BLACKPOOL SAFEGUARDING ADULTS BOARD
Annual Report 2018-2019

BLACKPOOL
SAFEGUARDING
ADULTS BOARD

CONTENTS

FOREWORD

I am pleased to present the Blackpool Safeguarding Adults Report for 2018-2019. The report sets out progress against our priority areas and highlights what more needs to be done to improve how we safeguard our vulnerable adults.

We have succeeded in achieving progress in a number of our priorities over the last year, but we know there is further work to be done. In particular, we need to do more work to understand the neglect and abuse of vulnerable adults especially financial abuse and the 'grooming' that is often associated with it.

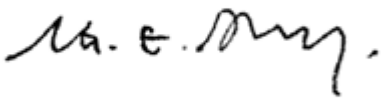
Partners have worked on a range of issues including; trafficking, modern slavery and neglect. We have identified that there needs to be more work to ensure all partners understand what 'Making Safeguarding Personal' and 'mental capacity' means to their organisations.

A key challenge for Safeguarding Adult Boards is to consider when multi-agency work appears to be less effective. In many cases a vulnerable adult fails to meet the level of vulnerability that triggers a multi-agency response. This is an area in which partners need to be more effective and there are plans to improve in this area.

A concern for SABs in ensuring residents are safeguarded, is the commissioning of local services. I am pleased that we have now included commissioned services on our sub groups and have included representation from our care homes. This will add to the effectiveness of the board moving forward.

A priority for this year will be to focus more on preventing abuse, as well as ensuring protection is proportionate and appropriate. We want to be ambitious and will be ensuring multi-agency approaches are promoted to ensure frontline staff are equipped to respond and reduce abuse. The business unit continues to improve the training packages available to partners.

This is my first report as chair of the board, and I would like to thank the previous chair for the work she has undertaken. I would like to thank all of the partners for their hard work and support this year. In particular, I would like to thank those in the third sector and the front line staff who do so much to protect our most vulnerable adults.



Stephen Ashley
Independent Chair
Blackpool Safeguarding Adults Board

1. THE BOARD

1.1 Purpose of the Board

The main objective of the Blackpool Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults who have needs for care and support* and are experiencing, or at risk of, abuse or neglect, and as a result of care and support needs, and the adult is unable to protect themselves. *whether or not the Local Authority is meeting those needs.

Blackpool Safeguarding Adults Board seeks to achieve this by co-ordinating and ensuring the effectiveness of each of its members in relation to adult safeguarding. We have a strategic role that is greater than the sum of the operational duties of our partners; we oversee and lead adult safeguarding across Blackpool and are interested in a range of matters that contribute to the prevention of abuse and neglect. Types of abuse and neglect under the Care Act 2014 include: physical abuse, domestic violence, sexual abuse, psychological abuse, financial abuse, modern slavery, discriminatory abuse, organisational abuse, neglect, and self-neglect. Blackpool Safeguarding Adults Board recognises that adult safeguarding is underpinned by:

Six principles set out in the Care Act:

Empowerment – People being supported and encouraged to make their own decisions and informed consent.

Prevention – It is better to take action before harm occurs.

Proportionality – The least intrusive response appropriate to the risk presented.

Protection – Support and representation for those in greatest need.

Partnership – Local solutions through services working with communities who have a role in preventing, detecting and reporting neglect and abuse.

Accountability – Accountability and transparency in delivering safeguarding.

In addition to these principles, it is also important that all agencies take a broad community approach to establishing safeguarding arrangements for complex cases.

Safeguarding Adults Boards have a statutory duty under S.44 of the Care Act 2014 to undertake **safeguarding adult reviews** in cases which meet the criteria. The purpose of a review is to identify lessons to be learnt and to drive improvements in practice.

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

Publish a Strategic Plan

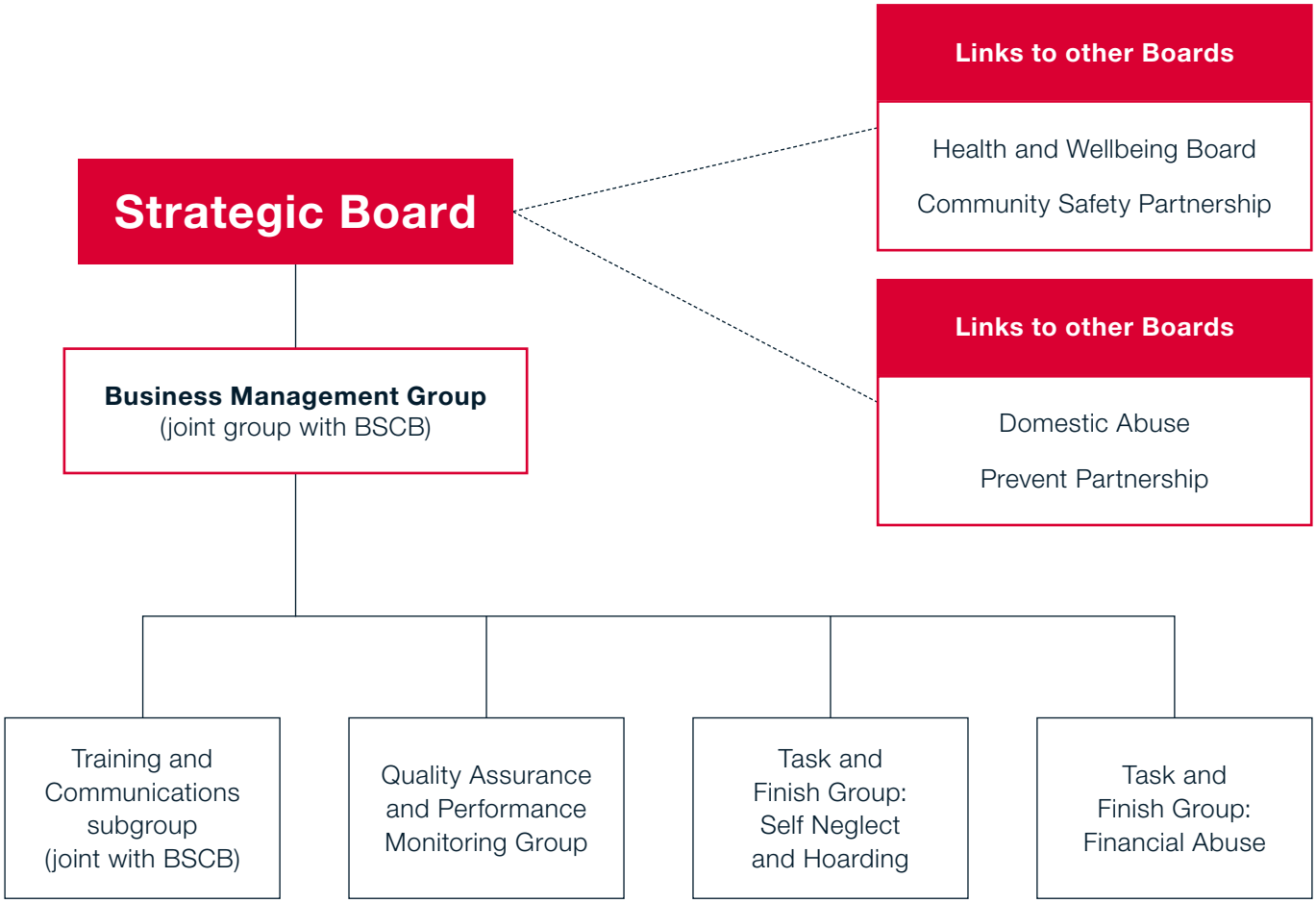
Publish an Annual Report

Undertake Safeguarding Adults Reviews

1.2 Board Structure

As a partnership, Blackpool Safeguarding Adults Board appoints an Independent Chair to oversee the work of the Board, provide leadership, offer constructive challenge, and ensure independence. The day to day work of Blackpool Safeguarding Adults Board is undertaken by the sub-groups. The board office supports the operational running of these arrangements and manages the Board on behalf of the multiagency partnership. To facilitate joint working, ensure effective safeguarding work across the region, and provide consistency for our partners who work across Pan Lancashire. The governance for the sub-groups is via the business management group that feeds into the Board.

Board Structure Chart 2018/19



Budget

The BSAB continues to be funded by a core group of Partners, with some income generated through charging for non-attendance at training courses. Financial contributions from Partners are essential for the BSAB to perform its function. Partner contributions also include additional resources of officer time and commitment to support the BSAB by attendance and chairing of subgroup meetings, delivering actions, training and access to Partner facilities.

Income and Expenditure Summary

Income		Expenditure	
Blackpool Council	76,886	Staff costs	149,150
Blackpool CCG	40,995	Independent Chair	7,072
Lancashire Constabulary	25,915	Training	2,025
Blackpool Coastal Housing	5,000	Board support costs	4,975
TOTAL INCOME	**151,786**	**TOTAL EXPENDITURE**	**163,222**

**Any overspend was funded through the previous year surplus.*

The BSAB team

The work of BSAB is supported by a small business unit, which is merged with the Blackpool Children's Safeguarding Board (BSCB) to provide additional resilience. The staffing structure and personnel have remained the same throughout the reporting period. Administration support continues to be provided to the Board by Democratic Governance. The BSAB element of the team consists of:

- A Business Development Manager
- 0.8 Full-time equivalent (FTE) Training Co-ordinators
- 0.95 FTE Democratic Governance Advisors to support meetings
- 0.5 FTE Analyst
- 0.5 FTE Training Administrator

1.3 Safeguarding Adults Board Membership

The Care Act clearly sets out that safeguarding board Membership must include:

- The Local Authority - Blackpool Council
- The Lead Health Commissioner – Blackpool Clinical Commissioning Group (BCCG)
- The Local Police- Lancashire Constabulary (Western/ Blackpool Division)

In Blackpool in addition to our statutory partners we also have membership from:

- Lancashire Fire and Rescue Service (LFRS)
- Blackpool Coastal Housing (BCH)
- Blackpool Teaching Hospitals (BTH)
- Lancashire Care Foundation Trust (LCFT)
- National Probation Service (NPS)
- Community Rehabilitation Company (CRC)
- North West Ambulance Service (NWAS)
- NHS England (NHSE)
- Blackpool and the Fylde College (Further Education and Higher Education)
- Blackpool Carer's Centre
- Public Health (part of the Local Authority)
- Healthwatch Blackpool

**A Membership List can be found in Appendix A*

Attendance at Board meetings

Attendance at meetings had been highlighted by the chair and was raised as an issue to the Boards in July 2018. There was concern that the CCG and police attendance at meetings would need to be addressed. It was acknowledged that there was no Adult Principal Social Worker in post until October 2018, so resolved the attendance of an Adult Services representative at Board meetings.

The membership of the Business Management Group (BMG) had been extended to include the Director of Resources for Blackpool Coastal Housing, during Q4.

The Quality Assurance and Performance Management (QAPM) Sub-Group had been poorly attended and was cancelled on two occasions during this reporting period due to poor attendance and the meeting not being quorate. Whilst on one of these occasions, a quorate meeting had been held a week after, the overall attendance was poor. This was regarded as being very disappointing and members of the group were asked to encourage attendance from the appropriate officers going forward, supported by a letter from the Independent Chair who had written out to members on this issue.

Agency	BSAB Board	BMG	Training	QAPM
Blackpool Council – Elected Member	75%	n/a	n/a	n/a
Blackpool Council – Adult's Services (other representatives)	100%	40%	100%	100%
Lancashire Constabulary – Western Division	75%	20%	80%	50%
Lancashire Constabulary – HQ Public Protection Unit	50%	n/a	n/a	50%
Blackpool CCG – Chief Nurse / Head of Safeguarding / Designated nurse	50%	80%	80%	50%
Blackpool Teaching Hospitals NHS Foundation Trust	75%	80%	100%	75%
Lancashire Care NHS Foundation Trust	100%	n/a	100%	50%
Cumbria and Lancashire Community Rehabilitation Company	100%	n/a	40%	100%
HM Prison and Probation Service	100%	60%	40%	100%
Blackpool Coastal Housing	100%	40%	60%	100%
Healthwatch Blackpool	50%	n/a	50%	50%

Please note: There was a gap in service provision during this period for Healthwatch Blackpool. Blackpool Coastal Housing and the new Adult service representative joined BMG in January 2019.

**This list does not include the Board's wider partners.*

2. What does adult safeguarding look like in Blackpool?

2.1 Blackpool Context

Population estimate and age profile

The resident population of Blackpool is approximately 139,000. Mid-2018 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.

	Total population	Males		Females		Age 0-14 years		Age 65 and over	
	No.	No.	%	No.	%	No.	%	No.	%
England	55,977,178	27,667,942	49.4%	28,309,236	50.6%	10,144,712	18.1%	10,179,253	18.2%
Blackpool	139,305	69,038	49.6%	70,267	50.4%	24,506	17.6%	28,402	20.4%

Source: ONS mid-year population estimates, 2018

Geodemographic segmentation

This section remains the same as 2017/18, the data has not been updated since the last annual report.

MOSAIC is a demographic profiling tool that is produced by Experian. MOSAIC categorises all households and postcodes into 'segments'. Each segment shares a set of statistically similar behaviours, interests or demographics. MOSAIC is especially useful for providing insight into the local population, service users and neighbourhoods and can be used to support sophisticated service development - right through from initial feasibility research into service design and marketing.

