REPORT TO CABINET
8 OCTOBER 2015

APPENDIX 'A'

Lancashire's Safeguarding Adults Board

Annual Report 2014-2015

September 2015

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Introduction

The profile of adult protection/ adult safeguarding has risen considerably since the Department of Health and Home Office's publication of *No Secrets* in 2000. The key responsibility for creating local arrangements for adult protection/ safeguarding adults is with local authorities in partnership with the police and the NHS.

Lancashire's population of almost 1.5m is supported by 12 districts (Burnley, Chorley, Fylde, Hyndburn, Lancaster, Pendle, Preston, Ribble Valley, Rossendale, South Ribble, West Lancashire and Wyre) and six Clinical Commissioning Groups (CCGs). The CCGs are grouped into three areas, North, Central and East. There are just over 300 residential homes and residential with nursing homes in the county, almost 200 home care providers and over 30 assisted living and extra care housing providers.

Abusive and harmful acts can happen anywhere. They may happen once or repeatedly in services that are regularly inspected as well as in our own homes - where we should be most safe. Being abused or being subject to neglect is to experience in the raw what it is like to be powerless.

The expectation of Lancashire's Safeguarding Adult Board (SAB) during its transition to becoming a statutory body by April 2015 was that all members of the Board, its networks, associated groups and relevant partners would contribute fully to adult safeguarding priorities and activities within the county. The safeguarding/ adult protection of citizens is and remains a high priority in care planning, commissioning and delivering services.

Our Priorities

In a democracy, public bodies are accountable to the public and to their elected representatives. The public and their representatives must be adequately informed about the activities of the public bodies and their use of public funds. The SAB is responsible for steering adult protection/ safeguarding activity across the county. To do this it has identified four long-term priorities:

1) To **provide strategic leadership** and **seek assurance of safeguarding quality and performance activity** across Lancashire, that is, our interventions are appropriate, proportionate and person-centred
2) To **work closely with all multi-agency partners and strategic boards** to **reflect our learning,** provide strategic vision across Lancashire and set clear and achievable aims and priorities
3) To ensure that SAB members, partners and agencies **share a common understanding** of what constitutes abuse and can recognise risk factors and the situations that should be reported
4) To ensure that the SAB has strategic links to **promote early intervention** to prevent harm and supports the creation of vigilant services and communities

The Law

The Care and Support Statutory Guidance issued under the Care Act 2014 outline three core duties: it must publish an *annual report* (for 2015-2016) which sets out *how the SAB is monitoring progress against its policies and intentions and should consider the following in coming to its conclusions:*

- *Evidence of community awareness of adult abuse and neglect and how to respond*
- *Analysis of safeguarding data to better understand the reasons behind the local data returns*
- *What frontline practitioners say about outcomes…and about their ability to work in a personalised way*
- *Better reporting of abuse and neglect*
- *Evidence of success of strategies to prevent abuse or neglect*
- *How successful adult safeguarding is linking with other parts of the system*
- *The impact of training and analysis of future need*

In addition, *the annual report must provide information about any Safeguarding Adult Reviews (SARs) that the SAB has arranged which are ongoing or have reported in the year,* including, *what the SAB has done to act on the findings.*

Also the SAB must publish a strategic plan for each financial year and it must conduct any Safeguarding Adults Reviews in accordance with Section 44 of the Care Act 2014.

This Annual Report is written in accordance with the Care and Support Statutory Guidance.

Local media and community awareness

The first task outlined in the Guidance is to consider **evidence of community awareness of adult abuse and neglect and how to respond**. The media play a critical if opportunistic role in describing adult abuse, neglect and such cruelties as human trafficking. As vehicles for *awareness raising* about safeguarding/ adult protection, the local press and regional television have an edge. The downside is that broadcast and print journalists decide what events to report and since reportorial attention is rarely directed at setting out contexts or providing assurance that matters are being addressed, the onus is on services and commissioners to assure Lancashire citizens of the actions taken to address the concerns raised and to reduce the likelihood of their recurrence.

Bleak as the coverage of world-wide atrocities has been for victims, the glimpses of victims' relatives have reaffirmed a truth for all of us: from the punching shock of knowing that something awful has occurred, to the ever diminishing hope that perhaps their relative did not suffer, to the anguish of not knowing what specifically happened to their relative – to their unique grief. It is clear that the victims include not only those who have been harmed, suffered and died.

Closer to home, some of Lancashire's *headlines* throughout 2014-15 are presented. These include some familiar themes. For example, Lancashire's Trading Standards has advised citizens to be on their guard against online scams, including emails about an alleged purchase with attachments containing malicious software; telephone cons and doorstop rip offs. Cold callers may promise to cut Council Tax bills; scam tour operators target Muslim pilgrims with false and misleading information;

doorstop sales people target elderly people and sell expensive, undated, freezer-filling quantities of unwanted food; telephone callers may (i) seek to secure control of personal computers; (ii) and suggest that bank card details are being used by criminals; (iii) suggest that the telephone will be disconnected unless immediate payments are made. Although the majority of scams go unreported, it is estimated that the cost to Lancashire citizens is around £64m each year.

In April 2014, Lancashire County Council's Health and Wellbeing Board submitted a £89m plan to central government setting out how health and social care in the county would be improved. The planned use of the *Better Care Fund* identified how the Council, NHS England, NHS Clinical Commissioning Groups, district councils and other organisation proposed to work together to provide better services. This was approved in February 2015.

