Safeguarding Adults Board
LEICESTERSHIRE & RUTLAND

Local Safeguarding Children Board
Leicestershire and Rutland

ANNUAL REPORT 2012 -2013

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Independent Chair:	Paul Burnett

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1. Foreword from Independent Chair

I am pleased to present the Annual Report for the Leicestershire and Rutland Local Safeguarding Children Board and Safeguarding Adults Board. This is the first time we have produced a combined report and follows the decision taken in January 2012, to closely align the work of the two Boards..

Publication of an annual report for LSCBs is a statutory requirement. Whilst it is not a requirement to publish the annual report for the SAB we believe this is good practice and reflective of our aim to be open and transparent in our business and assessment of performance.

The key purpose of the report is to assess the impact of the work we have undertaken in 2012/13 on service quality and effectiveness and on outcomes for children, young people and adults in Leicestershire and Rutland. Specifically it evaluates our performance against the priorities that we set in our Business Plans 2012/13 and other statutory functions that the LSCB in particular must undertake.

The last twelve months have witnessed some significant changes in the way we operate as a Board and for the agencies that constitute our Boards. Rutland County Council has experienced an Ofsted inspection of its child protection arrangements. The health sector has experienced significant change in its structures and organisational arrangements culminating in the creation of our Clinical Commissioning Groups (CCGs) and NHS England area team from April 2013. We saw the election of the first Police and Crime Commissioner in November 2012.

Towards the very end of the year the Department for Education (DfE) published the new Working Together arrangements and we anticipate Safeguarding Adults Boards becoming statutory bodies in the early part of 2014.

Whilst I am pleased that this report presents a considerable range of success and achievement, I note that outcomes from internal review processes and performance assessment, undertaken through our Quality Assurance and Performance Management Framework, indicate the need for further improvement. These will be addressed in our new three year Business Plan which is also presented as a joint Plan covering both children and adult services.

I would like to take this opportunity to thank all Board members and those who have participated in Subgroups for their continued commitment in 2012/13. In addition I would like to thank staff from across our partnerships for their motivation, enthusiasm and continued contribution to keeping the people of Leicestershire and Rutland safe.

Safeguarding is everyone's business. The achievements set out in this Annual Report have been achieved not just by the Boards but by staff working in the agencies that form our partnership. The further improvements we seek to achieve in 2013/14 will require continued commitment from all and I look forward to continuing to work with you next year in ensuring that children, young people and adults in Leicestershire and Rutland are safe.

I commend this report to all our partner agencies.

P. R. Burnett

Paul Burnett
Independent Chair, Leicestershire and Rutland Safeguarding Boards

2. EXECUTIVE SUMMARY

"I am pleased to present the Annual Report for the Leicestershire and Rutland Local Safeguarding Children Board and Safeguarding Adult Board"… Paul Burnett, Independent Chair

Why are we doing an Annual Report?

'Working together to safeguard children' (2010) sets out the requirement for Local Safeguarding Children Boards to produce an annual report with an analysis of the effectiveness of local safeguarding arrangements. The ADASS Standard 1.25f or Safeguarding Adults states that 'an annual review by the partnership of progress on its strategic plan using this national framework, and an annual report is produced

Progress on LSCB Priorities:

- Appointed a Training Project Development Officer to develop a Leicester, Leicestershire & Rutland Children's Workforce Safeguarding Learning, Development & Training Strategy

Progress on Joint LSCB / SAB Priorities:

- The LSCB and SAB Constitution and the Terms of Reference for the Boards and all of the Subgroups were reviewed to ensure they were relevant and fit for purpose
- Developed Communication & Engagement Strategy

The role of the **Leicestershire and Rutland Safeguarding Children Board** is to safeguard and promote the welfare of children and to ensure that local agencies co-operate and work well to achieve this

Progress on SAB Priorities:

- Safeguarding Adults Compliance audit undertaken in 2012 at a strategic level sought to assess the quality and effectiveness of safeguarding performance within all partner agencies.

LSCB Performance Data:

- **Leicestershire:** 14,741 contacts recorded, increase of 1%; referrals reduced by 3% to 6,165. 393 current child protection plans at 31st March 2013, decrease of 25%
- **Rutland:** 631 contacts recorded, increase of 21%. 63% (378) went onto referral, compared to 60% (327) last year. 23 current child protection plans at 31st March, increase of 53%

SAB Performance Data:

- **Leicestershire:** 1341 referrals (leading to investigation) received; 28% increase. 53% were substantiated or partially substantiated
- **Rutland:** 59 referrals (leading to investigation) received. 54% were substantiated or partially substantiated

Trainer's Network:

- LSCB Trainer's Network was established in January 2012
- SAB Trainer's Network continues to be well attended, providing support and resources

SCR Subgroup:

- 2 Domestic Homicide Reviews initiated
- SCR Learning Events held in January 2013

SEG Subgroup:

- LSCB and SAB Performance Score Cards developed

LSCB Development & Procedures

- Multi-Agency Referral Form (MARF)
- Report to Child Protection Conference Templates for agency partners and GPs

Communication & Engagement Subgroup:

- Communications & Engagement Strategies developed

CSE Subgroup:

- Child Sexual Exploitation Protocol launched in February 2013

LSCB Training & Development Task and Finish Group

- Appointed Training Project Development Officer to develop LLR Children's Workforce Safeguarding Learning, Development & Training Strategy

SAB Training Effectiveness Task and Finish Group

- Reviewed the Competency Framework to guide learning, evidence practice and support managers.

