Local Safeguarding Adults Board (LSAB)

Annual Report (2013-14) & Business Plan (2014-15)

Contents

Foreword	page 1
Blackburn with Darwen – The Local Picture	page 3
Context	page 3
Local Issues	page 3
Social isolation and loneliness	page 4
Dementia	page 4
Older People and Multiple Health Issues	page 4
Mental Health	page 5
Introduction to the Board – Role and Function	page 6
Structure	page 7
Budget & Resources	page 8
How we assure that organisations provide an effective safeguarding service	page 9
Serious Case Reviews & Multi-Agency Reviews	page 9
Case File and Practice Audits	page 10
Learning from Collecting Figures (Quantitative Data)	page 10
Learning from Auditing Practice (Qualitative Data)	page 11
Learning from those experiencing safeguarding interventions	page 11
Board Activity	page 14
Pan Lancashire and Cumbria Policies and Procedures	page 14
GP Protected Learning Event	page 14
Disability Hate Crime	page 15
Communication and engagement	page 16
Multi-Agency Safeguarding in Action	page 17
Developing Our Workforce	page 23
E-Learning	page 24
Summary of Evaluations and Feedback	page 25
How we have met our safeguarding priorities from April 2013 to March 2014	page 26
Our Priorities, 2014-15	page 35
2014-15 Business Plan	page 36
Appendix A - 2013-14 Board Membership	page 38
Appendix B - Care Act Guidance	page 39

Foreword

This fifth Annual Review describes the business of the Local Safeguarding Adults Board (LSAB) and its partner organisations from April 2013 to March 2014. It notes some of the national and local changes and provides examples of work that has been carried out by local organisations in safeguarding (protecting) adults at risk of harm as a result of abuse and/or neglect.

The 31st March 2014 was a significant date for safeguarding adults in that a new Care Act was passed. It sets out for the first time a statutory legal framework, including a requirement to have a Safeguarding Adults Board, to protect adults at risk who have extra needs arising from disability or illness and are unable to protect themselves. The full requirements of the Act will not be implemented until 2015. Draft guidance has recently been issued for consultation.

One of the requirements of the Act is for the Safeguarding Adults Board to produce an annual report and guidance has been developed about what that report should contain. We have tried to reflect the essence of the as yet incomplete guidance based on good practice, in writing our report this year.

One of the key safeguarding matters last year was the review into the shocking abuse of learning disabled 'patients' at Winterbourne View Private hospital and the subsequent Government requirements for information and performance improvement plans from health and social care organisations. Blackburn with Darwen partners have worked regionally and locally to improve strategic oversight, operational processes and service responses.

A recent Lancashire safeguarding review highlights the need for continuous vigilance of the safety of older people with dementia, particularly of those living in care homes. The co-ordinated work of social and health care practitioners, commissioners along with the Care Quality Commission remains a key strategy in the local area to assist all care and health providers to recognise and report abuse situations and improve service standards overall.

The local acute hospital trust has in the past year experienced significant scrutiny following the Keogh Review, including two CQC Inspections. The trust has made significant progress with implementing the improvement requirements. The CQC Report of July 2014, whilst significantly praising the positive management and cultural changes that have taken place, indicates the need for further improvements.

The structural changes in the NHS have been in place for over a year now. Significant challenges remain to ensure the changes in commissioning services are embedded and that providers are delivering effective services. Locally an event for all GPs to raise the profile of adult safeguarding was significant in helping local commissioners and providers to come together to understand their roles and relationships to keep at risk/vulnerable adults safe.

---

[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.

Foreword

One of the new organisations in the health and social care sector is Healthwatch which locally has joined the board and are working with the board to ensure the voice of the patient/service user is heard.

Similar to the health and care sector, in the criminal justice and public safety sector there are ongoing structural changes in response to reductions in government funding. For the police this has led to redesigning their divisional command structure including the introduction of a multi-agency safeguarding hub (MASH) to assist in screening police reports on vulnerable adults; for probation services the reforms to split the service have only just begun towards the end of the year and their impact will take some months to be felt. In addition to statutory provision, a key local improvement to using the skills and commitment of local people has been the work of the 'Resolve' group, who provide advocacy and support with and for disabled people to report hate crimes.

The local 'Transforming Lives' initiative (called Early Action by the police) will be a key local response in the new financial year to ensure incidents that do not meet the threshold for social care intervention are appropriately sign-posted to services that can help prevent the need for safeguarding services.

Our website has continued to be developed and now provides useful links to information and keeps people informed of key activities and decisions from the Board.

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, continues to be the major challenge for us all.

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

Shirley Williams
Independent Chair
Blackburn with Darwen Local Safeguarding Adults Board

[2] www.lsab.org.uk

Blackburn with Darwen
The Local Picture

Context

Blackburn with Darwen comprises the two towns of Blackburn and Darwen. The Borough has a population of 147,500. The Borough's population is one of the most ethnically diverse in the region with many residents of Indian or Pakistani heritage.

The most significant underlying population factor that will impact on demands for health, social care, and housing and community services and potentially increase health inequalities is the changing structure of the population. There is a projected increase in the numbers of older people, most significantly from a safeguarding perspective, very old people, who are more at risk of abuse and neglect, including self neglect. Attention to these changes is something that the Local Safeguarding Adults Board includes in the annual business plan, in terms of the safeguarding services needed to protect and prevent harm and abuse.

The Borough experiences high levels of material deprivation, being the 17th most deprived Borough based on the 2010 Index of Multiple Deprivation, with eight small neighbourhoods amongst the most deprived 1% nationally. In addition, Blackburn with Darwen is amongst the worst 20% of local authorities for fuel poverty, with over one in five households (21%) having to spend a disproportionate amount of their income heating their home, and almost one in three (30%+) in some neighbourhoods.

Local Issues

Life Expectancy - one of the key indicators of the health of individuals and communities is the trend in life expectancy of our residents. Blackburn with Darwen women have a life expectancy of 79.6 years (England 82.6 years), and men in the Borough have a life expectancy of 74.8 years (England 78.6 years). These are the fourth lowest life expectancies of any local authority, significantly lower than the North West and England averages, and the gap with England has, if anything, been widening in recent years. In the most deprived parts of the Borough, male life expectancy is as low as 68 years.

A reflection of these underlying structural and lifestyle factors is the fact that life expectancy in Blackburn with Darwen is three to four years shorter than the England average, and the gap is, if anything, getting wider. Within the Borough, male life expectancy in the most deprived tenth of neighbourhoods is 12 years lower than in the least deprived. As in England as a whole, approximately a third of deaths in Blackburn with Darwen are from circulatory disease and a quarter from cancer. However, Blackburn with Darwen has higher than average mortality rates generally, and death rates from these two major causes are no exception.

There are 62,000 people in Blackburn with Darwen diagnosed with at least one long-term condition (heart disease, stroke, high blood pressure, diabetes, mental illness, dementia, asthma, or chronic obstructive pulmonary disease). This is about half of the adult population. 65% of these people are of working age. By the age of 60 about half of the people with a long-term condition will have more than one. Diabetes, mental ill health, and a forecast increase in dementia are all particular issues for Blackburn with Darwen. Again adults suffering from long term conditions and more particularly those with dementia are at greater risk of being abused and neglected because they are often unable to protect themselves.

---

[1] The following draws on information in the Integrated Strategic Needs Assessment (ISNA) produced by the Public Health and Policy teams of the local authority. This identifies the priorities to improve the outcomes for all residents in the borough.

