AGENDA ITEM 4

Report to: Blackburn with Darwen Health and Well-being Board

From: Shirley Williams, Independent Chair of the Blackburn with Darwen LSAB

Date: 23rd September 2013

TITLE OF REPORT: **LSAB Annual Report 2012-13**

1. Purpose of the report:-

To update the Board on the effectiveness of the safeguarding vulnerable adult arrangements in Blackburn with Darwen. It sets out the activity of the LSAB in 2012/13 and highlights the priorities for 2013/14.

2. Action required of the Health and Well-being Board:-

To note the report.

3. Background

The Blackburn with Darwen LSAB has published an Annual Report and Business Plan document since 2010. Previous documents can be accessed on the LSAB's website (www.lsab.org.uk). The Annual Report sets out how the various functions of the LSAB have been fulfilled in 2012/13.

The priorities for the Board in 2012/14 are set out in the 2012/14 Business Plan (which is a separate document). They are, however, outlined from page 22 in the 2012/13 Annual Review.

4. Issues for consideration

This review of the local safeguarding arrangements is applicable to all local authority portfolios and to the partners of the local authority that work with the borough's vulnerable adults.

All member agencies of the LSAB are currently operating in an environment characterised by increasing demand for safeguarding and protective services but with limited and reducing resources due to budget restraints and structural changes within organisations. The work of the LSAB provides the council and its partners with opportunities to work together effectively and efficiently to safeguard and protect adults who may be at risk.

The document will be key evidence document in any regulatory inspection of safeguarding. For individual partners, their commitment and involvement in meeting the priorities of the LSAB will be a key area of judgement in their partnership work.

5. Recommendations

That the Board note the report and ensure the key safeguarding priorities are reflected in the Health and Wellbeing Strategy.

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Date: **4th September 2013**

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Blackburn with Darwen
Local Safeguarding Adults Board (LSAB)

Annual Report (2012-13)

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Introduction by the Independent Chair

This fourth Annual Review describes the business of the Local Safeguarding Adults Board (LSAB) and its partner organisations from April 2012 to March 2013. It notes some of the national and local changes, highlights concerns that have influenced safeguarding work, and provides examples of work that has been carried out by partners in safeguarding (protecting) adults at risk of harm as a result of abuse and/or neglect[1].

Research[2] published in March 2013 provides further evidence that adults with learning disabilities continue to receive poor and unequal attention in some health and care settings: this can be regarded as 'discriminatory abuse' and the research suggests this has contributed to the comparatively high rate of premature death amongst learning disabled adults.

Following publication of the Winterbourne View Serious Case Review and related reviews in 2012, there has been a great deal of local work taking place in services for learning disabled adults with complex needs to audit the local position and to bring about improvements. A small local establishment closed and more suitable accommodation and care was found for the former residents. Plans to bring about a more 'joined up' response from health and adult social care staff are now operational and 'stocktaking' work continues to ensure compliance with the government's plans for improvements for this potentially very vulnerable group of people.

Safeguarding the general population in hospital settings has taken greater prominence towards the end of the year with the publication of the second Francis Enquiry Report into the neglect and very poor practice that is believed to have contributed to a substantial number of premature deaths at Mid Staffordshire Hospitals. Blackburn with Darwen hospitals and commissioners are currently involved in a number of activities to assure the public that adults receive safe and compassionate attention as well as the best clinical treatment.

The plans for changes in NHS structures were put in place throughout the year and became operational at the end of March 2013. Whilst the new arrangements give me concerns about what is appearing to be a multi-layered NHS organisation with all the usual potential risks associated with such structures, it is good to note the strengthening of responsibility statements in relation to safeguarding adults in the new policy and assurance documentation.

In reading the findings and recommendations in the Francis Report, particularly the warning about, "the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation", I recognise that we have been fortunate to retain health representation on the Board of individuals well versed in safeguarding. It is also encouraging that senior members of the new health organisations are keen to be part of our Board arrangements.

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[1]The term 'vulnerable adult' and adult at risk/at-risk adult are used in this Report. BwD Multi-Agency Policy uses the terminology; 'adult at risk' recommended by the Association of Directors of Adult Social Services and now set out in the Care Bill 2013.
[2]www.bristol.ac.uk/cipold

Following recommendations from a development day for Board members in autumn 2012 and subsequent discussions, arrangements to create an even more joined up approach to children and adult safeguarding have been put in place. There are now four separate meetings a year for the LSAB and LSCB and joint 'planning the business' meetings in between. There are also greater expectations for delivery of priorities from sub groups/committees, a number of which operate across children and adults safeguarding. A review of Board membership has also resulted in a greater representation from voluntary sector partners and more senior representation from some statutory organisations. The Safeguarding Unit continues to ably support these developments to increase the Board's effectiveness.

We have seen a welcome development of our website[3], which is beginning to build up useful links to information and keep people informed of key activities and decisions from the Board.

Whilst there have been a number of concerns brought to my attention about the protection of individuals in Blackburn with Darwen over the past year, there have been none that have met the criteria to undertake a serious case review (SCR), though other types of reviews of practice have taken place. We have had involvement in an SCR that is likely to report later this year from another local authority.

Throughout the past year the Government has maintained its commitment to place Safeguarding Adults Boards on a statutory footing. At the time of writing this Annual Review the new Care and Support White Paper and now Care Bill has confirmed that commitment, though implementation is unlikely before 2015.

The challenges in relation to safeguarding remain the same: how can we continue to learn and act to support adults at risk, who are unable to protect themselves, to have maximum control over their lives and decision making and remain safe? The numbers who need support to keep themselves safe are increasing but statutory and voluntary organisations have fewer and reducing resources to assist people. Avoiding and managing the consequences of this unequal equation for 'at risk' individuals and for the reputation of organisations, including safeguarding boards, over the next year will be the major challenge for us all.

As always I am indebted to colleague Board members whose commitment, skill, and hard work enables me to carry out my work as Chair of the Board.

Shirley Williams

Shirley Williams
Independent Chair, Blackburn with Darwen LSAB

[3]www.lsab.org.uk

Introduction to the Board – Role and Function

Safety from harm and exploitation is one of our most basic needs. Being or feeling unsafe undermines our relationships and self-belief. "Safeguarding" is a range of activity aimed at upholding an adult's fundamental right to be safe. It is of particular importance for people who, because of their situation or circumstances, are unable to keep themselves safe.