SAB Procedures & Practice Subgroup:

- Review of the Leicester, Leicestershire & Rutland procedures and practice guidance.
- Review of the Information Sharing agreement

Safeguarding Children - Voluntary Community Sector (VCS) Reference Group

- Production of a Disclosure & Barring Service Leaflet

3. Safeguarding in Context

This report covers the financial year 2012/13 which provides a backdrop of financial review, reflected in immense organisational change and diminishing resources. These challenges have created a demanding context for safeguarding work. However, member agencies have continued to contribute to the LSCB/SAB budget which has ensured the delivery of the business plan.

The National Context

National legislation and policy changes were expected to take place in both the children and adult safeguarding arenas during the year. The updated version of ‘’Working Together to Safeguard Children’ was expected to be released in the autumn of 2012. However it was not published until 22 March 2013 to take effect from 15 April 2013. This had the effect of delaying policy and procedural decision-making which was postponed until the new guidance was released.

Similarly, Adult Safeguarding initiatives have been hampered by the delay of the Care Bill which was expected to become law during this financial year but has currently no fixed date for enactment. The Care Bill is planned to reform the law relating to care and support for adults and the law relating to support for carers, to make provision about safeguarding adults from abuse or neglect, to make provision about care standards, to establish and make provision about Health Education England, to establish and make provision about the Health Research Authority, and for connected purposes.

Several national Serious Case Reviews were published during this year. Of particular note was the Child U (Manchester) where the death of a child aged 4 years and 9 months by suffocation was caused by her mother who had mental illness. Recommendations around the Think Family protocol have been considered in relation to services in Leicestershire & Rutland. Another case was that of Yaseen Ali from Cardiff, a 7 year old boy who died in July 2010 as a result of complications from blunt force trauma inflicted by his mother. Recommendations included training for designated staff and particular awareness of domestic violence.

The Carlile Review of the Edlington Case (“J” children - Doncaster SCR) recommended a Review of procedures and awareness of home education issues and for nationally agreed thresholds. These issues are being considered in the SCR Subgroup.

Significant in the context of Safeguarding Adults was the publication of the reports into Winterbourne View and Staffordshire hospitals which have brought into sharp focus severe deficits in standards of care. The Safeguarding Adults Board has sought assurance from partner organisations in relation to the provision of care in the area.

Local Context

The Boards cover the geographical areas of Leicestershire and Rutland County Councils. Some of the agencies that are represented on the Boards work within Leicester as well as Leicestershire and Rutland. A smaller number also work across the East Midlands area. We are mindful of the need to ensure that these agencies are not duplicating their efforts when attending Boards or Subgroup meetings. Some of our Subgroups and Task and Finish groups are planned and delivered across the three authority areas.

In 2012 the development of Health and Wellbeing Boards have emerged as an important feature of the NHS reforms and are key to promoting greater integration of health and local government services. Work will be undertaken to ensure that the local Health and Wellbeing Board structure and priorities are linked with those of the Safeguarding Children and Adults Boards across Leicestershire and Rutland.

The Primary Care Trusts were also preparing to be replaced by the new Clinical Commissioning Groups.

Demographic context

According to Census 2011 information the usual resident population of Leicestershire was 650,489 and Rutland, 37,369.

In Leicestershire, 516,405 people (79.4%) of the population were aged over 18 years, 22% of these were aged over 65 years. In Rutland 29,249 (78.2%) were aged over 18 years, 26.8% aged over 65 years. Therefore there were 134,084 children (aged under 18 years) in Leicestershire and 8,120 in Rutland. They lived in 166,511 households in Leicestershire and 10,758 households in Rutland.

In these households, there was at least one dependent child in 66,606 (40%) households in Leicestershire and 3,947 (36.6%) households in Rutland.

There were 10,530 households in Leicestershire and 3,082 households in Rutland where one person in the household had long term health problems or disability and no dependent children lived there; while at least one dependent child lived in 10530 of these households in Leicestershire and 456 in Rutland. 14,956 households in Leicestershire described themselves as lone parents with at least one dependent child, of which 1,821 were male lone parents and 13,135 were female lone parents. 713 households in Leicestershire described themselves as lone parents with at least one dependent child, of which 130 were male lone parents and 583 were female lone parents. This compared with 105,365 households in the East Midlands and 1,311,974 in England.