Blackburn with Darwen
The Local Picture

Social isolation and loneliness
Through consultation with people of all ages it has become evident that there is a significant section of the local population that is socially isolated, and therefore at risk of loneliness. There is a clear link between loneliness and poor mental and physical health, with lonely and socially isolated adults being more likely to be admitted to residential care and individuals who are socially isolated being between two and five times more likely to die prematurely than those who have strong social ties. The influence of poor social relationships on the risk of death is comparable to well-established risks such as smoking and alcohol consumption. In Blackburn with Darwen many of the key risk factors for isolation and loneliness are common, including:

- low socio-economic status
- being aged 80+
- living alone
- having no access to a car / never using public transport
- living in rented accommodation
- living on low income or on benefits as main income
- having no access to a telephone
- hearing and sight loss

Those who are isolated in their communities with multiple health problems, particularly mental health problems, can be more easily identified as vulnerable and can become subject to targeted abuse and anti-social behaviour.

Dementia
As the number of older, particularly very old people, increases in Blackburn with Darwen the numbers suffering from dementia will also increase. Estimates indicate an increase in the number of residents aged 65+ with dementia of more than half (53%) between 2010 and 2030; this equates to 340 more women and 320 more men. There is no expectation that the number of those with early onset dementia (under 65) will increase.

An increasing number of people with dementia are occupying acute hospital beds and places in residential and nursing homes where, because of their illness, they are unable to protect themselves and are at greater risk of poor care and possible criminal abuse and neglect. Research also indicates that this group may be at increased risk in their own homes from paid carers and sometimes from family/friend carers, who often have care and support needs of their own.

Older People and Multiple Health Issues
Also known as co-morbidity, having multiple health issues brings a unique set of challenges for the individual and health and social care providers in particular. Current statistics around older residents with multiple health issues are not readily available; however, figures are available that give the total number of people in our population with at least one long term condition (LTC). This is taken from a smoking indicator which measures the percentage of people with an LTC who have their smoking status recorded. The measure gives the number of people in each GP practice with an LTC (which includes diabetes; cardiovascular disease; stroke; chronic obstructive pulmonary disease; asthma; psychotic and mental illness). This figure has been reported as being 35,400.

Blackburn with Darwen
The Local Picture

Mental Health

Poor mental health is highly correlated to low income, social isolation, and poor physical health. People with mental health problems are more likely to be targeted for abuse and also more likely to self neglect and/or harm themselves. While there are no clear measures for the level of mental ill-health, the Index Of Multiple Deprivation contains a "Mood and Anxiety Disorders" Indicator, which shows that over half (57%) of the small neighbourhoods (Lower Super Output Areas) in Blackburn with Darwen are amongst the worst 20% of neighbourhoods nationally.

In a 2009 North West Survey, Blackburn with Darwen performed remarkably strongly, returning the fifth highest score for mental wellbeing (WEMWBS) out of the 18 northwest authorities taking part.

Early indications from the 2012 survey, however, are that the borough has fallen to bottom place. Blackburn with Darwen has a particularly small proportion of respondents (6.9%) classified as having 'high' mental wellbeing. This compares with a North West average of 19.6%, and 27.0% in neighbouring East Lancashire. In 2011/12 Blackburn with Darwen had the seventh highest admissions to hospital for self harm in UK and also there were 55 deaths recorded as suicide for the three years 2009 to 2011, again a high number compared to other local authority areas.

Whilst the statistics on self harm and suicide may seem the most relevant to safeguarding, low mental wellbeing can also impact on physical health and the resilience of people to take care/protect themselves.

Spotlight on Future Priorities for the Health and Wellbeing Board:

- The need to provide work opportunities for current and future workforce at increasing income levels with high quality support to help all our residents into suitable employment.
- The need to provide and encourage active and positive choices for residents through strategic initiatives to support active lifestyles.
- The need to promote independence and social inclusion for the increasing numbers of older and very old residents, and to be able to meet the needs, with dignity and respect, of those who do require support.

[1] Carpenter et al (2009) The Organisation, Outcomes and Costs of Inter-Agency Training to safeguard and promote the welfare of children. London: DCSF

Introduction to the Board
Role and Function

The objective of the Blackburn with Darwen Local Safeguarding Adults Board (LSAB) is to help adults at risk of abuse and/or neglect and who are unable to protect themselves as a result of their needs relating to their physical or mental ill health or disability to keep safe. The Board does this by assuring itself that organisations with safeguarding responsibilities carry out their duties effectively, always ensuring the wishes and wellbeing of the adult remains at the centre of any intervention. An adult at risk and who needs support to protect themselves does not need to be receiving any services or to meet Blackburn with Darwen's Fair Access to Care eligibility criteria for care and support services.

The way in which the 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 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 enable adults 'at risk' to keep safe:

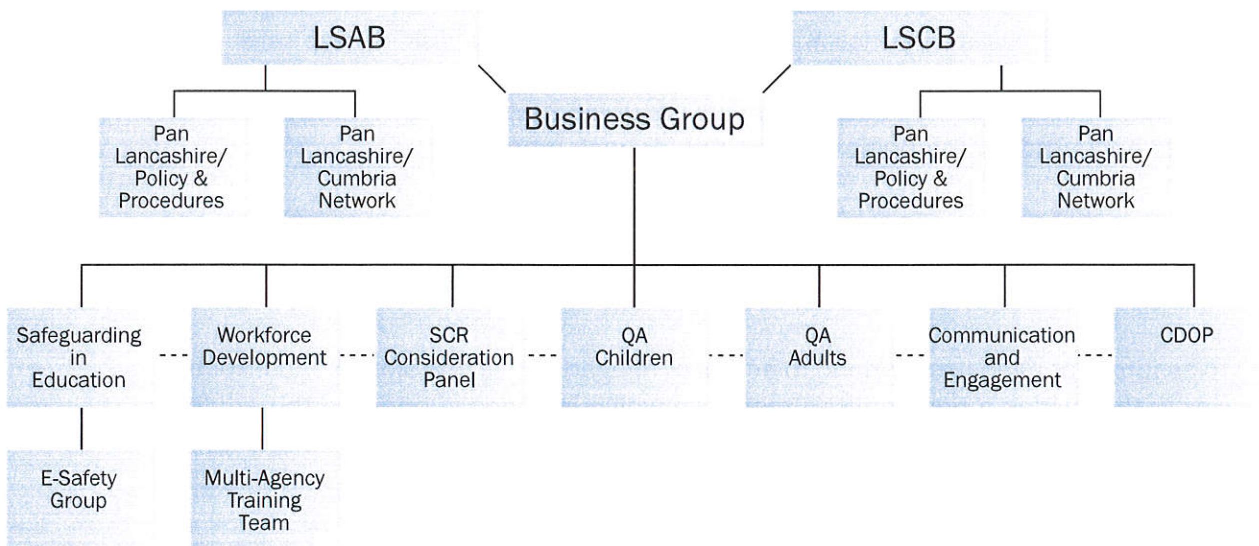
- To provide information to raise awareness about abuse of adults who may be at risk and to encourage communities to look out for each other;
- To assure that agencies in the statutory, voluntary, and private sector do all they can to prevent abuse and facilitate the provision of professional learning opportunities for staff to support this; and
- To assure that agencies respond to actual or alleged abuse in a skilled and effective way that provides a personalised response which includes supporting the adult to recover; ensuring access to advocacy; access to local justice systems; and whilst being mindful of capacity, respecting the right of the individual to choose to live their life in way that others may regard as potentially harmful.

Introduction to the Board

Structure

The LSAB is supported by the Safeguarding Unit. The Unit provides management and development support for both the adult and children safeguarding boards so that shared priorities and safeguarding themes and activities can be coordinated. The boards' business is managed and developed via the following committee structure. The Business Group meets between board meetings and reports activity, improvements, and key issues to the LSAB.

In addition to the main board, the Independent Chair also chairs the business group (with the LSCB Independent Chair), and from April 2014 chairs the Quality Assurance Committee.



