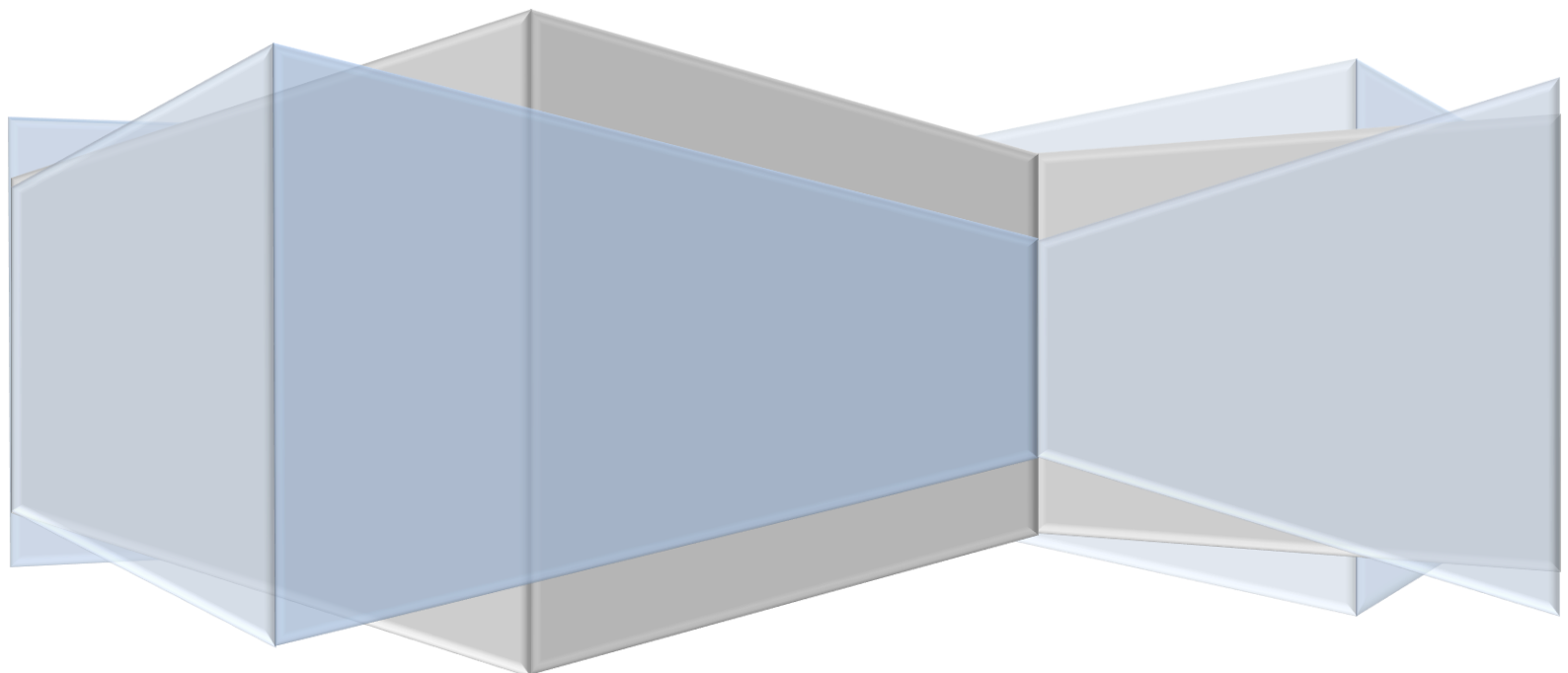




Halton Safeguarding Adults Board Annual Report 2015-16



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FOREWORD

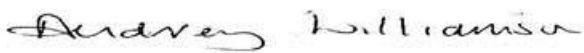
I am pleased to present the Safeguarding Adults Board's Annual Report 2015/16. We are required under the Care Act to produce an Annual Report which sets out the work of the partnership to safeguard vulnerable adults and to analyse the effectiveness of this work. I hope you find this report informative.

The Annual Report describes the developments during the last 12 months and provides case examples of how vulnerable adults are safeguarded. It highlights the challenges of implementing Making Safeguarding Personal, the Government initiative that enables vulnerable adults to play a central role when safeguarding concerns are investigated. Halton Safeguarding Adults Board will continue to monitor the outcomes for individuals who may need protection to ensure that their views are listened to.

Halton Safeguarding Adults Board will be improving the information it receives in the forthcoming year. We will review our performance framework to ensure that information provided is multi-agency rather than simply relying on one or two agencies to furnish the Board with information. This will also allow us to focus on outcomes or the quality of services as well as volume of safeguarding work.

On a personal level and having taken up the role of Independent Chair in November 2015, I have found working with Halton Safeguarding Adults Board both rewarding and challenging. Much has been achieved during this year and the partnership continues to prioritise safeguarding. We recognise there is more to do including raising awareness of safeguarding in our communities in order to prevent abuse and neglect taking place. There are clear plans to achieve this in our business plan next year.

Finally, I would like to thank all those who support Halton Safeguarding Adults Board, ensuring the smooth running of the Board's business. I would also like to thank all practitioners who work on a daily basis in this challenging area in Halton.



Audrey Williamson – Independent Chair

EXECUTIVE SUMMARY

A range of agencies and organisations have contributed to this report demonstrating both a commitment to this important area of work and to partnership working. It is only through agencies working together that vulnerable adults are truly safeguarded. Partnership work has always been a strength in Halton and this continues and is demonstrated in the Annual Report. All agencies are experiencing increasing demand for services but strong leadership continues to be provided by the three key agencies tasked with safeguarding vulnerable adults: Cheshire Police; Halton Borough Council and NHS Halton Clinical Commissioning Group, supported by a range of organisations including the Fire Service; Healthwatch; Probation Services and a range of health agencies.

Performance information is critical in assessing the effectiveness of safeguarding work. The implementation of the Halton Care Concerns Model by all providers this year, meant that the Board can be assured that the right referrals/concerns are being escalated to those agencies responsible for investigating them. This has led to a decrease in the numbers of safeguarding referrals to Adult Social Care Services, as practice issues are now being addressed by the Care Concerns Model in Halton.

The numbers of referrals concerning financial abuse have increased. This may be in part due to increased awareness of this form of abuse following the implementation of a Financial Abuse Toolkit, to enable agencies to assess potential risk in this area.

Performance data indicates that females aged 65 and over and receiving support in their own home due to a physical or sensory impairment, are most at risk of harm or abuse in Halton, therefore this is where the Board needs to focus its attention for future work.

Partner agencies have continued to support the work of Halton Safeguarding Adults Board and their contributions to helping to keep people safe in Halton have been summarised in this report, along with some of the key implementations the Board has put in place during this financial year.

INTRODUCTION

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 adults at risk 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 adults at risk
- ❖ Ensure the development of services to support people from hard to reach groups

The current membership of the Board includes representatives from each of the following:

- ❖ Halton Borough Council
- ❖ NHS Halton Clinical Commissioning Group
- ❖ Cheshire Constabulary
- ❖ Cheshire Fire and Rescue
- ❖ St Helens and Knowsley Hospitals NHS Trust
- ❖ Bridgewater Community Healthcare Trust
- ❖ Halton & Warrington Trading Standards
- ❖ Carer representative
- ❖ 5 Boroughs Partnership
- ❖ Age UK Mid Mersey
- ❖ Warrington & Halton Hospitals NHS Trust
- ❖ Care Quality Commission
- ❖ SHAP (advocacy)
- ❖ Riverside College
- ❖ Probation
- ❖ Housing Trust

The implementation of the Care Act 2014 from 1st April 2015, placed Safeguarding Adults Boards on a statutory footing for the first time. The Care Act states that Safeguarding Adults Boards have three core duties. They must:

- ❖ 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

CURRENT PICTURE IN HALTON

From taking a closer look at the data collated for the statutory Safeguarding Adults Collection in 2015/16, 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 to help keep people safe in Halton.

In 2015/16, 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. The alleged abuse is most likely to occur in the person's own home and perpetrated by someone who is known to the individual, for example, a relative or care worker.

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

PERFORMANCE

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) are 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 that this is only done when it is in the best interests of the person and there is no other way to provide appropriate care.

In March 2014, the Supreme Court issued a judgement that clarified an 'acid test' for what constitutes a deprivation of liberty. The acid test states that an individual who lacks capacity to consent to the arrangement for their care and is subject to continuous supervision and control and is not free to leave their care setting, is deprived of their liberty and should be the subject of a DoLS application (whether they are in a care home or hospital

setting). The judgement marked a significant change to practice and has led to a tenfold increase in the number of applications received 2013-14 and 2014-15.

An action plan was developed to address and coordinate the Halton response to the Supreme Court judgement. The Integrated Adults Safeguarding Unit coordinates and manages the DoLS assessments and reviews and acts on behalf of the Supervisory Body (the Local Authority). The team members include a DoLS Coordinator and two dedicated DoLS Assessors. The team is supported by a small pool of Best Interest Assessors drawn from care managers and there is an ongoing training programme established to ensure that all appropriate staff are trained to undertake this role going forward.

The data identifies the significant increase in the amount of requests for assessments rising by 302% from 2014 to 2015. In the period April 2015 to March 2016, the local authority received over 400 referrals. Please see the table below for a comparison in the number of DoLS applications received 2014/15 to 2015/16.

