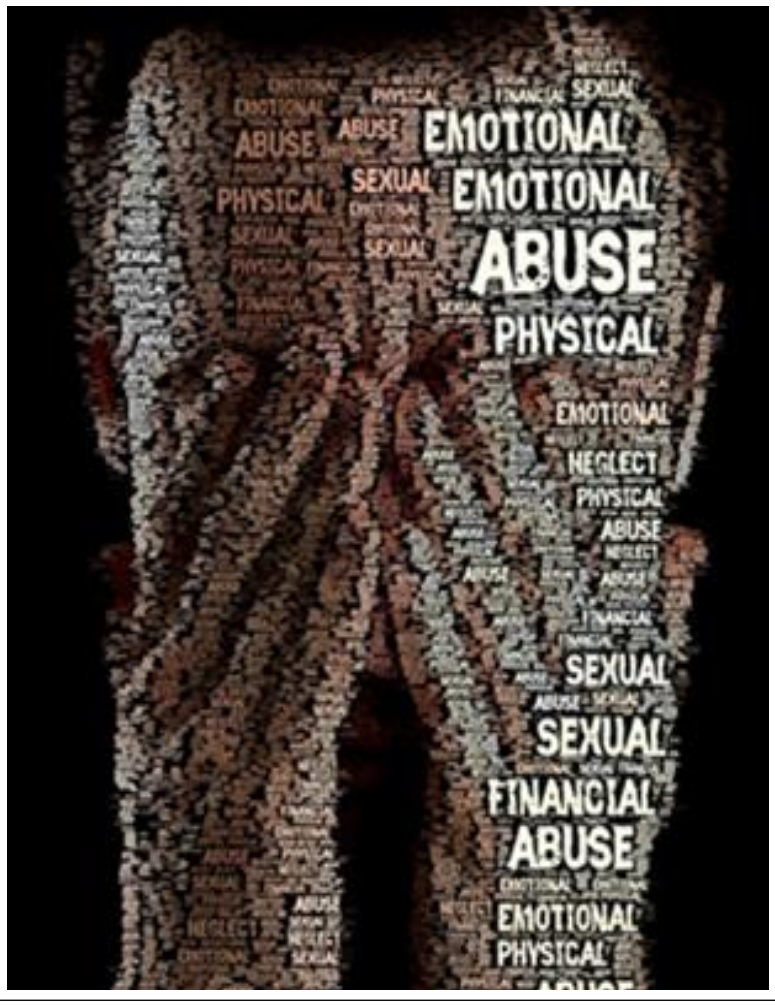
Leicester Safeguarding Adults Board

Annual Report 2015-16



Leicester Safeguarding

Adults Board Office

llradultsafeguarding.co.uk

LSAB@leicester.gov.uk

If you, or someone you know, are being abused, please get in touch...

Telephone

Leicester: **0116 454 1004**

Leicestershire: **0116 305 0004**

Rutland: **01572 758 341**

Leicestershire Police: 101 non emergency, **999** emergency

We work in partnership to keep adults safe in Leicester:

Leicester City Council

NHS

Leicestershire Police
Protecting our communities

LEICESTERSHIRE FIRE and RESCUE SERVICE
protecting our communities

healthwatch Leicester

National Probation Service

Safer Leicester Partnership
Working together for a safer City

Content

Introduction

This is the first report that I am presenting on behalf of the Leicester Safeguarding Adults Board (LSAB) as the new independent chair. Having taken on this role in January 2016 I have met with board members individually and facilitated a board development day in February 2016. The board development day gave us all an opportunity to discuss and decide on 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. It will be my ongoing challenge to provide the leadership necessary to make this strategy a reality. I have been very impressed with the previous achievements and the ongoing commitment of all board members and representatives and am likewise honoured and committed to continuous learning and improvement of local arrangements.

The LSAB continues to work closely with partners across Leicestershire and Rutland and our partners in children's services and the Safeguarding Children Board. Joined up arrangements will be strengthened going forward with continued commitment to the work of the LLR joint executive group. This is aimed at achieving a consistent approach across local boundaries.

We have identified that hearing the voices of adults at risk and involving adults, needs strengthening and this is therefore one of our strategic priority areas going forward. We are seeking to involve adults at risk via the LSAB reference group – to be established during 2016 and have established a task and finish group to embed the principles of 'Making Safeguarding Personal'.

The numbers and types of concerns raised have not varied significantly over the past three years. However, locally we have not had to implement major improvements relating to health and social care providers as has been the case previously.
With national cases of institutional abuse and failure to provide effective care not decreasing, this continues to be an area that the LSAB will monitor.

During last year there was no need to commission any safeguarding adults reviews (SARs). The adult review and learning group will continue to review cases and take account of national learning from cases.

This report represents a summary of the many achievements, agency commitment and overview of local safeguarding activities. The report reflects the work and improvements made and some of the learning we are taking forward to make future improvements.

I am impressed by the commitment of each and every partner agency and would particularly like to thank Councillor Palmer and Councillor Masters for their ongoing involvement, challenge and encouragement. The local Clinical Commissioning Group (CCG), Police and Adult Social Care have provided sufficient funding to enable the board 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)

Background and content

The Care Act 2014 introduced new safeguarding duties for local authorities, including:

- Leading a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens
- Making or causing enquiries to be made where there is a safeguarding concern, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
- Hosting safeguarding adults boards, including the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy
- Carrying out safeguarding adults reviews (SARs) when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them
- Arranging for the provision of independent advocates to represent and support a person who is the subject of a safeguarding enquiry or review, if required

This report will provide a summary of how these requirements are met in Leicester and will provide the necessary overview and assurance that safeguarding arrangements are robust and that the board enables and drives continuous improvement. In this respect we will also summarise and evaluate our 2015/16 strategies for improvement.

Leicester City Council's department for Adult Social Care is the responsible lead agency for providing care services for people in need, including those at risk of abuse. The Leicester Safeguarding Adults Board (LSAB) has given direction, support, guidance and quality assurance to safeguarding adults policies, procedures and practice in Leicester and via its local network across Leicestershire and Rutland. The multi-agency Safeguarding Adults Board's (SAB) role is to promote, inform and support safeguarding adults work. We ensure that priority is given to the prevention of abuse, and adult safeguarding is integrated into other community initiatives as well as links to other relevant inter-agency and community partnerships.

SAB have three core duties under the Care Act 2014 (gov.uk/guidance/care-and-support-statutory-guidance/safeguarding). They must:

(1) Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.

(2) Publish an annual report detailing how effective their work has been.

(3) Commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

This report will summarise how the Leicester Safeguarding Adults Board (LSAB) meets its core duties as well as evaluate the strategic plan it set out for 2015/16 and include the strategic plan for 2016/17.

In addition to the above, the LSAB has agreed to manage the statutory domestic homicide review (DHR) process (gov.uk/government/collections/domestic-homicide-review) on behalf of the Leicester Safer Partnership and, in this respect, we will be providing an update of DHRs and SARs undertaken during the reporting period (1 April 2015 to 31 March 2016).

Safeguarding activities in Leicester 2015/16

Leicester City Council has statutory delegated responsibility under Section 42 of the Care Act 2014 to make enquiries.

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there): -

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this part or otherwise) and if so, what and by whom.

Leicester City Council's Adult Social Care carries out this responsibility with some responsibility delegated and shared with University Hospitals Leicester (UHL) and Leicestershire Partnership Trust (Mental Health Trust). When information is received in relation to abuse, neglect and harm, a decision is made if the 'safeguarding adults thresholds' (as described by the Care Act – quoted) apply and an enquiry under Section 42 should be undertaken. A local procedural document is available for safeguarding practitioners to assist them to make this decision and to ensure consistency and compliance.

A total of 1,404 communications relating to concerns of abuse and neglect were received during 2015/16 by Leicester or its safeguarding partners. 641 of these were not responded to under local safeguarding adults procedures and did not meet the description of an adult at risk.

Table SG1a	Age band						
Counts of individuals by age band	18-64	65-74	75-84	85-94	95+	Not known	Total
Individuals involved in safeguarding concerns	597	176	257	317	43	14	1404
Individuals involved in Section 42 safeguarding enquiries	139	48	44	52	6	0	289
Individuals involved in other safeguarding enquiries	122	44	82	88	15	0	351

The table SG1a above shows that during 2015/16 a total of 640 individuals of a total of 1,404 led to enquiries being made. 289 cases led to Section 42 enquiries and 351 cases were signposted to other processes with a focus on resolving concerns, preventing harm and collating 'soft' information about the safety of care providers for example, indicating when there are 'ongoing' concerns being raised even when they do not meet safeguarding thresholds.

The LSAB receive information relating to all enquiries and are therefore able to take account of a wider range of information. Whilst this report will focus in the main on the analysis of Section 42 (statutory enquiries), it is important to note that the LSAB does have this information available as part of its indicator and data set and that it undertakes analysis of this information. As part of this report we will take account of the outcomes and actions resulting from 'other enquiries'.

Counts of enquiries by action, result and source of risk	Source of risk		
	Social care support	Other-known to individual	Other-unknown to individual
No action taken	38	18	40
Action taken and risk remains	9	11	15
Action taken and risk reduced	83	40	93
Action taken and risk removed	24	5	27

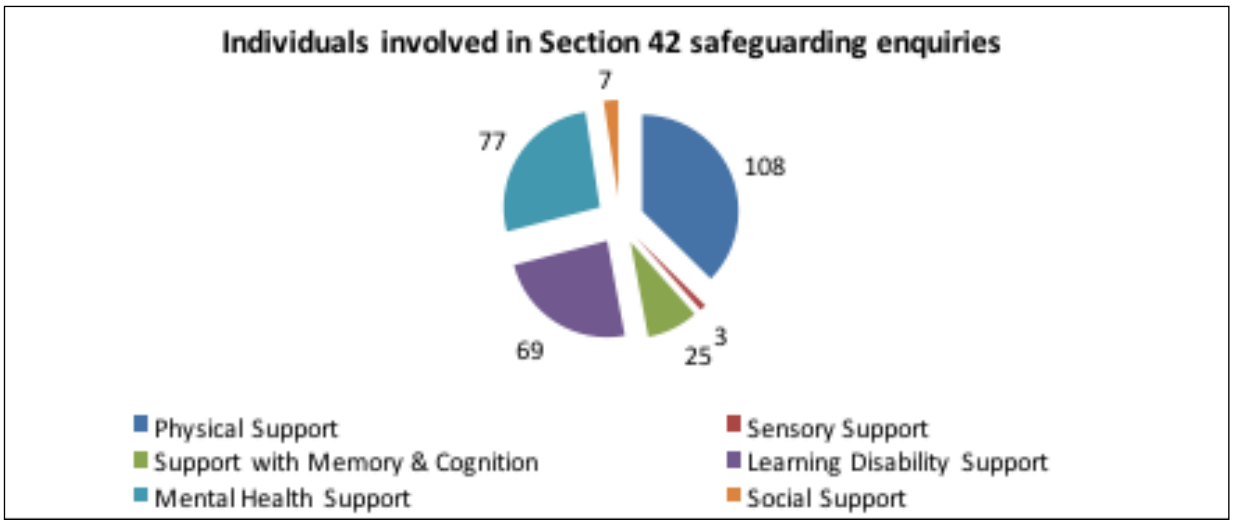
Table SG2 above shows if action was taken and if risks were reduced or remained. The table differentiates the sources of risk – social care support would indicate that the perpetrator is an employed carer and others known or unknown to the victim. Where the person is known this is likely to be family or friends but the data shows that this group faces the highest risk from paid care givers and people not known to them. The data also shows that action is not always taken and risks are not always removed or reduced. This is accepted and appropriate as 'adults at risk' have a right to be able to make and influence decisions relating to any risks that they face. The data however also clearly shows that in the majority of cases there was an opportunity to reduce and remove risks and prevent harm and abuse. The LSAB is assured that 'other enquiries' result in local adults being safer and are assured that help is available to prevent more serious harm, even when safeguarding threshold relating to Section 42 enquiries are not met at the time of information being received.