A service which has been in existence for over 100 years, albeit in different forms, was being changed beyond recognition. The Probation Service has been serving local communities, supporting justice and enabling offenders to resettle. It delivered some 200,000 court reports and supervised around 220,000 offenders each year on community orders and suspended prison sentences and those released from prison on licence. The Lancashire Probation Trust hosted a moving *legacy event* during May 2014. Although the probation service as a whole received the British Quality Foundation's Gold Medal for Excellence Award during 2011, the Conservative led coalition determined that it should change and a large portion of its work outsourced to private and voluntary sector providers. There are two heart-sinks for the service – the changes were not discussed with the judiciary and the changes will not result in any "savings."

In June 2014, a Learning Review of Significant Events at Hillcroft Slyne with Hest Care (Nursing) Home was published.[1] This had been commissioned by the Safeguarding Adults Board and it concerned the abuse of older people with dementia.

The legacy of Winterbourne View Hospital is bleaker than we imagined since Norman Lamb, the Minister of State at the Department of Health, has described the work to move people with learning disabilities out of assessment and treatment provision as an "abject failure."[2] The media cited the Health Services Journal which reported *"institutional inertia" among NHS and local government commissioners which had undermined efforts to hit the deadline. His part in driving the transition programme had been his "most depressing and frustrating" task.* He accused NHS England, one of multiple health and local government organisations which agreed to the June target, of failing to prioritise the transition effort. "*A significant proportion*" of those who remained inappropriately accommodated in hospitals were NHS England cases, he said. *"There hasn't been enough challenge within commissioners to do this."*

In July 2014, a Calderstones Foundation Trust[3] patient was threatened with being 'floored' by a Calderstones nurse in the waiting area of the Royal Blackburn Hospital. The patient responded, 'You don't need to restrain me.'[4]

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[1] www3.lancashire.gov.uk/corporate/web/viewdoc.asp?id=114359

[2] http://www.hsj.co.uk/news/commissioning/winterbourne-view-scheme-an-abject-failure-minister-admits/5070443.article#.U3ivS_ldV4w

[3] Calderstones is the only specialist learning disability trust in England

[4] http://www.lancashiretelegraph.co.uk/news/11350574.East_Lancs_nurse_told_patient_she_would_floor_her__court_told/

In September 2014, Lancashire County Council announced that work was to begin on the £160m *savings plan.* The Council had already agreed £140m out of the £300m *savings* between 2014-2018. Since 2010, £532m has already been delivered or approved since national funding reductions began in 2010, that is, a reduction of almost 40% since 2010.

During October 2014, the County Council promised *ethical homecare,* that is, it signed up to Unison's Ethical Care Charter setting out minimum standards for care at home. The charter states that visits should allow plenty of time for tasks such as help with personal care so that home care workers do not rush from client to client.

Also during October, the Lancashire Evening Post gave coverage to the impacts of modern slavery, including the different ways in which young people and adults at risk are exploited and trafficked.[5] Exploitation thrives by using coercion, deception and knowledge of a person's vulnerability. Detective Superintendent Sue Crawley, the head of Lancashire Police's Public Protection Unit highlighted the fact that *when it comes to trafficking adult males and females we are still on the journey of uncovering the full extent of it…Victims of trafficking do not realise they are victims.*

During November 2014, Trading Standards launched a *nominated neighbour* scheme. As part of a campaign entitled *Good Neighbours Stop Rogue Traders,* it invites neighbours to give postcards with their contact details to elderly or vulnerable neighbours to display at their front door. Since it is typically neighbours who make contact with the Council, it invites cold callers to make direct contact with the nominated neighbour. There is a compelling backstory: a man in his 90s lost around £90,000.00 to rogue traders; and an elderly woman was charged £3,000.00 to have her two bedroom bungalow painted.

Also during November safeguarding practitioners were reminded why a stance of concerned vigilance is necessary. The Care Quality Commission published a report concerning Cuerden Grange Nursing Home in Bamber Bridge. Since the home had failed to meet standards the regulator concluded that it was not safe, not consistently caring and not well led. The Lancashire Evening Post quoted Keith Lowe, the home's owner, *Over the last year we have had a change of management and unfortunately this has had an adverse effect on the home.* The role and individual responsibility of managers is critical to ensuring the safety of a home's residents. (It was in January 2014 that Judge Michael Byrne at the trial of the four Hillcroft care workers noted: *A lack of proper management allowed a culture to develop*).

In December 2014, the owners of Briarwood Rest Home at Lostock Hall and an employee appeared before magistrates in Preston. They faced charges including the ill-treatment and wilful neglect of an elderly resident. Lancashire County Council had placed staff into the home to work alongside existing staff once allegations became known, that is, a woman in her 90s was scalded in a hot bath; another resident was subject to force-feeding. The owners had informed the County Council that they had just two weeks to find alternative placements for the residents.

During December 2014, a CQC report (based on an inspection during July 2014) identified numerous problems at Calderstones FT including[6]

[5] http://www.lep.co.uk/news/victims-of-slavery-are-used-and-abused-in-many-ways-1-6897026

[6] http://www.lancashiretelegraph.co.uk/opinion/11677012.Failings_at_secure_unit_must_now_be_addressed/

- Overuse of physical restraint including 479 episodes (out of 1661) in six months where patients were held face down onto the floor contrary to national safety guidance
- Excessive resort to the seclusion and segregation of patients (333 incidents) including one kept in a flat on their own for six weeks
- Dirty and unsafe wards and rooms including a case where faeces were left on the floor for six hours
- Poor staffing levels with one ward often staffed by temporary nurses and inadequate night time cover on others
- Unsupervised patients
- Poor infection control and hand-washing facilities on wards
- Use of out of date medicines sometimes administered by staff without appropriate qualifications
- Poor practice on the storage and date labelling of food
- 43 per cent of patients had been in the hospital for more than five years.