The most recent version of MOSAIC was released in 2017. Households are categorised by 15 broad MOSAIC segments called 'groups'. These groups can be further broken down into 66 detailed MOSAIC segments called 'types'. Each group or type has an associated name and a detailed statistical profile. It is these profiles that paint a rich picture of the segments and provide insight into the local population.

The following are the total count and percentage of households within each high level mosaic group. A large majority of Blackpool households fall into 5 Groups; F, H, K, L and N representing 74% of all households in the town.

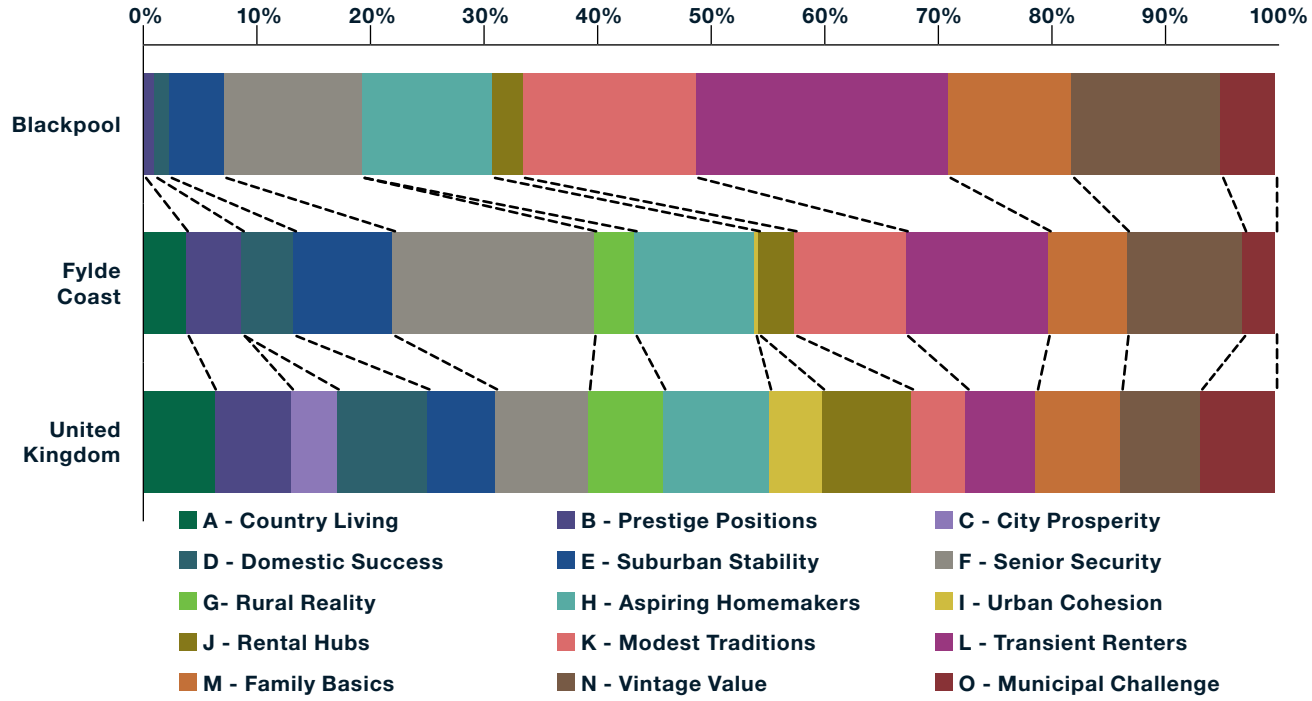
Figure 2: Percentage of households in each Mosaic group - Blackpool

Group Name	One-Line Description	Households	%
A Country Living	Well-off owners in rural locations enjoying the benefits of country life	35	0.1%
B Prestige Positions	Established families in large detached homes living upmarket lifestyles	569	0.9%
C City Prosperity	High status city dwellers living in central locations and pursuing careers with high rewards	0	0.00%
D Domestic Success	Thriving families who are busy bringing up children and following careers	904	1.41%
E Suburban Stability	Mature suburban owners living settled lives in mid-range housing	3,093	4.8%
F Senior Security	Elderly people with assets who are enjoying a comfortable retirement	7,842	12.2%
G Rural Reality	Householders living in inexpensive homes in village communities	21	0.00%
H Aspiring Homemakers	Younger households settling down in housing priced within their means	7,321	11.40%
I Urban Cohesion	Residents of settled urban communities with a strong sense of identity	29	0.0%
J Rental Hubs	Educated young people privately renting in urban neighbourhoods	1,705	2.7%
K Modest Transitions	Mature homeowners of value homes enjoying stable lifestyles	9,845	15.3%
L Transient Renters	Single people privately renting low cost homes for the short term	14,246	22.2%
M Family Basics	Families with limited resources who have to budget to make ends meet	7,005	10.9%
N Vintage Value	Elderly people reliant on support to meet financial or practical needs	8,427	13.1%
O Municipal Challenge	Urban renters of social housing facing an array of challenges	3,169	4.9%

*Source: Experian - Mosaic Public Sector 2017 **
Please note, this information has not been updated since last year

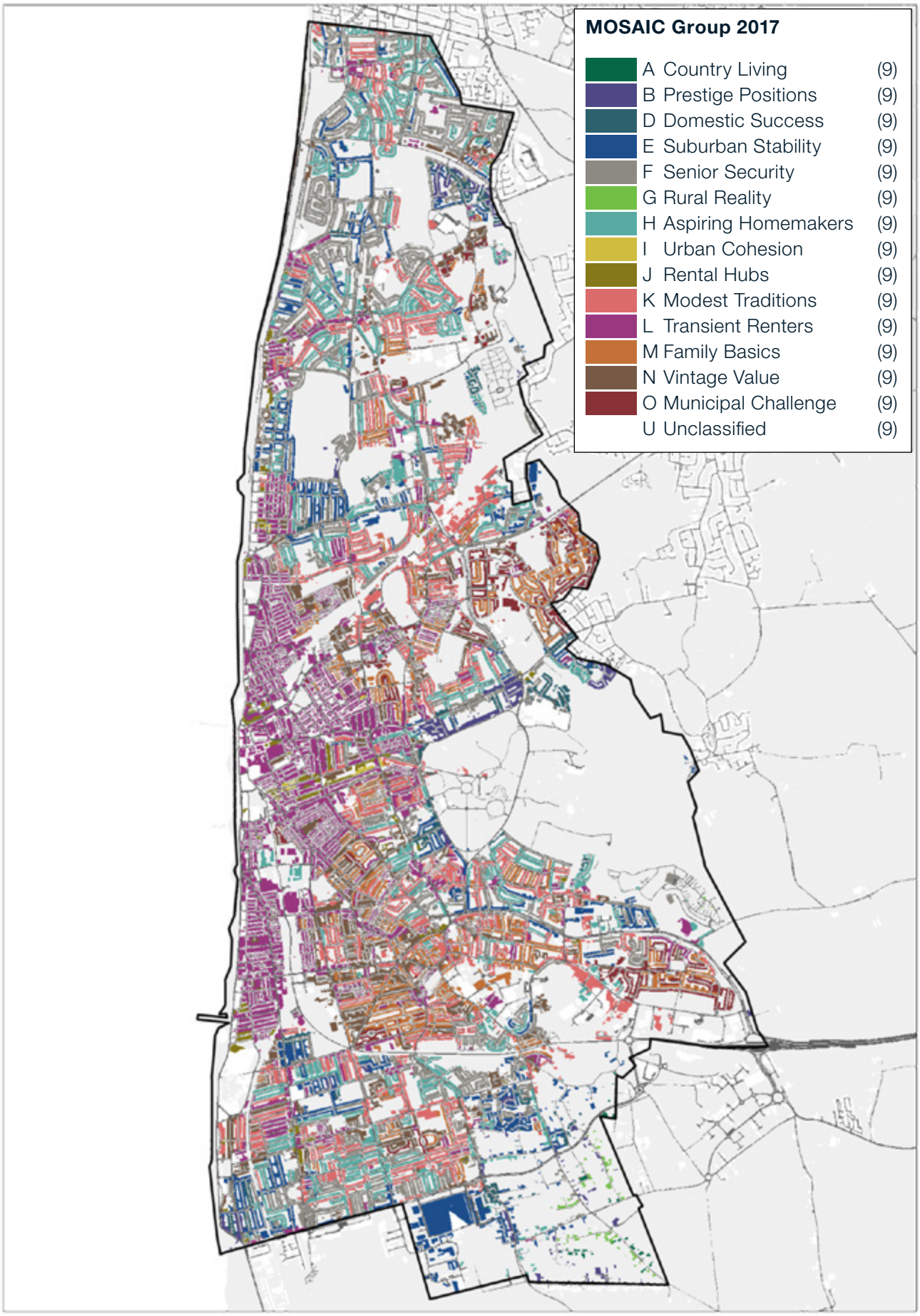
The bar chart below shows how households in each area are categorised. Blackpool has a bias toward the K to O segments with higher percentages of households in these groups.

Figure 3: Percentage of households in Mosaic groups - comparison of Blackpool, the Fylde Coast and the UK



Source: Experian - Mosaic Public Sector 2017.
Please note, this information has not been updated since last year

Each Blackpool postcode has been designated a Mosaic group that is most representative of the households it contains. Figure 4: Map of Mosaic Groups in Blackpool



Source: Experian Mosaic – Public Sector 2017

2.2 Blackpool's Health

Health in summary

The health of the people of Blackpool is worse than the England average. Blackpool is the most disadvantaged local authority in England and about 26% (6,855) of children live in low income families. Life expectancy is one of the key indicators of health in a population and for men in Blackpool it is the lowest in the country, for women it's the second lowest.

Health inequalities

Life expectancy is 13.6 years lower for men and 9.1 years lower for women in the most deprived areas of Blackpool compared to the least deprived areas.

Adult Health

While people may be living longer, they are spending more years in ill-health and the overall health burden is increasing. Sickness and chronic disability are causing a much greater proportion of the burden of disease as people are living longer with several illnesses. Across Blackpool this burden happens at a much earlier age than in other areas.

Alcohol-related mortality and harm is the highest in the country; the rate of alcohol-related hospital stays is 1,097 per 100,000 population, significantly higher than the national average of 632 per 100,000 and accounts for over 1,500 admissions per year.

Estimated levels of smoking and physical activity are significantly worse than average and approximately two thirds of the population are overweight or obese.

In response to these issues highlighted in the Blackpool JSNA, Public Health have developed the following strategies to address some of these issues:

Blackpool Sexual Health Strategy 2017-2020
Tobacco Free Lancashire Strategy
Blackpool Alcohol Strategy 2016-2019

Mental health

As well as poor physical health, Blackpool has the highest rate for diagnosed mental health conditions in the country such as schizophrenia, bipolar and psychoses as Blackpool is the second highest for depression. Mental health problems are among the most common forms of ill health and can affect people at any point in their lives. Mental health and physical health are inextricably linked. Poor physical health may increase the likelihood of developing poor mental health, and poor mental health may increase risks of developing, or not recovering, from physical health problems.

There were over 600 hospital admissions for self-harm in 2017/18, a rate of 466.5 per 100,000 population, two and a half times higher than the national average (2018/19 figures are not available). Over 22,000 people in Blackpool have been diagnosed with depression and over 2,700 have a severe mental illness; prevalence rates significantly higher than national averages. 12% of respondents to a GP patient survey stated they had a long-term mental health problem and claimant rates for benefits for mental and behavioural disorders are the highest in the country.

Suicide rates are significantly higher than the national average, in the period 2016-17, 51 people took their own lives in Blackpool. Lancashire and South Cumbria ICS have developed a suicide prevention logic model. https://www.lancashire.gov.uk/media/907935/lancs-sc-sp-logic-model1.pdf

The Public Mental Health Strategy and Action Plan 2016-2019 has been produced in response to these issues.

Drug Misuse

Drug misuse is a significant cause of premature mortality in the UK and Blackpool has significantly higher rates of drug users and drug related deaths than the national average. There are an estimated 2,000 opiate and/or crack cocaine users in Blackpool and the rate of 23.5 per 1,000 population is over two and a half times higher than average. The town has the highest rate of drug related deaths in the country which is over three times higher than the national average; in the period 2016-18 there were 94 drug related deaths.

There is also evidence to suggest that young people who use recreational drugs run the risk of damage to mental health including suicide, depression and disruptive behaviour disorders and regular use of cannabis or other drugs may also lead to dependence. Hospital admissions due to substance misuse in young people (aged 15-24 years) across Blackpool are the highest in the country with a rate of 329.3 per 100,000; the national average is 87.9. With over 50 admissions per year there is a generally increasing trend in young people being admitted.

These issues are being addressed by the Health and Wellbeing Board and Public Health through the development and implementation of the Blackpool Drug Strategy 2017-2020.

2.3 Safeguarding Adults s.42 Enquiries

The Care Act 2014 sets out our statutory duties and responsibilities for safeguarding, including the requirement to undertake Enquiries under section 42 of the Act to safeguard people. There was a reduction in the numbers of concerns reported to Adult Social Care from the same period last year, although there were some changes in the way numbers were reported during this reporting period, (further details below in the Adult Social Care section). Work was undertaken with other agencies involved with vulnerable adults to promote the use of the Safeguarding Decision Support Tool. This is helpful in clarifying which events may meet the threshold of a Safeguarding concern and which ones may not. This may be one of the factors accounting for the reduction in the number of concerns being raised. There has been an increase in the number of people who experience more than one safeguarding enquiry in a 12 month period, perhaps reflecting a greater understanding of repeat targeting of vulnerable adults.

