

LEICESTERSHIRE AND RUTLAND SAFEGUARDING ADULTS BOARD (LRSAB)

Annual Report 2018/19

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Independent Chair: Fran Pearson

Foreword



I feel privileged to have been appointed as the new independent chair of the Safeguarding Adults Board whose work is presented in this report. Although this report looks forward to the year we are currently in, it is in part about the impact of the Board during the year April 2018 to March 2019. I was not in post at that point, so it is my chance here to thank Robert Lake for his work as independent chair during that year.

Being curious, and asking for assurance that safeguarding work is genuinely effective, is at the heart of what we can all expect from Board members. During the year, organisations in Rutland and Leicestershire all stepped up and made their contribution to keeping adults, who are at risk of neglect and abuse, safe. This report gives more information not only on how they did that, but as importantly, how that was tested out by the Board.

A small survey of adults with care and support needs was carried out at the end of the year. There is more information on this in the report, but the overriding message was: what helps people in Rutland and Leicestershire feel safe is having someone around who they can talk to, and trust and rely on if they need help or support. It is our responsibility as a board to work together to foster that sort of reliable, trusting culture not just in organisations but across society as a whole. I look forward to working with you all to build on the Board's consistent work in this area during the past year.

Fran Pearson

Independent Chair of the Board.

Contents

Foreword	2
Summary	4
Board Background	5
Safeguarding Adults in Leicestershire	
Safeguarding Adults in Rutland	9
Safeguarding Adults in Leicestershire and Rutland	11
Business Plan 2017/18 Achievements	12
Operation of the Board	
Partner and Public Engagement and Participation	13
Challenge and Assurance	14
Learning and Improvement	17
Co-ordination and Procedures	19
Training and Development	19
Income and Expenditure 2018/19	
Rusinoss Plan Prioritios 2010/20	22

Summary

During 2018-19 the Leicestershire & Rutland Safeguarding Adults Board worked in line with the priorities in its business plan in order to improve safeguarding of adults with care and support needs in Leicestershire & Rutland. The Board:

- Tried a new approach to prevention of safeguarding need through links with community safety Joint Action Groups in Rutland
- Wrote guidance to support staff in assessing people's mental capacity in safeguarding work, based upon feedback from staff across agencies
- Updated thresholds for adult safeguarding and reviewed and updated multiagency safeguarding
- Surveyed adults with care and support needs regarding their safety and ensured the experiences of adults are a key feature of our Board meetings.

The Board also worked on six Safeguarding Adults Reviews, which found learning relating to: Mental Capacity Act; Multi-agency processes; Domestic Abuse; Substance Misuse and; Clarity of plans. Work on these areas is underway and some will continue in future priorities of the Board.

From the Board's audits of practice, assurance reports and monitoring of performance information across agencies the Board has:

- Identified that agencies continue to improve in Making Safeguarding Personal (MSP).
- Identified that agencies are developing their own processes as well as working with partners to improve adult safeguarding.
- Found that further work is needed to make sure adult safeguarding and mental capacity are considered in some agencies commissioning and contract management.
- Started to look into concerns regarding safeguarding of adults with complex and challenging needs.
- Revised processes to make sure immediate risks in safeguarding cases are considered within 24 hours.
- Reviewed and improved the Vulnerable Adult Risk Management (VARM) process to support more agencies to be involved in and clearer actions be carried out in work to support those at risk of self-neglect.

The Board has shared its learning and developments regarding adult safeguarding through its newsletter, through its network of local agencies' training staff and through one-off training events, including a joint conference with the Leicester SAB and Local Safeguarding Children Boards.

All of the Board's work has influenced the Board's priorities for 2019-20 which are:

- More effective multi-agency meetings regarding vulnerable adults.
- Ensure Mental capacity is considered appropriately in safeguarding adults.
- Better recognise and respond as a partnership to criminal exploitation of adults.
- Find out how well work with vulnerable young people in transition to adulthood assists prevention of adult safeguarding need.

