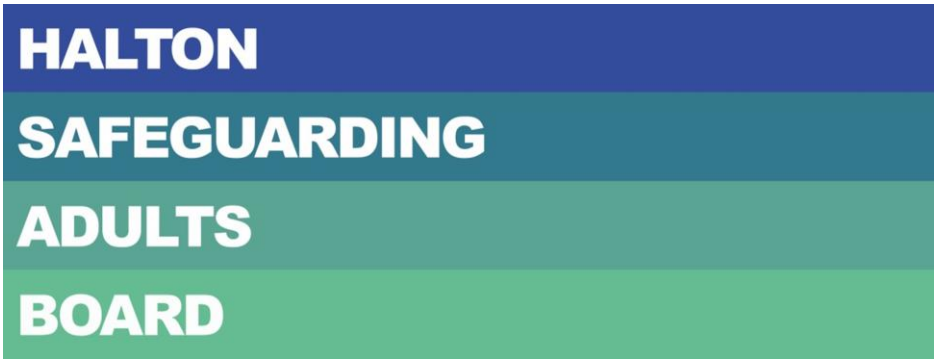
HALTON
SAFEGUARDING
ADULTS
BOARD

Halton Safeguarding Adults Board

Annual Report 2017-2018



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MESSAGE FROM THE CHAIR

As the independent chair of Halton Safeguarding Adult Board I am very pleased to present the annual report 2017/18. All Safeguarding Adults Boards are required to publish an annual report and analyse the effectiveness of the work across agencies to safeguard those adults who require additional support and care.

This year our annual report is short but full of information about how we have worked together. Our information shows that neglect and physical abuse remain the most frequently reported forms of abuse. There is also an increased awareness of emerging issues such as Modern Slavery and learning about this is taking place with neighbouring localities. In addition to statistical information we have described our work with Alice and Paul. Their stories show how we need to work together respectfully with individuals while seeking to ensure they are protected and safe.

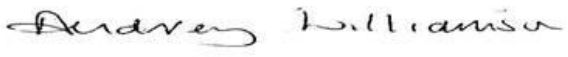
There have been some very positive developments during the last twelve months. I have particularly welcomed the establishment of a multi-agency training programme covering a range of topics including what to do if there is a concern about an adult requiring support. We are only halfway through the programme but all those working with adults have welcomed the opportunity to increase their skills. The programme will be evaluated but it is clear that training will continue to be needed next year.

We have also developed a marketing campaign to raise awareness across the partnership and local communities. A new website has been set up and posters and leaflets are available which highlight different forms of abuse. The more we are aware of how adults may be abused, for example through financial abuse and scams the better we are able to tackle the risks together.

As part of our preparation for this annual report we asked all agencies and organisations involved to provide us with information on how they had worked on our three priorities. The responses were very positive and are fully set out in the report. There remains more to do, particularly on our third priority which requires us to gain a greater understanding of the impact of mental health on individuals who may need protection. Overall however, the responses demonstrate that safeguarding adults work is taken very seriously across Halton.

I have also noted the resources which have been secured for safeguarding work. The three key agencies; Halton Council , Cheshire Police and Halton Clinical Commissioning Group have ensured that that there are sufficient resources to meet the needs of those adults who may be experiencing abuse. This commitment at a time of decreasing resources and increased need deserves to be recognised and allows for effective services to be delivered.

Finally I would like to thank all Board members for the support I have received throughout the year as well as the wider partnership forum which influences our work. I would also like to thank our Board Officer for her work particularly in developing the multi-agency training. Most importantly I would like to thank all those who work on a daily basis to make Halton a safer place.



Audrey Williamson – Independent Chair

Halton Safeguarding Adults Board

SECTION 1: OUR VISION

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

Safeguarding Adults is managed well in Halton and Halton Safeguarding Adults Board has shown a continuous strive for improvement in fulfilling it's statutory duties and a dedication to seeking and providing the best possible care and support to protect those members of our community that need it. This report provides a brief summary of the activities for the year 2017-2018.

Definition of adult safeguarding

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

Six key principles that underpin all adult safeguarding work

- Empowerment - People being supported and encouraged to make their own decisions and informed consent. "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens"

- Prevention - It is better to take action before harm occurs. "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help"

- Proportionality - The least intrusive response appropriate to the risk presented. "I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

- Protection - Support and representation for those in greatest need. "I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

- Accountability - Accountability and transparency in delivering safeguarding. "I understand the role of everyone involved in my life and so do they".

- Partnership - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me"

Duties of Safeguarding Adults Boards

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

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

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

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

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

- Halton Borough Local Authority
- NHS Halton Clinical Commissioning Group
- Cheshire Constabulary
- Cheshire Fire and Rescue
- North West Ambulance Service
- National Probation Services
- Healthwatch
- Halton Safeguarding Adults Partnership Forum Chair
- Elected member responsible for adult health and social care

Accountability and assurance

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

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

HSAB is also committed to recommendations from Department of Health Care and Support Statutory Guidance (issued under the Care Act 2014) which recommends using: *'Local Health and Wellbeing Boards to provide leadership to the local health and wellbeing system; ensure strong partnership*

working between local government and the local NHS; and ensure that the needs and views of local communities are represented. HWBs can therefore play a key role in assurance and accountability of SABs and local safeguarding measures'.

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

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

Halton Safeguarding Adults Board sub groups are:

- Health Sub Group (joint with Halton Safeguarding Childrens Board)
- Faith Sector Forum (joint with Halton Safeguarding Childrens Board)
- Safeguarding Adults Partnership Forum
- Safeguarding Adults Review Group

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

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

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

- *Joint subgroup with Halton Safeguarding Children's Board*

SECTION 2: WHAT THE STATISTICS FOR 2017-2018 TELL US

Key findings

Enquiries opened

- 670 adults with reported safeguarding concerns. The total number of concerns has decreased by 0.4% on last year and given the increase of just under 1% in adult population size for Halton this can be viewed as a decrease in overall prevalence.
- Of the concerns received, 73% of those were dealt with under the section 42 safeguarding criteria; this is an increase of 10% from 2016/17
- Highest age risk remains adults aged 75 years and over, accounting for 53% of safeguarding concerns.
- 2% decrease for adults aged 75-84 years (23%) and 2% increase for adults aged 85-94 years (26%) compared to last year.
- Gender ratio remains same as previous year at 40% males and 60% females.
- Ethnicity of adults was 92% White British, 0.75% were Asian/Asian British, 5.5% were either unknown or not declared.

Enquiries concluded

- Majority of enquiries received from Care Homes (19.5%), Independent Service Provider were 19%, Social Care Worker/Care Manager at 13.6% with Health and Hospitals at 16% and reports from relatives at 8.2%.
- The top 3 most frequently reported types of abuse remain the same as previous 2 years with a similar trend of neglect and acts of omission rising to 39.6% (8.6% increase on 2016-17); physical abuse decreasing by 5.5% to 21% and financial abuse 19.6%, decrease of 0.8% from 2016-17.
- 80% of risk sources are from service providers and other people known to the individual (16%).
- Location where abuse is most likely to occur is in the adults own home, at 44% this is a 3% drop since 2016-17; the second most likely location is in a nursing care home, with 24% of concluded enquiries.

Capacity, Advocacy & support

- For concluded enquiries, 39% of adults were assessed as lacking mental capacity, a 2% rise from 2016-17; with 26% of adults recorded as having capacity (decrease of 3% since 2016-17). Recordings of either did not know capacity or not recorded account for 35% of cases.
- 74% of all adults under a safeguarding enquiry were supported, either by an advocate, a family member or a friend. This is an increase of 12% since 2016-17.

Risk outcomes

- 83% of enquiries were risk was identified the risk was either removed or reduced.

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

The Safeguarding Adults Collection

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

Changes to 2017-18 data requirements

In early 2016, the NHS Digital, in conjunction with the Safeguarding Data Collection working group, proposed some changes to the 2017-18 data collection, to better monitor Safeguarding activity. The final list of changes was published in the September 2016 letter to councils, having been approved by the Adult Social Care Data and Outcomes Board (ASC-DOB, jointly chaired by the Department of Health and the Association of Directors of Adult Social Services (ADASS) and the Department of Communities and Local Government.

In 2016-17, the Concluded Section 42 Enquiries Source of Risk values for Domestic Abuse, Sexual Exploitation, Modern Slavery and Self-Neglect were voluntary. These total counts are now mandatory. Due to additional types of abuse now being available for selection, it is difficult to ascertain whether the decreases / increases in these are a true reflection or if there is shift to the types of abuse now available; what we have seen this year is an increase in more than one type of abuse per concern being recorded. Due to the above changes, some measures may not be comparable year on year.

This will be the third year of the SAC, which is an updated version of the Safeguarding Adults Return (SAR) which collected safeguarding data for the 2013-14 and 2014-15 reporting periods.

Safeguarding concerns and safeguarding enquiries

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

Safeguarding Enquiries (Strategy Discussion / Investigation) is the action taken or instigated by the Local Authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult to a more formal multi-agency plan or course of action.

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

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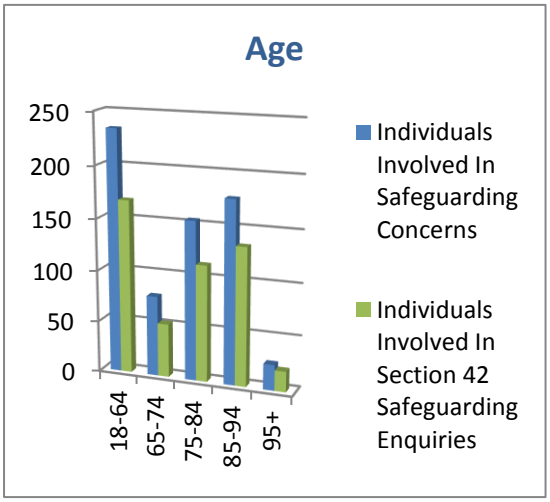
Profile of adults at risk

Prevalence of age /ethnicity/gender/mental capacity



Ethnicity

White British 92%
Asian/ Asian British 0.75%
Black/African /Caribbean /Black British 0.15%
Other ethnic group 0.6%
Undeclared/not known 5.5%

Gender

Male 40% Female 60%

Mental Capacity- Safeguarding Enquiries (Section 42)

39% lacked capacity
26% had capacity
35% unknown

What does this mean?

