Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Annual Report 2016 - 2017

Contents

1. Foreword by Independent Chair

Jane Geraghty

Having started my term as Leicester Safeguarding Adults Board (LSAB) independent chair in January 2016, I proudly present our annual report for the second time. This report details the activity and achievements of the LSAB during my first full year as independent chair.

I have been very impressed with the achievements and the ongoing commitment of all board members and representatives. In particular, I would like to acknowledge and give thanks to the members and chairs of our subgroups for providing their time, commitment and expertise. The subgroups drive forward the work of LSAB and are critical to its success.

The structure of Leicester Safeguarding Adults Board and its subgroups has been streamlined this year; with board members chairing subgroups and the disbanding of the 'delivery group'. This has enabled decisions to be made by the subgroups without having to go through the delivery group for ratification. The subgroups now have greater autonomy in how they deliver on business plan priorities remitted to them by LSAB.

As independent chair I have continuously developed relationships with board members and am committed to meeting with a host of key stakeholders both at strategic and service delivery level. Board development days gave us all an opportunity to discuss and decide upon a robust local strategy and to drive forward developments and initiatives that will ultimately provide protection from harm and abuse to the most vulnerable adults in Leicester.

A particular personal and professional interest of mine is the empowerment of the voice of adults at risk to be heard. Throughout 2016/2017 LSAB developed its Service User Reference Group. As LSAB's independent chair I have attended this group regularly, contributing leadership and direction to enable the group to come to fruition. Moving into 2017/2018 LSAB is motivated to strengthen further the voice of adults who use services to meet their health and social care needs. With this in mind, the Service User Reference Group will become a formal subgroup of LSAB. I am extremely pleased that board members Leicestershire Centre for Integrated Living and Healthwatch will be leading this subgroup on behalf of the board.

2016/2017 also drove forward two task and finish groups: one looking at organisational abuse and the other reviewing the embedding of Making Safeguarding Personal across partners. I am pleased to report that both of these groups have completed their remit, including the embedding of actions, and will now be monitored as business as usual. Further details of the work of these task and finish groups can be found in the main body of this annual report.

LSAB remains committed to working closely with partners across Leicestershire and Rutland and of course our partners in Leicester Safeguarding Children Board. Joined up arrangements have strengthened during 2016/2017, with continued commitment to the work of the Leicester, Leicestershire and Rutland (LLR) joint executive group, joint audit work, and joint multi-agency policies and procedures group. LLR joint multiagency policies and procedures group is aimed at achieving a consistent approach across local boundaries and has led to:

- A consistent safeguarding adults thresholds document which has been updated to reflect the Care Act 2014 principles

- The writing of LLR Vulnerable Adults Risk Management (VARM) guidance

I am impressed by the commitment of each and every partner agency and would particularly like to thank Leicester City Clinical Commissioning Group, Leicestershire Police, and Leicester City Council for providing significant funding, enabling LSAB to drive its priorities forward.

Finally, I would like to pledge my own commitment to learning and improvement and would like to thank local professionals and people for their vigilance.

Jane Geraghty
Independent Chair –
Leicester Safeguarding Adults Board

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2. Introduction

The Care Act 2014 introduced new safeguarding duties for local authorities, including establishing a Safeguarding Adults Board (SAB) for its area. The objective of each SAB is to help and protect adults in its area with needs for care and support who are experiencing (or at risk of experiencing) abuse or neglect and as a result of those needs are unable to protect themselves. It seeks to achieve this by coordinating and ensuring the effectiveness of each of its members.

Leicester Safeguarding Adults Board's (LSAB's) three statutory partners are Leicester City Council, Leicestershire Police and Leicester City Clinical Commissioning Group. Under the Care Act 2014 each SAB has three core duties:

- Publish a strategic plan for each financial year
- Publish an annual report
- Commission safeguarding adults reviews for any cases which meet the criteria

After the end of each financial year, SABs must publish an annual report clearly stating what the board and each member has done to achieve the board's objective and implement its strategy. The annual report must also provide information about any safeguarding adults reviews (SARs) that the SAB has arranged which is ongoing at the end of that year. It must report on the findings of safeguarding adults reviews that have concluded in that year and also state what the board has done during that year to implement the findings of SARs. Where the board decides during that year not to implement a finding of such a review, the reasons for that decision must also be given.

Every Safeguarding Adults Board must send a copy of its annual report to:

- the chief executive and leader of the local authority
- the police and crime commissioner and the chief constable
- the local Healthwatch
- the chair of the Health and Wellbeing Board

It is expected that these organisations will fully consider the contents of the report and how they can improve their contributions to both safeguarding throughout their own organisation and to the joint work of the board.[1]

LSAB's annual report represents a summary of the collaborative work undertaken by partners throughout 2016-2017 to achieve our business plan. It provides an overview of our achievements, partner commitment and local safeguarding activities. This annual report also looks ahead at LSAB's 2017-2018 priorities in our drive for continuous improvement.

[1] Department of Health (2017). Care and support statutory guidance [online] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed 1 June 2017].

3. Subgroups

The day to day work of Leicester Safeguarding Adults Board is carried out by its three subgroups whose priorities are set out by the board's business plan. Leicester Safeguarding Adults Board is extremely fortunate to have board members from each of the three statutory partners (Clinical Commissioning Group, Leicestershire Police, and Leicester City Council Adult Social Care) chairing each of the three subgroups. This commitment from partners allows for a more streamlined board structure with subgroups having greater autonomy than in previous years.

The detailed work of the subgroups throughout 2016/2017 is set out below, together with key priorities for 2017/2018.

3a. Performance, Effectiveness and Quality subgroup

Purpose

The Performance, Effectiveness and Quality subgroup reports to the Leicester Safeguarding Adults Board (LSAB). The work undertaken by the subgroup is directed by the strategic business plan, with one clear priority:

Establish and implement a clear quality monitoring framework to monitor business as usual.

Membership

The subgroup is made up of representatives from member organisations:

- Leicester City Council, Adult Social Care (Chair)
- Leicester City Council, Community Safety
- Leicestershire Police
- Leicester City Clinical Commissioning Group
- University Hospitals of Leicester
- Leicestershire Partnership NHS Trust
- Leicestershire Fire and Rescue Service
- East Midlands Ambulance Service

Achievements 2016/2017

The terms of reference and membership of the group were agreed. It was confirmed that a statutory data set would be submitted by Leicester City Council (LCC) and a shared local data set was developed for partner agencies across Leicester, Leicestershire and Rutland (LLR).

A Quality Assurance Framework was refreshed and put in place. This framework gave details of ten domains of quality assurance that the group would use to test safeguarding effectiveness and provide the LSAB with assurance across partner agencies. Its development enabled the group to achieve its priority of establishing a clear quality monitoring framework to monitor business as usual.

Throughout the year, themes from within statutory data were identified and referred to appropriate subgroups for further analysis and action. In addition, the group commissioned a number of audits to examine safeguarding effectiveness in Leicester:

In quarter one the group commissioned a single agency audit to examine cases where people have identified community safeguarding issues on admission to hospital. Findings: The overall findings were positive, with the audit concluding that all the cases within the audit were appropriately referred, none of the safeguarding issues identified could have reasonably been detected in the community, and the response from the discharge team was both timely and proportionate.

The group went on to commission an audit to consider in more detail the number of repeat safeguarding referrals in Leicester. Findings: Not all the repeat referrals related to separate safeguarding concerns; a large number of recorded referrals were the capturing of ongoing work after an initial referral and safeguarding activity had started. Where there had been the highest number of repeat referrals, good practice was noted with people reporting their

concerns appropriately and each referral helping to build a picture of the risks being presented.

In quarter four the group engaged with a Making Safeguarding Personal multi-agency audit across Leicester, Leicestershire and Rutland. This audit focused on safeguarding practice through observation and talking directly to involved individuals about their experience of a safeguarding enquiry. Findings: The audit found clear evidence that on the whole people within safeguarding enquiries are involved and informed. Recommendations that emerged from the audit included what to do when it is not possible to achieve the outcomes of the person e.g. when the individual does not want an enquiry that needs to go ahead due to risk to others.

