Meeting: **Adults and Communities Overview and Scrutiny Committee**

Date/Time: **Monday, 2 September 2024 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Mrs. A. Smith (0116 305 2583)**

Email: **angie.smith@leics.gov.uk**

Membership

Mr. T. J. Richardson CC (Chairman)

Mr. G. A. Boulter CC
Mr. B. Champion CC
Mr. N. Chapman CC
Mr. J. Miah CC
Mr. L. Hadji-Nikolaou CC
Mr. P. King CC

Please note: this meeting will be filmed for live or subsequent broadcast via the Council's web site at http://www.leicestershire.gov.uk

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 3 June 2024.		(Pages 5 - 12)
2.	Question Time.		
3.	Questions asked by members under Standing Order 7(3) and 7(5).		
4.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
5.	Declarations of interest in respect of items on the agenda.		
6.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.		

7.	Presentation of Petitions under Standing Order 35.		
8.	Leicestershire and Rutland Safeguarding Adults Board Annual Report 2023/24.	Independent Chair of the Leicestershire and Rutland Local Safeguarding Adults Board	(Pages 13 - 58)
9.	Performance Report for Quarter 1 2024/25 (April - June).	Chief Executive and Director of Adults and Communities	(Pages 59 - 72)
10.	Annual Adult Social Care Complaints and Compliments Report 2023-24.	Director of Adults and Communities	(Pages 73 - 92)
11.	Peer Review of Pathway for Adulthood.	Director of Adults and Communities	(Pages 93 - 124)
12.	Leicestershire County Council Adult Social Care Regulated Services.	Director of Adults and Communities	(Pages 125 - 136)

13. Date of next meeting.

    The next meeting of the Commission is scheduled to take place on 4 November 2024.

14. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Governance and Scrutiny website www.cfgs.org.uk. The following questions have been agreed by Scrutiny members as a good starting point for developing questions:

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

Members are reminded that, to ensure questioning during meetings remains appropriately focused that:

(a) they can use the officer contact details at the bottom of each report to ask questions of clarification or raise any related patch issues which might not be best addressed through the formal meeting;

(b) they must speak only as a County Councillor and not on behalf of any other local authority when considering matters which also affect district or parish/town councils (see Articles 2.03(b) of the Council's Constitution).

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Agenda Item 1

Leicestershire County Council

Minutes of a meeting of the Adults and Communities Overview and Scrutiny Committee held at County Hall, Glenfield on Monday, 3 June 2024.

PRESENT

Mr. T. J. Richardson CC (in the Chair)

Mr. G. A. Boulter CC	Mr. L. Hadji-Nikolaou CC
Mr. B. Champion CC	Mr. P. King CC
Mr. N. Chapman CC	Mr. J. Miah CC

In attendance

Mrs. C. Radford CC – Lead Member for Adults and Communities
Mr. T. Parton CC – Cabinet Support Member

1. Appointment of Chairman.

RESOLVED:

That Mr. T. J. Richardson CC be appointed Chairman for the period ending with the date of the Annual Meeting of the County Council in 2025.

Mr. T. J. Richardson CC in the Chair

2. Appointment of Deputy Chairman.

RESOLVED:

That M. N. Chapman CC be elected Deputy Chairman for the period ending with the date of the Annual Meeting of the County Council in 2025.

3. Minutes.

The minutes of the meeting held on 4 March 2024 were taken as read, confirmed and signed.

4. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 34.

5. Questions asked by members under Standing Order 7(3) and 7(5).

The Chief Executive reported that no questions had been received under Standing Order 7(3) and 7(5).

6. Urgent items.

There were no urgent items for consideration.

7. Declarations of interest in respect of items on the agenda.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

No declarations were made.

8. Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.

There were no declarations of the party whip.

9. Presentation of Petitions under Standing Order 35.

The Chief Executive reported that no petitions had been received under Standing Order 35.

10. Performance Report 2023/24 - Position at March 2024.

The Committee considered a report of the Director of Adults and Communities which provided an update of the Adults and Communities Department's performance for the year 2023/24. A copy of the report marked 'Agenda Item 9' is filed with these minutes.

Arising from the discussion the following points were made:

i. Members were encouraged to hear how libraries had morphed from simply lending books, to providing other services, and welcomed the increase in volunteers. It was queried how more could be done to encourage others to use libraries to deliver services from the County Council in a more cost-effective way.

ii. Members mentioned that there was a substantial increase in income from people accessing care. The Director said it was a discussion being had across the country in terms of how to balance out the increased demand for people in receipt of adult social care, which in turn increased revenue from contributions, with the cost of delivering those services.

iii. The Director continued that up to the first half of 2023/24, there had been a 1.5% increase in the number of people receiving services. However, through mitigations put in place for the latter half of the year, there had been a 4.5% reduction in the number of people in receipt of long-term support. He added that when put into financial context at the half-year point in 2023, Adult Social Care were £7million overspent, looking at potentially over £10million by the end of the financial year. Through mitigation of some of the increased demand, however, the overspend had been reduced to £2.5million (about 1% of the budget).

iv. A Member queried, if the outcomes of the 49.6k recorded contacts from people asking for advice and support could be broken down into types of

enquiry. The Director confirmed that a report had been brought to the Committee in June 2023 entitled 'Care Data Matters' which outlined a change in data and the information being reported by local authorities and providers of adult social care, one aspect of which was statutory reporting to NHS England. As a result, sequels to contacts that had previously been 'mapped' against layers of the Strategy for the Adults and Communities Department, namely 'Prevent', 'Reduce', 'Delay' and 'Meet' need, would need to adjust over the coming year and as such the format of the report was changing to reflect the new government data requirements. The Director undertook to provide further detail behind the contacts to Members for information.

v. A Member questioned in what format the 49.6k enquiries had been made, for example, by email, telephone or through the website, and if, it had been easy for people to find out information. Members were assured that the website and effectiveness of it, particularly for Adults and Communities, and been looked at over the years. The Director reported that there was a programme of work currently looking at improving Adults and Communities customer service, particularly focussing on some of the work that took place inside the Customer Service Centre. A report on the outcome of this work would be brought to the Committee later in the year detailing operational activity, trend analysis, and objectives going forward.

RESOLVED:

a) That the Performance Report 2023/24 – Position at March 24, be noted and welcomed.

b) That a further report be brought to the Committee under the new reporting format, to provide trend analysis on sources of referral.

11. Outcome of the Consultation on the Future of the Transitions Learning Programme.

The Committee considered a report of the Director of Adults and Communities the purpose of which was to share the findings of the consultation on the future of the Transitions Learning Programme (TLP) and to seek the views of the Committee on the proposals to close the service. A copy of the report marked 'Agenda Item 11' is filed with these minutes.

Arising from discussion the following points were made:

i. Two young people continued to access the TLP, both of whom had profound, multiple learning difficulties. When consulting on the service, other similar provision was discussed that would meet the needs of the young people, however, both of the young people's families felt that those schools weren't appropriate.

ii. Discussions continued with the families, and packages were being developed around each of the young people, each of whom had an Education Health Care Plan (EHCP), which meant there was a statutory obligation upon the County Council to deliver the provision set out within these. Members were assured that this did not change with regards to their educational needs which would still have to be met. The packages would also need to ensure

other provisions, such as access to occupational therapy and a speech and language therapist.

iii. From a legal perspective the packages would come under education other than in schools, which were packages developed for other children and young people in Leicestershire. The packages for the two young people involved would be highly complex, because of the complex needs of the two young people, but from a multi-agency perspective. By working with the families, there was confidence that adequate provision would be put in place to satisfy their ongoing needs as currently required in their EHCPs.

iv. Members queried what the difference would be for the two young people affected in terms of the service currently provided against what might be proposed, and how their transition across to the new provision would be managed. Members sought assurance that the process would be made as comfortable as possible for the young people and their families. Officers reported that there were concerns raised by the parents in terms of provision being delivered in the home environment. It was recognised that providing this outside the home did provide and important respite element for the families. However, by looking at alternative providers and working with NHS colleagues to provide a community base that could accommodate equipment required, it was felt that a package could be put in place. Parents would be involved in the discussions throughout to ensure any disruption during the transition would be minimised.

v. Members queried if the new provision would be detrimental or better than the current TLP provision. Officers reported that the provision would meet the needs detailed with the young people's EHCP but that this would be different, and it was recognised that for young people with significant disabilities, any change could be disruptive and a time of upheaval and stress, for them and their families. Officers would however seek to minimise this as much as possible through continued discussion with the families.

vi. Work would continue to ensure the new package for the two young people affected was put in place for September. It was acknowledged that the timing would be tight, but that as conversations had taken place over a period of time, with the needs and views of families being considered throughout, officers considered this to be achievable.

vii. Members were reassured that the young people had some respite outside of school time and that this would remain unchanged irrespective of whether or not the TLP continued.

viii. In response to a query, Members were informed that each young person with an EHCP had an annual review, so the packages of the two young people would be reviewed in this way and the views of the parents and carers, and the views of both the young people, would be taken into account as part of this process. Though the young people had very limited ability to express views, it was possible to know whether they were happy or experiencing distress and so the position would be monitored throughout.

ix. Members acknowledged the financial reasons for the removal of the TLP. Members were reminded that the service cost around £350,000 per annum, but at full capacity it would still run at a deficit, as it was costing more than the

funding received to run the service. The Programme could accommodate 7 young people in total and so was currently operating at a bigger deficit due to there being only two learners within the programme. The Director explained that the TLP was funded through three routes: Special Educational Needs; Adult and Community Services; Adult Education Services. Funding through special educational needs was funded on an individual basis, therefore, the fewer learners enrolled, the less funding was allocated, which meant the funding received was less than the cost of provision.

x. A Member queried what would happen if the alternative external provision cost the Council more than the current provision should a provider increase its costs in the future. Officers reported that for the two young people there would need to be very specific commissioning, therefore the package would have a cost implication, but with planning and working with special schools and colleges moving forward provision would be ensured within the system to be able to manage these costs effectively.

xi. Members sought assurance that they would be kept informed on the transition of the two young people to their new service provision. The Director undertook to provide Committee Members with an update after a period of settlement.

xii. Members noted that the support provided to the individuals would, from September 2024, fall under the remit of the Children and Family Services Department and would therefore be reported, as appropriate, to the Children and Families Overview and Scrutiny Committee. Members urged that there be continued monitoring of the provision to the young learners included in the recommendation to the Cabinet.

RESOLVED:

a) That the report on the Outcome of the Consultation on the Future of the Transitions Learning Programme be noted.

b) That, should the Cabinet's decision be to close the TLP, the Director be requested to, provide an update on the transition of the two young people affected following a period of settlement and that the Chairman of the Children and Families Overview and Scrutiny Committee be notified of the Committee's concerns regarding their transition and urged to also monitor their progress as considered appropriate, in discussion with the Director of Children and Family Services.

12. <u>Archives, Collections and Learning Centre.</u>

The Committee considered a report of the Director of Adults and Communities which provided an update on the outcome of the private scrutiny workshop held regarding the Archives, Collections and Learning (ACL) Centre. A copy of the report marked 'Agenda Item 12' is filed with these minutes.

The Chairman thanked all officers and Members who attended the workshop, which importantly had provided a holistic view of the issues and involved property and finance officers, as well as officers from the Adults and Communities Department.

He also thanked the Cabinet Lead Member who had also participated in the discussion.

In presenting the report, the Director advised that:

i. Accreditation status from The National Archives (TNA) had been retained for two years (usually six years) on the proviso that within the next two years the County Council resolved the ongoing issues around the storage and access to records, alongside another recommendation that digital records were progressed.

ii. There would be an Arts Council England accreditation assessment of the museum service. A date for this was yet to be confirmed but it was expected imminently.

iii. The capital and revenue projections requested at the workshop to cover a 25-year period for storage off site and retrieval, was being worked upon. It was the view of the Director that it would be a similar revenue cost to capital cost, so would likely be in the region of £20million. It was further noted that the £5million cost over the first five-year period included £1.7million capital requirement to maintain the Record Office at Wigston.

Arising from discussion, the following points were made:

iv. In light of the financial information made available during the private workshop, Members concluded that the cost of borrowing money to proceed with the new ACL Centre would not be dissimilar to the revenue required for the alternative options and would result in the Council having a building that would meet growing demand as was required for accreditation. It was recognised that further work was needed to fully assess costs over a 25-year period to inform the Cabinet's decision which was being produced.

v. Members noted that the risk of losing accreditation would mean the County Council could be instructed on how to store items by the appropriate bodies with no regard as to the cost which would still need to be met by the Authority.

vi. A Member queried if there was an opportunity to dispose of collection items to reduce the space required and raise some funds. The Director reported that there was a slight difference to museum collections and archive collections. The Museums Service had had an active programme of rationalisation and disposal since 2015, and there had been a reduction in collections over that time. With regards to the Record Office there was very little that was taken in to be stored that did not need to be retained, and with regards to the public record had an obligation to keep. No further space was being sought for museum collections as with a different configuration the number of buildings currently being used could be consolidated and reduced. With regards to the record office provision, the County Council are required by the TNA to have 25-years growth space and provision for that growth had to be secured to retain accreditation beyond the two years.

vii. The Director reported that other areas of funding had been explored but the County Council was precluded from most grant funding because the storage of records was a statutory requirement the Council had to budget for.

RESOLVED:

a) That the report regarding the Archives, Collections and Learning Centre be noted and welcomed.

b) That the report and comments of the Adults and Communities Overview and Scrutiny Committee be forwarded to Cabinet for consideration at its meeting on 21 June 2024.

c) That in light of the discussions held the Cabinet be advised that the recommendation of the Adults and Communities Overview and Committee was that the development of the ACL Centre be reaffirmed, and consideration given to funding being allocated to deliver this in the refreshed MTFS for 2024/25 – 2028/29.

13. Dates of future meetings.

The dates of future meetings of the Committee scheduled to take place on the following dates, all on a Monday at 2.00pm, were noted:

2 September 2024
4 November 2024
20 January 2025
3 March 2025
2 June 2025
1 September 2025
3 November 2025

2.00pm to 3.16pm CHAIRMAN
03 June 2024

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Agenda Item 8

Leicestershire County Council

ADULTS AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE 2 SEPTEMBER 2024

LEICESTERSHIRE AND RUTLAND SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2023/24

REPORT OF THE INDEPENDENT CHAIR OF THE LEICESTERSHIRE AND RUTLAND SAFEGUARDING ADULTS BOARD

Purpose of the Report

1. The purpose of this report is to seek the views of the Committee on the draft Annual Report of the Leicestershire and Rutland Safeguarding Adults Board (LRSAB) for 2023/24, attached as Appendix A to this report.

2. The Annual Report is the report of the Independent Chair of the LRSAB who must publish an annual report on the effectiveness of safeguarding adults in the local area. This is a statutory requirement under the Care Act 2014.

Policy Framework and Previous Decisions

3. The LRSAB is a statutory body established as a result of the Care Act 2014. The main purpose of the LRSAB is to ensure effective, co-ordinated multi-agency arrangements for the safeguarding of adults with care and support needs.

4. The Committee considered the Strategic Plan of the LRSAB for 2020-2025 at its meeting on 7 September 2020.

Background

5. Safeguarding Adults Boards have three core duties. They must:

   - Develop and publish a Strategic Plan setting out how they will meet their objectives and how their member and partner agencies will contribute;
   - Publish an Annual Report detailing how effective their work has been;
   - Commission Safeguarding Adults Reviews for any cases which meet the criteria for these.

6. The Annual Report relates to the second of these duties.

Annual report for 2023/24

7. The Annual Report provides details of the performance on the local approach to safeguarding adults in line with the requirements of the Care Act 2014.

8. The key purpose of the Annual Report is to assess the impact of the work undertaken in 2023/24 on service quality and on safeguarding outcomes for adults with care and support needs in Leicestershire and Rutland. Specifically, it evaluates performance against the priorities that were set out in the Leicester, Leicestershire and Rutland (LLR) SAB Business Plan 2023-25, which is attached for reference as Appendix B.

9. The key messages from the LRSAB, specifically in relation to Leicestershire are:

a) As is reported nationally, there continues to be pressure on the health and care services and their partners in Leicestershire, and in turn this impacts on the workforce.

b) Regarding the Self-Neglect business priority, the Board has continued work to replace the current Leicester, Leicestershire and Rutland (LLR) Vulnerable Adult Risk Management (VARM) Guidance with refreshed and rebranded LLR Self-Neglect Guidance and templates. Learning from local reviews and audits has indicated that there are some issues around the thresholds for the current VARM process. Consequently, there will be more in the new local Self-Neglect Guidance about risk levels and different types of services, with a view to ensuring each individual receives the right type of intervention. A Task and Finish Group has been working on this update.

The learning points from a Leicestershire and Rutland Safeguarding Adults Review and the Leicester, Leicestershire and Rutland Safeguarding Adults Boards' Multi-Agency Cuckooing Audit, completed in 2022-23, and Self-Neglect Audit completed in April 2024, have been fed into the process and will inform the new guidance. Cuckooing is a form of action, termed by the police, in which the home of a vulnerable person is taken over by a criminal in order to facilitate exploitation, usually associated with county lines drug trafficking.

The Board has continued to monitor, on a quarterly basis via the core dataset, the number of concluded enquiries where self-neglect is recorded as the type of abuse. Further work is being undertaken to capture business plan priority metrics, which will not be solely data driven work.

c) In regard to the Mental Capacity Act (MCA) priority, a Leicester, Leicestershire and Rutland Safeguarding Adults Boards' Multi-Agency Mental Capacity Audit was completed in October 2023.

The Board:

- commissioned Edge Training to provide MCA Training specific to the learning needs of the Safeguarding Adults Boards.

- started to consider how to establish an MCA Community of Practice which will bring staff together for MCA learning and development.

- delivered presentations on the MCA in Practice at the December 2023 Safeguarding Matters Live Event and to the Leicester, Leicestershire and Rutland Safeguarding Children Partnerships/ Safeguarding Adults Boards Voluntary and Community Sector Forum in February 2024.

- received a report from University Hospitals of Leicester NHS Trust (UHL) on the management of Deprivation of Liberty Safeguard (DoLS) applications.

d) In relation to the Domestic Abuse Business Priority, the Partnership supported a Domestic Abuse and Safeguarding Research Project, entitled “Perpetrators of Domestic Abuse Against Older Adults: Characteristics, Risk Factors and Professional Responses”, carried out by Durham University. The final draft of the report was presented to the Safeguarding Adults Boards at the end of 2023-24. Local partners are now considering the implications for their single agencies. The Safeguarding Adults Boards will then identify where a collective response, actions and monitoring are required. The results of this research will be actioned during the next business year 2024/25.

   The Board has also adapted a short video, produced by Norfolk Safeguarding Adults Board, for Leicester, Leicestershire and Rutland about Domestic Abuse in Older People, entitled “Hidden Harms”. It is now available on the Leicester, LRSAB YouTube Channel here and has been widely promoted.

   The Board carried out awareness raising in relation to the category of domestic abuse and the relationship between the people involved in the safeguarding enquiry.

e) There were fewer Safeguarding Adults Reviews commenced in 2023/24. Work continues to implement the lessons learnt from Safeguarding Adults Reviews.

Proposals/Options

10. The Committee is asked to consider the draft Annual Report for the LRSAB appended to this report and to make any comments or proposed additions or amendments. Any comments will be considered and addressed prior to the final report being published, if required.

Consultation

11. The Annual Report is produced as a summary of the work of the SAB which has been carried out in relation to safeguarding and prevention. The report will be published later in September 2024 on the Leicestershire and Rutland Safeguarding Adults Board website here.

12. All members of the Board have had opportunities to contribute to and comment on earlier drafts of the Annual Report.

Resource Implications

13. There are no resource implications arising from this report, as this is a retrospective report covering April 2023 to March 2024.

14. The LRSAB operates with a budget to which partner agencies contribute.

15. Safeguarding Adults Board partners have, along with safeguarding partners for safeguarding children, agreed to share the operating costs of the Safeguarding

Children Partnership (SCP) and SAB for Leicestershire and Rutland. Costs are shared between the Local Authorities, Police and Integrated Care Board.

16. As part of this agreement the County Council contributed £119,266 to the SAB and SCP in 2023/24. This is 33% of the total funding for the SAB and SCP (£364,633). This matches the contribution from 2022/23.

17. Expenditure has increased this year by £18,203. Staffing costs increased as a result of the agreed Leicestershire County Council pay award (as the staff are hosted by this Local Authority). Expenditure on Safeguarding Adults Reviews decreased due to the number of reviews already being in an advanced stage and alternative methodologies being used, as appropriate. As of 1 April 2024, the Safeguarding Adults Board's reserve funds stand at £95,350. Plans for further use of these reserve funds will be drawn up in the coming year. This amount has been held due to a potential increase in costs and has meant that partners have not been asked for an increase; however, this surplus will eventually be used and therefore all partners will be expected to ensure that the LRSAB is self-sufficient.

18. The County Council also hosts the Safeguarding Partnerships Business Office that supports the SAB and the SCP.

Timetable for Decisions

19. This report seeks comments from this Committee prior to presenting the report to Cabinet on 13 September 2024, particularly in relation to the business of the County Council.

20. Subject to consideration by the Cabinet, the Annual Report will be published by the end of September 2024 and presented at the meeting of Leicestershire's Health and Wellbeing Board on 26 September 2024 (to highlight safeguarding matters relevant to the work of the Health and Wellbeing Board and support effective partnership working).

Background Papers

Report to the Adults and Communities Overview and Scrutiny Committee on 4tSeptember 2023: "Leicestershire and Rutland Safeguarding Adults Board Annual Report 2022/23".

Circulation under the Local Issues Alert Procedure

None.

Equality Implications

21. The LRSAB seeks to ensure that a fair, effective and equitable service is discharged by the partnership to safeguard adults with care and support needs. At the heart of the work is a focus on any individual or group that may be at greater risk of safeguarding vulnerability. The Annual Report includes a summary analysis of the characteristics of the subjects of Safeguarding Adults Reviews.

Human Rights Implications

22. There are no Human Rights implications arising from this report.

Crime and Disorder Implications

23. The LRSAB works closely with Community Safety Partnerships in Leicestershire to scrutinise and challenge performance in community safety issues that affect the safeguarding and wellbeing of individuals and groups, for example domestic abuse and Prevent. The Safeguarding Partnerships Business Office also supports Community Safety Partnerships in carrying out Domestic Homicide Reviews.

Environmental Implications

24. The published LRSAB Annual Report will primarily be made available online in electronic form, rather than paper. There are no environmental implications arising from this report.

Partnership Working and Associated Issues

25. Safeguarding is dependent on the effective work of the partnership as set out in national regulation relating to the Care Act 2014.

Appendices

- Appendix A – Draft Leicestershire and Rutland Safeguarding Adults Board Annual Report 2023/24
- Appendix B – Leicester, Leicestershire and Rutland Safeguarding Adults Board Business Plan 2023-25.

Officers to Contact

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Safeguarding Adults Board
LEICESTERSHIRE & RUTLAND

Leicestershire & Rutland

Safeguarding Adults Board Annual Report - 2023-24

A Message from the Independent Chair

It is a privilege to introduce the Annual Report for Leicestershire and Rutland Safeguarding Adults Board (SAB) for 2023/24.

I am grateful to all partners for their contribution to the Board, and their ongoing support. It is important to lead the SAB in delivering its priorities as part of the continuous learning journey for all engaged in adult safeguarding, and the well-being of people in Leicestershire and Rutland. As highlighted, partners have been working hard to make a difference with and for people. They have continued to deliver services, provide care and support to people, and respond to the changing safeguarding needs and risks that occur in what can be described as challenging times for public services, and the effects post COVID-19. It would be fair to say this continued to impact upon people as seen by all partners.

The subgroups, and in particular the Chairs, are owed much gratitude for their dedication and commitment to ensuring that the SAB's priorities are delivered. There have been important areas of work undertaken in the year.

A high-level data dashboard has been agreed so that SAB partners are able to understand through a "temperature check" what this high-level data is telling us about where we need to explore and support frontline practitioners in their duties and, if issues occur with fluctuations, how we understand the reasons and ensure all partners contribute to resolving any that may arise.

Mental Capacity remains an area of significant work as it is the responsibility of partners to be able to identify and, on occasions, make decisions with regard to capacity in order to ensure safety and protection as required. Audit work, Safeguarding Adults Reviews and data highlight this is an area of continuing development across all organisations. An area of particular interest has been domestic abuse of those over 60 years and whether this is recognised in the same way as for the younger population. The SAB has worked with Durham University who have undertaken the research, and the SAB is currently considering the findings and will be developing actions which will be reported in the Annual Report for 24/25.

The SAB has set its priorities for 2024/25 on the basis of the information provided through reviews of practice as part of the audit work undertaken, data collection, safeguarding adults reviews, national feedback from reviews and emerging issues that have been identified. The SAB has agreed over the 2-year period 2023-2025 priorities of self-neglect, mental capacity and domestic abuse.

I would like to thank the Board Manager and the Team for efficiently and effectively managing the business of the Board. I would also like to acknowledge the work of the staff and managers across all statutory, voluntary and community partners who are committed to working together to keep people safe in Leicestershire and Rutland.

