



**Lancashire's Safeguarding Adults Board  
Annual Report 2015-2016**

DRAFT

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## Chair's Foreword

For the last eight years the Lancashire Adult Safeguarding Board has been chaired by Margaret Flynn and our gratitude is due to her for the work she has done in highlighting Adult Safeguarding as worthy of high priority and in championing the needs of vulnerable people. She has worked hard to establish the Board as an independent body and saw it through transition onto a statutory footing.

It falls to me as the current Chair of the Board to present this report which covers the last year of Margaret's tenure and I can take no credit for the work that has been done. The report reflects a range of activity designed to ensure that vulnerable people are as safe as they can be in Lancashire and I want to thank all those who have played a part in this.

The required contents of the Adult Safeguarding Board Annual Report are set out in government guidance and the report must set out how the Board is monitoring progress against its policies and intentions to deliver its strategic plan. We have also sought to explore what we now know about the vulnerabilities of people in Lancashire and how well-placed services are to respond to them.

Safeguarding vulnerable adults is a challenging agenda and will become ever more so as the impact of reduced budgets for public services continue to increase. We are given to understand that spending on public services will reduce by around £800 million and it would be naïve to assume this will not impact on services for the most vulnerable. One of the tasks of the Board will be to challenge agencies about service re-design to ensure the impact on those in need of safeguarding is mitigated as far as is possible.

A positive development during 2015-16 has been the development of a single business unit to support the work of both the Adult and Children safeguarding Board. This will enable us to work more closely together and approach safeguarding on a "whole family" basis. We have already agreed some joint work programmes and will undoubtedly discover more opportunities to enrich our work and make it more effective by working together.

Jane Booth

Independent Chair

Lancashire Adult Safeguarding Board.

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### Context – The Care Act and Adult Safeguarding

Care Act legislation became statutory on 1st April 2015.

The Government has set out six principles to underpin all work when safeguarding adults:

- Empowerment – taking a person-centred approach, whereby users feel involved and informed.
- Protection – delivering support to victims to allow them to take action.
- Prevention – responding quickly to suspected cases.
- Proportionality – ensuring outcomes are appropriate for the individual.
- Partnership – information is shared appropriately and the individual is involved.
- Accountability – all agencies have a clear role.

Safeguarding is described as protecting adults from abuse and neglect. The Care Act is a response to the recognition that the law and practice around this issue had become increasingly complex. The Care Act has made the following changes in regard to safeguarding adults:

- Safeguarding Adults Boards are now statutory;
- The Board must have an independent chair;
- The statutory members are the Local Authority, the Police and the CCG.
- The board is required to have a safeguarding plan and to publish annual reports detailing what it has done during the year to achieve its main objectives and implement the strategic plan; and
- The Board in specified circumstances the Board must Safeguarding Adult Reviews (SAR) and subsequent actions and these must be published.

As a result the Lancashire Safeguarding Adults Board is on a journey – the previous arrangements resulted in the Local Authority leading the work of the Board and the Board's independent identity, and indeed its role in championing safeguarding and challenging poor practice was often confused with the role of the statutory agencies. The statutory footing and independent status of the Board is now clear and paves the way for future developments.

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### The local context - what do we know about vulnerable adults in Lancashire<sup>1</sup>

- There are an estimated 1.18 million people in Lancashire of whom more than 80,000 are adults;
- The population of those aged over 65 is predicted to increase from around 10,000 recorded in 2010 to 32,000 by 2037;
- There are wide variations in levels of income, wealth and health across the county;
- The population is served by over 250 GP practices and five key NHS trusts;
- People receive support from a single police constabulary and fire and rescue service;
- Life expectancy has been increasing but there is a gap between those living in the most deprived areas and those in the more affluent areas;
- On average women will spend 19.7 years at the end of their lives in not so good health and the figure for men is 17.2 years (set against a lower level of life expectancy).

The data below relates to safeguarding enquiries or concerns:

	Age 18-64	Age 65-74	Age 75-84	Age 85 - 94	95+	Not known
Safeguarding concerns	1936	823	1563	1773	274	2
Safeguarding enquiries under Section 42	494	220	439	570	82	0
Other safeguarding enquiries	223	95	191	188	30	1

Note: Section 42 is the statutory response to an allegation of abuse or neglect.

The gender balance in respect of the above is female dominated which reflects the higher longevity rates of women.

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<sup>1</sup> Report of the Director of Public Health - 2016

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### **The remainder of this report is presented on behalf of the previous Chair:**

2015-16 has been an interesting and busy year for Lancashire's Safeguarding Adults Board and consequent on the implementation of the Care Act 2014, this report is set out as required by the *Care and Support Statutory Guidance* (March 2016).

The Guidance headlines concerning safeguarding are:

- adult safeguarding;
- abuse and neglect, understanding what they are and spotting the signs;
- reporting and responding to abuse and neglect;
- carers and adult safeguarding;
- adult safeguarding procedures;
- local authorities' role and multi-agency working;
- criminal offences and adult safeguarding;
- safeguarding enquiries;
- safeguarding adults board;
- safeguarding adults reviews;
- information sharing, confidentiality and record keeping; and
- roles, responsibilities and training in local authorities, the NHS and other agencies.

The Guidance also proposes somewhat muted expectations concerning self-neglect. The earlier Guidance (of October 2014) acknowledged the fact that self-neglect had been inconsistently addressed by safeguarding adults boards and mental health services throughout England.

Maintaining confidence in how the Safeguarding Adults Board goes about its work matters a great deal. Lancashire is a large county with a population of almost 1.5m, 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, with a single safeguarding lead representing two CCGs on the Board. There are 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. The Care Act 2014 states that the principal responsibility for creating local arrangements for adult protection/safeguarding adults resides with local authorities in partnership with the NHS and the police.

Abuse comes in many guises and the forms of harm and distress that people experience may overlap with criminal acts, with some people requiring medical attention. The Safeguarding Adults Board knows that typically, safeguarding/adult protection professionals across sectors have to deal with incomplete information – perhaps because a person does not have the capacity and/or is too traumatised to recall what has happened; or too loyal to a relative who is physically assaulting them; or too embarrassed and humiliated to tell someone. There are also services and agencies which deny and evade accountability since they do not want to be exposed

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to prosecution. Their services may be poor, ineffective or abusive but it is unlikely that they set out to be so.

This report includes some real, and some anonymised, “case studies” which have affected the thinking and practice of safeguarding/ adult protection practitioners in Lancashire. They highlight the complexity of the tasks facing practitioners, the settings in which abuse occurs and the challenges of identifying preventive measures.

The expectation of Lancashire’s Safeguarding Adults Board during its transition to becoming a statutory body in April 2015 was that all members of the Board, its networks, associated groups and partners would contribute fully to adult safeguarding priorities and activities within the county. This expectation has been broadly realised – even though the recession, sustained austerity and a contracting economy are the stark backdrop. Councils have been cut harder than the rest of the public sector and Lancashire County Council has had to make extensive “efficiency savings” by re-thinking the structure of its public services and management. Major organisational changes across all sectors have witnessed both management and staffing reductions which have impacted on safeguarding/ adult protection as key professionals have left. Necessarily this has impacted on the membership of the Board, on attendance and on the structures connected to the Board, for example its sub-groups (see Appendix 1).

