HALTON
SAFEGUARDING
ADULTS
BOARD

Halton Safeguarding Adults Board Annual Report

APRIL 2020 – MARCH 2021

Message from the Chair

This is my second annual report as Chair of Halton Safeguarding Board. All Safeguarding Adults Boards are required to publish an annual report to analyse the effectiveness of the work across agencies to safeguard those who require additional support and care. As Chair of the Halton Safeguarding Adults Board, I am very pleased to present the annual report 2020/21 which I hope you will find informative and useful.

On behalf of the Board, I would like to thank everyone for their hard work and ongoing commitment throughout this past year, all agencies have worked together to support the most vulnerable in our Borough.

In March 2020, the country went into lockdown due to Covid-19. Even with the constraints of working to social distancing measures, we were able to maintain our safeguarding adults work in Halton.

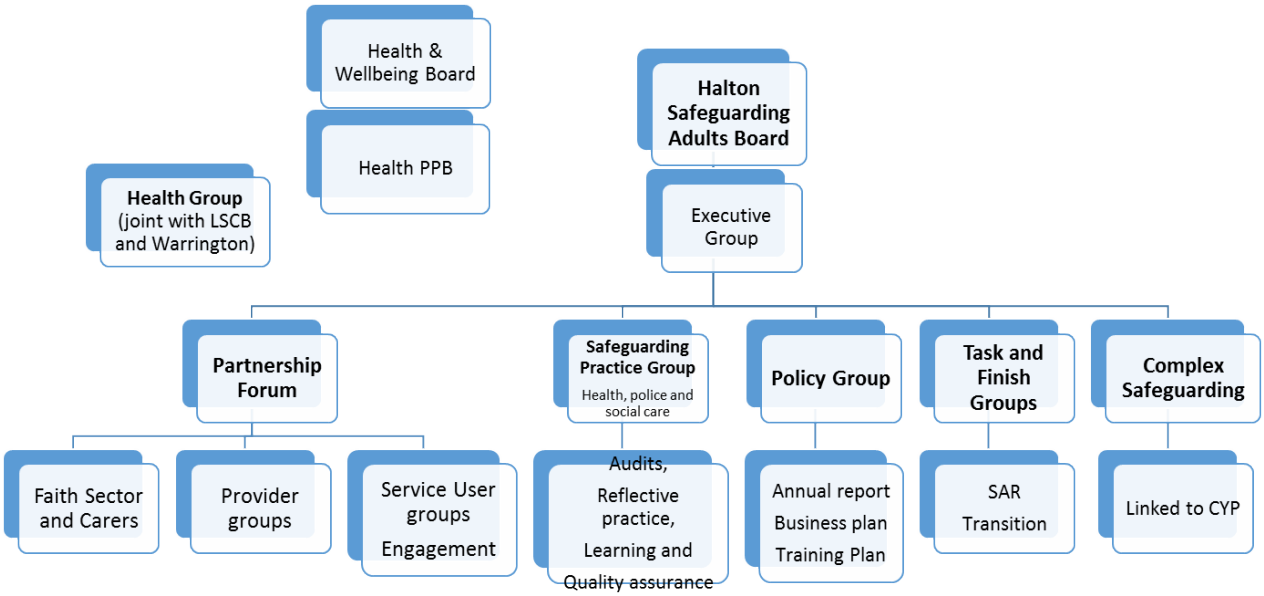
The context of our work over the next year, will remain focused on the safeguarding of adults, however, we want to further strengthen the voice of those who require services and ensure they influence how those services are delivered.

Thank you to all those who have worked hard to support the board, it has been a positive year and I am confident that by working together, we can continue to improve the lives and outcomes of many of our vulnerable residents.

Milorad Vasic

Strategic Director, People Directorate – Halton Borough Council

WHO ARE WE AND WHAT DO WE DO?