Board Background

Safeguarding Adults Board Arrangements

The Leicestershire & Rutland Safeguarding Adults Board (LRSAB) serves the counties of **Leicestershire** and **Rutland**. The SAB leads adult safeguarding arrangements and oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies

The Annual Report presented here sets out how effective the Board has been in delivering its objectives set out in its Business Development Plan. The report also includes an outline of the Safeguarding Adult Reviews (SARs) and other reviews carried out by the LRSAB, the learning gained from these reviews and the actions put in place to secure improvement.

The LRSAB normally meets four times a year. The Board is supported by an integrated Safeguarding Adults and Children Executive Group that also serves the Leicestershire & Rutland Safeguarding Children Board and supports joined up approaches across Children and Adult Safeguarding in the area.

In 2018 the LRSAB appointed a joint Chair with the Leicester Safeguarding Adults Board (LSAB) and shares some subgroups with the LSAB working jointly across the two areas. Further join up was considered, but paused to take account of the impact of work to set the new Multi-Agency Safeguarding Arrangements for safeguarding children.

The SAB is funded through contributions from its partner agencies. In addition to financial contributions, in-kind contributions from partner agencies are essential in allowing the Board to operate effectively. In-kind contributions include partner agencies chairing and participating in the work of the Board and its subgroups and Leicestershire County Council hosting the Safeguarding Boards' Business Office. The income and expenditure of the Board is set out on Page 21 of this report.

Independent Chair

The LRSAB is led by an Independent Chair. During 2018/19 Robert Lake worked as the Independent Chair for the Safeguarding Adults Boards in Leicestershire & Rutland and in Leicester City, but stepped down during the year due to health reasons. Fran Pearson has been appointed as the new joint Independent Chair for the two Boards from June 2019.

The Independent Chair provides independent scrutiny and challenge of agencies, and better enables each organisation to be held to account for its safeguarding performance.

The structure of the LRSAB and membership of the Board can be found on the Board's website www.lrsb.org.uk.

SAB Business Development Plan Priorities 2018/19

Priorities set by the LRSAB for development and assurance in 2018/19 were to:

- Prevent safeguarding need through building resilience and self-awareness in adults with care and support needs.
- Improve the understanding of capacity to consent and the application of the Mental Capacity Act across agencies
- Promote a better and more consistent understanding and use of adult safeguarding thresholds
- Ensure the work of the Safeguarding Adults Board is informed by adults with care and support needs



Safeguarding Adults in Leicestershire

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

Adult Safeguarding snapshot for Leicestershire:

551,802 adults live in Leicestershire¹.

4,810 safeguarding alerts (calls) to Adult Social Care

25% of alerts became safeguarding (s42) enquiries

49% of enquiries were substantiated, at least in part.

Financial abuse, Neglect and Omission and Physical Abuse remained the three most common categories of abuse.

★ 756 alerts from the public.

78% of people were asked about what they wanted to happen from the safeguarding enquiry.

In 94% of cases the persons desired outcomes were met, at least in part

99% of people felt listened to in conversations and meetings with people about helping them feel safe

5% of enquiries were ceased at the request of the individual

4,307 referrals for Deprivation of Liberty Safeguards (DoLS)

851 cases on the waiting list for DoLS

911 Paid Persons Representatives allocated to DoLS.

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

For the second year running fewer of these concerns met the threshold for a safeguarding enquiry to be undertaken than in the previous year, however more of the enquiries that were carried out found that abuse probably took place (were substantiated, at least in part) than the previous year. The application of thresholds for safeguarding enquiries was assessed by Leicestershire County Council and found to be consistent.

Making Safeguarding Personal continues to be further embedded in safeguarding practice with a greater proportion of people being asked about what they wanted to happen from the enquiry regarding their welfare. A slightly lower proportion of these

¹ ONS mid-year population estimates 2017

people's desired outcomes were met this year than last year, though this was 94% of people. Fewer enquiries were ceased at the individuals request than last year.

The new safeguarding structure within Leicestershire County Council with the Safeguarding Adult Team working at the front end of the process has been analysed. The analysis so far has shown that people who may be at risk are being seen quickly; immediate risk is being managed; and the person is more quickly being referred to the appropriate service for either ongoing safeguarding enquiry or for other support where required and the safeguarding thresholds are not met. This approach may also be supporting the improvement in Making Safeguarding Personal indicators.