The objective of a Local Safeguarding Adults Board (LSAB) is to help and protect adults in its area who are at risk of abuse and neglect and need assistance to stay safe

The way in which Blackburn with Darwen (BwD) Local Safeguarding Adults Board (LSAB) seeks to achieve this objective is to facilitate effective multi-agency collaboration and co-operation at all levels of safeguarding work. It provides a structure and mechanism for promoting good practice within the borough and mechanisms by which the people in BwD can be assured that each agency with safeguarding responsibilities is effective.

The work of the Board focuses on the following areas to keep adults 'at risk' safe:

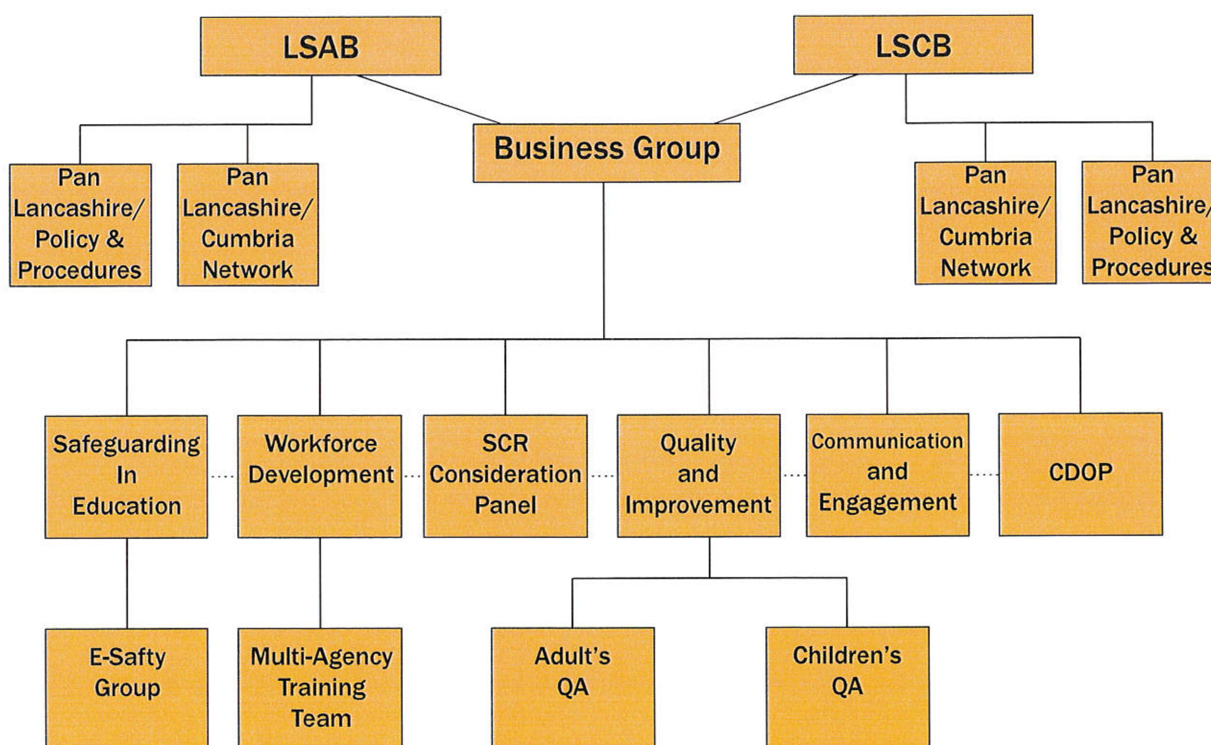
- To raise awareness about abuse of adults who may be at risk and to encourage communities to look out for each other;
- To ensure agencies do all they can to prevent abuse and provide professional learning opportunities to support this; and
- To ensure agencies respond to actual or alleged abuse in a skilled and effective way that safeguards the victim and ensures access to local justice systems, whilst supporting them to recover and have their wishes heard and respected.

Structures and Resourcing

Towards the end of 2012, the Local Safeguarding Adults Board (LSAB) and Local Safeguarding Children's Board (LSCB) revised their structures. The new arrangements became effective from 1st January 2013. The committees are more aligned with the Local Safeguarding Children's Board (LSCB) in order to promote joint working and create efficiencies. The new structure includes a business group which brings together the chairs of the committees, directors of adult and children's services and the LSAB and LSCB chairs to ensure the business of the boards is planned collaboratively.

The LSAB structure is supported by the Safeguarding Unit. The unit provides management and development support for both the LSAB and LSCB so that shared priorities and themes are coordinated. Board business is managed and developed via the following committee structure which report to the LSAB via the business group.

The new structure is outlined below:



Structures and Resourcing

Budget

The Safeguarding Unit is funded by a range of agencies to deliver against the functions of the Boards across both the children and adult safeguarding agendas. Agreed contributions by partner agencies for 2012-13, including ad-hoc contributions were as follows:

Children's Services & Education	£77,100
Adult Services	£50,000
NHS BwD Care Trust Plus	£50,000
Primary & Secondary Schools	£32,900
Lancashire Constabulary	£13,260
Lancashire Probation Trust	£5,967
Training 2000	£3,000
CAFCASS	£550
Early Years Training Contribution	£1,500
Total	**£234,277**

Contributions from partner agencies for the 2013-14 year will remain the same.

As well as the above financial contributions, many LSAB agencies provide their staff to deliver the multi agency training programmes and agencies commit staff time to attending as members of the committees.

Blackburn College and Newfield School continue to provide venues at no cost for the delivery of training. 40% of training sessions in 2012/13 were delivered using venues at no cost.

Below is a breakdown of the Safeguarding Unit's spending for 2012-13:

Salaries	£212,090
Fees: Independent Facilitators, CDOP, TRI-X Site & Website	£27,779
Training Costs	£13,125
E-Learning Courses	£15,000
Office, Travel, Committee & Meeting costs	£8,210
Total	**£276,204**

The additional £42,000 spent by the Unit has been met from reserves from previous year under-spends.