The final piece of work provided by the Performance, Effectiveness and Quality subgroup for the board in 2016/2017 was an annual assurance report. This report included qualitative and quantitative data, service user feedback and evaluations of staff awareness of safeguarding. It provided a comprehensive overview of the assurance work undertaken by the group throughout the year and was well received by the board.

Priorities for 2017/2018

1. To ensure that the LSAB has regular information about quality, performance and effectiveness and is therefore able to form a view on the level of assurance regarding safeguarding in Leicester.
2. To strengthen the Quality Assurance Framework in relation to user and staff feedback by improving:
   - The interface with the Engagement subgroup
   - The interface with the Training subgroup
3. To further develop the Quality Assurance Framework so that it explicitly relates to user experience and outcomes.

3b. Awareness, Public Engagement and Training subgroup

Purpose

The Awareness, Public Engagement & Training subgroup reports to the Leicester Safeguarding Adults Board (LSAB). The purpose of the group is to have oversight of public engagement, awareness raising, and training activities across partner agencies.

1. **There is an agreed public facing communication action plan and delivery that provides assurance that safeguarding messages are reaching all communities.**
2. **Workforce awareness raising – identify areas of the workforce that are not fully aware of safeguarding adults issues.**
3. **Develop and deliver a workforce awareness raising plan to provide assurance that all parts of workforce are aware of safeguarding issues.**
4. **Training competency framework will be reviewed to include Mental Capacity Act competencies.**

Membership

The subgroup is made up of representatives from member organisations:

- Leicester City Clinical Commissioning Group (Chair)
- Leicester City Council, Adult Social Care
- Leicestershire Police
- University Hospitals of Leicester

Achievements 2016/2017

The group reviewed partners' training data and conducted a training needs analysis to obtain assurances. This work also ensured that multi-agency training provided by the Safeguarding Adults Board is targeted appropriately to add value to the existing training programmes within partner agencies.

The existing access for care providers to safeguarding training provision delivered through Leicestershire Social Care Development Group was reviewed to maximise uptake from care homes within the city.

A pilot 'train the trainer' course for Mental Capacity Act (MCA) was run amongst the care provider sector. This was well received and an extension of the pilot has been agreed for 2017-2018.

Multi-agency workshops on learning from Leicester city safeguarding reviews was developed and delivered to frontline staff.

A joint Leicester, Leicestershire and Rutland training strategy was explored.

The group communicated well with the Service User Reference Group, building up strong links in regard to communication messages. This highlighted the importance of how the SAB engages with the public to ensure our message is effectively communicated so that engagement can be facilitated meaningfully.

Feedback from the service user forum was coordinated by the group and the development of a service user retention strategy in relation to a payment and expenses protocol was explored.

The group facilitated the production of a service user experience video.

Priorities for 2017/2018

At its development day in March 2017, LSAB recognised that the remit of the Awareness, Public Engagement & Training subgroup was too broad, with much overlap with the Service User Reference Group.

It was agreed that public engagement work would sit elsewhere and that for 2017/2018 the main focus of the Awareness, Public Engagement & Training subgroup would be training. The group was newly named as the Training subgroup and the new priorities are:

1. To establish the key knowledge gaps within frontline staff groups.
2. To establish a multi-agency training programme in line with priority areas for learning.
3. To review the LSAB competency framework and propose any developments.

3c. Adult Review and Learning subgroup

Purpose

The Adult Review and Learning subgroup reports to the Leicester Safeguarding Adults Board (LSAB). The group's main focus is to ensure that the LSAB meets its statutory responsibility under the Care Act 2014 to arrange for there to be a review of a case involving an adult in its area with needs for care and support when certain criteria are met. The work undertaken by the group is also directed by the following strategic business plan priorities:

Oversee and progress safeguarding adults reviews (SARs), domestic homicide reviews (DHRs) and other adult reviews.

Multi-Agency Case File Audit (MACFA) schedule to be agreed with the Performance Effectiveness and Quality group.

Membership

The subgroup is made up of representatives from member organisations:

- Leicestershire Police (Chair)
- Leicester City Council, Adult Social Care
- Leicester City Council, Community Safety
- National Probation Service
- Leicester City Clinical Commissioning Group
- University Hospitals of Leicester
- Leicestershire Partnership NHS Trust
- Leicestershire Fire and Rescue Service

Achievements 2016/2017

Due to no safeguarding adults reviews concluding in 2016/2017 there are no SAR findings to report on in this year.

During 2016/2017 the group has commissioned one SAR in line with the Care Act 2014. A review panel has been set up and an independent chair/author has been commissioned to oversee this review into the death of a young man with learning difficulties. This review will aim to promote effective learning and improvement actions for partner agencies to enable them to better protect adults with care and support needs in Leicester. The review is currently ongoing and findings will be included in the 2017/2018 LSAB annual report.

In addition to overseeing SARs for LSAB, this subgroup commissions DHRs on behalf of Safer Leicester Partnership. During 2016/2017 the group commissioned two new DHRs and progressed three reviews from previous years.

On two occasions the group also facilitated the sharing of single agency learning where the death of an adult in Leicester did not meet the criteria for a SAR or DHR.

An Appreciative Inquiry was undertaken by the group following a 'near miss' incident involving an adult in Leicester whose case had previously been heard at the local Multi-Agency Risk Assessment Conference (MARAC). This 'near miss' and learning from other Leicester city adult reviews also prompted the group to undertake a review of the local MARAC procedure including systems for sending, receiving and recording MARAC referrals.

As well as commissioning reviews, the Adult Review and Learning subgroup oversees and monitors single agency and multi-agency actions arising from adult reviews in Leicester. During 2016/2017 the group oversaw the successful completion of sixty-two separate actions from partners implementing learning from reviews.

To facilitate the work of the subgroup, local review systems and processes were updated throughout the year in line with revised statutory guidance. There is a renewed focus on engaging families in reviews. Learning from previous Leicester adult reviews has been collated and entered into a single database to facilitate the identification of themes and repeat learning with a view to improving the group's links with both the performance and the training subgroups as we move into 2017/2018.

Priorities for 2017/2018

1. To strengthen the linkages with the Training subgroup so that the process of moving from lessons identified to lessons learned is clear.
2. To strengthen the linkages with the Performance subgroup so that the assurance processes in place are able to pick up and give feedback on how well embedded change is in practice, as a result of SAR / DHR actions.
3. To maintain and build upon existing structures and relationship with Safer Leicester Partnership.

4. Task and finish groups

LSAB's task and finish groups ensure that our joint working is effective. Each task and finish group explores a specific theme focusing on that year's board priorities. 2016/2017 task and finish groups were:

- Financial abuse
- Young people's transition to adulthood
- Making Safeguarding Personal (MSP)
- Organisational abuse

4a. Financial abuse task and finish group

Objective: Prevent financial abuse of vulnerable adults by improved awareness of this form of abuse in local banks and building societies.

Update: At the board development day facilitated by Dr Adi Cooper OBE in March 2017, the board reflected that it had not been clear about its objective and expectations, which undermined delivery (as well as lack of capacity and prioritisation). In her feedback, Dr Cooper noted that this reflection provided evidence that the partnership is learning from its experience.

Priorities for 2017/2018: A national scheme, known as the Banking Protocol and being run as a joint venture between the police, Financial Fraud Action and National Trading Standards, is being rolled out. The scheme is aimed at ensuring banks and police are more active in protecting customers and involves the training of all bank staff. Taking into account the national approach outlined above, the board confirmed that this objective would not be renewed locally as a 2017/2018 board priority.

4b. Young people's transition to adulthood task and finish group

Objectives: To achieve assurance that young people, who are becoming adults with care and support needs and are at risk of abuse, are identified and appropriately supported. This includes young people who have been identified as being at continued risk as a young adult due to child sexual exploitation (CSE).

Update: During 2016/2017 the existing governance arrangements for CSE were explored to establish how these business plan objectives would be progressed. Locally, the Leicester, Leicestershire and Rutland (LLR) structure for CSE was refreshed, with a new operations group established to deliver the CSE agenda. LSAB has a presence at the CSE operations group through Leicester City Council Adult Social Care and Leicestershire Police representation.

