Halton Safeguarding Adults Board Annual Report
April 2024 – March 2025

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Message from Chair

My name is Denise Roberts and I am the Associate Director of Quality & Safety Improvement for NHS Cheshire & Merseyside. In October 2024, I commenced the role of Chair of Halton Safeguarding Adults Board.

I am very pleased to present the annual report of Halton Safeguarding Adult Board for 2024/25. The report is an opportunity to share the work of the Board more widely and it provides an overview of the progress and achievements made during this 12 month period which I hope you will find informative and useful.

During this year we have continued to embed the new structure of our Board and sub groups and it has worked well. We remain committed to ensuring that safeguarding is "Everyone's Business" across Halton.

The context of our work over the next year will be to focus on our strategic priorities for 2025/26 as agreed at the Strategic Planning Event held in February, with all sub groups playing a critical role in achieving our outcomes.

Finally I would like to extend my thanks to all those who continue to work hard to support the Board and their continued commitment and focus on safeguarding adults in Halton. By working together, we can continue to improve the lives and outcomes of many of our vulnerable residents.

I look forward to working with you all again this year

Denise Roberts

Chair of Halton Safeguarding Adults Board

HALTON
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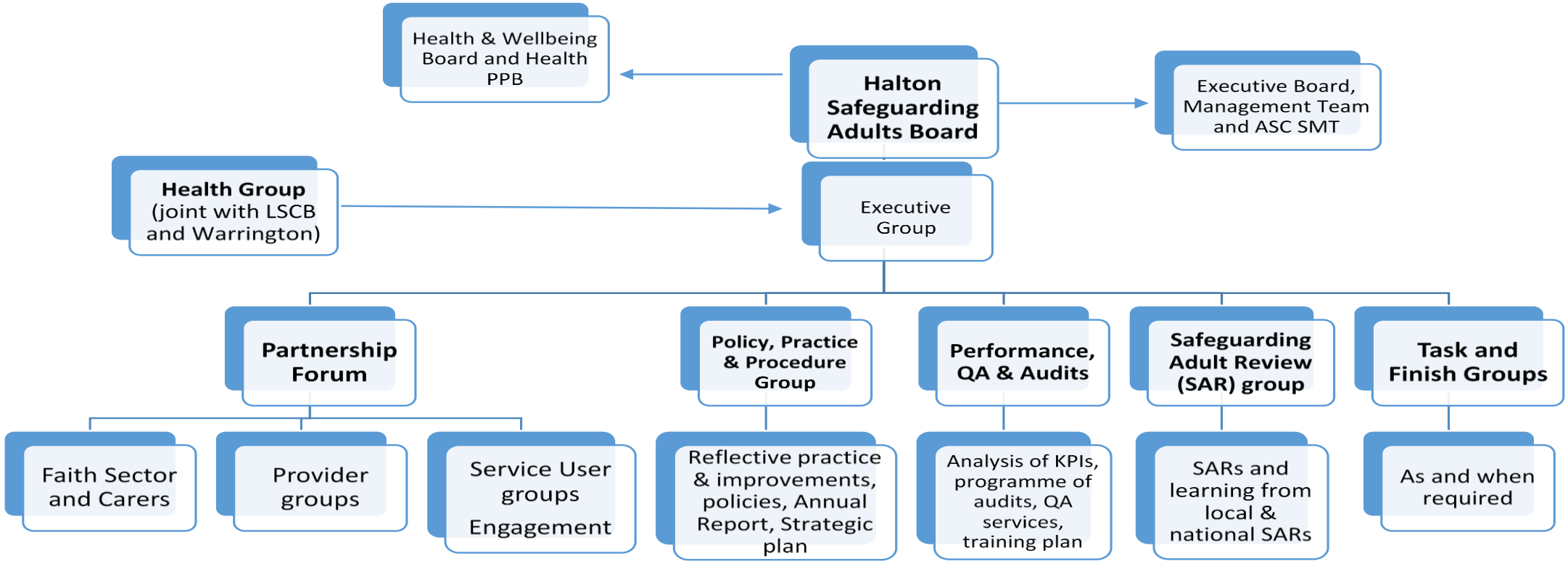
Overview of the Board



HSAB Partner Organisations

HALTON
SAFEGUARDING
ADULTS
BOARD

HALTON BOROUGH COUNCIL

NHS Bridgewater Community Healthcare NHS Foundation Trust

Cheshire Constabulary

Halton Children and Young People SAFEGUARDING PARTNERSHIP

NHS Cheshire and Merseyside

Mid Mersey ageUK

Cheshire Fire & Rescue Service

HM Prison & Probation Service

healthwatch Halton

NHS Mersey Care NHS Foundation Trust

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

NHS Mersey and West Lancashire Teaching Hospitals NHS Trust

NHS North West Ambulance Service NHS Trust

Independent Scrutineer

Halton SAB invited the role of an Independent Scrutineer to enhance the insight into the effectiveness of its arrangements. The role of the scrutineer is to ask questions about how well services are safeguarding people together, through its SAB arrangements.

During this reporting year, I have undertaken specific work on behalf of SAB to seek assurance about the effectiveness of the multi-agency audit process, and to consider the application and effectiveness of the SAR process. I have also attended all SAB and SAB Executive Group meetings, as well as the annual development session providing independent insights throughout the year.

The scrutiny insights have been reported to the SAB Executive and Board with an end of year scrutiny appraisal reflecting on the year and looking forward to 2025/26.

The overarching assurance statements considered are:

- Safeguarding partners are involved in strategic planning and implementation
- The wider safeguarding partners, including relevant agencies, are actively involved in safeguarding adults
- Making Safeguarding Personal – the voice of people in Halton processes are in place for data collection, performance and quality oversight
- There is a robust process for identifying and investigating learning from local SARs and national SAR analysis
- There is an active programme of multi-agency safeguarding adult training

Independent Scrutineer

In summary, the Halton Safeguarding Adults Board have adopted a strong culture of constructive challenge, ability of agencies to question and an appetite to be continually assured of the effectiveness of systems, policy and practice. The SAB Executive and Board have actively invited this culture between its members and through independent scrutiny which has been listened to carefully.

The themes , trends and areas of safeguarding that concern members, reflect the wider social issues including the cost of living, potentially attributing to some of the prevalent safeguarding issues such as self-neglect. Reassuringly, the SAB recognise that good quality intelligence is essential to an effective collaborative safeguarding system. The development of the performance framework invites qualitative and quantitative intelligence and provides a mechanism for "testing" and "listening". Overall, there is observation of robust arrangements for the SAB and its range of subgroups, tools and activity strengthens this further.

I outlined some observations about system working for cross-cutting areas of safeguarding, strengthening the partnership contributions, developing the preventative focus and voice of people in Halton and lastly tackling the persistent thematic areas that emerge through the SAB. I will continue to work with the SAB through a schedule of activity to strengthen the role responsibilities for acting as a critical friend and providing objective support, scrutiny and challenge.

