APPENDIX 10a

Blackpool Safeguarding Adult Board

Annual Report: 2022-23

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BLACKPOOL SAFEGUARDING ADULTS BOARD

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1. Foreword

Welcome to the Blackpool Safeguarding Adults Board's (BSAB) Annual Report for 2022/23, and my first for the Partnership having only been appointed in August 2023. This report accurately describes the challenges faced across the Partnership during 2022/23, post Covid and at a time when demand increased, and agencies continued to do their very best for the public of Blackpool.

Now more than ever partnerships need to be efficient and effective, ensuring every opportunity is taken for improvement. The Health and Care Act 2022 now provides legislation for the Care Quality Commission (CQC) to commence a meaningful and independent assessment of adult care provided at a Local Authority and Integrated Care System level. These inspections are now underway, and the Blackpool Partnership welcome the future inspection (no date confirmed) and see it as an opportunity for further improvement. We will also provide the appropriate information and people to evidence our commitment to keeping people safe, free from abuse and neglect across Blackpool.

In support of this statement, we intend to review BSAB membership/attendance, along with the roles and responsibilities of the supporting subgroups. A new three-year strategy will be in place by October 2023, with supporting priorities and identified outcomes. Going in to 2023/24, we are also committed to ensuring the learning from Safeguarding Adult Reviews (SAR's) quickly translates into improved service delivery and that we also have a demanding workplan for the year ahead which will translate into tangible outcomes in line with the Care Act 2014. The Board and wider Partnership are truly looking forward to the year ahead, where we will continue to listen to our service users, learn from where we could have done better and deliver the very best service possible.

In conclusion, I would like to thank all those people across Blackpool who have played their part over the last year in keeping people safe. That includes not just those with specialist roles and specific responsibilities for safeguarding but all those members of the public, family members and individuals who have taken steps to report concerns and seek improvements in services. Working together, we will reduce the number of people in need of care and support, and prevent abuse and neglect.

Steve Chapman

Independent Chair, Blackpool Safeguarding Adults Board

2. The Board – Purpose & Structure

2.1 Purpose of the Board

The Care Act 2014 requires a local authority to establish a Safeguarding Adults Board (SAB), which aims to help and protect individuals who it believes to have care and support needs and who are at risk of neglect and abuse and are unable to protect themselves, and to promote their wellbeing.

Section 43 (3) sets out how the SAB should seek to achieve its objective, through the co-ordination of members' activities in relation to safeguarding and ensuring the effectiveness of what those members do for safeguarding purposes.

A SAB may undertake any lawful activity which may help it achieve its objective. Section 43 (4) sets out the functions which a SAB can exercise in pursuit of its objective are those of its members. Section 43 (5) Schedule 2 includes provision about the membership, funding and other resources, strategy and annual report of a SAB. Section 43 (6) acknowledges that two or more local authorities may establish a SAB for their combined geographical area of responsibility. https://www.legislation.gov.uk/ukpga/2014/23/section/43.

Six principles are set out in the Care Act 2014:

Empowerment	**Prevention**	**Proportionality**
Protection	**Partnership**	**Accountability**

Making Safeguarding Personal

In addition to these principles, it is important that safeguarding partners take an approach to safeguarding that focuses on the person, not the process. It means that safeguarding should be person-led and outcome-focused, engaging the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice, and control, as well as improving quality of life, wellbeing, and safety.

2.2 Core Duties

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

2.3 What will we do?

Our vision is that as Partner organisations we will work together to protect people in our communities to promote wellbeing and rights being supported, safe from abuse and neglect.

2.4 Aims and Principles of Cooperation

Working together to ensure adults at risk are:

safe and able to protect themselves.

treated fairly and with dignity and respect protected.

able to easily access support, protection and services.

2.5 Partnership Structure

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

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

Members

- Blackpool Council
- Lancashire and South Cumbria Integrated Care Board
- Lancashire Constabulary
- Lancashire & South Cumbria Foundation Trust (LSCFT)
- Blackpool Coastal Housing
- Blackpool Citizens Advice
- Blackpool Teaching Hospitals
- Lancashire Fire & Rescue Service (LFRS)
- Northwest Ambulance Service (NWAS)
- Healthwatch Blackpool
- NHS England
- Northwest Probation Service
- Victim Support

2.7 Subgroups

The Subgroups reported for 2022/23 are all pan-Lancashire, covering Lancashire, Blackpool and Blackburn with Darwen, however this model is expected to change in 2023/24:

- Complex Vulnerabilities (including self-neglect task and finish group)
- SAB Learning and Development
- Voice/Making Safeguarding Personal
- Mental Capacity Act (MCA)/Deprivation of Liberty (DOLS), Liberty Protection Safeguards (LPS)
- Strategic Safeguarding Adult Reviews (SAR)

2.8 Complex Vulnerabilities Subgroup

The subgroup met on four occasions in 2022/23 (09.06.2022, 15.09.2022, 08.12.2022 and 16.03.2023)

Key objectives are:

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

2.9 Self Neglect Task and Finish group

The Task and Finish group met on six occasions in 2022/23 (28.04.22, 13.06.22, 12.07.22, 13.09.22, 14.11.22 and 08.03.22).

Self-neglect nationally is a frequent theme in SARs where people are living at home. The purpose of this task and finish group is to review the LSAB Self-Neglect Framework launched in March 2019 with a view to a pan-Lancashire approach. This group reports into the SABs Complex Vulnerabilities sub-group.

2.10 SAB Learning and Development Subgroup

The subgroup met on three occasions in 2022/23 (11.04.2022, 28.06.2022 and 15.08.2022). The group was stood down due to a governance review late 2022.

Key objectives are:

- To facilitate an integrated approach to safeguarding learning and development across Blackburn with Darwen, Blackpool and Lancashire.
- Develop an annual safeguarding adult workforce development plan alongside an operational plan in line with the Boards priorities.
- Development of multi-agency training resources
- Quality assure and approve any learning being delivered.
- Drive forward the recommendations of safeguarding adult reviews, domestic homicide reviews and learning reviews across the partnership and seek assurance that learning is embedded within practice

2.11 Voice/Making Safeguarding Personal Subgroup

The subgroup met on four occasions in 2022/23 (27.07.2022, 02.11.2022, 16.01.2023 and 24.02.2023)

Key objectives are:

- To ensure an effective mechanism is in place to capture the 'voice' of the adult in line with requirements of The Care Act 2014.
- To provide oversight and direction to Partners to ensure person centred approaches to safeguarding are embedded within practice.

2.12 Mental Capacity Act (MCA)/Deprivation of Liberty (DOLS), Liberty Protection Safeguards (LPS) Subgroup

The subgroup met on four occasions in 2022/23 (11.04.2022, 16.06.22, 06.10.2022 and 08.12.2022)

Key objectives are:

- To ensure an effective mechanism is in place to tackle the complexities associated with safeguarding adults in line with the 'prevention' principle of the Care Act 2014.
- To develop a mechanism to support those individuals that do not meet the thresholds of statutory criteria to access support from statutory services. Page 11 of 39

2.13 Strategic Safeguarding Adults Review (SAR) Subgroup

The subgroup met once in 2022/23 on 08.06.2022.

Key objectives are:

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

3. What is Safeguarding?

3.1 Section 42 of the Care Act 2014 requires that each local authority must make enquiries (or cause others to do so) if it believes an adult is experiencing, or is at risk of, abuse or neglect.

This applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it (Care Act 2014, section 42)

Safeguarding means protecting an adult's right to live in safety, free from abuse or neglect. We aim to make safeguarding personal, so we try to achieve the wishes and goals of the person at risk.

Who are adults at risk?

Adults at risk are people who need more help than others to stay safe. They are people who may need help to live an independent life. They could be people:

- With disabilities
- With mental health problems
- Who are ill for a long time
- Who are old

What is adult abuse?

Abuse is when someone's human and civil rights are violated by someone else.