Priorities for 2017/2018: The above objectives remain on the board's business plan for 2017/2018. A new Transitions Board is planned for the city, with LSAB working in partnership with Leicester Safeguarding Children Board.

4c. Making Safeguarding Personal task and finish group

Purpose

The Making Safeguarding Personal (MSP) task and finish group has one purpose: to drive work that will ensure MSP principles are embedded within the Leicester, Leicestershire and Rutland partnership taking into account the statutory responsibilities relating to safeguarding processes under the Care Act.

2016-2017 Priorities

1. The board will be assured on the delivery of MSP, including Section 42 enquiries.
2. The board will explore the use of the MSP toolkit.
3. MSP is fully embedded within local safeguarding activity and measured as part of data collection.

Membership

The subgroup is made up of representatives from member organisations:

- Leicester City Council, Adult Social Care (Chair)
- Leicestershire County Council, Adult Social Care (Deputy Chair)
- Leicestershire Police
- NHS England (Central Midlands)
- Leicestershire Centre for Integrated Living (LCiL)
- Independent Sector Rep, EMCARE
- Leicester City Clinical Commissioning Group
- Leicestershire Partnership NHS Trust
- University Hospitals of Leicester NHS Trust
- East Midlands Ambulance Service

Key Achievements

- Multi-agency audits have been completed and evaluated – areas of good practice identified alongside areas for organisational learning
- Agencies completed a questionnaire and feedback on the extent to which MSP is embedded within the organisation – a clear commitment and progress was evidenced
- The three local authorities are now reporting consistently using the adopted questions created by the East Midlands Safeguarding Adults Network
- Briefings on MSP have been delivered to providers
- A roadmap check was completed using the tool included within the ADASS commissioned MSP Temperature Check 2016 - significant progress was demonstrated by all
- It was agreed that the key actions, as set out in the multi-agency action plan, had been completed and the objectives for the task and finish group met. All members of the task and finish group agreed that MSP will transfer to business as usual

Priorities for 2017-2018

1. This task and finish group was closed down, having achieved its objectives. Areas of work have been absorbed as business as usual within partner agencies. Existing MSP linkages will continue through the board's Engagement subgroup (see below).
2. The LSAB 17/18 business plan has expanded the remit of the Service User Reference Group, which will be rebranded as the Engagement subgroup, with an enhanced focus on ensuring that engagement is meaningful and has impact. This provides an increased level of assurance in terms of the user voice remaining central to safeguarding going forward.
3. Further audit activity will be remitted via the Leicester, Leicestershire and Rutland audit group for 17/18 and all future audit activity will have the principles of MSP embedded within.
4. Changes relating to MSP will be referred to the Leicester, Leicestershire and Rutland Policies and Procedures Group, to include a library of resources. These will be stored on the Leicestershire board's website with a link.

4d. Organisational abuse task and finish group

Purpose

The group was established to provide assurance to LSAB that systems operating across Leicester city allowed for the identification of organisations / agencies that present a safeguarding risk.

2016-2017 Priorities

1. To provide assurance to the board that systems allow the identification of organisations / agencies that present a safeguarding risk.
2. To assure the board that actions are taken (and robust processes are in place) to address when systemic failures and concerns are identified.
3. Identify what influences the high numbers of referrals relating to adults in care environments compared to alerts about those that takes place elsewhere, and develop remedial actions, where needed, to redress the 'balance'.

Membership

The subgroup is made up of representatives from member organisations:

- Healthwatch (Chair)
- Leicester City Council, Adult Social Care (Deputy Chair)
- Clinical Commissioning Groups
- Leicester Safeguarding Adults Board Office

- University Hospitals Leicester
- Leicestershire Partnership Trust
- Independent Sector
- Care Quality Commission
- Leicestershire Police

Key Achievements

The group sourced from providers, assurances that mechanisms were in place that ensured the identification of organisations and agencies where a safeguarding risk can be identified. The reporting of such instances ensured that there was a multi-agency alert and all the relevant agencies were informed.

The group sought and received assurance that progress on all actions were monitored and reported within agreed protocols and timescales.

Existing groups e.g. the Information Sharing Group, the Quality Surveillance Group and LSAB, provided sufficient assurance that matters requiring escalation could be realised and actioned and were reported in a transparent environment.

The group discussed escalation processes and confirmed the local information sharing group existed to provide a forum for those issues to be discussed. There exists a further escalation pathway to the Quality Surveillance Group. For complete assurance the subgroup chair recommended that further assurance is sought from the two groups to ensure all relevant matters are being addressed.

The group confirmed that Leicester City Council Adult Social Care data was sufficient and would be incorporated into existing data collection frameworks (trends in incidents which provided an opportunity to share good practice or lessons learned from care incidents would need to be introduced as standard practice).

Priorities for 2017-2018

This task and finish group was closed down having achieved its objectives. Recommendations from this task and finish group to Leicester Safeguarding Adults Board are as follows:

1. Six month review to assure consisted approaches to confirm relationship reporting and assurance mechanism are comprehensive between the Information Sharing Group and the Quality Surveillance Group.
2. Training subgroup to develop training for private providers raising examples of good practice and learning opportunities from poor performing providers.
3. Approach CQC to request consistent engagement with the board and subgroups.
4. Request that where ‘Safe and Well’ visits are undertaken that outcomes include quantitative and qualitative data and client experience as necessary process.
5. Monitoring of ‘Safe and Well’ checks in homes and incorporating a summary of these into reports and updates into the Information Sharing Group.
6. Performance subgroup to include and monitor organisational measures in core data set.

5. Service user reference group

Underpinning the work of the subgroups and task and finish groups is the board's service user reference group.

Purpose

To ensure that people who use services and their carers and families play a central role in the development of local safeguarding policy and practice through oversight of and contribution to the work of the LSAB.

Increase direct engagement between the LSAB and people in local communities who are service users of agencies with safeguarding responsibilities.

The group identify with the six safeguarding principles and their work plan and ethic are based around these:

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

Prevention: It is better to take action before harm occurs

Proportionality: The least intrusive response appropriate to the risk presented

Protection: Support and representation for those in greatest need

Partnership: Local solutions through services working with their communities – communities have a part to play in preventing, detecting and reporting neglect and abuse

Accountability and transparency in safeguarding practice

Priorities for 2016-2017

1. To develop systems for sustainable 'expert-by-experience' feedback between local communities and LSAB.
2. To ensure that wishes, feelings and aspirations of people who have been involved with safeguarding events are accurately and fairly represented.
3. To ensure that public participation and awareness raising work of LSAB is fair and effective in terms of the process undertaken and the outcomes achieved.
4. To achieve and advance user representation.

Membership

The group consists of representatives from the local community alongside professionals from agencies with safeguarding responsibilities. Each agency identifies one professional member and one user representative (where appropriate) to join the group. Other group members are drawn from the wider public, including carers and family members, local authority staff, provider agencies, existing user groups and advocacy organisations.

Service user representatives from local organisations include:

- Age UK Leicestershire
- The Carers Centre
- Danbury Gardens / Hanover Housing
- De Montfort University
- Genesis
- Gypsy and Travellers Liaison Officer
- Healthwatch

- Leicester Centre for Integrated Living (LCIL)
- Leicester Ageing Together
- Leicester City Clinical Commissioning Group (CCG)
- Leicester City Council, Housing
- Leicester City Council, Safeguarding and Professional Standards
- Leicester LGBT Centre
- Leicester Safeguarding Adults Board (LSAB)
- Leicestershire Action for Mental Health Project (LAMP)
- Leicestershire Partnership NHS Trust (LPT)
- Leicestershire Police
- Living Without Abuse (LWA)
- Mosaic
- The Race Equality Centre
- Shama Women's Centre
- University of Leicester
- University Hospitals of Leicester (UHL)

We also have two regular service users in attendance.