Anna Berry

Independent Scrutineer – Halton Safeguarding Adults Board

Key Safeguarding Data 2024/25

HALTON SAFEGUARDING ADULTS BOARD

832 Safeguarding Concerns raised during 2024/25

337 Progressed to S42 enquiries

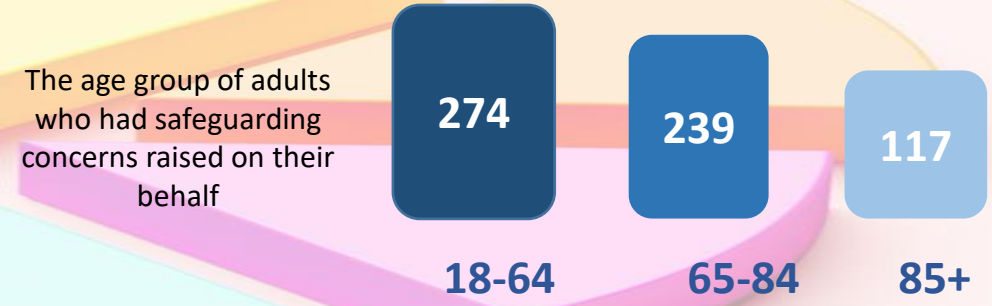
3% Increase safeguarding concerns

3% Increase in safeguarding concerns progressing S42 enquiries

41% Safeguarding Concerns relate to males

59% Safeguarding Concerns relate to females

The age group of adults who had safeguarding concerns raised on their behalf

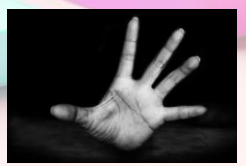


506 White British
8 Black & Minority Ethnic
7 Refused to disclose
109 Undeclared/Unknown

Ethnicity of those adults who had safeguarding concerns raised on their behalf

180

Safeguarding concerns involved allegations of neglect



61

Safeguarding concerns involved allegations of physical abuse

58

Safeguarding concerns involved allegations of financial abuse

In Halton, an adult at risk is most likely to be female, aged 65-84 and living in their own home and will suffer from neglect or acts of omission

Deprivation of Liberty Safeguards 2024/25

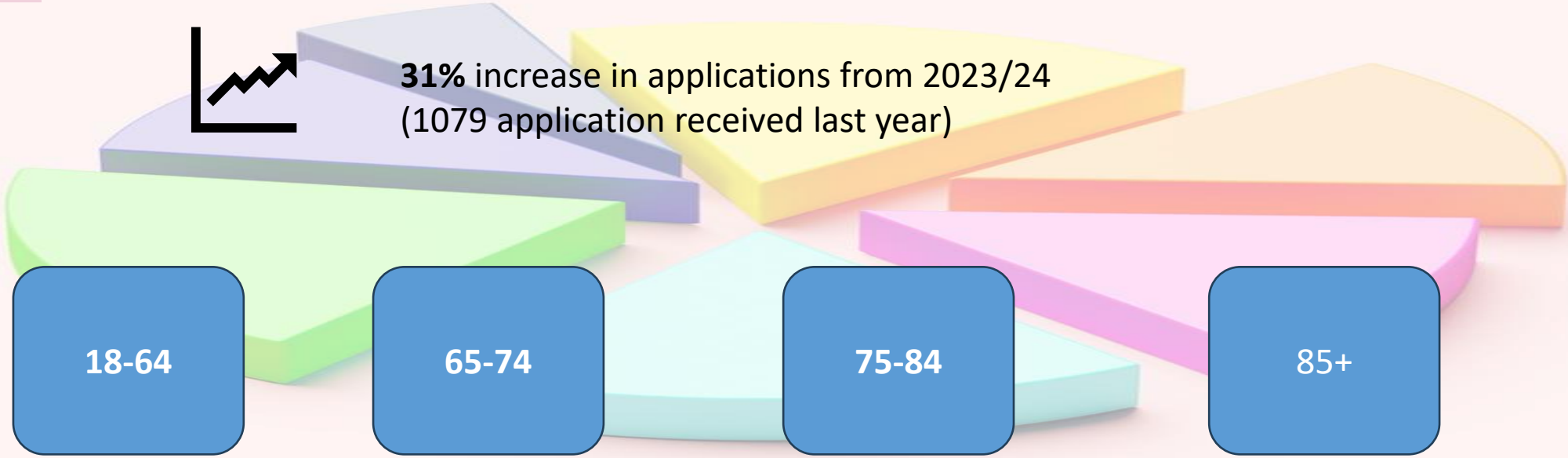
HALTON SAFEGUARDING ADULTS BOARD

1410 Applications received

49% of applications received for males

51% applications received for females

31% increase in applications from 2023/24 (1079 application received last year)



18%

12%

35%

33%

% of applications received broken down by age group

HSAB Priorities for 2024/25

Halton Safeguarding Adult Board Strategic Plan 2024- 2025

Our role is to help and safeguard adults with care and support needs by:

- Seeking assurance that local safeguarding arrangements are in place as defined in the Care Act.
- Assuring that safeguarding practice is person-centred and outcome focused.
- Work collaboratively to prevent abuse and neglect where possible.
- Ensuring that agencies and individuals work in a timely and proportionate manner where abuse or neglect has occurred.
- Seeking assurance that safeguarding practice is continually improving.
- Concern ourselves with a range of issue which may impact on people with care and support needs.

Partnership Forum | **Policy, Practice and Procedure Sub-Group** | **Performance, QA & Audit Sub-Group** | **SAR Sub-Group**

HSAB Responsibilities

Publish strategic plan

Publish annual report

Complete Safeguarding Adult Reviews when adults die or are seriously injured as a result of abuse/neglect

Strategic Priority 1

Communication and Involvement

Improve awareness of safeguarding across all citizens, communities and partner organisations.

Sharing learning from Safeguarding Adult Reviews and gain assurance of their related Action Plans Continue to seek assurance on LeDeR action plans and learning disability related safeguarding issues

Strategic Priority 2

Strategic Intervention and Early Intervention

Developing strategies that reduce the risk of abuse, as well as seeking assurance from partners

Seek assurance through audit activity that Making Safeguarding Personal is embedded into practice through safeguarding concerns and enquiries.

Continue to seek assurances that vulnerable young adults are transitioning safely into adult services.

Strategic Priority 3

Making Safeguarding Personal

Ensuring that adults with care and support needs are being supported and encouraged to make their own decisions.

Continue to review our leaflets and publications and involve citizens to hear their experiences to enable improvement.

Continue to identify relevant themes for multi-agency audits.

Strategic Priority 4

Learning development and assurance

Ensure safeguarding arrangements work effectively and learning is shared

Continue to develop a safeguarding dashboard that will be provide the Board with further themes, trends and analysis that can help with the Strategic Plan.

Continue to develop and implement the prevention strategy.

HSAB Achievements 2024/25

HALTON SAFEGUARDING ADULTS BOARD

Strategic Priority 1

Communication and Involvement

Improve awareness of safeguarding across all citizens, communities and partner organisations.

Sharing learning from Safeguarding Adult Reviews and gain assurance of their related Action Plans Continue to seek assurance on LeDeR action plans and learning disability related safeguarding issues

Learning from National SARs is included on the agenda of the SAR sub group

Themes from National SAR Learnings have been used for Multi Agency Audits

Updates from LeDeR Action Plans brought to HSAB on a regular basis

Strategic Priority 2

Strategic Intervention and Early Intervention

Developing strategies that reduce the risk of abuse, as well as seeking assurance from partners

Seek assurance through audit activity that Making Safeguarding Personal is embedded into practice through safeguarding concerns and enquiries.

Continue to seek assurances that vulnerable young adults are transitioning safely into adult services.

Making Safeguarding Personal questionnaire continues to be an integral part of the S42 enquiry process

Data related to Making Safeguarding Personal Outcomes is monitored through the HSAB Performance Dashboard which is produced on a quarterly basis

Transitional safeguarding continues to be a priority for the Board and work will continue into 2025/26

Strategic Priority 3

Making Safeguarding Personal

Ensuring that adults with care and support needs are being supported and encouraged to make their own decisions.

Continue to review our leaflets and publications and involve citizens to hear their experiences to enable improvement.

Continue to identify relevant themes for multi-agency audits.

7 minute briefings and toolkits are regularly added to HSAB website on various topics in relation to safeguarding

Domestic Violence in Older People animation personalized for Halton

Multi Agency Audit themes continue to focus on prevalent themes either locally or nationally

Strategic Priority 4

Learning development and assurance

Ensure safeguarding arrangements work effectively and learning is shared

Continue to develop a safeguarding dashboard that will be provide the Board with further themes, trends and analysis that can help with the Strategic Plan.

