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# Health and Social Care Overview and Scrutiny Committee

**Monday, 27th March, 2023**
**6.00 pm**
**Meeting Room A**

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**AGENDA**

**1. Declarations of Interest**

To receive any declarations of interest in items on the agenda.

**DECLARATIONS OF INTEREST FORM** **3**

**2. Minutes of the Meeting held on 21st November 2022.**

To approve as a correct record and to sign the minutes of the meeting held on 21st November 2022.

**21st November 2022** **4 - 5**

**3. Welcome and Apologies**

To welcome those present to the meeting and to receive any apologies for absence.

**4. Safeguarding Review Report and Recommendations**

To receive an update and recommendations.

**ReporttoScrutiny27.03.2023 LGA Review SAB report Proposal Recommendations March 2023** **6 - 11**

**5. Safeguarding Assurance Partnership Annual Report 2021/22**

To receive the Safeguarding Assurance Partnership Annual Report for 2021/22.

**BwD SAB Annual Report 2021-22 Report.final1.0** **12 - 48**

**6. CQC Assurance.**

To Receive a presentation on the Outcome of the Peer Challenge Day.

**7. Update on Care Home Assurance.**

To Receive an Update from the Strategic Director.

Date Published: 19th March 2023
Denise Park, Chief Executive

**DECLARATIONS OF INTEREST IN**

**ITEMS ON THIS AGENDA**

**Members attending a Council, Committee, Board or other meeting with a personal interest in a matter on the Agenda must disclose the existence and nature of the interest and, if it is a Disclosable Pecuniary Interest or an Other Interest under paragraph 16.1 of the Code of Conduct, should leave the meeting during discussion and voting on the item.**

**Members declaring an interest(s) should complete this form and hand it to the Democratic Services Officer at the commencement of the meeting and declare such an interest at the appropriate point on the agenda.**

MEETING:

DATE:

AGENDA ITEM NO.**:**

DESCRIPTION (BRIEF):

NATURE OF INTEREST:

DISCLOSABLE PECUNIARY/OTHER (delete as appropriate)

SIGNED :

PRINT NAME:

(Paragraphs 8 to 17 of the Code of Conduct for Members of the Council refer)

**PEOPLE OVERVIEW AND SCRUTINY COMMITTEE**

**21st NOVEMBER 2022.**

Present- Councillor J. Slater, in the Chair, Councillors Harling, Hardman, Smith and Whittingham.

Also Present- Paul Conlon, Democratic Services

1. **Welcome and Apologies**
   The chair welcomed those present to the meeting.

2. **Minutes of the Meeting held on 1st September 2022**.
   The minutes of the meeting held on 1st September were submitted.

   **RESOLVED**- that the minutes of the meeting held on 1st September 2022 be approved as a correct record and signed by the chair.

3. **Declarations of Interest**
   There were no declarations of interest made at the meeting.

4. **Terms of Reference for the Committee**
   The Committee received draft terms of reference for the consideration. The terms of reference had been drawn up to assist members in their work and give a greater understanding of the issues that were to be scrutinised by the Committee and how this could be done. The comments of the Committee would be forwarded to the Policy and Corporate Resources Overview and Scrutiny Committee for consideration.

   **RESOLVED-** That the terms of reference for the Health and Social Care Overview and Scrutiny Committee be noted.

5. **Quality Care Homes in the Borough**

   The Committee looked at the issue of Quality Care Homes in the Borough and the issues that they would raise with the Strategic Director at the next meeting and agreed a focus for a meeting to take place with the Strategic Director to look at the provision of care for adults in the borough.

   The Committee would wish to focus on the following –

   Can we look at the journey of a typical person going in to care, a person with specific needs and a person discharged from hospital?

   What is the current situation within the borough regarding care homes?

   How do we ensure we have and then maintain quality in the boroughs care home provision?

   Where do we stand legally on the provision of care homes in the borough?

   Do we have a duty to provide care homes?

   What happens if we have not got enough provision in the borough to meet need?

How would we deal with a provider withdrawing services at short notice?

Is the care market in the borough sustainable?

How does the Health and Wellbeing Boards Ageing Well Strategy tie in with care home provision?

What would happen if a care home in the brought suddenly closed? How would we deal with this?

The Committee discussed the way that the care homes affected the lives of many elderly people in the borough.

**RESOLVED**- That the next meeting of the Committee focus on the issue of Care Homes in the Borough and in particular issues of provision of quality.

6. **Progress of the Task Group looking at Leisure, Leisure Centre Usage and Re:fresh**.

The Task Group met on 1st November at Blackburn Leisure Centre and discussed with officers from the Public Health and Operational Services Department a number of issues that the committee had included in its scope of the topic.

- The scope of the refresh offer and who it was targeted to benefit
- The current offer and how this has developed historically
- The funding for the initiative both historically, now and in the near future.
- How users access the programme
- Booking arrangements for sessions
- Availability issues
- How leisure centres were dealing with the issues caused by the economic situation
- How leisure centres sought to attract people to centres and the methods used.

**RESOLVED**-

1. That the Executive Member be requested to report to a future meeting of the Committee on how the changes in the future funding for Re fresh will be managed, how this will impact on service provision and the impact on Leisure Centres.

2. That the Executive Member be requested to look at how accessibility to the re: fresh Programme is managed with particular regard to issues relating to digital bookings which may exclude some sections of the community.

3. That the Executive Member be requested to report back to the Committee on how reductions of funding will impact on the health of the borough and how the work on going in partnerships that could help mitigate this.

Chair at the meeting where the minutes were agreed……

Date……

**REPORT TO ADULTS & HEALTH SCRUTINY COMMITTEE**

**DATE:** 27th March 2023

**Regarding:** Review of Adult Safeguarding Arrangements

## 1. Purpose

The Strategic Director of Adults and Health has a statutory responsibility on behalf of the Local Authority to ensure a Safeguarding Board is in place, able to implement the requirements of the Care Act 2014.

The Local Government Association (LGA) in association with the Association of Directors of Social Services ( ADASS), were asked to organise an independent Consultant to undertake a review of the effectiveness of the arrangements in Blackburn with Darwen .

The request was to evaluate the effectiveness of the Pan Lancashire approach and the effectiveness of the local Board. The Consultant was then asked to make recommendations related to effective delivery of the statutory responsibilities of the SAB Board. These would be specifically in relation to the structure enabling assurance from partners about its effectiveness, set within a Pan Lancashire arrangement in preparation of a CQC Assurance Framework.

## 2. Methodology

2.1 Interviews:

- with all statutory partners - 45-minute sessions (list provided)
- with the Board Manager – 1 hour
- with DASS – 1 hour
- with Independent Chair – 1 hour

Dates were agreed between the consultant and Blackburn and Darwen for February
.

### 2.2 Literature Search Undertaken

Blackburn and Darwen provided the following for the consultant:

- A structure chart which shows the Pan Lancashire arrangement, and the new current arrangements.
- Copies of all the SAB Boards and Subgroups Terms of Reference
- Copies of minutes of the SAB Board Meetings for the last year December 21 to December 22.
- Copies of the subgroups for the last 9 months.