Analysis - Section 42 Enquiries

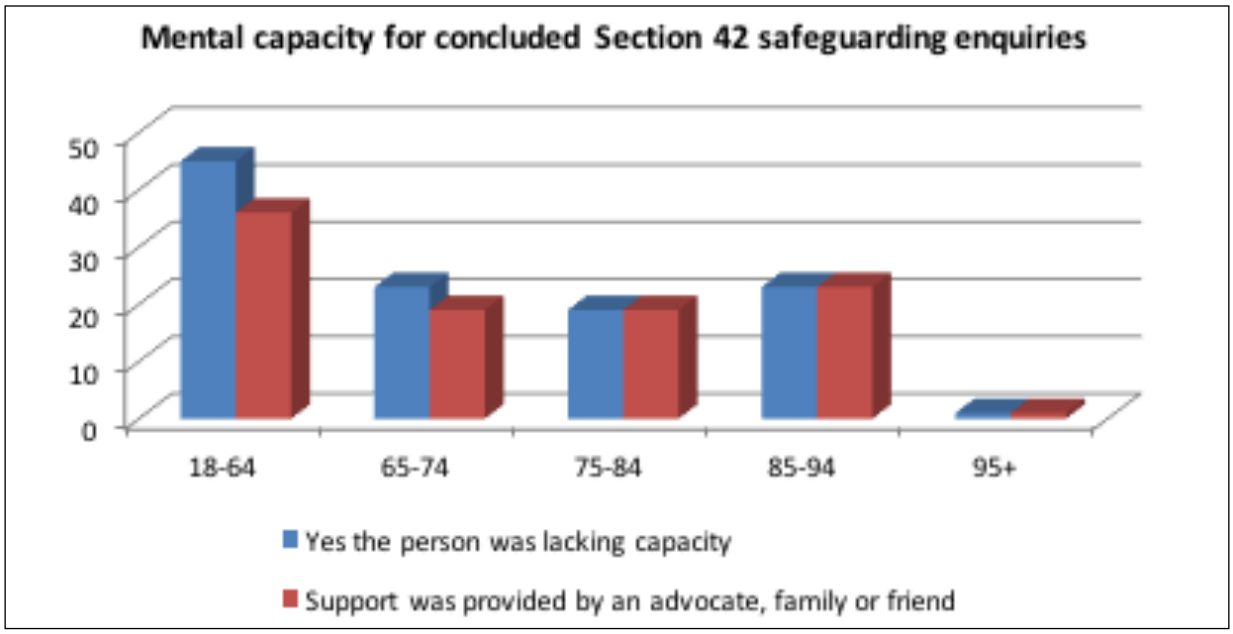
A total of 356 cases lead to Section 42 enquiries being made. Allegations of abuse were spread across the various categories of abuse and in many cases named more than one category.

Category of alleged abuse	Total – all sources
Physical abuse	98
Sexual abuse	14
Psychological abuse	51
Financial or material abuse	97
Discriminatory abuse	5
Organisational abuse	29
Neglect and acts of omission	95
Domestic abuse	7

In order to be eligible, the relevant person (the adult at risk) would have to have support needs that affect their ability (or cause an inability) to prevent harm. Cases taken forward showed that the adults at risk had a variety of support needs.

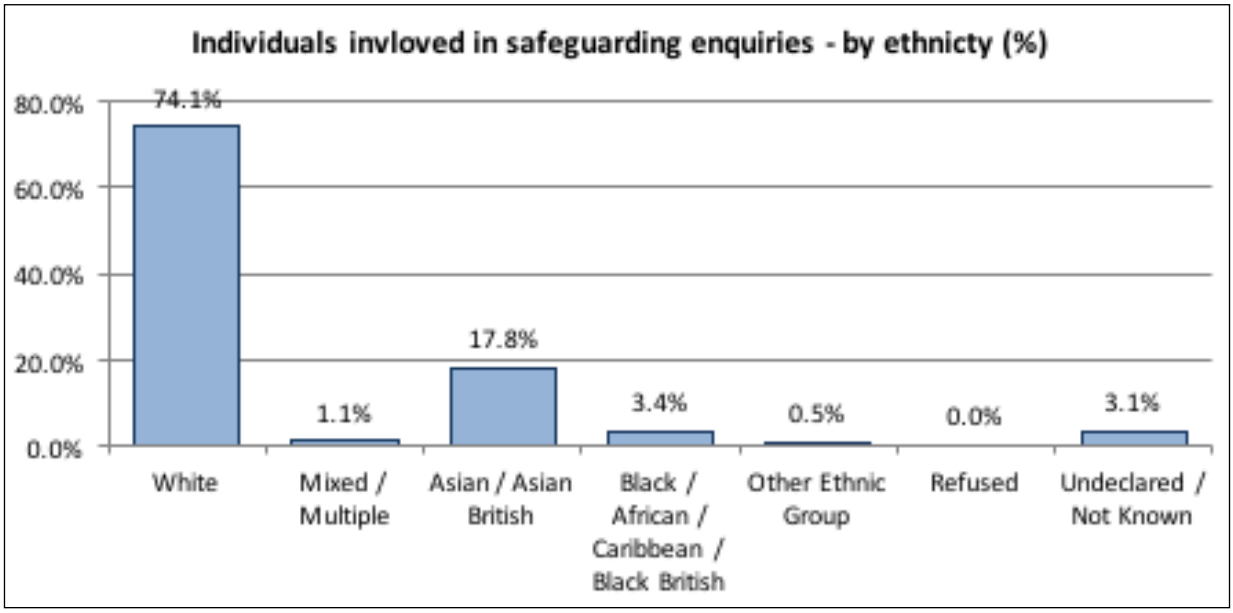


The table below shows that in over half of the cases leading to Section 42 enquiries, that the adult at risk lacked the mental capacity to safeguard themselves or to make decisions relating to their safety.

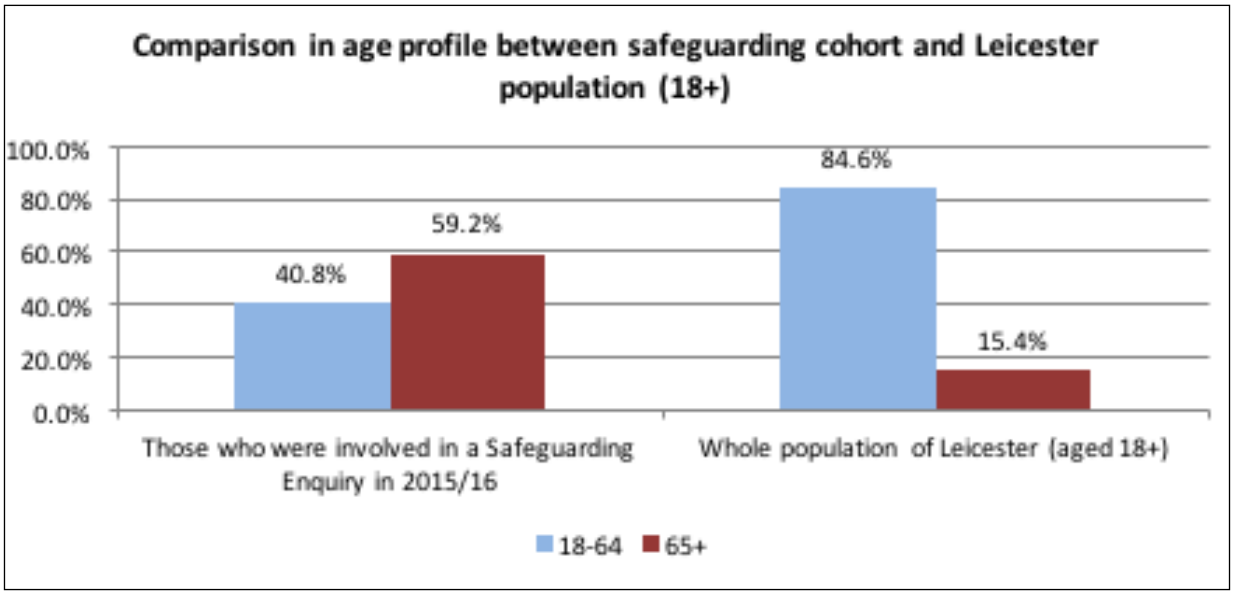


The majority were provided with advocacy in order for their voice to be heard and their right to be represented ensured. This data indicates and agrees with other national data that the loss of mental capacity increases the risk of harm and abuse. The fact that the local adult social care department is particularly monitoring and responding to new deprivation of liberty safeguards (DoLS) applications would hence make a lot of sense and shows that the DoLS process applies another layer of safeguarding as intended.

The table below shows the breakdown by ethnicity:



Cases taken forward for Section 42 enquiries do not reflect the ethnic make-up of Leicester. The local census of 2011 shows a population of: White 50.52%, Asian or Asian British 37.13%, Black and Black British 6.24%, Mixed 3.51% and Other 2%. This does not identify that white adults are at greater risk but perhaps that abuse against people from minority groups is less likely to be reported; an aspect that is debated and considered.

