



LEICESTERSHIRE AND RUTLAND  
SAFEGUARDING ADULTS BOARD  
(LRSAB)

# Annual Report

# 2017/18

## Document Status

---

<b>First draft completed:</b>	21/06/2018
<b>Approved by Board:</b>	25/10/2018
<b>Published:</b>	30/10/2018
<b>Report Author:</b>	Safeguarding Boards Business Office, Leicestershire & Rutland LSCB and SAB
<b>Independent Chair:</b>	Robert Lake

## Foreword



I am pleased to present the 2017/18 Annual Report for the Leicestershire and Rutland Local Safeguarding Adult Board (LRSAB). This is the first occasion on which I am presenting this report. I became the Independent Chair of the Board in April 2018 taking over from Simon Westwood who had served the Board with distinction and skill. Clearly, the work of the Board, as reflected in this Annual Report, was undertaken under Simon's stewardship. On behalf of all of those involved in or receiving safeguarding services in Leicestershire and Rutland, a very big thank you to Simon for all his hard work.

The report is published at the same time as the Annual Report for the Safeguarding Children's Board (of which Simon is still the Independent Chair). The report includes commentary on areas of cross-cutting work we undertaken through a joint business plan between the two Boards.

The key purpose of the report is to assess the impact of the work we have undertaken in 2017/18 on safeguarding outcomes for vulnerable adults in Leicestershire and Rutland. The report concludes that:

- 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 remains a prevalent area of abuse of adults in Leicestershire and Rutland and will be given continued attention.
- Good and consistent understanding of and responses to Mental Capacity is a development need across the workforce. (Research shows that this problem is experienced by several Boards across the country.)
- 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.

The LRSAB is a strategic body: much of the detailed work of the Board is taken forward by our various sub-groups/task and finish groups. These are the real workhorses for safeguarding and I must take this opportunity on behalf of the Board to thank all members of these groups for their continued commitment as well as to thank their employing agencies for contributing their participation. I would also want to place on record my appreciation of the work done by the members of the Board's Business Office, without whom the Board would struggle to be as effective as it is.

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

I trust that you will find this report informative and readable. If you have any comments you would wish to raise with me, I can be contacted via the SAB's Business Office [sbbo@leics.gov.uk](mailto:sbbo@leics.gov.uk).

A handwritten signature in black ink, appearing to read 'Robert Lake', with a horizontal line underneath.

Robert Lake

Independent Chair of the Board.

## **Contents**

Foreword	2
Summary	5
Board Background	7
Safeguarding Adults in Leicestershire	9
Safeguarding Adults in Rutland	11
Safeguarding Adults in Leicestershire and Rutland	12
Business Plan 2017/18 Achievements	13
Operation of the Board	
• Partner and Public Engagement and Participation	17
• Challenge and Assurance	18
• Learning and Improvement	21
• Co-ordination and Procedures	24
• Training and Development	24
Income and Expenditure 2017/18	26
Business Plan Priorities 2018/19	27
Partner updates	28

## 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.

Monitored data and information on a regular basis. Learning from this includes, in both areas:

- Fewer safeguarding enquiries from the cause for concern alerts received by Local Authorities.
- An increase in the proportion of people being asked about what they want to happen in their safeguarding enquiries and whose desired outcomes are met in those enquiries
- Numbers of referrals for Deprivation of Liberty Safeguards continue to rise

Worked on and reviewed progress against our Business Development Plan for 2017/18;

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

- A Safeguarding Adults Audit Framework (SAAF) process;
- Case reviews of frontline practice regarding safeguarding and domestic abuse.

Carried out Safeguarding Adult Reviews (SAR), other reviews of cases and disseminated learning from these across the partnership.

Supported the ongoing use of and confidence in the 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;

Sought assurance from partners regarding the work they have carried out over the year to safeguard adults with care and support needs;

More information on all of these areas can be found throughout the Annual Report

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 prevention approaches
- Supporting confident and consistent understanding of Mental Capacity
- 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 remains a prevalent area of abuse of adults in Leicestershire and Rutland.
- Good and consistent understanding of and responses to Mental Capacity is a development need across the workforce.
- 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.

## **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.

The Annual Report presented here sets out how effective the Board has been in delivering its objectives set out in its Business Plan. 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.

During the year the decision was taken by the SAB to increase join up with the Leicester City SAB, including a joint chair for the 2 SABs. The practicalities of this and impact on the joint arrangements between Leicestershire & Rutland LSCB and SAB are being worked out in 2018/19 alongside work to set the new Multi-agency safeguarding arrangements for safeguarding children. From July 2018 the LRSAB will no longer meet alongside the Leicestershire and Rutland Local Safeguarding Children Board, as the SAB aligns its operation more closely with the Leicester City Safeguarding Adults Board (LCSAB).

The LRSAB works closely with 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 25 of this report.

## **Independent Chair**

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

During 2017/18 Simon Westwood operated as the Independent Chair for both Safeguarding Adults and Children Boards in Leicestershire and Rutland. From 2018/19 Robert Lake has been appointed as a joint Independent Chair between the Leicestershire & Rutland and Leicester City Safeguarding Adults Boards as part of aligning safeguarding adults work across the two areas.

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.

The structure of the LRSAB and membership of the Board can be found on the Board's website [www.lrsb.org.uk](http://www.lrsb.org.uk).

## **SAB Business Plan Priorities 2017/18**

Priorities set by the LRSAB for development and assurance in 2017/18 were to:

- Develop a clear approach for Prevention of harm to adults, including increasing the unacceptability of abuse across the community
- Further embed Making Safeguarding Personal (MSP) across the Partnership
- Ensure adult safeguarding thresholds are understood and being utilised correctly
- Develop a clear consistent response to self-neglect and safeguarding for front line workers

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

- To be assured that in situations where domestic abuse, substance misuse and mental health difficulties are all present (toxic trio) the impact is recognised and responded to using robust multi-agency risk assessment, information sharing and sign posting to resources
- Children and vulnerable adults have effective, direct input and participation in the work of the Boards
- The Board is assured that the emotional health and well-being of adults and children and safeguarding risk is understood
- To strengthen multi-agency risk management approaches



## **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.

### **Adult Safeguarding snapshot for Leicestershire:**

- 546,011** adults live in Leicestershire<sup>1</sup>.
- ↔ **4,530** safeguarding alerts to Adult Social Care.
- ▼ **19%** of alerts became safeguarding (s42) enquiries.
- ▲ **46%** of enquiries were substantiated, at least in part.  
Financial abuse became one of the three most common categories of abuse alongside Neglect and Omission and Physical Abuse.
- ↔ **768** alerts from the public.
- ▲ **70%** of people were asked about what they wanted to happen from the safeguarding enquiry.
- ▲ In **96%** of cases the persons desired outcomes were met, at least in part.  
**97%** of people felt listened to in conversations and meetings with people about helping them feel safe
- ▲ **13%** of enquiries were ceased at the request of the individual
- ▲ **4,669** referrals for Deprivation of Liberty Safeguards (DoLS)
- ▲ **1,555** cases on the waiting list for Deprivation of Liberty Safeguards
- ▲ Paid Persons Representatives allocated to **49%** of DoLS.