- Copies of Policies and Procedures in relation to Safeguarding and the SAB Board including any Protocols, Contracts or Memorandum's of Understanding in place.
- Copies of Executive Meetings for the last year December 21 – December 22
- Copies of work plans for the SAB Board or Subgroups
- Copy of the SAB Strategy
- Copy of the last SAB Annual Report
- Copies of any Cabinet/Committee/Scrutiny/Health and Well Being Board Meetings that have discussed/reported safeguarding in the last year – December 21 – December 22

The consultant completed a website search to view information available to the public about the SAB.

## 3. Recommendations

The following recommendations and comments were the result of the 5 day review. The recommendations are in light of the fact the Lancashire safeguarding Adults Executive Group has been stood down and statutory accountability passed to the local place based safeguarding Adults Boards. Blackburn has appointed Dr Henri Giller as its Independent Chair.

14.1 The new local Governance will offer robust oversight of safeguarding work in Blackburn with Darwen. The local **Accountability Board** for each "Place" will offer the scrutiny to ensure the work is focussed on what matters within the Blackburn with Darwen patch.

14.2 The local SAB will need to set up the governance to enable the Panels to be created and served.

14.3 The Board will meet twice a year, chaired by the Leader of the Council, and attended by senior stakeholder representatives. This has been agreed in Blackburn with Darwen. There will be two parts of the meeting, Part 1 - assurance that identified risks and progress is monitored against the strategy and business/annual work plan for safeguarding, and Part 2 will select and anonymise safeguarding cases which will be presented to the Panel to consider examples of good practice or challenges and learning of what did and did not work.

14.4 Blackburn with Darwen should consider whether the current SAB Strategy is "fit for purpose". There is no local SAB Business Plan, and this needs to be addressed. The collective responsibility at a senior level does need to be clear with consideration whether it meets localised needs, based on qualitative and quantitative evidence.

14.5 It is recommended that a Blackburn with Darwen workshop is facilitated to jointly agree the Strategy and direction of travel, with the Annual Business/Work plan including clear and relevant aims, objectives and milestones in order for the SAB to better evidence its effectiveness.

14.6 With the new Lancashire Executive Leads Safeguarding Network being formed, this will hopefully renew the energy to demonstrate the benefit of a Pan arrangement at some level as there are likely to be common themes across the patch and whilst localised accountability is imperative, the benefit could be a loss to Blackburn with Darwen if not managed effectively. It is noted n that the three newly appointed place based Independent Chairs will be in communication with each other, and the Joint Partnership Business Unit (JPBU – located within Lancashire County Council) will evaluate agenda items that could be of value in each place.

14.7 The Pan Lancashire Partnership may want to consider through the Executive Leads Network, whether an overall 3-year Strategy could be agreed with for example 3 common areas to work on at a Pan Lancashire basis, with localised priorities for each “Place” based SAB. This could offer a consistent approach on common themes, and still enable some work to benefit the whole Partnership. This would need clear direction, however, could be driven by the Independent Chairs.

14.8 There is a need for a clear sense of direction and agreement about the work of the sub-groups, with deliverables to support the Board in its duties.

14.9 It is agreed that each Board will establish some of their own sub-groups based on their requirements. The plan is for this to be worked through with Independent Chair engagement with the DASS and Board Members.

14.10 It will be necessary for the partners to decide how best to deliver the duties and responsibilities through existing sub-groups, or whether these become localised to meet Blackburn with Darwen priorities,

14.11The sub-groups Terms of Reference should be reviewed to ensure they are fit for purpose and covering the areas detailed, so that attendance can be confirmed and the fluctuating and changing attendance minimised to ensure delivery of the key priorities within defined timescales.

14.12 There are at least quarterly written reports from the Chair of the sub-groups to the SAB about whether the work plan is tracked, and exceptions highlighted for action by the SAB as required.

14.13 Within any agreed Pan Lancashire sub-group framework, consideration will need to be given about how any differences between the 3 areas are managed to assist the sub-group chairs have authority to influence delivery of tasks, as this is being inhibited through each area/organisation not being willing/able to agree the joint framework so that differences can operate for the individual area’s if needed. It is proposed that the Independent Chairs will need to take on this role and the evolving role for the JPBU which is seen as key to this.

14.14 If there are any Pan Lancashire sub-group’s that remain it may be beneficial for an Executive lead member to operate as a mentor/coach to support the chair and sub-group due to the diverse nature of the Partnership and to enable clear accountability and direction and if agreed to ensure the responsibilities and accountabilities in each “Place” are clarified. Alternatively, the Independent Chair could assume this role if it is required.

14.15 It may be helpful to consider a job role/description for SAB members, so each partner is clear about the roles and responsibilities of being a SAB member.

14.16 It would be helpful for the SAB to consider how it enables a wider discussion of local themes to be assured or identify issues and challenges which may be shared and could be mitigated. An example would be quality assurance ensuring the issue with the care homes in the borough is addressed.

14.17 It is recommended that consideration is given to the data reporting from partners and analysis so there is clarity about how this informs the SAB. This is a key driver, and a designated sub-group will be able to investigate further to report back to the SAB and inform audits of practice across the “Place”. This will provide evidence the SAB’s grip on safeguarding.

14.18 It is important to clearly identify the SAB’s role in terms of prevention and protection. Case studies as highlighted in the Complex Safeguarding sub-group may be helpful to be discussed as part of the SAB to inform the wider partnership of the challenges and offer the assurance and the understanding of the lived experiences of residents. The **Accountability Board** will also benefit as proposed from this oversight.

14.19 It is recommended that the SAB consider further how they can evidence and understanding the quality of practice in safeguarding to ensure decision making is robust and consistent, informs learning, and leads to areas for deeper analysis. This could potentially flag more referrals to the Strategic SAR sub-group for consideration.

14.20 The SAB needs to seek assurance that the local multi agency policy is implemented at a local level. It has not been reviewed for five years and requires refresh.

14.21 It may be helpful for the SAB to review its membership to benefit from a wider range of partners for example DWP, CQC, GP, independent provider representatives, voluntary sector partners, service users, and carers.

14.22 It would be helpful to set minimum expectations for frequency of some sub-groups as Terms of Reference on occasions refer to meet on a “regular basis.”

14.23 In order to ensure representation at sub-groups a list of expected organisations/attendees for each meeting with a note of those who apologised, substituted, failed to attend/send any apology, would create more transparency and accountability for the delivery. Where necessary the SAB can then agree any actions or amend membership as required to meet the key priorities.

14.24 The SAB should summarise discussions and adopt a SMART approach to tasks and delivery so impact can be measured. The SAB would then have clear evidence and indicators for measures of success or understand the need for further action/mitigation.

14.25 A decision needs to be made about whether Learning and Development remains a Pan Lancashire sub-group as it requires support from the partnership. A suggestion

could be that the Training Leads in each organisation are required to attend this sub-group as they have the mechanisms to deliver learning within the organisation as its part of their role.

