Halton Safeguarding Adults Board Annual Report April 2023 – March 2024

HALTON
SAFEGUARDING
ADULTS
BOARD

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Message from the Chair

HALTON
SAFEGUARDING
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BOARD

I am very pleased to present the annual report of Halton Safeguarding Adult Board for 2023/24. 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 embedded 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 2024/25 as agreed at the Strategic Planning Event, 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.

Sue Wallace-Bonner

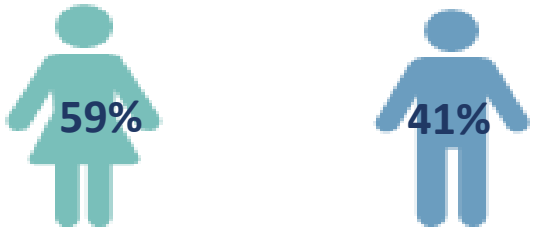
Executive Director, Adults Directorate Halton Borough Council

Key Safeguarding Facts 2023-24

HALTON SAFEGUARDING ADULTS BOARD

809 Safeguarding Concerns raised during the year

327 became S42 enquiries



More women than men were alleged victims

26% Decrease in the number of concerns raised, down from 1096 last year

25% Decrease in the number which progressed to S42 enquiries, down from 436 last year

18-64 65-84 85+

The age groups of people who had safeguarding concerns raised on their behalf

179

Concluded S42 enquiries involved allegations of neglect

49

Concluded S42 enquiries involved allegations of physical abuse

167

Concluded S42 enquiry allegations occurred in victim's own home

455 White British

12 Black & Minority Ethnic

Ethnicity of those who had safeguarding concerns raised on their behalf

In Halton, an adult at risk is most likely to be a female aged 65 or over living in their own home and will suffer from neglect or acts of omission perpetrated by a service provider

Deprivation of Liberty Safeguards (DoLS)

HALTON SAFEGUARDING ADULTS BOARD

1080 applications received

21% increase in the number of DoLS applications received last year, up from 894 in 2022/23

57% of applications received for females

43% of applications received for males

12%

Applications for 18-64 age group

15%

Applications for 65-74 age group

36%

Applications for 75-84 age group

37%

Applications for 85+ age group

Overview of the Board

HALTON SAFEGUARDING ADULTS BOARD

What is Halton Safeguarding Adults Board?

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

The role of the Board 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.

The 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	1. Publish an Annual Report
	2. Publish a Strategic Plan
	3. Conduct Safeguarding Adult Reviews

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 or our community that need it.

What does Safeguarding Adults mean?

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

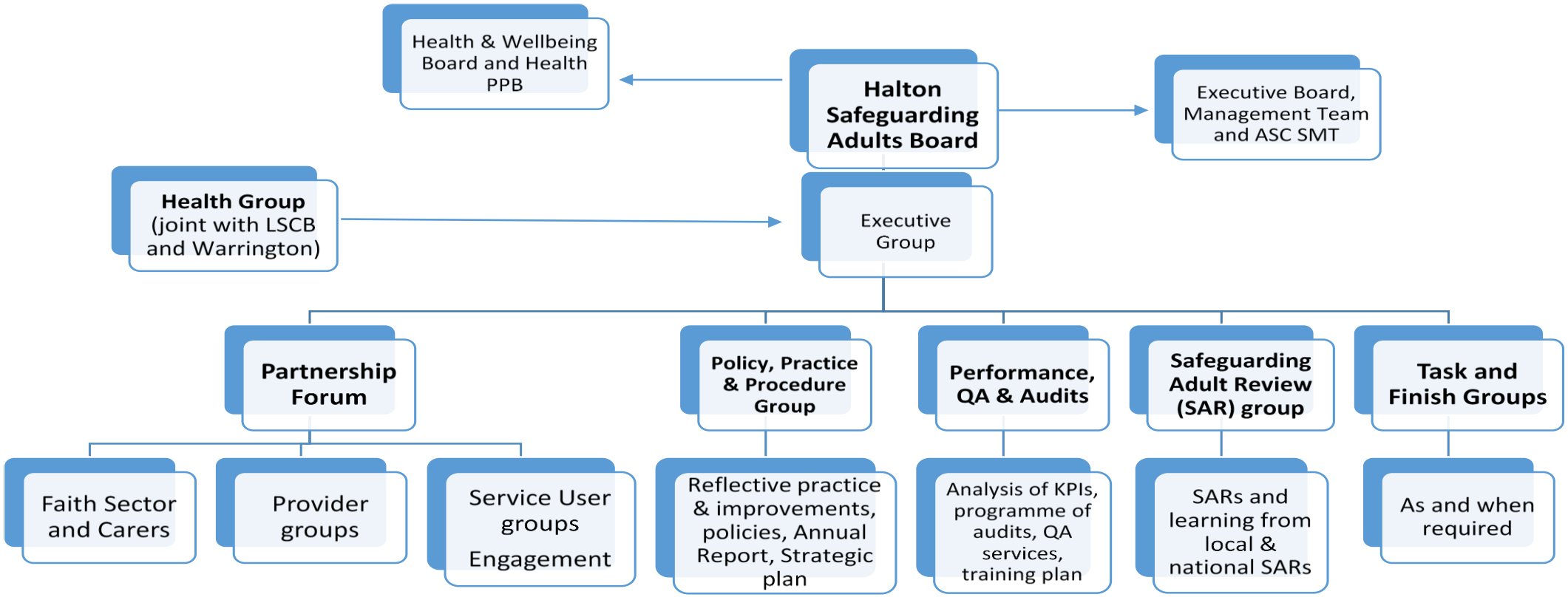
Adults with care and support needs are aged 18 and over and may:

- 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

Overview of the Board

HALTON SAFEGUARDING ADULTS BOARD

Halton Safeguarding Adults Board Structure



Overview of the Board

HALTON SAFEGUARDING ADULTS BOARD

Who are HSAB's partner organisations?

