Lancashire Safeguarding Adult Board

Annual Report: 2022/23

Publication Date: TBC
Final Draft 1.0 (10.08.2023)

lancashire safeguarding adults board

Contents

1. Foreword

Welcome to the Lancashire Safeguarding Adults Board's (LSAB) Annual Report for 2022/23, and my first for the Partnership having only been appointed in May 2023. During 2022/23 the role of the LSAB Chair was previously covered by both Stephen Ashley and more recently Tony Pounder. I would like to take this opportunity to acknowledge the considerable and effective leadership provided by them during this time of transition.

This report accurately describes the challenges faced across the Partnership during 2022/23, post Covid and at a time when demand increased, and agencies continued to do their very best for the public of Lancashire. Now more than ever partnerships need to be efficient and effective, ensuring every opportunity is taken for improvement.

The Health and Care Act 2022 now provides legislation for the Care Quality Commission (CQC) to commence a meaningful and independent assessment of adult care provided at a Local Authority and Integrated Care System level. These inspections are now underway, and the Lancashire Partnership welcome the future inspection (no date confirmed) and see it as an opportunity for further improvement. We will also provide the appropriate information and people to evidence our commitment to keeping people safe, free from abuse and neglect across the County.

In support of this statement, we have recently reviewed the LSAB membership, along with the roles and responsibilities of the supporting subgroups. A new three-year strategy will be in place by August 2023, with supporting priorities and identified outcomes. Going in to 2023/24, we are committed to ensuring the learning from Safeguarding Adult Reviews (SAR's) quickly translates into improved service delivery and that we also have a demanding workplan for the year ahead which will translate into tangible outcomes in line with the Care Act 2014.

The Board and wider Partnership are truly looking forward to the year ahead, where we will continue to listen to our service users, learn from where we could have done better and deliver the very best service possible.

In conclusion, 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. Working together, we will reduce the number of people in need of care and support, and prevent abuse and neglect.

Steve Chapman

Chair, Lancashire Safeguarding Adults Board

2. The Board – Purpose & Structure

2.1 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 are set out in the Care Act 2014:

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

Making Safeguarding Personal

In addition to these principles it's also important that safeguarding partners take an approach to safeguarding that focuses on the person, not the process. It means that safeguarding should be person-led and outcome-focused, engaging the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice, and control, as well as improving quality of life, wellbeing, and safety.

2.2 Core Duties

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

2.3 What will we do?

Our vision is that as Partner organisations we will work together to protect people in our communities to promote wellbeing and rights being supported, safe from abuse and neglect.

2.4 Aims and Principles of Cooperation

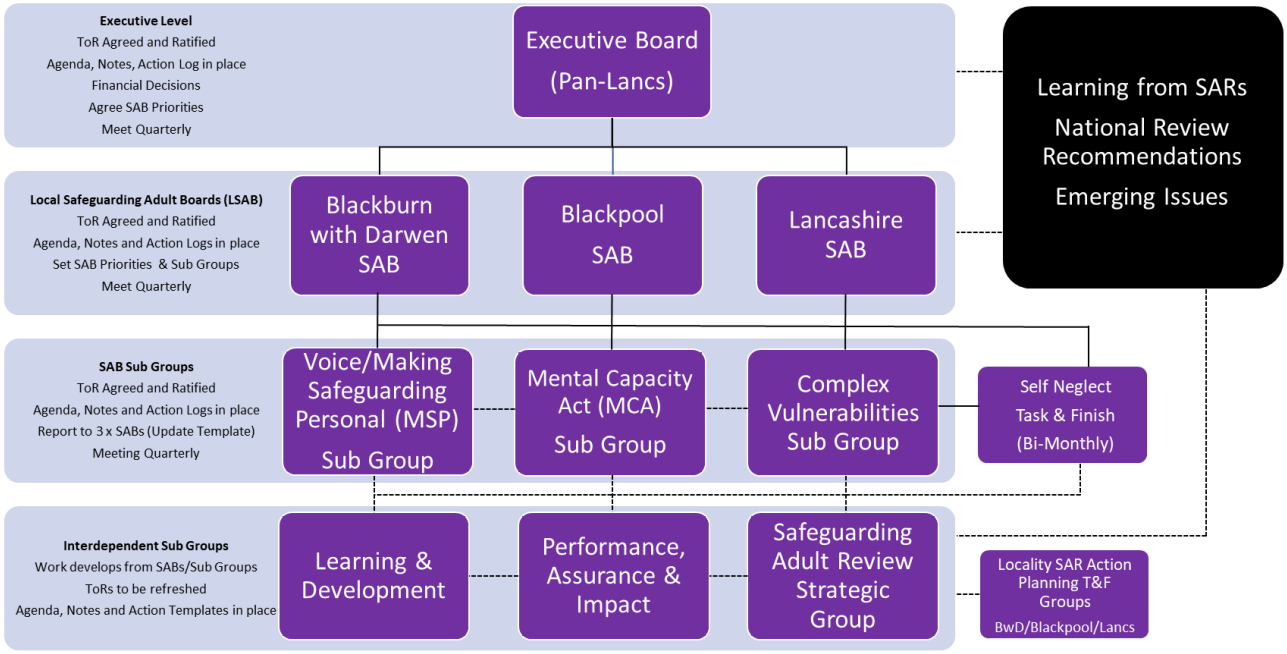
Working together to ensure adults at risk are:

- safe and able to protect themselves
- treated fairly and with dignity and respect protected
- able to easily access support, protection and services

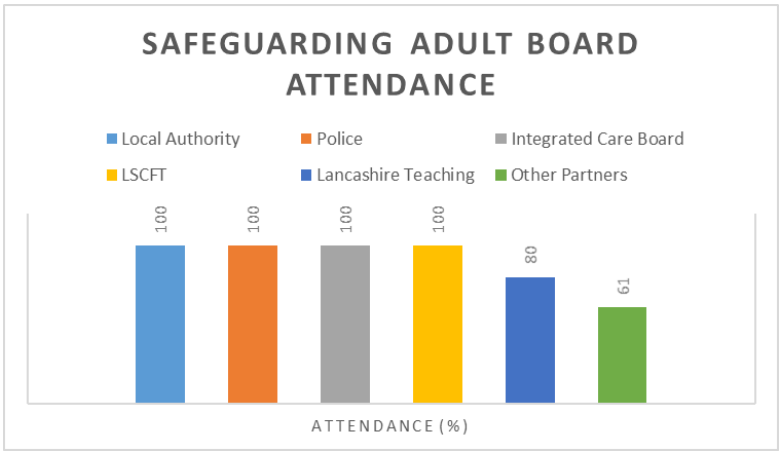
2.5 Partnership Structure

The SAB 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 subgroups and the Joint Partnership Business Unit (JPBU). See process on next page.

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).



2.6 Members 2022/23



- Lancashire County Council
- Lancashire and South Cumbria Integrated Care Board
- Lancashire Constabulary
- Lancashire & South Cumbria Foundation Trust (LSCFT)
- Mersey Care NHS Foundation Trust
- Lancashire Teaching Hospital NHS Trust (LTHT)
- East Lancashire NHS Trust (ELHT)
- Southport & Ormskirk Hospital Trust (SOHT)
- University Hospitals of Morecambe Trust
- Lancashire Fire & Rescue Service (LFRS)
- North West Ambulance Service (NWAS)
- Healthwatch Lancashire
- District Councils
- Department for Work & Pensions (DWP)
- Progress Housing Group (PHG)
- National Probation
- His Majesty's Prisons (HMP)
- Lancashire Women
- Active Lancashire

2.7 Subgroups

The Subgroups reported for 2022/23 are all pan-Lancashire, covering Lancashire, Blackpool and Blackburn with Darwen and include:

- Complex Vulnerabilities (including self-neglect task and finish group)
- SAB Learning and Development
- Voice/Making Safeguarding Personal

- Mental Capacity Act (MCA)/Deprivation of Liberty (DOLS), Liberty Protection Safeguards (LPS)
- Strategic Safeguarding Adult Reviews (SAR)

2.8 Complex Vulnerabilities Subgroup
The subgroup met on four occasions in 2022/23

Key objectives 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.

2.9 Self Neglect Task and Finish group
The Task and Finish group met on six occasions in 2022/23.

Self-neglect nationally is a frequent theme in SARs where people are living at home. 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 subgroup.

2.10 SAB Learning and Development Subgroup
The subgroup met on three occasions in 2022/23. The group was stood down due to a governance review late 2022.

Key objectives are:

- To facilitate an integrated approach to safeguarding learning and development across Blackburn with Darwen, Blackpool and Lancashire.
- Develop an annual safeguarding adult workforce development plan alongside an operational plan in line with SABs priorities.
- Development of multi-agency training resources
- Quality assure and approve any learning being delivered.
- Drive forward the recommendations of SARs, Domestic Homicide Reviews (DHRs) and learning reviews across the partnership and seek assurance that learning is embedded within practice

2.11 Voice/Making Safeguarding Personal Subgroup
The subgroup met on four occasions in 2022/23.

Key objectives 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.