Review of SAB arrangements

During 2020/21 it was timely for the SAB to have an additional priority to review the current arrangements, due to a new Chairperson being appointed in 2019.

The review of the structure took place over the course of 2020/21 in order to strengthen the focus of the SAB sub-groups, and reaffirm their purpose, aims and objectives. The SAB introduced two new sub-groups, as shown in the organisational chart above: the Policy Sub-group with a focus on the Annual Report, Strategic/Business Plan and Training Plan; and the Practice Sub-Group focussing on safeguarding audits, reflective practice, learning and quality assurance.

In order to support the main SAB, and create linkages between the SAB and Sub-groups a new Executive Group was formed to filter the work of the SAB, and monitor the progress of the sub-groups. Following the implementation of the new structure, reviews of the arrangements have been planned for early 2022 to ensure they are working successfully and achieving their aims.

What is Halton's Safeguarding Adults Board?

Halton Safeguarding Adults Board (HSAB) is a statutory partnership between the Council, Cheshire Police, NHS, the Fire Service and other organisations that work with adults with care and support needs in our borough.

The job of HSAB is to make sure that there are arrangements in Halton that work well to help protect adults with care and support needs from abuse and neglect.

What is our vision?

"Our vision is that people with care and support needs in Halton are able to live their lives free from abuse and harm"

Halton Safeguarding Adults Board

Halton Safeguarding Adults Board strives to show improvement in fulfilling its 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.

Board and its duties

Safeguarding Adults Board were established under the Care Act 2014		
Main SAB Objective	"To assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the safeguarding adult criteria".	
3 Core Duties	• Publish a Strategic Plan	• Publish an Annual Report
	• Conduct any Safeguarding Adults Reviews	

What is the purpose of the Annual Report?

The law states that we must publish a report every year to say what we have done to achieve our main goals and how our members have supported us to do this.

What does Safeguarding Adults mean?

Safeguarding Adults means stopping or preventing abuse or neglect of adults with care and support needs.

Adults with care and support needs are aged 18 and over and may:

- Have a learning disability
- Have a mental health need or dementia disorder
- Have a long or short term illness
- Have an addiction to a substance or alcohol
- And/or are elderly or frail due to ill health, disability or a mental illness

Who are HSAB's partner organisations?

OUR PRIORITIES IN 2020/21

Priority 1: Quality Assurance 	❖ Ensuring internal quality assurance frameworks are in place ❖ Ensuring any identified learning is shared ❖ Review of the safeguarding adults audit processes within Halton ❖ Sharing of information across HSAB members and provider services
Priority 2: Co-production & Engagement 	❖ Ensuring HSAB partner agencies have learning and professional development opportunities in place for their individual workforce ❖ Ensure there is a consistency and standardisation of safeguarding practice across Halton ❖ Ensure all agencies promote a making safeguarding personal (MSP) approach ❖ Ensure that there is effective communication of training opportunities shared within HSAB members and partner agencies ❖ Support the development of good multi-agency practice, sharing best practice, lessons learned and have the confidence to challenge decision making

	❖ To support adults at risk, informal carers and families with safeguarding and ensuring that they feel support within the safeguarding process
Priority 3: Learning & Professional Development  	❖ Reassurances that safeguarding approaches are developed actively including representation from all key areas ❖ Ensure that the voice of people who use services are heard, are involved in developing policy and are at the centre of any health and social care intervention ensuring their rights, wishes and feelings are at the heart of the decision making process
Priority 3: Review of the HSAB arrangements  	❖ Establishing new sub groups to further the development of safeguarding practice, assurances and accountability

WHAT HAVE WE BEEN DOING OVER THE PAST 12 MONTHS?

During the past 12 months, we have seen Government guidance change, at times on a daily basis. We have seen the implementation of the Coronavirus Act 2020, which has allowed easements for the Care Act 2014 for Adult Social care. However, in relation to the Deprivation of Liberty Safeguards (DoLS) and the Mental Health Act, there were no such easements, we therefore needed to think creatively to ensure people's rights were protected.