14.26 Whilst a SAR was recognised and referred to the SAB, it may be helpful for a further briefing for staff and managers across Blackburn with Darwen to ensure that there is a solid understanding of when it is necessary to refer for a SAR.

14.27 If the Strategic SAR sub-group remains, it will be necessary to ensure the membership representation is agreed and robust for each Placed based SAB in light of the accountability for Safeguarding Adult Reviews and the possible issues that can arise on publication relating to media and potential challenge, as the management and accountability is not as clear as it should be.

14.28 It would be advisable to ensure the DoLs plan incorporates some expected targets to monitor the risks due to the 360 DoLs reported as the current backlog.

14.29 It will be important to agree across the Pan Lancashire Partnership how the JPBU resources are structured and deployed in the new arrangements post April 2023.

14.30 A refresh of the website and its content, with a gap analysis would be beneficial and promotion of prevention along with any guidance to assist residents can only be beneficial.

## 14. Conclusion

There is a strong commitment to safeguarding and addressing areas for strengthening the accountability and scrutiny which is highlighted as part of this Review. There is also an understanding that a balance is needed to incorporate the benefits of the Partnership, alongside local accountability to ensure prevention, and protection for residents where required.

The following provides a check for partners:

*"The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. This will require the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in* ***'Making Safeguarding Personal'****. It should also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect."*
Reference: www.scie.org.uk

# Blackburn with Darwen Safeguarding Adult Board

## Annual Report: 2021-22

**Publication Date: March 2023**
Final Version:1.0



Blackburn with Darwen Safeguarding Adults

## Contents

# Foreword

The Annual Report sets out the outcomes the Board has achieved over the last 12 months and within the context of a health and care system prioritising our response to covid, protecting the most vulnerable adults in our communities and supporting our providers to offer good care in challenging circumstances.

As a system we have continued to ensure that people are safeguarded from abuse and continue to learn from the analysis of data that can be seen within the report. For example data shows that in comparison terms we have dealt with more allegations relating to act of neglect and omission.

As such we look to build on all the work undertaken during the course of the year to strengthen our safeguarding governance at a local level and continue to ensure our multi-agency partnerships are strong, effective and most importantly accountable to local people.

Mark Warren
Strategic Director of Adults and Health
Blackburn with Darwen Borough Council

# Glossary

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

# 1. The Board

## 1.1 PURPOSE OF THE BOARD

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

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

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

**Six principles set out in the Care Act 2014:**

| | | |
|---|---|---|
| **Empowerment** | **Prevention** | **Proportionality** |
| **Protection** | **Partnership** | **Accountability** |

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


## 1.2 PARTNERSHIP STRUCTURE

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

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

# 2. What does Adult Safeguarding look like in BwD

## 2.1 LOCAL CONTEXT AND BACKGROUND

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

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

## *2.2 POPULATION*

The latest Office for National Statistics (ONS) population estimates show that Blackburn with Darwen population size has increased by 5.0%, from around 147,500 in 2011 to 154,800 in 2021. This is lower than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800. This gives Blackburn with Darwen the highest population for any of the 14 Lancashire local authorities and the first one to exceed the 150 thousand mark.

Overall, in England, there has been an increase of 20.1% in people aged 65 years and over, an increase of 3.6% in people aged 15 to 64 years, and an increase of 5.0% in children aged under 15 years. In Blackburn with Darwen there has been an increase of 18.0% in people aged 65 years and over, an increase of 3.3% in people aged 15 to 64 years, and an increase of 2.9% in children aged under 15 years.

## 2.3 DEPRIVATION

The 2019 Indices of Deprivation revealed Blackburn with Darwen was ranked as the 14th most deprived area out of 317 districts and unitary authorities in England, when measured by the rank of average LSOA rank. The index is constructed from an array of deprivation indicators covering 'domains' such as poverty, health, education, crime, living environment, housing and access to services. The best-known output is the Index of Multiple Deprivation (IMD), which combines all 39 indicators. Deprivation at the Lower Super Output Area (LSOA) level shows the Index of Multiple Deprivation mapped for Blackburn with Darwen's 91 Lower Super Output Areas (LSOAs).

33 of them (i.e. over a third) are among the most deprived tenth (or 'decile') of LSOAs nationally, so Blackburn with Darwen clearly has more than its 'fair share' of very deprived LSOAs. Two of these LSOAs are among the most deprived 1% in England, and a further 12 are in the most deprived 5%. The Borough also has large rural LSOAs-that are less deprived areas. Each of the 'domains' also has its own index. On the Health Deprivation and Disability domain, 46 of Blackburn with Darwen's LSOAs (i.e. just over half) are in the most deprived decile, and none at all in the least deprived three national deciles. All of the commonly used methods suggest that Blackburn with Darwen is relatively more deprived in 2019, than in 2015.

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

## 2.4 SAFEGUARDING ADULTS SECTION 42 ENQUIRIES, 2021-22

| Counts of Safeguarding Activity | Count |
|---|---|
| Total Number of Safeguarding Concerns | **960** |
| Total Number of Section 42 Safeguarding Enquiries | **725** |
| Total Number of Other Safeguarding Enquiries | **110** |

| Counts of Section 42 Enquiries by Type of Risk | Count |
|---|---|
| Physical Abuse | **108** |
| Sexual Abuse | **37** |
| Psychological Abuse | **102** |
| Financial or Material Abuse | **155** |
| Discriminatory Abuse | **2** |
| Organisational Abuse | **4** |
| Neglect and Acts of Omission | **281** |
| Domestic Abuse | **32** |
| Sexual Exploitation | **1** |
| Modern Slavery | **2** |
| Self-Neglect | **72** |

A number of factors have been identified that may be inflating the numbers of safeguarding concerns and section 42 enquiries recorded in the Mosaic system for the period in question:

- Within Blackburn with Darwen, the Safeguarding Adults team takes a lead on cases where self-neglect is a concern. The team's work is routinely documented on the Safeguarding workflow, which may lead to over-recording of safeguarding issues for these cases.
- It has been noted that a very high proportion of Safeguarding Concerns have progressed to S42 Safeguarding Enquiries during the period. Processes and practice in the operational team are being reviewed to ensure that cases are progressed and recorded in line with the Continuum, and that cases are accurately classified in relation to section 42 criteria.

# 3. The role and achievements of Sub-Groups

### 3.1 CONTEXT

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

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

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

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

The Sub Groups reported on for 2021/22 are:

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

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

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

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

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

- Act on behalf of the three Safeguarding Adult Boards to ensure a robust, transparent and consistent approach to Complex Safeguarding Vulnerabilities.
- Monitor the delivery of its statutory duties with regard to carrying out on Complex Safeguarding Vulnerabilities

- Improve collaborative work across the partnership to provide a consistent approach to support people experiencing complex vulnerabilities.
- Ensure approaches to complex vulnerabilities are meaningfully implemented and embedded in practice by all partners, and that its effectiveness is measured to give confidence.