2.12 MCA/DOLS/LPS Subgroup
The subgroup met on four occasions in 2022/23.

Key objectives 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. Page 11 of 39

2.13 Strategic SAR Subgroup
The subgroup met once in 2022/23.

Key objectives 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. What is Safeguarding?

3.1 Section 42 of the Care Act 2014 requires that each local authority must make enquiries (or cause others to do so) if it believes an adult is experiencing, or is at risk of, abuse or neglect.

This applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it (Care Act 2014, section 42)

When an allegation about abuse or neglect has been made, enquiries are led by a qualified social worker to find out what, if anything, has happened. The enquiry will seek to establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

3.2 Who can raise a safeguarding concern?
Anyone can raise a concern about a vulnerable adult with care and support needs who is at risk of abuse or neglect.

This may be family or friend, a carer, a professional working with adults with care and support needs or somebody who thinks they have been abused. It may even be a tradesperson or a member of the public seeing something in a health/care setting or home.

Alternatively, if a person has contacted other professionals (such as the police, health services or voluntary organisations) and there is concern that abuse is taking place, those agencies will also raise a concern.

3.3 How to raise a safeguarding concern
There are a number of ways a safeguarding concern can be raised.

Whether you are a member of the public or a professional, you can contact the Customer Access Service using the dedicated safeguarding line 0300 123 6721 and follow the options applicable to you.

Alternatively, you can visit the website at www.lancashire.gov.uk/health-and-social-care/adult-social-care/report-a-concern-about-an-adult/ Here you will find information about Safeguarding including how to identify abuse and the types of abuse that can occur. There is also information on the Safeguarding process.

4. Activity and Performance Information

4.1 Local Context and Background
Lancashire is in the North West of England and is a shire county and "2-tier authority", meaning it is controlled by a county council (Lancashire County Council), and 12 local government district councils. The Joint strategic needs assessment (JSNA) can be found here jsna-annual-commentary-2022-23.pdf (lancashire.gov.uk)

The population within the Lancashire-12 area was 1,235,300, an increase of 0.7% on the 2020 mid-year estimate figure of 1,227,076, and an increase of 5% (63,961) since 2011, when the population was 1,171,339 people.

The highest percentages of children under 15 years across the Lancashire-12 area in 2021 were in Preston 19% (27,500), Pendle 19% (19,500), Burnley 19% (18,300), and Hyndburn 19% (15,500), while the lowest percentages of children under 15 were in Fylde 14% (11,300), Wyre 15% (16,500), and Ribble Valley 15% (9,400).

The districts with the highest percentages of population age 65 and over were Wyre 28% (31,100), Fylde, 28% (22,700), and Ribble Valley 24% (14,800). The districts Lancashire JSNA annual commentary 2022/23 7 with the lowest percentages of population over 65 years old were Preston 15% (21,800), Pendle 18% (17,200), Burnley 18% (16,800), and Hyndburn 18% (14,900).

All Lancashire-12 districts had between 2% and 4% of their population aged 85+, with the largest numbers of 85+ population in Lancaster (3,900), , Fylde (3,200), and West Lancashire (3,100), while the lowest numbers of people over 85 were in Rossendale (1,500), and Burnley and Ribble Valley (1,900 each).

Lancashire County Council provides long-term adult social care services to over 23,000 people each year. Over 15,000 people receive services enabling them to live at home (including home care, day care, direct payments, transport, meals and respite care), over 6,000 are supported in residential care and over 2,000 are supported in nursing care.

Recent surveys conducted with both carers and service users in Lancashire-12 indicate high levels of satisfaction generally with the adult social care services received, though satisfaction levels have shown a slight decrease from previous years. This in part may be a reflection of the difficulties in maintaining a high-quality service when resources are being stretched.

4.2 Safeguarding Activity

How Safeguarding was managed in Lancashire changed during this reporting year 2022/23

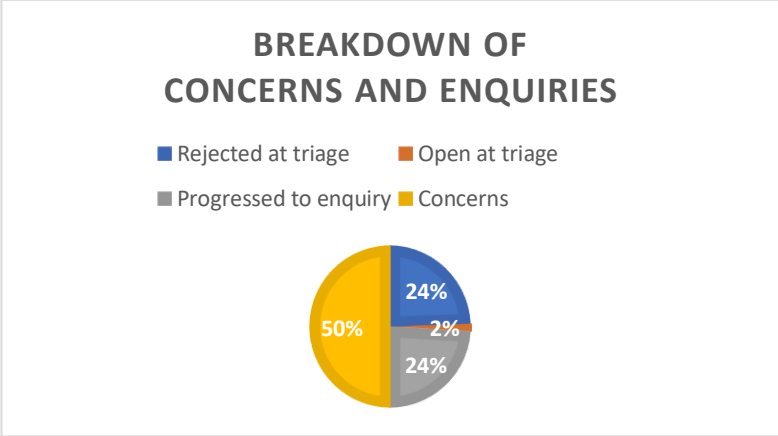
The new approach aims to be:

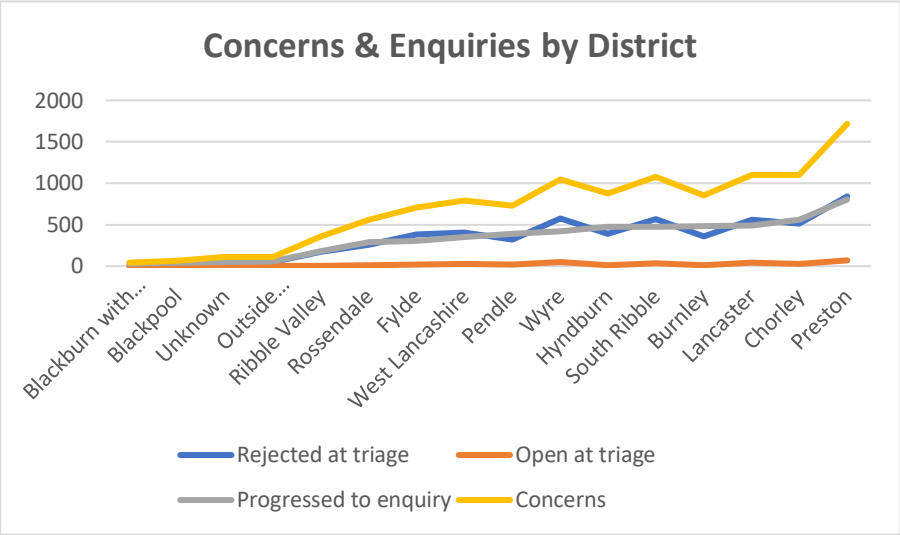
- A person-centered approach to all safeguarding activity
- An end to waiting lists of outstanding safeguarding concerns
- A desire for a single Safeguarding service, integrating MASH and Safeguarding Enquiry Service
- Better quality information to support safeguarding decisions
- Improved relationships with providers and partners
- Swifter responses and conclusions to safeguarding enquiries
- Standardised practices and processes

As of 7 March 2023 13,551 concerns have been received during 2022/23 to Lancashire County Council Safeguarding team, compared to 9208 in 2021/22.

24% of concerns raised, progressed to become a Safeguarding Enquiry.

6,103 enquiries have been closed during 2022/23.



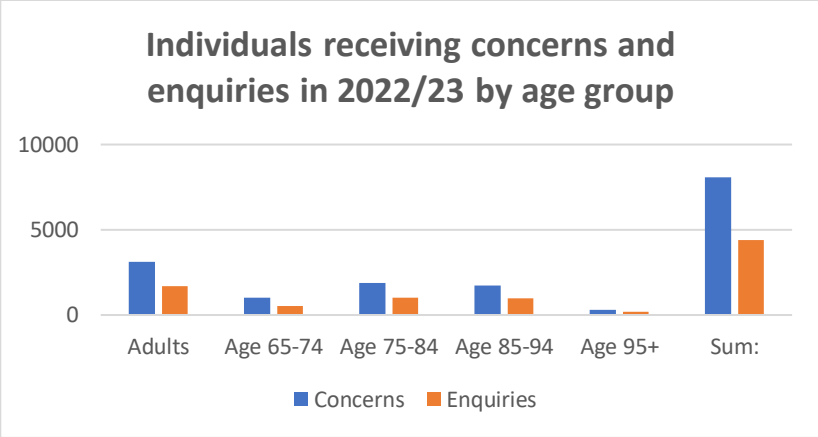


This table shows a breakdown of the concerns and enquiries by District area, including enquiries made to Lancashire relating to other areas such as Blackpool and Blackburn with Darwen.

Preston had the highest level of concerns flagged which also progressed to enquiry, but also has the largest population in the county.