In May 2020, the first set of guidance was released for assessing DoLS and capacity. Following this, we developed an easy read version of the guidance, guidance for staff members and care home guidance to help facilitate virtual assessments and information sharing. This worked well and depending on individual circumstances, we continue to undertake virtual assessments.

The learning from this was a shared vision from adult social care and the care sector, to work together to protect people from the spread of the virus, and also ensuring that people's rights were assessed and protected.

From the beginning of the pandemic, we needed to ensure that information was accessible and available for people to utilize. This included our safeguarding policies and associated templates, as well as our toolkits and e-learning modules. We ensured that the Halton Safeguarding Adults website contained all the relevant information available for people, care providers and social care staff to access freely, which lessened the demand on teams to provide in more traditional formats.

Prior to the pandemic, work had been undertaken on the development of a self-neglect toolkit and pathway. This was co-produced with a number of agencies including health, environmental health, fire service, mental health services and adult social care. The work was halted due to the pandemic, however, it was able to be finalised via a virtual working group. The toolkit is now fully implemented, working well and provides a consistent approach, as well as identifying our specific legal duties to support people who self-neglect or hoard. It identified that virtual development meetings do work and with the increased demand in responding to cases or self-neglect, the implementation was also timely.

Due to the demands on hospitals and discharge to assess, we identified pathways were not clear for the reporting of quality issues directly to the hospital involved. In Halton, we do not have an acute hospital in the area and people who live in Halton are admitted to hospitals in neighbouring authorities. This meant that there were different approaches for each hospital causing confusion, which was exacerbated during the pandemic. We worked closely with the hospital safeguarding leads and devised a streamline and consistent pathway for both hospitals. The "Concerning Discharge Process" has worked well in identifying themes, trends and seeking assurances in a timely manner from both trusts.

During the pandemic, it became evident through the increase of issues regarding GP Practices, that there was no clear process within the Clinical Commissioning Groups (CCGs) of obtaining assurances around safeguarding involving a GP. We therefore developed a referral and outcome took which is sent to the GP Practice Safeguarding Leads to investigate concerns within a 14 day timeframe, to allow enquiries to be made and outcomes to be shared. This again, has worked well in identifying themes and trends.

All face-to-face training ceased during the pandemic, however, recruitment continued therefore the need for essential training was still in demand. This resulted in the Integrated Adult Safeguarding Unit developing and delivering training to a number of different agencies and sectors, as well as in-house teams around safeguarding, DoLS and the Mental Capacity Act. Delivering training virtually was the learning from this, as a positive and cost-effective way of ensuring the workforce were up-to-date with the knowledge, skills and practice to deliver a legally defensible service to the people we support.

Another learning point was around visiting, when it became safer to conduct visits to people's homes, care homes and hospitals, we were aware of the Government guidance focusing on care settings and health professionals, however, not necessarily social workers. As a result of this, we have development a risk assessment, working closely with the care sector to ensure there was a criteria for when a visit needed to be undertaken. In other areas, public health led on such tools. We have developed this looking at how to mitigate the risk, knowing staff now have access to Personal Protective Equipment (PPE) and were now fully aware of the risks of the virus. This tool is still in operation and has been shared with Public Health and the care sector, as a standard to ensure that visits are planned, Lateral Flow Tests (LFT) are completed prior to a visit being undertaken and appropriate PPE is used, which has all worked well.

We have identified that the guiding principles of safeguarding have been fully implemented during Covid-19. This means in practice, working towards ensuring we adhere to Making Safeguarding Personal (MSP), looking at the preventative approaches needed and challenging others to ensure that we are taking measures to prevent safeguarding concerns being raised. We have seen changes to care management teams, which had a direct impact on safeguarding activity. This included care reviews not being completed, requests for assessments not being completed in a timely manner, resulting in referrals being made to safeguarding. We have tried to utilize non-statutory enquiries, especially around people who self-neglect, applying Section 11 of the Care Act and our duties, to ensure that relationships are achieved and people get the best quality service, given the resource constraints at present.