The number of calls to Adult Social Care, from professionals and the public, regarding a safeguarding concern stayed at a similar level to last year, greater than the year before.

Fewer alerts met the threshold for a safeguarding enquiry to be undertaken than in the previous year, however more of the enquiries that were carried out found that abuse probably took place (were substantiated, at least in part) than last year.

Making Safeguarding Personal is becoming more embedded in safeguarding practice with a greater proportion of people being asked about what they wanted to happen from the enquiry regarding their welfare. A greater proportion of these people's desired outcomes were met this year than last year. More enquiries being ceased at the individuals request than last year suggests Making Safeguarding

---

<sup>1</sup> ONS mid-year population estimates 2016

Personal is being implemented robustly, however the SAB case-file audit noted potential difficulties with this with regard to domestic abuse.

There was a continued increase in referrals for Deprivation of Liberty Safeguards (DoLS). Despite an increase in service capacity for assessments to be carried out overall there was an increase in the waiting list for DoLS in Leicestershire.

More people for whom there has been an application for Deprivation of Liberty Safeguards were allocated a Paid Persons Representative to advocate on their behalf in the assessment process than in previous years.

Leicestershire Adult Social Care has established a new Safeguarding Team to improve consistency in application of safeguarding thresholds and addressing initial areas of risk relating to safeguarding adults referrals. Initial indications are that, because this team can make additional enquiries than were possible in the customer service centre, this has meant that it is possible to gather additional information to enable more effective application of SA thresholds and MSP principles, and has resulted in less safeguarding enquiries requiring transfer to Locality Teams. Data on the direct impact of this is being sought by the Board.

Following ongoing positive joint work with Trading Standards around prevention of financial fraud and scams, Leicestershire are establishing an Adult Social Care post in the County Council Trading Standards team to further embed this effective work.

## **Safeguarding Adults in Rutland**

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

### **Adult Safeguarding snapshot for Rutland:**

- ▼ **30,873** adults live in Rutland.<sup>2</sup>
- ▼ **235** safeguarding alerts to Adult Social Care.
- ▼ **22%** of alerts became safeguarding (s42) enquiries.
- ▲ **60%** of enquiries were substantiated, at least in part.  
'Neglect and Omission' has become more prevalent as the most common category of abuse, present in two thirds of cases.
- ▼ **39** alerts from the public.
- ▲ **96%** of people were asked about what they wanted to happen from the safeguarding enquiry.
- ▲ In **95%** of cases the persons desired outcomes were met, at least in part.
- ↔ **15%** of enquiries were ceased at the request of the individual
- ▲ **223** referrals for Deprivation of Liberty Safeguards (DoLS)
- ▼ **8** cases on the waiting list for Deprivation of Liberty Safeguards
- ▲ Paid Persons Representatives allocated to **49%** of DoLS.

The number of calls to Rutland Adult Social Care, from professionals and the public, regarding a safeguarding concern reduced compared to the previous year, this is an ongoing reduction in calls from professionals over the last two years.

Fewer alerts met the threshold for a safeguarding enquiry to be undertaken than in the previous year, however more of the enquiries that were carried out found that abuse probably took place (were substantiated, at least in part) than last year.

Making Safeguarding Personal is becoming more embedded in safeguarding practice with a greater proportion of people being asked about what they wanted to happen from the enquiry regarding their welfare. A greater proportion of these people's desired outcomes were met this year than last year.

There was a continued increase in referrals for Deprivation of Liberty Safeguards (DoLS), however an increase in service capacity for assessments to be carried out supported a reduction in the waiting list for DoLS in Rutland.

---

<sup>2</sup> ONS mid-year population estimates 2016

More people for whom there has been an application for Deprivation of Liberty Safeguards were allocated a Paid Persons Representative to advocate on their behalf in the assessment process than in previous years.

Rutland has carried out some positive joint work with the LADO to improve the quality of a children's residential school which also accommodated over 18s.

In response a number of safeguarding adult enquiries regarding financial abuse Rutland County Council has initiated monthly meetings with Community Care Finance and Revenues and Benefits department to raise awareness and support early identification and prevention.

Rutland County Council have expanded their Prevention and Safeguarding team to provide a social worker and an Assistant Care Manager to provide a rapid response around cases where self-neglect and safeguarding are indicated

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

Following challenge the Board asked for an assessment of notification of Section 42 enquiries in healthcare settings to the local authorities. Health agencies reviewed cases and referrals and assurance was provided to the Board that notifications were generally, being made where appropriate, but some process issues existed. This resulted in a revision of guidance and the set-up of regular meetings between health in-patient settings and Adult Social Care.

The Police, Leicestershire County Council and Leicester City Council are working together to establish an Social Care post in the planned Multi-Agency Risk Assessment Conference (MARAC) hub, to help ensure that there is an effective and multi-agency approach to manage high risk domestic abuse cases on a daily basis and therefore early identifications of which cases also meet safeguarding thresholds.

Our partners provide assurance regarding safeguarding practice and development throughout the year to our Safeguarding Effectiveness Group, key points and developments are included in relevant sections of the report.

## **Business Development Plan Priorities**

Progress on the Boards priorities is outlined below.

### **SAB Priority 1 – Develop a clear approach for Prevention of harm to adults, including increasing the unacceptability of abuse across the community**

**We planned to** consider what prevention strategies and practice were in place relating to Safeguarding and develop a Prevention approach to support effective safeguarding (e.g. community awareness and resilience).

**We brought together** a group of key frontline professionals across Leicestershire and Rutland who identified and assessed current approaches to safeguarding prevention, areas of good practice and areas for further development.

The scoping work identified a broad multi-agency desire to support prevention, but a lack of knowledge of tools and services already in place.

**We started to pilot an approach to** effective multiagency Prevention work in local areas through an existing multi-agency group, Rutland Joint Action Group linked to the Safer Rutland Partnership.

**We plan to** implement and assess the development of the JAG as a forum for prevention and develop further community awareness raising regarding safeguarding adults.

### **SAB Priority 2 – Further embed Making Safeguarding Personal (MSP) across the Partnership**

**We planned to** embed principles of MSP across multi-agency safeguarding practice through awareness-raising, training and service development. We also planned to assess use of MSP in safeguarding and the impact of MSP through audits and performance information.

**We assessed** use of MSP in the multi-agency audits and monitored local authority data on MSP in our Safeguarding Effectiveness Group.

The audit showed that MSP was being used in practice. MSP data for local authorities regarding whether people are asked about the outcomes they would like from enquiries and whether those outcomes are achieved was higher than last year, but has shown a levelling off in performance after a steady increase in the previous year.