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 age UK

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

Priorities for 2023-24

HALTON SAFEGUARDING ADULTS BOARD

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

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 approach
- Ensure that there is effective communication of training

Learning & Professional development

- Reassurance 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

HSAB Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Priority	What we said we'd do	What we did
Quality Assurance 	Ensuring internal quality assurance frameworks are in place	Following a restructure of HSAB and its sub groups, the Board now has a clear reporting structure in place which ensures that work programmes are closely monitored and any issues are identified and resolved quickly.
	Share identified learning	The Safeguarding Policy, Procedure & Practice Sub Group ensures that any lessons learned or areas of good practice are shared and adopted where possible.
	Review of the safeguarding adults audit processes within Halton	The Safeguarding Adult Case File Audit policy was reviewed and updated in July 2022. There have been 3 multi-agency audits held during the year. The themes for the audits were: Self-Neglect; Neglect and Acts of Omission and Emergency Duty Team
	Sharing of information across HSAB members and provider services	The Chairs of each sub group are asked to share information within their groups on a regular basis, with quarterly reports presented to the main Board.

HSAB Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Priority	What we said we'd do	What we did
Co Production & Engagement	HSAB partner agencies to have learning and professional development opportunities in place for their individual workforce	An annual training programme is developed and delivered on behalf of the board, which is available to all partner agencies. A HSAB Members Induction Pack has also been developed so all members are clear about their role and responsibilities.
	Consistency and standardisation of safeguarding practice across Halton	All policy and procedure documents, toolkits and strategies developed in relation to adult safeguarding are agreed by HSAB and the relevant sub groups. All policies are reviewed on a 3 yearly basis ,, or earlier if required, to ensure they are reflective of current processes and legislation
	All agencies to promote a Making Safeguarding Personal approach	Making Safeguarding Personal is at the centre of all safeguarding practice in Halton, with a survey completed at the end of each S42 enquiry. Our multi-agency audits have found good evidence of Making Safeguarding Personal embedded in safeguarding working practices.

HSAB Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Priority	What we said we'd do	What we did
Co Production & Engagement	Implement effective communication of training opportunities within HSAB members and partner agencies	An annual training programme is developed and delivered on behalf of the board, which is available to all partner agencies.
	Support the development of good multi-agency practice, sharing best practice, lessons learned and have the confidence to challenge decision making	The Safeguarding Policy, Procedure & Practice Sub Group ensures that any lessons learned or areas of good practice are shared and adopted where possible. HSAB Partnership Forum have developed a Communications & Engagement Strategy for 2022-24 and action plan for delivery with partners.
	Support adults at risk, informal carers and families with safeguarding and ensuring that they feel support within the safeguarding process	By adopting the Making Safeguarding Personal approach to safeguarding practice in Halton, to ensures the adult at risk is at the centre of all decisions and are supported to ensure their desired outcomes are met. HSAB Partnership Forum led on the compilation, distribution and evaluation of an adult safeguarding awareness survey to support engagement with service users, family members/carers and the public regarding feedback on safeguarding services, to help shape services in the future.

HSAB Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Priority	What we said we'd do	What we did
Learning & Professional Development 	Reassurances that safeguarding approaches are developed actively including representation from all key areas	Development of New Safeguarding Case File Audit process was shared and tested with practitioners and managers including the Partnership Forum members in advance of implementation in July 2022. Partner representatives also invited to participate in mult-agency audits, with representatives from partner agencies given the opportunity to act as Lead Auditors.
	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 hear of the decision making process	Engagement survey /questionnaire was created and distributed in September 2022 through the SAB Partnership Forum for people who use services linked to safeguarding. Feedback was used to inform the Communication & Engagement Strategy.

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS

Halton Borough Council

Quality Assurance
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 staff on each group.

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

April 2023 – Self-Neglect
September 2023 – Neglect and Acts of Omission in a person's home
March 2024 – Emergency Duty Team

The audits have been well attended and have received positive feedback from Auditors and practitioners involved. As a result of the audit on Self-Neglect, the Multi Agency Risk Assessment Management Policy (MARAM) was developed in Halton and is in the process of being implemented in the borough.

As a result of the work plans undertaken by the HSAB sub groups, the Multi Agency Public Protection Arrangements policy (MAPPA) was updated and agreed by the Board. The Safeguarding Adult Review Sub Group have agreed and implemented a new Safeguarding Adult Review Policy which has been endorsed by Board members.

The Safeguarding Thresholds document was also revised and updated to ensure that all partners wishing to raise a safeguarding concern are clear about what action will be taken and by which team.

Co-Production & Engagement
The work that has been led by Halton Borough Council this year includes the planning and hosting of the HSAB Strategic Planning Event. This is an annual planning event that takes places every December and provides an opportunity for the Board members to contribute to priority setting for the Board and it's sub groups for the forthcoming year.

National Safeguarding Week was supported once again this year, with a series of Lunch & Learn events on various aspects of safeguarding hosted online. A pop up event was held in Widnes Market to raise awareness of safeguarding and was supported by several HSAB partner agencies. A radio broadcast was also recorded and played on hospital

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS

Halton Borough Council continued:

radio throughout the week to raise awareness of how people can identify possible signs of abuse and who to contact if they are concerned.

