Lancashire Safeguarding Adult

Annual Report: 2021-22

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lancashire safeguarding adults board

Contents

Foreword

The Lancashire Safeguarding Adults Board's (LSAB) Annual Report for 2021/22 provides a summary of the work it has undertaken during the year.

During 2021/22 the Chair of the LSAB was Stephen Ashley but by the point this report was drafted he had stepped down and I was appointed to the role of Chair on an interim basis. I would like to take this opportunity to acknowledge the considerable and effective leadership provided by Stephen during his years in the Chairs role and wish him well for the future.

It was another very challenging year in which the pandemic continued to play a major part in how society functioned, with changes to the routines and relationships experienced by individuals, families, businesses and communities. It is too early to say how big an adverse impact the pandemic has had on the health, wellbeing and safety of the population as a whole, but the future public enquiry will lay out many lessons for us all But for those people who are most vulnerable across the whole age range because of factors such as ill health, disability, or their particular living circumstances there can be no doubt the pandemic has added to the risks they face and many will have had a poorer quality of life and experienced slower or less effective responses to their needs than they would have wished for.

Organisations across the public sector continued to adapt the way they ran services, and by necessity they had to work to a different set of priorities and expectations. Staff were under continued and sustained tremendous pressures in all corners of the health, housing and social care sector – additional demand for support, complex new requirements and frequent changes to the measures they were expected to implement. Similarly, staff who work in the criminal justice sector had to implement many new measures to ensure people they were in contact with were dealt with safely and effectively.

Leadership across the county continued via the Lancashire Resilience Forum (LRF). Over the year there was considerable support provided and coordinated through the forum. One of the sub-groups of the LRF dealt specifically with adult safeguarding and this group was led by the three Directors of Adult Services (DASS) and chaired by the DASS for Lancashire County Council. The group continued to meet as an adult and health system responding to Covid-19 and driving transformational change to support people to stay safe and independent. Health organisations, the Police, third sector organisations and Public Health worked closely together to coordinate their response to the pandemic. This ensured that the most vulnerable received food and medical treatment and that care homes were able to function effectively.

It was clear that the work of the LRF was the priority in terms of safeguarding and as such much of the work of the safeguarding adult board was suspended. Sub-groups dealing with specific issues were put on hold to give professionals the time to concentrate on their front-line responsibilities. The Board did however remain in place to ensure that its statutory functions were fulfilled. Consequently, this year's Annual Report – as with the previous year's - may not fully reflect the huge amount of work undertaken.

Finally, I would like to thank all those people across Lancashire who have played their part over the last year in keeping people safe. That includes not just those with specialist roles and specific responsibilities for safeguarding but all those members of the public, family members and individuals who have taken steps to report concerns and seek improvements in services. 'Safeguarding is everyone's business' continued to be the mantra during the last year and it is important that we continue to promote that message in the years ahead.

Tony Pounder

Interim Chair, Lancashire Safeguarding Adults Board

Glossary

AED Accident and Emergency Department
ASBRAC Anti-Social Behaviour
ASC Adult Social Care
CAMHs Children Adolescent Mental Health service
CCG Clinical Commissioning Group
CHC Continuing Health Care
CQC Care Quality Commission
CSP Community Safety Partnership
DA Domestic Abuse
DBS Disclosure Barring Service
DHR Domestic Homicide Review
DOLs Deprivation of Liberty Safeguards
ED Emergency Department
ERISS Electronic Information Sharing System
FGM Female Genital Mutilation
HFSC Home Fire Safety Checks
IDVA Independent Domestic Violence Advocate
JSNA Joint Strategic Needs Assessment
LPS Liberty Protection Safeguards
LSAB Local Safeguarding Board
MALR Multi-Agency Learning Review
MAPPA Multi-Agency Public Protection Arrangements
MARAC Multi-Agency Risk Assessment Conference
MASH Multi-Agency Safeguarding Hub
MCA Mental Capacity Act
NHSE NHS England
NICE National Institute for Clinical Excellence
PCC Police and Crime Commissioner
PIPOT Person in Position of Trust
PVP Police Vulnerable Person (referral)
SAR Safeguarding Adult Review
SPOC Single Point of Contact

1. The Board

1.1 PURPOSE OF THE BOARD

The Care Act 2014 requires a local authority to establish a Safeguarding Adults Board (SAB), which aims to help and protect individuals who it believes to have care and support needs and who are at risk of neglect and abuse and are unable to protect themselves, and to promote their wellbeing. Section 43 (3) sets out how the SAB should seek to achieve its objective, through the co-ordination of members' activities in relation to safeguarding and ensuring the effectiveness of what those members do for safeguarding purposes.

A SAB may undertake any lawful activity which may help it achieve its objective. Section 43 (4) sets out the functions which a SAB can exercise in pursuit of its objective are those of its members. Section 43 (5) Schedule 2 includes provision about the membership, funding and other resources, strategy and annual report of a SAB. Section 43 (6) acknowledges that two or more local authorities may establish a SAB for their combined geographical area of responsibility.

https://www.legislation.gov.uk/ukpga/2014/23/section/43.

Six principles set out in the Care Act 2014:

Empowerment	**Prevention**	**Proportionality**
Protection	**Partnership**	**Accountability**

The Board has three core duties under the Care Act 2014:

1.2 PARTNERSHIP STRUCTURE

The Safeguarding Adults Board is supported by an Independent Chair to oversee the work of the Board, to provide leadership, offer constructive challenge, and ensure independence. The day-to-day work of the Board is undertaken by the Sub-Groups and the Joint Partnership Business Unit (JPBU).

The JPBU supports the operational running of these arrangements and manages the Board on behalf of the multi-agency partnership. The Board facilitate joint working, ensure effective safeguarding work across the region, and provide consistency for our partners who work across Pan Lancashire (Blackburn with Darwen, Blackpool and Lancashire).

2. What does Adult Safeguarding look like in Lancashire?

2.1 LOCAL CONTEXT AND BACKGROUND

The ceremonial county of Lancashire is in the North West of England and consists of the shire county of Lancashire and the "2 unitary authority areas" of Blackburn with Darwen and Blackpool. The shire county[1] area is a "2-tier authority", meaning it is controlled by a county council (Lancashire County Council), and 12 local government district councils. In contrast Blackburn with Darwen and Blackpool, each have just "1 unitary tier" of local government, which provides all local services.

The following information intends to provide a brief overview of the local demographic context for Lancashire, Blackburn with Darwen and Blackpool. Information provided for each upper tier council area (Lancashire County Council, Blackburn with Darwen council and Blackpool council) unless otherwise stated.

2.2 POPULATION

The Population and household estimates, England and Wales: Census 2021, published on 2nd November 2022, show that the total population for the Lancashire-12 area on 21st March 2021 was 1,235,354. The district with the highest population was Preston at 147,835 and that with the lowest was Ribble Valley at 61,561.

In the neighbouring unitary authority of Blackburn with Darwen the population figure of 154,739 exceeded that of Preston. The number of households shown for the Lancashire-12 area was 525,247, with 59,978 in Lancaster and 59,607 in Preston. There were 64,789 in the neighbouring unitary authority of Blackpool. The population density in the Lancashire-12 area was 427 persons per square kilometre, which was very close to the England figure.

2.3 DEPRIVATION

The deprivation section is dominated by the indices of deprivation (IMD) that has detailed results for very small areas. The results are used extensively to understand local issues, and to underpin policy objectives designed to tackle the range of problems faced in specific areas of the county. The IMD draws attention to some very severe deprivation issues in various urban centres in Lancashire that are among the most deprived areas in England. The county has a large number of small areas in the 10% most derived localities in England.

Lancashire's most deprived areas are in urban centres of towns in East Lancashire, Preston and Blackpool. These are localities that have undergone major economic and structural change over many years, and face various issues

Out of a total of 525,247 households in the Lancashire-12 area in March 2021, 252,315 (48%) were not classified to any of the four deprivation categories. This was just below of the England and Wales rate of 48.3%. For the Lancashire-14 area, the percentage was lower at 46.4%.

Chorley, Fylde, Ribble Valley and South Ribble were the four Lancashire authorities with over 50% of households in the not deprived category. In contrast, only 38.2% of households in Blackpool were in this category.

[1] The shire county area of Lancashire includes the 12 districts of Burnley, Chorley, Fylde, Hyndburn, Lancaster, Pendle, Preston, Ribble Valley, Rossendale, South Ribble, West Lancashire and Wyre

The percentages of households that were deprived in three or four domains were relatively small at the national level (under 4%), but high rates (above 6%) were recorded in Burnley, Hyndburn, Pendle, Blackburn with Darwen and Blackpool.

Blackpool was ranked third highest for households deprived in 2 dimensions, fifth for households deprived in 3 dimensions and sixth highest for households deprived in four dimensions.

2.4 SAFEGUARDING ADULTS SECTION 42 ENQUIRIES

Safeguarding concerns raised or enquiries that commenced during 2021/22 with the previous year comparison are detailed in the table below. Observations are:

- 43.45% of people included above saw their concern turn into a Section 42 enquiry (2020/21 was 47.25%).
- 60 additional concerns were raised this year (+0.65%)

Counts of Safeguarding Activity	2020/21	2021/22
Total Number of Safeguarding Concerns	9148	9208
Total Number of Section 42 Safeguarding Enquiries	4323	4001
Total Number of Other Safeguarding Enquiries	0	0

Abuse Type Description	2020/21	2021/22
Modern Slavery	22	28
Sexual Exploitation	29	43
Discriminatory	61	69
Organisational	97	118
Sexual	520	525
Self-neglect	554	598
Domestic Abuse	1625	1630
Financial and Material	2003	1971
Physical	2283	2264
Emotional/Psychological	3114	2980
Neglect and Acts of Omission	4121	4147

Neglect and Acts of Omission continue to be highest type of abuse. Emotional/Psychological abuse has reduced by 4.3% and Sexual Exploitation although small in numbers of referrals has increased by 48.27%

3 The role and achievements of Sub-Groups

3.1 CONTEXT

During this reporting period, partner organisations across pan-Lancashire were still responding to the population needs of the the Covid-19 pandemic, and many organisations were in a "recovery status" for both customers and staff, still experiencing periods of restrictions in how business was delivered. The Safeguarding Adult Board (SABs) Sub Group activity was suspended for most of the early reporting period, but began again in ernest from late 2021.

In addition to this, following the merger of the three Safeguarding teams across the three local authorities to become the pan-Lancashire Joint Partnership Business Unit in 2019-20, more resources to support Sub Group activity also became available.

The priorities of the Safeguarding Adult Boards and relevant sub groups, were refreshed, including memberships and Terms of Reference for each group, along with development of workplans. Work has progressed on these through to 2022-23 year, ensuring that recommendations from Safeguarding Adult Reviews linked to specific priorities and themes are actioned appropriately.

Many elements of the sub-group activity during this period was to seek assurance from relevant partners and to have an overview of work being done in relation to key priority areas.

The Sub Groups reported on for 2021/22 are:

- Complex Vulnerabilities (including Self Neglect Task and Finish Group)
- Voice/Making Safeguarding Personal
- Mental Capacity Act (MCA)/Deprivation of Liberty (DOLS), Liberty Protection Safeguards (LPS)
- Performance and Improvement
- Safeguarding Adult Reviews Strategic
- Learning and Development

3.2 COMPLEX VULNERABILITIES SUB-GROUP (INCLUDING SELF NEGLECT T&F)

The Sub Group met on three occasions in 2021/22 (06.09.21; 06.12.21; and 10.03.22)

This group cover various complexities associated with safeguarding. For example, those that do not meet thresholds of statutory criteria to access support from statutory services. The group will consider the core priorities of the Boards which included Domestic Abuse, Mental Health and Self-Neglect; and in addition, explore potential emerging risks and themes requiring assurance in terms of safeguarding, for example (not limited to) suicide; homelessness; and prevent.