In Leicestershire the Local Authority is looking at how MSP approaches tie in with Signs of Safety in Children's Safeguarding

**We plan to** understand partner agencies work on MSP in future years through the Safeguarding Adults Audit Framework (SAAF).

### **SAB Priority 3 – Ensure adult safeguarding thresholds are understood and being utilised correctly**

**We planned to** monitor compliance against local guidance on Section 42 enquiries and monitor partner data to understand the effect of Leicestershire Adult Social Care pathway restructure and identify other areas requiring further development. **We also planned to** assess understanding and use of thresholds through our multi-agency audits.

**We finalised** guidance for the Oversight Process of S42 Enquiries in NHS Settings was finalised and put into practice.

The Clinical Commissioning Groups, Leicestershire Partnership NHS Trust and University Hospitals of Leicester NHS Trust carried out a review of practice regarding Section 42 safeguarding enquiry notification in specific settings that identified improvements in processes to be applied.

**We monitored** adult safeguarding alerts to the local authorities from different sources, including health settings through our Safeguarding Effectiveness Group.

The multi-agency audit focussed on domestic abuse considered application of thresholds and found that in almost all of the eighteen cases thresholds were applied appropriately.

### **SAB Priority 4 – Develop a clear consistent response to self-neglect and safeguarding for front line workers**

**We planned to** develop a clear process across Leicester, Leicestershire and Rutland to support decision making in self-neglect cases, and a quality assurance and performance management framework to test the impact of this.

**We developed** Vulnerable Adults Risk Management (VARM) guidance across Leicester, Leicestershire and Rutland to provide more consistent approaches to 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.

Leicestershire County Council and Rutland County Council incorporated training on the VARM process within their safeguarding training.

**We ran** four half day multi-agency events at the King Power Stadium to raise awareness about the Vulnerable Adults Risk Management (VARM) process for frontline staff across agencies, including housing, Fire and Rescue, Police, Drug and Alcohol and Domestic Abuse services, Community Safety, General Practitioners (GPs) and other health staff.

228 practitioners attended the training events from over twenty different agencies with many positive comments. Confidence levels in understanding and using the VARM process increased with 98% of attendees at least fairly confident in using the VARM following training and the VARM guidance was revised based upon practitioner feedback from the event.

Twenty-nine high level self-neglect cases were referred to the VARM process in Leicestershire.

**We plan to** audit use of the VARM across a broad range of agencies in 2018 and agencies other than Adult Social Care will consider how their VARM activity will be reported to the

Board and how awareness raising around the VARM processes continues to be embedded on a multi-agency basis

Progress on the four priorities shared with the LRLSCB:

**LSCB / SAB Priority 1 – To be assured that in situations where domestic abuse, substance misuse and mental health difficulties are all present the impact is recognised and responded to using robust multi-agency risk assessment, information sharing and sign posting to resources**

**We planned to** develop a coherent, co-ordinated framework that delivers effective safeguarding responses where these three factors are present across families.

**We researched** the issues facing adult and children safeguarding and individual agencies with regard to this ‘trilogy of risk’.

**We developed** a package of customisable materials for agencies to use within their own organisations to communicate key messages and improve practice.

**We plan to** launch the materials in July 2018 and will assess the dissemination of the materials and the impact of this work through a quality assurance plan developed alongside the materials.

**LSCB / SAB Priority 2: Children and Vulnerable Adults have effective, direct input and participation in the work of the Boards**

**We planned to** research models of participation for children and vulnerable adults and develop an effective model for engagement of adults with care and support needs.

**We researched** models of engagement in place in other areas with regard to safeguarding adults. Further work is required to develop engagement with adults for the SAB.

**We plan to** develop engagement with adults for the SAB as part of the Safeguarding Adults Board Engagement priority for 2018/19, in conjunction with work underway with Leicester City Safeguarding Adults Board.

**LSCB / SAB Priority 3: The Board is assured that the emotional health and well-being of adults and children and safeguarding risk is understood.**

**We planned to** produce practice guidance and implement appropriate training and development activities to develop common understanding of emotional health and safeguarding risk across all agencies and ensure emotional health and safeguarding risk with regard to the broader family context is considered in safeguarding work with children and adults.

**We also planned to** review the Safeguarding Risk Assessment of the local Sustainability & Transformation plan for health.

**We explored** the gap in understanding and needs across the workforce with regard to emotional health and wellbeing and safeguarding. The breadth of scope for this piece of work meant that this work took longer than anticipated.

As a result of the assessment work, understanding emotional health needs of parents and carers was identified as the key area for work.

Further work will be taken forward by Future in Mind and Better Care Together within the Sustainable Transformation plan (STP).

Leicestershire Partnership Trust are developing their 'Whole family' approach which will support this.

#### **LSCB / SAB Priority 4: To strengthen multi-agency risk management approaches**

**We planned to** develop a structured multi-agency framework to enable a reflective supervision session to be used in cases where the issues are complex or entrenched.

**We created** an initial process following research into existing models locally and nationally and collating ideas and views of staff and tested the process.

**We plan to** test the process and adopt it by September 2018.

The impact of the process will be tested by reviewing outcomes for cases where the process has been used.



## **Operation of the Board**

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

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

The Board met four times during 2017/18. The membership of the Board can be found on the Boards website [www.lrsb.org.uk](http://www.lrsb.org.uk). Almost all partners attended all or the majority of Board meetings during the year and sent apologies for those they missed.

Engagement with the Criminal Justice Sector requires improvement. Whilst the Community Rehabilitation Company attended one meeting and sent apologies to all others, there was no attendance from the Prison Service or the National Probation Service to any SAB Board meetings during the year.

Due to a change in personnel the representative from the private care sector only attended the SAB development day considering priorities for 2018/19.

All agencies consistently engage well in the subgroups of the Board.

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

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

Despite the shared priority on engagement and participation for the SAB with the Safeguarding Children Board work on this for the SAB did not progress as planned during the year and further work is required on this.

The Board's Business office carried out some public engagement and awareness in Loughborough town centre in conjunction with Charnwood Community Safety Partnership (CSP). The team shared a market stall with the CSP, provided information leaflets and carried out a survey to assess understanding of and raise awareness of safeguarding adults issues.

Thirty-one surveys were completed, over half by people aged 65 years or over.

Over half of those surveyed said they knew someone who had been affected by abuse and the surveys identified some knowledge of adult abuse and how to respond to this.

The issues that concerned people the most were Anti-Social Behaviour and Financial Abuse. Board office staff members were able to advise a number of people where to seek advice and follow up on specific concerns.

Four people said that they, or someone they knew had experience of contacting services in relation to abuse or neglect, but feedback on the quality of response was varied. Two women praised the Police, Social Services and Women's Aid with regard to their response to Domestic Abuse, however they had had to wait a long time for counselling and access to group work

More events like this are planned.