90.6% of the population in Leicestershire, and 94.3% of the population in Rutland classified their ethnicity as white British. This compares with the East Midlands region where only 85.4% did not consider themselves white British, and 79.8% of England's population. Of those who don't consider themselves white British, 4.75% of Leicestershire's population considered themselves Asian or Asian British, and less than 1% Black/African/Caribbean or Black British. All ethnic minorities listed for Rutland totalled less than 1%.

In Leicestershire, 4951 (1.8%) of households reported they had no person in the household who spoke English as their first language. This was 101 households (0.7%) in Rutland. For East Midlands the figure was3.6% and nationally it was 4.4%.

4. About the Boards

Leicestershire and Rutland Safeguarding Children Board (LSCB)

The role of the Leicestershire and Rutland Safeguarding Children Board is to safeguard and promote the welfare of children and to ensure that local agencies co-operate and work well to achieve this. Its core objectives are set out in law, in Section 14 (1) of the Children Act 2004.

LSCB priorities

The Board provides strategic direction, scrutiny and challenge to performance across the relevant local agencies in Leicestershire and Rutland. The LSCB set out the following priorities in its business plan for 2012 - 2015:

1. To improve the effectiveness of the Local Safeguarding Children Board

2. Ensure the operational effectiveness of local Safeguarding Children partner agencies

3. Quality Assurance and Performance

4. Communication and Engagement - Develop a Communication and Engagement Strategy

5. Family and Community – Strengthen Multi Agency Working to prevent harm and abuse (A joint priority with SAB)

LSCB functions

''Working Together to Safeguard Children' (2010) sets out the key functions of a local safeguarding board.

In practical terms this means the following:

1. Learning from Serious Case Reviews

2. Learning and development through training

3. Quality assurance, monitoring and evaluating

4. Safeguarding policies and procedures

5. Communicating and raising awareness of safeguarding arrangements

6. Review of all child deaths in Leicestershire and Rutland

Leicestershire and Rutland Safeguarding Adults Board (SAB)

The role of the Leicestershire and Rutland Safeguarding Adults Board is to safeguard and promote the welfare of vulnerable adults and to ensure that local agencies co-operate and work well to achieve this.

SAB priorities

The Board provides strategic leadership and challenge for all the organisations across Leicestershire and Rutland that have responsibilities to safeguard adults from abuse. In 2012 the SAB set out the following priorities in its business plan as a focus until 2015:

1. To improve the effectiveness of the Safeguarding Adults Board

2. Ensure the operational effectiveness of the Safeguarding Adults partner agencies

3. Quality Assurance and Performance

4. Communication and Engagement - Develop a Communication and Engagement Strategy

5. Family and Community – Strengthen Multi Agency Working to prevent harm and abuse (A joint priority with LSCB)

SAB functions

These priorities sit alongside the general business of the Board. 'No Secrets 2000' sets out the key functions of a local safeguarding board.

In practical terms this means the following:

1. Learning from Serious Case Reviews

2. Learning and development through training

3. Quality assurance, monitoring and evaluating

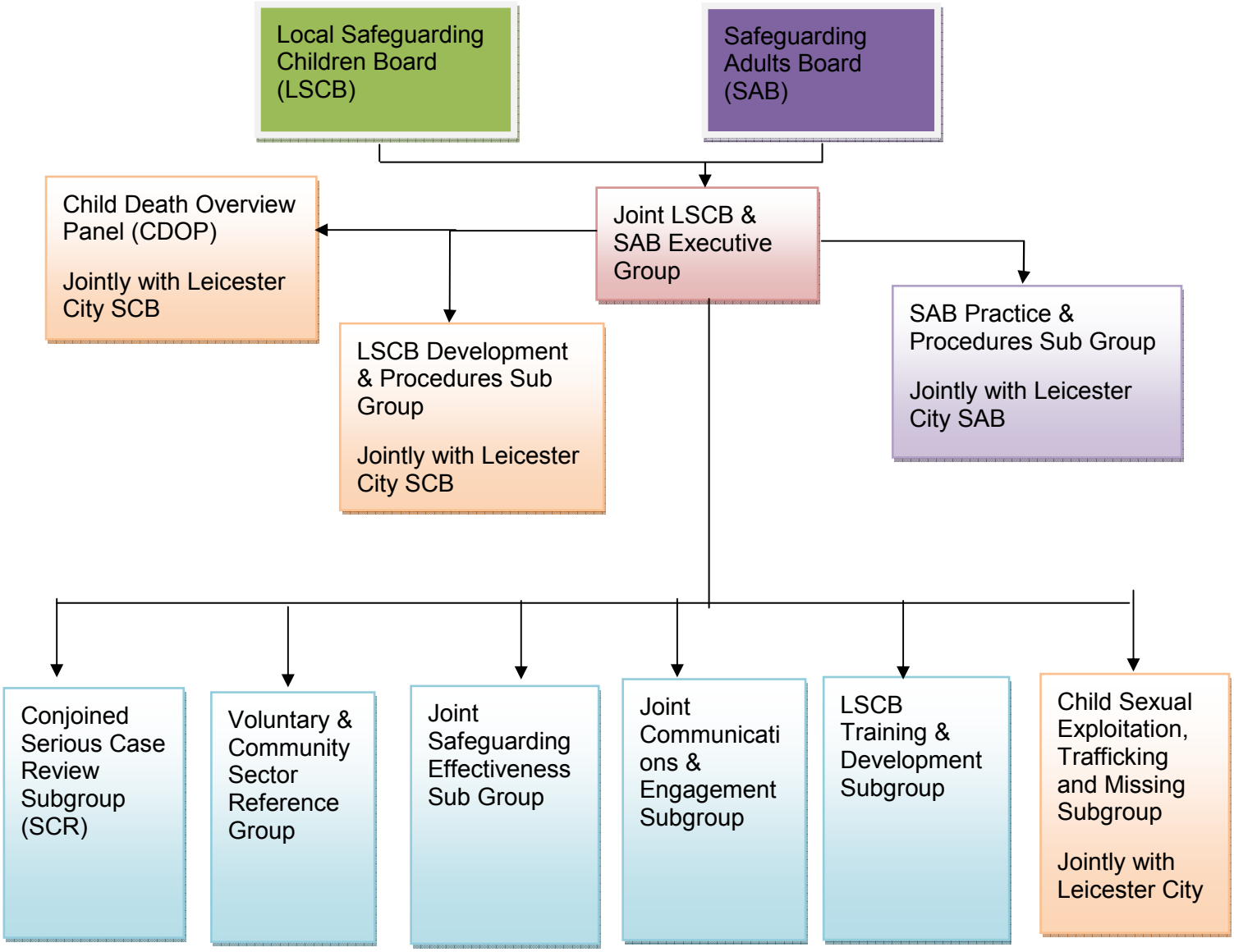
4. Safeguarding policies and procedures

5. Communicating and raising awareness of safeguarding arrangements

In order to deliver this core business, the two Boards meet as a 'conjoined' board for four meetings per year. The Board's business is scrutinised and developed by a smaller executive group that meets two weeks before and two weeks after Board meetings. The work of the Board is carried out by a number of Subgroups, some of which have task and finish groups. These are detailed in Section 8.

4.1. The Board and Subgroup Structure

The Board and Subgroup structure is shown below.



Please note that these functions/levels do not operate in isolation. This is a simple structure chart: the realities of communication across these areas is more complex and more constructive

4.2. Budget

All agencies made their full commitment to the funding of the LSCB and the SAB for the year. Due to not appointing to key posts until half way through the year, a underspend of £61,193 was added to the reserve account.

LSCB & SAB Budget 2012 -2013		
	Actual at end of period 12	
1571 - LSCB - Allocation for LSCB multi agency training provision.	£	29,502
1572 - New DHR Posts & Costs	£	24,614
1574 - Office Costs LSCB & SAB	£	60,000
1575 - Staffing Costs - LSCB staff	£	186,713
1578 - LSCB - SCR costs	£	8,573
1579 - LSCB - SILP costs	£	13,142
1585 - Staffing Costs SAB staff	£	60,581
1586 - SAB SCR costs	£	3,707
1587 - SAB SILPS costs	£	12,565
1588 - Allocation for SAB multi agency training provision.	£	10,000
TOTAL BUDGET ON EXPENDITURE	£	409,397
SAB INCOME	-£	161,921
LSCB INCOME	-£	308,669
TOTAL BUDGET ON INCOME	-£	470,590
BUDGET FOR 2012-13 FOR SAB & LSCB - underspend	£	61,193

4.3. Board Membership 2012/13

LSCB Full Members

Organisation	Title	Name
	Independent Chair	Paul Burnett
Leicestershire County and Rutland PCT and shadow East Leicestershire and Rutland CCG	Chief Nurse and Quality Officer	Carmel O'Brien
Health	Director of Nursing, University Hospitals Leicester (UHL)	Carole Ribbins
Leicestershire County and Rutland PCT and shadow West Leicestershire	Chief Nurse & Quality Lead	Caroline Trevithick
Health	Chief Nurse	Jackie Ardley
Strategic Health Authority and shadow NHS England	Assistant Director of Nursing, NHS Commissioning Board	Sharon Robson
NHS	Lead Children CAMHS & Safeguarding, Adults & Children. East	Jane Appleby