There were some significant currents and eddies during 2015-16: neither the prison nor probation service was represented at Board meetings, irrespective of previous membership/contributions; the Multi-Agency Safeguarding Hub (MASH)<sup>2</sup> got into difficulties when a “backlog” emerged and it ceased to be multi-agency; Tri-X, the organisation which hosts Lancashire’s “bespoke” safeguarding policy and procedures (with Blackburn with Darwen and Cumbria) now requires the considerable input of practitioners from these authorities to ensure they are updated and the Safeguarding with Providers Group has described accessing the procedures as “problematic;” it is increasingly difficult for commissioners to be “smart buyers” where competition is elusive; the flourishing of collaborative arrangements has resulted in parallel deliberations concerning adult safeguarding/protection; the unfamiliar discipline of a new (to adult safeguarding) focused administrative team requiring timely contributions from Board members has exposed weaknesses, most particularly in distinguishing processes from outcomes; domestic violence and Domestic Homicide Reviews are increasingly being brought to the attention of adult safeguarding; and extensive coverage of the carnage resulting from acts of terrorism and the government’s flagship anti-radicalisation strategy, Prevent,<sup>3</sup> are impacting on Muslim communities in Lancashire and elsewhere.

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<sup>2</sup> A single point of contact for professionals to report safeguarding concerns

<sup>3</sup> Preventing vulnerable people from being drawn into terrorism

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During December 2015, the Independent Chair stood down after eight years in the post. She chaired the January 2016 safeguarding board meeting and requested sight of the minutes of the March 2016 board meeting in order to write this report.

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**Case Study 1** concerns Alice and Bernard, an elderly couple. Both are living with dementia. When support staff noticed that Alice had a lot of bruises which neither Alice nor Bernard could explain, it was suspected that her mobility had become so compromised that she was falling. In spite of input from Occupational Therapy there was continuing concern about Alice's unexplained bruises. Eventually an application was made to the Court of Protection and a residential placement was identified for Alice. Once there, it was discovered that her body was covered in bruises which were consistent with multiple physical assaults. Options for her future remain under consideration and enquiries about the couple's history continue.

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### Our Priorities

The safeguarding/adult protection of Lancashire's citizens is a high priority in care planning, commissioning and delivering services. Abusive and harmful acts may happen once or repeatedly in services that are regularly inspected as well as in our own homes. Since Lancashire's SAB is responsible for steering adult protection/safeguarding activity across the county 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

History confirms that without a constantly renewed sense of purpose and direction, things fall apart. History confirms also that a transformed landscape of dispersed responsibility and accountability within a reducing public sector changes the nature of relationships and creates uncertainty. Adult

safeguarding/protection cannot address some of the fallout arising from changes to the public sector including the changes in public policy. For example, at a Pan Lancashire level – with safeguarding practitioners in Blackburn and Cumbria, and nationally with Safeguarding Adult Board Chairs – attention was focused on the role of the Designated Safeguarding Adults Manager, which the Department of Health abandoned during May 2015. Similarly, work was progressed with Lancashire Fire and Rescue concerning people who self-neglect and hoard and yet this group of citizens have been demoted in terms of the expectations of safeguarding practitioners in the revised Department of Health Guidance.



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Lancashire Care Association has been tenacious in alerting the Board to the challenges its members face, for example, being overwhelmed by the information requirements of Local Authority contract monitoring, Clinical Commissioning Groups' contract monitoring, the Care Quality Commission's inspections, adult safeguarding and Healthwatch Lancashire. There has been modest progress in terms of facilitating a mechanism for doing this. Although the shortage of nurses and Registered Care Managers within the residential and nursing care sector is a long-standing concern (not least because it is a factor associated with failing homes), attention to this is out with the scope of adult safeguarding and the contracted provider sector. Similarly, although older people developing avoidable pressure ulcers has been a consistent concern in Lancashire, there are not enough Tissue Viability Specialist Nurses, thus rendering some homes without any assistance.

In the light of home closures and homes subject to safeguarding attention a helpful rule of thumb during 2015-16 has been to ask the question: will scrutiny of the circumstances in this particular home add to the learning arising from the *Learning Review of Incidents of Significant Harm*? This was published during 2014 and it concerned the harmful behaviour of staff towards older people with dementia at Hillcroft Nursing Home in Slyne with Hest. Similarly, the review of homes in south east Wales investigated as Operation Jasmine<sup>4</sup> has been an illuminating backdrop to the work of the Quality and Improvement Planning (QIP) practitioners.

There are thriving networks in the county. For example, Lancashire Care Association is engaging with NHS England, Clinical Commissioning Groups and Commissioning Support Units, with the Home Improvement Group and with the RADAR<sup>5</sup> and the Quality Improvement Planning (QIP) processes, and yet, in the absence of a functional market (that is, one that is not just set up to compete on price) there are endemic dangers as Kennedy (2014)<sup>6</sup> noted: *If a care home is under financial pressure, there is a significant danger that corners will be cut and quality reduced...the opportunity cost of an impoverished care sector is huge for the NHS and the economy...The market is one that we have created but it doesn't work. The market should be managed to create what we want – good, viable care homes in the right places...care homes with the skills and capacity to support our ageing communities and our NHS.* At the close of 2015, the Safeguarding Adults Board was challenged by the LCA: *“When does underfunding, particularly informed underfunding, become a safeguarding issue?”*

Finally, people who lack the mental capacity to attend to their needs are among the most vulnerable in our communities. Crucially, their rights may be infringed by the nature of the health or social care with which they are provided. If this amounts to a

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<sup>4</sup> <http://gov.wales/topics/health/publications/socialcare/reports/accountability/?lang=en>

<sup>5</sup> Receive, Advise, Develop, Act, Refer

<sup>6</sup> Kennedy, J. (2014) *John Kennedy's Care Home Inquiry* York: Joseph Rowntree Foundation and Joseph Rowntree Housing Trust

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deprivation of liberty in breach of Article 5 of the European Convention on Human Rights, then there are safeguards for their protection. However, the safeguarding provisions are the subject of complex primary and subordinate legislation and interpretation by senior courts. In consequence, these provisions place onerous responsibilities on local authorities, social workers, home managers, hospitals and doctors. The complexities of the law, emergent case law and practice led to the creation of a new Pan Lancashire group which is a 2016 addition to the Board's sub-groups.

### Delivering our priorities

The Safeguarding Adults Board provides assurance on the governance of safeguarding activities. It does not provide governance for all organisations and businesses working to deliver adult safeguarding. Each organisation is accountable for its own activities, including reporting, most particularly with regard to matters of risk. The Safeguarding Adults Board is not 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, the requirements of regulation and the expectations of the Board.

### Evidence of community awareness of adult abuse and neglect and how to respond

**Adult Social Care** disseminates information to commissioned services and agencies supporting adults who may be "at risk," including learning disability forums, carers' groups and housing providers for example. The Leadership Groups involve Victims' Voice, Trading Standards, Citizens Advice and members of Community Safety Partnerships. The existence of such groups acknowledges the interest of individual professionals and agencies keen to contribute to adult safeguarding and learn about emergent concerns and practice.

The **CCGs** engage in "Quality walk arounds" in NHS services. These are occasions for CCG personnel to witness and discuss patients' experience and ensure that the mechanisms for raising concerns are known. **NHS Choices** is monitored by each CCG to identify local concerns which are raised by the local community which could indicate potential safeguarding referrals.