There are many types of abuse; some examples are:

- Physical
- Domestic
- Psychological or Emotional
- Self-neglect
- Neglect or Acts of Omission
- Sexual
- Discriminatory
- Organisational or Institutional
- Financial or Material
- Modern Slavery

Different people may abuse adults at risk; some examples are:

- Friends and family
- Professionals and volunteers
- Residential care staff
- Other people in a position of trust

The signs of abuse

There are many possible signs of abuse. Some examples include when the person:

- Has health and social care needs that are not being met
- Looks dirty or is not dressed properly
- Has an injury that is difficult to explain
- Seems frightened around certain people

3.2 Who can raise a safeguarding concern?

Anyone can raise a concern about a vulnerable adult with care and support needs who is at risk of abuse or neglect.

This may be family or friend, a carer, a professional working with adults with care and support needs or somebody who thinks they have been abused. It may even be a tradesperson or a member of the public seeing something in a health/care setting or home.

Alternatively, if a person has contacted other professionals (such as the police, health services or voluntary organisations) and there is concern that abuse is taking place, those agencies will also raise a concern.

3.3 How to raise a safeguarding concern

There are a number of ways a safeguarding concern can be raised.

Whether you are a member of the public or a professional, you can contact the Adult Social Care Department on 01253 477592 between 09:00 and 17:00 Monday to

Thursday and 09:00 and 16:30 on Friday. Outside of these hours, you can contact our Emergency out of hours team on 01253 477600.

Alternatively, you can visit the website at https://www.blackpool.gov.uk/Residents/Health-and-social-care/Social-care-for-adults/Forms/Referral-form.aspx and complete the online referral for, or email us at adult.socialcare@blackpool.gov.uk.

You can also write to us at:
Adult Social Care
Blackpool Council
PO Box 4
Blackpool
FY1 1NA.

4. Activity and Performance Information

4.1 Local Context and Background

The ceremonial county of Lancashire is in the Northwest of England and consists of the shire county of Lancashire and the "2 unitary authority areas" of Blackburn with Darwen and Blackpool.

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

The following information provides a brief overview of the local demographic context for Blackpool.

4.2 Population

According to Census 2021, Blackpool is the third most densely populated local authority in the Northwest, with 4046 people per square kilometre (compared to 4773 in Manchester, 4347 in Liverpool, 491 in neighbouring Fylde, and 397 in Wyre).

In Blackpool, admin-based projections of the population suggest it has increased by 0.3%, from around 141,100 in 2021 to 141,300 in 2022. England's overall population increased by 1.1% between 2021 and 2022.

In 2022, Blackpool ranked 169th for total population out of 331 local authority areas in Great Britain which is the same as in it ranked in 2021.

The Office for National Statistics (ONS) estimates illustrate that older people (65 years plus) account for a greater proportion of Blackpool's resident population than is observed at a national level.

Blackpool has a larger proportion of people aged 50 and over than the national average:

- 60,770 people aged 50+, 43 of the total population.
- 29550 people aged 65+, 21% of the total population.
- 14270 people aged 75+, 10% of the total population.
- At age 50+ the gender split is 48.8% male, 51.2% female.

- By age 75+ the gender split is 43.5% male, 56.5% female.

Projections of the population of Blackpool indicate that the number of residents over 65 will show a considerable increase within the next 25 years, far in excess of the levels of increase shown in all other age bands. The population aged 65 or over in Blackpool is projected to increase to 35,771 by 2043 which would make up over a quarter (25.3%) of Blackpool's total population.

4.3 Deprivation

The 2019 Indices of Multiple Deprivation revealed Blackpool ranked as the most deprived area out of 317 districts and unitary authorities in England, when measured by the rank of average lower super output areas (LSOA) rank and also by two of the other four measures.

In total, 39 (41.5%) of the LSOA in the authority were among the 10% most deprived in the country, of which 8 were also in the top 10 most deprived neighbourhoods in England.

4.4 Health and Social

The Health Index for England is a new measure of the health of the nation. It uses a broad definition of health, including health outcomes alongside health-related behaviours and location, with a Health Index score of 76.5 in 2021, Blackpool scored the least healthy local authority area in England.

It has been well documented over recent years that people are living longer and that the older age-groups will record some dramatic increases over future years, with associated financial implications and demand for health and social care services.

4.5 Safeguarding Adults Section 42 Enquiries

Safeguarding concerns raised or enquiries that commenced during 2020/21 with the previous year comparison are detailed in the table below. Observations are:

	2020/21	2021/22	2022/23	Comments
Individuals involved in Safeguarding Concerns	675	764	1250	Additional 486 people with a concern in the year (+63.6%)
Individuals involved in S42 Enquiries	272	281	511	S42 enquiries undertaken in the year has increased by nearly 82%. 40.1% of concerns went into S42 enquiries this year in comparison to 36.8% last year.
Individuals involved in Other Enquiries	32	37	104	Other enquiries have almost trebled in the year. Conversion rate has increased from 4.8% to 8.3%.
Males with a concern in the year	38%	40%	44%	Females still account for the majority of concerns raised. The sum of male and female proportions does not equal 100% as a proportion are recorded against records where the gender is 'unknown'.
Females with a concern in the year	57%	56%	54%	
Total number of Safeguarding Concerns	841	946	1564	Further and more substantial increase in the number of concerns raised in the 12m period April-March with an additional 618 concerns raised in the year (+65.3%).
Total number of S42 Enquiries	301	309	591	Almost double the number of S42 enquiries this year (+282/ +91.2%)
Total number of Other Enquiries	32	41	115	180% increase in the number of other enquiries undertaken this year!
Risk Identified	78.6%	84.4%	83.0%	Although there has been a significant increase in the number of enquiries which have been undertaken and concluded in the year, we see similar proportions of reported risk with no major changes in these proportions.
Risk – Assessment Inconclusive	5.6%	5.0%	5.7%	
No Risk Identified	12.4%	9.2%	7.7%	

Enquiry Ceased at Individual's Request	3.4%	1.4%	3.6%	
Number Lacking Capacity	62 (19.2%)	118 (32.8%)	183 (27.3%)	A smaller proportion of people are reported as lacking capacity this year. Those we reported as not known stay around 20%.
Desired Outcomes Fully Achieved	65.3%	71.8%	62.6%	We see a slight reduction in the proportion of clients whose desired outcomes are fully or at least partially achieved, most significantly for those that are fully achieved (-9.2%).
Desired Outcomes Partially Achieved	27.1%	22.3%	29.9%	
Desired Outcomes Not Achieved	7.6%	5.8%	7.5%	

The Primary Support Reason is not known for 60% of people with a concern and for half of those going into enquiries.

Physical Support		**Sensory Support**		**Support with Memory & Cognition**		**Learning Disability Support**		**Mental Health Support**		**Social Support**		**Not Known**	
21/22	**22/23**	**21/22**	**22/23**	**21/22**	**22/23**	**21/22**	**22/23**	**21/22**	**22/23**	**21/22**	**22/23**	**21/22**	**22/23**
42.9%	23.3%	1.3%	0.4%	12.4%	6.4%	7.3%	4.3%	10.6%	5.0%	2.2%	0.9%	23.2%	59.7%
36.8%	45.8%	1.5%	0.8%	9.9%	6.7%	5.1%	7.4%	7.4%	4.1%	0.7%	1.0%	38.6%	53.8%
21.9%	25.0%	0.0%	0.0%	9.4%	13.4%	0.0%	1.0%	12.5%	9.6%	6.3%	1.0%	50.0%	50.0%

Of those cases that had been concluded in the year, 'Neglect/Acts of Omission' continue to make up the highest proportion when looking at the type of abuse enquiries relate to. The least common type of abuse is 'Discriminatory with only 2 reported cases this year.

	Physical	**Sexual**	**Psychological**	**Financial**	**Discriminatory**	**Organisational**	**Neglect/Acts of Omission**	**Domestic**	**Sexual Exploitation**	**Modern Slavery**	**Self-Neglect**
	22/23	**22/23**	**22/23**	**22/23**	**22/23**	**22/23**	**22/23**	**22/23**	**22/23**	**22/23**	**22/23**
S42 Enquiries	25.2%	3.7%	8.8%	14.7%	0.1%	5.0%	31.3%	3.3%	0.4%	1.0%	6.3%
Other Enquiries	27.8%	4.8%	10.3%	11.9%	0.8%	4.0%	28.6%	4.0%	0.8%	0.0%	7.1%

The most likely places for abuse to occur remain as being in the individual's own home (40%), in a residential (24%) or a nursing home (12%).