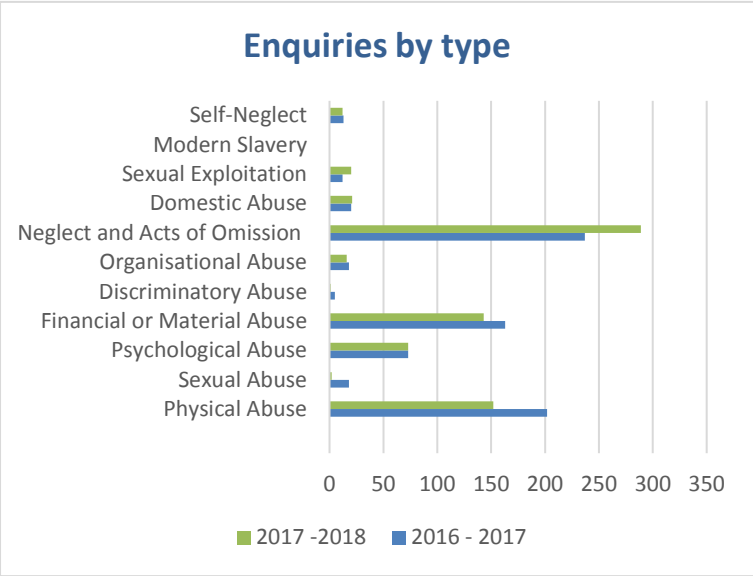
The prevalence of safeguarding concerns per age group can be seen as an increasing risk for the older population. That as people get older the risk continues to rise with over half the alerts relating to adults aged 75 years and older. This year there has been slight variation in prevalence, a decrease of 2% for adults aged 75-84 years old to 23% and a 2% increase for adults aged 85-94 years to 26%.
We have an aging population, with a projected 44% increase in adults aged 65 years plus living in Halton by 2036. This presents potentially greater demand for health and care needs over an increasing period of time. This year saw a slight increase in the numbers of adults who lacked mental capacity to make their own choices. Halton's demographics are changing, seeing an increase in diversity from ethnicity and gender perspectives for example Halton is home to a number of refugees and asylum seekers.

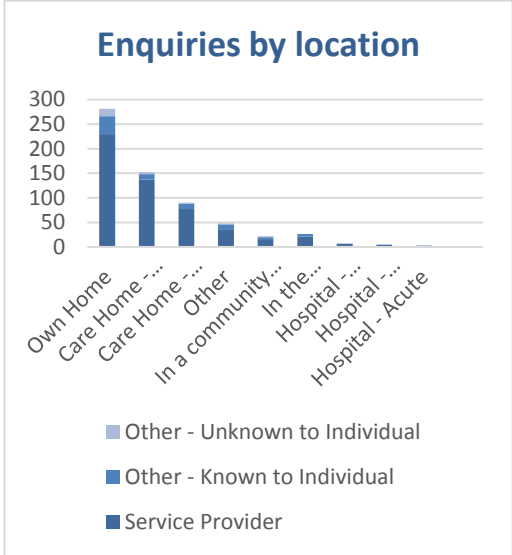
What can we do

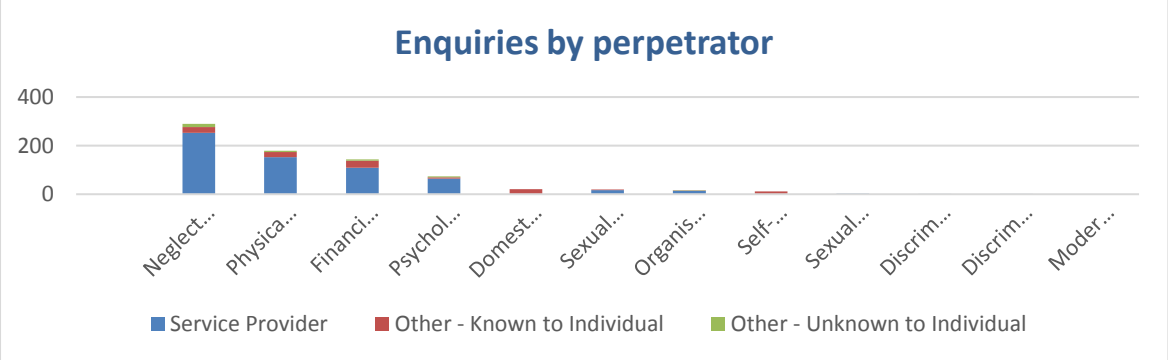
I. Capture diversity within our data- wider categories for gender and ethnicity, ensuring all data categories are completed.
II. All partners to be proactively inclusive and person-centred within their approach and a cultural approach with their service provision.
III. Scrutinise recording of mental capacity, whether this might be a need for training or awareness or may be due to systems improvement to conduct timely mental capacity assessments.
IV. Audit cases of safeguarding that include the highest indices of prevalence across type, location, age and perpetrator, to identify themes or trends.
V. HSAB to continue engagement with services /groups/ individuals including those representing minority populations, to increase participation and awareness across the borough and find more accessible ways to share safeguarding information.

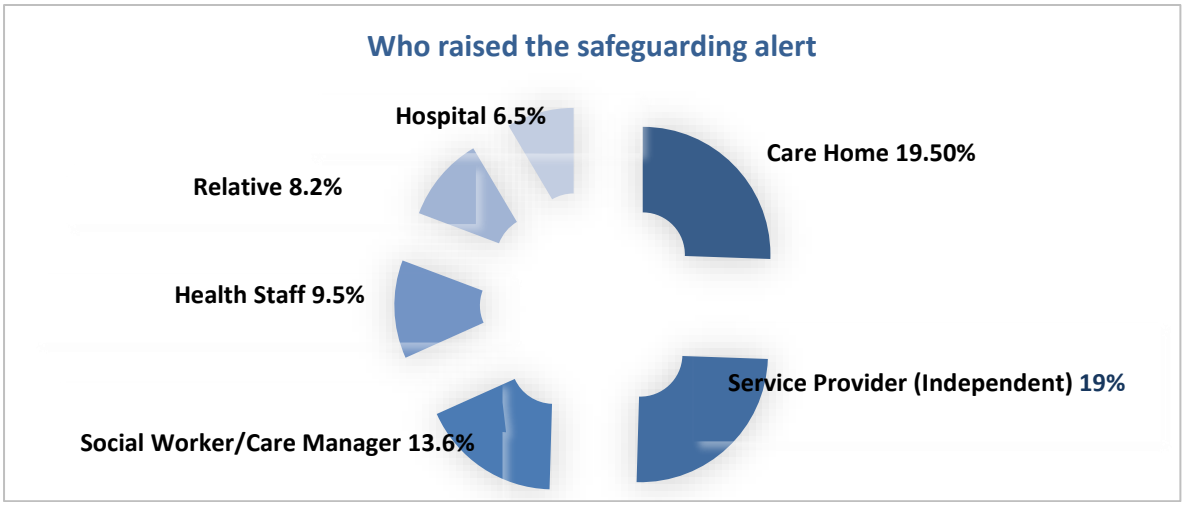
What has been reported

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









What does this mean?

Service Provider (independent) are services that work with or support adults who are receiving support or a care package, whilst they are living in their own home.
These figures are representative of all the safeguarding alerts that are received. Not all these referrals meet safeguarding criteria, for example, after an initial assessment, an alert may result in a review of a person's care plan where the adult is found to be not at risk of harm and therefore wouldn't need to be safeguarded. Anyone can make a referral and we can see the most common sources of referrals come from care homes, service providers (independent) and from social care/care management. There are significant referrals received from health sector and from relatives.

The top three most prevalent types of abuse recorded in the SAC remain the same as the previous 2 years with neglect and acts of omission continuing to rise and physical and financial abuse rates falling. 2017-2018 rates are: neglect and acts of omission increase of 8.6% to 39.6%, whilst physical abuse is down by 5.5% to 21% and financial abuse down 0.8% to 19%.

The most common location of abuse is the adult's own home at 44%, this year sees a drop of 3% from 2016-17 and a 5% drop since 2015-16 of section 42 enquires. There has also been a decrease in residential care homes by 3% to 14%, and there is an 11% increase this year to 24% of section 42 enquires from nursing care homes.

The predominant source of abuse is from service providers, up 10% on 2016-17. 13% of perpetrators were people known to the individual, this is a reduction of 7% from 2016-17. This year has also seen a reduction in rates of reporting from perpetrators not known at 4% compared to 7% in 2016-17.

What we also know from data gathered by Halton Domestic Abuse Forum around domestic abuse is older people aged 61 years+ are much more likely to experience abuse from an adult family member or current intimate partner than those aged below 60 years. That older victims are significantly more likely to have a disability (48% of victims aged 61 years+), for a third this is physical. Also, on average, older victims experience abuse for twice as long before seeking help than those aged under 61 years. In response Halton have strengthened the focus in the multi-agency domestic abuse awareness training to highlight and discuss domestic abuse and the implications it has on victims as well as ways in which it may manifest which are potentially different than in other domestic abuse situations due to the higher frequency of victims being dependent on the perpetrator for assisting them with day to day care requirements.
Training can be accessed by staff via www.haltonsafeguarding.co.uk/training.

There has been continued dedicated activity this year around medicines management which was highlighted within the area of neglect and acts of omission. Offering free specialist support, advice, resources and training to all care providers in Halton.

Most safeguarding alerts are raised by practitioners and professionals accounting for 88% of all alerts, with most coming from the care and support sectors. This is a positive picture meaning practitioners are proactive in reporting safeguarding concerns and working towards improved standards of care with a safe reporting culture.

What can we do

I. HSAB to continue to offer free resources including multi-agency training and marketing campaign resources to improve competency skills and improve practice. All resources are available on HSAB website www.haltonsafeguarding.co.uk.

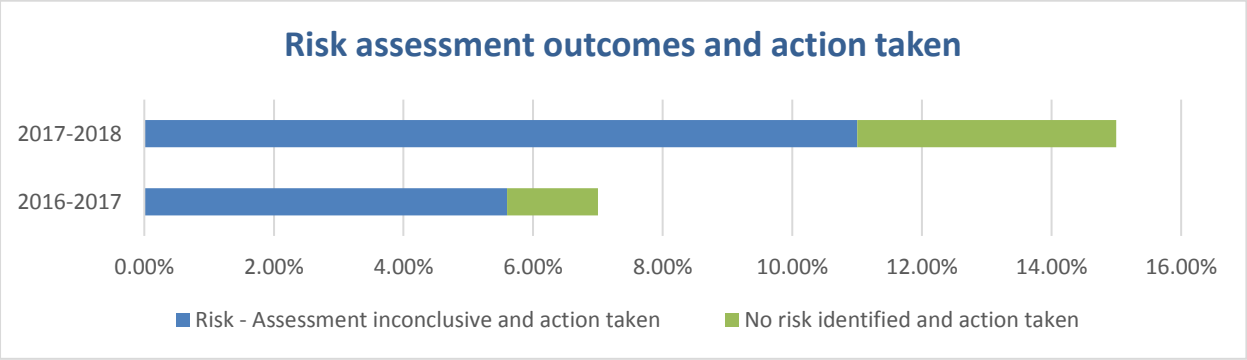
II. HSAB to continue engagement with services /groups/ individuals including those representing minority populations, to increase participation and awareness across the borough and find more accessible ways to share safeguarding information.