**Lancashire Police** proactively engages with partners at all levels with the aim of preventing crime, developing and enhancing confidence within communities, identifying and reporting adult safeguarding matters and preventing and detecting crime by bringing perpetrators to justice.

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**Case Study 3** - at University Hospitals Morecambe Bay NHS Trust the Named Nurse facilitates a full day work shop for all of the Trust's registered professionals. This reflects the implementation of the Care Act, 2014, changes within the MCA/DoLS case law, raising awareness of services and resources available locally for individuals with a diagnosed learning disability. The workshop also incorporates the PREVENT training, raising the awareness of vulnerable adults susceptible for radicalisation. The session aims also to embed into all areas within the Trust that "Safeguarding is Everybody's Business." As of January 2016, 74% of staff have attended Level 2 Safeguarding Adults Workshop training. As a direct reflection of the impact of the training, there has been an increase in the number of reported Patient Safety Incidents, and referrals into the Local Authority where abuse or neglect has been identified. Also, the Trust has seen a significant rise in the number of Deprivation of Liberty Safeguard applications.

Vulnerable Adult training is provided 'in house' and is supported by multi-agency partners.

To support the commitment to protect vulnerable citizens, Lancashire Police's Engagement and Media Units work alongside the Public Protection Units to promote initiatives such as "*In the Know*,"<sup>7</sup> which is a free messaging system where the public can be informed about coastline crime, rural crime and neighbourhood watch news, for example.

During 2015, a pilot 'Banking Protocol' was set up in Preston City Centre. This involved the Police, Trading Standards and Age UK Lancashire to train bank counter staff. The training included the raising of awareness around coercion and deception, and in particular the pressure placed on vulnerable individuals to release their monies for the unlawful gain of others. This pilot has been a real success and is now set to be rolled out across Lancashire. The benefits include the police receiving direct calls from banks regarding suspicious activities and concern about specific customers. This has not only safeguarded individuals but it has also raised confidence with other bank customers and staff.

Dedicated Single Points of Contact (SPoC) are assigned to investigation areas such as Missing from Home, Human Trafficking and Sex Workers. All these areas are connected to the people who are at an increased risk of becoming victims of crime. These Single Points of Contact work with external partners to raise community awareness of potential risks.

**Lancashire Care Association** as a member body is contributing as a partner to safeguarding activities; as the joint Chair of the Health and Social Care Partnership; and via membership of the 'Care Home Quality Assurance and Improvement Board.' Also, the LCA is seeking to help providers at crisis point by working with the QIP process to (a) identify 3rd party expertise from the independent sector (b) help QIP health and LA staff and (c) help the provider.

### **Analysis of safeguarding data to better understand the reasons that lie behind local data returns and use the information to improve the strategic plan and operational arrangements**

<sup>7</sup> <http://www.lancashire.police.uk/help-advice/in-the-know.aspx> (accessed 12 January 2016)

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Between January 2015 and 29 February 2016, there were 9,879 referrals to the MASH – an average of 705 a month. Of these, 3,377 proceeded to a safeguarding enquiry, that is, it was determined that 6,502 did not merit a safeguarding enquiry and individuals were directed elsewhere. Scrutiny of the figures concerning residential care shows that physical assaults (“service user on service user”) and neglectful care are exercising care homes and their commissioners, after which, the management of medicines in care homes is an enduring theme. Associated proactive and responsive work includes the development of safer professional practice in working with medicines and the development of a sample safeguarding policy for care homes.

Since the introduction of the MASH, low level safeguarding alerts have been managed through a risk management and prioritising process. Lancashire has been keen *not* to develop and promote “threshold criteria” because safeguarding practitioners want people to get in touch about their concerns irrespective of the apparent seriousness. This has enabled the local authority to be proactive and consider such avenues as the Quality Improvement Planning process. However, the following table confirms that a review is overdue.

**Table 1: Mash backlog data**

29.5.2015	423	02.6.2015	469
19.6.2015	435	10.7.2015	383
17.7.2015	439	31.7.2015	439
7.8.2015	444	28.8.2015	480
11.9.2015	469	9.10.2015	496
16.10.2015	477	2.11.2015	516
6.11.2015	554	15.11.2015	549
20.11.2015	546	27.11.2015	541
4.12.2015	528	11.12.2015	523
23.12.2015	461	15.1.2016	483
29.1.2016	493	05.02.2016	476
13/2/2016	473		

Care and nursing home provision in Lancashire has received a lot of negative media coverage as a result of poor practices and home closures. **NHS England**, the **Clinical Commissioning Groups**, **adult social care** and **Public Health** developed a programme of work around “benchmarking quality” and providing support to nurses in the sector.

All **CCGs** hold assurance meetings with their providers to discuss the local themes and data from safeguarding concerns.

All providers are required to report on their safeguarding data which is scrutinised and challenged by CCGs. This is fed in to **NHS England** systems to review and

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**Case study 4** –during 2015 a social worker made 30 safeguarding alerts about a single home on the basis of one visit. These included residents being locked in their rooms and staff sleeping when they should have been working. So serious were the concerns that the transfer of residents was considered by social care, the CQC, the police and the CCG. A QIP meeting set out the improvements required and identified the professionals willing to support these. Within four months, improvements were confirmed:

*“There’s a different feel to it”*

*“They’re more co-operative and proactive”*

*“They’re receptive to help and support.”*

The suspension of places was lifted and a valued nursing and residential home was retained in the County.

monitor across the County. This information is shared with service commissioners to support redesign and re-commissioning of services to meet patients’ needs more safely.

The **Lancashire Care Foundation Trust** shared a Serious Incident Board report during December 2015. This states that *“Lancashire is identified as the highest geographical area for suicide in the National Confidential Inquiry into Suicide and Homicide”* with 68 suicides occurring between April 2014 and September 2015.

Data has a key role in the planning and resourcing of **policing teams**. Police analysts pay particular attention to such data as: the number of recorded crimes; ages and gender of victims and offenders; the location of crimes; and the associated factors, for example – drugs and alcohol; the rates of crime over designated timeframes which highlight emerging trends and issues; the victim/offender relationship; and protecting vulnerable people (PVP) submissions via the Multi-Agency Safeguarding Hub (MASH). Such data enable targeted policing to focus resources where they are most needed, with the potential to predict crime patterns.

One of the recent adaptations to the Vulnerable Adult risk is the utilisation of an Adult Care Environment (ACE) tag. This is employed by the initial call taker, who ‘flags’ incidents that involve Adult Care Establishments for example. This searchable feature provides data to allow the identification of potential *‘resource intensive locations’* which may indicate criminal issues through to internal staffing /management concerns. This data permits pro-active intervention in the identified establishments.

### **What adults who have experienced the process say and the extent to which the outcomes they wanted (their wishes) have been realised**

Lancashire has not developed a consistent means of capturing the experience of adults known to safeguarding practitioners. Although it is encouraging that mini case studies are shared at Board meetings, at RADAR discussions and those identified during the Quality Improvement Planning process – including the part played by families, advocates and services supporting them – safeguarding practitioners have yet to identify a consistent means of bringing people’s experience to life. It is understood that those most at risk of abuse are likely to be the least able to speak for themselves. Similarly, the limited articulacy of people with learning disabilities or

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neurological impairments means that they may have difficulties in making themselves understood, and it is through the discussion of case studies that the Board is aware of such impacts as sleep problems, self-harm, aggression, reliving the experience and exaggerated “startle” responses, for example. Although case study examples and accounts of people’s behaviour are helpful in terms of illustrating particular points, evidence remains to be gathered systematically.