Of the types of risk identified no particular type of risk has seen a significant change. There has been a significant decline in safeguarding concerns raised in residential and nursing home settings. We think this was primarily due to a new safeguarding social worker post recruited to in Adult Social Care and based with the Contract Monitoring arm of the Commissioning team, which has provided some dedicated and directed support and advice to regulated services. In the overwhelming majority of concerns which went into s42 enquiries risks were removed or reduced.

Making Safeguarding Personal

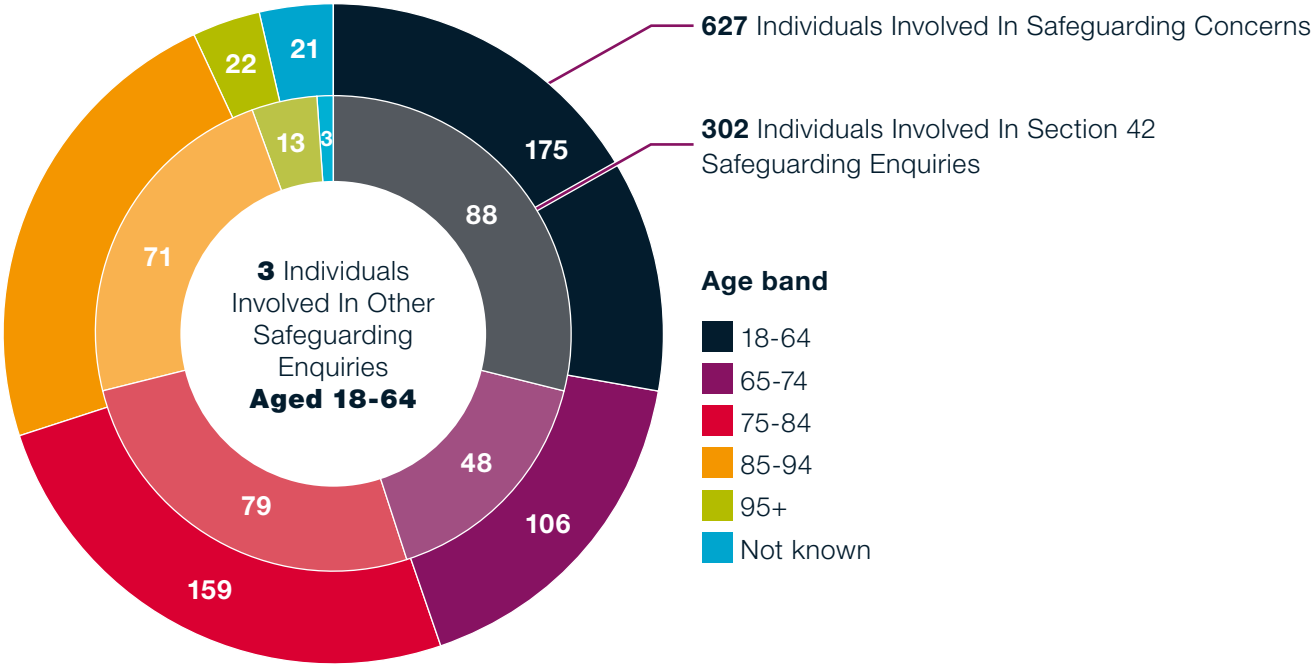
Making Safeguarding Personal is an important aim of the safeguarding adult process. Where possible, adult services aim to achieve this during the enquiry process to determine the outcomes the individual involved has identified for themselves. MSP during this period, showed that roughly the same numbers of people had the opportunity to express their preferred outcomes, compared to those who were not asked or no information was recorded. A much lower number of people of whom were asked, did not or could not express the outcomes they wished to see. Whilst there appears to be a significant amount of work to undertake in this area, compared to the same period last year 40% more people were being asked what outcomes they wanted to see compared to those who were not asked or there was nothing recorded. This has been identified as an area in need of improvement and is being pursued through targeted work.

Safeguarding Adults Collection Data (SAC)

Demographics Tables:

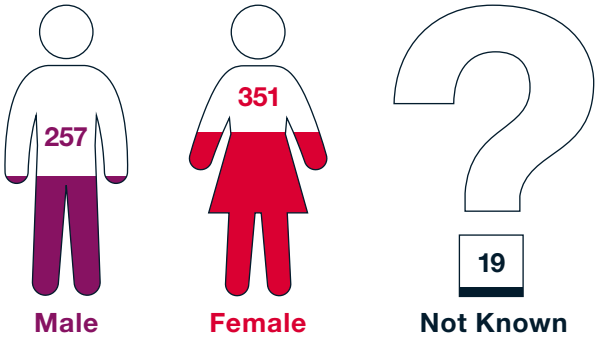
AGE BAND

Counts of Individuals by Age Band

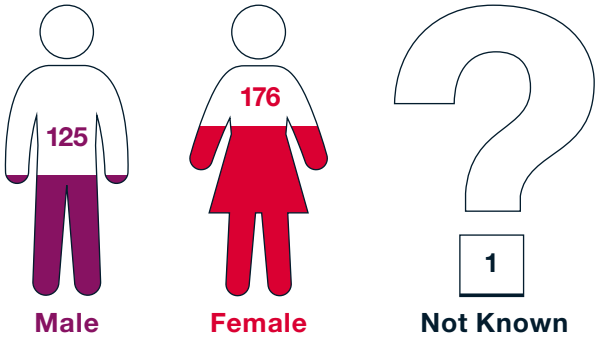


GENDER

627 Individuals Involved In Safeguarding Concerns



302 Individuals Involved In Section 42 Safeguarding Enquiries

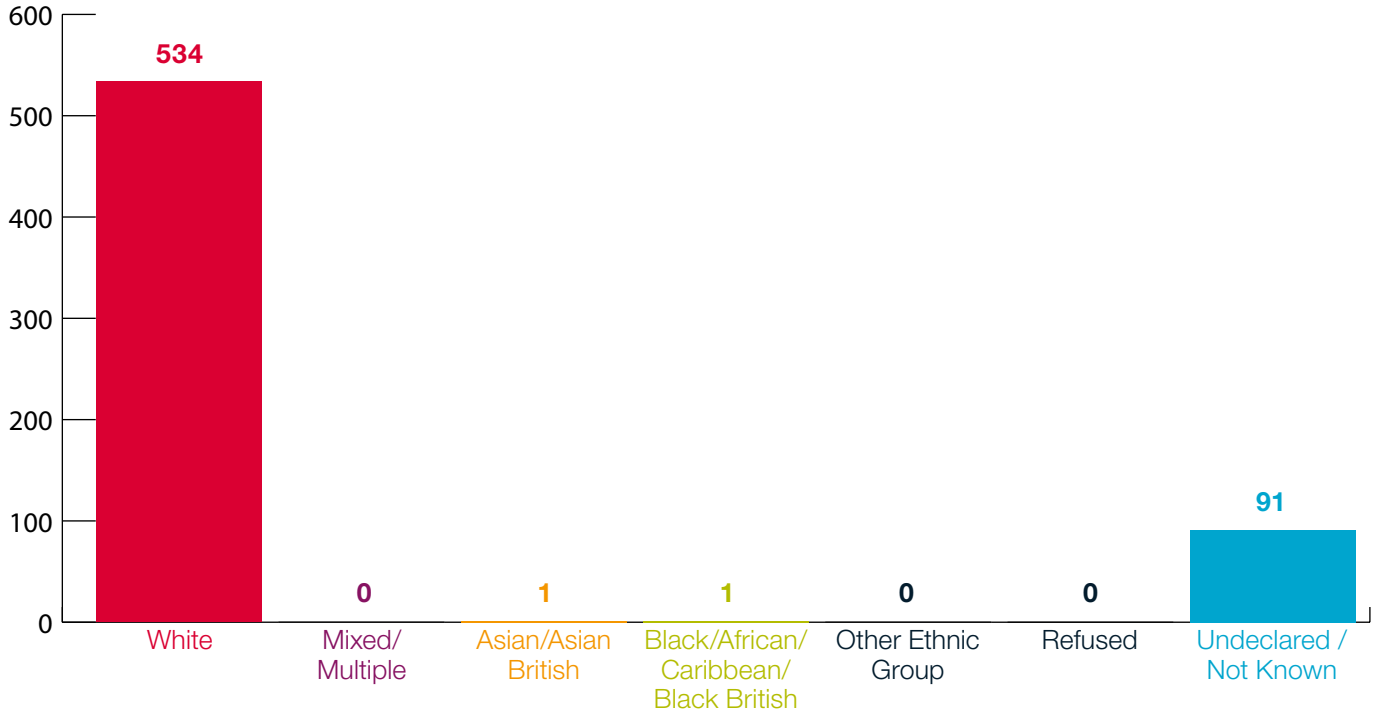


3 Female Individuals Involved In Other Safeguarding Enquiries

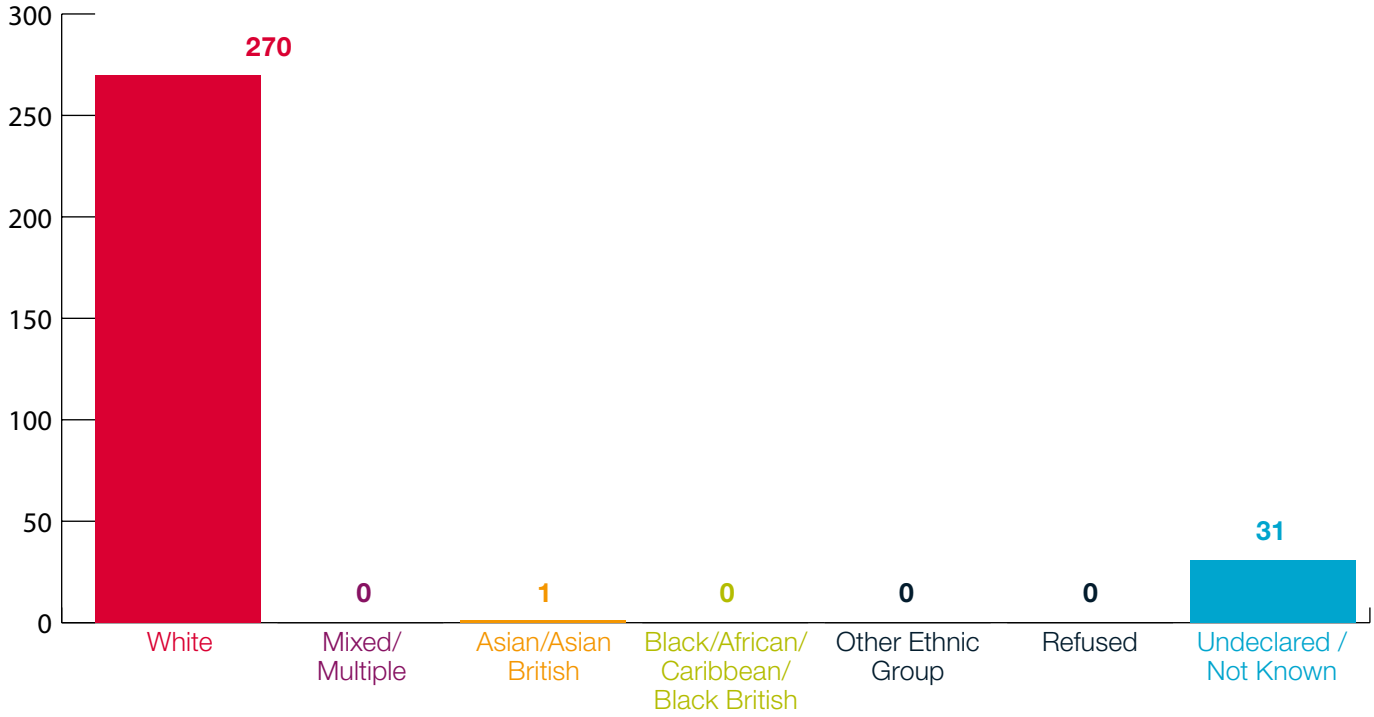
Safeguarding Adults Collection Data (SAC) (REQUEST PIE CHART & COLOURS)

ETHNICITY

627 Individuals Involved In Safeguarding Concerns



302 Individuals Involved In Section 42 Safeguarding Enquiries



Individuals Involved In Other Safeguarding Enquiries, **White 2**, **Black/African/Caribbean/Black British 1**

PRIMARY SUPPORT REASON

	Primary Support Reason								
Counts of Individuals by Primary Support Reasons	**Physical Support**	**Sensory Support**	**Support with Memory & Cognition**	**Learning Disability Support**	**Mental Health Support**	**Social Support**	**No Support Reason**	**Not Known**	**Total**
Individuals Involved In Safeguarding Concerns	265	13	115	41	145	14	1	37	631
Individuals Involved In Section 42 Safeguarding Enquiries	131	5	61	25	69	7	0	5	303
Individuals Involved In Other Safeguarding Enquiries	0	0	0	1	2	0	0	0	3

