Lancashire County Council

Scrutiny Committee

Friday, 16th December, 2016 at 10.00 am in Cabinet Room 'B' - The Diamond Jubilee Room, County Hall, Preston

Agenda

Part I (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Interests** Members are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
3.	**Minutes of the Meeting held on 18 November 2016**	(Pages 1 - 8)
4.	**Newton Europe Update**	(Pages 9 - 10)
5.	**Lancashire Safeguarding Adults Board - Annual Report 2015/16**	(Pages 11 - 54)
6.	**Work Plan and Task Group Update**	(Pages 55 - 60)
7.	**Urgent Business** An item of urgent business may only be considered under this heading where, by reason of special circumstances to be recorded in the Minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Member's intention to raise a matter under this heading.	
8.	**Date of Next Meeting** The next meeting of the Scrutiny Committee will be held on 13 January 2017 at 10:00am at the County Hall, Preston.	

Lancashire County Council

I Young
Director of Governance,
Finance and Public Services

County Hall
Preston

Lancashire County Council

Scrutiny Committee

Minutes of the Meeting held on Friday, 18th November, 2016 at 10.00 am in Cabinet Room 'B' - The Diamond Jubilee Room, County Hall, Preston

Present:

County Councillor Bill Winlow (Chair)

County Councillors

Ms L Collinge	R Shewan
C Crompton	V Taylor
S Holgate	D Watts
D O'Toole	G Wilkins
Mrs L Oades	B Yates
J Shedwick	

County Councillor Stephen Holgate replaced County Councillor Alyson Barnes for this meeting.

1. Apologies

None were received.

2. Disclosure of Pecuniary and Non-Interests

None were disclosed.

3. Minutes of the Meeting held on 23 September 2016

Resolved: That the minutes of the meeting held on 23 September 2016 at 10:00am be confirmed and signed by the Chair.

4. Residential and Domiciliary Care – Quality and Sustainability

The Chair welcomed County Councillor Tony Martin, Cabinet Member for Adult and Community Services; Louise Taylor, Corporate Director Operations and Delivery; Tony Pounder, Director of Adult Services; and Ian Crabtree, Head of Service Policy, Information and Commissioning, to the meeting.

A report was presented highlighting demographic pressures, increasing financial pressures on local government and significant workforce and retention difficulties

which had raised concerns that the quality and sustainability of the adult social care markets for home care, residential and nursing homecare were at risk. The national situation was particularly precarious in those segments of the care market which relied heavily on council funding. Weaknesses in the market were also impacting on other areas within the wider health and social care system, for example by creating delays in discharging patients from hospital.

Lancashire's home care and residential/nursing care markets broadly reflected those national patterns but there were some distinctive local features which were drawn out in the report.

The Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and bodies such as the Kings Fund continued to seek new ways of sustaining adult social care. And this report included an overview of how Lancashire was responding to some of these challenges with new commissioning and clinical models, plans for closer and further integration with the NHS and involving local communities in efforts to maintain health and wellbeing into older age. The County Council had also to be open about what people – both self-funders and those whose care was paid for by councils – could expect from social care in Lancashire, what constitutes a fair price for care, and about the council's ability to fund care needs for its population in the future.

Regarding finances, nationally the 2% Council Tax social care precept had raised £380m but the implementation of the National Minimum wage had cost £612m. It also benefited those areas with higher property values (typically in the South) rather than those with lower values (typically in the North).

The County Council was currently forecasting that it would receive additional resources of £84m as a result of additional funding from both Council Tax and Better Care Fund over the next five years, however the Medium Term Financial Strategy (MTFS) contained additional price and demand pressures of £176m over the same period.

The County Council faced a financial gap of approximately £148m by 2020/21, including a forecasted £92m shortfall in adult social care which was part of the overall shortfall in Health and Social Care identified in the Sustainability and Transformation Plan (STP) for Lancashire and South Cumbria.

The 2% Council Tax precept fell far short of addressing the financial gap for Adult Social Care. In 2017/18 the precept was estimated to generate £8.3m and the Better Care Fund would provide an additional £3.2m in Lancashire. However the price and demand pressures for Adult Social care total £37.7m resulting in an overall pressure for the service area of £26.2m in 2017/18.

Questions and comments by the Committee in relation to the report were as follows:

- In relation to Lancashire's home care provider agencies, concerns were expressed that only 5 had received an outstanding rating from the CQC

and Members enquired what could be done to improve the ratings of the others to good and outstanding. In 2014 the CQC had implemented a new regime in terms of inspections and the outstanding total was reflective of the national situation. It was much harder now under the new regime to get an outstanding rating.

- In terms of the GPs registration and where they are situated the Committee were informed that, Crisis services would respond in terms of the County Council's perspective. Crisis services offered immediate care in a person's home for a period of up to 72 hours and was often used as a tool to assess a person's needs upon discharge from hospital. LCC met with the Crisis service providers on a monthly basis and they had to meet key performance targets.

- Members were informed that the County Council was in the process of recommissioning home care services for older people and disabled adults. Following a five week market consultation exercise, the Cabinet Member for Adult and Community Services approved on 11 October 2016 the commencement of the procurement process. Following its completion the procurement was planned to start on 25 November and it was expected that the new framework agreement would commence in May 2017.

- In the CQC inspection regime it was discovered that smaller and locally based services were receiving good or outstanding ratings compared to bigger services which were serving more complex needs. LCC did aspire to have all its services rated good or outstanding. A key factor is down to good management of individual facilities.

- The residential care provider's biggest concern was not around the fee levels but around recruitment of staff. It was noted that nurses in nursing homes were of an older age group so there had to be different marketing strategies for recruiting nurses to nursing homes.