We see decreases in the proportions (total) reported in the following locations:

- Community Service (-1.2pp)
- Nursing Home (-1.9pp)
- Residential Home (-9.4pp)

and increases in those reported in:

- Own Home (+2.3pp*)
- In the Community (+2.8pp)
- Acute Hospital (+2.9pp)
- MH Hospital (+1.7pp)
- Community Hospital (+1.3pp)
- Other (+1.6pp)

*pp – percentage points

Own Home	**Community (Excluding Services)**	**Community Service**	**Nursing Home**	**Residential Home**	**Hospital – Acute**	**Hospital – Mental Health**	**Hospital – Community**	**Other**
22/23	**22/23**	**22/23**	**22/23**	**22/23**	**22/23**	**22/23**	**22/23**	**22/23**

S42 Enquiries	40.8%	6.5%	1.6%	11.9%	23.8%	6.0%	2.6%	2.5%	4.4%
Other Enquiries	38.1%	2.9%	1.0%	15.2%	22.9%	8.6%	6.7%	1.9%	2.9%
Total	40.4%	5.9%	1.5%	12.4%	23.7%	6.4%	3.3%	2.4%	4.1%

We have made some changes in the way we work with people who have experienced/are experiencing domestic abuse and this has created some increase in the number of concerns being raised. Previously, these may not have been logged within the Safeguarding process and were just referred on to other appropriate agencies at the time the information was received. We have also had some changes in the approach within the Adult Social Care Community team which has resulted in a potential of over recording, logging everything as a concern prior to information gathering and contextualising the information, relying instead on the enquiry process filtering these out. We are gradually moving back to a position of robust recording of issues raised and clear, evidenced decision making and application of the safeguarding matrix guidance as to why a situation does not meet S42 criteria and what actions are being taken instead. This, when fully worked through should give more of a balance but we can still see an increase in safeguarding work anyway, across all teams and service areas.

We are also still feeling the effects of the pandemic – successive lockdowns allowed for safeguarding concerns to go unnoticed/undetected in relation to a range of potential abuse/risks and these concerns are now being picked up by a wider range of people which has led to increased reporting.

Awareness around autism and available support has expanded the resources in the Autism Team who are now receiving more referrals for social care support. Safeguarding concerns has increased for those who may not have been on any Adult Social Care team's radar. Following the introduction of two Homeless and Changing Futures social workers (SWs), we have also seen an increase in the number of concerns and enquiries in the year – these SWs are working with people who are vulnerable to multiple disadvantages and present with a range of risks including extreme self-neglect and are often the recipients of abuse due to lifestyle.

The Harbour is a large psychiatric hospital in Blackpool that generates a lot of Safeguarding concerns; many of these are not Blackpool residents – the increase is related to a better awareness of safeguarding and the need to inform Local Authority (LA) partners. We work closely with LSCFT Safeguarding Leads, attending monthly meetings to provide a more joined up approach in Safeguarding adult work.

Other potential causes may be linked to wider care sector issues and an inability of the whole care sector to robustly recruit to all vacancies leading to issues caused by lower staffing levels and the additional pressures on remaining staff.

5. Safeguarding Adult Reviews

5.1 What is a Safeguarding Adult Review?

The LSAB may be required to undertake a Safeguarding Adult Review (SAR) when, because of abuse or neglect, an adult dies or is seriously harmed ***and*** there is a concern that agencies could have worked together more effectively to protect the adult. Formal processes are in place to carry out such reviews.

The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

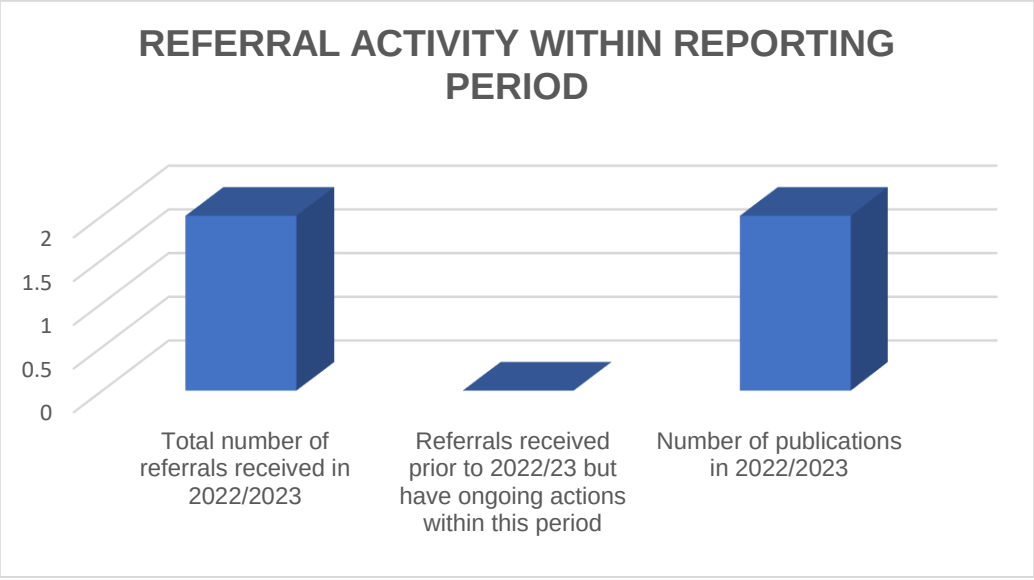
5.2 SAR Process

Any agency can request a Safeguarding Adult Review. Once a referral is made it will go through some key stages including initial scrutiny, consideration of meeting the SAR Criteria, and commissioning of an Independent Chair and Reviewer. Once the SAR process starts a number of panels will be held to understanding learning and involvement from relevant agencies and what could be done to support prevention. A report is then developed and published with a number of recommendations and actions for the Safeguarding Adult Board to take forward. Some recommendations may be for specific agencies, and some may be allocated to Subgroups already managing improvements along particular themes e.g., Self-Neglect.

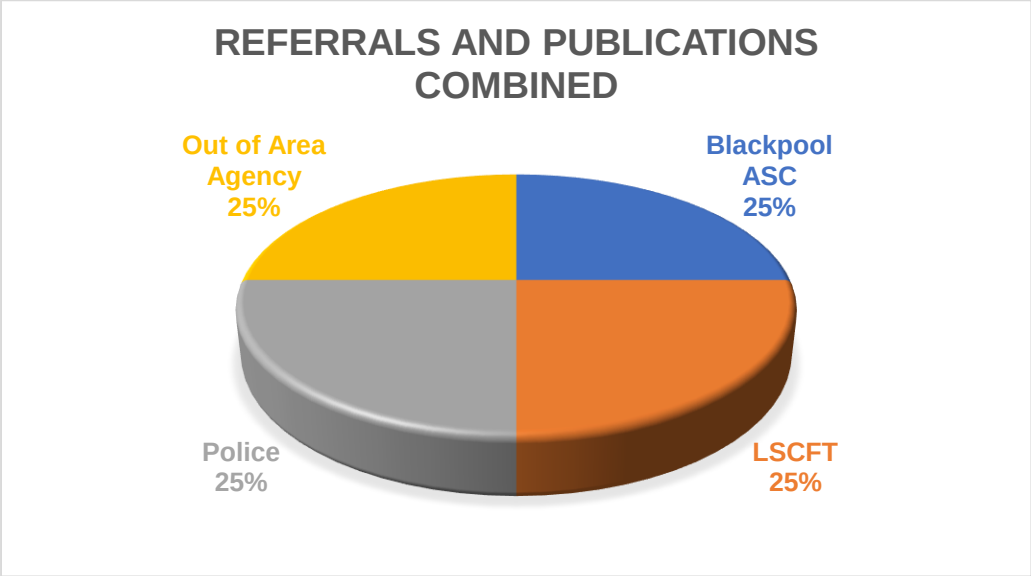
5.3 Blackpool SAR Activity

The findings from Safeguarding Adult Reviews in Blackpool are reported here, these include:

- the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),
- the reviews arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),
- what it has done during that year to implement the findings of reviews arranged by it under that section, and
- where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.