Also, the CQC had raised four areas of concerns over Guild Lodge in Whittingham, Near Preston in 2014:

- Failing to involve those concerned in patients treatment and decisions
- poor standards of care for those using the service
- failure to properly assess and monitor the quality of their service
- failure to effectively and safely maintain patients' records.

This medium and low secure forensic psychiatric hospital is operated by Lancashire Care Trust. The CQC advised that some of the patients had told their inspectors that they felt they were treated more as prisoners than as patients looking for help. Following the CQC's report on the falling standards at the Guild Lodge, an action plan was put in place to assist the health facility in improving its services.

Safeguarding Adults Boards in England sought to make sense of the *Care and Support Statutory Guidance Issued under the Care Act 2014,*[7] adult safeguarding now has to address more unusual, cruel and violent matters than those that were anticipated by *No Secrets* – including self neglect for example.

In January 2015, Guild Lodge in Whittingham was given a favourable CQC inspection report. Sue Tighe, the Network Director for the Specialist Services Network at Lancashire Care noted that: *We have worked hard to improve services across a number of areas described by our own staff and services users as requiring change and also those identified within the CQC inspection. Our focus of improvement ensured involvement from all stakeholders and front line staff, ensuring we learned and listened from their experience and knowledge.*[8]

In February 2015, The Alders Residential Home in Morecambe was subject to a police investigation following allegations which included unsafe levels of staffing and unsafe staff recruitment practices. Also, the Lake View Nursing Home in Withnell, Chorley closed in the wake of allegations of abuse against a resident. The concerns included poor medicines management, significant health and safety

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf (accessed on 17 January 2015)
[8] http://www.lep.co.uk/news/health/local/lancashire-hospital-improves-after-damning-report-1-7039181

risks, a high reliance on agency staff and shortcomings in the complaints process. The police attention focused on film footage which had been taken using a hidden camera.

Also in February 2015, it was confirmed that Stephen Bubb's report *Winterbourne View – Time for a Change* had implications for the future of Calderstones FT.[9]

In March 2015, Calderstones FT reported 80 clinical vacancies at the Whalley site.[10]

Also in March, the County Council, the 12 district councils and charities providing services to the victims of domestic violence received a grant of £750,000.00 to extend the provision of emergency and temporary accommodation, advocacy and support to women and children escaping abuse in Lancashire.[11]

During 2014 Lancashire Care Trust had recorded 600 occasions when mental health patients were subject to prone restraint in its in-patient facilities in Blackburn and Burnley (383 were recorded during 2013). It is believed that Lancashire Care Trust is the second highest user of prone restraint in England. It was confirmed by the Trust's Chief Executive in March 2015 that the use of prone restraint was to be removed from the Trust's training programme.[12]

Such media coverage confirms the fact that there are no cast – iron guarantees of *safety* and no single person or organisation can attend to the safeguarding/ adult protection of all its citizens. Each of us, as professionals, colleagues, neighbours, friends and relatives, has a significant role in taking action to prevent abuse. It is a shared enterprise and, as with all such activities, it requires capable and willing participants who grasp the fundamental cruelties that make up abuse e.g. humiliation, sexual assaults, inattention to such basic needs as the provision of food, drink and essential medication, perversions of restraint, punitive responses to behaviour which may be described as challenging, acts of cruelty and aggression, deficient care, and anti-therapeutic attitudes. The topic of restraint is not new to the Safeguarding Adults Board; and neither is the concern about care homes and heath settings.

Action for 2015-2016: The story of the year via the media – as reported to the public and professionals via various media sources – is often sensational. It is likely to trigger interest and concern. A website that is tuned into the media is likely to tell a better story and speak in a language that the public can follow instead of processes, acronyms and claims about lessons learned for example. Ensuring that Lancashire's Safeguarding Adults website reflects and enlarges on information featuring in the local press, regional and national news broadcasts should begin with a consideration of what is going to better inform the public and professionals.

[9] http://www.lancashiretelegraph.co.uk/news/11763417.Axe_threat_likely_for___deficient___hospital/

[10] http://www.lancashiretelegraph.co.uk/news/11870712.Calderstones_Hospital_hit_by_staff_shortages/

[11] http://www.lep.co.uk/news/help-for-victims-of-abuse-1-7156352

[12] http://www.lancashiretelegraph.co.uk/news/11828760.DANGEROUS_AND_HUMILIATING__Health_bosses_pledge_to_end_pindown_restraint_which_could_harm_patients/

Delivering our Plan

Although the Safeguarding Adults Board in Lancashire could not feasibly learn about the detail of all adult safeguarding referrals, it does expect to receive assurance concerning *outcomes* once it is known that citizens have been harmed in particular service settings. There is and has to be a culture of challenge because even though there is a safeguarding infrastructure in the county, cases reported in the Lancashire and national media are *the tip of the iceberg.* Crucially also, the SAB has to ask searching questions of key partners represented on the Board which, through providing or commissioning care, may be associated with the very harm they are seeking to address.

The SAB provides assurance on the governance of safeguarding activities in the county and most particularly on the types of outcomes secured (see table below). While the SAB *does not* provide governance for all organisations and businesses concerned with safeguarding/ adult protection, it does have systems and procedures to promote the conduct of its business and support the achievement of its priorities. Each organisation which contributes to the SAB is accountable for its own activities, most particularly with regard to matters of risk. The SAB cannot act as a substitute for the responsibilities of commissioned services and the services of public bodies. It is for commissioned services and public bodies to ensure that their business is conducted in accordance with the law and the requirements of regulation. Since we live in an increasingly networked society it is expected that SAB members will increase awareness of and engagement with the SAB's work through information technology.