Organisation	Title	Name
	Midlands Strategic Health Services	
EMAS	Clinical Quality Manager	Louise De Groot
Leicestershire County and Rutland PCT	Designated Lead for Safeguarding	Pamela Palmer
NHS	Consultant Paediatrician, Designated Doctor for Child Protection, Families, Young People & Children Services	Dr Sudir Sethi
Leicestershire Police	Detective Chief Inspector	Andy Sharp
Leicestershire Probation	Director Of Offender Management	Paul Hindson/Bob Bearne
LCC	Head of Strategy - Safeguarding Assurance	Chris Nerini
LCC	Director of Children & Young Person's Services (C&YPS)	Gareth Williams to December 2012 - Lesley Hagger from January 2013
LCC	Head of Youth Justice & Safer Communities	Phil Hawkins
LCC	Assistant Director - Children's Social Care (Vice Chair LSCB)	Walter McCulloch
Rutland County Council	Strategic Director, People	Carol Chambers
Rutland County Council	Assistant Director (Vice Chair LSCB)	Wendy Poynton
District Councils (LSCB)	Chief Executive (Hinckley and Bosworth Borough Council)	Steve Atkinson
CAFCASS	Manager	Jason Dent
Leicestershire Schools	Head teacher, St Denys CofE Infant School, Ibstock	Jane Sharp
Leicestershire Schools	Head teacher, Castle Rock High School, Coalville	Julia Patrick
Rutland Schools	Brooke Hill Primary School – Oakham	Sharon Milner
Leicester Shire Connexions	Chief Executive	Rosemary Beard
NSPCC	Service Manager	Rama Ramakrishnan
Loughborough College	Senior Designated Person for Safeguarding, Loughborough College, Rep for Further Education Colleges	Sue Foreman
Voluntary Action Leicestershire	CYP Project Manager	Wendy Brickett
	Lay Member	Lucy Pathan
	Lay Member	Sue Appleton

Participating Observer

LCC	Lead Member, Children and Young People's Services	Ivan Ould
RCC	Councillor –Lead Member for Children	Cllr Ken Bool

Board Advisor

LCC	Head of Legal Services - Children & Adult Services & Litigation	Lauren Haslam

SAB Full Members

Organisation	Title	Name
	Independent Chair	Paul Burnett
Leicestershire County and Rutland PCT and shadow East Leicestershire and Rutland CCG	Chief Nurse and Quality Officer	Carmel O'Brien
Health	Chief Nurse - LPT	Jackie Ardley
Health	Director of Nursing, University Hospitals Leicester (UHL)	Carole Ribbins
Strategic Health Authority and shadow NHS England	Assistant Director of Nursing, NHS Commissioning Board	Sharon Robson
NHS	Lead Children CAMHS & Safeguarding, Adults & Children. East Midlands Strategic Health Services	Jane Appleby
EMAS	Clinical Quality Manager	Louise De Groot
Leicestershire County and Rutland PCT	Designated Lead for Safeguarding	Pamela Palmer
Leicestershire Police	Detective Chief Inspector	Andy Sharp
Leicestershire Probation	Director Of Offender Management	Paul Hindson/Bob Bearne
Leicestershire County Council (LCC)	**Assistant Director - Personal Care & Support**	Heather Pick
LCC	Assistant Director Children & Young People's Service	Walter McCulloch
(LCC)	Adult Learning Officer - Learning For Work	Alison Doggett
District Councils (SAB)	Head of Communities & Neighbourhoods (Melton Borough Council)	Harinder Rai
Vista Blind	CEO	Jenny Pearce
LCC	Head of Strategy - Safeguarding Assurance	Chris Nerini
LCC	Head of Youth Justice & Safer Communities	Phil Hawkins
Rutland County Council	Strategic Director, People	Carol Chambers
Rutland County	Assistant Director	Wendy Poynton

Organisation	Title	Name
Council		
District Councils (Communications Group)	Children's Services Coordinator/IYSS Locality Manager (North West Leicestershire DC)	Clare McCrory-Smith

4.4. Agency Attendance at Board Meetings

Statutory LSCB members:

Independent Chair	100%
Leicestershire County Council Officers Lead Member	100% 75%
Rutland County Council Officers Lead Member	50% 25%
District Council representation	100%
Police	75%
Probation Service	75%
Youth Offending Team	100%
SHA/NHS commissioning Board and PCTs	100%
Leicestershire Partnership Trust	75%
University Hospitals Leicester Trust	50%
EMAS	100%
Consultant Paediatrician	75%
CAFCASS	50%
Schools	50%
Further Education Colleges	50%
Lay members – Leicestershire Rutland	100% 25%

LSCB Non Statutory members

NSPCC	50%
Voluntary Action Leicestershire	75%
Leicestershire County Council: Head of legal Services Adult Learning Officer	75% 75%
Leicestershire Partnership Trust: CDOP – Chair CDOP - Manager	75%

	50%
Melton Borough Council	25%

SAB members

Independent Chair	100%
Leicestershire County Council Officers	100%
Rutland County Council Officers	50%
District Council representation	100%
Police	75%
Probation Service	75%
SHA/NHS commissioning Board and PCTs	100%
Leicestershire Partnership Trust	75%
University Hospitals Leicester Trust	50%
EMAS	100%
Vista Blind	75%

5. Progress made against the Leicestershire and Rutland LSCB Priorities in 2012/13

Priority 1: ***Improving the effectiveness of the Local Safeguarding Children Board***

Priority 2: ***Ensuring the operational effectiveness of the Local Safeguarding Children partner agencies***

Priority 3: ***Quality assurance and performance***

Priority 4: ***Develop a communications and engagement strategy***

The Board is assured that Member organisations have robust safeguarding arrangements both individually and in partnership with the LSCB.