**Lancashire Police** has received feedback from individuals who have used the Sexual Assault Forensic Examination (SAFE) Centre at Royal Preston Hospital. Typically these people have been the victims of serious sexual crimes. Each month their feedback is received and reviewed. Most of the feedback is positive and it has been constructive in identifying areas for learning and development:

*“Excellent Service that took my feelings and emotions into consideration”*

*“They were really comforting and explained everything really well”*

During January 2016 the Home Secretary made it mandatory for all forces to collate data concerning domestic abuse victim ‘experiences’ as part of the annual data returns commencing. Lancashire Constabulary has a dedicated survey team which is working with and on behalf of domestic abuse victims.

Ongoing Care Quality Commission concerns regarding Calderstones<sup>8</sup> Foundation Trusts’ quality of care resulted in “enhanced surveillance” by NHS England. Extended contact with adults with learning disabilities and their relatives during 2014 (following a visit by the Department of Health) had identified concerns about safeguarding practice and people’s health care. This resulted in a social worker being located there for four weeks, a programme of visits by NHS England, Clinical Commissioning Groups and Healthwatch Lancashire. Since so few people had discharge plans, the aim of contact with Calderstones was “*to put in as much effort as needed*” in the light of prospective in-patient bed closures. This included the reduction of “*unnecessary admissions.*”

The “*Making Safeguarding Personal*” agenda is still in its infancy across **Lancashire’s health services**. There is work planned to begin addressing how to capture people’s views when alerts are being made on their behalf. Feedback to referrers remains inconsistent.

### **What front line practitioners say about outcomes for adults and about their ability to work in a personalised way with those adults**

**Adult social care** staff are conscious that “*making safeguarding personal*” and helping to turn a deteriorating situation around takes time. These important tasks may be compromised by the volume of safeguarding activity. Many practitioners report

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<sup>8</sup> Calderstones is the only specialist learning disability trust in England

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frustration that they cannot invest more time with individuals. There is concern that the focus on care home providers during 2015-16 means that NHS providers are “*under the radar*.” Also, their internal reporting is inconsistently shared with the Safeguarding Adults Board.

**NHS staff** state that they often feel disconnected from the safeguarding enquiry process. They report that on occasion they are asked to work beyond their skill set and role, whilst at other times their clinical skills and expertise are not fully utilised.

**Lancashire Police** acknowledges that although the parallel referral pathways are well used (for example concerning domestic violence and adult safeguarding/protection) modifications are required, since clarity of process is important for all safeguarding practitioners, as well as recognition of the limits and reach of each agency. The MASH has enabled knowledge, information and skills sharing and an understanding of respective roles. However, a review is merited.

**Lancashire Care Association**, through the Registered Care Managers, is attempting to ‘map’ the various groups that Registered Care Managers are involved with that are directly associated with or overlap with Safeguarding. From these meetings the LCA has learned of lots of groups with changing titles and uncertain function. Also, the LCA is concerned that the act of suspending placements in care homes means that independent sector providers are prevented from taking local authority funded and CCG funded residents. This compromises business viability and the LCA would like the suspension process to be reviewed. The LCA would favour some independent scrutiny of the information held and shared in RADAR meetings because the use of ‘grey’ information needs safeguards for those who are the subjects of discussions. While there will always be a need for discussions ‘in camera’ – as for example when there is a clear situation of safety for a care user, the response to which would be compromised if a provider were in the know - there nonetheless need to be the proper checks and balances to ensure that what happens is the exchange of necessary ‘intelligence,’ not gossip and prejudice.

### **Better reporting of abuse and neglect**

In order to achieve consistency in raising concerns about tissue viability and the prevention of pressure ulcers, **health** members of the Safeguarding Adults Board developed “*best practice guidance*.” Although 10% of pressure ulcers are unavoidable, some homes have struggled to deal with residents’ painful ulcers in the absence of Tissue Viability nurses.

The **CCGs** provide strategic leadership as a statutory partner of the SAB and as with all other NHS bodies have a duty to ensure that it makes arrangements to safeguard and promote the welfare of adults at risk of abuse. The CCGs monitor commissioned services including independent providers, voluntary, community and faith sector (VCFS), against clear service standards to ensure that all service users are protected

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from abuse and the risk of abuse. The CCGs are committed to achieve effective joint working with constructive relationships at all levels, promoted and supported by:

- Clear lines of accountability within the CCG for safeguarding
- Service developments which take account of the need to safeguard all service users, and informed, where appropriate, by the views of service users
- Staff training and continuing professional development so that staff have an understanding of their roles and responsibilities in regard to safeguarding adults at risk, implementation of the Mental Capacity Act and implementation of the Prevent agenda
- Appropriate supervision and support for staff in relation to safeguarding practice
- Safe working practices including recruitment and vetting procedures
- Effective interagency working, including effective information sharing.

**NHS England** has been working closely with GPs and Primary Care around their own compliance and has devised and implemented a system to secure safeguarding assurance through e-declarations around competency and understanding.

**Lancashire Police** has completed safeguarding CPD days (Child Sexual Exploitation/Domestic Abuse/ Female Genital Mutilation/Honour Based Violence/Adults at Risk) in 2015 and have scheduled further events concerning Coercive Control for 2016.

During January – February 2016, two Rape Workshops were held, that provided valuable guidance on the revised requirements for file submission to CPS. The delivery of WRAP training (Workshop to Raise Awareness of Prevent) to police staff in MASH has been completed and 'Adult at Risk' training is currently being developed.

Human Trafficking Training has also been provided to all Contact Management, and Public Enquiry Assistants and the SPOCs have delivered training to front line staff. In addition the Police and Crime Commissioner's office is committed to supporting this area of work and has funded a series of external training sessions to both Police and the multi-agency workforce.

**Lancashire Care Association** is exploring how to work jointly, in preventative mode, to identify and help providers who are 'at risk' pre QIP.

### **Evidence of success of strategies to prevent abuse or neglect**

The **Safeguarding Adults Board** discussed and shared briefings concerning modern slavery, domestic violence, forced marriage and self-neglect since these featured in the Guidance as being within the purview of adult safeguarding/ protection. These materials were shared with partner agencies, including the Lancashire Action Against Domestic Abuse.



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The **CCGs** have also been key partners in the development of the quality improvement process to support care providers in the improvement of quality and safety in care home settings. This has included providing significant support for failing care homes and service providers by NHS staff. Provision of additional wrap around services to support failing providers has been integral to being able to keep some services safe and functioning whilst they are closing down; alternatively it has also been instrumental in supporting providers to recover and prevent the need for closure.

The **police's** Quality and Compliance Managers are responsible for ensuring all Public Protection policies are accessible and understood by staff. Three managers have responsibility for (1) child protection/ child sexual exploitation/Missing From Home; (2) domestic abuse/honour based violence/female genital mutilation/vulnerable adult; and (3) rape/human trafficking /sex work/adults at risk

Lancashire Constabulary supports the National 'Ugly Mugs' scheme. This is the proactive sharing of intelligence that relates to violence against sex workers. The SPOCs and Intelligence Units work with partner support agencies to ensure that this information is circulated to safeguard sex workers whilst raising awareness both in the Constabulary and out in the wider area.