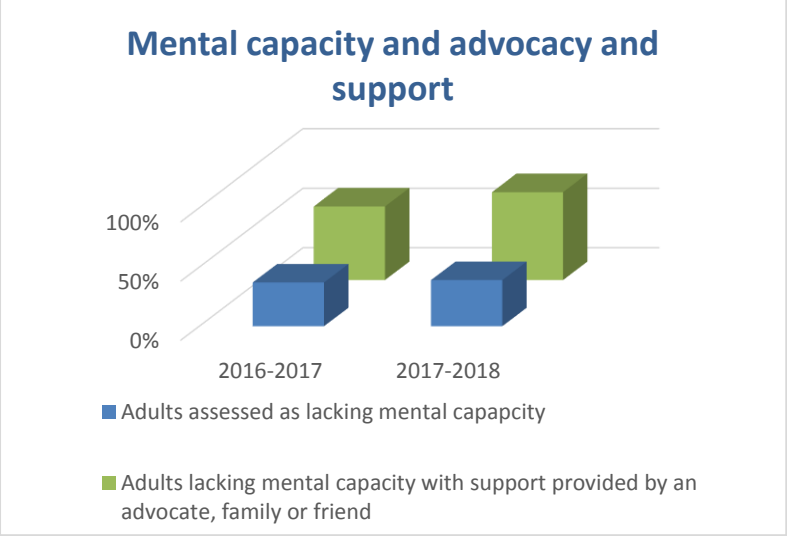
III. Audit cases of safeguarding that include the highest indices of prevalence across type, location, age and perpetrator, to identify themes or trends. This could enable a greater understanding of care and support provision from staff, carers and volunteers who attend an adult's home to support/care for them.

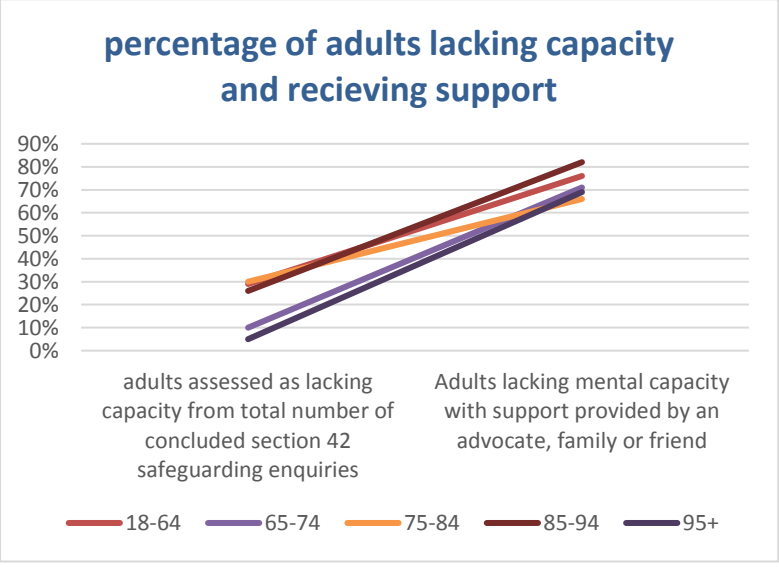
IV. All partners to understand their responsibilities in relation to knowledge, skills and professional practice, adopting 6 principles of safeguarding which is a person-centred approach and applies to preventing safeguarding alongside dealing with safeguarding concerns that are raised.

Profile of risk assessment outcomes and support

Risk assessment outcomes / mental capacity and advocacy and support







What does this mean?

During this reporting year in 92% of cases action was taken, this is a rise of 5% on previous year and we saw a drop in no action taken where no risk was identified from 6.6% to only 3% of cases. In total 83% of cases the risk was either reduced or removed and 74% of adults who lacked mental capacity received advocacy or support, an increase of 12% compared to 62% for 2016-17. We can see adults aged between 85-94 years received the most support at 82%, with 66% of adults aged 75-84 years old and 69% of adults aged over 95 years receiving support.

Every person has a right to choice and to decide what outcomes they would like. Adults at risk who have been assessed as lacking capacity will have their decisions made for them by a nominated representative and should always be considerate of the adult's personality, preferences and lifestyle choices that are already known, to ensure decisions are made in their best interest. There still remains a number of individuals who request no action to be taken even when there has been a safeguarding risk identified. This is due to many reasons but of the more common situations it can be where a person is being looked after by someone close to them, for example a family member. Halton safeguarding team listens to what outcomes the person wants and follows the Making Safeguarding Personal approach, that safeguarding balances the right to be safe with the right to make informed choices.

This data indicates a proactive approach to taking action, whether this is to provide safeguarding for an adult at risk or to assist with support and care plans for those adults who have not been assessed at risk of harm but may still benefit from services. This aids prevention of escalation, addressing emerging needs and early intervention can mean long-term reduction of safeguarding alerts.

What can we do

I. With a new advocacy service commissioned by Halton Borough Council, being provided by Healthwatch Halton, via a single point of access the accessibility of advocacy has already been considered and should provide easier and more efficient provision.
II. Partners can help by promoting and utilising the advocacy services to adults who may need this to ensure a proactive inclusive and person-centred approach within their service provision.
III. Capture diversity within our data- wider categories for gender and ethnicity, ensuring all data categories are completed.
IV. Scrutinise recording of mental capacity, whether this might be a need for training or awareness or may be due to systems improvement to conduct timely mental capacity assessments.
V. HSAB to continue engagement with services /groups/ individuals including those representing minority populations, to increase participation and awareness across the borough.

SECTION 3:

Here are two real-life experiences that provide an insight to the diversity of support needed in order to help safeguard an adult at risk. Names have been changed to protect the individual's identity and both have given consent to have their stories told.

The social care team work with the adult to help them get the help and support they need. Any adult who is receiving support makes their own decisions and choices about what they want to happen and all support staff work towards making this happen. This is called Making Safeguarding Personal and is described in the Care Act.

Making Safeguarding Personal is critical in adult safeguarding and is an important mechanism to enable individual experiences to be recognised and listened to and therefore achieve best outcomes as identified by the person themselves.

Both Alice and Paul demonstrate lived examples of how Making Safeguarding Personal and safeguarding has impacted their lives.

ALICE'S STORY

Alice

Alice was an 82 year old lady who lived in the community in her own home. Alice had a mental health diagnosis and had support with her needs, to help her remain as independent as possible. Alice lived alone, having been widowed some time ago.

Referral

A safeguarding alert was raised by her sister-in-law to the local authority. The sister-in-law, Sam, stated that Alice had been taken to a local clothes shop with a carer and the carer had spent a large amount of Alice's money on clothes for herself. The carer was a regular visitor to Alice, who she had grown to be fond of, so Alice was uncertain of what to do as she did not want to lose the relationship she had with the carer, who she considered as a 'friend'.

The alert was assessed and it was determined that a Section 42 enquiry was needed.

Requested outcomes

A social worker was assigned to Alice, who made arrangements to visit her in her own home. It was unclear on the alert what Alice's desired outcome was, so it became the priority of the social worker to obtain her desired outcome, compliant with the Making Safeguarding Personal approach.

The social worker visited and Alice was able to make her own decisions as she had mental capacity. Alice decided to proceed with the safeguarding enquiry and stated that she wanted to make a referral to the police. Alice was able to give details of which carer it was, so that arrangements could be made with the provider service to reduce the risks immediately.

Actions

The police were contacted and as part of the police led investigation, they asked an assessment was completed for Alice, to ensure she was able to manage her own finances. This assessment (Mental Capacity Act 2005) helped as it provided vital evidence and enabled them to proceed with a charge against the carer.
Before the case went to court, Alice sadly passed away through an unrelated health condition. The Police/CPS decided to continue with the investigation and the case went to court.

Review of outcomes: Safeguarding Social Worker statement

The carer pleaded guilty in court and was given a suspended sentence and rehabilitation order.

Although Alice passed away during the enquiry, her desired outcome was met. Family acting on her behalf was thankful for the support offered to Alice and them by the social worker.

What does this mean?

We can learn from Alice's experience how important the Making Safeguarding Personal approach is in order to identify the right outcome for the person and to help safeguard effectively. Using the Mental Capacity Act to assess mental capacity enabled successful completion of prosecution and to ensure Alice could make her own decisions around finances.
There is also some learning for practitioners around professional boundaries and understanding that building trust relationships are important in care and support provision but that this may impact on decisions that people being cared for might make.

What can we do

I. All practitioners to have an awareness that Making Safeguarding Personal is a cultural approach requiring working with individuals and utilising the six principles of adult safeguarding and that professional boundaries still apply.
II. For all partners to understand risks and choices and know where mental capacity is relevant.
III. For all partners to attain training and professional development to ensure current practice is compliant and safe.
IV. For carers and families to understand everyone has the right to choose what they would like to happen within safeguarding but also whilst they are being cared for.
V. HSAB to continue to promote the six principles of adult safeguarding.

PAUL'S STORY

Paul

Paul is a 55 year old made with a mild-moderate Learning Disability, who lived independently in a ground floor flat. Paul lived with his mother and father, but both passed away suddenly a few years ago. At that time, Paul remained living in the family home. However, he became a target by local youths and was subject to a sustained physical attack. As a result of this, he was relocated to his own flat where he resided at the time of the safeguarding alert.

Referral

A safeguarding alert was raised by his GP to the Local Authority. Paul had been in to see his GP with an injury. Paul has a sister but doesn't see her regularly. Paul disclosed to his GP that he had been assaulted by his 'friend' and he had an injury which needed treatment. The GP spent time with Paul who made further disclosures regarding his 'friend', stating that he takes his money and food off him, as well as forcing Paul to set fire to himself. The GP obtained his consent to make a safeguarding alert and followed local safeguarding procedures following some initial treatment for his injury.

The safeguarding alert was screened and assigned to a social worker.