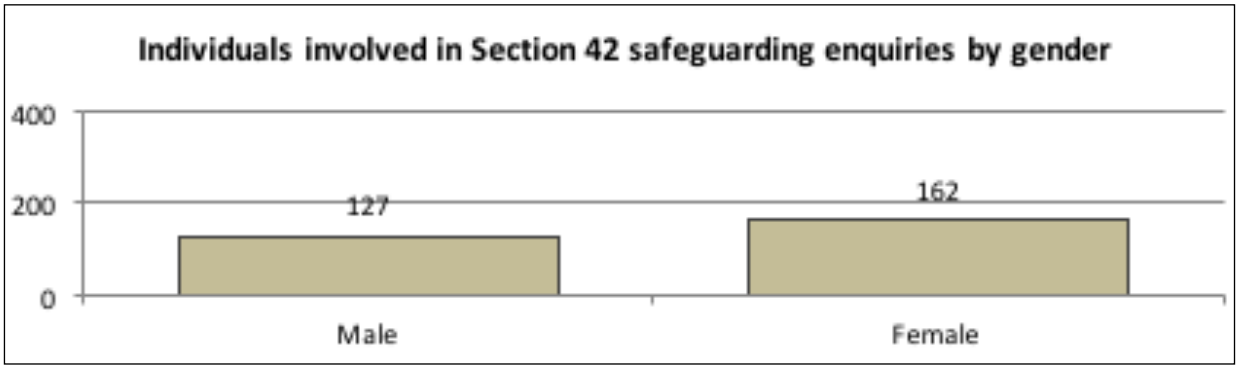


The population break down by age shows that Leicester is a ‘young city’ with almost 85% of the population being of working age. However, older people in the city experience a disproportionate risk of harm compared to their younger counterparts and the data clearly shows an increased risk the older you get.

Table SG1a Counts of individuals by age band	Age band						
	18-64	65-74	75-84	85-94	95+	Not known	Total
Individuals involved in safeguarding concerns	**597**	**176**	**257**	**317**	**43**	**14**	**1404**
Individuals involved in Section 42 safeguarding enquiries	**139**	**48**	**44**	**52**	**6**	**0**	**289**
Individuals involved in other safeguarding enquiries	**122**	**44**	**82**	**88**	**15**	**0**	**351**

Table SG1a further shows that this is the case relating to alerts, and all enquiries. This fact triaged with the fact that the majority of all cases identify paid carers as the main source of harm and abuse was taken into account by the LSAB when they made the decision to set up a task and finish group in 2016 to identify and address any concerns in the local care sector and provide assurance to the LSAB that local adult services provide safe and good quality care. Over 200 enquiries (Section 42 and other) related to the source of risk as paid carer(s).

In relation to Section 42 enquiries there is a 40:60 male/female split.



The gender distribution did not raise any concern for the board. Abuse is reported in almost equal numbers.

A challenge that this year's data identified was that a total of 86 individuals have had more than one safeguarding enquiry recorded during 2015/16.

- 43 have had a repeat Section 42 enquiry
- 43 have had a repeat 'other safeguarding enquiry'

Some individuals have had more than two enquiries in the year. The totals for the number of repeat enquiries are as shown:

Enquiry type	Number of repeat enquiries	Individuals involved in more than one
Section 42	101	43
Other enquiries	108	43
Total	**209**	**86**

This translates into almost a third of all Section 42 enquiries and around a quarter of other enquiries. The LSAB has identified a need to undertake case audits to identify if there is an issue with the way cases were and are responded to in the first place or if some other theme can be identified that lead to these high numbers of repeats. This aspect will be brought forward in the board's audit plans for 2016/17.

Table SG2c shows the outcome of enquiries including source of risk:

Table SG2c	Concluded Section 42 Enquiries		
Counts of enquiries by action, result and source of risk	Source of risk		
	Social care support	Other-known to individual	Other-unknown to individual
No action taken	15	11	35
Action taken and risk remains	0	5	14
Action taken and risk reduced	36	59	88
Action taken and risk removed	13	14	43

In the majority of cases action was taken and risks reduced or removed. This is not reflected in the fact that so many cases are referred for a second or even third time. The LSAB are moving forward to identify underpinning reasons for the number of repeat referrals by undertaking a programme of qualitative audits during 2016/17

The deprivation of liberty safeguards (DoLS) activity 2015/16

We report on activity relating to the deprivation of liberty safeguards (DoLS) for several years now and DoLS compliance continues to be challenged not only locally but nationally as well. The Supreme Court judgement relating to the cases and overruling previous judgements relating to P v Cheshire West and Chester Council and P&Q v Surrey County Council, have led to clarity and what is commonly known as the 'acid test', resulting in increased numbers of requests for authorisations to deprive adults of their liberty. Local authorities have to undertake a number of assessments in order to authorise a deprivation of liberty, or not if this is indicated. Assessors are highly trained and experienced professionals and overall there is an apparent national skills gap as well as an escalation of costs that both impacted on the ability of Leicester City Council and the majority of local authorities to comply with the authorisation process.

Adult Social Care has doubled the number of full-time best interest assessors (BIA) from three to six. These appointments were made in July and September 2015. However, as these were recruited internally, this depleted the pooled BIA assessors which reduced from 3.6 to 0.6 (full-time equivalent). Since October 2015, we have increased the pooled resource by an additional two BIAs. Each pooled BIA assessor 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. Until we build our pooled resource further, we will not see much benefit by way of completed assessments against the rate of requested authorisations. It is hoped that by the end of 2016 we will have an additional seven to eight pooled BIAs who are currently completing the training course. The authority also continued to utilise independent BIAs to complete assessments.

Over the past year Adult Social Care has increased the number of signatories for authorisation and sign off from five to ten with a further four being trained. 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 there continues to be a backlog of cases awaiting assessment. At the end of the period this accounted for 548. Overall 723 cases were assessed from a total of 1,833 cases. 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.

DoLS Activity 2015/16	Total
Referrals received	1833
Granted	693
Not granted	30
Withdrawn	562
Not yet signed off by supervisory body	548

Adult Social Care has reviewed the way cases are prioritised and is focused on reducing the backlog of new referrals from April 2016. This is in recognition of the risks when an adult, their situation and any risks are not known. Adult Social Care will no longer prioritise cases already subject to a standard authorisation that is due to expire. This change is based on the limited resources and how to use them to best protect adults at risk of harm and abuse. Independent legal advice was sought from Brown Jacobson in support of the change whilst recognising that whatever and whoever is prioritised for DoLS assessment; it still leaves some adults and the organisation at risk.

A significant risk factor influencing the change in prioritising requests, was the fact that with new requests for DoLS ‘sitting’ on the waiting list, there was no way to measure the risk attached to these individuals as the service was and is dependent on the managing authority providing all relevant information to support prioritising those with greater need correctly. In part, this was underpinned by learning from a safeguarding review (discussed later in the report) which identified that seven residents were waiting for assessments to be completed and that indeed harm and abuse might have been prevented, reduced the risk or ensured earlier alerts; had assessments been completed in a timely manner. The DoLS team and commissioners regularly exchange intelligence in order to further prioritise assessments and target stretched resources where adults maybe at the greatest risk.

Safeguarding adults reviews (SARs)

The Care Act 2014 requires local safeguarding adults boards (SABs) to include within the annual report information relating to any safeguarding adults reviews (SARs) that it has arranged. This includes reviews that have concluded in the year, that are still ongoing at the end of the year and also what has been done to implement the findings of any reviews.

A SAR should be arranged when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

In Leicester, the adult review and learning subgroup of the LSAB makes arrangements to carry out any reviews agreed by the board and the implementation of any recommendations.

During 2015/16 one SAR was concluded; this review had started in the previous year.

Care Home X was a care home located in Leicester, registered to provide care for 21 people with dementia, learning disabilities, mental health conditions, physical disabilities and sensory impairments. A whistle-blower had raised allegations of serious abuse and neglect of a number of residents at Care Home X residential home by care staff.

As a result of these allegations there was a police investigation, a responsive inspection from the Care Quality Commission (CQC) and an adult safeguarding investigation, carried out in line with local multi-agency safeguarding procedures. These enquiries and investigations identified further areas of concern, potentially affecting the whole resident group.

Council staff supported the provision of care in the home whilst the situation was progressed. The company which owned the home decided to cease operations and the home was closed 10 days after the allegations had been received. In the days before closure, all residents had been transferred into alternative accommodation and care settings.

A SAR was commissioned to identify any learning points regarding the actions of individual agencies in contact with this home prior to the allegations and whether agencies could have worked together more effectively.

A number of recommendations were made, all of which were accepted by and acted upon by the LSAB. These included:

- Improving the extent to which issues within a care home setting can be gathered together from individual residents' records
- Ensuring that families are involved in reviews of residents and that residents are engaged directly in quality and compliance assurance visits
- Ensuring that allegations which appear to be criminal in nature are swiftly reported to the police and that a multi-agency strategy discussion takes place
- Improving information regarding the training of staff and the use of deprivation of liberty safeguards within a care home
- Improving the joint response to investigating allegations in care homes

In response, a comprehensive action plan was developed and the delivery of actions overseen by the adult review and learning group. Progress has been made in a number of areas, including:

- Review of the joint protocol for completing large scale investigations
- The development of a care home team within Leicestershire Police
- The creation of a supported residents care team in Leicester City Council
- A refresh of the multi-agency information sharing meeting arrangements, bringing all agencies together to share information that is held about provider quality concerns
- Involvement of Healthwatch in supporting the board's work to address the level of safeguarding concerns arising within a residential or nursing care setting

No new SARs were arranged during 2015/16.

Domestic homicide reviews (DHR)

Three domestic homicide reviews (DHR) have been ongoing during this period. The LSAB has an agreement in place to undertake the reviews on behalf of the local community safety partnership. The reviews have been delayed due to the legal processes but all are now on schedule for completion during the summer of 2016.

The LSAB is assured that implementation of identified learning is being implemented whilst the review process is being completed. The LSAB's adult review and learning group has received quarterly updates in relation to all three DHRs ongoing, including updates on identified learning, themes and progress against early actions.

Safeguarding partner agencies - Annual reports

Organisation name:	Leicestershire Police
Name of person(s) completing the report:	T/Supt Jon Brown (Supt, Serious Crime), PS Gail Simpson (Crime & Intelligence Directorate Support Team) and Barney Thorne (Safeguarding Partnership Manager)
Partner agency logo:	Leicestershire Police Protecting our communities
Overview 2015/16: Safeguarding vulnerable people (both adults and children) has continued to be a major focus of policing activity during 2015/16: • We have referred over 7,000 incidents during 2015/16. • This has led to 129 multi-agency investigations.	

- We have issued 53 domestic violence prevention orders.
- Project 360 has been extended.
- New SARC (Sexual Assault Referral Centre) has been opened.
- Co-location of Signal (rape investigation) and Domestic Abuse and Complex Investigation Team to ensure best use of specialist resources.
- UAVA (United Against Violence & Abuse) has commenced providing force wide support via one referral pathway.
- PVP4 (protecting vulnerable people), a force wide training programme, is being delivered to all front line operational staff - this includes specific modules relating to adult safeguarding issues.
- The removal of the immediate threat of huge budget cuts, together with an increase in Precept has allowed the force to increase investment in resources for this area of business, but this will not largely have an impact until 2016/17 - this will see 38 detectives, 21 PSCOs (Police Community Support Officers) and 17 Investigative Support Officers join the directorate as we look to make the most of our resources.
- The Force continues to develop organisational structures and working practices to ensure policing for the future is as effective and efficient as it can be, and protects the most vulnerable in our communities. Ongoing projects include Blueprint 2020, whichcontinues the work commenced under Project Edison; the strategic alliance (with Northamptonshire and Nottinghamshire forces); and the force is also exploring use of the Cambridge Harm Index which indexes crimes on level of harm rather than number of occurrences, as a way of prioritising resources.