  Members stated that the most complaints they received were regarding assessments. Patients were waiting around in hospitals waiting to be assessed to go to a residential home or their own home. Members enquired if there had been any improvement in assessments or if there was anything in the pipeline for improvement. There was a lot of tracking of assessments by the NHS, hospitals and LCC about the reasons for delays in transfers of care. Delays around assessments were typically around pressures hospitals were facing. LCC was in daily contact with other authorities to make sure it could respond in a flexible way. The biggest cause for delays both nationally and locally was support packages at home. LCC was working on increasing its productivity with its providers. The work with Newton Europe was to provide better offers for individuals.

- It was felt people were being charged more for care if they were better off, had a good pension and many assets. Committee was informed The Care

Act came into force in 2014 and was implemented in 2015. If all had gone to plan Part 2 of the Act would have been implemented in 2016 which would have meant people would have been protected from high payments. The limits of payment would have been around £70,000. This was postponed until 2020 due to other financial constraints local authorities were under.

- As more and more responsibility was being put on carers it was felt more respite care was needed. It was felt that Central Government should look into this.

- Regarding recruitment it was stated that without the right staff in the right places there was always going to be a struggle. Members asked if there was something in place for recruiting, training and demonstrating career paths for people working in the care sector. An Adoption of Care Certificate had been launched as a requirement in 2016. It was pointed out that the turnover in staff was high and the challenge for organisations was getting a return on their investment of recruited and trained staff. There was an organisation called Skills For Care which did a lot to foster improved training and qualification levels for registered managers and frontline staff.

- There had been a reduction in investment in Primary Care Services both nationally and locally which meant it was more difficult to get a GP appointment and harder to get home support. This increased pressures on hospitals as more people were likely to turn up at them to get support. It was felt that GPs and other Primary Care Services were struggling under the weight of expectations.

- Regarding Extra Care, Capital Funding had been provided for an Extra Care Scheme in Chorley.

- Two years ago the Government announced it was taking a 1% cut in housing benefit of registered landlords. Until this was resolved, housing providers were loathe to develop any new schemes as this would put them at financial risk. There were two schemes ready to go but the hosing providers were not keen to progress until the housing benefit situation had been resolved. The Committee was informed that the housing benefit situation had recently been resolved so these schemes could now be taken forward.

- The age profile of people in residential care was dramatically different than to what it was 20 years ago. People were entering these homes much later in life now which was considered a success story as people were staying at home longer. However, the level of illness and disability of those people entering residential care was much more severe now.

- LCC was piloting the Quest for Care scheme in Lancashire. This involved Providers doing monthly returns in terms of their quality of service. It reflected what the CQC would do on an annual basis. Quest for Care would require some additional funding put into place so as to roll it out across the whole sector of residential care.

- A new escalation policy had been developed by LCC. The County Council was working with CCG commissioners to secure health clinical leadership, training and support for nurses in the care sector. The escalation policy was a framework for gathering information for people at the right level to decide if further intervention was required. The intervention would be to offer help and support. The Escalation Policy was a way for providers and LCC for taking into account all the information and interacting in an appropriate way with the CQC's views.

- The Adult Safeguarding Board had been set up for keeping people in Lancashire safe, well and healthy. It was important to know how organisations were sharing best practice in order to support the sector. If the quality was there then people would receive better care. Providers wanted to work with LCC and be proactive.

- Members asked if they could be kept informed of risks to the Authority's statutory obligations. They were informed that LCC was doing risk assessments of major challenges facing Adult Social Care.

- What people wanted was consistency from providers. They would prefer the same carer for every home visit. The Committee hoped that this would be considered when issuing new contracts.

- The Committee felt that there was a high turnover of staff within the care sector and that it was due to the zero hours contracts. As part of the new procurement LCC wanted to guarantee hours to providers which would remove zero hours contracts.

- When LCC signed contracts they expected the providers to be good or outstanding. If they fell into the inadequate section after a contract had been signed, LCC would do its best to help them improve their standards and subsequent rating.

- Members were assured that the 2% Social Care precept would definitely be spent on Social Care

Resolved:

i. The Committee considered the report

ii. A letter be sent by the Chair on behalf of the Committee to Central Government requesting that Government:
- Take account of change in demography and impact on demand and thus cost
- Emphasise the major financial shortfall and say that existing funding is not sustainable
- Ask for more support for primary care to reduce demand on adult services
- provide a new settlement particularly for the north
- Promote the wider determinants of health

5. Budget Scrutiny Working Group

Wendy Broadley, Senior Democratic Services Officer (Overview and Scrutiny), explained to the Committee that the Budget Scrutiny Working Group had the responsibility for considering budget proposals and issues on behalf of the Overview and Scrutiny Committees. The report presented set out the proposed approach for the budget proposals due to be considered by Cabinet in December 2016.

Resolved: The Committee agreed the approach to be taken by the Budget Scrutiny Working Group as set out in the report.

6. Workplan and Task Group Update

The Work Plan was presented to the Committee regarding upcoming topics and future topics not yet scheduled as well as an update on ongoing Task Groups.

Following discussions at the Chair's briefing it was agreed to move the Skills Agenda topic scheduled for the meeting on 16th December to a later date, and, also to swap the Flood Drainage Authority topic scheduled for 17th March 2017 with the Crime and Disorder Strategy scheduled for 13th April 2017.

Resolved:

1. The Committee approved the 2016/17 work plan.

2. The Committee agreed to amend the work plan as discussed.

7. Urgent Business

There were no items of Urgent Business.