Learning & Professional Development
Halton Safeguarding Adults Board subsidises a small programme of training to enhance opportunity and access to learning across Halton.

All training is now face-to-face and 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. Courses cover local process, policy and protocol and are not relevant to those out of area.

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**

HALTON BOROUGH COUNCIL

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Cheshire & Merseyside Integrated Care Board:

NHS Cheshire and Merseyside

Quality Assurance

NHS Cheshire & Merseyside Integrated Care Board (C&M ICB) Halton Place has received regular safeguarding assurance from NHS commissioned health providers. Safeguarding activity across Halton's large NHS Trusts has remained at a raised level throughout the year. NHS internal Trust Safeguarding Teams support and guide NHS staff with complex concerns ensuring appropriate actions are taken. Activity to NHS internal Trust Safeguarding Teams is consistently high, demonstrating that patient facing staff are identifying and acting on concerns. Trust staff follow internal safeguarding pathways to access expert safeguarding advice within the organisations. This has led to a high percentage of referrals from health converting into section 42 safeguarding enquiries.

The large NHS Trusts complete an annual safeguarding audit and assurance programme, there is a continuous cycle of improvement and strengthening of processes. This is supported by Specialist Safeguarding Teams, policy updates, mandatory and additional training around themes and emerging topics. During 2023/24, Bridgewater Healthcare NHS Foundation Trust conducted a safeguarding conference, topics included Trauma Informed Practice, All Age Exploitation and Organisational Safety.

NHS Cheshire & Merseyside ICB (Halton) and Provider Trusts have engaged in all multi-agency audit workstreams during 2023/24, this has led to learning being cascaded across Halton and the local health economy.

A safeguarding health data stream was developed during 2023/24, this illustrates safeguarding training levels and safeguarding activity at trust level, for the three large trusts that serve Halton residents. This provides a level of assurance regarding safeguarding knowledge and practices at the trusts.

NHS C&M ICB staff continue to support the health function across the region. There are several workstreams developing and strengthening practice, and areas include Mental Capacity, Prevent, LeDeR and information sharing pathways.

There has been a focus on Primary Care support with a programme of education in the form of training sessions, online platform and local

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Cheshire & Merseyside Integrated Care Board continued:

updates being provided. A Named GP was appointed to cover Halton earlier this year and this has strengthened the system.

Health continues 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 demographic now present at the centre to issues such as management, treatment and containment of a TB outbreak during 2023. The health system alongside partners adapted to effectively deal with the situation.

<u>Learning from Lives and Deaths (LeDeR)</u>
The LeDeR programme is subject to robust quality assurance. All reviews are quality assured by the senior reviewer and Local Area Contact. Focus reviews are all taken for discussion and approval via the C&M LeDeR Review Panel. In addition, a random sample is reviewed each quarter by NHS England and a North West Quality Panel.

Co-Production & Engagement
NHS C&M ICB and health providers have worked in partnership with other key partners to support Daresbury Initial Accommodation Centre.

The system has flexed to accommodate the changing nature of the centre. From the changes to population and demographic now present at the centre to issues such as management, treatment and containment of outbreaks during 2023. The health system alongside partners adapted to effectively deal with the situation. Monthly health meetings are ongoing in addition health joining partners at quarterly and reactive meetings as required.

NHS C&M ICB and health providers have worked collaboratively with Halton Borough Council safeguarding colleagues and the HSAB partnership on all subgroup areas. This includes participated in task and finish groups, audit workstreams and National Safeguarding Adults Week.

Health have supported all multi-agency audit workstreams during 2023/24, with health representatives acting as lead auditors on several audits.

<u>Learning from Lives and Deaths (LeDeR)</u>
The NHS C&M LeDeR programme works closely with experts by

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Cheshire & Merseyside Integrated Care Board continued:

experience, parents and carers. The C&M LeDeR Review Panel is supported by experts by experience and a parent representative. C&M undertook a conference in 2023 with NW Pathways to share LeDeR learning and undertook a morning of group work with people with a learning disability on keeping healthy and looking after your health. C&M LeDeR programme is working with People First Merseyside to plan several lunch and learn sessions for Quarter 3 and a face to face awareness raising session all related to End of Life/Advanced Care Planning and supporting their work on Dignity and Voices in Dying.

Learning & Professional Development

C&M ICB continue to support Primary Care colleagues via safeguarding themed webinars, NHS Futures Platform, monthly safeguarding newsletters and a Quarterly Primary Care Forum. The forum has been delivered by the Halton Safeguarding Named GP with support from the Halton Designated Nurses.

Prevent training with Halton Primary Care has been a focus during the later part of 2023, and this has led to additional sessions being offered to Primary Care Staff.

C&M NHS Trusts have continued to prioritise Mental Capacity Act adherence and strive to support and educate staff around the Act. The C&M Mental Capacity Act Forum meets bi-monthly. 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.

C&M Designated Professional and Named GP's have formed a network. The group meet bi-monthly reports and information are shared, NHSE safeguarding regional team attend and take relevant information back to the National Team.

<u>Learning from Lives and Deaths (LeDeR)</u>

The C&M LeDeR specialist service has now been in operation for over 12 months. Analysis of information/learning gained, has led to the production of a workplan for 2024/25. There are several improvement areas for action.

A C&M LeDeR forum has been in operation with meetings taking place

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Cheshire & Merseyside Integrated Care Board continued:

quarterly. The meeting is well attended and open to all.

A North West workstream has been set up which will focus on obesity and weight management and dysphagia – in particular choking deaths.

Organisational Activity

Since the transition from Clinical Commissioning Groups to Cheshire and Merseyside Integrated Care Board the organisations safeguarding provision across the region has commenced a process of alignment. Processes and practices are being reviewed with the aim of finding best practice and sharing and standardising this across the region.