Continue to develop and implement the prevention strategy.

HSAB Performance Dashboard has been reviewed, updated and streamlined to provide clear and concise data and information in relation to safeguarding in the Borough

Prevention Strategy Action Plan is reviewed, monitored and updated by each sub group at every meeting.

Prevention Strategy and Action Plan to be reviewed and updated in 2025/26

Partner Agency Updates

HALTON
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Halton Borough Council has continued to support the work of Halton Safeguarding Adults Board and it's sub-groups this year. The Board and all of it's sub-groups include at least two members of Halton Borough Council staff on each group.

The multi-agency safeguarding case file audits have continued this year with 3 audits completed as follows:

March 2024 – Emergency Duty Team
June 2024 – Domestic Abuse in Older People
November 2024 – Neglect and Acts of Omission in Care Homes

The audits have been well attended and have received positive feedback from both Lead Auditors and practitioners involved. All findings from the audits are presented to the Performance, Quality Assurance and Audit Sub-Group in the first instance and then shared wider with the Board. Key actions that have taken place as a result of these multi-agency audits have included the introduction of the Multi Agency Risk Assessment Management (MARAM) process, which has proven extremely useful when dealing with cases of self-neglect in particular. The Integrated Adults Safeguarding Unit has continued to roll out it's programme of action learning sets to the adult social care operational teams on how to complete Section 42 enquiries and the results of this learning is evident in the quality of the cases that have been audited this year.

During the year the following policy and procedure documents have been reviewed, updated and agreed by HSAB:

Safeguarding Adults Policy, Procedure and Guidance documents
MARAM Policy
Safeguarding Adult Review Policy
MARAC Operating Protocol
Self-Neglect Policy
Self-Neglect Toolkit

The work that has been led by Halton Borough Council this year has included the planning and hosting of the HSAB Strategic Planning Event. This is an annual planning event that took place in February 2025 and provides an opportunity for the Board members and sub-group members to contribute to priority setting for the Board and it's sub-groups for the forthcoming year.

Partner Agency Updates

HALTON
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National Safeguarding Week was supported once again this year by the Board, with a series of Lunch and Learn events on various aspects of safeguarding hosted online. The HSAB website was also updated with numerous resources relating to the daily themes of National Safeguarding Week which are accessible to all. A daily social media campaign was also held during the week with various awareness raising messages shared across all social media platforms by Board members.

HSAB continues to subsidise a small programme of training courses to enhance the opportunity and access to learning across Halton. The courses that are provided throughout the year are as follows:

- **Safeguarding Adults – Awareness and Responsibilities**
- **Provider-Led Concerns and Enquiries**
- **Mental Capacity Act – working with capacity assessments**
- **Self-Neglect Awareness**
- **Financial Abuse Awareness**

In addition to these courses, the Integrated Adults Safeguarding Unit provides Action Learning Set sessions for operational staff in adult social care to increase their confidence and competence in completing Section 42 enquiries. This work has been reflected in the quality of case recording noted during the multi-agency audits.

Partner Agency Updates

HALTON SAFEGUARDING ADULTS BOARD

NHS Cheshire & Merseyside Integrated Care Board Halton Place (NHS Cheshire & Merseyside ICB Halton) has continued to receive quarterly safeguarding assurance from NHS commissioned health providers. Safeguarding activity across Halton's large NHS Trusts has remained significant throughout the year. NHS Trust Safeguarding Teams continue to support and guide NHS staff with complex concerns ensuring appropriate actions are taken. Activity levels to internal Safeguarding Teams, demonstrate that patient facing staff are identifying and acting on concerns. Trust staff follow internal safeguarding pathways to access expert safeguarding advice within their organisations. Health safeguarding referrals to the Local Authority continue to show a high conversion rate to accepted Section 42 enquiries, indicating that in the main, appropriate referrals are being made by Health.

The large NHS Trusts complete a bi-annual safeguarding audit and assurance programme, this is comprised of a suite of commissioning standards. Assessment and rating are conducted, following which providers work towards compliance in any areas required. There is a continuous cycle of improvement which includes a quality focus.

During 2024/25, the large provider Key Performance Indicators (KPI) tool was submitted quarterly by large NHS Provider Trusts. This allows organisations to be mapped across the region, trends, patterns and risks can be drawn from the data. The intelligence gained assists in future planning around risks, training and work streams.

Areas below threshold compliance are highlighted, targeted and monitored via action plans. This process aided assurance across the system.

Trust side safeguarding processes are supported by Specialist Safeguarding Teams, policy updates, mandatory and additional training around emerging themes and topics.

NHS Cheshire & Merseyside ICB Halton and health providers have worked collaboratively with Halton Borough Council safeguarding colleagues and the HSAB partnership on all sub-group areas, task and finish groups and multi-agency audit workstreams (acting as lead auditors), this has led to learning being cascaded across Halton and the local health economy.

Health has continued to provide data to HSAB including quarterly safeguarding training data for inclusion in the HSAB dashboard. The data details safeguarding training levels, for the four large NHS Trusts that serve Halton residents. This provides a level of assurance regarding safeguarding knowledge and practices at the Trusts.

NHS Cheshire & Merseyside ICB Halton staff continue to prioritise Mental Capacity Act (MCA) adherence and strive to support and educate staff around the Act. The Cheshire & Merseyside MCA forum meets quarterly, chaired by the Halton Place Designated Nurse. The group is attended by NHS Trust providers and Designated Safeguarding Adult representatives. The group acts as a network, sharing national and local resources and devising strategies to strengthen practice across the region.

Partner Agency Updates

HALTON SAFEGUARDING ADULTS BOARD

Support for Primary Care has continued this year, with a programme of education in the form of training sessions, themed webinars via NHS Futures Platform (online platform), monthly safeguarding newsletter and Primary Care forum meetings. The Halton Named GP and Designated Nurse continue to support with ad hoc supervision.

During 2024/25, NHS Cheshire & Merseyside ICB Halton successfully secured 12 months funding to pilot the Identification and Referral to Improve Safety (IRIS) scheme across Halton. IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for general practices. As part of the programme, DVA training has been delivered to Primary Care staff across the borough, all practice staff have been included in the roll out, from reception staff to GPs. The training has increased awareness of DVA amongst staff which has led to an increase in referrals to the Halton Domestic Abuse Service.

Health continued to support the provision to Daresbury Initial Accommodation Centre. The system has flexed to accommodate the changing nature of the centre, from the changes to population and demographics at the centre to issues such as management, treatment and containment of outbreaks during the year.

NHS Cheshire & Merseyside ICB continued to chair monthly meetings, where themes, concerns and proactive work was conducted. During episodes of escalation, reactive meetings were called to mitigate risks in a timely manner. The health system alongside partners adapted to effectively deal with situations. The lived experiences of residents was conveyed at meetings (by agencies i.e. Red Cross, Migrant Health) and factored into plans. These actions supported much needed stability at the centre.

<u>Learning from Lives and Death – People with a learning disability (LeDeR)</u>
The NHS Cheshire & Merseyside LeDeR Specialist Service has now been in operation for over two years. The programme has continued the quality assurance process over 2024/25. Reviews are quality assured by experienced senior specialist reviewers and the Local Area Contact. The Cheshire & Merseyside LeDeR Review Panel review in depth focus reports. NHS England and the NW Quality Panel review a sample of reviews quarterly; this process provides confirmation and assurance that reviews are being correctly considered and processed.

The NHS Cheshire & Merseyside LeDeR programme works closely with experts by experience, parents and carers and the Cheshire & Merseyside LeDeR Review Panel is supported by experts by experience.