Period	2014/15	2015/16
Q1	38	84
Q2	51	131
Q3	53	80
Q4	48	115
Total	190	410

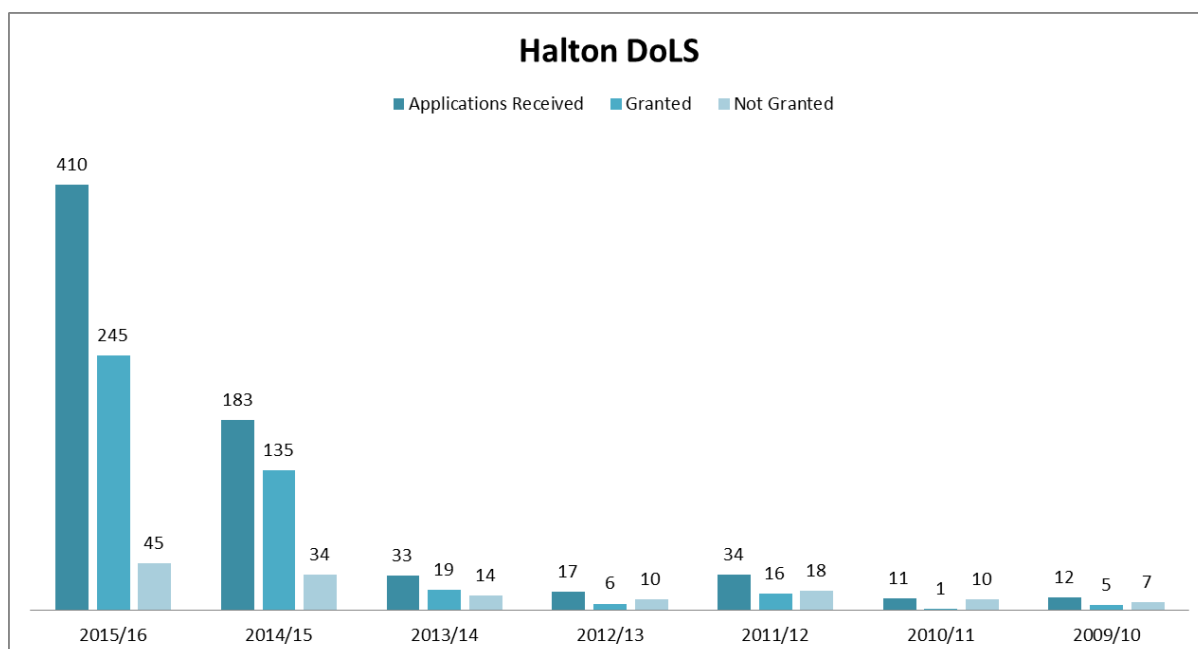


Figure 1: The figure above shows the increase in DoLS for Halton since it was introduced in 2009. DoLS applications have increased significantly since the 2014 Supreme Court Judgement, with an increase of 127 per cent from 2014/15 to 2015/16.

Despite the increase in DoLS applications received, Halton received the lowest number of applications of Councils in the North West.

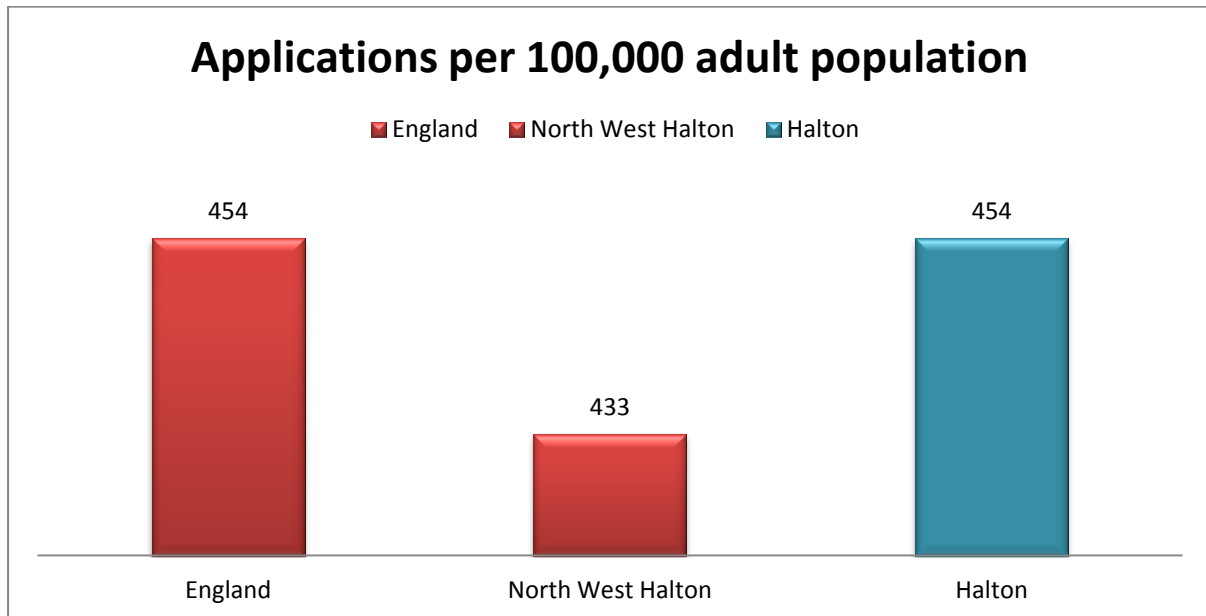


Figure 2: Applications received per 100,000 population, England, North West and Halton 2015-16 (Population data source Office for National Statistics – 2015 mid-year population estimates). Halton received 454 applications per 100,000 population, actual figures show that Halton received the lowest number of applications of all North West and Comparator Councils.

The results of the DoLS applications in Halton are as follows:

60% of DoLS applications were granted

11% of DoLS applications were not granted

10% of DoLS applications were withdrawn

19% of DoLS applications had not been signed off as at 31st March 2016 (the % of those not yet signed off were lower than the North West Average)

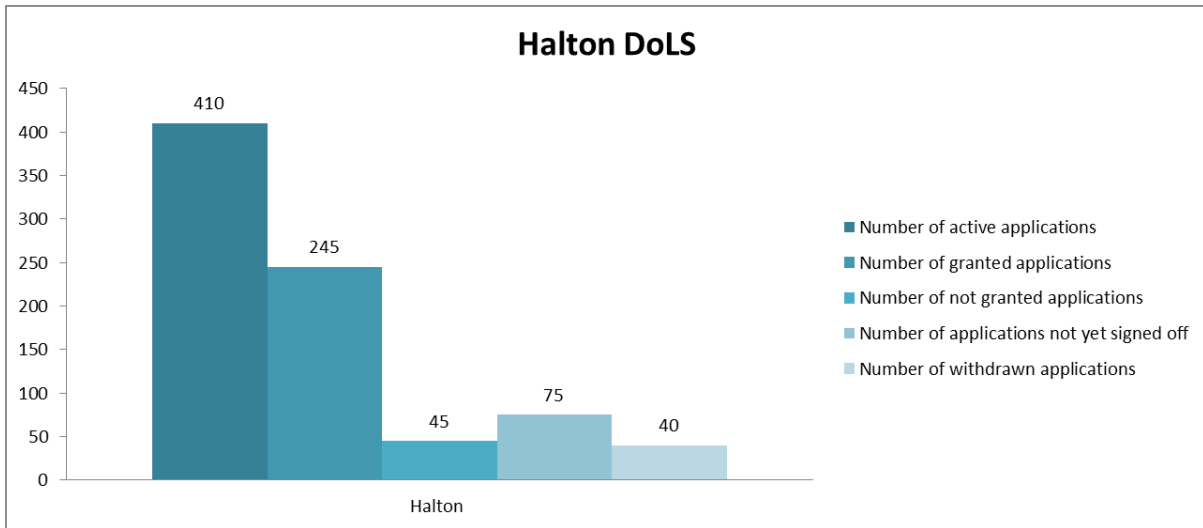


Figure 3: Halton figures for applications received, granted, not granted, not yet signed off and withdrawn for 2015-16