During 2023/24, the large provider Key Performance indicator tool was implemented, which allows organisations to be mapped across the region, trends and patterns and risks can be drawn from the data. The intelligence gained will assist in future planning around risks, training and work streams.

Following completion of a comprehensive Domestic Abuse mapping application, C&M ICB were successful in gaining 12 months funding to pilot the IRIS (Identification and Referral to Improve Safety) scheme across Halton Primary Care services. IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices. It is a partnership between health and the specialist DVA sector. C&M ICB Halton Primary Care services and Halton Domestic Abuse service are working in partnership to implement this programme.

NHS Cheshire and Merseyside

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Bridgewater Community Healthcare Foundation Trust continued:

NHS Bridgewater Community Healthcare NHS Foundation Trust

Quality Assurance

During 2023/24, the Trust has been able to provide significant assurance around safeguarding governance, policies and procedures, supervision and multi-agency engagement.

Feedback received from C&M ICB, indicated that our commissioners recognise and value the contribution the Trust makes to local multi-agency safeguarding arrangements and the support from the safeguarding team in providing support and supervision to staff to manage or prevent safeguarding situations from occurring by gaining support and decreasing risk at an early stage.

Good safeguarding practice identified throughout the year included:

- Examples of professional curiosity
- Multi-disciplinary team (MDT) working across teams and agencies Relationship building and maintaining contact with service user over a prolonged period of time
- Person-centered working and building up a trusting relationship
- Evidence of innovative working to try and build upon engagement with service user

Audits

The Trust has also contributed to all of the HSAB multi-agency audits during 2023/24 on S**elf-neglect**; **Neglect and acts of omission in a person's home** and the **Emergency Duty Team.**

Internally a Mental Capacity Act Compliance (re)Audit showed a significant improvement in the quality of assessments

HSAB Engagement

The Trust actively contributes to HSAB and Board Level and within the Partnership Forum, Performance, Quality Assurance and Audit and SAR sub-groups alongside working with Halton Domestic Abuse Partnership Board

Learning & Professional Development

The Trust achieved over 90% compliance in all adult safeguarding training at the end of Quarter 2 and have maintained that level of compliance since. In addition to delivering Level 3 safeguarding training, our Safeguarding Teams have delivered a variety of bespoke training sessions responsive to service needs as well as supporting the delivery of multi-agency safeguarding training.

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Bridgewater Community Healthcare Foundation Trust continued:

NHS Bridgewater Community Healthcare NHS Foundation Trust

Safeguarding Conference

The first annual Trust Safeguarding Conference took place on Thursday 23rd November 2023 with the theme of "Trauma Informed Practice" with presentations from Trust staff followed by an afternoon talk by 'Lads Like Us'. There were 50 attendees in the room and over 70 online tickets booked. Comments included:

"Mike from Lads Like Us was totally inspirational and made it so clear to understand the impact of trauma in really tangible terms and the way that we, as practitioners, can work to create positive impact within that context"

"I definitely feel more capable of considering the impact trauma can have on people when I am having conversations with them"

Organisational Activity

- The Trust's Safeguarding Adults Team were winners in the Bridgewater Annual Staff Awards. The awards panel: ***"A critical function, the Safeguarding Adults Team have made safeguarding a core business across the Trust"***
- Safeguarding oversight of all patient safety incidents and investigations within the Trust
- Building on the success of the HiCaFS service, the Trust has worked with partners to introduce a Halton virtual ward model. This will allow people to get the care they need at home, safely and conveniently, rather than being in hospital
- The Quality Review Visits have started to take place across the Trust. The Bridgewater Quality Review tool includes 12 standards based on the CQC new single assessment framework including safeguarding.
- The Trust has started work with the Advancing Quality Alliance to develop "Lived Experience Panels" across our services including the internal Trust LD Improvement Group and Think Local Act Personal
- The Safeguarding Adults Team are engaged with groups set up to improve the care of people with a learning disability
- The Trust's Safeguarding twitter account @BWSafeguarding is used to engage with patients, staff and the wider public.
- The Trust developed and launched a Care and Support Assessment Tool – Supporting Patients in Developing Treatment Plans Procedure. This compliments safeguarding activity relating to self-neglect and Making Safeguarding Personal.

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Healthwatch Halton

Quality Assurance

- All public feedback we receive on health and social care services is reviewed to highlight and report any safeguarding concerns
- This year we carried out a series of 'Listening Events' at local hospital sites to gather people's experiences of care at these services and monitor the quality of care and services, which includes assessing safeguarding practices. During these events we heard from over 320 people
- We carried out four 'Enter and View' visits to local care homes to view the quality of care provided to residents. Reports and recommendations from these visits are sent to service providers and commissioners to highlight good practice and areas for improvement
- We hold weekly outreach sessions at community venues across Halton which we also use to raise awareness of the role the public can play in safeguarding
- We continue to have representation at a wide range of stakeholder meetings which allows for regular sharing of information

Co-Production & Engagement

- We engaged with Halton Safeguarding Adults Board in the promotion of Safeguarding Adults Week with our e-bulletin, website and social media. We joined with other organisations to support the safeguarding week pop-up event at Widnes Market
- Working with Healthwatch Warrington we have carried out a project to look at the experiences of people being discharged from inpatient stays at Warrington & Halton Hospitals. The report includes a number of recommendations to improve the discharge experience of patients
- We have represented Healthwatch across Cheshire & Merseyside at meetings to review NHS Trusts Equality Delivery System (EDS) reports. The main purpose of the EDS is to help local people with characteristics protected by the Equality Act 2010
- Access to NHS dental services continues to be a concern for many vulnerable local residents. Through our sessions with local asylum support groups we've helped support people suffering serious dental issues to obtain NHS dental treatment
- Our Advocacy Hub Team Lead attends monthly safeguarding meetings at Gateway Recovery Hospital with external parties such as the Safeguarding Team and the Police. From this we now