Leicestershire County Council and health providers have continued to review referral numbers and thresholds decisions regarding some safeguarding enquiries in health settings. This is part of under the agreed oversight process for these enquiries, and the agencies have also kept the oversight approach in general under review.

There was a decrease in the number of referrals for Deprivation of Liberty Safeguards (DoLS). The increase in service capacity for assessments has meant more DoLS have been authorised, which has led to a reduction in the waiting list for DoLS in Leicestershire.

More people for whom there has been an application for DoLS were allocated a Paid Persons Representative to advocate on their behalf in the assessment process than in previous years. Because of the increase in DoLS authorised this year this remained at 44% of all DoLS.

Leicestershire County Council have placed two Adult Social Care posts in the Trading Standards team to embed positive joint work with Trading Standards around prevention of financial fraud and scams.

Safeguarding Adults in Rutland

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

Adult Safeguarding snapshot for Rutland:

31,709 adults live in Rutland.²



421 safeguarding alerts (calls) to Adult Social Care



14% of alerts became safeguarding (Section 42) enquiries

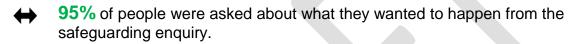


35% of enquiries were substantiated, at least in part.

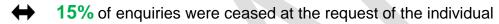
'Neglect and Omission' is the most prevalent type of abuse, responsible for more than 50% of cases.

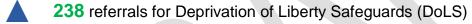


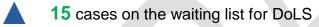
26 alerts from the public.



In 94% of cases the persons desired outcomes were met, at least in part.









89 Paid Persons Representatives allocated to DoLS.

Following reductions in the last two years the number of calls to Rutland Adult Social Care from professionals regarding safeguarding concerns almost doubled compared to the previous year. The number of calls regarding safeguarding concerns from the public reduced by a third.

A smaller proportion of the concerns raised met the threshold for a safeguarding enquiry to be undertaken than in the previous year and fewer of the enquiries that were carried out found that abuse probably took place (were substantiated, at least in part) compared with last year.

Making Safeguarding Personal remains well embedded in safeguarding practice with a high proportion of people being asked about what they wanted to happen from the enquiry regarding their welfare. A similar proportion of these people's desired outcomes were met this year as last year.

There was a continued increase in referrals for Deprivation of Liberty Safeguards (DoLS) and an increase in the waiting list for DoLS in Rutland.

² ONS mid-year population estimates 2017

More people for whom there has been an application for Deprivation of Liberty Safeguards (DoLS) were allocated a Paid Persons Representative to advocate on their behalf in the assessment process than in previous years. This was 53% of all DoLS, compared with 43% last year.

Following the change in numbers of alerts Rutland County Council trialled increased oversight of contacts in the form of managerial oversight in the screening of contacts, open Section 42 investigations and closures across adult social care. Through fortnightly meetings progress on all Section 42 enquiries and actions is monitored and followed up to avoid drift.

Rutland County Council's Rapid Response Assistant Care Manager and Senior Practitioner roles continue to respond quickly to concerns and go on to provide time limited, person centre outcomes for those adults who are deemed at risk of self-neglect and/or abuse. This service is non-means-tested to encourage those at risk of self-neglect to engage with support.

The Council has continued to develop its recording systems to support analysis of trends and themes and collate personalisation data.

Rutland County Council supports ongoing improvement and development of all practitioners within the Adult Social Care service in Rutland, including integrated Health colleagues through bi-monthly Safeguarding Continuous Professional Development (CPD) sessions. These sessions are consistently well attended and provide updates on SAB multi-agency audits, relevant case law, and practice updates. Workers are encouraged to present case studies for peer review and peer shared learning.

The service have developed a new forum for CPD in the form of 'Book Clubs' which each team holds monthly. This protected time allows practitioners to discuss research, articles, case studies and legal updates and develop their knowledge and practice.