Level	**Examples of Outcomes**
Individual/ victim	Immediate safety Long term protection Redress Support for recovery
Individual/perpetrator	Criminal justice system Disciplinary/ employment law Barring from the workforce Injunction Extra support - if a relative Extra help, training or supervision - if an employee
Service	Improved practice Links between providers Listening to people who use services and their relatives Training to prevent harm and abuse Increased professional advice and consultation Regulatory enforcement Closure
Commissioners	Clarity that safeguarding is a core function Changes to contract Service re-provision Partnership working
SAB and national policy	Multi-agency challenge

	Shared aims, purpose, policies and procedures Information sharing Safeguarding adult review, serious untoward incident, Domestic homicide review Feeding learning into policy and guidance

In the light of concerns about Calderstones Foundation Trust, patients and families raised safeguarding and health concerns during August 2014, after the Department of Health visit. Calderstones FT was put in 'enhanced surveillance' by NHS England for six months during which time the risks were explored. During February 2015, a Quality Improvement Board (QIB) was established to gain assurance from Calderstones FT that it is addressing the concerns raised by the CQC inspection. During 2014 there were 48 care and treatment reviews and 10 of the 48 people identified were discharged into more suitable care environments. The QI Board continue to monitor the overall situation and Monitor, which has compliance actions in place, is in attendance at the QIB. A further CQC inspection visit is due in October 2015.

Since the CCGs commission a range of health services, work has been undertaken during 2014-2015 to ensure that safeguarding is part of the procurement process of any new service. This places a clear expectation on all providers to evidence they have a good understanding of safeguarding, have effective whistleblowing systems and are signed up to Lancashire's Safeguarding Adults Multi-agency procedures.[13] Existing services must complete self assessments audits. CCGs have recently revised these so they are in line with the requirements of children safeguarding and feature in a single audit tool.

CCGs commenced *quality walk rounds/safeguarding assurance visits* across all services during 2014-2015, both announced and unannounced. This was focused on triangulating the information that providers are submitting within contract returns and draws on *soft intelligence* from patients and carers, and partner information (the Care Quality Commission and Lancashire County Council). By bringing all this information together CCGs are better equipped to assure themselves of the quality of safeguarding services as well as potential gaps in service provision.

Information about Serious Case Reviews/ Safeguarding Adults Reviews

*Domestic Homicide Reviews /Mental health homicide reviews and Multi Agency Reviews have provided significant learning both locally and nationally. In collaboration with CCGs, NHS England is commissioning appropriate support in Domestic Homicide and Mental Health Homicide Reviews across Lancashire. The learning from these are disseminated through the Lancashire Quality and Safety Meeting and the Health Safeguarding Advisory Forum…*In terms of *Domestic Homicide Reviews, health services have been fully engaged, and the learning from these shared with other providers. The outcomes from these are placed in meaningful action plans designed to embed best practice and change culture rather than surface change.*[14]

[13] Health summary for LSAB annual report
[14] Health Summary for LSAB annual report

A SCR and five multi-agency reviews were conducted during 2014-2015. The limited resources to support adult reviews has been an ongoing concern for the Adult Serious Case Review Sub Group.

One of the Multi-Agency Learning Reviews concerned the circumstances leading to the death of 'S' a 56 year old woman who died during 2013. She had been found in her home in a state of severe neglect. Her home was squalid. S was angry that the police forced entry into her home, not least because she was concerned about the security of her cats. S had been in contact with primary care, the police, social services and housing in the year before her death. She had had no recent contact with mental health services and Chorley Hospital staff had no reason to doubt her mental capacity when she declined to have a CT brain scan and subsequently discharged herself against medical advice. Since the front door of her home had been boarded up, S had no letter box and could not receive letters. A referral from the police to the MASH during May 2013 was *deemed not to hit a safeguarding threshold as currently, self-neglect is not recognised as meeting the criteria for…safeguarding intervention.*

S's mother made several attempts to engage the interest of services in her daughter's circumstances, including her mounting debts and rent arrears. She attributed her daughter's decline to her moving to the property in which she was found by the police. S had lived there for four years and in her previous home for 20 years.

Primary care communicated with S via correspondence and telephone. However, *S did not answer the phone.*

The Learning Review of Incidents of Significant Harm (LRISH) was published in June 2014, five months after three nursing home staff were jailed for periods ranging from four to eight months and one was given a community sentence for tormenting and abusing older people with dementia at Hillcroft Nursing Home in Slyne with Hest. All but one had some *senior* responsibilities at the home. During the trial their actions were described as *an indictment* of the home's managers. Judge Michael Byrne noted that there was *at the relevant times, a lax regime with weak and inadequate management on the unit which allowed this kind of conduct to carry on undetected and without proper and adequate control…some of the offences were gratuitous sport at the expense of vulnerable victims.*[15] Their offences took place between May 2010 and September 2011 when a receptionist and cleaner raised concerns. The four staff members were suspended but then reinstated with warnings. Lancashire CC and the CQC were made aware of allegations of harmful behaviour during late 2011/ early 2012 and contract monitoring visits were made to this home and five others in the group. During April 2011 social workers determined that a police investigation was merited. The County Council suspended new placements; sought assurance from Hillcroft Group that they would not accept self funders during the suspension period; and worked with NHS managers and the CQC to ensure the safety of residents in all of the Hillcrost homes. The suspension was lifted during February 2013. Prior to these incidents coming to light, Hillcroft Slyne was generally regarded by professionals and relatives as a 'good' home.

[15] http://www.theguardian.com/uk-news/2014/jan/10/hillcroft-nursing-home-carers-jailed-abusing-residents (accessed 11 January 2015)

Action for 2015-2016: to secure funding to support the SAB and Safeguarding Adult Reviews; to ensure that summaries of all forms of reviews are circulated to SAB members as one means of disseminating learning.