Seona Douglas

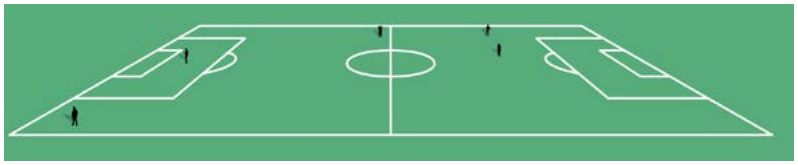
Local Context

The Census shows that, in 2021, the population of Leicestershire (not including Leicester City) rose from 650,600 in 2011 to 712,300. Across the 7 council areas in 2021, Blaby was home to around 5.6 people per football pitch-sized piece of land, Charnwood was 4.7 people, Harborough 1.2 people, Hinckley & Bosworth 2.7 people, Melton 0.8 people, North West Leicestershire 2.7 people, and Oadby and Wigston 17.5 people. More statistics regarding Blaby can be found here; for Charnwood here; for Harborough here; for Hinckley & Bosworth here; for Melton here; for North West Leicestershire here; and for Oadby and Wigston here.

As of 2021, of the East Midlands' 35 local authority areas our council areas are populated as follows:

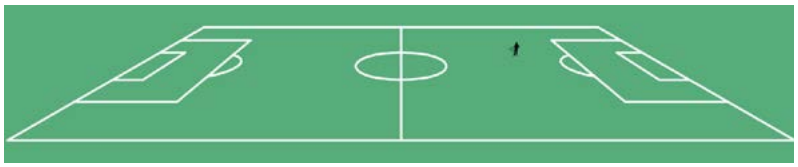
Blaby,
12th most densely populated

Around **6 people** on a football pitch-sized area of land



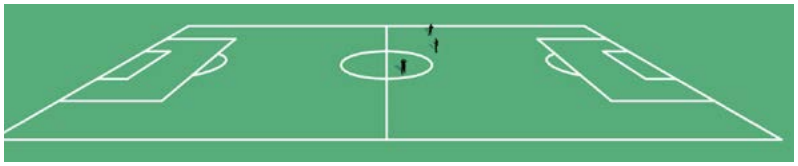
Charnwood,
13th most densely populated

Around **5 people** on a football pitch-sized area of land



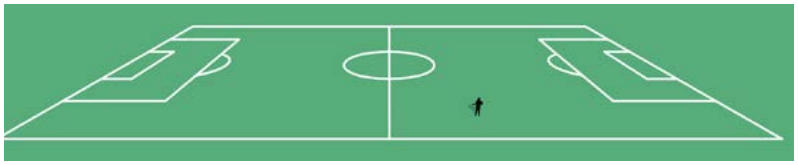
Harborough,
9th least densely populated

Around **1 person** on a football pitch-sized area of land



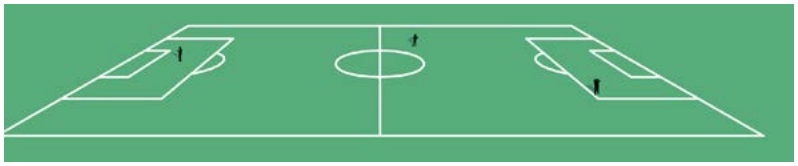
Hinckley & Bosworth,
16th most densely populated

Around **3 people** on a football pitch-sized area of land



Melton,
5th least densely populated

Around **1 person** on a football pitch-sized area of land



North West Leicestershire,
17th most densely populated

Around **3 people** on a football pitch-sized area of land

Oadby and Wigston,
5th most densely populated

Around **18 people** on a football pitch-sized area of land

The Census shows that, in Rutland, the population size increased by 9.7%, from around 37,400 in 2011 to 41,000 in 2021. This was higher than the increase for the East Midlands (7.7%). There was an increase of 31.2% in people aged 65 years and over, an increase of 4.0% in people aged 15 to 64 years, and an increase of 2.4% in children aged under 15 years. More statistics can be found here.

Rutland,
4th least densely populated

Around **1 person** on a football pitch-sized area of land

The Safeguarding Adults Board

The Care Act 2014 stipulates that each local authority must set up a Safeguarding Adults Board (SAB). The main objective of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area. A Safeguarding Adults Board must publish an annual report detailing what it has done during the year to achieve its main objectives and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action.

The work of the Safeguarding Adults Board is informed by the six key principles which underpin all adult safeguarding work, as set out in the Care and Support Statutory Guidance:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability.

The Leicestershire & Rutland Safeguarding Adults Board brings together organisations across the counties of Leicestershire and Rutland to oversee the multi-agency approach to safeguarding adults with care and support needs. The Safeguarding Adults Board:

- Sets how organisations should work together to safeguard adults with care and support needs
- Provides multi-agency training and development resources to support good safeguarding
- Tests how well organisations are working together and the difference this is making
- Reviews serious safeguarding incidents to identify improvements needed
- Uses learning and feedback to improve and develop how agencies work together to safeguard adults.

Safeguarding adults means helping adults at risk who need support from community care services to keep their independence, remain safe and exercise choice in their life. The Board partner agencies from the statutory, voluntary and independent sector come together to seek assurance that the persons thought to be at risk stay safe, are effectively safeguarded against abuse, neglect, discrimination, are treated with dignity and respect and enjoy a high quality of life.

The Independent Chair for Leicestershire and Rutland, Seona Douglas, is jointly appointed with the Leicester Safeguarding Adults Board.

The Safeguarding Adults Board members are made up of the following agencies:

LEICESTERSHIRE & RUTLAND SAB MEMBERSHIP	
Criminal Justice	Leicestershire Police
	HMP Prisons
	National Probation Service (NPS)
Emergency Services	East Midlands Ambulance Service (EMAS)
	Leicestershire Fire and Rescue Service (LFRS)
Health	Leicester, Leicestershire and Rutland Integrated Care Board (ICB)
	Leicestershire Partnership NHS Trust (LPT)
	University Hospitals Leicester NHS Trust (UHL)
Local Authorities (Leicestershire and Rutland)	Adult Social Care
	Lead Member
District and Borough Councils	Joint representative for all areas
Government Department	Department of Work and Pensions
Consumer Champions	Healthwatch

The full membership of the partnership can be found on the Safeguarding Adults Board website: https://lrsb.org.uk/sab-membership-list

The engagement of all partners, at a Board and subgroup level, is monitored. If a partner agency does not attend a number of meetings, this is escalated to the Chair of the group. If the matter remains unresolved, it is further escalated to the Independent Chair. Details of attendance at Board meetings across 2023-24 and the governance of the Board and its subgroups are available at Appendix 1.

The Leicestershire & Rutland Safeguarding Adults Board is funded by contributions from the safeguarding partners. Further information about finance and the budget is available at Appendix 2.

This is the statutory annual report of the Leicestershire & Rutland Safeguarding Adults Board outlining the work it has carried out during 2023/24. For more information on how the Board works, please visit https://lrsb.org.uk/adults

Safeguarding Data

Leicestershire

Safeguarding Enquiries and Alerts

	2022/23	2023/24
Total number of concerns (alerts) raised	5005	1732
Total number of enquiries	494	796
Conversion rate of concerns to enquiries	10%	46%

Concluded Enquiries by Types of Abuse

(more than one type of abuse can be recorded against enquiries so percentages will not add up to 100%)

	2022/23	2023/24
% of completed enquiries which record – Physical Abuse	26%	28%
% of completed enquiries which record – Domestic Abuse	9%	11%
% of completed enquiries which record – Sexual Abuse	9%	6%
% of completed enquiries which record – Psychological Abuse	25%	25%
% of completed enquiries which record – Financial or Material Abuse	24%	24%
% of completed enquiries which record – Modern Slavery	<1%	<1%
% of completed enquiries which record – Discriminatory Abuse	<1%	<1%
% of completed enquiries which record – Organisational Abuse	7%	5%
% of completed enquiries which record – Neglect and Acts of Omission	41%	35%
% of completed enquiries which record – Self-Neglect	5%	2%

Making Safeguarding Personal

	2022/23	2023/24
% of incidents risk removed	39%	30%
% of incidents risk reduced	52%	67%
% of incidents risk remained	10%	3%
% of Making Safeguarding Personal outcomes achieved *fully or partly	93%	95%

There has been a big change in Leicestershire's figures for this year due to a change in recording (alerts) and a change in process (enquiries), and this is obvious when looking at their overall numbers as shown in the table above. For alerts, they were previously capturing any concern for welfare contacts in their figures, but this was thought to be incorrectly inflating their numbers. Leicestershire are now capturing only those contacts, where in the contact, the question 'are safeguarding adults issues indicated' is answered as Yes. For enquiries, halfway through 2023/24 the internal process was changed to open all enquiries after initial triage, which has caused an increase in enquiries reported.

The most common category of abuse in 2023-24 remained neglect and acts of omission.

In 75% of safeguarding enquiries, the individual (or their representative) was asked their desired outcomes, and these desired outcomes were fully or partly achieved in 95% of cases.

Most common category of abuse in 2023-24 remained neglect and acts of omission

"Think the worker is just fantastic. Really lovely way about her as well; you do feel that she listens and that she understands us as a family."

"The Social Worker has done a lot for us. She is the best social worker that we have ever had. Did not have to wait long at all. She is a very warm and friendly person, very easy to get on with. I enjoy her visits."

"I feel better about dealing with my mental health issues – my worker listened to me and has made a difference."

"The worker was AMAZING. I don't know where I would be now without her. She went out of her way to help. She listened to what I needed... I really benefitted from the work and help she provided."

Feedback from people who use Leicestershire services

Rutland

Safeguarding Enquiries and Alerts

	2022/23	2023/24
Total number of concerns (alerts) raised	474	458
Total number of enquiries	56	51
Conversion rate of concerns to enquiries	12%	11%

Concluded Enquiries by Types of Abuse

(more than one type of abuse can be recorded against enquiries so percentages will not add up to 100%)

	2022/23	2023/24
% of completed enquiries which record – Physical Abuse	4%	14%
% of completed enquiries which record – Domestic Abuse	4%	3%
% of completed enquiries which record – Sexual Abuse	4%	3%
% of completed enquiries which record – Psychological Abuse	0%	3%
% of completed enquiries which record – Financial or Material Abuse	13%	22%
% of completed enquiries which record – Modern Slavery	0%	0%
% of completed enquiries which record – Discriminatory Abuse	0%	0%
% of completed enquiries which record – Organisational Abuse	0%	3%
% of completed enquiries which record – Neglect and Acts of Omission	75%	51%
% of completed enquiries which record – Self-Neglect	0%	0%

	2022/23	2023/24
% of incidents risk removed	17%	21%
% of incidents risk reduced	79%	79%
% of incidents risk remained	4%	0%
% of Making Safeguarding Personal outcomes achieved *fully or partly	75%	88%

The number of alerts and enquiries has remained stable.

Towards the end of 2022-23, Rutland started recording, where appropriate, more than one category of abuse against enquiries, whereas previously they would only record one. This approach to recording was embedded throughout 2023-24 and provides a true reflection of the abuse that occurred. The highest category of abuse remains neglect and acts of omission. There has been a further increase in financial abuse, with consecutive rises from 2021-22 to 2022-23 to 2023-24.

"Risk remained" in 0% of cases in 2023-24 and the percentage of Making Safeguarding Personal outcomes achieved rose to 88%.

There has been a further increase in financial abuse, with consecutive rises from 2021-22 to 2022-23 to 2023-24

"Open and up front – clear communication, I had no difficulty understanding what was going on."

"They built my mother's confidence back up. She didn't find it easy to accept help but she seemed to accept it off them, which was great."

"Can't think highly enough of them. They couldn't have done anything better. Really impressed. Good set up. I have heard people complaining about other Councils but I think we seemed to have cracked it here in Rutland. It was great."

Feedback from people who use Rutland services

Meeting our Strategic Priorities

The Leicestershire & Rutland Safeguarding Adults Board set a joint Strategic Plan for 2020-2025 with the Leicester SAB in 2020 which provides the framework for forward priorities of the two SABs.

The strategic priorities are:

Core Priorities

- Ensuring Statutory Compliance – carrying out the required functions of the SAB
- Enhancing Everyday Business of our partners

Developmental Priorities

- Strengthening User and Carer Engagement
- Raising awareness within our diverse communities
- Understanding how well we work together
- Prevention – helping people to stay safe, connected and resilient to reduce the likelihood of harm, abuse or neglect

The Safeguarding Adults Board also sets Business Plans to progress work as part of the Strategic Plan. The work on these business plan priorities is embedded within the assurance, training, procedure and review work of the Safeguarding Adults Board, outlined further in the following sections of this report.

The business plan priorities for 2023-25 are Self-Neglect, Mental Capacity Act and Domestic Abuse. Further detail on these is provided later in the report.

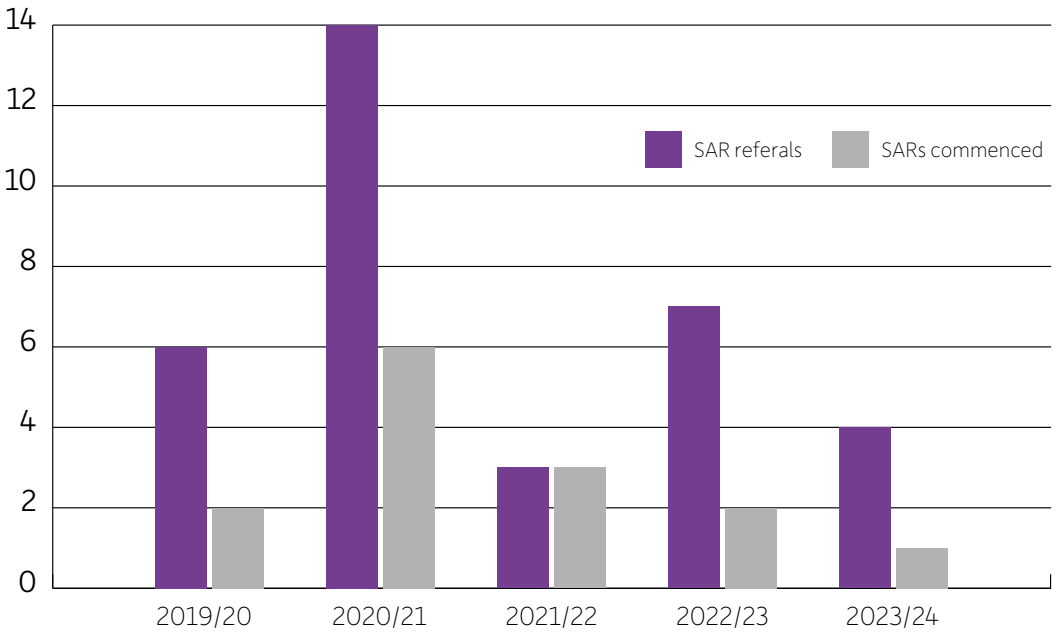
Core Priority 1: Ensuring statutory compliance

Safeguarding Adults Reviews

Safeguarding Adults Boards have a statutory duty under Section 44 of the Care Act 2014 to undertake Safeguarding Adults Reviews (SARs) into cases where individuals with care and support needs have been seriously harmed or died and abuse or neglect is suspected. When these reviews are undertaken they are focused on identifying how multi-agency safeguarding systems and practice can be improved in future.

During 2023-24, the Leicestershire & Rutland Safeguarding Adults Board had four referrals for Safeguarding Adults Reviews. It was identified that one of these referrals met the criteria for a review. With the other referrals, one case was initially referred as a potential Domestic Homicide Review (DHR) and then re-considered as a potential Safeguarding Adults Review but met the criteria for neither type of review, whilst the other two referrals came in just before the end of the financial year and will be considered early in 2024-25.

The chart below shows the number of referrals and Safeguarding Adults Reviews commenced (date case agreed to meet Safeguarding Adult Review criteria) each year for the past five years. In some cases, a Safeguarding Adults Review may have been referred in one year and commenced in the next year.



During 2023-24, the Safeguarding Adults Board continued work on four other Safeguarding Adults Reviews, with one review put on hold due to criminal processes.

All four of these Safeguarding Adults Reviews were completed, with three published on our website during the year and one due to be published in April 2024. Further information about the reviews published in 2023-24 is available at Appendix 3. Leicestershire & Rutland Safeguarding Adults Board also adds its published reviews to the National Safeguarding Adults Review (SAR) Library developed by the National Network for Chairs of Adult Safeguarding Boards.

Of the six people considered as subjects of reviews agreed, on hold or under way during 2023-24:

- Four were female and two were male
- Four were White British, one of Asian ethnicity and one of White and Black mixed heritage
- One was aged over 65 and one was aged under 25.

Since 2020, the Leicestershire & Rutland Safeguarding Adults Board has conducted four Safeguarding Adults Reviews where the subject has been an adult with a Learning Disability and another review is underway. The Board has identified that this is an over-representation of people with a Learning Disability as subjects of Safeguarding Adults Reviews and has addressed this by:

- Establishing better and closer links between the local Safeguarding Adults Boards and the Transforming Care Team and LeDeR (Learning from lives and deaths – People with a learning disability and autistic people) Team.
    - The Transforming Care Team delivered a presentation at Safeguarding Matters Live in June 2023 on the Dynamic Support Register (DSP), which is a pathway developed to provide support for individuals (all age) with a learning disability, autism or both who are deteriorating in their health and wellbeing whilst living in the community.
    - A formal Memorandum of Understanding between the Safeguarding Adults Boards and LeDeR has been agreed and implemented, to ensure that appropriate links are maintained as both have a statutory responsibility to complete reviews on the deaths of people with a learning disability and autistic people, where the criteria are met. These reviews can be completed as parallel processes and can provide an opportunity to share learning, data and offer opportunities for scrutiny and challenge.
- Working on establishing links with other groups whose focus is learning disabilities, such as the Learning Disability and Autism Collaborative, the Leicestershire Learning Disability Partnership Board and Rutland Learning Disability Partnership Board. These are partnership groups, which sit outside of the Safeguarding Adults Board governance structure, which have a learning disability remit and to where Safeguarding Adults Review learning could be fed in, allowing for a joined up, multi-disciplinary response to safeguarding adults with learning disabilities.
- Publishing a special issue of Safeguarding Matters in April 2023, with a focus on safeguarding adults with learning disabilities. It covered the following topics, which have been raised within local Safeguarding Adults Reviews:
    - Case Studies
    - The Voice of the Adult is Heard
    - Communication Passports
    - Being a Good Communicator
    - Addressing and challenging inappropriate language
    - Assessing Risk when essential care is not provided
    - Easy Read Resource – What is an Annual Health Check
    - Easy Read Resource – How to get a Health Check
    - Diagnostic Overshadowing
    - Mental Capacity
    - Easy Read Resource – Consent and Capacity
    - My Role – Primary Care Liaison Nurse (PCLN), Leicestershire Partnership NHS Trust (LPT)

Available to both practitioners and members of the public via our website, this resource encourages reflection on current practice, attitudes, blockers and solutions to supporting adults with learning disabilities to be safe and well.

- Disseminating to practitioners, in June 2023, a Learning Disability Week special Safeguarding Matters Digest with links to national resources from MENCAP and Change and local resources.
- Producing a local version of a short film created by Inclusion Gloucestershire entitled "Was Not Brought" which explains the importance of agencies recording whether a person "did not attend" or "was not brought" for their appointment. This message is brought to life by people who use services to explain the importance in noting this difference and why.

Other key areas of learning from the Safeguarding Adults Reviews during 2023-24 were:

- Understanding and application of the Mental Capacity Act (MCA), including in complex cases which have multiple factors such as learning disability, substance misuse, physical ill health, and domestic abuse
- Ensuring that multi-agency care and safety planning are discussed at the most appropriate multi-agency meeting, involving the appropriate professionals and the person, where possible
- Understanding of referral routes for services to ensure appropriate and timely referrals
- Safeguarding and the role of non-regulated services e.g., Personal Assistant (PA) service
- Understanding information sharing and issues of confidentiality and consent to share information with family members
- Understanding the impact of multiple risk factors
- The importance of taking a Whole Family approach, particularly when working with multi-generational households
- Understanding of pressure sores and recognition and management of these as a safeguarding issue, including when to seek medical support.

Action plans are in place to respond to and monitor areas of learning from reviews.

The Safeguarding Adults Board shared key messages from Safeguarding Adults Reviews through its quarterly Safeguarding Matters newsletter and Safeguarding Matters Live events, as well as the monthly Safeguarding Matters Digest emails. Safeguarding Matters has a wide reach, with over 2600 visits to the newsletter's webpage during 2023-24. To support workers to put learning from reviews into practice, the Board continues to use 7-minute learning briefings. These concise documents are focused on encouraging reflection and development within teams and by individuals to develop practice in response to the learning.

East Midlands Peer Review

In 2022-23, Leicestershire & Rutland Safeguarding Adults Board were involved in an East Midlands regional review of Safeguarding Adults Reviews. It took advantage of work commissioned by Partners in Care and Health to provide evaluation and advice on safeguarding adults work. Learning from this process was delivered to the Leicester, Leicestershire & Rutland Safeguarding Adults Boards in 2023-24 and is influencing future work.

Second National SAR Analysis

Leicestershire & Rutland Safeguarding Adults Board provided data and information for the Second National Analysis of Safeguarding Adults Reviews. This has been commissioned by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) as Partners in Care and Health to support councils to improve the way they deliver adult social care and public health services. The analysis will cover reviews completed nationally between April 2019 and March 2023. The report will be published in late summer/autumn 2024.

Core Priority 2: Enhancing Everyday Business

Multi-Agency Safeguarding Procedures

Leicestershire and Rutland Safeguarding Adults Board works with Leicester Safeguarding Adults Board to maintain up-to-date multi-agency adult safeguarding policies and procedures across Leicester, Leicestershire and Rutland. These policies and procedures are hosted on our dedicated website called the MAPP (Multi-Agency Policies and Procedures) www.llradultsafeguarding.co.uk/.

Throughout 2023/24 these policies and procedures continued to be reviewed and updated in line with learning from reviews, audits, and best practice.

Updates were made to the following procedures:

- Deprivation of Liberty Safeguards
- Disclosure and Barring
- Domestic Abuse
- Female Genital Mutilation
- Forced Marriage
- Guidance for Working with Adults at Risk of Exploitation: Cuckooing
- Independent Advocacy
- Mental Capacity
- Stage 2 – Lead Agency Decision using Safeguarding Threshold Guidance whether to proceed to referral
- Thresholds
- Working with Adults Affected by Child Sexual Exploitation and Organised Sexual Abuse

A full list of new chapters and amendments made can be found on the 'Amendments' page of the Leicester, Leicestershire and Rutland Multi-Agency Policies and Procedures.

Individuals can receive alerts regarding procedure updates by registering with the MAPP. If they have any comments or feedback on the procedures, they can use the contact form.

Learning, Development and Training

The Safeguarding Adults Board continued to support up-to-date training in single agencies, including all key partners and many care providers, through providing a competency framework for adult safeguarding and disseminating learning from reviews and updates to procedure and legislation.

The Leicestershire & Rutland Safeguarding Adults Board's training co-ordination and delivery function is shared with the Leicester Safeguarding Adults Board to support consistent and effective partnership working. The name of the Leicester, Leicestershire & Rutland (LLR) subgroup was changed in order to reflect the broader focus on learning and development rather than simply training. The subgroup coordinates the production of training resources and the organising of events in support of our priorities and learning from reviews. A blended approach to learning is adopted, incorporating video resources and resource packs alongside online training

sessions. This allows for a wide reach. The June 2023 online Safeguarding Matters briefing was attended, at times, by over 370 delegates with the December 2023 briefing attended by, at times, around 400 people, while the Safeguarding Basic Awareness Powerpoint, aimed at people who may work in a voluntary capacity or staff requiring a basic induction to children's and adults' safeguarding, has been visited over 3800 times on the website.

During 2023-24, the subgroup:

- Produced a local version of a short film created by Inclusion Gloucestershire entitled "Was Not Brought" about the difficulties faced by those who need assistance to access doctors' appointments.

- Provided online Safeguarding Adults and Children: Basic Awareness training for people who work or volunteer with children and/or adults and may be in a position to spot safeguarding concerns, with a plan to deliver future sessions both online and in person.
- Redistributed and promoted the "Guidance for Working with Adults at Risk of Exploitation: Cuckooing" in response to the learning from the multi-agency cuckooing audit completed in 2022-23.
- Supported the production of a new addition to the Building Confidence in Practice suite of resources, with the Professional Curiosity for Supervisors and Managers resource being published in January 2024.
- Linked in with the Performance Subgroup to receive training compliance data. To receive further assurance that each partnership agency is compliant with the required training standards, the Learning & Development Subgroup will hear presentations from each agency over 2024-25 where they will showcase their training and share good practice. This will compliment the other regulatory processes agencies already have to provide evidence for assurance.
- Carried out an analysis of Mental Capacity themes from Safeguarding Adults Reviews completed in Leicester, Leicestershire & Rutland to inform the commissioning and content of Mental Capacity training. Edge Training, the commissioned provider, has agreed to weave in local learning from Safeguarding Adults Reviews and local procedures to personalise their standard course materials.
- Commissioned Mental Capacity Act (MCA) Training which covers the following areas:
    - Mental Capacity Act awareness
    - Mental Capacity Act in practice
    - Advanced Mental Capacity Act training
    - Self-Neglect and the Mental Capacity Act.

The subgroup has commissioned 24 sessions, with a mixture of online and in-person sessions over a 12-month period commencing from March 2024. It has commissioned 18 basic sessions (the fundamental principles to ensure practitioners are trained in the basics) and 6 advanced sessions. Each session will host 25 delegates with 25 sessions reaching 600 delegates. The training programme was advertised widely, including via the website and the April 2024 issue of Safeguarding Matters. Most of this training will take place over 2024-25 and so the impact will be considered in next year's Annual Report.