Internal safeguarding adults governance and audit arrangements:

- Management structure has remained consistent during 2015/16 - Crime and Intelligence Directorate (CAID) headed up by the Ch Supt, supported by T/Supt (Serious Crime), DCI (Adult Serious Crime) and the Safeguarding Partnership Manager.
- New Force operating model was implemented during 2015/16 and is now embedded. Specialist departments were ring-fenced during this change to maintain continuity around safeguarding investigations – DAIU (Domestic Abuse Investigation Units), Signal and ARD (Adult Restorative Disposal) remits remain as before.
- 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 (Her Majesty's Inspectorate of Constabulary) and safeguarding board audits.

- A new audit regime began at the end of 2015, via the CAID Support Team. This is a rolling process of audits by department, quality assuring priority areas highlighted by HMIC inspections, SCRs (Serious Case Reviews), DHRs and self-assessment. Results and feedback go to departments via DCI Adult Safeguarding – domestic abuse and sexual offences audits have so far shown good compliance with required procedures and a good level of service.
- Quality assurance process introduced re Body Worn Video (BWV) use to ensure best possible evidence is captured, particularly where there may be reluctance to support prosecution.
- Achieving Best Evidence Group set up during 2015 to address issues around quality of video recorded evidence provided in relation to vulnerable and intimidated witnesses. This has resulted in an upgrade of equipment in all video recording suites, refresher training, clarification of procedures and a quality assurance regime around video interviews carried out.
- We are looking at new working practices to make the best use of our available resources for VRIs (visual recorded interviews) to ensure the highest quality possible.

Safeguarding adult work undertaken and key achievements:

- New SARC opened in March 2016 providing excellent resources for victims of sexual assault (adult only at this time).
- Project 360 extended.
- NHS England funded Mental Capacity Act training which was delivered to 16 key frontline managers across the force, with a vision to ensure an understanding is fostered around mental capacity. While this does not give us expertise, it will allow investigations to consider practical positive routes for some of our most vulnerable victims.
- Funding has been received from the Police and Crime Commissioner to set up an Integrated Vulnerability Management Unit. This will include CPNs (community psychiatric nurses), drug and alcohol workers, PCs aimed at assisting local authority colleagues with Section 135s. The project will then pool these new individuals with the Adult Referral Team and the Mental Health Triage Car giving greater expertise with a shared focus and goal.
- We have had to update our internal managing adults at risk procedure to be Care Act 2014 compliant, and have also taken this as an opportunity to raise expectations for officers around identifying vulnerable people and the use of strategy discussions.

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.):

We have seen a number of incidents involving care homes this year. Better understanding of the managing adults at risk procedure has led to an increase in the number of strategy discussions undertaken with multi-agency partners.

In several of these incidents, having a strategy discussion at the onset of the investigation has led to either a greater understanding of the incident, resulting in no further action, or allowing the incident to be escalated to the Force's Complex Investigation Team. This has resulted in multiple social workers initially embedding themselves at the beginning of the investigation which has been an excellent demonstration of multi-agency working, challenge and desire to get the best for our victims.

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:

A lot of our Neighbourhood Officers are tasked with seeking out opportunities to engage with the local community and take on a project to assist the community. One of our officers situated in Beaumont Leys came across a day centre for people with dementia. The outside of the day centre had become overgrown and there was little use made of it by the people who attended the centre. The officer asked internally for volunteers and went to local businesses, McDonalds, Greggs and B&Q in order to redevelop the garden, adding a pond and garden furniture and giving it a much needed lick of paint, all at no cost.

Following the project we have seen a surge in engagement taking place between officers and the local community around the day centre.

The challenges:

- Police forces nationally have for the last five years seen a reducing budget from the government. However, we are now in a position where although the budget has not increased via national funding, we have an opportunity to consider how we do what we do. This has seen us use the Cambridge Harm Index to ask the Police and Crime Commissioner to increase the precept from the council tax to allow us to grow in certain areas of the Force where resource is needed or if there is an opportunity to redevelop the work that we do.
- This year, as with past years, has seen an increase in reporting of historical sexual abuse. While these may not be considered as adult safeguarding investigations, the victims are predominantly adults now and may need safeguarding through the process as a result of trauma and abuse during childhood. These investigations carry a high degree of political and media attention for obvious reasons and as a result have led to the decision making being heavily scrutinised both organisationally and individually. When these investigations are reported in the media we have seen a direct increase in reporting from the public, particularly as local investigations have received national attention. This may present a challenge in the future as we currently have a small non-recent investigation team. However, they are situated within a large directorate of detectives and resources can be aligned if and when necessary.

Awareness raising and staff training:

- PVP4 training programme commenced in 2015 and will continue throughout 2016. Ten modules have so far been scheduled. These are delivered face-to-face by team leaders, using video input from specialist departments and supporting online resources. Modules specific to adult safeguarding have already been delivered around domestic abuse, mental health and crime in adult care settings. Two further modules on HBA/FM (honour based abuse/ forced marriage) and vulnerability referral forms are in development and will be released during the next few months.
- A series of regular updates by the DCI Adult Safeguarding has commenced which will follow the format of PVP and include any learning points arising from SCRs, DHRs or the internal audit results. The first one went out in April 2015 and included specific points around safeguarding adults - signposting people to the best kind of help, best practice to assist victimless prosecutions, and ensuring intelligence checks are completed.
- Managers from the adult referral team have given training to Force senior investigators (who lead investigations relating to death) to raise awareness of wilful neglect, the Mental Capacity Act and the Care Act. They were also given advice about investigations in health or care settings.

Organisation name:	Leicester City CCG
Name of person(s) completing the report:	Adrian Spanswick / Mina Bhavsar
Partner agency logo:	NHS Leicester City Clinical Commissioning Group

Overview 2015/16:

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.

Leicester City CCG hosts on behalf of the three Leicestershire, Leicester and Rutland CCGs, the safeguarding team, which includes designated professionals who cover children and adult safeguarding, designated doctor for safeguarding children, named GP for safeguarding children and heads of safeguarding for children and adults. It should be recognised that the designated professionals undertake a whole health economy role. The CCG collates assurance in relation to health providers as part of the contracting process.

The CCG gains assurance from all commissioned services which includes NHS statutory and independent healthcare providers. This activity occurs throughout the year to ensure continuous improvement and may consist of assurance visits and attendance at provider safeguarding committees.

Leicester City CCG is able to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding. These include:

- Governance arrangements, i.e. a named executive lead to take overall leadership responsibility for the organisation's safeguarding arrangements, this is the Director of Nursing and Quality (who is also chair of the CCG's Strategic Safeguarding Group).
- 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 in place for GPs.

The Leicester City CCG works with its inter-agency partners and is represented at senior level in LSAB by the Director of Nursing and Quality, with support by the consultant/designated nurse safeguarding children and adults. In addition the CCG has actively contributed to the subcommittees of the board.

Internal safeguarding adults governance and audit arrangements:

- Leicester City CCG, in partnership with West Leicestershire/East Leicestershire and Rutland, have a quarterly strategic safeguarding group (children and adults), which receives a safeguarding report, case review report, overviews policies and procedures and current key developments. All key papers are then reported through CCG's internal governance processes and then to the governing body on a monthly basis.
- Monitor implementation of CCG safeguarding strategy/plan and provide quarterly reports to the SSG in relation to safeguarding activity.
- Business continuity plan.
- Contribute to internal 360 assurance audit when requested. Last one completed July 2014.
- Consultant/designated nurse monthly meeting with Director of Nursing and Quality. In addition a meeting also takes place with the wider designated professionals from hosted safeguarding team on a monthly basis.
- Completion and submission of the safeguarding adults assurance framework for LSAB.
- Commissioner monitoring frameworks, systems and processes for large and small NHS providers.
- Monitor compliance against Care Act 2014, DADV, Crime and Victims Act 2004 and other key areas of legislation.
- Regular update and escalation/oversight of team/directorate and organisational risk assessment/register.
- Mental Capacity Act (MCA) checklist jointly agreed with Leicester Partnership Trust (LPT) and University Hospitals Leicester (UHL).

Safeguarding adult work undertaken and key achievements:

- The CCG's ongoing commitment and contribution to progress the LSAB business plan.
- Securing and overseeing 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 progressing LSAB priorities.
- Attendance, contribution and oversight provided from a CCG perspective in relation to DHR and SAR panel membership.
- Revised Mental Capacity Act (MCA) assurance provider template that has been aligned to the NHS contract for completion and return.
- High percentages of 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 2014/15 to city care homes, health practitioners and GPs.
- A further programme secured to deliver bespoke training (legal firms and/or experts in the MCA/DoLS field) aligned to gaps identified following 2013/14 training. Target group UHL staff, Community Health Council (CHC) staff (extending to domiciliary care providers), Leicestershire Partnership NHS Trust (LPT) and East Midlands Ambulance Service (EMAS) staff.
- Attendance and contribution from CCG Senior Executive/CCG hosted safeguarding team at LSAB and all subcommittees of the board.
- Attendance and contribution from CCG at Large Scale Investigations meetings and other relevant meetings for safeguarding enquiries.

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.):

CCG Prevent leads have been instrumental in finding a solution for a gap that emerged in the final parts of the pathway for individuals who were ready to be discharged from the Channel process. An exit strategy came into effect which allows individuals to continue receiving oversight in relation to their health and wellbeing from schools, primary care (GPs) etc.

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 we have engaged with a number of particularly vulnerable groups which includes those at risk of harm or abuse, most notably young carers, learning disability carers groups, the homeless, asylum seekers/refugees and learning disability patients. The engagement activity has covered a wide range of issues, from carer's rights to GP services, access requirements and mental health. We have also taken part in a number of workshops and events with local people at risk, to encourage people to give their views and get involved.

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 safeguarding team also supported the Engagement Manager when it was necessary to make a referral to the safeguarding team, after spotting a potential issue at a carer's event.

The safeguarding team are also integral to our strategy development, and have ensured safeguarding considerations are at the forefront of our work. As an example, the safeguarding team supported the development of a series of patient experience surveys. This involved advising the team on the needs of young carers, putting them in touch with external agencies and supporting a young person on work experience.

CCG is engaged with the LSAB with the safeguarding adults communication and engagement work stream.

The challenges:

- Educating and skilling up a diverse workforce to understand their roles and responsibilities in meeting the requirements of the Care Act 2014, Cheshire West etc.
- Delay of certain government guidance.