Towards the end of the year the SAB linked in with engagement work being undertaken by the Leicester City SAB, and has identified this as a standalone priority for 2018/19 that will cut across all of the work of the Board.

## 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 challenge was raised by the Board with safeguarding partners:

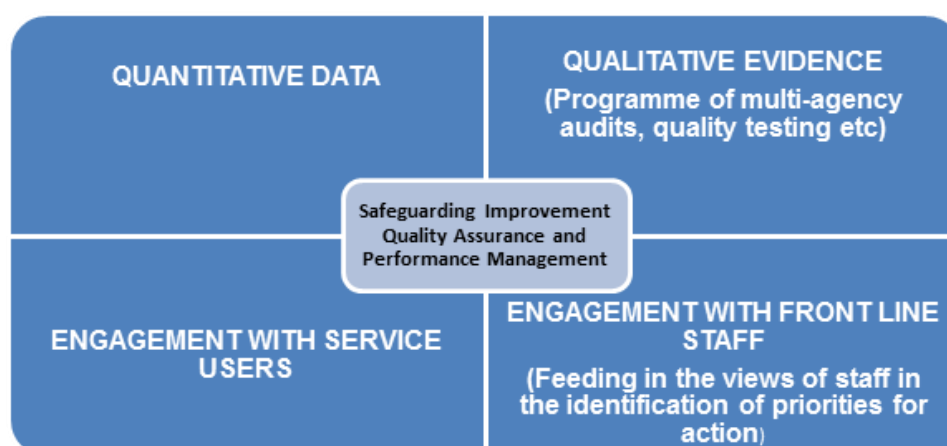
- Leicestershire County Council reported that they could not give assurance regarding their oversight of S42 safeguarding enquiries carried out by health providers, as they felt the numbers they were getting through were lower than expected and the council did not have evidence that everything that should be referred is being referred.

Following this challenge:

- A review of settings took place and assurance gained from all that their reporting procedures were being followed correctly.
- Thresholds and guidance regarding Section 42 enquiries were revised.
- Documents and processes in Health organisations were changed to support reporting
- A bi-annual review meeting for the Oversight Process has been set up.

### **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.



## Audits

During 2017-18 the SAB, along with Leicester 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.

The following agencies that work in Leicestershire or Rutland provided a SAAF audit return to the SAB:

- Leicestershire County Council Adults and Communities Service
- Rutland County Council People Directorate
- Leicestershire Police
- Leicestershire Partnership NHS Trust
- University Hospitals of Leicester NHS Trust
- West Leicestershire and East Leicestershire & Rutland Clinical Commissioning Groups (as one response)
- All seven District Councils in Leicestershire (as one response)

Audit returns from all of these agencies identify that they are 'effective' or 'excelling' across all or the majority of the compliance questions that are relevant to them.

The agencies and areas of work where further improvement was required were as follows:

- Clinical Commissioning Groups are working towards effectiveness with regard to managing increasing demand for DoLS and embedding the Mental Capacity Act in safeguarding.
- Leicester Partnerships NHS Trust (LPT) are working towards effectiveness regarding embedding the Mental Capacity Act within safeguarding and processes and regarding restrictions and restraint under the Mental Capacity Act.

The agencies and areas of work areas that were excelling were as follows:

- Leicestershire County Council are excelling in embedding Making Safeguarding Personal, alignment with multi-agency procedures and safeguarding adults leads advising and supporting commissioning.

The Fire & Rescue Service and Leicestershire & Rutland Public Health did not submit a response this year.

Commentary on audit returns from agencies identifies that a good level of testing is taken out in completing the audit. There is currently no direct challenge element to self-reporting of progress. The SAB process for SAAF compliance assurance will be reviewed in 2018/19 to consider how the process can be streamlined and more peer review and challenge of compliance findings can be introduced.

In addition to its 'SAAF' audit process the Board continued its approach to multi-agency auditing. During the year two safeguarding multi-agency case file audits were planned focussing on the following priorities:

- Domestic Abuse
- Strategy Meetings

Due to bad weather the final multi-agency discussion and analysis part of the Strategy Meetings audit did not take place by the end of the year, and had to be rescheduled later in Spring 2018. The audit was completed, and action put in place in response to the findings. This will be reported in the next annual report.

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 Domestic abuse audit of 18 cases found that:

- Overall there was good recognition on a multi-agency basis of when domestic abuse concerns are also safeguarding issues and good knowledge of domestic abuse processes and specialist support services.
- In all cases where risk was identified it was felt that this was reduced, although there were cases where the adult at risk then chose to re-establish contact with the perpetrator and further safeguarding enquiries/measures were then required.
- Due to the fact that adults at risk within safeguarding enquiries will have needs for care and support, perpetrators of domestic abuse may also be carers. This is clearly a complex situation as the adult at risk will often feel reliant on their carer and be fearful of losing the support they provide.
- Perpetrators of domestic abuse may also be family members, and the adult at risk may feel responsibility towards them, particularly where they are a parent of the perpetrator. This can be difficult as with two cases within the audit where the adult child had no alternative accommodation and the parent felt they are unable to ask them to leave their property.
- In the above situations and due to the care and support needs of adults at risk within safeguarding enquiries relating to domestic abuse, it can be difficult for the worker to speak to the adult at risk alone, and also be clear about the concerns, as the perpetrator will often also be present in the home, and it may not be easy for the adult at risk to leave the property to meet elsewhere, for example where the person may have dementia or there are mobility needs. There were positive examples of practice identified within the audit where creative approaches were used such as meeting at a GP surgery.
- In at least one case there was evidence of the 'Trilogy of Risk'-domestic abuse, mental health issues and substance misuse being present. Whilst there were no concerns about risks to children identified within the audit that had not been responded to, adult workers require ongoing support to recognise the additional risks that the presence of the Trilogy of Risk poses to children and other vulnerable people.
- In some cases the adult at risk within a safeguarding enquiry relating to domestic abuse will not want any further action to be taken, and as with all enquiries this requires careful consideration by agencies involved about whether it is appropriate to cease the enquiry taking into account Making Safeguarding Personal (MSP) principles but also the risk within the situation.

Agencies have taken away these learning points to embed this within their practice. An audit regarding the Vulnerable Adults Risk Management (VARM) tool is planned for 2018/19.

### 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.

Making Safeguarding Personal is an element of all reviews through a standard question set within terms of reference for reviews.