Resources

The Leicester, Leicestershire & Rutland Safeguarding Adults Boards provide numerous learning and development resources and these are available and promoted via the Safeguarding Matters newsletter, Safeguarding Matters Live events, Safeguarding Matters Digest emails and YouTube Channel. Further information is provided in Appendix 4.

Trainers' Network

The Leicester, Leicestershire & Rutland Safeguarding Adults Boards' Trainers Network is a forum that brings together individuals that deliver any learning and development activities relating to safeguarding adults. Individuals that complete the Train the Trainer course delivered by the Leicestershire Social Care Development Group (LSCDG) are invited to join the Network. During 2023-24, the Trainers Network did not meet but it will be relaunched in 2024-25, with two events being held, both online and in person.

Training Impact

During 2023-24, 60 additional people requested they be added to the Safeguarding Matters distribution list, with over 700 people now signed up.

"Very useful for updating practice."

"More training needed to boost staff confidence to raise safeguarding concern and know the appropriate action and approach to take."

"Very good, very informative and extremely educational."

"I found the session very informative across the board as it has given me a broader [view] of different contextual environments that I need to be aware of when engaging in my role."

Feedback from Safeguarding Matters Live events

Developmental Priorities 1 & 2: Strengthening User and Carer Engagement & Raising awareness within our diverse communities

Engagement

As in previous years, the Leicester, Leicestershire & Rutland Engagement & Communications Subgroup oversaw the Safeguarding Adults Boards' promotion of adult safeguarding during National Safeguarding Adults Week 2023 (20th-25th November). They produced a resource pack for organisations and partners.

They also supported four "See Something Say Something" campaigns in the financial year. These campaigns are two weeks long. The group provides assets and suggested messages to partners and stakeholders so that they can support the campaign from their social media platforms.

'What is Adult Safeguarding?' online information sessions have been regularly delivered to support those who work in Leicester, Leicestershire & Rutland, including to community members and groups. In 2023/24, 6 sessions were delivered and 109 people attended.

"I will review our Safeguarding Policy."

"Makes me more mindful of safeguarding in my role, just to make sure I'm picking up on things when I talk to people in my role."

"I have a clearer idea about what actions I could take if I suspected someone was in trouble."

"This training has given us a good insight into pointers to look out for which may highlight concerns to us. If this is the case, we would voice these concerns to our Manager."

Responses to the question "How will you use the information from this learning event?" following "What is Adult Safeguarding" session

During 2023-24, the Engagement & Communications Subgroup has:

- Developed a core safeguarding adults' message for all partners to use in their own publications
- Made links with communications leads in organisations to promote the "What is Adult Safeguarding" sessions via social media every quarter
- Developed an adult safeguarding survey which can be used at community events using a QR code and paper copies. The draft survey is currently being piloted by partners with people who use their services
- Adapted the Norfolk Safeguarding Adults Board's Older people and Domestic Abuse video, entitled "Hidden Harms", and launched this as part of Safeguarding Adults Week in November 2023.

The group is currently working with the Making it Real group at Leicester City Council to co-produce a new Leicester, Leicestershire & Rutland Safeguarding Adults leaflet. The Making it Real Group is made up of people who draw on social care or who care for someone who does, as well as people who work in social care. Gaining advice from people with lived experience will help to produce a more user-friendly and accessible leaflet.

Developmental Priority 3: Understanding how well we work together

Quality assurance and service improvement

The Leicester and Leicestershire & Rutland Safeguarding Adults Boards use their Quality Assurance Framework to support assessment of whether local safeguarding arrangements for adults are effective and deliver the outcomes that people want.

Performance data

The Leicester, Leicestershire & Rutland Safeguarding Adults Boards' Performance Subgroup collects, manages and discusses performance data and intelligence relating to safeguarding adults across the partnership. A high-level dashboard has been developed to help the Safeguarding Adults Boards understand any fluctuation on the patch, and ensure action is taken to reduce risks or understand the practice that lies under the data to ensure partners meet their legal duties and to seek assurance about partnership working and impact. The core dashboard stays consistent, with metrics that underpin the business plan priorities added and reviewed as priorities change. Data is collated and discussed on a quarterly basis to identify performance challenges and potential areas of good practice so that, where necessary, action can be taken to learn from or to improve safeguarding experience and to identify data approaches.

Self-Assessment

During 2022-23, the safeguarding partners and specific relevant agencies carried out a self-assessment audit of their safeguarding effectiveness. Safeguarding Adults Assurance Framework (SAAF) returns were fully analysed and presented to the Leicester and Leicestershire & Rutland Safeguarding Adults Boards during the 2023-24 business year. The majority of partner agencies provided some evidence that they were effective across all areas in the assessment. Where agencies judged themselves as not meeting the standard for being 'fully effective' against an area of assessment, additional information was required to indicate how they plan to achieve full effectiveness and by when.

A Safeguarding Adults Assurance Framework audit was not completed in 2023-24. A further process is being produced for the business year 2024-25. This will be focused on frontline staff and managers in partner agencies.

To enhance the process, it has been agreed to undertake Safeguarding Adults Assurance Framework self-assessments using different methodologies to obtain safeguarding assurance from agencies. A survey of frontline staff and managers is planned. This will enable the Safeguarding Adults Board to obtain assurance of the impact of recommendations and actions resulting from safeguarding reviews and multi-agency audits.

Audits

The Leicester and Leicestershire & Rutland Safeguarding Adults Boards carried out two multi-agency audit processes during 2023/24. The audit process brings together safeguarding leads from different agencies to give a multi-agency view on practice in safeguarding cases in order to identify areas of good practice and areas for learning and improvement. The audits focus on particular themes or parts of the safeguarding process. Practitioners are invited to give a frontline perspective on cases.

Thresholds Audit

The first audit focused on thresholds for access to services. The theme was selected as a result of continued learning from local Safeguarding Adults Reviews (SARs) and because the application of thresholds is a key multi-agency process. It looked at people's cases that met and did not meet safeguarding threshold criteria. The scope of the audit was 6 months from 1st July 2022 to 1st January 2023.

The audit demonstrated that thresholds are being applied appropriately and this is being documented. Thresholds are being used consistently and are seen as a useful tool by practitioners. Trends and themes are being picked up. This is leading on to further pieces of work. Repeated low level incidents are being acknowledged and, when they indicate a concern, they are being escalated for action. Enquiries and reviews continue even when a case does not meet the threshold criteria for Section 42. Learning that has emerged is acted on and disseminated. The results of this audit are more positive than those identified in the previous multi-agency Safeguarding Adults Board Thresholds audit carried out in 2016. Practice has improved, with more consistent use of the thresholds as a tool to support decisions around people's care.

Learning	Action and Outcome
In some cases, it was not clear from the recording what the rationale was for a threshold decision.	Leicester Adult Social Care had, and Leicestershire Adult Social Care were in the process of, updating their forms with clearer prompts for practitioners and a clear link to the Thresholds Guidance. Leicestershire's form has since been updated.
In terms of the category of abuse recorded, it was recognised in more than one agency's audits that domestic abuse is sometimes being incorrectly categorised as another kind of abuse – for example, physical abuse or sexual abuse. This is not as common when a current spouse is involved, but practitioners can get confused when the perpetrator is an ex-partner, co-habiting partner or another family member.	Awareness raising was carried out in relation to the category of domestic abuse and the relationship between the people involved in the safeguarding enquiry.
In relation to Making Safeguarding Personal, carers and loved ones could be prioritised more as part of discussions, when appropriate, particularly around outcomes, and them being fully involved in this.	This should be in line with best practice and the priorities set out in the LLR Carer's Strategy 2022-2025.
There can be difficulties in gaining a person's views when safeguarding enquiries and health transfers take place concurrently, particularly in community settings.	Awareness raising was carried out to highlight that it is not solely the responsibility of the Local Authority to establish a person's wishes and views, under 'Making Safeguarding Personal'. There is a systems responsibility to ensure that we "Make Safeguarding Personal".
There remains a lack of confidence in relation to mental capacity assessments and recording.	The learning from the audit was fed into the Learning & Development Subgroup who have commissioned Mental Capacity training.
It is important to provide feedback to referring agencies about cases that do not meet the threshold. Without formal feedback, agencies can be left with open safeguardings on their system.	Rutland Adult Social Care has a letter that they use. Leicester Adult Social Care and Leicestershire Adult Social Care are considering how they will provide formal and timely feedback to referring agencies.

Mental Capacity Audit

The second audit focused on mental capacity. An audit on this theme was undertaken by the Subgroup in September 2019 and it was agreed that a repeat audit would be beneficial, as mental capacity is still a consistent theme in Safeguarding Adults Reviews (SARs). It is also a business plan priority. Cases were selected from safeguarding enquiries where there was a documented capacity assessment on the enquiry. The scope of the audit was 12 months from 1st April 2022 to 1st April 2023.

Where mental capacity assessments were completed, good practice was identified by all auditing agencies, with some examples of proportionate capacity assessments, practitioners being persistent and joint assessments being carried out by agencies. Overall, when the Mental Capacity Act was followed, it led to better outcomes in respect of the safeguarding enquiries.

Learning	Action and Outcome
It was noted that all agencies can complete capacity assessments but it is sometimes wrongly assumed that this is the remit of Local Authority practitioners. Additionally, it needs to be clear that assessments are decision specific and require an assessment for each decision that has to be made.	The learning from this audit was fed into the Learning & Development Subgroup, which has commissioned multi-agency MCA training for access across the partnerships and is establishing an MCA Community of Practice that will bring staff together for MCA learning and development.
Where the mental capacity assessment was not completed, this was sometimes attributed to practitioner oversight or gaps in knowledge and sometimes to recording issues. A proportionate capacity assessment should always be completed at the outset of any safeguarding enquiry, where doubts about capacity arise. In assessing capacity, information needs to be given to the person around the whole safeguarding process.	
The rationale around practicable steps taken is sometimes lacking detail.	Agencies are to promote the need for more detailed recording around practicable steps taken to include clear rationale. Practitioners should be documenting in records what they have considered and used – for example, different communication methods.
Safeguarding enquiries where family members/ carers have Power of Attorney can be complicated.	The Procedures Subgroup is creating a procedure regarding "Working with People who have Lasting Power of Attorney", including key points for practitioners and how to check if there is a valid Lasting Power of Attorney in place. This is due to be published in early 2024-25.
The use of advocacy is not well embedded in safeguarding practice.	Awareness raising will be carried out regarding the importance of advocacy in safeguarding enquiries and the fact that, from 1st April 2024, the charity POhWER will provide all types of statutory advocacy on behalf of Leicester, Leicestershire and Rutland.

Learning from audits leads to recommendations and actions that are progressed and monitored. The learning is disseminated and informs changes required at both a system and practice level.

Other assurance work

Right Care Right Person

The Leicester and Leicestershire & Rutland Safeguarding Adults Boards have considered the local implications of "Right Care, Right Person" (RCRP). This is a collective national approach from the Home Office, Department of Health & Social Care, the National Police Chiefs Council, Association of Police and Crime Commissioners and NHS England which aims to ensure that individuals in mental health crisis are seen by the right professional.

Safe Care at Home Review

The Safe Care at Home Review was published in June 2023. This is a joint review led by the Home Office and Department of Health and Social Care (DHSC) into the protections and support for adults abused, or at risk of abuse, in their own home by people providing their care. In light of some of the issues raised in this national review, the Leicester and Leicestershire & Rutland Safeguarding Adults Boards agreed to partnership agencies assessing themselves against the 8 Key Findings. It was felt that this would provide a local overview, identifying good practice and challenges to address in light of the review. It was acknowledged that agencies may already be addressing the issues; however, the Safeguarding Adults Boards needed to understand the gaps and decide if there were actions for them or specific organisations. The agencies assessed themselves against each area and provided a Red, Amber, Green (RAG) rating. The Safeguarding Adults Boards agreed how to monitor any amber and red rated areas. In 2024-25, they will be seeking partners' assurance regarding their progress.

Developmental Priority 4: Prevention – helping people to stay safe, connected and resilient to reduce the likelihood of harm, abuse or neglect

Annual Business Plan Priorities

The Leicestershire & Rutland Safeguarding Adults Board worked with the Leicester Safeguarding Adults Board to identify shared priorities for 2023-25. These priorities were identified as a result of local and national learning.

The annual Business Plan was replaced with a two-year-plan to allow time to embed the outcomes of the key deliverables and, subsequently, analyse the impact of these outcomes.

The work on these business priorities was embedded within the assurance, training, procedure and review work of the partnership outlined further in the other sections of this report. Updates on this joint business plan are provided throughout the business year to the Boards.

Self-Neglect:

Seek assurance that local safeguarding partners are working together to effectively safeguard adults who self-neglect.

Rationale (as of 2023-24):

- *Safeguarding Adults Reviews have been or are being undertaken by Leicester SAB and Leicestershire and Rutland SAB as well as nationally, which have highlighted key learning in relation to self-neglect.*
- *There is a cross-over between our Mental Capacity Act priority and self-neglect.*

What we did:

- Continued work to replace the current Leicester, Leicestershire & Rutland (LLR) Vulnerable Adult Risk Management (VARM) Guidance with refreshed and rebranded LLR Self-Neglect Guidance and templates. A Task & Finish Group has been working on this update. The learning points from a Leicestershire & Rutland Safeguarding Adults Review and the Leicester, Leicestershire & Rutland Safeguarding Adults Boards' Multi-Agency Cuckooing Audit, completed in 2022-23, have been fed into the process. The learning from the Multi-Agency Self-Neglect Audit will also inform the new guidance (see below).
- Planned a Leicester, Leicestershire & Rutland Safeguarding Adults Boards' Multi-Agency Self-Neglect Audit, which will take place in April 2024. A Vulnerable Adults Risk Management (VARM) audit was completed by the Multi-Agency Audit Subgroup in 2018. The results from that audit will be compared with those from the 2024 audit and learning will be fed into the work around the LLR Self-Neglect guidance. Both Section 42/Safeguarding Self-Neglect and VARM cases will be audited. Additional agencies, who do not sit on the Audit Subgroup, will be invited to attend, including POhWER (Advocacy Service), Environmental Health, Housing, Leicestershire Fire & Rescue Service (LFRS) and Turning Point (Drug and Alcohol Service). This will ensure that the views/expertise of agencies which are often involved in self-neglect cases are provided during the audit process.
- Continued to monitor, on a quarterly basis via the core dataset, the number of concluded enquiries where self-neglect is recorded as the type of abuse. Further work is being undertaken to capture business plan priority metrics, which will not be solely data driven work.

Outcomes and Impact:

Learning from local reviews and audits has indicated that there are some issues around the thresholds for the current VARM process. Consequently, there will be more in the new local Self-Neglect Guidance about risk levels and different types of services, with a view to ensuring each individual receives the right type of intervention. Another issue identified is the escalation process in practice proving not to be effective; therefore, it needs to be revised. It is acknowledged that the launch of the new guidance has been delayed; this is mainly due to the complexity of addressing all identified issues around this complex form of abuse which differs from the other forms of abuse because it does not involve a perpetrator. Once the guidance has been finalised, it will be relaunched. Learning and development events and resources will support the relaunch.

Mental Capacity Act:

Seek assurance that local safeguarding partners are using the Mental Capacity Act to effectively safeguard adults where appropriate.

Rationale (as of 2023-24):

- *Local Safeguarding Adults Reviews and audits over last few years have identified MCA learning including around:*
  - *Best Interests*
  - *Advocacy*
  - *Recording of decisions and that assessments have been carried out*
  - *Complexity of co-existing conditions*
  - *Fluctuating capacity*
  - *Role of parents and carers / listening to them / sharing information with them (with permission)*
  - *Lack of understanding of the process by frontline workers and whose responsibility it is to carry out assessments*
- *Need for more suitable resources to support frontline practitioners in their daily practice in recognising the situations where a person's mental capacity is in question*
- *Demystifying the process*

What we did:

- Completed a Leicester, Leicestershire & Rutland Safeguarding Adults Boards' Multi-Agency Mental Capacity Audit in October 2023 (see the section on Developmental Priority 3 for further information).
- Commissioned Edge Training to provide MCA Training specific to the learning needs of the Safeguarding Adults Boards (see the section on Core Priority 2 for further information).
- Started to consider how to establish an MCA Community of Practice which will bring staff together for MCA learning and development.
- Delivered presentations on the Mental Capacity Act in Practice at the December 2023 Safeguarding Matters Live Event and to the Leicester, Leicestershire & Rutland Safeguarding Children Partnerships/ Safeguarding Adults Boards Voluntary & Community Sector Forum in February 2024.

- Received a report from University Hospitals of Leicester NHS Trust (UHL) on the management of Deprivation of Liberty Safeguard (DoLS) applications.

Outcomes and Impact:

A lot of work has been implemented during 2023-24; it has been informed by national and local learning from reviews and quality assurance processes.

As this is a 2-year priority, the realisation and impact of this work will become evident in 2024-25 and will be reported in next year's Annual Report. Feedback from the commissioned training will be evaluated in terms of the focus of future work and how skills and knowledge levels are influenced. It has been agreed that staff benefit from live case examples about implementing theory into practice so this will be a key focus moving forwards regarding the MCA Community of Practice, with a plan to offer "Lunch and Learn" sessions. Learning around the Mental Capacity Act will be shared with the Safeguarding Children Partnerships as mental capacity assessments should be completed, where required, with individuals aged 16+.

Domestic Abuse:

Understand local response to domestic abuse in older people and safeguarding adults.

Rationale (as of 2023-24):

- *Safeguarding Adults Reviews, Domestic Homicide Reviews and audits have been undertaken by Leicester SAB and Leicestershire and Rutland SAB, which have identified case specific learning in relation to safeguarding adults and domestic abuse in older people. A research project is being undertaken to better understand systems issues and our local response to older people experiencing domestic abuse who also come under safeguarding adults.*

What we did:

- Supported a Domestic Abuse and Safeguarding Research Project, entitled "Perpetrators of Domestic Abuse Against Older Adults: Characteristics, Risk Factors and Professional Responses", carried out by Durham University.
- Adapted a short video, produced by Norfolk Safeguarding Adults Board, for Leicester, Leicestershire & Rutland about Domestic Abuse in Older People, entitled "Hidden Harms". It is now available on the LLR SABs YouTube Channel and has been widely promoted.
- Carried out awareness raising in relation to the category of domestic abuse and the relationship between the people involved in the safeguarding enquiry.

Outcomes and Impact:

The final draft of the "Perpetrators of Domestic Abuse Against Older Adults: Characteristics, Risk Factors and Professional Responses" report was presented to the Safeguarding Adults Boards at the end of 2023-24. Local partners are now considering the implications for their single agencies. The Safeguarding Adults Boards will then identify where a collective response, actions and monitoring are required.

Priorities moving forwards

The Leicestershire & Rutland Safeguarding Adults Board is developing a new joint Strategy for 2024-2027 with the Leicester Safeguarding Adults Board. The Strategy provides the framework for forward priorities of the two Boards.

The three priorities in the Business Plan for 2023-25 are:

Self-Neglect

Mental Capacity Act

Domestic Abuse

For each of these areas, we have set out our rationale for prioritising the topic, and presented the key deliverables, leads, activities, impact measures and timescales. This will enable us to monitor progress and secure assurance that our actions are making a positive difference to the lived experience of adults with care and support needs. The Joint Leicester, Leicestershire & Rutland Safeguarding Adults Board Business Plan for 2023-25 is published on our website.

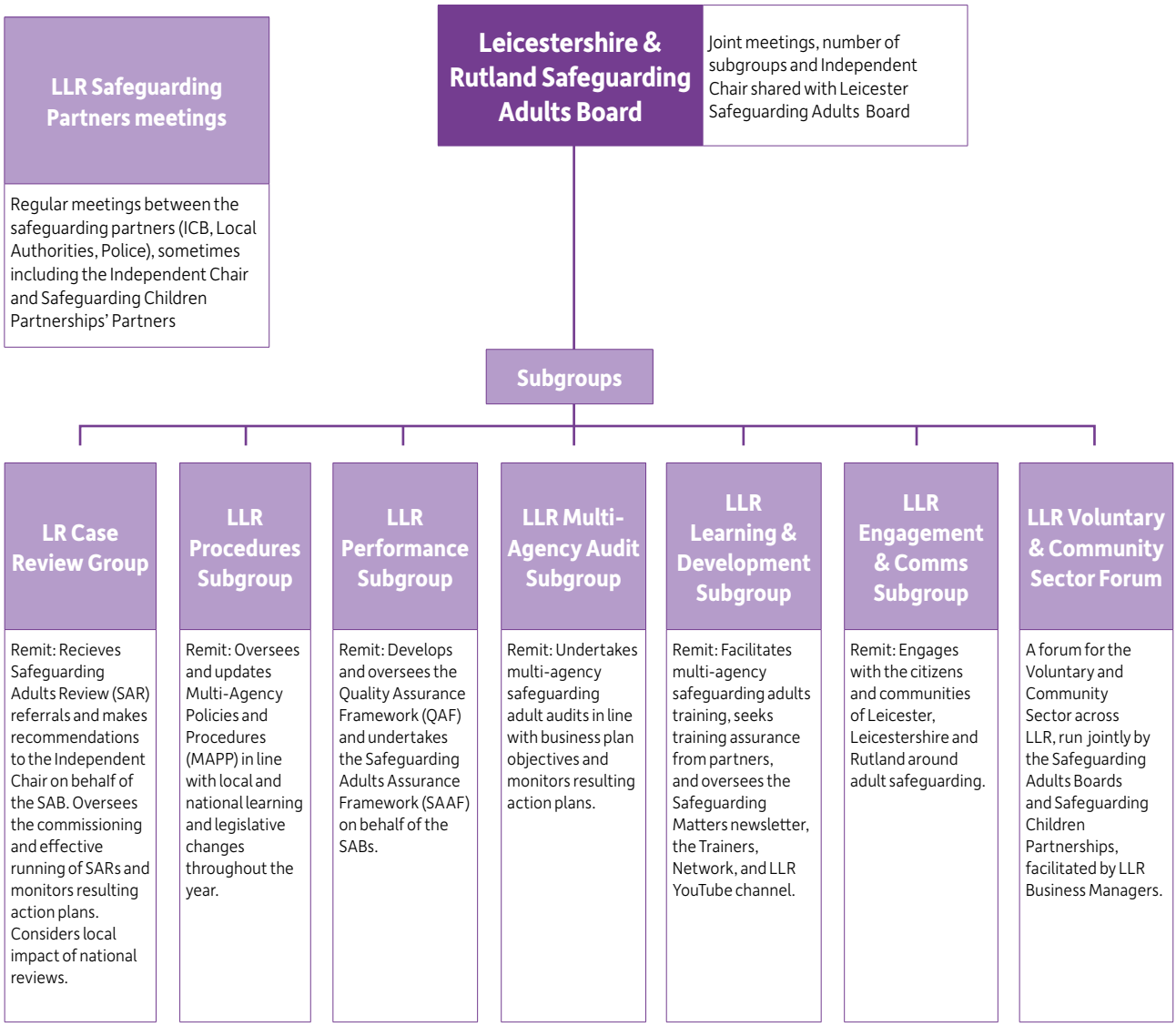
The Safeguarding Adults Board will also work to continue to meet its statutory responsibilities and continue to develop its approach to learning and improving safeguarding of adults.

Appendix 1 – Leicestershire & Rutland Safeguarding Adults Board and its subgroups

The table below provides details of agencies that are represented on the Leicestershire & Rutland Safeguarding Adults Board and their attendance at Board meetings in 2023-24. It may be that the Lead Officer delegated attendance to another officer.

Agency	Attendance at meetings					
	June 2023	August 2023	September 2023	December 2023	January 2024	March 2024
Leicestershire Adult Social Care	✓	✓	✓	✓	✓	✓
Rutland Adult Social Care	✓	✓	✓	✓	✓	✓
District and Borough Councils	Apologies	Apologies	✓	Apologies	✓	Apologies
Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB)	✓	✓	✓	✓	✓	✓
Leicestershire Partnership NHS Trust (LPT)	✓	✓	✓	✓	✓	✓
University Hospitals Leicester NHS Trust (UHL)	✓	✓	✓	✓	✓	✓
East Midlands Ambulance Service (EMAS)	Apologies	✓	✓	✓	✓	✓
Leicestershire Police	✓	✓	✓	✓	✓	✓
HMP Prisons	✓	✓	✓	✓	✓	✓
National Probation Service (NPS)	✓	✓	✓	Apologies	✓	Apologies
Leicestershire Fire and Rescue Service (LFRS)	✓	✓	✓	✓	✓	✓
Department of Work and Pensions	✓	Apologies	Apologies	Apologies	Apologies	Apologies
Healthwatch	✓	✓	✓	Apologies	✓	✓
Leicestershire Lead Member	✓	✓	✓	✓	Apologies	✓
Rutland Lead Member	✓	✓	✓	✓	✓	✓

The structure chart below demonstrates the governance of the Board and its subgroups.



Appendix 2 – **Finance**

The work of the Safeguarding Adults Board is supported by the Leicestershire & Rutland Safeguarding Partnerships Business Office that also supports the Safeguarding Children Partnership and carries out Domestic Homicide Reviews. The Safeguarding Adults Board is funded by contributions from its partners.