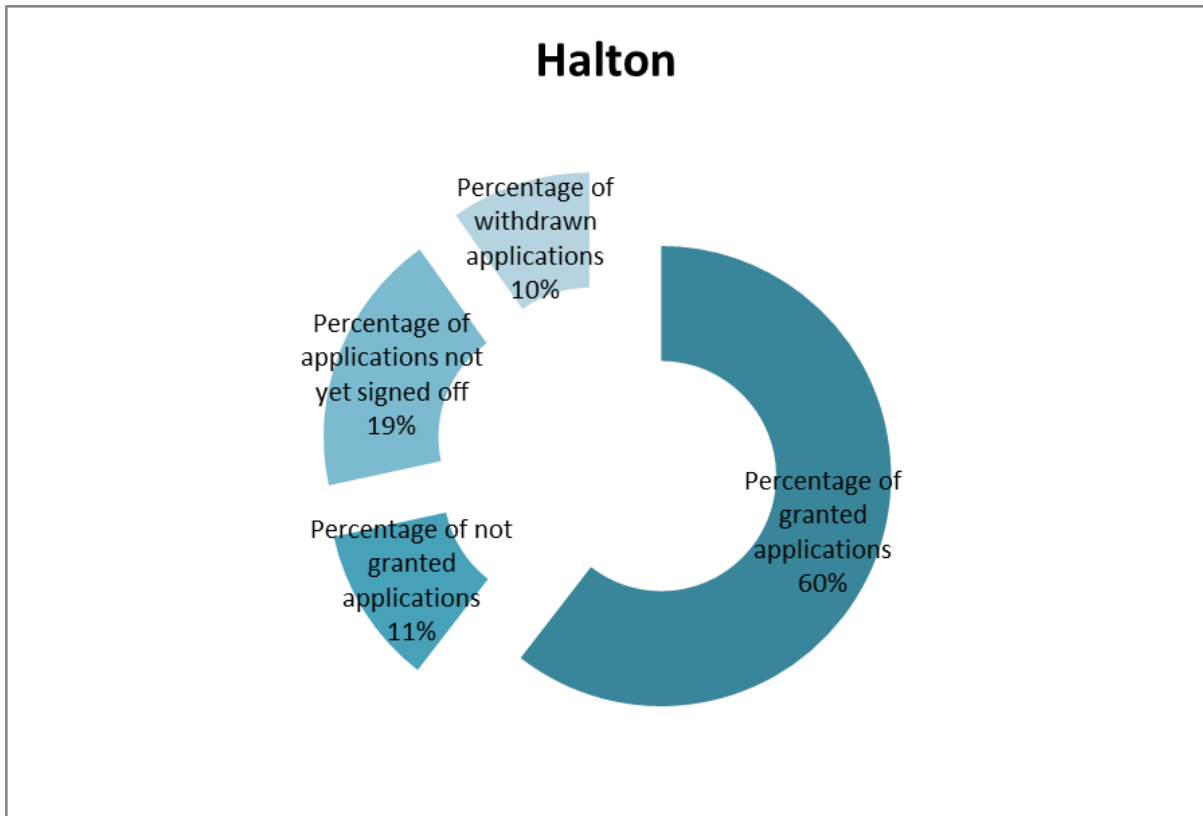


Figure 4: The percentages in relation to figure 3 for Halton

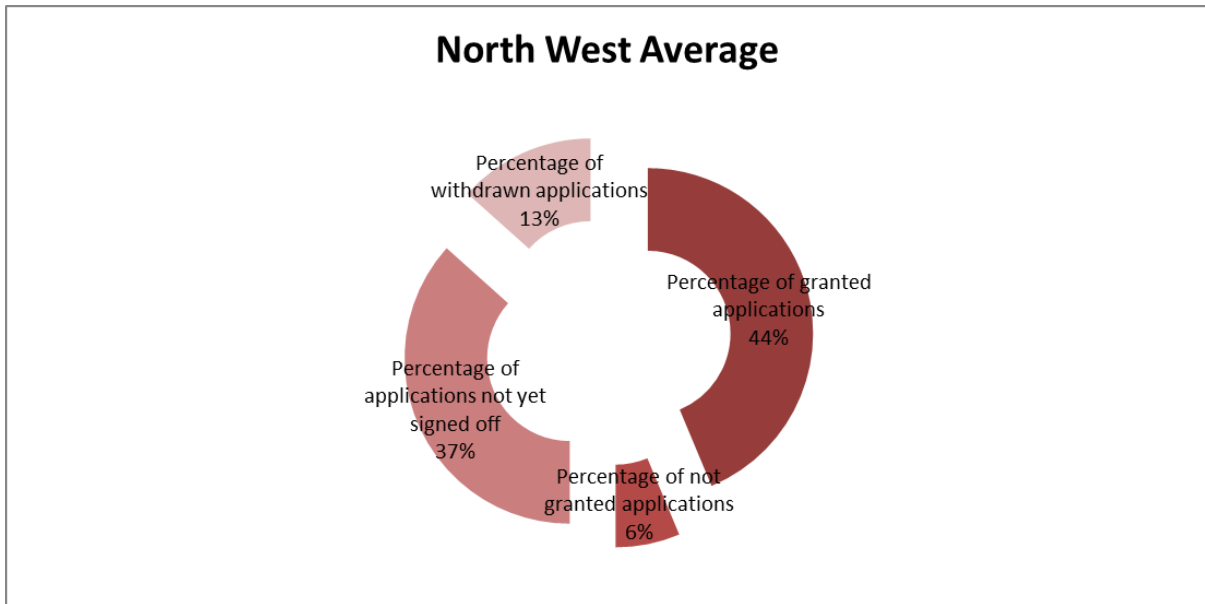


Figure 5 – The averages percentages in relation to figure 3 for the North West

When comparing Halton’s figures against comparator local authorities, Halton again received the lowest number of applications. While Halton did not perform as well as comparator authorities who received a higher number of applications, this could be attributable to staffing issues within the Safeguarding Unit. On the whole Halton has performed well with 70% of applications received being completed and signed off as at 31st March 2016.

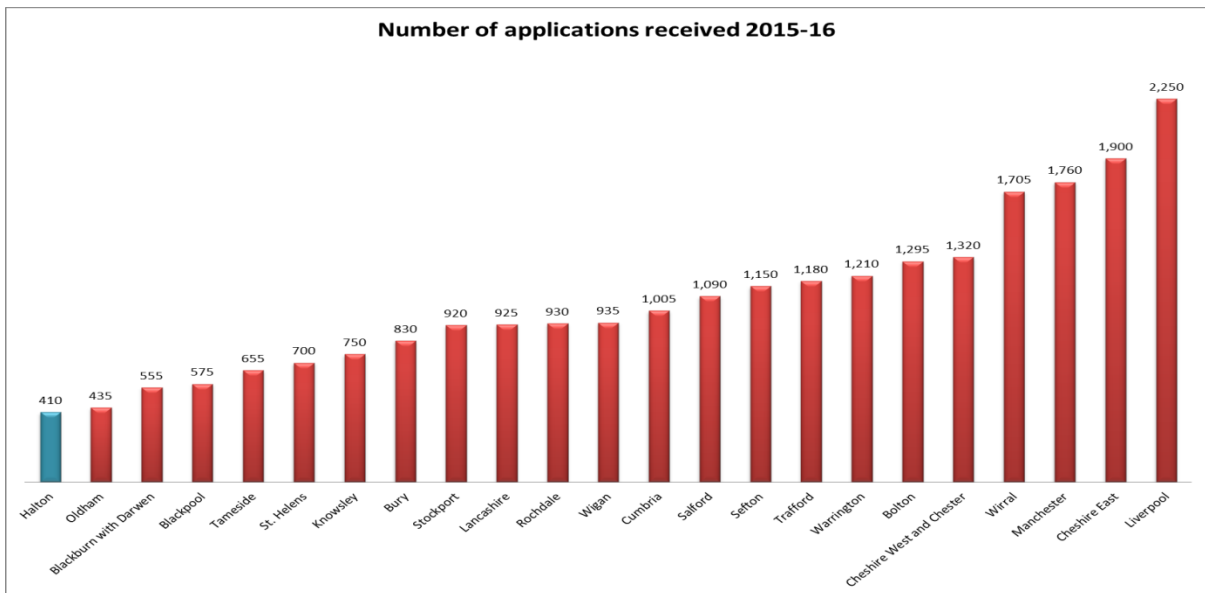


Figure 6: Applications received for North West Councils 2015-16

Safeguarding Adults Collection

The Safeguarding Adults Collection (SAC) is a mandatory performance return to be completed for the Health and Social Care Information Centre, to provide statistics from local authorities across the country regarding their safeguarding adult activity during the period 1st April 2015 to 31st March 2016.

The SAC data collection only includes cases of suspected abuse where the Council safeguarding service has been notified and recorded on their system. It does not include cases where partner agencies have dealt with the allegation and not shared the information with the Council. Therefore there may be cases of abuse that have not been reported to Councils.

The Care Act 2014 came into effect on 1st April 2015 and under Section 42 of the Act, for the first time it made safeguarding adults a statutory duty. This means where a local authority has reasonable cause to suspect that an adult in its area (whether or not they are ordinarily resident there):

- (a) Has needs for care and support (whether or not the authority is meeting any of those needs) **and**
- (b) Is experiencing, or is at risk of, abuse or neglect **and**
- (c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it

If this is the case, the local authority must make whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Definitions and terminology from previous years collections have changed to meet current practices. Therefore, care should be taken when making comparisons to previous years due to these changes.

Key Findings:

In 2015/16 it was found that adults most at risk from abuse were female, aged 65 and over and receiving care in their own homes. They are most likely to receive support due to a physical or sensory impairment. Overall Halton's performance remains stable from 2014/15 and in line with England and North West averages.

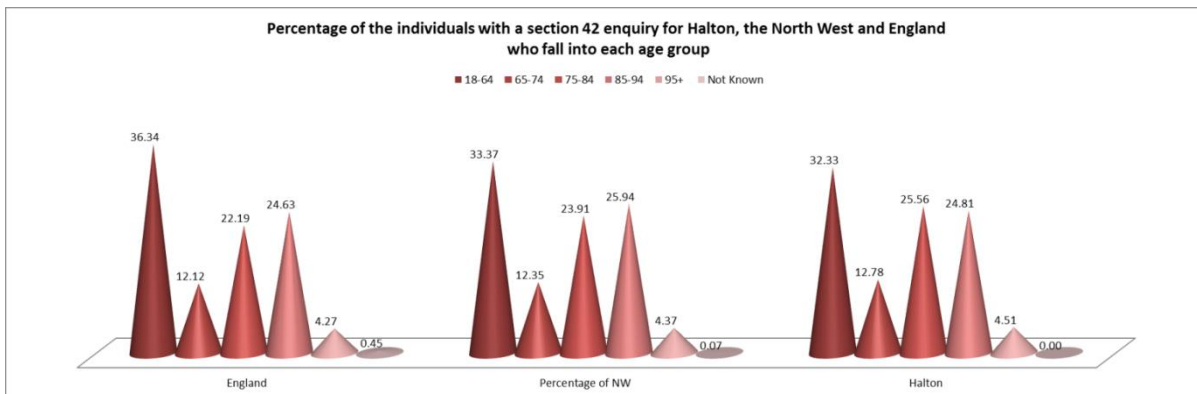


Figure 1 – Percentage of individuals with a Section 42 Enquiry by age

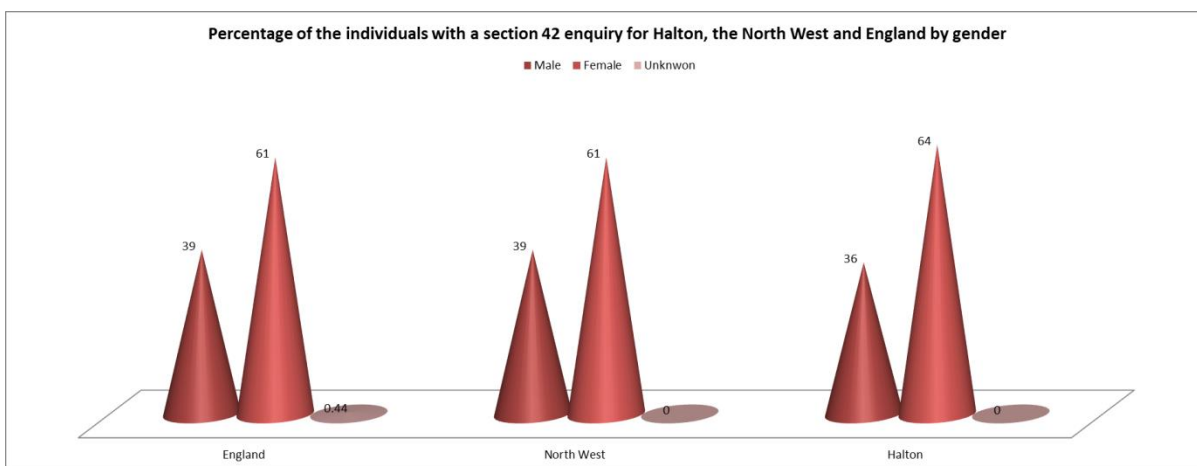


Figure 2 - Percentage of individuals with a Section 42 Enquiry by gender; Halton figures differed slightly from England and the North West with a higher percentage of females with a Section 42 Enquiry.