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Healthwatch Halton continued:

receive updates from the Safeguarding Team to advise of safeguarding enquiries and to support any enquiries not received from the hospital to be supported. The Halton advocacy service also receives notifications of seclusion notices and Long Term Segregation (LTS) from both hospitals (Gateway Recovery Hospital and the Brooker Centre) and this allows for IMHA (Independent Mental Health Act) support to be offered in a timely manner. We also attend the Mental Health Law Governance Group from Merseycare due to providing IMHA support at the Brooker Centre.

- Halton Advocacy provide IMHA support at the Gateway Recovery Hospital in Widnes covering 6 units (3 female and 3 male) and at the Brooker Centre in Runcorn covering 2 wards (1 female 1 male). Halton Advocacy have a presence on each ward or unit each week. In the last reporting year 266 referrals were received between the 2 hospitals and this excludes the seclusion alerts and LTS notifications
- As well as supporting safeguarding concerns or alerts within secure settings the advocacy service supports Care Act referrals for safeguarding enquiries and reviews. These can be in a variety of locations such as the community, care homes and hospital settings

Learning & Professional Development

All Healthwatch Halton staff and advisory board members take part in a range of online e-learning sessions in subjects such as Diversity, Inclusion & Belonging and Adult and Child Safeguarding Levels 1 and 2. In addition, our Advocacy Hub Team regularly undertake advocacy qualifications across different elements of the statutory services Healthwatch Halton provides.

healthwatch Halton

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Mersey Care Foundation Trust:

Quality Assurance

Mersey Care Fountation Trust (MCFT) has supported HSAB with the multi-agency audits, acting as lead auditors. The audits have resulted in learning such as implementation of the Multi Agency Risk Assessment Management (MARAM) procedure and learning around Making Safeguarding Personal.

MCFT is represented on the Quality Assurance Sub Group.

MCFT undertake audits of practice within the footprint of the Trust, including Halton, which results in action plans to further strengthen safeguarding practice. During 2023/24 we have completed audits on: Domestic Abuse, Appropriateness of safeguarding referrals to the Local Authorities (which included a review of the effectiveness of Safeguarding Duty Hub), self-neglect and Making Safeguarding Personal. Each audit has highlighted good practice, but areas for improvement and learning which has been set out within action plans. Learning has included: development and launching Domestic Abuse Practice Guidance, development of training & supervision sessions, updating safeguarding recording documents, update Safeguarding Duty Hub practice etc.

Learning from each audit has been added to the agenda for team specific safeguarding adults supervision as a briefing to ensure learning is shared with frontline practitioners.

Co-Production & Engagement

MCFT has support the Task and Finish Group for Domestic Abuse and Older Adults.

MCFT delivers an internal training package on Making Safeguarding Personal (MSP), and we completed an audit on MSP during Quarter 2 2023/24, reviewing how MCFT practitioners applies MSP in practice which resulted in the MSP training package being further developed.

Learning & Professional Development

MCFT supported HSAB during Safeguarding Adults Week, delivering Trauma Informed Safeguarding Practice training. MCFT was part of the HSAB National Safeguarding Adults Week Task and Finish Group.

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Mersey Care Foundation Trust continued:

MCFT has been part of the HSAB MARAM Task and Finish Group. MCFT have delivered training internally to promote the newly created HSAB MARAM process within Halton and supported the development of a 7 minute briefing as well as a HSAB training package.

MCFT has a modular training offer each year, which is accessible for MCFT Halton practitioners. During National Safeguarding Week, MCFT delivered a number of sessions covering aspects of safeguarding highlighted as concerns raised by our practitioners.

All our teams in Halton have 3 monthly Safeguarding Adults Supervision where further professional development is provided on safeguarding matters. MCFT has put significant work in to put this into place this year after writing our Safeguarding Adults Supervision Standard Operating Procedure.

MCFT Safeguarding Adults Service provide Thematic Group Supervision which is available to all adult practitioners across the Trust footprint. Sessions have included:

- Self-neglect
- Care Act 2014 and making good safeguarding referrals
- Coercive and controlling behaviour
- Exploitation

The sessions have been very well attended.

NHS Mersey Care NHS Foundation Trust

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Probation Service:

HM Prison & Probation Service

Quality Assurance
We continue to undertake monthly quality assurance activity across the service, this is internal activity alongside regular audits and inspection.

Across the Probation Delivery Unit, our quality is good in comparison to other delivery units across the North West.

Regionally we are prioritizing quality improvement over the next 12 months and have developed a quality improvement plan which is currently being implemented.

Co-Production & Engagement
We have a defined engaging people on probation strategy and have identified leads in Halton. The co-production activity is undertaken both nationally and regionally, via focused groups and forums.

We are holding our inaugural people on probation awards ceremony in April 2024 in Halton and are seeking nominations from all probation practitioners.

Learning & Professional Development
As part of our quality improvement focus, internally we have developed a Learning & Development plan to support the improvements needed. Probation practitioners also attend the CPD and training events delivered by the partnership.

Organisational Activity
We continue to have strong MAPPA partnerships across Halton which enables us to manage the most complex and risky individuals effectively.

Integrated Offender Management works well across Halton with excellent partnership working across key stakeholders. In particular police, probation and CGL.