Section 2: Case Detail Tables

	Concluded Section 42 Enquiries			Other Concluded Enquiries				
Counts of Individuals by Primary Support Reasons	**Physical Support** **Sensory Support** **Support with Memory & Cognition**			**Learning Disability Support** **Mental Health Support** **Social Support**				
	Service Provider	**Other - Known to Individual**	**Other - Unknown to Individual**	**Service Provider**	**Other - Known to Individual**	**Other - Unknown to Individual**	**Total Section 42**	**Total Other**
Physical Abuse	33	82	14	0	0	0	129	0
Sexual Abuse	3	10	3	0	0	0	16	0
Psychological Abuse	16	36	2	0	1	0	54	1
Financial or Material Abuse	17	48	9	0	0	0	74	0
Discriminatory Abuse	1	0	0	0	0	0	1	0
Organisational Abuse	17	2	0	0	0	0	19	0
Neglect and Acts of Omission	143	28	5	0	0	0	176	0
Domestic Abuse		5			0		5	0
Sexual Exploitation	0	0	0	0	0	0	0	0
Modern Slavery	0	0	1	0	0	0	1	0
Self-Neglect		8			1		8	1

ENQUIRIES: Location and Risk

Counts of Enquiries by Location and Source of Risk	Concluded Section 42 Enquiries			Other Concluded Enquiries				
	Source of Risk			Source of Risk				
	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Total Section 42	Total Other
Own Home	52	72	7	0	0	0	131	0
In the community (excluding community services)	1	12	3	0	0	0	16	0
In a community service	1	3	0	0	0	0	4	0
Care Home - Nursing	51	11	5	0	0	0	67	0
Care Home - Residential	79	27	1	2	0	0	107	2
Hospital - Acute	2	7	4	0	0	0	13	0
Hospital - Mental Health	1	27	10	0	0	0	38	0
Hospital - Community	3	7	0	0	0	0	10	0
Other	7	12	1	0	0	0	20	0

RISK ASSESSMENT OUTCOMES

Risk Assessment Outcomes: Was a risk identified and was any action taken / planned to be taken?	Was a risk identified and was any action taken / planned to be taken?			Source of Risk				
	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Total Section 42	Total Other
Risk identified and action taken	173	130	23	0	1	0	326	1
Risk identified and no action taken	4	10	3	0	0	0	17	0
Risk - Assessment inconclusive and action taken	6	4	2	0	0	0	12	0
Risk - Assessment inconclusive and no action taken	0	0	0	0	0	0	0	0
No risk identified and action taken	5	5	0	0	0	0	10	0
No risk identified and no action taken	9	11	1	0	1	0	21	1
Enquiry ceased at individual's request and no action taken	1	13	1	0	0	0	15	0

RISK OUTCOMES:

Risk Outcomes: Where a risk was identified, what was the outcome / expected outcome when the case was concluded?	Concluded Section 42 Enquiries			Other Concluded Enquiries				
	Source of Risk			Source of Risk				
	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Total Section 42	Total Other
Risk Remained	6	3	0	0	0	0	9	0
Risk Reduced	104	86	13	0	1	0	203	1
Risk Removed	67	51	13	0	0	0	131	0

3. Safeguarding Adults Board Priorities

Through Partnership work and with adults at risk of abuse, harm or neglect, we aim to ensure people are:

- Safe and able to protect themselves from abuse and neglect;
- Treated fairly and with dignity and respect;
- Protected when they need to be;
- Able to easily get the support, protection and services that they need.

Business plan

The Board partnership development day held in April 2018 encouraged Partners to reflect on the work of the Board to determine priorities for the business plan 2018-20. The business plan is available on the Blackpool Safeguarding Adults Board website. The Board aims to have recognised and active leadership to safeguard adults in each of the statutory partner agencies and others linked to the BSAB. The 2 year business plan was published in 2018.

3.1 Priority one – To understand and review safeguarding responsibilities and arrangements of Board partners in light of national and local changes.

One of the main aims of this priority is to ensure BSAB Partners take account of the legislative changes to the Blackpool Safeguarding Children Board over 2018-2019 and impact on Blackpool Safeguarding Adults Board. Consideration must to be given to the implications resulting from the changes in legislation, and to remain updated on transitional arrangements, and new arrangements. The Business Development Manager and Chair have attended Pan Lancashire meetings since January 2019 to participate in discussions. All Board Partner leads are expected to understand and communicate legislative frameworks for adult safeguarding, once the new arrangements are finalised. Whilst discussions have been ongoing, a 'hub and spoke' arrangement was preferred to maintain local decision making and accountability, but to place other elements on a Pan Lancashire basis, where appropriate.

Cross cutting opportunities were identified to maximise and ensure links are maintained between BSAB and BSCB. Current and cross cutting themes were reviewed and any implications were considered. Work continues to be explored and progressed, in relation to Transitions and All age exploitation and the Board have developed links with the AWAKEN team and Blackpool Young People's Service (BYPS) to discuss all age exploitation.

There has been continued development of policy and procedures for both Adults and Children Boards on a Pan-Lancashire footprint in line with service developments. To reflect the changes to the Pan-Lancashire policy and procedures, key priority themes included updated information on financial abuse and self-neglect. The Pan Lancashire Anti-Slavery partnership (PLASP) toolkit had been adopted for use in Lancashire, Blackburn with Darwen, and Blackpool for use during 2018/19. The People in Positions of Trust (PIPOT) policy was reviewed and updated, as well as ensuring GPPR compliance. It is expected that the Deprivation of Liberty Safeguards legislative changes will be updated once available, during the next reporting period.

3.2 Priority two – To gain a better understanding of local safeguarding priorities and improving responses

The Board introduced a new QA Framework during 2018/19, which was originally developed by Blackburn with Darwen Safeguarding Boards. The new performance management framework helped to capture relevant information and help highlight and identify safeguarding priorities. Other methods of gaining insight included feedback from Partners, from frontline practitioner events such as the Multi professional discussion forums (MPDF) and training evaluation forms to identify effective learning. Effective and high quality information sharing was promoted through the new dataset to give assurance to, and allow appropriate challenge by BSAB partners. It has helped to support and embed good practice and identify measurable outcomes for service users reviewed to ensure fit for purpose. Feedback on service user consultation is also captured within the framework. The QA Framework is hoped to identify patterns and trends to monitor and manage risks or potential risks of multi-agency audits to gain a shared awareness of the quality of service provision across agencies.

A need was identified to use common language and terminology across Board partners, using plain English and avoiding acronyms which can often cause confusion with varying interpretations.

Relevant learning opportunities from Safeguarding Adult Review (SAR) reports, action plans, and progress reports are explored and shared with the Board Partners. Learning for Blackpool was identified from the Newcastle Joint Serious Case Review concerning sexual exploitation of children and adults with additional vulnerabilities, resulting in discussions on all age exploitation mentioned under Business Plan- Priority 1. The aim was to gain an understanding of what works well and doesn't work well in achieving improved outcomes for service users. A Learning and Improvement Framework (BSAB) had been developed, with learning that had been taken from across Lancashire and nationally to inform the framework. Although there had not been a Serious Adults Review (SAR) in the last 4 years ensuring an up to date framework would ensure that the BSAB was prepared in the event of one.

3.3 Priority three – Raising awareness and promoting engagement

The Board aims to promote and develop effective relevant links with a wide range of partners, including the public, voluntary, community and faith sectors. The Board Business Development Manager has developed links with the Richmond Fellowship, a mental health support service who work with Blackpool residents. Healthwatch Blackpool was recommissioned during 2018/19 and despite a gap in service provision is now actively involved with the work of the Board again, promoting the voice of service users. Blackpool Carers Centre are an active 3rd Sector Partner as they represent the voice of the carer community in Blackpool. The Board has developed links with the Clewer Church group who are involved in promoting the work of the Pan Lancashire Anti-Slavery partnership (PLASP), and can identify and support victims.

Awareness was raised in autumn 2018 on Domestic Abuse through a campaign aimed at the public, and delivered by Pan Lancashire Communication and Engagement Sub-Group. An event was hosted by the Pan Lancashire Boards to promote awareness to professionals working with those likely to be affected by domestic abuse.

Professionals received financial abuse and self-neglect awareness to promote the new frameworks and pathways through launch events held in April 2019, aimed at front line officers. Awareness on modern day slavery was promoted through the PLASP roadshows. A Blackpool roadshow is planned for autumn 2019, hoped to maximise impact as the campaign will be promoted during the Blackpool illuminations.

A Pan Lancashire Communication and Engagement strategy was produced and approved by the Board in April 2019. Blackpool has agreed to lead on the 'service user engagement' priority on behalf of Pan Lancashire Safeguarding Boards. The Boards agreed on the need for joint and coordinated leadership with and by other key partners, to tackle common emerging safeguarding themes collectively though short term task and finish groups. The Business Manager attended a LGA Making Safeguarding Personal event held in March 2019. The event had included a discussion workshop on abuse reporting feedback from which had been good. Attendees had been informed that the Local Government Association was hoping to draft a national tool for use by local authorities to embed MSP into practice by the end 2019.

3.4 Priority four – Prevention and early intervention of safeguarding issues

The Board required access to available data to identify trends to enable partners to develop effective multi-agency responses through early intervention, to prevent and learn from potential areas for improvement, any gaps or other barriers. It is hoped this can be captured through the QA framework returns and other safeguarding data collated through Partners.

Prevention and early intervention of mental health concerns through awareness and the development of relevant strategies has been implemented through Mental Capacity and Deprivation of Liberty Safeguards training. Resilience building is being explored by the Board training coordinators and LCFT officers. Opportunities such as mental health 'first aid' training, to develop resilience and 'mental wealth' are being developed by Blackpool and the Fylde College.

The prevention of financial abuse from a public and professional perspective has been promoted to a range of agencies and the National 'Loan Sharks' Training was offered free of charge.

During 2018/19, the Board introduced Multi Professional Discussion Forums (MPDF's) aimed to act as a vehicle to better understand the views of front practitioners with practical experience who are able to identify and justify what changes should be made to improve practice and outcomes for vulnerable service users, through emerging themes identified. The first MPDF was held in October 2018 to discuss Self Neglect and was attended by various agencies, including GP's and those with lived experience. The second MPDF was held in January 2019 on Adult Sexual Exploitation and was attended by Victim Support, 3rd Sector agencies such as Hope for Justice who work predominantly with victims of modern slavery.

4. The Role and Achievements of the Sub-Groups

The Board has a number of Sub Groups to assist in the delivery of its function.

4.1 Training and Communications Sub-Group

The purpose of this sub-group is to provide the strategic lead to promote learning and development by the Board and within its partner agencies. It is responsible to the Board for the planning, delivery and evaluation of multi-agency safeguarding training and the verification of single agency training. The sub-group is also responsible for the Board communications activities with professionals, service users, and the public. This work is co-ordinated with Pan- Lancashire colleagues, and the sub-group is responsible for ensuring that the Board meets its statutory requirements in relation to multi-agency training.

The Training Sub-Group ensures consistent standards of the safeguarding adults training provision. The group facilitates networking opportunities and the sharing of lessons learnt and best practice to a range of Partner organisations. The Training Subgroup ensures the development of safeguarding practice and promoted improvements to practice through training across all partner organisations in Blackpool. The group ensures that each organisation is completing the most relevant training, encouraging better outcomes for adults at risk and disseminates good practice examples.

The Terms of Reference were reviewed in March 2018 and the group agreed to hold responsibility for the Boards' communications activities, both at a pan Lancashire and local level, including Seven minute briefings produced in conjunction with Lancashire Safeguarding Boards. The training offer was expanded to include adult exploitation during this period. The January 2019, the Board's Multi Professional Discussion Forum covered Adult Sexual Exploitation and work was undertaken to organise associated training. A list of the new courses are mentioned below. Sub-Group attendance during this period was generally good.

During Q2 the Board ceased to be able to use facilities at the Technology Management Centre at the end of October 2018. Bookings made beyond then, were transferred to the Solaris Centre or the Grange. Blackpool Coastal Housing was installing wireless (Wi-Fi) technology at all its community centres and were identified as potential training venues going forward.

The long standing Chair of the Sub-group Cathie Turner had retired and a new Chair for the Sub-Group and a replacement was sought. The group wished to extend their thanks for her contributions as the Chair of the Training and Communications Sub-Group. A police representative was invited to sit as the Chair of the Sub-Group and the Adult Social Care - professional lead as the Vice Chair.

The Training work plan was produced in line with the new business plan 2018/19.

New Courses:

'The Blackpool Way' course was developed to become the primary course for professionals starting to work in Blackpool, included within the Multi-Agency Safeguarding Adults course to commence in October 2018 and was already over-subscribed, demonstrating the demand for the course.

Criminal exploitation training was being developed to focus on safeguarding children but in due course this could be expanded to include adult victims of exploitation

Modern day slavery is covered within the Safeguarding Adults Multi Agency training offer, but the group recognised that the PLASP toolkit and more train the trainer sessions were needed. This is being led by the PLASP group. The Board recognised that modern day slavery overlapped with other forms of adult exploitation, including human trafficking, and cuckooing.

Adults with additional needs was an area being explored, in particular for those individuals who may be more vulnerable due to have learning difficulties or physical disabilities.

Mental Capacity Act or **Deprivation of Liberty Safeguards (DoLs)** was being explored by the Board training coordinators, as it was recognised that there was no advanced level training at present. This will be developed in line with the new legislation.