8. Date of Next Meeting

The next meeting of the Scrutiny Committee will take place on Friday 16th December 2016 at 10.00am in Cabinet Room B (The Diamond Jubilee Room) at the County Hall, Preston.

I Young
Director of Governance, Finance and Public Services

County Hall
Preston

Scrutiny Committee
Meeting to be held on Friday, 16 December 2016

Electoral Division affected:

Newton Europe update

Contact for further information:
Wendy Broadley, Senior Democratic Services Officer (Overview & Scrutiny),
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Executive Summary

In June the Scrutiny Committee received a presentation from Newton Europe which provided the Committee with an overview of how the role and remit of Newton's is contributing to the transformation of the design and delivery of services which will result in improved outcomes for adults. It was agreed that further updates would be provided to inform members on the progress being made.

Tony Pounder, Director of Adult Services and Stephen Knight, Newton Europe will attend the Committee to present an update

Recommendation

The Scrutiny Committee is asked to note and comment on the update

Background and Advice

At the meeting in June the Committee was provided with a presentation on an overview of how the role and remit of Newton Europe was contributing to the transformation of the design and delivery of services which would result in improved outcomes for adults.

Newton Europe had provided technical support to Adult Services as well as guidance and input into a major change programme. The programme was called Passport to Independence. What was important to note was that this built on the knowledge, skills and values of the existing managers and leaders in the organisation and staff on the front line.

Adult Services had secured technical knowledge from Newton Europe that it felt it needed to better organise some of the processes, practices and systems. The overall approach for this was in three stages:

Lancashire County Council

- Assessment – identifying where the biggest opportunities for improvement were. It was noted that Adult Services practitioners' time was not making the best use of
- Design – what were the solutions and how do we know they work. Stage 2 had begun in February 2016 and would end in August 2016
- Implementation – rolling out that supported practice transformation across the county, locality by locality. The implementation stage would take 12 – 14 months.

Adult Services staff were playing a central role in driving this forward. A massive part of the work was understanding what needed to be changed and this was where support from Newton Europe was essential. In terms of the improvement approach the programme covered Older People (OP), Physical Disabilities (PD), Learning Disabilities (LD) and Mental Health (MH).

By ensuring citizens and their families were at the centre of social care services in Lancashire, Adult Services would empower and equip staff and citizens with the information and tools so they were able to work together to achieve the desired outcomes, whilst promoting independence and wellbeing.

Tony Pounder and Stephen Knight will present an update to the Committee highlighting progress made of the Passport to Independence programme

Consultations

n/a

Implications:

This item has the following implications, as indicated:

Risk management

There are no significant risk implications in this report

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel
n/a	n/a	n/a

Reason for inclusion in Part II, if appropriate

Scrutiny Committee
Meeting to be held on Friday 16 December 2016

Report of the Independent Chair of the Safeguarding Adults Board

Electoral Divisions affected:
All

Lancashire Safeguarding Adults Board Annual Report 2015-16
(Appendix 'A' refers)

Contact for further information:
Victoria Gibson, (01772) 538352, LSCB/LSAB Business Manager
victoria.gibson@lancashire.gov.uk

Executive Summary

Lancashire County Council is a lead member agency of Lancashire Safeguarding Adults Board (LSAB). The LSAB must produce and publish an Annual Report. The draft report for 2015-16 was presented to the Scrutiny Executive prior to publication in September and the final version is now being formally presented to the full Scrutiny Committee together with an update on the work the LSAB has completed in the interim.

The report is attached as an Appendix A. The main body of the report was written by the previous Chair of the Board, who resigned earlier in 2016. Interim arrangements were made for the Chair of the Children's Safeguarding Board to also Chair the LSAB and this has now been confirmed up to March 2018.

The report draws attention to the impact of changes in legislation which have put the Board on a statutory footing; it provides a brief local context and information about the Board's priorities in 2015-16, together with analysis of data, it reports on coordination and collaboration between services and draws conclusions re adult safeguarding. The report concludes with a review of news during the year which highlights issues in safeguarding.

What is clear from the report is that adult safeguarding is challenging. Adult vulnerability is complex. The demographic profile of the community will continue to include increasing numbers of people who fall into service user groups more vulnerable to risk of abuse or neglect (including self-neglect) because of their health or social care needs or issues of mental capacity, abuse and neglect. The challenge for agencies in making a proportionate response and delivering a personalised service in response to safeguarding issues is increased by reducing resources for all services,

Lancashire County Council

The change in the statutory basis of the LSAB and the establishment of a joint business support unit with the Children's Board has enabled the Board to be more pro-active, to develop a formal business plan, and to develop effective sub-groups to deliver the plan. The main body of this report reflects on work completed since April 2016 or currently in progress; there is much being done and more to do. This busy agenda is only made manageable through the commitment of the LSAB members and its business unit.

Recommendation

Scrutiny is asked to consider the content of the Annual Report and the more recent work of the Board and identify any areas it may wish to comment on and any action it may wish to take.

Background and Advice

Since April 2015 the LSAB has had a statutory responsibility to ensure the effectiveness of work undertaken by its members and partner agencies to safeguard adults in Lancashire. This Annual Report reflects on the work undertaken in this regard in Lancashire for the 2015-16 financial year. The report is attached at Appendix 'A' for information. The Lancashire Board has an Independent Chair who has the responsibility, with amongst others, to promote good practice and collaborative working. The Chair of the Board is accountable to the Council's Chief Executive who is, in turn, responsible for ensuring its effectiveness. The Director of Adult Services is a member of the LSAB, as is the Lead Member.