Safeguarding Adults across Leicestershire and Rutland

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

The Clinical Commissioning Groups (CCGs) have been working with GPs to support improved adult safeguarding practice of GPs. The CCG Safeguarding team has developed the Children's Safeguarding Quality Markers GP self-assessment tool to reflect adult safeguarding, supporting GPs to ensure they have robust adult safeguarding arrangements in place. In addition, the team has developed a safeguarding adults template for the GP electronic records system which supports GPs in documenting information relating adults at risk and safeguarding concerns. This also acts as an aide memoire to ensure risks are managed and Making Safeguarding Personal principles are employed to ensure a high quality of safeguarding referrals which have the service user at the centre.

Looking forward the CCG will lead work on developing an integrated heath safeguarding meeting, improving community health services involvement in safeguarding enquires and improving safeguarding training opportunities for CCG staff and GPs.

The Police are leading a project to develop an Adult Safeguarding Hub to support effective partnership working. the project team has begun to meet with partner agencies to shape a joint vision for the project.

A dedicated Adult Social Care MARAC (Multi-Agency Risk Assessment Conference) post has been established across Leicester, Leicestershire and Rutland. The MARAC process specifically supports high-risk victims of domestic abuse and this post will ensure Adult Social Care Services engage effectively with the MARAC and support effective joint working around domestic abuse and adult safeguarding.

University Hospitals of Leicester NHS Trust have seen a 40% increase in internal safeguarding adult contacts. This suggests a greater awareness of staff to recognise and respond to potential safeguarding concerns.

The Trust has broadened the remit of the agencies safeguarding committee structure to have oversight of people with learning disability and dementia with a commitment to continually improve services. It has also revised the Trust website to help members of the public access up to date information about the Trust's safeguarding services.

Business Development Plan Priorities

Progress on the Board's priorities is outlined below.

SAB Priority 1 – Prevent safeguarding need through building resilience and self-awareness in adults with care and support needs.

Our plan said we would assess the development of the Joint Action Group (JAG) as a forum for prevention and develop further community awareness raising regarding safeguarding adults. We also planned to gain assurance that the needs of young people requiring additional support into adulthood are reviewed and supported in a timely and preventative way through that transition.

The development of the pilot approach to effective multiagency prevention work in local areas through an existing multi-agency group, Rutland Joint Action Group developed stronger links across partners which supported improved screening and triaging of cases inside and outside of the JAG to ensure people got the most appropriate multi-agency response. This will continue to be developed and will feed into our forward priority on effective multi-agency meetings.

We commenced scoping of transitions from child services to adult services and the potential for this to prevent future adult safeguarding need. This will be continued under the priority for 2019/20 shared with Leicester SAB.

SAB Priority 2 – Improve the understanding of capacity to consent and the application of the Mental Capacity Act across agencies

Our plan said we would look to understand specific reasons why staff struggle to confidently implement the principles of the Mental Capacity Act (MCA) and will develop partnership approaches to demystifying mental capacity and support effective assessments in future.

We assessed staff confidence regarding MCA through a survey across partner agencies capturing views of 145 staff and managers. From this we developed draft guidance for decision making in safeguarding enquiries for all agencies, taking into account the views expressed by frontline staff. We plan to finalise the guidance and launch it in 2019.

SAB Priority 3 – Promote a better and more consistent understanding and use of adult safeguarding thresholds

Our plan said we would review and revise our Safeguarding Adults Thresholds document and communicate this well across partners.

We revised the thresholds and launched them at a multi-agency SAB conference in November 2018. We produced a briefing pack to be used in team meetings across partner agencies to raise awareness and support understanding.

Our thresholds guidance document has been used as the basis for the agreed East Midlands regional approach and has been adopted by other areas.

We will test application of the new thresholds through our multi-agency audits.

SAB Priority 4 – Ensure the work of the Safeguarding Adults Board is informed by adults with care and support needs

Our plan said we would work with advocacy agencies and existing engagement and participation groups in partner agencies to set up the Board approach for engagement and participation in the priorities and work of the Board.

We also planned to review Making Safeguarding Personal (MSP) approaches locally through available data and information from each partner as to their work to embed MSP.

We have presented an individual adult safeguarding case study at each Board meeting to focus the Board on the experience of vulnerable adults we are working to safeguard.