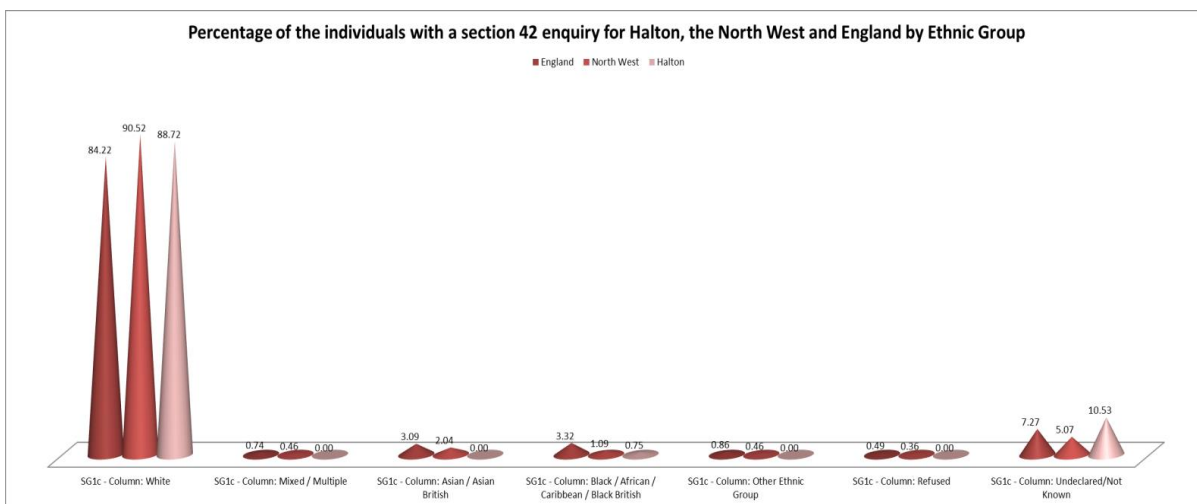


Figure 3 - Percentage of individuals with a Section 42 Enquiry by ethnicity

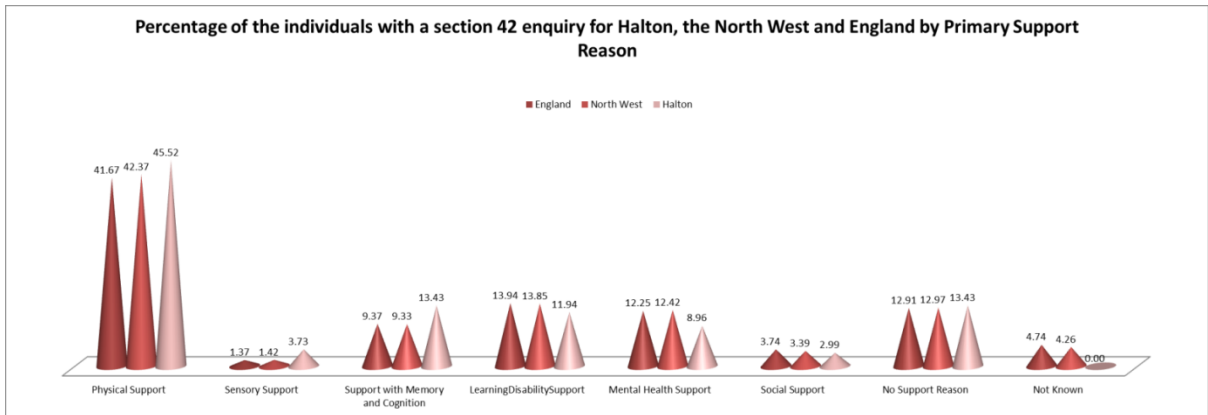


Figure 4 - Percentage of individuals with a Section 42 Enquiry by Primary Support Reason; as can be seen above Halton have a higher percentage of individuals with a PSR of physical support, sensory support and support with memory and cognition and a lower percentage of individuals with learning disability and mental health support.

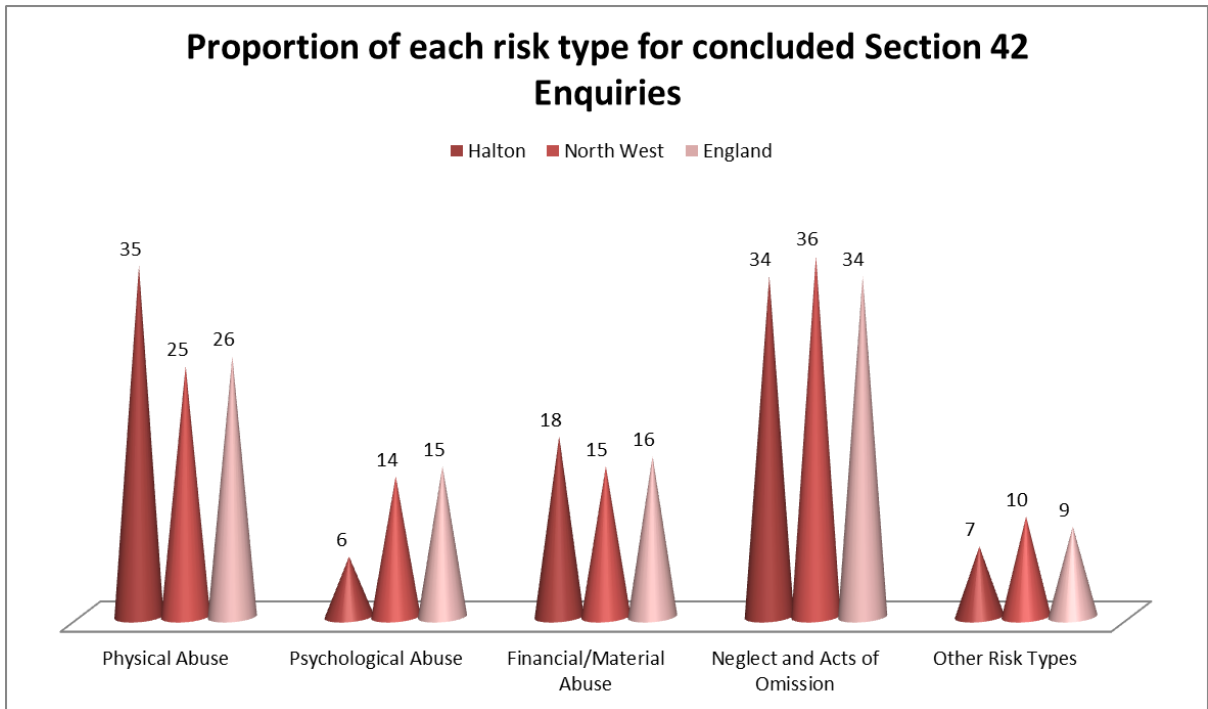


Figure 5 - Proportion of each risk type for concluded Section 42 Enquiries; while Halton have similar figures for most types of risk, however higher and lower for Physical abuse and psychological abuse.

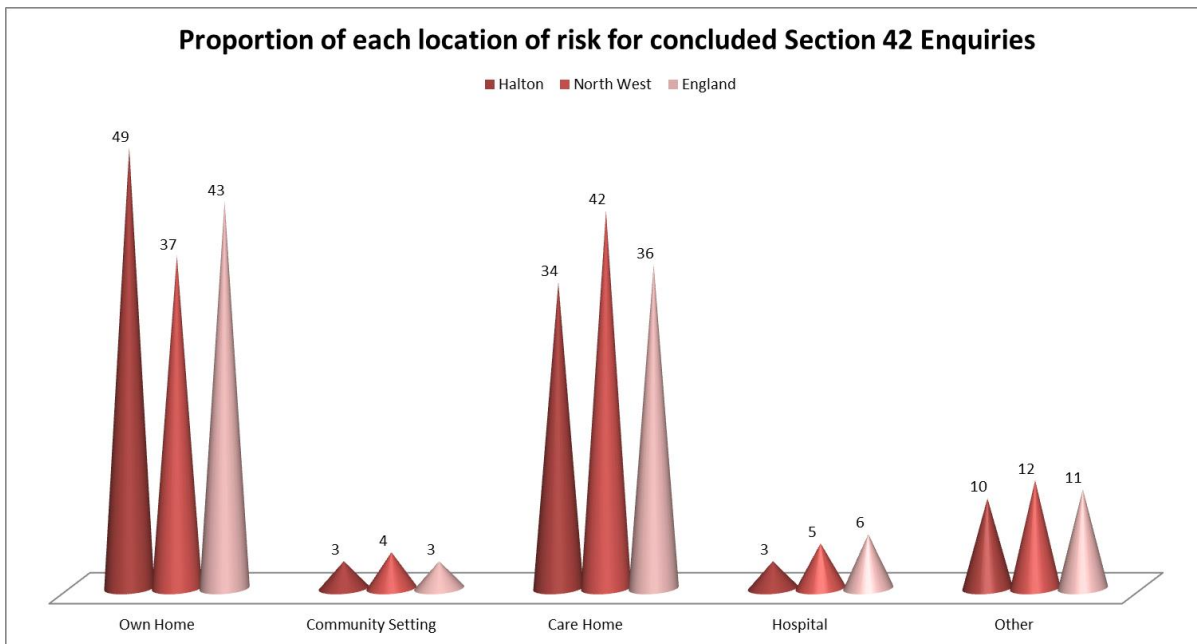


Figure 6 - Proportion of each location of risk for concluded Section 42 Enquiries; again figures are similar across Halton, England and the North West, with a shift for Halton who have higher a proportion of risk occurring in the individuals own home and fewer in care homes; for these areas, the figures are more in line with the rest of England.

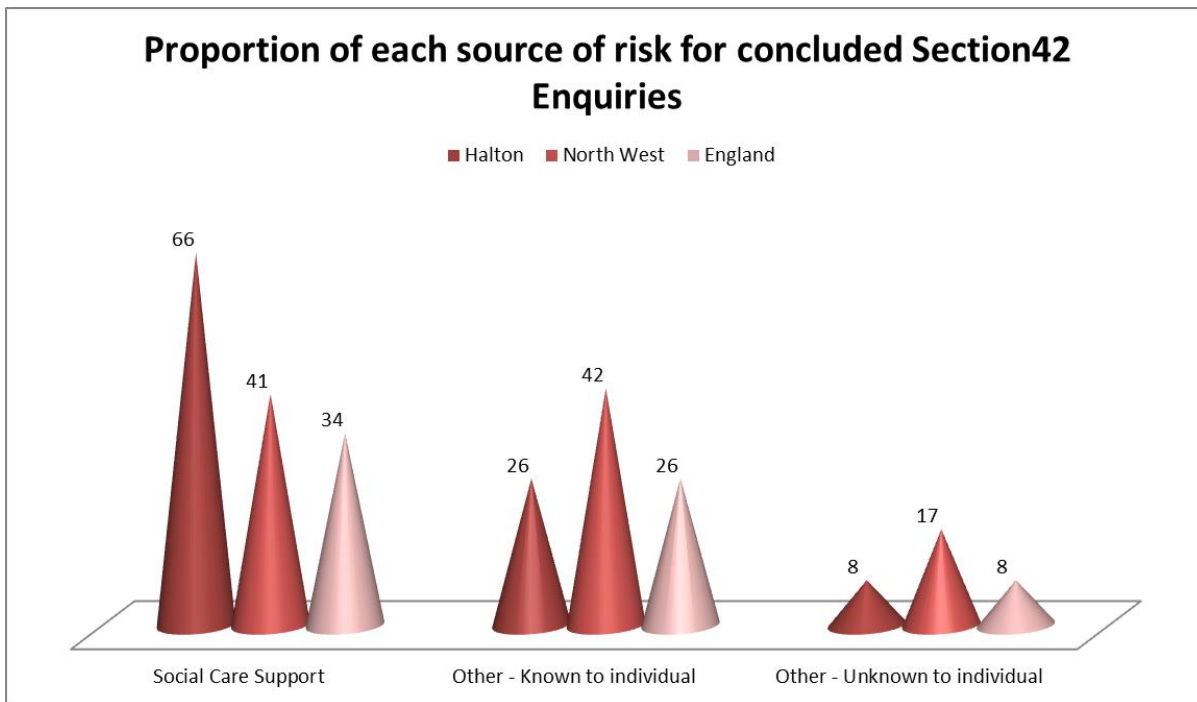


Figure 7 - Proportion of each source of risk for concluded Section42 Enquiries. Halton have considerably higher numbers of Social Care Support reported to have been the source of risk, with other figures being in line with those for England.