The purpose of the Complex Vulnerabilities Sub-group aims to:

- Act on behalf of the three Safeguarding Adult Boards to ensure a robust, transparent and consistent approach to Complex Safeguarding Vulnerabilities.
- Monitor the delivery of its statutory duties with regard to carrying out on Complex Safeguarding Vulnerabilities
- Improve collaborative work across the partnership to provide a consistent approach to support people experiencing complex vulnerabilities.
- Ensure approaches to complex vulnerabilities are meaningfully implemented and embedded in practice by all partners, and that its effectiveness is measured to give confidence.

The key objectives of the Sub-group are:

- To ensure an effective mechanism is in place to tackle the complexities associated with safeguarding adults in line with the ‘prevention’ principle of the Care Act 2014.
- To develop a mechanism to support those individuals that do not meet the thresholds of statutory criteria to access support from statutory services.

- To provide oversight and direction to Partners to ensure appropriate approaches to complex safeguarding are embedded within practice and partner systems, policies, processes and identified training needs.

SELF NEGLECT TASK AND FINISH GROUP

The Task and Finish group met once in 2021/22 on 20.1.22.

The purpose of this task and finish group is to review the LSAB Self-Neglect Framework launched in March 2019 with a view to a pan-Lancashire approach. This group reports into the SABs Complex Vulnerabilities sub-group. Self-neglect nationally is a prevalent theme in SARs, and during this reporting period across pan Lancashire 5 of 9 SARs have involved recommendations in relation to self-neglect.

3.3 'VOICE' MAKING SAFEGUARDING PERSONAL (MSP) SUB-GROUP

The Subgroup met on three occasions in 2021/22 (09.08.21; 16.12.21; and 14.03.22)

Purpose of 'Voice' Making Safeguarding Personal (MSP) Sub-group:

- To act on behalf of the three Safeguarding Adult Boards to ensure a robust, transparent and consistent approach to MSP.
- To monitor the delivery of its statutory duties with regard to carrying out Making Safeguarding Personal (MSP)
- Improve the use across the partnership of qualitative information on people's experience of the safeguarding system.
- Ensure MSP is meaningfully implemented and embedded in practice by all partners, and that its effectiveness is measured to give confidence.

The key objectives of the Sub-group are:

- To ensure an effective mechanism is in place to capture the 'voice' of the adult in line with requirements of The Care Act 2014.
- To provide oversight and direction to Partners to ensure person centred approaches to safeguarding are embedded within practice.
- To ensure 'engagement' at the ground level is included in strategic decision-making processes when reviewing partner systems, policies, processes and to identify training needs.

3.4 MENTAL CAPACITY ACT (MCA)/DEPRIVATION OF LIBERTY (DOLS), LIBERTY PROTECTION SAFEGUARDS (LPS) SUB-GROUP

The Subgroup met on two occasions in 2021/22 (*31.08.21 and 09.12.21)*

The group advises the Safeguarding Adult Boards on processes, procedures, and outcomes in relation to the implementation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) 2009, including progress of how the Act is embedded in practice across the multiagency/ multicultural partnerships.

The Mental Capacity (Amendment) Act 2019 introduced the Liberty Protection Safeguards (LPS) and will replace the current DoLS. The draft code of practice consultation for LPS ~~c~~ommenced in Spring with the feedback to be submitted by 14 July 2022. Individual agencies were invited to share their feedback responses with the group. It was identified that there were similar themes and feedback queries from the agencies which responded

Agencies are required to ensure the workforce are skilled and ready for implementation, with the Boards seeking assurance around LPS readiness and implementation. MCA has continued to be a key learning theme across SARs and DHRs. The group have started to make positive progress on the workplan and have identified priority areas of focus for the coming year. This has included embedding learning from safeguarding adult reviews, LPS agency readiness and strengthening audit and assurance methods to demonstrate that the MCA principles are prioritised across the partnership.

Purpose of the MCA/DoLS/LPS Sub-group:

- To act on behalf of the three Safeguarding Adult Boards to ensure a robust, transparent and consistent approach to MCA/DoLS/LPS.
- To monitor the delivery of its statutory duties with regard to carrying out MCA/DoLS/LPS.
- Improve collaborative work across the partnership to provide a consistent approach to support MCA/DoLS/LPS.
- Ensure approaches to MCA/DoLS/LPS are meaningfully implemented and embedded in practice by all partners, and that its effectiveness is measured to give confidence.
- Adopt a shared learning approach identifying good practice and relevant quality standards in MCA/DoLS/LPS and be instrumental in supporting and developing best practice across the Safeguarding Adult Boards.
- Identify potential barriers to best practice or areas of risk regarding implementation for MCA/DoLS/LPS, with a view to identifying strategies to address them and standardise where possible.
- Develop systems to ensure best practice information is available for service users, families/carers, and the public about MCA/DoLS/LPS and promote the rights of individuals who may lack capacity to consent, incorporating service user views into practice development initiatives where appropriate.
- Ensure local procedures comply with national guidance and produce new guidelines and best practice tools as required.
- Practice development initiatives based on identified themes and trends within agencies and learning from reviews to be shared through the Safeguarding Adult Boards and appropriate sub-groups for relevant action.
- Identify issues, risks and emerging themes and escalate to the Safeguarding Adult Boards and the Adult Executive Board as appropriate.
- Produce a programme of assurance to ensure that agencies fulfil their responsibility against the legal frameworks set out in MCA/DoLS/LPS.
- Provide regular practice briefing updates as appropriate to share themes and trends, disseminate learning and to provide case law updates, which will support in providing frontline practitioners with practice experience and best practice developments.
- Act as critical friend where advice/opinions can be sought and recommendations made regarding MCA/DoLS/LPS implementation, which promote the welfare of adults and children as appropriate.

The key objectives of the Sub-group are:

- To ensure an effective mechanism is in place to tackle the complexities associated with safeguarding adults in line with the ‘prevention’ principle of the Care Act 2014.
- To develop a mechanism to support those individuals that do not meet the thresholds of statutory criteria to access support from statutory services.

- To provide oversight and direction to Partners to ensure appropriate approaches to MCA/DoLS/LPS are embedded within practice and partner systems, policies, processes and identified training needs.

3.5 PERFORMANCE, ASSURANCE AND IMPACT SUB-GROUP

The Subgroup met on three occasions in 2021/22 (21/09/22; 16/12/21; and 16/3/22)

Purpose of Performance, Assurance and Impact Sub-group**:**

- To act on behalf of the three Safeguarding Adult Boards to ensure a robust, transparent and consistent approach to multi-agency Performance, Assurance and measuring Impact.
- To seek assurance from multi-agency partners those services for adults with care and support needs across Lancashire are safe, continually improving and aspiring to be of high quality.
- To challenge agencies regarding the impact of their safeguarding activity and establish how the safeguarding partnership can be assured that it is making a difference.
- To seek assurance that agencies have sufficient performance information and appropriate analysis available to evidence their safeguarding activity.
- To ensure the three Safeguarding Adult Boards have sufficient understanding of emerging risks and known priorities, to enable action to be taken to mitigate risks and issues.
- To ensure that the assurance and impact activity undertaken by the three safeguarding adult boards is reflective of Local, Regional and National learning.

The key objectives of the Sub-group are to oversee a number of activities in respect of Performance, Assurance and Impact, including: -

- To develop, implement and deliver a programme of multi-agency audit activity, to be based on board priorities.
- To seek assurance regarding actions and learning from Safeguarding Adults Reviews.
- To have oversight of themes and learning arising from single agency audit activity and to challenge any quality issues that may emerge.
- Agencies to complete an annual compliance audit, providing assurance to the sub-group that they are compliant with minimum safeguarding standards as specified in the Care Act. Returns to be analysed with challenge as appropriate.
- To provide a multi-agency forum where safeguarding quality assurance issues can be discussed, resolved and shared.
- Provision of regular, timely, meaningful performance data with single agency analysis to accompany the quantitative information.
- To advise other SAB boards and sub-groups about recommended areas of focus based on themes emerging from assurance activity and performance information.
- To work in conjunction with the Safeguarding Adult Review sub-group to seek assurance regarding the timeliness, completion, learning and impact of the SAB case review processes.
- To work in conjunction with the Voice sub-group to ensure effective communication with service users and their families in order that this information can be used to measure impact and drive change.

The group is currently under review in 2022/23 period to consider how best to develop a system to enable the board to seek assurance to demonstrate that learning is embedded, and reduce the risk of similar themes reoccurring.

3.6 SAFEGUARDING ADULTS REVIEW (SAR) STRATEGIC SUB-GROUP

The Subgroup met on three occasion in 2021/22 (16.06.21; 08.09.21; and 08.12.21; 09.03.22 was postponed).

Section 44 - Care Act 2014 requires a Safeguarding Adult Board to carry out a Safeguarding Adult Review in the circumstances described. Statutory Guidance (section 14.133 onwards) sets this out in more detail. More specific supporting information on SARs can be found in the Pan-Lancashire Multiagency Safeguarding Policy and Procedures and the individual Safeguarding Adult Board's own protocol and process documents.

This Strategic Sub-Group provides oversight for the 3 Local authority areas. This group does not make decisions on new referrals being processed as a SAR. It will remain the responsibility of the individual local authorities areas (Blackburn with Darwen, Blackpool and Lancashire) Safeguarding Adults Boards. This Strategic SAR Sub-Group will look at consistency across all 3 areas.

Purpose of SAR Strategic Sub-group**:**

- To act on behalf of the three Safeguarding Adult Boards to ensure a robust, transparent and consistent approach to the SAR process.
- To monitor the delivery of its statutory duties with regard to carrying out Safeguarding Adult Reviews (SARs),
- To ensure regular audits of selected cases are undertaken including, where necessary, safeguarding adult reviews (SARs).
- To ensure that the lessons from reviews are widely disseminated and the learning to improve frontline practice is embedded across all member agencies.

The key objectives of the SAR Strategic Sub-group are:

- To ensure an effective SAR process is in place and in line with the Pan-Lancashire Multi-agency Safeguarding Policy and compliant with requirements of The Care Act 2014.
- To provide oversight, direction and ensure quality control mechanisms for the SAR process, including but not limited to referrals and timelines.

3.7 LEARNING AND DEVELOPMENT SUB-GROUP

This subgroup met on two occasions during 2021/22 (21.09.21 and 13.12.21; 28.02.22 was cancelled).

The purpose of the learning and development sub-group aims:

- To act on behalf of the three Safeguarding Adult Boards to ensure a robust and consistent approach to learning and development in stakeholder agencies.
- To monitor the delivery of the training programme.
- Ensure safeguarding messages are implemented and embedded in practice by all partners, and that its effectiveness is measured to give confidence.

The functions and key objectives of the learning and development Sub-group are:

- To facilitate an integrated approach to safeguarding learning and development across Blackburn with Darwen, Blackpool and Lancashire.