Protocols are in place which establish the relationship between the LSAB, the health economy, police and other partners. A protocol is also being developed to ensure the overlapping responsibilities of the Community Safety Partnership and the two Safeguarding Boards in areas such as CSE, Domestic Abuse and Extremism are well-managed.

The Annual Report drew the following conclusions:

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.

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.

The previous Chair expressed disappointment that agencies had required prompts to share information about the outcomes they are achieving with, and on behalf of, adults at risk. New arrangements have been put in place and all key agencies now provide data about performance on a quarterly basis. A programme of multi-agency audits has also been planned and has all agency commitment.

Critically, the report was not able to provide information about Safeguarding Adult Reviews – none were undertaken during 2015-16. The Chair was critical of a decision not to commission a Safeguarding Adult Review following the death of Continuing Health Care funded patient in a nursing home. New arrangements for review of cases and decision making about such reviews have now been developed. One review is on the point of completion and a further reviews is underway.

The Annual Report reflects on the extent to which the level of referrals in 2015-16 was impacting on the ability of social care staff to manage the associated enquiries and case work. Delays in processing referrals and in dealing with assessments linked to deprivation to of liberty were unacceptable.

Although the County is large, the case for hosting three leadership groups was becoming less credible, particularly since attendance at these was reported as uneven and diminishing. These have now been combined into a single county wide meeting.

Website development was seen as essential, not least in terms of prompting all agencies to respond to events which feature in the media in Lancashire and nationally. This was not a new concern. The annual report of 2014-15 had 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."* Development of a more effective website has now been completed and is currently out for feedback from LSAB members. The website will go live to wider networks by Friday 16 December.

In the current year to date the LSAB has been undertaken the following work – some elements already completed and others are work in progress:

- Established an effective joint Business Unit;
- Conducted of a Board Development Day leading to establishment of priorities for the future and a comprehensive Business Plan;
- Developed a multi-agency agreement about appropriate thresholds for referral to Adult Services – a continuum of need document;
- Established a Self-Neglect Task and Finish Group to ensure robust policies and procedures are in place;
- Developed a multi-agency data set and agreed multi-agency audit framework;

- Identified some resources (limited at present) to support multi-agency safeguarding training;
- Leading on the Review of the Multi-agency safeguarding Hub (MASH);
- Developing a communication strategy and linking with local press to reach members of the public with safeguarding messages e.g. Suicide rates and use of Emollients;
- Developed comprehensive policies, procedures and training around MCA – which was recognised as good practice and now being promoted for use by NICE nationally;
- Produced an MCA media resource which was shortlisted to the final 3, National Patient Safety & Healthcare Transformation Awards and raised the profile of the work of the subgroup in Lancashire and the LSAB;
- Linked with Mental Capacity Act (MCA) Regional Group so as to be able to influence the national agenda based on the practice of the Lancashire subgroup;
- Produced Information and Guidance for Providers on the handling of medication errors and determining when the circumstances should be considered as requiring a safeguarding alert referral;
- Promoting 'React to Red' NHS campaign to Prevent Pressure Ulcers;
- Developed a 7 minute briefing (7MB) around safer recruitment for Care Providers when using Agency staff and circulated this across health and social care networks in Lancashire;
- Established a small Task and Finish group to work in partnership with the Lancashire Fire and Rescue Service to develop 7MB around smoking and emollients and, with the ratification of the LSAB, the briefing has been shared widely across health and social care providers and communities in Lancashire. Examples of the 7MBs are attached as Appendix 2;
- Meeting with Alternative Futures Group who coordinate a North West safeguarding network for 3rd sector providers. This network provides a useful communication link for the LSAB sub group to link with and share information and promote the safeguarding agenda;
- Supported a Safety Culture Briefing. LCC Safeguarding and Patient Safety staff are currently working to promoting safety and a learning culture with 17 Homes in Lancashire. Dependent on the findings from the project the LSAB Practice with

Providers sub group has agreed to support the project in rolling out the project to care and nursing homes across the County;

- NICE guidance to promote good oral health within commissioned service – a task and finish group is in progress to provide a 7 minute briefing to promote good oral health in services and to reduce the incidence of neglect in this area;
- Revised policy and procedures re Safeguarding Adult reviews and introduced a new model including a tracking system to ensure action plans are completed;
- Extending the work of the LSCB Online safeguarding Officer to support the LSAB;
- Embedding the principles of Making Safeguarding Personal into the audit programme;
- Extending the LSCB section 11 audit and challenge process to agencies working with adults.

Consultations

The LSAB has consulted with all partner organisations in the preparation for the Annual Report and is seeking to work more closely with Healthwatch to ensure service user views inform the work of the Board.

Implications:

LCC hosts the work of the Board which is resourced via a multi-agency budget. There are no additional direct implications for finance or human resource management further to those already provided by LCC and partner agencies for LSAB purposes.

Risk management

All partner agencies need to be fully engaged with services and support to safeguard adults in order that they are happy, healthy and safe from harm.

Appendix A: LSAB annual report 2015/16

Appendix B: 7 minute briefings

List of Background Papers

Paper	Date	Contact/Directorate/Tel
Lancashire Safeguarding Adult Board Annual Report 2015/16	July 2016	Victoria Gibson/01772 538352

7 minute Briefing Series

Reason for inclusion in Part II, if appropriate

N/A

Lancashire's Safeguarding Adults Board

Annual Report 2015-2016

Published September 2016

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 adults with care and support needs who are vulnerable to abuse and neglect. 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 those with care and support needs 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 know about the vulnerabilities of people in Lancashire and how well-placed services are to respond to them.

Safeguarding adults at risk of abuse and neglect 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

Contents Page

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
- In specified circumstances the Board must conduct 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.

