



LEICESTERSHIRE AND RUTLAND  
SAFEGUARDING ADULTS BOARD  
(LRSAB)

# Annual Report

# 2016/17

## Document Status

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<b>Independent Chair:</b>	Simon Westwood

## **Foreword**



As the new Independent Chair of the Leicestershire and Rutland Safeguarding Boards from April 2017, I am pleased to present the Annual Report for the Leicestershire and Rutland Safeguarding Adult Board (LRSAB) 2016/17. I would like to record thanks to Paul Burnett, the previous Chair for his leadership of the Board during the period this report relates to.

On behalf on the Board I want to thank all those; particularly parents and carers, front line staff and volunteers who day in and day out support vulnerable children, families and adults to improve their lives. The board will continue to play their part in building a culture where vulnerable adults, children, young people, carers and families are listened to and their views influence practice.

The report is published at the same time as the Annual Report for the Safeguarding Children Board. The reports include commentary on areas of cross-cutting work we have undertaken through our joint business plan.

The key purpose of the report is to assess the impact of the work we have undertaken in 2016/17 on safeguarding outcomes for vulnerable adults in Leicestershire and Rutland.

There is clear evidence of sustained strong partnership working across the safeguarding communities of Leicestershire and Rutland. In the recent Ofsted review of the LRLSCB the report stated “The board has developed an ethos of constructive challenge and support. It has taken a thoughtful and flexible approach, sensibly working closely with the Safeguarding Adults Board and Leicester City LSCB in areas of common concern.”

Though the report is joint for the areas of Leicestershire and Rutland it provides distinct findings about practice and performance in each area.

The Safeguarding Boards exist to provide support and critical enquiry to ensure that organisations work together to reduce or prevent possible abuse and neglect.

The Leicestershire vision and strategy for adult social care 2016 – 2020 is to promote, maintain and enhance people’s independence so that they are healthier, stronger, more resilient and less reliant on formal social care services.

In Rutland, a peer review in March 2017 found there is a good awareness of the principles of Making Safeguarding Personal and the overriding ethos that “safeguarding is everyone’s business” being a clear message to and owned by the workforce.

During a continuing period of change the Board will continue to focus attention on keeping adults' safe through promoting the expectations on partners of; helping people and supporting communities to stay well and independent; enabling maximum choice and control and ensuring people have a positive experience of care and support.

We can never eliminate risk entirely. We need to be as confident as we can be that every child and vulnerable adult, are supported to live in safety, free from abuse and neglect. The Board is assured that, whilst there are areas for improvement, agencies are working well together to safeguard adults in Leicestershire and Rutland.

I hope that this Annual Report will help to keep you informed and assured that agencies in Leicestershire and Rutland are committed to continuous improvement, being open about what needs to improve and transparently identifying the challenges in achieving this, not least the continuing pressure to do more with less resources.

**Finally, if you have safeguarding concerns about any vulnerable adult or child please act on them; you might be the only one who notices.**

A handwritten signature in black ink, appearing to read 'S Westwood', with a stylized flourish at the end.

Simon Westwood

Independent Chair

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## **Summary**

The Board is assured that, whilst there are areas for improvement, agencies and workers are working well together to safeguard adults in Leicestershire and Rutland.

In reaching this conclusion, we have:

Challenged those who work directly with adults with care and support needs to listen to what they are saying, respond to them appropriately and Make Safeguarding Personal, including through a workshop with care providers to improve working with local authorities. Information on this can be found throughout this report;

Monitored data and information on a regular basis. The *Safeguarding Adults in Leicestershire* and *Safeguarding Adults in Rutland* sections of this report tell you what we have learnt from this including, in both areas:

- Increases in safeguarding 'cause for concern' alerts
- A shift towards a lower proportion of safeguarding enquiries regarding residential settings and more in community settings
- An emergence of financial abuse and domestic abuse in safeguarding enquiries
- An increase in the proportion of people being asked about their outcomes and whose desired outcomes are met in safeguarding enquiries throughout the year
- An increase in the proportion of social care services users that feel safe and that say services make them feel safe.

Reviewed how we are doing as a Partnership, including an assessment on progress against our Business Development Plan for 2016/17;

Conducted a series of formal audits of our safeguarding arrangements, including:

- A Safeguarding Adults Audit Framework (SAAF) process;
- Case reviews of frontline practice which have included considering safeguarding thresholds and Making Safeguarding Personal.

Our formal audit activity is covered in the *Challenge and Assurance* section of this report;

Carried out Safeguarding Adult Reviews (SAR), other reviews of cases and disseminated learning from these across the partnership. This is summarised in the *Learning and Improvement* section of this report;

Supported the development of a Vulnerable Adults Risk Management (VARM) tool to support consistent responses to vulnerable adults who do not meet thresholds for access to safeguarding services, particularly in relation to self-neglect;

Invited our partners to contribute accounts of the work they have carried out over the year to safeguard adults with care and support needs;

The nature of the Board is holding partners to account and promoting learning and improvement therefore the Board is always considering how it can further improve safeguarding practice. The key areas for further development include:

- Developing a clear effective approach to prevention
- Ensuring thresholds are understood and agencies are compliant with the Care Act with respect to safeguarding enquiries
- Further embedding of Making Safeguarding Personal principles and the VARM
- Strengthening the participation of and engagement with adults with care and support needs and frontline practitioners in the work of the Board.

### Key Messages

- Workers and agencies work well together to safeguard adults in Leicestershire and Rutland.
- 'Making Safeguarding Personal' (MSP) is influencing practice across agencies and more people in Leicestershire and Rutland have more say in the enquiries about their safeguarding.
- Financial Abuse and Domestic Abuse are emerging areas of abuse of adults in Leicestershire and Rutland.
- Oversight of enquiries carried out in Health settings requires more work to gain assurance.
- The Board will continue to challenge and drive improvement in safeguarding of adults, including developing its own approach to engagement and participation of adults with care and support needs.

## **Board Background**

The Leicestershire & Rutland Safeguarding Adults Board (LRSAB) serves the counties of **Leicestershire** and **Rutland**. It became a statutory body on 1st April 2015 as result of the Care Act 2014.

### **Characteristics of Leicestershire & Rutland**

Leicestershire is a two-tier authority area with a population of 667,905. Whilst we are not aware of the total number of adults with care and support needs there are 105,423 individuals who report their day-to-day activities are limited and 130,084 adults aged 65 and over living in Leicestershire<sup>1</sup>.

Rutland is a unitary authority area with a population of 38,022. There are 5,788 individuals who report their day-to-day activities are limited and 8,830 adults aged 65 and over living in in Rutland<sup>2</sup>.

In Leicestershire, 11.1% of the population identify as from Black / Minority / Ethnic Groups (BME). Of those that do not identify as 'White British', the largest groups identify as 'Asian or Asian British' (6.3%) or 'White other' (1.9%).

In Rutland, the percentage of the population who are BME is 5.7%. The largest ethnic monitory group identified in Rutland is 'White other' at 2.1%.

The Joint Strategic Needs Assessment for Leicestershire identifies that by 2037 the total population is predicted to grow by 15%. However, the population aged over 85 is predicted to grow by 190%, from 15,900 to 45,600 people, and the population aged 65 to 84 is predicted to grow by 56%, from 106,000 to 164,900 people.

It is estimated that there are around 9,700 people aged 18-64 with learning disabilities in Leicestershire and 500 in Rutland<sup>3</sup>. These numbers are predicted to stay fairly stable in Leicestershire over the next 15 years to 2030, but to drop by around 7% in Rutland over that period.

### **Safeguarding Adults Board Arrangements**

The Care Act requires that the SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. It requires the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal'. It should also concern itself with a range of issues which can contribute to the well-being of its community and the prevention of abuse and neglect, such as:

- The safety of people who use services in local health settings, including mental health
- The safety of adults with care and support needs living in social housing
- Effective interventions with adults who self-neglect, for whatever reason
- The quality of local care and support services

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<sup>1</sup> ONS mid-year population estimates 2014

<sup>2</sup> ONS mid-year population estimates 2014

<sup>3</sup> Figures from [www.pansi.org.uk](http://www.pansi.org.uk)

- The effectiveness of prisons in safeguarding offenders
- Making connections between adult safeguarding and domestic abuse.

The LRSAB Business Plan sets out the key strategic objectives of the Board and how these will be met. The Annual Report presented here sets out how effective the Board has been in delivering its objectives. The report also includes an outline of the Safeguarding Adult Reviews (SARs) and other reviews carried out by the LRSAB, the learning gained from these reviews and the actions put in place to secure improvement.

The LRSAB normally meets four times a year alongside its partner Board: the Leicestershire and Rutland Local Safeguarding Children Board. Each of the four meetings comprises an Adults Board meeting, a Children Board meeting and a Joint meeting of the two Boards. The Board is supported by an integrated Safeguarding Adults and Children Executive Group and a range of subgroups and task and finish groups formed to deliver the key functions and Business Plan priorities.

The LRSAB works closely with Leicester Safeguarding Adults Board (LCSAB) on many areas of work to ensure effective working across the two areas. The LRSAB and the LCSAB have established a joint executive that oversees joint areas of business for the two Boards.

The SAB is funded through contributions from its partner agencies. In addition to financial contributions, in-kind contributions from partner agencies are essential in allowing the Board to operate effectively. In-kind contributions include partner agencies chairing and participating in the work of the Board and its subgroups and Leicestershire County Council hosting the Safeguarding Boards Business Office. The income and expenditure of the Board is set out on Page 37 of this report.

### **Independent Chair**

The LRSAB and the LRLSCB are led by a single Independent Chair. The independence of the Chair of the SAB is a requirement of the Care Act 2014.

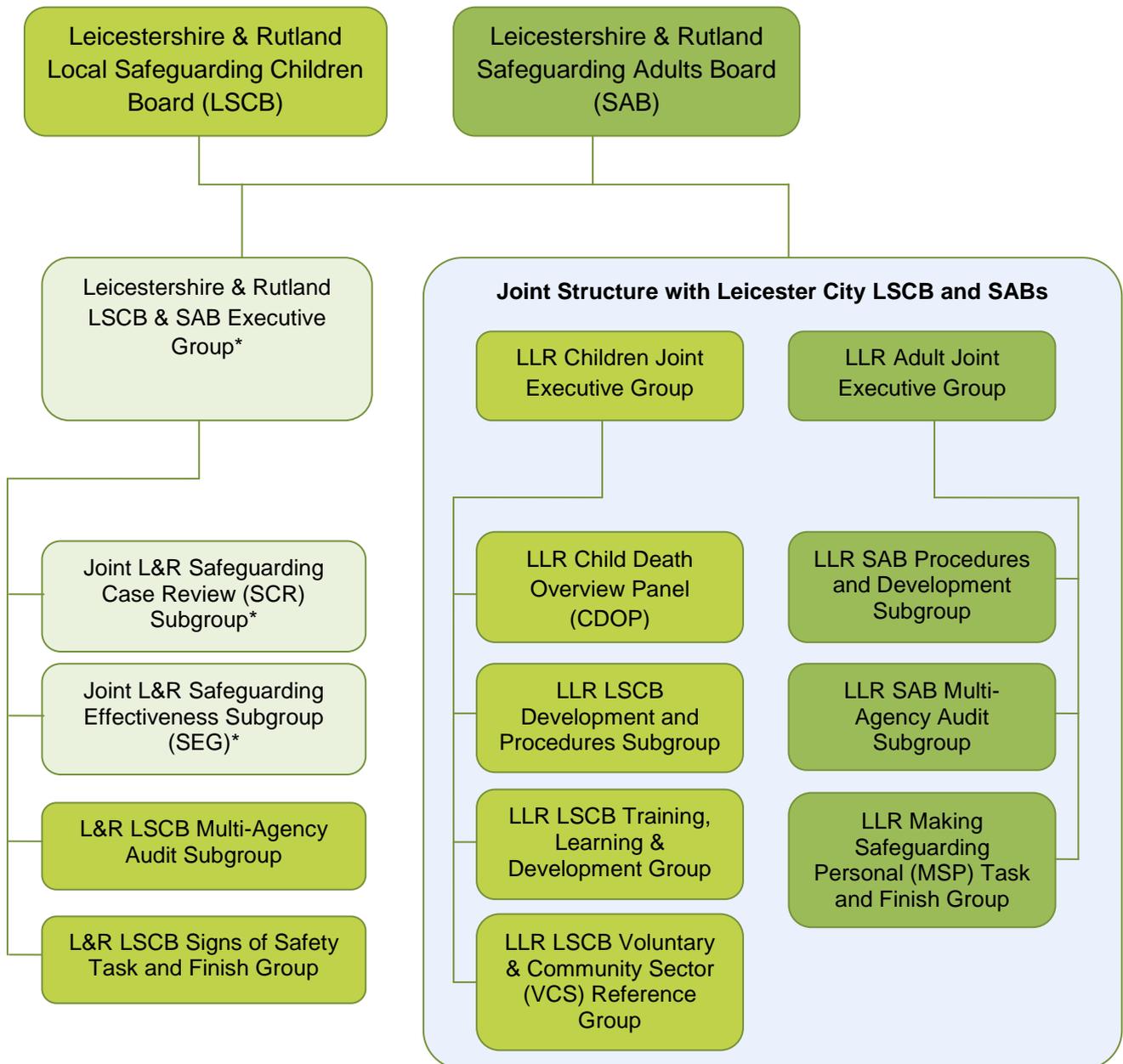
The Board's former Independent Chair, Mr Paul Burnett, stepped down at the end of March 2017 after almost six years in the role. Leicestershire and Rutland have agreed to continue to have a joint Chair for both Safeguarding Boards to reflect the need for cross-cutting approaches to safeguarding. Mr Simon Westwood has been appointed as Independent Chair of both Boards commencing in April 2017, initially for one year while the implications of the Children and Social Work Act 2017 and the future of partnership arrangements for Safeguarding Children and Adults in Leicestershire and Rutland are considered.