HSAB participated in National Safeguarding Adults Awareness week during November 2020, with national collaborations with the Ann Craft Trust. Locally, HSAB collaborated with other statutory, private and voluntary services following key themes set over a seven day period, covering the following areas:

- **Safeguarding and Wellbeing**
- **Adult Grooming**
- **Understanding Legislation**
- **Creating Safer Places**
- **Organisational Abuse**
- **Sport & Activity**
- **Safeguarding in your Community**

In light of Covid-19 restrictions, consideration had to be given on how best to promote awareness to members of the public and professionals, in relation to safeguarding in general and also in line with the above themed areas.

A working group was formed to discuss the requirements of the event and agreement was reached that the most positive and interactive way forward, was to utilize social media platforms as much as possible during the week.

Last year's 7 minute briefing sessions were presented via YouTube videos; the links were also be available on our own and external partner agency social media sites.

Information was promoted via the HBC Intranet and Internet, Twitter, Facebook and Instagram pages.

We secured a place in Halton Carer's Centre's Newsletter and Healthwatch also used the article in their e-Bulletin.

Despite the pandemic lockdown restrictions, promotion and awareness-raising was successfully undertaken via social media platforms with a separate theme covered every day for seven days.

PARTNER ACHIEVEMENTS

Cheshire Constabulary

In early 2019 a review of Response and Investigation work streams was initiated, with a view to make efficiency savings during 2020/21 and beyond. Response and Investigations review established significant interdependencies between work streams across the constabulary. As a result the Cheshire Futures Programme commenced in October 2019.

Demand analysis established inefficiencies in the existing operating model of the force, therefore the Cheshire Futures Programme was to consider the benefits of a Functional Command Model to address the inefficiencies of the current Geographical Command Model.

The design principles of the Cheshire Futures Programme were as follows:

"We Care"
Resources and responsibility will be distributed **fairly**

Resources and responsibility will be distributed **equitably**

Resources and responsibility will be distributed **appropriately** in accordance with organizational need

The full business case was due to be scheduled for July 2020, due to Covid-19 this was delayed until October 2020. The main changes highlighted in the business case were:

- 8 local policing units removed
- Geographical local policing units command replaced with 4 functional commands and 3 operational command units
- There would be 4 functional commands:
  - **Response and Resolutions command**
  - **Local Investigation command**
  - **Neighbourhood, Prevention & Safeguarding command**
  - **Major Crime command**
- There would be 3 Operational Command Units
  - **North – Halton & Warrington LA areas**
  - **East – Cheshire East LA area**
  - **West – Cheshire West & Chester LA area**

- Current local policing footprint maintained for Response and Resolution and Local Investigations Commands
- Current local policing footprint enhanced for Neighbourhoods, Prevention & Safeguarding Command
- Specialist capabilities enhanced for major crime command

The benefits of the highlighted changes are as follows:

- Scalable model that enables officer uplift and future austerity to be accommodated without wholesale organisational restructure
- Increase in dedicated neighbourhood resources
- Resources consistently matched to demand within functional commands and across geography
- Improved accountability and governance
- Increased flexibility of specialist resources
- Improved consistency of service across the constabulary
- Enhanced local focus of neighbourhood resources
- Enhanced local focus of preventative resources
- Enhanced local focus of safeguarding resources

Health Operational Safeguarding Sub Group

NHS
Halton Clinical Commissioning Group

The Health Operational Subgroup has active engagement from Lead Named Nurses and Professionals from health services and covers both the children and adults safeguarding agendas. Due to Covid-19, the group has met virtually in May and June 2021.