The local context - what do we know about vulnerable adults in Lancashire[1]

- There are an estimated 1.2 million people in Lancashire (Lancashire-12 footprint) of whom more than 900,000 are adults;
- The population of those aged over 65 is predicted to increase from around 10,000 recorded in 2010 to 34,000 by 2039;
- 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 abuse or neglect.

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

[1] Report of the Director of Public Health - 2016

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 pan Lancashire of 1.5 million, of which 1.2 million reside within the Lancashire-12 footprint. They are 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). During the period of reporting 2015-2016 the Lead Nurse represented North Lancs and Fylde & Wyre CCGs, Head of Safeguarding Adults and Mental Capacity Act Lead represented East Lancs CCG and Head of Safeguarding up to her retirement in December 2015 replaced by Designated Lead Nurse for Safeguarding Adults and Mental Capacity Act in January 2016 for Chorley and South Ribble & Greater Preston and West Lancs 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 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)[2] 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

[2] A single point of contact for professionals to report safeguarding concerns

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,[3] are impacting on Muslim communities in Lancashire and elsewhere.

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.

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.

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

[3] Preventing vulnerable people from being drawn into terrorism

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.

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[4] 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[5] 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)[6] 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*

[4] http://gov.wales/topics/health/publications/socialcare/reports/accountability/?lang=en

[5] Receive, Advise, Develop, Act, Refer

[6] Kennedy, J. (2014) *John Kennedy's Care Home Inquiry* York: Joseph Rowntree Foundation and Joseph Rowntree Housing Trust

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 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.

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.

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.
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*,"[7] 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 Fire and Rescue (LFRS) proactively engages with partners at all levels with the aim of preventing harm and making Lancashire safer.

LFRS during their home fire safety visits identify and report adult safeguarding matters. LFRS have a training programme that delivers Fire Safety training to care and health providers, which helps to ensure safety of their service users. LFRS are an active partner within the Multi Agency Safeguarding Hub (MASH) which provides useful

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

opportunities for multi-agency safeguarding. LFRS audit premises to ensure that the fire safety requirements of the Regulatory Reform (Fire Safety) Order 2005 are in place and managed to keep vulnerable adults safe. LFRS complete arson assessments and fit safety equipment to households where the occupiers are identified as being at risk.

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

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 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.

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.

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 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[8] 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 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

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

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 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.

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 pro-active 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.
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)[9] 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 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

[9] Meetings about the high risk domestic abuse cases involving the police, health, child protection and housing practitioners for example

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 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

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.[10]

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. There was no business support for this sub-group at this time and the Chair of the sub group stepped down during 2015[11].

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.

[10] This is one of the 14 providers no longer subject to the QIP process

[11] *Further enquiry has shown that within the reporting period a total of eleven referrals were received for consideration by the group. Of the referrals five were recommended for a single agency review, five were recommended for a look back and learn review and one case did not meet the criteria due to no evidence of multiagency failings. Identified themes reflect those nationally focusing on areas of practice including record keeping, supervision, consent / application of the principles of the MCA, recognition of family and their needs, risk management of complex situations, accountability, complex funding arrangements and the recognition of the responsible agency, responsibility around continued reviews and assessments, self-funding service users, leadership, joint working, training, risk assessment and understanding in what constitutes abuse and self-neglect.*

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[12] 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 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*

[12] 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

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).[13]

- 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.

- A patient at Calderstones Medium Secure Unit was attacked by two other patients.[14] 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.

[13] The Guidance states: *SABs **must** arrange a SAR when an adult in its area dies as a result of abuse of 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.*

[14] http://www.lancashiretelegraph.co.uk/news/13347033.Probe_into_attackson Calderstones_patient_by_two_men/ (accessed 17 July 2015)

- 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.[15]

- 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 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*."[16]

- 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.

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

[16] http://www.lancashiretelegraph.co.uk/news/pendle/nelson/13409702.Police_issue_warning_over_roof_repair_scam/ (accessed 15 January 2016)

- There was imprisonment of a care worker who had plundered £71k from her clients' accounts.[17] 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.[18] She humiliated him, forced him to have cold showers and slapped him; and a patient at a privately run psychiatric unit hanged himself.[19] 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*."[20]

- A 60 year old man was jailed at Preston Crown Court for defrauding four adults, three with dementia and one with a learning disability.[21] Using his working knowledge as a financial advisor this man defrauded the four of £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.[22] 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.[23]

[17] 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)

[18] http://www.mirror.co.uk/news/uk-news/cruel-carer-jailed-after-forcing-5132029 (accessed 1 July 2015)

[19] http://www.lancashiretelegraph.co.uk/news/13436949.Patient_at_secure_mental_health_unit_found_hanged_by_staff_member/

[20] http://www.lep.co.uk/news/local/pensioner-jailed-for-sexually-abusing-disabled-woman-1-7411166

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

[22] http://www.lep.co.uk/news/local/care-home-boss-convicted-of-ill-treating-elderly-residents-1-7416165

[23] http://www.lep.co.uk/search?query=Cuerden+grange&p=header (accessed 12 September 2015)

- 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.

- 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:

- **I**t 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.*[24]
- 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."[25]

[24] http://www.theguardian.com/society/2015/oct/30/nhs-hospital-england-people-learning-disabilities-to-close-calderstones-winterbourne-view (accessed 8 November 2015)
[25] http://www.thinkjessica.com/

- 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.[26] 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.[27]
- 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.[28] 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 the County. The former health minister is campaigning for equality of access to treatment for people with mental health problems.[29]
- 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=7oNinI_YXLc&feature=youtu.be

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

[27] http://jech.bmj.com/content/early/2015/10/26/jech-2015-206209 (accessed 8 November 2015)

[28] http://www.theyworkforyou.com/debates/?id=2015-12-03a.591.0 (accessed 8 November 2015)

[29] Interview in *Primary Care Today: Supporting Integration in Primary Care* issue 35

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.[30] 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*."
- 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.