A single funding arrangement for the Safeguarding Adults Boards and Safeguarding Children Partnerships for 2020 onwards has been agreed between the statutory partners for the Safeguarding Adults Boards and the Safeguarding Children Partnerships for Leicester, Leicestershire & Rutland. At that time it was also agreed how the contributions would be split across the two.

The contributions from partners for the Leicestershire & Rutland Safeguarding Children Partnership and Safeguarding Adults Board as a whole for 2023/24 can be seen below alongside contributions for the previous year:

	2022/23	**2023/24**
Leicestershire County Council	£119,266	£119,266
Rutland County Council	£50,367	£50,367
Leicestershire Police	£97,500	£97,500
Leicester, Leicestershire & Rutland Integrated Care Board (LLR ICB)	£97,500	£97,500
Total income for SCP and SAB	**£364,633**	**£364,633**

Overall expenditure across the Safeguarding Children Partnership and Safeguarding Adults Board for 2023/24 was £356,749.

Expenditure for the Safeguarding Adults Board was apportioned as follows:

	2022/23	**2023/24**
Staffing	£115,342	£130,010
Independent Chairing	£5,418	£9,997
Support Services	£0	£0
Operating Costs	£4,540	£6,076
Engagement	£0	£75
Case Reviews	£6,975	£4,320
Total Expenditure	**£132,275**	**£150,478**

Staffing costs increased as a result of the agreed Leicestershire County Council pay award (as the staff are hosted by this Local Authority). The cost of the Independent Chair was lower in 2022-23 because there was a vacancy for part of the year. Expenditure on Safeguarding Adults Reviews decreased due to the number of reviews already being in an advanced stage and alternative methodologies being used, as appropriate. As a result of the above factors and gaps in filling vacancies on the team, a reserve has built up over time of £95,350. This amount has been held due to a potential increase in costs and has meant that partners have not been asked for an increase in contributions; however, this surplus will eventually be used. All partners will be expected to ensure that the Leicestershire and Rutland Safeguarding Adults Board is self-sufficient.

Appendix 3 – Safeguarding Adults Reviews completed in 2023-24 by Leicestershire & Rutland Safeguarding Adults Board

Safeguarding Adults Reviews are published on our website for 1 year and are available here.

Past reviews are still available and accessible via the National Safeguarding Adults Review (SAR) Library.

SAR*	Publication Date	Synopsis	Learning
SAR "Nigel"	26.04.23	Nigel died as a result of Covid-19 when he was 38-years-old. He had cerebral palsy, a learning disability and autism. He required 24-hour support and a wheelchair to mobilise. Nigel lived with his parents and attended a Day Centre. At the time of his death he was being treated for swallowing problems and, as a result, he had experienced significant weight loss. At the time of his death his Body Mass Index (BMI) was 9. He had also developed pressure ulcers.	**Lesson 1:** Not all professionals were aware of communication passports. **Lesson 2:** There is no evidence of professionals maximising opportunities to discuss and explain the best interest principle to parents. **Lesson 3:** Professionals allowed parents to continue to make decisions for Nigel instead of consulting the Mental Capacity Act. **Lesson 4:** Detailed records must be kept of best interest decisions; this is not only good professional practice but necessary should a decision or decision making process be later challenged or reviewed. **Lesson 5:** The professional was not appropriately supported to progress safeguarding concerns. **Lesson 6:** The referral process that the Day Centre followed did not provide staff with enough information to ensure that they understood the options available to them if their concerns remained, or Nigel deteriorated post the referral being submitted. **Lesson 7:** Weight management and onward specialist referrals, where weight has been identified as a concern, are a priority. **Lesson 8:** Nigel's care and support was not coordinated by any lead professional. **Lesson 9:** The role of the Learning Disability Primary Care Liaison Nurse is not widely known amongst professionals within the agencies and organisations who support adults with learning disabilities.

SAR*	Publication Date	Synopsis	Learning
SAR "Claire"	14.02.24	Claire is diagnosed with Down's Syndrome, a learning disability and osteoarthritis. Claire lived with, and was cared for, by her sister and niece. She was taken to hospital suffering dehydration, and a grade 4 pressure wound which had caused sepsis and required surgery. The pressure wound was so severe it resulted in Claire being an inpatient at the hospital for a number of weeks, and Claire still required nursing thereafter. The criteria for this review were met as whilst Claire, an adult with needs for care and support, has thankfully not died, it is believed that she would have, had she not arrived in hospital when she did.	**Question 1:** How can GP surgeries in the local area assure LRSAB that Learning Disability Review templates are fit for purpose and include the individuals' 'lived experience'? **Question 2:** How can partner agencies assure LRSAB that professionals are understanding of the impact of language, are using positive language when referring to a disability or a person with a disability, and are addressing inappropriate language if used by carers and/or family members? **Question 3:** How can LRSAB be assured that all organisations are promoting advocacy services and empowering their practitioners to know when and how to seek advocacy services? **Question 4:** How can LRSAB be assured that professionals from all services do not deny a person with learning disabilities the equal right to be heard by having conversations with family members or carers instead of with the individual directly? **Question 5:** How can LRSAB be assured that professionals understand and consider diagnostic overshadowing when working with service users? **Question 6:** How can LRSAB ensure that professionals, and carers in the area, can easily access information which will help them understand what support is available to carers? **Question 7:** How can LRSAB ensure that professionals from all services are aware that referrals can be made to the fire service for a safety check? **Question 8:** How can partner agencies assure LRSAB that professionals from all services understand how to make a safeguarding referral to Adult Social Care? This must take into consideration any high turnover of staff and use of agency staff.

SAR*	Publication Date	Synopsis	Learning
SAR "Angela"	21.03.24	Angela was in her early 30's at the time of her tragic death. Angela had a long history of mental health problems, a learning disability, alcohol and drug addiction. Professionals had longstanding concerns regarding Angela's vulnerabilities particularly regarding intimate and peer relationships.	**1.** Understanding and Application of the Mental Capacity Act in complex cases which have multiple factors such as learning disability, substance misuse, physical ill health, and domestic abuse. **2.** Understanding the person's lived experience, including the impact of a learning disability. **3.** Ensuring that multi-agency care and safety planning is discussed at the most appropriate forum e.g., strategy meeting/case conference under S.42 of the Care Act or Vulnerable Adults Risk Management (VARM) as Angela had been deemed to have capacity, living in a way that was significantly harmful, and reluctant to engage. **4.** Safeguarding and role of non-regulated services e.g., Personal Assistant service. **5.** Family and carers – understanding information sharing and issues of confidentiality and consent to share information with family members. **6.** Multiple risk factors – domestic abuse including coercive and controlling behaviour, exploitation, and substance misuse were present in her life and her relationships. Whilst efforts were made to discuss these issues and concerns with Angela (and at times she was incredibly open), her learning disability and fluctuating capacity affected her understanding of the impact of these issues and risky behaviours. **7.** Weight management – Angela, although described as always very slim, had an extremely low body weight. Where there are concerns about low body weight, these need to be monitored and action taken if necessary. Adults with a learning disability should have an Annual Health Check regardless of their capacity.

*Safeguarding Adults Reviews can be labelled using codes and acronyms, as agreed with family members where possible.

Appendix 4 – Learning & Development Resources

The LLR SABs' YouTube channel continues to develop a bank of safeguarding videos and other resources that can be utilised by partners for learning and development – for example, in single agency training and supervision. It is used to share local and national learning content, especially that which aligns with the Safeguarding Adults Boards' Business Plan priorities.

As in previous years, during 2023-24, two print issues of the Safeguarding Matters newsletter were published, with a focus on disseminating learning from reviews and audits and promoting procedural updates. The April 2023 issue was a special issue on Safeguarding Adults with Learning Disabilities.

Following the successful launch of Safeguarding Matters Live in 2022-23, two events were held in June 2023 and December 2023. These are live online briefings for all staff across the children and adults multi-agency partnerships. They share learning from reviews and audits, procedure and guidance updates, and resources to support practice. The slides from the events are made available via our website and sessions are available to watch on the YouTube Channel. Topics covered in 2023-24 included trauma-informed practice; the Dynamic Support Pathway; mental capacity; and developing awareness of unconscious bias.

The Safeguarding Matters Digest is a monthly email, which is used to disseminate local and national safeguarding information in a concise and regular format. In June 2023, a Learning Disability Week special digest was disseminated with links to national resources from MENCAP and Change and local resources, including a link to the Tricky Friends video.

The Safeguarding Matters newsletters and Live PowerPoints and videos are available via our website and YouTube channel. Individuals can request to be added to the distribution list so that they are informed of publication and event dates by emailing lrspbo@leics.gov.uk. The Safeguarding Matters Digest is disseminated via email to those that have signed up to receive it. To be added to the distribution list, individuals can email lscpb@leicester.gov.uk.

Leicestershire County Council

Leicestershire Police
Protecting our communities

Rutland County Council

NHS
Leicester, Leicestershire and Rutland

Leicestershire and Rutland Safeguarding Adults Board (LRSAB) and Leicester Safeguarding Adults Board (LSAB) Joint Business Plan for April 2023 to March 2025

We have identified three priority areas for us to focus our collective efforts over the next two years, following the principle that we should concentrate our capacity on a small number of topics, in order to have significant impact, and focus our resources. Based on our analysis of the situation across Leicester, Leicestershire and Rutland (LLR) we have identified the following priority areas:

1. **Self-Neglect**
2. **Mental Capacity Act**
3. **Domestic Abuse**

For each of these areas, we have set out our rationale for prioritising the topic, and presented the key deliverables, leads, activities, impact measures, and timescales. This will enable us to monitor progress and secure assurance that our actions are making a positive difference to the lived experience of our residents.

1. Self-Neglect

Rationale:

- Safeguarding Adults Reviews have been or are being undertaken by Leicester SAB and Leicestershire and Rutland SAB as well as nationally, which have highlighted key learning in relation to self-neglect.
- There is a cross-over between our Mental Capacity Act priority and self-neglect.

Key Deliverable	Lead	Activity	Impact Measure	Timescale
Receive assurance that local safeguarding partners are working together to effectively safeguard adults who self-neglect	Performance Subgroup	Ensure that self-neglect is a focus in performance and assurance activity by: monitoring within the core data set and providing SABs with metric that speaks to this priority. Responding to requests for assurance arising from other business plan activity – for example, from the multi-agency audit.	N/A as is itself assurance activity	
Multi-agency audit	Audit Subgroup	Undertake a multi-agency audit in relation to self-neglect	N/A as is itself assurance activity	Audit to be planned for April 2024
Making local and national learning	Training Subgroup	Develop a 7-minute briefing in relation to	Staff survey	January 2024

around self-neglect accessible to practitioners		self-neglect in Safeguarding Adults Reviews		
Improved staff awareness and understanding locally of the routes to supporting adults who self-neglect	Training Subgroup	Promote the re-launch of the self-neglect and VARM guidance	Staff survey and/or pre and post event questionnaire	February 2024
Improved resources and guidance for supporting individuals who self-neglect	Policy & Procedures Subgroup	Conclude the review of the VARM guidance	1. Staff survey 2. Number of times the relevant resources have been accessed 3. Multi-agency audit	December 2023
Increase awareness in the Voluntary and Community Sector (VCS) of self-neglect including ways to support individuals who self-neglect	VCS Safeguarding Forum	Ensure that self-neglect is a focus at one of the forums during 2023/24	Pre and post forum evaluations	March 2024

2. Mental Capacity Act (MCA)

Rationale:

- Local Safeguarding Adults Reviews and audits over last few years have identified MCA learning including around:
    - Best Interests
    - Advocacy
    - Recording of decisions and that assessments have been carried out
    - Complexity of co-existing conditions
    - Fluctuating capacity
    - Role of parents and carers / listening to them / sharing information with them (with permission)
    - Lack of understanding of the process by frontline workers and whose responsibility it is to carry out assessments
- Need for more suitable resources to support frontline practitioners in their daily practice in recognising the situations where a person's mental capacity is in question
- Demystifying the process

Key Deliverable	**Lead**	**Activity**	**Impact Measure**	**Timescale**
Receive assurance that local	Performance Subgroup	Ensure that MCA is a focus in performance and	N/A as is itself assurance activity	

safeguarding partners are using the Mental Capacity Act to effectively safeguard adults where appropriate		assurance activity by: monitoring within the core data set and providing SABs with metric that speaks to this priority. Responding to requests for assurance arising from other business plan activity – for example, from the multi-agency audit.		
Multi-agency audit	Audit Subgroup	Undertake a multi-agency audit in relation to MCA	N/A as is itself assurance activity	Audit completion due October 2023
Improved awareness and use of the Mental Capacity Act across the partnerships	Training Subgroup	Undertake a thematic analysis of MCA learning from local and national reviews.	Staff survey	March 2024
Improved awareness and use of the Mental Capacity Act across the partnerships	Training Subgroup	Establish an MCA Community of practice which will bring staff together for MCA learning and development.		March 2024
Improved staff awareness and understanding locally of the use of MCA	Training Subgroup	Commission multi-agency MCA training for access across the partnerships Target some training at managers to build confidence in leaders in MCA in the system.	Training evaluations	March 2024
Improved understanding of the lived experience of local people	Engagement & Comms Subgroup	Develop a targeted engagement activity aimed at informal carers who have had experience of being involved in MCA assessments / decisions for the cared for person that has an agreed purpose, target audience, and feedback route or governance to hear the experiences of people.		July 2024
Improved resources and guidance for use of the MCA	Policy & Procedures Subgroup	The LLR MCA procedure was reviewed and updated in February 2023. The role of the policy and		April 2024

		procedures group will therefore be to respond to learning identified from other business plan activity – for example, should the multi-agency audit identify any required changes to the procedure.		
Increase awareness in the Voluntary and Community Sector (VCS) of MCA	VCS Safeguarding Forum	Ensure that MCA is a focus at one of the forums during 2023/24	Pre and post forum evaluations	March 2024

3. Domestic Abuse

Rationale:

- Safeguarding Adults Reviews, Domestic Homicide Reviews and audits have been undertaken by Leicester SAB and Leicestershire and Rutland SAB, which have identified case specific learning in relation to safeguarding adults and domestic abuse in older people. A research project is being undertaken to better understand systems issues and our local response to older people experiencing domestic abuse who also come under safeguarding adults.

Key Deliverable	**Lead**	**Activity**	**Impact Measure**	**Timescale**
Receive assurance that local safeguarding partners are working together to effectively safeguard adults who self-neglect	Performance Subgroup	Ensure that Domestic Abuse is a focus in performance and assurance activity by: monitoring within the core data set and providing SABs with metric that speaks to this priority. Responding to requests for assurance arising from other business plan activity – for example, from the multi-agency audit.	N/A as is itself assurance activity	
Understand local response to domestic abuse in older people and safeguarding adults	LSAB and LRSAB in conjunction with Durham University	Completion of research project		Autumn 2023
Once findings of research project have been	LSAB and LRSAB Board Office to	Respond to learning from the research project.		Winter 2023

delivered, set up a work group to address issues identified and improve domestic abuse and safeguarding adults for older people locally.	set up working group.			

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Agenda Item 9

Leicestershire County Council

ADULTS AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE 2 SEPTEMBER 2024

PERFORMANCE REPORT FOR QUARTER 1 2024/25 (APRIL - JUNE)

JOINT REPORT OF THE CHIEF EXECUTIVE AND DIRECTOR OF ADULTS AND COMMUNITIES

Purpose of the Report

1. The purpose of this report is to present the Committee with an update of the Adults and Communities Department's performance during the first quarter of 2024/25, namely, April to June 2024.

Policy Framework and Previous Decisions

2. The Adults and Communities Department's performance is reported to the Committee in accordance with the Council's corporate performance management arrangements.

Background

3. The metrics detailed in Appendix A to this report are based on the key performance measures of the Adults and Communities Department for 2024/25. These are reviewed through the annual business planning process to reflect the key priorities of the Department and the Council. The structure of Appendix A is aligned with the Ambitions and Strategy for the Adult and Communities Department 2020-2024, '*Delivering Wellbeing and Opportunity in Leicestershire*'. This strategic approach is based on a set of principles with the person at the centre, ensuring the support they receive can deliver the right outcomes. Appendix B outlines the 'layered' model designed to maximise independence – to Prevent, Reduce, Delay and Meet needs.

4. Appendix A is also structured in line with the Council's Strategic Plan 2022-26. This sets out the Council's overall policy framework approach and is based on five aspirational strategic outcomes: Clean and Green, Great Communities, Improved Opportunities, Strong Economy, Transport, and Infrastructure, and Safe and Well.

5. On 5 June 2023, the Committee received a report with regard to the Department for Health and Social Care publication *Care Data Matters*. This outlined a range of developments relating to adult social care data as set out in a roadmap through to 2028. One aspect of the roadmap was a marked transformation in the data local authorities are required to collect and report to NHS England. An example of this is the change from reporting the sequel to a contact with the authority. It is currently unclear how NHS England will use the new dataset to report outcomes of requests for services, and as such this report will read slightly differently from previous reports in relation to this area of activity.

6. Where a national average is quoted, including in Appendix A, it will relate to the year 2022/23. The national averages for the most recent year - 2023/24 - will be known when national figures are published by NHS England in December. It is expected that this will also provide the first opportunity to see comparative national data for new metrics such as living at home with friends or family noted in paragraph 10.

7. Several metrics are not part of the Adult Social Care Outcomes Framework (ASCOF), in particular those relating to Communities and Wellbeing, and do not have a national average to compare performance with. As such, local targets have been agreed and Appendix A outlines progress towards these by comparing performance to a milestone position at the end of the first quarter.

Performance Update: April to June 2024

Adult Social Care

8. During the 12 months to the end of June 2024, the Council received 50,600 **contacts**, similar to the preceding 12 months – just a 1% increase from 50,020. Two-thirds (33,400) of the contacts were received via telephone or email, and over half being a self-referral or from a family member. A further third (16,700) were received from Health services which was 215 or 13% more than the previous 12-month period.

9. Three-quarters (38,460) of contacts relate to people who did not have a commissioned service at the time of a call or when an email was received by the Authority. Of these, 45% (17,300) went on to receive an assessment whilst 34% (13,080) resulted in advice, information, and/ or signposting to another service. Other outcomes include support for safeguarding, end of life, and the deprivation of liberty.

10. Measuring whether someone **lives in their own home** is one way to assess independence. One of the changes to adult social care reporting and the national outcomes framework involves the extension of this metric to all age-groups and to all reasons for support, not just those with a learning disability as has been the case previously. To allow for national comparison the metric in Appendix A (ASCOF 2E) remains for now as focussing on learning disability only. This shows a similar performance to last year (currently 86% living at home or with family), and higher than the latest known national average.

11. An area of focus for Care Data Matters and the collation and reporting of new adult social care metrics, is the time people have to **wait for an assessment** of their need, and services if they are required. NHS England is currently working on definitions and methodology to this end. In the meantime, local reporting will continue to use the approach set up for the Market Sustainability and Improvement Fund (MSIF) outlined in the report to the Committee on 5 June 2023. As at the end of June 2024 there were 604 people awaiting an assessment in Leicestershire, a reduction of 169 from 773 at the end of the previous quarter (March 2024) and a considerable reduction from 1,575 when a baseline position was reported as part of the MSIF in January 2023. Furthermore, the number waiting for six months or more at the end of the first quarter was 29, down from 36 at the end of March and 71 in January 2023.

12. **Reablement** is a short and intensive service to help people who have experienced deterioration in their health (and/or have increased support needs) to relearn the skills required to keep them safe and independent at home. During the first three months of 2024/25 over 1,200 people benefited from a reablement service for the first time, 18% more than 1,065 during the equivalent period last year.

13. Both existing metrics to measure a local authority's performance in this area have been retained in the revamped ASCOF – ASCOF 2A: the proportion of people with no continued needs post reablement, and ASCOF 2D: where people are living at home 91 days following hospital discharge and reablement. For the first of these metrics Leicestershire's performance during the first quarter of 2024/25 (89.6% or 1,125 out of 1,255) remained the same as last year and notably higher than the latest national average (78%). The second ASCOF metric shows that 90% (519 out of 577) people discharged from hospital to a reablement service between January and March 2024 were living at home 91 days post discharge. This is similar to 88% last year and above the latest known national average of 82%.

14. **Avoiding permanent placements in residential or nursing care homes** is a good indication of maximising independence and delaying dependency. Research suggests that where possible, people prefer to stay in their own home rather than move into permanent care. For people aged 18-64 there were 13 admissions during the first quarter of 2024/25 giving an early forecast for the full year of 57, slightly lower than the 60 during 2023/24. For people aged 65 or over there were 237 admissions during the first quarter giving a current forecast of 849 admissions, marginally less than the previous year (858). However, these are early forecasts based on just one quarter and it is expected that there will be a shift in the projection as the year progresses.

15. The County Council remains committed that everyone in receipt of long-term, community-based care should be provided with a **personal budget**, preferably as a direct payment. The revamped ASCOF focuses attention on the use of direct payments only as a way of measuring if people have choice and control over the care they access. At the end of the first quarter 34% (1,736 out of 5,061) of people in receipt of a long-term community service were doing so via a direct payment. This is similar to last year (36% or 1,795 out of 5,043) and higher than the latest national average of 26% at the end of March 2023.

16. Local authorities are required to conduct two **statutory surveys** – an annual survey of people in receipt of social care services and a similar survey of carers on a biennial basis; both were undertaken in 2023/24. Whilst there was a significant improvement amongst carers **finding information** since the previous survey (up from 49% to 56%), people in receipt of services showed a small reduction (from 62% to 59%). A second metric included in Appendix A – ASCOF 5A – showed a notable increase in the proportion of people who use services feeling they have as much **social contact** as they would like (up from 39% to 45%). For carers, however, the proportion remained similar to the previous survey at 25%. The final page of the appendix includes the response to the question on whether services people are in receipt of help them **feel safe**. There was a small reduction in the proportion who stated that services do help them feel safe (down from 85% to 83%). For 2024/25, only the survey of people in receipt of social care services will be undertaken (in February 2025).

17. A **safeguarding** alert can include any concern for welfare and will often require a response from the Authority, but not necessarily in relation to safeguarding. During the first quarter of 2024/25 there were 515 alerts, a 15% increase on 438 during the same period last year. Once an alert has been investigated into any potential risk of abuse or neglect there may be need for a more in-depth enquiry under Section 42 of the Care Act 2014. Between April and June 2024 there were 235 enquiries, a notable increase on 120 during the comparable period of the previous year. This was due to a change in process as to when to determine whether an alleged concern meets safeguarding thresholds: following an audit last spring, an enquiry is now opened earlier to consider this aspect. The initial phase of the ASCOF revamp includes a new metric that monitors the proportion of completed enquiries where the outcome of an identified risk was that it was reduced or removed. During the first quarter of 2024/25 95% (169 out of 177) of enquiries involved an identified risk being reduced or removed, very similar to 96% (524 out of 547) during the full year 2023/24.

18. Under the Care Act 2014's statutory guidance, councils should undertake a **review of care plans** no later than every 12 months (although this is not a legal duty). Undertaking reviews regularly helps to identify if outcomes set out in the original support plan are being achieved. During the first three months of 2024/25, 75% (4,033 out of 5,362) of people who had been in receipt of services for at least a year had been reviewed in the past 12 months, similar to the position at the same point last year (74% or 3,912 out of 5,307), and notably higher than the latest known national average of 55%.

Communities and Wellbeing

19. There is no national performance framework covering the Communities and Wellbeing section of the Adults and Communities Department and as such performance is monitored against locally agreed targets. Appendix A highlights monthly milestones for performance to meet the annual targets.

20. During the first quarter of 2024/25 there were 39,100 **visits to heritage sites** in Leicestershire. This is similar to the equivalent period of last year (40,100) and the milestone of 37,700k for the first quarter of the current reporting year.

21. There were 181,800 physical **visits to Council managed libraries** during the period April to June 2024, 40,200 more than the comparable three months of the previous year (141,600). Whilst the number of visits falls short of the first quarter milestone (195,000), the difference should be made up by the Summer Reading Challenge, which is a free holiday activity for children, which aims to improve children's reading skills and confidence, taking place this year between 6 July and 7 September. The total loans figure includes 186,000 junior loans which is similar to the number of loans during the same period last year (190,000) and 279,000 E-loans, already 48,000 higher than last year, and continues the upward trend in loans of electronic material.

22. The Department's **Creative Learning Service** supports schools across the County with a wide range of resources, pupil sessions and professional help to stimulate reading and creative learning across the curriculum. Between April and June there were 6,200 attendances at Creative Learning Service workshops, 200 more than the milestone for the period, and 300 more than the equivalent period last year (5,900).

23. There were 5,700 hours of **volunteering** at libraries, museums and heritage services between April and June 2024, higher than the 5,000 milestone and coincidently, the same as the comparable three months last year.

24. The **Leicestershire Adult Learning Service's** performance relates to the proportion of learning aims due to be completed in a given period that were successfully achieved. The last academic year started in September 2023, and overall performance of 84.3% at the end of June 2024 is slightly lower than the position in the previous year (85.3%), and short of the 90% target. As noted in the report presented to the Committee on 3 June 2024, the gap between performance and the target is due, in part, to the learner achievement rates for GCSE English (33% performance against a 65% target) and GCSE Mathematics (also 33% against a 70% target). GCSE results for the academic year are expected 22 August 2024 and performance of these programmes will be set out in the next Quarter 2 Performance report to the Committee in January.

Conclusions

25. For adult social care, performance during the first quarter has either continued the excellent performance of the previous year or shown improvement; outcomes of reablement and a lower level of permanent admissions to care homes being examples. Comparative national data will be published in the autumn.