Acting on the findings

Re S, a member of staff in the practice where S was registered has undertaken safeguarding training and will assume the role of *safeguarding lead.* There was no coordinated response. Housing assumed that since the police and GP were aware of S's deteriorating circumstances that an adult safeguarding referral was unnecessary. People who self neglect deserve the multi-agency attention of adult safeguarding. This position is endorsed by the Care Act 2014.

Re LRISH, although the Hillcroft Group had a General Manager who was well regarded, it was speculated that at a time when the Group was planning to open another home, the General Manager was *overloaded with responsibilities.* Also, there had been three managers in under four years which perhaps accounts for the inappropriately lenient response when concerns were raised initially. That is, the behaviour of the staff was not seen as criminal. The author concluded that the system of care provision is *inherently flawed* bringing *together in artificial living spaces large groups of unrelated and generally incapacitated adults to be taken care of by mostly good kind people who are inadequately trained, poorly rewarded in terms of pay, working conditions and esteem and whose owners need to make a profit on their often not inconsiderable investment. We need to find a different way…*

Shirley Williams presented the LRISH to the SAB and, with the Head of Active Intervention, met with the relatives of people who had been harmed. The review has been shared with practitioners and commissioners and the County Council accepts that its protocol regarding allegations was flawed at the relevant time; models of care are dated and the Extra Care Housing strategy and new *provider development* is beginning to address this; workforce development extends across the care home sector; and alerts are being audited. The review confirms the challenge of adult safeguarding/ protection: concerned vigilance is an ongoing activity. It cannot cease because a home is perceived to be *good.*

Analysis of safeguarding data – themes and concerns

Lancashire's referrals to adult safeguarding have risen year on year as awareness about different kinds of abuse has grown and in 2014-2015 there were over 4000 concluded investigations. Nationally, it is not clear whether or not this is the result of an increase in reporting or an upward trend in absolute terms.

All safeguarding alerts in Lancashire are directed via Lancashire's Customer Services Centre to the Multi Agency Safeguarding Hub (MASH).

Health services report serious incidents through the STEIS system (Strategic Executive Information System). NHS England local area team or the appropriate CCG ensure that the investigation into the incident is robust and that learning is disseminated via the Quality and Safety meeting.[16]

Since pressure ulcer development is a high area of risk across care home provider settings, during 2014 a CCG lead assumed responsibility for a multi-agency Skin Care Pathway group. This brought together expertise across Lancashire to develop a best practice guide to help practitioners determine when the development of a pressure ulcer becomes a safeguarding matter. The guide provides clear instruction and best practice examples of preventative approaches in reducing the risk of pressure ulcer development. The guide is expected to be launched in early in 2015.

The inappropriate administration of covert medication was also identified as a challenge in the county. A pilot, two page leaflet was launched to support services in understanding their roles and responsibilities. This has received very positive feedback from frontline services and primary care and it is hoped that it will be launched across Lancashire later this year.

In response to concern about the quality of some care homes in Lancashire, various initiatives are in train. These range from the creation of dedicated specific nursing teams to support care homes, to district nurses implementing ward round systems at homes to ensure that all residents are reviewed effectively.

The watermark running through feedback from referrers is "feedback." That is, the SAB has to engage with the concerns of referrers. Too often, referrers are not informed about outcomes, including the decision whether or not there is to be a safeguarding inquiry. This is unlikely to drive people's confidence in adult safeguarding/ protection.

Action for 2015-2016: ensure routine reporting and analysis of adult safeguarding data at each SAB meeting; and challenge agencies to describe their actions and learning in terms of providing referrers with feedback.

What frontline practitioners say…

Lancashire was involved in the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) project *Making Safeguarding Personal* (MSP) during 2013-2014. This explicitly supported moves towards a rebalancing of adult safeguarding in the direction of more personalised and outcomes-focused approaches. This was highly valued, not least because professionals immersed in the approach found that *it reconnects them with social work values and methods, and with skills in negotiation, working with risk, planning, recording, motivational interviewing and family conferencing, and emphases anew the importance of relationship-based practice* (Preston-Shoot and Cooper 2015[17]).

[16] Health Summary for LSAB annual report

[17] Preston-Shoot, M. and Cooper, A. (2015) Editorial – making safeguarding personal, *The Journal of Adult Protection, 17, 3,* 149-150

The Principal Social Worker recently delivered a presentation to the North Area Leadership Group about Making Safeguarding Personal and Senior Social Workers in safeguarding teams have delivered learning events for staff.

In addition, eight Advanced Practitioners in adult safeguarding carry out three audits of safeguarding practice each month. The resulting information is used with teams and individuals to highlight good practice and areas for development. The information is also shared with the safeguarding practice group to identify and consider themes that need to be addressed across the county, for example, older people's susceptibility to scamming.

Better reporting of abuse and neglect

The Safeguarding Practice Group (which includes Advanced Practitioners from Adult Social Care) meets regularly to address practice issues. Their recent work programme included (i) the development of a learning resource for the chairs of safeguarding meetings, (ii) work with the trainer delivering training events on safeguarding enquiries to ensure that the approach and materials draw from ongoing learning and experience. The group also considers how lessons from reviews and service user feedback may be incorporated into practice. It is currently working on practice in relation to providers and secure settings to ensure that staff carrying out such enquiries are confident, skilled and supported and that decision making is sound and defensible. The staff bulletin "Practice Matters" (February 2015) provided an example of the group's work concerning the TRI - X procedures with Pan Lancashire's and Cumbria's Safeguarding Adults Boards.