We carried out a survey of vulnerable adults to identify what affected their safety and feelings of safety and made contact with advocacy agencies. A representative from an advocacy agency attended our January 2019 Board meeting as an observer.

We reviewed data available regarding MSP from across agencies, identifying that not all agencies collect data, but are able to demonstrate a variety of approaches in place to support the application of MSP in their specific settings.

Operation of the Board

Partner and Public Engagement and Participation

Partner Engagement and Attendance

The Board met three times during 2018/19 as it met in April 2019 rather than March 2019. The membership of the Board can be found on the Board's website www.lrsb.org.uk. Almost all partners attended all or the majority of Board meetings during the year and sent apologies for those they missed.

Engagement with the Criminal Justice Sector improved this year, the Community Rehabilitation Company attended two meetings and sent apologies to the other, however there was no attendance from the National Probation Service to any SAB Board meetings during the year.

The Prison Service are now more involved in the Board with a representative from a local prison. Operational matters have prevented them from attending the Board regularly, but they have been involved in the Board's priority setting. The Board will develop engagement following consideration of the recommendations from the Association of Directors of Adult Social Services (ADASS) survey of SAB and prison engagement.

There was no attendance from care or voluntary sector representatives this year.

All agencies consistently engage well in the subgroups of the Board. The Police, CCG and Local Authorities all provide Chairs for these groups.

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

Public Engagement & Participation

The Board contacted partners to identify opportunities to link in with existing engagement work.

A small survey of adults with care and support needs was carried out at the end of the year through SAB partners. The survey focussed on what supported people to feel safe in order to influence the work of the SAB. Responses were received from 33 adults.

The major factor for supporting people to feel safe was having people around they could talk to and trust and rely on if they need help or support.

Things in the community were the main areas that made people feel unsafe – including unknown/loud/drunk people or groups of young people, but also environmental factors relating to mobility, such as inconsiderate road and pavement users and pavement works and street lighting.

This highlights the importance of considering and addressing isolation, but also how all agencies consider the needs of the most vulnerable people in providing their services.

Engagement will continue to be developed in the normal business of the Board.

<u>Assurance – Challenges and Quality Assurance</u>

Challenge Log

The Board keeps a challenge log to monitor challenges raised by the Board and the outcomes of the challenges. During the year the Board raised a challenge with safeguarding partners regarding Transforming Care and safeguarding.

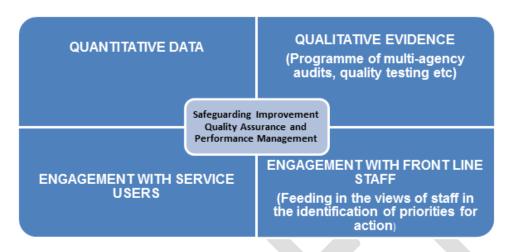
Transforming Care is a national programme that started in 2015, to try and make sure people with learning disabilities and other particularly complex and challenging needs, are treated as near to their own home as possible and not in remote specialist settings.

A report on Transforming Care identified that the project was behind target for individuals transferring into the community. The Board wrote to the Transforming Care Plan Board to seek assurance that individuals under Transforming Care approaches are safe now and future arrangements are in place to maintain safety.

Following this challenge assurance reporting regarding people considered under Transforming Care approaches was set up during 2019 along with greater understanding of the governance arrangements for this group of adults.

Quality Assurance and Performance Management Framework

The Board operates a four quadrant Quality Assurance and Performance Management Framework as outlined overleaf. This is overseen by the Boards' Safeguarding Effectiveness Group (SEG) shared with the LSCB. The outcomes of and findings from this performance framework are incorporated in the relevant sections within the report.



Audits

During 2018-19 the SAB, along with Leicester SAB carried out a Safeguarding Adults Audit Framework (SAAF) audit that tests agencies compliance against their safeguarding duties within Care Act 2014 through an organisational assessment against safeguarding standards. The SAB had considered alternative approaches but identified this approach as providing the assurance required.