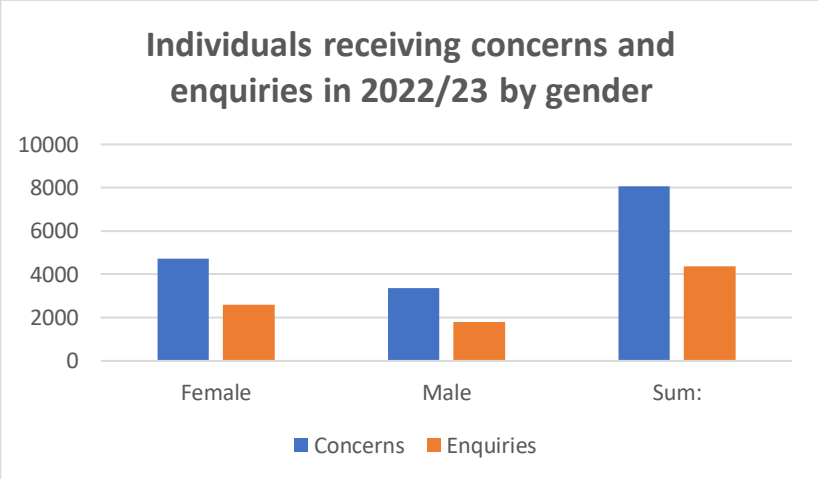
Breakdown of Concerns and Enquiries (Age Group).

Age 75-84 are highest group in Older Adults



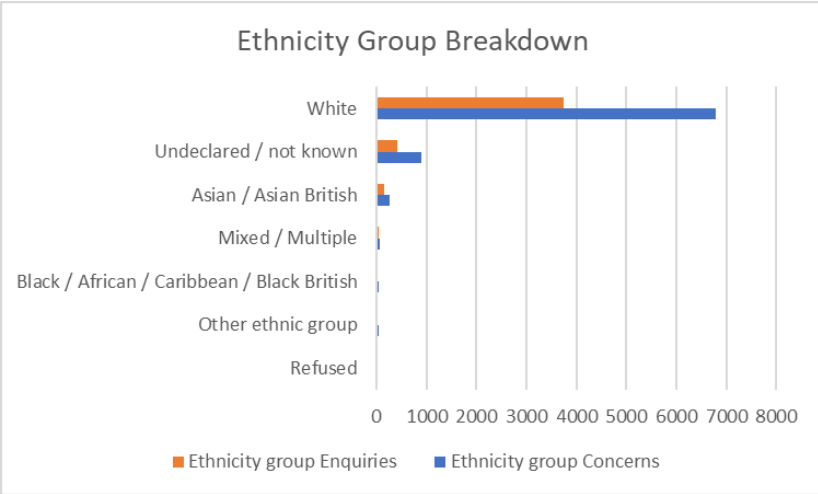
Breakdown of Concerns and Enquiries (Gender)

Females are higher for both Concerns and Enquiries

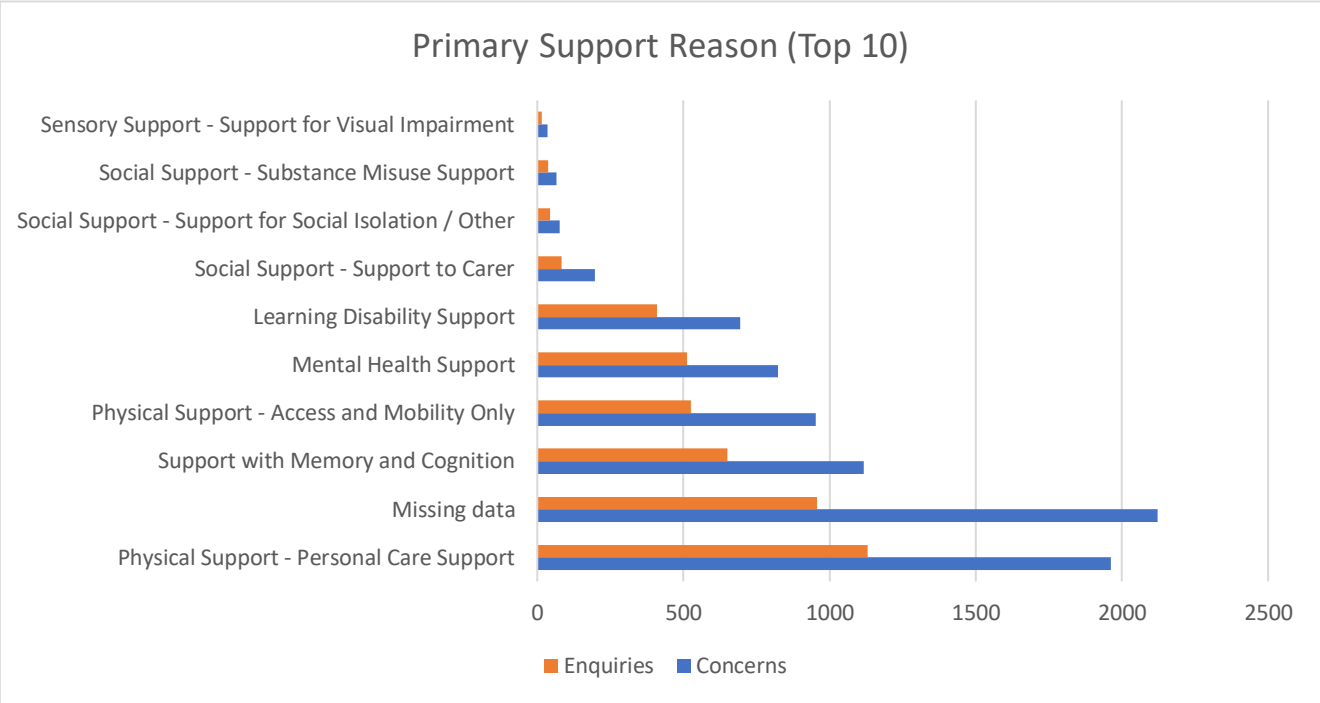


Breakdown of Concern and Enquiries (Ethnicity)

White is the largest number for both Concerns and Enquiries

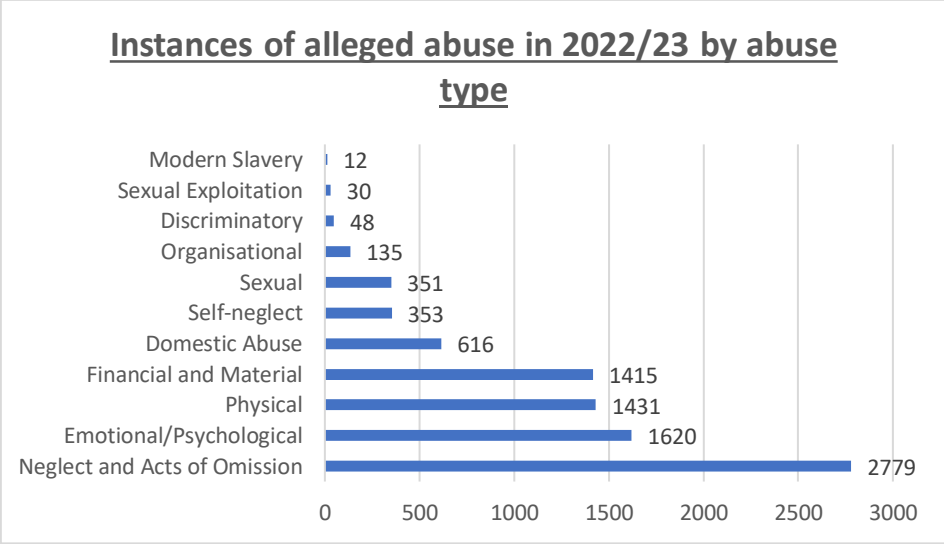


Primary Reasons for Enquiries and Concerns for 2022/23 are Personal Care Support, Support with Memory and Cognition and Physical Support (Access and Mobility).



Breakdown of Enquiries Closed in 2022/23
(Abuse Type)
Neglect and Acts of Omission, Emotional / Psychological, and Physical Abuse as top three reasons.

These also matched the top three reasons in comparison to data in 2021/22



The number of Safeguarding Alerts has reduced by 9 % and at this point it is understood that this is due to the increase of quality in professional referrals that have been raised on the Safeguarding online reporting for LCC. The complexity of alerts has increased and this has had an impact on resources availability to deliver. There is also a shortage of Social Work staff and increase in agency workers which also impacts on a stable service offer.

Changes in the operating model to a strengths based operating model has made significant improvements to the services we deliver.