Key Achievements

- The group has provided a consultative platform for key LSAB work (e.g. business plan and annual report)
- Participated in the production of a service user voice video and prepared materials for it to be utilised within a training package.
- The group has worked with the Making Safeguarding Personal (MSP) task and finish group - this group implemented MSP within Leicester. Now all service users who have been through a safeguarding process are asked a standard set of questions throughout to ensure their views are sought formally at various stages.
- Created 'standardised' questions to ask service users within the East Midland Safeguarding Adults Network
- Populated a library of awareness dates calendar and identified opportunities to engage
- Undertook research into generating a social media campaign
- Commenced research into sustainable membership models with a view to increase recruitment and retention of service users in the group
- Forged relationships with existing LSAB subgroups with the performance and training brief
- Drafted a communications strategy

Priorities for 2017-2018

The service user reference group will become a formal subgroup of LSAB with a new name: Engagement subgroup. The newly formed subgroup's priorities will be:

1. To review the terms of reference and ensure the broader remit is reflected.
2. To ensure that the wishes, feelings and aspirations of people who have been involved with safeguarding events and their carers are accurately and fairly represented.
3. To develop a sustainable approach to gathering additional qualitative feedback from people who have been involved with a safeguarding event.
4. To ensure an agreed public facing communications action plan that provides assurance that safeguarding messages are reaching all communities.
5. To develop the interface between users and the LSAB and its subgroups / task and finish groups, so that engagement is meaningful and has impact.

6. Partner statements

Organisation name:
Leicester City Council Adult Social Care

Name of person(s) completing the report:
Jane Boulton

Overview 2016/17:

Leicester City Council has statutory responsibilities for safeguarding activity, as defined within the Care Act, including the establishment of a Safeguarding Adults Board.

The Leicester Safeguarding Adults Board (LSAB) office continues to be hosted within the local authority and sits within Adult Social Care (ASC), in the Safeguarding and Professional Standards team, with oversight from the Head of Safeguarding and Professional Standards. This arrangement ensures a link between strategy, performance and operational processes and facilitates continuous learning and practice improvements relating to safeguarding.

ASC received 2672 safeguarding alerts during 2016/17, with 690 meeting the threshold to progress to a safeguarding enquiry.

Adjusting for repeat alerts, the safeguarding activity relates to 609 people:

- 262 were aged 18-64, with 347 aged 65 or over
- 366 were female and 243 were male

The percentage figures for the three largest ethnic groups are as follows:

69% White (423/609)
17% Asian (106/609)
5% Black (28/609)

In terms of Making Safeguarding Personal, people are asked to identify their desired outcomes from the safeguarding process. 88.8% of individuals who were asked for and gave desired safeguarding outcomes had these outcomes fully or partially met in 2016/17.

Over the last 12 months work has continued to strengthen the approach to safeguarding activity and to make both processes and data collection more robust – all aimed at providing a sufficient level of assurance about the provision of consistent and high quality activity and positive outcomes for service users.

There has been continued investment in the development of partnership work, which has resulted in positive professional relationships. Where possible, work has been approached and progressed from a Leicester, Leicestershire and Rutland (LLR) / multi-agency perspective.

Internal safeguarding adults governance and audit arrangements:

- The ASC performance unit is responsible for safeguarding data collection, which is shared with the LSAB and subgroups. Safeguarding data is reported quarterly to the ASC leadership team in the form of the integrated performance report
- ASC has become a member of the LLR multi-agency audit group and participated in an MSP audit. A programme of audit will be set for 17/18 and is likely to include threshold decisions, complex cases and exploration of “outcomes not met” under MSP.

- ASC has undertaken single agency audits looking at repeat referrals and has introduced a structured programme of audit across ASC. There is an option for a thematic approach to audit activity which for 17/18 will include safeguarding related activity (MSP, Vulnerable Adults Risk Management (VARM) et al.). Audit activity is monitored via the Professional Standards and Governance Board (PSGB).
- Revised safeguarding metrics have been developed and will add a richness of data moving forward into 17/18. A separate process will be introduced to consider timeliness of concluding safeguarding enquiries
- Learning events routinely arranged following SARs / DHRs to disseminate and implement practice requirements identified in action plans
- Process established for monthly oversight / confirm and challenge meetings with health colleagues who undertake S42 enquiries in NHS settings on behalf of the local authority
- Completion of SAAF (Safeguarding Adults Assurance Framework) for LSAB

Safeguarding adult work undertaken and key achievements:

- Safeguarding included as a key strategic objective for ASC
- Regular attendance at LSAB, subgroups and active contribution to meeting aims and objectives – includes LLR MSP task and finish group, LLR audit group, LLR policies and procedures subgroup, Performance Effectiveness and Quality (PEQ) subgroup, and Adult, Review and Learning Group (ARLG) subgroup
- Development of an LLR VARM
- Development of more robust arrangements for implementing and embedding MSP, including improved data collection
- Involvement in the development of clear and concise LSAB business plan
- Involved in SARs / DHRs / multi-agency case file audits and dissemination of organisational learning within the local authority. Three workshops held for operational team leaders to consider the organisational learning arising from the reviews
- Active participation in pilot peer review of LSAB – positive feedback received in terms of being aspirational, with a clear ambition to improve
- Revised activity and business process measures developed
- Reviewed arrangements for user engagement – led on the development for a new post for LSAB engagement officer
- In the process of developing an LLR training offer to cover core and key areas of safeguarding
- Oversight procedure for S42 enquiries undertaken in NHS settings agreed within LLR
- The principal social worker (PSW) has taken a lead role in terms of the interface with operational best practice and the agreed priorities of the LSAB

Best practice example (how we have supported an adult at risk of harm and abuse to keep safe, prevent harm, abuse and neglect or helped the person to access justice etc.):

The development of a revised LLR, multi-agency VARM and associated awareness raising within organisations has made a positive contribution to keeping people safe from harm. One specific example included a man with a history of non-engagement with statutory agencies, with numerous safeguarding related alerts being made. Through a systematic, multi-agency approach to the concerns, adhering to the principles of MSP, it was possible to secure a level of engagement sufficient to put in place proportionate measures to reduce the identified risks.

How we engaged and consulted with local people and or adults at risk of harm or abuse and how this impacted on our safeguarding adults work:

- MSP LLR multi-agency audits undertaken – although small in scale, useful feedback/ assurance was obtained. As a result, changes were made to data collection to ensure appropriate information was obtained. Furthermore, a commitment has been given to incorporate the voice of the person into all future audit activity.
- Active involvement with LSAB service user reference group – in order to ensure that the user voice remains central to safeguarding activity, the principal social worker has been offered as a named link to ASC. Furthermore, ASC has taken a lead role in the development of the revised LSAB engagement officer post, with a focus on increasing and improving the level of user engagement – especially within groups and communities considered "hard to reach".

The challenges:

- To ensure that data collection is sufficiently robust to gather meaningful and accurate intelligence to provide assurance in terms of safeguarding activity and to inform practice and performance improvements
- To increase the level of user engagement and feedback
- To review the training offer and consider the most effective delivery of key training

Awareness raising and staff training:

- Safeguarding competencies exist across ASC, although further work is required in terms of measuring effectiveness against the existing competencies
- E-learning modules for core safeguarding activity
- LLR training offer under development to meet the immediate training needs of frontline staff and managers – to be ASC led, but through Workforce Training and Awareness subgroup
- Options for the delivery of training within ASC are currently under review
- ASC staff have access to UAVA (United Against Violence and Abuse), MARAC (Multi-Agency Risk Assessment Conference) and MAPPA (Multi-Agency PublicProtection Arrangements) training – and these need to continue to be promoted

The deprivation of liberty safeguards (DoLS) activity 2016/17

DoLS Activity	Number of DoLS assessments requested City DoLS service	Leicester	LCC/DoLS	344	362	416	390
DoLS Activity	Number of assessments on the waiting list	Leicester	LCC/DoLS	617	582	637	630
DoLS Activity	Number of assessments on the waiting list by type - UHL	Leicester	LCC/DoLS	105	49	22	21
DoLS Activity	Number of assessments on the waiting list by type - LPT	Leicester	LCC/DoLS	29	46	52	22
DoLS Activity	Number of assessments on the waiting list by type - Care Homes	Leicester	LCC/DoLS	483	487	563	630

Adult Social Care (ASC) currently has six full-time best interest assessors (BIA). The current number of pooled BIAs has increased over the past year to 13. Each pooled BIA is required to undertake six assessments per year (if they are full-time employed), or four if they are working on a part-time basis or employed as a team leader. A further four individuals are being supported to train as BIAs beginning September 2017. They should qualify by April 2018 which, if successful will raise the pooled resource to 17 and further assist in being able to increase service output.