Awareness raising and staff training:

- Online eLearning
- Face-to-face MCA session
- Face-to-face Prevent sessions
- Face to face safeguarding adults training planned March 2015 and delivered 2016 (PLT (Protected Learning Time) slot not available until 20 April 2016)
- Safeguarding briefings via CCG newsletter

Organisation name:	Leicestershire Partnership Trust
Name of person(s) completing the report:	Rachel Garton, Trust Lead Safeguarding

Partner agency logo:

Leicestershire Partnership NHS
NHS Trust

Overview 2015/16:

2015/16 was a period of significant change in relation to safeguarding within LPT and the wider safeguarding partnership, both in terms of changes to guidance and legislation and changes to key staff roles. The implementation of the Care Act 2014 necessitated consideration of how well we work as individuals and as part of the wider partnership to safeguard those adults at risk that we care for. Learning from

Operation Yewtree, the overarching 'Lessons Learnt Report' authored by Kate Lampard, a full compliance visit from the Care Quality Commission (CQC) in 2014/15 and information sourced from our internal safeguarding audits and investigations, provided a timely opportunity for LPT to review elements of safeguarding process and practice, helping to focus its safeguarding work and review systems, processes and procedures. This work has begun to cement existing good practice and bring about change - a positive step towards continual service improvement.

Internal safeguarding adults governance and audit arrangements:

The Chief Executive of the Trust is ultimately responsible for safeguarding arrangements; he/she is supported by the Chief Nurse, who is the executive responsible for safeguarding within the Trust, the Head of Professional Practice and Education and the Trust Lead for Safeguarding Children and Adults.

Each of LPT's three divisions holds a monthly safeguarding forum, with a bi-monthly Trust-wide Mental Capacity Act forum also in place. These groups are overseen by the Trust's safeguarding committee, which in turn reports to the Quality and Assurance Committee (QAC), a subgroup of the Trust board. QAC receives a regular highlight report. Terms of reference for the group are reviewed annually.

The Safeguarding Committee provides the strategic leadership and co-ordination of the quality assurance processes that underpin the clinical governance agendas for safeguarding activity across the Trust; the committee is chaired by the Chief Nurse and membership includes professional leads across divisional areas, safeguarding named professionals and training and human resources staff. Each division is represented on the committee.

The Safeguarding Committee oversees the safeguarding annual audit plan, which in 2014/15 included a Trust wide annual safeguarding audit, sent out to all clinical staff via survey monkey, a 360 assurance audit of Mental Capacity Act and a 'Think Family' audit. Action plans are monitored via the Trust audit department and overseen by the safeguarding committee.

Safeguarding adults work undertaken and key achievements:

A number of key objectives were achieved in 2015/16, the following list is not exhaustive:

- Adult safeguarding team co-authored and delivered joint training, with LPT Specialist Nurse for Domestic Violence, to practitioners who work within Mental Health Services for Older People (MHSOP).
- Divisional leads, supported by adult safeguarding specialist nurses developed and sustained an MCA Champions forum, involving key staff from practice areas who are in a position to bring about positive change in practice.
- Data collection and analysis, whilst further work is needed, has improved year on year.
- Development of an integrated forum - seeing children's and adult's safeguarding teams working in greater alignment.

- Between April 2014 and April 2015, the Adult Safeguarding Team responded to approximately 860 calls on the adult safeguarding advice line from staff with safeguarding concerns. Specialist advice has been provided on thresholds, referrals and procedures or wider risk management.
- Safeguarding adults training remained green throughout 2014/15, with all areas consistently achieving upwards of 85% compliance.
- The Trust Prevent policy has been in place since September 2014, with 2,109 staff already trained in Prevent by April 2015.
- Training figures are monitored by the bi-monthly safeguarding committee.
- MAPPA (Multi-Agency Public Protection Arrangements) training now forms part of the full-day Trust induction program and the Level 2 safeguarding adults training.
- A MAPPA briefing is also available to staff attending Trust induction. Bespoke sessions have been carried out in the Community Health Service (CHS) division and training was also rolled out to medical staff in 2015.

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.):

Specialist Nurse Safeguarding Adults have recently supported two separate multi-agency safeguarding strategy meetings in relation to domestic violence for older people. The decision to investigate met the threshold for a higher level concern. LPT Safeguarding Nurse supported the meeting by:

- Providing expert advice to other agencies about Domestic Violence Assessment (DVA) in older people.
- Advice in relation to the use of the risk identification and assessment and management model using the Domestic Abuse, Stalking and Harassment and Honour Based Violence tool (DASH (2009)).
- Information sharing with agencies involved.
- Supporting LPT practitioners involved in care and treatment of the victims.
- The outcome of both meetings established the risks and potential level of harm was increased in both cases to meeting the threshold for a serious concern. Protection plans were put in place for both victims and separate referrals to Multi-Agency Risk Management Conference (MARAC) were completed.

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:

This has been a challenging area and one which is a priority moving forward in terms of consultation with local people, or adults at risk. As an organisation we are embracing the ‘making safeguarding personal agenda’ and hope to make significant progress in this area in the year ahead.

The challenges:

2015/16 was a stimulating year for safeguarding due to the fast growing agenda. The safeguarding team, colleagues within divisions, and partners, have worked hard to ensure LPT is effective in keeping its service users free from harm. This in itself is not without its challenges – to continually feel assured around the safety of our patients, it is vital that learning is embedded into practice; this can be difficult due to the often reactive nature of the work. The adults safeguarding team's key aim for 2015/16 is to promote visibility in practice areas and provide additional face-to-face support to practitioners.

Involvement and participation of service users, carers and the public is difficult to achieve in a meaningful way. We plan to work with the local safeguarding boards to ensure we are at least as a baseline seeking views of service users of their experience of safeguarding whilst in our care, including how safe they feel in our services.

The ever growing agenda adds significant pressure to the safeguarding training provision - ensuring we adequately equip staff with the knowledge and skill required to effectively safeguard without unlimited training resource. A review of training is underway to ensure best use of time and provision in order to continue to give staff a good training experience that can be easily translated into practice.

Managing inward and outward facing work and ensuring the two are aligned is an ongoing challenge, close working with partners and good internal integrated working is a continued priority for LPT moving forward.

Awareness raising and staff training:

All Trust staff receive adult safeguarding awareness as part of their core mandatory training package. Clinical staff also receive safeguarding adults training at Level 2 and bespoke sessions in relation to required safeguarding topics as and when needed.

Organisation name:	University Hospitals of Leicester NHS Trust
Name of person(s) completing the report:	Sarah Meadows

Partner agency logo:

University Hospitals of Leicester NHS
NHS Trust

Overview 2015/16:

The Trust continues to prioritise adult safeguarding arrangements and the team has expanded over the past 18 months, with the addition of two safeguarding specialist nurses, to support the service. This has enabled improvements in data collection and sharing, innovative service developments, as well as a strengthening of existing processes. The team continues to receive increasing numbers of referrals year on year.

Internal safeguarding adults governance and audit arrangements:

Adult safeguarding arrangements are governed by the UHL Safeguarding Assurance Committee (SAC), chaired by the Deputy Chief Nurse and with representation from the clinical management groups (CMGs) and the CCG designated nurses.

The overarching role of the SAC is to review and endorse key performance safeguarding indicators for UHL and performance manage their implementation. The SAC monitors and supports the Trust's compliance with relevant legislation, national policy and guidelines and provides a forum to review the effectiveness of the CMGs to ensure robust safeguarding practice. The SAC has oversight of lessons learned from safeguarding incidents and SARs/DHRs. The SAC also has oversight of any risks associated with adult safeguarding and takes/recommends actions required to mitigate those risks. The SAC reports directly to the Executive Quality Board and regular reports are provided to the Quality Assurance Committee and CCGs (via CQRG (Care Quality Reference Group)).

In addition to SAC, the adult safeguarding professionals participate in LSAB and CCG assurance processes, monitored through CCG CQRG meetings and equivalent LSAB groups such as the Performance, Effectiveness and Quality (PEQ) subgroup.

Safeguarding adult work undertaken and key achievements:

- Increased capacity of the UHL Safeguarding Team in late 2014, from one staff member to three, this has enabled the service to be increasingly responsive and to widen its sphere of practice. It has also enabled service development and innovative practice.
- Development and implementation (from January 2015) of the Trust-wide MCA/DoLS intensive support project. This is an initial 18 month project aimed at supporting practitioners to embed MCA/DoLS theory into practice. The project has been developed and implemented by the adult safeguarding team with no additional resource and is an example of best practice.
- Development of domestic abuse guidance, policy and training for UHL staff.
- Participation in a number of SARs/DHRs, as Independent Management Review (IMR) authors and panel members. Development and implementation of a range of actions to improve practice, following lessons learned.
- Strengthened links with the UHL Patient Safety Team – cross fertilisation of learning and ensures that adult safeguarding is central to Serious Incidents and Complaints, where appropriate.
- We were instrumental in developing the pathway for local authorities to oversee health-led investigations from 1 April 2015 (Care Act requirement) and our openness and transparency has facilitated smooth transition of processes and robust change to assurance processes.
- We have facilitated a huge increase in the number of DoLS applications submitted by the Trust.

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.):

Miss EJ

This young woman presented with a history of self-neglect, substance misuse and was being exploited by others. She was a known sex worker who was struggling to cope with her addiction. She was seriously unwell and initially non-compliant with treatment. The adult safeguarding team and the wider clinical team spent many weeks and months developing a meaningful relationship with her. The team were compassionate and non-judgemental in their dealings with her - something that she greatly valued. The team employed consensual supervision whilst she was in our service in order to enhance compliance. The team engaged her with support services that could support her post discharge. The team facilitated multi-agency communication, gained her confidence and subsequently her compliance with treatment regimes. For the first time in many years she abstained from substance use and entered a recovery programme. She 'got clean' and became fit for surgery (which she underwent successfully). She was discharged to her own flat with support from New Futures.

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:

- Through lessons learned from internal safeguarding incidents, Serious Incidents and Complaints and participation in LSAB commissioned reviews.
- It is standard practice for the adult safeguarding team to consult with patients/ significant others during safeguarding adult enquiries and this is captured within our reports.
- Through Friends and Family Test (FFT).

The challenges:

- Representation at the various LSAB (city and county) groups remains challenging although we remain committed to the partnership.
- Escalating number of DHRs over the past year has placed additional pressure on the service although we are on track with single agency actions.

Awareness raising and staff training:

- Implementation of the 'essential to job role' eLearning modules for Consent, MCA and DoLS for all staff with direct clinical contact with patients.
- Revised mandatory safeguarding adults training, to include awareness of Prevent. Currently 94.56% staff are trained in adult safeguarding.
- Provided face-to-face training for staff that are unable to access eLearning.
- Provided individual training/awareness raising sessions with key groups of staff following DHRs i.e. Emergency Department staff and musculoskeletal staff.
- Development of webpages dedicated to safeguarding adults for both staff and members of the public.The ever growing agenda adds significant pressure to the safeguarding training provision - ensuring we adequately equip staff with the knowledge and skill required to effectively safeguard without unlimited training resource. A review of training is underway to ensure best use of time and provision in order to continue to give staff a good training experience that can be easily

Organisation name:	National Probation Service
Name of person(s) completing the report:	Jeanne Smith / Carolyn Maclean

Partner agency logo:

National Probation Service

Overview 2015/16:

In June 2014 Leicestershire and Rutland Probation Trust was dissolved and under what is described as Transforming Rehabilitation, two new organisations were created - the National Probation Service (NPS) and the Community Rehabilitation Company (CRC). This necessitated a significant amount of organisational chaos affecting every aspect of the organisation, for example NPS no longer has any corporate services and Leicestershire, Leicester and Rutland (LLR) is now part of the Midlands Division. LLR lost its local training unit who would keep training records and deliver the safeguarding training and large numbers of cases were transferred to Offender Managers both before and after the split. The NPS was given new responsibilities at Court and new processes were introduced to manage these. Senior Probation Officers were also given additional responsibilities, particularly in relation to managing human resources.