Be assured that partner agencies are engaged with children and young people. Be assured that service providers within partner agencies, regardless of status are delivering effective safeguarding provision for children and young people.

a) Section 11 Audit

What was planned?

It was planned that all partner agencies would take part in the annual Section 11 (Children Act 2004) audit to test understanding and compliance with safeguarding responsibilities of frontline professionals.

What action did the Board take?

The LSCB instigated the audit in August 2012. Responses were received from 102 professionals from the chosen sample areas of Hinckley & Bosworth and Rutland. 14% of the respondents reported they worked with adults; 30% stated they worked with children and 46% stated they worked with families of all ages. The other 10% stated 'Other'. 69% went on to say they worked directly with children as part of their role.

The responses were analysed and a report was presented at the Safeguarding Effectiveness Group on 6th march 2013.

What has been the impact?

There was clear evidence of compliance by frontline professionals. 89% of respondents stated they feel they are able to work well with staff in other agencies when safeguarding children and young people.

98.9% of respondents stated they knew who in their organisation to tell or seek advice from if they have a safeguarding concern about a child.

An encouraging 95.8% of respondents reported that they could recognise the signs of abuse or neglect in children or young people.

64.2% of the respondents stated that they knew their organisation has a process for ensuring the learning from Serious Case Reviews or other learning or review processes is relayed back to staff in order to improve practice. However only 36.8% stated they had been advised of such investigations in the last year and what has been

learned from them. An SCR Learning Event was held in January 2013 to disseminate learning from SCRs to partner agency professionals in order to address this.

What developments and improvements are required in the future?

Partner organisations will be asked to provide evidence of their arrangements and outcomes for children and adults in need of safeguarding via the Performance Management Framework. A full Section 11 audit will take place next year.

b) Further develop single and multi-agency safeguarding audits

What was planned?

The Safeguarding Effectiveness Group (SEG) Audit Group was set up as a subgroup of the SEG to further develop single and multi-agency safeguarding audits. Single Agency Safeguarding Audits was added as an agenda item to the SEG.

What action did the Board take?

Agencies are encouraged to present single agency audits at SEG meetings. The SEG Audit Group, on behalf of the Board, has created a schedule of multi-agency audits to respond to recommendations from learning and review processes.

An audit of Strategy Discussions was completed in October 2012 and a report presented to the SEG in November 2012.

What has been the impact?

The schedule of multi-agency audits has increased the number of multi-agency audits being undertaken. Among the recommendations of the audit of Strategy Discussions were that work is progressed to ensure the two sets of procedures (Children's Social Care and the LSCB) are uniform, clear and link to each other and that the electronic links lead the reader to the right place in the procedure manuals; and that the process for consultation with health colleagues is reviewed so their inclusion in decision making becomes routine in accordance with procedural guidance rather than the exception.

What developments and improvements are required in the future?

The audit schedule contains several planned multi-agency audits for the year.

Reporting in the Performance Management Framework will include information from multi-agency and single agency audits - including relevant quantitative data, views of service users, view of staff and front line managers.

c) Continue to develop the core data set within the Balanced Score Card

What was planned?

The Performance Management Framework (PMF) was to be progressed through the employment of a Business Analyst.

What action did the Board take?

A Business Analyst was appointed for six months to progress the PMF.

What has been the impact?

The PMF will be developed to pilot stage

What developments and improvements are required in the future?

The PMF will be implemented to enable the Boards to deliver the Business Plan and evaluate the impact of their work and outcomes achieved in relation to the safeguarding of children and adults in need of safeguarding.

The Board is assured that resources are efficiently and effectively deployed to support the Business Plan.

What was planned?

Review of funding arrangements to assure that resources are efficiently and effectively deployed to support the Business Plan.

What action did the Board take?

The Board reviewed investment methods, methods for staff deployment and the funding formula for agency contributions. Methods for projection, monitoring and expenditure were reviewed and refined.

What has been the impact?

Budget is aligned with business priorities

What developments and improvements are required in the future?

Monitoring of budget to ensure alignment with business plan will be ongoing

Quality assure the link between training and the effectiveness of practice.

Children's Workforce Safeguarding Learning, Development & Training Strategy

What was planned?

Appoint a Training Project Development Officer to develop a Leicester, Leicestershire & Rutland Children's Workforce Safeguarding Learning, Development & Training Strategy.

Set up a Trainer's Network to support trainers providing safeguarding training in their own organisations.

What action did the Board take?

Training Project Development Officer was appointed in September 2012, following the appointment of an Administrator (employed by VAL) in April 2012.

The first meeting of the Trainer's Network was 10 January 2013. The group meet on a quarterly basis.