Safeguarding Developments

Multi-Agency Safeguarding Hub
The introduction of the Multi-Agency Safeguarding Hub (MASH) in April 2012 has provided a more robust approach to identifying vulnerable adults within the Borough and ensuring they are provided with the correct level of support. The MASH has also been successful in identifying vulnerable people who do not meet the statutory thresholds for social care support and facilitates the signposting to other services. This includes Early Action teams, Neighbourhood Policing and voluntary organisations.

The MASH is the initial point of contact for a safeguarding adult alert (sharing of a concern) and is responsible for screening the alerts in order to provide a multi-agency response to determine whether or not the alert requires further investigation by the specialist safeguarding team.

The MASH has led to more effective communication between key agencies as it facilitates appropriate information sharing and immediate and secure access to records and data.

Learning Disability Services
There are currently 778 people in BwD who have been diagnosed with a learning disability, with 387 being assessed as eligible for social care services and in receipt of a commissioned service/personal budget. A number of changes were implemented to the service provision over the last 12 months, the main development being the co-location of the Social Work team with the Learning Disability Community Nursing and Speech and Language teams. This change has brought obvious benefits of more joined-up working arrangements and coordinated responses. The closer working arrangements allow a more streamlined response to referrals and crisis support, enabling the most appropriate professional to respond to the immediate needs.

Since the relocation of Contracts and Quality Assurance teams to the Town Hall offices, more coordinated working arrangements have been implemented and a piece of work around tendering new contracts for learning disability providers has taken place. It allows a wider range of providers who have met specific criteria to bid for work within the Borough. This has resulted in more choice, quality and control for service users, particularly those who are in receipt of a personal budget and who are arranging their own care.

Throughout the review process, the social work team are able to identify areas of concern with provider services and address jointly with the quality team. This early intervention often prevents the need for more formal safeguarding procedures being implemented; however, the learning disability service has strong links with safeguarding colleagues and support joint investigations where necessary.

Safeguarding Developments

The past twelve months has seen the development of a register of people with learning disabilities who are assessed as high risk of harm to the public. These arrangements aim to ensure a robust response co-ordinated with the right professional involvement is in place for those individuals who present with forensic challenges, safeguarding concerns, or who are detained in secure settings. This was introduced partly due to the recent Winterbourne Review and partly due to an audit of historical practices highlighting gaps in risk management practice. This has not come without challenge when presenting new concepts to some agencies. However, with the greater understanding we have seen the development of safer joint working practices.

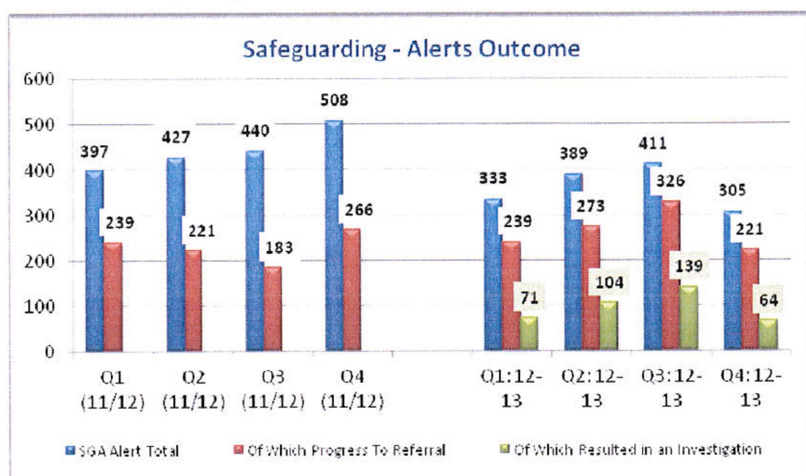
Domestic Abuse Partnership

The Home Office Standing Together Programme undertook an inspection of Domestic Abuse Services in 40 areas across the country in 2012/13. Blackburn with Darwen received the 'excellent' rating and ranked first on the national league table with a score of 48 out of a possible 52. The assessor's report concluded the domestic abuse arrangements have many characteristics of effective partnerships, a history of multi-agency working, developed partnership structures, strong leadership, dedicated funding, good communication between partners and an understanding of domestic violence in its widest social context. It has absorbed the lessons from domestic homicide reviews and several serious case reviews.

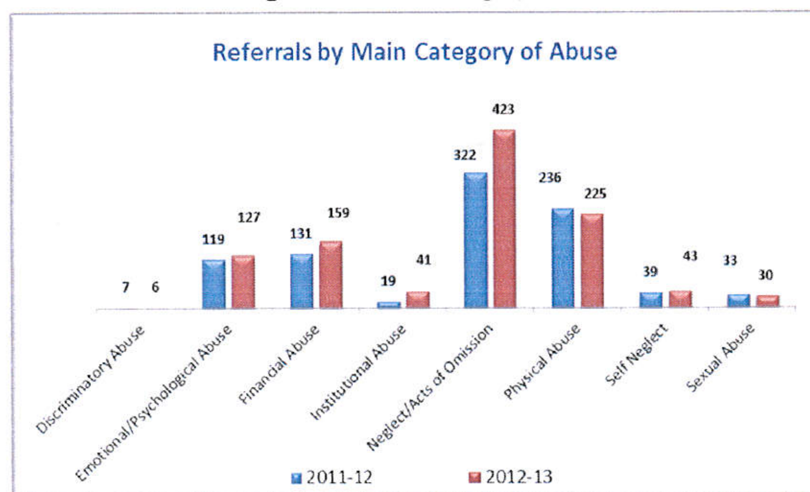
Performance and Data

As illustrated in the chart below, the proportion of Safeguarding Adult Alerts which turned into formal referrals during 2012-13 was between 70% and 80%. This compares favourably with the data in 2011/12 (prior to the introduction of the Multi-Agency Safeguarding Hub) when the percentage of alerts converting to referrals was only 50%.

The 2012-13 data also shows that the conversion rate from a referral (red columns) to a formal investigation (green columns) was between 30% and 40%. Many of the cases that reached the formal 'referral' stage prove, following analysis, to be issues of quality rather than abuse. These cases were addressed through the Council's quality assurance arrangements.



The table below details the categories of abuse compared to 2011-12. Neglect and 'Acts of Omission' continues to be the highest referral category.