4.3 What is a Safeguarding Adult Review (SAR)?

The SAB must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The SAB must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

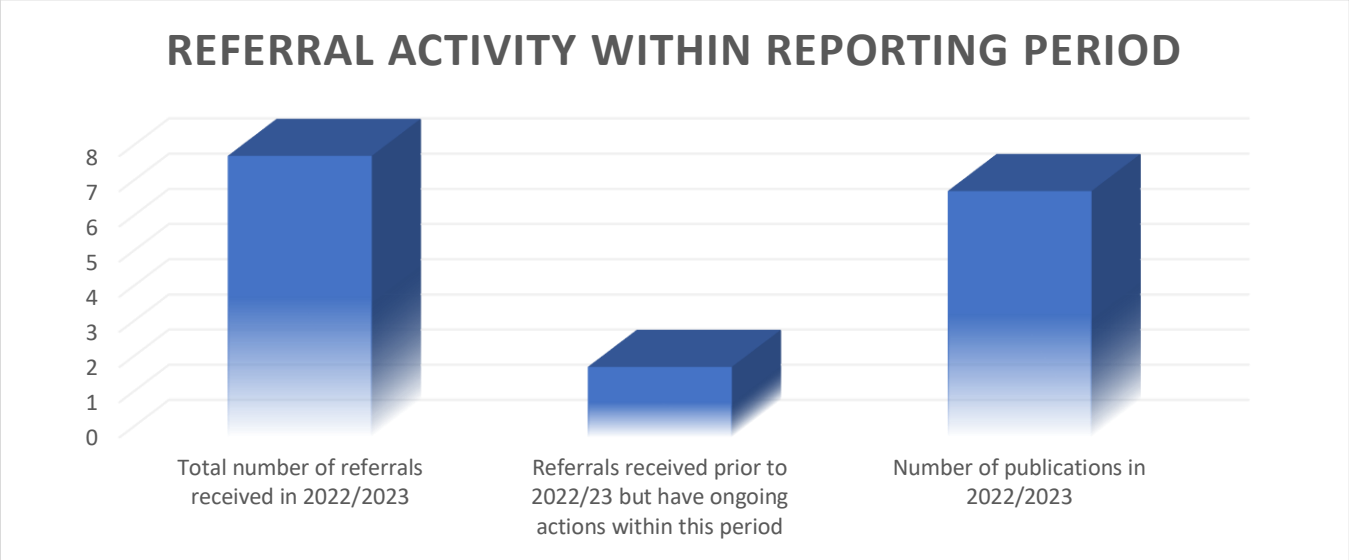
4.4 SAR Process

Any agency can request a SAR. Once a referral is made it will go through some key stages including initial scrutiny, consideration of meeting the SAR Criteria, and commissioning of an Independent Chair and Reviewer. Once the SAR process starts a number of panels will be held to understanding learning and involvement from relevant agencies and what could be done to support prevention. A report is then developed and published with a number of recommendations and actions for the SAB to take forward. Some recommendations may be for specific agencies, and some may be allocated to Sub Groups already managing improvements along particular themes e.g. Self Neglect.

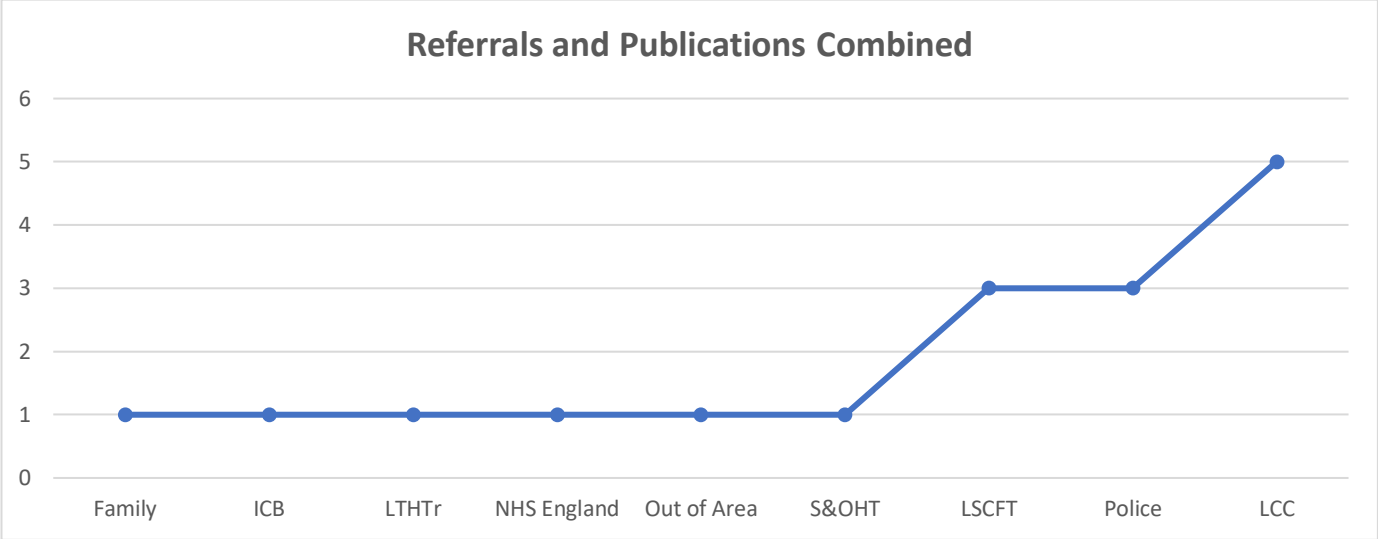
4.5 Lancashire SAR Activity

The findings from SARs in Lancashire are reported here, which include:

- the findings of the reviews arranged by the SAB under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),
- the reviews arranged by the SAB under that section which are ongoing at the end of that year (whether or not they began in that year),
- what the SAB has done during that year to implement the findings of reviews arranged by it under that section, and
- where the SAB decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

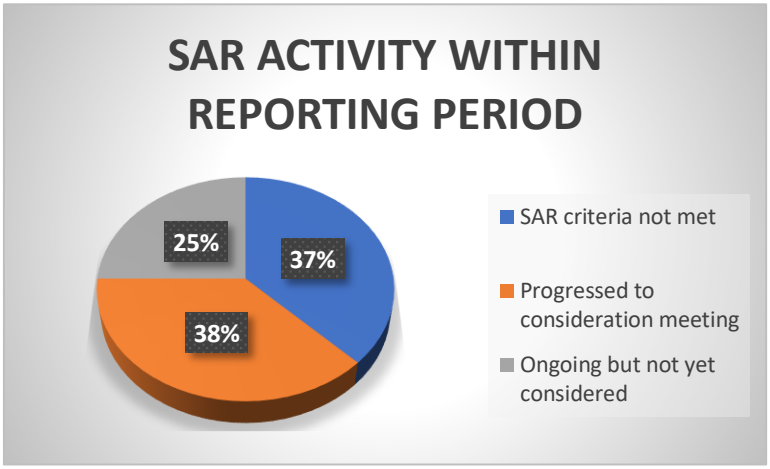


The activity being reported on in this period as shown in the above has been broken down into agencies who have referred, below.



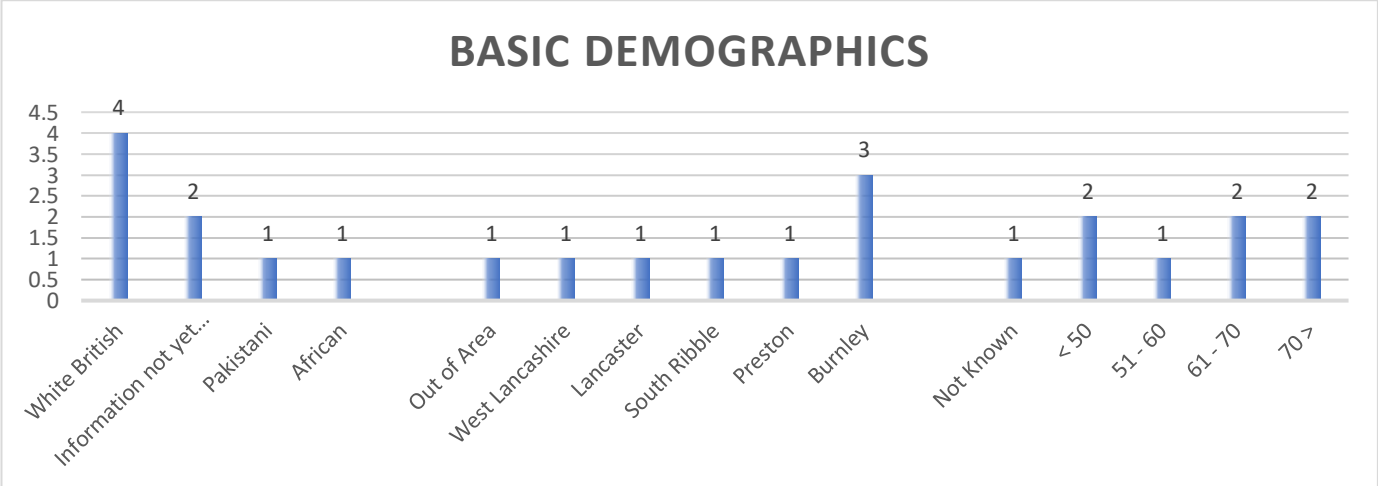
During this reporting period – 1st April 2022 to 31st March 2023, the SAB received **eight** referrals for SARs Review. Of these, **one** has progressed to become a joint SAR/DHR which is currently ongoing.

Three did not meet the criteria, **two** were progressed to a consideration meeting, one of which met the criteria and the other didn't. The remaining **two** referrals are currently in progress.