The Independent Chair provides independent scrutiny and challenge of agencies, and better enables each organisation to be held to account for its safeguarding performance.

The Independent Chair is accountable to the Chief Executives of Leicestershire and Rutland County Councils. They, together with the Directors of Children and Adult Services and the Lead Members for Children and Adult Services, formally performance manage the Independent Chair.

## Structure of the Board

The Board has established subgroups and task and finish groups to function effectively and achieve its objectives. The structure of the LRSAB and LRLSCB at the end of 2016/17 can be seen below. Membership of the Board can be found at Appendix 1.



## **SAB Business Plan Priorities 2016/17**

Priorities set by the LRSAB for development and assurance in 2016/17 were to:

- Build community safeguarding resilience and be assured that people living in the community who may be experiencing harm or abuse are aware and know how to seek help
- Be assured that thresholds for Safeguarding Adult alerts are appropriate, understood and consistently applied across the partnership
- Champion and support the extension of Making Safeguarding Personal (MSP) across the Partnership and secure assurance of the effectiveness of multi-agency processes/working and evidence of positive impact for service users
- Assure robust safeguarding in care settings – including health and social care at home, residential and nursing care settings.

In addition, the LRSAB shared the following priorities for development and assurance with the LRLSCB:

- To be assured that there are robust and effective arrangements to tackle domestic abuse
- To be assured that Mental Health Services incorporate robust arrangements to reduce safeguarding risk to children and adults including those supported through the Mental Capacity Act, Deprivation of Liberty Standards (MCA, DoLS) and the Learning Disability Pathway
- To be assured that the Safeguarding element of the Prevent strategy (Preventing Violent Extremism) is effective and robust across Leicestershire and Rutland.

## **Safeguarding Adults in Leicestershire**

From its scrutiny, assurance and learning work the Leicestershire and Rutland SAB assesses that organisations are working well together in Leicestershire to safeguard adults with care and support needs.

This section provides a detailed overview of the performance information and activity in Leicestershire regarding Safeguarding Adults.

### **Prevention activity**

Prevention activity in Leicestershire has focused on work with Trading Standards and Providers of Care and Support.

### **Work with Trading Standards**

A piece of scoping work in Leicestershire identified that around 40% of the people Trading Standards are alerted to by the national Scam Hub are known to Adult Social Care. A joined-up prevention approach is being developed with Trading Standards to address this including locating a member of the Trading Standards Team within the Customer Service Centre for one day a week on a trial basis to respond to referrals which are received around fraud or scams where safeguarding thresholds are not met. Planned prevention work also includes an awareness session for Service Managers to support their teams to recognise potential scams and to be aware of which groups may be particularly vulnerable to being targeted by scams.

An internal audit of such cases by Leicestershire County Council found that appropriate safeguarding enquiries have been undertaken where required.

### **Work with independent provider services**

Leicestershire County Council has facilitated several events working with providers, including workshop sessions using case studies to support understanding around Making Safeguarding Personal (MSP) at the Leicestershire county Council Residential and Domiciliary Care provider forums and presenting to the recent East Midlands Care Association (EMCARE) conference.

The LRSAB ran a workshop with providers of residential and domiciliary care in early 2017. The workshop incorporated providers' role in applying safeguarding thresholds to determine whether a safeguarding referral is required or whether an alternative response may be more appropriate and also in relation to the emphasis within the Care Act guidance on service providers undertaking more safeguarding enquiries.

The workshop received positive feedback and several providers have requested follow up sessions, which the Council are looking to facilitate. In addition Leicestershire County Council is carrying out ongoing work to audit incident forms from provider services to better understand where the Council can best focus support to providers to ensure they report appropriate incidents. This will allow a focus on incidents where Council input is required to reduce risk, supporting effective use of resources.

Safeguarding data indicates that the Council has effectively worked with Residential Care Providers to reduce risk in recent years as the percentage of safeguarding enquiries undertaken in care homes in Leicestershire has dropped from 61.6% in 2015/16 to 38.9% in 2016/17, with a reduction of 134 (23.5%) enquiries from those settings. This work continues and there is also a focus on work with domiciliary and supported living provider services.

Leicestershire Fire and Rescue Service commenced a pilot seconding a member of staff to work with the police Adult Referral Team to improve information sharing and joint working.

### Contacts and Assessment

There has been a 30% increase in safeguarding and concern for welfare alerts made to Leicestershire County Council from 2015/16 to 2016/17, with 4,406 alerts received in 2016/17. A similar proportion of alerts proceeded to enquiries as the previous year (29% compared to 28%).

The number of alerts from the public has increased by 1% (ten alerts) compared to the previous year however a higher proportion of these alerts are proceeding to enquiries – 233 compared to 132 (16.9% to 29.5%).

In 2016 a provider withdrew from the new Help to Live at Home (HTLAH) service in Leicestershire shortly prior to its launch. This may have been the cause of part of the increase in alerts. The Board was assured that, though some delays in visits had taken place, the Council's contingency plan had been effective in minimising the disruption as much as possible and ensuring the safety of adults receiving services. The Board also noted the hard work of Leicestershire County Council staff to achieve this.

The Council have undertaken several internal safeguarding audits. Based upon the outcomes from these audits and the increasing referral numbers, it has been identified that that a key area of focus should be continuing to develop consistent and robust approaches to applying safeguarding thresholds and addressing initial areas of risk relating to safeguarding adult referrals. In response to this, within the restructure of the Adult Social Care pathway the focus of the Leicestershire Safeguarding Adults Team has been revised, as outlined in the partner update section.

### Safeguarding Enquiries

The number of alerts that proceeded to a safeguarding adult enquiry in Leicestershire increased by 15% to 1,012, and the number of enquiries that found that abuse probably took place (enquiries that were fully or partially substantiated) fell by 4% to 553.

The number of enquiries ceased at the individuals' request increased each quarter, in line with the roll out of MSP and people having more say in enquiries, with 11% of all enquiries ceased at the individuals request during the year.

There has been a significant increase in the proportion of enquiries within community settings rather than residential settings from 40% to 66% within community settings in 2016/17.

The three main types of abuse across all enquiries in Leicestershire were Physical Abuse, Emotional Abuse and Neglect & Omission, with notable decreases in Neglect & Omission and notable increases in Financial Abuse, Domestic Abuse and Self-Neglect.

There has been ongoing work between Leicestershire County Council, UHL and LPT Safeguarding Teams since June 2015 when the Local Authorities became responsible for oversight of safeguarding enquiries where alleged abuse or neglect has occurred in in-patient settings.

Since the commencement of this responsibility there have been some issues in relation to low referral numbers, and measures have been put into place to try and address this. This has included clear oversight guidance being put in place, led by Leicestershire County Council, regular joint threshold application meetings and independent investigation by the Council in some enquiries.

The Council, working with Leicester City Council, has also facilitated training for LPT Unit Managers and Patient Safety Teams around safeguarding thresholds which has been well received and further sessions are planned. There has been some increase in referral numbers this year; however, numbers remain lower than expected so this work will continue and the issue has been escalated to the Safeguarding Adults Board for ongoing monitoring.

#### Implementation of Making Safeguarding Personal (MSP)

The Leicestershire County Council MSP action plan, developed in June 2016, was almost complete by the end of the year. To support staff to embed the principles of MSP in safeguarding practice there have been over twenty training sessions delivered within the Council to staff and managers. Changes to the council's case management system also support staff to evidence this in case recording.

The changes support the Council and SAB to more easily audit whether outcomes of people involved in safeguarding enquiries are being achieved and whether individuals felt involved and informed within the enquiry. Multi-agency actions have been taken forward through the Leicester, Leicestershire & Rutland (LLR) SAB MSP Task and Finish Group. More information on this can be found in the Business Plan Priority section on Making Safeguarding Personal.

The SAB has been able to review data regarding views of people involved in enquiries for the first time this year. Through the year an increasing proportion of people were asked about the outcomes they wanted from the enquiry, from 58% in the first quarter of the year to 71% in the last quarter and there was an 18% increase in the numbers of cases where outcomes were recorded.

The desired outcomes were achieved (fully or partly) in 95% of enquiries throughout the year.

The SAB multi-agency audit regarding MSP found there was good progress in Leicestershire with regard to embedding these principles in practice. The findings of this are outlined in more detail in the Challenge & Assurance section of this report.

## **Safeguarding Adults in Rutland**

From its scrutiny, assurance and learning work the Leicestershire and Rutland SAB assesses that organisations are working well together in Leicestershire to safeguard adults with care and support needs.

This section provides a detailed overview of the performance information and activity in Rutland regarding Safeguarding Adults.

### **Prevention activity**

The Council report that prevention is embedded within the Adult Social Care and Safeguarding approach in Rutland.

A peer review of Rutland Adult Social Care in March 2017 particularly noted the “focus on non-eligible citizens and developing approach to working with those people who have been institutionalised historically”, within an overall “excellent offer to the people of Rutland” where “outcomes are good.”

Rutland County Council has embedded a new Adult Social Care role, Assistant Care Manager (ACM), within the Prevention and Safeguarding Team who can provide time limited and person centre outcomes for those adults who are deemed at risk of being re-referred as a Safeguarding Adult’s enquiry. This service is non-means-tested to encourage those at risk of self-neglect to engage with support.

This approach has contributed to a reduction in referrals to the long-term team with less than 10% of all new contacts transferred for long term intervention.

Leicestershire Fire and Rescue Service commenced a pilot seconding a member of staff to work with the police Adult Referral Team to improve information sharing and joint working.

### **Contacts and Assessment**

Rutland has seen a slight reduction in safeguarding cause for concern alerts compared to the previous year (29), but a significant (171%) increase in alerts from the public (24 to 65) and a similar proportion of public alerts become enquiries as the previous year (13% compared with 16%).