Further detailed work is planned for 2013-14 to develop a set of performance data that assures the LSAB that safeguarding practice is safe and effective. This will include determining local data that is easy to understand, purposeful and captures safeguarding activity.

Board Developments and Key Achievements

LSAB Website

The Board commissioned the development of an independent website for practitioners and partner agencies. The new website provides access to the safeguarding policy framework, latest news and information updates, key messages, local multi-agency training opportunities and e-learning. There are also useful links to other local and national services. The website allows colleagues to register for updates and receive immediate alerts from the LSAB.

The website address is: **www.lsab.org.uk**

Pan Lancashire and Cumbria Network

Colleagues from Lancashire, Cumbria, Blackpool and Blackburn with Darwen safeguarding Boards have committed to a safeguarding partnership that jointly focuses on themes and issues that are equally relevant to all four areas. The aim is to agree protocols to assist colleagues across boundaries and also share resources and funding to maximise efficiencies. The partnership includes the Independent Chairs and Business Managers from across the four Boards.

Currently the partnership is involved with the following shared projects:

- Developing a Pan Lancashire and Cumbria adult safeguarding policy and procedures manual
- A coordinated approach to raising awareness of financial abuse
- Progressing learning from Winterbourne View Hospital (regarding learning disability services) and The Francis Enquiry (public enquiry into Mid Staffordshire Hospitals Trust)
- Progressing the dignity in care agenda

The adult safeguarding procedures will be available on the LSAB website from September 2013 and updated regularly in line with local, regional and national developments.

Disclosure and Barring Service Event

The Disclosure and Barring Service (DBS) became operational in December 2012 replacing the Independent Safeguarding Authority (ISA) and Criminal Records Bureau (CRB). This new organisation has responsibility to manage criminal record checks and receives referrals from organisations where there are concerns about an individual's suitability to work with vulnerable adults.

In January 2013 the Board facilitated a 'duty to refer' event to raise awareness about the changes to the Vetting and Barring Service; provide guidance about pre-employment checks; and update colleagues about the definitions of a regulated activity for adults. In total 300 professionals attended the event and regular information updates have been made available on the LSAB website.

Safeguarding in Action

The vignettes below try to illustrate some of the key questions in safeguarding adult work:

- How do we identify an adult at risk of harm who is unable to protect themselves;
- How can agencies work together to safeguard people, particularly those who do not want intervention; and
- How do you know when we have made a positive difference to the person

The first vignette is a lesson to us all that safeguarding is everyone's business and a keen eye and sensitive probing from staff at the front line can be a true lifeline for potentially vulnerable people.

Vignette 1

Mr S, a 67 year old man, moved into sheltered accommodation when he was 60 due to his health and mobility problems. An outgoing man, friendly, self sufficient, self funding and independent, Mr S was happy to have contact via the linked sheltered service provided by Twin Valley Homes. Staff from Twin Valley Homes noticed he was not himself and over a few days made gentle enquiries at which point he mentioned that he had a local private cleaner and was very unhappy.

Staff concern increased as his personal hygiene, health and the property seemed to be declining. Staff spoke to his family to encourage extra support. The family established he was being targeted by a neighbour who had taken thousands of pounds from him over a matter of 4-6 weeks. This situation was alerted to the safeguarding team and became a full safeguarding investigation. Evidence came to light that he was being bullied, blackmailed and given drugs without his knowledge to keep him compliant and reliant on his neighbour.

The police, together with Mr S's family and Twin Valley Homes arranged with his consent for Mr S to move to a place of safety. Staff ensured that a suitable property had all services available and worked with charitable organisations to obtain furniture so that his distress was minimised. The perpetrators were arrested and charged.

Mr S moved into the new scheme and following medical intervention returned to his old self very quickly. He has become a popular member with other tenants and has established himself within the community, encouraging other tenants to engage with social activities. Mr S has become a valued member of the OPEN group (Older Persons Engagement Network) and has explained to staff that he feels safe and valued in his new home.

This was a very serious case which has had a very positive outcome for Mr S and his family.

Safeguarding in Action

This second vignette illustrates how closer partnership working and co-location of staff can lead to more effective responses to difficulties being experienced in families.

Vignette 2 - Blackburn with Darwen Multi-Agency Safeguarding Hub
Staff at the Multi-Agency Safeguarding Hub (MASH) received information that a woman was being abused by her 15 year old son. A social worker and police officer were able to refer the individual to mental health services for support.

Due to the co-location of staff within the MASH, the Adult Services' worker discussed with Children's Services concerns about the child. This led to an Initial Assessment being undertaken which meant that social workers visited this young person to ensure that the right level of support was put in place. The MASH has enabled a quicker response from all services as the appropriate colleagues are located together.

This example demonstrates the value of a multi-agency response to meet the needs of this particular family.

One of the key strengths of the Adult Social Care (ASC) safeguarding team is its strong partnership links with the police and community safety team and it was these links that proved vital in securing Anti Social Behaviour Orders (ASBOs) for three individuals who had targeted older and vulnerable people in the Borough for money.

Vignette 3
Three individuals regularly approached local residents by knocking on their doors and windows in the early hours of the morning begging for cash. On some occasions, they would even offer to get their victim's shopping, taking their money but never returning with any goods.

The safeguarding team received a number of referrals and it was extremely difficult to decide on the most appropriate form of action to take. All adult abuse cases present complex practice and ethical issues for professionals and this one was similar to many others.

The older people being targeted did have capacity to make their own decisions and some people who were lonely welcomed the attention. Some even considered those harassing them as friends. The evidence, however, was that they were being treated in an abusive manner. Colleagues from Adult Social Care (ASC) were keen to build positive relationships with the older people so that the problems being identified could be dealt with sensitively.

Safeguarding in Action

The safeguarding team, together with colleagues from ASC, set up support visits, undertook risks assessments to understand the level of risk and shared information and intelligence with the police.

Case conferences were established with the police and staff from the Community Safety team. Evidence was collected that demonstrated that there were grounds to make use of anti-social behaviour legislation to protect the vulnerable residents, although this approach had never been taken before in Blackburn with Darwen. The court was asked to grant orders which would prevent the perpetrators from coming into contact with people over the age of 65. A number of agencies provided evidence and supported the victims to make statements for the Community Safety team to use when making the application. It took the court several hours to grant the orders as the approach was unprecedented.