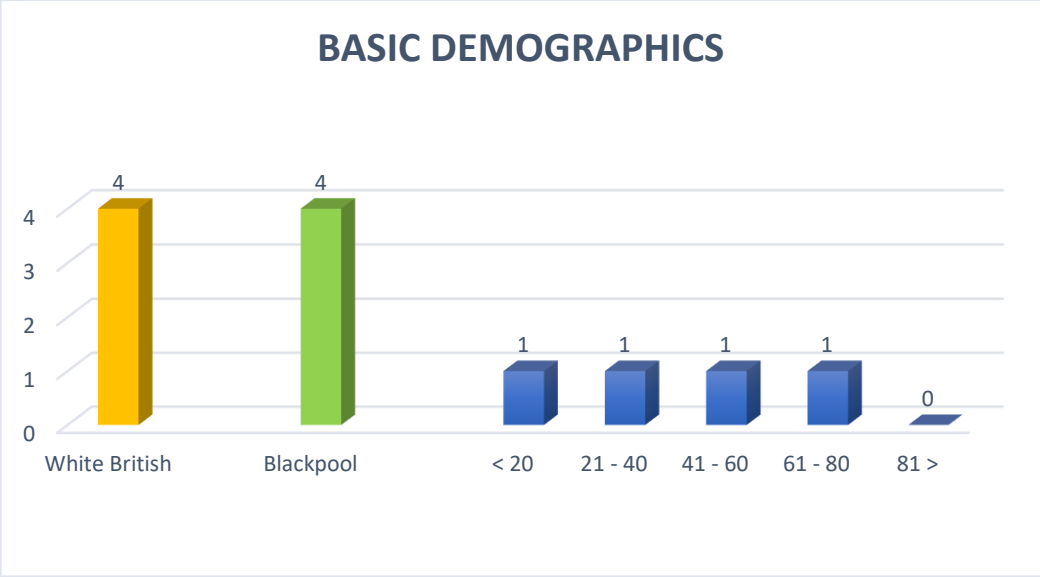
The activity being reported on in this period as shown in the above has been broken down into agencies who have referred, below.



During this reporting period – 1st April 2022 to 31st March 2023, the Safeguarding Adult's Board received **two** referrals for Safeguarding Adult Review. Both are currently in progress.

Demography of People

When looking at the demography of the subjects of the referrals being reported on within this period, below is a summary of the these which outlines the ethnicity, district and age range:



5.5 Published SARs

The following two referrals were received prior to the reporting period, but were published within the reporting period:

Case 1 - Adult Q

This case concerns a nineteen-year-old male who passed away in March 2019. The disease or condition leading directly to death was determined to be 'acute asthma', and 'severe obesity' was recorded as a significant condition contributing to his death.

Adult Q was a care leaver (now referred to as care experienced) in Trafford who had left his long-term foster care placement and moved to live with his father and stepmother just after his eighteenth birthday. Thereafter he moved with his family to Blackpool where he accessed primary and specialist care for health issues including increasing obesity. He continued to be supported by the Trafford Aftercare Team as a care leaver. Adult Q died after his relationship with his father and stepmother broke down and whilst arrangements were being made for him to move to emergency accommodation in Trafford. However, at the time of his death, Adult Q was still living with his father and stepmother in Blackpool.

The key themes and learning points are summarised below:

- Assessing risks when care leavers 'return to their parents'.
- Cross border working
- Effectiveness Assessments
- Support to address obesity
- Safeguarding concerns overlooked
- Mental Capacity
- Lived Experience
- Deficits in the Leaving Care Offer
- Supporting Care Leavers

An action plan was created in conjunction with the Trafford SAB based on the recommendations and the majority of these actions have now been implemented.

Case 2 - Adult V 'Jessica'

Jessica was born with Down's Syndrome. As Jessica developed, her level of independence was established; she was independently mobile but required someone with her to access the community. Jessica lacked capacity for many of her decisions but was able to make basic choices when offered options from things she knew and had experience of. Jessica was dependent on others for her meals and the provision of a clean and tidy home environment.

Jessica lived with her mother (Ann) and siblings. When Jessica was 18 years old, Ann moved Jessica from East Sussex to Leeds. In 2016 when Jessica was 21 years old, the family moved to the Blackpool area.

Jessica died at home, aged 24 years as a result of severe emaciation and neglect and widespread and severe scabies infection. There was no evidence of Jessica's hygiene or personal needs having been met for a considerable length of time. Following Lancashire Constabulary commencing a criminal investigation, Jessica's mother pleaded guilty to gross negligence manslaughter and was sentenced to 9 years and 7 months imprisonment.

The focus of the Safeguarding Adult Review was the circumstances surrounding Jessica's deterioration and death.

The key themes and learning points are summarised below:

- Transference of Information Across Borders
- Referrals
- Whole Family Approach
- Carer's Abuse
- Jessica's Voice
- GP Safeguarding

This report was published in April 2023.

5.6 Learning and Implementation Activity

For all published SARs during 2022/23, action planning meetings have taken place to review the recommendations and actions from all reports have been progressed by either key agencies or through the Subgroup Activity. Highlights include:

- Review and implementation of how certain safeguarding concerns and enquiries are managed in Blackpool
- A review of the operational processes on how high-risk Domestic Abuse cases are managed
- Changes to how agencies share information to support vulnerable adults e.g., access to information virtually to support mental health assessments
- How carers assessments are shared with relevant agencies (now sent to GPs)
- New delivery model in health to manage safeguarding issues on more placed based approach to support prompt action and interventions
- New home packs - support included for vulnerable residents in social housing
- Improved escalation process around contracts with commissioned services

Recommendations which have been multi agency and are linked to particular themes have been allocated to subgroups as referenced earlier in this report. Each has a workplan with key areas of focus including:

- Mental Capacity Assessments (MCA)
- Domestic Abuse
- Mental Health
- Voice of the Adult
- Making Safeguarding Personal
- Self-Neglect
- Multi-agency working

Policies and procedures

A number of policies and procedures have been reviewed and updated to make sure they align with changes to legislation including the Domestic Abuse Act and Mental Capacity Act. Guidance including seven-minute briefings and toolkits have also been developed to support staff learning circles, awareness events and quick references on the Blackpool Safeguarding Adults Website.

Work was also completed to support changes to Liberty Protection Safeguards (LPS) including multi-agency response to consultation, planning and engagement with partners on understanding what needs to be put in place.

Training

Learning from Reviews events have been set up for front-line staff and a programme for 2023/24 is in development. Across the partnership staff have been encouraged and have attended awareness training covering Trauma Informed and Suicide Prevention sessions. The Safeguarding Adult Board has also supported awareness campaigns, including White Ribbon, National Safeguarding Week and MCA Awareness Week.

Risk Management

Issues have been progressed to the Safeguarding Adult Board where there are concerns around increased pressures in health and social care and potential risks to increased safeguarding of vulnerable adults around particular themes. These have included seeking assurance on demand management on access to in-patient mental health beds, resident to resident harm incidents, and progression of work to support front line services in managing self-neglect.

Assurance

Assurance has been sought around Domestic Abuse pan-Lancashire approach, and changes have been proposed on the process of how high-risk cases are managed. Surveys on Domestic Abuse and MCA have been developed for frontline staff to provide an understanding of subject areas and help identify where training and awareness needs to be strengthened. The outcomes of this work will be analysed in early 2023/24.

Activity has also taken place to ensure that organisations have protocols in place for Making Safeguarding Personal (MSP).

Healthwatch 'Voices' Project Proposal

Healthwatch Together have proposed a commissioned Project to the Safeguarding Adults Boards to deliver a robust engagement project which will review the involvement of people within the safeguarding process. The Project will look to start in Summer 2023 into 2024. We know processes are more successful when they involve people as fully as possible; engaging with people to increase understanding, choice, and control so that we improve the quality of life, wellbeing, and safety of the individual. The project will explore:

- The experience of the individual
- The experience of the carer (where applicable)
- The experience of the professional

Scope

The number of people to engage with will be determined by the number of consenting individuals identified by each Council. Estimations have been made using safeguarding closure data gathered from Blackpool Council, Blackburn with Darwen Borough Council and Lancashire County Council (in comparison with local authority population sizes).

