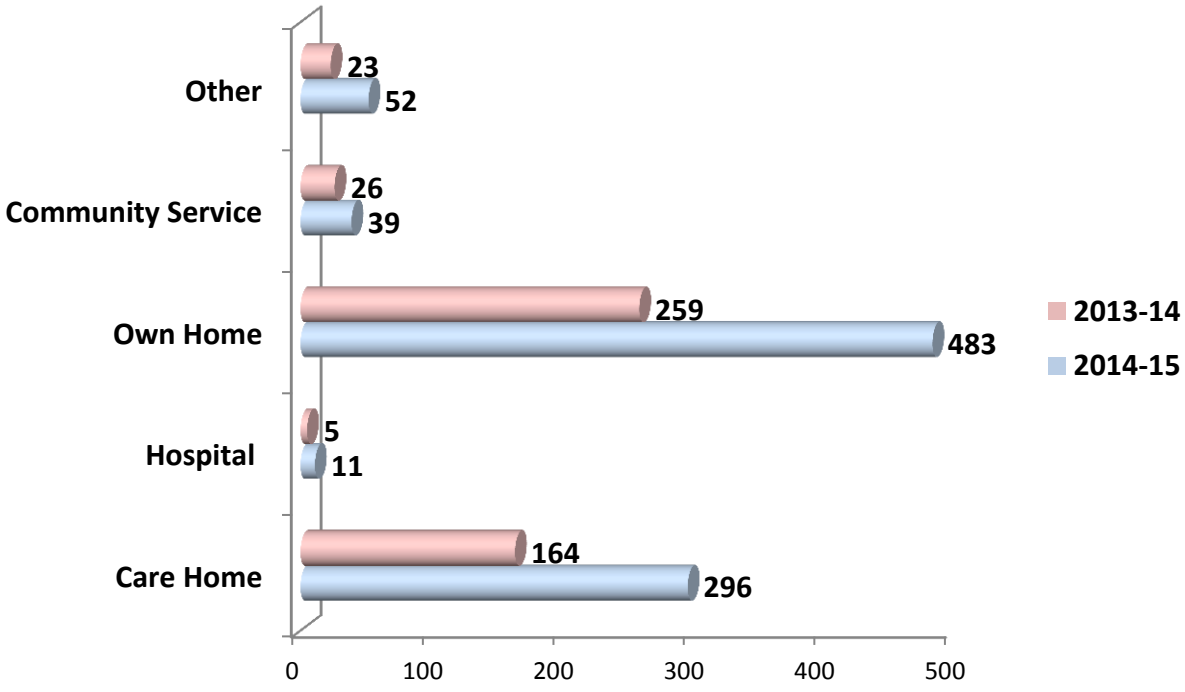


Location of Abuse	2014/15 Total
Care Home	296
Hospital	11
Own Home	483
Community Service	39
Other	52

**please note the figures above exceed the total number of safeguarding referrals received, as some allegations involve more than one location of abuse*