Actions

A visit was undertaken to Paul's address. It became evident that Paul was struggling to maintain his own needs, including cleaning his flat, self-care needs as well as take his own medications. In addition to the concerns raised by the GP, Paul had acquired 10 cats and various items of junk from other residents in the block of flats. It became evident that he was being exploited as well as being subject to the concerns raised in the alert. The social worker spent time with Paul to go through each concern that he had, to inform what can be done next. All options were discussed with Paul and Paul agreed to a police referral, as well as a social care assessment, to look at how Paul can meet his own needs in the medium to long term.

In regards to the social care assessment, the safeguarding social worker made the appropriate referrals and organised a Multi-Disciplinary Team meeting, to pool information and determine actions. Paul was a part of this meeting. This included housing, health, social care, police and his GP. This provided Paul with a clear vision of what support can be offered, as well as focusing on what he can do for himself, building on his confidence and self-esteem to complete this.

Requested outcomes

In relation to the safeguarding concerns, Paul was reluctant to contact the police initially, feeling that he would be subject to further incidents and being called a 'grass'. Reassurance was offered and Paul accepted that he would initially speak to the police, as he had lost confidence in them following a previous incident. Paul agreed to a joint visit with the social worker and the police. Police were contacted at the time of the visit and they arrived to speak to Paul 1 hour later.

Paul felt reassured that the social worker stayed with him while the police visited him. Paul disclosed all the information to the police that had been shared previously and at the end, decided he wanted to officially make a complaint to the police. This resulted in interim actions being taken to prevent the person alleged to have caused harm from visiting/contacting him, which again gave Paul reassurance.

A police-led enquiry was undertaken. The police had asked Paul if he wanted to complete a video interview. Paul requested that the social worker needed to be present to support. This was facilitated by the police who wanted to achieve best evidence.

Review of outcomes: statement

The case went to court and although the person alleged to have caused harm pleaded not guilty, he was sentenced to 20 months in prison. Paul was happy with the outcome.

Following the initial concern, Paul expressed a desire to move home. He was supported by adult social care and housing and has now moved home, to a place where he feels comfortable. In addition, he now has a support package in place to continue to support Paul to maintain his independence and ability to keep himself safe, in the community.

What does this mean?

Paul's story provides an example of what is sometimes called 'mate crime' where an adult is befriended and whilst the adult may think the relationship is genuine the befriender then exploits and abuses. This is particularly difficult to manage when there are any support and care needs as the adult is more likely to be in an imbalanced power-dynamic relationship. To understand that some people enter relationships that are difficult for them to manage due to power and coercion.

We can also see how important the roles of other practitioners are in detecting and supporting safeguarding concerns. Here the GP was critical in helping Paul, he raised an alert and acted upon this immediately. Additionally a Multi-Disciplinary Team (MDT) was brought together with Paul to identify the best outcomes for him and this enabled an effective support and care package. Paul was supported by a range of services which provided a positive outcome.

What can we do

I. All partners to have an awareness of adult safeguarding, to enable effective and efficient response to abuse indicators. To attain training and professional development to ensure current practice is compliant and safe.
II. All partners to learn about 'mate crime' and abusive relationships.
III. For service providers to encourage professional curiosity and utilise models of multi-agency working within their provision.
IV. HSAB to continue to promote the six principles of adult safeguarding.
V. HSAB to continue engagement with services /groups/ individuals including those representing minority populations, to increase participation and awareness across the borough.

SECTION 4: LEARNING FROM REVIEWS

Under the Care Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews. Halton SAB commissioned a Safeguarding Adult Review (SAR) and Halton CCG commissioned a Multi-Agency Review (MAR) during 2017-2018 with resulting Action Plans derived to address the recommendations within these reviews. SABs also hold responsibility to manage and monitor the progress of Action Plans from all safeguarding reviews. Halton SAB also oversees the local reviews from the Learning Disabilities Mortality Review (LeDeR) Programme.

The Learning Disabilities Mortality Review (LeDeR) Programme

The Learning Disabilities Mortality Review (LeDeR) Programme is the first national programme of its kind aimed at making improvements to the lives of people with learning disabilities, commencing 2015 and now extended to May 2019.

The LeDeR was a recommendation from the Confidential Inquiry into Premature Deaths of People with a Learning Disability (CIPOLD); to conduct a review into why people with learning disabilities die and what can be learnt from their deaths with a view to improve the standard and quality of their care. The LeDeR Programme is delivered by the University of Bristol and is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The Programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR Programme also collates and shares the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

- Halton is part of the Cheshire and Merseyside LeDeR steering group and as such enables Halton to share learning from deaths locally and nationally.
- Halton currently has 10 reviewers, who are in the process of completing 4 reviews. They are all new to LeDeR reviews and although they are all practitioners, these will be their initial reviews.
- No reviews have been completed to date and when they have will be subject to rigorous quality assurance from the Local Area Contact and then a Multi-Agency Panel.

Safeguarding Adults Review and Multi-Agency Review

During 2017-2018 a Safeguarding Adults Review and a Multi- Agency Review was completed, along with Action Plans that addressed the recommendations within these review reports.

Practitioner learning events took place prior to the SAR report being written and during the implementation of the Action Plans; the SAR event was on 1/09/17 and MAR on 8/09/17. Frontline staff and service leads were invited to attend to share the learning from these reviews and to contribute to identifying appropriate activities to address the recommendations from the reviews. Attendees found the events helpful to their practice and a summary report was provided to HSAB.

Following the completion of the Action Plan activities, there was a recommendation to establish a SAR Group. This newly formed SAR Group requested an executive review meeting where HSAB members and invited stakeholders from the SAR and MAR review panels examined the whole process of commissioning reviews, the writing and implementing of Action Plans and identifying key learning outcomes. Also in attendance were representatives from North-West Borough Health, Halton Clinical Commissioning Group, Halton Borough Council, Warrington Safeguarding Boards, Police, Probation Services and the independent chair for Halton Safeguarding Adults Board (HSAB) and the HSAB Officer. The executive review meeting took place on 18/05/18 and an independent expert with specific expertise in reviews was invited to facilitate the meeting; Lisa Cooper, Deputy Director Quality & Safeguarding (NHS England North).

Some key learning from the reviews were:

- Both were young adults and mental and emotional health issues were present from childhood. Working more closely with children's boards was discussed and as mentioned HSAB have a representative from Halton Safeguarding Children's Board already on the HSAB. HSAB have now invited a representative from Public Health to attend future HSABs.

- Cross-border challenges were evident in the SAR process. Having an understanding of where responsibility lies when an adult moves to another area and/or transfers from children to adult services. The potential to address this gap in information sharing and/or handover via hosting a Multi-Disciplinary Team meeting when a person is identified meeting this criteria was discussed. Cross-border principles to be agreed and will then be shared. Additionally, it was felt agreement is needed on who will hold agencies to account and bring this cross-border agreement together.

- People being 'invisible' to services or not being 'picked up' by services was also discussed. The challenge that some adults are not known to services was recognised as difficult to address. Potentially this links with recognising significant events/traumas/family problems identified during childhood can have a significant impact on adulthood.

- Personalisation within the review and learning could be improved, e.g. age, gender, nationality, culture, details to demonstrate inclusivity and capture whether this person is representative of Halton. An understanding of whether this influences information gathering, service provision and practitioner learning.

- To capture professional curiosity within reports. Generally to encourage this in practice and recognise this is usually built from experience. Conversations with practitioners (including provider visits by HSAB) towards building a culture of professional curiosity.

Work continued into 2018-2019 reporting year and these updates will be provided as part of the ongoing learning process to and from HSAB to all its partners and across the wider Halton community.

There has been a lot of development nationally around SARs, given that Safeguarding Adults Boards generally are still in their relative infancy of development and there have been many and varied mechanisms by which SARs have taken place. All Safeguarding Adults Boards were invited to participate in a National Consultation process and Halton SAB was part of this. The learning from this research has resulted in a National SAR Library, where all local authorities who have undertaken a SAR shares the learning and resources, so that safeguarding adults reviews nationally can offer a more consistent and effective approach.

What does this mean?
Positive proactive approach to the learning process enabled multi-disciplinary understanding across adult and children's sectors and across geographical boundaries between authorities. Having independent reviewers and learning event facilitators enabled effective assessment and evaluation of the process. 360 learning approach has allowed learning events for all stakeholders, to fully participate including HSAB members and HSAB will continue this as an ongoing process utilising the newly formed SAR Group as a mechanism for sharing good practice. HSAB partners identified in the reviews and all those that attended the learning events demonstrated commitment to safer practice and safeguarding prevention. That HSAB are prepared with SAR Group, family liaison established guidance for any commissioned SAR that may be requested or needed. Enabling a more efficient and timely process that is focussed on the recommendations and activities that put the recommendations in to practice. Access to the National SAR Library- where shared learning and resources and models of good practice can be accessed.
What can we do
I. All partners including frontline staff are aware of their responsibility to learn from Safeguarding Reviews and Action Plans, to consider implications within their own working/ service areas. II. All partners to have an awareness of adult safeguarding, to enable effective and efficient response to abuse indicators. To attain training and professional development to ensure current practice is compliant and safe. III. For service providers to encourage professional curiosity and utilise models of multi-agency working within their provision. IV. HSAB to continue engagement with services /groups/ individuals including those representing minority populations, to increase participation and awareness across the borough.

SECTION 5: PROGRESS AGAINST OUR PRIORITIES

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

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

The following is a snapshot of the work and activities from Halton Safeguarding Adults Board, it's sub-group and partners, that took place during 2017 to 2018.

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

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

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

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

Subgroup and partner activity

- Halton Borough Council-Adult Social Care

Adult Social Care undertake the majority of Section 42 safeguarding enquiries on behalf of the Local Authority. Social Workers and Occupational Therapists are the regulated professionals within the service and their professional practice is a vital part of Making Safeguarding Personal and ensuring positive outcomes. The Principal Social Worker sits on the Partnership Board in order to advise and support and provides regular performance reports to both Boards.
Developing resilient communities and introducing the role of community connectors will further enhance the prevention agenda and ensure that Halton is a safer place to live.

The Integrated Adult Safeguarding Unit (IASU) is an operational front line team, who coordinate Section 42 safeguarding enquiries to complex/high risk safeguarding concerns that are raised.
IASU has strategic lead in key areas for Halton such as Self Neglect, Anti-trafficking, Persons in a Position of Trust (PIPOT), Mental Capacity Act and the Deprivation of Liberty Safeguards.
IASU has responsibility to ensure that there is an established process for Safeguarding Adults with key stakeholders such as North West Boroughs and the Gateway Recovery Centre. A focus on these two stakeholders within the past year has resulted in better outcomes for people who use their services, from a safeguarding perspective.