- To ensure ‘engagement’ at the ground level is included in strategic decision-making processes when reviewing partner systems, policies, processes and to identify training needs.
- Develop an annual safeguarding adult workforce development plan alongside an operational plan in line with the Boards priorities.
- Development of multi-agency training resources
- Quality assure and approve any learning being delivered. The Sub-group may establish task and finish group with co-opted members from partner organisations to undertake specific activities such as quality assurance of current training material and newly commissioned courses.
- Drive forward the recommendations of safeguarding adult reviews, domestic homicide reviews and learning reviews across the partnership and seek assurance that learning is embedded within practice

The learning and development sub-group will link to other SAB Sub-groups where they have an important role to play in matters such as:

- Sharing learning and development needs identified through the sub-group with the Performance, Quality Assurance and MSP Sub-groups.
- Communicate with Partners and the Safeguarding Adult Review Sub-group and ensure publication of SARS on the SAB website(s) is promoted
- Sharing any communication and public interest matters on safeguarding related issues from SARS to ensure that partners are aware of any implications for their organisations

During this reporting period and the ongoing challenges faced due to the Covid-19 pandemic recovery, the main priority has been to ensure any training offered was accessible to both the adults and children's workforce, with the majority of training sessions made available in a virtual format using platforms such as Microsoft teams, as a new way of working. Hybrid sessions were explored, however the majority of services requested the continuation of virtual sessions. Many work streams were placed on hold or transferred to virtual meetings due to the restrictions, which has resulted in exploring different ways of working.

All learning and development is currently held on the Aspire Learning Management System (LMS) which has continued to be procured whilst new systems are explored, there is a hope that we are able to find a system that is able to meet the wider demand as the business unit expands its remit across the wider area and offers more automated functions for a more streamlined process.

During this reporting period there was a significant reduction of training courses available, the main focus continued to be aligned to the core programme and priorities of the Children's Safeguarding Assurance Partnership and the Safeguarding Adult Boards.

Courses delivered included - Child Neglect; Multi-agency approaches to the impact of Domestic Abuse focusing from an Adult and Child perspective; and Hope4Justice supported the delivery of Modern-day slavery and Human trafficking awareness sessions. Training has continued to be delivered by a mix of external trainers and the multi-agency practitioner training pool. Focusing on one of the key adult priorities of domesitc abuse 'a multi-agency approach to Domestic Abuse on adults' session which was co-developed and co-delivered by a wider group of professionals from across the three areas of Blackburn with Darwen, Blackpool and Lancashire.

Learning and Development Priorities:

- **Improvement and maintenance** of the present training availability through the safeguarding partnerships
- **Respond to and adapt to new opportunities** for Learning and Development for an all-age workforce and throughout the transition to new CSAP arrangements
- **Platforms and delivery methods** reactive to meet changing expectations, whether its face to face, virtual or a hybrid model. Look at talking heads, animations and extended 7MB offer
- **Transition to a new system** upgrade for delivery of an e-learning and learning management system
- **Continue to respond to identified need** from Safeguarding Adult Reviews (SARs) and national and local agendas to deliver evidence based, responsive, effective and cost-efficient learning and development opportunities to Lancashire safeguarding practitioners.

4 Lancashire Safeguarding Adult Reviews Activity

4.1 SAFEGUARDING ADULT REVIEW PROCESS - UPDATED

During the reporting period the SAR process was updated. The main changes included strengthening the SAR referral forms submitted by partner agencies. We emphasised the importance of highlighting the reasons the referring agency believe the case should be considered as a SAR under s.44 Care Act. This was to ensure the referral form contained sufficient information at the outset to ensure the rationale for a SAR was clearly addressed. The criteria and rationale was not often completed and we now ensure the SAR referral is signed off by the referring agency's senior management for quality assurance purposes.

Previously, the SAR consideration group was attended by a number of agencies and discussed different SAR referrals during the same meeting which did not allow focused discussions on individual SAR referrals. We recognised it was difficult to capture the decisions and rationale accurately for each case referred. We now hold individual SAR consideration meetings which include the key statutory partners agencies directly involved in supporting the individual. We introduced a consideration process form which clearly includes the rationale on for pursuing or not pursuing a SAR and is now accurately recorded during any decision-making processes. We have ensured a consistent approach to SARs across the 3 SAB areas. The SAR process will be reviewed in 12 months.

4.2 LANCASHIRE SAR ACTIVITY

Carried over from the previous reporting year -1st April, 2020 to 31st March, 2021:

- **Adult K -** An 80year old adult was admitted to Hospital in a poor state of health, dehydrated, malnourished and there was evidence of self-neglect. The publication of this report was delayed due to an ongoing Coronial process. – **Now published 10/05/22**
- **Adult L –** This involved an assault from a service user in rest home. Missed opportunities were identified to safeguard Adult L and place the perpetrator in a suitable placement**.** The publication of this report was delayed due to an ongoing Coronial process however this has now concluded- **Now published 10/05/22**
- **Adult M & alleged perpetrator –** This case involved supported shared accommodation with two other men, one presented with mental ill health (Alleged perpetrator) who set fire to his own clothing. Adult M died due to smoke inhalation.
- The recommendations from the SAR reports were being translated into actions at the time of writing this report. – **Now Published 06/09/22**

During this reporting period - 1st April 2021 to 31st March 2022 the safeguarding Board received **seven** Safeguarding Adult Review referrals for consideration during this reporting period, **five** were reviewed and deemed not to meet the criteria and **two** continued to an initial consideration meeting, however are awaiting the completion of parallel reviews. The following Safeguarding Adult Reviews are currently still being undertaken or have been concluded outside of the reporting period.

Just after the reporting period these reviews concluded and have been published on 10/05/2022:

- **Adult O -** This case involved complex mental health needs, with the person displaying self-neglect and hoarding issues, which agencies evidenced a lack of understanding of and evident that agencies did not communicate effectively. This is now published, and multi-agency work has started to develop a framework with clear guidance around self-neglect.
- **Adult P** – This case involves an ex-veteran, who suffered with poor mental health and substance misuse issues with significant self-neglect. Concerns were raised around the persons vulnerabilities; however, learning identifies a lack of multi-agency information sharing and a delay in escalation of concerns.

Ongoing SARs include:

- **Adult S** SAR commenced during this reporting period; however, it is related to a historical case looking back over 30 years. This case involved a care leaver and the living arrangements made following the closure of a facility which catered for those with mental impairment. Due to the historical nature of this case, the SAR panel recognised that the events would not occur now as systems and processes have since been developed to address the issues raised within this review. The review provided assurance to the SAB that this scenario would not exist today due to the advancement of systems.
- **Adult T** SAR commenced during the reporting period and learning will be included within the next year's annual report. Adult T had previously suffered a stroke and had reduced mobility, and family members were the main care givers and any agency involvement focused on communication within themselves rather than the person. There were signs of self neglect and an unwillingness to engage with support services, which were not addressed in a timely manner. It is also clear that the Covid Pandemic significantly impacted on this person and access to appropriate escalation processes.

4.3 ACTIONS FROM SAR RECOMMENDATIONS

The LSAB had a considerable backlog of SAR actions which had not been completed since 2017. The JPBU have translated many of these actions into the priority themed workplans of the various sub-groups, which are being actioned and progressed. A group of key partners regularly review the actions to ensure that progress is being made and assurance is sought to support prevention of future issues.

5 Prevent Activity

5.1 OVERVIEW

The Lancashire Local Authority landscape consists of a County Council, twelve districts and 2 unitary authorities. From a Counter Terrorism perspective, Blackburn with Darwen (BwD) has received funding for Prevent since the implementation of the strategy in 2008. From 2019, Blackburn with Darwen Borough Council (BwDBC) established a `Centre of Excellence' to oversee Prevent delivery for the whole of Lancashire. An annual report for 2021/22 was presented to the three Lancashire Adult Safeguarding Boards, and although reported separately, we have included a summary of the overall training delivered as part of the safeguarding activity to protect vulnerable adults.

5.2 TRAINING

Prevent returned to face-to-face delivery but with the option for online sessions when requested by partners. This hybrid option has allowed them to continue to deliver high quality, bespoke training to a

variety of sectors. Feedback has been very positive with many organisations encouraged to contact the Prevent team and seek training, support or advice after recommendations from peers.

Training provided related to Adults across Lancashire for 2021-22

Blackburn with Darwen	2011
Blackpool	602
Lancashire County Council	255
Pan-Lancashire	2481
Total*	5349

*whilst Covid restrictions in place virtual sessions where offered to anyone in Lancashire

The main groups engaged with have included front line staff from a variety of sectors including Education, health, local authority, probation etc. 92 Community / third sector groups were engaged with including domestic abuse services, refugees/asylum seeker support groups, sporting providers, alcohol partnerships, outreach services, community forums, women's centres, Salvation Army etc.

5.3 TRAINING DELIVERED

The following demonstrates the range of training offered, supporting partners to delivery their statutory Prevent Duty obligations by ensuring front line staff understand the risk of radicalisation, how to report concerns and safeguard individuals.

- Prevent Refresher Webinars (Topics include: online safety, emerging trends, Prevent, Channel, case studies, counter terrorism risk and threat, British Values, risk assessments, Prevent in practice etc.)
- Webinars to enhance understanding of conservative, religious and cultural practices
- Train the trainer resources to enable organisational trainers to utilise standardised products across the Lancashire Prevent Partnership
- Established a Health training sub group to develop bespoke Prevent training for NHS staff.
- Commissioned service to deliver - Understanding Islamist, Extreme Right Wing and Mixed, Unclear, and Unstable ideologies
- Cyber Choices webinars to enhance their knowledge of the project with aims to safeguard young people being exploited into committing cybercrime.

6 Partner Activity

LANCASHIRE COUNTY COUNCIL (LCC) – ADULT SERVICES

The Local Authority safeguarding responsibilities and functions are defined within the Care Act 2014 which states Adults have the right to live life free from harm and abuse and with dignity and respect. It is important that all agencies who work with adults who may be at risk from abuse are involved in the prevention of abuse.

The local authority retains the responsibility for overseeing a safeguarding enquiry and ensuring that any enquiry satisfies its duty under Section 42 to decide what action (if any) is necessary to help and protect adults experiencing or at risk of abuse or neglect and to ensure as necessary that appropriate action is taken. The Care Act 2014 also introduced the requirement to record additional categories of abuse such as Female Genital Mutilation, Modern Slavery, Self-neglect, so called Honour Based Violence and

Domestic Abuse. It should be noted that these categories may be seen within other categories of abuse. The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect and to promote wellbeing within local communities

Some of LCC's Key Achievements include:

During 2021 /2022 the unprecedented circumstance of the Covid-19 pandemic and aftermath made the objective of returning to business as usual an ongoing challenge. This required the council to continuously prioritise our response so that those at risk of harm, abuse or neglect continued to be protected. This was particularly relevant during the times of the year when new variations of the covid strain emerged and surged (e.g., Omicron in December 2021 and January 2022). This required the Council's safeguarding service to continuously adapt and respond with flexibility to support both those who are particularly vulnerable and service providers from whom services are commissioned.

The achievements realised during this period include:

• The council commissioned an independent social care agency to clear a backlog of 1200 lower risk safeguarding section 42(1) safeguarding enquiries, ensuring robust contract monitoring regarding the quality of the work undertaken. The risks to vulnerable adults of this significant backlog of safeguarding alerts had been a source of concern and was addressed successfully during the year.

• A whole system safeguarding redesign for a comprehensive new model to provide a 'One Service' safeguarding model restarted in September 2021 (commenced prior to the Covid 19 pandemic and paused during 19/20) was approved and implemented.

The new model brought into operation in the year removes both functional and geographical barriers to improve service delivery and service user experience. To achieve this the council's safeguarding staff moved into the new ways of working in three phases from 1/11/2021 to 24/04/22 by which time all safeguarding staff in the service were operating in line with the requirements of the model. Whilst work continues to embed the new ways of working the key principles which were set out at the start of the project have been realised as follows:

✓ The volume of referrals has reduced, and the quality of information contained within referrals has improved as only concerns that are appropriate are routed into the service.

✓ Changes in demand is responded to flexibly through the virtual triage function, with an ability to utilise the safeguarding workforce as needed from across the service.