The NHS Cheshire & Merseyside LeDeR programme has continued to work with People First Merseyside (DAVID) Project – Dignity and Voices in Dying, joining forces to deliver lunch and learn sessions and face to face awareness raising sessions regarding End of Life/Advanced Care Planning. A conference is planned for 2025. Further advancements are planned, with the development of an easy read Advanced Care Plan document, this will be produced with the support of experts by experience (parents and carers).

Partner Agency Updates

HALTON
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Analysis of information/learning gained from year one of the programme led to a work plan. During 2024/25, work has progressed around obesity and weight management, dysphagia and choking.

Work has progressed via a NHS Cheshire & Merseyside LeDeR Forum. The forum meets quarterly with an established membership and an open offer to any new members. A LeDeR newsletter is produced by the group, with the aim of cascading learning.

A North West event took place during 2024/25 with a focus on obesity and weight management (and choking deaths). The NW Toolkit was promoted and cascaded to practitioners and organisations. Several case studies and webinars were delivered across Cheshire & Merseyside (Obesity and Weight Management). Work to improve practice around weight management has progressed on several fronts.

LeDeR Priority areas for focus during 2025/26 have been set as:

Advanced Care Planning – North West Conference planned to increase awareness of advanced Care Planning/End of Life Care for people with a learning disability

Dysphagia and choking deaths

Highest Medical Certificate of Case of Death (MCCD) – Respiratory and Circulatory Disease Mild Learning Disability with MCCD

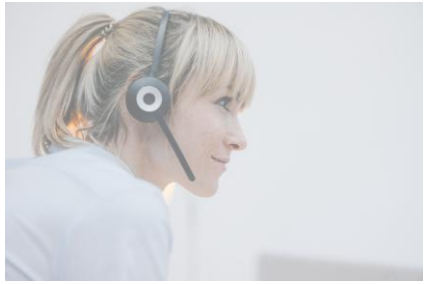
NHS Cheshire & Merseyside LeDeR updates have been shared with Halton Safeguarding Adults Board. A representative from the LeDeR Team attended HSAB to provide assurance to the Board during 2024/25.

Partner Agency Updates

HALTON
SAFEGUARDING
ADULTS
BOARD

Partner Agencies are reminded about their responsibility in notifying Cheshire Police to any breach of Orders (Non-Molestation/Restraining Orders) or breach of bail conditions.
Research shows us that early detection of crime and proactive policing of breaches protects victims and allows reassurance within the most vulnerable.
Safeguarding is everyone's responsibility.
The reporting of breaches should not be left for the victims to decide on their own safety versus reporting. The decision for a professional not to report any known breaches should not be based on their rapport and relationship with the victim and the family.
Reporting should be made via 101 and threat and risk indicators should be explained at the time of the reporting with evidence recorded.

Serious Case Review Team
Serious.case.review@cheshire.police.uk



Partner Agency Updates

HALTON SAFEGUARDING ADULTS BOARD

The Safeguarding Adult Team have continued to provide strong support to clinical teams with reactive, ad-hoc and group safeguarding supervision and training throughout the year. The team are recognised across Bridgewater as approachable, resourceful and knowledgeable and utilised by front line practitioners as an expert resource.

Compliance with mandatory training in Safeguarding Adults, Mental Capacity Act Training, PREVENT and WRAP3 exceeds 90% and compliance across the Trust.

The Safeguarding Adult Team make a significant contribution to both Halton and Warrington Safeguarding Adult Boards, contributing to multi-agency audits, strategic and operational meetings and learning reviews.

Safeguarding activity across Bridgewater has increased throughout 2024-25, this provides assurance around practitioner's recognition of, and response to, abuse and neglect in a timely manner.

The Safeguarding Team contributed to the development of the MARAM process, including development and delivery of training around the MARAM process, this has proved to be a success with an increase in referrals and support for Bridgewater patients.

The Team engaged with both Halton Safeguarding Adults Board in the promotion of Safeguarding Adults Week. Details were disseminated in the Trust bulletin and on Twitter, with support provided with the programme of Lunch and Learn events.

<u>MARAC and Domestic Abuse</u>:
Focussing on a Think Family approach, the Safeguarding Adult Team now routinely screen MARAC listings and provide information for those people who are open to Bridgewater services, to support multi-agency decision making. For those identified, records are flagged to ensure staff have the relevant information for the patients they are engaging with. This supports Bridgewater's safeguarding children teams' contribution to MARAC and provides more robust and holistic information to support families and children.

<u>Trauma Informed Practice:</u>
In response to local learning and audits, Level 3 safeguarding adult training has been revised to include childhood trauma and is delivered from a trauma informed perspective to support staff in adopting a trauma responsive approach to their practice

Partner Agency Updates

HALTON SAFEGUARDING ADULTS BOARD

Hoarding and Self-Neglect:

In response to self-neglect and hoarding being identified as a theme, a bespoke training package was developed and 7-minute briefing to encourage staff to be professionally curious. Practitioners are now encouraged to complete the universal "Clutter Scale" as an evidence-based tool to support assessments and care plans.

In November 2024, the senior safeguarding nursing team hosted the Trust's annual safeguarding conference. The theme was domestic abuse. The conference was a huge success and attended by 57 delegates. The conference included presentations from both adult and children Bridgewater Safeguarding Teams and guest speakers from Warrington Borough Council Domestic Abuse Hub, My CWA (Cheshire Without Abuse), Cheshire Police and Brainkind. Topics discussed included domestic abuse statistics, male victims, perpetrator programmes, policing responses to domestic abuse, non-fatal strangulation and traumatic brain injuries.

Domestic Abuse has remained a focus throughout the year, with training delivered on non-fatal strangulation to strengthen practitioner recognition and response to this.

The team have oversight of incidents and contribute to the Directorate Incident Review & Learning Group (DIRLG) across all divisions to ensure review of incidents from a safeguarding perspective.

The safeguarding adult's nurses facilitate bi-monthly Safeguarding Advocates meetings across Halton. This provides an opportunity for regular updates and promotes discussion around current cases and themes and trends being observed. These have been successful in learning through case discussion and upskilling practitioners.

Quality Review Visits have continued across the Trust with input from safeguarding. The Bridgewater Quality Review tool includes 12 standards based on the CQC single assessment framework including safeguarding.

There has been a focus on Mental Capacity Act (MCA) in response to learning and audit completed, bespoke training has been developed and delivered and the electronic patient records now includes an MCA template to support with assessment and documentation.

Partner Agency Updates

HALTON
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Trinity Safe Space has reviewed all it's policies, updating anything which needed to be. All relevant emails from the Halton Safeguarding Adults Board have been sent out to the Safeguarding Faith Forum; Faith Leads and their Safeguarding Officers. The email distribution list has been updated as contacts change and new people have been added. Personnel have been encouraged to attend multi-agency safeguarding training.

Trinity Safe Space has done 1:1 engagement with "beneficiaries" and surveys about which activities they would like to attend. A funding application was submitted and was successful so some of the activities will be starting soon. These are to give people something to do with their time, to improve their mental health. We engage continuously with individuals at our drop-ins and through messaging, as we try as best as we can to meet their needs. Many of the needs are regarding poverty, mental ill health and housing/homelessness. We get very positive feedback from people about how we make them feel and how we try our best to help and support them.

The email updates about training have been circulated to the Safeguarding Faith Forum, the Halton and St Helens Voluntary Community Action mailing list and to Trinity Safe Space volunteers.

Some of the volunteers from Trinity Safe Space have attended multi-agency training as have some from the voluntary community and faith sector. Information gained has been shared by email and conversations e.g. about the steep rise in the recreational use of Ketamine. The Chair has recently attended the Prevent, Ketamine and Trauma Informed Safeguarding training sessions. Prevent is particularly relevant to Trinity Safe Space.

It is important to keep informed about up-to-date training and development in case they do not receive this in their organisations.

The LADO offered to do a bespoke training session on the role of the LADO for the sector, this has not yet taken place.