This positive result demonstrated the effectiveness of the partnership approach. By working together and by thinking innovatively, vulnerable residents in Blackburn with Darwen were protected from harm.

These events allowed ASC, police and partners to give the message to the public that protection of potentially vulnerable people and prevention of future abuse will include taking whatever means open to partnership agencies in order to protect the most vulnerable in the Borough.

The relationship between domestic violence and safeguarding adults is complex. Research indicates that women, in particular, who have a disability, are more likely to be the victims of domestic violence than non disabled women. The key role played by voluntary sector organisations and the use of advocacy in safeguarding is demonstrated in the following vignette.

Vignette 4 – Domestic Abuse

The police received a silent 999 call and when the number was traced the police found it had been used by a person with a vulnerable marker on the address due to previous domestic abuse incidents. The police investigated but Ms K stated it had been a verbal altercation only and that she had not been assaulted. She did, however, disclose that her partner was her main carer and that she was going for a serious medical procedure the following day.

An Independent Domestic Violence Advocate (IDVA) contacted the unit where Ms K was to have the medical procedure and liaised with staff to facilitate a call to Ms K, who agreed for the IDVA to visit her in hospital. The IDVA completed an assessment of risk. Ms K, who had capacity to make her own decisions, did not want any information to be disclosed to anyone else. She said she feared the repercussions from reporting. She also stated that she wanted to stay in the relationship, but wanted the abuse to stop.

Safeguarding in Action

During contact with the IDVA Ms K did disclose some actual physical violence and serious controlling behaviours in her long relationship. Both the perpetrator and victim had complex needs and other issues that compounded risks in their relationship, including the use of drugs and dependency on alcohol.

Intervention

Colleagues from Women's Aid supported the hospital to raise awareness of the indicators of domestic abuse and the risks to patients. Ms K had failed to attend some key appointments and this had not been followed up. Women's Aid staff informed hospital staff about the potential risks of domestic abuse incidents.

Safety planning took place and Ms K was given a safety mobile phone, as well as equipment to ensure she had a safe place in the house if abuse was to reoccur (including door wedges and personal safety alarm). Information was provided and left in the hospital as this was a safe place for her to read through the information.

Ms K was aware that any incidents of abuse could be reported to the police and that the IDVA would be able to support her through the criminal justice process. Ms K was also made aware of civil options in order to protect her. However in this case she remained in the relationship. She was informed that she could contact the WISH centre for further information if so required.

A referral was made for a Multi-Agency Risk Assessment Conference (MARAC). This resulted in safety actions including the community beat manager & housing officer conducting visits to check on the property in line with tenancy agreements.

Following a referral to the adult safeguarding team a joint visit with the IDVA was carried out at the hospital; this approach encouraged Ms K to speak to the social worker and gained trust in services.

Referrals were made to a range of other local services to support Ms K with problems of substance abuse and poor mental health. Colleagues that supported Ms K with her physical health needs were made aware of how her domestically abusive situation could result in her not keeping appointments.

Through multi-agency planning and intervention, Ms K was referred to the mental health team and was allocated a Community Psychiatric Nurse (CPN).

Safeguarding in Action

She was referred for support to a local housing needs agency so that Ms K understood the accommodation options available to her.

The above case study demonstrates effective multi-agency working and the protection of an adult at risk. The outcome of the intervention was positive and enabled Ms K to gain support and assistance with the abusive situation.

Vignette 5 demonstrates the importance of understanding and assessing the capacity of adults to make decisions and how this ability can fluctuate with illness. It also shows that the abused adult is our first priority but with sensitive challenges to a carer from agencies working in partnership, both the adult at risk and the carer can benefit from intervention.

Vignette 5 – East Lancashire Hospital Trust
Mr A suffered from chronic health needs and he required help with most activities of daily living. He was physically disabled and also cognitively impaired, which often led to increased frustration and agitation. He lacked the mental capacity to make some decisions and lacked the ability to communicate his wants and needs. He lived with his elderly mother, who was his main carer.

He was admitted to the Royal Blackburn Hospital with a delirium, caused by an infection. Mr A's acute confusion exacerbated his cognitive impairment, and as such his frustration and agitation increased and he became quite aggressive. The fact that he was also in an unfamiliar place, surrounded by clinical equipment and staff who he did not know, increased his anxieties.
Mr A's mother visited one afternoon and was witnessed hitting her son across his face by hospital staff. They intervened immediately and his mother left the ward. A safeguarding alert was raised.

When the hospital safeguarding team went to see Mr A they found that he lacked the mental capacity to make a decision regarding what he wanted the team to do, and how best he could be supported. He could recall nothing about the incident. As he had acute confusion, it was decided that he would be given time to recover further, with the hope that he may regain capacity. Prior to hospital admission he had been assessed as 'normally having capacity to make most decisions', although communication was a barrier at times. Since admission he had required one-to-one supervision to support him with all of his needs and minimise the risks of falls.

Safeguarding in Action

The hospital safeguarding team liaised closely with the Local Authority safeguarding team, who advised that the police should be informed of the alleged assault by Mr A's mother if he did not regain capacity soon after the incident. The police were contacted and it was requested that Mr A's mother be treated sensitively as it was possible that she was not managing the increasing demands on her as Mr A's main carer. It was also important to recognise that a uniformed police officer calling to see Mr A's mother would probably cause her to be alarmed and think they were bringing bad news regarding her son. The police therefore deployed a plain-clothes officer who was able to interview Mr A's mother in a sensitive manner. It was clear that she was struggling to manage her son, and she was extremely upset that he had become so much worse due to the medical condition.

Mr A's mother returned to the hospital and she was supported to have her own needs assessed. It was recognised that she was also vulnerable and in need of help. In hospital her son had access to a full multi-disciplinary team, who were able to assess and provide support in the form of advice, aids and adaptations. He accessed physiotherapy, occupational therapy and speech and language therapy, as well as medical and nursing staff.

Prior to discharge there was a review of the care needs of Mr A to enable his mother to have support to care for him at home and to ensure his needs were fully met. This also allowed her to have some respite from the 24 hour care responsibilities that she had prior to admission.