✓ Social care and health providers are being supported to take a greater role in safeguarding persons within their care.

✓ Social workers have greater capacity and ability to make decisions and intervene on the most appropriate course of action to support persons with care and support needs.

✓ The new model continues to support the Safeguarding service to have lead oversight, provide guidance and support to promote good Safeguarding practice, intervene as appropriate providing proportionate responses agreed with the vulnerable adult and underpinned by making safeguarding personal principles.

✓ The safeguarding service is now successfully managing the demand for statutory safeguarding enquiries without the accumulation of a backlog.

✓ The redesigned service structure and ethos fully implemented during this year is enabling flexibility and person- centred approaches sanctioning and empowering

social worker practitioners on the front line to do 'what is needed and proportionate ' to reduce risks and provide individual protective measures through safeguarding plans

• The Council's Contracts service, Care Home Interventions Team and Safeguarding Service has continued to work together and refine its comprehensive multi-agency procedures, partnership working and practice in responding to safeguarding concerns through its RADAR and Quality, Provider Improvement Planning (QPIP) arrangements in care homes

• The Council has taken the lead and managed the safe transition of residents to alternative placements when several care homes during the year closed or de-registered their nursing provision. When during the year these situations arose the council's now proven multi agency provider failure procedures have supported a well- coordinated approach to reduce the potential for residents to experience negative impact.

• All councils safeguarding staff who were enabled to work from home during lockdowns and government measures continue to be supported to benefit from the flexibility of having both the opportunity to work from home and office working.

During 2021/22 enhanced levels of support continues to be provided to Care Quality Commission regulated services (eg Care homes, Home Care, Supported Housing) in Lancashire this included:

- Supporting residents, service users and staff with testing, vaccination, and booster vaccination.
- Asymptomatic mandatory testing for the Council's social care employees continued throughout the year to help prevent transmission of the virus to vulnerable adults in care homes and community settings.
- We continued to distribute and monitor financial grants to support providers with infection prevention and control regimes up until the end of March 2022
- We continued to arrange Provider webinars to support domiciliary, supported living and residential providers and responded to the level of advice and support Providers needed by changing the frequency of these by moving the Webinars from weekly to fortnightly and then every three weeks. The final webinar took place on 8th April 2022
- My Home Life were commissioned to work with a group of identified homes during 21/22 to assist with leadership development, care home culture and overall quality improvement.
- Although the County Council has decommissioned the local Care Capacity Tracker, we continued to promote with providers, the national Capacity Tracker. This ensure valuable information was shared with Department for Health and Social Care on the continued challenges the sector in Lancashire continued to experience. Furthermore, and during the year and ongoing we continue to explore options with Local Authority partners and the NHS across the system to understand how we can better collect and utilise market intelligence to improve service quality.

During 2021/2022 when new variations of the Covid strain emerged and surged and especially in December 2021 and January 2022 when Omicron was prevalent it became necessary once again to step up to 7 days working to support those providers who were experiencing very significant difficulties. This included up to twice daily meetings, using a multi-disciplinary approach with health and social care professionals coming together to support Providers who required such support.

Although the UK Government removed most of the Covid 19 pandemic restrictions in England. on 19 July 2021 the Council has continued to offer support and guidance to care providers throughout the year and particularly as government guidance continued to change as Covid variants emerged and affected residents, staff and visiting arrangements.

LCC ADULT SERVICES - CASE STUDY

A safeguarding alert was raised with the Council by another local authority due to concerns brought to their notice by a family friend of an elderly and vulnerable gentleman. For the purposes of this case study referred to here as Jack.

Usually resident in the referring local authority area, the intelligence received suggested that Jack had been befriended over several years with increasing concerns that Jack was being isolated from neighbours, family, and his local community. The concerns had heightened when Jack was relocated to Lancashire by an alleged perpetrator of abuse and a so called 'friend.'

The safeguarding concerns received included allegations of emotional and psychological abuse, financial and material abuse with coercion and control. It was further alleged that Jack had been pressured by his so-called friend to sell his home, where he had lived over many years and moved to Lancashire, into a house with this person, the alleged perpetrator of abuse.

Immediate information gathering took place and the safeguarding worker established no previous safeguarding concerns were held with the Council. Checks with relevant partner agencies returned no information held regarding Jack, his health status, health conditions or mental capacity.

It was established that Lancashire Police had recently completed a welfare check to the home as had the Police in his local area. From the information obtained, the safeguarding social worker assumed Jack's mental capacity[2] and determined that the police having conducted a recent welfare check, there was no imminent risk. The safeguarding worker deemed the best course of action was to try and speak directly with Jack to gain his wishes and views as to his wellbeing, safety and home circumstances.[3],[4]

Attempts to contact Jack in a variety of ways including telephone, letters and home visits all proved unsuccessful.

The safeguarding social worker also received calls from Jack and it appeared that Jack was being directed by someone in the background on what to say. which aroused suspicions that face-to-face contact with the Jack was being purposefully restricted.

Strategy discussions with partner agencies to determine next steps took place and during this time, the safeguarding worker received an anonymous call from a member of the public, advising of a new address where Jack and 'his so-called friend/ alleged perpetrator' had moved. Further allegations of abuse were made and such new allegations suggested an escalation in risk which prompted the safeguarding worker to request a police welfare check at the new address.

The safeguarding worker and police attended the address and found Jack and alleged perpetrator of abuse to be in the home. At the visit it was deemed that Jack lacked capacity to understand the safeguarding concerns and to agree a plan to protect himself. Jack was unable to give a coherent account of the length of time he had been residing in Lancashire, that his house in his local area had been sold and Jack was unaware he was the owner of the current house. A best interests decision was made at this time with the Police on site and in telephone consultation with Jack's family. It was determined that it was unsafe to leave Jack in the house who presented as extremely vulnerable, even though the Police took action to remove the alleged perpetrator from the home and change the house locks.

It was necessary to provide Jack with an immediate place of safety and enable Jack to return to his home town, however this was not immediately available due to family and travel circumstances.[5]

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[2] Principle 1, Mental Capacity Act 2005

[3] This course of action in accordance with the key principles of safeguarding as detailed in the Care Act 2014 (Principle 1 empowerment and 3 proportionality)

[4] Care Act 2014 and Department of Health's Making Safeguarding Personal

[5] Mental Capacity Act 2005, Principle 5, least restrictive option considered first

Jack was provided with a place of safety in a local Council Care Home where Jack's needs and capacity could be assessed.[6] During Jack's stay in the Care Home although it was confirmed that Jack lacked mental capacity, Jack consistently expressed a wish to return to his home town.

Following the interventions above, further multi agency working continued and was co-ordinated by the safeguarding social worker, including the following actions:

- Information shared by Lancashire Police with Jack's local Police force who agreed to commence an enquiry.
- Information shared with the local authority in which Jack had ordinary residence who agreed to commission a care home placement in Jack's local area.
- Effective communication and partnership working with colleagues including adult social care, the Council Care Home providing Jack with a place of safety, the other local authority and proposed care home near to Jack's home town to enable a residency capacity assessment and a social care needs assessment to be completed.
- Continued information sharing and partnership working with the Police to ensure good communication on Jack's whereabouts and circumstances for the purposes of a Police criminal investigation regarding the alleged perpetrator which was ongoing.
- Continued liaison throughout with Jack's family to achieve the desired outcomes wanted by Jack and his family.

The outcome of this case enabled by a robust multi-agency response coordinated by the Council's safeguarding worker helped Jack to return to his local area, his support network re-established, and Jack's accommodation needs met by his local authority who commissioned care home accommodation where Jack's care, support and safety needs are being met.

The Police enquiry in respect of the person causing harm to Jack is ongoing.

LANCASHIRE CONSTABULARY

The Constabulary's role is to collaborate with partners to uphold the 6 principles of safeguarding.

Our purpose is to prevent and detect crime and preserve the King's peace. Our vision is simple: Preventing and fighting crime. Keeping our communities and people safe.

Our Strategy - To deliver on our vision there are five key areas we must focus on:

- Put victims at the heart of everything we do
- Reduce crime, harm, and antisocial behaviour
- Effectively respond to incidents and emergencies
- Investigate and solve crimes and deliver the best outcomes to all

  Deliver an outstanding service to the public and build confidence

Headquarters Public Protection Unit (PPU) Priorities: DA; Exploitation; Missing Persons; Rape and serious sexual offences (RASSO); Stalking or Harassment

- Creation of specialist Rape teams and an improved response to Rape. Joint operational improvement meeting (JOIM) with Crown Prosecution Service (CPS)
- DA ongoing review; in conjunction with supporting MARRAC and existing MARAC
- Continued support for victims of exploitation through specialist exploitation teams

  Economic department and Fraud continued collaboration to support vulnerable adults

[6] Care Act 2014 safeguarding principles prevent harm and protect and Mental Capacity Act 2005, Principle 4 decisions taken in best interests.

Awareness of Adults Safeguarding was raised through:

- Media campaigns e.g. No Excuse for Abuse; Victim First; Fraud and Vulnerable Adults with Action Fraud; Victim Focused internal campaign and continue collaboration with Lancashire Victim Service in conjunction with the Office of Police and Crime Commissioner (OPCC)
- Training- We have had hundreds of new police officers recruited this year. The officers receive both the new Policing Education Qualifications Framework (PEQF) module from the College of Policing and our 3-day Vulnerability focused internal delivery; Force PPU team lead on specialist training across all PPU areas to various departments as evidenced in s11.
- Vulnerability Coaches- a continuing dissemination of all vulnerability related awareness materials are shared
- HQ PPU Development Manager role- specific to the HQ PPU Priorities. These staff work with colleagues internally and through the partnerships to develop and drive activity to improve our response to vulnerability related business.
- Mental Health Spoc- a sergeant role who coordinates the Force response specifically to Mental Health and works in conjunction with departments to improve our response to MH related interventions
- Adult Safeguarding Week awareness raising in November
- Each Basic Command Unit (BCU) has a Vulnerable Adult lead Detective Inspector who also acts as the PIPOT SPOC.

Service users and carers were supported through:

- Strategic governance through the Vulnerability strategy and Protecting Vulnerable Persons Board
- Live time MASH working to ensure referrals are dealt with in a timely manner
- Digital capability for frontline staff through the use of Pronto and Vulnerability app to offer immediate assistance for all vulnerability related matters
- Ongoing MARRAC implementation support
- Specialist training for staff investigation into all vulnerability related areas
- Mental Health SPOCS in each BCU
- Translation of SAR learning into action plan activity

Views of Adults at risk were sought:

- At present we undertake a survey for those involved with DA incidents and are about to also include Stalking or Harassment. The feedback from these surveys directly influences improvements to the Force response.
- Work closely with the Violence Reduction Network (VRN) who capture the lived experience of survivors, and these have been included in the training delivered to frontline staff to hear first-hand accounts of involvement with the police. This has improved understanding in relation to e.g., ACEs and Trauma and afforded an improvement in staff being able to engage with those most vulnerable and signpost them to the most appropriate resource for support. The impact of this will be evidenced through audit and assurance work collected from action plans.
- All related national; regional and local related reports are scrutinised to ensure learning from any research is influencing the Force response accordingly, e.g., Police super-complaints: force response to police perpetrated domestic abuse

Safeguarding Priorities for 2022/23 are:

- Domestic Abuse and Stalking or Harassment
- Exploitation
- Missing Persons
- Rape and serious sexual offences (RASSO)

These priorities are set after careful consideration of evidence from the Force Management Statement (annual) and the feedback thereafter from our inspectorate, His Majesty's Inspectorate of Constabulary Fire and Rescue Service (HMICFRS); the National Vulnerability Action Plan (which is the National Police Chiefs Council led benchmarking process for Forces); internal and Joint agency Audit report evidence and the Force risk register. The PVP Board is the ongoing vehicle for assessing and assurance related decision making.