Partner Agency Updates

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Pauline Ruth has been heavily involved in supporting 5 suicidal men over the past few months. Two of them reached crisis level – she had to call an ambulance for one who had seriously self-harmed and had to talk down the other as he was in the middle of a busy road trying to be knocked over. The other three are not at crisis level at the moment but need ongoing support. This has highlighted the lack of an easily negotiable pathway into timely, relevant mental health services which are trauma informed and puts a strain on scant resources in the charity.

The other major issue we are dealing with is homelessness in the cohort of newly granted refugees, because of the shortage of suitable housing. We are helping people look for private rented accommodation but come across barriers of deposits, guarantors, unregistered landlords etc. They are very vulnerable to abuse, exploitation and hate crime.

As a result of these issues, a funding expression of interest has been submitted to the Lloyds Bank Foundation by Trinity Safe Space in partnership with Recharge and Restore; Citizens Advice, Halton and SHAP Ltd, to support and influence system change, with the intertwining themes of mental health and homelessness.

TRINITY
SAFE SPACE

Partner Agency Updates

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As part of our internal quality assurance processes, we undertake full internal case audits on a monthly basis. These are completed by our regional Quality Team and focus on the overall quality of case management and assessment; they will also include a review of partnership engagement and collaboration in relation to effective risk management and intervention.

The most recent audit findings evidences that our overall rating was good with a score of 2.70 and a year-to-date score of 2.56 which just falls into Amber.

In addition to the above, we have recently undertaken an internal audit in relation to Domestic Abuse and Safeguarding Checks and whether the information received into the Probation Service has informed our assessments and risk management. The outcome of this audit will be shared with the partnership once available. There is a commitment to continue with focused quality internal audits over the next 12 months.

We are also fully engaged with multi-agency audits and have nominated cases and attended multi-agency forums across the partnership.

The Probation Service is a National Organisation with national policies and processes. We have a national Engaging People on Probation (EPOP) Strategy which enables co-production of key policies and process across England and Wales. Once completed these are then implemented across local Probation Delivery Unit (PDU) areas and functions.

As part of this strategy there is a requirement for Local EPOP delivery plans to be embedded within each Probation Delivery Unit. Halton has an established EPOP lead who is proactive in engaging with people on probation, as well as working with our EPOP volunteers across the PDU.

One of our focuses for 2025/26 is to establish People of Probation engagement forums which will be chaired by the Head of Probation. The purpose will be to listen to the experiences of the people we supervise, adapt our internal processes from this feedback and encourage more EPOP volunteers.

This year has had a real focus on continued professional development with the North West probation region. We have implemented a Quality Improvement Plan which saw a requirement for all staff to refresh their mandatory training as well as attend new training events, focusing on risk assessment and management.

In addition to the above, we promote multi-agency training across the Halton Team and have now set up a monitored tool to improve attendance and engagement at these events.

Partner Agency Updates

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From a national position, we have this year introduced Professional Registration for all Qualified Probation Officers, which ensures qualified staff keep up-to-date with their mandatory training and CPD on an annual basis to continue their registration.

We have worked closely with the OPCC in implementing the Domestic Abuse Co-ordinators as part of the PCC Serious Violence duty. We have a dedicated Police Domestic Abuse Co-Ordinator in Halton, who works collaboratively with Probation Practitioners in working with Serious Domestic Abuse Perpetrators in assessing and managing risk.

We have mobilised a new Cheshire wide Registered Sex Offender Delivery in collaboration with Cheshire Constabulary, the new model focus on joint working with Police and Probation Offender Managers, focusing on engagement and risk management.

We continue to lead on MAPPA delivery across Cheshire, which focuses on the risk management of offenders and the safeguarding of victims and vulnerable adults.

HM Prison & Probation Service

Partner Agency Updates

HALTON
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BOARD

Riverside College is currently working towards "College of Sanctuary" award.

One World Week (celebrating our students from different cultures and raising awareness to our whole college population about the difficulties that students and asylum seekers face):

- **Engaged with several partners across the borough including Halton Borough Council, Trinity Church, zero waste and local businesses to develop a week of activities**
- **Wellbeing events for all adult students e.g. coffee mornings, conversation clubs, Zumba, crafts**
- **Coffee mornings are an ideal way to prevent loneliness and build communities for our adult students (this happens on a monthly basis)**
- **Raising aspirations – meet the staff event**

Safeguarding training provided for all staff members. A variety of CPD sessions are run throughout the year, relevant to the local and surrounding areas.

Race for Hope – college event held in the park which takes place annually. Creates a sense of community, empathy and compassion. A lot of our students are impacted by cancer, so this gives time for students to raise money but to also have conversations.

Partner Agency Updates

HALTON
SAFEGUARDING
ADULTS
BOARD

Halton Carers Centre received the Star Standard and Improving Quality Kitemarks in 2023 and intents to submit again at the end of 2025

We always work alongside/in partnership with carers rather than "doing to". This year we have developed our volunteering programmes enabling more carers to lead sessions and co-produce our services

Our carer review processes and annual whole centre monitoring are robust systems and structures for listening to carers to ensure their voice is heard

All Halton Carers Centre staff and volunteers have appropriate training for their role

We are proud of our safeguarding records and take our responsibility to ensure strong safeguarding practices for both the carer and the cared for

Our staff, volunteers and trustees all receive training appropriate to their role and we work closely with Halton Social Services and Adult Social Care Teams to share good practice and support carers to keep themselves and their loved ones safe

Partner Agency Updates

HALTON
SAFEGUARDING
ADULTS
BOARD

Healthwatch Halton has focused on assuring the quality of local care services through direct visits and observations. We have carried out two Enter & View visits to local care homes to assess the care quality and dignity of residents. Additionally, we conducted a joint 'A&E Watch' observation at Whiston Hospital's Accident and Emergency department (with Healthwatch Knowsley), to gather real-time patient experiences. The resulting report highlighted good practices as well as areas needing improvement and we presented its recommendations to the Hospital's Prust's Patient Experience Committee for action. We continue to escalate serious care quality concerns promptly – feedback from our hospital listening visits is reported back to the Trust's each quarter and any urgent issues (such as unsafe discharge cases) are raised immediately with providers. For example, at one hospital meeting we flagged a signage and communication problem which led to the Trust implementing improvements to its patient letters and improving directional signage at the hospital. This proactive approach has ensured that patient feedback leads to tangible service quality improvements.

During the past year, we have delivered a total of 276 outreach and engagement sessions across Halton, hearing feedback from over 5,800 local residents. These face-to-face sessions allow us to gather a wide range of views on health and care services. Working jointly with other local Healthwatch across Cheshire & Merseyside, we also facilitated Listening Events at local hospitals to co-produce improvements in urgent and acute care. Our sessions at Whiston Hospital A&E and at Warrington & Halton Hospitals invited patients and families to share first-hand experiences, which we fed back through our reports to the providers and commissioners of the services.

Our outreach was inclusive and targeted, ensuring the voices of vulnerable or seldom-heard groups were captured. We met people in settings convenient for them – from mental health hubs and homeless hostels to veterans' breakfast clubs, over 55s housing and other community venues and centres.

For example, during quarter 4 we engaged with residents at a homeless shelter (Brennan Lodge), a veteran's morning club, a vision support group for people with visual impairments and a local primary school. By bringing engagement into these diverse venues, we reached individuals who might not otherwise give feedback, ensuring community insights inform adult safeguarding work, All feedback is shared with providers, commissioners and Healthwatch England to help influence service improvements.

Our Advocacy Hub Independent Mental Health Advocate (IMHA) Team continue to attend monthly safeguarding meetings at Gateway Recovery Centre (GRC) with external parties such as the Halton Borough Council Safeguarding Team, the GRC Safeguarding Team and the Police. We now receive updates from the Safeguarding Team to advise on safeguarding enquiries, and this allows for any enquiries not received from the hospital to be supported.