LSAB Annual Report (2013-14)
LSAB Business Plan (2014-15)

Introduction to the Board
Budget & Resources

The Safeguarding Unit is funded by a range of agencies to deliver the functions of the Boards across both the children and adult safeguarding agendas. Agreed contributions by partner agencies for 2013/14, including ad-hoc contributions were as follows:

Children's Services & Education	£76,700
Adult Services	£50,000
NHS BwD Clinical Commissioning Group	£50,000
Primary & Secondary Schools	£32,900
Lancashire Constabulary	£13,260
Lancashire Probation Trust	£5,967
Training 2000	£3,000
CAFCASS	£550
Independent School Contribution	£400
Total	£232,777

Contributions by partner agencies for the 2014/15 year will remain broadly similar with the addition of £4,000 from Blackburn College.

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.

The Safeguarding Unit's staffing and costs were approximately £249,000 in 2013/14. Below is a breakdown of the Safeguarding Unit's spending for 2013/14:

Salaries	£196,866
Fees: Independent Facilitators, CDOP, TRI-X Site & Website	£39,228
Training Costs	£9,522
Office, Travel, Committee & Meeting cost	£3,505
Total	£249,121

The additional £16,344 spent by the Unit has been met from reserves from previous year underspends.

How we Assure that Organisations Provide an Effective Safeguarding Service

All partner safeguarding organisations are required to produce both quantitative and qualitative information about how well they are carrying out their safeguarding responsibilities. The Board agreed in 2013/14 the principles of a 'Learning and Improvement' Framework. The framework outlines a number of monitoring activities the Board's Quality Assurance Committee would undertake to monitor the quality of practice and the effectiveness of services in safeguarding at risk (vulnerable) adults. The activities include:

- All agencies looking closely at the circumstances where an adult/group of adults with health and/or care needs have been seriously harmed or neglected, often referred to as serious case reviews or multi-agency learning reviews;
- Multi-professional examination of records of adults who are known to agencies/ receiving services to ensure quality of practice, often referred to as case file/practice audits;
- Multi-professional discussion forums (MPDFs) to learn from and with front line staff about areas of practice that can be improved, including aspects of multi-agency practice;
- Formal commitment, referred to as 'Declarations' by all agencies represented at the LSAB and its committees outlining what they do to monitor the quality of the work they do, how they analyse what difference their work makes to the outcomes for individuals, and how they contribute to improvements within and across organisations.

Serious Case Reviews & Multi-Agency Reviews

The Safeguarding Adults Board has not received any referrals in the 2013/14 year to undertake a serious case review. There have been a number of discussions at the Quality Assurance Committee and with the Safeguarding Unit about cases; in all instances it was decided that reviews, which are time consuming and often expensive processes, were unlikely to result in additional multi-agency learning. Where applicable, individual agencies or sectors were recommended to undertake an internal review and any lessons applicable for wider agencies on the board were identified and brought to the attention of the Quality Assurance Committee.

A Serious Case Review undertaken by another local authority in 2012/13, which involved a former Blackburn resident, has not been finalised by that local authority. However, during the review process, which has involved some Blackburn with Darwen staff, learning has been identified and improvement action taken.

How we Assure that Organisations Provide an Effective Safeguarding Service

Case File and Practice Audits

The Board has not undertaken any multi-agency case file and practice audits during the 2013/14 year (March 2013 to April 2014), but the Quality Assurance Committee has agreed a programme of case file audits and Multi-Professional Discussion Forums (MPDFs) for the 2014/15 year.

Learning from Collecting Figures (Quantitative Data)

Since 2011 the Government has required local authorities as the lead agency in safeguarding adults to collect a range of data. This includes, identifying numbers of adults they are 'alerted' about where there are concerns about their safety; the type of abuse being alleged; who (family, paid carer at home/ residential care etc.) is alleged to be the abuser; and what was found/action taken.

Whilst some useful information has been produced it has not been reliable enough, due to different definitions and varying sophistication of data collection systems, to allow councils to reliably compare data and potentially learn from each other about how to improve their own and partner agency practice. There is also criticism that the voice of the person who has gone through the safeguarding process has not been heard as the concentration has been on collating data. The figures below, whilst numerically accurate, do not necessarily tell us how well adults are being safeguarded in our community. They do identify further questions we can ask and confirm that given that research tells us that there is always an under reporting to official organisations of abuse and neglect, there is significant evidence of concerns about adults at risk in our local community.

Social Care - The adult social care safeguarding team received 1,337 alerts in 2013/14 compared to 1,438 in 2012/13, a reduction of 7%. This reduction was in line with expectations, reflecting greater awareness among partner agencies of cases requiring a formal safeguarding alert, and the improved screening now carried out through the Multi-agency Safeguarding Hub (MASH). The proportion of alerts in 2013/14 which resulted in a formal referral was 76%, marginally higher than the previous year (74% in 2012/13) and indicating better targeting of resources on cases requiring detailed work.

The proportion of referrals leading to formal investigation was 33%, marginally lower than the previous year (36% in 2012/13). The referrals which do not progress to formal investigation relate in a large part to issues of service quality rather than safeguarding, and are scrutinised through regular meetings between the adult safeguarding, commissioning and complaints teams. Any issues of concern not requiring formal safeguarding intervention are dealt with through direct contact between the commissioning team and the service provider in question.

The above core safeguarding data is reported on a quarterly basis to the Quality Assurance Committee and is monitored through the Council's Corporate Plan. From Quarter 1 (April - June) of 2014/15 onwards, further detailed data on the outcomes of investigations and case conferences will be included in reports to the QA committee. Work is also underway on capturing qualitative information on the experiences of people involved in adult safeguarding processes.

How we Assure that Organisations Provide an Effective Safeguarding Service

To address some of the deficiencies of the quantitative data information collection process, the Government has initiated a small pilot project with a few local authorities in 2014/15 to look at collecting less data but of an improved quality focusing on key outcomes for people. This project is expected to report back in the autumn of 2014.

Learning from Auditing Practice (Qualitative Data)

In Blackburn with Darwen information of a qualitative nature has begun to be more systematically collated in 2013/14.

Staff in Adult Social Care has undertaken one internal audit of a number of social care files. This has resulted in improved guidance being provided to social workers for undertaking safeguarding case conferences and review conferences.

An audit of files of people who have been identified as self neglecting was also undertaken and this has led to recommendations about improvements in a number of practice and training areas. This has included reviewing training on the Mental Capacity Act and Guidance including the increasing number of legal judgments that 'clarify' and influence practice.

Learning from those experiencing safeguarding interventions

Whilst Blackburn with Darwen has not received complaints about safeguarding practice from people who have experienced safeguarding, we have (along with most other areas) not been proactive about collecting, collating, and analysing feedback from those who have been directly affected. This has been identified as a national priority for change in safeguarding practice.

A national sector-led initiative 'Making Safeguarding Personal (MSP)' began in 2012/13 with four councils taking part. In 2013/14, supported by funding from the Department of Health and the Local Government Association's Safeguarding Adults Programme, over 50 councils volunteered to participate in one or more levels of improvement activity. This work under MSP aims to shift emphasis from processes to a commitment to improving outcomes for people at risk of harm. The key focus is on developing understanding of what people wish to achieve, recording their desired outcomes, and then checking how effectively these have been met as a result of safeguarding interventions. Blackburn with Darwen has recently agreed to be part of the next wave of councils participating in the programme.

Health – (a) Commissioners – a particular challenge for some commissioners has been the commissioner's ability to gather together information they hold from contract monitoring processes. For all the commissioners, this information tends to be held in different units of their organisation or sub-commissioned to another organisation to undertake. Whilst internal reporting processes are in place, it has proven difficult to evidence the effectiveness of safeguarding arrangements in commissioned services.

---

[4] This is a contentious area of work nationally and has been identified for further Government action/guidance.

How we Assure that Organisations Provide an Effective Safeguarding Service

The Clinical Commissioning Group (CCG) has a Safeguarding Assurance Committee which is a sub-group reporting to the Quality Performance and Effectiveness Committee. This sub-group provides oversight, challenge and scrutiny to the safeguarding arrangements of CCG commissioned services as well as to those of the CCG. A Blackburn with Darwen Safeguarding Unit representative is a member of the Safeguarding Assurance Committee. The CCG declaration identifies the safeguarding risks currently on their corporate risk register and the actions being taken to mitigate the risks. The CCG has recently commissioned an external independent evaluation of their safeguarding arrangements; this has recently reported and an action plan has been developed. This will be monitored via the CCG Quality Performance and Effectiveness Committee.