All cause for concern alerts in Rutland are screened and triaged through the single point of contact. If threshold for a formal investigation is met then they are allocated within 24 hours to workers across the three teams in Adult Social Care.

The Council’s Prevention and Safeguarding Team operate a duty function provided by Adult Social Care practitioners. This allows for immediate engagement with the adult at risk. All assessments and safeguarding documentation require management oversight prior to sign off so all work is scrutinised to promote best practice.

The Multi-Agency Audits carried out during the year evidenced positive practice in Rutland in relation to application of safeguarding thresholds recorded on the contacts and evidenced Making Safeguarding Personal (MSP) and Adult at risk outcomes being recorded throughout contact and assessment.

## Safeguarding Enquiries

The number of safeguarding enquiries carried out in Rutland has increased by 71% to 77 in 2016/17. Just over a third (34%) of all enquiries found that abuse probably took place (enquiries that were fully or partially substantiated), this compares with just under half (44%) of the 45 enquiries in 2015/16.

The number of enquiries ceased at the individuals' request increased each quarter, in line with the roll out of MSP and people having more say in enquiries, with 12% of all enquiries ceased at the individuals request during the year.

There has been a continued increase in the proportion of enquiries within community settings rather than residential settings from 53% in 2015/16 to 72% within community settings in 2016/17.

The two main types of abuse in enquiries were Financial Abuse and Neglect & Omission. Domestic abuse is becoming more common.

The County Council have made significant changes to their case management system during the year to enable better capture and recording of the views and wishes of those involved in safeguarding enquiries in line with the principles of the Mental Capacity Act and to ensure that risk is appropriately assessed and managed within the enquiry.

The council's learning approach with safeguarding Continuous Professional Development (CPD) sessions for all Adult Social Care practitioners and integrated Health colleagues supports good safeguarding enquiry processes.

## Implementation of Making Safeguarding Personal (MSP)

The SAB has been able to review data regarding views of people involved in enquiries for the first time this year. Through the year, an increasing proportion of people were asked about the outcomes they wanted from the enquiry, from 50% in Q1 to 100% in Q4 and there was an increase in the numbers of cases where outcomes were recorded.

The desired outcomes were achieved in a large majority (94%) of enquiries throughout the year.

Rutland County Council has made changes to its Safeguarding Adults information system to include mandatory sections on the wellbeing principles and outcomes and MSP, which have supported the embedding of these principles and recording and evidencing of outcomes. Personalisation surveys are completed at the end of the safeguarding episode and record the adult's satisfaction with the process.

MSP has been embedded throughout training and guidance within Rutland including within

- Rutland County Council Safeguarding Guidance
- New Starter Induction training
- The E-Learning module on safeguarding adults for all new starters.

The Peer Review of Rutland Adult Social Care found that the positive journey towards greater personalisation was evidenced in case examples, case audit and the values of the members of the workforce that the reviewers met.

Rutland have used the East Midlands Safeguarding Adults Network Regional Benchmarking Tool and the ADASS Temperature Check to assess progress on embedding MSP, comparing favourably in these with positive outcomes.

The SAB multi-agency audits during the year have found Rutland County Council to be clearly undertaking and evidencing MSP principles with no recommendations to change practice.

In addition to these independent audits, RCC have recently developed a Quality Assurance Framework that allows staff to undertake structured reviews of casework, which includes reviewing the case from a MSP perspective as a standard in all audits to ensure MSP is embedded into general practice and identify opportunities for improvement.

MSP is a core agenda item on the monthly Continuing Professional Development (CPD) sessions conducted with the RCC ASC teams and the council is looking to promote MSP at the Learning Disability Forum.

Rutland County Council are looking to commission training for providers to promote personalisation through the use of commissioning and direct payments.

Multi-agency actions have also been taken forward through the SAB Task and Finish Group. More information on this can be found in the Business Plan Priority section on Making Safeguarding Personal.

### Transforming Care

As part of the LLR Transforming Care programme Rutland County Council are embedding Positive Risk Behavioural Support with a focus on supporting Service Users, providers, transfer of care services and lessening the impact of behaviours that challenge, thereby supporting the management of risk.

- Accessible Information has been embedded in the Councils' case management system which considers preferred communication format in relation to initial contacts taken via the Prevention and Safeguarding Team.
- Promoted awareness with specialist workers by attending workshops and training events
- Promoted awareness across SEND and Children's services on Transforming Care Agenda and safeguards
- The use of the Admittance Avoidance Register has promoted prevention work and joint working with health.

## **Safeguarding Adults across Leicestershire and Rutland**

The Police have seen a 66% rise in the number of adult safeguarding referrals they have made across Leicester, Leicestershire & Rutland to nearly 13,000. It is believed this is related to greater recognition of vulnerability by frontline officers, following training.

### **Mental Capacity Act, Deprivation of Liberty Safeguards (MCA, DoLS)**

The Mental Capacity Act, Deprivation of Liberty Safeguards (MCA, DoLS) provide a legal framework around the deprivation of liberty designed to protect the interests of vulnerable adults without the capacity to consent to care and treatment.

The DoLS service is hosted by Leicestershire County Council on behalf of Leicestershire and Rutland.

Following the significant increases in previous years, referrals for DoLS in Leicestershire & Rutland continued to increase from 3,395 in 2015/16 to 3,944 in 2016/17. Referrals have increased across all settings. Care homes are the main source of referrals (2,849), though referrals from private hospitals doubled from 55 (2015/16) to 106 (2016-17).

The increase, in part, is due to proactive work by the DoLS service and the Safeguarding and Compliance teams in Leicestershire and Rutland, with care providers and hospitals, and the number of providers and hospitals with no or low referrals has reduced.

Referral rates in Leicestershire and Rutland have remained high in comparison with other areas, which is identified as a result of careful interpretation of case law and good stakeholder relationships. Despite this and the proactive work mentioned, it is considered that the number of referrals does not represent the number of people who should have a DoLS assessment, given the number of care homes and hospital beds in Leicester, Leicestershire and Rutland.

As reported last year, additional financial resource to support the extension of this service to cope with the demand has been provided by the Local Authorities. At the end of March, the service had 14.5FTE (Full Time Equivalent) Best Interest Assessors, 10 more than in 2015/16 and are recruiting to have a team of 19.

The increase in resource has resulted in a reduction in the size of the waiting list, from 1,897 at the end of March 2016 to 973 at the end of March 2017. This included 784 urgent assessments in Leicestershire and 24 urgent assessments in Rutland that were outstanding. Most assessments have a wait of at least nine days. The SAB has received assurance that cases are being risk assessed and the most serious cases are being prioritised.

There has been an increase in Paid Advocates (Paid Persons Representative [PPR]) from 15% of cases to 40% of cases following case law in 2016. Leicestershire have devised what is thought to be the first procurement framework nationally to ensure service users have access to a diverse range of PPRs. Due to the national increase

in demand, Leicestershire have revised the frequency of visits in certain circumstances to release capacity within the current PPR providers.

Guidance continues to change and the Law Commission has recently given formal feedback from its review of the legislation and proposed new Liberty Protection Safeguards.

### Transforming Care

Transforming Care is focussed on making sure there is the right support for people to be discharged from inpatient hospital care and helping people who are at risk being admitted. This incorporates learning from national reviews and includes working towards the minimal number of arrangements where people are placed or receive their support out of the Leicestershire and Rutland area.

An on-line Risk Admission Avoidance register was introduced locally in January 2016 and has resulted in many more people (increased from five at the end of December 2015 to 78 in January 2017) identified as at risk of admission to inpatient settings due to their learning disability or autism and receiving support to prevent unnecessary admission.

The Safeguarding Board reviewed progress on the Transforming Care Plan and safeguarding impact during the year and noted that:

- Progress on reducing the number of inpatients was behind the planned schedule
- There is a broad level of support in place for people at risk of admission
- Procedures to prevent unnecessary admission into inpatient settings: Care Treatment Review and Blue Light meetings are preventing unnecessary admissions (63 across Leicester, Leicestershire and Rutland in the year to May 2017)
- A lack of appropriate accommodation for people waiting to be discharged from in-patient settings is a key risk to progress in providing appropriate and effective care and support.

The Board will continue to seek assurance regarding how this programme is supporting safeguarding of people with care and support needs, particularly with regard to learning disability and autism.

## **Business Development Plan Priorities**

**SAB Priority 1 – Build community safeguarding resilience and be assured that people living in the community who may be experiencing harm or abuse are aware and know how to seek help**

### **We planned to...**

- Survey public understanding of safeguarding adults (abuse and harm)
- Initiate campaigns including awareness raising process
- Analyse existing referral information and data to understand the trajectory of contacts from the public and conversion to referrals
- Identify strategies and approaches to build resilience and raising safeguarding awareness

### **We did...**

- Produced awareness publicity on adult safeguarding and distributed this through partners and community locations across the country.
- Carried out campaigns on financial scams with specific work with Social Care staff in Leicestershire.
- Reviewed data on contacts from the public and conversion of these to referrals was included in the dataset through the Safeguarding Effectiveness Group (SEG) of the Board.
- A piece of work was carried out in Leicestershire regarding alerts to Trading Standards regarding scams which found 40% of these were known to Adult Social Care.

### **The impact was...**

- An increase in alerts from the public in both Counties, more significantly in Rutland (212% increase from 24 to 75).
- In both areas the number of enquiries that arose from alerts from the public increased.
  - In Leicestershire there were 233 compared to 132, conversion rate of 30% compared to 17% the previous year.
  - In Rutland there were 10 compared to 4, conversion rate of 13% compared to 16% the previous year.

### **Further work required...**

- Further work is required to understand understanding and awareness regarding adult safeguarding in the public. This will be considered within the forward Board Priority on Prevention.

## **SAB Priority 2: Be assured that thresholds for Safeguarding Adult alerts are appropriate, understood and consistently applied across the partnership**

### **We planned to...**

- Test out, through case audits, how thresholds are currently applied
- Ensure the updated document is available to staff
- Continue to monitor the number of Safeguarding cause for concern alerts from Health providers raised with the Local Authorities in Leicestershire and Rutland
- Develop an effective escalation procedure for staff to use regarding referrals to Adults Social Care to ensure consistent thresholds.

### **We did...**

- Reviewed the Thresholds document, published it on the SAB Procedures website and distributed Thresholds business cards to frontline practitioners across agencies providing a clear 'signpost' to the Thresholds document on the website.
- Carried out a multi-agency case audit with a focus on thresholds.
- Developed 'Guidance for the Oversight Process of 'Section 42' NHS Safeguarding Enquiries in Leicester City, Leicestershire and Rutland', with implementation supported by training and regular operational meetings between health agencies and Local Authorities.

### **The impact was...**

- There is now consistent reporting on alerts to the Safeguarding Effectiveness Group (SEG).
- The number of alerts from Health providers to the Local Authorities has increased by around 50% compared to the previous year, from 79 to 123 in Leicestershire, and from 21 to 29 in Rutland, though the numbers dropped off at the end of the year after an initial increase.

### **Further development required...**

- Data on referrals, including from Health providers, suggests that there may still be elements of under-reporting and over-reporting into Adult Safeguarding in some areas. Therefore, Safeguarding Adult Thresholds will continue as a priority into 2017/18.
- Cause for concern alerts from different sources will continue to be analysed and the dataset to the SEG will be revised to include:
  - The total number of cases received by Health Safeguarding Teams and subsequently discussed at the meetings between Adults Social Care and Health providers
  - The number of cases which met the higher level or serious safeguarding concern and result in enquiries
  - How many of the enquiries were substantiated.
- The Board will continue to review progress with regard to oversight of Section 42 NHS safeguarding enquiries.