4.6 Demographics

When looking at the social demographics of the referrals being reported on within this period, below is a summary of the these which outlines the ethnicity, district and age range:



4.7 Published SARs

The following seven referrals were received prior to the reporting period 2022/23, but were published within the reporting period:

Case 1 - Adult K

This case concerns an 80-year-old male who passed away in hospital, the immediate cause of death was identified to be sepsis and leg ulcer, with evidence of other contributory health conditions including community acquired pneumonia, chronic obstructive airways disease and Atrial Fibrillation (AF). The presentation of Adult K on admission to hospital gave professionals cause for concern; he was reported to be in a poor state of health, dehydrated, malnourished and with evidence of self-neglect.

Adult K was cared for at home by his wife. He had refused healthcare for a number of years and concerns regarding his self-care specifically arose from March 2018 up until his death in December 2018. From August 2018 onwards, Adult K's wife had reported difficulties in caring for Adult K, she also had her own medical needs which would impact on her ability to continue to provide care for her husband.

A week before admission to hospital, Adult Social Care undertook an equipment assessment and subsequently a full care and support assessment. This led to a support package being agreed in Adult K's best interests, although sadly Adult K was admitted to hospital not long after this assessment and was not able to benefit from this support prior to his death.

The key themes and learning points are summarised below:

- Prevention
- Carer's Assessment
- Self-neglect
- Mental Capacity
- Public Awareness of Self-neglect
- Holistic Working

Case 2 - Adult L

This case involved resident on resident harm within a care home setting and concerns were raised that partner agencies could have worked together more effectively to protect Adult L. Due to the nature of the incident, NHS England were responsible for commissioning a Mental Health Homicide Review (MHHR) so together, it was decided to jointly commission an independent review to meet the requirements of both a SAR and MHHR.

Adult L had a diagnosis of Alzheimer's and lived in a Lancashire Care Home; she was injured after an incident at her Care Home. During the incident Adult L was pulled from her bed in the night and physically assaulted by a male Care Home resident (second adult), resulting in her sustained a fractured hip and fractured shoulder which required hospitalisation. Adult L died 2 months after this incident at the age of 91, her cause of death was established to be a subdural bleed. The second adult had dementia and had a history of violence when agitated.

The focus of the SAR was the circumstances surrounding the physical assault against Adult L, including placement planning and the care and support provided to both Adult L and the second adult by all agencies in the year prior to the incident. Although the Safeguarding Adult Referral was received in respect of Adult L, the second adult was vulnerable by virtue of his dementia diagnosis, it is therefore the case that many of the learning themes arising from the review relate to the care and support provided to the second adult.

The key themes and learning points are summarised below:

- Pre-admission Assessment and Information Sharing
- Domestic Violence and Abuse
- Risk Management
- Monitoring of Second Adult's Placement
- Lack of multi-agency discussion
- Needs of other care home residents
- Violence against staff and other residents

- Whistle-blowing
- Deprivation of Liberty Safeguards (DoLS)

Case 3 - Adult M

This case concerns three males, known for the purposes of the review as David, George and William. All of the men were known to have alcohol dependence and suffered from various physical illnesses and mental health problems, they were all in receipt of health and social care support.

David, George, and William lived together in accommodation provided by an independent social housing landlord. Each had their own agreed levels of support provided by a private company, but no staff were permanently resident at the premises.

In July 2019, a fire was discovered at the house. David was discovered deceased within the property and William suffered burns and smoke inhalation but managed to exit the property safely. George was found close by with a note which made clear his intentions to end his own life by setting fire to himself. It appears his mental health had deteriorated in the weeks prior to the fire. George was convicted of manslaughter and is serving a custodial sentence.

The key themes and learning points are summarised below:

- Placement Process
- Timely reviews and risk assessments
- Management oversight and escalation
- Information sharing
- Involvement of Primary Care

Case 4 - Adult O

Adult O had a diagnosis of Paranoid Schizophrenia, Moderate Learning Disability, type 2 diabetes and high blood pressure. She refused medication with the exemption of a depot injection for her pre-determined medical condition which she accepted as part of her routine without any real understanding of its purpose.

Agencies attempted to support Adult O with known hoarding and self-neglect, but engagement proved to be difficult for her. Adult O's Mental Capacity was questioned. An assessment was undertaken which concluded that she had capacity around self-care and hygiene.

Following multiple no access visits over a 2-day period in February 2020, police forced entry to Adult O's home. Sadly, she was found to be deceased. The cause of death was determined as natural causes.

The key themes and learning points are summarised below:

- Self-neglecting and Hoarding
- Compliance with Valid Consent
- Mental Capacity
- Making Safeguarding Personal and Non-Engagement
- Working relationships between agencies and within agencies
- Lead Professional

Case 5 - Adult P

Following complaints from the public about Adult P's behaviour, Police Officers attended his home address and found that Adult P, who had previously suffered and addressed alcohol misuse, had relapsed and began to misuse alcohol again. Adult P was found to be living in very poor home conditions and neglecting his needs. He told professionals that his mental health was deteriorating and on occasion he reported feeling suicidal.

Upon receipt of a safeguarding referral the Multi-Agency Safeguarding Hub referred Adult P to mental health services which triggered the commencement of an initial assessment.

In the meantime, Adult P attended the hospital Emergency Department on several occasions under the influence of alcohol and feeling unwell. On all but one occasion, he left the hospital before being seen.

Within six weeks of professionals learning of Adult P's decline, a neighbour reported a concern having not seen him for a while. Police officers attended the address and sadly found Adult P deceased.
The key themes and learning points are summarised below:

- COVID-19
- Multi-Agency Safeguarding Hub Referral Process
- Recognising and Addressing Dual Diagnosis
- Understanding the Mental Health Act/Mental Capacity Act
- Alcohol Dependency
- Professional and Public Knowledge of Available Support
- Multi-Agency Models and Convening Multi-Disciplinary Team Meetings

Case 6 - Adult T

In July 2020 Mary was taken to hospital by ambulance following a fall at her home where she lived with her husband. Upon arrival, staff at A&E were concerned about her presentation and care and referred her to social services. As a result, support was offered to Mary but, for reasons unknown, she was unable to engage. In October 2020 Mary was further admitted to hospital with significant dehydration, emaciation and multiple pressure sores. Sadly, she passed away a few days later, aged 74.
The focus of the SAR was the circumstances surrounding her unnoticed decline of health and frailty.
The key themes and learning points are summarised below:

- Management of Patient Non-Engagement with Health Services
- Consideration of Mental Capacity
- Understanding of Controlling Relationships in Older People
- Recognition of Self-Neglect and Application of the Self-Neglect Framework
- Effectiveness of Information Sharing
- Effects of COVID-19 Pandemic on the support afforded to Adult T
- Professionals' Assessment of the Family

The following SAR is reported here as this was managed within the reporting period, but was published on 24th April 2023:

Case 7 - Adult S

This 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.

The Summary of Learning Points for this case are below:
LP1: Assessments considering whether to approve a person as a carer for a vulnerable adult should consider finances in detail. This should include detailing how the person's finances are being managed and where any monies being received including any benefits are being paid. This should include checking relevant documentation including bank statements and documentation from regarding benefit payments.
LP2: Statutory partners should ensure that financial auditing is in place and across their services where carers are approved for vulnerable people.
LP3: All approved placements for vulnerable adults should have support plans which actively consider and review the activities and stimulation which each person being cared for requires.
LP4: GP Surgeries should ensure that all vulnerable persons who qualify for an annual health check receive the same. This should include making arrangements to visit persons at home to complete the health check for those who cannot attend the surgery.
LP5: Services providing live in carers to vulnerable adults should review whether annual health checks are being accessed and support their carers to access annual health checks for the persons they are caring for.
LP6: Keeping accurate records and in particular responding fully to enquiries/concerns from families in a timely manner. This should be recorded on the case management system.

LP7: Agencies should recognise the importance of all significant relationships when making best interest decisions under the Mental Capacity Act 2005 and that practitioners check their own practice in respect of this.
LP8: Consideration is given by agencies working with vulnerable adults to ensure that appropriate documentation is retained around the person's journey and decision making processes.

4.8 Learning and Implementation Activity
For all published SARs during 2022/23, action planning meetings have taken place to review the recommendations and actions from all reports have been progressed by either key agencies or through the Sub Group Activity. Highlights include:

- Large scale review and implementation of how safeguarding concerns and enquiries are managed in Lancashire
- A review of the operational processes on how high risk domestic abuse cases are managed
- Changes to how agencies share information to support vulnerable adults e.g. access to information virtually to support mental health assessments
- How carers assessments are shared with relevant agencies (now sent to GPs)
- New delivery model in health to manage safeguarding issues on more placed based approach to support prompt action and interventions
- New home packs - support included for vulnerable residents in social housing
- Improved escalation process around contracts with commissioned services

Recommendations which have been multi agency and are linked to particular themes have been allocated to subgroups as referenced earlier in this report. Each has a workplan with key areas of focus including:

- Mental Capacity Act (MCA)
- Domestic Abuse
- Mental Health
- Voice of the Adult
- Making Safeguarding Personal
- Self-Neglect
- Multi-agency working

Policies and procedures
A number of policies and procedures have been reviewed and updated to make sure they align with changes to legislation including the Domestic Abuse Act and Mental Capacity Act. Guidance including Seven minute briefings and toolkits have also been developed to support staff learning circles, awareness events and quick references on the Lancashire Safeguarding Adults Website, including Making Safeguarding Personal, Covert Medication Policy, access to caselaw.