The key objectives of the Sub-group are:

- To ensure an effective mechanism is in place to tackle the complexities associated with safeguarding adults in line with the 'prevention' principle of the Care Act 2014.
- To develop a mechanism to support those individuals that do not meet the thresholds of statutory criteria to access support from statutory services.
- To provide oversight and direction to Partners to ensure appropriate approaches to complex safeguarding are embedded within practice and partner systems, policies, processes and identified training needs.

SELF NEGLECT TASK AND FINISH GROUP

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

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

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

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

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

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

The key objectives of the Sub-group are:

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

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

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

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

The Mental Capacity (Amendment) Act 2019 introduced the Liberty Protection Safeguards (LPS) and will replace the current DoLS. The draft code of practice consultation for LPS was due in April 2021 but was delayed into 2022, with an expected 12-week consultation period. Agencies will need to ensure the workforce are skilled and ready for implementation, with the Boards seeking assurance around LPS readiness and implementation. MCA has continued to be a key learning theme across SARs and DHRs.

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

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

The key objectives of the Sub-group are:

- To ensure an effective mechanism is in place to tackle the complexities associated with safeguarding adults in line with the 'prevention' principle of the Care Act 2014.

- To develop a mechanism to support those individuals that do not meet the thresholds of statutory criteria to access support from statutory services.
- To provide oversight and direction to Partners to ensure appropriate approaches to MCA/DoLS/LPS are embedded within practice and partner systems, policies, processes and identified training needs.

### 3.5 PERFORMANCE, ASSURANCE AND IMPACT SUB-GROUP

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

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

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

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

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

### 3.6 SAFEGUARDING ADULTS REVIEW (SAR) STRATEGIC SUB-GROUP

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

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

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

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

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

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

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

### 3.7 LEARNING AND DEVELOPMENT SUB-GROUP

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

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

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

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

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

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

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

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

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

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

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

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

Learning and Development Priorities:

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

# 4. Blackburn with Darwen Safeguarding Adult Reviews Activity

### 4.1 SAFEGUARDING ADULT REVIEW PROCESS - UPDATED

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

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

### 4.2 BLACKBURN WITH DARWEN – SAR ACTIVITY

There was only **one** referral that proceeded to a Safeguarding Adult Review during this reporting period.

**Adult U** SAR was commenced during the reporting period, learning will be included within the next year's annual report. initial overview is that Adult U failed to have their basic needs met, there was a lack of multi agency information sharing with poor communication and failure to escalate or act on concerns raised with supporting someone with complex needs. With some lessons to be learned around Transition from children's services into adult services when children are on radar to adult services.

# 5. Prevent Activity

### 5.1 OVERVIEW

The Lancashire Local Authority landscape consists of a County Council, twelve districts and 2 unitary authorities. From a Counter Terrorism perspective, Blackburn with Darwen (BwD) has received funding

for Prevent since the implementation of the strategy in 2008. From 2019, Blackburn with Darwen Borough Council (BwDBC) established a `Centre of Excellence' to oversee Prevent delivery for the whole of Lancashire. An annual report for 2021/22 was presented to the three Lancashire Adult Safeguarding Boards, and although reported separately, we have included a summary of the overall training delivered as part of the safeguarding activity to protect vulnerable adults.

### 5.2 TRAINING

Prevent returned to face-to-face delivery but with the option for online sessions when requested by partners. This hybrid option has allowed them to continue to deliver high quality, bespoke training to a variety of sectors. Feedback has been very positive with many organisations encouraged to contact the Prevent team and seek training, support or advice after recommendations from peers.

Training provided related to Adults across Lancashire for 2021-22

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

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

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

### 5.3 TRAINING DELIVERED

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

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

# 6. Partner Activity

**BLACKBURN WITH DARWEN BOROUGH COUNCIL – ADULT SAFEGUARDING TEAM**

The Local Authority has statutory responsibilities to safeguard adults at risk of abuse or neglect, set out in Sections 42 to 47 of the Care Act 2014, and Chapter 14 of the Care and Support Statutory Guidance. These responsibilities include:

The duty under section 42 of the Act to complete Safeguarding Enquiries into suspected abuse or neglect of adults with care needs who are unable to protect themselves;

The duty under section 43 of the Act to establish a Safeguarding Adults Board (SAB) to provide assurance 'that local safeguarding arrangements and partners act to help and protect [vulnerable] adults in its area' (Statutory Guidance para 14.133).

Blackburn with Darwen Adults Safeguarding Team ensures that the local authority is compliant with its statutory responsibilities under section 42 and ensures that safeguarding enquires are case managed for those adults identified at risk.

Adult Safeguarding achievements in 2021/22

- Successful outcomes achieved following collaboration with the community safety team to protect vulnerable adults who were experiencing homelessness.
- Partnership working with the community safety team addressing specific needs within the travelling community; ensuring care act assessments were completed with anyone considered at risk during eviction processes.
- Continued our organisational safeguarding work despite national restrictions during the Covid-19 pandemic. This required significant collaboration with our quality assurance colleagues within commissioning and supporting the sector to recognise safeguarding concerns.
- Collaborated with colleagues internally and externally (eg CQC and health) to facilitate a coordinated response following a provider failure. The safeguarding adult's team were integral to the decisions being made regarding the adults at risk.

Awareness of Adult Safeguarding raised through:

- Training was delivered internally and externally to various teams, partners and providers, including delivery of the Safeguarding Adults Continuum and PIPOT policy (People in a Position of Trust).
- Promotion of National Safeguarding Week.
- Specialist training by Matt Graham on Risk and Mental Capacity incorporating Safeguarding issues was commissioned for the department.
- The department's Practice Development worker ran training sessions with the Safeguarding Team for CMHT staff, ASYE learners and Social Work students.
- In June 21, Senior Social Workers from the operational team hosted an online workshop on Adult Safeguarding for colleagues across the department.

Making Safeguarding Personal has been further embedded within the team's processes and associated documentation which promotes the voice of the service user and carers. Where necessary the team have made referrals for Care Act advocacy to ensure the voice of the adult at risk is heard. Similarly, the team have incorporated person –centred/ trauma informed practice, in completing safeguarding enquires, which has included interviewing people at risk in an environment they feel safe.

Making Safeguarding Personal is an integral part of the team's standard processes for responding to safeguarding concerns. Within S42 enquiries, safeguarding workers routinely seek the views and desired outcomes of the adults at risk, and document this within the care record. Where possible, safeguarding staff are expected to speak directly with the person at the centre of the enquiry, or their appropriate advocate or supporting family member if the person is not able to participate directly. Agreed safeguarding outcomes are used to structure the enquiry process and are embedded in the documentation accordingly.

Adult Safeguarding priorities for 2022/23

- Continuous improvement and review of safeguarding operational processes to ensure a high quality of service including: person-centred responses to safeguarding concerns; timely and accurate record keeping; routine strategy meetings; embedded MSP processes and clear outcomes.
- Streamline shared safeguarding processes with partner agencies – (ELHT/ LSCFT) to ensure health based safeguarding enquires are person centred, timely and completed in accordance with the wider S 42 processes.
- Actively engage with the department's business plan objective regarding adult safeguarding including our governance arrangements and processes to support and protect adults at risk in the area.
- Support the introduction of Safeguarding Champions across providers in Blackburn with Darwen.
- Review operation of the BwD Safeguarding Adults Board; Commission Local Government Association to support with this, with a view to peer review of arrangements.
- Review processes to evidence that all staff in social care teams understand multi-agency procedures for safeguarding
- DOLS structures and arrangement to be reviewed
- Review processes and functions of centralised operational SGA team.