The delivery of the GP Safeguarding eight point framework was one of the key targets of the CCG Quality Premium in 2013/14. The target was for 90% of GP practices to be compliant with the safeguarding framework. The framework includes: initial training needs analysis; signposting to relevant training; promoting safeguarding leadership within practices; support with policy development; and the development of a CCG safeguarding intranet/internet web page. Performance exceeded the 2013/14 target with 100% of practices reporting as compliant.

(b) Providers - information from community health, mental health, and drug/alcohol providers shows that agencies providing these services generally know the demand and supply issues faced by their agencies in relation to safeguarding activity.

The levels of safeguarding activity within larger provider services at both single-agency and multi-agency levels are monitored in detail in their internal reporting/performance monitoring mechanisms. All the provider services, have detailed analysis of the training their practitioners have received on safeguarding; the data across the different providers shows a very good level of compliance with Care Quality Commission (CQC) standards. 100% of staff members in the drug/alcohol service provider have received internal mandatory adult safeguarding training; the percentage of staff in Lancashire Care Foundation Trust's (LCFT) community health and mental health services receiving level 1 training is high and compliant with CQC standards and all staff members receive safeguarding training at corporate induction. Level 2 training (Safeguarding Adults and Mental Capacity Act) is provided as part of rolling programme of training, this is not mandatory, but essential training for certain staff groups and set as a Trust standard to develop competencies and safe care. There is an overall increase in attendance levels for Level 2 training across LCFT with 61 sessions having been delivered over the year. There has also been a significant increase in the delivery of the Government's anti-terrorism training across LCFT since January 2014. The training of a further nine Prevent facilitators in January, making a total of 13 within the Trust, has enabled the increase in delivery and uptake of this programme of training

The Acute Trust has undergone a significant level of scrutiny in the past year following the Keogh investigation, including two CQC unannounced inspections. The investigations and inspections resulted in improvement actions being recommended and the Trust has kept the Board informed of progress made with the actions through meetings with the Independent Chair and information provided at Board and committee levels. This is in addition to the assurance activity the Trust has undertaken with health commissioners, the local authority and local politicians.

How we Assure that Organisations Provide an Effective Safeguarding Service

Similar to other health providers, the level of demand for safeguarding services is reported by the Acute Hospital Trust. On average in 2013/14, 35 alerts per month were raised by staff across the organisation to their internal hospital safeguarding team; an average of seven alerts per month in 2013/14 were raised against the Trust (by other agencies and family members) about concerns over some hospital practice that they felt had put the patient at risk. For alerts raised by hospital staff, the highest proportion relates to neglect identified by staff; for alerts raised against the hospital, early discharge appears to be the most common issue. This data will be a useful way for the Board to measure the impact and success of the actions the Acute Trust has taken to improve their safeguarding practice.

The acute hospital trust has also provided a breakdown of the number of staff completing the various internal adult safeguarding courses; 747 staff receiving training in 2013/14.

In all the provider services, considerable quality assurance and auditing activity has taken place. Safeguarding practice areas where internal practice audits were undertaken include: compliance with learning from serious case reviews; reviews of case recording & IT systems; record keeping in community nursing where mental capacity is an issue; and impact and practice improvement through level 2 safeguarding training. All internal auditing activity has resulted in the findings being translated into actions that are monitored for completion.

Criminal Justice - Police data focused on domestic abuse and vulnerable adult referrals is captured on their 'Protecting Vulnerable People' database. Whilst monthly comparisons of the data in 2013/14 show a stable level of demand, comparison to previous years identifies a significant increase in the demand for police protective services. The police attribute the additional demand to the safeguarding training that all frontline officers and detectives have received and improvement in their skills to identify vulnerable (at risk) adults. In the Eastern Division, detectives in the Public Protection Unit (PPU) had additionally benefited from bespoke training entitled 'Smarter Safeguarding'.

The additional demand in safeguarding services from the police has resulted in a second review of the PPU in two years.

The police report that 1,007 'vulnerable adult referrals' were responded to by their officers in the borough during 2013/14. These referrals were risk assessed by their officers; 46% standard (low) risk, 45% medium risk and 9% high risk. The police report that the introduction of the MASH has resulted in better quality assurance/management oversight in cases with improved identification of vulnerability and risk. It has also been more effective at reducing risk.

Voluntary, Community & Faith Sector - information from this sector has been limited to a few agencies that are directly commissioned to provide services and so a summarised overview of the sector's safeguarding activity will not be possible given the very different services they provide. In general, information from these agencies appears to be more detailed with identified measures for outcomes and impact of services (more likely due to outcome focused contract monitoring processes the services are subject to). Training data provided from the services identifies a high level of their staff receiving appropriate safeguarding training and accessing the Board's multi-agency training.

Board Activity

Pan Lancashire and Cumbria Policies and Procedures

The Pan Lancashire and Cumbria safeguarding adult partnership launched the online policies and procedures manual on Thursday 17 October 2013. Key partners from all four Boards attended the event, held at Lancaster University.

The online manual provides access to a shared approach to adult safeguarding across the four areas, including consistent language and commonly used terms. The manual is also linked to local protocols and external sources of information and guidance.

For the adult workforce the online manual has provided easy access to up-to-date guidance and links to research.

GP Protected Learning Event

In November 2013 the LSAB supported colleagues from Blackburn with Darwen Clinical Commissioning Group (CCG) to facilitate a safeguarding adult training event for local GP practices.

The event was well supported with over 200 colleagues from GP practices attending. The event focused on safeguarding adults and the Mental Capacity Act.

Board Activity

Disability Hate Crime

On the 18 September, 2013 representatives from the LSAB attended the launch of a local disability hate crime support group – RESOLVE.

RESOLVE is a welcoming action group which gives people a chance to share their experiences of disability hate crime in a safe environment, and support is also available to help people report hate crime. The group gives people a chance to be heard, as well as an opportunity to make changes to their lives and make informed and supported choices.

Following the launch event members of the group were invited to attend a Board meeting as part of a safeguarding theme focusing on hate crime. Group members shared their own personal and powerful stories and presented to the Board the journey of RESOLVE so far and information about a third party reporting approach for disability hate crimes called 'Support to Report'. The initiative is provided via the RESOLVE group in conjunction with Lancashire Constabulary.

The group were joined by a Police Sergeant from the Hate Crime and Cohesion Unit, who provided an overview of the local picture in relation to hate crimes and how partner agencies can work together with Lancashire Constabulary to support victims.

Towards the end of the presentation and discussion, the RESOLVE members asked the LSAB to help them by:

- Raising awareness about disability hate crime
- To tell others about Support to Report
- Encourage others to get involved with the RESOLVE group
- Ask RESOLVE to speak at local services
- Look out for RESOLVE's disability awareness training September 2014

Board members have continued to support the work of this local support group and will be inviting members to a subsequent board meeting to provide an update.

Board Activity

Communication and Engagement

Throughout the year the LSAB website has been busy with various posts and information about safeguarding adults. This has included regular updates from the Disclosure and Barring Service (DBS), information about the Care Act 2014 and news about local events and engagement with practitioners, service users and their families.

Snap-shot of communication:

- Advocacy Focus
- Dignity Action Day
- World Mental Health Day
- Carers Week

www.lsab.org.uk

Additionally in February 2014 the LSAB, together with the Local Safeguarding Children Board (LSCB) launched a Twitter feed - @BwDSafeguarding. The launch of the safeguarding Twitter feed has proved popular and an effective communication tool to share local news and events and also be part of a local, regional and national safeguarding network. The Safeguarding Boards have nearly 80 followers.