Work was also completed to support changes to Liberty Protection Safeguards (LPS) including multi-agency response to consultation, planning and engagement with partners on understanding what needs to be put in place.

Since the end of the reporting period, this work has since been stood down by the government and the impact of this decision will be progressed into the next reporting year.

Training
Learning from Reviews events have been set up for front-line staff and a programme for 2023/24 is in development. Across the partnership staff have been encouraged and have attended awareness training covering Trauma Informed and Suicide Prevention sessions. The SAB has also supported awareness campaigns, including White Ribbon, National Safeguarding Week and MCA Awareness Week.

Risk Management
Issues have been progressed to the SAB where there are concerns around increased pressures in health and social care and potential risks to increased safeguarding of vulnerable adults around

particular themes. These have included seeking assurance on demand management on access to in-patient mental health beds, care home resident safety planning, and progression of work to support front line services in managing self-neglect.

Assurance
Assurance has been sought around domestic abuse pan-Lancashire approach, and changes have been proposed on the process of how high risk cases are managed. Surveys on domestic abuse and MCA have been developed for frontline staff to provide an understanding of subject areas and help identify where training and awareness needs to be strengthened. The outcomes of this work will be analysed in early 2023/24.

Activity has also taken place to ensure that organisations have protocols in place for Making Safeguarding Personal (MSP).

4.9 Healthwatch 'Voices' Project Proposal
Healthwatch Together have proposed a commissioned Project to the SABs to deliver a robust engagement project which will review the involvement of people within the safeguarding process. The project will look to start in Summer 2023 into 2024. We know processes are more successful when they involve people as fully as possible; engaging with people to increase understanding, choice, and control so that we improve the quality of life, wellbeing, and safety of the individual.

The project will explore:
• The experience of the individual
• The experience of the carer (where applicable)
• The experience of the professional

Scope
The number of people to engage with will be determined by the number of consenting individuals identified by each Council. Estimations have been made using safeguarding closure data gathered from Lancashire County Council (in comparison with local authority population sizes).

The target is based on population figures and safeguarding data provided by Lancashire County Council, Blackpool and Blackburn with Darwen Council.

Healthwatch Together will work with the SABs to independently support them to review their safeguarding process. Healthwatch will provide expert advice on engaging with people, both members of the public and multi-agency professionals to gather their thoughts, experiences, and opinions.

This feedback will be used to generate realistic recommendations which Healthwatch will report on following the project and will review 12 months post initial professional survey findings to monitor achievement and implementation.

5. Contribution from Statutory Partners

5.1 Lancashire County Council
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 engage 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 of the Act to decide what action (if any) is necessary to help and protect adults with care and support needs, experiencing or at risk of abuse or neglect and to ensure that appropriate action is taken. The Local Authority has the statutory duty to establish a safeguarding board and to publish a strategic plan, publish an annual report and conduct SAR in specific circumstances.

In undertaking its responsibilities to safeguard individuals, it is important to do so in a way that supports the adult in making choices and having control in how they choose to live their lives by 'Making Safeguarding Personal.' At its core, this approach includes promoting an outcomes based approach in safeguarding that works for an individual resulting in the best experience possible

The Care Act 2014 also 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. Together with partners we seek to raise public awareness so that professionals and other staff and communities as a whole play their part in preventing, identifying, and responding to abuse and neglect.

Key Successes in 2022/23

A Redesigned Safeguarding Adult service:
The Council's redesigned safeguarding adults service implemented between November 2021 and April 2022 was completed and the new model is now business as usual. The change programme ended on 31.3.2023 with a face-to-face meeting with Health and Police partners when presentations and data demonstrated the benefits realised together with evidence of a much-improved service user journey.

The key service delivery objectives achieved are: single social worker approach to delivering statutory section 42 requirements, a timely response, and ensuring the service user is directing how the risks to their safety and wellbeing is best managed and the outcomes they want to achieve. The service developed a portal with improved guidance of raising a safeguarding alerts and provided extra support for providers in raising alerts the service has received a reduction of 9% of alerts which may be due to improved quality of information.

Supporting Adult Safeguarding colleagues
The service deployed significant resources to promoting the health, wellbeing, and work balance of staff within the safeguarding service. We believe this has contributed to the service being able to retain confident, competent, and experienced practitioners who are delivering safe, legal, and person-centred practice.
We continued to support a "hybrid model" enabling staff to work from home and office bases which is reducing travel, time and expenses and enabling increase contact time with service users and keeping vulnerable adults safe by providing a timely response.

Striving for best safeguarding practice
Making Safeguarding Personal is the strengths based model applied in the safeguarding service ensuring that at each step of the enquiry, the views of the person who is at risk are heard and outcomes where possible met. At times it difficult to meet the preferred outcome fully due to the nature of the issue however outcomes partially or fully met is on an upward trend having improved during this reporting year from 70.7% to 94.9%

We refreshed and commissioned two days safeguarding training and ½ day caseload management training and delivered across the whole safeguarding workforce.

As part of the council's commitment to safer communities all staff within the service were given refreshed training regarding the Prevent agenda and the service has appointed Prevent champions to maintain active awareness raising in this key area. The service also has representation at the Channel panel which is an early intervention scheme that supports individuals at risk of radicalisation.

We relaunched the Provider forums to share learning, information, and guidance with sector specific forums for Care/Nursing homes and for Homecare.

We reviewed and finalised the contract monitoring process and procedure for out of area placements and implementation is in progress.

We promoted use of the Social Care Training Hub which offers providers access to free non-mandatory training. The Hub has financial support from monies awarded by Health Education England.

Key Challenges in 2022/23
Recruitment to permanent vacancies with staff experienced in safeguarding adults work has been particularly challenging. These vacancies filled with agency staff create continuing difficulties for the staffing budget.

Post Pandemic there continued to be significant work needed with registered care providers regarding their responsibilities to meet assessed care needs and deliver safe services by competent and well-trained staff. The social care support officer team, which became fully operational as part of the redesigned safeguarding service, is supporting care providers to understand the importance of when to raise a safeguarding alert and when required how to provide good quality referral information.

A small number of providers have unfortunately gone into liquidation giving short timescales to relocate residents to new care homes which in itself creates a crisis situation where residents need to be moved safely. Safeguarding services are fully involved with this work ensuring the safety of residents

The regulated care sector reports that they are continuing to deal with the impact of the pandemic. Continued challenges with recruitment and retention in the sector has led to organisations struggling to provide quality care – and where this is being undertaken it has often been at prohibitive costs of agency staff.

Priorities for 2023/24

1. To implement a revised electronic safeguarding audit tool to ensure that there is continuous improvement in service delivery and practice.
2. To review the existing framework and communication arrangements with internal lead officers regarding DHRs, and making sure there is rich agency learning, within a non- blame culture and an opportunity for continuous improvement
3. To improve the resilience of the Triage service within the safeguarding adults service by implementing robust contingency plan arrangements so that demand is well-managed and avoids the accumulation of an unacceptable backlog.
4. To undertake in partnership with health partners, commissioners and providers theme specific safeguarding deep dive activity and route cause analysis to make recommendations and find solutions to reduce the risks of the below identified harm.