26. Performance across Communities and Wellbeing is mixed. The number of people visiting heritage sites, and the overall loans at libraries are either up on last year, or in line with previous figures and the quarter one target. Visits to libraries and the number of junior loans are both slightly below the quarter one milestones although it is expected that the summer reading challenge will have a positive impact on this.

27. Monitoring and analysis continues on a regular basis including key metrics of activity and performance across the Adults and Communities Department.

Background papers

- Adult Social Care Outcomes Framework
- Delivering Wellbeing and opportunity in Leicestershire – Adults and Communities Department Ambitions and Strategy for 2020-24
- Leicestershire County Council Strategic Plan 2022-26
- Better Care Fund
- Adults and Communities Overview and Scrutiny Committee 3 June 2024 – Performance Report (Item 10)

Circulation under the Local Issues Alert Procedure

28. None.

Equality Implications

29. The Adults and Communities Department supports vulnerable people from all diverse communities in Leicestershire. However, there are no specific equal opportunities implications to note as part of this performance report.

Human Rights Implications

30. Data relating to equalities implications of service changes are assessed as part of Equality Impacts Assessments.

Health Implications

31. Better Care Fund measures and associated actions are overseen and considered by the Integration Executive and Health and Wellbeing Board.

Appendices

- Appendix A - Adults and Communities Department Performance Dashboard for Quarter One (April to June) of 2024/25
- Appendix B – Adult Social Care Strategic Approach

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Appendix A

Adults and Communities Performance 2024/25
April to June 2024

Performance Rating and Progress

- Performing **better** than the latest national average or local target
- Performing **similar** to the latest national average or local target
- Performing **below** the latest national average or local target

- Performance has **improved** on last year
- Performance is **similar** to last year
- Performance is **not as good** as last year

PREVENT NEED

Leicestershire County Council's Strategic Plan 2022-26	**Safe and Well** Carers and People with care needs are supported to live active, independent, and fulfilling lives

Measure	Description	Aim	Rating	Progress	2024/25 Performance	2023/24 Performance
ASCOF 3C	% of SUs who find it easy to find information	High	67.2% 22/23 Nat. Ave.	▼	Survey is annual and will next run in February 2025	59.3%
ASCOF 3C	% of carers who find it easy to find information	High	59.1% 23/24 Nat. Ave.	▲	Survey is biennial and will next run in October 2025	56.1%

Measure	Description	Aim	Rating	Progress	2024/25 Performance	2023/24 Performance
Local	Hours of Volunteering (Heritage & libraries)	High	5.0k Local Q1 Milestone	◀▶	5.7k	5.7k

Leicestershire County Council's Strategic Plan 2022-26	**Great Communities** Cultural and historical heritage are enjoyed and conserved

Measure	Description	Aim	Rating	Progress	2024/25 Performance	2023/24 Performance
Local	Heritage visits	High	37.7k Local Q1 Milestone	◀▶	39.1k	40.1k
Local	Library visits	High	195.0k Local Q1 Milestone	▲	181.8k	141.6k
Local	Total library loans	High	605.1k Local Q1 Milestone	▲	599.0k	558.4k
Local	Junior loans	High	211.3k Local Q1 Milestone	◀▶	186.2k	189.9k
Local	E-loans	High	256.7k Local Q1 Milestone	▲	279.4k	231.8k
Local	Total community library issues	N/A	For Information Only	N/A	69.5k	70.8k
Local	Community library children's issues.	N/A	For Information Only	N/A	39.0k	39.6k
Local	Attendances at Creative Learning Service workshops	High	6.0k Local Q1 Milestone	▲	6.2k	5.9k

Leicestershire County Council's Strategic Plan 2022-26	**Strong Economy, Transport, and Infrastructure** There is close alignment between skill supply and demand

Measure	Description	Aim	Rating	Progress	2024/25 Performance	2023/24 Performance
Local	LALS Success Rate	High	90% Local Target 2023/24 (Academic year)	◀▶	84.3%	85.3%

REDUCE NEED

Leicestershire County Council's Strategic Plan 2022-26	**Improved Opportunities** Young people and adults are able to aim high and reach their full potential

Measure	Description	Aim	Rating	Progress	2024/25 Performance	2023/24 Performance
ASCOF 2E	% of people living at home or with family	High	80.5% 22/23 Nat. Ave.	◀▶	86.3% (1,169 out of 1,355)	85.3% (1,206 out of 1,414)

Leicestershire County Council's Strategic Plan 2022-26	**Safe and Well** Carers and People with care needs are supported to live active, independent, and fulfilling lives

Measure	Description	Aim	Rating	Progress	2024/25 Performance	2023/24 Performance
ASCOF 5A	% of SUs who had as much social contact as they would like	High	44.4% 22/23 Nat. Ave	▲	Survey is annual and will next run in February 2025	44.9%
ASCOF 5A	% of carers who had as much social contact as they would like	High	30.0% 23/24 Nat. Ave.	◀▶	Survey is biennial and will next run in October 2025	25.4%
Local	Number of people awaiting a care assessment	Low	<773 Position as at 31st Mar 2024	▲	604 End of June 2024	773 End of March 2024
Local	Number of people awaiting a care assessment for more than six months	Low	<36 Position as at 31st Mar 2024	▲	29 (5% of total waiting at end of Jun-24)	36 (5% of total waiting at end of Mar-24)

DELAY NEED

Leicestershire County Council's Strategic Plan 2022-26	**Safe and Well** Carers and People with care needs are supported to live active, independent, and fulfilling lives

Measure	Description	Aim	Rating	Progress	2024/25 Performance	2023/24 Performance
ASCOF 2A	% of people who had no need for ongoing services following reablement	High	77.5% 22/23 Nat. Ave	◀▶	89.6% (1,125 out of 1,255)	89.6% (3,856 out of 4,304)
ASCOF 2D ***BCF***	Living at home 91 days after hospital discharge and reablement	High	82.3% 22/23 Nat. Ave	◀▶	89.9% (519 out of 577)	88.4% (539 out of 610)
ASCOF 2B	Permanent admissions to care (aged 18-64) per 100,000 pop.	Low	14.6 per 100k pop. 22/23 Nat. Ave	▲	13.1 per 100k Pop. Forecast 57 Admissions in 24/25	14.0 per 100k Pop. Actual 60 Admissions in 23/24
ASCOF 2C ***BCF***	Permanent admissions to care (aged 65+) per 100,000 pop.	Low	560.8 per 100k pop. 22/23 Nat. Ave	▲	551 per 100k Pop. Forecast 849 Admissions in 24/25	566 per 100k Pop. Actual 858 Admissions in 23/24

MEET NEED

Leicestershire County Council's Strategic Plan 2022-26	**Safe and Well** Carers and People with care needs are supported to live active, independent, and fulfilling lives

Measure	Description	Aim	Rating	Progress	2024/25 Performance	2023/24 Performance
ASCOF 3D	Adult aged 18+ receiving direct payments	High	26.2% 22/23 Nat. Ave	◀▶	34.3% (1,736 out of 5,061)	35.6% (1,795 out of 5,043)

Leicestershire County Council's Strategic Plan 2022-26	**Safe and Well** People at most risk are protected from harm

Measure	Description	Aim	Rating	Progress	2024/25 Performance	2023/24 Performance
ASCOF 4A	% of service users who say that services have made them feel safe	High	87.1% 22/23 Nat. Ave.	▼	Survey is annual and will next run in February 2025	82.5%
ASCOF 4B	% of safeguarding enquiries where the identified risk was reduced or removed	High	New ASCOF metric from 2023/24 No national figures yet available	◀▶	95% (169 out of 177)	96% (524 out of 547)
Local	% of service users who received their annual review	High	57.1% 22/23 Nat. Ave	▲	75.2% (4,033 out of 5,362)	73.7% (3,912 out of 5,307)

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Appendix B

Delivering Wellbeing and Opportunity in Leicestershire

Adults and Communities Department, Ambitions and Strategy for 2020 – 2024

Prevent need

We will work with our partners to prevent people developing the need for specialist health and social care support. We will achieve this through information and advice to enable people to benefit from services, facilities or resources that are not focused on particular support needs, but which contribute towards wellbeing and are available for the whole population. Examples include libraries, adult learning services, museums, and associated digital services; green spaces, places of worship, community centres, leisure centres, information and advice services. We will promote wellbeing and work together through active citizenship with families and communities (including local voluntary and community groups). We will help people develop confidence to enable them to speak up and share concerns about their safety and wellbeing.

Reduce need

We will identify those people most at risk of needing social care support in the future and intervene early wherever possible to maintain wellbeing and prevent further need for services (for example people with a new diagnosis of dementia; newly-bereaved; people at risk of isolation; low-level mental health problems; and services for carers). Targeted interventions aim to prevent further needs developing and ensure that people do not become dependent on health and social care. Services might include information and advice, minor adaptions to housing which improve accessibility or provide greater assistance for those at risk of a fall, or telecare services.

Delay need

This focuses on support for people who have experienced a crisis, or who have a defined illness or disability, for example, after a fall or a stroke, following an accident or onset of illness and on minimising the effect of disability or deterioration for people with ongoing conditions, complex needs or caring responsibilities. It includes interventions such as reablement, rehabilitation, and recovery from mental health difficulties. We will work together with the individual, their families and communities, health and housing colleagues to ensure people experience the best outcomes through the most cost-effective support.

Meeting need

The need for local authority funded social care support will be determined once personal and community resources and assets have been identified and fully explored. People with social care needs, assessed as being eligible for funding through the local authority, will be supported through provision of a personal budget. The personal budget may be taken as a direct payment or can be managed by the council. Wherever possible the council will work with people to provide a choice of provision which is suitable to meet people's outcomes, however in all cases the council will ensure that the cost of services provides the best value for money. Whilst choice of provision is important in delivering the outcomes that people want, maintaining people's safety, independence and achieving value for money are the priorities.

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Leicestershire County Council

ADULTS AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE 2 SEPTEMBER 2024

ANNUAL ADULT SOCIAL CARE COMPLAINTS AND COMPLIMENTS REPORT 2023-24

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

Purpose of the Report

1 The purpose of the report is to provide members of the Committee with a summary of the complaints and compliments received in respect of adult social care services commissioned or provided by the Adults and Communities Department during 2023-24. The Annual Report is appended.

2 The Committee is asked to note the report and invited to make comments.

Policy Framework and Previous Decisions

3 The Committee last received a report on complaints and compliments on 4 September 2023. This report covered the year 2022-23 and the Committee requested that reports continue to be presented on an annual basis.

Background

4 The Department has a long-standing statutory duty to have a complaints process in place for adult social care. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, effective from 1 April 2009, introduced a two-stage process with flexible investigation methods and timescales to suit the nature and complexity of the complaint. If the complainant is unhappy with the outcome after stage one, they can ask the Local Government and Social Care Ombudsman (LGSCO) to investigate.

5 The regulations provide a framework for those handling a complaint relating to a local authority's social care functions - this includes directly provided services and independent services provided through commissioning.

6 The actions, omissions, or decisions of the local authority in respect of social care functions are covered. The regulations do not, however, apply more generally to independent providers.

7 People who are paying for their own social care (self-funders) may complain to the local authority, for example, about assessment or failure to assess. Services people have arranged or purchased themselves are not covered but the local authority could be challenged if it commissions those services, for example, by a complaint that it

has commissioned a sub-standard service or is not performance managing contracted services sufficiently.

8 The Adults and Communities Department is contacted on a daily basis by service users, carers and other interested parties to share concerns, request information or seek clarity on care arrangements. These queries are dealt with and resolved at a local level within care teams or through the Directorate without recourse to the formal complaints process. The Complaints Team does, on occasion, also receive queries and concerns that suggest an adult requires immediate support or that raise safeguarding concerns. Such reports are best handled outside of the formal complaints procedure and are referred into the Customer Service Centre or allocated workers for urgent consideration as appropriate in accordance with relevant safeguarding protocols.

9 Under the complaints' regulations, there is a further requirement to produce an annual report that reviews the effectiveness of the complaints and compliments procedures and provides a summary of statistical information. The appended Annual Report fulfils this requirement and presents a summary of the complaints handled in 2023-24.

10 Complaints and compliments about all other aspects of the Adult and Communities Department are reported separately as part of the corporate complaints process.

Key Points

11 Complaint volumes increased significantly during 2023-24 compared to the previous year (382 compared to 204).

12 When complaint volumes are set against the context of overall numbers in receipt of long-term support during the year (10,600), it remains the case that a small percentage go on to make a formal complaint (382 complaints which equates to approximately 2%).

13 For complaints resolved during 2023-24, the proportion where fault was identified increased from the previous year (190 complaints or 50%, compared to 61 or 30%). The principal factor affecting this was an increase where 'delay' was a primary cause.

14 During the year, the LGSCO assessed or investigated 19 new complaints (approximately 5% of the total volume). This figure compares with 23 investigations started in 2022-23.

15 The LGSCO published Final Decisions on 17 complaints during the year. Fault was found in four instances. This was a decrease from 2022-23 (nine). Details for each of the cases appear within the appended report.

16 Resolution of complaints has improved, with 164 (43%) complaints resolved within 10 working days (72 or 35% in 2022-23) and 279 (73%) resolved within 20 working days.

17 This shows that 363 (95%) of cases are responded to within 40 working days and just three complaints exceeded the statutory maximum time allowed (65 working days). These were complex cases all seeking a review of the original decision.

18 This year marks the second full year of reporting on timescales for complaints where a senior manager review was offered. This has proved an effective way of ensuring complaints have been appropriately remedied before escalation to the LGSCO.

19 A total of 29 complaints were referred to a senior manager for review during the year if a complainant remained unhappy with an initial response provided to them. This was a reduction on the 2022/23 figure (44). Timeliness of responses at this stage also saw a significant improvement with 90% completed within 20 working days.

20 The most common complaint theme was again around care-planning. This is a broad area where complaints are often around professional decision-making and professional opinion. There are no significant changes to the types of complaint being made this year.

21 There have been good examples this year of how systemic learning has been identified and implemented. In 70 cases (37%) where complaints were upheld, clear actions were highlighted by Investigating Managers to improve future performance.

22 Whilst the report understandably focuses on complaints, adult social care services did receive 52 compliments during 2023-24. This is a healthy increase on the previous year (29) and continues to add balance to the annual report and recognises the good work that is also taking place across the Department. The majority of compliments highlight the professionalism, support, and empathy shown by the service during difficult times, examples of which are included in the Appendix.

Recommendations

23 The Committee is asked to:

a) Note the Adult Social Care Complaints Annual Report, covering the period 1 April 2023 to 31 March 2024.

b) Provide comment and feedback on the content and analysis within the report.

Background Papers

Report to Adults and Communities Overview and Scrutiny Committee: 4 September 2023 – Annual Adult Social Care Complaints and Compliments Report 2022/23 - https://democracy.leics.gov.uk/ieListDocuments.aspx?CId=1040&MId=7109&Ver=4

Circulation under the Local Alert Issues Procedure

24 None.

Equality Implications

25 The Adults and Communities Department supports vulnerable people from all the diverse communities in Leicestershire. Complaints and compliments are an important way of ensuring that service responses are fair and equitable to all sections of society. This report does not highlight any specific equal opportunities implications.

Human Rights Implications

26 There are no human rights implications arising from the recommendations in this report.

Partnership Working and Associated Issues

27 The National Health Service Complaints (England) Regulations 2009 places a duty to co-operate on local authorities and health organisations. During the year, 4 complaints were handled under joint complaints protocols using an agreed joint complaints handling framework. No issues were experienced with partnership working.

Officers to contact

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Appendix

Social Care Statutory Complaints and Compliments: Annual Report - April 2023 - March 2024

Leicestershire County Council

Adult Social Care

Statutory Complaints and Compliments Annual Report April 2023 – March 2024

Business Services
Corporate Resources Dept

Contents

1. Purpose and Context of Report

1.1. Purpose & Scope

The purpose of this report is –

- To report on Leicestershire County Council's (LCC) adult social care complaints and compliments activity from 1 April 2023 to 31 March 2024.
- To set out future developments and planned improvements.
- To meet the Council's statutory duty requiring the production of an annual report each year.[1]

This report provides analysis and comment for Adult Social Care Services on all complaints managed under the statutory complaints process. Those complainants not qualifying under the statutory process have been considered under the County Council's Corporate Complaints and Compliments Annual Report presented to the Scrutiny Commission.

1.2. Background Context

The Adult Social Care Service sits within the Adults and Communities Department, and both arranges and supports the provision of a wide variety of services.

This includes helping people to remain living independently in their own homes with increasing levels of choice and control over the support they receive. When this is no longer possible, the department supports residential or home care as well as having lead responsibility for safeguarding adults at risk of harm.

10,600[2] people received long-term support from the Social Care service during 2023-24. This was a 1.7% increase on the previous year (10,421) primarily due to a significant rise in home care.

The department always aims to provide high quality services that meet the needs and circumstances of individuals and their families. The department actively promotes involving clients and carers in shaping services; using their skills and experiences to help ensure they meet customer needs. However, given the personal and complex nature of some adult social care services, sometimes things do go wrong.

The complaints process is a mechanism to identify problems and resolve issues. If things go wrong or fall below expectation, the County Council will try to sort things

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[1] Statutory Instrument 2009 no.309 (18)

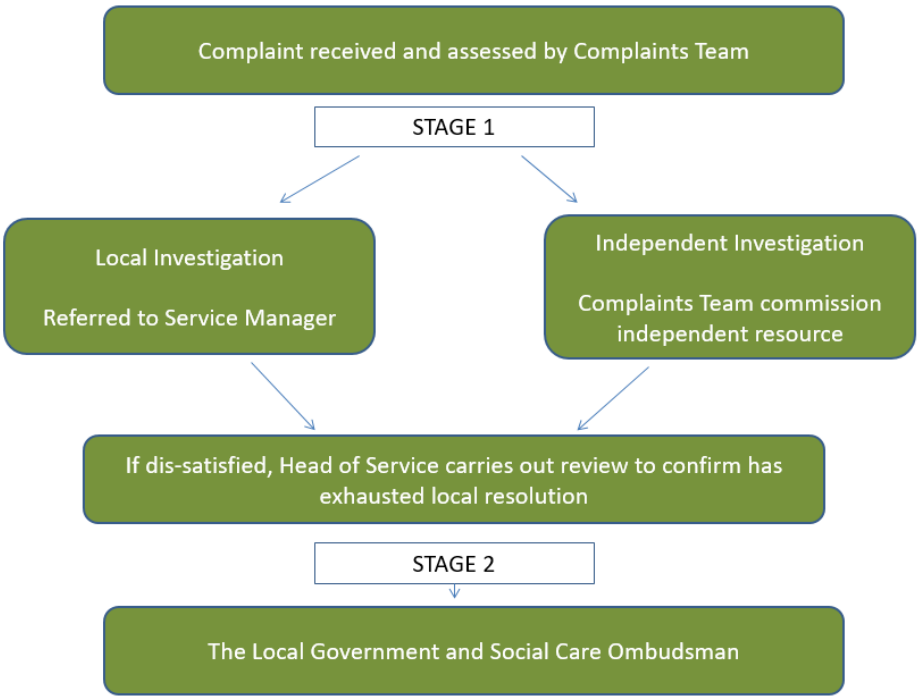
[2] Figures supplied by Performance and Business Intelligence Team

out quickly and fairly. Learning from our mistakes and concerns that are raised is used to make changes and improve services.

Analysis of information about complaints received during 2023 -24 gives Adult Social Care an opportunity to reflect on the quality of the services it provides and consider how well it listens and responds to service users.

2. Adult Social Care Complaints Procedure

The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009 outlines the statutory responsibilities of the County Council. This is broadly set out below:



The above procedure was designed to offer Local Authorities flexibility to resolve complaints in the most appropriate manner. Stage 1 resolution can therefore consist of several processes (for example meetings or reviews) but the Local Authority must not unduly delay finalising this process which should always be concluded within 65 working days.

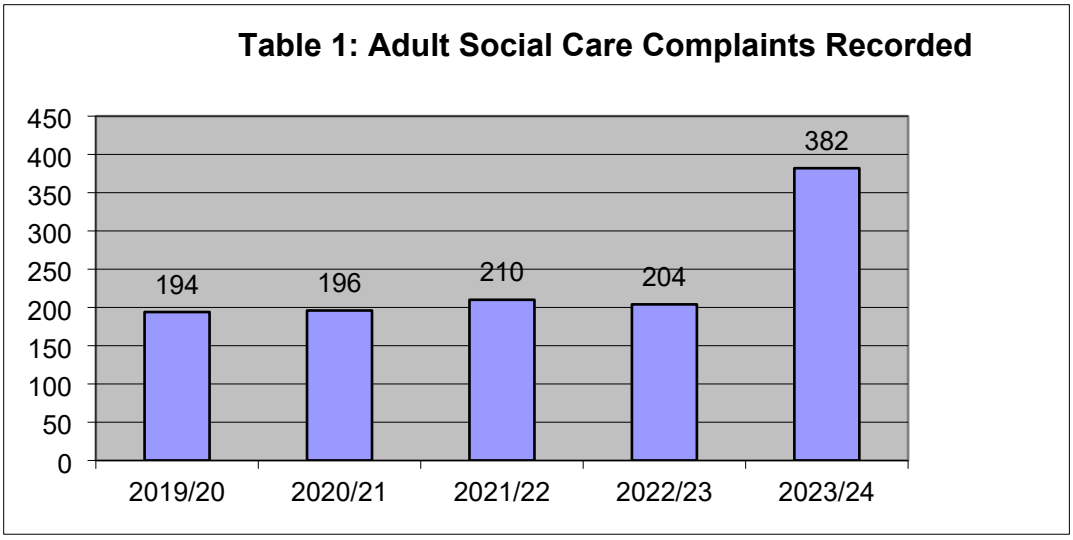
The Local Authority must advise all complainants of their right to approach the Local Government and Social Care Ombudsman should an agreed resolution not be found.

During 2023-24, no independent investigations were commissioned.

3. Complaints and compliments recorded in 2023-24

3.1 Complaint Volumes

Graph 1: Adult Social Care Complaints recorded over last 5 years.

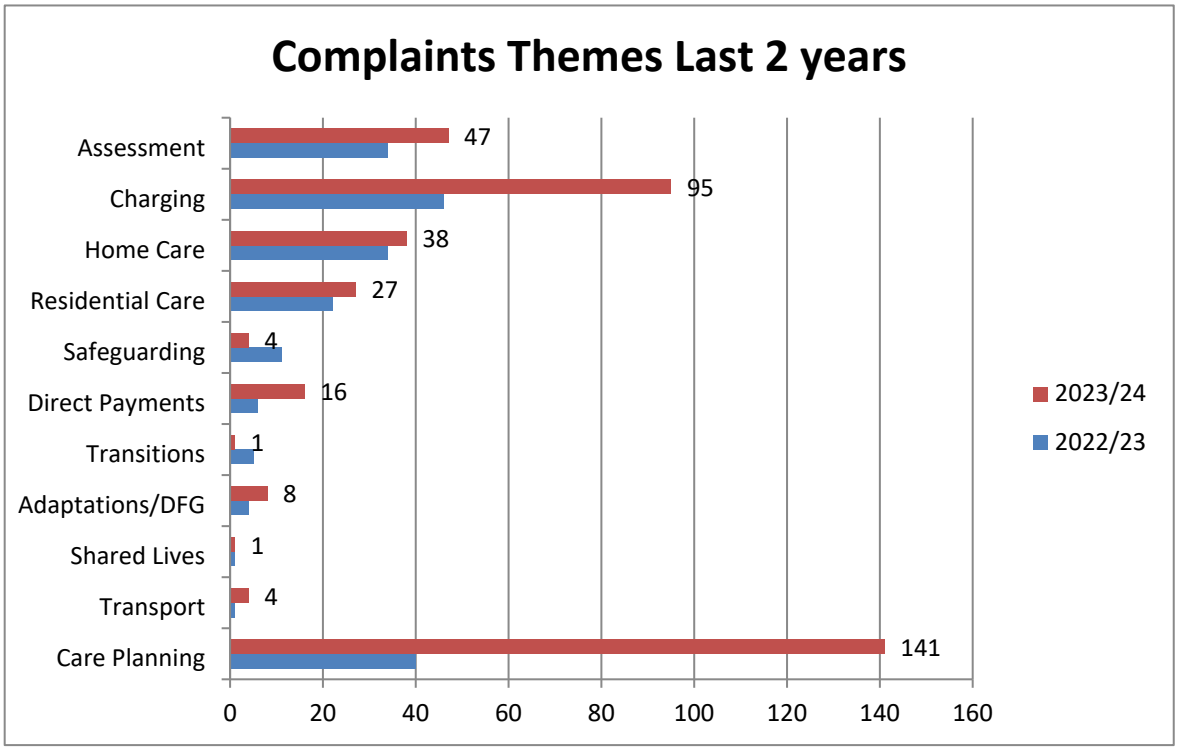


As illustrated above, the total number of social care complaints responded to this year increased significantly (87%) following several years of stability.

When considered against the context of service users in receipt of long-term support, complaints continue to represent a relatively low number at 1.9%.

3.2 Complaints by Theme

Graph 2: adult social care complaints by theme



Complaint themes mirror the Local Government and Social Care Ombudsman classifications and can provide helpful insight as to the underlying topics that are generating complaints.

The largest segment is also the broadest category around Care Planning. This equates to 37% of the overall volume.