The target is based on population figures and safeguarding data provided by Blackpool Council, Lancashire County Council and Blackburn with Darwen Borough Council.

In Summary

Healthwatch Together will work with the Safeguarding Adults Boards to independently support them to review their safeguarding process. Healthwatch will provide expert advice on engaging with people, both members of the public and multi-agency professionals to gather their thoughts, experiences, and opinions. This feedback will be used to generate realistic recommendations which Healthwatch will report on following the project and will review 12 months post initial professional survey findings to monitor achievement and implementation.

6. Board Strategy/Priorities for 2022/23

6.1 Priorities and Achievements

The Care Act guidance advises that the Safeguarding Adult Board should report on:

(a) what it has done during that year to achieve its objectives,

(b) what it has done during that year to implement its strategy,

(c) what each member has done during that year to implement the strategy,

As the country headed out of the pandemic changes in the BSAB leadership and membership meant a clear strategy was not in place for this year however, priorities around the following areas have been the areas of focus, delivering work through Subgroups mentioned earlier in this report. These cover:

- Voice – Making Safeguarding Personal
- Complex Vulnerabilities on Domestic Abuse, Mental Health and Self Neglect
- Mental Capacity Assessments/Deprivation of Liberty (MCA/DOLS)
- Resident to Resident Harm

7. Contribution from Statutory Partners

7.1 Blackpool Council

Blackpool Council's safeguarding responsibility is to work with all our departments, partner agencies and monitor how to protect vulnerable people with a view to keeping them safe in line with Blackpool Safeguarding Adult's Board.

The Council receives notifications of a concern for an adult at risk, utilises the threshold guidance to determine safeguarding threshold is met.

The Council has a duty to lead on safeguarding work, direct enquires to be undertaken and works across all teams/agencies and partners to reduce the risk to the person. Keeping the person at the centre of the safeguarding and working with them to keep them safe and reduce the risk of the situation occurring again.

Key Successes in 2022/23

From an Autism perspective, a lot of proactive work undertaken to ensure the person and voice of the person is central to the safeguarding process. To look at what reasonable adjustments can be put in place to support the person to be part of the safeguarding meeting and process.

Utilising different venues and adapting the way meetings are delivered so the person can be fully involved.

Learning from SAR's – Learning from Adult Q shared widely internally, via a session to all adult social care staff and going forward externally so lessons learnt can be shared and practice improvements implemented.

Persons in a Position of Trust (PIPOT) process has been restructured to ensure a more structured and consistent approach utilising a check & balance approach.

Mental Health – Improved partnership working with LSCFT safeguarding team and we have set up a monthly meeting between safeguarding managers/leads across both services to discuss safeguarding enquires generated by the Harbour.

The trust has produced an information request form for safeguard leads – this has led to a better quality of information being shared e.g., Datix reports (NHS incident reports). This has also led to improved responses to enquiries, enhanced information sharing and the enquiry being concluded in a timely manner and ultimately improving outcomes for people.

Safeguarding Leads – Peer Support Groups – set up in both Adult Social Care and Mental Health Service areas – These help to provide a safe and supportive place for leads to bring case discussions, learning from each other, share good practice and identify training needs.

Adult Social Care Health Teams have continued to work closely with our partners in the Acute Trust to collaboratively work through safeguarding concerns, reflect on practice and offer constructive professional feedback.

(Transfer of Care HUB) TOCH have set up meetings to discuss governance issues linked to safeguarding. Adult Social Care Health also attended this year's Safeguarding and Mental Capacity Conference/Training event set up by the Trust.

Regular Peer Support Sessions arranged for Social Workers by Team Managers in Adult Social Care Health Teams has included sessions on safeguarding and staff well-being. Enabling staff to feel supported in their lead role, share learning experiences and practice. This has been a valued event for staff to seek/offer advice and information.

We have also invited guest speakers to team meetings from Horizon and Changing Futures.

Key Challenges in 2022/23

- Improvement required in the application of consistent approach to use of the thresholds for safeguarding.
- Improvement in 'making safeguarding personal' consistency across the department.
- Improvements in contextualising safeguarding, evidence-based recording to support decision-making.
- Providers telling us they feel overwhelmed by the safeguarding process and greater communication and support required.
- Safeguarding Leads have requested support to enhance their knowledge around safeguarding especially in the progression of becoming a safeguarding lead and what the expectation is in this role.
- Overall improvement in all staff's learning and development to roll out refresher awareness and training in relation to safeguarding policy, pathways and practice.
- To address the improvements and challenges - A safeguarding Improvement Plan has been developed to address and implementation the work required across the department and wider.

Priorities for 2023/24

1) Consistent application of the safeguarding thresholds guidance, contextual safeguarding and recording.
2) Improve the partnership working internally and external with partner and other agencies.

7.2 Lancashire Constabulary

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

Our purpose is to prevent and detect crime and preserve the King's peace.

Our vision is simple: Preventing and fighting crime. Keeping our communities and people safe.

Our Strategy

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

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

- Deliver an outstanding service to the public and build confidence

Key Successes in 2022/23

- "Right Care, Right Person" has seen a reduction in deployments to "Concern for Welfare" thereby ensuring that the person is attended to by the right agency/professionals to address any concerns.
- Street Triage (Police & Mental Health Services working collaboratively) has been rolled out in East Lancashire in January 2022 to provide a collaborative response to individuals presenting to the Police in MH crisis, to ensure that they are assessed and supported appropriately at the point of contact.
- There has been a reduction in the number of individuals detained under s136 MHA.
- Op Signature is now adopted as our response to victims of fraud, which requires a uniformed response to anyone who is the victim of courier fraud or romance fraud who is aged over 70 years and/or presents as vulnerable.
- Think Victim campaign commenced in 2021 and seeks to raise awareness and improve quality of investigations. The focus has been heavily weighted towards identifying vulnerability in, for example, elderly persons.
- Efficiencies in MASH has seen processing of VA referrals without delay and, for periods, "live" time.

Key Challenges in 2022/23

- Supporting and liaison with care settings for those young people aged 18-24 to assist with a trauma informed police approach once adulthood has been reached.
- Increased community liaison from the uplift in Community safety officers evidences the commitment to "Plan on a Page" priorities.
- Launch of Right Care Right Person and ensuring the model is working and that the impact of the changes can be measured.
- Continued multi-agency response to exploitation.
- Review of Force response to Domestic Abuse and Rape and creation of specialist rape teams.
- Embedding the Force response to Violence against Women and Girls strategy through the National Police Chiefs Council and the College of Policing national framework for delivery.
- Delivering training to support the recruitment of hundreds of new police officers into Force.

Priorities for 2023/24

1) Improving the Force response to rape and serious sexual assault through Op Soteria, a new national operating model for the investigation of rape and serious sexual assault
2) Improving the quality of Domestic Abuse investigations.
3) Op Warrior is the Force response to tackling serious and organised crime. Operation Warrior targets the individuals and gangs involved in crime, as well as associated issues such as violence and intimidation, large scale drug supply, exploitation and fraud, all of which can cause serious harm to local communities.
4) The change programme known as the TOM (Target Operating Model) started in April this year and will look at how we can make our processes and functions more victim focused, more efficient and more effective.

7.3 Agency: Lancashire & South Cumbria Integrated Care Board (NHS)

Health and Care Act 2022

This period of report saw significant change in view of ICB health and care act legislation 2022, moving 8 CCGs into on ICB organisation.

The ICB became the statutory partner of the Safeguarding Adult Board on 1st July 2022 being accountable for a wide range of safeguarding activity to support the whole population of Lancashire and South Cumbria.

The ICB is established with the expectation to: -

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

A core contribution of improving outcomes in population health and healthcare is through assurance and scrutiny of the health services we commission to meet the needs of our population. This includes through the Board ensuring that organisations that provide health services have the right procedure in place to keep people safe from abuse and neglect and a workforce which is skilled and empowered to do so. Additionally, that multiagency working is evident and leading to robust risk assessment and collaboration.