IASU coordinate the Safeguarding Champions forum for provider services and the MSP Forum for Care Management Staff within the Local Authority. IASU attend and support Multi-Agency Risk Assessment Conference (MARAC), Anti Trafficking forum, Halton Domestic Abuse Forum (HDAF), and the Faith Sector Forum.

Other areas of Adult Social Care (ASC) include Adult Placement Service, Halton Supported Housing Network and Halton Day Services. All ASC follow the safer recruitment process, which keeps close links with Human Resources, providing safe recruitment and efficient DBS checks. The staff induction process that follows includes Care Certificates for staff and good shadowing processes.

There are good links across services with the Safeguarding Unit and Initial Assessment Teams and provider services which helps to break down barriers and staff are confident to report and seek advice. Also good links with carers and general groups helps build good community links and so it's easier to listen to what peoples' need are.
These additional ASC services have led on creating and attending events to promote people's awareness, supporting staff to develop and attend events. Questionnaires for people who uses services/staff/carers have been created with activity promoting all actions from questionnaires.

- Halton Clinical Commissioning Group:

NHS Halton CCG is a statutory NHS body with a duty to safeguarding adults.
NHS Halton CCG as a commissioner of local health services has contractual and performance frameworks in place to assure that the organisations from which they commission have effective safeguarding arrangements in place, including recruitment, policies and training.

NHS Halton CCG is responsible for securing the expertise of Designated Professionals on behalf of the local health system.

A clear line of accountability for safeguarding is reflected in the CCG governance arrangements.
NHS Halton CCG has actively contributed to and supports the Halton Prevention Strategy and action plan.

NHS Halton CCG has contributed to the Halton Care Homes Development Strategy and continues to support the development of safe, quality, services within the care homes sector.
NHS Halton CCG has supported the development of the Well Halton vision and initiative to improve the health and well-being of everyone in borough.
NHS Halton CCG has undertaken joint work with IASU to improve the safeguarding referral guidance for staff especially in respect of medicines management.

NHS Halton CCG and HSAB are actively working with Halton LA to align key aspects of the Prevention, Loneliness and Wellbeing strategies to make Halton a safer place to live.
Public engagement and co-production underpins all aspects of commissioning and service review and design undertaken by Halton CCG. The CCG requires its commissioned services to report on Making Safeguarding Personal and Voice of the Child through quarterly performance reporting.

The CCG has a comprehensive engagement plan where there is opportunity for consultation and engagement. There have been a number of stakeholder events prior to service redesign to ascertain the voice of the service users locally. These include support to the Halton Peoples Health Forum. A detailed engagement plan focused on the changes within CAMHS and the development of the thrive model and work with the young LGBTQ community in collaboration with Addaction.

- Public Health

PH supports a number of services that focus upon the wider determinants of health (e.g. Substance Misuses, 0-19, Family Nurse Partnership, Health Improvement, etc.). Adults are supported to manage drug and alcohol problems (see Successful Treatment for Opioids and non-representation within 6 months – PHOF data).
Part of wider Safer Halton Partnership with strategic oversight of community safety.
Implementation of Suicide Strategy and Alcohol Strategy.
Development of Obesity Strategy.
PH commissioning seeks to ensure the voice of service users, partners and other stakeholders are at the heart of service redesign and delivery. e.g. public questionnaire

- St.Helen's and Knowsley Hospitals

Identification of potential safeguarding issues improved by policy implementation and training.
Staff are able to access support from the safeguarding team when concerns are identified.
STHK has patient experience lead and council who ensure patient contribution and participation is a priority within the Trust.

- Warrington and Halton Hospital Foundation Trust (WHHFT)

A multi-agency approach to safeguarding adults has supported this priority. There are processes in place between partner agencies that facilitate the scrutiny of concerns that are raised. Training and education have supported awareness raising of the safeguarding agenda across the Trust. New standalone policy was developed 'Managing Safeguarding Allegations Against Staff & People in Position of Trust (Pipot) Policy' ensure there was clear guidance on managing allegations against staff and volunteers working with children and/or adults at risk in line with those of the HSCB and HSAB.

- Bridgewater

Practitioners from Bridgewater have been able to highlight concerns within residential care setting and refer these to Social Care for further investigation. In some cases this has been directly related to the person in the care home but on other occasions practitioners have identified wider safeguarding and care concerns, recognised these and took action to report them to the local authority.

Hearing the voice of service users and the principles of Making Safeguarding Personal, are included within Bridgewater's Level 3 Safeguarding Adults training package. The outcome from this was particularly apparent with a practitioner within the Speech and Language team and her support for two different individuals and the risks they wished to take with eating and drinking.

- Northwest Borough Healthcare Trust

The Safeguarding Adult team has expanded during the reporting year with the addition of a second Advanced Practitioner post into the team. This has allowed for increased support to the Halton borough and a refreshed approach to partnership working. The Safeguarding Adult team have co-located themselves within the borough to increase opportunities to support staff and be more visible across the Trust. Work has been undertaken to examine health referrals into safeguarding with joint training and awareness raising being implemented with our local authority partners.

All care is delivered under the Care Programme Approach which promotes working with the service user. Care plans are required to be signed by the service user as a standard expectation. This is audited frequently to ensure the standard is met. Service users are asked to complete patient experience questionnaires both in community and in-patient environments so we can review the impact we are having within services.

The Trust has a service user forum which has a "take it to the top" section whereby a senior leader will attend to answer any questions, address concerns raised directly with our service user groups.

The Trust has a successful Involvement Scheme where a team supports service users and carers to participate in Trust activity. This includes attendance at Trust Board meetings, interviewing potential new staff, completing audits and running service user activities

- Halton Haven

Ensuring the Hospice Safeguarding, DOLS and Mental Capacity Policies are in place and reviewed regularly.

The Hospice conducts Patient and Carer Surveys to gain feedback on our service provision. Comments and suggestions are reported to the Board of Trustees and actions taken as appropriate.

- Cheshire Fire and Rescue Service

Completion of 7965 safe and well visits to residents of Halton.

- North West Ambulance Service

The Safeguarding Team in NWAS provide training and information on a wide range of issues such as Child Sexual Exploitation (CSE), hoarding and domestic abuse to raise awareness across the Trust. Assurance is provided to the NWAS board and director through regular safeguarding assurance and performance reports.

Regular topics are covered in formats such as seven minute briefing and learning lessons to quickly get awareness and information out to staff. NWAS has been acknowledged as having an extremely high level of Prevent awareness in the organisation. We currently have 93% of staff trained and we are one of the top 3 organisations in the country which has been acknowledged by NHS England. NWAS has also provided Prevent training to all staff.

The Safeguarding Manager and practitioners support information sharing between the LADO/PIPOT and the Trust HR department. NWAS has an allegations against staff policy which is adhered to in relation to any allegations made.

The Safeguarding Team has undergone enhanced DBS checks. NWAS Safeguarding Policy reflects the procedure to be followed when unregulated visitors are NWAS premises or support the organisation. NWAS conforms to safer recruitment practices and has a DBS procedure in place that reflects current national guidance. Mandatory employment checks are carried out on all staff prior to commencement of employment.

- Cheshire and Greater Merseyside Community Rehabilitation Company

In delivering Probation services, the work of CGM CRC is underpinned by desistance theory and characterised by a strength based approach. Personalisation is key to our work with all service users in which we seek to balance the needs of these service users to reduce reoffending against the risk they pose to members of the public. The safeguarding of both the adult service users we manage and those affected by their behaviour is central in our service delivery.

The CRC is contractually obliged by the Ministry of Justice to undertake service user feedback surveys every 6 months. This allows for those directly affected by our work to articulate the impact that it has on them. We have also developed a service user council group and 'User Voice Forum' which enhance our understanding of service user issues and experiences and which allows us to work collaboratively with the service users to support change where necessary and

practice improvement in all areas including safeguarding as and when appropriate. These processes are in turn overseen by several operational managers within CGM CRC who lead on service user engagement and help facilitate the person-centred culture within the organisation. In terms of front line work linked to child and adult safeguarding, we routinely engage with service users whereby safeguarding and vulnerability issues are discussed and interventions offered. Our induction and assessment processes with service users are designed to enable vulnerabilities and/or needs to be identified and planning for the monitoring of these where necessary and the introduction of appropriate interventions and signposting. The scope of our assessment draws out any concerns an individual may have and supports the professional case holder in recognising areas where they may need support. We offer support to vulnerable people and we operate a culture of empowerment and encouragement.

The CRC is subject to annual Operational Assurance Audits. This process is external and focusses on our strengths and areas for development. CGM CRC shows strengths in: establishing Practice Days on a monthly basis and ensuring that child and adult safeguarding is a key module on the Virtual College and accessible to staff.

Our areas to focus on include: more specific sentence plans; acting on risk management information, this will sit within the Quality Improvement Plan.

- Halton Provider Forums

Awareness sessions on care concerns and safeguarding offered by IASU during Provider Forums. Skills for Care; "What Do I Need to Know About Safeguarding Adults?" booklet highlighted. Consistent safe practice across Providers in Halton, ensuring compliance to local and national guidance and therefore reducing potential care concerns and safeguarding alerts

- Halton Domestic Abuse Forum (HDAF)

HDAF representative participated in the development of the Safeguarding Prevention Strategy Action Plan.

Operation Enhance - Increased victim engagement with protection and support services earlier in the cycle of domestic abuse. Operation Enhance initiative led to significant improvements in the service provided to victims of domestic abuse and victim engagement with a wide range of services. The key recommendation therefore follows that more widespread commissioning of this service will serve to benefit victims lives in the immediate aftermath of an abusive incident, their lives in the long term regarding recognition and escaping abusive relationships as well as allowing Cheshire as a force to improve victim trust/satisfaction/engagement.

Increased support for children living with domestic abuse to be safer and develop their resilience. Challenge and support for perpetrators to reduce current and future risk. Provided additional capacity for victim support services at the first possible opportunity to enable learning and evaluation evidence to inform the design of future commissioned services

- Healthwatch:

Regular 'Enter & View' visits to local health & social care services, intelligence collected during Enter & Views has fed into national reports from Healthwatch England.
Gathered 370+ comments and 500+ completed surveys on local services through the Healthwatch Website Feedback Centre.

- Age UK Mid-Mersey

Age UK created a partnership with local trading standards office to ensure clients were protected from scams and door step pressure sales/cons. Older people were made more aware of how to tackle and be more resilient to "scamming" approaches and are supported to find redress.

We introduced "champions" in staff teams to deliver targeted loneliness and isolation programs, funded internally. Introduced a new telephone befriending scheme – 'Call in time' to offer capacity assistance to face to face service.