We have developed stronger processes to improve the management of people convicted of sexual offences across Halton. We now meet weekly with the Management of Sexual Offenders and Violent Offenders (MOSOVOS) team to review and ensure all risks are being managed effectively.

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Probation Service continued:

Our commissioned services continue to support individuals across our caseloads focusing on the following areas:

- Finance benefit and debt
- Education training and employment
- Personal wellbeing
- Accommodation

We also commission a specific service for women which is delivered in collaboration with Halton's Women's Centre.

HM Prison & Probation Service

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Mersey and West Lancashire Teaching Hospitals NHS Trust:

NHS Mersey and West Lancashire Teaching Hospitals NHS Trust

Quality Assurance

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) have an annual audit plan covering all aspects of safeguarding. 2023-24 captured safeguarding adult contacts into the safeguarding team, DoLS and MCA Policy compliance and management for domestic abuse.

Learning and good practice is identified and shared within the Safeguarding Assurance Group, training and supervision.

Co-Production & Engagement

During 2023-24, MWL safeguarding team have increased the engagement of vulnerable adults, particularly patients with a learning disability and/or autism, carers and families.

A quarterly patient experience meeting is now held, attended by patients and carers, local support groups, safeguarding and learning disability staff and patient experience teams.

This provided the opportunity for patients to share their experience, both positive and negative. Action is taken, where possible, to improve Practice.

This forum is also used to share key information and updates from guest speakers such as the local community Police Officers.

Learning & Professional Development

MWL has a specific training needs analysis which identifies competency requirements for all staff within the Trust. In order to support the safeguarding adult agenda, staff are allocated training in the following areas:

- Safeguarding Adults levels 1-4 (dependent on role)
- Mental Capacity
- Learning Disability
- Prevent

In addition, staff are provided ad hoc training in key area such as domestic abuse, as well as the opportunity to attend any additional training provided by the local safeguarding adult boards.

Partner Achievements 2023/24

HALTON SAFEGUARDING ADULTS BOARD

Mersey and West Lancashire Teaching Hospitals NHS Trust continued:

Training compliance is monitored by the safeguarding team and reported monthly to Trust Board, as well as quarterly via the Key Performance Indicators to the Integrated Care Board, quality assured by local place Designated Nurses.

Organisational Activity

In July 2023, the legacy St Helens and Knowsley organization merged with Southport and Ormskirk. The safeguarding teams remain visible across all sites, all policies have been reviewed and harmonised and opportunity taken to review process in order to streamline and improve practice. MWL now supports five local Safeguarding Adults Board.

During this reporting period an external safeguarding compliance audit has been completed by MIAA (specialist provider of assurance and solutions services to the NHS), this was a review of safeguarding agenda across all sites. The key lines of enquiry focused on the following areas:

- Strategy
- Policies and Procedures
- Governance arrangements
- Staff role and responsibilities
- Training and multi-agency working

An overall rating of substantial assurance, with areas of high was received.

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Policy, Practice & Procedure Sub Group Update

HALTON SAFEGUARDING ADULTS BOARD

Chair: Marie Lynch – Operational Director, Care Management, Safeguarding & Quality, Halton Borough Council

The Policy, Practice and Procedure Sub Group meets on a quarterly basis.

This Sub Group has overseen the development and implementation of the new MARAM policy (as a result of the self-neglect multi-agency audit). The Financial Abuse Toolkit (as a result of the multi-agency audit on financial abuse in 2022/23) and Modern Slavery Toolkit were also developed and endorsed by the sub group.

Harmful Sexual Behaviour has been a key topic discussed by this sub group during the year. There is a cohort of individuals open to adult social care that may have a learning disability/autism, that are engaging in potentially harmful sexual behaviour, causing risk to themselves and/or others as they are as risk of being enticed into engaging with vigilantes, leading to threats of violence or criminal activity/behaviour. Information on this topic will be included in updated Safeguarding Policy and Procedures, a task and finish group is also being set up to look at the development of a local protocol on this subject.

This group also oversee the preparations for National Safeguarding Week, which took place during 20th – 24th November 2023. The theme for this year was Safeguarding Yourself and Others. A series of lunch and learn events were held during the week, a pop up event to raise awareness of safeguarding and a radio broadcast was played throughout the week on local hospital radio.

Safeguarding Adult Review Sub Group Update

HALTON SAFEGUARDING ADULTS BOARD

Chair: Helen Moir - Divisional Manager Independent Living, Halton Borough Council

Following the restructure of the sub groups the first meeting took place on 2nd February 2023 via MS Teams.

The HSAB Safeguarding Adult Review (SAR) Sub Group meets on a quarterly basis.

Although the SAR Policy was not due for renewal until 2024, it was felt that it needed to be reviewed due to the formation of the new SAR Sub Group. The policy was subsequently reviewed and updated and endorsed by Board members.

The standing items on the agenda for this sub group include:

- Update from Task & Finish Group re: Mervyn SAR
- Whorlton Hall SAR
- Published SARs

The group has also considered two SAR referrals made in November 2022 and December 2023.

A 7 minute briefing has also been developed to help raise awareness of what a Safeguarding Adult Review is and how to make a referral.

This briefing has been shared with partners and has been added to the HSAB website.

Performance, Quality Assurance & Audit Sub Group Update

HALTON
SAFEGUARDING
ADULTS
BOARD

Chair: Kersten Southcott - Detective Chief Inspector, Cheshire Constabulary

HSAB Dashboard reviewed quarterly by group. Trends and themes are identified. The data influences audit workstreams, HSAB training provision and recommendations for policy strengthening or development.