Claire's Law gives members of the public a '*right to ask*' police where they have a concern that their partner may pose a risk to them or where they are concerned that the partner of a family member or a friend may pose a risk. Police and partner agencies will carry out checks and if they show that a partner has a record of abusive offences, or where there is other information to indicate that there may be a risk, the police will consider sharing this information.

Domestic Violence Protection Notices/Orders will be issued in circumstances where no enforceable restrictions can be placed upon a perpetrator. The principal aim of the process is to provide some respite and allow agencies to safely engage and work with the victim.

### **Feedback from Healthwatch Lancashire, adults who use care and support services and carers, community groups, advocates, service providers and other partners**

Healthwatch Lancashire submits written information to each Safeguarding Adults Board meeting including its work programmes concerning learning and development activities, public involvement and evidence of ensuring effectiveness. It embeds within its recruitment practices of staff, volunteers and Board the principles of safeguarding. Also, its Work Plan is focused on staff and volunteers obtaining feedback of service users, carers and relatives about health and adult social care services across Lancashire.

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Drawing from:

- Community engagement - in health, social care and community settings
- Patient Engagement Days – including surveys in healthcare settings
- Care circles – forms of group work
- Mystery shopping
- Campaigns
- Patients' Stories
- Membership of patient voice groups and strategic quality performance committees
- Working with health and social care providers to offer a 'lay person' perspective at events such as: Mock Inspections, quality improvement activities and events, and annual Patient Led Assessment of the Care Environment (PLACE)

With its statutory powers of Enter and View, Healthwatch Lancashire obtains first hand feedback about the experiences of people using health and adult social care services. The feedback is presented in a report form, initially presented to the service provider for consideration and comment prior to publication and sharing with relevant stakeholders. Every month Healthwatch Lancashire provides an update to RADAR on the visits and ratings of its Enter and View visits to care homes across Lancashire.

### **How successful adult safeguarding is at linking with other parts of the system, for example children's safeguarding, domestic violence, community safety**

**Adult social care** has operational links with children's safeguarding and e-learning packages are shared between the services, not least because honour based violence, forced marriage and domestic abuse occur over the life course. There are joint learning opportunities. Collaboration with the Community Safety Partnerships is a critical means of developing problem-based learning.

**Lancashire Police:** Adult Safeguarding Leads and Adult Social Care staff are key members of the MARAC steering group. The Multi-Agency Risk Assessment Conference (MARAC)<sup>9</sup> protocol now includes Adult Safeguarding and wider links to other support services. The Review of MASH during 2016 will seek to improve safeguarding, processes and outcomes for those who are vulnerable.

Membership of Lancashire's Safeguarding Adults Board was extended to include the Children's Head of Safeguarding, Inspection and Audit.

### **The impact of training carried out in this area and analysis of future need**

**Adult social care** receives broadly positive feedback concerning its learning events and e-packages. Similarly, its "learning circles" for staff are valued opportunities for

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<sup>9</sup> Meetings about the high risk domestic abuse cases involving the police, health, child protection and housing practitioners for example

## Appendix A

discussing risk assessments and management, individual and home/ward level safeguarding outcomes and ways of averting potential safeguarding issues. Five learning and development priority areas have been identified during 2015-16: statutory responsibilities consequent on the MCA 2005 and the Care Act 2014; safeguarding in residential homes; safeguarding adult reviews; and the safeguarding challenges arising from preventing radicalisation and modern slavery, for example.

**NHS England** funded a Female Genital Mutilation Conference; various Child Sexual Exploitation events; the provision of Court of Protection skills and mock court skills training for safeguarding practitioners; a GP safeguarding toolkit; MCA/DoLS training via e-learning package; MCA/DoLS training for community based staff delivered by Afta-Thought (a theatre group); and MCA/ DoLS training for GPs delivered by a local barrister.

**CCGs** have been working with **NHS England** and with **Lancashire CC** in delivering these events and where needed, hosting them.

Prevent training has been significantly invested in across all health services, and the North West continues to be seen as a hub of good practice. Due to Burnley being considered a priority area, the local health provider, with the CCG, has made the decision to make WRAP training mandatory for all staff. This significant investment is showing a much greater awareness and knowledge.

CCGs are key stakeholders in the RADAR process across Lancashire. This ensures that there is health information being provided around early warning signs of failing services. This early intervention supports quality improvement and the prevention of further harm.

NHS England and the CCGs are all heavily involved in media use to share messages of safeguarding and best practice. Recently NHS England produced pocket books on the Care Act and one on Safeguarding Adults which are being distributed through the CCGs to providers and communities. These highlight responsibilities and give clear guidance on what to do when people are concerned around potential safeguarding alerts.

Also, the Safeguarding Adults Board is developing “Seven Minute Briefings” to which the CCGs are key contributors. These are addressing topics such as Prevent, the MCA, safer recruitment, the use of agency staff and fire prevention (see Appendix 2). They are distributed through health and social care services and providers and are displayed in patient areas to help spread awareness of safeguarding adults.

### **How well agencies are cooperating and collaborating**

There is encouraging evidence of the willingness of all parties to explore the phenomena of abuse and harm from the perspectives of victims and those

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responsible for the harm; to understand why it is under-reported; to understand contexts; and to be cautious about “explaining” it as a result of the onset of dementia for example.

Through a collaborative approach, the **CCGs** and the **Local Authority** have launched a Safeguarding Adults and Mental Capacity Act (MCA) champion model across the care home sector. This has been a significant development with ‘sign up’ from partner agencies to share best practice.

The champion’s model approach seeks to strengthen safeguarding and MCA arrangements and has the capacity to improve practitioner confidence and competence in supporting adults at risk and in understanding their safeguarding responsibilities.

There has been a significant programme of work in seeking to address the challenges facing the care home sector. Part of this work has resulted in the decision by **Lancashire CC** and the **CCGs** to invest in a pilot for a new contracting monitoring mechanism. The current system fails to give assurance around the quality of the care across the sector. The pilot has been designed to look in detail at how we can both streamline the contract monitoring process, whilst also making it more robust and relevant, with a focus on quality and safety indicators.

The **CCGs** have been key partners in the development of the quality improvement process to support care providers in the improvement of quality and safety in care home settings. This has included providing significant support for failing care homes and service providers by NHS staff. The provision of additional ‘wrap around’ services to support failing providers has been integral to being able to keep some services safe and functioning whilst they are closing down. Alternatively it has been instrumental in supporting providers to recover and prevent the need for closure.

The **CCGs** chair both the MCA sub-group and the Safeguarding Adult Review sub-group, and vice chair the Learning and Development sub-group, the Quality Assurance sub-group and all three Safeguarding Area Leadership Groups. There is active representation from the CCGs at all sub-group meetings and they lead on multiple “task and finish” work streams.

**Lancashire Care Association** is committed to the principle that Safeguarding is “Everybody’s Business” and through its role as a membership body, through its input to the LSAB and subgroups, its work as a registered body for criminal records to help providers recruit properly and safely, and through its strategic role on the Health and Social Care Partnership Steering Group. It seeks to work effectively with health and local authority partners and service providers to ensure a whole-systems approach to delivering safe care.

## Conclusions

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Lancashire's Safeguarding Adults Board has benefitted from the learning arising from members' association with such pan-Lancashire and national activities as work concerning the Mental Capacity Act 2005 and Prevent, the Chair's North West network and the English network of Safeguarding Adult Board Chairs. While modelling collaboration is essential to addressing adult abuse, there is concern that this may be undermined by capacity, staff time, structures and processes. Bringing together public health, patient safety and safeguarding adults in Lancashire is pragmatic and ambitious.