    - Altercations and serious incidents between residents in Care settings where those individuals have complex care needs.
    - Choking Incidents (in care settings)
    - Self neglect

5.2 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

Key Successes in 2022/23

- "Right Care, Right Person" has seen a reduction in deployments to "Concern for Welfare" thereby ensuring that the person is attended to by the right agency/professionals to address any concerns.
- Street Triage (Police & Mental Health Services working collaboratively) has been rolled out in East Lancashire in January 2022 to provide a collaborative response to individuals presenting to the Police in mental health "
- "Op Signature" is now adopted as our response to victims of fraud, which requires a uniformed response to anyone who is the victim of courier fraud or romance fraud who is aged over 70 years and/or presents as vulnerable

- Think Victim campaign commenced in 2021 and seeks to raise awareness and improve quality of investigations. The focus has been heavily weighted towards identifying vulnerability in, for example, elderly persons.
- Efficiencies in MASH has seen processing of VA referrals without delay and, for periods, “live” time.
- There has been a reduction in the number of individuals detained under s136 MHA. The data for the recent years that evidence that decline last year are as follows:
  2019/20 – 1427
  2020/21 – 1353
  2021/22 – 1506
  2022/23 – 1220

Key Challenges in 2022/23

- Supporting and liaison with care settings for those young people aged 18-24 to assist with a trauma informed police approach once adulthood has been reached.
- Increased community liaison from the uplift in Community safety officers evidences the commitment to “Plan on a Page” priorities
- Launch of Right Care Right Person and ensuring the model is working and that the impact of the changes can be measured
- Continued multi-agency response to exploitation
- Review of force response to domestic abuse and rape and creation of specialist rape teams
- Embedding the force response to Violence against Women and Girls strategy through the National Police Chiefs Council and the College of Policing national framework for delivery.
- Delivering training to support the recruitment of hundreds of new police officers into Force

Priorities for 2023/24

1. Improving the force response to rape and serious sexual assault through Op Soteria, a new national operating model for the investigation of rape and serious sexual assault
2. Improving the quality of domestic abuse investigations
3. "Op Warrior" is the force response to tackling serious and organised crime. Operation Warrior targets the individuals and gangs involved in crime, as well as associated issues such as violence and intimidation, large scale drug supply, exploitation and fraud, all of which can cause serious harm to local communities
4. The change programme known as the TOM (Target Operating Model) started in April this year and will look at how we can make our processes and functions more victim focused, more efficient and more effective

5.3 Lancashire and South Cumbria Integrated Care Board (LSC ICB)

Health and Care Act 2022 - This period of report saw significant change in view of ICB health and care act legislation 2022, moving 8 CCGs into on ICB organisation.

The ICB became the statutory partner of the Safeguarding Adult Board on 1st July 2022 being accountable for a wide range of safeguarding activity to support the whole population of Lancashire and South Cumbria.

The ICB is established with the expectation to:-

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

A core contribution of improving outcomes in population health and healthcare is through assurance and scrutiny of the health services we commission to meet the needs of our population. This includes through the Board ensuring that organisations that provide health services have the right procedure in place to keep people safe from abuse and neglect and a workforce which is skilled and empowered to

do so. Additionally, that multiagency working is evident and leading to robust risk assessment and collaboration.

We ensure that where there are lessons to be learnt from SARs as a partnership, a health system or single agency, these are embedded and shared across health organisations where appropriate. We are connected to the governance arrangements within the NHS Trusts across Lancashire and South Cumbria to assure the organisations actions are embedded.

The ICB ensures that there are effective arrangements in place for sharing information between organisations and the health system where someone might be at risk of being harmed.

We employ specialist safeguarding expertise to support the whole health economy including 'Designated Professionals' and 'Named GP's' who specialise in safeguarding adults and the Mental Capacity Act.

The safeguarding team at the ICB are connected to regional and national workstreams to ensure the voice and representation of our communities is heard at every level.

Key Successes in 2022/23

Learning

The ICB has held a number of learning and development sessions for safeguarding across the health economy to support the themes and trends from safeguarding activity. These have followed a Appreciate Enquiry model and included bring service user voices to the core of how we consider safeguarding challenges. The sessions have explored themes including self-neglect, suicide & trauma informed approaches, and the invisible male.

The ICB has improved the connectivity between all incidents which are reported by our NHS providers to ensure that there is robust safeguarding expertise applying scrutiny and support and ensure that any themes or trends which may impact on our ability to effectively safeguard our population are identified and considered across the whole health economy.

Assurance and Performance

The ICB has focussed on aligning reporting and our use of data in assurance across the previous 8 CCG footprints. This has supported us in developing a more robust dashboard of activity to improve how we respond to challenges and how we deploy our resources to respond to risk.

We have maintained place-based assurance meetings during first year of ICB and while safeguarding Delivery Model being developed to ensure there is a safe transition to the new ways of working.

Partnership collaboration

The ICB continues to lead on partnership work around how we respond to self-neglect within our communities. This work has brought a range of partner organisations together to truly reflect on existing ways of working and consider how we agree a shared value set and approach to supporting complex individuals who self-neglect and place an emphasis on taking a more preventative and trauma informed approach to practice.

The ICB has led the relaunch of the Safeguarding Champions Model across the Regulated Care Sector. So far topics have included: Resilience Hub Support for Regulated Care Staff; Learning from SARs and Safe Recruitment Practices (incl. PIPOT, exploitation, case studies).

Two ICB wide 'Primary Care' safeguarding conferences were held in September 2022 with 96 GP practice staff in attendance. The sessions included learning from DHRs, importance of routine enquiry, coding of records and think family. Local GP Safeguarding forums have continued to improve safeguarding practice across all Primary Care which have included sessions on the '999 reunite' scheme and clinical responsibility for DHR/ SAR chronologies

The ICB chairs and leads on a pan-Lancashire Mental Capacity workstream which has been actively working with partners to improve MCA practice. This has included re-launching guidance on how health and social care professionals prescribe and administer covert medication.

The ICB also presented a case study of excellent practice to the National Safeguarding Adult Network to showcase some of the best practice and strong multi-agency working across our system.

Duty to Co-operate
The ICB has established links with Violence Reduction Network (VRN) and VRN Partnership Board. The ICB, along with partners, has endorsed a pledge and committed to delivering a trauma informed workforce and is working with partners to ensure that this is rolled out across organisations. So far, over 4,500 staff have been trained across Lancashire and South Cumbria.

Emergency Department Navigators are commissioned via VRN from Acute Services across the system. ICB have worked in year to strengthen the future resilience of this recognised clinical model of delivery, additionally ensuring all Trust areas have access.

Key Challenges in 2022/23

Workforce
Although we have not seen the same unique pressures on health services as there was during the pandemic, there remains significant work by all health services in both recovery and responding to the ever-growing demand on NHS services. This continues to be a challenge for NHS workforce to have the capacity to attend training and some partnership meetings. Although this reduced capacity has impacted on training and some development meetings, all key safeguarding protection meetings have remain a key focus and always prioritised by staff.

The safeguarding workforce across the ICB and health economy remains static and does not reflect the diversity of our communities. Work is ongoing in how we can attract a wider and more diverse range of professionals into the safeguarding agenda. An ICB set workforce plan has been agreed along with allocated funding and a plan is in development to support a move into a new delivery model.

Deprivation of Liberty delayed Applications.
The ICB has inherited a number of Court of Protection applications for Deprivation of Liberty which remain outstanding. Additional resources have been put in place to support this work and the ICB continue to closely monitor. In all cases there is a robust risk assessment applied to ensure any concerns or immediate actions are identified and resolved, and that there is a risk-based prioritisation model in place for any other work needed.

New ICB arrangements
There are historic safeguarding commissioning arrangements across Lancashire and South Cumbria based on the local arrangements which were historically established by Clinical Commissioning Groups. The ICB is driven to deliver an equitable offer and only have variance within the safeguarding offer when there is warranted reason to do so.

Analysis of Impact from SARs
There has been reduced assurance and audit undertaken on a multi-agency basis due to the lack of an effective quality assurance subgroup for the LSAB. Although there has been a focus on ensuring actions resulting from SARs are monitored, there is a need to improve our assurance the learning is embedded and having a positive impact on our population.

Priorities for 2023/24 - Statutory Deliverables

Safeguarding Delivery Model
Implementation and appraisal of the ICB safeguarding delivery model. This will be a move to a single team working at system across Lancashire and South Cumbria for economies at scale that are value added, plus Place based focus so we know our local community populations needs.
As part of our developing model and strengthening our connections across the Northwest, the ICB is leading work with Greater Manchester ICB and Cheshire and Mersey ICB in developing a peer supervision model and stronger cross working and co-development of best practice tools.

Learning
The ICB is aligning the outstanding actions from SARs to ensure the ICB has a single aligned approach to responding to actions. This includes being clear in our approach to learning communications, evolving how we learn from reviews, embedding an open learning culture and different learning styles to support our workforce. Ensuring we are clear what learning is to support front line practice and for the system. The ICB will device a clear audit programme that will form part of its overall assurance and accountability framework.

We plan to introduce a research best practice forum with academic partners to ensure safeguarding professionals are appraised of latest research practice that benefit outcomes of our vulnerable communities and individuals.

Continuous Improvement
As we begin to work as a single health system across Lancashire and South Cumbria we are focussed on ensuring that our data and key performance indicators are fully aligned and support a maturing the dashboard. Our Safeguarding Assurance Framework will be reviewed to reduce impact and bureaucratic demand on services and move to being more thematic basis and reflective of the learning from reviews and incidents.

As part of developing our local 'Place Based' offer we want to ensure we are consistent and equitable in how we support and local health services and our communities. Within this we must consider how we measure and record safeguarding activity so that it is more outcome focussed.
This continuous improvement work includes developing a health economy wide audit calendar, a proactive communication and campaign strategy and a refresh of governance and connectivity for local multiagency groups and networks.

Workforce
Focus on developing and widening the diversity and capability of the safeguarding workforce across the entire health economy and consider succession and workforce longevity for this cohort. This includes how we deploy the resources and skills available within the ICB to best deliver high impact and best value for our population. In order to achieve that we will be placing a strong focus on the training and knowledge of our workforce to ensure they can meet the ever-evolving safeguarding agenda.