## BLACKBURN WITH DARWEN BOROUGH COUNCIL - CASE STUDY

Category of abuse- Psychological (Verbal/ cohesion, control and modern day slavery)

Adult R attended a sexual Health Services and disclosed that she had been brought to the UK for an arranged marriage. Adult R's husband has Down's Syndrome and she had not been informed that he has learning difficulties. Adult R disclosed; she was being put under pressure to have a baby by her in-laws that she is a carer for her husband, she carries out all household tasks and is sent to her room when her work is complete. Adult R said she has a bank account, but her Father in Law controls this. She shared she is not allowed to leave the home alone (Her father in law was waiting in the car outside the clinic for her) and Adult R has her phone checked. Furthermore, since the last appointment, Adult R overheard her father in law talking, stating he is going to fly her to Bangladesh and 'dump her there'.

The safeguarding team agreed to meet with Adult R during her next appointment. Adult R shared that her desired outcome were to move to a place of safety away from the family. She had brought with her documents; including her passport, registration for GP, bank account details, Home Office documents and Marriage certificate.

A referral was made to a local charity who support with domestic abuse support and assist with arranging a refuge placement and contact was made with police to ensure the potential crime of modern day slavery was reported. Police attended and support Adult R to be removed to a place of safety overnight.

Over the next few days, the safeguarding social workers within safeguarding and EDT liaised with Adult R, Housing, Police, the domestic abuse charity, a local hotel and an interpreter to ensure Adult R was kept up to date, that she in a safe place (initially a hotel) and then over to an out of area refuge. Where she would be offered a support worker, immigration support and emotional support for the trauma she has experienced. Adult R is now safe and has no plans to return to the local area.

**BLACKBURN WITH DARWEN BOROUGH COUNCIL – DOMESTIC ABUSE AND VULNERABLE PEOPLE**

2021-22 has been a year of emerging from the Covid pandemic and services to address domestic abuse have started to regain some aspects of face-to face provision. The online service provision for victim, perpetrator and children's programmes during the lockdowns of 2020-21 provided another way of delivering services, and for some participants it provided a more flexible way to benefit from the programmes. The number of reported incidents of domestic abuse to both police and domestic abuse service providers remained lower than the pre-pandemic levels and it is expected with lockdown restrictions likely to ease in the summer of 2022, that more reporting of incidents will occur.

During the year, planning for the new Blackburn with Darwen (BwD) Multi-Agency Risk Reduction Assessment & Coordination (MARRAC) team has led to the virtual team becoming operational in January 2022. Partners in the team meet several times a week to share information, discuss interventions and plan for further interventions for those domestic abuse cases that are deemed to be a high risk of harm for the victim. The new model has a focus on all three of the 'MEs' in any domestic abuse incident: the reduction of risk for a victim and increasing their protection; the reduction of the risk posed by a perpetrator, and addressing the harm and recovery of any children involved with the adults. At the heart of the interventions for the three MEs is a key focus on working with them in a trauma informed and domestic abuse aware way and ensuring all protection and prosecution tools are utilised.

During the year, the Domestic Abuse Act 2021 was introduced and the new BwD Domestic Abuse Partnership Board was established. The new requirements in the Act have been consulted upon across local partners and with our neighbouring Lancashire and Blackpool partners. Work is ongoing to ensure the full provisions of the Act are implemented including working alongside the Office of the Police and Crime Commissioner to access funding opportunities and with the new Domestic Abuse Commissioner on best practice and excellence.

**BLACKBURN WITH DARWEN BOROUGH COUNCIL - HOUSING AND HOMELESSNESS**

The team continue throughout the year to discharge the authorities statutory duties in relation to homelessness. The number of applications increased significantly, however through hard work and the use of dispersed accommodation the use of B&B accommodation has not been needed. By far the biggest issues for the borough are the oversupply of HMO type accommodation, the influx of chaotic individuals from neighbouring boroughs and the subsequent evictions from the HMO's resulting in rough sleeping.

In order to address the single homeless problem we have been successful in securing over £1.6 million from DLUHC under two of their funding programs, RSI (Rough Sleeper Initiative) and RSAP (Rough Sleeper Accommodation Program). The RSI has enabled us to build a single homeless team consisting of a HMO Co-ordinator, 2 in-reach support workers and 2 rough sleeper case navigators. The team is having some great success in preventing evictions and supporting those on the streets to get offers of accommodation. The RSI funding is being used to maintain and develop our 'Housing First' accommodation project for rough sleepers. Stepping Stones have procured 30 flats and houses from within the private sector, these self-contained furnished properties are let to rough sleepers irrespective of their needs and problems. Support is then tailored to the individuals in order to empower them to maintain the tenancy and access support for any substance misuse, mental health or other support needs they have until they are ready to move on to their own accommodation.

Winter provision – SWEP (Severe Weather Emergency Protocol) Like the previous year we utilised the 'homeless pods'. 12 self-contained portable units of accommodation that were operated between the months of November 2021 and March 2022. This ensured that we were able to get rough sleepers off the streets during the cold weather months and stop the genuine risk of them freezing to death on the streets. 18 individuals passed through the pods before be assisted to secure suitable alternative accommodation. The pods were a great success the previous year and they will be used again in 2022/23.

The Changing Futures programme is a £64 million joint initiative by the Department for Levelling Up Housing and Communities (DLUHC) and The National Lottery Community Fund, the largest funder of community activity in the UK. The fund is for local organisations to work in partnership to better support those who experience multiple disadvantage, including homelessness, substance misuse, mental health issues, domestic abuse, and contact with the criminal justice system. People in this situation are among the most vulnerable in our communities, often with past experiences of trauma. Getting coordinated support from local services can be difficult, and this can lead to greater risk of homelessness, ill health, and increased contact with the criminal justice system. This in turn can result in greater pressures on services that respond to crises such as A&E, policing and homelessness services.

Changing Futures Lancashire is county wide across four localities and is being led by BwD Borough Council, via a core programme team who led on the coproduction of the funding bid that built on what already existed to help the most disadvantaged people, and won £6.499m in funding up to March 2024. The Changing Futures approach puts people with Lived Experience at the heart of service delivery, through a team of Navigators – people with lived experience who are now in paid roles and are being trained via modern apprenticeships. The Navigators are part of a Multi-Disciplinary Team that considers all referrals to the programme, and aims to start providing support to those eligible within 48 hours via outreach, meeting beneficiaries in places they feel comfortable.