HSAB training offer was developed this year to increase skills, knowledge and capability of the Halton workforce. Following audit findings training was updated to strengthen self-neglect awareness for staff.

The group has progressed and further developed data streams to strengthen the HSAB Dashboard. A health data stream was implemented from January 2024. This provides added assurance regarding safeguarding assurance.

Safeguarding Multi-Agency audits have been completed for the following areas:

- Emergency Duty Team
- Self-Neglect
- Neglect and Acts of Omission (in person's own home)

Following the self-neglect multi-agency audit, the needs for a MARAM process was identified. A Task and Finish Group has taken this forward.

Partnership Forum Update

HALTON
SAFEGUARDING
ADULTS
BOARD

Chair: Mark Weights – CEO, Sustainable Housing Action Partnership

The Partnership Forum meets on a quarterly basis and includes membership from several partner agencies, voluntary and third sector organisations and the faith sector. The meetings are well attended.

A Prevention Strategy was developed on behalf of the Partnership Forum. The action plan from this strategy is included in the work plans for all sub groups to ensure that key themes are embedded throughout our work.

The Communications and Engagement Strategy was updated for 2023. The Partnership Forum are looking to hold an event on awareness raising and a Task and Finish Group has also been set up to look at awareness raising for domestic violence in older people.

A newsletter is produced on behalf of the Partnership Forum on a quarterly basis and is distributed to all HSAB Board members and sub group members and published on the HSAB website

The Partnership Forum supports National Safeguarding Week on an annual basis.

The forum receives regular information updates from partner agencies about the work they are involved in within the borough relating to adult safeguarding and highlight any issues to be escalated to the main board.

HSAB Strategic Planning Event

HALTON SAFEGUARDING ADULTS BOARD

The Strategic Planning Event was held on Thursday 18th January 2023 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 Mers age UK

NHS Mersey Care NHS Foundation Trust

NHS Mersey and West Lancashire Teaching Hospitals NHS Trust

healthwatch Halton

Wellbeing enterprises

Local Government Association

Steve Tingle – Care and Improvement Advisor for London, 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 was used in order to develop a "Plan on a Page" to summarise the main priorities for HSAB for 2024/25.

National Safeguarding Week

HALTON SAFEGUARDING ADULTS BOARD

HSAB supports the National Safeguarding Adults Week on an annual basis, it took place this year during 20th – 24th November 2023. 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:

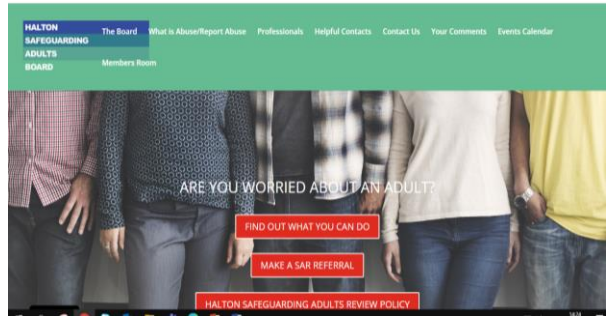
The aim of the campaign this year was ***"Safeguarding Yourself and Others"***. Each day during National Safeguarding Week focuses on a key theme, the daily themes for this year were as follows

Day	Theme
Monday	What is my role in safeguarding adults?
Tuesday	Let's start talking – Taking the lead on safeguarding in your organisation
Wednesday	Who cares for the carers? Secondary and Vicarious Trauma
Thursday	Adopting a Trauma Informed Approach to Safeguarding Adults
Friday	Listen, Learn, Lead – Co-production with Experts by Experience

National Safeguarding Week

The campaign consisted of:

A pop up event held at Widnes Market to raise awareness of adult safeguarding



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

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

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

HSAB implemented a new Safeguarding Case File Audit Policy in July 2022. The aim of the policy is to provide a robust audit process which is central to HSAB quality assurance system and offers front line staff an opportunity to reflect in a safe environment.

The safeguarding adults audits are centred on analysing quality with a view to gauging how effective our safeguarding practice is, in improving outcomes for the service user. The process is focused on learning and any recommendations are monitored. The process does not focus on the individual practitioners (although feedback will be given), but assists senior and service managers by providing evidence of recurring key issues/patterns or trends in safeguarding practice across adult services, as a means of informing future improvement and development.

The multi-agency audits took place in April 2023 with the theme of Self-Neglect. Three cases were selected and as a result of this audit, a new Multi Agency Risk Assessment Management (MARAM) process was launched in Halton.

The next round of multi-agency audits took place in September 2023. The theme for this audit was neglect and acts of omission in a person's own home. The following round of audits took place in March 2024 with the theme being safeguarding concerns initially received out of hours by the Emergency Duty Team. No issues were found and the triage system for dealing with safeguarding concerns works well across partners.

Right Care Right Person

HALTON
SAFEGUARDING
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Right Care Right Person is an operating model designed to ensure that when there are concerns for a person's welfare linked to health and/or social care, the right person with the right skills, training and experience will respond to provide the best possible service.

The model was developed by Humberside Police and is being rolled out nationally. It is currently being implemented across Cheshire using a phased approach.

Protecting the public, especially those who are vulnerable, will always be a core role of policing and this will be at the centre of any decisions that Cheshire Police make about incidents reported. However, Police Officers are often left looking after people with mental health or social care needs who require specialist medical care that officers from Cheshire Police cannot provide.

The Police will of course still be required to attend some incidents alongside medical or mental health workers and Cheshire Constabulary is fully committed to protecting people where there is an immediate risk to like or a risk of serious harm.