In summary, it was a year of significant investment in reorganisation and trying to balance these demands with keeping the organisation running to a high standard. Despite the high level of change, LLR was the only area in the Midlands to maintain case auditing arrangements. The MAPPA Thematic Inspection in 2014/15, but published in 2016, provided many examples of good practice - the MAPPA Manager is a Senior Probation Officer with the NPS. The Integrated Offender Management Team (IOM) also continues to perform strongly.

Internal safeguarding adults governance and audit arrangements:

The internal governance is that within the Midlands Division, Senior Probation Officers were assigned local responsibility for adult safeguarding/board arrangements. There has been limited capacity in relation to auditing due to the size of the organisation and the restructuring of the organisation. The Deputy Head of NPS – LLR has functional responsibility for adult safeguarding.

In terms of audit arrangements, adult safeguarding is not specifically targeted. The context of any audit that is conducted is around the management of risk of serious harm and vulnerability. 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. Offender Assessment System (OASys) assessments require the vulnerability of all cases to be assessed – this includes self-harm, suicide, learning disabilities etc. Where needs are identified, the expectation is that the Offender Manager will then make contact with the necessary service provider.

Safeguarding adults 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. It is 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 partner in 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.):

Submitted by the Offender Manager, City North.

In terms of the support offered to this case, this included:

We completed some work on domestic violence including warning signs of perpetrators, materials from the Freedom Programme were used in sessions (which were adapted accordingly) and I ensured I was responsive to her learning needs and used a lot of visual aids.

I liaised with the offender managers for the co-defendants to ensure non-contact licence conditions were implemented to safeguard this case, as she experienced intimidation from them. She also feared any potential contact from them.

I worked closely with her Learning Disability Social worker to help access community resources and support, such as a drama group to help empower her and develop her social confidence and constructive use of time. This social worker initially accompanied the case to Supervision appointments including her pre-sentence report interview as a way of offering her support.

I also contributed to safeguarding assessments regarding her child, attended child protecting meetings and also supported her practically and emotionally at a meeting where she met the adoptive parents of her child.

She also engaged in a work placement within Probation where she acquired new skills. We also visited Voluntary Action Leicester and we approached charity shops for voluntary work. She also engaged with Move-On as a way to develop her employability.

This case was referred to a Mother and Baby project where she resided for a period of time; this placement prevented any further harm in context of domestic abuse and also safeguarded her vulnerability. As part of Supervision, we also had some appointments at Sure Start Centres to help develop her confidence in accessing community resources.

There were also warning markers on her address in relation to her vulnerability and being a victim of domestic abuse.

When this case had moved on to independent accommodation, which was a shared house, checks were made on the occupants within this address to prevent any future abuse or harm. Also there was liaison with the landlord regarding this case's vulnerability to ensure appropriate measures were in place.

When this case's Order ended she wrote a blurb about her experience on Probation and how much she appreciated the support offered to her. Towards the end of the Order she had developed her confidence and had secured part-time work.

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:

There are several ways in which information is gathered from both individual service users and groups of service users:

- NPS undertake regular offender surveys, primarily as a means of gathering service user feedback. The Offender Survey 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.
- Every offender has an OASys assessment completed by an Offender Manager and 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.
- Each offender is also required to complete a self-assessment questionnaire which would provide a further opportunity to identify adult safeguarding issues.
- The BTEI (Birmingham Treatment Effectiveness Initiative) map is also used with offenders, of which one of the purposes is to identify adult safeguarding issues.

The challenges:

It is reported anecdotally by NPS staff that they are struggling to obtain services for adults who are vulnerable/challenging. Whilst some may have a package of care in place when in the community, should they go into custody, decisions are frequently made to close the case and then re-open assessments when the case is due to be released or has already been released. This in effect causes additional work and frequently slows down service delivery. A more helpful approach would be for these cases to be put in a pending file thus avoiding the need for a duplication of assessments. The view at present is that there is not a collective sense of responsibility for difficult/vulnerable individuals with low-level multiple needs. The challenge is how we work together to address this.

Awareness raising and staff training:

The NPS – LLR have appointed a Senior Probation Officer who is the lead on diversity. Whilst in post, she has delivered and facilitated a range of training with marginalised groups, dementia and ADHD being just three examples. The NPS is also involved in DHR trawls and, where appropriate, with reviews; the learning from these investigations being shared with staff. Staff are frequently invited to attend events delivered by partners, charities etc. in order to extend their knowledge and facilitate closer working relationships.

Strategic business plan 2015/16 – Evaluation and review

During 2015/16, the LSAB set out four strategic priority areas to be completed over the next two years. These were underpinned by objectives, actions needed and taken, outcome and impact measures. The board had set timescales for completion of work and ensured that there were key lines or reporting by its subgroups, members and safeguarding partner agencies.

The Care Act 2014 was coming into force and the board needed to ensure that it met its statutory functions and reviewed the impact the changes would have in relation to the functioning, structure and priorities of the now statutory board. Dr David Jones, the LSAB chair for almost three years, retired from his role as independent chair of the adult board and this resulted in the recruitment of a new Independent Chair, Jane Geraghty.

Strategic Priority Area 1 – Core business: Partnership, governance and board functions

The LSAB reviewed the structure, functioning and cycle of review and revision and made strategic improvements in relation to:

- The board agreed a Constitution and the Terms of Reference in relation to all subgroups and task and finish groups. As part of this exercise, the board also reviewed membership and representation and improved this when needed. An example of this was Healthwatch joining the LSAB as a full member in March 2016. The board continued to work locally with Leicestershire and Rutland and continued joint working with the Safeguarding Children Board.
- Processes were reviewed and revised in order to make improvements to the reporting arrangements. The LSAB recognised that further financial investment would be needed during 2016/17 in order to ensure a fully functional and effective board office.
- The LSAB reviewed its financial position and agreed revised funding arrangements from April 2016.
- The board agreed and commissioned development and training opportunities for the general public, user groups and professionals in order to drive consistent improvements in safeguarding. This had a particular focus on working with individuals in a family context, joined working to safeguard children and young adults in the transition to adulthood etc.

- The table shows the level of attendance by safeguarding partner organisations at LSAB board meetings during 2015/16.

Date	CQC	Police	CCG	EMAS	ASC	Prison	NHS	UHL	LPT	NPS	CSC	LCIL	EMC	Healthwatch
18-05-2015	N	Y	Y	N	Y	Y	Y	Y	Y	Y	N	N	N	
17-09-2015	N	Y	Y	N	Y	Y	N	Y	Y	N	N	N	Y	
17-12-2015	N	Y	Y	Y	Y	N	N	Y	Y	Y	N	N	Y	
10-03-2016	N	Y	Y	Y	Y	N	N	Y	N	N	N	Y	Y	Y
	0%	**100%**	**100%**	**50%**	**100%**	**50%**	**25%**	**100%**	**75%**	**50%**	**0%**	**25%**	**75%**	**100%**

- Statutory board members (ASC, CCG & Police) attended 100% of meetings. This shows a high level of commitment by statutory organisations. With the exception of University Hospitals Leicester (UHL), no other agency attended 100% of meetings and, overall, there is an average attendance level of under 50% in relation to non-statutory safeguarding partner organisations. Hence attendance remained a challenge during 2015/16.

Strategic Priority Area 2 – Prevention and protection

- The LSAB and its partners worked alongside and supported ASC in implementing a family approach to working with people. In this respect there were workshops and training events for professionals and members of the public. The ASC recognises the importance of taking a holistic approach that goes beyond the needs of the individual and takes account of each person's support networks and any challenges and support family brings with it.
- Female genital mutilation (FGM) was a focus of the children and adult boards across Leicester, Leicestershire and Rutland and a joined approach was led by the CCG and resulted in guidance and strategies being launched during July 2015. It culminated in the launch of a public video: youtube.com/watch?v=2XdHwHGJHCk&feature=youtu.be
- Information relating to FGM lrsb.org.uk/fgm-female-genital-mutilation and applicable procedures were updated.
- The board particularly welcomed the fact that the new Care Act included self-neglect and hoarding and set itself a target of identifying any local concerns. This has since been revoked by government and therefore remains an area of focus with local procedures in place or being developed.

Strategic Priority Area 3 – Partnerships and communications work – Hearing the voice of the people

The LSAB had particular focus on working with adults at risk, local community groups aimed at increasing participation in the board's strategic work, review of safeguarding experience and in anticipation of 'Making Safeguarding Personal' (MSP). The board and Adult Social Care invested in a work stream lead post to facilitate and progress this very important aspect.

The Participation & Communication Work Stream consulted extensively with 'participation partners,' a wide and diverse group of local people who use services or are carers and family members, staff or members of the general population with a particular interest in adult safeguarding.

The participation partners gave the following, important messages:

- Participants told us: "Adult safeguarding posters and leaflets should be redesigned, reflecting our feedback about simple language and strong imagery".
- We responded by: Redesigning our posters and leaflets with clear messages and strong images. The newly designed resources have now been distributed to our existing partner organisations, but also to more varied environments where people might experience bullying or abuse, such as licenced premises and public spaces.
- Participants told us: "The LSAB should have a dedicated forum for eliciting regular feedback from local users of safeguarding services".
- We responded by: Working closely with partners, we developed an 'Expert by Experience' working group. The group has met regularly and has taken forward their self-determined agenda, including a film of user experiences of safeguarding and planning the development of the future expert feedback model.
- Participants told us: "The LSAB should use our experiences to provide learning and training that will improve services".
- We responded by: Working with a suitably experienced local provider, we have commissioned a film of user experience, to be used as a training and public awareness tool about adult safeguarding. The film will be available for viewing in August 2016 and is aimed at adults at risk and professionals.
- Participants told us: "We want a dedicated, independent user group".
- We are responding by: Working with our participation partners to design the future engagement model between the safeguarding adults board and the local community. A dedicated user reference group is being developed that will be responsible for the future participation and community engagement work for the partnership. Members of our Expert Feedback and Engaging with Diverse Communities groups will work alongside user representatives from safeguarding partner agencies, providing the core membership for this group.

Working closely with the local authority to develop and embed the 'Making Safeguarding Personal' (MSP) approach locally. To support this aim, we have made MSP one of our strategic priorities for 2016/17 and have set up a dedicated board subgroup to oversee that this work is progressing as it should, and to gain assurance that our partner organisations are equally committed to the approach.