LANCASHIRE CONSTABULARY - CASE STUDY

- Domestic Abuse - Safeguard, Investigate, Prevent – West Division, Blackpool (Commenced April 2022 and on-going)
- Volume of DA incidents: 24 (crime and non-crime between Feb 2019 and March 2022)
- Collaboration - Civil Orders team, Custody Investigation Team, Neighbourhood Policing Team,
- Blackpool Safeguarding team, West DA Review team, Blackpool Council and FCWA

Background:

XX is a vulnerable, repeat DA victim. X is both vulnerable by being a victim of DA as well as her own health issues and substance addictions. X has dependant on alcohol with addiction relation issues for several years, resulting in her own children being taken into care – this includes a child she that both X and the perpetrator are the parents of Y.X is recorded as having been in a few relationships where Domestic Abuse has been a factor, and as such presents as vulnerable. X has medical concerns including two heart attacks, a mini stroke, the removal of two tumours, a hip replacement and bone transplant, suffers from epilepsy and has a prosthetic leg. The perpetrator, DF, has significant previous offending history and has been in a number of relationships which have concerned Domestic Abuse, and has previously had restraining orders against a number of ex-partners including against X. X and DF have been in a 'on / off' relationship since 2018. Both parties have children with ex-partners who have been removed from their custody. They have one child together, who was removed from their care at four months. X and DF currently reside in separate addresses, however, appear to spend a significant amount of time at each other's addresses. There have been previous restraining orders within their relationship, which DF has convictions for breaching. X has been offered a Claire's Law disclosure, she was partially given this information in April 2022 and refused for it to be completed stating that 'she knew it all already'. During the period June 2019 to June 2020, DF had convictions of a number of offences against X and this culminated in a Restraining Order being in place and DF eventually goes to Prison to serve a 48 week sentence in June 2020. The offences in this period include criminal damage, DF letting himself into X's property, he has attempted to strangle her and threats to kill her. In May 2020 X attempts to kill herself by hanging and is taken the Hospital as being deemed to have no capacity, at this time she discloses potential rapes, however, does not wish to make full disclosures at the time. The next incidents begin in June 2021. In September 2021 DF is captured on CCTV of a neighbour assaulting X and receives a further short custodial sentence.

DVPN Applied: The incidents begin again in March 2022; there are five further high-risk incidents, where No Further Action (evidential difficulties) are applied and culminate in a DVPN / DVPO being issued on the 7th of March 2022. The order expired on the 14th of April 2022. It is important to note here, that at this point, due to the vulnerabilities of X combined with the volume of incidents, X is undermined as a victim in an evidential sense. What is meant by this is not to detract from the seriousness of the offences

committed against X, or the increasing, escalating risk that is noted and can be seen. Grave concern at this point is felt by all professionals and X's family around her welfare and what may become of her. However, X at this point will disclose to some professionals and not others. She will feel safe in the presence of an IDVA to show bruising and disclose, but in the presence of another Officer will state that offences did not happen. That is the real evidential issue. Not that X is not believed, heard, or supported, but that to the evidential test, X has sadly undermined herself on a pro-longed level. Progressing criminal cases and the breaches of the DVPO at this point starts to feel like an impossibility. During the period of the DVPO, DF was arrested for breaches on three occasions, he contested every breach and no breaches were held at Court. The evidence in the breaches, again heavily relied on X, who was not sure around her support for the investigations and therefore provided conflicting accounts to the Police, which could unfortunately not be relied upon in Court. At this point, DF is also arrested for a further number of criminal offences; rape and threats to kill. What is established at this point is that what is detailed above, that X cannot be relied upon as the sole source of this evidence, and the matters are investigated and closed as the rape being an offence already investigated, and the threats to kill not being able to be evidenced down to reliance on X. This does not blame X for these outcomes but highlights the complexities of Domestic Abuse and its impact in a case such as this.

Civil Injunction considered: On the 26th of March direction was provided by Blackpool Council, that a civil injunction may be explored in relation to the continues Harassment, Alarm and Distress that DF was causing to X, as well as other members of the public. The benefits of the order being that prohibitions would facilitate breaches that would not be evidentially reliant on X, the order could be put in place for up to two years. The prohibitions would exclusion zones and be evidenced by third parties and CCTV. Lancashire Police Civil orders team were briefed and supported the application, and the process began. The West Civil Orders officer became the key witness in the proceedings and using the Chronology from the DVPN prepared a supporting application for the Civil Order. This not only utilised the evidence that X was being caused harassment, alarm and distress by DF, but numerous calls during the relevant period were from neighbours and members of the public also evidencing HAD being caused to them.

Application:

- The Civil Injunction was prepared for an ex-parte hearing,
- The Civil Injunction did not require the support of X,
- Lancashire Constabulary Legal Services became the application (the Council can apply in conjunction with the Police when the evidence is weighted on them),
- Planning allowed for the application to be made on the 14th of April 2022, the same date that the DVPO would expire.

Safeguarding and prevention:

- During the period from Monday the 28th of March to Thursday the 21st of April (the actual date of the Civil Injunction application and an interim order being granted) Blackpool NPT and Safeguarding team worked collaboratively to ensure that X was protected and that any opportunity to proactively ensure that DF was not breaching his DVPO or in a position to cause harm to X,
- During this period targeting hardening was applied to X's home address, her mother's home address (Ring Doorbells, lighting, lock changes and National Monitoring alarms) and SPOCS were put in place for X to start to build a rapport, Housing options were explored,
- Fylde Coast Women's Aid were re-introduced to X, having previously disengaged, to ensure she was supported emotionally.

Issues: Timing – An intensive fortnight of action took place by all teams working towards the ex-parte hearing being planned by Legal Services on the 14th of April – due to court time, this did not end up getting heard until the 21st, and therefore for a period of 7 days there was no order in place to protect X.

Current position:

- An interim Civil Injunction has been granted
- On the 3rd of May 2022, DF attended court and confirmed that he would be contesting the order, he would legally represent himself and call X and her mother, as witnesses,
- DF now has time to prepare his defence and the case will have a full contested hearing between July and September 2022 (TBC),
- X and DF remain part of the top three on the DA risk register to be monitored and managed by NPT and the safeguarding team,
- X has nominated Police SPOCS for safeguarding and contact,
- Police will support FCWA to encourage X to engage in support,
- The injunction remains part of the live targeting in Blackpool, driven via RAT.

LANCASHIRE & SOUTH CUMBRIA CLINICAL COMMISSIONING GROUPS (LSCCCG)

Lancashire and South Cumbria CCGs have a statutory duty to ensure that arrangements are made to safeguard and promote the welfare of children, young people, and adults to protect them from abuse or the risk of abuse. The CCGs are required to take account of the principles within the Mental Capacity Act and to ensure that health providers from whom they commission services have comprehensive policies relating to the application of MCA (2005) and if appropriate MCA Deprivation of Liberty Safeguards (2009).

As commissioners of local health services CCGs are required to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place; including independent providers and voluntary, community and faith sector, to ensure that all service users are protected from abuse and the risk of abuse.

The CCGs Designated Lead Professionals for Adults, Children and Children in Care are embedded in the clinical decision-making of the organisation, with the authority to work within local health economies to influence local thinking, practice development and continuous safeguarding improvement.

Designated Lead Professionals for Safeguarding are experts within the field and strategic leaders. They are integral in all parts of the CCGs commissioning cycle, from procurement to quality assurance and in the delivery, development, and review of services to ensure that the views and wishes of adults and children are clearly sought and respected.

The Covid response has been a significant challenge across health and social care. The CCGs have focused on supporting and enabling a multi-agency response to many of the challenges this has created for our vulnerable population. This has including reviewing system assurance models, adopting a more robust reactive safeguarding offer, and working closely with local authority partners on patient safety issues. Specifically support in to care homes and the wider regulated care market and contribution to outbreak management within the CCG Safeguarding teams.

As a wider health system, there is acknowledgement that there is a repeat of similar themes and trends coming from Safeguarding Adult reviews. In response to this several learning sessions have been held via an Appreciative Inquiry Model across Lancashire & South Cumbria. The sessions have explored themes including Self Neglect, Suicide & Trauma Informed approaches, and the Invisible Male.

The CCGs also supported the launch the 999 ReUnite scheme to help people that have conditions such as Dementia, Alzheimer's or any other mental health condition to be returned home quickly and safely should they go missing. The scheme works in partnership with the Herbert Protocol and has had a successful pilot in the Blackpool, Fylde, and Wyre areas. The CCGs are working with partners across the ICS (Integrated Care System) to develop an implementation plan with health providers and Primary Care. The 999 ReUnite pilot is led by the CCG and supported by Lancashire Fire & Rescue Service, NWAS and the L&SC CCG's. The scheme uses NFC technology to support the safe return of vulnerable adults who live alone with dementia should they become lost.

Workforce expertise has continued to be a focus for the CCGs, with recurring learning themes seen in application of the Mental Capacity Act. Service development initiatives have included the development of MCA grab sheets and guidance for vaccinations as well as significant work in preparing for the introduction of the Liberty Protection Safeguards, including strategic and operational development. Across the CCG's the safeguarding teams are represented on the National LPS Clinical Reference Group and Regional LPS meetings of NHS England. A LSC Implementation LPS Steering Group has been established and chaired by the CCG safeguarding team. The purpose of the group is to prepare for the implementation of the LPS. A plan on a page has been developed which outlines expectations over the coming year for the Responsible Bodies and Health Partners. Additional interim resource has been secured to support planning and readiness for implementation. A workplan is in place which enables performance monitoring and progress against LPS readiness requirements

The CCG Safeguarding teams have worked across multiple workstreams as part of the response to Covid, ensuring that there is safeguarding expertise within all discussions around Mental Health, Regulated Care, Communications, Vaccinations and Primary Care response. Work included ensuring there are appropriate safeguarding and MCA support processes within the refugee and asylum seeker programmes across Lancashire and South Cumbria.

Alongside this local work, the appointment of an executive lead for safeguarding across Lancashire & South Cumbria has meant we have been able to influence key wider NHS agendas and ensure safeguarding is considered throughout the transformation to the Integrated Care Board in July 2022.

L&SC safeguarding system now operates in a portfolio model to ensure safeguarding priorities are achieved in the most effective way.

Although the CCGs do not provide direct care to patients and service users, we do support individuals where there are highly complex safeguarding or welfare issues or where there is a need for intervention by the Court of Protection. When this is required, the CCGs work closely with individuals and families to ensure they are as fully involved in the process as they can be and empowered to make decisions where they can.