Complaints were mostly about poor communication, delays and waiting times for allocation of workers or key decisions. This is also reflected in the higher uphold rate this year as complaints about delay are always more likely to be upheld than those about professional judgement or decision making.

Charging complaints continued to be received in significant volume during the year (35% of the overall volume). There is significant work taking place in this area to try to generate improvements but at the heart of the complaints are timescales for completion of financial assessments.

It is good to see that despite significantly more Home Care provision this is not an area generating additional complaint volumes.

Whilst the LGSCO has not yet released their annual report for 2023-24, it is important to note that in the most recent edition (2022/23), they stated the following:

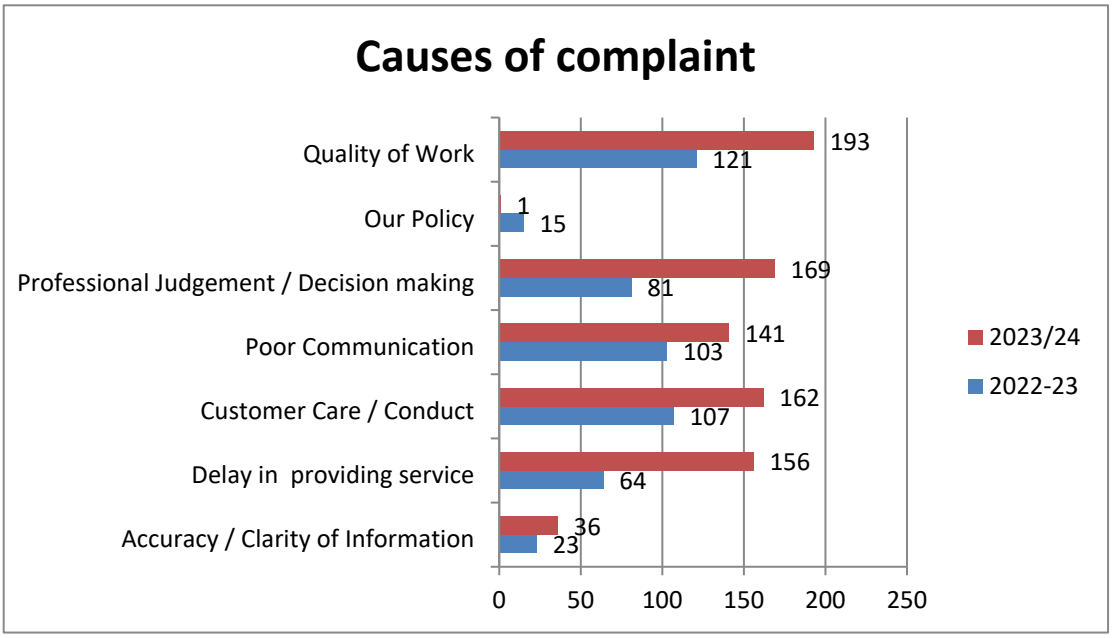
“The eight public interest reports focused on familiar issues – the challenges of timely and proper assessing and care planning, as well as charging for care and support”.

With this in mind, Leicestershire County Council’s complaints would seem to mirror the national picture.

3.3 Primary cause of complaints.

The Complaints team also undertake analysis of each complaint to try to understand any significant factors. This can help prioritise areas for the department to focus on improving.

Graph 3: Complaint causes for Complaints resolved last 2 years.



Recording allows for multiple causes to be selected. So, if a complaint features "delay" as well as "Customer Care" then both will be selected. It follows that the data above will not match the overall number of complaints resolved.

Quality of Work remains the most frequently identified topic cited within complaints. This is of little surprise as it is the broadest category, including for quality of home and residential care. There are far more cases this year with multiple categories selected which makes any compelling conclusions difficult to draw.

3.4 Joint Complaints

The Health and Social Care complaints regulations place a duty on Local Authorities to work together with health partners in responding jointly to complaints[3]. Leicestershire County Council accordingly has a joint complaint handling protocol, supported by a multi-agency group, which sets out common guidelines and approaches to this.

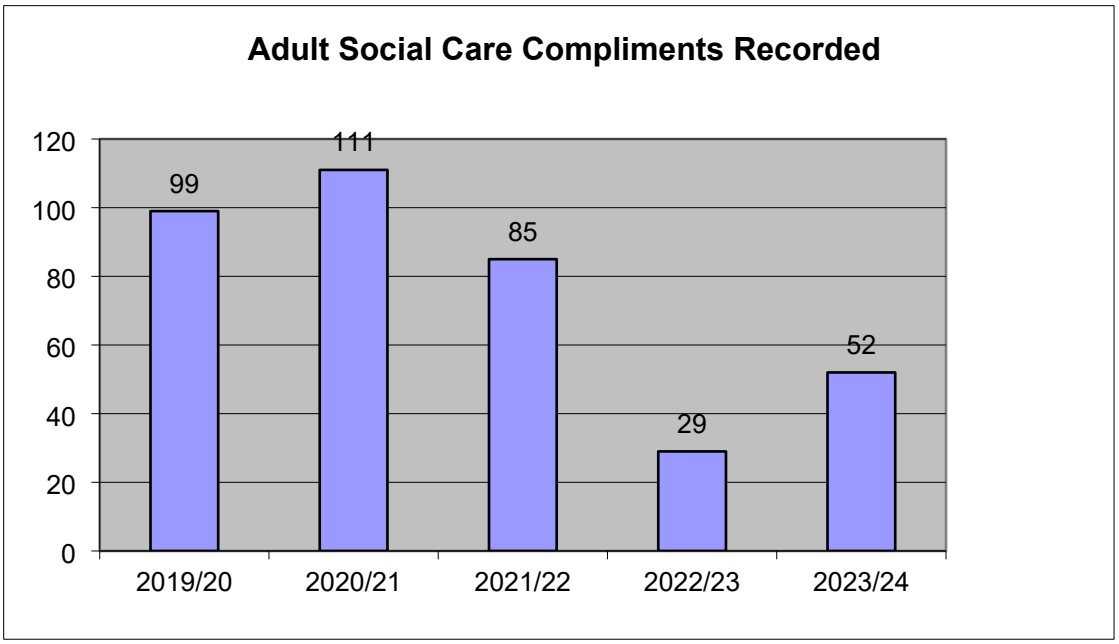
[3] Statutory Instrument 2009 no. 309 (9)

Members include Leicester City Council, the Integrated Care Board (ICB), University Hospitals Leicester (UHL) and the Leicestershire Partnership Trust (LPT).

During the year 2023-24, two complaints were considered using the Joint Complaints protocol. No difficulties were experienced this year with partnership working.

3.5 Compliments received 2023-24

Graph 4 below shows the long-term trend in compliments recorded.



There has been an increase in compliments recorded during 2023-24 following the significant reduction last year. As many compliments are received directly by front line team, it is hard to say whether this is truly reflective of the overall amount.

It is always important to recognise the good work that is being delivered by the department and to provide balance within the complaints annual report. For this reason, the complaints' function does encourage the recording of un-solicited compliments which can either be submitted directly online or if received by council officers should be passed on for central recording.

A small selection of the compliments received can be found in Appendix A. They show some of the 'real-life stories' where Adult Social Care makes a huge difference to peoples' lives.

The Complaints team will continue to work closely with the department to try to reflect all the unsolicited feedback received across the teams and ensure visibility in annual reports.

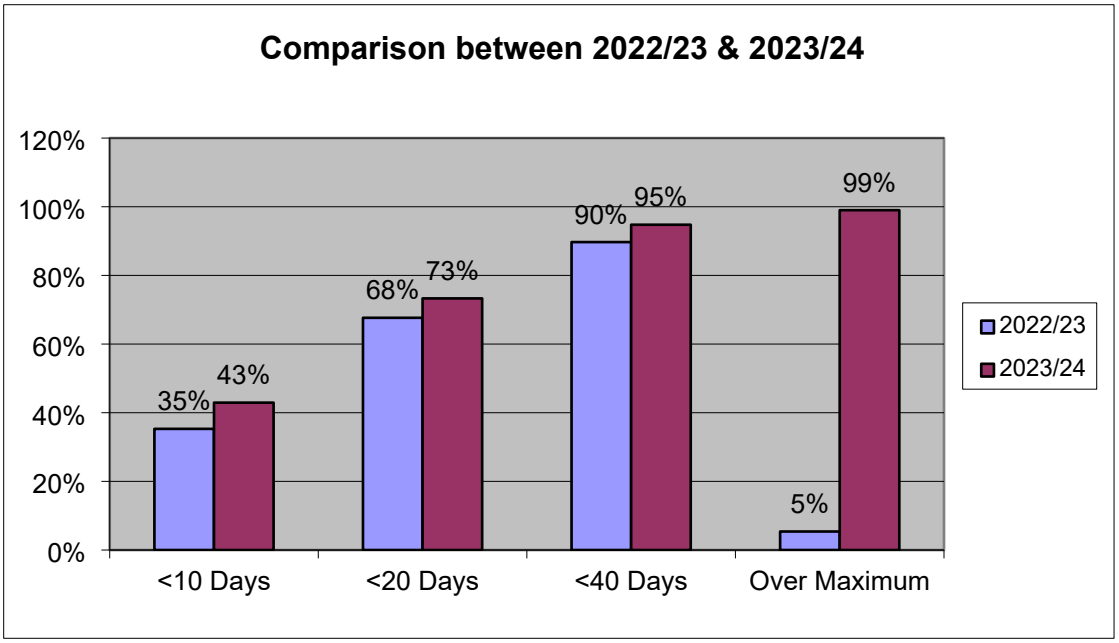
4. Complaints resolved 2023-24

The key performance indicators for speed of response, outcomes, causes and identified learning are linked to complaints that have been *resolved* within any given reporting period rather than received.

This is important as it ensures that full data sets can be presented, both to departments on a quarterly basis, and at year end. It also avoids the scenario whereby Ombudsman findings of maladministration might not appear in annual reports (where outcomes are not known at the time of production).

4.1 Responsiveness to complaints

Graph 5: Adult Social Care Performance at Stage 1



The above graph shows a further improved performance at each of the performance indicators. 73% of all complaints were responded to within 20 working days and 99% within the statutory timescale of 65 working days.

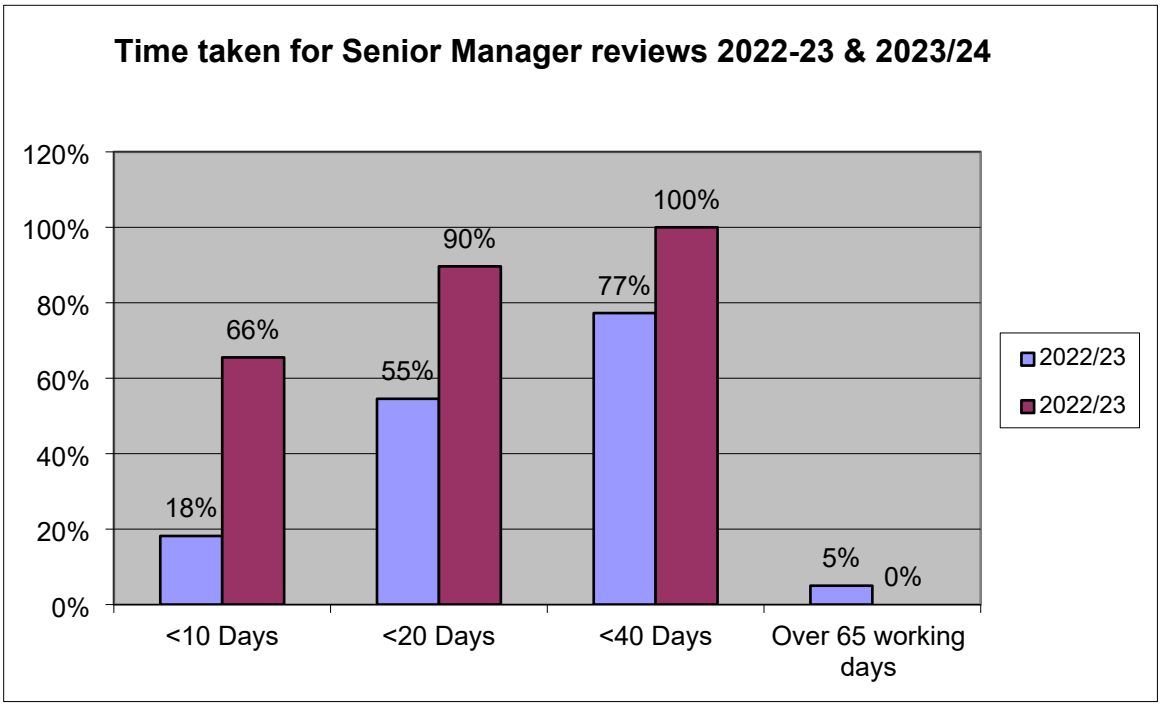
Whilst the statutory regulations give wide flexibility in terms of response times and allow up to 65 working days for complaints to be resolved, a key expectation of the public is that their concerns are dealt with promptly and this report provides good assurance of the department's commitment to this despite the challenges seen this year.

Adult Social Care Performance at Review Stage

29 complaints requested escalation to the Council during the year and were reviewed by a senior manager. This was a reduction on 2022/23 (44).

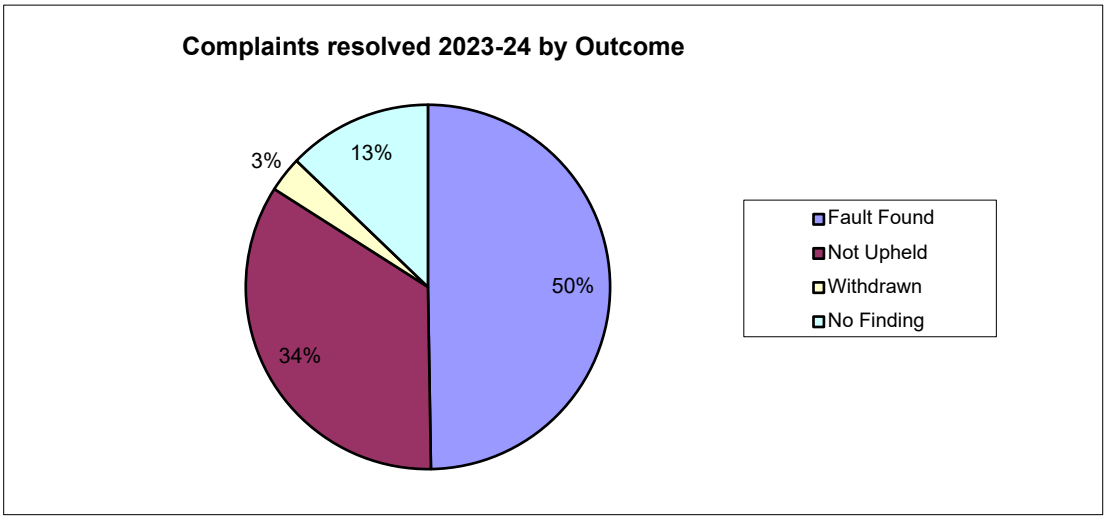
It is pleasing to see the clear improvement in timeliness of responses with 90% completed within 20 working days.

Graph 6: Adult Social Care complaints reviewed by Senior Managers



4.2 Complaint Outcomes

Graph 7: Adult Social Care complaints recorded by outcome.



Graph 6 above shows that 190 (50%) complaints were upheld. This is a significant increase on the previous year (31%) with the principal reason being the increase of complaints solely about delays. Prompt acceptance and ownership of any mistakes can help prevent costly complaint escalation including to Senior Managers and the Local Government and Social Care Ombudsman.

5. Learning from Complaints

Complaints are a valuable source of information which can help to identify recurring or underlying problems and potential improvements. We know that numbers alone do not tell everything about the attitude towards complaints and how they are responded to locally. Arguably of more importance is to understand the impact those complaints have on people and to learn the lessons from complaints to improve the experience for others.

Lessons can usually be learned from complaints that were upheld but also in some instances where no fault was found but the Authority recognises that improvements to services can be made.

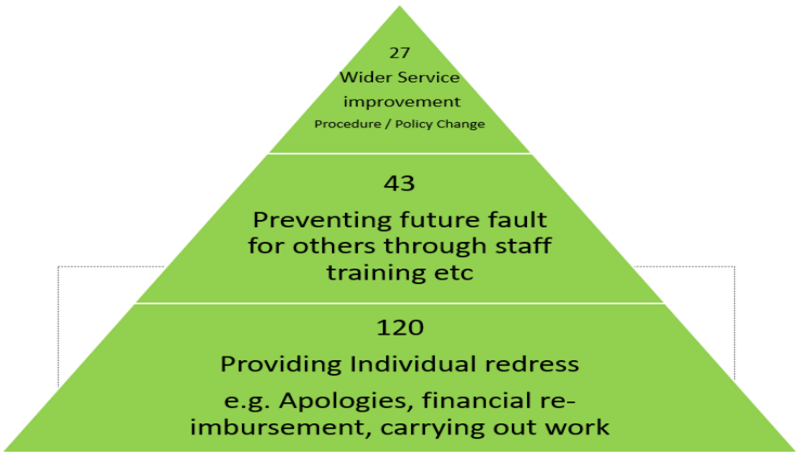
Occasionally during an investigation, issues will be identified that need to be addressed over and above the original complaint. The Complaints Team will always try to look at the "bigger picture" to ensure that residents receive the best possible service from the Council.

5.1 Corrective action taken.

All the 190 complaints where fault has been found have been reviewed by the Complaints Team to ascertain what action the relevant department has taken, both in remedying the fault, and any wider learning to avoid such issues occurring in the future.

Remedial action typically consists of both individual redress (e.g., apology, carrying out overdue work) and wider actions that may affect many. The diagram below shows the actions taken during 2023-24. 37% of complaints upheld resulted in clear actions that should improve service for other residents. This is a slight increase on the previous year (33%)

Graph 7: Actions taken for upheld complaints 2023-24



The most common action taken was staff training. There are lots of good examples of this taking place both at individual and team level. These included:

- reminding teams of the need to keep accurate records.
- refresher training on safeguarding procedures
- challenging and escalating disagreements with discharge arrangements being proposed by Health partners.
- more thorough questioning of care providers when concerns are raised.
- bespoke training provided on dealing with dementia.

The most powerful are whole system changes, where it is identified that a process or policy needs amending. There were again several such scenarios during the year arising from local investigation. Notably:

- Review of resourcing levels to ensure improvement made to timeliness of completing financial assessments.
- Changes to IVR system to reduce wait times at front door and ensure calls routed more efficiently to the correct persons / teams.
- Better arrangements for ensuring duty teams are signposted if officers are on leave.

Financial redress was also arranged on several occasions this year and to ensure that the complainant was put back in the position they would have been in had the fault not occurred. Typically, this is re-imbursement of care costs where these had either been calculated wrongly or there was evidence that clear explanations were not given.

The Local Government and Social Care Ombudsman expects Councils to consider such financial redress as appropriate and has introduced new reporting this year highlighting those occasions where Councils have already put things right before consideration by the Ombudsman.

6. Local Government Ombudsman

6.1 New complaints received by the Ombudsman 2023-24

Should a complainant remain dissatisfied following internal consideration of their complaint, they can take their complaint to the Local Government and Social Care Ombudsman to seek independent investigation.

The Ombudsman will usually check with the Authority whether the complaint has exhausted the Local Authority's complaints procedure. Where this has not been done, the Ombudsman will usually refer the complaint back to the Authority, to give us an opportunity to attempt to resolve the complainant's concerns through our internal complaints processes first.

The Local Government and Social Care Ombudsman opened enquiries on 19 complaints during the year. This represents approximately 5% of the overall complaints.

6.2 Complaints resolved by the Ombudsman 2023-24

The Ombudsman made decisions on seventeen cases during the year with fault being found in 4 cases (24%). This represents a lower number of adverse decisions to last year (9) and a reduced proportion of fault (23%).

There were no decisions issued as Public Reports

Brief details for the four cases where fault was found appear below:

1. **Fault found on how the Council considered a deprivation of assets case.**

The Ombudsman did not find fault with the Council's decision making but did find fault that it had delayed in communicating the decision to the family.

The Council agreed to make an apology and a symbolic payment of £250 in recognition of this.

2. **A complaint regarding assessed charges following a move into a care home.**

The Ombudsman found that the Council had charged the service user in line with its policy but that there had been delays in communication which caused both uncertainty and frustration. It missed the opportunity to provide timely advice to the family.

The Ombudsman also found the Council took too long to complete a DOLS assessment.

The Council agreed to issue an apology and make a payment of £300.

3. **A complaint regarding the quality of care delivered by a care home.**

The Provider rather than the Council had responded to the formal complaint and had accepted fault and apologised to the family.

The Ombudsman determined that the Council (as the commissioner) should also make a payment of £300 and take steps to work with the provider on making improvements to record-keeping, dealing with pressure sores and identification of health concerns.

4. **Sending of invoices to a service user having agreed previously not to do so.**

The Council had already apologised for having sent an invoice to a service user having previously agreed to correspond with a representative. The Ombudsman agreed this was a suitable remedy and no further action was warranted.

For the remaining thirteen complaints

- In five cases the Ombudsman decided not to investigate, either because there was no evidence of any fault, or the matter had already been appropriately addressed by the Council.
- In five cases, the Ombudsman determined that the complaint was premature for them and asked the Council to respond through our complaints procedure.
- In two cases, the Ombudsman, after detailed investigation, was satisfied with the actions the Council had taken.
- In one case the Ombudsman concluded initial enquiries with a finding that the matters complained about were outside of his remit.

The Ombudsman also monitors remedies being carried out by the Council where fault has been found and remedial actions proposed. Failure to carry out remedies within agreed timeframes is recorded as non-compliance and can lead to public reports being issued. All 4 of the above cases were recorded as compliant (100%). This compares to the national average of 99%

7. Monitoring the Process

The Complaints Team continues to support Adult Social Care Services to manage and learn from complaints. The key services offered are -

1. Complaints advice and support
2. Production of Performance Reports
3. Liaison with the Local Government and Social Care Ombudsman
4. Quality Assurance of complaint responses
5. Complaint handling training for Operational Managers
6. Scrutiny and challenge to complaint responses

Assistance continues to be routinely provided to Service Managers and other associated managers in drafting responses to complaint investigations. This helps ensure a consistency of response and that due process is followed.

Quarterly performance reports are produced and delivered at Senior Leadership Team (SLT)

8. Final Comments

There has been a significant increase in complaint volumes this year following a stable period over the last few years.

It is clear that a significant factor is keeping up with demand and responding in a timely fashion. There are specific issues noted with timeliness of completing financial assessments but also clear that these are known issues and service improvement work is already taking place.

It is also encouraging that despite the volume increases, response timescales improved and there were less complaints escalating to the Ombudsman with fewer decisions finding maladministration.

Some of the complaints concerned delivery of care by providers and in these instances, complaints data is routinely shared with our Quality and Improvement team who work closely with providers in making improvements as required.

It is vital that service users are provided with a complaints process that is easy to access and fair. This year’s Annual Report shows that Adult Social Care does listen and provides a number of examples of how complaints intelligence directly drives and improves service delivery.

Appendix A: Sample of compliments received 2023-24

- Thank you to S and G for the high level of support they both provided during a particularly stressful time for me personally.
- A massive 'Thank you' to the finance team for all your assistance over the past few months with the funding for my mother's residential care.
- Thank you, Y, for all your help and support over the last few months, it was greatly appreciated.
- Thank you to N & J Home First West for being outstanding, kind, professional and very helpful in arranging help for my parents.
- Thanks to P and your team for the work you completed at The Trees recently with our young person.
- We would like to offer our sincere thanks to S who has been a great help to us in arranging a care plan.
- E has been so caring to both mum and I and very quickly put a number of things in place to support us both. I'm so grateful.
- Thank you to B for the diligence, professionalism and empathy that you showed to my parents and me during a difficult time.
- Thank you, Z for all your help with a complex service user, your approach has helped in building a trusting relationship with him.
- Thank you, Z, for all the help and support that you provided to my parents during a very difficult time.
- I would like to thank J for listening and supporting me. J was very sympathetic, friendly and approachable.
- I would like to express my gratitude for the way H helped me though the financial confusion relating to set up of care funding for my aunt.
- Thank you, R, for the invaluable help and support you've provided to both my mother and me.
- Thank you, S, for all your help with a complex benefits case and to P for all of your help and advice.
- Thank you, M, for getting my son moved so quickly and for being compassionate and supportive. I finally feel safe and free.

Agenda Item 11

Leicestershire County Council

ADULTS AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE 2 SEPTEMBER 2024

PEER REVIEW OF PATHWAY FOR ADULTHOOD

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

Purpose of the Report

1. This purpose of this report is to provide the Committee with the findings and recommendations from the Peer Review undertaken on the effectiveness of the current pathway to adulthood, with a focus on the Young Adult Disabilities (YAD) Team managed and operated by the Adults and Communities Department.

2. The review was carried out in May 2024 by a team led by Andy Smith, Strategic Director of People Services at Derby City Council, the findings of which, and action plan containing recommendations for improvement, are presented as appendices to the report.

Policy Framework and Previous Decisions

3. The focus of the Peer Review links with the Council's Preparing for Adulthood (PFA) Strategy and Whole Life Disability Strategy.

4. A wider corporate review of PFA services is underway and is relevant to the recommendations taken from the review.

5. PFA has been a key theme in Local Authority Care Quality Commission (CQC) inspections conducted with other local authorities. The CQC will consider the effectiveness of the pathways young people take as they move from children's services to adult social care services.