Strategic Priority Area 4 – Quality assurance and effectiveness of multi-agency practice

The Safeguarding Effectiveness Group (SEG) reviewed and revised the data collected and the way this was presented to the board. The SEG implemented an audit cycle that collated information about multi-agency practice from organisations and individuals and identified no concerns overall from these findings. Audits undertaken focused on the use of questionnaires. The outcome confirmed that:

- Partner organisations, professionals and staff are aware of safeguarding adults and safeguarding children reporting procedures.
- This included the majority of professionals stating that they are aware of specialist support relating to radicalisation, domestic abuse, modern slavery and so on.
- Staff was reported to have appropriate levels of training and this was confirmed by individual respondents.
- Overall professionals felt supported by their managers.

Whilst the LSAB focused on the knowhow of organisations and professionals involved in preventing or responding to abuse over the past two years, for 2016/17 there will be a focus on the outcomes for individuals. Not as perceived by professionals (as was the case in previous surveys and audits), but as judged by the adult at risk. The LSAB plans to have this quality aspect central in its monitoring of safeguarding practice and has set up a task group to implement 'Making Safeguarding Personal'. The board is seeking assurance around the experience of individuals and has taken account of this year's data analysis in making this decision.

Strategic Priority Area 5 – Workforce Development

The board was particularly seeking:

- A workforce who are able to understand and apply safeguarding knowledge and have the skills to respond according to safeguarding concerns, in a way that is proportionate to their roles and responsibility.
- A workforce who are skilled and able to recognise and represent the voice of the adult, empowering choice and decision-making where possible.
- A workforce who are able to take appropriate action in relation to whistleblowing / escalation of concerns / resolving professional disputes.
- Organisations that are committed to training and developing their workforce to have a good understanding of safeguarding and apply this within their organisation.
- Practitioners who are able to demonstrate competence, confidence and a commitment to safeguarding children, young people and adults.

- Strategic and organisational commitment to safeguarding adults and to support their workforce to be highly skilled and trained to support service users.
- Strategic and organisational commitment to offer assurance of the impact of their safeguarding learning.

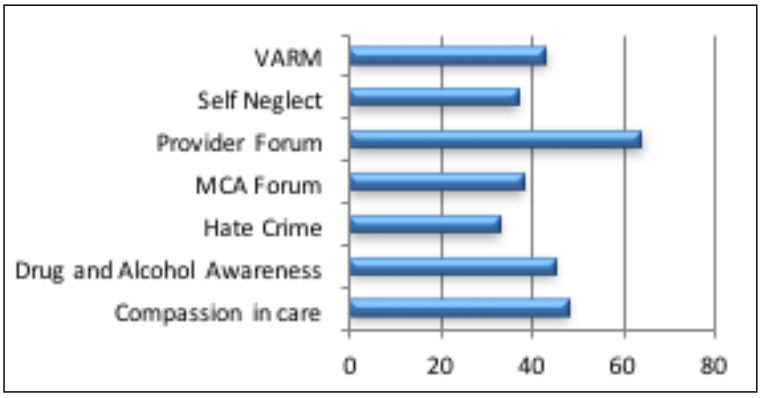
The SEG audits and analysis provided assurance to the board that effective training is being delivered both through the LSAB (multi-agency training) and within safeguarding partner organisations. Partner agency reports provide their own evidence of internal training provision.

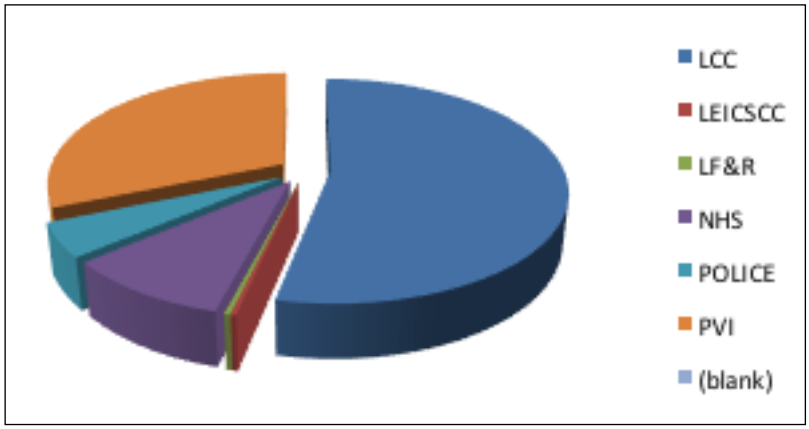
The LSAB's multi-agency training provision was attended by over 350 delegates participating in ten events.

Numbers in attendance

There were two compassion in care sessions, three drug and alcohol awareness raising sessions, two sessions looking at issues of self-neglect and the Leicester Vulnerable Adults Risk Management (VARM) system, one MCA forum looking at Court of Protection and two MCA provider only forums (funded by NHS MCA improvement project monies). Areas were focused on specialist knowledge and knowledge gaps as identified through reviews, audits and surveys undertaken during the year or identified by data or otherwise.

The table shows the total numbers of attendees on each specialist course provided:





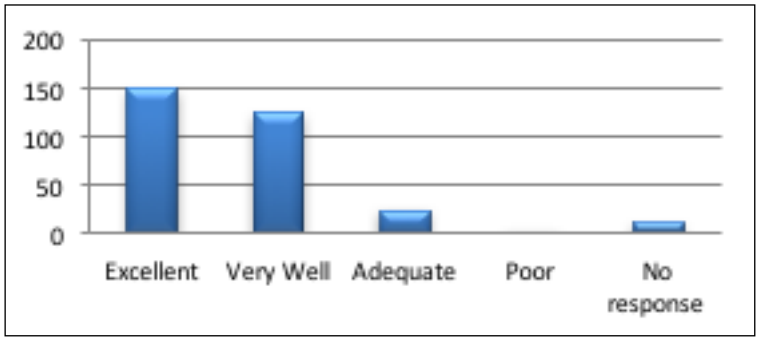
The breakdown of delegates in relation to the organisation they work for is broken down in the table below. It shows that delegates from all safeguarding organisations were able to access multi-agency training.

Overall ratings of events

At the end of each training session delegates were asked to rate the sessions from one to ten, one being poor ten being excellent. Delegates were also asked to rate the speakers and facilitators. These were rated as poor, adequate, good, very good, or excellent.

The combined results from all completed evaluation forms on the day were:

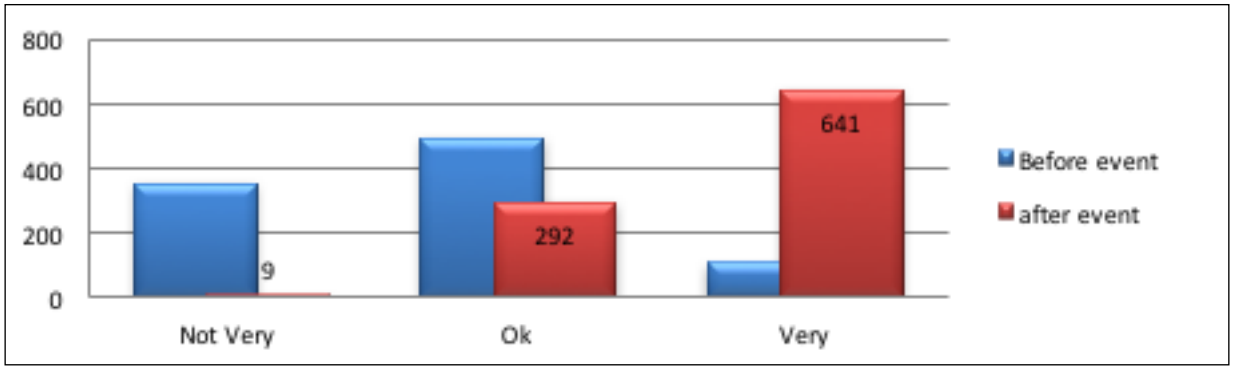
Overall ratings of events



Learning

Each delegate was asked about their level of awareness, confidence, or understanding of the specific areas being covered during a session, before and after the session:

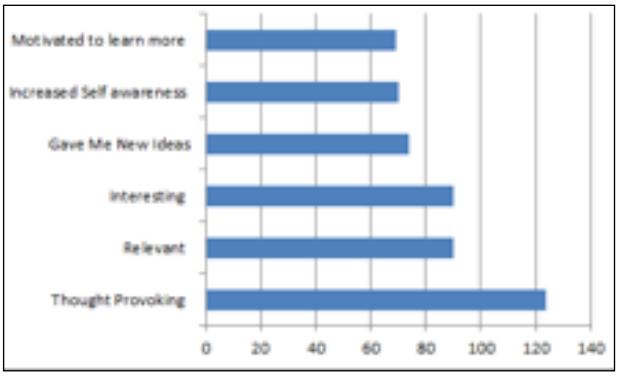
Learning after the events overall ratings



The table clearly shows that delegates felt that the learning increased their knowledge about the specific subject area in almost all instances. Appendix 1 includes a full breakdown of all training course learning and feedback.

Key thoughts from delegates

At the end of the sessions delegates were asked to select three key words/phrases that best described how they viewed the training sessions.



The table shows the top six chosen, from a list of 25.

Information available to the LSAB shows a good level of training provision locally and it plans to continue to provide specific multi-agency training during 2016/17.

Improving safeguarding in 2016/17 – Strategic plan 2016/17

At the beginning of 2016, the board and many of its member organisations underwent a major change of personnel. Dr David Jones retired from his role as independent chair after three years of leading the LSAB and supporting its developments and improvements. A new Police & Crime Commissioner was voted in and his representative on the LSAB for many years is due to retire in the summer of 2016. A further retirement of the CCG lead and changes within the leadership and management of Adult Social Care with a major structural review during 2015, has resulted in an almost complete change of major leaders within the safeguarding adults arena locally.

In February 2016 the new Independent Chair, Jane Geraghty, supported by Dr Ade Cooper facilitated the board to review and revise its business priorities. The following priorities were agreed for 2016/17:

Core business/statutory requirements:

1. Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
2. Publish an annual report detailing how effective their work has been.
3. Commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

Strategic business priorities:

1. 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.
2. This includes young people who have been identified as being at continued risk as a young adult due to child sexual exploitation.
3. To provide assurance to the board that systems allow the identification of organisations/agencies that present a safeguarding risk.
4. To assure the board that actions are taken (and robust processes are in place) to address when systemic failures and concerns are identified.

5. Identify what influences the high numbers of referrals relating to adults in care environments compared to alerts of abuse that takes place elsewhere, and develop remedial actions, where needed, to redress the balance.

6. The board will be assured on the delivery of 'Making Safeguarding Personal', including Section 42 enquiries.

7. The board will explore the use of the 'Making Safeguarding Personal' toolkit.

8. 'Making Safeguarding Personal' is fully embedded within local safeguarding activity and measured as part of data collection.

9. There is an agreed public facing communication action plan and delivery that provides assurance that safeguarding messages are reaching all communities.