Close partnership working with other agencies and by adopting a sensitive approach enabled the hospital safeguarding team to support two vulnerable adults within one family. What began as a negative experience led to a positive, supportive outcome for both Mr A and his mother.

Vignette 6 focuses again on the great importance of understanding mental capacity and demonstrates how adults can be supported to make safe decisions by jointly planned, sensitive, and persistent work by a number of professionals. This case example demonstrates the detailed work of many professionals to ensure this 'at risk' gentleman died as he wished at home.

Vignette 6 – Lancashire Care NHS Foundation Trust
Mr W was a 75 year old gentleman who lived alone with support from his caring daughter who visited him three times week. Mr W had been diagnosed with a chronic medical condition.

District nurses historically visited twice daily to administer medication. However due to the terminal diagnosis, the input by district nurses was increased due to his end of life nursing and care needs.

Safeguarding in Action

Following a short spell in Royal Blackburn Hospital, Mr W self discharged himself home. Though his health was deteriorating, he refused support from health and social care providers at home and refused to attend any further hospital appointments or admissions. At the time of discharge from hospital there were no concerns regarding Mr W's mental capacity.

Fluctuating mental capacity developed during the following weeks due to his deteriorating condition. Visual hallucinations and anxiety were noted with frequent calls to the police being made by Mr W.

Police responded to the emergency calls and subsequently requested support from North West Ambulance Service (NWAS). Ultimately, on arrival to Mr W's home, the paramedics were sent away and Mr W continued to refuse intervention and support from local agencies. As his health and mobility deteriorated and weakened, Mr W was highlighted as being at risk from falls and injury.

Colleagues recognised that Mr W had increasing comfort and end of life care needs which although had been identified and acknowledged, remained unmet due to Mr W refusing help. Therefore a multi-disciplinary alert was made to the Local Authority safeguarding team, led by the district nursing service.

The agency involvement and coordinated approach to Mr W's needs included his GP, District Nurse Team, Rehabilitation Team (Occupational Therapists and Physiotherapists), Lancashire Constabulary, North West Ambulance Service and Adult Social Care.

Intervention
District nurses identified and highlighted safeguarding/self neglect concerns and reported these to the Local Authority safeguarding team.

The Named Nurse (senior safeguarding advisor) provided support to the district nurses in terms of advice with this complex case. There was also contact between the district nurses, named nurse and social worker from the Local Authority safeguarding team, to discuss and agree a shared action plan from a multi-agency perspective.

It was agreed that Mr W's situation was of concern due to his deteriorating end of life prognosis and the increased risks that living alone presented. The importance of supporting Mr W and his wishes to remain at home was a key priority for professionals throughout the case management process. The mental capacity of Mr W fluctuated but his wish to remain at home was of paramount importance to all the professionals involved.

Safeguarding in Action

Every effort was made to maintain Mr W at home and reduce the risks of harm in a coordinated way involving all professionals and importantly Mr W's daughter.

A number of multi-disciplinary team (MDT) meetings/discussions took place between agencies. These included Mr W and his daughter. As a result of the MDT meetings/discussions an agreed management plan was implemented with the consent of Mr W.

A full care plan was developed with all relevant agencies involved, including sharing of information between colleagues to meet the continued needs of Mr W. He was able to stay at his own home and was fully involved in decisions about his care.

Outcome
Mr W was at risk of significant harm due to his deteriorating health and his ongoing social care needs whilst living independently. The risks were managed by a joined-up and collaborative approach, where agencies worked together with Mr W and his daughter. Mr W's confidence and reassurance improved as a consequence of the coordinated multi agency approach to his care and support.

A care agency was commissioned to visit three times per day and this was welcomed and accepted by Mr W in order to maintain his comfort and safety. District nurses continued to deliver end of life nursing care and Adult Social Care remained involved.

Mr W remained at his own home, comfortable and engaged with local services which enabled him to die peacefully and with dignity.

Workforce Development Activity September 2012 – July 2013

The workforce development programme incorporates both the adult and children's safety agenda. 2012–2013 was another successful year with a total of 61 workshops being offered covering 18 topics. The information below covers both adults and children.

1455 places were offered of which 1312 were booked, representing a booked rate of 90%.

There was an increased demand for Designated Person (Education), Safeguarding Adults and Safer Recruitment workshops which has resulted in a waiting list and colleagues being signposted to e-learning as an interim measure.

Cancellations

Cancellations amounted to 236 places which represents 18% of all bookings.

Five courses were cancelled due to no trainer being available (sickness) or a low booking rate of less than 10 delegates per course.

Did Not Attend (DNA)

From the 1312 places booked, 133 delegates failed to attend and did not cancel in line with the cancellation policy.

E-learning

The Board launched e-learning provision in July 2012. During this period a total of 916 people had accessed the five e-learning courses, 240 completing the Safeguarding Adult course. Further work to raise awareness and increase numbers will be carried out during 2013-14.

Workforce Development Activity September 2012 – July 2013

Evaluation

Attendees at the training are asked to complete an evaluation form following the training session so that the LSAB is able understand if the learning objectives are being met and plan any improvements/changes to the courses. Attendees found the courses helpful for the following main reasons:

- Provides information to improve knowledge on identifying risks and indicators of abuse
- Provides information on local service provision
- Provides information on what the multi-agency approach to working should be
- Provides information on how to share information.

Attendees are also asked how they will apply what is learnt from the training and how the training will impact on their practice. Below is a summary of the main points recorded on how the learning was to be applied:

- Cascade and share learning within teams and organisations
- Apply training in practice and amend agency procedures and service provision
- Improve multi-agency and multi-disciplinary approach to working
- Use knowledge of services to access these services
- Improve information sharing and communication with other agencies
- Improve recording practice.

LSAB Development Day / Safeguarding Adult Review

Development Day

A Board development day was held on the 11th October 2012. It was a productive and well attended day that enabled the Board to identify its key priorities and provide direction and focus to the role and function of the committees.

The priorities for the Board identified on the day are detailed within the business plan.

Safeguarding Adult Review

In March 2013, a safeguarding adult review, commissioned by the Council's Executive Director (People) and led by the Safeguarding Unit, took place. The focus of the review was to gain feedback from staff within the Local Authority and health agencies about our local safeguarding arrangements.