The Programme seeks to test new ways of working in three ways:

1. At Individual Level we are testing if our minimal assessment and rapid response means people get better quicker
2. At Service Level we are testing if the integrated teams provide more joined up support more quickly
3. At System Level we are using the learning from 1 and 2 to set system change priorities

Dynamic information sharing agreements mean there is no need for repeat assessments – any additional information needed to provide effective support is through conversations and rapport building. The East locality is also led by BwD Borough Council, and was the first of the four localities to go live in January 2022. By the end of March 2022, East was supporting 100 beneficiaries. (Mark not sure if you need this next bit as its this year not last….) and at the end of September 2022 was nearly at capacity with 173 beneficiaries.

The early signs are that this approach is working and the coproduction at the front end enabled us to create a service model that can move quickly and compassionately.

For more information here is a film about our programme
https://www.youtube.com/watch?v=0RRKccw7PJ8

**LANCASHIRE CONSTABULARY**

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

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

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

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

  Deliver an outstanding service to the public and build confidence

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

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

  Economic department and Fraud continued collaboration to support vulnerable adults

Awareness of Adults Safeguarding was raised through:

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

Service users and carers were supported through:

- Strategic governance through the Vulnerability strategy and Protecting Vulnerable Persons Board
- Live time MASH working to ensure referrals are dealt with in a timely manner

- Digital capability for frontline staff through the use of Pronto and Vulnerability app to offer immediate assistance for all vulnerability related matters
- Ongoing MARRAC implementation support
- Specialist training for staff investigation into all vulnerability related areas
- Mental Health SPOCS in each BCU
- Translation of SAR learning into action plan activity

Views of Adults at risk were sought:

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

Safeguarding Priorities for 2022/23 are:

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

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

## LANCASHIRE CONSTABULARY - CASE STUDY

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

**Background:**

XX is a vulnerable, repeat DA victim. X is both vulnerable by being a victim of DA as well as her own health issues and substance addictions. X has dependant on alcohol with addiction relation issues for several years, resulting in her own children being taken into care – this includes a child she that both X and the perpetrator are the parents of Y.X is recorded as having been in a few relationships where

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

**DVPN Applied:** The incidents begin again in March 2022; there are five further high-risk incidents, where No Further Action (evidential difficulties) are applied and culminate in a DVPN / DVPO being issued on the 7th of March 2022. The order expired on the 14th of April 2022. It is important to note here, that at this point, due to the vulnerabilities of X combined with the volume of incidents, X is undermined as a victim in an evidential sense. What is meant by this is not to detract from the seriousness of the offences committed against X, or the increasing, escalating risk that is noted and can be seen. Grave concern at this point is felt by all professionals and X's family around her welfare and what may become of her. However, X at this point will disclose to some professionals and not others. She will feel safe in the presence of an IDVA to show bruising and disclose, but in the presence of another Officer will state that offences did not happen. That is the real evidential issue. Not that X is not believed, heard, or supported, but that to the evidential test, X has sadly undermined herself on a pro-longed level. Progressing criminal cases and the breaches of the DVPO at this point starts to feel like an impossibility. During the period of the DVPO, DF was arrested for breaches on three occasions, he contested every breach and no breaches were held at Court. The evidence in the breaches, again heavily relied on X, who was not sure around her support for the investigations and therefore provided conflicting accounts to the Police, which could unfortunately not be relied upon in Court. At this point, DF is also arrested for a further number of criminal offences; rape and threats to kill. What is established at this point is that what is detailed above, that X cannot be relied upon as the sole source of this evidence, and the matters are investigated and closed as the rape being an offence already investigated, and the threats to kill not being able to be evidenced down to reliance on X. This does not blame X for these outcomes but highlights the complexities of Domestic Abuse and its impact in a case such as this.

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

**Application**:

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

**Safeguarding and prevention:**

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

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

**Current position:**

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

**LANCASHIRE & SOUTH CUMBRIA CLINICAL COMMISSIONING GROUPS (LSCCCG)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**LANCASHIRE & SOUTH CUMBRIA CLINICAL COMMISSIONING GROUPS – CASE STUDY**

- Male and adult son lived together.
- Following a hospital admission male required significant care and support, including nursing needs.
- A Section 42 alert was raised due to no access visits from care agency staff, and following ambulance attendance they discovered the male in poor state of hygiene surrounded by very poor environmental conditions.
- Son's refusal for care visit access, suspected risk of coercion and control/undue influence on Father's ability to access the required nursing care and self-care support presented as a high risk to agencies.
- Section 42 enquiry commenced; the Social Worker engaged health support in undertaking risk assessments which triggered the use of the self-neglect framework multi-disciplinary team response.
- Initially the risk required the Police to support Social Worker and District Nurse access in a sensitive and proportionate manner allowing the male to be seen alone, this enabled the presenting risk to be assessed and discussed openly, and the males wishes to be communicated.

- An initial plan of care was agreed with the male and his son.
- Due to the assessed nursing and social care needs of the father, previous history of non-engagement, poor environmental conditions, and suspected undue influence of son regarding access to care and support, the self-neglect framework support was commenced.
- Designated Lead nurse coordinated and led the multi-disciplinary process following the self-neglect framework.
- Fire service, housing, environmental health practitioners in addition to health and social care workers and domiciliary care agency staff worked collaboratively as a multi-disciplinary team with the male service user and his son.
- Both the male and his son's autonomy was protected using a consultative approach, maintaining their control, communicating the care need and risk explicitly, agreeing the timing of and numbers of visits and agreeing the pace of any changes to the environment to support the required care to be delivered. All agencies worked proactively together in a person-centred way to understand the relationship between the father and son whilst maintaining a focus on the direct care needs of the father and the presenting risks, including if safeguarding from domestic abuse coercion/control/undue influence was required.
- Relationships were built by the visiting domiciliary care agency practitioners and district nurses in order to gain trust, with a direct and honest approach to any conversations with both father and son regarding any immediate issues noted, the risk of not engaging in the nursing care required, importance of taking prescribed medicines, pressure area care, and support for personal hygiene and the living environment. Visiting practitioners articulated any actions that they were taking clearly.
- Despite a direct approach being required on occasion, autonomy was respected, and work was able to progress at a pace that was comfortable and acceptable to both, and workers were able to establish their wishes and feelings and understand their long-standing relationship.
- Although initial reluctance to engage with assessment as a carer, significant steps were made to offer informal support through a third sector agency to adult son, with the offer of a carer's assessment kept open.
- Sharing information in a timely and appropriate way was essential to understanding and managing risk, agreeing a plan and coming back together to evaluate progress and plan next steps.
- This case study has been recognised as a good practice example, which has been shared nationally via the Safeguarding Adults National Network (SANN).

**LANCASHIRE AND SOUTH CUMBRIA CARE FOUNDATION TRUST (LSCFT)**

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

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

Our strategic approach to safeguarding is linked to our agreed Safeguarding Strategy 2022-2025. This links to the Trust Safeguarding Policies and Procedures. LSCFT takes a Think Family approach to safeguarding practice. Our Safeguarding Strategy takes account of the updated priorities and business plans of the Safeguarding Boards and Partnerships, our commissioned safeguarding specifications and updated safeguarding multi-agency systems and processes across the County. Our Safeguarding

Strategy aims to ensure our services protect and prevent harm, abuse or neglect for service users and their families.