Looking over 2015-16, the Quality Improvement Planning process, which is triggered when information is received which causes concern about a particular setting to support people safely, has involved 76 providers during 1 April 2015- 29 February 2016. The process is securing valued results for residents and staff. One case study concluded:

*The proprietor and manager have expressed their gratitude for the support they have been given during the quality improvement planning process and have confirmed their ongoing commitment to driving up quality.<sup>10</sup>*

Rearranging tasks into more integrated processes has been critical during 2015-16 in Lancashire. Feedback concerning the provision of consistent administrative support from the Business Unit (since September 2015) has made a significant and positive difference to the work of the Board and its subgroups. The Action Monitoring Log has sharpened the distinction between the Board's expectations and the actions of individuals insofar as it offers concrete information about what individuals/ agencies are doing. However, given the Board's tolerance of the subgroups developing and promoting a Compact, revising governance arrangements and refreshing the Terms of Reference for the sub-groups, it is disappointing that agencies have required prompts to share information about the outcomes they are achieving with, and on behalf of, adults at risk. For example, the disquiet concerning the decision not to commission a Safeguarding Adult Review following the death of Continuing Health Care funded patient in a nursing home, suggests that a disclosure of *conflicts of interest* should be added to the Compact. This necessary addition should remove individuals/ agencies from the discussion or determination of matters in which their interest might suggest a danger of bias.

The increase in referrals is impacting on the ability of social care staff to manage the associated enquiries and case work. Necessarily there is a dependency on providers to undertake a greater volume of enquiries which presents risks in terms of oversight and potential for challenge regarding objectivity.

Critically, this report is not able to provide information about Safeguarding Adult Reviews in terms of the number undertaken during 2015-16. The Chair of the sub group stepped down during 2015 and did not forward any information to the Board.

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<sup>10</sup> This is one of the 14 providers no longer subject to the QIP process

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A single review concerning a failing care home underlined the development required in joint working and escalation processes. The issues which prevailed at this home during 2013 such as medication mismanagement, staff shortages and moving and handling concerns are reflected in many of the homes subject to the Quality Improvement or RADAR processes.

Although the County is large, the case for hosting three leadership groups is becoming less credible, particularly since attendance at these is reported as uneven and diminishing. Lancashire's investment in place-based commissioning and initiatives to improve neighbourhoods and public spaces is being led by Public Health.

Website development is essential, not least in terms of prompting all agencies to respond to events which feature in the media in Lancashire and nationally. This is not a new concern. The annual report of 2014-15 noted that, *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, region and national news broadcasts should begin with a consideration of what is going to better inform the public and professionals.*

### News headlines<sup>11</sup> in Lancashire and England

The following sample of what is published and broadcast reveals a great deal about the matters that safeguarding/adult protection practitioners are addressing: medication errors; failing care homes; harm in hospitals; rogue cold callers; scamming; the use of deception in relationships and marketing; exploitation; alcohol abuse; suicide; institutional models of service provision; domestic abuse; and hate crime. All of these are taking place at a time when services are being cut, legislation enacted and its guidance being amended. The media play an opportunistic role in describing adult abuse, neglect and cruelties such as human trafficking. However, because broadcast and print journalists decide what to report, the onus is on services and commissioners to assure Lancashire citizens of the immediate actions taken and the actions which may reduce the likelihood of their recurrence. It will be seen that variety and complexity are the norm in adult safeguarding.

#### During **April 2015**:

- The Network Director for Specialist Services at Lancashire Care Foundation Trust reported that: *“Over the weekend it has transpired that a small group of service users have ingested medication not prescribed to them. Our main*

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<sup>11</sup> During May 2015's Safeguarding Adults Board meeting, the Chair reminded members that giving the SAB advance notice of events is preferable to learning about these via the media

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*concern at the moment is ensuring that those thought to have taken the substances receive medical attention and preventing further misuse. As such, service user movements have been limited on site so that the situation can be contained and managed accordingly.”* The outcome is unknown at the time of writing.

### During **May 2015:**

- The Deputy Chief Inspector of the Care Quality Commission wrote to local authorities about the CQC’s new regulatory duty of Market Oversight, the purpose of which is *“to protect people who may be placed in vulnerable circumstances due to the failure of a ‘difficult to replace’ adult social care provider.”* The CQC’s monitoring of the “financial sustainability” of a sample of providers would enable it to determine *“where we believe business failure is likely and that service delivery may be affected to the extent that Local Authorities may need to step in to ensure continuity of care, we will notify the relevant Local Authorities of this.”*
- The Safeguarding Adults Board and the Children’s Safeguarding Board proposal to merge key business and support functions was agreed. It was acknowledged that the adults’ board and its sub-groups had been disadvantaged by limited administrative support – most particularly in terms of commissioning resource intensive Safeguarding Adult Reviews (SARs).<sup>12</sup>
- The Department of Health opted to abolish the role of the “Designated Adult Safeguarding Manager” as set out in the *Care and Support Statutory Guidance* of October 2014.
- Lancashire Libraries and Museums promoted a weeklong series of events to support Dementia Awareness Week.
- The Chair circulated a briefing concerning self-neglect to the Board for onward distribution and discussion.

### During **June 2015:**

- East Lancashire Hospital Trust identified a *“significant safeguarding issue”* on a unit for older patients. As a result a *“group safeguarding alert was raised on behalf of 24 patients.”* The outcome is unknown at the time of writing.

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<sup>12</sup> The Guidance states: *SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult...a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.*

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- A patient at Calderstones Medium Secure Unit was attacked by two other patients.<sup>13</sup> The safeguarding referral was substantiated and one of the men was subsequently prosecuted, albeit for assaulting another person. An investigation led by a psychiatrist recommended that there should be: compliance with stated levels of observation; well-structured handovers; changes to supervision levels; and that staff should not leave observation duties without being replaced. The safeguarding board also learned that Calderstones was facing staff recruitment challenges.
- A patient whose care home placement was funded by NHS Continuing Health Care died having been assaulted by a resident. Although it was believed that a Safeguarding Adult Review was necessary, and the Independent Chair set out a series of questions for the sub-group to consider, the Sub-Group asserted that scrutiny by a Strategic Executive Information System (StEIS) would suffice. The outcome had not been shared with the Safeguarding Adults Board at the time of writing.
- A nursing home in Freckleton was judged to be “inadequate” in every inspection area. It was warned that unless changes were made, it could face the possibility of closure.<sup>14</sup>
- NHS England published *Safeguarding Vulnerable People in the NHS – Accountability and Assurance framework; Managing Safeguarding Allegations against Staff Policy and Procedure; Safeguarding Alerts Policy and Procedure; and Safeguarding Policy.*

### During July 2015:

- The first Conservative budget introduced the National Living Wage. Although this was welcomed by the health and social care sectors because of its potential to improve the status of careers in caring for people, the implications for residential, nursing and domiciliary care are stark: are there the resources to fund their service delivery?
- The Chair shared the findings/executive summary of *In Search of Accountability: the review of the neglect of older people living in care homes investigated as Operation Jasmine.*
- The County Council reflected on ways of “preventing people from being drawn into terrorism” - a duty under the Counter Terrorism and Security Act 2015. This involved the provision of learning opportunities for Advanced

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<sup>13</sup> [http://www.lancashiretelegraph.co.uk/news/13347033.Probe\\_into\\_attackson\\_Calderstones\\_patient\\_by\\_two\\_men/](http://www.lancashiretelegraph.co.uk/news/13347033.Probe_into_attackson_Calderstones_patient_by_two_men/) (accessed 17 July 2015)

<sup>14</sup> <http://www.lep.co.uk/news/local/inspectors-slam-freckleton-home-as-inadequate-1-7290705> (accessed 15 January 2016)



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Practitioners and Principal Social Workers and the production of Practice Bulletins, for example.