Multi-Agency Safeguarding in Action

This section brings together examples of partnership work outlining how agencies assist people to remain safe whilst making their own choices about how they live their lives, or being assisted to do this if they lack capacity to ensure their own safety. In all the examples, the names of the service users have been changed to ensure their anonymity.

Jackie is a user of both drug and alcohol services. She was the subject of an unprovoked attack sustaining serious injuries. The police made a number of arrests of people believed to have attacked her. Concerns were raised via the Multi-Agency Safeguarding Hub (MASH) to the local authority safeguarding team as she was deemed to be at very high risk of further attacks. The alleged main attacker had a long history of offences including domestic abuse with other females.

Support was provided by a social worker from the local authority's Safeguarding Adults Team working closely with staff from the Women's Information and Self Help (WISH) Centre, who provided Jackie with emotional support. Jackie also received support from both drug and alcohol services. The case was referred to MARAC (Multi Agency Risk Assessment Conference) – a forum to bring partner agencies together to identify and support people at high risk of domestic abuse. The police provided her with personal safety items and adaptations to her property which would trigger an immediate police response. Markers were put on the property identifying her as a vulnerable person and at very high risk.

The local authority's Housing Needs staff members were also involved and organised new accommodation at a confidential address. The local authority's Safeguarding Adults Team liaised with the local housing provider to make adaptations that would minimise the risk of people getting into Jackie's flat. A worker from Adult Social Care assessed Jackie's needs on discharge from hospital and arranged a package of care to support to enable her to live independently. This direct support has been reduced as Jackie's condition improved, though care staff maintained telephone contact twice a day to offer support.

The alleged perpetrators appeared in court and Jackie attended to give evidence resulting in all three being convicted of the offence. They have since been released having served their sentences. Jackie appears to be coping well.

There are a high number of properties in the Blackburn with Darwen area that offer single room and shared facilities accommodation to people; also known as Houses of Multiple Occupation (HMOs). A significant number of adults in this type of accommodation are particularly vulnerable due to past circumstances sometimes associated with physical and mental illness/disability. Some of these HMOs are of concern to local people and agencies. Agencies have limited powers to enforce improvements. However, the example below illustrates how one person, who appears to have suffered from financial abuse, has been assisted.

Multi-Agency Safeguarding in Action

Following a joint council/police operation in which a warrant was served on a House of Multiple Occupancy (HMO), documents were seized from the office of the property including details of all current residents. Jack had lived at the HMO for a significant period of time and in the documents seized were confidential letters unopened of which he was unaware.

The social worker from the local authority's Safeguarding Adults Team and police officers visited and took Jack to the bank to check his account. It transpired that £10,000 had been taken from his account without his knowledge. The police are investigating this along with several other counts of fraud.

Jack agreed to move out of the HMO into a short term residential placement where he was supported by the housing provider and local authority housing needs team to apply for a tenancy. He was offered a one bedroom flat in a sheltered accommodation complex and was provided with assistance to purchase everything required for a new home. When Jack moved in, a support package was provided by the local authority re-enablement service to ensure he was able to manage independently. Jack has made an excellent transition to becoming independent and has settled well in the tenancy.

Adults with learning disabilities are more likely than other people to be targeted and abused by others, including within their own family and by paid staff in various living settings. However, unless the adult lacks mental capacity, it is important that their choices about what risks they take are respected.

Jacques has a severe learning disability and previously lived with his mother, father and sibling. His mother was frail and his sibling had serious health problems. Jacques divulged to a counsellor that he, his sister, and his mother had experienced years of physical, sexual and psychological abuse from his father. This was alerted to the local authority's Safeguarding Adults Team and subsequently reported to the police. Due to lack of evidence and the fact that the allegations were historic the police were unable to take any action from a criminal perspective. A referral was made to the Women's Information and Self Help (WISH) Centre who maintained regular contact and offered support. After much deliberation Jacques' mother and sister decided to remain within the home with the father who was now physically frail.

However, Jacques lacked capacity to decide whether to stay in the family home and a best interest decision was required. As well as the abuse issues it was clear that the family were struggling to meet his needs. Although reluctant to see him go, the family agreed that Jacques could move into supported living accommodation. The multi-agency Learning Disability Team worked alongside the Safeguarding Adults Team and facilitated the move and transition.

Jacques is now thriving in a supported living tenancy.

Multi-Agency Safeguarding in Action

Jamila is a 65 year old lady living in Blackburn. Her reluctance to access health and social care services for a number of years made her vulnerable to having poor health outcomes. As her health began to deteriorate the risk of harm became significant.

Jamila was referred to a Lancashire Care Foundation Trust's (LCFT's) treatment room clinical service based in Blackburn. She was reluctant to consent to the prescribed treatment and lifestyle advice and her attendance at the treatment clinic became sporadic. She was identified as requiring additional time and input as a vulnerable adult in order to support her to accept and receive appropriate treatment. The safeguarding adult named nurse was asked to provide additional support and supervised the case management of Jamila by the treatment room staff ensuring that her mental capacity was considered and her decision over consent was respected.

As a result trust and respect were developed between Jamila and the staff nurse and it was identified that she had some underlying personal and mental health issues with which she needed support. A multi-disciplinary approach was initiated and coordinated by the staff nurse in order to coordinate adequate social care and health support. This involved the local housing provider, local authority safeguarding adult team, district nurses, GP, and community social care services. The joint working focussed on the vulnerability of Jamila and the safeguarding needs of this lady who was beginning to engage slowly with agencies.

Jamila accepted further referrals to acute services including urology, dermatology and mental health services provided by East Lancashire Hospitals Trust (ELHT).

Jamila experienced an improvement in her mental and physical health and wellbeing. The multi-disciplinary approach and involving safeguarding professionals empowered the nursing team also to deliver care to Jamila with confidence and competence.

Some adults have very high and complex needs and may lack capacity to protect themselves. They may also pose dangers to others, so they need others to make decisions to restrict their liberty 'in their best interests', but with the aim of helping them to return to living in the community.

Jordan, a 25 year old living at home with parents and younger siblings, has a learning disability with significant challenging behaviours and a diagnosis of Autistic Spectrum Disorder. Due to his physical aggression and a number of assaults on family members, Jordan was detained in hospital under the provisions of the Mental Health Act.

The hospital observed and assessed Jordan's behaviour and devised a communication support plan including a visual daily planner. Over a period of 12 months, through the use of the planner and other aspects of the support plan, the number of incidents of aggression had reduced down to only three incidents.

Multi-Agency Safeguarding in Action

A multi-disciplinary team meeting agreed that Jordan was ready for re-integration into the community and a community placement was identified.

Jordan will have 2:1 support during the daytime, 1:1 'wake and watch' support in his flat and access to background support at all times. An application for complex package of support was approved. Referrals have been made to the Forensic Support Service, Behavioural Outreach, Psychology and the Speech and Language Therapy services. The identified teams will be working alongside the team from the hospital around Jordan's transition back into the local community.

The Fire and Rescue Service often become aware of vulnerable people when called out to check properties, or offer advice about fire safety. They are a key service in alerting safeguarding workers about people who are not managing in their own homes and can also put in place preventive measures to improve safety. On occasion the level of risks posed by individuals to themselves, and potentially others, may be best mitigated by moving them to more supported accommodation.

The Community Fire Safety Team visited a property after a referral was made by an operational crew at Blackburn Fire Station. The referral was in respect of a man displaying signs of self-neglect. When the fire officer arrived at the property Jhangir was having difficulty moving around his home. His clothes appeared dirty, suggesting that they hadn't been changed or washed for some time.

The property was tidy but the kitchen was not clean and the fridge was found to contain various harmful items including out of date meat. On top of the cooker there was a large saucepan full of oil which Jhangir confirmed was used to cook chips. Although he said he had a carer who called to see him, his home and lifestyle presented a number of risks.