[30] www.politicshome.com/health-and-care/articles/story/hospitals-told-cut-staff-tackle-nhs-funding-crisis (accessed 9 February 2016)

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.

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.[31]

During March 2016:

- The Department of Health published its revised adult safeguarding guidance.[32] 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 [S1])*
- *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*

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

[31] http://www.briefreport.co.uk/news/anit-abuse-muslim-helpline-launched-in-lancashire-3955502.html
[32] https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding (accessed 16 March 2016)

learning resource which will be available on the website of the Social Care Institute for Excellence:

http://pub.lucidpress.com/MCABLBNetwork/ [33]

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.

[33] Accessed 24 March 2016

Safe use of Agency staff

01 Background

The reason for this briefing is:

a) An incident where an agency member of staff, employed to work with adults with care and support needs (ACSN). Proved to be unsafe. A subsequent safeguarding enquiry discovered that the member of staff had been posing as someone else. The CQC advised that, when using agency staff, employers still have the responsibility for checking that staff are 'fit and proper'

b) A number of safeguarding alerts involving agency care staff or nurses, with allegations including neglect and omissions of care

c) To raise awareness with care providers to understand their responsibilities when using agency staff, in line with legislation and guidance.

Why it matters 02

To ensure the safety of residents and service users, service providers must assure themselves that anyone working in their service is competent and safe to do so. This includes staff who are employed via agencies.

It is the law that persons employed for the purposes of a regulated activity are 'fit and proper'. This is defined as: " (a) be of good character, (b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and (c) be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed."

03 Information

All services using agency staff must provide the staff with access to their organisational policies and processes to ensure that they understand their responsibilities when working with ACSN.

04

Responsibilities of the care provider include:

- Policy & procedures for managing adult abuse, or the risk of abuse including whistleblowing procedures
- Satisfying themselves that agency staff have been recruited appropriately (including reference checks and Disclosure and Barring (DBS) checks) and are inducted and trained and provided with ongoing supervision
- Checking the online NMC website to ensure nurses are registered

05

- Managing allegations against persons working with adults at risk, including reporting to professional bodies in relation to misconduct
- If there are concerns that a staff member (agency or not) has caused harm, or poses a risk of harm to vulnerable groups; care providers have a legal obligation to refer relevant information to the DBS service **www.gov.uk/government/organisations/disclosure-and-barring-service**

06 What to do

- Use an agency you are confident complies with the above; establish your requirements for fit, proper staff
- Check written references and DBS. if in doubt about fitness to practice speak to the agency to obtain details of previous employers
- Where possible, request agency staff whose competence is already established
- Raise a safeguarding alert where there is an allegation of abuse or neglect, report any practice concerns to the agency and/or professional body
- Observe practice

07 Questions to consider

- Are your practice and processes for using of agency staff robust? Always?
- Do you record actions taken to evidence safe use of agency staff?
- Are you confident you are compliant with the CQC regulations?

lancashire safeguarding adults board

Emollients and Smoking

1 Background

Protection from fire and prevention of future deaths
Several tragic deaths of residents within care homes have led to the Coroner making recommendations about the appropriate levels of fire safety within care facilities. Are these deaths avoidable? – Yes. The issues need urgent consideration and action by care home Registered Managers, nominated individuals and care teams, to identify critical risks associated with individuals

The Fire Safety Order 2005 requires the identification of individuals at risk as part of the fire safety risk assessment for the premises and to take appropriate action to remove or reduce the risk.

2 Why it matters

A personal risk assessment for each resident is critical for their own safety and that of other residents and staff. This will assess the needs of the individual in conjunction with care workers and family and consider their habits, physical and mental capacity, and their environment. The risk assessment should be recorded and considered as part of their care plan, other assessments and personal evacuation plans, and kept under review.

3 Information

Coroner's advice is that you must consider the risk posed by individuals smoking on your premises, particularly if the person at risk has limited mobility. This follows inquests into the deaths of high-risk smokers with mobility problems from burn injuries as a result of matches or cigarettes dropping on to clothing or bedding.

4

Emollient creams are used to treat dry skin conditions and some patients are often in bed for lengthy periods due to illness or impaired mobility. Certain creams can be highly flammable (e.g. those that are paraffin-based) and pose a significant risk in the event of a fire. The fire risk posed by the use of such emollient creams is significantly increased when the user is smoking. The individual's bedding and clothing can also become impregnated with cream, increasing flammability and the risk to the user.

5

Following recent fire deaths in Lancashire the Coroner highlighted that the use of such creams should be risk assessed and action taken to reduce the harm. The use of emollient creams must be considered in your fire risk assessment to ensure that all reasonably practicable steps are taken to reduce the risk of a fire and its likelihood of occurring.
http://www.nrls.npsa.nhs.uk/patient-safety-videos/paraffin-based-skin-products/

6 What to do

This increased risk of fire posed by smoking whilst using flammable emollient creams is so significant that it must be avoided.