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

- Leicestershire County Council Adults and Communities Service
- Rutland County Council People Directorate
- Leicestershire Police (Including Office of the Police and Crime Commissioner)
- Leicestershire Partnership NHS Trust
- Leicestershire & Rutland Fire and Rescue Service
- University Hospitals of Leicester NHS Trust
- West Leicestershire and East Leicestershire & Rutland Clinical Commissioning Groups (as one response)
- Leicestershire & Rutland Public Health
- All seven District Councils in Leicestershire (as one response)

Audit returns from all of these agencies identify that they are 'effective' or 'excelling' across all or the majority of the compliance questions that are relevant to them, however more areas were identified as working toward effectiveness than last year, mainly due to the new or revised questions.

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

- The Office of the Police and Crime Commissioner are working towards
 effectiveness with regard to Safeguarding Adult leads advising and supporting
 commissioning and evidencing their commissioned providers have embedded
 the Mental Capacity Act in safeguarding.
- Leicestershire & Rutland Fire and Rescue Service are working towards effectiveness with regard to a link to prevent in Safeguarding adults policy and systems for collating carers/service users views and concerns
- Clinical Commissioning Groups are working towards effectiveness with regard
 to incorporating Making Safeguarding Personal (MSP) in safeguarding
 strategy planning and delivery, involvement of service users in strategy
 discussions, dissemination of SAB 'Trilogy of Risk' materials, processes to
 ensure immediate action to implement protective measures for safeguarding
 and evidencing their commissioned providers have embedded the Mental
 Capacity Act in safeguarding.
- Leicester Partnerships NHS Trust (LPT) and District and Borough Councils are working towards effectiveness regarding dissemination of SAB 'Trilogy of Risk' materials.
- Leicestershire & Rutland Public Health are working towards effectiveness with regard to embedding safeguarding adults in contracting and procurement, including assurance that providers have robust safeguarding adults standards and processes and Safeguarding Adult leads advising and supporting commissioning.

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

 Leicestershire County Council are excelling in leadership of safeguarding adults, reporting on safeguarding adults in commissioning assurance and accountability and process for effectively contributing to reviews.

The SAB process for SAAF compliance assurance will be reviewed in 2019/20 to consider a direct challenge element.

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

- Strategy Meetings
- Vulnerable Adults Risk Management (VARM) approach

The audit process involves individual agencies auditing a sample of their own case files using a common tool and bringing audits and learning to a multi-agency meeting to be reviewed across partners. The cases are selected at random by the individual agencies, or by the local authority for provider agencies to prevent any potential bias.

The VARM audit was carried out in two parts, the first focussing on identifying cases and the second considering progress and outcomes.

The key findings of the strategy meeting audit were that:

 In the majority of cases, single agency strategy discussions rather than multiagency meetings were held, and therefore opportunities for multi-agency input were potentially being lost. This was partially due to the need to assess and address immediate risk within 24 hours.

- Immediate risk was being clearly assessed by most, but not all agencies in all cases.
- There were no cases where the person involved, or their advocates were
 directly involved in strategy discussions or meetings, in one case the person
 had been invited to the meeting. In one third of cases there was evidence of
 discussion by the lead agency with the person or their advocate within the
 early stages of the enquiry.

Following this audit, processes were altered to ensure immediate risks were considered within 24 hours and all agencies were invited to a strategy meeting within five days. This has resulted in key agencies such as the police being invited to and involved in more strategy meetings supporting better multi-agency safeguarding.

Agencies were asked to follow up with their own assurance and reported back to the Board by the end of the year that processes have been changed and internal assurance was showing that immediate risks were now being considered in all cases. There are a number of factors that mean that involvement of individuals in strategy meetings is not appropriate or difficult, however the Board were concerned this did not become a default position and therefore followed this up in the SAAF.

The VARM audit found that in most cases criteria were applied appropriately, correct agencies were invited to the initial VARM meeting, initial action plans were appropriate, and individuals were aware of the VARM. The follow up found that in most cases risks were reducing and VARM cases were being closed, and practitioners and managers found the VARM approach useful.

For a notable proportion of cases (30-50%) not all the necessary agencies engaged in the process from the outset, individuals had not been effectively engaged in the process, and actions were not as specific as they could be as the process developed.