KEY IMPLEMENTATIONS DURING 2015/16

Advocacy Hub

Advocacy is delivered in two distinct ways in Halton. There are commissioned and non-commissioned services that deliver a varying array of advocacy across the borough. The current advocacy provision was reviewed in 2014. The review highlighted the following issues:

- ❖ There is no partnership working for commissioned advocacy services
- ❖ There are a whole range of organisations providing signposting and low-level advocacy who have been given no support or training
- ❖ Each service operates to a different set of targets
- ❖ There are clear gaps in some monitoring e.g. time taken on a case, nature of the care etc.
- ❖ Some areas are clearly under-utilised i.e. older people; carers
- ❖ There is a definite need for specialist advocacy within the borough, however, the specialist providers need to be linked via a more integrated pathway
- ❖ There is a wide disparity between unit costs for services



Recommendations from the Review:

1. Complete a review of existing befriending services in the borough and decide on future strategy in relation to this distinct area
2. Complete a skills audit of voluntary and community sector staff in relation to advocacy.

3. Establish a provider lead for the Advocacy Hub. This will be carried out by redesigning the existing service specification to include the Hub and Spoke Model as described below.
4. Devise and implement specific training to support low level Advocacy provision. This will be completed by the Advocacy Hub lead once this has been established.



Advocacy Hub and Spoke Model:

The proposed model of advocacy for Halton is a Hub and Spoke Model. It is proposed that the Hub is managed by a lead organisation, this provider would still be expected to deliver generic and Independent Mental Health Advocacy as well as managing the Advocacy Hub.

The Spoke element of the service will be in two parts, the commissioned elements where these services will contribute towards delivering the agreed targets of the Hub. Each of the providers will report directly to the Advocacy Hub in terms of both referrals and performance information and if required will be able to deliver generic advocacy.

The second part will be to support non-commissioned organisations to register with the HUB. This will give them access to training, peer support, information and signposting. This list below identifies some of the organisations who would be invited to register:

- ❖ Sure Start to Later Life
- ❖ Red Cross
- ❖ Alzheimers Society
- ❖ Vision Support
- ❖ Deafness Support
- ❖ Age UK Mid Mersey
- ❖ The Stroke Association
- ❖ Halton Healthwatch
- ❖ Carers Centre

Making Safeguarding Personal

Making Safeguarding Personal is a joint Local Government Association (LGA) and Association of Directors and Adult Social Services (ADASS) programme, that support Councils and their partners to develop outcome-focused, person-centred safeguarding practice. The approach aims to facilitate a shift in emphasis in safeguarding from undertaking a process to a commitment to improving outcomes alongside people experiencing abuse or neglect.

Making Safeguarding Personal (MSP) is a shift in culture and practice in response to what is now known about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives so therefore empowering the adult at risk and working alongside them. The key message about this approach is a shift from a process supported by conversations to a series of conversations supported by a process.



Local Implementation:

Whilst it was acknowledged that practitioners are implementing person-centred safeguarding practice, this was not sufficiently evidenced on previous recording systems. A significant piece of work was undertaken to develop a system that evidences this practice. All safeguarding adults electronic records have been reviewed and redesigned to ensure that all care management teams can demonstrate that:

- ❖ Safeguarding assessments capture outcomes expressed by the adult at risk
- ❖ Safeguarding assessments evidence that person-centred interventions have been put in place for services who have defined the outcome they want
- ❖ Safeguarding assessments demonstrate the number and percentage of people whose expressed outcomes are fully or partially met

- ❖ Internal audits show the number and percentage of cases that close after case conference which has person centred protection plans that empower them to resolve the circumstances that put them at risk
- ❖ Internal audits show the number and percentage of people or their representatives who participated in the safeguarding process through regular consultation, attendance at meetings and that they received regular feedback evidencing that they have been kept at the centre of the process
- ❖ Internal audits show that the number and percentage of people who lack capacity have recorded Mental Capacity Assessments and Best Interest Decisions
- ❖ Internal Audits show that the number and percentage of people who were offered an independent advocate and the number of people who were supported by an independent advocate or both
- ❖ Service user feedback demonstrates the difference that the safeguarding process has made to their wellbeing

Halton has worked with MSP at bronze level and presented the work undertaken at the ADASS Spring Conference 2014, prior to the implementation of the Care Act and are advanced in our progress compared to other authorities.

We have undertaken a whole service redesign to incorporate person centred involvement and the capturing of outcomes. A full programme of workshops has been held to support both practitioners and managers and a MSP group established. The new IT system went live in July 2015 and the first report on outcomes was presented to the Board in November 2015.

HOW ARE WE KEEPING PEOPLE SAFE IN HALTON?

Financial Abuse Toolkit

In January 2015, a report regarding the local and national picture of financial abuse was presented to the Safeguarding Adults Board. As a result of this report, it was agreed that a Task and Finish Group would be established in order to develop a Financial Abuse Toolkit, for use by practitioners and the general public to raise awareness of what constitutes financial abuse and what actions can be taken to reduce the risk and hopefully prevent people experiencing this type of abuse.



The Task and Finish Group was established and met in March 2015. As a result of the meeting, a Financial Abuse Toolkit was drafted which was based on a similar model used successfully in East Sussex. The toolkit provides an overview of the wide ranging types of financial abuse which can affect people and also provides information and advice regarding potential victims and perpetrators; support services available and local case studies.

The toolkit can be used by both front line staff and the general public in order to raise awareness and help to make the local community more vigilant to this type of abuse.

The toolkit has been developed into an e-learning module which all Halton Safeguarding Adult Board partner agencies are able to access at:

<http://enable.learningpool.com>

Medication Errors

During 2014/15 there had been a number of large scale investigations into providers of social care and health care services, accounting for a large proportion of the referrals relating to neglect or omission with medication errors being a dominant feature.

Neglect is the deliberate withholding or unintentional failure to provide appropriate and adequate care and support, where this has resulted in, or is highly likely to result in the person experiencing severe ill health or adverse effects.

The National Patient Safety Agency (NPSA) defines a medication error as an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred.

“A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of, the health care professional, patient or consumer”

(National Coordinating Council for Medication Reporting & Prevention)

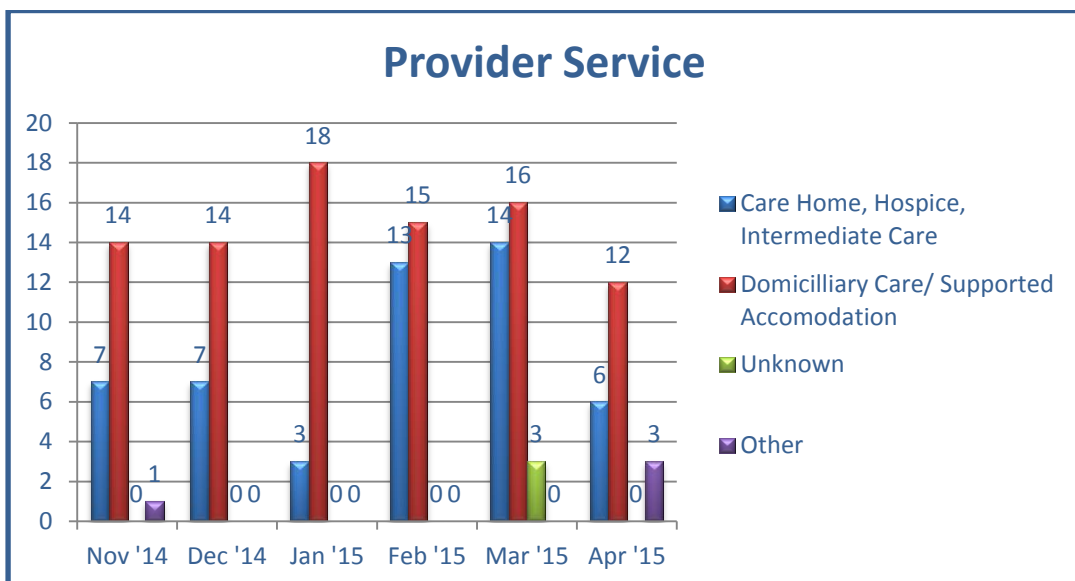


Care providers who are commissioned to provide any medication administration service within a care plan are responsible for ensuring that people using this service will have their medicines at the times they need them and in a safe way.

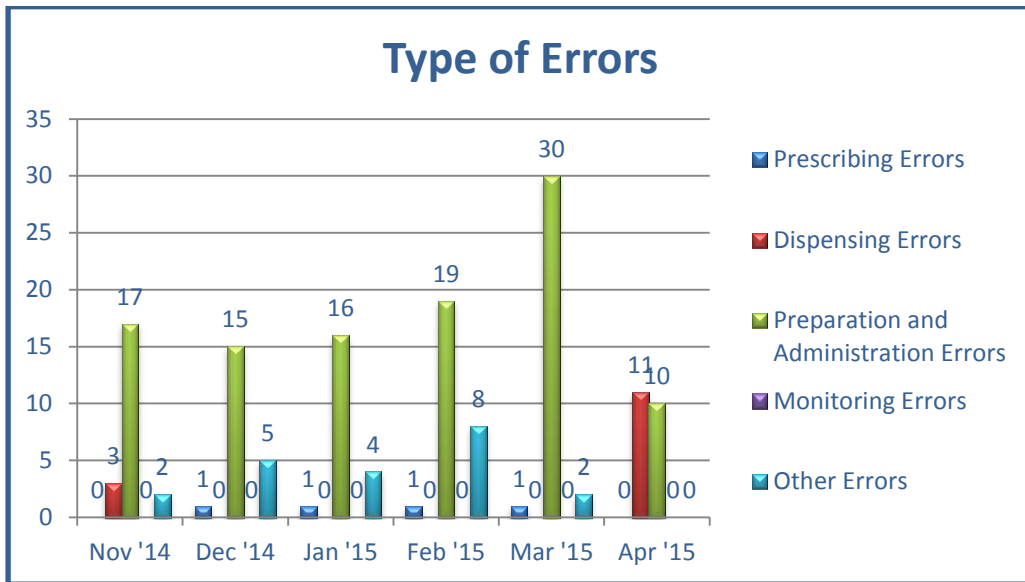
Medication incidents have a number of causes, such as lack of knowledge, failure to adhere to system and protocols, interruptions, staff competency, poor handwriting and instruction and poor communication.