Partner Agency Updates

HALTON
SAFEGUARDING
ADULTS
BOARD

The current statutory areas of support provided by the Halton Advocacy Hub are:

- **IMHA – Independent Mental Health Advocate: For those patients held within a secure setting**
- **IMCA – Independent Mental Capacity Advocate: For those clients deemed to lack capacity for decisions around Change of Accommodation (CoA), for serious medical treatments (SMT) and for Safeguarding Enquiries**
- **Care Act – For those deemed with a substantial difficulty around care and support needs/planning for reviews of care and both safeguarding enquiries and reviews**
- **RPR – Relevant Person's Representative for those clients deemed to lack capacity around accommodation needs and requiring independent support whilst on a Deprivation of Liberty Safeguards (DoLS), residing primarily within a care home setting or hospital setting**
- **IMCA DoLS – For those clients deemed to lack capacity and this includes the IMCA 39A role, IMCA 39C role and the IMCA 39D role. Also this includes the 1.2 rep to provide support for those residing in a community placement ordered by the Court of Protection**
- **ICAS – Independent Complaints Advocacy Service: Supporting individuals with an NHS complaint**
- **Litigation Friend – For those individuals objecting to their DoLS and requiring support from the IMCA to make a 21A challenge to the Court of Protection**

During the past year the advocacy service has supported safeguarding areas in:

- **1 long term segregation (weekly visiting from advocacy)**
- **31 seclusion notices**
- **36 IMHA complex safeguarding enquiries/alerts**
- **20 Care Act Safeguarding referrals**
- **16 39D IMCA**
- **36 39A IMCA**
- **11 1:2 representatives**
- **193 RPR**

Partner Agency Updates

HALTON SAFEGUARDING ADULTS BOARD

Healthwatch Halton has invested in continuous learning and collaboration to strengthen safeguarding. Our staff team have all completed a number of training courses this year in the following areas:

- **Safeguarding Adults levels 1&2**
- **Mental Health Awareness**
- **Learning Disability**
- **Stress Awareness**
- **County Lines**
- **Diversity, Inclusion and Belonging**
- **Autism Awareness**
- **Equality & Diversity**

Staff are also provided the opportunity to attend any additional training provided by Healthwatch England, Halton Borough Council and local voluntary sector organisations.

Our staff and volunteers contributed significantly to Patient-Led Assessments of the Care Environment (PLACE) at local health sites – volunteers provided over 80 hours of their time in one quarter alone to support annual PLACE visits at Warrington & Halton Hospitals, Whiston Hospital, Mental Health Units and other care facilities. This hands-on involvement not only helped improve hospital environments but also developed our volunteers' understanding of quality standards.

We continue to be an active partner on local strategic forums representing the patient voice. We share emerging concerns and trends from the community and have raised specific safeguarding issues when needed, so that partner agencies can take coordinated action. For instance, we have highlighted recurring issues like hospital discharge problems and access to services, ensuring they are on the multi-agency radar.

Our team engaged in awareness initiatives such as National Safeguarding Adults Week to boost public awareness of safeguarding issues.

Throughout the year, 9 Healthwatch volunteers contributed over 150 hours of their time across various activities (from Enter & View visits to our reading panel for patient information).

This commitment to professional development and volunteer support has enhanced our capacity to safeguard adults: it equips our team with up-to-date knowledge and ensures we can effectively champion adults' rights and wellbeing in Halton.

Partner Agency Updates

HALTON SAFEGUARDING ADULTS BOARD

Mersey Care Foundation Trust has continued to support the Task and Finish Group for Domestic Abuse and Older Adults.

Mersey Care Foundation Trust is represented on the Quality Assurance Sub-Group and continues to support audit activity within Halton both as representatives at audits and acting as Lead Auditors.

Each year Mersey Care Foundation Trust agrees a minimum audit cycle. During 2024-25, two audits were completed on appropriateness of referrals to the Local Authorities (Quarter 2 and Quarter 4) which focused on the advice provided by Mersey Care Foundation Trust Specialist Leads within the Safeguarding Duty Hub and whether the recommendation to make a safeguarding adult referral was appropriate as well as auditing whether practitioners took the advice and followed through with making a referral and any subsequent actions. Quarter 1 audit was completed on patient-on-patient incidents within mental health inpatient settings and Quarter 3 audit focused on quality assurance regarding Domestic Abuse Risk Assessments and MARAC referrals. All audits highlighted positive practice and provided assurance around safeguarding practice, however, action plans to address learning were in place and have all been completed.

Mersey Care Foundation Trust has a dedicated Patient and Public Engagement Team that continues to engage with stakeholders on service provision and development.

During 2024-25, a Safeguarding Adults Specialist training package was put in place which had significant emphasis on Making Safeguarding Personal and how to ensure this is applied in practice.

During 2024-25, significant work was completed on launching Mersey Care Foundation Trust Safeguarding Links Network, formerly Safeguarding Champions/Ambassadors. Each team now has a dedicated Safeguarding Adults and Children Link. We have had two Safeguarding Links Away Days in 2024-25, one focusing on Exploitation and one day focused on Neglect; all speakers during those days were external partners. The away days had adult and children focus and was attended by both children and adult links, further reinforcing our Think Family Strategy.

A Training Needs Analysis is completed yearly; mandatory safeguarding training remains in place and is undertaken based on roles and responsibilities. Mersey Care Foundation Trust are above compliance (90%) with all levels of Safeguarding Adults Training.

Partner Agency Updates

HALTON SAFEGUARDING ADULTS BOARD

Mersey Care Foundation Trust has a modular training offer each year, which is accessible for Mersey Care Foundation Trust Halton practitioners. The training subjects during 2024-25 were:

- Exploitation
- Self-Neglect and Hoarding
- Safeguarding Adults Specialist
- Domestic Abuse
- Trauma Informed Safeguarding Practice

For World Suicide Prevention Day, Mersey Care Foundation Trust Safeguarding Team took the opportunity to raise awareness of the link between Domestic Abuse and Suicide, addressing learning from Domestic Homicide Reviews. This was a well-attended event with positive feedback from frontline staff members.

During Safeguarding Adults Week, Mersey Care Foundation Trust had an internal training offer aiming to address recurrent safeguarding concerns. The offer comprised of:

- Domestic Abuse Routine Enquiry
- Non-recent sexual abuse
- Hoarding Awareness
- Police: Introduction to Personal Safety
- Trauma Informed Safeguarding Practice
- Cuckooing
- Pressure Ulcers: Neglect and Acts of Omission

During the Thursday of Safeguarding Adults Week, Mersey Care Foundation Trust invited Halton colleagues to join us for Trauma Informed Safeguarding Practice.

To ensure robust implementation of Mersey Care Foundation Trust Domestic Abuse Policy and Practice Guidance, toolkit sessions were set up for Mersey Care Foundation Trust practitioners. These were short 1 hour sessions focusing on “how to” and reinforcing the expected response to Domestic Abuse. The toolkit sessions are:

- Routine Enquiry
- Responding to Domestic Abuse
- Domestic Abuse Risk Assessments, MARAC referrals and Professional Judgement

Partner Agency Updates

HALTON SAFEGUARDING ADULTS BOARD

All our teams in Halton continue to have 3 monthly Safeguarding Adults Supervision where further professional development is provided on safeguarding matters.

Mersey Care Foundation Trust has continued to raise awareness of the MARAM process during 2024-25, by creating a dedicated page for MARAM on the safeguarding intranet and a 7-minute briefing has been created and distributed. Mersey Care Foundation Trust Safeguarding Adults Policy has also been updated to highlight MARAM as expected practice for suitable cases.