We promoted and supported Halton Open and other engagement groups. We helped and supported older peoples engagement groups to build it membership and capture local voices.

- Department for Work and Pensions (DWP)

All staff at the job centre have had a safeguarding update. All know who to contact if they thought there was a safeguarding issue.

- Change Grow Live (CGL)

CGL provide representation at Safeguarding Adults Partnership Forum. Contributed towards discussions within the Partnership Forum. Shared learning within the CGL team provided from CGL representative.

- Trading Standards

Responded to doorstep crime incidents, and raised awareness with neighbours. The victim should be better protected against future incidents and better able to deal with cold callers. Provided 'No Cold Calling' cards and letterbox stickers to victims and made them available to all residents via Halton Direct Links. Cards and stickers should deter some cold callers and provides advice on how to handle them.

Issued press releases and iCAN messages to warn residents of doorstep crime incidents and scams. General awareness raising activities should help residents to better able to protect themselves from rogue cold callers.

Issued press releases and a short video about loan sharks. Raising awareness amongst the general population of loan sharks should help residents to better able to protect themselves from loan sharks.

Prosecuted two rogue builders who had preyed on people who were in vulnerable situations and publicised the cases by press releases and iCAN messages. Prosecutions punish the offenders,

deter other likely offenders and demonstrate to the community that action is taken to protect the community.

Prosecuted a seller of counterfeit cosmetics, perfumes, GHD hair straighteners and publicised the case by a press release and iCAN message. Prosecutions of counterfeit goods can deter likely offenders and removes potentially unsafe goods from the market.

Dedicated scams officers work with individuals who have been caught out by scams, local groups and services to raise awareness of scams and to provide advice on how to avoid being scammed in the future. Scams can have a massive effect on the well-being of individuals, their mental health, confidence and relationships with others as well as their finances. Our work is intended to reduce the impact of scams in Halton.

- Halton Housing Trust

We offer support for new and existing customers, including debt management and maximising income, providing a gateway to other support agencies. Assisting customers to sustain their tenancy.

- Halton Carers Centre

Ensure referral pathways are appropriate for all stakeholders and widely marketed. Met with other sub-group members to ensure referral pathways are adequate. Smoother transition between services.

- Halton Disability Partnership

Following successful Lottery grant there is a reconfigured service for safeguarding adults focus, to allow expanded safeguarding service. Currently 300 Safeguarding Reviews (all existing caseloads).

- Faith Sector Forum

  - Discussed and dealt with safeguarding concerns within the faith sector.
  - Publicised the Herbert Protocol widely and encouraged people to use it.
  - Carried out and updated DBS checks.
  - Updated the faith leads' and safeguarding representatives' contact details.
  - Discussed personal safety for ministers/volunteers who are alone, including security measures.
  - Circulated the Sports England safeguarding adults document.
  - Chaired Faith Forum meetings.
  - Shared intelligence between areas.
  - Attended the Adults' Prevention Strategy Prevention task and finish group in February.
  - Disseminated safeguarding information to faith sector contacts.
  - Discussed and disseminated the Pan Cheshire Modern Slavery Strategy's launch.
  - Discussed and disseminated the People in Positions of Trust Strategy.

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

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

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

Following the success of HSAB's first Awareness Day Event in March 2018 the board have made a commitment to host annual Awareness Days and take more opportunities to raise the public profile of safeguarding adults and the work of the HSAB. PCC David Keane was invited to this event and said it was the first event he had been invited to from a Safeguarding Adults Board. The event also invited an expert by experience Iris Benson, who was very warmly received. Iris shared her personal story which delegates found very powerful, moving and positive. Iris was described by many as *'inspirational'*. HSAB will continue to engage with service users and members of the public as well as practitioners and formal and informal carers to establish strong partnership links across the community and strengthen the work of HSAB further, keeping work relevant and accessible.

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

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

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

Subgroup and partner activity

- Halton Borough Council-Adult Social Care

All services contracted to provide care and support are required to ensure there staff undertake relevant safeguarding training. This is monitored through the quality assurance / contract compliance process.

The Integrated Adults safeguarding Unit (IASU) supports a positive learning and culture across adult social care. IASU have completed bespoke awareness sessions for provider services, focusing on Safeguarding Adults, Care Concerns, Mental Capacity Act and Deprivation of Liberty Safeguards. This has provided HSAB with areas of focus for the training sessions. IASU has implemented internal governance arrangements, focusing on Safeguarding Enquiries and completed Best Interests Assessments (DoLS), providing feedback to the individuals/teams, to ensure Social Work Practice remains evidence based and defensible.

IASU have led on a workshop within the SAB event in March 2018, focusing on Safeguarding Adults and giving an overview of the team, what safeguarding means to us and providing information and advice to attendees, from a range of backgrounds such as informal carers, the police, faith sector and care staff.

As part of the work undertaken with the unit, we regularly support the Quality Assurance Team and the regulator CQC in monitoring and the sharing of information/intelligence, to ensure that any specific issues can be addressed; which includes the validity and effectiveness of training and support offered by provider services, to their workforce. This information is usually obtained through safeguarding enquiries and forms part of the preventative approach undertaken by the unit.

The Principal Social Worker chairs the Social Work Matters Forum which shares ideas, concepts and research for practitioners. Six Social Workers have been trained as Action Learning Set facilitators to ensure learning and reflection around cases. Social Workers attend the Making Safeguard Personal practitioner group for support and guidance from the Integrated Adult Safeguarding Unit.

Training is provided for all staff including face to face, e-learning; and the use of competencies e.g. care certificate, creating work sheets to build on staffs' knowledge with use of CQC KLOE. Staff are continually reminded about safeguarding not only in training but part of their supervisions and support visits. Seniors attend the Safeguarding Champions meetings and then cascade information learned across their teams and service area. Creation of good quality induction processes and training, using the 15 care certificates and safe practices to induct staff/volunteers/agency workers.

- Halton Clinical Commissioning Group:

Supporting the development of a positive learning culture across partnerships for safeguarding adults.

NHS Halton CCG supports it's workforce to access appropriate training and development in respect of safeguarding adults.

NHS Halton CCG requires commissioned services to understand the training needs of staff and provide the appropriate training to meet needs and provide safe effective care.

NHS Halton CCG provides expertise and support to primary care services in Halton to raise awareness, knowledge and skills in respect of adult safeguarding. A network is in place for safeguarding leads underpinned by practice visits and training as identified.

Input to Pan Cheshire work-streams/training to support adult safeguarding agenda.
NHS Halton CCG supports and scrutinises engagement from commissioned services with the safeguarding agenda for Halton. There is also active engagement with neighbouring CCG areas to ensure NHS Halton CCG have oversight of additional providers who may potentially deliver services for the population of Halton.

NHS Halton CCG has a contractual quality and safeguarding performance framework in place with commissioned services and will escalate any identified risks as appropriate.

One GP Practice from NHS Halton CCG has voluntarily acted as a PILOT site for the NHSE online virtual college Section 11. The scope of this will be expanded within the subsequent reporting year and the CCG are keen to include all GPs. The online tool reports assurance in respect of safeguarding children and adults at risk.

A local area contact is identified in the CCG for the LEDER reviews. The CCG have also identified and trained reviewers. The CCG actively contributes to the LEDER reviewing process.

The CCG and the commissioned providers have undertaken a Lampard self – evaluation with this reporting year and all the providers have detailed a reasonable level of assurance. This has been directly reported to the HSAB and HSCB. Safer Recruitment is part of the NHS standard contractual framework. This framework ensures all CCG and health providers follow safer recruitment guidelines.

- Public Health

Commissioned services are required to undertake mandatory training. The Health Improvement Team (HIT) provide training in areas such as self-harm, MECC, etc. The Mental Health Team also provide local Mental Health Hubs. Health Trainers offer NHS Health Checks, Workplace Health, and Impaired Glucose Resistance (IGR) work.

- St.Helen's and Knowsley Hospitals

STHK has a dedicated safeguarding adult training needs analysis ensuring all staff within the trust are trained to the recommended level in relation to safeguarding adults

- Warrington and Halton Hospital Foundation Trust (WHHFT)

Multi-agency training is made available to trust staff. Learning from Serious Case Reviews is shared via the trust joint adults and children's safeguarding committee and also incorporated into face to face training. TNA's provide training guidance to staff. Safeguarding at the trust has been reviewed, the Trust uses eLearning for level one and two adult safeguarding. The adult safeguarding team deliver level three face to face training twice monthly across both Halton and Warrington sites. Following cross site daily WRAP training sessions the trust has increased awareness of the prevent agenda, updates are provided on a three yearly basis. Trust staff have had access to computer desk top safeguarding information and the adults team have used promotional stands to raise awareness of adults at risk. The adult team have delivered single point lessons and seven minute briefings.

A training resource has been written and a safeguarding resource file has been produced for all areas. The file contains information and flow charts explaining referral processes for all aspects of safeguarding. The file contains contact numbers and guidance for staff to refer to and follow, for example, MCA /DoLS domestic abuse, modern slavery and self neglect. Trust staff also have access to a safeguarding adults web page via the Trust intranet hub. The web page contains SOP's video's and guidance about all aspects of safeguarding. The Trust solicitors have been asked to assist the Trust in its training provision.

The care of patients with a Learning Disability has undergone a recent audit, the audit looked at how we care for our learning disability patients and how we accommodate their reasonable adjustments. Work is underway on an emergency care pathway, trust wide easy read documents have been written, we have an LD policy and a flagging system for in patients, work is about to begin on flagging outpatients.

MCA training has been supported by weekly (currently daily at time of report), staff have been exposed to single point lessons and 7 minute briefings in order to support knowledge and practice. A training aide has been written. Staff complete an electronic daily capacity check form which details patients who may lack capacity staff describe how they are managing their patients and what the outcome is. The form is submitted to the adult safeguarding team for quality checking, this happens on the day the form is submitted and advise is given as soon as the form is reviewed.

- Bridgewater

Bridgewater provides Level 2 Safeguarding Adult training via e-learning for all staff. Team leaders in clinical roles will also undertake Level 3 training.

There is a good working relationship with Halton Integrated Adult Safeguarding Unit and the Named Nurse Safeguarding Adults at Bridgewater. This has facilitated information sharing both where concerns have been raised about practice within Bridgewater, and where Bridgewater staff have raised safeguarding concerns about individuals in the wider community.

- Northwest Borough Healthcare Trust

The Trust has a robust, mandatory Safeguarding Adult at Risk training programme. This is supplemented by a variety of bespoke training programmes on issues such as domestic abuse,

Prevent and Mental Capacity Act. We have run two highly successful conferences in the reporting year which were fully booked within weeks. The conferences tackled subjects such as exploitation, modern slavery and trafficking.