**SAB Priority 3: Champion and support the extension of Making Safeguarding Personal (MSP) across the Partnership and secure assurance of the effectiveness of multi-agency processes/working and evidence of positive impact for service users**

**We planned to...**

- **Preparing the Workforce:** Ensure all agencies involved in safeguarding enquiries to have a clear plan of how MSP principles will be embedded in practice within their agency.
- **Embedding MSP Principles in Practice:** Ensure Safeguarding Adults Reviews (SARs) include consideration of how MSP principles were applied in each case. Consider and make any amendments required to Multi-Agency Policy and Procedures and internal processes. Keep informed of Local, Regional and National multi-agency picture relating to MSP.
- **Measuring Effectiveness:** Collate information to give assurance of the effective embedding of MSP principles in practice.
- **MSP Tasks Relating to Provider Services:** Raise awareness of MSP principles within provider services in Leicester, Leicestershire and Rutland and their role within this.
- Identify how the SAB will support provider services in addressing workforce development needs relating to embedding MSP principles in safeguarding practice.
- Evaluate and review how provider services are supporting individuals within safeguarding enquiries in line with MSP principles.

**We did...**

- **Preparing the Workforce:** Undertook a Deliberative Inquiry at L&R SAB to ensure all agencies are aware of the requirement and signed up.
- Assessed and challenged each agencies implementation of MSP.
- Communicated MSP principles with the Independent and Voluntary sectors through briefings and Trainers Network.
- **Embedding MSP Principles in Practice:** Added MSP questions as a standing item to the Terms of Reference for Safeguarding Adult Reviews.
- Completed the Association of Directors of Adult Social Services (ADASS) MSP Temperature Check.
- Added a section on MSP to Multi-Agency Policies and Procedures (MAPP).
- Added a library of MSP tools to the Board's website, with links from the MAPP.
- **Measuring Effectiveness:** Carried out a Multi-Agency audit process regarding MSP with Leicester City SAB, including active safeguarding enquiries to ensure feedback from the individual.
- **MSP Tasks Relating to Provider Services:** Presented on and discussed MSP with representatives from a number of provider services through the Trainers Network and the EMCARE Annual Conference in March 2017.
- Included MSP as a topic in the SAB Safeguarding Effectiveness Workshop – Supporting Care Providers in March 2017.
- The Leicestershire Social Care Development Group (LSCDG) and Learning and Development reviewed current multi-agency safeguarding training to ensure MSP principles are reflected.

### **The impact was...**

- The number of cases where desired outcomes were asked and where those outcomes were met increased through the year in Leicestershire and Rutland.
- There was an increase in the proportion of service users reporting that they feel safe and that services have made them feel safe in Leicestershire and Rutland, and an increase in the proportion that feel they have control over their daily lives in Leicestershire.
- The live and case file audit found that the practice of the workers observed or spoken to was in line with MSP principles and workers were positive about the principles of MSP.
- The audit also found that on the whole people are being kept involved and informed within the enquiries, and effective work to engage people in understanding enquiries can gain agreement to continue.
- The ADASS MSP Temperature Check identified that Local Authorities and the Police have made significant progress on embedding MSP in many areas. University Hospitals of Leicester (UHL) have embedded this in a proportional way, and further support for development was required for the Clinical Commissioning Groups (CCGs).
- ADASS and the Local Government Association (LGA) expressed interest in the audit model used in Leicestershire & Rutland with its element of getting feedback directly from those involved in the enquiry. Leicestershire has also been asked to present the audit model to the East Midlands Safeguarding Adults Network

### **Further development required...**

- As the live audits and temperature check were positive and everything had been progressed on the action plan, the work of the Task and Finish Group was completed by the end of the year.
- All future SAB multi-agency audits will incorporate MSP to test that MSP principles remain embedded, and the SAB will continue to seek assurance and support practice development regarding MSP as part of core business
- The MSP tool library on the SAB website will continue to be updated.

## **SAB Priority 4: Assure robust safeguarding in care settings – including health and social care at home, residential and nursing care settings**

### **We planned to...**

- Clarify safeguarding frameworks in both Care Home and Domiciliary Care settings and secure assurance that there is appropriate practice guidance in place
- Review Quality Assurance and Performance Management Framework to test effectiveness of safeguarding in care settings to include home care settings
- Identify any workforce development requirements to support improved quality and performance and be assured that this is delivered
- Assess and analyse current data to establish a targeted response to awareness raising and training needs.

### **We did...**

- Updated the Performance Reporting Framework (PRF), monitored by the Safeguarding Effectiveness Group (SEG), with new indicators under this Priority to ensure that relevant data is collected
- Reviewed the Care Homes training matrix used by the CCG, CQC and Local Authorities to check compliance.
- Ran a Safeguarding Workshop for residential and community care providers in March 2017 attended by 52 participants from the Adult Sector workforce, including Independent Providers, Contracting and Compliance Officers, Safeguarding Leads and Quality and Assurance Leads. The workshop provided input to providers on key areas regarding safeguarding and provided a forum for providers, the Local Authorities and the Board to identify ways to improve safeguarding practice together. The topics covered included: Developing your competency; Provider Role in Safeguarding Enquiries; Thresholds; and Making Safeguarding Personal.

### **The impact was...**

- The SAB has a fuller picture of safeguarding issues in care settings including health and social care at home, care home and nursing care settings.
- A significant reduction in safeguarding enquiries in residential settings in both Leicestershire and Rutland, alongside a slight reduction in the proportion of enquiries that were fully or partially substantiated in those settings.
- The provider workshop identified ways in which the providers, Local Authorities and the SAB can work together to improve practice when safeguarding concerns are identified:
  - The importance of continual two way feedback throughout the enquiry between the provider and Council
  - Introduce more descriptive enquiry outcomes to inform current practice and future risk
  - Build familiarity with the Thresholds Guidance to aid decision making
  - Attend appropriate training to develop competence and confidence.

### **Further development required...**

- Potential data sets regarding domiciliary care settings will be considered by the Safeguarding Effectiveness Group (SEG) for the 2017/18 performance framework.
- Follow up progress with providers and the Local Authorities on ways forward agreed at the workshop

In addition the LRLSCB shared three priorities for development and assurance with the LRSAB:

**LSCB / SAB Priority 1: To be assured that there are robust and effective arrangements to tackle domestic abuse**

**We planned to...**

- Scrutinise the new Domestic Abuse Pathway for services for victims (including children, young people and adults) ensuring it is fit for purpose and embedded across the partnership (UAVA)
- Ensure that there are effective information sharing arrangements in place to support the effective delivery of the pathway for services
- Be assured that there are effective preventative processes and intervention services in place for domestic abuse perpetrators.

**We did...**

- Reviewed progress on the domestic abuse pathway work and domestic abuse data and identified key gaps between the capacity of Independent Domestic Violence Advocate (IDVA) services and the demands being placed upon those services.
- The work on domestic abuse pathways has identified some elements of the system where Domestic Abuse related information sharing pathways work effectively, and where there are some high profile gaps.
- The Leicester, Leicestershire and Rutland Domestic Violence Delivery Group (DVDG) has worked to develop the use of Integrated Offender Management (IOM) to reduce the harm caused by DV perpetrators.

**The impact was...**

- Partners secured additional funding to increase IDVA services from April 2017.
- Reports of DA to the Police reduced compared to the previous year in both Leicestershire and Rutland, but referrals to MARAC increased.
- The majority of people from Leicestershire and Rutland receiving support regarding domestic abuse felt safer (88% and 98% respectively)
- Data is not yet available to measure effectiveness of the IOM approach.

**Further development required...**

- The DVDG is seeking further funding to increase the capacity of the Multi-Agency Risk Assessment Conference (MARAC) and its support functions to improve the overall response to domestic abuse across the partnership landscape.
- The Task and Finish Group were unable to complete work on the pathways, affected by complexity of pathways and capacity within agencies. This is being further considered by the Community Safety Partnerships.
- A Priority Perpetrator Intervention Tool and the CARA (Conditional Cautioning and Relationship Abuse) programme are being introduced in the area in 2017 to enhance the range of options and consistency of practice with regard to domestic abuse perpetrators.
- The LSCB will continue to monitor domestic abuse impact and further develop approaches through the joint priority on the Trilogy of Risk (Domestic Abuse, Substance Misuse and Mental Health).

## **LSCB / SAB Priority 2: To be assured that Mental Health Services incorporate robust arrangements to reduce safeguarding risk to children and adults**

### **We planned to...**

- Seek assurance from the **Suicide** Prevention Plan Strategy Group that the strategy is reducing risk
- Seek assurance that current information and resources available to children, young people and adults on **Self-Harm** are used across the LSCB and SAB partnership
- Seek assurance that the **Emotional Health and Well-being** pathway is robust and fit for purpose
- Seek assurance that the **CAMHS (Child and Adolescent Mental Health Service)** review includes improved safeguarding outcomes
- Seek assurance from agencies that their workforce, across both Children and Adult services, have an appropriate understanding of the **Mental Capacity Act and Deprivation of Liberty Safeguards (MCA DoLS)**
- Seek assurance that the **Learning Disability Pathway** includes safeguarding outcomes.

### **We did...**

- The initial plan made very slow progress due to the breadth of the scope of the priority and delay in identifying a lead to drive this forward. The plan was revised in early 2017 to gain assurance through a series of assurance questions from key agencies and partnerships leading work on these areas.
- The Board received a report on the developing Adult mental health pathways in March 2017.

### **The impact was...**

- The Board gained assurance that the Leicester, Leicestershire & Rutland (LLR) Suicide Audit and Prevention Group oversee and analyse suicide data and consider safeguarding issues within the revised Suicide Strategy and Action Plan (2017-2020).
- Safeguarding and Child Protection will be explicitly included the revised Children and Young People Mental Health Transformation Plan
- The Board gained assurance that the adult mental health pathway was robust.

### **Further development required...**

- Reports to the Board on Child Mental health pathways, MCA DoLS and Transforming Care regarding Learning Disability, were scheduled for the June 2017 LSCB and SAB meetings.
- The Board has recommended that safeguarding is explicitly considered within any revisions to the Sustainable Transformation Plan (STP) within Health.
- Audit of deaths by suicide being carried out for the Child Death Overview Panel (CDOP) to come to the LSCBs Safeguarding Effectiveness Group (SEG).
- Significant further work is required to gain assurance on these areas. These have been incorporated in the Joint Business Development Plan Priority for 2017/18 on Emotional Health and Well-Being.

### **LSCB / SAB Priority 3: To be assured that the Safeguarding element of the Prevent strategy (Preventing Violent Extremism) is effective and robust across Leicestershire and Rutland**

#### **We planned to...**

- Receive regular reports on Prevent work and safeguarding, including training and awareness raising
- Support and promote Prevent awareness to the public and particular groups of professionals.

#### **We did...**

- The Board considered safeguarding assurance with regard to Prevent through a deliberative inquiry at its meeting in July 2016.
- Showcased the Alter Ego “Going to Extremes” theatre production during its development at a joint City and Counties LSCB learning event to promote this to frontline staff and gain their input into its development.
- Two Prevent awareness sessions were delivered to foster carers and prospective adopters in 2016.
- The Board supported a local funding bid to support the promotion of Prevent awareness sessions with young people and training of carers and parents of people with learning disabilities.

#### **The impact was...**

- Across Leicestershire and Rutland over 6,000 people have now been WRAP (Workshop to Raise Awareness of Prevent) trained.
- The “Going to Extremes” production started touring Leicestershire and Rutland in March 2017 with 41 performances booked in schools and public locations between March and May 2017. This production has been well received by schools and pupils and is being considered by other areas.
- The Leicestershire schools annual safeguarding survey in 2016 identified that compliance with the new Prevent duty in schools is high and almost all schools (91.2%) had or were in the process of completing a Prevent risk assessment.
- The number and quality of Channel referrals from the County have increased, particularly from schools.
- In Leicestershire’s inspection Ofsted noted that “The ‘Prevent’ duty work and agenda are embedded and continuing to develop in Leicestershire. There is clear strategic governance, and creative operational work is being undertaken to raise awareness and identify and respond to risks. There is a good understanding of the nature of potential extremism in the area, and effective individual work with young people is described.”