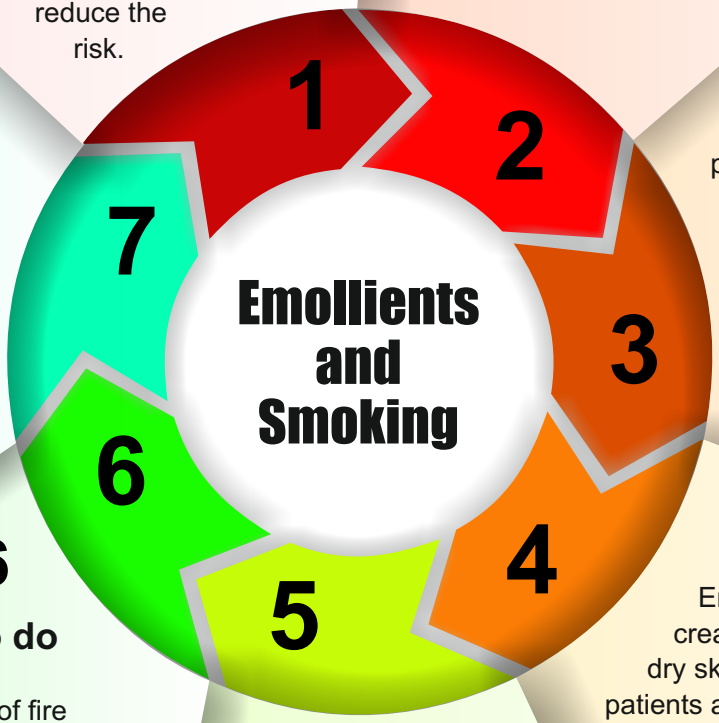
Fire retardant covers, bedding or clothing for smokers must always be provided.

There must be sufficient numbers for items to be laundered at the correct temperature.

This is the responsibility of the care home owing a duty of care for the health, safety and wellbeing of individuals who may be at heightened risk.

7 Questions to consider

Is the individual a smoker?
Are emollients being applied? Does this product contain paraffin? If Yes?
Share the risks with:
Individuals
GP/Nurse Prescriber
Family member
ACT; CONSIDER AN ALTERNATIVE PRODUCT



FIRE SAFETY

BRIEFING NOTE - RESIDENTIAL & NURSING CARE

INDIVIDUAL FIRE RISK ASSESSMENTS BEING INCLUDED UNDER THE REGULATORY REFORM (FIRE SAFETY) ORDER 2005 IN THE FIRE RISK ASSESSMENT

Background

Fatal Fire in Lancashire

An incident occurred in a residential nursing home near Preston where a Male person aged 69 died after smoking whilst covered in emollients. The episode happened on 27th December 2015 at 07:45.

This tragic event follows on from fatal fires in London, Surrey and West Sussex.

The Coroner's reports are summarised on the following pages below.

Introduction

Care Homes – protection from fire and prevention of future deaths

Several tragic deaths of vulnerable residents within care homes have led to the Coroner to make recommendations about the appropriate levels of fire safety within care homes.

The Fire & Rescue Services believe that some of these deaths were avoidable - and believe that the issues need urgent consideration and action by care home Directors and owners to identify critical risks associated with individual clients.

Fire Safety Law

The Regulatory Reform (FS) Order places a duty on the responsible person to carry out a suitable a sufficient FRA (Fire Risk Assessment).

Article 10 Principle of prevention to be applied specified in Part 3 of Schedule 1 appears to have been laid out in a descending order of possible application with "avoiding risks" seen as the most ideal and "instructions to employees" as the least favourable option. This train of thought is similar to that laid down in the H&S guidance insofar as it is better to avoid risks than to simply address the problem with additional protective measures.

Regulation 28 Coroners reports

London: Rita Dexter Deputy Commissioner

Death of Mrs Parle

In 2010 a dementia patient smoked in her bedroom where her nightwear came into contact with a naked flame.

Matters of Concern

- *Art 9(1); Failure to make a suitable and sufficient assessment of the risks to which relevant persons are exposed.*
- *Art 11(1); Failure to effectively; plan organise, control, monitor and review the preventative and protective measures.*

Surrey: Michael Burgess Assistant Coroner.

Death Vera Lillian Steele

In 2012 a heavy smoker was taken into the Garden. She was still in her night dress with a blanket over her legs. Whilst the carer was gone she dropped a lit match onto her lap.

Matters of Concern

- *Obtain a fire apron or smock*

West Sussex: Ian Christopher Wilkinson Assistant Coroner

Death of Mr B

In 2015 a pipe smoker was taken into a conservatory. He had his pipe lit and the staff left him alone, the presumption was that he was wearing a fire retardant smock, this was not the case and he set himself on fire. Smoke Detection alerted the staff and he was extinguished. Additionally he was covered in paraffin based cream that is also flammable

Matters of Concern

- *Centraben emollient cream is paraffin (24%) based product and does not display any fire risk warning on the bottle.*
- *Diprobase emollient cream is paraffin (21%) based product but contains fire hazard warning but had not been examined.*

- *NPSA (National Patient Safety Agency) reported in 2007 on paraffin based products but focused on 50% plus content or emulsifying ointments.*
- *NPSA commissioned the HSE to undertake fire hazard testing with SOFT WHITE PARRAFFIN. It is not clear that subsequent cases have occurred or been highlighted.*
- *There is little information conveyed or publicised about the two products.*
- ***Risks should be assessed and action taken***

London: Dr Fiona Wilcox Coroner

Death of Mrs Rosina Mary McDonald

In 2015 a mental health patient had a fire in her bedroom as a result of 2 modified cigarette lighters.