We ensure that where there are lessons to be learnt from Safeguarding Adult Reviews as a partnership, a health system or single agency, these are embedded and shared across health organisations where appropriate. We are connected to the governance arrangements within the NHS Trusts across Lancashire and South Cumbria to assure the organisations actions are embedded.

The ICB ensures that there are effective arrangements in place for sharing information between organisations and the health system where someone might be at risk of being harmed.

We employ specialist safeguarding expertise to support the whole health economy including 'Designated Professionals' and 'Named GP's' who specialise in safeguarding adults and the Mental Capacity Act.

The safeguarding team at the ICB are connected to regional and national workstreams to ensure the voice and representation of our communities is heard at every level.

Key Successes in 2022/23

- **Learning**

The ICB has held a number of learning and development sessions for safeguarding across the health economy to support the themes and trends from safeguarding activity. These have followed a Appreciate Enquiry model and included bring service user voices to the core of how we consider safeguarding challenges. The sessions have explored themes including self-neglect, suicide & trauma informed approaches, and the invisible male.

The ICB has improved the connectivity between all incidents which are reported by our NHS providers to ensure that there is robust safeguarding expertise applying scrutiny and support and ensure that any themes or trends which may impact on our ability to effectively safeguard our population are identified and considered across the whole health economy.

- **Assurance and Performance**

The ICB has focussed on aligning reporting and our use of data in assurance across the previous 8 CCG footprints. This has supported us in developing a more robust dashboard of

activity to improve how we respond to challenges and how we deploy our resources to respond to risk.

We have maintained place-based assurance meetings during first year of ICB and while safeguarding Delivery Model being developed to ensure there is a safe transition to the new ways of working.

- **Partnership collaboration**

The ICB continues to lead on partnership work around how we respond to self-neglect within our communities. This work has brought a range of partner organisations together to truly reflect on existing ways of working and consider how we agree a shared value set and approach to supporting complex individuals who self-neglect and place an emphasis on taking a more preventative and trauma informed approach to practice.

The ICB has led the relaunch of the Safeguarding Champions Model across the Regulated Care Sector. So far topics have included: Resilience Hub Support for Regulated Care Staff; Learning from Safeguarding Adult Reviews and Safe Recruitment Practices (incl. PIPOT, exploitation, case studies).

Two ICB wide 'Primary Care' safeguarding conferences were held in September 2022 with 96 GP practice staff in attendance. The sessions included learning from Domestic Homicide Reviews, importance of routine enquiry, coding of records and think family. Local GP Safeguarding forums have continued to improve safeguarding practice across all Primary Care which have included sessions on the '999 reunite' scheme and clinical responsibility for DHR/ SAR chronologies

The ICB chairs and leads on a pan-Lancashire Mental Capacity workstream which has been actively working with partners to improve MCA practice. This has included re-launching guidance on how health and social care professionals prescribe and administer covert medication.

The ICB also presented a case study of excellent practice to the National Safeguarding Adult Network to showcase some of the best practice and strong multi-agency working across our system.

- **Duty to Co-operate**

The ICB has established links with Violence Reduction Network (VRN) and VRN Partnership Board. The ICB, along with partners, has endorsed a pledge and committed to delivering a trauma informed workforce and is working with partners to ensure that this is rolled out across organisations. So far, over 4,500 staff have been trained across Lancashire and South Cumbria.

Emergency Department Navigators are commissioned via VRN from Acute Services across the system. ICB have worked in year to strengthen the future resilience of this recognised clinical model of delivery, additionally ensuring all Trust areas have access.

Key Challenges in 2022/23

- **Workforce**

Although we have not seen the same unique pressures on health services as there was during the pandemic, there remains significant work by all health services in both recovery and responding to the ever-growing demand on NHS services. This continues to be a challenge for NHS workforce to have the capacity to attend training and some partnership meetings. Although this reduced capacity has impacted on training and some development meetings, all key safeguarding protection meetings have remained a key focus and always prioritised by staff.

The safeguarding workforce across the ICB and health economy remains static and does not reflect the diversity of our communities. Work is ongoing in how we can attract a wider and more diverse range of professionals into the safeguarding agenda. An ICB set workforce plan has been agreed along with allocated funding and a plan is in development to support a move into a new delivery model.

- **Deprivation of Liberty delayed Applications.**

The ICB has inherited a number of Court of Protection applications for Deprivation of Liberty which remain outstanding. Additional resources have been put in place to support this work and the ICB continue to closely monitor. In all cases there is a robust risk assessment applied to ensure any concerns or immediate actions are identified and resolved, and that there is a risk-based prioritisation model in place for any other work needed.

- **New ICB arrangements**

There are historic safeguarding commissioning arrangements across Lancashire and South Cumbria based on the local arrangements which were historically established by Clinical Commissioning Groups. The ICB is driven to deliver an equitable offer and only have variance within the safeguarding offer when there is warranted reason to do so.

- **Analysis of Impact from Safeguarding Adult Reviews**

There has been reduced assurance and audit undertaken on a multi-agency basis due to the lack of an effective quality assurance sub-group for the LSAB. Although there has been a focus on ensuring actions resulting from safeguarding adult reviews are monitored, there is a need to improve our assurance the learning is embedded and having a positive impact on our population.

Priorities for 2023/24

<u>Statutory Deliverables</u>

- **Safeguarding Delivery Model**

Implementation and appraisal of the ICB safeguarding delivery model. This will be a move to a single team working at system across Lancashire and South Cumbria for economies at scale that are value added, plus Place based focus so we know our local community populations needs.

As part of our developing model and strengthening our connections across the Northwest, the ICB is leading work with Greater Manchester ICB and Cheshire and Mersey ICB in developing a peer supervision model and stronger cross working and co-development of best practice tools.

- **Learning**

The ICB is aligning the outstanding actions from Safeguarding Adult Reviews to ensure the ICB has a single aligned approach to responding to actions. This includes being clear in our approach to learning communications, evolving how we learn from reviews, embedding an open learning culture and different learning styles to support our workforce. Ensuring we are clear what learning is to support front line practice and for the system. The ICB will device a clear audit programme that will form part of its overall assurance and accountability framework.

We plan to introduce a research best practice forum with academic partners to ensure safeguarding professionals are appraised of latest research practice that benefit outcomes of our vulnerable communities and individuals.

- **Continuous Improvement**

As we begin to work as a single health system across Lancashire and South Cumbria, we are focussed on ensuring that our data and key performance indicators are fully aligned and support a maturing the dashboard. Our Safeguarding Assurance Framework will be reviewed to reduce impact and bureaucratic demand on services and move to being more thematic basis and reflective of the learning from reviews and incidents.

As part of developing our local 'Place Based' offer we want to ensure we are consistent and equitable in how we support and local health services and our communities. Within this we must consider how we measure and record safeguarding activity so that it is more outcome focussed.

This continuous improvement work includes developing a health economy wide audit calendar, a proactive communication and campaign strategy and a refresh of governance and connectivity for local multiagency groups and networks.

- **Workforce**

Focus on developing and widening the diversity and capability of the safeguarding workforce across the entire health economy and consider succession and workforce longevity for this cohort. This includes how we deploy the resources and skills available within the ICB to best deliver high impact and best value for our population. In order to achieve that we will be placing a strong focus on the training and knowledge of our workforce to ensure they can meet the ever-evolving safeguarding agenda.

The ICB is dedicated to adopting a more pro-active approach to safeguarding and working with partners through multi agency working arrangements to consider how we can support transformational work which places stronger emphasis on preventative models of care. We need to ensure that the voice of adults with care and support needs are at the heart of our future commissioning strategy as an organisation and that safeguarding is a golden thread throughout everything we do.