#### **Further development required...**

- Funding for the Counties’ Prevent Officer comes to an end in October 2017. An exit strategy is being planned in preparation for this to continue the partnership work on Prevent through the Hate and Prevent Delivery Group.
- The work of Prevent linked to safeguarding will continue to be monitored by the Board as business as usual.

## **Operation of the Board**

### **Partner and Public Engagement and Participation**

#### **Partner Engagement and Attendance**

Due to changes in meeting scheduling in 2017 the Board met five times during 2016/17. The membership of the Board can be seen in Appendix 1.

Whilst the Police, Rutland County Council, and the Fire Service attended all meetings, attendance for other agencies was mixed.

Leicestershire County Council and the two Clinical Commissioning Groups each attended the majority of meetings and sent apologies for any missed. Attendance by the District Councils improved during the year with the appointment of a new representative, who attended both meetings following their appointment.

Other Health partners and the Voluntary Sector representatives attended around half the meetings during the year. Engagement with the Criminal Justice Sector remains poor. Whilst the Community Rehabilitation Company attended one meeting and sent apologies to another, there was no attendance from the Prison Service or the National Probation Service to any SAB Board meetings during the year.

Attendance by the Private sector also remained low with attendance at only one meeting.

Agencies consistently engage well in the subgroups of the Board.

In 2017/18 the Board will look to develop links with Universities in the area regarding their approaches to safeguarding adults.

The new Independent Chair of the Board will engage with agencies to ensure appropriate attendance.

#### **Public Engagement & Participation**

The Board reviewed its approach to Engagement and Participation at the start of the year tasking individual Business Plan priority leads with incorporating this in their work on the priorities, rather than through a separate group.

The Making Safeguarding Personal Multi-agency audit included specific feedback from the people subject to the cases being audited.

Working with the co-production service at Leicestershire County Council, the Board involved adults with care and support needs in the recruitment of the new Independent Chair of the Board.

Agencies have identified how they are hearing and responding to the voice of service users, for example, University Hospitals of Leicester have recruited a patient partner to sit on their internal Safeguarding Assurance Group to ensure that a service user perspective is considered in any safeguarding work undertaken within the Trust.

However, engagement with and participation of vulnerable adults within the work of the Board on the Business Plan priorities has otherwise been challenging.

Further work is required on this and the development of engagement and participation has been identified as a Priority for the SAB shared with the LSCB.

## Assurance – Challenges and Quality Assurance

### **Challenge Log**

The Board keeps a challenge log to monitor challenges raised by the Board and the outcomes of the challenges. During the year the following challenges were raised by the Board with safeguarding partners regarding the following topics:

- Multi-Agency Audits: at the start of the year the Board Chair challenged Board members to work together to implement an effective approach to multi-agency audits that supported a comprehensive assurance framework for the Board.
- Contributions of agencies to the budget of the Board and potential budget reductions; the Board challenged partners to strategically consider their budget contributions to the Board.
- Gaps in quality and accuracy of data provided to the Board and its Safeguarding Effectiveness Group (SEG); the Board challenged all partners to review and ensure accuracy of data provided to the Board.

Following these challenges:

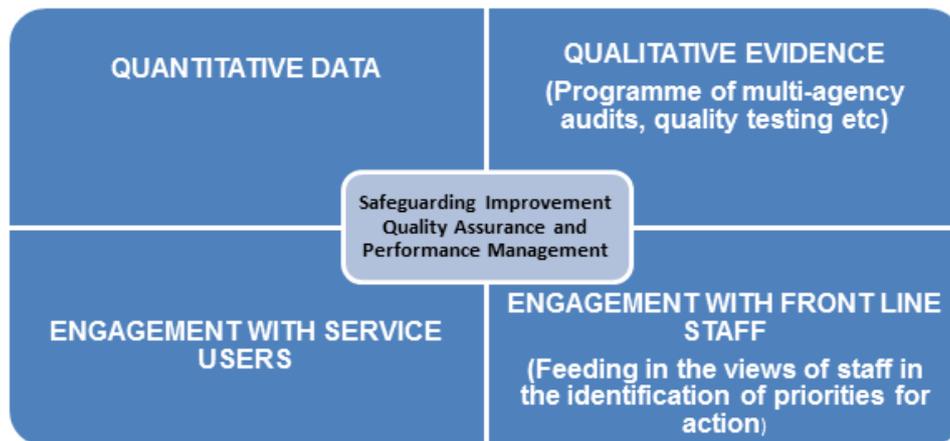
- A robust framework for multi-agency audits is in place and two multi-agency audits were carried out by the SAB in 2016/17.
- Further discussions are taking place regarding the future structures of the Board and the arrangements for setting agency contributions to the Board, and
- Partners have undertaken to ensure accurate data is provided, with no data issues identified in the quarter following the challenge.

### **Quality Assurance and Performance Management Framework**

The Board operates a four quadrant Quality Assurance and Performance Management Framework as outlined overleaf. This is overseen by the Boards' Safeguarding Effectiveness Group (SEG) shared with the LSCB. The outcomes of and findings from this performance framework are incorporated in the relevant sections within the report.

The detailed elements of this are reviewed each year to ensure this provides assurance regarding core safeguarding business as well as Business Plan priorities and other emerging issues.

The overall model is also reviewed and engagement elements of the framework, both with staff and service users, require some further development in the coming year.



## Audits

During 2016-17 the SAB carried out a Safeguarding Adults Audit Framework (SAAF) Audit that tests agencies compliance against their safeguarding duties within Care Act 2014 through an organisational assessment against safeguarding standards.

Audit returns from the nine agencies that work in Leicestershire or Rutland identify that most agencies consider that they are 'effective' or 'excelling' across the majority of the compliance questions that are relevant to them.

- District and Borough Councils identify they have further work to do to be effective in embedding safeguarding effectively in procurement and contract management.
- Public Health identify that Prevent and MSP principles are not effectively embedded in their planning, but these will be considered in their review of clinical governance arrangements. They do not yet have effective 'whistleblowing' procedures, but these are planned.
- University Hospitals of Leicester NHS Trust (UHL) are working towards compliance regarding benchmarking safeguarding concerns and enquiries
- Leicester Partnerships NHS Trust (LPT) are working towards effectiveness regarding MSP, MCA DoLS, restrictions and restraint, supervision and escalation, and addressing historical allegations, but report that safeguarding is not effectively integral in evaluation of services.

Commentary on audit returns from agencies identifies that a good level of testing is taken out in completing the audit. The SAB carries out a front-line practitioner audit bi-annually to check the findings of the SAAF audit, however there is currently no direct challenge element to self-reporting of progress. The SAB process for SAAF compliance assurance will be revised in 2017/18 to reduce the burden on agencies and incorporate more peer review and challenge of compliance findings.

In 2016/17 the Board introduced a new approach to multi-agency auditing, with a plan of case file audits during the year. During the year, two Multi-agency audits were carried out focussing on the following priorities:

- Use of thresholds for adult safeguarding
- Making Safeguarding Personal.

The audit process involves individual agencies auditing a sample of their own case files using a common tool, and bringing audits and learning to a multi-agency

meeting to be reviewed across partners. The cases are selected at random by the individual agencies. An independently selected random case sample will be considered by the SAB in future.

The Making Safeguarding Personal audit added a live audit element. This included direct observation of agency practice, discussions with service users about their experience of the enquiry and with workers about their understanding of MSP. This approach has gained much interest from other authorities and SABs in the region and national bodies such as the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS).

The Thresholds audit of 24 cases found that:

- In the majority of cases thresholds were being appropriately applied with some inconsistencies in recording within LPT
- There is potential to improve information sharing in cases where both LPT and UHL are involved, and are overseen by Adult Social Care
- Recording in case notes regarding decision making about proceeding to 'Section 42' enquiries could be improved across agencies, referencing safeguarding thresholds
- There may be benefit in further work regarding joint responses between Leicestershire Police and Adult Social Care regarding safeguarding referrals involving known domestic abuse cases.

The outcome of the audit includes

- Three-way meetings with LPT, UHL and local authorities have been set up and are operating well.
- Domestic abuse has been adopted as a priority for the SAB for 2017/18 (within Trilogy of Risk).

The Making Safeguarding Personal Audit of nineteen cases, four of which were the live audits, found that:

- On the whole, people are being kept involved and informed within enquiries. A further area of work within agencies may be to ensure that the worker has a clear focus on establishing the extent the person wishes to be updated about the safeguarding enquiry, which will clearly vary, to avoid any further anxiety.
- Some people will change their minds about wishing the enquiry to cease, where workers establish their reasons for this, and talk to them about benefits of the enquiry and alternative outcomes (negotiated outcomes).
- Evidencing support to involve and inform people in the enquiry is important alongside achieving outcomes, as the desired outcomes for an individual will not always be possible to be achieved – for example when they do not want an enquiry and this needs to go ahead due to risk to others.
- It remains difficult to engage with people about their experience of safeguarding enquiries. Agencies should focus on establishing this whilst the enquiry is ongoing, with a worker the person has established a working relationship with, to have the best opportunity of supporting the person to express their views.

Agencies have taken away these learning points to embed this within their practice. Progress will be tested with a follow up audit on MSP in 2018. Thresholds will be considered as a key part of multi-agency audits in 2017.

### Learning and Improvement

#### **Safeguarding Adults Reviews and other Learning Reviews**

The SAB Safeguarding Case Review Subgroup (SCR Subgroup) receives information from agencies about serious incidents of abuse and considers if a Safeguarding Adult Review (SAR) or alternative review process is required to ensure multi-agency learning is captured and implemented. The group has provided a forum for professional scrutiny, advice and guidance to safeguarding leads for organisations. Single agency reviews have been discussed and felt by all members to be a valuable resource provided by the group as an opportunity for partnership reflection and support.

The Subgroup continues to retain full and appropriate membership from key partners and attendance levels have been good.

The Board have agreed to incorporate the following MSP questions into all reviews:

- Was the service user consulted?
- Were they listened to?
- Did they contribute?
- Did they feel safer?

In 2016/17, the SCR Subgroup received the following referrals for consideration and the table below outlines their progress as of March 2017:

Gender	Harm Factors	Type of Review	Progress
Female	Mental Health / Domestic Abuse / Substance Misuse	SAR (Appreciative Inquiry)	Review completed
Female	Alcohol misuse / Self Neglect	Alternative Review (Appreciative Inquiry)	Review completed
Female	Mental Health	SAR	Review underway
Male	Neglect	SAR	Awaiting Crown Prosecution Service decision
Female	Self-Neglect	Independent Review of work undertaken by Multi-Agency Safeguarding Group	In progress
Female	Substance Use	To be decided	Collating information
Female	Mental Health	Single agency review	Closed - satisfied with the findings of agency report and action plan
Female	Drugs / Alcohol	No review - did not meet criteria	Closed

## Learning from reviews

The two reviews completed in 2016/17 have focussed on issues of Mental Health, Alcohol Misuse, Domestic Abuse and refusal of services. Whilst the circumstances surrounding the cases were different, six themes have been drawn together.

**Theme 1 – ‘Better Conversations’:** Staff in all agencies to be reminded of the importance of ‘Better conversations’ at the point of referral so they result a shared understanding of what the concerns, desired outcome for service user and next steps are.

**Theme 2 – ‘Service users reluctant to engage’:** This can be a very complex and challenging area for staff to deal with. Staff should consider creative and partnership solutions to development engagement.

**Theme 3 – ‘Understanding Domestic Abuse and Older People’:** Staff to be reminded that in assessing Domestic Abuse situations they have a good understanding of aspects and impact of domestic abuse and consider specific vulnerabilities and relationship dynamics for individuals.