The audit process identified and recommended a number of improvements from specific findings be addressed in the review of the VARM process, which has now taken place.

The audit also identified improvements could be made with regard to assessing Mental Capacity – this has been fed into the work on the Mental Capacity Guidance under this Board's priorities.

Agencies have taken away these learning points to embed this within their practice. Audits regarding the application of the Mental Capacity Act and Thresholds and regarding Financial Abuse are planned for 2019/20.

Learning and Improvement

Safeguarding Adults Reviews and other Learning Reviews

The Board carries out Safeguarding Adult Reviews regarding vulnerable adults who have died or been seriously harmed. These reviews consider how agencies worked together and identify how we can improve working together to safeguard vulnerable adults in future.

The Board commenced three Safeguarding Adults Reviews and one alternative safeguarding adults review during the year. Two of these had been referred to the Board in the previous year, but had been awaiting the outcome of other processes before commencing.

The Board worked on two other reviews that had commenced in the previous year and completed one of these reviews. The other review related to a particularly complex case and is nearing completion.

The harm factors identified in cases reviewed during the year were:

- Mental ill health
- Suicide
- Substance misuse
- Neglect
- Lack of Mental Capacity
- Domestic abuse, present with mental ill health and substance misuse.

The learning emerging from cases reviewed during the year included:

Theme 1 – Understanding Mental Capacity: In cases reviewed evidence of application of the Mental Capacity Act was not always available. Staff should have knowledge of the Mental Capacity Act relevant to their role; however, in practice, staff are supporting decision making all the time, so need to assume capacity unless there are indicators to the contrary for that individual. Staff should be clear who is assessing capacity and what the impact of lack of capacity is on daily living and should make good records of decision making.

Theme 2 – Join up across different multi-agency processes. In complex cases many different multi-agency processes may be underway regarding the case, such as community safety, domestic abuse, care plan approach, child safeguarding and adult safeguarding. Improve operation of multi-agency meetings and assessment processes to support understanding of the full picture of needs and risks for an individual and support join up of activity.

Theme 3 – Understanding Domestic Abuse: Staff to be reminded that in assessing Domestic Abuse situations they have a good understanding of aspects and impact of domestic abuse and consider specific vulnerabilities and relationship dynamics for individuals.

Theme 4 – The impact of Alcohol misuse: Supporting people who misuse drugs and alcohol can be challenging, complex and unpredictable. Staff should additionally consider resources and expert advice available and how they may be accessed, including information for children of parents who misuse alcohol.

Theme 5 – Clear plans: The need for clear 'end of life' care plans, understood by all concerned, including methods of hydration.

Domestic Homicide Reviews

The LSCB and SAB manage the process for carrying out Domestic Homicide Reviews (DHRs) on behalf of and commissioned by the Community Safety Partnerships in Leicestershire and Rutland. While learning and actions are managed by the Community Safety Partnerships., this arrangement allows a clearer collaborative picture of things that affect safeguarding. Three DHRs were underway at the end of the year.

Development Work and Disseminating Learning

The SAB produces a quarterly newsletter in conjunction with the Safeguarding Children Board, called Safeguarding Matters. This is used to disseminate key messages including from reviews and audits across the partnership and to front-line practitioners. Findings from reviews are reflected in the themes of Safeguarding Adults training events.

Learning has also been shared through the Board's Trainers Network and single agency internal and single agency internal processes.

Co-ordination of and Procedures for Safeguarding Adults

In addition to work on Safeguarding Adults Thresholds outlined under the Board's priorities. The Board has carried out an extensive review and update of its multiagency procedures for safeguarding adults. This involved partners and incorporated views of practitioners and resulted in a refreshed streamlined online manual to support individuals to refer to and use the procedures more effectively.

Alongside this, guidance on the Vulnerable Adults Risk Management (VARM) tool has been revised from the findings of the VARM audit and procedures around County Lines (drug-related exploitation) relating to vulnerable adults has been developed.

Future work planned includes:

- A framework for multi-agency meetings
- Procedures around adult criminal exploitation

Training and Development

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

The SAB commenced a review of the competency framework at the end of the year, the revised framework will be launched in the Autumn of 2019.