The key priority of the group is:

Group to revisit the work plan considering the impact pf Covid-19 and refocused safeguarding priorities. Group to ensure work plan aligns to Halton SAB priorities and alignment to Warrington SAB priorities as a joint meeting is facilitated.

Learning Disability Mortality Review

The Learning Disability Mortality Review (LeDeR) programme is part of a national focus upon improving the lives and care of people with learning disabilities. It has derived as an

outcomes from a series of national reports that describe that whilst care in many instances has improved over the last decade, many aspects have not. There are still marked health inequalities for people with learning disabilities. Compared to that of the general population. These health inequalities are not inevitable, and progress can be achieved by preventative and/or timely access healthcare.

Reviewing the circumstances surrounding the deaths of people with a learning disability provides a real opportunity to learn from the past to help prevent avoidable deaths and improve future care for others.

Since 2019, NHS Halton CCG and NHS Warrington CCG agreed to take a combined approach to delivery of the LeDeR programme through the establishment of a LeDeR panel, shared Local Area Contact and agreed governance frameworks to capture local learning.

Locally across Halton & Warrington in 2020/21, there have been 36 new deaths notified to LeDeR for local review. In total, 62 deaths have been reviewed or quality assured through the LeDeR panel, as this also included a backlog of reviews. Four reviews have been removed, as they were found to be out of scope as the individuals did not have a learning disability. There are 10 reviews that remain ongoing, so will be reported on in the 2021/22 report.

NHS England and NHS Improvement (NHSEI)

NHSEI have worked together as a single organisation since April 2019, to help improve care for patients and provide leadership and support to the wider NHS. Below is a summary of the work NHSEI have been involved with over the last 12 months:

- National Host Commissioner Forum commencing 6th July 2021
- National Interim Units of Concern Protocol – to complement the host commissioner guidance in process of being signed off
- Lots of material being shared and stored on the futures MCA resource file
- Consultation for Code of Practice will commence soon, Government expected to provide their response in winter
- Plan for implementation of LPS remains for April 2022
- NICE has published guidelines that covers how to make shared decision-making part of everyday care in all healthcare settings. It promotes ways for healthcare professionals and people using services to work together to make decisions about treatment and care. It includes recommendations on training, communicating risks, benefits, and consequences, using decision aids and how to embed shared decision-making in organisational culture and practices.

North West Ambulance Service

NHS North West Ambulance Service NHS Trust

Policies and Procedures

During 2020/21 The Prevent Guidance and the Safeguarding Vulnerable Persons Procedures were updated.

Mersey Internal Audit

The Safeguarding Team welcomed Mersey Internal Audit (MIAA) into the Trust in November 2020 and worked with them to provide information of the safeguarding activity for the whole Trust. The draft report was received in January 2021. Following a review of the report, a management response was returned to MIAA in February. The final report received provided substantial assurance for the safeguarding agenda.

Safeguarding Concerns and Mental Health rejections

The primary reason for the rejection of safeguarding concerns continues to be Mental Health. During the COIVD-19 pandemic all mental health Trusts established a 24-hour mental health crisis helpline, this was a welcome resource which is envisaged will remain in place following the pandemic. Although this helpline provides a vital service for patients, not all mental health patients will meet the criteria for the mental health crisis help. This continues to leave a gap for patients who are suffering with mental ill health.

Training

Safeguarding compliance figures are monitored closely by the Executive Leadership Team. Figures are reported to the Safety Management Group, the Quality Performance Committee and Operation Outstanding Meetings on a bi monthly basis. Figures that are reported include the safeguarding module compliance. The end of year training figures for compliance are Level 1 and 2 training 82 per cent across the Trust; Level 3 (based on the previous TNA) 83 per cent and Level 4 100 per cent. The Safeguarding Team are continuing to work with the corporate learning and development department and local service delivery areas to improve the compliance figures.