Policy, Practice & Procedure Sub-Group Update

HALTON SAFEGUARDING ADULTS BOARD

The Sub-Group has promoted the use of the National Pressure Ulcer Guidance with Halton nursing homes. As of April 2025, all local NHS Trusts, local hospice and Halton nursing homes have agreed to use the guidance and an easy-read version of the guidance has been developed

A range of policies were updated and agreed by the sub-group including the Self-Neglect Toolkit and Self-Neglect Policy, MARAC Protocol and PiPOT (Persons in a Position of Trust) Policy

A MARAM Task and Finish Group produced a 7-minute briefing which was made available to the public and professionals via the HSAB website

A Halton Professional Challenge and Escalation Policy was written following implementation of the MARAM policy. The policy provides information on how to escalate concerns when there is professional disagreement

A small task and finish group met to review the Halton guidance around Harmful Sexual Behaviour for people with learning difficulties

The sub-group was involved in the planning for National Safeguarding Week, which took place from 18th – 22nd November. Partner agencies helped to deliver sessions over the week and there was good attendance at the sessions

As part of National Safeguarding Week in November in series of lunch and learn sessions were held with partners on the themes of County Lines and Trauma Informed Practice

As part of the implementation of Halton's MARAM process, a series of lunch and learn sessions were held for professionals and delivered by members of the sub-group

Prevention Strategy Action Plan reviewed and updated at every meeting

Safeguarding Adults Review Sub-Group Update

HALTON
SAFEGUARDING
ADULTS
BOARD

Safeguarding Adult Review (SAR) Sub-Group reviewed and updated the Safeguarding Adult Review Policy & Procedures

The group has considered a number of SAR referrals received and feedback provided to Halton Safeguarding Adults Board in terms of outcomes and recommendations

The sub-group considered the link between SARs and Modern Slavery and considered ways of raising awareness in the borough

Suggestion of a Task and Finish Group to look at the link between SARs and Homelessness

Membership of the SAR sub-group was expanded in October 2024 and includes representation from Halton Domestic Abuse Service; Age UK, Mersey Care and Adult Social Care

A 7-minute briefing was produced on Gambling and Domestic Abuse and shared via the HSAB website

Members of the SAR Sub-Group attended a SAR learning event held in September 2024 hosted by Liverpool Safeguarding Adults Board
Agreed that a separate Screening Panel will be responsible for screening SAR referrals, which is made up of statutory members of the group (Local Authority; Police; Health)

The group considered National Learning from SARs including key themes for autistic people and adults with a disability

Halton's Commissioning Lead for learning difficulties is undertaking a piece of work around the National Learning from SARs

A Self-Neglect Task and Finish Group has been established to look at the early identification of self-neglect. There is multi-agency membership of this group including Cheshire Fire and Rescue; Cheshire Police; Housing and DWP

Prevention Strategy Action Plan reviewed and updated at every meeting

Performance, Quality Assurance & Performance Sub-Group Update

HALTON
SAFEGUARDING
ADULTS
BOARD

The HSAB Performance Dashboard is presented to this group on a quarterly basis. The format of the dashboard was reviewed and updated following a review

The HSAB Training Programme for 2025/26 was agreed and circulated to all partner agencies. A small Task and Finish Group was established to review the content of the training packages to ensure they were still accurate and met the needs for Halton. Training course content was amended as appropriate.

Multi-Agency Audits took place in March 2024; June 2024 and November 2024 with the findings and identified areas of learning reported back to the sub-group and to HSAB (please see Multi-Agency Audit section for further details of findings and recommendations as a result of these audits

Terms of Reference for the group were reviewed and updated during 2024/25 and membership of the group updated

Areas of improvement identified from Multi-Agency Audits including ensuring that agencies attend the audits when requested. All sub-group members are now notified of the cases to the audited so they can undertake necessary checks of their agency's involvement with the adult at risk

Prevention Strategy Action Plan reviewed and updated at every meeting

Partnership Forum Update

HALTON
SAFEGUARDING
ADULTS
BOARD

The Partnership Forum supported National Safeguarding Week through establishing a Task and Finish Group to organise events to support the theme of the week

A Task and Finish Group to focus on Domestic Violence in Older People was established. This group has had an animation on this topic personalised for Halton and is available to view on the HSAB website

The Terms of Reference for the Partnership Forum were reviewed and updated in October 2024

A Partnership Forum survey was conducted in November 2024 to gain feedback as to how the Forum operates and suggestions for improvement

Partnership Forum to be re-launched in 2025/26 following discussion at the HSAB Strategic Planning Event

Priority areas for the Partnership Forum to focus on for 2025/26 are as follows:

- **Hard to Reach Groups**
- **Domestic Violence in Older People**
- **Co-production**

Prevention Strategy Action Plan reviewed and updated at every meeting

HSAB Strategic Planning Event

HALTON SAFEGUARDING ADULTS BOARD

The Strategic Planning Event was held on Tuesday 11th February 2025 at the Karalius Suite, DCBL Stadium Widnes. The event was attended by representatives from the following organisations:

Halton Borough Council
NHS Bridgewater Community Healthcare NHS Foundation Trust
Cheshire Constabulary
NHS Cheshire and Merseyside
Mid Mersey ageUK
HM Prison & Probation Service
Local Government Association
Cheshire Fire & Rescue Service
NHS Mersey Care NHS Foundation Trust
Department for Work & Pensions
TRINITY SAFE SPACE
SHAP
Riverside College Widnes & Runcorn

Kathy Clark – Care & Improvement Adviser for the North West in Care & Health, Local Government Association facilitated the event on behalf of Halton Safeguarding Adults Board. The current issues and priorities for the Board were discussed with the three main areas of focus highlighted as:

- Ensuring that organisations have a quality assurance process in place
- Co-production and engagement
- Learning and professional development

Attendees were split into small working working groups to discuss these main areas of focus. The feedback from these working groups will be used in order to develop a "Plan on a Page" to summarise the main priorities for HSAB for 2025/26.

National Safeguarding Week 2024

National Safeguarding Week 2024

HALTON SAFEGUARDING ADULTS BOARD

HSAB supports the National Safeguarding Adults Week on an annual basis, it took place this year during 18th – 22nd November 2024 The campaign came about through a national collaboration with Ann Craft Trust and the Safeguarding Adults Board Managers Network, supported by University of Nottingham. Locally, HSAB collaborated with the following statutory, private and voluntary services to help raise awareness of National Safeguarding Week across Halton:

HALTON BOROUGH COUNCIL

PossAbilities

NHS Cheshire and Merseyside

NHS Mersey Care NHS Foundation Trust

Cheshire Constabulary

NHS Bridgewater Community Healthcare NHS Foundation Trust

The aim of the campaign this year was *"Working in Partnership"*. Each day during National Safeguarding Week focuses on a key theme, the daily themes for this year were as follows

Day	Theme
Monday	Look, Listen, Ask – Developing Professional Curiosity
Tuesday	Working in Partnership: How to work effectively with the people you support
Wednesday	Establishing Professional Boundaries
Thursday	Recognising Exploitation: The ladder of criminality
Friday	Professional & Organisational Learning

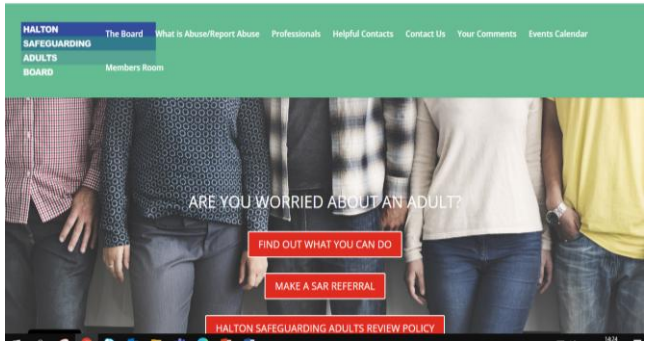
National Safeguarding Week 2024

HALTON
SAFEGUARDING
ADULTS
BOARD

The campaign consisted of:

A series of Lunch & Learn events were held online for each of the daily themes for all HSAB Partner organisations to attend

HSAB Website fully updated and has a dedicated National Safeguarding Week tab with all information easily accessible



Daily social media messages published on all HBC Social Media Platforms

Mersey Gateway Bridge lit up in HSAB colours to mark the start of National Safeguarding Week

Multi Agency Audits

HALTON SAFEGUARDING ADULTS BOARD

Audit: March 2024 Theme: Emergency Duty Team	
Number of Cases Audited: 3	
Outstanding	0
Good	1
Satisfactory	0
Requires Improvement	2
Audit: June 2024 Theme: Domestic Violence in Older People	
Number of Cases Audited: 3	
Outstanding	1
Good	0
Satisfactory	1
Requires Improvement	1
Audit: November 2024 Theme: Neglect and Acts of Omission in Care Homes	
Number of Cases Audited: 3	
Outstanding	0
Good	1
Satisfactory	1
Requires Improvement	1

HSAB Training Overview

HALTON SAFEGUARDING ADULTS BOARD

Halton Safeguarding Adults Board subsidises a small programme of training courses to enhance opportunity and access to learning across Halton. This training is offered free of charge to those living and working in Halton and who have a direct involvement in the care and support of adults with additional needs. This includes volunteers, carers, those employed through a personal budget and those who use services.

Safeguarding Adults – Awareness & Responsibilities

A range of people may be involved in supporting adults with additional needs to live their day to day lives. This session will provide staff, volunteers and carers (paid or unpaid) with the knowledge and understanding of adult safeguarding requirements and enable them to recognise their own responsibilities within this process.

Safeguarding is everyone's business and this course looks at how and why safeguarding adults is important, what constitutes abuse and harm and when and how to raise a safeguarding concern.

It is aimed at ensuring participants can respond to concerns effectively and take appropriate action where there is an identified risk of harm.

Number of places available during 2024/25: 108
Number of places attended during 2024/25: 65

Provider-Led Concerns & Enquiries – Local Policy & Procedure

This session has been designed to widen awareness and understanding of the processes in Halton for raising concerns about adult social care practice that fall short of constituting a safeguarding concern.

The Provider-Led Concerns and Enquiries model (implemented in 2020) replaced the previous Care Concerns process, placing emphasis on those delivering services, to scrutinise their own practice, learn from the experience and make positive changes.

By taking a look at the journey to this point the session will explain what provider-led concerns and enquiries are and why a new system has been implemented. It will equip those delivering adult social care with a clear understanding of safeguarding thresholds and the process to follow where there is a low level safeguarding incident.

Number of places available during 2024/25: 72
Number of places attended during 2024/25: 37

HSAB Training Overview

HALTON
SAFEGUARDING
ADULTS
BOARD

Mental Capacity Act – Working with Capacity Assessments

The Mental Capacity Act 2005 is fundamental in supporting people with their decision making and should be applied throughout all service areas across adult social care.

The CQC specifically focus on this area as part of their regulation of services.

This session will provide information and give confidence around the application of the MCA within the participant's specific service area.

Number of places available during 2024/25: 60
Number of places attended during 2024/25: 35

Self-Neglect Awareness

Working with self-neglect can be extremely challenging as help and support is not always accepted. A person who shows a serious disregard for their own self-care and wellbeing may put their own health and safety at risk as well as those around them.

Gaining a basic understanding of the features, signs and symptoms of self-neglect will allow participants to be vigilant of risk factors and know how and when to take action.

Number of places available during 2024/25: 72
Number of places attended during 2024/25: 26

Financial Abuse

The manipulation of money and other economic resources is one of the most prominent forms of coercive control, depriving vulnerable individuals of the material means needed for independence, resistance and escape.

Financial abuse is an aspect of "Coercive Control" – a pattern of controlling, threatening and degrading behaviour that restricts a victim's freedom.
It is important to understand that financial abuse seldom happens in isolation; in most cases, perpetrators use other abusive behaviours to threaten and reinforce the financial abuse.

Financial abuse involves a perpetrator using or misusing money, which limits and controls the vulnerable person's current and future actions and their freedom of choice. It can include using credit cards without permission, putting contractual obligations in their partner's name, and gambling with family assets.

Financial abuse can leave people with no money for essentials such as food and clothing. It can leave them without access to their own bank accounts, with no access to any independent income.

Number of places available during 2024/25: 72
Number of places attended during 2024/25: 25

Case Study - Mrs J

HALTON
SAFEGUARDING
ADULTS
BOARD

Context:
A safeguarding concern was raised in relation to neglect and acts of omission. The safeguarding concern was raised by a residential care home manager in regard to a care home ward round contact delivered by primary care. The safeguarding concern involved Mrs J – an 88 year old lady with a diagnosis of dementia.

Action:
The safeguarding concern was received from a local care home manager in relation to some concerns around the wellbeing of a patient within the care home.

It was reported that Mrs J had been discharged from hospital following a suspected stroke, fortunately, following assessment in hospital, it transpired that Mrs J had not suffered with a stroke.

The day after discharge, staff felt that Mrs J was still not her usual self, it was reported that she was extremely lethargic, her mobility was impaired with her being unsteady on her feet and she was not drinking enough fluids, despite being offered fluids by the staff and that she appeared generally unwell in comparison to her usual presentation. The manager of the care home asked whether the GP would review Mrs J as part of the weekly "MDT ward round".

Following the ward round, the GP visited Mrs J and decided that Mrs J was best placed to remain at the care home, with the staff who knew her well within her familiar surroundings and where monitoring at the care home could continue.

The following day, Mrs J had a fall and banged her head, an ambulance was called and paramedics raised some concerns around Mrs J's presentation, particularly around dehydration and why medical support was not requested sooner for Mrs J. Care Home Manager felt there may have been potential missed opportunities to identify deterioration and obtain medical treatment sooner and that communication had not been as robust as it might have been between care home staff and health professionals.

Case Study – Mrs J

HALTON
SAFEGUARDING
ADULTS
BOARD

As part of a Section 42 enquiry, the safeguarding lead at the GP surgery was asked to complete an internal investigation to explore the concerns and identify if there were any lessons to be learned from a health perspective, whilst alongside this, the care home manager reviewed the process used by care staff during ward round meetings.

The investigation was completed as requested and shared with the adult safeguarding team for review. This evidenced that the concerns were explored alongside the GP and the following was identified:
It was identified that more robust information sharing was required at the MDT ward round, in order to ensure that all involved are in agreement with the plan and are happy that all relevant information has been shared effectively with all attending colleagues and that actions are followed up as agreed.

Outcome:
In Halton, where a safeguarding concern is raised and it involves health professionals from a GP surgery, we use a form called a GP concern and response form. This is a process where we ask the safeguarding lead at a specific surgery to complete some fact finding around an identified concern and to feed back their findings and identify if there is anything that could have been done differently. As a result of this particular safeguarding enquiry, the MDT ward round process has been updated and is now a lot more robust. The process now includes a pro-forma which clearly documents that the resident has been reviewed, an up-to-date recording of observations including weight, blood pressure reading, and SATs. During the meeting all discussions and treatment plans are documented and shared between all attendees to ensure that agreed actions are completed.

Learning:
From this particular Section 42 enquiry, it was advised that although there was a weekly MDT ward round, the process for capturing the discussion and the agreement around what happens next was not effective on this occasion. This had led to disagreements between the care home manager and the GP on what the best course of action should be. When Mrs J continued to deteriorate and paramedics were asked to respond, this highlighted a lack of action to care home staff, who felt that the GP had not fully reviewed the patient and had not agreed any actions.

As a result of the enquiry, the MDT ward round process is more formal and more effective, to ensure that professionals are working more cohesively to ensure the safety and wellbeing of the residents.