**Theme 4 – ‘Understanding Mental Capacity’:** Staff should have knowledge of the Mental Capacity Act relevant to their role; however, in practice, staff are supporting decision making all the time, so need to assume capacity unless there are indicators to the contrary for that individual and be clear who is accessing capacity, and what is the impact of Mental ill-health on daily living.

**Theme 5 – ‘The impact of Alcohol misuse’:** Supporting people who misuse drugs and alcohol can be challenging, complex and unpredictable. The issues are closely linked to **Themes 1, 2 and 4**. Staff should additionally consider resources and expert advice available and how they may be accessed.

**Theme 6 – Self-Neglect:** Staff need to be able to recognise Self-Neglect and be familiar with how to respond

The importance of use of the Threshold Guidance for Adult Safeguarding was highlighted through these themes.

The SCR Subgroup also considered an alternative joint Children and Adults review involving a young person who had recently moved into adulthood but were satisfied with the findings of both Council and Mental Health Service internal reports, and identified no further learning.

## Domestic Homicide Reviews

The LSCB and SAB manage the process for carrying out Domestic Homicide Reviews (DHRs) on behalf of and commissioned by the Community Safety Partnerships in Leicestershire and Rutland. This is managed through the joint Children and Adults section of the Boards’ SCR Subgroup.

Two DHRs were completed during the year and the Community Safety Partnerships were awaiting feedback from the Home Office Quality Assurance Panel on these at the end of the year. Three further potential Domestic Homicide Reviews were considered, two did not meet the criteria, however an alternative review was carried out on one of these cases, and the third was in consideration at the end of the year.

### **Development Work and Disseminating Learning**

The SCR Subgroup also reviewed the Boards' Learning and Improvement Framework and updated the referral form and the Domestic Homicide Review Procedures.

The LSCB produces a quarterly newsletter –Safeguarding Matters to disseminate key messages, including from reviews and audits across the partnership and to front-line practitioners. Issues of Safeguarding Matters can be found on the SAB website: <http://lrsb.org.uk/newsletters>

Learning has also been shared through single agency internal processes, Learning Events and the Trainers Network.

### **Learning Disability Mortality Review (LeDeR) Programme**

In response to the Confidential Inquiry into the deaths of people with learning disabilities (CIPOLD) that found that 42% of such deaths were deemed to be “premature” a national project was set up to review deaths of people aged 4 and above with learning disabilities to identify learning to:

- Drive improvement in the quality of health and social care service delivery for people with learning disabilities
- Help reduce premature mortality and health inequalities in this population
- To influence practice at service, individual practice and professional level

This programme links into the wider framework for mortality reviews outlined in the National Guidance of Learning from Deaths framework produced by NHS England in March 2017.

Leicester, Leicestershire & Rutland was one of the original pilot sites for this review programme. A steering group with membership across agencies including a number of providers was set up in 2016 and reviews commenced from 1<sup>st</sup> November 2016.

Oversight for the steering group is provided through the Joint Executive of the Leicester City and Leicestershire and Rutland Safeguarding Adults Boards.

Deaths of children with learning disabilities continue to be reviewed by the Child Death Overview Panel (CDOP) in line with its statutory function, and learning from these is shared with the LeDeR programme.

During 2016/17 two reviews were commenced, both were still in progress at the end of the year.

The first thematic safeguarding report from the national programme indicates learning around the following themes:

- Main causes of death as pneumonia, aspiration pneumonia and sepsis.
- Systems issues
- Interagency communication and working
- The direct provision of care
- Adherence to legislation and guidance on the Mental Capacity Act 2005
- The need for training, such as regarding learning disability awareness, mental capacity and bowel health.
- Communication with families, carers, and people with learning disabilities.

These are being considered by the steering group to identify any action to be taken locally.

### Co-ordination of and Procedures for Safeguarding Adults

In response to learning from the reviews and audits of practice, alongside research findings and review findings nationally, the Board has developed and updated safeguarding procedures as follows:

- Made changes to the Multi-Agency Policy and Procedures to improve accessibility and allow more timely changes to local documents
- Development of a Vulnerable Adults Risk Management (VARM) process to enable multi-agency working to identify risk and look for creative solutions particularly in cases of Self-Neglect
- Ensuring the procedures reflect the principles of Making Safeguarding Personal
- Updating the Escalation and Professional Disagreement Process
- Added signposts with the Multi-Agency Policy and Procedures to additional information on Forced Marriage, Human Trafficking and Modern Slavery and Preventing Violent Extremism
- Thresholds guidance updated to include Domestic Abuse
- Reviewed templates for Record of Strategy meeting, Conference agenda and Professional Report to Conference
- Commenced development of a Memorandum of Understanding between the Councils and Health where abuse is alleged to have occurred within a health setting.

Future Work planned includes:

- Completion and final sign off the Information Sharing Agreement (ISA)
- Final sign off of the Council and Health Memorandum of Understanding
- Further development of guidance on Modern Slavery, Human Trafficking and Prevent
- Reviewing guidance regarding allegations made against staff.

### **Vulnerable Adults Risk Management Process (VARM)**

In response to the increase in alerts regarding self-neglect and an identified need for a consistent response to the often complex nature of these cases with a lack of engagement; Vulnerable Adults Risk Management Process (VARM) Guidance has been developed by the three Local Authorities in Leicester, Leicestershire and

Rutland, with assistance from Leicestershire Police. This has been considered by and is supported by the LRSAB.

The guidance focuses on co-ordinating a multi-agency approach to provide more consistency in working with people in situations of risk, where they are not engaging with agencies and in particular for working with people at high risk in relation to self-neglect. It is felt this approach is likely to be more effective than using the safeguarding process for self-neglect, where the person is felt to have capacity to understand the risks involved, given there is no abuse by a third party. This is an LLR approach, which will support partner agencies working across all three areas.

Initial training has been undertaken on the VARM with Council Service Managers and feedback from this shows this approach is welcomed as being a positive development to better support operational practice when working with people who are at risk through self-neglect.

### Training and Development

The SAB, through its Safeguarding Effectiveness Group regularly requests information from its partners regarding the effectiveness of their safeguarding training programmes.

During the year the SAB has challenged the Local Authorities regarding the lack of information they were able to provide to give assurance on workforce training and competency. At the end of the year assurance had been received from all partners regarding the safeguarding training and competence of their workforce.

The Trainers Network has met four times with regular attendance of forty staff from the Independent, Statutory and Voluntary Sector who have a responsibility for developing and delivering learning and development opportunities.

The Network continues to give participants the opportunity to discuss and develop their organisations approach in light of : National and local developments in practice and procedures; Learning from reviews (national and local); Embedding the Competency Framework and updates to Training materials and resources.

During 2016/17, the focus has been on Making Safeguarding Personal, updating of Training material for 'Reporting concerns, allegations or disclosures of abuse' and finding creative ways to embed the competency framework into staff development

The Network supports dissemination of information and awareness raising materials such as Safeguarding Matters, Leaflets and training events.

Feedback from the group has been sought on levels of understanding of MSP and ease of access to the procedures.

## **Leicestershire & Rutland SAB and LSCB Income and Expenditure 2016-17**

	£
<b>SAB Contributions</b>	
Leicestershire County Council	52,830
Rutland County Council	8,240
Leicestershire Police	7,970
Clinical Commissioning Groups (West Leicestershire and East Leicestershire & Rutland)	18,386
University Hospitals of Leicestershire NHS Trust	7,970
Leicestershire Partnership NHS Trust	7,970
<b>Total SAB Income</b>	<b>103,366</b>
<b>LSCB Contributions</b>	
Leicestershire County Council	123,390
Rutland County Council	52,250
Leicestershire Police	43,945
Clinical Commissioning Groups (West Leicestershire and East Leicestershire & Rutland)	55,004
Cafcass	1,650
National Probation Service	1,347
Derbyshire, Leicestershire, Northamptonshire and Rutland Community Rehabilitation Company (Reducing Re-offending Partnerships)	7,778
<b>Total LSCB Income</b>	<b>285,364</b>
<b>Total Income (LSCB &amp; SAB)</b>	<b>388,730</b>

	£
<b>SAB and LSCB Operating Expenditure</b>	
Staffing	205,496
Independent Chairing	49,115
Support Services	38,234
Operating Costs	14,831
Case Reviews	11,870
Training Co-ordination and Provision (LSCB)	55,641
Voluntary Sector Assurance Project (LSCB)	11,850
<b>Total SAB &amp; LSCB Operating Expenditure</b>	<b>387,037</b>

<b>Surplus</b>	<b>£1,693</b>
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<b>LSCB &amp; SAB Reserve account at end of year</b>	<b>£59,930</b>
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## **Partner updates**

Our partners provide assurance regarding safeguarding practice and development throughout the year. Key achievements and areas for development for partners are outlined in Appendix 2 to this report.

## **Business Plan Priorities 2017-18**

Review and analysis of learning, performance information and emerging issues have led us to identify the following priorities for 2017-18:

<b>Development Priority</b>	<b>Summary</b>
1. Prevention	Developing a prevention strategy, assurance regarding safeguarding elements of local prevention strategies and developing community awareness
2. Making Safeguarding Personal (MSP)	Continuing development of MSP across partners
3. Thresholds	Identifying and addressing gaps regarding over and under-reporting
4. Self-Neglect	Establishing and embedding a robust process for practitioners to respond to self-neglect

The following priorities are shared with the Leicestershire & Rutland Local Safeguarding Children Board for 2017-18:

<b>Development Priority</b>	<b>Summary</b>
1. The 'Trilogy of Risk'	Assessing approaches to safeguarding adults and children where domestic abuse, substance misuse and mental health issues are present
2. Participation and Engagement	Establishing visible effective participation by children and vulnerable adults at Board level
3. Emotional Health & Wellbeing	Develop understanding of emotional health and well-being across the partnership and gain assurance regarding Better Care Together (BCT) and the Sustainable Transformation Plan (STP) that work is addressing safeguarding issues, particularly re: mental health
4. Multi-Agency risk management / Supervision	Develop a multi-agency supervision approach for risk management in safeguarding adults and children

## **Appendix 1 - Membership of the SAB 2016/17**

### **Independent Chair**

#### **Members**

Borough and District Councils (represented by Melton Borough Council)  
Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation  
Company (DLNR CRC)  
East Leicestershire and Rutland Clinical Commissioning Group (CCG)  
East Midlands Ambulance Service (EMAS)  
East Midlands Care Association (EMCARE)  
Leicestershire County Council  
Leicestershire Fire and Rescue Service (LFRS)  
Leicestershire Partnership NHS Trust (LPT)  
Leicestershire Police  
National Probation Service (NPS)  
Prison Service  
Rutland County Council  
University Hospitals of Leicester NHS Trust (UHL)  
Voluntary Action LeicesterShire (VAL)  
West Leicestershire Clinical Commissioning Group (CCG)

#### **Observer status:**

Leicestershire County Council Lead Member for Adult Social Care  
Rutland County Council Lead Member for Adult Social Care and Health

#### **Professional Advisers to the Board:**

Boards Business Office Manager  
Legal Services for the Safeguarding Boards  
Adult Safeguarding Leads in the two Local Authorities  
Designated Nurse Children and Adult Safeguarding – CCG hosted Safeguarding  
Team

## Appendix 2 - LSCB Partner updates in full

### **East Leicestershire & Rutland Clinical Commissioning Group (ELRCCG) and West Leicestershire Clinical Commissioning Group (WLCCG)**

#### **Developments with regard to the agencies approach to safeguarding in the year:**

**Maintaining Statutory Responsibilities:** During 2016/17 West Leicestershire CCG and East Leicestershire and Rutland CCG (hereafter known as the CCGs) continued to exercise their statutory responsibility towards safeguarding children and vulnerable Adults. The CCG Chief Nurses represented their CCG as a statutory member of the Leicestershire and Rutland Safeguarding Children Board and the Safeguarding Adult Board. The CCG Deputy Chief Nurses represent their CCG at the Leicestershire and Rutland Safeguarding Children and Adult Executive.