During the 2016/2017 financial year the local authority reduced the number of independent BIA's utilised due to both a mixture of increased cost and financial burden upon ASC, as well as not having the infrastructure to be able to process the volume of work required. During this period two full-time DoLS administrators were recruited. This resulted in the DoLS service having 2.6 DoLS administrators thereby bringing a period of stability in processing the work when looking forward.

Over the past year the Adult Social Care has increased the number of signatories for authorisation and sign off increase from 10 to 12. Sign off by a senior manager with sufficient knowledge is crucial in ensuring that those assessments completed are of sufficient quality to withstand legal challenge and ensures that the rights of individuals are safeguarded.

The DoLS activity table shows that, quarter by quarter, there continues to be a backlog of cases awaiting assessment. The safeguards provided under DoLS for people who are deprived of their liberty, of course, do not protect the people on the waiting list and hence the LSAB has included this on its risk register for ongoing monitoring and improvement.

Adult Social Care has reviewed the way cases are prioritised and continues to focus on reducing the backlog of new referrals from April 2017. This is in recognition of the risks when an adult, their situation and any risks are not known. ASC has continued over the past year to not automatically assess individuals where a standard DoLS authorisation had previously been granted. This was a necessary action undertaken, but has had the positive impact of ensuring that we have been able to assess more individuals for whom we had never received an assessment under DoLS and for whom without assessment, identifying true risk to the individual was difficult to gauge. For those individuals for whom the DoLS authorisation has since expired, there is an agreement with the existing paid person's representatives (PPR) to remain supporting those individuals. This provides an added safeguard to ensure that if circumstances do change for the individual then assessment under DoLS can be re-prioritised.

Organisation name:
Leicestershire Police

Name of person(s) completing the report:
Barney Thorne

Overview 2016/17:

- In 2015/2016 we made 7,782 referrals, 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 (PVP4) training programme (data has been supplied to the board throughout the year). 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 an HMIC (Her Majesty's Inspectorate of Constabulary) review Leicestershire Police has stopped reviewing high-risk assessments as 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 Domestic Abuse 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.
- Since the Blueprint programme started in 2016, around 150 ambassadors have signed up to be involved in this major initiative and help to shape the future of policing in Leicester, Leicestershire and Rutland. The Blueprint programme will assist the force in restructuring and realising the budget which has been set for Leicestershire Police.

Internal safeguarding adults governance and audit arrangements:

- Growth in senior management within Crime and Intelligence Directorate (CAID). There is now an additional detective chief inspector (Siobhan Barber) to assist with SCRs, SARs and DHRs.
- Growth in staff and constable position within specialist departments within CAID.
- Adult Referral Team now has two detective constable posts. These posts support the force in investigations around care homes and other significant safeguarding adults investigations.
- Governance structure: daily DMM (conference call) which addresses immediate tasking and resourcing issues; monthly Crime and Intelligence Directorate (CAID) tasking and co-ordination meeting which discusses data, resource issues, specific tasking; Performance Development Group which discusses performance at chief officer level. This is supported by Force and directorate audit regimes, and management of departmental action plans derived from Force, regional and national objectives. Governance also provided via HMIC and safeguarding board audits.

Safeguarding adult work undertaken and key achievements:

- Safeguarding Vulnerability Hub has successfully integrated CPN's, drug and alcohol workers, PCSO's, mental health PC's, the Adult Referral Team and the mental health triage car.
- A bid has been submitted to the Home Office for access to funding in regard to the Violence Against Women and Girls national strategy. This bid was written alongside partners from the Police, Police and Crime Commissioner, local authorities (LLR) and third-party agencies.
- Leicestershire Police are the only police force in the country to run a Real-time Suicide Surveillance Programme. Alongside partners from the local authorities (Public Health) we have begun to analyse data which allows us to respond to suspected self-inflicted deaths. We have also implemented a referral system for those bereaved by suicide.

Best practice example (how we have supported an adult at risk of harm and abuse to keep safe, prevent harm, abuse and neglect or helped the person to access justice etc.):

- During the cold winter months local police community support officers (PCSO) 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 widows and there was

evidence of extreme damp in the property along with evidence of no personal care, the property being in 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.

- 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.

How we engaged and consulted with local people and or adults at risk of harm or abuse and how this impacted on our safeguarding adults work:

- As an organisation we have regular contact in many different forms with the public, each case is unique and on occasions present challenges on how we as an agency respond which in turn influences our policies and procedures.
- We have engagement with a variety of multi-agency sub groups to share information around how we and partner agencies respond to the public. Multi-agency audits are completed to better understand our business and how we need to adapt it to meet the needs of local people and adults at risk of harm.
- Regular attendance at the User Carer Group meetings has given opportunities for service users to feed back their experiences and influence both ours and our partner agencies' work.

The challenges:

- 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 / remove this demand.
- To better engage with private sector partners with a view of sharing reducing demand.

Awareness raising and staff training:

- PVP4 training programme continues to be updated. This year has seen a module addition on Making Safeguarding Personal (MSP). The programme now includes modules on domestic abuse, FGM (female genital mutilation), honour based abuse / forced marriage, crime in adult care settings, Voice of the Child, CSE, mental health, Missing, human trafficking and modern slavery, vulnerability referral forms & crime recording, sexual violence and MSP. Over 5,000 packages have been completed by officers in 2016/2017.
- A series of regular updates by the DCI Adult Safeguarding continues to be rolled out, following the format of PVP and including any learning points arising from SCRs, SARs, DHRs or the internal audit results.

Organisation name:
University Hospitals Leicester NHS Trust

Name of person(s) completing the report:
Michael Clayton

University Hospitals of Leicester NHS
NHS Trust

Overview 2016/17:

University Hospitals of Leicester NHS Trust is a large organisation which 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 LSAB in particular.

We have been involved in the new multi-agency audits developed by the board, 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; thereby strengthening the voice of service users during adult safeguarding investigations.

In 2016 the Trust had two comprehensive inspections by the Care Quality Commission, 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:

- We reviewed our approach to safeguarding training
- Introduced new guidance and training for staff on the use of the Mental Capacity Act
- Introduced new guidance on the application of consent for people who lack capacity to make decisions

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 domestic violence advocate to work in our emergency department.

Internal safeguarding adults governance and audit arrangements:

The Trust has an internal safeguarding assurance committee which meets monthly. There is representation from all clinical management groups and also a patient partner.

The purpose of this group is to share information and undertake internal scrutiny of the Trust's safeguarding arrangements.

On a quarterly basis updates are proved to the Trust's Executive Quality Group which is a subgroup of the board.

As part of the contractual arrangements with Clinical Commissioning Groups a quarterly performance data submission is made to Leicester City CCG.

The Trust is regulated by the Care Quality Commission who inspect and monitor the Trust's performance. They undertook a comprehensive inspection in July 2016, and published their findings report in January 2017.

The Trust undertakes both internal audits and participates in multi-agency audits to review the effectiveness of safeguarding practice

Safeguarding adult work undertaken and key achievements:

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.

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Best practice example (how we have supported an adult at risk of harm and abuse to keep safe, prevent harm, abuse and neglect or helped the person to access justice etc.):

During 2016 in partnership with the LSAB, we undertook targeted work to ensure the voice of adults was captured in our safeguarding investigations.

We have completed work to ensure the MSP principles are captured in investigations.

By listening to the views of service users we have been able to ensure that investigations consider the opinions of service users.

The inclusion of a patient partner onto our safeguarding assurance committee has ensured that the view of services users is represented in our safeguarding development plans.

How we engaged and consulted with local people and or adults at risk of harm or abuse and how this impacted on our safeguarding adults work:

- As outlined earlier
- Adopting Making Safeguarding Personal
- Introduction of a patient partner

The challenges:

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 areas:

- We are going to review our approach to information sharing and liaison work for children and families requiring early help.
- Complete further work to introduce the national child information sharing project.
- Complete further internal audits to ensure that practice in consent to treatment and detecting safeguarding issues in our emergency department are embedded.