7.4 Agency: Lancashire and South Cumbria NHS Foundation Trust

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

- Inpatient and Community mental health services
- Perinatal mental health services inclusive of inpatient perinatal Mental Health unit
- Forensic services including low and medium secure care
- Physical health and wellbeing services
- Learning Disabilities and Autism
- Eating Disorders

Our strategic approach to safeguarding is linked to our agreed Safeguarding Strategy 2022-2025, which takes account of the updated priorities and business plans of the Safeguarding Boards and Partnerships, our commissioned safeguarding specifications and updated safeguarding multi-agency systems and processes across the County. Our Safeguarding Strategy aims to ensure our services protect and prevent harm, abuse or neglect for service users and their families. LSCFT takes a Think Family approach to safeguarding practice.

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

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

Delivery of our priorities is monitored and reviewed via the Safeguarding Team portfolio groups and our internal governance structures.

Key Successes in 2022/23

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

LSCFT continues to collaborate across Local Authority Safeguarding services to strengthen information sharing, support provider led enquiries and ensure clinical contribution in Section 42 referrals, with independent oversight is provided within this by LSCFT Safeguarding team. An agreed pathway is in place in Blackpool.

We have continued to promote understanding and key messages in relation to domestic abuse via organisational communications, focused supervisions and training initiatives. Continue to deliver monthly lunch and learn sessions as a way of cascading key messages across the organisation. We support the preceptorship programme and LSCFT induction, promoting the safeguarding service and delivering key messages.

We have carried out significant activity to raise awareness of the Think Family Agenda, connecting safeguarding adults with the safeguarding children's agenda. We have trained over 1,000 practitioners in L3 Think Family safeguarding training during 2022/23.

We have revised all safeguarding adults training packages, written a training brochure that supports the mandatory training offer. Developed an electronic course evaluation which has increased the level of assurance around safeguarding training having a positive impact on practice.

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

In view of changes to the Blackpool MARRAC model, LSCFT have revised information sharing pathways to support timely information sharing and effective risk management.

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

Self-neglect together with neglect feature within Safeguarding Adult Reviews, we have issued briefings in regard to this issue to strengthen awareness and support complex case activity as required.

LSCFT continues to work collaboratively with Adult board members to develop and implement best practice relating to Self-Neglect, Mental capacity, complex vulnerabilities subgroups.

Key Challenges in 2022/23

Application of routine enquiry and DASH - LSCFT have a key role in supporting prevention activity aligned to the Domestic Abuse Act to fulfil core safeguarding responsibilities. This will require a review of training to promote understanding of Domestic abuse, its links to emotional well-being, mental health and the impact. We have continued to contribute to the MARAC processes with such increased activity, which has placed a greater demand on our resources.

Self-neglect/MCA –

LSCFT recognise the challenge of supporting service users where self-neglect is a feature of their presentation. Good evidence in applying the principles of MCA allows for multi-agency

responses and shared care planning. LSCFT will continue to enhance the quality of MCA activity to raise standards and achieve best practice.

Mandatory Safeguarding Level 3 training compliance -

Mandatory training compliance is not where we would like it to be following the introduction of a new compliance monitoring system. We have worked hard to offer more accessible training for staff. Think Family is a theme we see in our SI's and safeguarding reviews, therefore we will continue to embed this approach across the Trust, staff will think about family rather than an individual. This approach will support LSCFT to meet both local and national requirements, competences, standards and safeguarding responses.

Priorities for 2023/24

The Safeguarding Strategy has been developed and supports the Trusts vision, values and quality priorities. We will strive to embed a “culture of vigilance” throughout the organisation where safeguarding is an important part of everyday care.

LSCFT aims to promote empowerment, autonomy and human rights for adults, including those who lack mental capacity under the Mental Capacity Act 2005. Ensure services have effective safeguarding arrangements in place and are compliant with MCA.

We will continue to work on improving MCA compliance across the Trust, via ongoing audit activity, an updated training strategy, the provision of continued specialist MCA advice and supervision, and other mechanisms of quality improvement. We will enhance the quality of MCA activity to raise standards and achieve best practice, including celebrating good practices and identifying areas to strengthen. This work will continue whilst we await further updates from Government regarding the implementation of the Liberty Protection Safeguards and / or other changes to the substantive MCA 2005.

We will continue to undertake targeted awareness raising and specific audit work in terms of perpetrators of Domestic Abuse and establish and effective MARAC model across Lancashire with our partners. We will aim to have routine enquiry embedded in practice and evidenced in clinical records that appropriate responses have taken place.

We will take steps to improve practice in relation to self-neglect and neglect of adults. We will continue to work with the Safeguarding Adult Board in improving the self-neglect strategy.

We will demonstrate a learning organisation by learning lessons from case reviews and embedding best practice across the Trust.

7.5 Blackpool Teaching Hospitals NHS Foundation Trust

Blackpool Teaching Hospitals (BTH) is committed to safeguarding and promoting the health and welfare of all patients and service users. We are committed to an agreed strategic approach in relation to arrangements for safeguarding patients/service users and implementing the Care Act (2014), Mental Capacity Act (2005), Children Act (1989) and Working Together (2018) across the organisation.

We have three main hospitals providing acute services to around 330,000 local residents. The organisation also provides specialist tertiary care for cardiac and haematology services, delivers community health services to over 445,000 residents including those in North Lancashire and hosts the National Artificial Eye Service across England. Plus, we provide urgent and emergency care services to an estimated 18 million people who visit the seaside resort each year.

BTH is dedicated to identifying and safeguarding adults at risk in line with statutory legislation and guidance. All staff are across the organisation are appropriately trained to the right level to fulfil their roles and statutory duties. There is also a thriving safeguarding champions programme of over 200 staff with additional and enhanced knowledge.

Furthermore, complex safeguarding advice and support is available from the corporate safeguarding team including out of hours. The corporate team have a range of professionals with specialist knowledge too which includes sexual health, domestic abuse, contextual safeguarding and serious violence. BTH is responsible for identifying safeguarding concerns in relation to adults at risk, raising appropriate safeguarding referrals and contributing and implementing appropriate safeguarding plans. BTH is committed to ensuring compliance with the Mental Capacity Act 2005 (MCA) and that staff are appropriately trained and able to implement MCA appropriately.

BTH are committed to supporting the embedding of MCA and Deprivation of Liberty Safeguards (DoLS) into practice across the organisation. Enhanced quality assurance processes, monitoring of themes and trends and additional measures due to the high number of unauthorised Dols are in place, and reporting is in line with Trust governance processes. Support is also offered and provided at complex Best Interest Meetings across the Trust.

BTH continues to strengthen our commitment to co-produce integrated care, working with health and social care partners and as such BTH has corporate oversight, monitoring and assurance of Care Act s42 enquiries and investigations involving the Trust and ensures clinical input to professionals as well as attends adult strategy meetings as appropriate. Trends and themes are identified, and quality assurance mechanisms are enacted to support regulatory work internally and externally to the Trust, taking a proportionate and timely response.

BTH is dedicated to tackling violence against women and girls strategy (2021), Domestic Abuse Act (2021) and Victims Bill (2023) and have a dedicated Violence Against Women and Girls Team which incorporates Health Independent Domestic Violence Advisers (IDVA's) and Health Independent Sexual Violence Adviser's (ISVA's) who support both patients and staff who may have experienced, or are experiencing, sexual violence and/ or domestic abuse.

BTH has secured additional external funding to expand the Health ISVA service, providing support to victims of sexual violence across the local footprint at both East Lancashire Hospital Trusts (ELTH) and University Hospitals of Morecambe Bay Foundation Trust (UHMBT). This has provided consistent support, available to victims across Pan Lancashire in line with the Violence Against Women and Girls (VAWG) agenda and Sexual Offences Act (2003). BTH has further secured external funding to expand the Hospital IDVA service both at BTH, and including, UHMBT in line with Domestic Abuse Act (2021). This has enabled BTH Health IDVA's to reach more victims across BTH and UHMBT footprints and including reaching victims during unsociable hours.

BTH commitment to investing in our local community and collaborating with partner agencies has expanded its Domestic Abuse services via Operation Provide; a service that commenced in response to DAV during the Covid pandemic and has continued post pandemic. Victims are receiving timely support, and as a result, this has significantly increased victim engagement with Safeguarding and Police investigations. The Op Provide service has been nationally recognised by various high-profile awards and includes robust academic evaluation. Initial service launched in Blackpool and Fylde Coast and has expanded to Lancaster and has increased resources over both areas to reach more victims during core and unsociable hours. Nationally this model now stands out as the lead in reducing homicide to victims and ensure we adhere to the Domestic Abuse Act 2021.