During 2014 the Pan Lancashire group met and updated the Tri-X procedures in line with the Care Act 2014. These were agreed by the Senior Management Teams and are now live on the web for ease of access. They include

- Blackburn with Darwen Safeguarding Adults
- Blackpool Safeguarding Adults
- Cumbria Safeguarding Adults
- Lancashire Safeguarding Adults

The Safeguarding Adult Tri-X Procedures are intended to support good practice and credible professional judgement, and to:

- Provide a coherent and consistent framework for recognising and taking action to prevent abuse of adults in need of safeguarding
- Recognise and promote the benefits of effective multi-agency working through dialogue and co-operation, to form a collaborative partnership between the agencies that have contact with adults in need of safeguarding
- Describe the common values, principles and law that underpin the protection of adults in need of safeguarding
- Define the different types of abuse, signs, symptoms and indicators

- Define the roles of each agency
- Ensure that information on allegations and incidents of abuse is collected, monitored and reviewed in order to inform future practice
- Complement other related policies, procedures and guidance.

Evidence of success of strategies to prevent abuse or neglect

Lancashire CC contributed to a pilot study which was commissioned by the Health and Social Care Information Centre (HSCIC). Information about adult safeguarding outcomes was gathered from 41 participating councils across England. Since previous safeguarding data collections have focused solely on activity, this exercise acknowledged the need to gather personal views and what are described as the 'softer' outcomes from adults at risk.

Participating authorities were asked to select cases to represent the mix of client groups spread across the categories of abuse. The 26 adults interviewed had been through a recent safeguarding investigation and they were asked for their views about the safeguarding process and outcomes in person to person interviews. (There was an option to interview a relative, friend, carer or Independent Mental Capacity Advocate (IMCA) and one relative and an IMCA contributed in a person to person and a telephone interview respectively. The interviewees were drawn from Central, North and East Lancashire. As a result, the views of 26 adults at risk (face to face), one relative (face to face) and one IMCA (telephone) were gathered.

Questions which were asked by professionals working within Active Intervention and Safeguarding, included, for example: *Do you feel that you are safer now because of the help from people dealing with your concern?* This is to form the basis of a new performance indicator in 2015/16 when it is planned that the survey will be a mandatory data collection for all local authorities. The survey could not be conducted by the investigating worker to remove any chance of bias, and to help vulnerable adults give honest and open feedback. Interviews took place in a 10 week period from early May 2014, and results have been anonymised and submitted to the HSCIC for analysis. A report containing overall survey results from all 41 authorities was published in November 2014 and is available on the HSCIC website.[18]

The majority of responses showed that people were either very happy or quite happy with how involved they had been in the safeguarding process, and how well they had been communicated with throughout the investigation. Since one person stated that they didn't feel safer as a result of the safeguarding process, a new safeguarding alert was raised by the interviewing officer. Most people expressed satisfaction at participating in the survey and appreciated the consideration given to their experience.

[18] http://www.hscic.gov.uk/media/15358/Developing-an-Adult-Safeguarding-Outcomes-Measure-for-Inclusion-in-the-Adult-Social-Care-Outcomes-Framework/pdf/Safeguarding_Outcomes_Measure_Pilot_report_final_v2.pdf (accessed 20 March 2015)

All councils reflected that although the exercise takes time and is resource intensive, it was worthwhile for the interviewees and for the councils in terms of understanding how to make the best use of limited resources.

The safeguarding adults' leadership group was created to provide operational leadership in embedding best practice in terms of agency responses and ensuring consistent and valued outcomes for adults. The membership includes key partners in health, the Police, the Care Quality Commission, Probation, Victim Support and the Lancashire Care Association.

The group facilitates Safeguarding Adult Local Network events on a quarterly basis around the Safeguarding Adults Board's long term priorities. Meetings with multi-agency professionals have been hosted in Lancashire East, Central and North. These have considered the requirements of the Care Act 2014 in respect of safeguarding and the principles informing the ways in which professionals across agencies should work with people.

During 2014, people's vulnerability to being *scammed* has led to some shared work with the county council's Trading Standards service. That is, adults known to have care and support needs have been identified by Trading Standards as potential victims.

Significantly however, during 2014 attendance at SALG has been variable and there have been discontinuities. This is the result of organisations being reconfigured with associated changes in roles and responsibilities.

Action for 2015-2016: considering ways of re-invigorating commitment to the work of the leadership groups – the goals of which are explicitly aligned to the SAB's priorities

Lancashire Care Association Ltd is a member body for independent sector providers (private and 3rd sector care homes and domiciliary care providers) and is a partner on, and jointly chairs, the Social Care Partnership (Lancashire CC, CQC, LDCPF, CCG and CSU colleagues) with LCC for adults and older people. This was established in 2005 as a strategic body for joint working between LCC and LCA and conduit to the hundreds of providers in the independent sector which delivers the bulk of the care the council commissions. The SCP Steering Group meetings are available online on the LCA and LCC websites. The Social Care Partnership (SCP) brief has extended from older people's services and social care to adults, including older people, and involves health and social care. There are local provider forums around the county which report to the SCP Steering Group . Safeguarding is a significant feature of this local authority-provider dialogue.

During April 2014 the joint LCC / CCGs/ LCA / LC hosted a 'Developing our Safeguarding with Adults Partnership' event which considered: a statement of principles, a guide for providers, a safeguarding adults' investigation report template, MASH recommendations and a process map.

The main LCA innovation for 2014 has been the setting up of the Registered Care Manager Network. This is a peer group support network for Registered Managers facilitated by LCA. The role of the Registered Manager in managing quality and safety in the care home setting and domiciliary care setting is crucial. They are also, in their leadership role, central to the setting of workplace culture. The LCA facilitated RCM Network is aimed at supporting and building up a peer group for RCMs.