The ICB is dedicated to adopting a more pro-active approach to safeguarding and working with partners through multi agency working arrangements to consider how we can support transformational work which places stronger emphasis on preventative models of care. We need to ensure that the voice of adults with care and support needs are at the heart of our future commissioning strategy as an organisation and that safeguarding is a golden thread throughout everything we do

5.4 Lancashire South Cumbria Foundation Trust (LSCFT)

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

- Inpatient and Community mental health services
- Perinatal mental health services inclusive of inpatient perinatal Mental Health unit
- Forensic services including low and medium secure care
- Physical health and wellbeing services
- Learning Disabilities and Autism
- Eating Disorders

Our strategic approach to safeguarding is linked to our agreed Safeguarding Strategy 2022-2025, which takes account of the updated priorities and business plans of the SABs 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. LSCFT takes a Think Family approach to safeguarding practice.

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 objectives, triangulating this with dissemination of learning from SARs and DHRs.

Delivery of our priorities is monitored and reviewed via the Safeguarding Team portfolio groups and our internal governance structures.

Key Successes in 2022/23
LSCFT continue to strengthen safeguarding practice & systems to sustain compliance with revised statutory Safeguarding, MCA and Prevent Guidance and responsibilities.

LSCFT continues to collaborate across Local Authority Safeguarding services to strengthen information sharing, support provider led enquiries and ensure clinical contribution in Section 42 referrals, with independent oversight provided within this by LSCFT Safeguarding team. There is a well-established process for receiving requests for provider led responses within Central and West and Pennine localities, with dedicated Social Workers in the team providing the oversight. This is being improved with the implementation of regular interface meetings to discuss Adult Safeguarding relevant to Mental Health service users.

We have continued to promote understanding and key messages in relation to domestic abuse via organisational communications, focused supervisions and training initiatives. 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 Multi Agency Risk Assessment Co-ordination (MARAC).

We have carried out significant activity to raise awareness of the Think Family Agenda, connecting safeguarding adults with the safeguarding children agenda. We have trained over 1,000 practitioners in L3 Think Family safeguarding training during 2022/23.

We have revised all safeguarding adults training packages, written a training brochure that supports the mandatory training offer. Developed an electronic course evaluation which has increased the level of assurance around safeguarding training having a positive impact on practice. We continue to deliver monthly lunch and learn sessions as a way of cascading key messages across the organisation. We support the preceptorship programme and LSCFT induction.

Self-neglect together with neglect feature within SARs, we have issued briefings in regards to this issue to strengthen awareness and support complex case activity as required

LSCFT undertake regular safeguarding visits to Central & West and Pennine to mental health inpatient units and there is a current focus on strengthening information sharing with Local Authority as part of safeguarding alerts, reporting of safeguarding incidents and implementation of key safeguarding messages into practice.

LSCFT continues to work collaboratively with Adult board members to develop and implement best practice relating to Self-Neglect, Mental capacity, complex vulnerabilities subgroups.

Key Challenges in 2022/23
Domestic abuse and implementation of the new multi-agency risk reduction assessment and coordination (MARRAC) pathway/Application of routine enquiry and DASH - LSCFT have a key role in supporting prevention activity aligned to the Domestic Abuse Act to fulfil core safeguarding responsibilities. This will require a review of training to promote understanding of domestic abuse, its links to emotional well-being, mental health and the impact. We have continued to contribute to the Multi-Agency Risk Assessment Conference (MARAC) processes with such increased activity, which has placed a greater demand on our resources.

Self-neglect/MCA – LSCFT recognise the challenge of supporting service users where self-neglect is a feature of their presentation. Good evidence in applying the principles of MCA allows for multi-agency responses and shared care planning. LSCFT will continue to enhance the quality of MCA activity to raise standards and achieve best practice

Mandatory Safeguarding Level 3 training compliance - Mandatory training compliance is not where we would like it to be following the introduction of a new compliance monitoring system. We have worked hard to offer more accessible training for staff. Think Family is a theme we see in our SI's and safeguarding reviews, therefore we will continue to embed this approach across the Trust, staff will think about family rather than an individual. This approach will support LSCFT to meet both local and national requirements, competences, standards and safeguarding responses.

Priorities for 2023/24
The Safeguarding Strategy has been developed and supports the Trusts vision, values and quality priorities. We will strive to embed a "culture of vigilance" throughout the organisation where safeguarding is an important part of everyday care.

We will continue to work on improving MCA compliance across the Trust, via ongoing audit activity, an updated training strategy, the provision of continued specialist MCA advice and supervision, and other mechanisms of quality improvement. We will enhance the quality of MCA activity to raise standards and achieve best practice, including celebrating good practices and identifying areas to strengthen. This work will continue whilst we await further updates from Government regarding the implementation of the Liberty Protection Safeguards and / or other changes to the substantive MCA 2005.

We will continue to undertake targeted awareness raising and specific audit work in terms of perpetrators of domestic abuse, and establish and effective MARAC model across Lancashire with our partners. We will aim to have routine enquiry embedded in practice and evidenced in clinical records that appropriate responses have taken place.

We will take steps to improve practice in relation to self-neglect and neglect of adults. We will continue to work with the Safeguarding Adult Board in improving the self-neglect strategy
We will demonstrate a learning organisation by learning lessons from case reviews and embedding best practice across the Trust.

5.5 NHS Hospital Trust (Southport and Ormskirk)

Key Successes in 2022/23

- The successful bid and recruitment of a Health Independent Domestic Abuse Advisor (HIDVA) from the Lancashire Ministry of Justice funding. Collaboration with Sefton Local Authority to provide a second HIDVA for Southport and Ormskirk NHS Trust from the Merseyside Ministry of Justice funding. This has supported the learning from recent DHRs highlighting the requirement for Acute Trusts to have on-site HIDVAs.
- Successful business case and subsequent recruitment of a substantive Learning Disability and Autism Practitioner to develop a workforce to care for patients with a LD and or autism.
- Development of a Deprivation of Liberty Safeguards (DOLS) portal streamlining the process for the completion of DOLS authorisations.
- Continued bi-weekly meetings with Sefton Local Authority Safeguarding Team to discuss cases referred, information required and outcomes.
- Achieving >90% compliance in all 6 levels of safeguarding training

Key Challenges in 2022/23

- The release of staff for training with the competing demand of clinical activity and pressures
- Vacancies within the Safeguarding team
- Preparing for the implementation of Liberty Protection Safeguards
- Staff completing safeguarding documentation in busy clinical areas

Priorities for 2023/24

- We will develop and embed the role of the HIDVA and increase staff awareness in relation to domestic abuse and the potential opportunity for support during health appointments and visits.
- We will increase awareness and responsiveness to self-neglect working as a multi-agency partnership.
- We will work in new ways under a new organisation and aligning safeguarding processes across the new organisation with St. Helens and Knowsley NHS Trust.
- We will ensure the Safeguarding Team undertake Trauma Informed Training, incorporating the principals into their practice.
- We will ensure the Trust is compliant with the requirements of the Domestic Abuse Act (2021).
- We will ensure the Trust is compliant with the Serious Violence Duty (2022)
- We will implement the Oliver McGowan e-learning for all staff.
- We will support the Learning Disability (LD) and Autism agenda providing clinical expertise in LD and autism and drive the LD and Autism improvement plan.
- We will continue to ensure the development of a network of safeguarding ambassadors.
- We will seek to maintain training compliance ensuring compliance to the intercollegiate documents.
- We will ensure compliance with the NICE Guidance 'Integrated health and social care for people experiencing homelessness,' (2022)
- We will increase staff awareness of advocacy and other services such as IMCAs.

6. Looking Ahead to 2023/24

6.1 2023/24 Strategy

A Strategy for the Lancashire SAB is in development and will be set out with agreement of key partners, and focus on the learning from SARs and agreed priorities which will consider:

- Compliance with Statutory Duties
- User and carer engagement
- Raising awareness in communities
- Board operation
- Prevention
- To identify good practice and areas for improvement
- Transitions - children to adult

6.2 Business Plan

Having a clear Business Plan to review and report on progress will be a key area going forward to 2023/24, and include areas of focus on:

- Prevention and Engagement - Feedback, partnership
- Managing and responding - Understanding 'safeguarding concern'
- Data and performance
- Learning from and shaping practice - Identification, assessment, and management of risk
- Assurance and audit work - Tracking compliance/Self-assessment
- Empower - Making Safeguarding Personal (MSP)

7. Board Finance & Resources

7.1 During 2022/23 Lancashire has had a shared partnership responsibility which is supported through both financial investment and resourced through a Joint Partnership Business Unit (JPBU) to deliver the following:

- Secretariat management and support to the SABs
- Support to Sub Group activity and associated task and finish groups
- Commissioning of SARs
- Funding the role of Independent Chair
- Develop and Publish Annual Reports
- Learning and Development in relation to learning from case reviews on pan-Lancashire/multi-agency level
- Development of pan-Lancashire guidance in relation to key priorities
- Publicity and Communications