**LSCB/SAB support from CCG Designated Professionals:** The CCGs have maintained the expertise of Designated Nurses Safeguarding Children and a Designated Doctor Safeguarding Children. The CCGs commit the Designated Nurse role and the CCG Safeguarding Team to provide extensive support to the LSCB/SAB. During 2016/17 this has been in terms of: chairing the LSCB/SAB Safeguarding Effectiveness Group; membership of a number of LSCB/SAB Sub Groups including the Serious Case Review Sub Group; Chairing a LSCB Child Alternative Review; Panel member of the 2016/17 Child Serious Case Reviews, Adult Reviews and Domestic Homicide Reviews. Taking a leading role in the promotion of the Neglect Toolkit.

The Designated Nurse Safeguarding Children and Adults has contributed to the LSCB/SAB 2017 Safeguarding Matters publication promoting Safeguarding Supervision.

**The work of the CCG Named GP's Safeguarding Children** This role ensures that the GP safeguarding leads in all of the GP Practices (across Leicestershire, Rutland and Leicester City) receive consistency in safeguarding information and support in addition to mandatory safeguarding training. The CCG Named Safeguarding GP's delivers children's safeguarding training to GPs and leads the GP Safeguarding forums and GP Safeguarding Bulletins

The GP Safeguarding Forums 2016/17 have included the following topics.

- Meeting with Social Care Managers
- Complaints from GPs regarding the lack of continuity regarding access to Children's Social Care
- The quality of GP referrals to Children's Social Care

The GP Forums provide a venue for discussion for information the LSCB/SAB disseminate to GP Practices in addition to emailed information.

**The CCG Heads of Safeguarding Children and Adults** support the Designated Professionals to ensure effective interface with the Safeguarding Boards is maintained and delivery of the priorities for the CCG Hosted Safeguarding Team continue to be met.

**GP Safeguarding Advice Line.** Provided by the CCG Hosted Safeguarding Team this is available to all GPs across Leicester, Leicestershire and Rutland

### **MCA/DoLs - Rainbows Project: My Adult My Child- website**

The NHS England MCA Improvement Programme was launched across Leicestershire, Lincolnshire and Rutland in 2015 the aim is to increase understanding about and implementation of the Mental Capacity Act by adding value to existing local activity and plans. This initiative was fully supported by the LSCB/SAB. A Designated Nurse Safeguarding led the User Group work stream for the Improvement Programme that developed the website My Adult- Still My Child.

The website was launched in September 2016, it is aimed at those new to making Best Interest Decisions and especially those caring for a young person in transition to adult services. To this end it is a valuable resource for parents/carer and professionals. Parents and carers from Rainbows Hospice Loughborough and Together for Short Lives ensured that the website was co-produced and inspired by those who have experienced decision making within health and welfare settings and felt unprepared or challenged without such guidance.

**CCG Safeguarding Assurance:** throughout 2016/17 the CCG Quality and Assurance Group and Governing Body has received assurance the status of how commissioned health services have in place key safeguarding requirements for adults and children

### **Impact of developments and work carried out**

**Designated Nurse Chair of LSCB Safeguarding Effectiveness Group** has maintained a focus on continuous improvement with regards to reporting from meaningful and accurate data to demonstrate the effectiveness of partnership working. This has enabled discussion and partnership challenge at the LSCB. Key results include raising the profile of: the Voice of the Child: strengthening multi-agency care planning for Children in Need: Establish the level of children and adult safeguarding training across the partnership: the lack of an agreed information sharing pathway for Domestic Violence: compliance with the Care Act 2014.

**CCG Named Safeguarding Children GPs** The impact of the work of the CCG Named Safeguarding GP's is evidenced by well attended and evaluated GP Forums and above 90% uptake of children and adult safeguarding training for all GPs across the CCG. To this end the role has raised the profile of safeguarding across the CCG.

**GP Advice Line** The introduction of the GP advice line providing support and guidance to GPs this has been well received and GPs acknowledge it helpfulness – evidenced by GPs contacting Social Care with safeguarding concerns.

**The audit work with GP Practices** has resulted in:

- Domestic Violence/Abuse – GP Policy and Guidance being developed and training commissioned
- GPs have easy access to GP Referral form via PRISM. This has provided evidence of both the good work currently being undertaken by GPs and areas for improvement. To increase in knowledge and confidence will have enabled GPs to make better decisions regarding Safeguarding.

### **Areas for further development or action to support safeguarding**

- Supporting the GP practices as required following submission of the GP Quality Safeguarding Markers.
- Continued dissemination of learning from LSCB /SAB to GP Practices
- Continues application of the locally agreed Safeguarding Adults Thresholds with health commissioned services
- A Domestic Violence/Abuse Policy will be available for GP practices

## Leicestershire County Council

### **Developments with regard to the agency's approach to safeguarding in the year:**

In response to internal safeguarding audit findings, the focus of the LA Safeguarding Adults Team has been revised within the restructure of the Adult Social Care pathway.

Threshold assessment will be carried out by the Customer Service Centre. Local Area teams will have an increased role in safeguarding enquiries, with the safeguarding team only involved in brief interventions establishing enquiries, desired outcomes and initial strategy meetings where an individual is not already known to services.

This approach is intended to ensure that immediate risk is consistently addressed, and that the adult at risk's views and wishes are established as soon as possible. It will also ensure that ongoing resources are prioritised appropriately according to levels of risk. Additional practice guidance has been developed to support the safeguarding and Locality Teams around the changes, including for Locality Teams around undertaking Organisational Safeguarding enquiries which were previously undertaken primarily by the Safeguarding Team.

The County Council have made significant changes to the safeguarding enquiry 'forms' on their case management system during the year to enable better capture and recording of the views and wishes of those involved in safeguarding enquiries in line with the principles of the Mental Capacity Act and to ensure that risk is appropriately assessed and managed within the enquiry. Developments include:

- New Making Safeguarding Personal screens where details are captured about how the individual's outcomes are discussed with them and how these will be achieved
- Requirements to evidence that Mental Capacity Assessments have been undertaken where there are doubts about the person's capacity to make decisions about the enquiry and how best interests decisions have been made
- Mandatory risk assessments and manager oversight and approval
- Consultation with the adult at the conclusion of the enquiry to capture their views about how involved and informed they felt within the enquiry, and whether their outcomes have been achieved.

Based on the outcome of safeguarding audits and feedback from staff, the Leicestershire safeguarding training programme, which had been delivered by an external agency, has been reviewed. Delivery has been moved in-house within the Council to ensure that local processes and practice requirements are reflected, as well as statutory duties under the Care Act.

The new training offer is more aligned to the SAB training competencies. It will move away from the previous model of a mandatory day of training every 3 years, and focus on a core day around statutory responsibilities, with a series of shorter 'bolt on' modules, focussed on areas identified through audit as key areas of focus for

practice. These will include risk assessment, mental capacity assessment within safeguarding enquiries, supervision, effective safeguarding meetings, working with service providers in enquiries and domestic abuse and coercive control. The Council's approach to the Competency Framework around safeguarding is also being developed to support managers and staff to easily review and assess competency in these areas within supervision.

This model of training will ensure that learning is ongoing throughout the year, and there is a focus on practical support as well as on statutory duties and theoretical models. There will also be work undertaken by Lead Practitioners to help facilitate workshop type sessions on particular themes using case studies in team meetings to learning and development around safeguarding is not only reliant on formal training sessions.

Safeguarding Training sessions for the new Service Managers have already been undertaken and feedback from this has been very positive, with consistent comments that this approach feels more relevant to operational safeguarding practice. New practice guidance is also in place in light of the changing focus of the Safeguarding Team in the new structure, and work has been undertaken by the Safeguarding Lead Practitioner around managing safeguarding case with social workers across the care pathway.

#### **Impact of developments and work carried out**

The impact of the restructure of Adult Social Care will not be seen until 2017-18. The developments of the Council's information system have supported the increase in recording of desired outcomes in safeguarding enquiries and ensured the Council is able to report on Making Safeguarding Personal data, both internally to the SAB and, as required, to the East Midlands Safeguarding Adults Network.

#### **Areas for further development or action to support safeguarding**

In response to feedback from staff, the Council is looking to make the training for recording safeguarding enquiries more relevant to practice by basing this on case examples.

## **Leicestershire Fire and Rescue Service**

### **Developments with regard to the agency's approach to safeguarding in the year:**

A full time member of staff has been seconded to work with the police Adult Referral Team. This is a pilot project to look at how we can improve information sharing and joint working. This is the first time that we have had a named person who can manage ongoing cases.

We have developed a new partner referral form and risk matrix for prioritising requests for home fire safety checks, so our work can be targeted at the most vulnerable.

Hoarding risk matrix is being used widely by our crews.

Community safety staff attended mental health first aid training. We are now looking at rolling it out to the wider work force.

Two practitioners attended training for adult fire setters with a view to working with mental health professionals and/or prisons when appropriate.

Nationally, fire services are moving towards the production of standard safeguarding best practice advice for this sector, which will be very welcome. The Safeguarding Manager recently attended a National Conference .

### **Impact of developments and work carried out**

Our new VP officer is attending incidents together with police officers and other agencies – e.g. housing and ASC. We have good examples of multi-agency working in cases of self-neglect.

We know that our operational crews are much more aware of safeguarding responsibilities as our Designated Safeguarding Officer is receiving much more frequent enquiries and requests for advice.

### **Areas for further development or action to support safeguarding**

New scenario based Safeguarding training package is being developed – we aim to launch it by September.

We are currently looking at the structure of our internal safeguarding / vulnerable people team to ensure that we have an adequate number of people who can respond appropriately to alerts from firefighters and referrals from external agencies. Mental Health first aid training for operational managers – see above comments. After the pilot secondment project with the Police, we will make a decision as to the best case management system to use for VPs – i.e. one which will support multi-agency working.

The set-up of a new national fire service safeguarding group, which our Safeguarding manager will attend, should support us in improving our practice.

## Leicestershire Partnership NHS Trust (LPT)

### Developments with regard to the agencies approach to safeguarding in the year

**Feedback from a CQC review of health services for Children Looked After and Safeguarding in Leicester City was the catalyst for strengthening the implementation of the Whole family approach to safeguarding.** LPT adopted a Whole Family Approach to Safeguarding in 2016/17, building on the Think Family work already underway in LPT. Implementation will include replacing the traditional level 2 adults safeguarding training and level 3 safeguarding children training with the combined 'Whole Family' safeguarding training. LPT have also implemented systems to improve communication across adult & children's services within LPT and promoted the 'Whole Family Approach' via posters and monthly bulletins and changes to electronic systems.

**It was identified by the CQC that the quality of Inter-agency referral forms submitted by School Nurse, CAMHS practitioners and Adult Mental Health practitioners required improvement.** LPT have developed and implemented an Inter-Agency Referral Standard Operating Guidance to improve the quality of inter-agency referrals submitted to Children's Social Care. Quality reviews of Inter-agency referral forms submitted to Children's Social Care by school nurses, CAMHS and adult mental health staff are conducted quarterly.

**MAPPA:** A MAPPA Audit tool developed, improving on a pre-existing audit tool developed in 2013/14. The audit was carried out in June 2016.

**Section 42 Enquires:** An improved process for Council Oversight and effective multi-agency working in relation to Safeguarding enquires under section 42 of the Care Act was developed. Improved internal processes, which ensure more robust governance relating to Section 42 enquires, were also put in place.

**Mental Capacity Act:** A MCA improvement plan was developed and supported by the LPT Chief Nurse.

### Impact of developments and work carried out

**Inter-agency referrals:** The quality reviews will measure the level of improvement in relation to inter-agency referrals submitted to Children's Social Care, helping to ensure the right service is provided at the right time.