Domestic abuse one-day course to primarily focus on the impact on adults, but from autumn 2018, there were two courses: 'working with adults' and 'working with children'. Coercion and Control were to be added to the existing training offer. The Public Health- Bystander project to tackle sexual or domestic violence was developed. A train the trainer exercise had taken place in December 2018 and Blackpool and the Fylde College had agreed to undertake a pilot to commence in February 2019. This included the use of a dedicated toolkit to build skills to intervene safely.

Mental Health First Aid course and academic resilience training was offered by Blackpool and the Fylde College.

Financial Abuse was an area that had identified a gap in frontline practitioners' knowledge and minimal reporting of incidents by practitioners or the public. An offer had provided a series of half-day briefings on the topic on a no-cost basis by the national body leading on tackling illegal money lending. The intended audience included frontline staff from housing and community safety officers through to health professionals. The launch of the new financial abuse guidance and pathway was planned for April 2019, linked to the work of the financial abuse task and finish group.

Self Neglect and hoarding for staff working with adults, was the most well attended course. The new Self Neglect framework and pathway was planned to be launched in April 2019, and the Board had invited an 'expert by experience' to bring the real life learning from her experiences to the attention of practitioners.

Safeguarding Adults Review Workshops (SAR) were reviewed. Although, there had been no Blackpool SARs during this reporting period, workshops had been developed to reflect local priorities and highlight learning from local and national SARs and Domestic Homicide Reviews (DHR's).

Training Course Evaluations

There had been poor completion rates for electronic evaluations since their introduction with a 23% pre and post completion rate, during Quarter 1. The evaluations were quick to complete and better quality responses were generated from the electronic versions even though fewer were received. Telephone evaluation consultation were commenced to gain follow up from training. This was initially undertaken by the Training Co-ordinators, although subgroup members were asked to participate.

The Boards had developed use of the Google forms tool with Quick Response (QR) codes used on the day, during Q2. There had been low response numbers initially but had increased significantly with a good deal of positive feedback. During this period, the evaluation formats were placed on the web and phone calls were made to secure more feedback, to measure impact a number of weeks after attendance. Pre-course returns were around 59% and post-course around 68%. Feedback on courses was generally very positive. Trends were sought including the impact of courses on the frontline. Line managers were encouraged to complete evaluations through supervision following course attendance. This was reinforced by Board members.

Training Needs Analysis

Some of the areas identified through the Training Needs Analysis, included potential new topics identified as the, use of interpreters, advocacy, achieving best evidence, adverse childhood experiences and Making Safeguarding Personal (MSP).

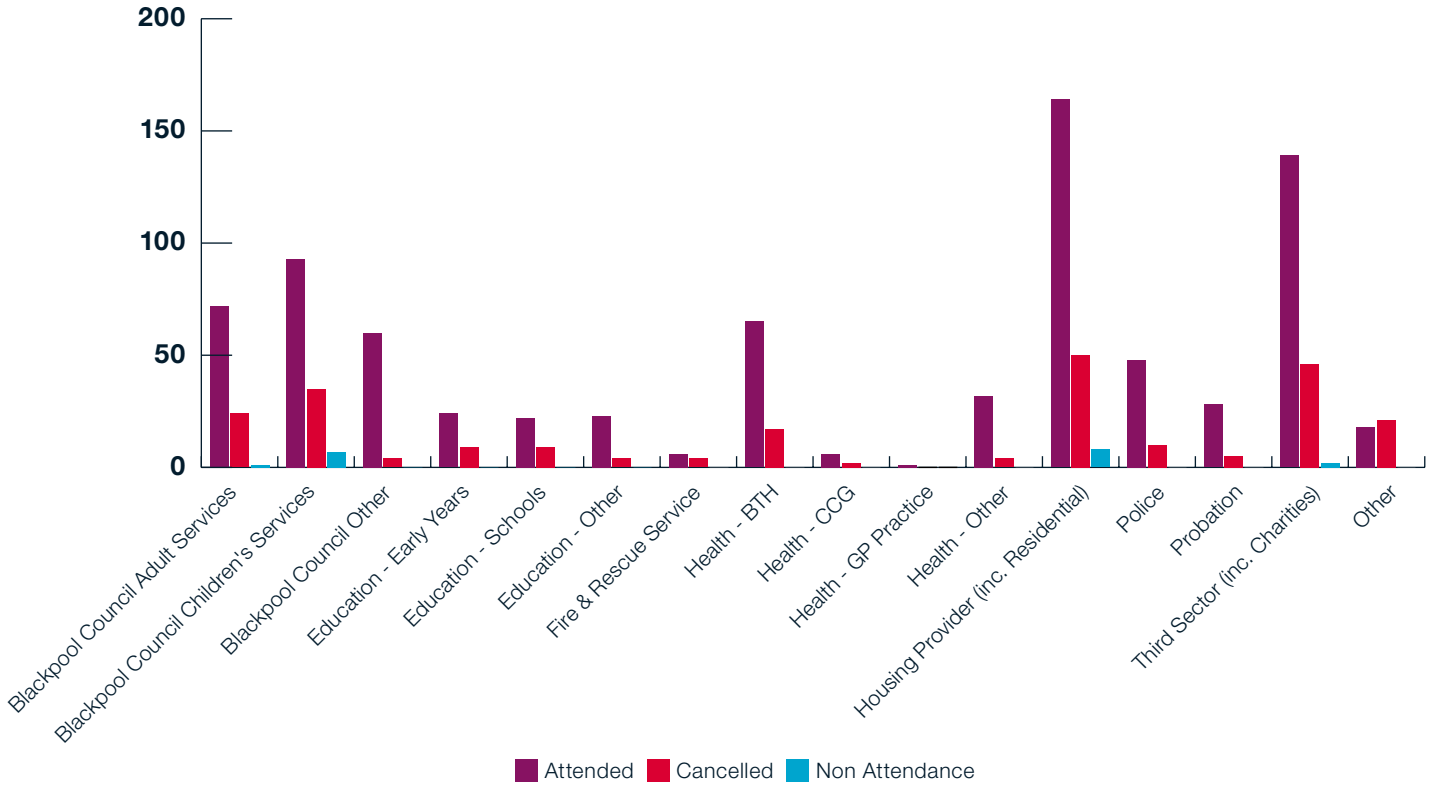
Training Course attendance

Training attendance had improved over the last year compared to 2016-2017, while the number of cancellations prior to the day and non-attendees on the day had both reduced. However, there remained a significant number of cancellations and non-attendees which both cause an administrative burden and waste spaces that might have otherwise been filled. Attendance at some courses were reducing, with a number running recently with fewer than twenty people on a session. Members were asked to encourage staff to notify the Safeguarding Board Team if they were unable to attend training to avoid charges.

Overall, it was recognised that training was delivered to 200 more staff than the previous year, notably, attendance from Probation colleagues had risen. It was found that courses were not attended to capacity, despite often being over-booked and that this was seen as a wasted resource.

The 'Workshop to Raise Awareness of Prevent' (WRAP) training was proving problematically low, which was felt to be due to the majority of practitioners who required this training having already attended it. Care Homes were recognised as the biggest non-attendees from September to November 2018. There were improvements in gaining income and reduced non-attendance although some delegates were still failing to attend courses.

Safeguarding Training Attendance



Courses	Number of Sessions	Attendance
Adults Multi Agency Safeguarding	3	65
Dementia Awareness	3	27
Domestic Abuse Awareness & Referral Pathways	2	40
Domestic Abuse Awareness & Referral Pathways	2	39
Domestic Abuse: Analysing the impact	1	19
Fire Safety	4	46
Forced Marriage, Honour Based Violence & Female Genital Mutilation Awareness	3	47
Hidden Men	2	40
Hoarding	3	53
Hoarding and Self-Neglect	1	29
Mental Capacity & Deprivation of Liberty Safeguards Awareness	2	28
Parental Mental Health and its impact on Children	3	58
Safeguarding Adults Review Workshop	2	33
Stop Loan Sharks	4	59
Substance Misuse & Safeguarding	3	57
Toxic Trio & Safeguarding	2	41

4.2 Pan Lancashire Communications and Engagement Group

It was agreed that Pan Lancashire Communications and engagement activity would link into the Blackpool Training and Communications Sub-Group. Five pan Lancashire campaigns would be undertaken, with the first being a back to basics campaign highlighting the role of Safeguarding Boards. The role of the pan Lancashire group was to promote the awareness of safeguarding. It was recognised that public awareness raising was needed as the website and training offer were geared toward professionals. All agencies were welcome to attend the pan Lancashire meetings.

A logo for use in Pan-Lancashire awareness campaigns was developed as a common design for use in campaigns involving the Adults and Children's Safeguarding Boards from Blackpool, Blackburn with Darwen and Lancashire. The logo would only be used for Pan-Lancashire public campaigns and that area specific literature and campaigns would retain individual logos. The logo had been developed after careful consideration involving all the Pan-Lancashire Boards. Leaflets were produced for the public which outlined the role of the Boards and actions to tackle abuse. A Safeguarding Conference was held in November 2018 to raise awareness of the Exploitation of Adults and Children. A Domestic Abuse campaign was delivered in autumn 2018, to launch the new domestic abuse framework. A modern slavery awareness campaign is planned for autumn 2019 in Blackpool. This will be delivered in partnership by the PLASP and Blackpool Safeguarding Adults Board.

The Pan Lancashire group had identified five key priorities for Safeguarding Boards, including;

- Learning from Reviews,
- Engagement with Service Users
- Engagement with the Seldom Heard
- Communications Pathways and Strategy
- Key Messages and Themes

Blackpool is leading on the 'Engagement with service user's' priority. (Pan Lancashire Safeguarding Boards Communications and Engagement Strategy)

4.3 Case Review Subgroup

The purpose of the Case Review subgroup is to deliver the primary mechanism by which the Board exercises its statutory duty under the Care Act to arrange a Safeguarding Adults Review (SAR). This occurs when someone with care and support needs within its locality dies or is significantly harmed as a result of abuse or neglect, whether known or suspected, and there is a concern that Partner agencies could have worked more effectively together to protect the person.

Safeguarding Adult Review Protocol

The Safeguarding Adult Review (SAR) guidance was reviewed by the Business Development Manager, and the Protocol was adopted at Pan-Lancashire level. The document forms part of the Pan-Lancashire multi-agency policy and procedures, and was approved and agreed by the Pan- Lancashire Safeguarding Adults Boards. The Board have not undertaken any SAR's during 2018-19. However, the SAR briefings continue to be delivered based on Pan Lancashire and national SAR's, and based on identified key and emerging themes. The protocol is referred to in the briefing session.

Learning from parallel processes

Consideration continues to be given to Safeguarding Adult Reviews (SARs), and learning from parallel processes such as Domestic Homicide Reviews (DHRs), Serious Incident Reviews (SIRs), Coroners Inquests and Learning Disabilities Mortality Reviews (LeDeR). Each process may review cases and issues from different perspectives but highlights the importance of working together to ensure consistency between parallel processes.

Safeguarding Adults Review Briefings

Although the BSAB has not had any SARs in the last few years, a pro-active approach has been taken by delivering SAR Briefings as learning opportunities for better outcomes. The purpose of the reviews is to learn and not for blame, briefings are proportionate and relevant with a focus on effective learning.

In consultation with Pan-Lancashire colleagues, and taking into account regional and national review information were considered, with no recent reviews within Blackpool so proactive learning needed to be secured from wider sources. A Pan-Lancashire learning approach would allow for consistency and support agencies that operated across Pan-Lancashire. Focus would be given to themes linked to the Board priorities.

Briefings have been delivered through the Board which aimed to promote good multi-agency working guidance, challenge and focusing on supporting people and families being realistic about their capabilities. To deliver learning messages about improvement and change, leading to better awareness of the SAR process and how learning can be translated into practice for professionals.

Shared learning with the Coroner

A working relationship with the Coroner for wider learning to share information continued, to discuss common areas of interest, e.g. vulnerable homelessness people, and to allow the Coroner's office to gain a better understanding of safeguarding work and challenges. This link was originally established with the Board for information to be shared on cases which may be of mutual interest.

Learning Disabilities Mortality Review (LeDeR) Programme.

The Board continues to have an interest in this piece of work, being led by NHS England. It aimed to review deaths within specific criteria, people aged over 4 years old and under 74 with learning difficulties, to reduce the number of preventable deaths through lessons learnt. The number of current and forecast reviews within Blackpool (and Lancashire) had been noted and concerns had been re-iterated over the staffing resources required to effectively run the Programme as the resource was significantly low for the amount of work required. The Board requested to remain updated on progress and developments.

Blackpool Drug Strategy 2017-2020 and Action Plan

Public Health highlighted the need to raise awareness of drug related deaths in Blackpool. There were two stands to the Strategy, the first strand was reducing drug related deaths, and the second element was tackling drug misuse to prevent misuse and promote recovery. The local approach mirrored that advocated nationally including legislation and the local Action Plan had taken into account the local needs assessment which had identified local issues needing to be tackled. This work could potentially link in with the SAR briefings to prevent drug related deaths, which has been recognised as an area of growing concern.

Criteria for undertaking a Safeguarding Adults Review (SAR)

The statutory criteria for undertaking a Safeguarding Adults Review (SAR) is covered under s.44 Care Act. The sub-group decide what course of action to take in accordance with statutory guidance.

The criteria can be found in Appendix B.

Consideration of potential SAR's during 2018/19

The Board had received one SAR referral during this period, from another area.