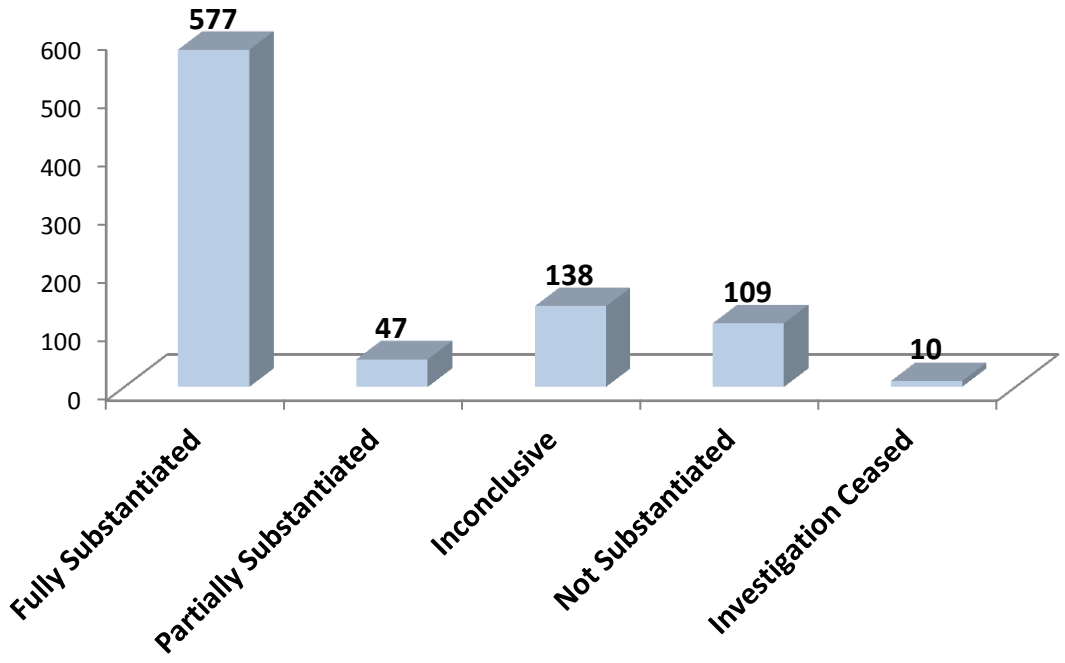


Location of Abuse	2014-15	2013-14
Care Home	296	164
Hospital	11	5
Own Home	483	259
Community Service	39	26
Other	52	23

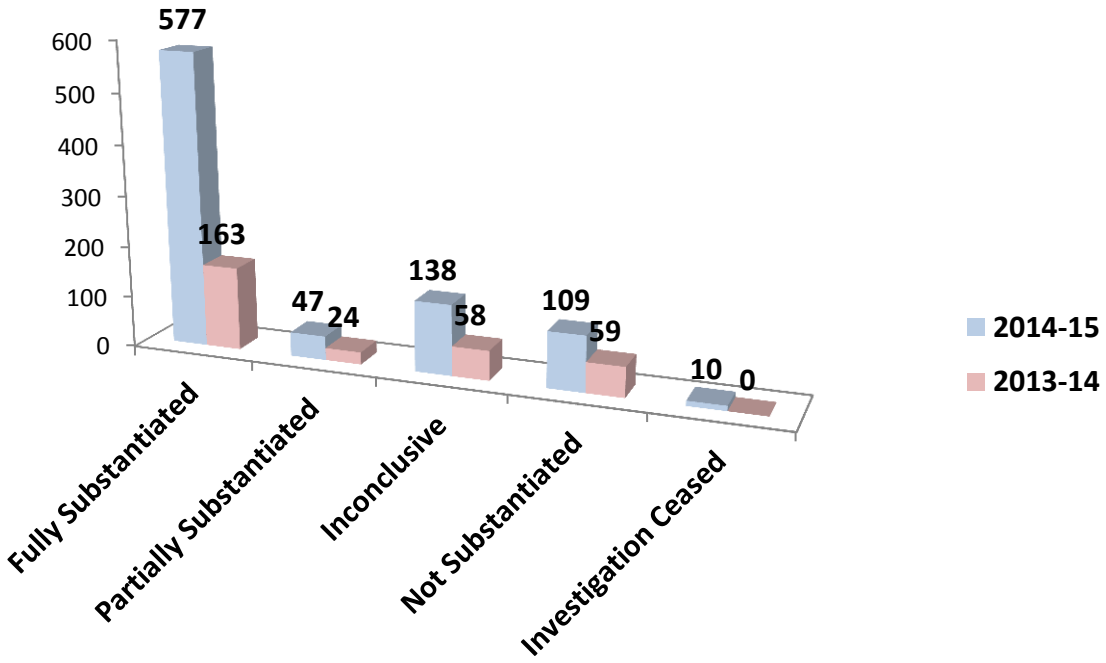


Conclusion of Referral	2014/15 Total
Fully Substantiated	577
Partially Substantiated	47
Inconclusive	138
Not Substantiated	109
Investigation Ceased	10

Conclusion of Referral Breakdown



Conclusion of Referral	2014-15	2013-14
Fully Substantiated	577	163
Partially Substantiated	47	24
Inconclusive	138	58
Not Substantiated	109	59
Investigation Ceased	10	0



6. FUTURE PRIORITIES

The priorities for 2015-16 which Halton Safeguarding Adults Board will be working towards are as follows:

EMPOWERMENT – *I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens*

PREVENTION – *I receive clear and simple information about what abuse is, how to recognise signs and what I can do to seek help*

PROPORTIONALITY – *I am sure that the professionals will work in my interests, as I see them and they will only get involved as much as needed*

PROTECTION – *I get help and support to report abuse and neglect. I get help so that I am am able to take part in the safeguarding process to the extent to which I want*

PARTNERSHIP – *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*

ACCOUNTABILITY – *I understand the role of everyone involved in my life and so do they*