What has been the impact?

The LLR Children's Workforce Safeguarding Learning, Development & Training Strategy outlines the move to competencies based on requirements for different groups rather than set levels of training, and has been endorsed by partner agencies after a period of consultation.

Feedback from participants in the Trainer's Network is very positive.

What developments and improvements are required in the future?

Evidence to show the new arrangements for the delivery of multi-agency training are established: Quality Assurance of Training as part of the Performance Management Framework.

The Trainer's Network will continue to meet to support the trainers.

Develop a CYP engagement strategy that secures the involvement of service recipients by promoting the voice of young people. Gain assurances that residents within Leicestershire and Rutland are instrumental in the safeguarding of children and babies. Develop more effective communications with managers and staff in constituent agencies.

d) Communication and Engagement Strategy

What was planned?

Combine the findings and recommendations from the Flack report and the Performance Framework to develop an LSCB Engagement Strategy.

''Safeguarding Matters'' is to be developed as a bi-monthly publication to be distributed widely throughout Leicestershire & Rutland.

Plan a strategy to engage children, young people and families in the evaluation and development of the Board's work.

Raise awareness of Private Fostering in Leicestershire and Rutland.

What action did the Board take?

The LSCB Engagement Strategy was developed through the Communications & Engagement Subgroup in draft in January 2013 and agreed at the C&E Subgroup meeting on 24th May 2013.

The first edition of "'Safeguarding Matters'" was published in February 2013 and has been published bi-monthly since then.

The board has improved the notification procedures used by councils when children in care move areas – this has contributed to a new protocol being agreed by all agencies in the East Midlands.

Awareness of Private Fostering arrangements has been raised through the review and release of pamphlets.

What has been the impact?

Professionals in LSCB partner agencies are clear about any new guidance or changes through "'Safeguarding Matters'" and the Communication and Engagement Strategy.

Communication between partner agencies has improved. Partner agency professionals have requested additional copies of 'Safeguarding Matters' and feedback has been overwhelmingly positive.

What developments and improvements are required in the future?

The website will be developed. The Engagement Strategy will be implemented, especially in relation to the engagement of children and young people.

Further awareness raising of Private Fostering arrangements and evaluate the impact of the work.

Monitor the effectiveness of safeguarding practice as outlined in the Business Plan: Reduce the number of children and young people that are referred into child protection by improving the quality and impact of early help. Seek assurances that work undertaken in relation to safeguarding babies, who continue to remain at acute risk in Child Protection cases has had impact. Reduce the number of cases requiring Child Protection Plans and Care proceedings and the percentage of children looked after at period end with three or more placements during the year. Increase the number of looked after children cases which are reviewed within required timescales

. Increase the stability of placements of looked after children in care for at least 2.5 years

What was planned?

These issues were monitored on a quarterly basis at the Safeguarding Effectiveness Group through the Performance Scorecard. See **SEG** (Section 8.2) and **Performance Overview** (Section 9) for more information.

Early Help Services and Duty Team have undergone significant restructuring in Leicestershire Children & Young Person's Services. Early Help Services now include services such as Children's Centres and Youth Service. This has resulted in difficulties in monitoring effectiveness.

What action did the Board take?

The Safeguarding Effectiveness Group reviewed the Performance Scorecard and highlighted issues which needed to be dealt with or referred to other agencies to deal with.

What has been the impact?

See the **Performance Overview** (Section 9) for more information.

What developments and improvements are required in the future?

Monitoring through the Performance Scorecard will continue this year until the implementation of the Performance Management Framework which will monitor effectiveness in the future.

An audit of Referrals to Early Help (Leicestershire) and Team Around the Family (TAF, Rutland) to assess multi-agency engagement will be conducted next year when the re-structuring in Leicestershire services has stabilised.

SEG will develop multi-agency audits to monitor the effectiveness of the stated priorities.

Further develop consultation with children, young people and families to ensure their 'voice' informs evaluation and practice development.

Incorporate learning from single and multi-agency investigations, including Serious Case Reviews (SCRs) and Significant Incident Learning Processes (SILPs), into the work of agencies and the LSCB. Involve operational staff in learning events to ensure there will be on-going evidence of the impact of the learning received. Ensure action is taken in response to the Munro Review and Working Together 2013 as it impacts on safeguarding children practice.

What was planned?

Develop strategies to ensure that practice is adjusted where required to reduce significant harm to children; further develop guidance for high quality supervision; and ensure that challenge and escalation occurs when required in safeguarding practice.

Review the work of Munro and 'Working Together 2013' when it is published.

SCR Action Plans should be responded to in a timely way.

What action did the Board take?

The SCR Subgroup commissioned an event in January 2013 aiming to develop the practice of frontline practitioners through learning from Serious Case Reviews (SCR) and Significant Incident Learning Process (SILP).

SCR Agency representatives will continue to ensure actions arising from recommendations are completed within their agency.