The Trust has engaged with all case review processes within the reporting year. We have been key panel members of the Halton Safeguarding Adults Board SAR and MAR. We have supported practitioner forums for operational services involved with the cases. The Trust has a lessons learned forum whereby all cases are taken to share learning which is supported by the Safeguarding Team.

The Trust provides mental health and learning disability services to the Halton borough. As such we are required to complete comprehensive safeguarding assurance tools and meet NHS Contractual Standards for Safeguarding which are monitored by the Halton Clinical Commissioning Group. This data set is shared with the health sub-group to the respective Safeguarding Boards.

- Halton Haven

Hospice staff have annual safeguarding training updates. A workforce which is aware and understanding of safeguarding issues and know what to do if they suspect someone is at risk.

- Cheshire Fire and Rescue Service

Annual completion of Adult Safeguarding Training for all members of staff as well as awareness raising sessions for station managers and members of the fire investigation group. Greater understanding amongst members of the service with regards how to identify and raise safeguarding alerts.

- North West Ambulance Service

The safeguarding team have reviewed the training needs analysis to ensure relevant staff groups receive level 3 safeguarding training. The safeguarding team and clinical support hub provide advice and support for staff 24/7.

The Safeguarding Team has been in contact with all its Safeguarding Adult and Childrens Boards and maintains a log of meetings and minutes received. NWAS provides information and reports to all Local Safeguarding Childrens Boards and Local Safeguarding Adults Boards as requested.

Any learning from Serious Case Reviews (SCR), Safeguarding Adults Reviews (SAR) and Domestic Homicide Reviews (DHR) are added to the corporate action tracker. Practitioners engage in the review process and are able to provide perspective.

NWAS reports safeguarding figures to the board and the safeguarding team is currently looking at data mapping of the concerns raised to provide any patterns or trends. NWAS raise concerns to social care.

- Cheshire and Greater Merseyside Community Rehabilitation Company

Throughout 2017 and 2018 CGM CRC has sought to develop and improve child and adult safeguarding knowledge and practice. This has focussed on developing staff awareness and supporting staff training and supervision. The creation and improvement of Quality Assurance measures which are described below, has also been a focal point of the development of safeguarding practice. The establishment of clear lines of accountability and improved processes throughout the organisation is an ongoing priority.

The CRC introduced the Interchange Quality Assessment Model in 2017. Since that time, 4 quarterly reports have been published that shows improvements in the quality of Safeguarding Children and Adults. This includes: timely risk assessments; requests for Domestic Abuse Perpetrators in all cases; swifter access to interventions such as the HELP programme. The Building Better Relationships Accredited Programme ehlps with improvement in compliance; swift enforcement of non-compliance and a reduction in reoffending.

As with all quality assurance models, there remain areas for further improvement in respect of which CGM CRC have developed a Quality Improvement Plan. This is held by the senior strategic lead and visited for progress monthly.

- Halton Provider Forums

Provider Forum has provide opportunity for raising awareness of care concern and the safeguarding model.

Also awareness and discussion about HSAB website: www.haltonsafeguarding.co.uk. MUST tool awareness re; nutrition. Safeguarding Annual Report discussed with providers at forum. This ensures we have staff that are confident and competent in understanding and responding to potential safeguarding indicators and care concerns which enables appropriate and effective referrals to safeguard.

- Halton Domestic Abuse Forum

At least 8 sessions of free multi-agency domestic abuse training is available in the Borough with an addition four dates for sexual assault services. Have staff that are confident and competent in understanding and responding to potential safeguarding indicators and care concerns which enables appropriate and effective referrals to safeguard.

HDAF representative attended HSAB awareness event and disseminated learning from a range of workshops to all staff. Followed up with in service discussions. Staff have ability to learn from peers and engage with other community services to build capacity and resources to aid robust safeguarding practices.

- Healthwatch:

Working in partnership with the HBC Quality Assurance team and attending Care Home and Home Care Forums.

- Age UK Mid-Mersey

Staff teams in Halton were encouraged to attend safeguarding training and awareness. Our induction policy was expanded to include safeguarding priorities. Three staff team leaders completed the course and continued to trickle down learning and experience to colleauges.

- Department for Work and Pensions (DWP)

Awareness session covered for complex needs and safeguarding. Staff all have specialised subjects for vulnerabilities.

- Change Grow Live (CGL)

All CGL staff complete internal safeguarding adults training. CGL staff promote campaigns to raise awareness of support available for those requiring additional service support e.g. Domestic Abuse information. Competent staff recognise when safeguarding adult issues arise during case coordination. Service users aware of support available, assertive engagement within services for those required.

CGL Halton increasing to two designated safeguarding leads for the Halton service. Supervision specific to discussing safeguarding cases available for staff, providing support and oversight.

- Halton Carers Centre

All staff attend safeguarding training, raised at every team meeting and discussed at Trustee meetings.

- Faith Sector Forum

- Reviewed the Safeguarding in the Faith Sector event from March 2017.
- Training needs identified at Faith Safeguarding Event: Street Pastors re referral process; more detailed information on internet safety re adults at risk as well as children and young people; safer recruitment and management of volunteers.
- Trained Eucharistic Ministers who visit people in their homes.
- Used the term “people at risk or at risk of harm” rather than “vulnerable adults”.
- Wrote and disseminated widely, safeguarding newsletters through the Parish weekly newsletter and to faith sector contacts.
- Had discussions with some faith contacts and others about compiling a report for the two boards, which details many safeguarding issues/potential safeguarding issues prevalent in Halton - compiled most of this report and circulated it widely. Sought agreement to have representation from the faith sector on the Halton Child Poverty Group.
- Helped to plan, organise and introduce the Borough-wide Development Day.

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

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

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

Subgroup and partner activity

- Halton Borough Council-Adult Social Care

All staff receive Mental Capacity Act (MCA) training and all appropriate staff are trained as Best Interest Assessors and undertake applications to the Court of Protection. Staff use the principles and ethos of MCA to help people remain in control of their lives. Safeguarding is discussed in all individual and group supervisions and at team meetings. Staff have attended Safeguarding Adults Review (SAR) learning events and shared the best practice within their teams.

Integrated Adults Safeguarding Unit (IASU) coordinates the legal updates for Best Interests Assessors, to ensure that their practice is evidence based and defensible. This includes any legal updates, in relation to the interface between the Mental Capacity Act and the Mental Health Act, including Case Law updates and how they impact on practice.

IASU have taken part in the SAR/MAR events organised by HSAB, with a view to sharing the learning from these within team, reflecting on practice and within supervisions and sharing with care management.

IASU has promoted the training offered by HSAB to provider services and adult social care via various groups.

IASU consists of experienced social work staff, including an Approved Mental Capacity Professional. IASU also has close professional relationships with Section 12 Doctors, who complete assessments within the DoLS Framework. These assessments are scrutinised and fed back to the Mental Health Assessors.

IASU had responsibility to provide awareness sessions to provider services on Care Concerns, Safeguarding and the Mental Capacity Act/Deprivation of Liberty Safeguards.

We ensure that the principles of the Mental Capacity Act are adopted by provider services and stakeholders in relation to safeguarding enquiries and DoLS and if not, provide information, advice and support.

IASU have 4 social workers who have recently been trained to complete investigations within the LeDeR review framework (Learning Disabilities Mortality Review Programme).

IASU complete the screening of Police referrals to adult social care, ensuring that any concerns raised by police regarding mental health, are signposted to the correct agency with the appropriate guidance.

- Halton Clinical Commissioning Group

NHS Halton CCG has actively contributed to SAR, MAR, and Thematic Review learning events where Mental Health was identified.

NHS Halton CCG has provided input to the suicide prevention agenda in Halton.

- Public Health

Health Improvement Team (HIT) provide training in areas such as self-harm, MECC, etc.
Public Health have developed the Suicide Prevention Strategy.

Public Health provide the Sure Start to Later Life service and Substance Misuse services.

- St.Helen's and Knowsley Hospitals

STHK has recently revised the Mental Health Policy to provide improved guidance to staff. The psychiatric liaison team are now available 24/7 to support patients with mental health issues, and work closely with the safeguarding adult team. Partnership working with safeguarding adult team and mental health team ensures patients receive the relevant support.

- Warrington and Halton Hospital Foundation Trust (WHHFT)

The Trust has a focus on mental health and has conducted a review of its services. The MH review examined training, emergency care provision, administration, policy and a renewed meeting structure. There are audits planned to test the effectiveness of the outcomes of the review. Lessons learnt from incidents are shared throughout the Trust.

- Bridgewater

Community practitioners are identifying where there are concerns about self-neglect and referring through to Social Care. It is apparent from a review of concerns raised last year that there is evidence of good multi-agency involvement to work towards a solution with service users.

- Northwest Borough Healthcare Trust

The core business of the Trust in Halton is to deliver mental health services, both community and in-patients. The Safeguarding Adult Team are dedicated to supporting staff to provide safe care which acknowledges the complexities of mental health and the impact it has on how we protect adults at risk. The Trust delivers mental health services under the Care Programme Approach (CPA) which has robust risk assessment tools and care plans.
Using the risk assessment tools under CPA staff are able to identify risk in terms of degree and nature and utilise strategies to manage this risk with service users.

- Healthwatch

Working with the Halton Health Improvement Team we've added a database of over 100 mental health support services to our website A-Z pages.

- Cheshire Fire and Rescue Service

Commissioned mental health awareness training, delivered to prevention team (all advocates). Greater understanding of terminology used and referral pathways.

- North west Ambulance Service

NWAS continues to use mental health pathways where they are in place and safeguard vulnerable patients.

- Cheshire and Greater Merseyside Community Rehabilitation Company

As an Organisation, CGM CRC supports partnership working linked to child and adult safeguarding in many ways. An example of this is our contribution to Multi- Agency Risk Assessment Conferences (MARACs), whereby cases of domestic abuse where victim/ adult safeguarding concerns are assessed as medium or high risk are discussed and a multi- agency response is determined. CGM CRC service users may be discussed at MARACs as either the identified perpetrator or a victim of domestic abuse. There is an Interchange Manager with operational lead for risk and MARAC across each local delivery unit. This manager attends safeguarding related sub-groups and acts as a single point of contact for staff with regards to risk and MARAC.

We have dedicated staff linked to MARAC and we view ourselves as specialist's risk assessors of domestic abuse perpetrators with strong and effective partnerships with victim services. CGM CRC is the only Home Office commissioned organisation that delivers perpetrator programmes regardless of the risk assessment and therefore provides high level interventions to cases that fall into the MARAC and adult safeguarding arena.