Safeguarding Triage Deep Dive

Over a 4-week period the safeguarding team carried out a deep-dive review in relation to the safeguarding concerns which were being raised by the Trust. The findings show that there were a large number of safeguarding concerns being raised and shared inappropriately with Social Care. Following this report, extensive work has taken place with Social Care departments across the Trust footprint. The work which has been carried out has been done to facilitate a new safeguarding process, which will ensure that the information is shared to either safeguarding or early helps teams appropriately.

Healthwatch Halton

Healthwatch Halton joined with other SAB partner agencies to plan and attend the Adult Safeguarding Awareness Week event, held in Runcorn Shopping City to promote safeguarding across Halton

Our Community Outreach Leads give information on safeguarding along with contact details, to members of the public at outreach sessions held within the community. During the past year, 153 outreach sessions have been held, resulting in engagement with over 2700 people.

Our Healthwatch Halton and Healthwatch Advocacy staff teams undertook safeguarding training through Halton Borough Council, in addition to our organisation's own mandatory online safeguarding training.

Healthwatch Halton work closely with the Quality Assurance Team at Halton Borough Council to share information and any good practice or concerns we've noted during our "Enter and View" visits to local care homes and other service providers.

As part of the "Enter and View" programme of visits to local care homes, Healthwatch Halton has developed an online feedback form. This was set up to allow residents, their family members, or members of staff at the care homes, to feedback their comments if they were unavailable at the time of our visit.

Healthwatch Halton board members and volunteers are currently engaged in a programme of online training sessions covering the following topics:

- Safeguarding
- Equality and Diversity
- GDPR Essentials
- Mental Health Awareness
- Cyber Security

WHAT IS A SAFEGUARDING ADULT REVIEW (SAR)?

Under the Care Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adult Reviews.

A Safeguarding Adult Review takes place when agencies who worked with an adult who suffered abuse or neglect, come together to find out how they could have done things differently to prevent harm or death.

A SAR does **not** seek to blame anyone; it tries to find out what can be changed to that harm is less likely to happen in the future in the way it did to other people.

The law says HSAB must arrange a SAR when:

- There is reasonable cause for concern about how HSAB, its partners or others worked together to safeguard the adult; **and**

- The adult died and HSAB suspects the death resulted from abuse or neglect; **or**

- The adult is alive and HSAB suspects the adult has experienced abuse or neglect

During 2020/21, Halton did not conduct any Safeguarding Adult Reviews, however, NHS Halton Clinical Commissioning Group (CCG) implemented and embedded the Learning Disabilities Mortality Review (LeDeR) processes and learning from incidents; with formal reporting to HSAB for assurance. All LeDeR reviews are delivered within the national expected timescales, and there is good partner engagement and support for this agenda across Halton.

Halton CCG along with Warrington CCG, developed and hosted a LeDeR Conference, to promote learning with key messages being delivered through dramatization of real life experiences. This was supported by the development of a legacy video, which has been shared across the partnership. The legacy video can be viewed via the following link:

https://vimeo.com/430665513/9c96dc68c8

KEY SAFEGUARDING FACTS FOR 2020-21

1098
Concerns Received
(1068 in 2019/20)

336
Section 42 Enquiries
(489 in 2019/20)

Top 3 Primary Support Reasons for concluded Section 42 Enquiries:

- Physical Support
- Learning Disability Support
- Mental Health Support

Top 3 Types of abuse for concluded Section 42 Enquiries:

- Neglect and Acts of Omission
- Financial and Material
- Physical

Top 3 Locations of Abuse for concluded Section 42 Enquiries:

- Own Home
- Care Home – Residential
- Care Home - Nursing

53.9%
Asked what outcomes they want
(81.5% in 2019/20)

76.8%
Risk reduced or removed
(89% in 2019/20)

90.1%
Outcome fully or partially met
(91.5% in 2019/20)