Adult D

This case was referred to Blackpool from another area. The referring Safeguarding Adults Board had carried out their own review and produced a report. The report was shared along with the findings which had identified some potential learning for Blackpool. Although, the circumstances did not meet the Care Act criteria, as the Perpetrator was a Blackpool resident and not the Victim. The Blackpool Board considered this case, and the found that all the relevant agencies had worked well together. They found the decision of one professional may have contributed to the result of the perpetration, but not through the actions of the agencies involved. The organisation responsible for the professional in question, had provided reassurance to the Board that it had been addressed internally.

4.4 QAPM Sub-group activity

The Performance Sub Group is responsible for ensuring that Blackpool Safeguarding Adults Board has a clear quality assurance framework. The new performance monitoring system was adopted and the group agreed to revise their terms of reference in March 2018. It delivers a range of business as usual matters, including management of the performance data and intelligence, assurance activity, including outcomes to consider qualitative data. The Safeguarding Adults Board's quality assurance framework details domains of quality assurance that the Performance Sub Group uses to measure safeguarding effectiveness across the partnership. Throughout 2018/19 the Performance Sub Group requested, received, and was scrutinised information in line with the quality assurance framework including performance data, narratives, audits, training and where highlighted issues of interest were reported to the Safeguarding Adults Board.

5. Partner activity

Blackpool Council – Adult Social Care

Adult services continue to work with local partner agencies and organisations to try and improve local safeguarding arrangements. Adult Social Care recruited a Head of Safeguarding in October 2018, part of whose responsibilities involved developing this area.

Data collection regarding safeguarding concerns raised with the local authority and how these were dealt with, including those that went on to become s42 enquiries, has been refined in line with ADASS guidance to make more meaningful national comparisons between areas, (dependent of being adopted nationally). Comparative figures for all Local Authorities are published annually on the NHS Digital website.

A regular qualitative peer audit system was put in place to look at safeguarding practice, and was used to consider any practice improvements arising from these. A senior managers' audit process is being developed, with similar aims. The use of the decision support tool was evidenced and described as proving helpful to some organisations and providers in clarifying whether to raise safeguarding concerns

A dedicated social worker with safeguarding lead expertise has been working within the contract monitoring team, (the local authority team that monitors regulated care providers in Blackpool, both residential/nursing homes and domiciliary care agencies). There have been identified benefits to this, both providing support for local social care Providers for advice and assistance, and in acting as safeguarding lead for the safeguarding concerns raised in regulated services. This has offered a degree of consistency and continuity which had been missing.

During the last two quarters of the year, adult social care received a significant increase in the number of concerns received over the same period last year. This can be explained in part by a number of factors: better awareness and information sharing with providers; a greater understanding of what might constitute a safeguarding concern through increased use of the Decision support tool; the numbers of anonymous safeguarding concerns from care homes where a particular individual is not identified so the default position is safeguarding concerns apply to the number of beds there are in the care establishment.

There appear to be a low number of domestic abuse cases being referred into ASC, and work continues to try and understand why this may be.

Whilst the overall numbers remained relatively small, there was an increase in the numbers of people who lack capacity in relation to a safeguarding enquiry who needed to be supported by advocates. Not all of these people were able to receive the allocation of an advocate. This has highlighted some shortages in the provision of formal advocacy services. The commissioning team are working on improving the availability of advocacy services in line with statutory Care Act requirements.

The Making Safeguarding Personal guidance is a key part of the audit arrangements in place. Variations in the recording of whether people had information recorded regarding their expressed outcomes has led to safeguarding leads receiving guidance to ensure that this is captured within the enquiries records. Guidance has also been issued to safeguarding leads to try and ensure that those involved in the enquiry receive formal notification of the outcomes, including any follow up actions. The data during this period showed that adults at risk who were referred to the council were supported to reduce or remove the risks to themselves in over 97% of cases.

Blackpool Coastal Housing

Blackpool Coastal Housing had undergone a restructure to include safeguarding as an essential element of roles to give the officers working with an individual who requires safeguarding assistance.

A high number of visits by BCH to properties in poor conditions, where tenants may be affected by neglect, hoarding and suffered from health or addiction issues. A report will be produced this year that will analyse and evaluate the work carried out by the Neighbourhoods team. This will evidence the effectiveness of the service in preventing issues from escalating into more serious problems requiring assistance from Adult Social Care and Mental Health services.

A review was underway into the services offered by BCH's Supported Housing teams. That included the Sheltered Housing service, Positive Transitions, More Positive Together, Resettlement Services and Care and Repair. A scope of works has been put together to review the demand for these services, especially for younger customers who need support to maintain their tenancies. The findings will be published later this year and findings will shared with the safeguarding board and performance group.

BCH have reviewed their safeguarding policy to ensure it is in line with requirements. Systems were put in place to identify, report and support families in need of interventions such as Support Plans, Right Track and Early Warning processes. A booklet has been produced for staff to enable easy reference and BCH contractors to report and identify risks through the Early Warning process. A system was put in place to identify safeguarding needs within the in-house system. BCH consistently learn from cases but were not able to evidence this, and was identified as an area in need of improvement and systems were to be redesigned to reflect this. Supervisions would include a percentage of safeguarding audits in addition to current case load audits. Case Studies of work were carried out to improve outcomes for their customers. BCH evidenced that their contractors and in-house officers had a greater understanding of safeguarding due to their increase in the number of Early Warnings reported.

BCH carried out quality audit activity through 'Justification' exercises when taking legal action against customers with safeguarding concerns to ensure BCH had acted reasonably and proportionally when taking action against vulnerable adults. Improvements were be made to internal recording of information.

A protocol is in place with ASC to discuss complex issues involving individuals BCH made some changes to the way they record safeguarding data, including on the number of referrals made to agencies for substance misuse, self-neglect and financial abuse. This was being explored and whether the quality of this data could be improved. BCH were committed to improving the quality of the safeguarding information collected and how it could identify and compare trends. BCH aimed to evaluate and analyse the data to identify areas of good practice and for improvement. Due to raised thresholds in children and adult services, had impacted on BCH workloads and increased expectations.

Data was collated but it did not accurately reflect the demand on BCH services. For example, they carried out over 500 visits to households with potential safeguarding issues, within a six month period. BCH viewed this work as essential in preventing issues from escalating into causes for concern that could impact on Adult Social Care. BCH had increased capacity to deal with safeguarding issues and helped through the employment of an extra housing officer to deal with safeguarding related issues. BCH provided training to other services based on the Hoarding Toolkit created by BCH staff.

BCH CASE STUDY

Early Warning Referral - Mrs B

BCH received an early warning NOTIFICATION from the gas team (external contractor). Claire completed a tenancy audit and found Mrs B to be extremely vulnerable with no support from services and was partially blind living in poor conditions.

Since Claire had been working with Mrs B, and supported her to gain help from mental health and social services. Mrs B was supported from in house Homes Best to tidy and clean round the property, referral made to SPA, referral made to sensory impairment for assessment around visual impairment, all through social services.

Claire also requested 'Vitaline' and key safe, and discussed ongoing services to maintain her environment with Mrs B and she stated that she was willing to pay a cleaner on a private basis.

Blackpool Teaching Hospitals (BTH)

Blackpool Teaching Hospitals had improved information sharing arrangements between agencies, including health providers and other health professionals, Primary Care and GP Practice to ensure support was timely, co-ordinated and consistent. Work has been undertaken with GP practices to develop a robust system for information sharing of significant safeguarding concerns, including IG and data protection legislation through information sharing protocols and procedures, including confidentiality and risk assessment. Attendance at MARAC, had assisted with the GP to share information that is quality assured and fed back. GP's were aware of vulnerable patients registered with their practice, and linked to the MARAC training. The number of contacts by GP Practice staff to the duty line for safeguarding advice and support are unable to ascertain as contacts were recorded with other Safeguarding enquiries. Emerging themes from advice episodes and complex cases delivered by named and safeguarding professionals on FGM and Domestic Abuse.

There remained a high demand for advice and support regarding Domestic abuse case within the organisation. BTH had a health IDVA in post to support staff and patients and raise awareness of domestic abuse. There were a number of enquiries made to the team relating to organisational abuse. It is likely that these will overlap with the enquiries regarding neglect and omissions of care.

The trust has identified a gap in data and are in the process of developing systems to capture s42 safeguarding investigations including those involving the trust.

The trust has reviewed all safeguarding adult training in line with the intercollegiate document published in 2018 and there is expected to be a change in compliance rates, particularly for Level 3 training. There was a training recovery plan in place and moving forward, level 3 compliance rates will be captured. There was a noted increase in identification and appropriate escalation of self-neglect cases. A total of 30 enquiries were made in Q1 and Q2 regarding self-neglect compared with 56 enquiries in Q3 and Q4. This has led to improved multi-agencies working which is now supported through the pan-Lancashire self-neglect framework.

Case study 1 – Patient 1 in a care home, was being seen by the wellbeing support team to help manage anxiety and reduce 999 calls being made by patient from care home (without staff knowledge). Patient disclosed she had given her bank card to a friend but they had not returned the card. Patient had no way of knowing how much money had been taken from her account. Attempts to contact the friend had not been successful. Patient did not wish to involve Police and was deemed to have capacity to make that decision.

Safeguarding Plan:

- ***Inform bank of potential card misuse and check for unauthorised activity.***
- ***Refer to Adult Social Care as potential financial abuse.***
- ***Continue to attempt to contact friend to return card.***
- ***Consider advocacy support / direct payments / budget planning to help patient manage money safely in the future.***

Outcome: The Friend returned the card, no financial abuse appeared to have occurred. Adult Social Care and wellbeing support worker providing ongoing support to manage finances.

Case study 2- Patient 5 - (Blackpool) Complex and sensitive case. 25 year old female with profound disabilities cared for at home by mum.

Gradual concerns that mum may not be acting in the best interest of the patient. Disengaging from health professionals if they did not agree with her care plan. Declining nutritional support as felt certain products were 'poisoning' patient. Declining psychological support to meet her own needs. Ultimately refused to provide rescue medication during seizures as felt the medication was 'poison'. Would only administer Schedule one drug bough over the internet.

Safeguarding Plan:

- ***Admitted to hospital as place of safety***
- ***Hospital staff liaised with Learning Disability Team to formulate care plan and discuss plan going forward.***
- ***Hospital staff vigilant during visiting times – nursed in viewable bed space as clinically appropriate.***
- ***Mum supervised during medication administration.***
- ***Opportunity taken for neurology review whilst in hospital. Also received input from dietician and occupational therapist.***
- ***Close attention paid to pressure areas, ensuring suitable mattress / PAC etc. Known to District Nurses - ? Prescribed medi-honey.***
- ***Application made to Court of Protection resulting in patient being transferred to residential placement whilst multi-disciplinary discussions took place (including mum as part of the process) to determine best way forward.***
- ***Application made to the Home Office to request leave for schedule 1 drug be prescribed as deemed to be clinically appropriate.***

Blackpool Clinical Commissioning Group (BCCG)

BCCG as a commissioning organisation do not collect section 42 enquiry data because this is an operational safeguarding function with performance data collected within the provider services commissioned by the BCCG. Quarterly reports were received from the larger providers which encompass the requested information and an annual safeguarding audit to seek assurance that BCCG commissioned organisations are undertaking their safeguarding responsibilities. The one provider service that sat within BCCG was the Continuing Health Care (CHC) Team. Social workers are co-located within the team, all safeguarding referrals go direct into adult social care and hence were counted in Social care figures. CHC safeguarding activity data was not collated separately to avoid a duplication of data collection.

BCCG seeks assurance annually from all contracted adult services, that mandatory adult safeguarding training is undertaken. Adult facing service within the BCCG (Continuing Health Care Team) are trained. All training was monitored by the safeguarding team and reported into the Safeguarding Governance Meetings which are held quarterly. The training compliance target is 85%. Service user feedback was collated by provider services in different formats and audited yearly as part of annual safeguarding audit reviewed their safeguarding supervision model. Supervision allows reflection and learning on practice to embed safeguarding within practitioner roles.

Safeguarding supervision took place in management 'one to one' meetings and through case discussions as necessary. To ensure adequate provision of safeguarding supervision, plans were progressed to commence group safeguarding supervision in Q3 facilitated by the Deputy Designated Nurse for Safeguarding. This would allow for case discussion and learning from reflective practice and highlight any areas of training need.

BCCG introduced Safeguarding GP Leads forums for primary care facilitated by the Deputy Designated Nurse for Safeguarding BCCG. These events were aimed at providing a forum for primary care to share best practice around safeguarding and to facilitate consistent safeguarding practices and processes. The forums assist with continual professional development in safeguarding and to date speakers have attended to raise awareness of the risks of radicalisation, Loan Sharks and safeguarding processes.

During this reporting period, the long standing BCCG Board representative retired and Board thanked her for her contribution to the work of the Board.

CL-Community Rehabilitation Company (CRC)

The CRC classified a huge number of their service users as vulnerable adults in relation to mental health, drug use, alcohol use, social exclusion, lack of or poor accommodation, criminal record, lack of employment or other useful activity and financial problems. However, it would be unlikely that most of our service users would meet the official Care Act criteria of 'vulnerable adult' under the S.42 definition. It would be unlikely that the CRC would make referrals to adult services.

Services would not be requested from the agency but rather delivered via court orders and prison licences on a statutory basis.