Further evidence of partnership working linked specifically to adult safeguarding is in evidence in relation to CGM CRC's contribution as a statutory agency to both Domestic Homicide and Adult Safeguarding Reviews. Learning from these reviews are communicated through the organisation via formal training events, staff and team meetings, practice development days and individual supervision.

Our current local training plan has identified several key areas with regards to training needs around safeguarding and working with vulnerable adults and as such we have developed an array of workshops to address this need; Working with sex offenders, Understanding hoarding, Working with 18-25 year old service uses, Homelessness, Mental health, The changing drug culture, The toxic trio, Victim support worker's role and Personality disorders. These workshops are available to all staff and are delivered on a regular basis.

The CRC Safeguarding Policy stipulates that all operational staff must attend at least one safeguarding training event per year and Safeguarding forms part of our induction processes. All staff are also expected to undertake periodic refresher training. We continue to work towards all

case holding staff to access the safeguarding training opportunities through our wider partnership activities.

- Halton Provider Forums

Dementia Action Alliance dates distributed. Providers may have changed practice or wish to share learning to encourage wider understanding across sectors or reduce gaps in support.

- Halton Domestic Abuse Forum

The Sexual Assault Referal Centre (SARC) manager report at the end of quarter 4 notes that clients classed as having a disability have increased during the last financial, an increase of 77% with mental health issues and a 46% with physical disabilities.

- Age UK Mid-Mersey

Age UK have partnered with Mind in Halton and also secured funding to deliver a local MH resilience training for older people reaching over 70 individuals and groups. A report was produced on the outcomes and success of the pilot for dissemination to stakeholders and share experiences with a direct link into MH resilience and safeguarding.

- Department for Work and Pensions (DWP)

Mental health training for all staff from MIND

- Change Grow Live (CGL)

Review pathways between CGL and community mental health team, implementing quarterly joint review meetings. Operational issues between two services discussed and resolved on regular basis. Discussion of joint cases for a joined up approach to providing services. Assertive assessment from CHMT for CGL service users. CGL invited to ward review for patients with drug and/or alcohol concerns pre-discharge.

- Halton Housing Trust

Staff are trained to identify the signs of mental health. One member has been trained to train other colleagues. Visiting staff are more aware of the signs and can make referrals both internally and to other specialist agencies.

Attended a SAR Review learning event, gaining greater awareness of the safeguarding process and better partnership working.

Provide support and assistance to more vulnerable customers, so more tenancies surviving due to additional support available.

- Halton Carers Centre

Engage better with carers of adults with mental health conditions and ensure the needs of both the individual being cared for and the carer are jointly met. Carers who may be heading to crisis identified sooner.

Embed Transition Protocol into practice and develop pathways for people in need of mental health support. Procedures drawn up between sub-group partners to ensure smoother transition for people between services. Smoother transition for carers between services, more awareness.

- Faith Sector Forum

Attended HSCB sexual abuse training day, which discussed effect on mental health. More awareness of effect of sexual abuse on people's mental health and the lasting impact of this. Discussed the difficulties of gaining consent from adults to ask for help and support for them and methods people have used to get around this/achieve success e.g. through the Fire and Rescue Service's routine home visits. Raised awareness of the issue of gaining consent from adults and the processes and procedures to follow in such cases. Increased knowledge of the role of the Fire and Rescue Service.

SECTION 6: THE YEAR AHEAD

Halton Safeguarding Adults Board wants to continue to build on it's successes and partnerships. Looking at the evidence and data gathered for this report to use the 'What can we do' as recommendations for action. This will help to focus the activities where the need is greatest and ensures an efficient and effective Board that is able to be genuinely inclusive of all members of our community. This supports the Care Act model of a coproduced Safeguarding Adults Board and will enable the best possible outcomes.

HSAB will continue to use local intelligence and information, national statutory guidance (e.g. the Care Act 2014 specifies the functions of a Safeguarding Adults Board) to inform it's work. Additionally other sources of information gathering is used along with multi-agency work addressing safeguarding issues from sectors outside of statutory provision, including the community and voluntary sector. Ongoing community and service user consultations continue across HSAB activities. All of this information and guidance is used to shape what services and support is made available, to ensure the most appropriate use of resources for those adults identified as at risk of harm.

This year will see the revision of screening within the Integrated Adults Safeguarding Unit (IASU) and the Initial Assessment Team. So that all safeguarding referrals or alerts are triaged by the same team providing safeguarding consistency, ensuring information is fedback to referers, it will inform practice of others referring in, aid greater understanding of thresholds and what care concerns, safeguarding concerns and what safeguarding alerts mean in practice. This will also help embed professional expectations and help define roles and responsibility within teams more consistenly.

The new Healthwatch provider for Halton will gather intelligence from a public questionnaire which will be used to inform work for the coming year, building on the mental health work already done. Additionally Healthwatch will provide the newly commissioned advocacy service for Halton.

This year will see social media activity and increased public profile of safeguarding adults, building on the marketing plan and following the launch of the marketing campaign. There will be a continued commitment of public engagement, with public and practitioner events, borough-wide circulation of information and resources across partner networks, publications and social media outlets.

All HSAB priorities and work activities comply with the 6 principles of adult safeguarding. The priority recommendations for 2018-2019 are:

Quality Assurance:

Review of current data/intelligence sources in referrals and alerts to be inclusive of the growing diversity of culture with Halton. To promote person-centred approach across all services working and supporting adults, ensuring it is adopted throughout the lifecourse of adults with care and support needs and those at risk of harm. Undertaking audits for quality assurance. Taking in to account of

models such as Making Every Adult Matter, Making Safeguarding Personal and applying Mental Capacity considerations when appropriate.

I. Data capture to be broadened out to enable diversity and inclusion to be captured more effectively: wider categories for gender and ethnicity, if Mental Capacity has been assessed and whether the adult's voice has been captured and ensuring all data categories are completed.
II. All partners to be proactively inclusive and person-centred within their approach and within service provider cultures.
III. Scrutinise recording of mental capacity, whether this might be a need for training or awareness or may be due to systems improvement to conduct timely mental capacity assessments.
IV. Audit cases of safeguarding that include the highest indices of prevalence across type, location, age and perpetrator, to identify themes or trends. This could enable a greater understanding of care and support provision from staff, carers and volunteers who attend an adult's home to support/care for them.

Learning and Professional Development:

To continue to improve the skills and competencies of the local workforce through a range of resources. To aid a positive culture around safeguarding adults and an understanding that all practitioners and carers who work with or support an adult have a duty of care and a responsibility to make themselves aware of safeguarding risks.

V. HSAB to continue to offer free resources including multi-agency training, information leaflets, toolkits and additional resources to raise awareness, build on competency skills and improve practice. All resources are available on HSAB website ww.haltonsafeguarding.co.uk.
VI. All partners, including families and carers to have an awareness of adult safeguarding, to enable effective and efficient response to abuse indicators.
VII. All partners to attend awareness events, training and professional development to ensure current practice is compliant and safe.
VIII. All partners to understand their responsibilities in relation to safeguarding adults knowledge, skills and professional practice; adopting the six principles of safeguarding which is a person-centred approach and applies to preventing safeguarding through early engagement and intervention alongside dealing with safeguarding concerns that are raised.
IX. All partners make themselves aware of impact on adults at risk of 'mate crime' and abusive relationships.
X. All partners including frontline staff to be aware of their responsibility to learn from Safeguarding Reviews and Action Plans, to consider implications within their own working/ service areas.
XI. HSAB to continue to promote the six principles of adult safeguarding.

XII. All partners to have an awareness that Making Safeguarding Personal is a cultural approach requiring working with individuals and utilising the six principles of adult safeguarding. Knowing this is applicable for safeguarding prevention and early intervention support as well as when there may be a safeguarding issue.

XIII. For professionals to understand and apply professional boundaries consistently.

XIV. For all partners to understand risks and choices and know where mental capacity is relevant.

Coproduction and Engagement:

The Care Act 2014 requires SABs to have a model of coproduction in order to fulfil its core duties (see section 1). In addition the Care Act statutory guidance 14.137 states:

'Safeguarding requires collaboration between partners in order to create a framework of inter-agency arrangements. Local authorities and their relevant partners must collaborate and work together as set out in the co-operation duties in the Care Act and, in doing so, must, where appropriate, also consider the wishes and feelings of the adult on whose behalf they are working.'

XV. HSAB to continue engagement with services /groups/ individuals including those representing minority populations; to increase participation and awareness across the borough and find more accessible ways to share safeguarding adults information and involve the public in safeguarding adults.

XVI. For service providers to encourage professional curiosity within their staff teams and utilise models of multi-agency working within their provision. To be open to professional challenge to improve working practices and identify opportunities to engage wider than their service area with other partners and be inclusive to service users and the public.

XVII. Partners can help by promoting and utilising the new advocacy service commissioned by Halton Borough Council, being provided by Healthwatch Halton, via a single point of access. Using the advocacy service for adults who may need this to ensure a proactive, inclusive and person-centred approach within their service provision.

XVIII. For carers and families to understand everyone has the right to choose what they would like to happen within safeguarding but also making their own lifestyle choices whilst they are being cared for.

Section 7: Appendix

APPENDIX A: BOARD MEMBERS

- Independent Chair – Audrey Williamson
- Halton Borough Council - Sue Wallace-Bonner
- NHS Halton Clinical Commissioning Group – Michelle Creed
- Cheshire Constabulary – DCI Louise Cherrington (Previous rep Gareth Lee)
- Cheshire Fire and Rescue – Emma Coxon
- North West Ambulance Service - Andrea Edmonson (previous rep Vivienne Forster)
- Probation Services (Cheshire CRC) - Jenny Archer-Power
- Healthwatch - Elizabeth Learyod (previous rep Hitesh Patel)
- Elected member responsible for adult health and social care - Cllr Tom McInerney (previously Cllr Marie Wright)
- Halton Safeguarding Adults Partnership Forum Chair – Mark Lunney (Mark Weights deputising)

APPENDIX B: PARTNERS AND CONTRIBUTORS

HALTON
SAFEGUARDING
ADULTS
BOARD

APPENDIX C: CONTACT DETAILS

Email: HSAB@halton.gcsx.gov.uk
Call: 01515 511 6825
Website: www.haltonsafeguarding.co.uk
Address: Halton Safeguarding Adults Board, Oak Meadow, Peelhouse Lane, Widnes. WA8 6TJ


HALTON
SAFEGUARDING
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BOARD