4
Safeguarding involved strangers who were unknown to the victim

116
Concluded safeguarding enquiries listed the source of risk as known to the victim

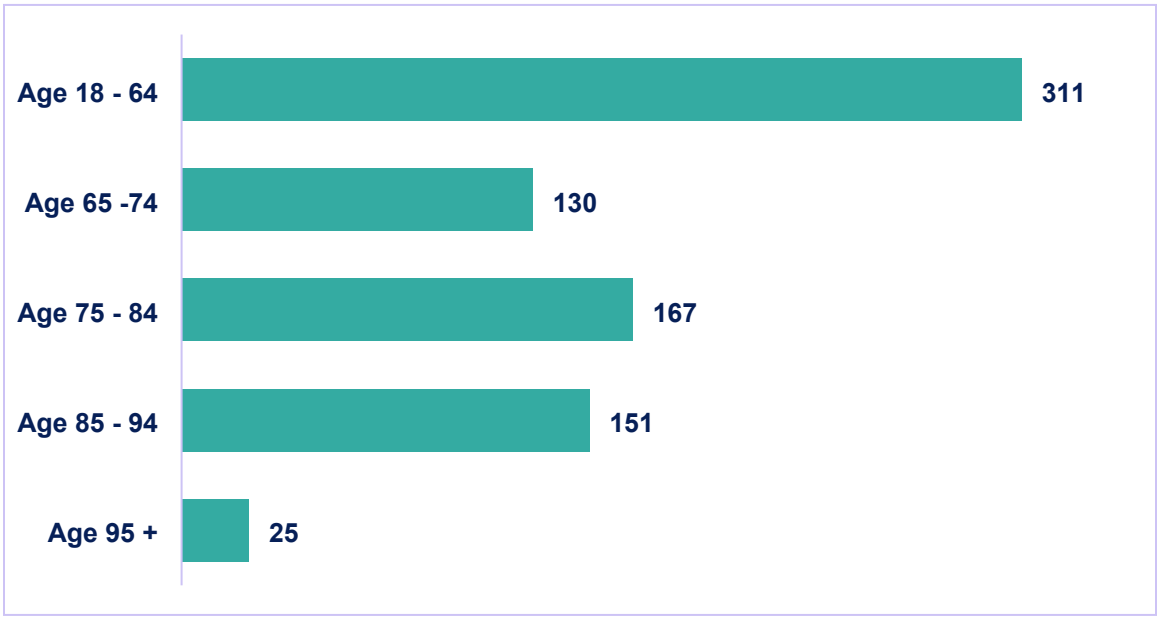
111
Safeguarding allegations involved abuse by social care staff