The Board provides some multi-agency training, but due to limited resources much of the multi-agency safeguarding adults training is provided through individual agencies training programs, such as Leicestershire County Council.

The Board linked with the Leicester and Leicestershire & Rutland Safeguarding Children Boards to deliver a Safeguarding Conference incorporating the following cross-cutting themes:

- Adverse Childhood Experiences (ACEs)
- The importance of participation and the voice of the child
- Coercive Control
- Mental Capacity Act 2005

This was a successful event with 103 participants across the partnership agencies from adult's and children's services, and across LLR. The evaluations showed that staff from all areas had found the information given was interesting and relevant.

The SAB, through its Safeguarding Effectiveness Group regularly requests information from its partners regarding the effectiveness of their safeguarding training programmes. Partners have provided assurance that they are providing up to date training to staff to improve safeguarding awareness and address specific areas of need. Specific areas covered by agencies include Prevent in University Hospitals of Leicester (UHL) and Leicestershire Partnership Trust (LPT). Leicestershire Fire & Rescue Service (LFRS) have completely redesigned their training and completed roll-out the new safeguarding training package to all public-facing staff.

The Board supports a Safeguarding Adults Trainers Network across Leicester, Leicestershire and Rutland, which met four times during the year with regular attendance of forty staff from the Independent, Statutory and Voluntary Sector who have a responsibility for developing and delivering learning and development opportunities.

The Network continues to give participants the opportunity to discuss and develop their organisations approach in light of national and local developments in practice and procedures and learning from reviews (national and local). The Network also supports dissemination of information and awareness raising materials such as Safeguarding Matters, Leaflets and training events.

Feedback from the group has been sought on the review of the Competency Framework and development of guidance regarding the Mental Capacity Act.

Leicestershire & Rutland SAB and LSCB Finance 2018-19

	£
SAB Contributions	
Leicestershire County Council	52,798
Rutland County Council	8,240
Leicestershire Police	7,970
Clinical Commissioning Groups (West Leicestershire and	15,930
East Leicestershire & Rutland)	
University Hospitals of Leicestershire NHS Trust	7,970
Leicestershire Partnership NHS Trust	7,970
Total SAB Income	100,878
LSCB Contributions	
Leicestershire County Council	83,061
Rutland County Council	52,250
Leicestershire Police	43,940
Clinical Commissioning Groups (West Leicestershire and	55,760
East Leicestershire & Rutland)	
Cafcass	550
National Probation Service	1,348
Derbyshire, Leicestershire, Nottinghamshire and Rutland	3,000
Commmunity Rehabilitation Company (Reducing Re-	
offending Partnership)	
Total LSCB Income	239,909
Total Income (LSCB & SAB)	340,787
	£
SAB and LSCB Operating Expenditure	
Staffing	210,469
Independent Chairing	25,867
Support Services	30,500
Operating Costs	12,935
Case Reviews (SAB)	15,505
Case Reviews (LSCB)	13,461
Young Peoples Advisory Group (LSCB)	1,736
Training Co-ordination and Provision (LSCB)	39,600
Total SAB & LSCB Operating Expenditure	350,073
	-
Deficit	£9,286
LSCB & SAB Reserve account at end of year	£41,760

Business Plan Priorities 2019-20

Review and analysis of learning, performance information and emerging issues have led the Board to identify the following priorities for 2019-20:

Development Priority	Summary
Effective Multi-	Multi-agency meetings regarding vulnerable adults are
Agency meetings	effective in supporting safeguarding adults and
	prevention of safeguarding need. This will consider the
	adaptation of the 'Signs of Safety' methodology for
	safeguarding adults.
Mental Capacity	Be assured that people without capacity to consent are
	being safeguarded in current practice and with the
	introduction of Liberty Protection Safeguards.
Adult Criminal	Improve the recognition and co-ordinated partnership
Exploitation	response to criminal exploitation of adults.
4. Safeguarding in	Be assured that work with young people who have
Transitions	been assessed as requiring additional support to
	reduce risk and vulnerability assists prevention of adult
	safeguarding need.

Action plans are in place for each of these priorities.