10. Workforce awareness-raising – identify areas of the workforce that are not fully aware of safeguarding adults issues.

11. Develop and deliver a workforce awareness-raising plan to provide assurance that all parts of workforce are aware of safeguarding issues.

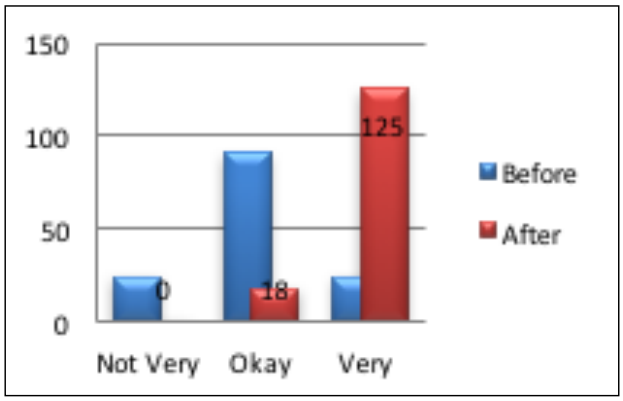
12. Oversee and progress SARs, DHRs and other adult reviews.

In order to achieve its priorities, the board has reviewed its membership and strengthened it where this was needed:

- Healthwatch will be represented from 2016 onward.
- All agencies providing services will be represented in recognition of the fragmentation of the service.
- The LSAB has communicated with CQC about their lack of attendance during 2015/16.
- It has reviewed and where needed revised its network and structure (see Appendix 2 – Board Structure Chart).
- A new service user reference group will support the board's work from July 2016.
- The board office has been strengthened through the appointment of a DHR coordinator and full time administrator. Temporary appointments have been made for the board manager to provide stability in the medium term.
- There is an appropriate budget in place through funding and a three-way split by the statutory partners: Adult Social Care, CCG and Police.

Appendix 1 – Training specific feedback

Learning from events for specific training sessions



Compassion in care

16% before the session not very aware, confident or knowledgeable of subject. After session this went down to **0%**.

64% before the session thought their knowledge; confidence in awareness of subject was okay compared **10%** after the session.

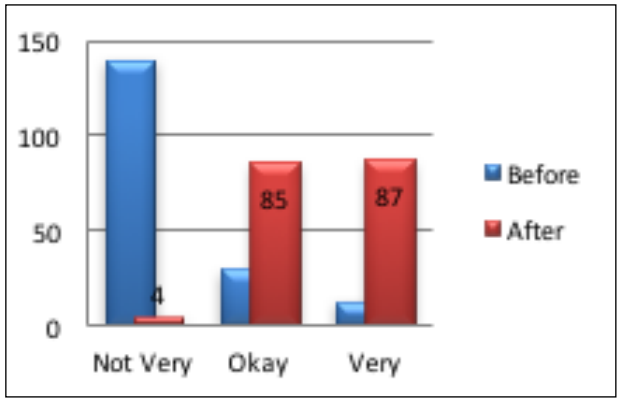
17% were very aware, confident or knowledgeable before the session, **87%** after the session.

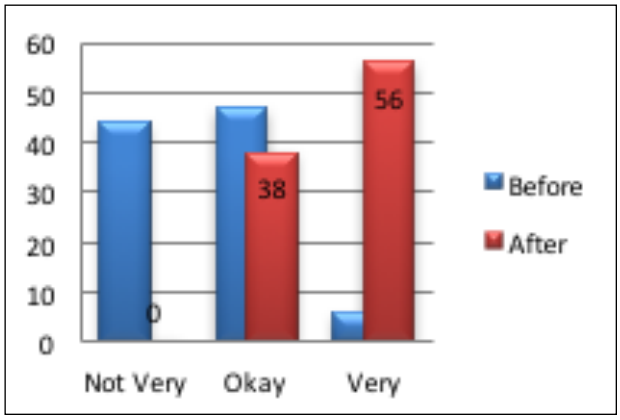
Drug and alcohol awareness training

77% before the session not very aware, confident, or knowledgeable of subject. After session this went down to just **2%**.

20% before the session thought their knowledge; confidence in awareness of subject was okay compared to **59%** after the session.

8% were very aware, confident or knowledgeable before the session, **61%** after the session.





Hate crime and Prevent awareness

45% before the session not very aware, confident, or knowledgeable of subject. After session this was **0%**

48% before the session thought their knowledge; confidence of awareness of subject was okay compared to **39%** after the session.

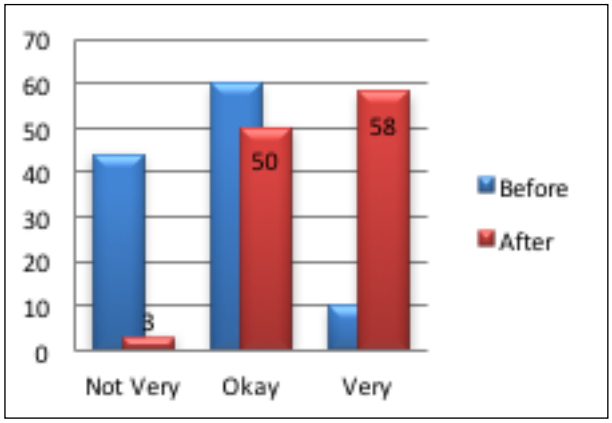
6% were very aware, confident or knowledgeable before the session, **58%** after the session.

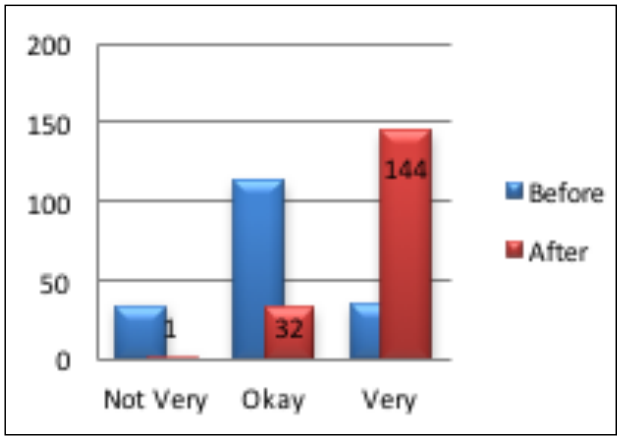
MCA forum – Court of Protection

37% before the session not very aware, confident, or knowledgeable of subject. After session this went down to just **3%**

53% before the session thought their knowledge; confidence of awareness of subject was okay compared to **44%** after the session.

9% were very aware, confident or knowledgeable before the session, **51%** after the session.





MCA provider only forum

18% before the session not very aware, confident, or knowledgeable of subject. After session this went down to just **0%**.

63% before the session thought their knowledge; confidence of awareness of subject was okay compared to **18%** after the session.

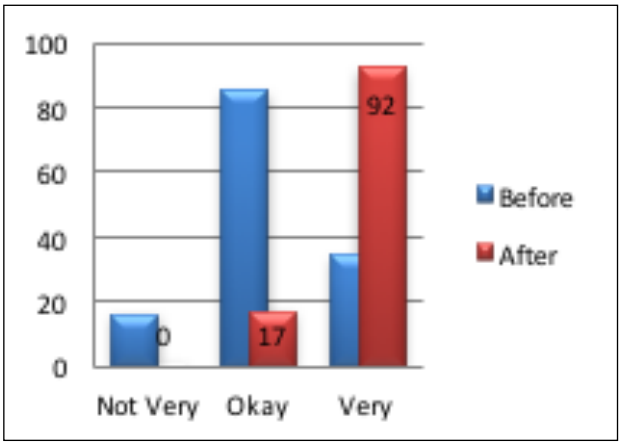
19% were very aware, confident or knowledgeable before the session, **80%** after the session.

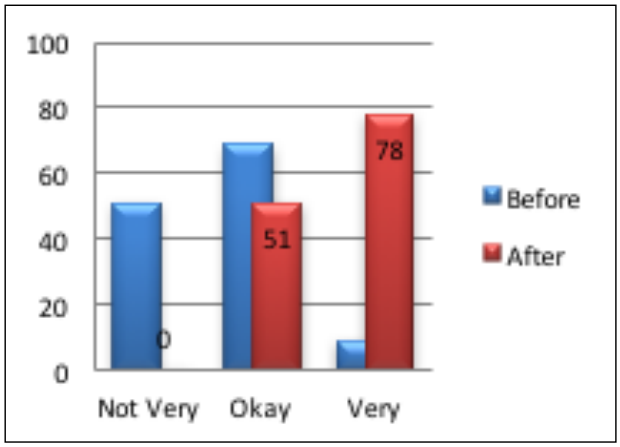
Self-neglect

12% before the session not very aware, confident, or knowledgeable of subject. After session this went down to **0%**.

63% before the session thought their knowledge; confidence of awareness of subject was okay compared to **12%** after the session.

25% were very aware, confident or knowledgeable before the session, **68%** after the session.





Vulnerable Adults Risk Management (VARMS)

40% before the session not very aware, confident, or knowledgeable of subject. After session this went down to **0%**.

53% before the session thought their knowledge; confidence of awareness of subject was okay compared to **40%** after the session.

were very aware, confident or knowledgeable before the session, 60% after the session.

Health and Wellbeing Board

East Midland SAB

Leicester City Council & Scrutiny Committee

National SAB Chair Meeting

Leicester

Safeguarding Adults Board

Chair – Jane Geraghty (Independent)
Board Office Support – Barbara Grell (LSAB Manager

Adult Learning & Review
Chair – Simon Cure
Leicestershire Police
Board Support - LB

Performance, Effectiveness & Quality
Chair – Ruth Lake (LCC)
Board Support – TE & B

Awareness & Public Engagement & Training
Chair – Adrian Spanswick
Board Support - TE

LSAB Service User Reference Group

MARAC
MAPPA
SV & DV
Strategy

Making Safeguarding Personal
Lead – Jane Boulton (ASC)
Deputy – Jenny Williams
Board Support – TE

Making Safeguarding Personal
Lead – Jane Boulton (ASC)
Deputy – Jenny Williams
Board Support – TE

Institutional Abuse
Lead – Healthwatch
Deputy – Ann Ford
Board Support – BG

LLR Financial Abuse
Lead – Barney Thorne (Police)
Deputy –
Board Support – BG

LLR LSCB CSE, Trafficking & Missing Subgroup
LSAB Rep – TBC
Chair – Victor Cook
Service Manager Safeguarding Adults Leicestershire CC

Communication Work stream
LLR
LSAB link – JW
Chair – Barney Thorne (Police)
Board Support – TE

LLR SAB Procedures and De-velopment Subgroup
LSAB link – Jane Boulton
Chair – Mark Goddin
(ASC Leicestershire)
Board Support – TE

Safer Leicester Partnership

ADASS, LGA, National & Regional Safeguarding Adults Board Network

LSAB Subgroups

LLR Groups

LSAB Task & Finish Groups

Safer Leicester Partnership Link