Matters of Concern

- *Current guidance is insufficient relating to RAs in Residential Care;*
- *Not required to take into account individual risk factors.*
- *Recorded in individual care plan*
- *Do not account for persons access to fire sources*
- *Include appropriate control measures*
- *Reviewed according to decline in cognitive behaviour*

Individual Fire Risk Assessments of residents

Individual fire risk assessments for each resident are critical for their own safety and the safety of other residents and staff. A risk assessment will assess the needs of the individual in conjunction with care workers and family and consider their habits, physical and mental capacity, medication and their environment. This should be recorded and must also be considered alongside their care plan, other assessments and personal evacuation plans.

The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person. This is particularly important when working with individuals where there is reason to doubt mental capacity in understanding fire safety and risks.

The Mental Capacity Act is intended to be supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

The five statutory principles are:
1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made, on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Where there is reasonable belief to doubt an individual's capacity relating to fire safety, it is good practice for staff to carry out a proper assessment of a person's capacity to make decisions. The findings of the assessment must be recorded within the care records.

This is critical where residents are known to be smokers and/or may be in possession of ignition sources such as lighters and matches as these add greatly to the risks of a fire starting. From this information care and sheltered home operators and other responsible persons must identify the appropriate control measures and additional equipment to best manage the risk of fire and protect individuals at greater risk. These could include:

- Supervision of smoking (only allow gas lighters, NO matches), or the removal of such ignition sources. Including the control of cigarettes.
- Fire retardant nightwear and bedding (protection apron or smock could be worn or draped).
- Additional smoke detection and telecare systems;
- Water mist or sprinkler systems.

All healthcare staff involved in the prescribing, dispensing or administration of paraffin-based skin products are also reminded that bandages, dressings and clothing in contact with paraffin-based products, for example white soft paraffin, white soft paraffin, liquid paraffin or emulsifying ointment are easily ignited with a naked flame or cigarettes.

Any risks identified and measures put in place should be recorded in the significant findings of the fire risk assessment. *These should be* regularly reviewed particularly where there is a decline in cognitive ability or mobility.

Scrutiny Committee
Meeting to be held on 16 December 2016

Electoral Division affected: None

Work Plan and Task Group Update
(Appendix 'A' refers)

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Executive Summary

The plan set out at Appendix 'A' summarises the work to be undertaken by the Committee in the coming months, including an update on Task Group work. The information will be updated and presented to each meeting of the Committee for information.

Recommendation

The Committee is asked to approve the 2016/17 work plan.

Background and Advice

A draft work plan for 2016/17 has been provided at Appendix A indicating areas of work for future scrutiny. The Committee is asked to consider and approve the topics identified.

Information on the current status of work being undertaken by the Committee and Task Groups is presented to each meeting for information.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

There are no significant risk management implications.

List of Background Papers

Paper	Date	Contact/Directorate/Tel
N/A		

Reason for inclusion in Part II, if appropriate

N/A

Appendix A

Scrutiny Committee Draft Work Plan 2016/17

18.11.16

Date of Cmttee		Report	Lead Officer	Purpose of subject and scrutiny method
22.7.16		**Planning Matter task group report – Cabinet Member response**	Andrew Mullaney	The formal response of the Cabinet Member for Environment, Planning & Cultural Services to the recommendations of the Planning Matter task group
		TAMP Update	Karen Cassar	Committee to receive an update on the work of the TAMP task group including content from Steve Berry, Department for Transport
		Highways	Phil Durnell	Update on the latest position regarding resources, footpaths, highways and white lines. To include a summary of the procedure for responses to elected members.
23.9.16		**Crime & Disorder – PREVENT**	Pam Smith	
		Review the current measures to counter racism, xenophobia and hate crime	Saeed Sidat	Resolution of a NOM submitted to Full Council on 21 July

14.10.16		Meeting cancelled		
18.11.16		**Residential & Domiciliary Care**	Ian Crabtree	Residential and domiciliary care – viability and sustainability
		Overview of the process for budget scrutiny	Josh Mynott	Report on how budget scrutiny will be undertaken
16.12.16		**Service transformation for adults**	Tbc by Tony Pounder	Picking up from Newton's presentation in June – STPs and the issue of working alongside NHS colleagues – following up themes that have been identified – Passport to Independence
		Adult Safeguarding	Jane Booth	Report of the LASB
13.1.17		**Skills Agenda**	Tbc by Louise/Eddie	Equipping people for life and impact on other areas of individuals life chances/outlook etc
		Summer 2015 water contamination report	Drinking Water Inspectorate	Independent Report
		Community Infrastructure & Assets	Tbc by Clare Platt	Capacity of communities
		Pooled Budgets	Tbc by Mike	Integrated working – major impact on future ways of working of the

			Kirby	authority. Possibly use services for adults with LD as the focus
10.2.17		**Core systems of the council**	tbc	Comparisons with other Las, best practice
		Skills agenda	Tbc by Louise/Eddie	Equipping people for life and impact on other areas of individuals life chances/outlook etc
17.3.17				
		Crime & Disorder Strategy		Annual scrutiny of the strategy
13.4.17		**Flood & Drainage Authority – effectiveness of control**	Alan Wilton and/or Rachel Crompton	• Drainage processes • Flood risk within the planning process • Regulatory framework • Partners – UU, EA etc • Update from officers re grants • Scrutiny of flood incident reports – outcomes from them
		Flooding & drainage update	Rachel Crompton	As per minutes of May meeting

Future Topics: not yet scheduled

- Bus Services and Subsidies
- Rail Travel – Update on developments since Task Group
- Commissioning Authority

Task groups and Sub Groups update

Children's Services Scrutiny Committee:

- YOT – final report presented to Committee 7.9.16
- SEND – progress update presented to Committee 7.9.16
- Fostering & Adoption(Promotion of fostering) – sub-groups approved at Committee 7.9.16
- TAMP task group – refresh meeting arranged for 14.12.16