A number of 'Key Lines of Enquiry' helped the review team to determine areas of good practice and strengths, and also to identify areas for further consideration.

The three days proved to be productive and have resulted in a safeguarding action plan being developed and a 'task and finish' group being established to drive forward the findings.

A snapshot of the positive feedback received included:

- Some effective approaches to safeguarding (particularly the specialist safeguarding team)
- A strong commitment and focus by staff
- Good training opportunities
- Multi-Agency Safeguarding Hub (MASH) developments

Areas for consideration included:

- Improving communications
- Reviewing safeguarding policy and procedures
- Developing a safeguarding Quality Assurance Framework
- Strengthening service user voice

Progress is reported to the LSAB via the Quality Assurance Committee.

Business Plan Progress - Review of 2012-14 Priorities

There has been good progress made to complete and deliver against the priorities and actions set out in the 2012/14 business plan. The table below RAG rates the completion of each priority; green for complete, amber where work is ongoing, and red where progress has been slow and the objectives of the task have not been fully realised.

Priority: Communication & Engagement		
Focus	**Actions**	**Progress**
Strengthen participation and engagement with users of safeguarding services and their families to encourage their voices to be heard and acted upon	– Develop approaches to obtain the views of service users about their individual safeguarding journey, to contribute towards improving practice and shaping safer and empowering services.	All activity is being reviewed by the new Communications and Engagement Committee. This is included in the 2012-14 business plan. The main activity relating to this action will be progressed during 2013-14.
Develop the Communication and Engagement Committee to ensure a focus on safeguarding adults and engagement with agencies, practitioners, service users and members of the public.	– Establish the committee structure, membership, terms of reference and operational plan. – Identify ways to raise the awareness of multi-agency safeguarding messages, training and practice changes to practitioners. – Learn from evidence based research into effective methods of communication and engagement with adults.	As part of the Safeguarding Unit review, the newly formed Communication and Engagement Committee became effective from January 2013. The committee has developed a work plan to focus on the safeguarding themes for service users, practitioners and members of the public. The LSAB website includes information about local services and provides access to training and e-learning.
Develop and maintain the LSAB website.	– Continue to develop information updates, key messages and resources to assist practitioners to access support and guidance.	The LSAB website is now operational and distributes regular updates when new information is posted. The site address is: www.lsab.org.uk

Business Plan Progress - Review of 2012-14 Priorities

Priority: Communication & Engagement

Focus	Actions	Progress
Continue to raise awareness of adult safeguarding in the wider community by developing creative publicity and communication engagement tools.	– Support public awareness campaigns to raise awareness of particular issues and themes. – Provide key messages following Board meetings. – Develop a range of printed materials to communicate a range of safeguarding information. – Share learning from reviews across the partnership. – Identify ways to effectively communicate with the Private, Voluntary and Independent sectors.	The LSAB has continued to raise awareness of adult safeguarding at many different forums across the Borough – this includes the fifty plus partnership, Health and Wellbeing Board and internal health safeguarding meetings. Key messages have been circulated widely after each Board meeting, capturing the work and priorities of the Board. There have been no Serious Case Reviews this year; however the Board remains focused on learning from regional and national findings, in particular the Winterbourne View recommendations. Representatives from the Safeguarding Unit attend the Adult Social Care partnership, Adult Workforce Development Partnership and independent sector forums.

Business Plan Progress - Review of 2012-14 Priorities

Priority: Multi-Agency Learning and Development

Focus	Actions	Progress
Continue to develop the learning and development arrangements and ensure sufficient capacity within the multi-agency training pool.	– Respond to local training needs and priorities to plan, deliver and evaluate safeguarding training. – Develop the training pool to ensure multi-agency representation, knowledge and skills. – Continue to provide specialist e-learning programmes. – Develop and implement a local workforce development strategy. – Explore learning opportunities for middle and senior managers, using evidence-based research and learning from case reviews and serious incidents.	Workforce development opportunities have been offered this year inline with the previous training needs analysis. The Workforce Development Committee has continued to monitor and evaluate the training provided to ensure it remains fit for purpose and relevant to the adult workforce. Specialist programmes have been commissioned, including the provision of a range of e-learning packages. The training pool capacity has increased this year; however it requires further strengthening during 2013-14. Discussions took place about training for senior managers; however the recent Training Needs Analysis (TNA) confirmed that it was not a priority for 2012-13.
Share professional learning and sector developments across Board partners.	– Develop processes to provide access for Board members to inter-agency frontline practice and concerns; to inform their professional development as Board members.	Representatives from the LSAB have attended various partnership meetings and forums. Staff from the Safeguarding Unit have also attended partner agency internal safeguarding committees to facilitate sharing of information and learning across the partnership.
Disseminate lessons from reviews and practice audits	– Identify opportunities to include lessons from case/ incident reviews into local training programmes and workforce development initiatives.	Local, regional and national lessons from case reviews have been incorporated into safeguarding training and e-learning (where appropriate) The Safeguarding Unit has developed a Learning and Improvement summary record that collates all the lessons and findings from Serious Case Reviews (SCRs) and Multi-Agency Reviews (MARs). This has been discussed at the QA Committee.

Business Plan Progress - Review of 2012-14 Priorities

Priority: Governance, Partnerships and Accountability		
Focus	**Actions**	**Progress**
Develop the effectiveness of the Board	– Review membership in line with partner changes and Board development – Determine seniority of Board members – Establish a robust approach to identify multi-agency risks, including impact of cuts on services/budgets. – Develop effective induction processes for Board members – Establish regular one to one meetings between the LSAB Chair and Board members. – Develop an annual review of the Board Chair – Plan an annual development day – NB the Board will consider the implications of statutory footing for the LSAB.	LSAB membership was considered as part of the Safeguarding Unit structure review. Board Membership consists of senior representatives from across the partnership (see appendix A). The Board have discussed local risk areas and this has been a focus at several Board meetings. A Board induction booklet has been drafted and will be implemented during 2013-14. A 360 degree appraisal was conducted on the independent chair The Board annual development day took place in October 2012 and the Board agreed a set of priorities and focus for the year ahead.
Continue to work closely with Pan Lancashire and Cumbria networks.	– Continue to attend and contribute to regional meetings. – Share best practice and learning across the partnership.	The Pan Lancashire and Cumbria partnership network has continued to work together on regional issues and identify efficiencies where possible. This has included commissioning joint policies and procedures, joint training guidance and raising awareness of regional safeguarding issues.