In 2017/18 the SCR Subgroup received two referrals for consideration and the table overleaf outlines their progress as of April 2018:

Gender	Age	Harm Factors	Type of Review	Progress
Female	20	Mental Ill-health - Suicide	SAR	Author appointed and Panel process underway
Female	69	Elderly couple query attempted and assisted suicide – both survived	Potential SAR	Did not meet the criteria. SCR Subgroup assured that safeguards were put in place

The Subgroup also continued work on four cases referred in 2016/17:

Gender	Age	Harm Factors	Type of Review	Progress
Male	90	Neglect in Care - Died	Potential SAR	Awaiting Crown Prosecution Service decision
Female	34	Substance Misuse – Died following an assault	SAR	1 <sup>st</sup> Draft out for consultation
Female	54	Chronic Self-Neglect - Died	SAR	Review completed
Female	66	Domestic Abuse Mental Ill Health, Alcohol – serious injury	SAR	Final Report out for consultation

#### **Learning from reviews**

Learning from the reviews that commenced in 2016/17 contributed to the six learning themes reported in last year's annual report as follows:

**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.

### **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.

One DHR was completed during the year. Two further potential DHRs were considered, one is being taken forward as a DHR locally and the other is being reviewed in another geographical area.

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

The SAB produces a quarterly newsletter in conjunction with the Local Safeguarding Children Board, called Safeguarding Matters. This is used to disseminate key messages including from reviews and audits across the partnership and to front-line practitioners.

The September 2017 Edition of Safeguarding Matters was a ‘Learning from Reviews’ Special. This edition was relevant to all staff whether the workers focus is on adults or children, front line or practice supervisor/manager

Learning has also been shared through the Trainers Network and single agency internal and single agency internal processes, including to GPs via the Primary Care Safeguarding Children Quality Markers (SCQM) tool.

The Board carried out a review of Safeguarding Matters and the Board website with practitioners across partners. Feedback included that Safeguarding Matters was a useful tool for keeping up to date with safeguarding learning, and also for disseminating safeguarding information across teams. Some areas for improvement were identified regarding design and highlighting items of interest for specific audiences.

The Boards website was felt to be easy to access and find relevant information on, but not so easy to find out what had been updated. Some areas for improvement were identified with regard to colours used and adding Board papers to the site.

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

The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. The programme is led by the University of Bristol, and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

Locally the programme reports into the Joint Executive of the Leicestershire & Rutland and Leicester City Safeguarding Adults Boards. After initial work to commence the programme in 2016-2017 the programme went fully live in Leicester, Leicestershire and Rutland (LLR) on 1 October 2017.

The programme received 42 referrals between 1 October 2017 and 17 July 2018 across Leicester, Leicestershire & Rutland, three reviews have been completed.

Indicative findings from these referrals and reviews include:

- Average age of death for those with Learning Disabilities is lower than the life expectancy for the general population.
- Twice as many deaths of people with learning disabilities occur in hospital than in the community
- The most prevalent causes of death are respiratory related conditions.

The priorities for the programme locally are to:

- Recruit further LeDeR reviewers
- Continue to raise awareness of the programme with stakeholders
- Begin to formulate Action Plans based upon the findings of completed LeDeR reviews
- Integrate LeDeR into LLR's programme of work to improve services for people with learning disabilities (through mechanisms such as the Learning Disabilities Partnership Boards & local/regional strategies)

## 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 local safeguarding procedures as follows:

- Completion and sign-off of the revised Safeguarding Adults Information Sharing Agreement (ISA)
- Developed procedures regarding Modern Slavery
- Developed an Advocates policy
- Strengthened reference to mental capacity and best interests processes in the section regarding Self-Neglect
- Updated information for practitioners on Preventing Violent Extremism
- More information to support practitioners to recognise and respond to ill treatment and wilful neglect
- Updated the Escalation and Professional Disagreement Process
- Reviewed guidance on Thresholds and Section 42 enquiries in health care settings
- Revised guidance on the VARM
- Updated guidance for Managing allegations re persons in positions of trust

Future Work planned includes:

- Review of the structure of procedures to streamline them and support practitioners to utilise them more easily.

## Training and Development

The Competency Framework for safeguarding adults in Leicester, Leicestershire & Rutland sets out minimum competencies and standards across the adults workforce and gives advice as to how practitioners can meet these requirements through learning, development and training. This supports practitioners, managers and organisations to ensure a good level of competence across the partnership workforce with regard to safeguarding adults.

The SAB, through its Safeguarding Effectiveness Group regularly requests information from its partners regarding the effectiveness of their safeguarding training programmes. All partners have provided information to assure the Board that staff are appropriately trained.

The Board does not have general resource to support Multi-Agency Safeguarding Adults training. Some multi-agency training is provided through individual agencies training programs, such as Leicestershire County Council.

Leicestershire's training has included eighteen days of a new 'Safeguarding Adults in Practice' core day, to approximately 400 front line staff and supporting bolt on workshop modules, including Domestic Abuse and Coercive Control.

The Board ran four half-day VARM training courses in conjunction with the Leicester City SAB to increase awareness and effective use of the VARM to support prevention of safeguarding need.



The Board supports a Safeguarding Adults 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.

The Network also 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 and this feedback has influenced further developments to procedures.

## **Leicestershire & Rutland SAB and LSCB Finance 2017-18**

	£
<b>SAB Contributions</b>	
Leicestershire County Council	52,798
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>£103,334</b>
<b>LSCB Contributions</b>	
Leicestershire County Council	84,003
Rutland County Council	52,250
Leicestershire Police	43,940
Clinical Commissioning Groups (West Leicestershire and East Leicestershire & Rutland)	55,760
Cafcass	1,100
National Probation Service	1,348
Derbyshire, Leicestershire, Northamptonshire and Rutland Community Rehabilitation Company (Reducing Re-offending Partnerships)	3,000
<b>Total LSCB Income</b>	<b>£241,401</b>
<b>Total Income (LSCB &amp; SAB)</b>	<b>£344,735</b>
£	
<b>SAB and LSCB Operating Expenditure</b>	
Staffing	214,966
Independent Chaining	22,500
Support Services	30,500
Operating Costs	13,500
Case Reviews	16,290
Training Co-ordination and Provision (LSCB)	55,641
<b>Total SAB &amp; LSCB Operating Expenditure</b>	<b>£353,397</b>
<b>Deficit</b>	<b>£8,662</b>
<b>LSCB &amp; SAB Reserve account at end of year</b>	<b>£51,268</b>

### **Business Plan Priorities 2018-19**

Review and analysis of learning, performance information and emerging issues have led us to identify the following priorities for 2018-19:

<b>Development Priority</b>	<b>Summary</b>
1. Prevention	Prevention of Safeguarding need through building resilience and self-awareness in adults with care and support needs
2. Mental Capacity	Improve the understanding of capacity to consent and the application of the Mental Capacity Act across agencies
3. Thresholds	Promote a better and more consistent understanding and use of adult safeguarding thresholds
4. Engagement	Ensuring the work of the Safeguarding Adults Board is informed by adults with care and support needs

In addition the Board will consider developing safeguarding adults work on Financial abuse in partnership with Community Safety Partnerships and consumer protection agencies.

For 2018-19 there are no priorities shared with the Leicestershire & Rutland Local Safeguarding Children Board.