Awareness raising & staff training:

- All staff are required to have safeguarding adult training and there is a tiered approach to training dependent on staff roles and responsibilities.
- Clinical staff are also required to attend training on mental capacity, consent, DoLs and Prevent.
- Performance is monitored monthly.

Organisation name:

National Probation Service – Leicester, Leicestershire and Rutland (LLR) Cluster

Name of person(s) completing the report:

Michael Hopkinson

Overview 2016/17:

The National Probation Service (NPS) continues to experience a period of significant change. After the organisational restructures of Probation services under Transforming Rehabilitation in June 2014 resulted in the establishment of the National Probation Service and an array of Community Rehabilitation Companies (CRCs), the NPS Efficiency, Effectiveness and Excellence (E3) review over the past eighteen months has effected significant change once again. Phase1 of this review has led to significant changes within community supervision, Approved Premises and Courts, with further changes on the horizon to our work with victims, within prisons and within MAPPA.

Encouragingly, in spite of these challenges, LLR was the top performing cluster within the Midlands division, continuing to deliver a positive service to offenders, victims, our partner agencies and communities. We have been involved in thematic reviews relating to rehabilitative activity and the impact of novel psychoactive substance misuse on offenders, and contributed to research on how staff are supported in working with difficult and challenging offender groups. In spite of organisational and re-organisational pressures, LLR remain committed to delivering a quality service, and learning from our practice and partnerships.

Internal safeguarding adults governance and audit arrangements:

The Senior Operational Support Manager (Deputy Head) for NPS – LLR has functional responsibility for adult safeguarding, and reports back to the Head of Service.

The core work of the NPS is the assessment and management of harm. This may include those who present a risk of serious harm, vulnerable individuals and victims. In terms of audit arrangements, adult safeguarding is not specifically targeted, but is a consistent thread throughout quality assurance and auditing of case management and court reports. This means that the context of any audit that is conducted is around the management of risk of serious harm and vulnerability. Offender Assessment System (OASys) assessments require the vulnerability of all cases to be assessed – this includes self-harm, suicide, learning disabilities etc. An Equality Information Form is completed with every service user, to identify potential vulnerabilities, as is a self-assessment questionnaire. Where needs are identified, the expectation is that the Offender Manager will then make contact with the necessary service provider. Quality assurance and case audits of OASys and pre-sentence reports highlights any deficits or areas for development, which is then fed back to the operational staff and their managers.

Safeguarding adult work undertaken and key achievements:

Throughout the transitional period, NPS have continued to ensure that the core adult safeguarding training has been delivered. This now takes place via e-learning followed by a classroom event.

As is the case each year, it remains difficult to separate out the key achievements as adult safeguarding is an intrinsic part of the work of the National Probation Service. Adult safeguarding remains a key consideration of the work of MAPPA and, as such, they continue to make a significant contribution to the management of those cases where safeguarding is an issue.

Best practice example (how we have supported an adult at risk of harm and abuse to keep safe, prevent harm, abuse and neglect or helped the person to access justice etc.):

A best practice example was Probation staff's work with L, a high risk offender with a long history of Exposure offences who was managed at MAPPA Level 2. As a teenager L had been the victim of a road traffic accident, leaving him with significant physical disabilities. In addition, he had been diagnosed with schizophrenia and was himself considered a vulnerable adult. The quality of the Probation Officer's work with him was outstanding, with extensive joint work with MOSOVO police staff and liaison with Adult Social Care (ASC) and housing. The Probation Officer worked hard to address the limitations of how referrals are dealt with by ASC and housing whilst an offender is in custody. The crux of the issue was that despite a request made whilst he was in custody for him to be the subject of a community care assessment, this became a lengthy, protracted process and not completed within a reasonable time frame. The delay meant that L was not able to access appropriate accommodation upon release. Extensive liaison was undertaken between the Probation accommodation officer and housing, who, once on board, worked diligently to source appropriate accommodation. It was as a direct result of Probation's intervention, perseverance and dedication that the offender finally secured his own tenancy, with a care package put in place including intensive support of daily contact and care, enabling L to retain as much independence as possible whilst also meeting his care needs. This supported the vulnerable adult L, but also contributed to effective safeguarding of potential victims by managing his risk.

How we engaged and consulted with local people and or adults at risk of harm or abuse and how this impacted on our safeguarding adults work:

Over the past year, NPS LLR have:

- Implemented the Offender Survey. This is a national survey that is carried out once each year. The surveys are collated and the results published. The information gathered is then used to inform safeguarding adults work.
- Completed a full OASys assessment on every offender we supervise. 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.

- Encouraged and support every offender to complete a self-assessment questionnaire which would provide a further opportunity to identify adult safeguarding issues.
- Continued to use BTEI (Birmingham Treatment Effectiveness Initiative) maps with offenders, of which one of the purposes is to identify adult safeguarding issues.
- Implemented a new equality information form, for us to capture data at the earliest point of contact with a service user, to inform how we work with them in a responsive and considered approach.

The challenges:

Unfortunately, whilst looking back over the progress made in this past year, it is still reported by operational staff that they continue to struggle to obtain services for adults who are vulnerable or particularly challenging. The most common frustration seems to relate to case closures when a case enters custody; rather than the case being placed on hold, decisions are often made to close the case which then causes significant work trying to reopen the case or requesting assessments closer to the offender's release.

The loss of our linked Community Psychiatric Nurses and lower level provision through Improved Access to Psychological Therapies was also significant in this past year. This provision, via the Liaison and Diversion scheme, was reported as being particularly helpful both by offenders using the service, and by Probation staff for the added value it provided the case and how it informed their case management. Staff have since reported their frustrations at subsequently accessing services for vulnerable service users, or struggling to secure advice or information about how best to work with a service user.

Awareness raising and staff training:

As a result of the E3 review, a large number of staff have already moved or are in the process of moving to new teams and new areas of working. There has been a significant drive over the past year to ensure that all staff across all grades complete safeguarding adults workbooks, with a view to completing face-to-face training to reinforce the learning and offer opportunities to discuss issues with trainers. Feedback from the Divisional Training Unit in relation to LLR's roll-out of Adult Safeguarding training is encouraging, with just over 80% of our current staff having completed the workbook in 2017. Adult safeguarding face-to-face events are now planned throughout 2017, for those who have completed the workbook to attend and further develop their knowledge and understanding of safeguarding issues.

In addition to the Training Unit's roll-out of adult safeguarding training, LLR have maintained the Senior Probation Officer who leads on diversity and equality. She is now part of a Midlands network of diversity leads who co-ordinate and deliver input to operational and support staff. She is supported by our Divisional Equality and Diversity Manager.

LLR and the broader NPS continue to review all Serious Further Offences, where an offender under our supervision commits various violent or sexual offences. Feedback

over this past year has been encouraging, indicating staff are managing their cases to a good standard. Learning points from Serious Further Offences, together with information and learning from DHRs and SARs are shared with managers in senior leadership meetings, and then filtered to operational staff in team briefings. Additionally, staff are frequently invited to attend events delivered by partners, charities etc. in order to extend their knowledge and facilitate closer working relationships.

Organisation name:
Leicestershire Partnership NHS Trust (LPT)

Name of person(s) completing the report:
Rachel Garton

Overview 2016/17:

2016/17 has seen an increased commitment with LPT (Leicestershire Partnership NHS Trust) to support the safeguarding agenda at both a strategic and operational level. We have strengthened the safeguarding governance arrangements and the work programme for the forthcoming year will build on these foundations, this will enable us to incorporate and prioritise new emergent themes and challenges. Our partnership working with other agencies has continued, and new members of the safeguarding team as well as the appointed Head of Professional Practice have been able to forge effective working relationships, to strengthen our ability to safeguard vulnerable adults, families, young people and children.