A subsequent visit was carried out, which confirmed the view that he was unable to care for himself and was at risk of harm through self neglect. His carer reported that he had previously had three calls a day from Jhangir to assist with his care, but Jhangir's goal was to be able to live independently.

As a result of this visit the fire officer contacted Adult Social Care and Jhangir's social landlord to discuss the health and safety concerns and levels of risk. His GP was asked to visit and carry out a health and wellbeing assessment.

Following assessment and careful discussions with agencies Jhangir agreed to move to a residential care home where his needs could be met.

Families can experience multiple physical and mental health problems that result in abuse. This needs sensitive investigation from a range of workers.

Multi-Agency Safeguarding in Action

John lived in privately rented accommodation with his son who suffers from a mental health issue and regularly uses illicit drugs. As a result of the safeguarding investigations and multi-agency intervention meetings it transpired that John's son was abusing him.

With the assistance of his family, John agreed to move to a retirement housing scheme. He settled in very well, his health has improved and he is an active member of the retirement housing scheme becoming more social and integrated with other residents.

Abuse of alcohol is a key factor in increasing poor health, self neglect, domestic violence, and being at risk of abuse and/or of getting involved in abusing others.

Jonty was drinking alcohol regularly, had suffered from seizures requiring treatment at the hospital's accident and emergency unit.

Jonty had a learning disability and a social worker was involved with his care.

Jonty was living alone in the family home which he had shared with his parents before they died. The house was not appropriate for him as the property was in a poor state and he had limited life skills to enable him to be safe. There was a fear that he would become more socially isolated if he remained in the property. Greater Manchester West NHS Trust worked closely with the local authority adult social care team and a housing provider to source suitable accommodation.

A multi-agency meeting was arranged to review Jonty's continuing health and social care needs. Following the meeting a care plan was agreed. With the level of intervention identified in the care plan it was determined that Jonty would benefit from a shared lives (adult foster care) arrangement which has proved positive and successful.

Jonty continues to receive support for his alcohol use and has not needed to access A & E care.

Josephine is a 77 year old with a complex health disease and anxiety issues.

Her son had not lived at home for a number of years, but in the last twelve months, he visited his mother repeatedly demanding food and money. Josephine's son regularly uses illicit drugs, is dependent on alcohol and has mental health needs. His mother is frightened by him as when she lets him in he talks to imaginary individuals in the room. Police were called to the property on several occasions to find Josephine in a very distressed and agitated state as a result of her son's behaviour.

Multi-Agency Safeguarding in Action

An Independent Domestic Violence Advocate (IDVA) has supported Josephine in securing a non-molestation order and completing a safety plan. Issues continued and Josephine continued to receive visits and harassment from her son. As a result her son was sentenced to a period of imprisonment for breaching the order.

Josephine was referred to the Multi-Agency Risk Assessment Conference (MARAC) due to the number of times the police had been called out, however it was decided that it would be beneficial to hold a multi-disciplinary meeting so that her needs could be discussed in more detail. Key agencies identified included the IDVA, social worker, police, probation and mental health services. A member of staff from the hostel that the son had been staying at was also invited. The meeting agreed a multi-agency plan enabling key agencies to work together to identify key areas for support and intervention to increase Josephine's safety and reduce the son's offending behaviour.

A whistleblowing report identified concerns about a member of staff in a local care provider. This included poor moving and handling techniques, breaching confidentiality, and alleged intimidation of service users. The local authority's commissioning team undertook a joint visit with the local authority's safeguarding adult's team and investigated the care provider's actions.

The investigation found that aspects of practice in the care service were deemed to be inappropriate.

As part of the all investigations, including an internal review by the care provider, it was found that the main concern stemmed from the staff culture and morale which was in turn impacting on the quality of care to the residents. An action plan was formulated to address the practice and quality issues. Mentors were introduced to coach and support staff to provide the very best service for their service users.

A customer satisfaction exercise was undertaken with a view to gain service user perceptions; and a survey of staff was completed to help develop the professional code of conduct. Confidentiality and data protection training was provided for all employees and volunteers.

Several monitoring and assurance visits followed to ensure the quality of care had improved. Discussion took place with staff, service users and family members which acknowledged and confirmed the improvements and positive outcomes.

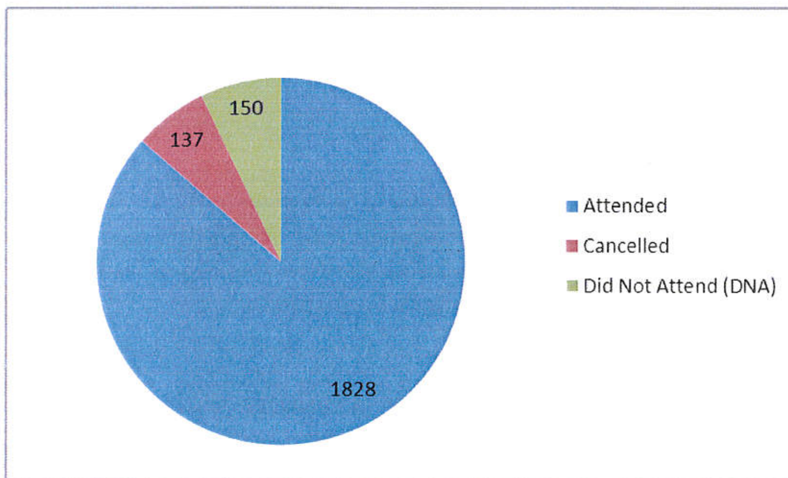
The service provider also took disciplinary action against staff alleged to have breached professional boundaries.

Developing Our Workforce

2013/14 was another successful year with a total of 78 workshops being offered covering 18 topics, across the adult and children's workforce.

2,115 places were offered to staff across a number of agencies, representing an increase of 69% compared to 2012/13.

1,944 places were booked, representing a booked rate of 92%, which is slightly higher compared to the previous year (90% in 2012/13). The overall attendance rate is 94% (1,828 attendees). This represents an increased attendance rate of 22%. The significant increase in the available places and attendance is as a result of a series of extra briefings offered during the year.



Cancellations

Fewer delegates cancelled (137) compared to the previous year (236). This represents 7% of all bookings.

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

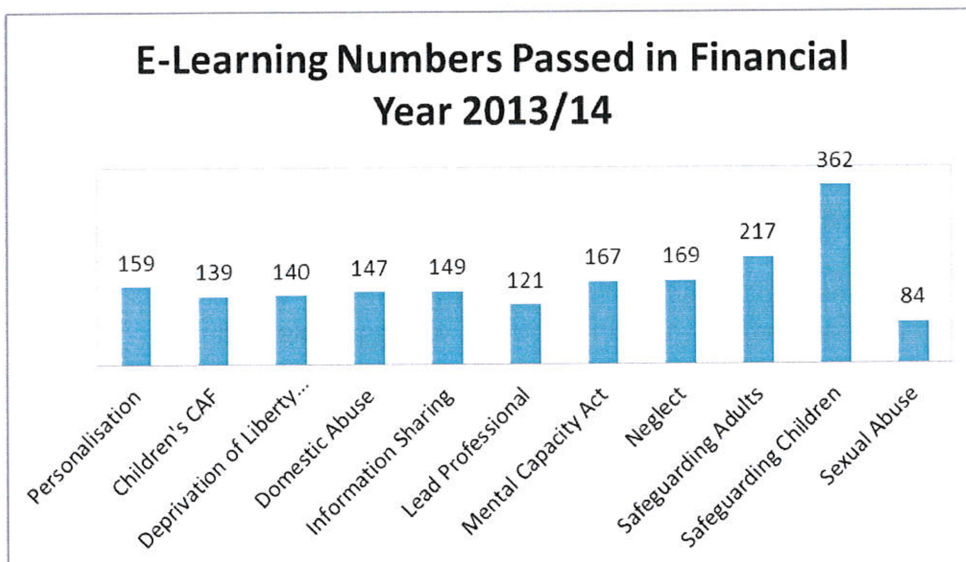
Did Not Attend (DNA)

From the 1,944 places booked, 150 delegates failed to attend and did not cancel in-line with the cancellation policy. This equates to £11,250 as per the £75.00 non-attendance charge.

