Leicester, Leicestershire and Rutland (LLR)

Safeguarding Quality Assurance



# Our approach to understanding quality



#### A shared approach

The Leicester Safeguarding Adults Board and Leicestershire & Rutland Safeguarding Adults Board work together to ensure that adults in our area are supported to stay safe from harm and abuse.

We share a Safeguarding Adults Quality Assurance Framework.

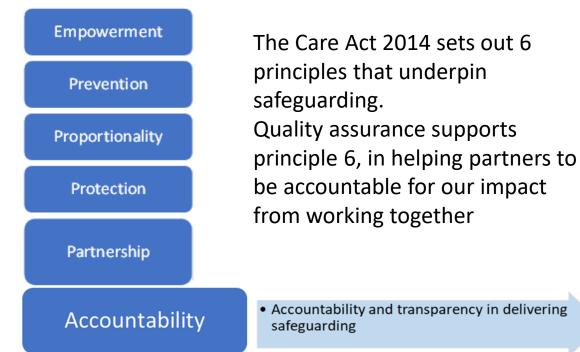
This helps us to understand how well we ae working together to achieve our vision.

### **Our Vision**

A city and counties where people are able to live their lives without abuse or harm from others because:

- Abuse is not tolerated
- People know what to do if abuse happens
- People and organisations work together to prevent and respond to abuse

#### **Our Principles**



### What we do to assure quality





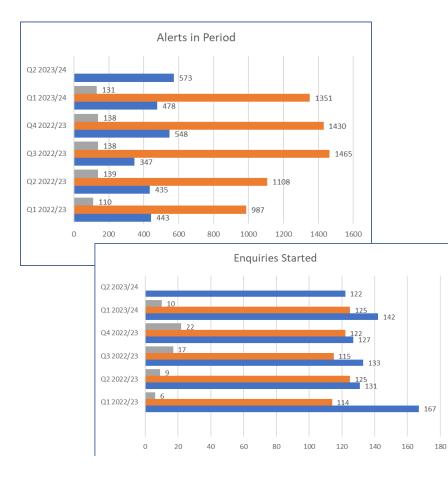
#### Our approach

We have a quality assurance framework with 4 domains. This draws in varied sources of information including:

- Safeguarding Annual Assurance Framework (SAAF) Audit
- Performance data
- Quarterly agency narratives
- Learning from Safeguarding Adults Reviews
- Individual agency board reports
- Inspection reports and peer reviews
- Complaints and commendations
- Multi-agency / single agency practice audits
- Feedback from people in our communities
- Information from staff and from training

Evidence is drawn together in an Annual Assurance Statement.Assurance in overseen by the LLR Performance Subgroup.Regular reports are shared with the Safeguarding Adults Boards.Key issues are included within the Safeguarding Annual Reports.

## What do we know / what does this mean?



#### Using information to drive improvement

Doing something with the information we gather is essential.

The Performance Subgroup monitors a range of data and other information regularly, to identify if there are concerns, changes or trends that we should address.

The Subgroup brings different sources of information together, to ensure we understand the issue clearly – this is called 'triangulation'.

We ask – "does our data, and feedback from staff and external reviews point to the same issue or concern" – so we can be confident we are taking the right action.

#### An Example

- The level of alerts recorded by Councils is very different, but the number of safeguarding enquiries completed is more similar
- Audits tell us that there is good application of our shared thresholds guidance so we understand that enquiries are started consistently between councils
- External peer reviews have also told us that the recording of alerts is an issue to explore, looking at national and regional benchmarking
- Staff and data tells us that when changes were made in one council, it reduced the number of alerts recorded

We are now confident that the difference is due to recording alerts rather than reflecting an actual difference in safeguarding activity.

The Subgroup will monitor changes in data to see if this changes as we expect (recorded alerts in one council should reduce).

The impact will be that staff working in LLR have a shared understanding, we focus our time on the right activity and people at the centre of the concern receive an appropriate response. This supports the principle of proportionality.

• The least intrusive response appropriate to the risk presented

# Our plans – what we are focusing on next

The L and LR Safeguarding Boards share a strategic plan and annual business plan.

We have used the 2022/23 quality assurance work to inform our 23/24 business plan priorities

There are 3 priorities:

- Self-Neglect
- Domestic abuse of older people
- Mental Capacity

We continue to have 'business as usual' – our ongoing attention given to performance and quality

A dashboard has been developed for the Safeguarding Adult Boards – to help the SAB take assurance about our partnership working and impact.

The core dashboard will be consistent over time.

Metrics that underpin our priorities will be added and will change, as our priorities change over time.