Business Plan Progress - Review of 2012-14 Priorities

Priority: Governance, Partnerships and Accountability

Focus	Actions	Progress
Link with the Blackburn with Darwen Health and Wellbeing Board	– Ensure the annual report is taken to the Health and Wellbeing Board. – Respond to accountability structures within the political arena and relevant partnership Boards.	The Chair of the Board attends the Health and Wellbeing Board annually to present the LSAB annual report. Planned meeting are also held with the Executive Director People (Director for Adult Services) and the Chief Executive of the Local Authority. The Executive Member for Health and Adult Social Care is a participating observer at the LSAB.

Priority: Quality Assurance, Performance and Learning Lessons

Focus	Actions	Progress
Monitor the safeguarding arrangements within Houses of Multiple Occupation (HMOs)	– Receive quarterly reports from the HMO multi-agency steering group. – Develop effective links to the quality assurance, evaluation and compliance of HMOs in relation to safeguarding and protection. – Respond to safeguarding themes and trends occurring within HMOs.	The LSAB and Safeguarding Unit receive updates from the multi-agency HMO Steering Group and links have been established with the Prison Service, Local Probation Office and Housing Needs Team. Identified Board members attend the multi-agency HMO Steering Group. The main activity relating to the third action will be progressed during 2013-14.

Business Plan Progress - Review of 2012-14 Priorities

Priority: Quality Assurance, Performance and Learning Lessons		
Focus	**Actions**	**Progress**
Develop processes for gaining assurances that agencies are working from local current legal and good practice evidence base.	Raise the profile of key safeguarding concerns, including: – Financial Abuse – Learning Disabilities and Complex Needs – Residential Provision for adults with complex needs – Domiciliary Care – Domestic Abuse	A Pan Lancashire and Cumbria approach has been taken to raise awareness of Financial Abuse. A local action plan has been developed post Winterbourne View. The LSAB has established links with local social care partnership forums and domiciliary care provider forums. The Board has received reports regarding local domestic abuse service provision.
Development of a quality assurance framework	– Identification of adult performance data framework. – Implementation of the performance framework and analysis of multi-agency safeguarding activity. – Monitor the effectiveness of the Multi Agency Safeguarding Hub (MASH).	This is being developed and progressed by the new Quality Improvement and Quality Assurance committees. This is included in the 2012-14 business plan. The main activity relating to the third action will be progressed during 2013-14.

Business Plan Progress - Review of 2012-14 Priorities

Priority: Quality Assurance, Performance and Learning Lessons

Focus	Actions	Progress
Ensure learning from Serious Case Reviews (SCRs) and Multi-Agency Reviews (MARs) are communicated, embedded in practice and evaluate the impact changes are having on practice	– Learning from local reviews and national reviews collated regularly and communicated to all agencies. – Evaluation of impact changes are making to practice through themed audits. – Ensure the SCR and MAR processes remain robust and fit for purpose. – Ensure regional and national lessons from reviews are considered and implemented as applicable.	There has been no Serious Case Reviews commissioned by the LSAB this year. However, we have contributed to a Review of a person who used to be resident in Blackburn. This report will be published later in 2013. The Safeguarding Unit has developed a Learning and Improvement summary record that collates all the lessons and findings from Serious Case Reviews (SCRs) and Multi-Agency Reviews (MARs). This has been discussed at the QA Committee.
Develop Pan Lancashire LSAB Polices and Procedures	– Contribute to developing shared policies, procedures and guidance across Blackburn with Darwen, Lancashire and Blackpool.	Pan Lancashire and Cumbria Safeguarding Adult procedures have been developed and it is anticipated they will be published on the LSAB website in September 2013.
Continue to receive reports from partnership Boards	Thematic reports include: – Domestic Abuse – Forced Marriage and Honour Based Abuse – Channel – Multi Agency Public Protection Arrangements (MAPPA) – The Fifty Plus Partnership – Community Safety Partnership – Learning Disability Partnership – Local Safeguarding Children Board	Regular reporting has been established and a board calendar has been developed. This is managed by the Business Group.

2012-13 Board Membership

Organisation	Board Member	Job Role
	Shirley Williams	Independent Chair, Blackburn with Darwen LSAB
Blackburn College	Barry Griffiths	Head of Learner Services
Blackburn with Darwen Borough Council	Councillor Mohammed Khan	Executive Member Health and Adult Social Care
Care Quality Commission (CQC)	Dawn Hodgkins	Compliance Manager
Lancashire Constabulary (Divisional Public Protection Unit)	Dean Holden	Detective Chief Inspector
Public Health	Dr Gifford Kerr	Consultant, Public Health
Lancashire Care NHS Foundation Trust	Bridgett Welch	Assistant Director of Nursing (Safeguarding Adults)
Twin Valley Homes	Ian Bell	Head of Housing Twin Valley Homes
Lancashire Probation Trust	Janet Thomas	Assistant Chief Executive
East Lancashire Hospital Trust	Kathryn Bonney	Safeguarding Lead (Adults)
Blackburn with Darwen Borough Council, Children's Services and Education	Linda Clegg	Director of Children's Services
Blackburn with Darwen Safeguarding Unit	Paul Lee	Head of Safeguarding
Blackburn with Darwen Borough Council, Legal Services	Paula Johnson	Solicitor
Blackburn with Darwen Borough Council, Adult Services	Peter Soothill	Head of Adult Social Care
Lancashire Fire and Rescue	Peter Frazer	Fire Safety Manager
Blackburn with Darwen Borough Council	Sally McIvor	Executive Director People (DASS)
Lancashire Constabulary (Force Public Protection Unit – Police HQ)	Sue Cawley	Detective Chief Inspector
Blackburn with Darwen Care Trust Plus	Susan Crorken	Head of Safeguarding & Designated Nurse
Voluntary, Community and Faith (VCF) sector	Vicky Shepherd	Deputy Chief Officer, Age UK Blackburn with Darwen
Voluntary, Community and Faith (VCF) sector	Vivienne Blackledge	Project Manager, WISH Centre