**Whole family:** Adult staff are now able to access details of a child's health visitor or school nurse where necessary and appropriate via a single point of contact.

**MAPPA Audit:** this was targeted more specifically to relevant Mental Health / Learning Disability services. Results provided some supporting evidence that LPT MAPPA cases were largely correctly identified by category and level, and that cases that were not correctly identified were subsequently corrected and alert wording changed to ensure future cases were recorded correctly.

**Section 42:** Improved processes have resulted in more robust systems to support implementation of Making Safeguarding Personal.

**MCA:** Greater assurance that principles of the MCA are fully applied within LPT clinical areas.

**Areas for further development or action to support safeguarding**

From April 2017, LPT will deliver Level 3 Whole Family safeguarding training to all LPT adult & children clinical staff.

Repeat MAPPA Audit June 2017 to compare results.

Further work in embedding the Whole Family approach to Safeguarding and MCA improvement.

## Leicestershire Police

### **Developments with regard to the agencies approach to safeguarding in the year**

In 2015/2016, we made 7,782 adult safeguarding referrals across Leicester, Leicestershire and Rutland; in 2016/2017, we have seen a 66% rise to nearly 13,000 referrals. The trend continues to show an increase of reports monthly.

We are still analysing the full reasons behind this increase but currently we believe this to be down to our Protecting Vulnerable Persons (v4) training programme. This has led to increased recognition of vulnerability by frontline officers.

We have also seen that, as partner agencies' resources are declining, we are being called upon by the public and those agencies to respond. As Policing duties are to protect life and property, this often can mean that we are charged with responding to calls that aren't to investigate crime. We see a particular rise in demand in the evenings and at the weekend.

This has led to 98 multi-agency investigations. This is a 23% drop from 2015/2016. This supports the theory that we are not seeing a rise in vulnerable adults who are the victims of crime, but we are seeing a rise in the number of vulnerable adults who are in need of partner services' support but have called upon the police to attend.

We have issued 84 domestic violence prevention orders. Following a HMIC review, Leicestershire Police has stopped reviewing High-risk assessments domestic incidents. This has seen a 50% increase in the number of high-risk assessments following a domestic incident. In order to manage this we have had to move to a weekly MARAC.

A Multi-Agency DV Executive group has been formed, chaired by Assistant Chief Constable Rob Nixon.

To meet the increasing demand upon the Domestic Abuse Investigation Unit, there has been an active recruitment to increase the establishment. Some work has also been completed within the localised Force Investigation Units to ensure officers' awareness with dealing with Domestic Abuse cases.

We have introduced the Herbert Protocol: a missing form which is completed when someone is diagnosed with Dementia. If they go missing and the police are needed to help find them, the form is handed over, detailing a current photograph, hobbies and previous jobs. This assists us to find the missing individual as soon as possible. We have worked closely with the Alzheimer's Society who have helped us to design the form and will assist with the completion of it.

### **Impact of developments and work carried out**

There has been positive feedback from the HMIC about the vulnerability culture Leicestershire Police operates within, including confirmation that there is a good understanding of vulnerability at all levels within the Force.

During the cold winter months, local Police Community Support officers found an elderly male drunk in the city. They engaged with him and agreed to get him home safely. When at his premises it was highlighted that he had no gas or electric; they noted the house was cold due to having broken windows and there was evidence of extreme damp in the property along with evidence of no personal care, with the property being in a poor and dirty state presenting a health hazard. The PCSOs engaged the following day with the Adult Referral Team who called for an urgent multi-agency response. The male was identified as suffering with the effects of hypothermia and was hospitalised. The house being privately owned posed problems but these were overcome to make repairs; support was given around finances and paying the amenities bills to ensure a better quality of life for the gentleman. The reason for the male going out to public houses and getting drunk was due to the public houses being warm.

### **Areas for further development or action to support safeguarding**

- To identify smarter ways to meet demand in a world of ever decreasing resources both within our organisation and the demand impact from partners.
- To better identify hidden demand again looking at smarter ways to reduce or remove this demand.
- To better engage with private sector partners with a view of sharing and reducing demand.
- The Force is developing an overall Vulnerability Strategy and a Children's Strategy to ensure the voice of the child is incorporated into every strand of policing.
- A review of the Force's Missing from Home process has just been completed, and new working practices are awaiting finalisation, following consultation at local level through to the National Police Chiefs Council.
- Police and Crime Plan 2017-21 includes a focus on specific areas with links to safeguarding adults: Alcohol and drug related incidents; Domestic Violence and Abuse including coercion; Human Trafficking and Modern Day Slavery; Mental Health; Missing from home individuals; Prevent strategy and Sexual violence.
- Leicestershire Police will maintain the regime of internal audits and co-operation with reviews (both internal and external, eg SCRs, DHRs, SILPs etc) to ensure continued compliance with the need to recognise, identify and report vulnerability.

## **Rutland County Council**

### **Developments with regard to the agencies approach to safeguarding in the year**

RCC has embedded a new Adult Social Care role – Assistant Care Manager (ACM) – within the Prevention and Safeguarding Team who can provide time limited and person centred outcomes for those adults who are deemed at risk of being re-referred as a Safeguarding Adult's enquiry. This service is non-means-tested to encourage those at risk of self-neglect to engage with support.

Currently there are three ACM posts and Rutland plans to recruit one more ACM and a social worker to extend capacity and provide a more rapid response to enquiries where safeguarding, neglect and self-neglect are indicated. The ACMs are managed and supported by a Senior Practitioner to provide professional support and development.

Rutland County Council has made changes to its Safeguarding Adults case management system to include mandatory sections on the wellbeing principles and outcomes and MSP. Accessible Information standards are now embedded within the system which considers preferred communication format in relation to initial contacts taken via the Prevention and Safeguarding Team.

These system changes mean outcomes now follow through to point of closure within the safeguarding episode and practitioners are required to record and evidence whether outcomes have been achieved for the adult and how they were achieved. Personalisation surveys are completed at the end of the safeguarding episode and record the adult's satisfaction with the process. Rutland County Council's performance team regularly review this data and identify trends and themes in order to shape service development moving forward.

All Adult Social Care practitioners who are responsible for processing enquiries have completed safeguarding adults training at an investigator level.

All practitioners within the Adult Social Care service in Rutland, including integrated Health colleagues, attend Safeguarding Continuous Professional Development (CPD) sessions bi-monthly. These sessions include updates in relation to MSP and provide support and guidance on any MSP related issues within care management. Any feedback from audits and system changes are disseminated and discussed and workers are encouraged to present case studies for peer review and peer shared learning.

Adult Safeguarding Basic Awareness Training (In House) is provided to all new starters within Adult Social Care and refresher training ongoing for current employees – 7 sessions in the last year, two more booked. Attendees include REACH team, PAs, Social Workers, OTs, Case Managers, Hospital Discharge Team (all disciplines), Team Assistants and staff recently new in post.

Staff Health Check (Adult PSW Health Check) completed by frontline workers to encourage them to discuss professionalism within practice and how they would like RCC to move forward in relation to developing their skills as practitioners.

### **Impact of developments and work carried out**

The prevention approach with the ACMs has contributed to a reduction in referrals to the long term team with less than 10% of all new contacts transferred for long term intervention.

The changes to the Case Management System mean outcomes now follow through to point of closure within the safeguarding episode and practitioners are required to record and evidence whether outcomes have been achieved for the adult and how they were achieved. Personalisation surveys are completed at the end of the safeguarding episode and record the adult's satisfaction with the process. Rutland County Council's performance team regularly review this data and identify trends and themes in order to shape service development moving forward.

Training feedback forms have rated the training highly and indicate that attendees have felt that it will be beneficial to their roles. Localised training with relevant links and case studies have proved popular.

A peer review of Rutland Adult Social Care in March 2017 found:

- Overall there is an excellent offer to the people of Rutland and outcomes are good
- Reviewers were impressed with commitment, enthusiasm, values and attitude of all the staff we met, at all levels
- Reviewers were particularly impressed with the whole council approach around support into employment encouraged directly by the Chief Executive
- The focus on non-eligible citizens (prevention) and developing approach to working with those people who have been institutionalised historically was particularly noted
- Strong focus on personalisation moving forward in relation to all areas of practice (embedding personalisation within all aspects of social care)
- Good leadership in relation to professional development and positive that Health colleagues are invited into and attend continuous professional development sessions.

### **Areas for further development or action to support safeguarding**

A programme of internal audits will always consider MSP, outcomes and the quality of the documentation linked to the safeguarding episode. Further development of the Liquid Logic information system, contacts and safeguarding documentation will be looked at on an ongoing basis. Training will be developed internally around completion of the safeguarding episode with supporting guidance for all staff within the social care team.

Further development will be ongoing regarding legal literacy, coercion and control, VARM and criminal / civil law interactions. The additional ACM and Social Worker to be recruited will also enhance the response to safeguarding enquiries in Rutland.

Increased quality assurance around personalisation within multi-disciplinary teams.

Forward development of training:

- CPD Meetings to be unified with OTs and also include general “Social Care CPD” meetings now as well as “Safeguarding CPD” meetings
- Ongoing refresher sessions of Adult Basic Awareness for Social Care staff
- Working with HR to ascertain which RCC staff have completed e-learning so that future training can be tailored to meet unmet needs
- Senior Practitioner will be working across Adult Social Care to evaluate the Adult Safeguarding Competency Framework and this will take into account practitioner’s use of MSP
- Asset Strength Based Training will be delivered within the next 3 months.

## **University Hospitals of Leicester NHS Trust (UHL)**

### **Developments with regard to the agencies approach to safeguarding in the year**

University Hospitals of Leicester NHS Trust is a large organisation that employs around 15,000 staff. Safeguarding patients and protecting them from harm and abuse is integral to the work that we do.

The Trust has supported the work of the Leicestershire and Rutland Safeguarding Boards, in particular:

- We have been involved in the new multi-agency audits developed by the Boards; overall these have provided additional assurance that our practices are generally robust
- We have supplied quarterly performance data to help build up a greater understanding of safeguarding performance and we introduced a patient partner
- Undertaken work to implement 'Making Safeguarding Personal'; therefore strengthening the voice of service users during adult safeguarding investigations.

In 2016, the Trust had two comprehensive inspections by the Care Quality Commission (CQC), which considered the Trust's approach to safeguarding. Their findings led to the development of an action plan and, as a consequence, the following changes to practice were made:

- Introduced new guidance and training for staff on the use of the Mental Capacity Act
- Increased the capacity of our maternity safeguarding team in response to increasing levels of referrals.

As a Trust, to strengthen the voice of service users, in November 2016 we secured a patient partner to sit on our internal Safeguarding Assurance Group. This helps ensure that a service user perspective is considered in any safeguarding work undertaken within the Trust.

We also secured funding for a hospital based Independent Domestic Violence Advocate (IDVA) to work in our Emergency Department.

### **Impact of developments and work carried out**

In response to the issues raised above, we believe we have changed practice in the following areas:

- Making Safeguarding Personal has strengthened the way in which staff talk to adults in need of safeguarding, to ensure their views are listened to
- Audits are being carried out to demonstrate greater understanding by staff of the use of mental capacity assessments and their application when consenting patients for treatment
- The voice of the patient is being firmly embedded in the work the Trust does, making sure we consider the impact of our work on patient care.

In response to recommendations made by the CQC, our completion of actions has strengthened our internal safeguarding systems to ensure that best practice is followed.

The role of the IDVA is to provide early support and advice to victims of domestic violence whilst they are considered in a place of safety, helping them to make decisions about personal safety.

**Areas for further development or action to support safeguarding**

As a Trust, we strive constantly to improve our practice; for the new financial year we are going to undertake further work in the following area:

- Complete further internal audits to ensure that practice in consent to treatment and detecting safeguarding issues in our Emergency Department are embedded.