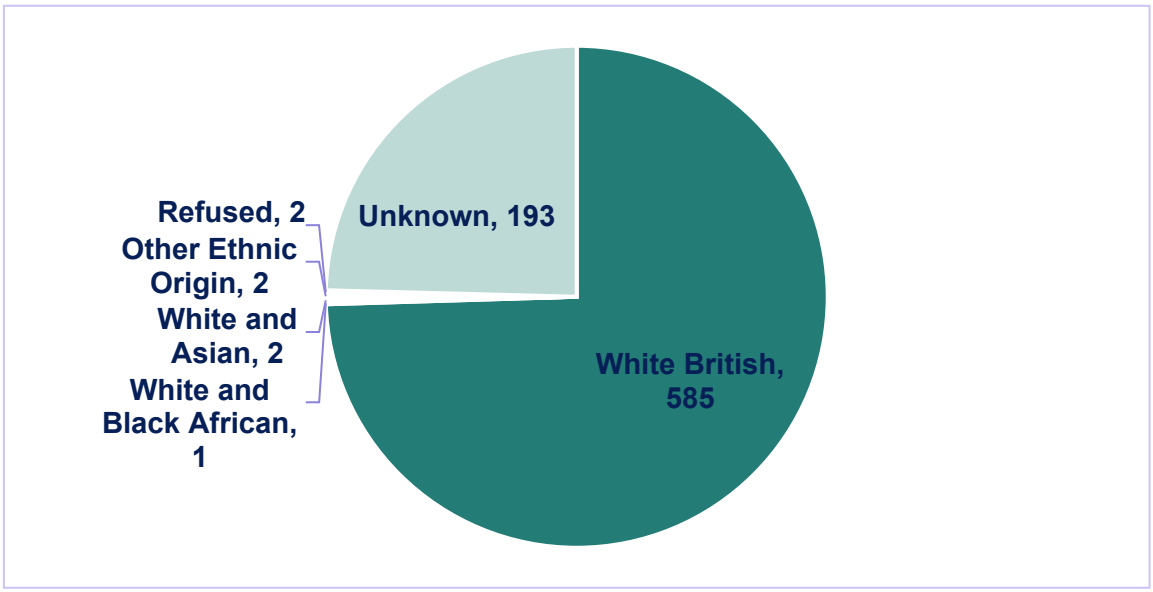
DEMOGRAPHICS FOR INDIVIDUALS INVOLVED IN SAFEGUARDING CONCERNS

Females
478

Males
305

The highest number of concerns received are for females aged 18-64 (162)





DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) FOR 2020-21

569
Applications Received
(637 in 2019/20)

415
DoLS Granted
(339 in 2019/20)

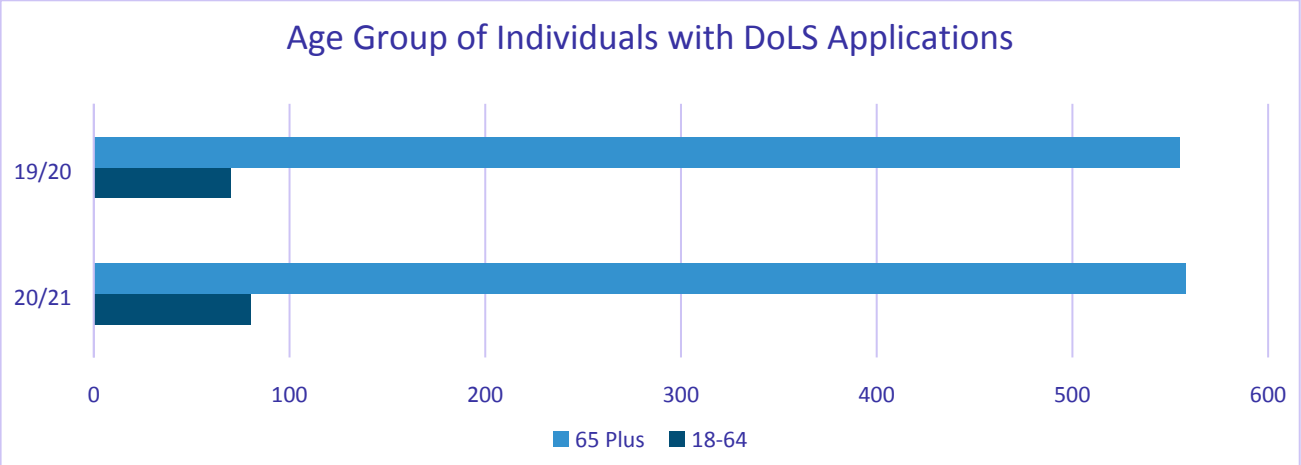
Top 3 Disability for DoLS Applications:

- **Mental Health needs - Dementia**
- **Mental Health needs - Other**
- **Physical Disability**

DEMOGRAPHICS FOR INDIVIDUALS WITH DEPRIVATION OF LIBERTY SAFEGUARDS

Females
389

Males
249



WHAT ARE OUR PRIORITIES FOR 2021/22?

Priorities for 2021/22 are in keeping with this year's over-arching work areas as these remain relevant. However, actions underneath each priority area will be updated as work progresses, with sub-group work programmes being monitored through the HSAB Executive Group to ensure consistency, relevance and progress.