A domestic abuse perpetrators programme and specified activity requirement and during Q3 and Q4- 4 men in Blackpool participated. For perpetrators who undertake the programme a women's support worker was available for their partners and provided by the CRC. The CRC attended and contributed to MARAC meetings regularly but did not keep specific data on numbers of meetings attended or cases discussed.

The CRC acknowledged that evidence of Domestic Violence checks needed improvement, and were not undertaken in 57% of cases. The risk and public protection lead (Deputy Director) with Lancashire Police, have developed a more efficient information sharing procedure. The CRC found through internal audits that cases were not managed in line with current safeguarding practice in almost 60% of cases. ROs need further safeguarding training, if required, bespoke training. All audits inform development activity and advise training partners to match the needs of CRC. Ongoing audit of cases is undertaken to evidence improvements. Overall safeguarding practice needed to be enhanced but there were areas of good practice.

A drug rehabilitation requirement and an Alcohol Treatment Requirement were ordered via the courts links relevant service users into supervision by the CRC and substance misuse services. All CRC practitioners in Blackpool received safeguarding training, supervision, and ongoing training in house or through the BSAB. Safeguarding adults training includes substance misuse training, emotional resilience and domestic abuse.

Through audit activity of the Death under Supervision Reviews whilst subject to supervision, the CRC identified the need for: a documented handover when cases were transferred, good evidence of a supportive approach, management oversight when required and this was well-recorded. Most cases had accurate risk registers, flexible and sympathetic approach to service users' often challenging circumstances. Pro-active liaison with mental health services, timely referrals to partners, assessments completed on time, to ensure the sentence plan delivery is prioritised and evidenced in the case record. To aid the embedding of effective practice, areas of good practice were shared with practitioners via training, development and communication with middle managers. Mandatory Professional Practice Workshops have refocussed staff on the requirements of good practice in the CRC.

A new internal QA process was developed and ratified by the Senior Management Team and middle manager group. This included more frequent oversight and auditing of a greater number of cases to be undertaken by all middle managers and overseen by the Senior Management Team. The auditing of cases was ongoing and routine practice in the CRC and whilst the case audits were often not specifically aimed at adult safeguarding issues, these would routinely be identified within any case review. In order to improve their work with vulnerable young adults, one of our Blackpool ROs was on a placement at BYPS. The availability of training at regular intervals either in house or from the BSAB has helped in respect of safeguarding adults, and included substance misuse training, emotional resilience and domestic abuse. A volunteer and mentoring service was in place which could be used to offer additional support to vulnerable service users. The CRC has put together a policy document in respect of safeguarding adults which was available for all practitioners and managers.

Lancashire Care Foundation Trust (LCFT)

LCFT focussed upon improving the information available to the Safeguarding team to support the safeguarding of children and adults at risk and improve practice. Safeguarding performance was monitored by commissioning CCG's on a quarterly basis via the LCFT Safeguarding Group, contractual arrangements and performance meetings. During 2018/2019 the Trust Safeguarding Team have worked closely as a statutory partner with the Children and Adult Safeguarding Boards in line with the complex changing landscape of children and adult safeguarding arrangements. We remain core members of key multi-agency arrangements, including MARAC (Multi-Agency Risk Assessment Conferences), MASH (Multi-Agency Safeguarding Hubs), MAPPA (Multi-Agency Public Protection Arrangements) and the Channel Panel.

Safeguarding activity across the organisation is increasing, demonstrated by a significant increase in the information being shared, referrals, concerns and daily contact to LCFT Safeguarding Team for advice and support.

The effectiveness of safeguarding systems is assured and regulated by several mechanisms including:-

- Internal assurance processes via LCFT Safeguarding Group Quality and People Committee, and Quality and Safety Sub Committee.
- Partnership working with the Adult and Child Safeguarding Boards.
- External regulation and inspection.
- Local safeguarding reviews and assurance processes, implementing learning from Safeguarding Practice Reviews (SCRs), safeguarding Adult Reviews and Domestic Homicide Reviews (DHRs) to support our drive to learn and continually improve safeguarding practice.
- Effective contract monitoring through quarterly reporting to the NHS Clinical Commissioning Groups
- The NHS Accountability and Assurance Framework submission and monitoring

LCFT has integrated the Local Safeguarding Adults Board (LSAB) priorities and plans in determining its own strategic plans to protect adults from abuse and neglect within the networks, also incorporating plans into their business, reporting progress to LCFT Safeguarding Group. The Safeguarding Group performed an assurance function to ensure increased assurance in safeguarding practice that is embedded across clinical practice which can be evidenced within the network governance arrangements. Training was provided on 'Making Safeguarding Personal' and following the publication of the Adults Intercollegiate document Safeguarding and MCA leads reviewed the training model to ensure that training is better targeted to staff according to role, knowledge and competency requirements commensurate with individual's occupational role and responsibility: This approach has significantly increased the overall levels of Safeguarding Adults and MCA compliance across all LCFT networks.

The Safeguarding Team continue to provide support to staff working within inpatient and community mental health services across the locality, regular meetings take place between the LCFT team and principal social worker to strengthen partnership working and application of safeguarding processes .

The LCFT Safeguarding Vision for 2019-22 was revised. A 'Making Safeguarding Personal' review and assessment was undertaken of adult safeguarding practice in relation to making it personal against the ADASS MSP Audit Frameworks. LCFT were keen to understand the safeguarding journey and impact on service users and their families, and recognise how practice and understanding of safeguards can significantly influence the power imbalance and circumstances. Learning from Safeguarding Practice Reviews for children and Safeguarding Adult reviews is disseminated via learning briefs across the whole organisation. Recent learning included use of interpreters during assessments and asking about carer's responsibilities at contacts/referrals, and ensuring complex cases are discussed in Multi-disciplinary team meetings.

During 2018/19 the Safeguarding and Quality Improvement team have commenced a Quality Improvement project to strengthen staff awareness, knowledge and confidence in holding conversations in relation to routine enquiry of Domestic Abuse.

Some key successes have been achieved through collaborative working, with an acute health provider and Lancashire Constabulary. There has been a development of a clear pathway for patient attendance at the local Emergency Department, and the launch of a joint Hate Incident and Crime Procedure with Lancashire Constabulary. The latter has been acknowledged Trust wide – winning the Diversity and Inclusion Staff award and put forward for the NHS Parliamentary award (Wellbeing at Work). Trust wide policy and processes for tackling Hate Crime are being taken forward.

National Prison and Probation Service (NPS)

The National Prison and Probation Service (NPS) had made referrals to mental health and substance misuse services. However, the NPS case recording system did not allow to identify the numbers or types of adult safeguarding referrals made. Referral and access to such services were monitored through staff supervision and management oversight of cases. Flags were used to highlight safeguarding concerns on the universal contact record but was unable to identify when referrals were made. NPS were funding 2 admin workers for the MASH and were informed daily in cases where a PVP was submitted by the police in relation to any of the offenders supervised. The NPS was committed to release middle managers, senior managers and other probation staff to attend Safeguarding Board meetings relevant to the NPS. The ACO has chaired the SAR sub group on behalf of the Board for the last 3 years.

The NPS manage statutory orders but cannot control the demand from the Courts. They have used a work load measurement tool which is able to indicate the demand on officers' time based on work carried out. Establishment figures are based on workload demand. These figures are reviewed and updated annually.

There are ongoing challenges with regards recruitment of Probation Officers, workload was high amongst this staffing group in particular, with improvements over the last six months. Action was taken to mitigate this risk, as Probation Service Officers were appropriately used within Case Support roles and undertaking wider duties. There was a relative improvement at the Blackpool Office as there had only been 2 agency employed Probation Officers in post.

There had been a good use of interventions offered by CRC who provided valuable services to address offending behaviour, manage risk and support reintegration. The HM Inspection report highlighted and commended the NPS for the provision of outstanding support for victims.

Blackpool Probation offices were part of the Lancashire project to improve engagement for people with Autism. Autism Standards Project has been awarded accreditation from the National Autistic Society. Significant work was undertaken to develop staff knowledge with regards understanding Autism, accessing diagnosis, and support. Evidence identified within this assessment indicates that staff now have a greater understanding of Autism and Learning and Disability more generally, the impact on service users lives, experience of the Criminal Justice System, and appropriate reasonable adjustments. Autism Champions were placed in all Offices who continued to share their learning and was cascaded with arrangements for ongoing support. NPS were successful in their assessment by the National Autism Society and were the first Probation area in the country to receive the award.

NPS supported the MARAC and MASH review with a staff member seconded to the review, and had continued to fund 2 admin workers for the MASH. As a result of MASH changes PNC was now checked only for the suspect, as such no longer able to identify situations where service users are the victim or present within the incident. The PNC check in advance of sending PVP to partners has resulted in a significant reduction in the number of PVP's processed. This was considered positive in terms of managing demand, there was a concern that NPS are not aware of incidents in which service users who may be subject to Probation supervision are present or a victim. Each OASys assessment in which High risk of serious harm was identified was countersigned by a Senior Probation Officer to assure of quality. For Probation Service Officers, all OASys assessments require countersignature. Management Oversight meetings are undertaken for all service users identified as posing a high risk if serious harm, if subject to an indeterminate sentence.

Multi agency working is used to monitor and manage risk and need within our agency. Training in safeguarding has been refreshed for all staff and new training on multi-agency practice and information sharing to help with reduced risk and need. SAR and DHR learning outcomes are shared in teams. More stringent Management Oversight arrangements have been implemented within the NPS North West Division. Clear and time scaled Domestic Abuse action plan and progress towards priority objectives were monitored at the North West Domestic Abuse Leads meeting. NPS continued to be represented on the Claire's Law Panel at Senior Probation Officer level. Guidance was being developed to assist staff managing stalking and harassment cases.

Lancashire Police

Lancashire Constabulary is committed to Safeguarding; providing a victim focused service that identifies vulnerability, pro-actively addresses the needs of the individual and engages with our multi-agency partners to ensure the correct support at the earliest opportunity. The Headquarters Public Protection Unit is the strategic arm to provide guidance and steer, ensuring that officers are correctly informed on procedures and policy within areas of business contained with the field of Public Protection. These areas are in terms of Adults, Domestic Violence (DV), Forced Marriage, Missing Person (Adults), FGM, Human Trafficking, Sex Workers, Rape and an all-encompassing category, covering all identified adult vulnerability situations. .

The audits undertaken in West BCU by Chief Inspectors have been valuable to assess safeguarding practice, outcomes and multi- agency working. Overall since the start of 2018, the audits show good grading improving and inadequate cases falling. Vulnerable Adult Abuse investigations of a criminal nature are dealt with in the main, by the investigation hub.

Lancashire Police Case study: Making Safeguarding Personal

WEST case as follows:

Female who is in her late 70's, lives alone with her son who is profoundly deaf, makes 16 calls to the police in the 5 days. All calls made by female are in respect of her adjacent neighbours, who are shouting through the walls that they are going to come round and set her house on fire, throw acid in her face, rape her, fire bomb her house, come round with petrol and obtaining a fire arm.

The Officer in the case, spoke to all parties, giving them to opportunity to speak and for him to have the time to listen. It became clear that the accusations made by the elderly lady were unfounded and actually impossible to have taken place given the related circumstances. Indeed the neighbours were concerned for the welfare of the lady given the allegations that were being made against them. Indeed upon researching records there was evidence to highlight similar acquisitions made by the lady approximately a year ago, which again were found to be totally without substance.

As the officer became more concerned with the general health and welfare of the lady, they even suggested that an appointment with her GP may be in order as he felt (although not medically trained) that there may have been early dementia symptoms and possible urine infection, which they felt could lead to the hallucinations.

The Officer took it upon themselves to make contact with Lucy's daughter and asked if she can speak with her mum with the view of seeking a general health check-up and in particular, for them to consider the two above mentioned areas. The Daughter agreed to do this.

Although the officer did feel that there were issues with the allegations presented by the lady in question, they made a request for Environmental Health to install sound monitoring equipment as a matter of urgency placed 28/03/2019; as this will rule out for certain, any issues of noise and anti-social behaviour. As such, these actions not only addresses the possible health and wellbeing, it also covers the points raised by the complainant and will hopefully establish the true situation for possible further action and making this form of action personal to the Lady. Adult Social Care have also been made aware of the full circumstances.

The West Exploitation Team at Blackpool have been implemented and have tackled modern slavery in Blackpool and the surrounding areas. There were a number of multi-agency brothel visits in Blackpool to identify sexual exploitation. The partnership involving the police, community safety team and outreach support workers is becoming very effective and skilled at tackling potential incidents of sexual exploitation in Blackpool.

Adult human trafficking referrals have increased over the last year, which reflected a greater understanding from partner agencies through the training delivered and PLASP (Pan Lancashire Anti-Slavery Partnership). There was an increase in reporting from the public and Partner agencies now reporting include DWP, local authority, environmental health, fire, health and HMRC. All categories of exploitation have been reported in this time period with the exception of domestic servitude. This type of exploitation remains hidden and is under reported. In this time period we have continued to raise awareness. The OPCC along with police, held a multiagency table top exercise in January 2019 to promote joint working between agencies. In March, a jointly held business event for Lancashire businesses to raise awareness of how modern slavery can be found in their supply chains.

The demand on Lancashire Constabulary to attend to mental health related incidents was analysed recently in a study which found that in 2018 there was between 9-10% of all Police demand where MH could have been a factor. There are ongoing concerns about the level of demand on the police especially due to services in this area being stretched. The police had been transporting patients to hospital rather than fulfilling their core role. This practice was not supported and was harmful to many patients at a time of crisis in their life and undignified. As a result, processes and agreements were developed to prevent practice which is not centred on the needs of patients.