Ensuring that safeguarding is at the heart of the organisation within every aspect of patient care, has been a significant priority for the Trust following on from the Care Quality Commission (CQC) Review of Health Services for Children Looked After & Safeguarding in Leicester City, published in August 2016. In response to the CQC report the Trust has embraced the development of the 'Whole Family Approach' to safeguarding. The Whole Family Approach is our local safeguarding strategy that recognises the need of the child or vulnerable adult within their family and to improve processes and procedures to ensure strong communication and joined up working between teams across Leicestershire Partnership NHS Trust (LPT) for the benefit of everyone in a family.

The safeguarding team will continue to work in partnership with staff across all directorates as well as multi-agency partners to ensure that:

- Families, vulnerable adults, young people and children are kept safe
- Practice, policies and guidance are developed
- New and innovative training opportunities are provided
- Service delivery is quality assured
- Investigations are conducted when things go wrong
- Lessons learned are shared to inform changes in practice for continuous improvement

Internal safeguarding adults governance and audit arrangements:

The safeguarding governances structure and the safeguarding annual audit plan are available on request.

Safeguarding adult work undertaken and key achievements:

- Strengthened the safeguarding governance structures particularly within adult mental health (AMH)
- Development of a model for Whole Family working, including Whole Family training, easier access to workers details to ensure greater information sharing and an associated communication strategy.

- Development of a robust internal and external audit plan.
- Completion of a MCA case note audit to test out areas of improvement following 2015-16 audit and inspection.
- MSP embedded within sec 42 enquires across LPT
- Commissioned an improved safeguarding adult database which will enable streamlined retrieval of data for evidence and outcomes.
- Developed a Trust wide MCA improvement plan.

Best practice example (how we have supported an adult at risk of harm and abuse to keep safe, prevent harm, abuse and neglect or helped the person to access justice etc.):

The adult safeguarding team review all incidents within LPT to identify those that meet LLR thresholds and to also identify themes within service areas. An increase in patient on patient racial abuse was noted within a particular AMH acute inpatient area and the specialist nurse was able to visit the area and establish from the ward manager the difficulties managing a group of young males who were being racially abusive to each other. This had led to verbal and physical altercations with various victims and perpetrators. With the support of LPT hate crime lead and police hate crime officer the specialist nurse was able to facilitate targeted joint work within this area which included raising awareness of hate crime and consequences of engaging in such activity. The multi-disciplinary team was also involved and was supported to enforce a zero tolerance approach ensuring that patients were made aware of the consequences and the impact on their care and treatment if they participated in hate crime activity.

This example identifies how with partner agencies, LPT was able to remove the risk of harm occurring both to the victim and alleged perpetrators but also improve the environment for all patients creating a safer experience whilst an inpatient. This also improved the working atmosphere for staff, raised awareness amongst staff of hate crime and reduced the number of racial abuse incidents and physical assaults.

How we engaged and consulted with local people and or adults at risk of harm or abuse and how this impacted on our safeguarding adults work:

In LPT this has been an area of challenge, however 2016/17 has seen the implementation of Making Safeguarding Personal, which champions greater collaborative working with service users in protecting them from harm and abuse. Greater involvement of service users and cares in safeguarding is a key priority for LPT 2017/18 and is included in LPT's safeguarding Whole Family Annual Report.

The challenges:

- Delivery of the MCA improvement strategy, within expected timescales across all areas of the Trust.
- To meet the growing demands of the safeguarding agenda to a consistent high standard.

Awareness raising & staff training:

- In 2016/17 LPT developed a new approach to safeguarding training. From April 2017 Adult and Children staff will receive all safeguarding training together and there is a move away from traditional level 2 and 3 safeguarding training towards a Whole Family approach to training.
- Additional Whole Family e-learning modules are being developed to support staff.
- Prevent WRAP training forms part of safeguarding training, as does MAPPA training.
- An MCA Champions group was developed in 2015 and this has gained momentum in 2016/17, helpings staff to be more aware of and better supported in exercising their duties under the MCA and DoLS.
- A program for increased safeguarding supervision and visibility in clinical areas is planned for 2017/18.

Organisation name:
Leicester City CCG

Name of person(s) completing the report:
Adrian Spanswick

NHS
Leicester City
Clinical Commissioning Group

Overview 2016/17:

Leicester City CCG is a statutory NHS body with a range of statutory duties, including safeguarding adults and children. CCGs are responsible for commissioning most hospital and community healthcare services. CCGs as commissioners of local health services need to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place.

The Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHS England 2015) outlines clearly that safeguarding is a fundamental element of commissioning and describes how CCGs meet their statutory responsibilities.

Leicester City CCG has the following appropriate systems in place for discharging their statutory duties in terms of safeguarding:

- A named executive lead who takes overall leadership and responsibility for the organisation's safeguarding arrangements, currently this is the Director of Nursing and Quality
- The Director of Nursing and Quality chairs a safeguarding group for the Leicester City, Leicestershire and Rutland CCGs.
- CCG policies setting out a commitment and approach to safeguarding, including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults as appropriate.
- A CCG safeguarding adults training programme for GPs.
- LCCCG is represented at senior level at LSAB by the Director of Nursing and Quality, with support from the Consultant/Designated Nurse Safeguarding (children and adults). In addition the CCG hosted safeguarding team proactively contributes to the subgroups of the board.

Internal safeguarding adults governance and audit arrangements:

The CCG provides assurance to NHS England that it is discharging their safeguarding duties, by completing a dedicated template and electronic system, which has been established in 2016. The hosted safeguarding team contributed to its development.

Additional scrutiny and accountability in relation to the work of the CCG hosted safeguarding team, the Director of Nursing and Quality hosts a monthly meeting with the Consultant and Designated Nurse and Leicestershire and Rutland Chief Nurses to provide strategic leadership and manage any identified risks and challenges.

The Leicester City CCG, in partnership with West Leicestershire / East Leicestershire and Rutland CCGs, have a bi-monthly safeguarding group meeting (children and adults), which receives safeguarding reports, case review reports and policies and procedures and discusses key developments. All papers are then reported through the CCG's internal governance processes and the CCG governing body.

The CCG hosted safeguarding team are required to:

i. Complete and submit the safeguarding adult's assurance framework for LSAB on behalf of the CCG.

ii. The CCG gains assurance from all commissioned services which includes NHS statutory and independent healthcare providers using the CCG Safeguarding Assurance Template. (Monitor compliance against NHS Standard Contract S32; Care Act 2014, MCA 2015 and other key areas of legislation.) This activity ensures continuous improvement and may consist of assurance visits to a provider.

iii. Provide regular update and escalation/oversight of team/directorate and organisational risk assessment/ register.

Safeguarding adult work undertaken and key achievements:

CCG contribution to safeguarding adult work in Leicester city:

- The CCG's ongoing commitment and contribution to progress the LSAB business plan.
- There is attendance and contribution from CCG senior executive/CCG hosted safeguarding team at LSAB and all subcommittees of the board.
- Securing and overseeing statutory health provider and primary care engagement for DHRs, SARs, SILPs (Serious Incident Learning Process), and providing support and monitoring of resulting actions.
- Attendance, contribution and oversight provided from a CCG perspective in relation to DHR and SAR panel membership.
- Contribution to the Multi-Agency Improvement Programme processes.

Key achievements:

- High percentages of Leicester City GPs have completed and continue to complete, their safeguarding adults training Level 2 and 3.
- Prevent training programme in place for GPs.
- A successful MCA / DoLS programme funded by NHS England delivered 2016/17 to domiciliary staff; health practitioners and GPs/practice nurses. There was a real emphasis to deliver a comprehensive targeted MCA training to our health providers including general practitioners (GP's) across LLR to improve knowledge and competencies around the application of the Mental Capacity Act and undertaking capacity assessments.

How we engaged and consulted with local people and or adults at risk of harm or abuse and how this impacted on our safeguarding adults work:

Over the past year the engagement team has been an integral part of the CCGs safeguarding adults work. As a member of the LSAB reference group the Head of Engagement and Experience co-wrote a communications plan to assist the LSAB in

disseminating safeguarding information to service users, carers and members of the public. This has helped to put safeguarding at the forefront of our engagement, especially when engaging with a large number of particularly vulnerable groups.