The CCGs work closely with Healthwatch, customer care and other community focussed services to better understand the experiences and views of our population. Learning from reviews, feedback and outcomes from complaints and serious incidents is incorporated within safeguarding service development initiatives. This demonstrates safeguarding practice improvement, and supports the Person's voice in contributing to service user feedback of how people experience health services, and whether they are achieving the outcomes they would like

The CCGs and wider NHS health system have several high priority areas. The four key priorities are:

- As the CCG's prepares for the NHS Reform into the Integrated Care Boards, we have a priority to maintain the Safeguarding System development and ensuring system stability during this period. This includes preparation for the Safeguarding Accountability and Assurance Framework, and CCG closedown, along with transfer of safeguarding risk with appropriate due diligence
- LPS preparedness considering the MCA Amendment Act
- COVID recovery and restoration
- Developing and maturing key performance indicators and system working across the newly formed integrated Care Board. Including changes in responsibilities, accountability, and organisational culture. There is a commitment to strengthen approaches to learning through audit to assure safe effective services across the L&SC Integrated Care Board

LANCASHIRE & SOUTH CUMBRIA CLINICAL COMMISSIONING GROUPS – CASE STUDY

- Male and adult son lived together.
- Following a hospital admission male required significant care and support, including nursing needs.
- A Section 42 alert was raised due to no access visits from care agency staff, and following ambulance attendance they discovered the male in poor state of hygiene surrounded by very poor environmental conditions.
- Son's refusal for care visit access, suspected risk of coercion and control/undue influence on Father's ability to access the required nursing care and self-care support presented as a high risk to agencies.
- Section 42 enquiry commenced; the Social Worker engaged health support in undertaking risk assessments which triggered the use of the self-neglect framework multi-disciplinary team response.
- Initially the risk required the Police to support Social Worker and District Nurse access in a sensitive and proportionate manner allowing the male to be seen alone, this enabled the presenting risk to be assessed and discussed openly, and the males wishes to be communicated.
- An initial plan of care was agreed with the male and his son.
- Due to the assessed nursing and social care needs of the father, previous history of non-engagement, poor environmental conditions, and suspected undue influence of son regarding access to care and support, the self-neglect framework support was commenced.
- Designated Lead nurse coordinated and led the multi-disciplinary process following the self-neglect framework.
- Fire service, housing, environmental health practitioners in addition to health and social care workers and domiciliary care agency staff worked collaboratively as a multi-disciplinary team with the male service user and his son.
- Both the male and his son's autonomy was protected using a consultative approach, maintaining their control, communicating the care need and risk explicitly, agreeing the timing of and numbers of visits and agreeing the pace of any changes to the environment to support the required care to be delivered. All agencies worked proactively together in a person-centred way to understand the relationship between the father and son whilst maintaining a focus on the direct care needs of the father and the presenting risks, including if safeguarding from domestic abuse coercion/control/undue influence was required.
- Relationships were built by the visiting domiciliary care agency practitioners and district nurses in order to gain trust, with a direct and honest approach to any conversations with both father and son regarding any immediate issues noted, the risk of not engaging in the nursing care required, importance of taking prescribed medicines, pressure area care, and support for personal hygiene

and the living environment. Visiting practitioners articulated any actions that they were taking clearly.

- Despite a direct approach being required on occasion, autonomy was respected, and work was able to progress at a pace that was comfortable and acceptable to both, and workers were able to establish their wishes and feelings and understand their long-standing relationship.
- Although initial reluctance to engage with assessment as a carer, significant steps were made to offer informal support through a third sector agency to adult son, with the offer of a carer's assessment kept open.
- Sharing information in a timely and appropriate way was essential to understanding and managing risk, agreeing a plan and coming back together to evaluate progress and plan next steps.
- This case study has been recognised as a good practice example, which has been shared nationally via the Safeguarding Adults National Network (SANN).

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST (LTHTR)

Lancashire Teaching Hospitals is an acute trust providing services to an estimated 390,000 people in Preston, Chorley and South Ribble, as well as specialist care to 1.5 million people across the region. We are also the Major Trauma Centre for Lancashire and South Cumbria and provide a range of specialist regional and tertiary services including Neurology and Neurosurgery, Cancer, Renal and Vascular.

The Trust integrated Safeguarding Team comprises of Adult and Child Safeguarding, Mental Health, Learning Disability, Autism and Dementia and includes nurses and social workers who support patients with additional vulnerabilities covering all aspects of the Care Act (2014) and Mental Capacity Act (2005).

The team ensure recognition, timely response and supportive decision making around care and treatment. Our responsibility to work in a multi-agency supportive model ensures seamless and continued care delivery and supports transition and longer-term planning on discharge. Core functions of the team include responsibility for the management of Section 42 allegations against the Trust, participation in MARAC, support for complex case management in relation to MCA legislation, representation at SAR and DHR's and management of PiPoT for the organisation.

The organisation has the relevant governance structure in place to seek assurance that safeguarding functions are robust and effective. This includes a monthly assurance Safeguarding Board in which representatives from the ICB attend.

Key Achievements in 2021/22

- Consolidation of the Multi-Agency Safeguarding Hub (MASH) pilot to reduce impact of unnecessary safeguarding investigations in line with the Lancashire Safeguarding Adults Board Threshold document.
- Trust wide compliance across all levels of Adult Safeguarding/MCA/DoLS and Prevent training.
- Strengthened digital developments through ward whiteboards to support vigilance/compliance and monitoring of patients with Safeguarding/MCA/DoLS vulnerabilities.
- Strengthened incident reporting system (Datix) redesign to facilitate MASH incident management processes, enabling visibility and monitoring of learning and themes and trends.
- Quarterly Safeguarding Champion Events focusing on all age safeguarding agenda business.
- Themes and trends analysis of safeguarding concerns/incidents internally recognised and externally identified on admission shared with relevant partner agencies to enable public health economy analysis.

- Collaborative participation with electronic module builds in outpatients & audiology to ensure MCA compliance is included.
- Strategic participation across the Lancashire & South Cumbria ICS and Regionally with NHSEi regarding the legislative changes to replace DoLS with Liberty Protection Safeguards (LPS).
- Monthly MCA Trust wide drop in sessions to support continued growth and knowledge in complex MCA patient management.
- Development and implementation of bespoke safeguarding supervision for high acuity departments
- Newly appointed senior MCA/LPS lead professional role to support implementation of Liberty Protection Safeguards.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST (LTHTR) - CASE STUDY

- Patient has Hepatic Encephalopathy and significant history of alcohol dependency and hoarding. The patient is estranged from his family although did have contact with his partner. Patient presented to A&E with a sizeable moisture lesion on both buttocks, wounds on both arms and a foot ulcer. The patient's clothing needed to be cut off as they were heavily soiled. A safeguarding referral was made by LTHTR in relation to self-neglect.
- The patient's social worker visited them in hospital on the day of their admission and advised hospital staff that a care home placement was being explored while their property was being cleared (severe hoarding). The patient was admitted to hospital for eight days in which they were assessed by the Tissue Viability Nursing team. On the eighth day, the patient requested to be discharged. They were found to have capacity to make the decision to self-discharge against medical advice and their partner was able to accommodate them.
- Seven days later, the patient returned to hospital after their social worker called for an ambulance as the patient was not responding to their knocking at the door. The previous discharge to their partner's address had quickly broken down and the patient had returned to their home address. Paramedics requested support of the fire brigade to gain access to the property as the patient was not responding. The patient was found to be confused, extremely unkempt, with a foot ulcer, exposed tendons and with very poor mobility. They were found to be eating and defecating in a very small space within one room as the property was cluttered. The property had no running water, and the patient was using buckets for toileting purposes. The social worker rang the LTHTR safeguarding team to make them aware of the concerns.
- The safeguarding team then liaised with the ward to highlight the concerns around self-neglect but also mental capacity as the social worker was concerned about executive function. The safeguarding team led on two separate MDTs which involved Adult Social Care, Commissioning Support Unit, matron and ward manager, the Hospital Alcohol Liaison Service and Integrated Discharge Service. Actions were set for the doctors to complete a mental capacity assessment around care and treatment in which they found that the patient lacked capacity based on their executive function and placed them on a DoLS. Actions were also set for the social worker to assess capacity around care and support needs for discharge, the discharge assessment nurse (DAN) to complete a nursing assessment, a flag to be created on the LTHTR system to highlight the risk of self-discharge, liaison with Environmental Health to clean up the property (21 day notice put on the property), ward manager to liaise with medics regarding the impact of Hepatic Encephalopathy on cognition, referral for advocacy, joint visit to the patient by Adult Social Care and the Trust safeguarding team and for the social worker to review the patient's care and support needs in the community following discharge.
- Although the patient lacked capacity to make the specific decision in relation to their care and support needs on discharge, with support and emphasis on building a rapport, they became less reluctant to the possibility of going into interim care subject to their property clean up and review of their care and support needs. A best interest decision was made for the patient to go into interim 24-hour care with the emphasis on them returning home following a period of care and property clean-up. The patient was successfully discharged to interim nursing care.
- This was a good example of multi-agency working, the hospital taking a lead on self-neglect and the adult social care social worker supporting discharge planning as they had developed a good rapport with the patient.

SOUTHPORT AND ORMSKIRK NHS TRUST

Southport and Ormskirk NHS Trust safeguarding team is responsible for ensuring that robust and effective systems are in place to support the Trust in working effectively to safeguard adults who are at risk of abuse or neglect.

The safeguarding team is a multi-functional team providing both operational and corporate responsibilities across the hospital sites, with the adult's team based at Southport. The team work closely with both Sefton Council and Lancashire County Council and support the work of the Local Safeguarding Boards for Merseyside and Lancashire.

Adult Safeguarding achievements in 2021/22

- We achieved >90% compliance in all six levels of safeguarding training
- We processed a 19.5 % increase in DoLS authorisations
- We developed and introduced a Service Level Agreement with Merseycare, to provide a Mental Health Administration Service for patients detained under the Mental Health Act
- We developed a Memorandum of Understanding with Light for Life Homeless Service
- We provided ongoing collaboration with IT to develop the MCA and DoLS portal

Awareness of Adult Safeguarding was raised:

Through Safeguarding ambassadors

- Launched in January 2020 across the Trust to support sharing information and disseminate training/lessons learned

Through representation at the planned and unplanned governance meetings

- Safeguarding is a core agenda item at the monthly meeting

Information included in Trust news

- 7-minute briefings / Local SCB and Local SAB newsletters / /safety notices / safeguarding ambassadors / links to Local SABs

Safeguarding Briefs

- Newsletters circulated to all relevant staff
- External training circulated to all relevant staff

For adult safeguarding referrals, other than in an emergency when the LA 'duty team' will be contacted, staff complete an internal referral form which is then attached to a datix (incident reporting system).

All safeguarding concerns will be quality assured and checked by the safeguarding team prior to submission to the Local Authority this includes were necessary contacting the patient and or their family/ carers and supporting them through the Trust safeguarding processes.

Where adults have capacity 'Making Safeguarding Personal' (MSP) allows them to express the outcomes they would want, and to uphold their right to refuse a referral, (where there is no concern regarding the wider public interest, or risk of serious harm to themselves). In accordance with the principal of MSP there were 26 individuals who had capacity to refuse intervention, and a referral was not made.

Adult Safeguarding priorities 2022/23

- We will plan and prepare in preparation for the implementation of the LPS process, ensuring the Trust meets it statutory obligations
- We will apply for all available external funding for an HIDVA
- We will present a business case and recruit for a substantive Learning Disability and Autism Practitioner
- We will continue to improve the completion of the safeguarding documentation in AED
- We will continue to ensure the development of a network of safeguarding ambassadors

SOUTHPORT AND ORMSKIRK NHS TRUST CASE STUDY

Situation - An adult female was brought by ambulance to Southport A&E following a welfare concern raised by another Acute Hospital. Paramedics reported that on arrival, the house was full of insects, large amounts of household waste, human excrement and there was evidence of extreme hoarding. Due to the severity of the hoarding issues at the property, the fire service had to be contacted to clear a route through to the patient, to enable paramedics to assess her and bring her to hospital. At this time the patient advised that she was struggling to cope.

A Safeguarding referral was made to the Local Authority by North West Ambulance Service (NWAS) and concerns were reported to the Hospital Safeguarding Team by A&E staff. The decision was made that the patient required an inpatient admission due to the social concerns identified.