Training materials and access to external support via the BSAB websites have enabled MCA training to be delivered to officers through and number of continuous personal development arenas. This form of training was further supplemented by additional training delivery within the training package provided by a SPOC for Mental Health to new entrants. Further training is currently being developed with the assistance of CQC, who have agreed to deliver local based sessions to both Detective and uniform officers.

The Pan-Lancashire Vulnerable Adults Partnership meetings have been chaired by HQ Public Protection Unit for the last 2 - 3 years, bringing together Adult Social Care leads within each of the Local Authorities, together with CQC, Health and supervisory attendance from each of the Intelligence Hubs, who represent vulnerable adult (VA) investigation. This meeting provides an opportunity to share best practise and consolidate work on a Pan Lancashire footing.

Lancashire Police QA Activity involved considerable work that has been on-going within the Rape investigation agenda. The findings from a number of cases assigned to audit/review highlighted that improvements were required in, the recording of a rational decision making on case files, correct procedure for closure needed to be consistent across the county, increased awareness of officers regarding digital disclosure requirements for case files and a requirement to improve the pathways for third party material submission.

Various actions were undertaken to address this, through a targeted audience to maximise the learning and awareness raising. Events commenced in October 2018.

The HQ – PPU Dip sampling of 'live' cases regarding VA investigation and association with 'The office of Public Guardian'- All cases were found to be aligned correctly and communication was taking place between organisations. Quarterly Rape scrutiny meetings examined cases brought to the meeting by external partners who engaged with rape investigation, such as the CPS and support agencies to identify and areas for development or gaps in provision for the victim/survivor. Good working relationship have been established between the investigating officers and Disability and Autism Team, Blackpool ASC and the CQC. Increased public confidence in how the initial contact with the police will be victim focused, offering the correct external support (ISVA) from an early stage of any investigation may have contributed to the increase in the reporting of rape.

NHS England and NHS Improvement

Direct safeguarding referrals are generally made through primary care, CCGs and health care providers, but NHS England and NHS Improvement (NHSE&I) also generates its own safeguarding referrals especially in relation to issues and/or concerns arising from complaints. Although staff are not front line practitioners per se all NHSE&I staff are required to undertake safeguarding training commensurate to their roles and responsibilities.

Lancashire and South Cumbria Safeguarding Integrated Care System (ICS) network has been identified nationally as an area to support the development of a transformational model of safeguarding across the ICS. A working group has been formed to develop the proposal for change and a subsequent implementation plan. There is a clear commitment to a combined adult and children system wide approach to safeguarding across the ICS.

NHSE&I must provide protection for patients from any primary care performer who is not suitable, or whose efficiency to perform those services may be impaired. NHE&I's central role is to ensure that the NHS delivers better outcomes for patients within its available resources. The performer's list system supports NHSE&I in the delivery of this central role to ensure a consistency of primary care service delivery, to ensure that services are safe and effective and to ensure continuous improvement of quality. A requirement on safeguarding is included in all contracts issued to health care providers by NHSE&I ensuring that all contracted providers have completed safeguarding training appropriate to their role and are aware of requirements to identify safeguarding issues and reporting procedures.

Lancashire Fire and Rescue Service (LFRS)

An overview of the LFRS Safeguarding activities included Safeguarding Adults Referrals made in March 2018, were 43. By March 2019 this had increased to 108, demonstrating over a 100% increase in referrals.

LFRS deliver safeguarding training, which is mandatory through an eLearning programme which had been completed by the majority of staff in the Service. This included staff in development, support staff and all grades/rank. A senior LFRS officer attended the NFCC Safeguarding Group and was in the process of completing the NFCC Safeguarding Assessment Toolkit on behalf of LFRS.

LFRS have raised awareness of safeguarding through the Safeguarding Service Order, which had been updated and the referral process flow had been sent to all Stations to display on their Notice Boards. Four Routine Bulletin articles had been issued between January and March to raise awareness about Safeguarding and the process to follow. A Safeguarding Toolbox Talk had been developed which had been presented to all the new Whole time Recruits and to all CFS Staff at the Prevention Seminar. The CFS Teams disseminate this to Operational staff in their Areas.

All referrals were quality assured by the Prevention Support Team and any that required clarification were returned to the originator and line manager to reiterate the correct process flow to follow. Offers to provide talks to staff had been made, and continue to be made, by the Prevention Support Team members.

Blackpool Carer's Centre

The demand on services is increasing each year for Blackpool Carer's Centre, due to high numbers of new referrals entering the service, along with carers already known to the service reaching a new crisis point or change in circumstances resulting in them re-accessing our support. A numerical increase has been noted in carers accessing support from the organisation, had seen an increase in complexity of the support needs which carers present with. It was important to note, just 1% of current service users fall into the safeguarding categories provided.

The Carer's Centre service operates proactively, dealing with issues as they arise and designing an individual support plan in partnership with the carer, aimed at tackling their most pressing issues or areas of most need.

Their support is delivered under a time limited model, aimed at achieving specific outcomes for each individual whilst minimising service dependency. This delivery model has coped well with the increase in case complexity, in terms of retaining a low level of safeguarding concerns. As a third sector organisation, the most pressing risk to their business continuity is the sustainability of funding. Short term commissioning and an increase in the level of competitiveness for grant funding, represent difficulties in strategic planning over the medium and long term.

Healthwatch Blackpool

Healthwatch Blackpool were actively involved and attended multi-agency meetings for safeguarding led services and were actively involved in the task and finish groups for developing the policy and procedure for Self-Neglect and Hoarding, and ensuring representation from people who have lived experience of self-neglect and hoarding. Three new volunteers completed safeguarding training, through the online I-pool training and the Engagement Manager attended the BSAB Multi-Agency Safeguarding Training. Healthwatch Blackpool appointed a Data Analyst to collate and present feedback from local citizens regarding their experience of health and adult social care services across Blackpool. The reports would offer an alternative perspective to that of the provider, commissioner and regulator and provides the Board with information that should flag good practice and highlight early on issues with service delivery, ultimately to avoid instances of potential safeguarding and offer mechanisms for learning.

Healthwatch Blackpool have worked on a project to identify the needs of people receiving care in their own homes. This information could be utilised to inform commissioners of the 'wants/needs' of service users and their families. The information shared could highlight good practice and concerns that if addressed early would prevent potential safeguarding issues being raised. Other potential opportunities for learning may arise from the following Healthwatch projects such as, access to cervical and breast screening for women with learning disabilities and 'Hear my/our story', where case studies highlight real life experiences of service users. (Healthwatch Annual Report)

What's next for 2019/20

There have been some key emerging themes that have been brought to the attention of the Board over the last year. Board Partners have highlighted the below areas to be considered as potential priorities for the new Business Plan in March 2020.

Pressure Care – transfer in care settings

A short term task and finish group will be set up in the autumn of 2019 for relevant agencies to join the subgroup, such as tissue viability nurses and care home representatives. This group will review and update current tools and materials available to staff to support those with pressure care needs. The aim is to ensure information is shared across the local system to prevent, and where necessary, address poor quality of care issues to enable a proactive approach to maintaining high quality of care in relation to pressure care and transfers in residential and nursing care settings.

Adult exploitation - Cuckooing

The term "cuckooing" refers to the process by which a person exploits a resident's vulnerability and/or threatens violence, in order to use their premises for criminal acts. Individuals may be targeted as a result of a learning disability, physical disability, mental health, substance misuse, frailty or age etc. (this list is not exhaustive). The exploitation can include: grooming, forced entry to the address, property being taken over by others, keys being taken, the resident being coerced or forced into criminality, encouraged to use drugs, the "payment" for use of the address with drugs (or the supply of drugs at reduced cost), sexual exploitation and physical abuse. It is important to highlight that children and young people can also be victims, through living in the same address, sexual exploitation or as a result of being coerced into gang activity. There is a need to review the current process of referrals and ensure pathways are suitable for agencies to use. We should aim to raise awareness across practitioners and public of what cuckooing is and who may be affected by this and to ensure that we have transparent systems to address and act on cuckooing.

Modern Day Slavery

The work on modern day slavery continues with the aim of developing effective multi-agency plans for safe, quality and timely responses to create positive outcomes for victims by enabling identification at the earliest point. We will achieve this by raising awareness across the partnership and supporting communities to counter modern slavery through equipping key professionals, community members and residents to understand what modern slavery is in the broadest context and how to respond. The Pan Lancashire Anti-Slavery Partnership (PLASP) continues to be supported by the Safeguarding Boards, and the use of the PLASP toolkit and training offer for professional to identify and respond to victims will continue.

Complex vulnerabilities

A Complex Vulnerabilities Panel will be established in autumn 2019, to consider how services interact with individuals who possess complex safeguarding issues but do not meet thresholds for formal intervention, under statutory criteria covered by s.42 Care Act. The aim is to consider the roles and responsibilities of all agencies to work together so that every vulnerable adult in the borough has the best possible outcome. The work will include embedding this into practice within all agencies.

Appendix A

BOARD MEMBERSHIP

Criminal Justice	National Probation Service Community Rehabilitation Company
Emergency Services	Lancashire Police North West Ambulance Service Lancashire Fire and Rescue Service
Health	Blackpool Clinical Commissioning Group Lancashire Care Foundation NHS Trust Blackpool Teaching Hospitals NHS Trust NHS England
Local Authority	Adult Social Care Commissioning Public health Public protection unit
Housing	Blackpool Coastal Housing
Elected Member	
Service User Voice	Healthwatch Blackpool Carers Centre
Education	Blackpool and the Fylde College

Appendix B - s.44 Care Act – Safeguarding Adult Review criteria

The grounds for initiating a Safeguarding Adults Review (SAR) are:

A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if -

(a) there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(1) Condition 1 is met if -

(a) the adult has died, and

(b) the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(2) Condition 2 is met if -

(a) the adult is still alive, and

(b) the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

(3) The Safeguarding Adults Board may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

The adult who is the subject of the Safeguarding Adults Review need not have been in receipt of care and support services for the Safeguarding Adults Board to arrange a review in relation to them.

Note - the criteria for undertaking Safeguarding Adults Reviews does not apply to any case involving an adult in so far as the case relates to any period during which the adult was -

(a) detained in prison, or

(b) residing in approved premises.

Appendix C

Section 4: Making Safeguarding Personal (MSP) Tables

MSP Table for Concluded Section 42 Safeguarding Enquiries	Age Group						
For each enquiry, was the individual or individual's representative asked what their desired outcomes were?	18-64	65-74	75-84	85-94	95+	Not Known	Total
Yes they were asked and outcomes were expressed	86	34	72	65	7	3	267
Yes they were asked but no outcomes were expressed	10	10	8	9	1	1	39
No	15	5	12	14	3	2	51
Don't know	7	4	9	2	2	1	25
Not recorded	3	3	4	3	0	0	13
Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases were the desired outcomes achieved?	18-64	65-74	75-84	85-94	95+	Not Known	Total
Fully Achieved	48	21	42	36	5	3	155
Partially Achieved	26	9	25	22	2	0	84
Not Achieved	12	4	5	7	0	0	28

MSP Table for Other Concluded Safeguarding Enquiries	Age Group						
For each enquiry, was the individual or individual's representative asked what their desired outcomes were?	18-64	65-74	75-84	85-94	95+	Not Known	Total
Yes they were asked and outcomes were expressed	2	0	0	0	0	0	2
Yes they were asked but no outcomes were expressed	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Don't know	0	0	0	0	0	0	0
Not recorded	0	0	0	0	0	0	0
Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases were the desired outcomes achieved?	18-64	65-74	75-84	85-94	95+	Not Known	Total
Fully Achieved	1	0	0	0	0	0	1
Partially Achieved	0	0	0	0	0	0	0
Not Achieved	1	0	0	0	0	0	1

GLOSSARY

ASBRAC	Anti-Social Behaviour
ASC	Adult Social Care
BMG	Business Management Group
BSAB	Blackpool Safeguarding Adults Board
BSCB	Blackpool Safeguarding Children Board
BTH	Blackpool Teaching Hospitals NHS Foundation Trust
CAMHs	Children Adolescent Mental Health service
CCG	Clinical Commissioning Group
CHC	Continuing Health Care
CQC	Care Quality Commission
CRC	Community Rehabilitation Company
CSP	Community Safety Partnership
DA	Domestic Abuse
DBS	Disclosure Barring Service
DWP	Department of Work and Pensions
DOLs	Deprivation of Liberty Safeguards
ED	Emergency Department
ERISS	Electronic Information Sharing System
FGM	Female Genital Mutilation
HFSC	Home Fire Safety Checks
IDVA	Independent Domestic Violence Advocate
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LGA	Local Government Association
LGBT	Lesbian Gay Bisexual Transgender
MALR	Multi-Agency Learning Review
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MFH	Missing From Home
NEET	Not in Education, Employment or Training
NHSE	NHS England
NICE	National Institute for Clinical Excellence
OPD	Outpatients Departments
PCC	Police and Crime Commissioner
PPB	Prevent Partnership Board
PPNG	Patient Participation Networking Group
PVP	Police Vulnerable Person (referral)
QAPM	Quality Assurance and Performance Monitoring Group
SAR	Safeguarding Adult Review
WRAP	Workshop to Raise Awareness of Prevent