Supporting carers continues to be a focus for the team, with the development of a plan which supports the city-wide Carers Charter. Other notable areas of work concerning vulnerable adults at risk of abuse or harm have included leading an LLR-wide consultation for the procurement of mental health support services and the re-procurement of specialist primary care services, both of which continued our engagement with mental health service users, asylum seekers and the homeless. In February of this year we won a prestigious national patient experience award for our innovative approaches to our engaging with these communities. This has offered assurance to our governing body and providers that we are inclusive in our engagement activities and have strong relationships with local partners to assist us in reaching out to our patients. In the same month we booked onto the Leicester Centre for Integrated Living event 'Choices Unlimited' and made plans to engage with a wide range of disabled service users from across Leicester at the April event.

We have taken part in a number of workshops and events with local people at risk, to encourage people to give their views and get involved and the engagement team has an internal structure in place to make sure that any safeguarding issues can be quickly dealt with should anything arise. This includes providing contact phone numbers at events, and liaising with any issues of concern.

The challenges:

A key challenge facing the CCG is to ensure that GP's and staff understand and are able to apply the Mental Capacity Act 2005 legislation and ensure that staff are able to protect those who lack capacity and enable them to take part, as much as possible in decisions that affect them by being able to apply the principles of the Act. The CCG will continue 2017/18 to support frontline practice by commissioning high quality training.

Organisation name:
Leicestershire Fire and Rescue Service

Name of person(s) completing the report:
Helene Sutliff

Overview 2016/17:

2016/17 was a year of significant restructure, following a period of political turbulence and a change of senior management.

Our work is not restricted to accident response; LFRS is committed to the prevention of accidental injury and premature death and safeguarding forms an integral part of that. The Care Act places a responsibility on us to address the frequent cases of self-neglect we encounter. In 2016/17 we have focussed very much on improving our partnership working. For some years we have had a seconded Detective Police Constable (DCI) with us, and in 2016/17 we also placed a member of our community safety team within the Police Adult Referral team, to manage the response to vulnerable adults more effectively and learn from each other's practice. We have also committed to partnership schemes such as the Braunstone Blues. Much of the work we do with vulnerable adults is carried out by our Community Safety Team, which for several months in 2016/17 was very short staffed, but is now up to full strength.

Internal safeguarding adults governance and audit arrangements:

There is an internal safeguarding lead who acts as the Designated Safeguarding Person and is responsible for policy and arranging appropriate training for staff. In 2016/17 for the first time we have a member of staff responsible for monitoring vulnerable adult cases and case managing them when appropriate. Our Director of Service Delivery has overall responsibility for community risk management, which includes safeguarding.

LFRS has an internal process in place to ensure all safeguarding concerns are submitted through a Vulnerable Persons form which is available to all operational staff and support staff who are working with the community we protect and serve. This includes useful contact numbers for out of office hour's concerns and safeguarding leads internally for guidance.

LFRS does not have specific audit arrangements for adult safeguarding although we would always carry out an internal review of any fire death or serious fire injury. However, with the creation of the new vulnerable person's co-ordinator post this is something we plan to progress.

Nationally, it is early days for Fire Services in determining what constitutes best practice in terms of their internal safeguarding procedures. In early 2017 LFRS attended the first ever national Safeguarding in the Fire Service conference and workshop. We will continue to work with other F&R services to ensure that our own practice is continually improving.

Safeguarding adult work undertaken and key achievements:

In 2016/17 we worked to target our Home Fire Safety Checks (HFSC's) more efficiently to those most at risk. We created a new online partnership referral form and risk matrix, and in some localities we have extended HFSC's to 'Healthy Safe and Secure' visits when we look at a wider range of vulnerabilities and risks. We have led on advice about assessing risks related to hoarding.

In cases of domestic violence, we worked with the police and other agencies, to offer a service to make the victim safer in their home through the fitting of smoke alarms, letterbox security devices, window alarms and tailored advice regarding security and fire safety. We also worked with a psychologist to support delivery of an intervention programme for adult arsonists within a residential mental health setting.

When our staff see vulnerable people in their homes and identify unmet needs over and above what LFRS can support, we contact a range of other agencies to try to reduce the risks to the individual. Additionally, our Fire Prevention Officers, who inspect residential homes and houses of multiple occupancy, have identified risks and worked with housing providers to make those premises safer.

We look at the behaviours and vulnerabilities associated with serious fires in homes; the department restructure in 2016/17 makes it easier for us to 'join up the dots' following a serious fire and to raise awareness of this information both internally and externally.

Best practice example (how we have supported an adult at risk of harm and abuse to keep safe, prevent harm, abuse and neglect or helped the person to access justice etc.):

Our seconded fire officer to the Leicestershire Police adult referral team was made aware of concerns about an elderly man who was a victim of burglary. When police officers attended they raised concerns about his hoarding and the associated fire risk.

The fire officer visited the property to assess the risks highlighted and completed a home fire safety check. The elderly gentleman lived alone in a social housing owned property, he suffered from depression and anxiety and was on medication for various health conditions.

The hoarding in the property was in all rooms with newspapers stacked to ceiling level in most rooms, blocking exits and natural light from windows. The gentleman struggled to dispose of newspapers, believing they had some use, which impacted on his health e.g. the kitchen was inaccessible and he was unable to cook.

Initially the task was to build rapport with the gentleman to offer support for addressing issues such as fires, fall hazards and avalanche conditions. Instead of insisting on an immediate and overwhelming clean-up, an action plan was created with realistic time-scales to reduce clutter to reduce fire risk.

A GP referral was made, and the housing officer was contacted by fire service to assist. The fire and housing officers scheduled regular joint visits to provide

moral support and monitor improvement of decluttering and to remove filled bags.

The gentleman has made significant progress in clearing his home, which has reduced risks to his health and safety. He receives ongoing support from the housing officer who acts as a communication link with other agencies.

How we engaged and consulted with local people and or adults at risk of harm or abuse and how this impacted on our safeguarding adults work:

We worked with partners and residents of Braunstone to build a healthier, safer and more secure community. This year our commitment to the tri-service Braunstone Blues project has had continued success and the project has now been extended to the Highfields area. The 'Blues' teams work in the Braunstone and Highfields area of the city, made up of dedicated personnel from three blue light services that include: Leicestershire Fire and Rescue Service, Leicestershire Police and East Midlands Ambulance Service. The long term aim is to work with partners to create a joined up and informed community that looks after its own. The partnership supports people to become more independent and educated about keeping themselves and their neighbours safe and well, thus reducing the number of emergency calls in the area and the consequent demands on already stretched healthcare resources.

The team carries out home visits to identify problems and offer appropriate advice and support and signposting to other service. People are also offered help with loneliness, anxiety, depression and dealing with antisocial behaviour. Those who have recently been to A&E are targeted. The team has also trained members of the community to deliver free Life Skills courses to Braunstone residents.

Because of the positive response from the community, LFRS aims to extend its current system of home fire safety checks to offer wider 'Healthy Safe and Secure' visits to all areas in 2018.

The challenges:

- Staff will need upskilling to carry out extended safe and well visits. This will also have financial implications at a time when our budget is shrinking.
- Our existing Vulnerable Persons database was not designed to be a case management system, and we need to look at other suitable systems which will facilitate sharing of information between partners and tracking individual cases.
- The delay in national Fire Service guidance for adult safeguarding.
- The vast majority of our alerts about vulnerable adults centre around self-neglect and/or fall below safeguarding thresholds. Consequently, we need to ensure that we embed the VARM model and have an effective working relationship with other support agencies.

Awareness raising and staff training:

Following concerns raised by our fire safety team (who carry out statutory inspections of business premises), we have arranged for the team to receive awareness training in modern slavery and people trafficking. In 2016/17 our community safety educators (who visit people in their homes) have attended training on financial abuse and cybercrime. They have also received input from LCC private sector housing officers so they can in future offer better support to tenants who are at risk.

As we considered that our existing online safeguarding awareness training was not sufficiently relevant to the role of (and therefore meaningful to) fire service staff, we have commissioned a new safeguarding training package which we will roll out in 2017/18. The community safety team have undertaken Prevent training and we are now encouraging firefighters to take this up as well. They also attended a two-day mental health first aid course.

Regular safeguarding reminders and updates are published in our internal Weekly Update.