Background

6. Peer Reviews are an important part of sector-led improvement activity in the East Midlands and this is one of 10 such reviews being carried out in the East Midlands over a two-year cycle. The Peer Review process is designed to support the Council's performance by identifying its areas of strength and areas for development. The framework for this round of reviews focused on:

   - What is working well?
   - What does not work as well and why?
   - What areas for improvement are you prioritising and why?

7. It is also widely recognised that early preparation for adult life is crucial to success and for young people to have a positive experience as they become independent and

move into adult life. Successful preparation for adulthood focussing on the young person's strengths to enable independence has great benefits to both the Council and to young people receiving support. PFA is a key theme for CQC assessment, and the review will support ongoing preparation for future assessment.

8. The Review Team was asked to consider the following Key Line of Enquiry (KLOE):

"*To review the effectiveness of the current pathway to adulthood for young people within Leicestershire to ensure timely independent outcomes for young people and Best Value for the authority are achieved.*

Consideration for part of the review to focus on the current methodology for identifying the cohort of young people that will require an intervention?"

9. The Review Team was chosen based on the skills, experience and interest in the chosen area, and included colleagues from the local authorities in Derby, Nottingham, Nottinghamshire, and West Northamptonshire.

10. A range of documentary evidence including policy, process and guidance information, and key service performance data was provided to the Review Team in advance.

11. The Review Team had access to the Department's case recording system (Liquidlogic Adult System) and were supported to view care and support assessments, case records and support plans. The cases reviewed were a mixture of young people whose support from YAD was either concluded or part way through. This gave the Review Team an opportunity to look at areas of practice, to look at journey of the young person and what outcomes were achieved.

12. On 7 May 2024 a 'Team to Teams' session took place. This involved members from the YAD Team meeting with members of the service equivalent in Derby City Council. The teams explained what their current process for supporting young people involved, what was working well and things they would like to see reviewed.

13. On 13 and 14 May 2024, a series of meetings explored the views and experiences of a wide range of professionals from the Department's Adult Social Care teams, Children and Family Services, and key Health partner representatives. Meetings were also held to seek the views of young people and parent carers to understand their experience of the service provided.

Summary of Key Findings

14. The detailed findings are set out in Appendices A and B attached to this report and are summarised below.

15. The YAD Team was observed to be positive, passionate and highly motivated to deliver positive outcomes for young people. There was evidence of a strong sense of team working and of being well respected by stakeholders, internal and external partners.

16. Caseloads in the YAD Team are kept at a realistic and manageable level with a focus on case progression supervision evident in the case records. The Review Team

found examples of great practice and joint working. The reablement offer was especially valued by the young people and parent carers that were consulted.

17. Whilst the YAD Team has good links with special educational schools, the Peer Review highlighted future opportunities for the service to expand this to develop and strengthen links with mainstream schools and wider relevant community services.

18. Whilst the managers from the YAD and Disabled Children's Service, managed within the Children and Family Services Department, meet on a regular basis and have strong working relationships, the review identified opportunities to bring together the front-line workers to share training and practice. Further opportunities to strengthen the relationship between YAD and the Special Educational Needs and Disability Team (SEND) managed within Children and Family Services were also identified. Work has commenced following the review and initial meetings have been arranged to support greater partnership working.

19. The Peer Review identified areas of practice and process that are working well with the service. There is a clear process in place for identifying the young people who have an Education Health and Care Plan (EHCP) and will receive a service from the YAD Team. Allocation of cases is supported by the use of a prioritisation tool along with information gathered at regular cohort meetings with the Disabled Children's Service. The Team has clearly identified documentation such as pre-assessments and My Journey to Adulthood Plans, as well as the care and support assessment.

20. Young people stated they felt they had been included in the support planning process and were able choose their personal assistants and service to meet their needs. Young people articulated they felt encouraged to become as independent as possible as they moved through into adulthood with the reablement worker being highly valued and flexible in their approach.

21. The Peer Review considered that the pathway for young people who do not have an EHCP was less clearly defined and this was identified as an area for future development. Families told the Review Team they did not feel informed about what to expect if the YAD Team was not involved and gave an impression of service that is not equitable for all where an EHCP is not in place.

22. Work is being completed to identify young people who do not have an EHCP in place and are likely to have social care needs in adulthood. The pathway for this cohort of young people will be mapped out as part of the peer review action plan to understand if a process for identification could be developed.

23. The prioritisation tool is not always accurate in determining the level of need a young person may have. During the case audit several young people had been rated as *Medium*, but went on to require a significant intervention from the Team.

24. A review of the prioritisation tool will take place to look at the effectiveness and accuracy of identifying risk.

25. The case audits also highlighted that pre-assessments and the 'My Journey to Adulthood Plans' were not always being completed and care and support assessments often need to be updated before a young person turned 18. There is an

opportunity to look at better ways of capturing the information required whilst continuing to meet statutory requirements.

26. In response to this the YAD team have been prioritised for the roll out of 3 Conversations and this is expected to commence week commencing 2 September 2024. The 3 Conversation model is a particular strengths-based approach to providing services that work collaboratively with people seeking support, including carers. Conversation 1 and 2 will replace the need for a pre-assessment and My Journey to Adulthood to be completed as this can be incorporated in to the conversation held.

27. The closure summaries completed by the allocated YAD worker at the end of an intervention did not always fully reflect and capture the work that had been completed with a young person regarding the achievements and outcomes they had achieved.

Other Observations

28. The Review Team found that the move to a single Adults and Children's Occupational Therapy Team based within the Adults and Communities Department had resulted in significant improvement in the waiting times for assessments for young people.

29. There was a collective view that the Transforming Care Pathway, focuses on making sure there is the right support for people with a learning disability and or autism to be discharged from inpatient hospital care at the right time and also helping people who are at risk of being admitted, was clear and working well and the arrangements with Health around joint funding appeared to demonstrate value for money.

30. To consider developing a shared understanding and definition of transition and PFA (because transitions and PFA are related but also distinctively two different concepts and processes) which can be clearly articulated by all those involved from the young people and their families to the professionals around them. Working together to co-produce this will assist with strengthening the interface between teams and services around the young person.

31. Transition focuses on moving from one service to another. PFA should start early, from age 14, and means preparing for: higher education and/or employment, independent living, participating in society and being as healthy as possible in adult life.

Proposals/Options

32. The Peer Review findings and presentation, are attached as Appendices A and B respective to this report, have been shared with the wider corporate review of PFA to assist with identifying the opportunities set out in the review.

33. An action plan has subsequently been developed, attached as Appendix C to this report, to address the recommendations and findings and work has started on implementing the actions.

Consultation

34. A number of workshops took place on 13 and 14 May 2024 as part of the review and were held at County Hall The workshops were ran by the Peer Review Team and were held for both internal County Council participants from adult services and Children and Family Services as well as for external participants including:

- Young people experiencing or have experienced transition;
- Parents and carers who have young people transitioning or transitioned;
- Health colleagues from Children's and Adults services;
- External and third sector providers.

35. The workshop for parent/carers was advertised by the Leicestershire SEND Hub.

Resource Implications

36. The delivery of the action plan can be achieved within existing departmental resources and the Preparation for Adulthood Project.

Timetable for Decisions

37. It is intended that all the work set out in the action plan will be completed by January 2025.

Conclusions

38. The recommendations from the Peer Review Team have been considered and an action plan has been agreed which builds on identified strengths and includes specific actions to address the areas for development with the aim of improving the experience of young people moving into adult social care services.

39. Some of the actions will be considered as part of the corporate PFA workstream as outlined in the attached action plan for example developing a collective understanding and definition of transitions and PFA and defining the pathway for young people is not clear where no EHCP in place.

40. The Committee is invited to comment on the findings and recommendations of the Peer Review and the action plan.

Background Papers

- Preparing for Adulthood Strategy - https://www.leicestershire.gov.uk/sites/default/files/field/pdf/2019/2/1/Preparing-for-adulthood-strategy.pdf
- The Whole Life Disability Strategy - leics.sharepoint.com/sites/childrenandfamilyservices/Shared Documents/Forms/AllItems.aspx?id=%2Fsites%2Fchildrenandfamilyservices%2FShared Documents%2Fwhole-life-disability-strategy%2Epdf&parent=%2Fsites%2Fchildrenandfamilyservices%2FShared Documents

Circulation under the Local Issues Alert Procedure

41. None.

Equality Implications

42. There are no equality implications arising from this report that require the completion of an Equality Impact Assessment (EIA) at this time. However, an EIA will be undertaken, as actions are developed further, if required.

43. The Peer Review highlighted that the pathway for young people who do not have an EHCP may be less clear, and as such the Council needs to ensure that there are equitable opportunities and outcomes achieved for all young people transitioning into adult services.

Human Rights Implications

44. There are no human rights implications arising from this report.

Appendices

Appendix A – Leicestershire Peer Review Findings Letter
Appendix B – Leicestershire Peer Review presentation
Appendix C - Leicestershire Peer Review Action Plan

Officers to Contact

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Derby City Council

Stronger Families, Resilient Children

Ofsted Outstanding Provider

Mr Jon Wilson
Leicestershire County Council
By Email

Team	People Services
Contact	Andy Smith
Our ref	AS/SF
Email	andy.smith@derby.gov.uk
Tel	01332 643556
Minicom	01332 640666
Date	12 June 2024

Dear Jon,

Re: Leicestershire Peer Review

Can I start by thanking you for the excellent organisation and hosting of the recent peer review team. As you know as a DASS whilst challenging because we're all so busy it is always a pleasure and a privilege to be able to take time out to step into another council to look at their practice. The team were all impressed with the level of commitment, enthusiasm and honesty of your teams and I know they have all taken back learning into their own organisations.

As you know this is only the second of our revised regional process and whilst we have expanded our time on site and enhanced our pre site work we still do recognise that it is a point in time in your journey of improvement. I do hope that you find our insights useful, and they can assist in your thinking about the further development and progress around transition and pathways to adulthood particularly as it seems to be a key area of focus in CQC assessment.

I have enclosed copies of our presentation from the day, which includes more detailed feedback on the case audit and the team to team sessions and a short report highlighting the most prominent findings; hopefully this will assist in the preparation of your subsequent action plan and I look forward to hearing how things are progressing in a few months' time when we meet up again for our reflection session.

All the best,

Andy Smith
Strategic Director of People Services
Derby City Council

Leicestershire Peer Challenge Review
May 2023

The review was undertaken by a team led by Andy Smith Strategic Director People Services from Derby.

Review Team

- Andy Smith – Lead DASS Derby City Council
- Amy Brock – Assistant Director, West Northamptonshire Council
- Iris Peel – Group Manager, Nottinghamshire County Council
- Liz Sagi – Moving into adults development manager, West Northamptonshire Council
- Margot Summerbridge – PSW, Derby City Council
- Oliver Bolam – Head of MH and Whole Life Disability, Nottingham City Council
- Sharon Buckby – Director of Learning Inclusion and Skills, Derby City Council
- Sue Wilson – Support role, EM ADASS

Background

The Peer Review process is one of the cornerstones of the East Midlands Branch approach to the Sector Lead Improvement and support offer to both support members to prepare for CQC assessment and review their existing offer. As a Branch we strongly believe that Local Authorities should work together to take collective responsibility for the performance of the sector with a focus on improving the experiences and outcomes of the people we serve.

This peer review is one of 10 reviews being carried out in the East Midlands over a 2-year cycle. Following the evaluation of the previous round we have decided to retain our simplified approach focusing on the 3 key questions:

- What is working well
- What is not work well
- Areas for Development

EAST MIDLANDS PEER CHALLENGE PROCESS

Following our evaluation of the previous cycle and ongoing learning from the CQC assessment process we have maintained our 3-stage approach but have strengthened our case audit through adding feedback from the person and/ or their family and allocated more time on site for the team to triangulate the information received before offering their formal feedback presentation.

The Key Line of Enquiry was agreed between the Host and Reviewing Directors and the review team was chosen based on their skills, experience and interest in the chosen area. Relevant key background information, polices and data were requested and submitted in advance for the review team to consider.

Frontline Teams from the Host and Review Local Authority met and had the opportunity to look at the Key Line of Enquiry from an operational perspective.

A number of individuals who draw on care and support were identified where the review team focused on the persons journey and the outcomes that were achieved via conversations and case file audits.

The onsite review consisted of a number of meetings with key relevant stakeholders identified jointly by the host and review teams.

Evidence was triangulated and the formal feedback presentation was prepared and delivered on day 2 of the review.

KEY AREAS OF ENQUIRY

To review the effectiveness of the current pathway to adulthood for young people within Leicestershire to ensure timely independent outcomes for young people and Best Value for the authority are achieved.

Consideration for part of the review to focus on the current methodology for identifying the cohort of young people that will require an intervention?

SUMMARY OF KEY FINDINGS

I think the first area to highlight is the focus of the review and information we received. Whilst we were asked to review the current pathway into adulthood most of our information and contacts related to the younger adults with disabilities team (YAD) and it became apparent quite early on day one that the YAD is only one of the pathways for young people to transition into support in their adult lives which meant we were unable to comment on the whole process.

The YAD Team

The team members we met both in the team to team and the interviews were passionate, highly motivated, and clearly focused on delivering good outcomes for the young people they worked with, many had been with the team for several years which shows the level of commitment and satisfaction in their roles. There was a strong sense of team, and they are highly regarded by the other stakeholders and both internal and external partners that we met. Caseloads were kept low and there was a focus on progression supervision and tracking which was evident in case records. There were some examples of great practice, joint working and flexibility and the reablement offer is clearly highly valued particularly by the young people and families we spoke to.

Whilst the team was well connected within their own patch and with identified special schools they linked with it was less evident beyond that e.g. SEND, welfare rights/benefits, virtual and mainstream schools. The review team felt that there were real opportunities to strengthen their relationships in particular with the EHCP team and virtual schools.

Practice and Process

There is a clear process in place for identification of young people who meet the criteria of YAD, and the team manager meets regularly with their counterparts in children's services to discuss upcoming young people. There is an agreed prioritisation tool, but the reviewing team questioned its effectiveness particularly for those young people who were identified as "medium" risk as during the case audit work it was noted that the young people had very different levels of need.

If a young person didn't meet the criteria for the YAD the young person's journey was less clear to both children's workers and parents, we heard of multiple pathways and staff spoke of it feeling like a "two tier "service; combine this with parents talking about a lack

of signposting or understanding of the pathways it did lead us to reflect on the equity of experience for young people between those who move through the YAD and those who don't which may be something to reflect on prior to CQC assessment.

Whilst there is clear process in place which included pre assessment and a journey to adulthood plan there wasn't much evidence of them being used and workers reported they were often missed, and they had some clear ideas and views on simplifying the process pathway by combining aspects of assessment and support planning.

We did see a couple of examples of more strength-based assessments and support plans but the majority we viewed were still quite deficit based; this may be addressed as part of the roll out of three conversations as it requires a different strength-based approach.

One of the areas we heard most about in the team to team was the application of the Target Operating Model (TOM) with its clear processes and timescales, whilst it has driven up performance it clearly is bringing some challenges and unintended consequences for the YAD staff. There was a sense that it had reduced professional autonomy and creativity and the dashboard was being perceived as a management tool that was creating additional anxiety and stress that clearly wasn't its intended purpose.

Other observations

Moving to a joint adults and children's OT team has had a significant impact around improving the waiting times for assessment for young people which is impressive.

There was a collective view that the Transforming Care Pathways was clear and working well and the arrangements with health around joint funding sounded value for money.

Whilst there is a clear systematic flow of information between children's services and the YAD this doesn't appear to be happening for those young people on other pathways for example between CYP, ASC and Health. This lack of visibility in both numbers and costs will impact on the local authority's ability to commission strategically.

Recommended areas for Improvement

Within the context of a future CQC assessment our key recommendations centre around taking the opportunity to take stock and reflect on the areas that with some focus could be clarified and/or strengthened. It was noted that the Council has scheduled a corporate review of adult social care and the reflections from this peer review could potentially assist this review in the following ways:

- Developing a shared understanding and definition of transition and preparing for adulthood (because transitions and PFA are related but also distinctively two different concepts and processes) which can be clearly articulated by all those involved from the young people and their families to the professionals around them. Working together to co-produce this will assist with strengthening the interface between teams and services around the young person.

- Reviewing the information already held within children's services to ensure you can take a strategic overview of all those young people who might transition into adult services identifying numbers, costs, current pathways and processes to ensure you can take a more strategic approach to meeting their needs. This might also inform single or joint strategic commissioning priorities.

- Reviewing the YAD to make sure you are making the best use of their considerable skills and experience of supporting young people on their journey to adulthood.

- Supporting gaining a better understanding of the experiences of those young people who move into adult services outside YAD to understanding their experiences of transition planning possibly through a joint PSW led thematic review.

In summary reviewing the KLOE we were asked to look at:

To review the effectiveness of the current pathway to adulthood for young people within Leicestershire to ensure timely independent outcomes for young people and Best Value for the authority are achieved.

- We can only comment on the YAD pathway which appears effective but this is only a limited proportion of the young people who are moving through services

- Evidence that the YAD team are striving to maximise independence but as this is only a proportion of the young people and they do not have costs prior to YAD we cannot comment on best value aspect.

Consideration for part of the review to focus on the current methodology for identifying the cohort of young people that will require an intervention?

- Methodology and criteria for YAD is clear but this is not effectively and consistently picking up all young people transitioning into adult services. The suggested areas for consideration above would help with this.

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13th & 14th May 2024

Leicestershire Review

directors of adass
adult social services
East Midlands

Key Line Of Enquiry

- **To review the effectiveness of the current pathway to adulthood for young people within Leicestershire to ensure timely independent outcomes for young people and Best Value for the authority are achieved.**
-
- **Consideration for part of the review to focus on the current methodology for identifying the cohort of young people that will require an intervention?**
-

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Case audit Working

- Young people stay within the team while cases are active
- There is a system for identifying young people
- Evidence of regular progression supervision in case files and target dates for activities eg closure . Most met the 3 weekly cycle
- Some examples of good strength-based assessment
- Team manager meets regularly with children's services to highlight young people for YAD
- Caseloads are kept low and good use of reablement team members
- Named Links with schools in localities
- Good example of person centred “shared support “ within a family

Case audit – Areas for development

- A lot of Assessments viewed were still based on deficit model not very strength based.
- EHCP plans were not all up to date . One we saw had not been updated since 2019
- Some evidence of great assessments and support plans but not always recorded correctly in line with the LCC process – Activity not always recorded
- Processes referred to in team to team not evident on files eg pre assessments, journey to adulthood plan
- The prioritisation tool doesn't appear to be identifying well in the medium priority area . Saw young people identified as medium who were more complex and others whose needs appeared quite low
- Some files appear to still be open but not active or in need of intervention

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Team to Team – Working Well

- A strong and passionate team , the majority of whom had been there for a significant time . One worker had been supported to undertake social work training within her role, agency workers reported the support she received was excellent " where there's a will there's a way"
- New workers offered a buddy system which was highly valued
- Team morale is clearly very strong
- Multiple channels for sharing, support and joint working – weekly informal team catch ups ,group supervision , what's app group
- Clear process for allocation, activity and tracking progress
- Good understanding of the care act and role of preparing for adulthood
- Supervision was highly valued including individual and group
- Final EHCP plan offers an opportunity to catch up with young person and those involved in their support in final year of school
- Access to step through accommodation for young people
- Staff give young person and their families their one page profile

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Team To Team – Areas for development

- Increased use of agency in social work posts but this is being addressed
- The TOM did feel prescriptive and may be reducing the workers ability to be creative as well as increasing risk of duplicating work eg an assessment done at just 17 often needed to be repeated just before adulthood as needs and aspirations can change- "would like some autonomy back"
- Unanimously workers reported the use of the dashboard at GSM had The TOM had increased stress and anxiety levels – (it goes red) "Creates a sense of dread"

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Working well within the YAD

The YAD service is helping young people prepare for adulthood and supporting them to maximise their independence to reduce the need for long term support

Young people we spoke to said they were involved in their support planning and choice of PA's

Communication works well where there are strong relationships eg with disabled childrens, review team and health

Staff spoken to were passionate about their work and colleagues and partners perceived that they were aspirational for their YP

Reablement workers were highly valued by staff and the families we met. Workers focus on progression with the flexibility to work with YP pre 18

The adult teams described an appropriate and proportionate handover

Link workers with special schools

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Working well within the YAD

YAD operates within a multi agency approach

Effective working relationship between disabled children's team and YAD

Complaints numbers are reported as low

Recognition of the need for flexibility in approach where YAD skill set more appropriate to meet need– e.g. some young people referred to team not subject to EHCP.

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Not working as well Yad

- **Whilst managers worked well together there was a missed opportunity to bring frontline workers (and other professionals) together to share training and practice**
- **Whilst relationship are strong with those in same patch the team appears to be working in a bit of a silo and doesn't appear to have links with teams eg SEND , benefits and virtual schools**
- **Opportunities to strengthen the relationship between YAD and EHCP team (linked to contributing to annual reviews)**
- **No link workers in mainstream schools**

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Working Well – other pathways

- Our evidence and insight on other pathways is limited
- Joint adults and children's OT team has reduced waiting times for young people considerably
- Collective view that there are clear TCP pathways for children and adults
- Arrangement with health linked to joint funding for TCP is value for money.
- Positive Behaviour Support Team effectively working with providers to appropriately reduce levels of support needs for young people and therefore costs
- Learning for Independence Service (within Adult Learning) work with people with a learning disability with the opportunity to expand this to work with people with more complex disabilities

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Not working as well- general

- ***The transition and pathway for CYP referred to YAD is well articulated and understood but less so for young people who transfer via other pathways. This leads to a reflection about the equity of experience . If people don't go through the YAD pathway there is no pre 18 work done***
- ***Confusion from parents talked to about lack of clear signposting and understanding of pathway***
- ***Information pack and letter do not reflect what is on the website and no easy read versions***
- ***Reflections from review and internal teams is that pathways feel like a 2 tier service***

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Not working as well- Other pathways

- ***Strategically children's and adult services working on developing a shared practice and value culture although this not fully embedded in teams especially outside DCS and YADT.***
- ***For children not referred to the YADT there is not a systematic flow of information between CYP and Adult Services and Health***
- ***Transition from Aspirations (Step Through) is often delayed due to lack of planning and/or suitable provision but perceived by some that it's a male only service***
- ***General lack of joint commissioning although an ambition to do this.***
- ***No visibility of costs of CYP care and support packages which impacts on ability to strategically commission***
- ***The strategic positioning of PFA in key boards – e.g. SEND Board - in order to ensure focus on partnership responsibilities and outcomes.***

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Refection's on Key Line Of Enquiry

To review the effectiveness of the current pathway to adulthood for young people within Leicestershire to ensure timely independent outcomes for young people and Best Value for the authority are achieved.

- We can only comment on the YAD pathway which appears effective but this is only a limited proportion of the young people who are moving through services

- Evidence that the YAD team are striving to maximise independence but as this is only a proportion of the young people and they do not have costs prior to YAD we cannot comment on best value

Consideration for part of the review to focus on the current methodology for identifying the cohort of young people that will require an intervention?

- Methodology and criteria for YAD is clear but is this effectively picking up all YP transitioning into adult services ?