Safeguarding and DoLS issues such as consistency, fairness and capacity, along with the general concerns around the level of monitoring across different agencies, have featured substantially in these meetings. The threat, to RCMs and system resources from mismanaging DoLS applications and safeguarding alerts is substantial. Building a better bridge between RCMs and local and health authority processes re Safeguarding and DoLS is a core part of this developing network.

Linking with other parts of the system

RADAR meetings[19] (RADAR: Receive, Advise, Develop, Act, Refer) are multi-agency meetings involving the Care Quality Commission, Lancashire County Council, Clinical Commissioning Groups and Commissioning Support Unit representatives. These meetings discuss the services where concerns have been raised. The meetings identify and record key areas where improvement is needed. This information feeds into the Safeguarding Adults Leadership Group and the Safeguarding Adults Learning and Development Group.

In the context of sustained austerity and rising demand for services, the SAB acknowledges the need to (i) work with other agencies and forums in Lancashire (ii) ensure that adult safeguarding is embedded into related strategies and to (iii) place a greater focus on primary prevention, that is, *working upstream* rather than dealing with the bleak consequences of abuse. This involves the commissioning and design of safe services, safe recruiting and customised training for example.

North, Central and East Lancashire commissioning teams have hosted provider forums supported by partners and guest speakers. These meeting have been attended by varying numbers of providers and have been used as a platform for information sharing, information gathering and promoting good practice.

Agencies have cooperated and collaborated with the Quality Improvement Planning process (QIP) and this has also been used to encourage individual providers to engage with the provider forums. Providers have worked collaboratively through contributing to the Safeguarding Adult Leadership Groups and the Lancashire County Providers' Practice Group.

The following tables capture the investment of all agencies in encouraging improvement by working across professional groups and organisations to develop support as well as improvement tools.

RADAR Meetings (held monthly/bi-monthly)

	North	**East**	**Central**
Residential/Nursing homes	35	44	33
Domiciliary providers	14	4	1
Acute providers	4	1	0
Total Number of providers discussed at RADAR	**53**	**49**	**34**

[19] RADAR's Terms of Reference are *to gather and collate data/ intelligence to provide an evidence base of themes, common issues and recommendations to share with the Safeguarding Leadership Group…future commissioning decisions…to refer serious concerns, multiple alerts to the QIP group*

Quality Improvement Planning Meetings (arranged as required)

	North	**East**	**Central**
Residential/Nursing Homes	7	10	12
Domiciliary Providers	0	1	0
Acute Providers	0	0	0
Concluded QIPS	4	8	9 (3 home closures within these figures)
Ongoing QIPS	3	3	1
Total number of QIPs	**7**	**11**	**12**

Provider Forums have also been seeking to facilitate shared learning:

North Forums are held on a quarterly basis and the average number of people attending was 29 per forum.

Key themes/guest speakers

Care Home Support Team	Liz Dalke, Shannon Skerratt and Jane Hornby
End of Life / 6 Steps	Vivienne Trott
Deprivation of Liberty Safeguards	Anita Lindon
Lancashire Care Association	Paul Simic
Empower Charity Advocacy	Julie Dalton
Dementia Friendly Communities	Diane Armstrong Age UK
Older & Out	Drew Dewing-Drake
Multi-Agency Safeguarding Hub (MASH)	Lisa Lloyd

East Forums are held on a quarterly basis and the average number of people attending was 18 people per forum.

Key themes/guest speakers

Infection Control Prevention Control	Kathleen Healy (Public Health)
Equipment Services	Sue Lord
Sexual Health	Donna Welch
End of Life/Six Steps	Jeanette Shepherd
Delayed Hospital Discharge	Andrea Isherwood
Activity in Care Homes	Pauline Johnston

Central Forums are held on a bi monthly basis and the average number of people attending was 20 per forum.

Key themes/guest speakers

Safeguarding updates	Terry Mears
Hydration Toolkit	Lesley Spall (LCFT)
Clear Perspectives	Louise Yates
Safety of Medicines in Care Homes	

The provider forums also include updates from Commissioning, Contracts and Care Navigation, and an opportunity for providers to raise issues.

In addition, across Lancashire, NHS England's Local Area Team (LAT) provides support for safeguarding and strategic direction for health services. The LAT, as part of its statutory duties, undertakes quarterly assurance reviews with all the Clinical Commissioning Groups (CCGs). These reviews focus on the performance of CCG in meeting their responsibilities. Effective safeguarding arrangements for adults forms part of the assurance process and there is regular scrutiny of governance within CCGs. The focus of these reviews is on what work is being undertaken and what the actual positive impact is for patients and service users. Also the LAT has set up a Health Safeguarding Advisory Forum. This forum helps to bring health partners from commissioning and provider organisations together and allows for discussion on national, regional and local issues.

Most recently NHS England has led Improvement programmes following the Lancashire Teaching Hospitals Foundation Trusts and Calderstones Foundation Trust CQC Inspections. Enhanced surveillance of local care providers e.g. General Practices, nursing homes via Quality Surveillance Groups are hosted by NHS England on a monthly basis. This approach has enabled the LAT to work in a preventative way with providers, as well as responding reactively, to reduce the risk of abuse from occurring.

The Collaborative Safeguarding Group was set up during 2014 to enable commissioners from across Lancashire come together to commission safeguarding services and ensure that service providers are clear about the expectation of commissioners. The group have also supported the development of contract quality standards and a joint assurance framework on which to base assessment of quality and safeguarding.

Health Trusts and the local authority have been worked together to improve safeguarding investigations (NB, after April 2015, these are referred to as safeguarding *enquiries*). This has included basing social workers on site to support complex investigations, and Lancashire County Council providing training and support around complex Mental Capacity Act 2005 and Court of Protection challenges. This investment acknowledges the critical need for specialist and ongoing training to ensure the legal literacy of practitioners.