Our Trust Safeguarding Strategy aligns the national and key local priorities to improve safeguarding outcomes in LSCFT.

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

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

**Adult Safeguarding achievements in 2021/22**

LSCFT continue to strengthen safeguarding practice & systems to sustain compliance with revised statutory Safeguarding, MCA and Prevent Guidance and responsibilities.

LSCFT continues to support collaboration across Local Authority Safeguarding services (BwD, Lancashire and Blackpool ) to strengthen information sharing, support provider led enquiries and ensure clinical contribution in Section 42 referrals, where this is appropriate.

Independent oversight is provided within this by LSCFT Safeguarding team.

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

We have also developed training in relation to:

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

LSCFT also now support an introduction to Domestic Abuse and Routine enquiry within the trust preceptorship programme for nurses/ Allied Health Professionals and will support the medic development plans in Dec 22.

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

A revised MARRAC model has been operational in BwD since Jan 22 and LSCFT have a dedicated Specialist Safeguarding Practitioner aligned to the core team MARRAC/ CADS team. Unfortunately,

Lancashire have been slower to progress a revised MARAC model and this continues to place a significant demand within the Safeguarding team. It has been discussed within the PLDASG (Domestic Abuse Strategic Group) that Lancashire hope to have a new model in place by January 2023 and a project lead is in place to support this. LSCFT remain committed to supporting developments and await updates.

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

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

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

LSCFT continue to raise awareness of adult safeguarding through:

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

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

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

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

Adult Safeguarding priorities for 2022/23

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

**LSCFT CASE STUDY**

The patient concerned is a 22 year old female with a diagnosis of EUPD. On admission, her self-harming behaviour increased in both frequency and impulsivity. The patient has had four urgent surgical procedures under General Anaesthetic (GA) to remove spoons, batteries and coins in a short space of time. She is detained under the Mental Health Act on a mental health ward within LSCFT.

The anaesthetist and the surgeon raised serious concerns about this to the local authority safeguarding adult team.

'The patient is subjected to GA and a prolonged therapeutic endoscopic procedure with insertion of an over tube into her oesophagus. There are risks associated to GA, but also a risk of oesophageal or gastric perforation when trying to remove large foreign bodies from the Upper Gastro Intestinal tract. In her case the spoon cannot fit all inside the over tube when it is removed, which increases the risk of oesophageal perforation'

The specialist safeguarding practitioner from the safeguarding team liaised with the ward to ascertain what the plan of care was for the patient and what measures were in place to help facilitate her recovery.

The ward have been working alongside the Personality disordered clinically managed network in collaboration with the Personality Disordered pathway policies, procedures and therapies. It was advised by the Personality Disordered Care Management Team that the patient has chronic mental health difficulties that require some engagement and acceptance of self-responsibility, should she want to work towards her recovery. It would be a concern that removing all items that may present a risk would remove any self-responsibility for her and reinforce that she requires a restrictive approach to care and would not replicate a real world environment that she will undoubtedly move back into, it is important that the patient work towards a commitment to maintaining her own safety.

The Local Authority Safeguarding adults team agreed to close down the alert with the following comments;

Making Safeguarding Personal – The patient was able to take part in this enquiry and fortunately the surgeon was able to get the spoon out of the patient's stomach and she didn't come to any significant or long-lasting harm.

Continuum – The patient has care and support needs and was deemed to be at risk of abuse.

Capacity – The patient has a diagnosis of Emotionally Unstable Personality Disorder and is currently sectioned in Hospital under the Mental Health Act and lacks capacity with regards to this concern. The patient is being supported by staff from LSCFT.

Rationale - The evidence gathered has identified that no significant or long-lasting harm has occurred and appropriate risk measures are in place, therefore the case can be closed to safeguarding

**NORTH WEST AMBULANCE SERVICE (NWAS)**

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

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

## HIS MAJESTY'S PRISON AND PROBATION SERVICE (HMP)

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

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

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

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

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

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

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

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

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

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

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

Adult Safeguarding Priorities 2022/23

- Ensure that every establishment has a nominated senior lead who is competent, confident and knowledgeable of all aspects relating to safeguarding. This will include the appropriate training for the identified leads.
- SMT lead for Safeguarding will work closely with the Healthcare Team and Adult Social Care Team. The Safeguarding lead along with the Head of Healthcare will act as the link with the Safeguarding Adults Board (SAB) at the Local Authority.
- Establishments have refreshed local safeguarding policies in place that identify the responsibilities of the organisation and staff to identify risk at a multi-agency level, ensure early multi-agency support and how we work together in partnership.
- Links with the community are strengthened further through established structures and reaching out to other organisations.

**PROBATION SERVICE (PS)**

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

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

Adult Safeguarding achievements in 2021/22

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

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

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

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

## LANCASHIRE FIRE AND RESCUE SERVICE (LFRS)

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

Adult Safeguarding achievements in 2021/22

- Continued to expand training and increase awareness of safeguarding across all LFRS groups
- Begun to develop more extensive tiered training plan for all staff with levels appropriate to their role.
- Quality Assurance Checks completed on all referrals to identify relevant issues/trends and to inform/develop staff as appropriate.
- Enhanced strategic visibility via detailed performance reporting to continually drive awareness and enhance quality of referrals.
- Two members of staff from the Service Headquarters Safeguarding Support Team achieved the nationally recognised Level 4 National Fire Chiefs Council Safeguarding 'Train the Trainer' qualification.

Adult Safeguarding awareness to staff through:

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

Adult Safeguarding priorities for 2022/23

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

### LFRS – CASE STUDY

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

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

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

**PROGRESS HOUSING GROUP**

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

Adult Safeguarding achievements in 2021/22

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

Awareness raised of Adult Safeguarding:

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

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

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

Adult Safeguarding priorities for 2022/23

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

**PROGRESS HOUSING – CASE STUDY**

Referral details: A visit was carried out to a Progress Housing Group property for an inspection due to the poor condition of the property. While at this address the tenant told our member of staff that she was scared of her brother who had moved into the property some time ago. Due to his behaviour towards her (which included him being very abusive and shouting at her), she added that she sits in her bedroom most evening to get away from him. The tenant went on to tell the staff member that he (the brother) will not give her any money towards bills and expects her to pay for everything. The property is in a poor condition and her brother expects her do all the cleaning. The tenant is very unsteady on her feet and uses a walking frame to get about the property. She is not able to get out of the property said the brother talks down to her and calls her names, making her frightened and unsettled in her own home. She wants him to leave the property but scared of what he will do if she asks him to leave. Our member of staff explained that they could make a safeguarding referral, but it would mean us passing on her details to another agencies, which she agreed to.

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

**THE WISH CENTRE**

The Wish Centre is a specialist domestic abuse service providing advice, accommodation, help, support and advocacy services for victims, children and people who perpetrate abuse. Safeguarding is a key priority for the organisation potentially every service user whether they are a victim, perpetrator or young person will have a safeguarding concern that needs assessment.

**Adult Safeguarding achievements in 2021/22**

- Ensuring Safeguarding is part of our induction process for all new staff / volunteers.