Action plans are in place for each of these priorities.

## **Partner Updates**



**West Leicestershire**  
Clinical Commissioning Group



**East Leicestershire and Rutland**  
Clinical Commissioning Group

Leicestershire and Rutland and West Leicestershire Clinical Commissioning Groups (CCGs) are committed to the promotion of safeguarding adults, supporting the work of the safeguarding board and to support staff and partners to undertake their safeguarding responsibilities.

In 2017/18 the CCGs demonstrated their support to the promotion of the adult safeguarding agenda by increasing the Adult Safeguarding and Mental Capacity Act component of a Designated Nurse role with a view to ensuring the voice of the Adult at risk is more equitably represented in its work.

We have strengthened internal and external processes to support care homes where care may have fallen below the expected standard.

In an attempt to increase the knowledge of adult safeguarding within our future workforce, safeguarding adults training is provided to pre-registration nursing students - this includes raising awareness of board procedures and elements of board work.

We have worked with GP practices to improve safeguarding adult understanding and provide support to GPs, CCG and external staff with regard to management of complex cases.

Relevant policies have been reviewed and amended. Systems to ensure adult safeguarding is integral to our procurement processes have been enhanced and safeguarding adults is also a prominent feature in our processes for seeking assurance regarding quality of care from providers of commissioned services.

In addition to the production of the Domestic Violence and Abuse Policy that has been disseminated to all GP Practices across Leicestershire and Rutland, UAVA have been commissioned by the CCGs to deliver Managing Disclosures of Domestic Abuse briefings to all GP Safeguarding Leads. UAVA have also provided Train the Trainer sessions to all members of the CCG Safeguarding Team to enable the team to continue to deliver the Domestic Abuse briefing sessions to GP's once UAVA have delivered their CCG 6 commissioned sessions.

The CCGs undertake work on an ongoing basis to promote the work of the LRSAB. The Safeguarding Team led the arrangements for the Safeguarding Health Network- a quarterly meeting of safeguarding leads from all of the CCG commissioned services. During Q3 and Q4 two meetings have taken place: discussions included the pending changes in DoLS legislation and the delivery of the NHSE highlight report for adults safeguarding.

Leicestershire & Rutland Safeguarding Children Board / Safeguarding Adults Board information has been cascaded to the Safeguarding Health Network that includes NHS and Non NHS Providers.

Messages from Adult Serious Case Reviews and Domestic Homicide Reviews have been cascaded to GP's via the Primary Care Safeguarding Children Quality Markers Tool (SCQM).

The CCGs' commitment to safeguarding and working in partnership will continue into 2018/19.



There is currently work ongoing with Trading Standards within LCC after some initial scoping identified that around 40% of the people Trading Standards are alerted to be the national Scam Hub are known to Adult Social Care (ASC).

Following initial pilot activity in 2017 the Adults and Communities Department has agreed to fund two workers to provide awareness-raising of scams and rogue traders to vulnerable people and organisations who support them. Trading Standards workers will also provide support to victims and social care workers through co-working. ASC are working closely with Trading Standards and have delivered joint training to front line staff and managers.

We have been involved in a review of the MARAC process with the Police and agreed to host a Social Care post within the planned MARAC Hub to provide advice guidance and support at initial referral stage. The post will help ensure that there is an effective and multi-agency approach to manage high risk domestic abuse cases on a daily basis and therefore early identifications of which cases also meet safeguarding thresholds. The recruitment process is underway for this post.

This year has seen a major refresh of our internal training programme with Core Modules and e-learning now available to all staff. This has led to a 93% take up of the new offer. Safeguarding audits and views of staff and managers were used in shaping the new training offer. The core training day uses real and live anonymised case studies in order to accurately reflect the work and challenges workers can face within their practice. Active participation and discussion is encouraged throughout the training sessions. All practitioners are asked for confidence scores before and after the training day and this has evidenced a consistent improvement in confidence levels within safeguarding practice. In addition to the core training the Lead Practitioner for Safeguarding and Learning and Development advisors have delivered further training and workshops, including around Organisational Safeguarding, Financial Fraud, Domestic Abuse and Vulnerable Adults Risk Management (VARM).

In order to respond to increasing numbers of safeguarding referrals, a key area of focus for LCC has been to continue to develop consistent and robust approaches to applying safeguarding thresholds and addressing initial areas of risk relating to safeguarding adults referrals. Therefore the focus of the Safeguarding Adults Team has been revised.

The purpose of the Safeguarding Adult Team is to ensure that there is a consistent and timely approach to applying safeguarding thresholds at the 'front end' of the process, and in identifying and addressing immediate risk and establishing the outcomes of the person involved, in line with Making Safeguarding Personal principles. The new team has recently become operational and therefore is on-going analysis of the impact on throughput and allocation of safeguarding cases. Early indications are that the through initial swift responses including meeting with the adult at risk as soon as possible, the team are able to more quickly identify where safeguarding thresholds are not met and alternative signposting and referrals are required to manage any risk. This enables the Locality Teams to focus their resources on adults at risks who may be unable to protect themselves from abuse, and is likely to result in lower numbers of safeguarding enquiries being reported by LCC going forward.

Discussions are on-going with Signs of Safety (SoS) consultants looking at developing this approach for adults, particularly around a model for safeguarding meetings.

We have been working on processes to support staff to effectively evidence robust decision making within safeguarding practice, potentially based on SoS model and a new case recording template has now been developed and is being piloted across several localities, and this will be audited in the next couple of weeks.

Following the development of our database to better record and report on how the principles of Making Safeguarding Personal are being applied, we can evidence the increasing numbers of people who feel their outcomes are being met and they felt listened to within the safeguarding enquiry.

We have facilitated workshops and training with NHS colleagues to improve the shared understanding of Section 42 oversight duties and application of safeguarding thresholds within health settings.

We are committed to working with independent providers and the Care Quality Commission (CQC) to improve the quality and safety of care provided. This year has seen a reduction in safeguarding investigations in care home settings.

Our safeguarding data evidences that LCC 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. This work continues and there is also a focus on work with domiciliary and supported living provider services.

LCC has active membership of the SAB subgroups and we have had significant involvement in the review and update of several key pieces of safeguarding

guidance, including VARM, People in Positions of Trust (PIPOT) and Thresholds and the current review of the Multi-Agency Policy and Procedures. The revised LLR thresholds guidance is now being adopted regionally by the East Midlands Safeguarding Adults Network (EMSAN) with a proposal that this is taken forward by the Association of Directors of Adults Social Services (ADASS) potentially on a national basis.

The SAB Audit Group is also chaired by the LCC Lead Practitioner for Safeguarding and has successfully delivered multi-agency audits around Domestic Abuse and Strategy meetings in the last year.