The National Patient Safety Agency (NPSA) has divided definitions of medication errors into the following categories:

- ❖ Prescribing errors
- ❖ Dispensing errors
- ❖ Preparation and administration errors
- ❖ Monitoring errors
- ❖ Other errors including poor or inadequate communication and recording etc.



The graph above provides local data regarding the type of provider service who have made and then report the medication error. Initial analysis would cause concern regarding domiciliary care services and the higher incidence of reported errors, however, there is evidence to support that errors made within the care home setting are not being reported by themselves rather it appears to be other visiting professionals who identify the errors as part of a care review or wider scale investigation.



In line with the NPSA definitions the above table highlights that 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 of medication has been recorded incorrectly or not recorded at all. The increased incidents of dispensing errors in April is in the main attributed to a decision made by one pharmacist in respect of 7 residents prescriptions, which were not available at the acute hospital setting.

Where 'other errors' are recorded, this includes scenarios where there have been insufficient stock, missing medication or missed calls by domiciliary care providers resulting in medication not being administered.

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 CCG Medicines Management Team so that trends, themes and ongoing support can be identified.

Halton NHS CCG Medicines Management Care Home Support Team (MMCHST) have been in post for over 6 months and have identified areas of good practice and areas which require improvement in regards to medicines management. When issues are identified the MMCHST offer advice on best practice to guide the home towards improvement. Issues surrounding controlled drugs have been reported to the Safeguarding Team and the Controlled Drugs Accountable Officer. Halton Safeguarding Team investigated the issues, informed the Police (where necessary) and offered support to the care home. Recently there was a very successful care provider forum where the MMCHST and Safeguarding Team co-presented on the subject "Mental Capacity Act and covert administration of medication". This was well received and demonstrated a united approach to local issues. The presentation is part of a project whereby the MMCHST will audit care homes documentation for the covert administration process and help to identify, and offer guidance, on where improvements are needed. The MMCHST will liaise with the Safeguarding Team if improvements are not sufficient after an agreed timeframe. Currently only a small number of medicines related safeguarding alerts come through to MMCHST, however, there are plans to work closer with the Safeguarding Team in the near future.

Care Concerns Model

Protecting vulnerable people from abuse, harm and exploitation in Halton is a key priority for the Council and its partners. It is important to ensure that resources are targeted to ensure they are used effectively and to ensure clear indicators exist regarding procedures that should be followed. The Care Act 2014 stipulates that safeguarding alerts received must be dealt with a proportionate response, whilst also adhering to the desired outcomes of the adult at risk.

Sometimes a concern arises which leaves managers uncertain as to whether it should be dealt with as a safeguarding matter or as one that constitutes poor practice but does not warrant initiating the Safeguarding Adults Procedures.

There will be occasions when it is appropriate for provider agencies to respond to incidents of poor practice without the need to instigate Safeguarding Adults Procedures.

Poor practice will always require a satisfactory response and this remains a provider service manager's responsibility. If it is not challenged it can result in a further deterioration in standards leading to longer-term difficulties or even catastrophic consequences for some individuals.

The Care Concern Model guidance outlines those circumstances in which the provider service should take responsibility for dealing with incidents as a matter of poor practice rather than referring them as safeguarding concerns and how those arrangements will be monitored.

Dealing with Incidents/Issues of concern:

On receiving information about an incident/concern, the provider service manager should determine whether it is appropriate for it to be dealt with under the Safeguarding Adults Procedures or as a Care Concern.

Identifying Care Concerns:

In making the decision, the Manager of the provider service should consider the nature, seriousness and other relevant circumstances of the incident/issue. Provider services will be expected to identify, investigate and rectify Care Concerns – poor practice in which the standard of care provided has fallen short of that expected and satisfactory, including failure to meet a service user’s care/support needs – but which have not resulted in any harm to an adult at risk.



Care Concern Alert Process:

The main purpose of identifying a Care Concern is to rectify any deficiency immediately, understand why care was compromised and put in place measures to ensure that there is no repetition.

To support this process and to ensure that there is a full investigation and any lessons learnt are acted upon to improve service standards, the provider service must:

- ❖ Refer to the Thresholds Framework to determine if the criteria for a provider-led investigation is met
- ❖ Undertake the investigation
- ❖ Complete the Care Concern Alert Form and send it as soon as possible within 5 working days of the care concern being raised to the Quality Assurance Team – Halton Borough Council

Role of Halton Borough Council:

If Halton Borough Council considers that a matter notified to them as a Care Concern warrants further consideration for initiation of the Inter-Agency Safeguarding Adults Procedures, they will agree who will lead this process and will contact the manager of the provider service in accordance with agreement reached in a strategy discussion.

If not dealing with the referral through the Safeguarding Adults Procedures, it may be considered appropriate to take other action in addition to the Care Concern investigation by the provider service, for example:

- ❖ Assessment/Care Management/Review
- ❖ Complaints Procedure – Customer Care Team
- ❖ Disciplinary Procedure
- ❖ Contract Compliance – Quality Assurance Team
- ❖ Referral/Signposting to related services e.g. Drug/Alcohol Services; Trading Standards; Community Safety; Safeguarding Children/Child Protection; Domestic Abuse services etc.

Monitoring Arrangements:

Providers will be responsible for ensuring the ongoing quality of service standards and any actions that need to be taken as a result of the Care Concern.

All care concerns will be subject to quality assurance and where appropriate the Quality Assurance leads may contact the provider, where collective concerns arise or if best practice lessons can be learnt and shared at Provider Forums.

Safeguarding Champions

The Safeguarding Champions Forum was established in 2014 by the Integrated Adult Safeguarding Unit. The purpose of the forum is to provide a group where a provider service nominates a representative within their service (not necessarily a manager) to be the champion, who has a genuine interest in safeguarding and is able to disseminate any information discussed within the forum. The Safeguarding Champions do have the opportunity to decide upon agenda items and during the most recent meetings, the champions have been tasked with listing what information they would find most useful to be discussed at future meetings to determine how the agenda can be structured. Agenda items include Serious Case Reviews/Safeguarding Adult Reviews; any relevant case law; Making Safeguarding Personal; Mental Capacity Act and Deprivation of Liberty Safeguards etc.

The meetings are held on a quarterly basis and cover domiciliary care, care homes and other agencies (for example: Community Bridge Building Team; Adult Placement; Day Services; Supporting Living providers). Colleagues from the Police; Warrington and Halton Hospital Safeguarding Matrons; Care Home Support Team, Medicine Management Team and the Adult Safeguarding & Dignity Officer attend the forum to present an overview of the work they are involved in. Information that is current to social work practice is also discussed at meetings, types of information that have been presented/discussed include the financial abuse toolkit; self-neglect and domestic violence. Champions are asked to complete group exercises, which are aimed to increase their awareness and knowledge around a particular topic.

Following the establishment of the Safeguarding Champions Forum, members of the Integrated Adult Safeguarding Unit have attended a number of different services offering support, advice and awareness raising on safeguarding and care concerns. Awareness sessions are tailored to the needs of the provider, whom their representative has attended the Forum and raised issues/concerns. The forum is attended by 15-30 champions and feedback has been positive. The next step is to look at establishing a similar forum for Mental Capacity Act awareness, which would work in a similar fashion but aimed at more senior positions within each service, to ensure that the Mental Capacity Act is being followed and good practice guidance and examples are shared. This is being proposed due to the additional scrutiny now being given by the Care Quality Commission around the Mental Capacity Act and Deprivation of Liberty Safeguard within placement settings.



NHS Halton Clinical Commissioning Group (CCG) requires all its commissioned providers to evidence how they enable and encourage service users to share their views to influence service delivery and change. This is monitored through contractual arrangements and performance monitoring of the quality schedule and in particular the safeguarding Key Performance Indicators. NHS Halton CCG facilitates a number of forums that enable service users to engage with health commissioners.

NHS Halton CCG requires that all CCG staff, Governing Body Members, Member Practice Staff and staff in all services it commissions, receive mandatory safeguarding training. During 2015/16 NHS Halton CCG has developed a Training Needs Analysis of all its staff members to identify the levels of safeguarding training required, to ensure that staff are appropriately trained and that they are aware of abuse and the right to a safe and dignified life. The NHS Halton CCG commissioned provider services are required to evidence that staff are aware of the risks of abuse and staff compliance with training

trajectories. This is monitored by NHS Halton CCG on a quarterly basis and reported to the Governing Body.

All NHS Halton CCG commissioned health providers are required to evidence that they have policies and procedures in place that safeguard their service users. The health providers must provide assurance to NHS Halton CCG that their policies and procedures are compliant with current legislation and clearly identify roles and responsibilities in relation to discharging safeguarding duties. NHS Halton CCG monitors compliance via the safeguarding key performance indicators.

NHS Halton CCG has supported the introduction of the role of a Mental Capacity/DoLS Coordinator within the CCG Designated Professionals Safeguarding Adults Team. This role will enable the Halton health community to respond appropriately to the requirements of the Mental Capacity Act, by providing advice and support for health commissioned services, ensuring that health service providers have access to and attend relevant training and monitor the quality of DoLS applications.

NHS Halton CCG employs Designated Safeguarding Professionals to support and enable the CCG to discharge their statutory duties. A key aspect of the Designated Safeguarding Professional's role is to facilitate the embedding of safeguarding within commissioning and performance management across the health economy and to work across the local health system to support other professionals in their agencies on all aspects of safeguarding.

The organisation has reviewed the contracts with its commissioned health providers. The CCG employs a range of performance monitoring measures to seek assurance from providers and demonstrate compliance with safeguarding duties. Assurance is monitored via contractual compliance, provider quarterly reporting against specific safeguarding key performance indicators, audit and through attendance at provider safeguarding committees and announced and unannounced provider visits.



The Trust has an approved Safeguarding Strategy which sets out the Safeguarding Assurance Framework for the implementation of safeguarding arrangements within the organisation, the accountability structures and the methods of monitoring to provide assurance of delivery of safe working practices in line with Trust Safeguarding Policies.

The Safeguarding Adults Team provide advice, guidance and support to all Trust staff, as well as training and quality checking safeguarding adults' activity in each of our 5 Boroughs covering all of our services (Mental Health; Learning Disabilities; Later Life and Memory Services; Child and Adolescent Mental Health Services; Forensic and Community Health Services). Under the Making Safeguarding Personal Agenda, practitioners reporting concerns to the team are guided to asking the individual concerned what they want to happen, are they aware of safeguarding and what this means to them and more importantly, what they don't want to happen.