Safeguarding input - On receipt of the above concerns, liaison took place between the Hospital Safeguarding Team and ward staff. At this time, the female advised that she had support from a friend and did not require any additional support as she was able to manage all activities of daily living independently. Liaison then took place with the Local Authority to follow up on the outcome of the referral made by NWAS and provide updated information. The Local Authority advised that concerns regarding self-neglect were already known to them and they were liaising with environmental health regarding an ongoing management plan, which included going to court for a compulsory clearance order. Due to the female refusing Social Workers access to the property, the Local Authority were experiencing difficulties in assessing the female's care and support needs.

Following this discussion, the Hospital Safeguarding Team worked cohesively with the allocated Social Worker to assess the female whilst she was in hospital. The female's behaviour both prior to and during her hospital stay, in addition to the circumstances in which she was found, gave reason to doubt her capacity in relation to her returning to her own property on discharge. On discussion with the female regarding home conditions, she was unable to weigh up information relating to the risks of returning home, unable to acknowledge that the level of clutter in the property would severely impede mobility, and that the large amounts of human excrement and infestation of insects posed a serious health risk both to herself and to others living in the same block of flats. The female remaining fixed in the belief that the state of the property related to a previous clearance attempt by the council. The female was assessed to lack capacity in relation to decisions regarding discharge, demonstrating impaired executive function

Outcome / Result - On discharge the female went to stay with a friend and the social worker and environmental health are continuing to work with her in the community. Prior to hospital admission the social worker was experiencing difficulty contacting the female to assess her capacity, care and support needs. Through professionals working in partnership and the female being assessed by health and social care staff during an inpatient stay, greater insight was gained into the lived experiences of the female to enable her to be effectively safeguarded on discharge.

LANCASHIRE AND SOUTH CUMBRIA FOUNDATION TRUST (LSCFT)

LSCFT provide health and wellbeing services across Lancashire and South Cumbria including:

- Secondary mental health services
- Perinatal mental health services
- Forensic services including low and medium secure care
- Inpatient child and adolescent mental health services
- Physical health and wellbeing services

Our strategic approach to safeguarding is linked to our agreed Safeguarding Strategy 2022-2025. This links to the Trust Safeguarding Policies and Procedures. LSCFT takes a Think Family approach to safeguarding practice. Our Safeguarding Strategy takes account of the updated priorities and business plans of the Safeguarding Boards and Partnerships, our commissioned safeguarding specifications and updated safeguarding multi-agency systems and processes across the County. Our Safeguarding Strategy aims to ensure our services protect and prevent harm, abuse or neglect for service users and their families. Our Trust Safeguarding Strategy aligns the national and key local priorities to improve safeguarding outcomes in LSCFT.

The Safeguarding team has led the implementation of the priorities within the Trust Safeguarding Strategy and through analysis of the impact of delivery of the nine core priority areas, triangulating this with dissemination of learning from SARs and DHRs.

Delivery of our priorities is monitored and reviewed via the Safeguarding Team portfolio groups which include: Training, MCA/LPS, Prevent, Looked After Children, Domestic Abuse, Self-Neglect, Learning Lessons, Safeguarding Risks Outside the Home (Contextual Safeguarding), Hidden Harm within the Home, Violence Reduction and Health Partnership System Improvement and Reform.

LSCFT continue to strengthen safeguarding practice & systems to sustain compliance with revised statutory Safeguarding, MCA and Prevent Guidance and responsibilities. LSCFT continues to support collaboration across Local Authority Safeguarding services (BwD, Lancashire and Blackpool) to strengthen information sharing, support provider led enquiries and ensure clinical contribution in Section 42 referrals, where this is appropriate. Independent oversight is provided within this by LSCFT Safeguarding team.

We have carried out significant activity to raise awareness of the Domestic Abuse agenda by developing a Domestic Abuse and Think Family webinars, connecting safeguarding adults with the safeguarding children agenda. The webinars have ensured that key safeguarding messages have continued to be shared across the organisation within the restraints of the pandemic.

We have also developed training in relation to:

- Domestic Abuse
- HBA/Forced marriage and FGM,
- DASH (Domestic Abuse, Stalking and Honour Based Violence) Assessments
- MARAC
- Raise awareness about the role of the IDVA (Independent Domestic Violence Advocate)
- Domestic abuse in the context of Young people perpetrated within Family contexts.
- A focus on perpetrators.

LSCFT also now support an introduction to Domestic Abuse and Routine enquiry within the trust preceptorship programme for nurses/ Allied Health Professionals and will support the medic development plans in Dec 2022.

We have continued to engage with multi agency partners to co deliver training, ensure a co-ordinated approach to domestic abuse and actively strengthened internal processes for MARAC.

Lancashire have been slow to progress a revised MARAC model and this continues to prove a significant challenge due to the upward trend in cases discussed within MARAC. It has been communicated within the PLDASG (Domestic abuse- strategic group) that Lancashire hope to have a new model in place with April 23 and a project lead is in place to support this. LSCFT remain fully committed to supporting developments and await updates.

We have developed a robust process together with LCC Safeguarding Adults team to ensure that all section 42 enquiries are conducted in a thorough and timely manner.

We have raised the profile of contextual safeguarding, trauma-informed care and Think Family. We have worked with our adult facing services to further embed Think Family and contextual safeguarding into practice.

LSCFT recognise that the issue of self neglect is a significant feature within Safeguarding Adult reviews and have issued briefings in regards to this issue to strengthen awareness and support complex case activity as required.

LSCFT continue to raise awareness of adult safeguarding by:

- Lunch and learn sessions available to all practitioners across the organisation
- Publication of Safeguarding adult weeks structure programme of events
- Designated safeguarding resource accessible for all on LSCFT sharepoint,
- Learning forums and best practice groups within all Networks
- Safeguarding portfolio groups:
- Webinars

Supporting service users and cares remains top priority for LSCFT. The promotion of Making Safeguarding Personal is an integral part of Adult Safeguarding training and this reinforces the importance of engagement with service users within safeguarding activity. Likewise capacity to consent to a safeguarding concern is embedded as part of practice, and/or if a decision is to be made either with carers/family or in the individuals best interests. These messages are reinforced through the direct support provided to networks by the Specialist Safeguarding Practitioners.

In supporting the Section 42 process, the service user is consulted during the completion of the completion of provider led enquiry.

Safeguarding training reiterates the autonomy of adults and ascertaining their wishes on how they wish to proceed in the event they have experienced abuse or harm.

Safeguarding Adult Priorities for 2022/23

- Improved oversight of MCA implementation as NHS organisations prepare and discharge duties under the Liberty Protection Safeguards. We will undertake preparatory work within LSCFT and engage across the safeguarding system in relation to the implementation of the Liberty Protection Safeguards.
- Improve practice in relation to self-neglect including interface with MCA and Adult Risk Management process.
- Maintaining a focus on the Prevent agenda, vulnerability and prevention.
- Ensure services have effective safeguarding arrangements in place and are compliant with MCA.

LSCFT – CASE STUDY

Service User was detained under s.3 MHA 1983 on a mental health ward. The service user has a learning disability and was used to a structured routine/responses. Unfortunately the nature of the ward environment had not been conducive to their recovery and very challenging behaviour presented. The service user was overstimulated in the ward and as a result there were multiple assaults and injuries to staff. The Service user had also started to display new behaviours of racist/verbal insults, and masturbation. The use of Positive and Safe (PAS) techniques has been limited in its effectiveness and on one occasion when mother was visiting she tried to intervene with staff resulting in her being pulled to the ground and the service user was strangling her.

The service User was spending increased amount of time in seclusion.

Staff concerns about the amount of time spent in seclusion (daily) and concerned about this not being the least restrictive option. The service user was not well enough to be discharged back to their supporting living accommodation however the ward environment was having a negative impact on their mental health, in spite of several escalations an alternative bed/provision had not been identified.

Ward staff worked alongside learning disabilities colleagues (LSCFT/blue ribbon) along with input from the Mental Health (MH) law team and safeguarding team. It was noted that when the service user was in the seclusion room, they were not consistently presenting as distressed and given the correct interaction and support, they responded well to the team with reports on one day that there wasn't any incidents on the ward and the service user presented much more calm, settled and overall happier.

A bespoke plan was agreed due to the service user responding better to their safe, low stimulus environment when secluded which would replicate their supported living arrangements. The plan was to use seclusion as a therapeutic intervention (not a restrictive practice) and care plan / timetable a holistic and supportive care plan. The service user would be nursed in the safety of their "bedroom" (seclusion room) with a structured routine / plan for nursing interaction and intervention thus, providing them with a low stimulus environment which is safe and therapeutic to their sensory needs. It would also allow for meaningful interactions and staff to plan this accordingly to ensure their needs are met consistently.

A covert medication plan was agreed with input from the safeguarding/MH law team to ensure this was implemented lawfully and as a result the service user was concordant with his prescribed treatment plan (objective for admission). Input from the, multi disciplinary team has allowed the service user to feel safer and more settled. As a result there is reported to have been significantly less incidents and the service user has been easier to engage and support. The service user's mother was involved in all aspects of the care planning.

The service user is currently approaching discharge back to their community setting, demonstrating the importance of working collaboratively in a person centred way.

NORTH WEST AMBULANCE SERVICE (NWAS)

The NWAS Safeguarding Annual Report provides an overview of safeguarding activity for NWAS during 2021-21 and assurance relating to the scoping, development and implementation of safeguarding related processes.

Safeguarding activity has fluctuated during 2020-21, this is largely attributed to the Covid-19 pandemic. A decrease in concerns raised was seen during April 2020, since then concerns have continued to steadily grow.

HIS MAJESTY'S PRISON AND PROBATION SERVICE (HMP)

Prison Service Instruction 16/2015 sets out HMPPS responsibilities for Adult Safeguarding in Prison. Lancashire Prisons all produce local safeguarding policies in line with this instruction. Adult safeguarding in prisons means keeping prisoners safe and protecting them from abuse and neglect. This is underpinned by six key principles of the Care Act.

Prison staff have a common law duty of care to prisoners that includes taking appropriate action to protect them. Prisons have a range of processes in place to ensure that this duty is met. These also ensure that prisoners who are unable to protect themselves as a result of care and support needs are provided with a level of protection that is equivalent to that provided in the community. Definitions of abuse and neglect are based on those used in the Care and Support Statutory Guidance issued by the Department of Health in October 2014.

The service continued to ensure that all prisoners and staff were protected from the Covid-19 virus, including maximising vaccination programme and testing regimes.

COVID outbreak sites were managed effectively with support from key stakeholders including NHS and Public Health England.

The prisoner population was managed effectively to ensure cohorting arrangements were effective and minimised the risk of COVID spreading across establishments.

Exceptional delivery plans were developed to ensure business continuity to address the potential risks and detrimental impact to prisoner and staff wellbeing.

Online staff training and prisoner induction packages are raising awareness of safeguarding.

Establishments provided safe, purposeful and sufficient regimes, whilst supporting the more vulnerable with wellbeing checks and daily interactions.

Utilised a challenge support and intervention planning approach to support individuals with safeguarding needs and to appropriately challenge those who present a risk to others.

All establishments provided a buddy or resident scheme to provide appropriate adult social to assist another prisoner in meeting his/her care and support needs.

Establishments have continued to engage with the prisoner population over the period through face to face meetings, consultation sessions and surveys. Understanding the needs of the prisoner population allows establishments to adopt a strategic direction and allocate resources appropriately.

Adult Safeguarding Priorities 2022/23

- Ensure that every establishment has a nominated senior lead who is competent, confident and knowledgeable of all aspects relating to safeguarding. This will include the appropriate training for the identified leads.