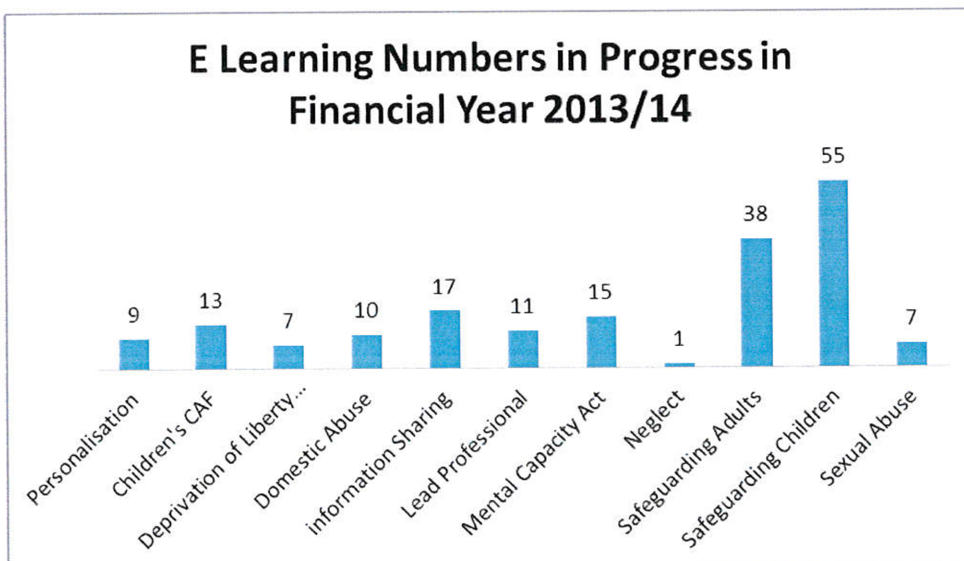
Developing Our Workforce

E-Learning

1,854 individual sucessfully completed e-learning courses between 1 April 2013 and 31 March 2014. 380 individuals are currently in progress of completing an e-learning course, which is a total of 2,234 people accessing the e-learning portal.



Completed:



Developing Our Workforce

Summary of Evaluations and Feedback

From the evaluation forms completed at the end of each face-to-face workshop, delegates provided the following reflective comments:

- Helped me to understand the local developments and thresholds
- Provided an update regarding the single assessment
- Enabled me to recognise the signs and indicators of abuse and neglect
- Useful to meet colleagues and share experiences and best practice
- Enabled me to support children, young people and families

Summary of how the workshops will influence practice:

- Share learning with colleagues and teams
- Enhance multi-agency working
- Improve information sharing between colleagues and external agencies
- Develop techniques to communicate effectively with children, young people and adults
- Listen to service users
- Offer appropriate challenge

Quality Assurance – Peer Observations:

Throughout the year colleagues from across the safeguarding committees completed peer observations of partner agency safeguarding training and the LSAB/LSCB multi-agency workshops.

A total of five partner agencies were observed with positive feedback and good practice being seen. Nine multi-agency workshops have been observed and the feedback has been positive with evidence of multi-agency engagement, sharing of best practice and identification of future practice developments to improve outcomes for children, young people and adults at risk.

Priorities – 2014-15:

- Develop shorter themed briefing sessions to reflect local need and feedback from the professional discussion forums
- Review the e-learning contract to ensure the courses are fit-for-purpose and demonstrate best value
- Enhance the evaluation of training to capture the impact on outcomes for children, young people, adults and families
- Conduct a full training needs analysis to inform 2015-16 workforce planning
- Evaluate the success and impact of the safeguarding workbooks

How we have met our Safeguarding Priorities
April 2013 to March 2014

Priority: Communication & Engagement

Focus	Action	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.	The Communication and Engagement Committee has identified neighbourhood events and local support groups that are linked to the LSAB. The LSAB has continued to develop themed Boards that enable service users and practitioners to have a voice and influence service design and delivery. The Quality Assurance Committee is developing professional discussion forums for front line practitioners to feedback service users experience and contribute to reviewing and improving local safeguarding services. The LSAB has made a commitment to strengthen voice and service user engagement and this will be a key priority for 2014-15
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.

How we have met our Safeguarding Priorities
April 2013 to March 2014

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. The site address is: www.lsab.org.uk
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.	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.
	Provide key messages following Board meetings.	Key messages have been circulated widely after each Board meeting, capturing the work and priorities of the Board.
	Develop a range of printed materials to communicate a range of safeguarding information.	There have been no serious case reviews commissioned by the Board this year; however the board remains focused on learning from regional and national findings, in particular the Winterbourne View recommendations.
	Share learning from reviews across the partnership. Identify ways to effectively communicate with the Private, Voluntary and Independent sectors.	Representatives from the Safeguarding Unit attend the Adult Social Care Partnership, Adult Workforce Development Partnership and independent sector forums.

How we have met our Safeguarding Priorities

April 2013 to March 2014

Priority: Multi-Agency Learning and Development		
Focus	**Action**	**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.	Workforce development opportunities have been offered this year in line 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.
	Develop the training pool to ensure multi-agency representation, knowledge and skills.	The training pool capacity has increased this year; however it requires further strengthening during 2014-15.
	Continue to provide specialist e-learning programmes.	Specialist programmes have been commissioned, including the provision of a range of e-learning packages.
	Develop and implement a local workforce development strategy.	A Workforce Development Strategy has been produced
	Explore learning opportunities for middle and senior managers, using evidence-based research and learning from case reviews and serious incidents.	Discussions took place about training for senior managers; however the recent Training Needs Analysis (TNA) confirmed that it was not a priority for 2014-15.

How we have met our Safeguarding Priorities
April 2013 to March 2014

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 featured at the QA Committee.

How we have met our Safeguarding Priorities

April 2013 to March 2014

Priority: Governance, Partnerships and Accountability		
Focus	**Action**	**Progress**
Develop the effectiveness of the Board	Review membership in line with partner changes and Board development	LSAB membership was considered as part of the Safeguarding Unit structure review.
	Determine seniority of Board members	Board Membership consists of senior representatives from across the partnership (see appendix A).
	Establish a robust approach to identify multi-agency risks, including impact of cuts on services/budgets.	The Board have discussed local risk areas and this has been a focus at several Board meetings.
	Develop effective induction processes for Board members	A Board induction booklet has been agreed and is a priority for implementation during 2014-15.
	Establish regular one to one meetings between the LSAB Chair and Board members.	One-to-one meetings have taken place on an ad hoc basis
	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.*	The 360 degree appraisal of the independent chair, which has confirmed an extension of contract, will be repeated in 2014/15. The planned Board annual development day had to be cancelled in 2013/14 due to unforeseen circumstances but is scheduled for 2014/15 when compliance with the Care Act 2014 will be a key topic.

How we have met our Safeguarding Priorities
April 2013 to March 2014

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.
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. Meetings are also held with the Executive Director People (Director of Adult Social 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.

How we have met our Safeguarding Priorities

April 2013 to March 2014

Priority: Quality Assurance, Performance and Learning Lessons		
Focus	**Action**	**Progress**
Monitor the safeguarding arrangements within Houses of Multiple Occupation (HMOs)	Receive quarterly reports from the HMO multi-agency steering group.	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.
	Develop effective links to the quality assurance, evaluation and compliance of HMOs in relation to safeguarding and protection.	Identified board members to attend the multi-agency HMO Steering Group.
	Respond to safeguarding themes and trends occurring within HMOs.	The main activity relating to the third action will be progressed during 2014-15.
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 Board 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.