As active members of EMSAN we have delivered guidance on effective safeguarding Audit assurance tools and the use of agreed thresholds for front line workers. Shared practice across the region helps to embed best practice and influence consistent standards. The work of the EMSAN is fed back to the LRSAB through the Safeguarding Adult Review (SAR), Policy and Procedures and Safeguarding Effectiveness Group (SEG) subgroups.

Deprivation of Liberty safeguards have continued to present a challenge in 2017-18 as demand for sign-offs continue to rise. We have targeted our most experienced staff to undertake training and qualification to carry out Best Interest Assessments to most effectively manage this demand and continue to prioritise those most at risk for urgent assessment and authorisation.



Rutland County Council (RCC) continues to utilise its Adult Social Care role – Assistant Care Manager (ACM) – within the Prevention and Safeguarding Team in order to provide time limited and person centred outcomes for those adults who are deemed at risk of being re-referred as a Safeguarding Adult enquiry. This service is non-means-tested to encourage those at risk of self-neglect to engage with support.

Previous year's plans to recruit another ACM and a social worker to extend capacity and provide a Rapid Response role were agreed and there are now two practitioners in these posts fulfilling the remit of the roles to provide a quick response in cases where safeguarding, neglect and self-neglect are indicated.

Case example of the type of support provided;

*Practitioners responded to a case of an adult who was self-neglecting, was in poor health and who had no support from family. The adult was very resistant to support at first and it took regular visits from our ACM over a couple of months to build a relationship and trust. The adult did subsequently agree to support in the form of assistance in accessing health appointments and the provision of regular personal care in a respite bed. RCC also supported to deep clean his property and secured a*

*grant to provide him with new furniture. He also agreed to a package of support in his home which was personalised to include support to access the community once a week and manage his own tasks e.g. shopping. Recent feedback from him would suggest that he is recovering well from his acute episode and is happier in his home environment.*

RCC continues to monitor and develop its Liquid Logic system to provide accurate measures of reporting relating to safeguarding enquiries in order to identify trends and themes to shape service development moving forward. East Midlands Safeguarding Adults Network questions have been included within the RCC Personalisation survey which is completed at the end of any safeguarding enquiry to record the adults experience of the process.

All new Adult Social Care practitioners who are responsible for processing enquiries have completed safeguarding adults training at enquiry 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 are consistently well attended by the service and provide updates on Leicester, Leicestershire & Rutland multi-agency audits, relevant case law, and practice updates. Workers are encouraged to present case studies for peer review and peer shared learning.

Adult Safeguarding Basic Awareness Training (in-house) continues to be provided to all new starters within Adult Social Care and refresher training ongoing for current employees.

Further development will be ongoing regarding legal literacy, case law as it develops, and learning from audits and quality assurance.

- Building closer links between Adult Social Care, housing and community safety colleagues – improving community resilience
- Continuing to develop closer working across ASC and Children's social care - domestic violence and mental health
- CPD on domestic abuse and training provided to embed the trilogy of risk suite of resources





Leicestershire  
**Police**  
Protecting our communities

### **Adults At Risk**

We have continued to raise the understanding of adults at risk by our frontline staff through training and communication strategies. This has resulted in an 8% increase in AAR referrals to 14,000 in 2017/2018

HMIC said;

“The force is fully committed to identifying and helping vulnerable people. It now works even more effectively with partner organisations. This helps it to get a co-ordinated view of the number of vulnerable people in the local community and of the needs which these people have. Officers and staff recognise when people are at risk of harm, and the force provides a comprehensive range of services to deal with the effects of mental ill-health, particularly through the work of the proactive vulnerability engagement (PAVE) team.”

### **Domestic Abuse**

We view the increased reporting of Domestic Abuse as positive rising by 12.5% in 2017/18 to 18,000 incidents. This increased demand does create capacity issues with a reduced workforce. We utilise a range of tactical options to resolve situations including domestic violence prevention orders (increase of 41%), disclosures under Claire’s Law, as well as supporting victims to arrange their own preventative orders. We take a lead role in multi-agency working both tactically through MARAC and strategically through the Domestic and Sexual Violence and abuse Executive and Operations group. We have worked with partners to create a, Vision, Strategic Objectives, recommendations and a delivery plan, all derived from the Joint Strategic Needs Assessment.

Improvements in how the force deals with domestic abuse have been recognised; the force has had two “Good” inspections from HMIC;

“Victims of domestic abuse now receive a better service from the force. This is because the force works more closely with partner organisations, has more staff who have been trained to carry out safeguarding, and because there are more frequent multi-agency meetings to consider high-risk cases. Joint work between the force and other organisations has resulted in an exemplary sexual assault referral centre (SARC). The centre offers comprehensive professional support to victims of sexual assault.”

### **VAWG & Safeguarding Hub Project**

Funding from the Home Office Violence Against Women and Girls Strategy, is enabling us, together with partners, to make improvements to MARAC and the Domestic Abuse Support Team. The Force has embarked upon a project to create a single Safeguarding hub. This will create a holistic process which reviews, researches and assigns an appropriate response which is better able to deal with the complex needs of service users. Although this will start as predominately a Police

capability, we are working with partners to exploit opportunities to work together so that our collective offer is more effective and efficient for the user.



We successfully introduced a hospital 'independent domestic violence advisor' (IDVA) into the Emergency Department at the Leicester Royal Infirmary. The IDVA has been instrumental in supporting the team to secure refuge for a woman who had no recourse to public funds due to her circumstances. The IDVA has also ensured that a number of patients have received specialist domestic abuse support before leaving the department.

We transferred all of our safeguarding records for maternity, children and adults onto an electronic database to ensure data is kept in one place. This means that the team have ready access to cases and information, to enable us to cross reference information that the Trust holds on safeguarding concerns

We delivered accredited PREVENT WRAP training to over 7,475 staff as part of a plan to train 87.9% of clinical staff by April 2018, as part of our NHS England contractual requirements

We embedded the principles of Making Safeguarding Personal into the core business of adult safeguarding. This means that the adult safeguarding nurses can ensure the wishes of the adult are central to our investigations.

We have worked with safeguarding partner agencies to complete 5 multi-agency audits.

We have promoted the use of the NHS England Safeguarding App. This means that staff using the App have immediate access to consistent information about safeguarding and the wider agenda such as Mental Capacity Act.

We have worked with local authority partners to review the system for undertaking internal safeguarding adult investigations, and to provide assurance that this is compliant with the Care Act. This means that we have good arrangements in place to appropriately investigate adult safeguarding concerns which occur within the Trust, and that we can demonstrate lessons identified and learned.

# LEICESTERSHIRE

## FIRE and RESCUE SERVICE

2017/18 has seen significant improvements in the way we work with partners and target our activities at the most vulnerable people.

Referrals for Home Fire Safety Checks are now triaged according to risk information provided by partner agencies, so we can respond quickly to those people most in need. The main role of the Community Safety team is to manage high fire risk cases, and work with the occupant and relevant agencies to reduce the risk of fire. In cases when there is a direct threat of arson we visit the property the same day.