The impact of training

During 2014, Lancashire Workforce Development Partnership[20] was commissioned to raise awareness about adult safeguarding across the county's workforce. A toolkit resulted from this

process which was designed and agreed by a sub-group of the SAB – the Provider Practice Group - to support individuals and businesses providing services[21] when safeguarding alerts are raised concerning commissioned services. It is acknowledged that it is appropriate for providers to make initial enquiries unless there are circumstances concerning the nature and extent of the abuse which would render this unfeasible.

Learning materials about safeguarding adults/ adult protection are available to the county's provider services on Lancashire County Council's website, for example:

- Statement of Principles (118 KB, Word Document)
- Recommendations of the investigator to the Multi Agency Safeguarding Team Template (130 KB, Word Document)
- Guide for Providers when Considering Safeguarding Concerns (124 KB, Word Document)
- MASH - LCC Adults Process Map (192 KB, Word Document)

Feedback indicates that a diverse range of learning and professional development opportunities are valued. Where these are clearly linked to a provider's strategic goals, tracked in learning logs and followed-up in supervision, for example, the greater the likelihood of learning being transferred into people's work settings.

The CCGs organised and funded free learning events about the Mental Capacity Act 2005. The events were for (i) care home providers (ii) social workers, nurses and allied health professionals and (iii) GPs, during October and November 2014. This was drama based, involving the AFTA thought theatre group. Feedback was consistently positive. Also, funding was secured to employ an MCA co-ordinator for Lancashire, with a primary focus of establishing networks, improving practice and standardising ways of working, for health and social care. The Lancashire MCA implementation group is currently developing a suite of quality indicator tools to enable care providers to demonstrate MCA compliance or alternatively formulate action plans to support MCA compliance and improve patient experience. These tools once finalised will be submitted to the Social Care Institute of Excellence repository to support best practice example tools. The group are also developing a media resource for MCA implementation which will be available across all services within the health and social care economy and to members of the public.

The multi-agency training group has undertaken to commission new safeguarding adults e-learning aligned with the Care Act 2014 safeguarding duties and philosophy. It is envisaged that this will be ready for all agencies to access during the Summer of 2015.

Although work on the impact of safeguarding learning opportunities is ongoing, the LWDP is exploring the alignment between what training claims should happen and what really happens. As a

[20] A company limited by guarantee and controlled by Lancashire County Council within the meaning of Part V of the Local Government and Housing Act (1989). It supports the independent care sector (as defined within the Lancashire County Council boundaries), by valuing and investing in the social care workforce to provide subsidised staff training and development opportunities, with the ultimate purpose of improving Social Care in Lancashire for service users.

[21] Providers include domiciliary agencies, supported living services, residential homes, nursing homes, acute hospital care and community health services

single component of practice improvement, the importance of follow-up is being built into training programmes.

A voluntary process for service providers which is aligned with learning and development opportunities is the Quality Improvement Planning (QIP). This involves partners working with residential and nursing homes and domiciliary agencies to support the development of Quality Improvement Plans. This has resulted in such tangible improvements in the provision of engaging activities and increasing the awareness of a provider's ways of preventing abuse or neglect for example. In some instances this has resulted in reductions to the numbers safeguarding alerts from particular providers, or an increase in reporting alerts due to a provider's enhanced understanding of the safeguarding process. In addition, focused working with safeguarding practitioners, infection prevention specialists, Lancashire County Council's contracts, the Care Quality Commission and the Commissioning Support Unit takes a detailed look at particular concerns and the risks posed. Possible outcomes from this process include action plans and specific offers of support to the provider.

Due to the increasing risk of vulnerable adults being targeted by radicalisation, NHS England has ensured that Prevent is a key component of safeguarding training for all health professionals. It is now a contractual requirement to deliver Prevent training, thus ensuring that vulnerable people who could be targeted by individuals intent on radicalisation are identified. Lancashire's hospitals have facilitators who are providing Prevent training to their staff. NHS England in collaboration with the CCGs are performance monitoring this element of work via contract meetings.

Training in Safeguarding Adults is a key indicator on all NHS Trust 'Dashboards' across Lancashire. There is a rolling programme focussing on both training new staff and refreshing and upskilling existing staff. Across health services we have a 91% rating of fully trained staff in safeguarding adults.

To support the training there has been some excellent best practice developed through the use of a champions' model to safeguarding adults and support Mental Capacity Act implementation. Some provider trusts have had this model well embedded for a number of years and this is recognised as an innovative approach to implementing safeguarding practice into service areas. All provider trusts across Lancashire are now working towards rolling this out across both acute and community services, with the practice well embedded in most services and aimed to be in all providers by the end of 2015. These models see staff with an interest in safeguarding and MCA implementation receiving additional training and support so that frontline staff are never far from a colleague who can support them with some of the challenges around safeguarding adults.

Finally, domestic abuse has been a key area of development with health agencies' engagement in the multi-agency work in developing services to embed NICE guidance in to all health services. Independent Domestic Violence Advocates are being piloted and domestic abuse has been included in training packages across health services.

Conclusions

This report glimpses an extensive programme of work with a view to keeping Lancashire's adult citizens safe or responding effectively when adults are harmed. The twin challenges facing all services are real terms budget reductions and rising demand and these are impacting on adult safeguarding/ protection. The SAB is ambitious. For example, digital technology offers new opportunities to maximise awareness of and engagement with our work to maximise its impact – while maintaining use of a wide range of other forms of communication. The SAB continues to respond to the challenge of maintaining or improving service delivery and is exploring ways of adjusting to doing more with less and working *harder as well as smarter.*