- Lancashire Police advised people not to do business with people on their doorstep, most particularly with people offering to undertake “*free, no obligation roof surveys.*”<sup>15</sup>
- Lancashire County Council Trading Standards backed a campaign “*to encourage more people to speak up and report a scam.*” It is believed that nationally, only 5% of people who have been scammed report what happened to them. Hence the theme of “*Don’t be rushed, don’t be hushed*” for National Scams Awareness Month.
- There was imprisonment of a care worker who had plundered £71k from her clients’ accounts.<sup>16</sup> She had been the manager of a charity supporting adults with learning disabilities and was responsible for managing their money, yet over a period of six years she stole from them. As the relative of one of her victims reported, “*...we feel so incredibly hurt and betrayed. She was welcomed into our home and was like one of the family, considered a friend...we put our complete trust in her.*”
- The safeguarding board considered two cases: one concerning a former Anglican Bishop who was assaulted by a care worker at a home in Chorley.<sup>17</sup> She humiliated him, forced him to have cold showers and slapped him; and a patient at a privately run psychiatric unit hanged himself.<sup>18</sup> He had been detained under the Mental Health Act.

### During August 2015:

- A pensioner was jailed at Preston Crown Court for sexually abusing a woman with learning and physical disabilities. The judge stated that the pensioner had “*exploited her vulnerability*” to his “*own advantage.*”<sup>19</sup>
- A 60 year old man was jailed at Preston Crown Court for defrauding four adults, three with dementia and one with a learning disability.<sup>20</sup> Using his working knowledge as a financial advisor this man defrauded the four of

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<sup>15</sup> [http://www.lancashiretelegraph.co.uk/news/pendle/nelson/13409702.Police\\_issue\\_warning\\_over\\_roof\\_repair\\_scam/](http://www.lancashiretelegraph.co.uk/news/pendle/nelson/13409702.Police_issue_warning_over_roof_repair_scam/) (accessed 15 January 2016)

<sup>16</sup> <http://www.lep.co.uk/news/local/carer-stole-71k-from-vulnerable-people-she-had-been-trusted-to-look-after-1-7377013> (accessed 8 November 2015)

<sup>17</sup> <http://www.mirror.co.uk/news/uk-news/cruel-carer-jailed-after-forcing-5132029> (accessed 1 July 2015)

<sup>18</sup> [http://www.lancashiretelegraph.co.uk/news/13436949.Patient\\_at\\_secure\\_mental\\_health\\_unit\\_found\\_hanged\\_by\\_staff\\_member/](http://www.lancashiretelegraph.co.uk/news/13436949.Patient_at_secure_mental_health_unit_found_hanged_by_staff_member/)

<sup>19</sup> <http://www.lep.co.uk/news/local/pensioner-jailed-for-sexually-abusing-disabled-woman-1-7411166>

<sup>20</sup> <http://www.lancasterguardian.co.uk/news/crime/man-jailed-for-defrauding-elderly-and-vulnerable-victims-out-of-400k-1-7416201> (accessed 30 August 2015)

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£400k. At his trial it was acknowledged that he had deliberately “*targeted*” his victims.

- In addition, the owner of a care home in Lostock was told to “*expect a prison sentence*” after being convicted of ill-treating elderly residents in her care.<sup>21</sup> The home was closed during June 2014 after it was discovered that residents had been force-fed and that one resident was denied medical treatment after she sustained scalds to her legs, feet and buttocks from a bath.
- A “failing” nursing home in Bamber Bridge closed after a damning CQC inspection. It resulted in residents having only days to find alternative accommodation. The owners attributed their decision to close to the shortage of nurses willing to work in the nursing home sector.<sup>22</sup>
- Also during August, a report for Lancashire County Council’s Cabinet revealed that it will have to save “*an additional £223m by April 2020...on top of the £152m...agreed in February...between 2011 and 2020 the council will have delivered savings of £685m.*”

### During September 2015:

- A roofer was jailed for poor work for which he charged extortionate prices. Home owners were targeted during “cold calling” and once a job had begun they were persuaded that because the roofing problems were so serious it would cost several thousands of pounds.
- It was in early September that the Safeguarding Adults Board learned that five care home closures had impacted on the lives of around 100 people. These included three nursing homes, the re-provision of which was challenging because of the difficulties in recruiting nurses to the sector. The resulting resident reviews and reflections on the adverse consequences for the Multi-Agency Safeguarding Hub have exercised safeguarding practitioners throughout the year.
- NHS England: Lancashire and Greater Manchester hosted an event for almost 200 people: *Resilience in the Care Home Sector – Vital to NHS success*. This underlined the vital learning that there is nothing resource efficient about a failing care home if people’s mental and physical health is compromised. The event highlighted valued practice from around the County, including pathways for older people living with frailty, tele-health work, ways of looking after staff as well as residents and more general ways of enhancing quality.

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<sup>21</sup> <http://www.lep.co.uk/news/local/care-home-boss-convicted-of-ill-treating-elderly-residents-1-7416165>

<sup>22</sup> <http://www.lep.co.uk/search?query=Cuerden+grange&p=header> (accessed 12 September 2015)

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- East Lancashire CCG was proactive and assertive in addressing the challenge by a private psychiatric unit that it was not obligated to share personal staff information for the purposes of adult safeguarding.

### During October 2015:

- It was determined that Calderstones is to close. This is four years after the BBC's broadcast concerning Winterbourne View Hospital, *Undercover Care: the Abuse Exposed* which illustrated the long-term detention of adults with learning disabilities believed to be too challenging to live in ordinary neighbourhoods. *Calderstones, which has 223 beds, is seen as symbolic of the NHS's reluctance to abandon entirely the institutional model of care and support for learning disabled people.*<sup>23</sup>
- Lancashire Police hosted a "Vulnerable Adult" conference which addressed the learning arising from the review of incidents of significant harm at Hillcroft Slyne with Hest Care (Nursing Home); partnership working with Trading Standards; Operation Jasmine; and "Think Jessica."<sup>24</sup>
- The Chair circulated information concerning two Serious Case Reviews published by Suffolk's Safeguarding Adults Board.
- The Institute of Alcohol Studies surveyed nearly 5000 police officers, ambulance staff, NHS medics and firefighters.<sup>25</sup> It turns out that dealing with alcohol related incidents is hazardous. At a time when alcohol takes a disproportionate share of emergency services time and resources, there is the ever present fear of being attacked. Over half of the ambulance staff surveyed reported that they have been sexually harassed or assaulted by drunken patients. Alcohol and drugs play very significant roles in safeguarding/adult protection referrals.

### In November 2015:

- The *Journal of Epidemiology and Community Health* published an article concerning the correlation between the Work Capability Assessment, increases in suicide and people's worsening mental health.<sup>26</sup>
- Lancashire County Council's MCA practitioners responded to the Law Commission's consultation concerning Deprivation of Liberty Safeguards. This reflected learning from all sectors in Lancashire.