Due to the significant amount of external funding secured and reporting requirements to different central government departments, OPCC, and associated inspectorates, ICB and internal, BTH corporate teams have expanded the business support function. This is to evidence outputs and outcomes, services be academically evaluated, recognised nationally via awards and national visits as well as support other Trusts nationally to launch similar services. The corporate safeguarding team are able to support bids with evidence and analysis which we have been very successful to improve outcomes to some of our most vulnerable and disadvantaged people locally.

BTH are committed to the Serious Violence Duty, to prevent and reduce serious violence. BTH provides a robust ED Navigator service following a scoping exercise, initially commenced at BTH. BTH have now expanded this service locally, hosting ED Navigators at both ELHT and UHMBT with positive comment from the Home Office on the successes of the service and fidelity of the model. Further, academic evaluation evidences a cost-effective service with good outcomes for low costs and compliant with the serious violence duty from central government and Violence Reduction Networks key aims.

BTH has aligned strategic objectives to co-produce high quality services with a key focus on preventative care and reducing health inequalities, working alongside the local ICB. BTH is an active member of the Pan-Lancashire Safeguarding Adult Board and participates in a number of sub-groups of the PL-SAB as well as multi-agency reviews such as SAR's and DHR's. Quality safeguarding practice is delivered in line with Blackpool Teaching Hospitals policy and procedures and Local Safeguarding Adult Board (LSAB) and Children's Safeguarding Assurance Partnership (CSAP), agreed protocols incorporate evidence-based practice based on national, regional and local guidance. Quality care provision across the Trust includes protecting people from harm (safety); delivering targeted support that works (effectiveness) and making sure patients and service users have a positive experience in care (Experience). The BTH corporate safeguarding team enhances support for all staff across the organisation in the delivery of excellent safeguarding practice and upholds the values and principles of wellbeing and Making Safeguarding Personal (MSP).

Key Successes in 2022/23

- BTH have continued to embed the '7-day DOLS Assurance Framework' across the acute inpatient setting ensuring that all patients who are subject to DoLS receive an independent review of the restrictions in place to ensure they are necessary and proportionate. In 2022, BTH was shortlisted as a finalist in the patient safety category for Nursing Time Awards for our MCA/ DoLS assurance framework illustrating the strength and commitment of the BTH workforce around vital regulatory work.
- BTH corporate team has expanded community safeguarding support and provision by providing an enhanced and dedicated service to our all our community services around patients who may be high risk of self-neglect, complexity and disadvantage to promote multi-agency working, wellbeing and strengths-based approaches.
- BTH Emergency Department (ED) Navigators embedded at Blackpool, Lancaster and East Lancashire Emergency Departments in support of the Violence Reduction Unit's (VRU) work across Lancashire.
- BTH Operation Provide in partnership with Lancashire Police embedded in practice at Blackpool and Lancaster and recognised at the Nursing Times Awards. The Operation Provide model of practice will be shared nationally by the police as a recognised model to reduce domestic homicides.
- BTH prioritises a learning culture by providing a robust training plan which includes weekly face to face Level 3 Safeguarding Adults and MCA bitesize training sessions, delivered by the Trust's corporate safeguarding team. Training compliance for these, as well as Prevent, have all exceeded Trust compliance figures and in line with national guidance. BTH also delivers bespoke training, and including, Domestic and Sexual Abuse

awareness sessions to upskill the BTH workforce to recognise and respond to victims of SV and/or DAV.

- BTH is supported by a robust Safeguarding Champions model which has been rolled out across the Trust to provide a forum for all safeguarding champions to meet in order to network, share best practice and lessons learnt across the networks. This model currently has over two hundred safeguarding champions signed up to the role from a variety of the BTH workforce Trust wide. The integration of a safeguarding champions' model across the organisation offers a robust support mechanism within each service area. The Safeguarding Champions are in turn supported, supervised and guided by the organisations corporate safeguarding team. The development of Safeguarding Champions across the organisation enhances and streamlines safeguarding practice in order to ensure consistency, up-to-date competency and confidence in responding to safeguarding adults, families and their carers.
- In September 2022 BTH hosted its first face to face annual safeguarding champions conference, facilitated by Hill Dickinson at the De Vere Hotel, Blackpool. The conference had over 100 attendees from across BTH as well as Blackpool Council partners and the ICB to learn further around Mental Capacity Act, DoLS and the implementation of LPS to support our integrated approaches to care, our vital regulatory work and to seek consultation around the roll out to the amendment of the MCA (2019).
- BTH Health IDVA's and Health ISVA'S provide immediate support and safety planning to patients and staff across the organisation and local area by ensuring victims are referred to appropriate services for longer term support and receive a trauma informed risk management plan.

Key Challenges in 2022/23

- There are high levels of deprivation in Blackpool, which experiences the greatest deprivation of all of England's local authorities and there are similar pockets of deprivation in Wyre, particularly in Fleetwood, all of which BTH provides health care services. There has been an increased pressure on the health and social care system resulting in rising levels of unmet need, increasingly impacting the NHS and causing unnecessary strain on critical services, where there is limited capacity to note for this report.
- Department of Health and Social Care announced the implementation of the Liberty Protection Safeguards (LPS), the Mental Capacity (Amendment) Act 2019, will be delayed in this parliamentary government. Operational and strategic work had taken place over a long period of time in preparedness to roll out LPS and the delay was disappointing for our most vulnerable patients who would have come under the proposals. Whilst BTH mitigates this risk by providing a seven-day review of all DoLS patients in our hospital sites, the risk of unauthorised DoLS applications remains a risk for BTH and patients continue to not have access to the necessary safeguards of which intended.

Priorities for 2023/24

- BTH key priorities triangulate in the continuation of our MCA Improvement journey Trust wide enhancing quality and responsiveness to patients who lack capacity who access our care.
- Strengthen our Self Neglect response working alongside partner agencies to balance risk, keeping people safe and respecting their wishes.
- Continuing to tackle domestic abuse and sexual violence as a key priority and including addressing perpetrators of abuse.
- Continue to enhance and develop a culture and skilled workforce at BTH who can respond to safeguarding adults at risk, particularly around wider vulnerabilities such as exploitation and radicalisation.

8. Looking Ahead to 2023/24

8.1 As we move towards 2024, the Board will focus on ensuring a clear three-year strategy is in place, with a supporting business plan. The Annual report for 2023/24 will consider what progress has been made in support of this strategy and business plan.

Data accuracy will also be a priority, given we have seen significant increases in concerns and subsequent enquiries recorded for 2022/23. While Safeguarding demand has certainly increased (as evidenced in this report and in line with regional and national increases), at this stage the BSAB is unable to accurately determine the length and breadth of this demand. This is key to ensuring appropriate use of resources and commissioning of services/interventions going forward.

This report also outlines the level of depravation and ill health across Blackpool when compared to other districts/areas across the country. It also outlines the expected increase in the population of people of 65 in the next 25 years. At a time when there has been limited investment in adult social care nationally, these challenges will not be addressed through finance alone. Agencies, partnerships and communities need to work together to ensure early intervention and problem solving becomes daily business to reduce the risk of escalating needs across our communities. Here in Blackpool, we have a reputation for innovative safeguarding across our partnerships and communities, and we will look to maximise these relationships to deliver the very best services aimed at preventing people developing care and support needs.

9. Board Finance & Resources

9.1 During 2022/23 Blackpool has had a shared partnership responsibility which is supported through both financial investment and resourced through a Joint Partnership Business Unit (JPBU) to deliver the following:

- Secretariat management and support to the Adults Safeguarding Boards
- Support to Subgroup activity and associated task and finish groups
- Commissioning of Safeguarding Adult Reviews (SARs)
- Funding the role of Independent Chair
- Develop and Publish Annual Reports
- Learning and Development in relation to learning from case reviews on pan-Lancashire/multi-agency level
- Development of pan-Lancashire guidance in relation to key priorities
- Publicity and Communications