Phase 1 relates to Concern for Welfare and went live in Cheshire on Monday 8th January 2024. Further phases relating to the management of mental health and missing persons will be implemented at a later stage.

What is Concern for Welfare?

In its simplest form it is concern for a person or group of people expressed by another person or partner agency. Those concerns are made directly or indirectly to the Police in the expectation that the Police will assume responsibility and legal liability for those people and seek to mitigate or minimize any apparent risk posed. This will usually present as a request made via the Force Control Room for a welfare check or visit to be made.

What is the change that you need to be aware of?

The Police will only attend a Concern for Welfare call for service if it is deemed:

- An immediate threat to life or serious harm
- A crime is reported
- Partnership staff are in danger of death or serious harm
- Police action is required to prevent a child from suffering significant harm

Unless this threshold is reached the Police have no duty to act

Right Care Right Person

HALTON SAFEGUARDING ADULTS BOARD

Referral Pathways

Cheshire Police will no longer act as incident co-ordinators for partners or the public; instead people will be asked to call other service providers who are best placed to respond to the person's needs. Cheshire Police will signpost callers to the local authority referral hubs on their website:

www.cheshire.police.uk/rcrp

For more information:

The Right Care Right Person Team at Cheshire Constabulary can be contacted at the following email address:

rightcare.rightperson@cheshire.police.uk

The team shares regular information bulletins, meetings are also being held at a strategic and tactical level and there is senior manager representation from Halton within these groups.

Case Study

HALTON SAFEGUARDING ADULTS BOARD

Halton Borough Council Integrated Adult Safeguarding Unit (IASU) make all safeguarding enquiries that are required for adults at risk who are inpatients at Gateway Recovery Centre (GRC).

GRC is a locked rehab unit for patients with complex mental health disorders. There are 6 separate wards, 3 for men and 3 for women.

Due to historic concerns around the safety of patients at GRC, IASU have remained closely involved with the hospital in relation to the safeguarding of patients, the raising of safeguarding concerns, completing enquiries and offering advice and guidance in complex situations. Also in order to identify safeguarding themes and trends.

IASU has a weekly safeguarding meeting with the safeguarding lead and the lead social worker at the hospital, where updates are provided on existing safeguarding enquiries and discussions are held around any new concerns. In addition to this, there is a wide multi-disciplinary team (MDT) meeting held on a monthly basis with IASU, Healthwatch advocacy, Integrated Care Board Safeguarding Lead and a linked Police Officer from Cheshire Police.

A safeguarding concern was raised by Aintree Hospital in relation to a patient who had, whilst detained at GRC under Section 3 of the Mental Health Act 1983, jumped from a bridge onto a carriageway below, sustaining significant injuries as a result.

The referrer, reported that they had no details of the context of the incident, however, they raised the safeguarding on the basis that the patient had come to significant harm whilst an inpatient in a mental health hospital.

Upon making contact with the safeguarding lead at GRC, IASU was advised that at the time of the incident, the patient was out of hospital on Section 17 unescorted leave, which had been agreed by the patient's responsible clinician. IASU was also advised that the patient had been using periods of unescorted leave for several months without incident an that this incident was unexpected and unpredicted. IASU was further advised that a '5 point risk assessment' is carried out with all patients prior to them leaving the hospital. IASU requested that the risk assessment that was completed prior to the incident in question be shared with the Unit as part of the safeguarding screening process.

It transpired that this particular patient had used two separate periods of leave on the day of the incident, one at 4pm for 30 minutes in order to leave the perimeter of the hospital to smoke and a second period of leave at 6pm for 60 minutes in order to go to a nearby shop. This was usual for this patient and was written into care plans and agreed by health professionals at the hospital.

IASU was initially sent the risk assessment that had been completed at 4pm – this showed that a risk assessment had been completed with the patient at 4pm and had been inputted onto GRC database a few minutes later. IASU realised that this was not the relevant risk assessment for the incident and requested that the risk assessment that was carried out at 6pm be shared with the Unit. When the risk assessment was received it was noted that it was documented that whilst the risk assessment was recorded to have taken place at 6pm (time inputted manually by completing staff member) this was not inputted onto the database until 9pm (time stamp captured by database)

Case Study

HALTON
SAFEGUARDING
ADULTS
BOARD

As a result of this and IASU's concern that perhaps the risk assessment had not been done prior to the period of leave, it was felt that a S42 enquiry was needed to ensure that the documentation was not completed retrospectively and therefore the risk could have been identified earlier.

As a result of the local authority making a decision that a S42 enquiry was required, GRC commenced an internal investigation which was completed by an external professional, who is not based within the hospital. The investigation, once completed, was shared with the local authority for analysis and in order to inform the S42 safeguarding enquiry.

The investigation was comprehensive and included an interview and statement from the nurse in charge who completed the risk assessment and a rationale as to why this was not inputted into the database until later in the evening. It also demonstrated that care plans, clinical notes, risk assessments and daily records were reviewed, as was the process of risk assessments around Section 17 leave in general.

In addition to the above, IASU was able to speak to the patient who was recovering in hospital and discuss our concerns. As a result of the conversation, it was confirmed by the patient that a risk assessment was completed by the nurse in charge prior to leaving the hospital and the patient admitted that at that time, they had not given any indication that it was their plan to self-harm.

The case study highlights how professional curiosity and clarifying details can at times better ensure the safety and wellbeing of service users, it also highlights the ongoing positive relationship between the hospital and the local authority. Since the local agreement has been in place, there is a positive level of transparency and collaborative working, with the safeguarding lead and the management team at GRC welcoming advice and guidance and at times, scrutiny from the local authority to improve the service.