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Areas of focus from Case and team to team

- **Closure summaries may be helpful particularly if further work may be needed at a later date or to assist review and audit**
- **Outcome letter could be expanded to include more information about the outcomes of contact with service inc decisions and next steps**
- **3 conversation's and revised paperwork may assist in improving strength based approaches**
- **Incorporating the journey to adulthood into assessment or support plan**
- **Would like to work more closely with leaving care PA's possibly invite to group supervision of talking about a young person they know**
- **Carrying out pre assessment on allocation and delaying full assessment to just before 18th birthday to allow for needs and aspirations to change**
- **More young people to have opportunity to work with reablement workers to enable them to maximise skills and independence**
- **Less focus on dates and more on outcomes and activities – " 3 weeks doesn't always give enough time to do anything or for significant "**

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Recommendations areas for Improvement

- **Develop a collective understanding and definition of transitions and preparing for adulthood**
- **Strategic overview of those young people who might transition from CYP to adult services – Numbers, costs, pathways , processes and commissioning opportunities**
- **Information sharing agreement between childrens and adults services LA and Health**
- **Thematic audit (PSW LED) of young people that transition to ASC directly (not YAD) to understand transition planning and experiences**
- **Review of YAD to ensure you are making best use of their skills and experiences inc link worker role and prioritisation tool**
- **Strengthening the interface between YAD , EHCP team and virtual school**
- **Quick Win - Ensure website and information are up to date**

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Questions and reflections

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East Midlands

Leicestershire Peer Review - Preparation for Adulthood

Action Plan July 2024

KLOE - To review the effectiveness of the current pathway to adulthood for young people within Leicestershire to ensure timely independent outcomes for young people and best value for the authority are achieved
Consideration for part of the review to focus on the current methodology for identifying the cohort of young people that will require an intervention

Themes	Evaluation from Peer Review	Measure for success	Actions	When	Who	RAG	Completed	Notes
YAD Team	Reablement offer proactive in achieving independence outcomes for YP	Increased reablement capacity to include wider cohort of YP coming through the service	Scope number of young people with an EHCP who would benefit from reablement as part of their PFA	Oct-24	YAD Team Leader and Manager			In progress. Meeting to discucss held on 2nd Aug
		Cost reduction for A&C	Cost, demand analysis/potential savings	Oct-24	YAD Team Leader and Manager, Lead Practitioner and Finance			In progress. Meeting to discucss held on 2nd Aug
		Tracked increased independence outcomes of young people	Review function and purpose CRW role and outcomes achieved in YAD and wider OC teams.	Jan-25	Head of Service and Lead Practitioner			
	The team are working in silo in their link area's and would benefit from having stronger relationships with wider teams and partners (key stakeholders, health, midland and Lancs, ICS, public health, housing)	Clear IAGO for mainstream schools on PFA offer.	Review information available for mainstream schools. Refine offer post corporate review	Oct-24	Strategic Service Manager			In progress. Meeting to discucss held on 2nd Aug
	Strengthening the interface between YAD , EHCP team and virtual school	Develop stronger and robust interface working with SENA and Virtual schools	Team managers and team leader to set up monthly meetings with SENA team. Develop clear escalation process	Sep-24	Strategic Service Manager, YAD Team Leader and Manager			Meetings have now taken place with CIC and LAC service managers. Information session planned at whole team day on YAD service. Anne to progress with setting up meetings with SENA team.
	Website information is not accurate		Update information on LCC website		Completed		May-24	
Practice and Process	Develop a collective understanding and definition of transitions and PFA		Will incorporate as part of wider corporate review of PFA	N/A	Change Manager			
	Pathway for young people is not clear where no EHCP in place	Clearly defined pathway for all young people transitioning to adulthood	Will incorporate as part of wider corporate review of PFA	N/A	Change Manager			
	Key documents are not being completed - pre assessments and my journey to adulthood plan	Revised documentation clearly recorded for all young people	Set up workshop with YAD Team to look at reasons why these are not being completed and to scope alternatives for consideration. Closure Summary temple to be reviewed to prompt workers to capture intervention and outcomes. Opp for shared learning from CFS. This is an issue that has been highlighted for wider care pathway	Jan-25	Head of Service and Lead Practitioners			
	Closure summaries not always recorded or do not evidence outcomes achieved	Closure summary evident on all cases, this can be tracked as part of ongoing PDC.						
	Outcome letter to include more information about the outcomes of the contact with the service and includes decisions and next steps							
	Assessments written in deficit model not strength based & assessments completed at 17 often need to be updated prior to turning 18	Strength bases assessments to be evident	strength based workshop to be completed with YAD team	Sep-24	Lead Practitioners			Initial 3c's meeting with LP completed. Roll out due to take place by end of Aug
			Introduction of 3C's - consideration for YAD to be priority for roll out					
	Dashboard and case progression KPI's - staff perception this has reduced autonomy and increased anxiety	Dashboard/KPI's to be embraced across the whole team as a way of working. To be viewed as something to positively reinforce work achievements	LP's to complete workshops with wider care pathway to revisit the roles, responsibility, decision making, professional accountability within the operating model	Jan-24	Lead Practitioners			
	Parents feedback - lack of signposting and information on preparation for adulthood		Will incorporate as part of wider corporate review of PFA		Change Manager			
	Lack of joint commissioning		Will incorporate as part of wider corporate review of PFA		Change Manager			
Cohorts	Prioritisation tool not effective - evidence of MED cases being complex and requiring significant intervention	Accurate risk stratification tool to support timely allocation	Review risk tool. Is there another tool that is more effective.	Jan-25	Head of Service, Service Manager (Disabled Children's Team) and Performance Manager			
	Lack of systematic flow of information between CYP, Adult Services and Health for young people outside of YAD remit	Information sharing agreement to be in place between CYP, Adults and Health (inc Midland and Lancs)	Will incorporate as part of wider corporate review of PFA		Change Manager			
	Process for young people who do not have an EHCP is not clearly defined	Clear pathway and defined offer for young people who do not have an EHCP but are likely to have needs for care and support in adulthood	Will incorporate as part of wider corporate review of PFA		Change Manager			
Data	Lack of data on number of young people requiring ASC without an EHCP	Improved data that focuses on all young people accessing ASC	Set up meeting up task and finish group to look at available data	Jan-25	Head of Service			
			Map journey of YP with no EHCP					
			Demand modelling for future					
	Cost analysis - POC £ CFS compared to first ASC POC £ not currently available		Analyse 10 -15 case for cost comparison from CFS and YAD					
			Will incorporate as part of wider corporate review of PFA		Change Manager			

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Agenda Item 12

Leicestershire County Council

ADULTS AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE 2 SEPTEMBER 2024

LEICESTERSHIRE COUNTY COUNCIL ADULT SOCIAL CARE REGULATED SERVICES

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

Purpose of the Report

1. The purpose of this report is to provide the Committee with an overview of the Adults and Communities Department's in-house provision of services which are required to be regulated and inspected by the Care Quality Commission (CQC).

Policy Framework and Previous Decisions

2. On 20 July 2021, the Cabinet agreed that:

   i) The refurbished facilities at The Trees in Hinckley be used for the provision of short breaks, taking the total number of beds at the site to 12;
   ii) The Smith Crescent facility in Coalville be closed as a place for the provision of short breaks;
   iii) Alternative provision for existing users of the short break services at the Smith Crescent facility, tailored for each individual, be provided at one of the other in-house short breaks facilities at Hinckley, Melton Mowbray and Wigston;
   iv) The proposal for a replacement short breaks facility at the Cropston Drive site in Coalville, previously agreed in 2019, be withdrawn as it was not possible to achieve an economically viable development, and the existing demand could be accommodated within the remaining Short Breaks Services;
   v) Revised development proposals for the Cropston Drive site in Coalville are now developed for future consideration by the Cabinet.

3. On 14 December 2021, the Cabinet agreed changes to the Council's in-house Community Life Choices (CLC) services as follows:

   i) The in-house short breaks services integrate a CLC offer as part of people's short breaks stay at the existing facilities in Melton Mowbray, Wigston and Hinckley;
   ii) The services for adults currently providing long-term maintenance CLC packages to be closed to new referrals and appropriate alternative provision be sourced for existing service users via the CLC Framework;
   iii) All in-house CLC services for adults providing long term maintenance CLC packages to cease, and such services to be provided in future through the CLC Framework.

4. Services highlighted in this report contribute to both the County Council's Strategic Plan and Adult and Communities Department 2020-2024 '*Delivering Wellbeing and Opportunity in Leicestershire*' Strategy, with associated Medium Term Financial Strategy savings targets.

Current In-House Services

5. The Council directly provides the following adult social care services which are all registered and regulated by the CQC:

- Melton Short Breaks, Melton Mowbray;
- Melton Supported Living, Melton Mowbray;
- The Trees Short Breaks, Hinckley;
- Carlton Drive Short Breaks, Wigston;
- Waterlees Court Supported Living, Wigston;
- Smith Crescent Supported Living, Coalville;
- Leicestershire Shared Lives Scheme;
- Homecare Assessment and Reablement Team (HART).

Short Breaks Services

6. The Council directly manages and delivers overnight respite/short breaks and supported living services in the County for adults with autism and profound and multiple learning disabilities. The in-house workforce is trained in supporting people requiring positive behaviour support; and administer a number of health-delegated tasks that are pertinent to the persons health and wellbeing. The services also provide an urgent response in cases of adult safeguarding and breakdown in community based care packages.

7. The accommodation is purpose-built offering level access throughout. All locations offer single occupancy bedrooms, with most rooms providing ensuite facilities. The accommodation is suitably adapted for wheelchair access and maintains specialist equipment on site such as profile beds, ceiling track hoists to assist with the transfer of people who are non-weight bearing, and multi-sensory environments for stimuli, therapeutic interventions and relaxation. Facilities include the provision of specialist baths and shower facilities and equipment such as changing spaces/beds and shower chairs.

Service Performance, Risks and Issues

8. Below is the short breaks bed utilisation for the period 2023/24:

Name of Service	Number of beds available	Number of people registered to access the service	Total number of bed nights occupied in 2023/24
Melton Short Breaks	5	28	940
Carlton Drive Short Breaks	7	49	1,427
The Trees Short Breaks	12	47	1,361

9. The occupancy levels within Short Breaks Services have not fully recovered post the COVID pandemic. One of the main factors limiting occupancy is sufficient staffing. Recruitment at The Trees and Melton Short Breaks has proved to be difficult and has impacted occupancy rates, a full complement of skilled staff is required to run a safe service. There has been an increase in the deployment of temporary agency staff.

10. Melton is a rural area and has limited transport infrastructure in and out of the town making it less accessible for staff who do not drive. There has also been an increase in the number of residential care homes in the area predominantly supporting older people making the market for employee's very competitive in offering choice.

11. All of our in-house short break's services predominantly offer part time contracts due to the shift patterns on offer which include working on weekends, public holidays, unsocial hours, this is not always appealing to candidates who are looking for full time contracts and/or have other personal commitments.

12. The service locations and current CQC rating for the Council's Short Breaks Services are:

Service and location	CQC rating	Date of last inspection
Melton Short Breaks Victor Avenue, Melton Mowbray	Requires Improvement	15 November 2023
The Trees Short Breaks Service Deveron Way, Hinckley	Good	25 October 2017
Carlton Drive Short Breaks Service Carlton Drive, Wigston	Good	14 October 2019

13. There is no set schedule for CQC inspections to take place.

14. Melton Short Breaks was inspected by the CQC in November 2023. The regulator highlighted some cause for concern and reported regulatory breaches. The Council has acted to address the issues, with a detailed action plan being produced that provides the activity and response to address the CQC's findings. A summary is given in the table below:

Regulatory element not being met	Summary of actions taken
Regulation 11 **Need for consent - The provider failed to clearly record people's mental capacity, and to ensure that relevant best interest decisions were completed**	• All service staff continue to undertake refresher training in Mental Capacity Act/Best Interest Decisions. • The Council has developed a comprehensive bespoke training programme in regard to Mental Capacity and Liberty Safeguards training for Managers. • The service has adopted the Council's Mental Capacity Act Practice Guidance.

	• As good practice, staff will be appraised on the principles of the Care Act to ascertain a wider understanding of the care system and objectives.
Regulation 12 **Safe care and treatment – The provider failed to ensure the proper and safe management of medicines**	• The service has conducted a full review of its Medication Pathway and Procedure. • New systems training is being implemented at the service which will improve the safe management of medication and accountability. • Investment in securing a permanent medication room, designated for the sole purpose of improving medication management and safety, organisation, and mitigating risks.
Regulation 13 **Safeguarding service users from abuse and improper treatment – Staff were not aware of their responsibilities to prevent, identify and report abuse**	• Safeguarding training is being refreshed for staff as good practice to update and improve knowledge, understanding in this subject and how to raise any matters of concern. • Enhanced training and deployment of train the trainer programme in safeguarding at the service. • All staff have completed learning in relation to the Whistleblowing Policy and Procedure and escalation reporting processes.
Regulation 18 **Staffing –** **The provider failed to ensure staff received sufficient training and support**	• Full review of all mandatory and required staff training at the service. • Refresher training in Equality, Diversity and Inclusion will be completed at the service. • The service action plan is to review the care and support needs of all service users and this will incorporate principles of inclusivity and personalisation. • Food hygiene and safety training and systems are being reviewed to ensure effective delivery and handling of food.

15. The service continues in making improvements in the safe delivery of services and is ensuring that learning and improvements identified are implemented across all in-house provided short breaks and supported living services.

<u>Feedback from those who access in-house Short Breaks Services</u>

16. Below is some of the feedback received from parents, carers, commissioners and individuals who have received support from Short Breaks Services:

    a) “each time *(name)* stays he picks up extra skills, just little things mainly, but for him that’s a big deal in such a short period of time. It makes me feel better about his eventual transition from home to his own accommodation”.
    b) “Just wanted to say thanks for giving *(name)* such a lovely time the last week. She really does love it and us knowing that makes such a massive difference to us as a family and lets us give the other two kids a holiday they wouldn't normally get”.
    c) *“(name’s)* improvement has been remarkable thanks to the people who have worked with *(name)* this year. we appreciate all you have done”.
    d) “Its been amazing and lovely, I’ve had amazing dinners. *(Staff name),* she makes me smile, I am very happy I get my own key”.
    e) “Our two sons find change and new settings difficult due to their autism. We have found the staff at The Trees to be very friendly, very helpful and very

accommodating towards us all as a family. We are grateful for all their patience and support".

f) "I wish to give recognition and positive feedback to all staff at The Trees who supported (*name)* during a difficult time in his life. From an adult social care perspective, working in partnership with The Trees has been a positive and productive experience. I have found staff to be knowledgeable, proactive and responsive in the face of adverse circumstances for (*name)*. Their commitment to minimising (*name's)* emotional distress has ensued a smooth transition for (*name)".*

Supported Living Services

17. The Council's Supported Living Services provide domiciliary support for people who have learning disabilities in shared accommodation who reside with a tenancy agreement in various properties and locations in Leicestershire. Facilities are a mix of both purpose-built accommodation and traditional semi-detached/terrace housing, owned and managed by a social landlord.

Service Performance, Risks and Issues

18. Recruitment at the Melton Supported Living service has proved to be difficult.

19. All of the Council's in-house supported living services predominantly offer part time contracts due to the shift patterns on offer which include working on weekends, public holidays, unsocial hours, this is not always appealing to candidates who are looking for full time contracts and/or have other personal commitments.

20. Recruitment from overseas has been considered as an approach to increase the number of available staff for each service however the income threshold required for sponsorship is not met for support worker roles.

21. As the Council has nomination rights for the in-house supported living services in particular for Melton Supported Living and Waterlees Court; a void charge/fee can be applied by the Social Landlord to the Council for vacant rooms which is equivalent to the rent rate. The in-house supported living services utilise the Council's Supported Living Pathway to minimise risk and ensure that suitable individuals are referred to the service.

22. The service locations, size and current CQC rating for the Council's Supported Living Services are as follows:

Service and location	Number of beds available	CQC rating	Date of last inspection
Melton Supported Living Service, Victor Avenue/ Halifax Drive, Melton Mowbray	13	Good	28 May 2019
Waterlees Court, Support Living Service Aylestone Lane, Wigston	15	Good	27 February 2023
Smith Crescent Supported Living Service, Coalville	8	Good	13 November 2018*

Cossington Road, Sileby and Frederick Street, Loughborough			

***** A review of the information and data available to CQC about this service was undertaken on 25 April 2023. The CQC did not find evidence that it needed to reassess the rating at that stage.

Feedback from those who access the in-house Supported Living Services

23. Below is some of the feedback received from parents, carers, and individuals who have received support from Supported Living Services:

    a) "You have provided *(name*) with sanctuary, hospitality, food, comfort, joy, reassurance, compassion, love. You have respected his dignity and supported his right to live as independent a life as possible".
    b) "I live here to become independent. Waterlees helps me learn things for my future".
    c) "I would like to thank staff for all their care in dealing with *(name)* when suffering with a heart attack for their quick response and support to family.
    d) "I never did any cooking, I now can peel potatoes and cut salad because staff showed me".
    e) "I feel safe and like to go out alone, I'm independent".

Shared Lives Scheme

24. Leicestershire Shared Lives Scheme provides the person with a personalised service, maintaining autonomy, and living independently in their community. This could be through living with someone else in a supportive arrangement and/or receiving day or respite provision, normally from the Shared Lives carer's home. This can be an alternative service to living in a care home and or supported living. The Shared Lives carers are self-employed and are paid for the support they provide.

25. The Leicestershire Shared Lives Scheme is a well-established scheme and celebrated its sapphire birthday in 2023. The service fosters good relations with regional/national links, Shared Lives Plus and its stakeholders including the Council's Transitions Services. Currently, there are 78 Shared Lives carers registered with the scheme accommodating 42 individuals in long-term living arrangements, supporting approximately 60 individuals with respite arrangements throughout the year, and supporting 48 individuals with day opportunities.

26. The Scheme provides services to the following people:

    - older persons living with dementia;
    - young persons in transition from foster care;
    - persons with a learning disability or physical impairment;
    - persons living with mental health needs;
    - persons who are leaving hospital but are not quite ready to go home.

Service Performance, Risks and Issues

27. The Scheme continues to recruit, promote and increase its pool of registered Shared Lives carers for long-term, respite and day service provision.

28. The service has secured a grant from the Accelerating Reform Fund and is joint working with other regional schemes in developing the service provision, delivery and growth opportunities particularly increasing our pool diverse communities.

29. The CQC last inspected the service on 31 January 2019, and the current rating is 'Good'. A review of the information and data available to CQC about the Shared Lives Scheme was undertaken on 14 December 2022. The CQC did not find evidence that it needed to reassess the rating at that stage.

Feedback from those who access the Leicestershire Shared Lives Scheme

30. Below is some of the feedback received from Shared Lives carers, and individuals who have received support from the Scheme:

a) "*(name)* is finding the Shared Lives day service and respite very beneficial. It is giving him a setting that he feels at home with to socialise with friends of his own age, enjoy their company and share experiences with them. The three young men work well together, helping with the gardening and cooking, changing beds, shopping and preparing their lunch and evening meals, if staying over. *(name)*understands the need for maintaining the property, doing odd jobs around the house and is using skills he has acquired from College and the WHM in order to do this. *(name)* is enjoying his respite from us"
b) "This is an extremely valuable, worthwhile and satisfying career and since becoming a Shared Lives Carer my stress level has reduced"

c) "I love to spend time with (SHL Carer) she helps me and listens to my worries"
d) "I like to go to (SHL Carer) we have a good chat together and I am looking forward to our Christmas festivities planning"
e) "I feel really comfy at my carers home"
f) *(name)*, previously homeless: *(name)* states how much he enjoyed living with *(SHL Carers)* and family and that he would like to stay. He said he feels safe.

Homecare Assessment and Reablement Team

31. The Council's HART service is designed to help individuals develop the confidence and skills they need to live as independently as they can at home and in their local community. The service also provides urgent short-term support for people experiencing an immediate need for social care without which they would be at risk of hospital admission due to further deterioration, or a possible admission to a care home.

32. The team works closely with other professionals and agencies who may be involved in the person's care including Community Health, physiotherapists, and nursing staff, this is via a daily Multi-Disciplinary Team approach. The service is non-chargeable for up to six weeks, although the average duration of the support provided is approximately two weeks.
33. The service has two main areas of focus: reablement support and short-term urgent support.

Reablement support

34. This is short-term support in the person's home to help them regain their independence and get back to managing practical aspects of day-to-day living. This may include:

- Personal care such as washing and dressing;
- Preparing food and drink;
- Helping the person get around their home.

35. Following completion of reablement support, the team will complete individual assessments for ongoing need and commission services as appropriate. The team will also make onward referrals to other relevant services, for example, care technology, and will also consider any informal carer impacts and complete associated assessments accordingly. The service will also ensure that where people have requirements for ongoing support they are made aware of charges and ensure financial assessments are requested for completion.

Short-term urgent support

36. The HART team provides an intensive short-term personal care and reablement service for people who are at high risk of deterioration and require urgent social care support to help them remain independent and living at home. This service is available for up to 72 hours and focuses on:

- Supporting people in the most effective way during a period of crisis;
- Helping people avoid admission to hospital or a care home;
- Providing safe and well checks for people who are frail or at risk, to reassure them if they have become confused or distressed;
- Helping individuals return home from hospital quickly by providing reablement to help them restore their health, wellbeing, and independence;
- Providing out of hours support to meet urgent need due to a crisis at home or care breakdown;
- Supporting people with urgent nutritional needs in an emergency.

HART Performance

37. On average, HART commences circa 100 new packages of reablement support per week. Reablement is a key element in managing demand for adult social care and performs well against national Adult Social Care Outcomes Framework (ASCOF) indicators:

- ASCOF2A: Percentage of New Clients who received Reablement Services where no further request was made for ongoing support (current calendar year):

Month (2024)	Jan	Feb	Mar	Apr	May	Jun
Leicestershire %	89.6	89.5	89.6	90.7	89.8	89.6
National Average %	77.5	77.5	77.5	77.5	77.5	77.5

- ASCOF2D: Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement / rehabilitation services (current calendar year):

Month (2024)	Jan	Feb	Mar	Apr	May	Jun
Leicestershire %	89.1	89.3	88.4	87.3	88.1	89.9
National Average %	82.3	82.3	82.3	82.3	82.3	82.3

38. The service is registered with CQC and was last inspected 11 December 2019. The service is currently rated as 'Good'. A review of the information and data available to CQC about HART was undertaken on 6 July 2023. The CQC did not find evidence that it needed to reassess the rating at that stage.

HART Service Developments

39. HART was part of the Adult Social Care Target Operating Model work to increase productivity and flow within the service and provide a clear framework for performance targets, these changes are embedded within the service. To further support and embed this work, the service has recently been reviewed and restructure to ensure that it continues to maximise resource activity and effectiveness.

40. This work included combining HART and the former HART urgent support function of the Crisis Response Service (CRS) into a single structure to maximise flexibility and reduce travel time and mileage. Consequently, the service also aims to reduce its carbon footprint accordingly.

41. Also included within the recent restructure was additional service capacity, funded through the Discharge Grant. This funding aims to support local authorities to build additional adult social care and community-based capacity to reduce hospital discharge delays. This is currently temporary funding, with further updates awaited given the recent change in government.

42. This has resulted in increased weekly reablement new starts – the April to July 2023 average was 79.71, with April to July 2024 rising to 98.76. It should be noted that although additional capacity has been funded, challenges around recruitment into the direct social care sector remain and there continue to be vacant posts within the service.

43. Further analysis of the service, including performance, is due to be undertaken to ensure it is as effective as possible and whether there is scope for further investment to improve outcomes.

Feedback from those who have received support from HART

44. Below are some case vignettes from those who have received support from the HART Service:

    a) Rose was referred to the HART Service by a member of the mental health team, which had been providing support to her. Rose is a 61-year-old woman who lived alone and had been experiencing symptoms related to depression. Rose reported that she was finding life a real challenge and at the time HART became involved she indicated that she did not feel she could wash herself or cook a meal, as she described herself as feeling really depressed. Rose also has a Stoma and it remains very important that she is able to keep herself and her environment hygienic.

Rose was struggling to maintain her personal hygiene, Rose stated that she had not had a shower since discharge from hospital in December 2023 she was reluctant to have a shower due to fear of falling. The HART service provided a morning care call, to assist Rose to work towards her goals. HART agreed the goals with Rose set goals and encouraged Rose to regain her confidence and independence. The HART service work with Rose for 3 weeks, Rose left the service with no onward package of care as Rose was confident and able to do all tasks herself.

Feedback received from Rose - All the carers were kind and compassionate. They all introduced themselves and helped me to shower. I felt safe at all times and never felt rushed. Overall I feel it was a very positive experience and I achieved the aim of improving my confidence to shower alone.

b) Maggie is an 80 years old woman who had total left knee replacement. Prior to discharge from hospital, staff made referral to adult social care as Maggie needed support with personal care including washing and dressing, it was identified that Maggie was unable to do these tasks independently. The initial request from the hospital team was a request to support Maggie with two care calls a day. The HART services provided a period of reablement for three weeks. Maggie left the service with no onward package of care as Maggie was confident and able to do all tasks herself.

Feedback received from Maggie - What do I say about the HART team? First of all, let me say that all the staff that visited me were so nice. Every person who came into my house were wonderful. They couldn't do enough for me. What a brilliant team you have! Thank you so much. You were all great!

Resource Implications

45. The following Medium Term Financial Strategy (MTFS) savings have been achieved relating to the services covered in this report:

i) AC7 2023/24 – Review of Direct Services/Day Services/Short Breaks. Savings target of £430,000.

ii) AC18 2023/24 – Reprovision of in-house day services. Savings target of £300,000.

iii) AC16 2023/24 – Improving outcomes from homecare assessment and reablement team (HART)/(CRS). Savings target of £230,000.

iv) AC17 2023/24 – Alignment of HART/CRS services. Savings target of £230,000.

46. A further savings target is on track to be achieved:

v) AC10 2024/25 – Improving outcomes from HART/CRS. Savings target of £1.27million (the total is £1.5million, which includes the previously achieved £230,000 in 2023/24).

47. Recruitment and retention of staff working in the direct care sector remains challenging, with the Council continuing to advertise a significant number of vacant posts. These include continuous recruitment of staff into the services.

48. A review is being undertaken of both the Short Breaks and Supported Living Services as part of the cross-departmental Prevention Review and departmental medium term financial planning. The reviews are expected to report before the end of the year.

49. The Short Breaks Service review will consider the current utilisation of short breaks services, potential provision of services to children and young people, the availability of external provision, the relative costs and benefits of the in-house service compared to external provision and the opportunity to increase income.

50. The Supported Living Services review will consider the costs and benefits of in-house service compared to external market provision and whether the Council should seek to operate in particular market segments

Background Papers

- Report to the Cabinet: 20 July 2021- Provision of Short Breaks and Supported Living Services https://democracy.leics.gov.uk/ieListDocuments.aspx?MId=6445 – item 32
- Report to the Cabinet: 14 December 2021 – Provision of In-House Community Life Choices Services (Day Services) - https://democracy.leics.gov.uk/ieListDocuments.aspx?MId=6449 – item 87
- Leicestershire County Council Strategic Plan 2022-26
- Delivering Wellbeing and opportunity in Leicestershire – Adults and Communities Department Ambitions and Strategy for 2020-24

Circulation under the Local Issues Alert Procedure

51. None.

Equality Implications

52. There are no equality implications arising from this report.

Human Rights Implications

53. There are no human rights implications arising from this report.

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