### During December 2015:

- Norman Lamb led a debate in the House of Commons concerning out-of-area mental health placements at times of crises.<sup>27</sup> The Health and Social Care Information data indicates that Lancashire is one of four localities which send their patients out of their area most often because there are too few beds in

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<sup>23</sup> <http://www.theguardian.com/society/2015/oct/30/nhs-hospital-england-people-learning-disabilities-to-close-calderstones-winterbourne-view> (accessed 8 November 2015)

<sup>24</sup> <http://www.thinkjessica.com/>

<sup>25</sup> <http://www.theguardian.com/society/2015/oct/26/violence-against-emergency-services-prompts-police-call-for-end-to-24-hour-licensing>

<sup>26</sup> <http://jech.bmj.com/content/early/2015/10/26/jech-2015-206209> (accessed 8 November 2015)

<sup>27</sup> <http://www.theyworkforyou.com/debates/?id=2015-12-03a.591.0> (accessed 8 November 2015)

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the County. The former health minister is campaigning for equality of access to treatment for people with mental health problems.<sup>28</sup>

- A UK accountancy firm, Mazars, published its *Independent review of deaths of people with a learning disability or mental health problem in contact with Southern Health Foundation NHS Trust April 2011 to March 2015*. This showed that the NHS had failed to investigate an astonishing number of the 700+ 'unexpected deaths' within a single trust; only 30% were investigated. Less than 1% of deaths in learning disability services were investigated compared with 60% of the unexpected deaths in adult mental health services,
- Lancashire County Council, Collaborations for Leadership in Applied Health Research and Care (CLAHRC) and other partners led work on engaging with care home residents. *Closer to home, the Way We Were...NOW!* is one example of improvement work in Lancashire's care homes. The work was presented at the CLAHRC *Evidence for Change* event during December 2015 and is available at:

[https://www.youtube.com/watch?v=7oNinl\\_YXlc&feature=youtu.be](https://www.youtube.com/watch?v=7oNinl_YXlc&feature=youtu.be)

However, an estimated 20% of care homes were delivering inadequate care across Lancashire, according to the CQC.

- At the end of December 2015, the Chair circulated notes for the Safeguarding Board – and for onward distribution – concerning (i) Safeguarding Adult Reviews and (ii) an anonymised summary of the review of death by suicide. The former reflect the Board's concern regarding its open-ended responsibility to undertake SARs in an era of austerity. Conducting a Serious Case Review (which pre-dated SARs) concerning the suicide of a person at a mental health in-patient unit was atypical at the time since there had been a Serious Untoward Incident (SUI) report commissioned which claimed that the psychiatric service was not at fault. The review contained lessons which the SUI had not considered.

### During January 2016:

- Monitor and the NHS Trust Development Authority issued the instruction to reduce staffing even though this will have a detrimental effect on patient safety.<sup>29</sup> Nurses and other frontline medical workers are anticipated to be in the firing line. This is just three years after Robert Francis' report in Mid Staffs which underlined the importance of safe staffing. A Department of Health spokesperson sidestepped the concern noting, "*We expect all parts of the NHS to have safe staffing levels – making sure they have the right staff, in the right place, at the right time.*"

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<sup>28</sup> Interview in *Primary Care Today: Supporting Integration in Primary Care* issue 35

<sup>29</sup> [www.politicshome.com/health-and-care/articles/story/hospitals-told-cut-staff-tackle-nhs-funding-crisis](http://www.politicshome.com/health-and-care/articles/story/hospitals-told-cut-staff-tackle-nhs-funding-crisis) (accessed 9 February 2016)

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**Case Study 2** concerns Maureen who is 75. Since having a stroke she has lived in a residential home. When a dietician visited to review Maureen's nutrition she was informed that although Maureen had enjoyed a lunch of sausage, mashed potatoes and peas, she had choked afterwards. Maureen had recovered but since her care plan stipulated that she should have a pureed diet, the dietician was concerned. A safeguarding alert was raised by the dietician and this triggered an enquiry, which established that staff supporting Maureen did not understand what was meant by a pureed diet or why this was important to Maureen's care. The dietician contributed to the safeguarding enquiry and the resulting multi-agency work. There had been a high turnover of staff which had compromised their skill mix and communications.

- At the end of 2015 and the beginning of 2016, flooding devastated parts of the County, December 2015 having been the wettest month ever recorded. Storms Eva, Frank and Desmond prompted astonishing emergency service responses and, from adult social care, a sustained programme of visits to people who were known to social care services, including those with cognitive and/or physical impairments, mental illness and final illnesses. Many such people live alone and some live with carers who may be frail themselves. They are at different stages of their lives – from young adults to very frail older people. Contacts involved staying with people waiting to be rescued; ensuring that those who wished to remain in their homes had the means to stay warm, had enough food, clean water and their medications; helping people to move their furniture and belongings; checking that the residents of care homes were safe from the floods and that the staff were supported to move people's belongings and beds to upper floors. People living close to care homes were extraordinarily attentive – they arrived wanting to help tackle damage arising from floods and lost power supplies. In spite of the closed roads and suspended rail services, many people made their way to stricken localities with food, water, clothes and gifts as well the means to help people dispose of sodden furniture and white goods and clean what was left.

### During February 2016:

- Lancashire County Council and Greater Together supported a campaign to raise awareness of domestic abuse. “*Be a lover not a fighter*” encouraged people to talk about the fact of violence in the home: on average, two women are killed every week and two men are killed every month in the UK.
- An anti-abuse Muslim helpline was launched in Lancashire.<sup>30</sup>

### During March 2016:

- The Department of Health published its revised adult safeguarding guidance.<sup>31</sup> Unfortunately, key sections which contain conflicting guidance have not been amended, that is:

#### 14.2 The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs [S11])
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

<sup>30</sup> <http://www.briefreport.co.uk/news/anit-abuse-muslim-helpline-launched-in-lancashire-3955502.html>

<sup>31</sup> <https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding> (accessed 16 March 2016)

## Appendix A

*14.5 Where someone is 18 or over but is still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25 (see also chapter 16). Where appropriate, adult safeguarding services should involve the local authority's children's safeguarding colleagues as well as any relevant partners (e.g. the Police or NHS) or other persons relevant to the case. However, the level of needs is not relevant, and the young adult does not need to have eligible needs for care and support under [S2] the Care Act, or be receiving any particular service from the local authority, in order for the safeguarding duties to apply – so long as the conditions set out in paragraph 14.2 are met.*

*14.6 Local authority statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not, and regardless of setting, other than prisons and approved premises where prison governors and National Offender Management Service (NOMS) respectively have responsibility.*

- The pan Lancashire Mental Capacity Act 2005 practice group, a multi-agency group with health and social care colleagues from commissioning and provider organisations, drew from their collective experience to produce an excellent learning resource which will be available on the website of the Social Care Institute for Excellence:

<http://pub.lucidpress.com/MCABLBNetwork/> <sup>32</sup>

The resource includes a video and e-book; the video illustrates the key elements of the MCA and professional actors take viewers through a number of scenarios/practical demonstrations. The e-book provides additional information with links to complementary resources.

- The Safeguarding Enquiry Service transferred to Public Health.

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<sup>32</sup> Accessed 24 March 2016