The Safeguarding Adults Team have been involved with a Trust wide review of the consent agenda to ensure that service users and their carer's are fully involved in decisions regarding their care and treatment and that any decisions made, should the individual concerned lack the capacity to consent, are in their best interests.

The Trust is commissioned by 5 Clinical Commissioning Groups (CCGs) to provide safeguarding services across the organisation. The Trust Safeguarding Assurance Group is held on a quarterly basis which invites the Designated Nurses to support the Trust with assuring compliance and standards of safeguarding practice. The respective CCGs monitor the Trust's contractual performance, quality, safety and safeguarding arrangements through a joint Clinical Quality and Performance Group with 3 respective locality Quality, Safety and Safeguarding Monitoring Groups.

During the past year the Trust has significantly developed the Lessons Learned Forum, which enables systematic analysis of a range of patient quality and safety information including the outcomes of internal and external reviews following incidents in order to identify and improve the quality of services. A series of lessons learned events have taken place across the Trust during the past year involving practitioners aimed at the sharing of information and to improve clinical practice.



The National Probation Service manages those who have been through the courts and receive a prison sentence for serious offences. Many such cases have perpetrated some form of domestic violence. Along with the Police, in appropriate cases, disclosure takes place with any new partner of that offender. In some cases, it is clear that the offender targets vulnerable partners and work undertaken with the couple involves ensuring that the new partner and potential victim understands what abuse is, which takes it beyond physical abuse to ensure that they have some knowledge with which to protect themselves and where to seek help, if required.

Dangerous offenders are managed under Multi Agency Public Protection Arrangements (MAPPA). Some of our most dangerous offenders also have mental health issues themselves, suffer from a Personality Disorder or have learning disabilities. They are not permitted to attend MAPPA, as in the past the information gained by offenders at a MAPPA meeting has placed them in a position to further abuse. However they are asked to provide a thought map to inform the meeting of their understanding of risks they present, the protective factors that are present and their needs and strengths and what they think the meeting could most effectively set up to meet their needs and protect those who may also be at risk from them.

The National Probation Service has recently published an Adult Safeguarding Policy and Practice Guidance. These have been made available to all Probation staff who have had a briefing on them and their contribution to adult safeguarding made explicit. Quite a lot of emphasis is on assessment so in the early stages of the order or license, the Probation Officer is asked to take an investigative approach to tease out any care and support needs the offender may have or present. They are made aware of the referral process to adult social care and also the escalation process as necessary. They are also asked to consider all the forms that abuse and neglect might take and be aware of the possible indicators to be aware and fully engaged in prevention.

The Probation Officers manage many cases where the victims are at risk and in need of care and support and where the offender will constantly harass or breach restraining orders. The victim liaison officers and the Probation Officers understand the many reasons the victim may have in not reporting further abuse and respect, but will also seek to empower victims to seek the support they need to keep them safe. On the other side, the Probation Officer needs to ensure that the controls and constraints that can be imposed on the perpetrator take some responsibility away from the victim that they should not have to "own".



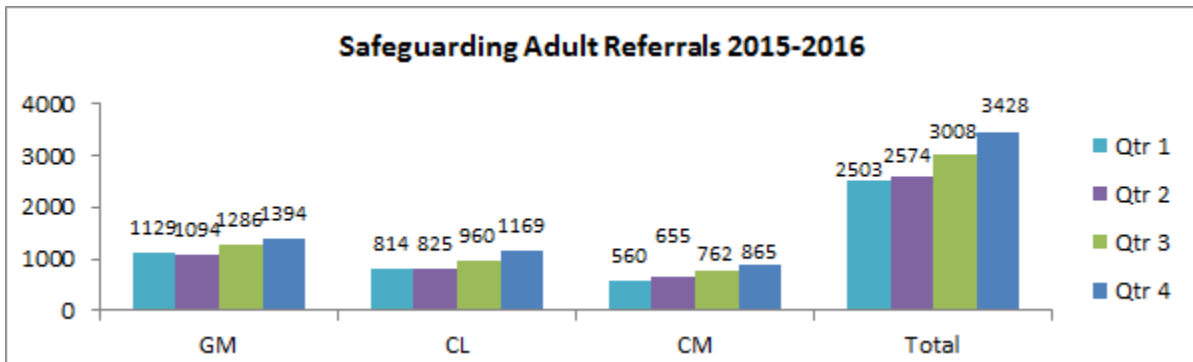
North West Ambulance Service



North West Ambulance Service NHS Trust (NWAS) is a regional service providing pre-hospital emergency care, urgent care and 111 services and Patient Transport Services.

Safeguarding activity has increased throughout the year, which is reflected in the increase in the numbers of safeguarding concerns raised about adults at risk. The numbers are broken

down into geographical area (GM = Greater Manchester CM = Cheshire and Mersey and CL = Cumbria and Lancashire)



The implementation of the Care Act 2014 with its focus on personal choice and empowerment for patients has resulted in an increase in requests to be involved in Adult Reviews and Strategy Meetings. Senior Clinicians and Managers support staff with engagement in safeguarding processes and regularly represent the Trust at associated meetings.

Each month the NWSAS safeguarding concerns rejected by Adult and Children’s Social Care are scrutinised to understand the themes and either re-allocated to the correct service or to the patients GP. Less than 6% of adult concerns are rejected. The rejections relate predominantly to mental ill health for adults and the Trust is working towards developing referral pathways with partners to address the risks.

Quality Audits

Audits have been introduced to monitor the quality of safeguarding calls made by staff to the Trust Support Centre. This provides additional data relating to safeguarding knowledge and how the process has facilitated information sharing. Early indicators show that referral information is of a high quality and is captured and documented by the Support Centre Advisors accurately. Areas for improvement are highlighted and raised with the staff concerned for their learning.

PREVENT Awareness and Training

92% of all NWSAS staff have now received WRAP 3 training, which is the ‘workshop to raise awareness of PREVENT’ and part of the Government’s anti-terrorism strategy. Prevent is any terror related activity that takes place in the pre-criminal space. WRAP is included within mandatory training for all staff and compliance with this national requirement has increased during 2015/16.

The Trust will be updating its mandatory training relating to Human Trafficking, Modern Slavery and Domestic Abuse in the next year. Training in these subjects is currently available within the Trust Learning Zone and is accessible to all staff.

St Helens and Knowsley Teaching Hospitals NHS Trust

The Trust has a Safeguarding Adult Training Strategy and Needs Analysis, which is scrutinised by its commissioners and the Designated Safeguarding Adult Leads within the Clinical Commissioning Group.

The Trust has achieved 97% compliance with its Level 1 Training which is directed to ALL staff and equips staff to recognise and identify abuse and to alert a member of staff to make a referral. The Trust Safeguarding Team provides the training resource and advice and guidance to all areas of the Trust.

Overall Trust Safeguarding Activity which is captured in quarterly reports is broken down for each care group – Medical, Surgical, Clinical Support and St Helens, so that they can see the nature of their own safeguarding activity and its consequences. Records are kept of the areas from which safeguarding contacts are made which demonstrates that increasingly all areas are in contact with the safeguarding team seeking advice and, where necessary, being encouraged to make referrals. This provides overall assurance that all areas are engaged with the safeguarding agenda.

The Trust requests information from a range of agencies, to assist in enquiries and investigations relating to safeguarding incidents; care concerns; potential safeguarding adult reviews and fatalities which need to be managed in a consistent and robust manner, ensuring that the sharing of information is consistent with the Caldicott Principles and the Data Protection Act.

Whilst the Safeguarding Team acts as the single point of contact for such enquiries, the Team confer both with the Trust's Information Governance Team and the Legal Services Department to ensure compliance with the legislative framework around information sharing.



Age UK Mid Mersey has services that go into older people's homes, like our home visiting service for benefits checks and our practical support service. Our staff are very experienced

and will report back to line managers if they have concerns about the wellbeing of an older person.

Age UK work closely with the safeguarding team sharing what information is necessary and also speak to social workers to share any important factors. At all times this is done whilst being sensitive to the person's needs.



All Senior/Case Managers attend multi-agency training with the aim of ensuring they are aware of the signs of abuse and what to do/who to contact if they have concerns.

The Cheshire & Greater Manchester Community Rehabilitation Company (CRC) has policies in relation to staff responsibilities, in terms of safeguarding of adults and the potential impact on those who are involved with vulnerable adults; specifically policies in relation to safeguarding children, child sexual exploitation and working with domestic violence perpetrators and their responsibilities in relation to the protection of victims.

Cases are discussed in monthly Risk Management Review meetings between Senior/Case Managers and their Line Managers, to ensure that the identified risks are addressed, not only for the individual but for those who have contact with them and may be adversely affected by the individual's vulnerability.

Service User feedback is important to the CRC and regular reviews and self-assessment is built into our process to ensure that we are meeting the needs of individuals. Formal feedback is collated locally on a quarterly basis and CRC wide twice per year. Individual team performance and CRC-wide performance is disseminated and action plans devised, implemented and reviewed regularly.

Staff are required to attend domestic abuse training to ensure they are competent in working with those service users who have committed offences in the context of intimate/family relationships. Learning is supported by regular line management supervision, professional development days and peer support.



The organisation ensures all colleagues feel comfortable and confident to challenge as appropriate. Colleagues feel able to and do communicate/information share in a robust timely and effective manner, colleagues are open honest and transparent at all times without fear of reprisal.

The organisation ensures that all staff have regular training provided, this enables all colleagues to have a robust understanding of the many forms of abuse, how to recognise signs and how to seek help. Safeguarding is an agenda item at every staff meeting. Safeguarding concerns are reviewed at every clinical governance meeting.

The organisation ensures safeguarding concerns are reported in a robust and timely manner to all relevant parties. Relevant information is shared as applicable and proportionate assistance is received accepted and acted upon from safeguarding colleagues.

The organisation ensures all care and intervention is person-centred. Information is communicated in a robust and timely manner, permission is sought prior to any interaction or disclosure. Dignity, equality and diversity are heavily integrated into the care provision.



Trading Standards have dealt with victims of financial abuse perpetrated by strangers such as doorstep criminals and scammers.

All such victims are provided with advice and guidance on how to deal with cold callers on the doorstep, on the phone, through email and letter so that they are less vulnerable when they are targeted again. The option of registering with the Mail and Telephone Preference Services is also discussed with them.

All victims are given free materials that provide a prompt to assist them to deal with uninvited doorstep and telephone callers and mass marketing mail. A 'No Cold Calling' letterbox sticker tells uninvited callers to leave without knocking, a 'No Cold Calling' card for display in glass doors and windows carries the same message with reminders for the householder on the reverse so that they are prompted to deal with cold callers safely when answering the door.