We now have a designated adult safeguarding coordinator who triages and follows up safeguarding concerns. Cases are predominantly related to neglect or self-neglect, often in association with fire risks and concerns about health and well-being. The co-ordinator is based within the police adult referral team, which facilitates information sharing and more efficient partnership working. We conduct joint home visits with partners and regularly contribute to Vulnerable Adult Risk Management (VARM) meetings to support high-risk cases.

Our Community Safety staff attend relevant multi agency training and contribute to the training programme. We offer training to front line staff in partner agencies (e.g. domiciliary carers, adult social care, and police) on identifying and reporting fire safety. All our public-facing staff have received safeguarding awareness training and individual teams receive further training relevant to their role. For example, our Fire Safety Officers (who carry out inspections of businesses) requested training on modern slavery.

Over the last 12 months LFRS has continued to work with hoarders and has contributed to hoarding and self-neglect workshops both locally and nationally.

Following serious fires we always offer a 'Post Incident Response' to help reassure the local community and offer fire safety information and home checks to neighbouring properties. Our fire station managers attend district community safety partnership meetings, in order to work together to reduce those risks to the community and to individuals.



The National Probation Service in Leicester, Leicestershire and Rutland (NPS LLR) places adult safeguarding at the heart of our practice, both in relation to preventing further victims and in our work with offenders. Adult safeguarding also remains a key consideration of the work of Multi-Agency Public Protection Arrangements (MAPPA) and, as such, our work in partnership with both statutory and duty-to-cooperate

partners continues to make a significant contribution to the management of those cases where safeguarding is an issue.

The core adult safeguarding e-learning is completed by all staff at all grades. It is a requirement for new staff to complete within their probationary period, and is refreshed every 3 years across the whole staff group. For front line staff, this is followed by a face to face learning event. Additional learning opportunities across the county are offered to staff as they become available, together with internal reflective practice sessions and line management supervision, in which safeguarding issues are reviewed, and guidance and oversight provided.

NPS LLR gives consideration to the care and support needs of offenders in the community (including pre and post-custody) and work in partnership with offenders and local authorities where such needs exist. Every offender supervised by NPS LLR has a full OASys assessment completed, identifying risks posed by and to the offender. An ongoing dialogue takes place between the Offender Manager and the offender in relation to issues of known vulnerabilities. Action is then taken in response to this and recorded appropriately. Every offender is encouraged and supported to complete a self-assessment questionnaire which provides a further opportunity to identify adult safeguarding issues.

Operational managers complete quality assurance audits on risk management and sentence plans to ensure oversight of practice capability amongst our staff, with identification and action in relation to safeguarding issues forming a key part of these quality assurance audits. These audits are due to increase in frequency over the year ahead, together with a planned inspection by Her Majesty's Inspectorate of Probation.

At a senior management level, NPS LLR continue to engage positively with the Safeguarding Adults Boards, contributing to the Review Sub Group and Domestic Homicide Reviews. Learning is shared with staff across NPS LLR in written format and in team briefings, together with divisional and national learning from Serious Further Offence reviews.

NPS LLR remain committed to delivering a quality service, and learning from our practice and partnerships.



Safeguarding touches everyone's lives at some time, including the lives of the service users and staff of Leicestershire Partnership NHS Trust (LPT). Many of our service users have experienced abuse of some kind, or may be at risk of experiencing abuse either now or in the future. Few of these service users exist in isolation, which is why in 2017 LPT have continued to build on the work to adopted a 'Whole Family' approach to safeguarding, including moving to a position of a Whole Family safeguarding team instead of separate Adult and Children team.

Training and information for staff has been adapted in relation to Individual and organisational responsibilities and in line with promoting a Whole family approach. Likewise, LPT has continued to work towards improving health outcomes for Looked after Children (LAC) and supporting the Child Death Overview Process (CDOP).

The Trust has launched a Community Mental Capacity Act Champions Group to build on the work of the In-patient Champions group in supporting consistent good practice in assessing Mental Capacity.

The PREVENT Statutory Duty was introduced in 2015, placing specific statutory obligations on health organisations and other partners to support the protection of individuals vulnerable to exploitation by extremist groups. Moving forward LPT will have a Prevent Lead and Prevent co-ordinator as part of the Whole Family Safeguarding Team, who will ensure compliance with statutory responsibilities including training delivery.

Given the vulnerabilities of those we work with in LPT, we must continue to focus on 'Early Help' and Prevention and lesson learning in 2017-18 in order to prevent the risk of Abuse to Vulnerable Adults and Children in contact with LPT services. LPT is closely monitored in relation to safeguarding activity both internally and externally to ensure the organisation is compliant with statutory requirements placed upon health organisations.



Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company (DLNR CRC) is responsible for the supervision of low and medium risk of harm adult offenders, the provision of a range of rehabilitative interventions for CRC and National Probation Service (NPS) cases and the delivery of 'Through the Gate' (TTG) services in Resettlement Prisons. This work involves working with adult offenders who are both perpetrators of abusive behaviour and individuals who present with multiple vulnerabilities

Safeguarding is a core statutory function of DLNR CRC. Risk assessment and risk management is one of its key activities, driving all its activities with service users. Safeguarding considerations are considered within assessment and risk management plans at all stages. DLNR CRC use specialist risk assessment tools such as Offender Assessment System (OASys) and Spousal Assault Risk Assessment (SARA) to support defensive decision making across all areas of risk. All operational staff are trained in safeguarding as part of their core training and DLNR CRC has a competency framework to ensure that all cases are allocated to appropriately trained staff on the basis of identified risk and need.

DLNR CRC work with a significant number of cases that are perpetrators of domestic abuse. All our case managers are specifically trained for this work and we also deliver two programmes dependent upon risk and need. These programmes are

called Building Better Relationships Programme and Safer Choices respectively. In all this work we also employ partner link workers to provide support to victims of abuse through linking them with local specialist agencies. DLNR CRC are a key participating partner in local Multi-Agency Risk Assessment Conference (MARAC) arrangements. We have established protocols for the exchange of information to support decision making and also attend all MARAC's with listed cases.

DLNR CRC recognise that abuse can also occur in other contexts and across other vulnerabilities. DLNR CRC is committed to working with its adult social care, substance misuse, housing and health partners from both the statutory and voluntary sector to support a joined up approach to prevent and reduce the escalation of abuse.

DLNR has quality assurance mechanisms to support the maintenance of effective practice standards. All team managers within DLNR CRC attend 'Quality Days' on a monthly basis during which case records are sampled and quality assured. DLNR CRC also have an Internal Audit team who undertakes themed audits across DLNR. DLNR CRC are also subject to audits through Her Majesty's Prison & Probation Service (HMPPS) contract management team and HM Inspectorate of Probation (HMIP).