How we have met our Safeguarding Priorities

April 2013 to March 2014

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 Quality Assurance Committee. A revised dataset and agency declaration has been piloted and will be further strengthened in 2014-15. The main activity relating to the third action will be progressed during 2014-15.
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 2014. No audits have taken place Robust processes are in place 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.

How we have met our Safeguarding Priorities

April 2013 to March 2014

Develop Pan Lancashire LSAB Policies 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 & 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.

Our Priorities
2014-15

The Board have agreed the following priority areas of work based on the national drivers, local needs and any outstanding actions from last year's business plan. The voice of the service user, through their ongoing involvement in the board's themes has been reflected where applicable.

1. Prepare for implementation of the Care Act (2014) and contribute to consultations on the guidance relating to safeguarding
2. Implement the action plan to improve quality assurance processes, including having regard to equality impact assessments, and monitor the impact on improving outcomes for adults
3. Monitor the 'Making Safeguarding Personal' initiatives and learn from best practice
4. Audit and quality assure the effectiveness of MASH
5. Ensure implementation and monitor the training and staff development action plan
6. Continue to invest in initiatives, including the Pan-Lancs & Cumbria partnership, to ensure best use of reduced resources at a time of increasing demand due to demographic factors and legal judgements, e.g. changes to the Deprivation of Liberty Safeguards (DoLS)
7. Strengthen the voice of the more at risk/vulnerable adults in Blackburn with Darwen by their greater involvement in board meetings/events

Business Plan
2014-15

Priority	Actions	Responsible Committee	Completion Date
Prepare for implementation of the Care Act (2014) and contribute to consultations on the guidance relating to safeguarding	• Set up task & finish group of Board members to draw up the consultation response to the draft guidance. • Set up a Board development event to audit compliance with Care Act and Guidance proposals and create action plan	Board	August 2015 Development Day October 2014 (Actions to be completed by March 2015)
Implement the action plan to improve quality assurance processes, including having regard to quality impact assessments, and monitor the impact on improving outcomes for adults	Complete actions from the 2013-14 business plan: • Implementation of adult performance framework and analysis of multi-agency safeguarding action • Set priorities/methodology for audit in 2015/16 • Monitor the impact of DoLS judgements	Quality Assurance Committee	March 2015
Monitor the 'Making Safeguarding Personal' initiatives and learn from best practice	• Receive reports and monitor ASC action plan	Quality Assurance Committee	February 2015
Audit and quality assurance the effectiveness of MASH	Complete actions from the 2013-14 business Plan: • Monitor the effectiveness of MASH	Quality Assurance Committee	July 2015

Business Plan
2014-15

Priority	Actions	Responsible Committee	Completion Date
Ensure Implementation and monitor the training and staff development action plan	• Develop shorter themed briefing sessions to reflect local need and feedback from the professional discussion forums • Review the e-learning contract to ensure the courses are fit-for-purpose and demonstrate best value • Enhance the evaluation of training to capture the impact on outcomes for children, young people, adults and families • Conduct a full training needs analysis to inform 2015-16 workforce planning • Evaluate the success and impact of the safeguarding workbooks	Workforce Development Committee	June 2015
Continue to invest in initiatives, including the Pan-Lancs & Cumbria partnership, to ensure best use of reducing resources at a time of increasing demand due to demographic factors and legal judgements, e.g. changes to DoLS	• Review working of Pan Lancs meetings • Identify opportunities for joint training • Identify commissioning across the footprint	All Committees	March 2015
Strengthen the voice of at risk/ vulnerable adults in Blackburn with Darwen by their greater involvement in board meetings/ events	• Themes of Board and committee meetings to include service user views and participation by groups like Resolve, Over 50s & Healthwatch • Communication messages and priorities from the Board are produced with consideration of the voice of the service user	All Committees Board & Communications and Engagement Committee	Ongoing Ongoing

Appendix A
2013-14 Board Membership

Organisation	Board Member	Job Role	Nominated Deputy
NHS England	Susan Warburton	Assistant Director NHS England	Carole Pantelli
Blackburn with Darwen Borough Council	Councillor Khan	Executive Member for Adult Social Care and Health	N/A
Care Quality Commission (CQC)	Tracey Devine	Compliance Manager	N/A
Lancashire Constabulary	Joanne McHugh	Detective Chief Inspector	DI Claire Holbrook
Public Health	Dr Gifford Kerr	Consultant, Public Health	Dr Helen Lowey
Lancashire Care NHS Foundation Trust	Janet Thomas	Deputy Director of Nursing	Bridgett Welch
Twin Valley Homes	Ian Bell	Head of Twin Valley Homes	Will send a colleague when unable to attend
Lancashire Probation Trust	Janet Thomas	Assistant Chief Executive	Mick Kenny
East Lancashire Hospital Trust	Kathryn Bonney	Safeguarding Lead (Adults)	Bridgett Welch
Blackburn with Darwen Borough Council, Children's Services	Linda Clegg	Director of Children's Services	N/A
Blackburn with Darwen Safeguarding Unit	Paul Lee	Head of Safeguarding	N/A
Blackburn with Darwen Borough Council, Legal Services	Paula Johnson	Solicitor	Gillian Emmott
Blackburn with Darwen Borough Council, Adult Social Care	Pete Soothill	Head of Adult Social Care and Prevention	Katherine White
Lancashire Fire and Rescue	Duncan Emmett	Fire Safety Manager	N/A
Blackburn with Darwen Borough Council	Sally McIvor	Executive Director, People (DASS)	N/A
Local Safeguarding Adults Board	Shirley Williams	Independent Chair	N/A
Lancashire Constabulary (Force Public Protection Unit – Police HQ)	Dean Holden	Detective Chief Inspector	DI Claire Holbrook
NHS BwD Clinical Commissioning Group (CCG)	Susan Clarke	Head of Safeguarding & Designated Nurse	Jane Carwardine
NHS BwD Clinical Commissioning Group (CCG)	Kim Smith	Head of Quality	Dr Malcolm Ridgway
Voluntary, Community and Faith (VCF) sector	Vicky Shepherd	Chief Executive, Age UK Blackburn with Darwen	N/A
Voluntary, Community and Faith (VCF) sector	Vivienne Blackledge	Project Manager, WISH	N/A

Appendix B
Care Act Guidance

Extract from the draft Care Act guidance on what should a Safeguarding Adults Board's annual report look like.

The Safeguarding Adults Board must produce an annual report. This annual report must clearly state what both the board and its members have done to carry out and deliver the objectives and other content of its strategic plan.

Specifically, the annual report must provide information about any Safeguarding Adults Case Reviews that the board has arranged which are ongoing or have reported in the year. The report must state what the board has done to act on the findings of the case reviews or, where it has decided not to act on a finding, why not.

The annual report on the plan should set out how the board is monitoring progress against its policies and intentions to deliver. The board should consider the following in coming to its conclusions:

- community awareness of adult abuse and neglect and how to respond;
- what individuals who have experienced the process say;
- what front line practitioners say about implementing policies and procedures;
- feedback from local Healthwatch, people who use care and support and carers, community groups, advocates, service providers and other partners;
- how successful adult safeguarding is at linking with other parts of the system, for example children's safeguarding, domestic violence, community safety;
- the effectiveness of training carried out in this area and analysis of future need; and,
- how well agencies are co-operating and collaborating.

The report is meant to be a document that can be read and understood by anyone. It is therefore critical that the report is in plain English and free from jargon and acronyms as far as possible. Most boards are likely to publish reports on their websites. Boards should consider making the report available in a variety of formats including easy read. Boards will need to establish ways of publicising the report. Every SAB must send a copy of its report to:

- the Chief Executive and Leader of the local authority;
- the local policing body;
- the local Healthwatch; and
- the Chair of the Health and Wellbeing Board.

Blackburn with Darwen Safeguarding Unit
Lower Ground Floor
Blackburn Town Hall
King William Street
Blackburn
BB1 7DY

01254 585297

www.lsab.org.uk www.lscb.org.uk