- SMT lead for Safeguarding will work closely with the Healthcare Team and Adult Social Care Team. The Safeguarding lead along with the Head of Healthcare will act as the link with the Safeguarding Adults Board (SAB) at the Local Authority.
- Establishments have refreshed local safeguarding policies in place that identify the responsibilities of the organisation and staff to identify risk at a multi-agency level, ensure early multi-agency support and how we work together in partnership.
- Links with the community are strengthened further through established structures and reaching out to other organisations.

PROBATION SERVICE (PS)

The PS shares information and works with other agencies including Police, Local Authorities, Health Services and Third Sector organisations. We are a statutory partner, along with Police and Prisons, in Multi Agency Public Protection Arrangements (MAPPA) whereby we have a clear framework to share information and plan how we work together manage risk from our most serious nominals.

Although the focus of the Probation Service is on those who cause harm, we are also identifying people who are themselves at risk from abuse and take steps to reduce this. We also recognise the impact of previous trauma on the health, wellbeing and behaviour of people on probation and our staff are being trained in trauma informed approaches.

Adult Safeguarding achievements in 2021/22

- Introduction of the EPOP role to ensure the voice of the service user is heard.
- Recruitment of Health and Justice leads to develop partnerships supporting our most vulnerable cases.
- Local engagement with Lived Experience teams.

All staff are required to complete mandatory training with refresher sessions every three years. Additional training re Trauma Informed and Neurodiversity are also offered with an expectation all staff complete by 2023.

We have a dedicated team, Engaging People On Probation (EPOP) who provide feedback and suggestions on service improvement from the people we work with. The pan Lancashire Changing Futures project includes colleagues with lived experience and we are listening to what is needed for systems change. Prison Leavers projects are in place in some parts of the County. There is always a balance between managing risk and rehabilitation, the support and insight of people who understand this and can explain to others is valued.

Adult Safeguarding priorities for 2022/23: Probation Health and Justice leads will be in place, leading in development of better understanding of multi -agency approaches to safeguarding vulnerable adults in the Criminal Justice System.

LANCASHIRE FIRE AND RESCUE SERVICE (LFRS)

LFRS not only identifies potential safeguarding concerns whilst attending emergencies but also during the delivery of a wide range of community safety activities, such as our Home Fire Safety Check offer and youth engagement activities. Whilst our staff do not support service users and carers individually in a ‘case-work’ sense, they often work in a multi-agency setting where a co-ordinated approach is necessary e.g. self-neglect.

Adult Safeguarding achievements in 2021/22

- Continued to expand training and increase awareness of safeguarding across all LFRS groups
- Begun to develop more extensive tiered training plan for all staff with levels appropriate to their role.

- Quality Assurance Checks completed on all referrals to identify relevant issues/trends and to inform/develop staff as appropriate.
- Enhanced strategic visibility via detailed performance reporting to continually drive awareness and enhance quality of referrals.
- Two members of staff from the Service Headquarters Safeguarding Support Team achieved the nationally recognised Level 4 National Fire Chiefs Council Safeguarding 'Train the Trainer' qualification.

Adult Safeguarding awareness to staff through:

- Safeguarding cards continued to be provided to every new member of staff to wear with their lanyard.
- Safeguarding training provided to all new recruits.
- Awareness talks provided at Area Team meetings and face to face talks provided at Stations.
- Mandatory on-line safeguarding training package completed by all staff. This is monitored at least twice a year and reminders sent to staff as needed.
- Monthly and Quarterly referral reports produced and shared with Senior Managers - specific and identifiable information about those referred is not included in the reports.

Adult Safeguarding priorities for 2022/23

- Develop and begin to roll out the tiered awareness training with levels in line with job roles.
- Continue to increase/improve the quality of the information we include on the referrals being made.
- Ensure LFRS meets the National Fire (Service) Standard for Safeguarding.
- Work towards developing a more secure referral system to LA Social Care Teams, such as through Egress Secure Workspace

LFRS – CASE STUDY

During an arranged Home Fire Safety Check in early Mar 2020 the lady asked the LFRS Community Safety Advisor to knock-on next door to check on a gentleman as she was concerned for his welfare. The staff member observed signs of hoarding, untidiness, uncleanliness and the property being in a very poor state of general repair. A referral was made to Age UK for support. The occupant, in his mid-60s, had mobility issues, struggled to cook for himself and had a speech impediment which made it difficult for him to talk over the phone to speak to services/request help, but he still wanted to maintain his independence. He was initially willing to accept some help and the neighbour did help from time to time.

The LFRS staff member arranged a revisit date to check on progress. The physical revisit was delayed due to Covid but when it was possible in Oct 21 the situation hadn't improved. This is likely due to the pandemic; however it also seems that LFRS were, at the time, the only service who the gentleman would actively engage with. The gentleman had initially refused a referral to Social Services (Falls Team and Telecare) and Age UK mainly because he thought he would have to pay for help. The LFRS staff member decided to step up the concern and made a safeguarding referral to LCC, due to hoarding/state of property/self-neglect concerns and again arranged a LFRS welfare revisit for 6 months later. The referral was actioned by LCC, contact made, and a package of care and support put in place.

The revisit, approximately 6 months later, saw a dramatic improvement in living standards and the gentleman's condition. He had now accepted external support. The house was no longer cold; it was cleaner, repairs had been done and decent food was available. The gentleman had a 'falls' pendant and had regular carer support and he was very grateful for all the support that was available to him. He has also now had mobility assistance equipment installed into the property due to intervention by LCC.

PROGRESS HOUSING GROUP

The Group provides accommodation to a range of people, including general needs, older people, people with a learning disability or autism, mental health needs, the homeless and women and children escaping

domestic abuse. The Group is a landlord and as such has a significant role to play in the lives of people who live in our properties. The Group has a key safeguarding role to play in keeping people safe, alongside colleagues in social care, health and the police as we are well placed to identify people with care and support needs, share information and work in partnership to co-ordinate responses. PHG also delivers Lifeline, telecare and emergency responder services across Lancashire keeping people safe and enabling them to live independently in their own homes. PHG is represented on LSAB on behalf of all housing providers and as such communicates out key messages from the Board.

Adult Safeguarding achievements in 2021/22
During the period 01/04/2021 to 31/03/2022 colleagues at Progress raised 137 safeguarding alerts to Social Services. Of these 137 referrals 60 where either upheld or part-upheld by Social Services. As a result, 60 of our tenants got the help needed, that otherwise may have gone undetected. The number of referrals was greater than in 2020/21 (92 referrals made) and also greater than in 2019-2020 (84 referrals made). This may indicate that our safeguarding training is effective in creating awareness around safeguarding in general as well as training on how to identify and log safeguarding alerts. We anticipate that the roll out of our third-party safeguarding training will only invoke more awareness around safeguarding reporting procedures and will be reflected in the number of referrals our organisation makes during the 2022- 2023 period.

Awareness raised of Adult Safeguarding:
We started offering new safeguarding courses. We also have sessions on MYLO, the Group's online learning platform, covering various aspects of safeguarding such as hoarding. We also publish articles on our intranet to raise awareness and run campaigns to highlight certain issues, such as the White Ribbon campaign raising awareness to our customers of domestic abuse.

Supported service users and carers through the Safeguarding Adults procedure through:

- We refer into MARAC to safeguard any adult that is at high risk of domestic abuse. We also refer into the South Ribble Integrated Team which delivers a multi-agency approach to helping anyone that is identified as needing support from multiple agencies.
- How do you seek the views of adults at risk? What difference has this made to your work?
- In our schemes for homeless people and women escaping domestic abuse, we do this through key-working and training sessions. We undertake an equality impact assessment when reviewing our safeguarding policies, seeking the views of those who will be most affected by the policies. When working with specific individuals regarding a safeguarding issue, we ensure their views are taken into account when taking action to support them. Ensuring we seek the views of tenants and customers means that our service is focused on what the individual wants and needs and leads to better outcomes for those individuals.

Adult Safeguarding priorities for 2022/23

- Continue to raise awareness of safeguarding procedures and comply with mandatory training requirements.
- Undertake a full review of our safeguarding policies and procedures using an external consultant.
- Review and update safeguarding information pages on the Group's intranet.
- Develop our skills and knowledge through networking and continue to attend the Learning Disability and Autism Housing Network Safeguarding Sub-group.

PROGRESS HOUSING – CASE STUDY

Referral details: A visit was carried out to a Progress Housing Group property for an inspection due to the poor condition of the property. While at this address the tenant told our member of staff that she was scared of her brother who had moved into the property some time ago. Due to his behaviour towards her

(which included him being very abusive and shouting at her), she added that she sits in her bedroom most evening to get away from him. The tenant went on to tell the staff member that he (the brother) will not give her any money towards bills and expects her to pay for everything. The property is in a poor condition and her brother expects her do all the cleaning. The tenant is very unsteady on her feet and uses a walking frame to get about the property. She is not able to get out of the property said the brother talks down to her and calls her names, making her frightened and unsettled in her own home. She wants him to leave the property but scared of what he will do if she asks him to leave. Our member of staff explained that they could make a safeguarding referral, but it would mean us passing on her details to another agencies, which she agreed to.

Safeguarding outcome: Social Services contacted the tenant and although she did not wish for them to contact the Police to ask her brother to leave, they were able to take the following provide her a package of care to support her with personal care and meal preparation. In addition a referral was made to Age Concern and agencies who could support her with shopping. The tenant now knows that as well as the practical support provided to her, there are agencies she can rely on for advice and assistance if required.

HEALTHWATCH LANCASHIRE

Healthwatch Lancashire is the independent public voice for health and social care in Lancashire.
Our statutory responsibilities include:

- Obtaining the views of people about their needs and experience of local health and social care services. Local Healthwatch make these views known to those involved in the commissioning and scrutiny of care services.
- Compiling reports and making recommendations about how those services could or should be improved.
- Promoting the involvement of people in the monitoring, commissioning and provision of local health and social care services.
- Providing information and advice to the public about accessing health and social care services and the options available to them.
- Escalating the views and experiences of people to Healthwatch England, helping us to carry out our role as national champion.
- Making recommendations to Healthwatch England to advise the CQC to carry out special reviews or investigations into areas of concern.

We have a duty to recognise and report safeguarding concerns. We undertake engagement with the public utilising a range of methods, including providing information and signposting support. This can include safeguarding advice and guidance.

During 2021/22 we actively championed the rights of the public to live a life free from abuse and neglect:

- 100% of staff were trained in safeguarding adults, safeguarding children, Prevent and GDPR.
- We introduced an internal safeguarding dashboard to enable us to track, monitor and report on safeguarding concerns raised to the local authority.
- Raised safeguarding concerns appropriately.

We raised awareness through:

- Safeguarding training and development for all staff
- Facilitating a Trustee training session highlighting their safeguarding responsibilities using SCIE guidance
- Taking part in Safeguarding Adults Awareness Week and Advocacy Awareness Week

We ensured the appropriate provision of information and support including the right to receive independent advocacy under the Care Act 2014. Through our Enter and View project we identified practice which could be an early indicator of abusive culture and worked with the care home quality team to address.

We regularly engage with the public including people who have care and support needs, people with complex needs, carers, people experiencing mental ill health and people from hard to reach communities. We adapt our approach and communication style accordingly using a range of methods including easy read information.

We are hoping to run a pan-Lancashire project in partnership with other local Healthwatch to hear the experiences of people who have been through the safeguarding process, carers and practitioners. This is to establish whether the safeguarding process is personal, person-led and supportive of the person to achieve their goals. Learning will be identified and recommendations made for improving services.

7 Board Priorities 2022-23

- Mental Health
- Domestic Abuse
- Self-neglect
- 'Voice' Making Safeguarding Personal (MSP)
- Mental Capacity & Liberty Protection Safeguards