All victims are invited to join iCAN, which is the Trading Standards email alert system used to warn members of doorstep crime incidents , scams and to provide general consumer information.

Trading Standards work to raise awareness with the general population about what scams are and how to avoid them through iCAN messages, press releases and talks to community groups.

We provide training to the staff of other council services and local organisations so that they are able to spot if one of their clients or service users has fallen victim to a scammer or door step criminal.

Some people told us that they began to be targeted by scammers when they lost a partner so we have provided the Registration Service with scams and doorstep crime awareness raising materials, which are given to every person who registers a death.

The Service has 11 call-block devices that they can loan to people who have been caught out by scams and who receive a lot of cold calls – 55% of all calls to those people have been blocked because they were either scams or marketing calls. We worked with people who had been caught out by scammers and saved them £46,445.

Trading Standards have developed links with other organisations and professionals so that we can work together to support, both emotionally and practically, those who have been victims of doorstep criminals or scammers. We will also put victims in touch with local groups and activities so that they can benefit from making connections with people outside of their homes.



Healthwatch Halton has a duty to ensure that adults with care and support needs and their families rights are upheld through having their alleged incidents recognised and taken seriously and responded to in a timely manner. Healthwatch Halton therefore ensures that individuals making a complaint or disclosure is taken seriously and ask individuals what action or outcome they would like to achieve from their disclosure/information/complaint.

When discussing concerns/safeguarding issues with individuals the Healthwatch Halton support team explain that any concerns or safeguarding issues may need to be shared with the appropriate authorities, if they disclose that they or others are at significant risk of harm.

In line with best practice, Healthwatch Halton review documents regularly to ensure that they are up to date, suitable and reflect best practice and this includes the Safeguarding Adult Policy. Healthwatch Halton are committed to staff and volunteers having access to Halton Borough Council e-learning modules and adult safeguarding training. As raised with the SAB to ensure that directors, staff and volunteers working within Healthwatch Halton are able to recognise and respond appropriately when information is disclosed. Healthwatch Halton also ensures that all staff and volunteers during Enter & View training are aware of what constitutes abuse; those adults with care and support needs who are most at risk of abuse and the signs and indicators of abuse.

During an Enter & View visit, the manager is informed at the start of the visit that any safeguarding concerns identified during the visit will be explained to the manager before leaving the home. Any immediate action required to safeguard adults will be taken and that where appropriate the visit will be terminated and the safeguarding reporting process will be followed in accordance with the revised Healthwatch Halton Safeguarding Policy and Procedures.

Following the visit a further discussion is held via telephone with the relevant monitoring officer for the care home, to discuss the results of the visit including identified care concerns or safeguarding issues. To enable the monitoring officer to act quickly and prevent any care concerns escalating into safeguarding issues which includes the Healthwatch lead raising an alert with Halton Borough Council Safeguarding Unit following disclosures, when appropriate.

Healthwatch Halton has a responsibility of being responsive to what they identify as the consumer champion of health and social care and reporting identified trends and themes directly to the Safeguarding Adults Board.

**Warrington and
Halton Hospitals** 
NHS Foundation Trust

The Trust policy has set out agreed key principles for work in relation to safeguarding vulnerable adults. The human and civil rights of vulnerable adults who are cared for in Warrington and Halton Hospitals NHS Foundation Trust will be promoted and protected. The independence, well-being and choices of vulnerable adults will be actively promoted. Vulnerable adults will be assumed to have capacity except where it is established that this is not the case. Where a vulnerable adult lacks the mental capacity to make decisions, assistance will be offered on a multi-disciplinary basis to achieve his/her best interests. A vulnerable adult who has mental capacity has the right to take risks. Services will recognise

and accept that an individual has the right to self-determination that may involve a degree of risk. Agencies will undertake and record risk assessments to monitor this.

All investigations and assessments of vulnerable adult abuse will take account of people's ethnic origins, gender, sexuality, age and disability, religious and cultural background and be carried out in an appropriate setting, manner and language. When intervention is necessary to reduce risk to a vulnerable adult, account will be taken of the disruption to the service user and every effort will be made to minimise this and to keep it in proportion to the identified risks.

Prevention from harm or abuse is a primary goal. Prevention involves helping the person to reduce risks of harm and abuse that are unacceptable to them. Prevention also involves reducing risks of neglect and abuse occurring within health services. The Trust supports this process through staff education.

Staff are made aware of their obligation for support and representation for those in greatest need. There is a duty to support all patients to protect themselves. There is a positive obligation to take additional measures for patients who may be less able to protect themselves.

All staff are train in adult safeguarding to level 1 or 2, they are supported and empowered to recognise abuse and report this with confidence. Staff are supported to be able to be involved to a level they feel competent to do so with the knowledge to understand who they can turn to when required for support with reporting.

The Trust promotes proportionality and least intrusive response appropriate to the risk presented. Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses must be the least restrictive of the person's rights and take account of the person's age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way. This process is supported by partnership working with local solutions, through services working with their communities. Safeguarding adults will be most effective where citizens, services and communities work collaboratively to prevent, identify and respond to harm and abuse.

The Trust has a facility that allows staff to 'speak out safely' if they have any concerns of any sort and this is monitored at all times by senior staff. Trust policies support our staff in their actions if they need to report abuse and they offer guidance on how to do this. During training staff are exposed to the relevant documents that they should use and are aware that the safeguarding team are here to support their practice. Staff are informed during training of how to raise a concern, they are reassured that reporting is the right and safe

thing to do, even if a situation arises where they doubt this. Staff are encouraged to report abuse of any category at all times regardless of who the suspected perpetrator may be.

The Safeguarding Team work closely and in partnership with relevant agencies and professional groups to allow for risks to be identified and plans put in place where ever possible allowing patients to continue to maintain their right to a family life.

CASE STUDIES

Case Example

In November 2014, the police made Trading Standards that they had been contacted by a Runcorn bank who was concerned about a large cash withdrawal Mrs M (a lady in her 80's) was trying to make. We made contact with the lady and her brother and discovered that she had been targeted by a trader who said they could flag her garden for £3,000. From her bank statements it was clear that she had probably paid the trader around £6,000. The money had been taken out a few hundred pounds at a time.

Mrs M had a poor memory and couldn't remember the transactions but she described different people asking for money at different times. It appeared that the lady had been repeatedly targeted by several doorstep criminals.

An officer worked with Mrs M and her brother to look at different ways Mrs M could use to protect herself and arrangements that could be put in place to reduce the risk of her withdrawing large amounts of cash to pay doorstep criminals or scammers.

Case Example continued:

Mrs M was given a 'No Cold Calling' window card and letterbox sticker. Mrs M decided to contact the bank and ask them to put a limit on the amount that could be withdrawn at a time and to give her brother access to her account online.

Some months later Mrs M's brother contacted the service again because Mrs M had tried to take a large amount of money out of her account. She had received a phone call from a man who said he had her money from the time she had lost the £4,000 but the cheque had been made out incorrectly and he needed £2,000 in cash first.

Mrs M agreed to a call-blocking device that we have loaned to her and we have passed her details to Cheshire Police who were considering putting a camera in her property that would only activate when the door was answered.

We told Mrs M about coffee mornings/meetings organised by Age UK and she agreed to her details being passed to the Age UK organiser. Mrs M went to the group and enjoyed it.

Case Example

A 90 year old lady was due to be discharged from hospital after having a fall and breaking her wrist. She was struggling due to poor mobility to do her garden and shopping. Age UK completed a benefit check for her and discovered she was not in receipt of Attendance Allowance. With her consent we ordered the Attendance Allowance forms and arranged for someone to go to her home and complete these. She was successful with her Attendance Allowance claim and now receives over £80 per week, meaning she can now afford to employ a gardener and get a taxi to do her shopping.

NEXT STEPS

Halton Safeguarding Adults Board is undergoing a period of reconfiguration with a review of the membership of the main board and the development of a Safeguarding Adults Partnership Forum to support the work of keeping people in Halton safe. This reconfiguration will ensure that the correct agencies are represented on the Board and members are able to make key decisions regarding work to be implemented by the Board or agreeing resources to support this work.

Through the Board's Business Plan we will monitor the work that has been undertaken by all partner agencies and we will continue to strive to make continued improvement in the safeguarding of adults in our borough.

The Sub Groups of the Board will report into the Board on a regular basis to provide updates regarding the work they have undertaken to assure the Board that adults at risk of harm or abuse are being supported effectively to keep safe and that we are Care Act compliant.

FUTURE PRIORITIES

Halton Safeguarding Adults Board held a Development Session on 11th March 2016, in order to agree future priorities for the Board. The session utilised an 'Appreciative Inquiry' model as a template for the session. Initially Board members were asked to look at the current reality for Halton Safeguarding Adults Board and to consider the following questions:

- ❖ What are you proud of?
- ❖ What is working well?
- ❖ What are your concerns, fears, issues?
- ❖ What are the challenges facing the Board?
- ❖ What opportunities exist for the SAB that could be utilised?
- ❖ What hopes do you have for the Board?

After discussing those areas, members were then asked to think about a common vision for the Board and to then identify actions that will enable the Board to achieve that vision.

The event allowed members to step out of the usual pace of everyday life or workplace and reflect on how we could all improve the effectiveness of the Board.

The following are options for a vision statement for the Board which were suggested at the Development Day:

No Neglect; No Abuse; No Discrimination; No Fear; No Decision about me without me

Yes to Empowerment; Yes to Quality; Yes to Involvement; Yes to Communication; Yes to Dignity

Ensuring ALL adults at risk: live, work and are supported to live in an environment free from abuse, exploitation, harassment, violence and aggression

To ensure that Halton has a culture that does not tolerate abuse, works together to prevent abuse and knows what to do when abuse happens

The following areas will form the main strategic aims of Halton Safeguarding Adults Board for 2016/17:

- ❖ **Strengthening the Board**
- ❖ **Early Intervention and Prevention**
- ❖ **Awareness Raising and Engagement with the Community**
- ❖ **Performance and Quality Assurance of Providers and Services**
- ❖ **Making Safeguarding Personal – listen to and do when adults tell us about their experiences of abuse and neglect, and the services and support they receive**

Key objectives have been identified for each of these priority areas following discussions at the Development Day and these have been collated into a Strategic Plan for Board. The Strategic Plan will be a fluid and flexible document whereby additional objectives may be added to the plan as various work streams progress through the course of the year. Progress reports will be presented to the Board at regular agreed intervals during the year for each of the key objectives to ensure all areas of the Strategic Plan are being monitored and any issues can be resolved at the earliest opportunity.