- Safeguarding is discussed in all team meetings and during casefile supervision
- All safeguarding alerts are discussed immediately with a line manager and the designated safeguarding lead
- Staff have been asked to book on any new training that has been recommended by the safeguarding boards. At present staff have either attended or are due to attend trauma informed training.

Awareness of Adult Safeguarding is raised through:

The adult continuum of need has been shared with staff and we have safeguarding policy in place. The safeguarding leads in the organisation are clearly identified in the organisations safeguarding policy. There is also a safeguarding lead for the board of trustees and safeguarding is on the trustees agenda in every meeting.

The CEO writes a weekly all staff email with updates and these include safeguarding updates. Relevant reports, publications etc are highlighted in the weekly email and there is a Resources folder on the staff intranet where these are stored for reference.

The Wish Centre does not operate a waiting list for anyone requiring advice and support – we aim to respond to anyone who is referred, or self refers within 48 hours. We have maintained this response during Covid restrictions. There is a waiting period for service users seeking counselling and therapeutic programmes.

Refuge operated as normal during 2021/ 22 with staff on site supporting service users and a range of activities was provided for service users, staff tested twice weekly, and we requested that all new service users arriving on site tested prior to coming to us and once they had arrived. Staf encouraged service users in refuge to get vaccinated and liaised with public health to ensure testing kits and PPE equipment was accessible. Public health messages were also reinforced on site.

Staff supported residents who tested positive with shopping to ensure covid guidance was followed.

Adult safeguarding staff are one of the core agencies who need to be present at the Marac meeting where high-risk DA cases are heard this ensures that a multi-agency response is given to service users. The Wish Centre is also linked in with Changing futures which supports adult service users with multiple complex needs.

We hold a number of annual service user consultations with service users accessing our refuge accommodation, our programmes including our children and young people programmes, our adult victim programme and our behaviour change programmes. These consultations inform our operational and strategic plans.

**Adult Safeguarding priorities for 2022/23**

- Increasing the number of older people accessing our services (we have identified a need for this for a number of years and have been successful in securing a dedicated post to work with older people)
- Increasing training sessions on domestic abuse with frontline practitioners and employers

## THE WISH CENTRE – CASE STUDY

### Behaviour Change Team – case study (AB)

AB self-referred to the Wish Centre with the support of his daughter CA. AB recognised that throughout his marriage to JB, he had been an abusive, controlling and bullying husband and father. AB is 78 years of age and in an attempt to change his behaviour, he had previously undergone a course of counselling, CBT therapy and hypnotherapy. None of the interventions had been successful and the intermittent incidents of abuse between AB and his wife continued unabated.

In an effort to keep herself safe, JB had taken to residing with their daughter and her family, initially on a full-time basis and then as time went on, she would return to her own home with AB and stay there for a couple of days at a time, supporting him with appointments and leaving to return to her daughter's when inevitably there was another incident of abuse.

In his self-referral form, AB stated he wished to access support because "I don't want to hurt my wife anymore by threatening her and being abusive." Contact was made with AB, and it was quickly established that if work were to be undertaken, it would be with his wife at the forefront of any intervention as abuse was clearly ongoing, and JB was putting herself at risk by returning home periodically.

After lengthy negotiation with AB's daughter, (who fortuitously works as a nurse and therefore has a good understanding of safeguarding) it was decided to offer AB the opportunity to access the Make the Change perpetrator prevention programme. The 15 weeks course was to be delivered online (as opposed to face-to-face group work) as it was felt that this would allow AB a greater chance of success given his age and ill health. The programme was to be facilitated on a one-to-one basis with the support of daughter, who would help her father to download and log onto the Zoom App each week. She would then withdraw to another room until she was required to assist with the logging off process. AB gave written consent to the above.

In addition, daughter agreed to act as an informal support worker for mum, sharing any information around risk with the caseworker / facilitator. JB was to remain with daughter and her family until work was well under way, and further reviews of risk had taken place. Family was also given details of their local domestic abuse service and initial safety planning was facilitated by the Wish Centre ISS IDVA.

At the time of writing this case study AB has completed five sessions of the programme, with particular attention being given to practical strategies he can make use of when starting to experience feelings of loss of control. Whilst the eradication of entrenched behaviour is clearly challenging, AB is developing new skills in an effort to bring about lasting behaviour change. To support this, the caseworker has encouraged engagement with his GP (to establish the impact if any, of possible memory impairment) and with Adult Social Care; the service is due to undertake an assessment shortly.

Whilst staff have been working with AB, an incident of abuse has occurred when JB briefly returned home during the Christmas holidays. This resulted in police being called, although no further action was taken. In the circumstances the victim and her daughter followed appropriate safety advice, and following a review of risk, all parties agreed that the Wish Centre intervention should continue as AB appears to be making sound, if sometimes faltering progress.

As he now begins work which concerns the impact of domestic abuse on children, AB will be asked to consider the affect his behaviour has had on his own (now adult) children and in turn on his grandchildren who, on occasions have been subject to his mood swings and unpredictable behaviour. Although progress is slow to change entrenched behaviour without this intervention JB would have remained at risk whereas now she is confident in following safety advice and AB is becoming more aware of the impact of his behaviour.

## HEALTHWATCH BLACKBURN WITH DARWEN

Healthwatch Blackburn with Darwen are the independent local champion for people who use health and social care services. We are here to make sure that those running services, put people at the heart of care. We also have the following statutory duties: -

- Gathering views and understanding the experiences of patients and the public
- Making people's views known
- Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinized

- Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC)
- Providing advice and information (signposting) about access to services and support for making informed choices

We have further developed our relationships with other agencies with a focus on safeguarding and increased our multi-agency working with BwD Council Quality and Engagement Team, Pennine Regulated Care team, the CQC and East Lancashire Hospitals Trust.

We have appropriately raised safeguarding concerns with BwD Safeguarding team which have been brought to our attention through our information and signposting provision, taking calls from residents, and through our Enter and View visits programme into local care homes.

All safeguarding issues raised with partners have been responded to positively and acted upon.

All staff and volunteers undertake Level 1 and 2 Safeguarding training provided by BwD Council.

There is a culture of open discussion around safeguarding within the team and we undertake local training by partners on safeguarding and share updates from the CQC and other agencies on this topic amongst the staff and volunteers.

Our information and signposting offer supports individuals with any concerns they may have or if they need guidance to access relevant support. We work closely with partner agencies, referring people to advocacy and other support agencies where required.

Healthwatch Blackburn with Darwen engages with all of our local community and has a focus on engaging with vulnerable adults and those whose voice may not otherwise be heard. We ensure that we visit all care homes in the borough once every three years because we are aware of the heightened risk which such closed environments may present.

Adult Safeguarding priorities for 2022/23

- To gather views and experiences of people who have accessed the local safeguarding provision
- To continue to support the work of the Safeguarding Board and its subgroups.
- To continue to provide opportunities for residents of all backgrounds to share their views and experiences of services.
- To continue to develop our multi-agency working, supporting individuals to access the help they need.

# 7. Board Priorities 2022-23

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