SEG monitored the effectiveness of the integration of learning through multi-agency and single agency audits and the Section 11 audit.

Procedures were reviewed in line with recommendations from SCRs and SILPs.

What has been the impact?

127 professionals attended the event which covered themes relevant to both children and adults in need of safeguarding. The evaluation of the event indicated that 70% of the participants thought the presentations and overall learning event were “useful” or “very useful”.

Audits, such as the Strategy discussion audit, highlighted examples of good practice and focussed on challenges that required action.

What developments and improvements are required in the future?

Audits will be conducted into the effectiveness of multi-agency working which will contain questions in relation to how learning from review processes has been integrated into practice. Audits will include the safeguarding of babies and the monitoring of child protection plans. The Performance Management Framework will also require evidence to demonstrate that the learning from these reviews has influenced practice and reduced significant harm to children.

Implementation of the recommendations of ‘Working Together 2013’ will be required.

6. Progress made against the Leicestershire and Rutland's SAB priorities in 2012/13

Priority 1: ***Improving the effectiveness of the Local Safeguarding Adults Board***

Priority 2: ***Ensuring the operational effectiveness of the Safeguarding Adults partner agencies***

Priority 3: ***Quality assurance and performance***

Priority 4: ***Develop a communication and engagement strategy***

1.1 and 1.4 What was planned?

To develop a Quality Assurance and Performance Framework that includes: performance data to evaluate impact; a programme of multi-agency and single agency audits; service user feedback; engagement with the front-line.

To develop a Safeguarding Adult Board (SAB) Engagement Strategy that includes the voluntary, independent sector and service users.

To ensure that front-line staff are aware and engaged with the work of the SAB by involving operational staff in task & finish groups where appropriate and there is a two way information sharing and learning communications process.

What action did the Board take?

The Board agreed the following actions:

The implementation of a Performance Scorecard to provide data on safeguarding activity (see Section Performance Overview).

The on-going development of the Performance Management Framework to bring together not only the quantitative data but qualitative and narrative information from service users and frontline practitioners.

A review of the Board and Subgroup representation and terms of reference to ensure effective contributions and clarity of purpose. A record of Board attendance can be found on page 11.

A programme of audits were planned including the Safeguarding Adults Compliance Audit to support the development of the Performance Management Framework (this mirrors the Children's Section 11 audit).

Development of a communication and engagement strategy.

What has been the impact?

Through regular attendance at Board meetings, Board members have highlighted the contribution they can make to safeguarding adults. Board members have cascaded information throughout their own organisations and have

ensured the business plans within their own agencies contains appropriate cross reference and relevance to the SAB Business Plan.

The involvement of frontline practitioners and specialist workers, e.g. Performance Analysts, and Community Safety officers, have enriched the work of the Subgroups offering a wide breadth of knowledge and experience but also ensuring that changes to policy and procedure are embedded.

What developments and improvements are required in the future?

Safeguarding Adult Boards are to be placed on a statutory footing and a review of compliance with those statutory duties will be undertaken.

Putting the Communication and Engagement Strategy into action to support the performance framework and raise awareness.

1.2 1.6 3.3 3.4 What was planned?

The Board is assured that Member organisations have robust and safe commissioning and contracting arrangements with Safeguarding Adults integral to any process.

Be assured that all service providers within partner agencies, regardless of status are delivering effective safeguarding provision for adults in need of safeguarding. Seek assurances through audits of the impact upon intervention in vulnerable adults' lives.

What action did the Board take?

The Safeguarding Adults Compliance audit undertaken in 2012 at a strategic level sought to assess the quality and effectiveness of safeguarding performance within all Partner agencies.

240 staff from across children and adult services attended four briefings on their responsibilities under the new Disclosure and Barring service.

Assurances sought from organisations as a result of the Mid Staffordshire reports.

What has been the impact?

Whilst we have seen an improvement in the monitoring of the standards of care the referral rates continue to rise.

The impact of national reviews and enquires will have been a contributory factor.

What developments and improvements are required in the future?

Information gathered from the strategic level audit will provide the basis for a front line practitioners' audit which will be undertaken in September 2013 and will test out assurances given at the strategic level. For exampleif the strategic response was that all staff know how to access procedures the question would be "Do you know how to access the Safeguarding Adults procedures?"

Further to the Francis report into Mid Staffordshire hospitals assurance will continue to be sought on the quality and safety of care and will continue to be a priority area.

Develop QA process to enable alert process so that the Board is sighted on and understand management of risks, especially high level risks.**1.3 What was planned?**

The Board is assured that resources are efficiently and effectively deployed to support the Business Plan.

What action did the Board take?

The budget to support the work of the Boards is regularly reviewed and the role of the Board Officers and clerical support are developing generically to meet the needs of both adult and children safeguarding priorities.

What has been the impact?

The budget is aligned with business priorities.

What developments and improvements are required in the future?

Board resources will be targeted on delivering the Business Plan outcomes but steps will be taken to identify more efficient and effective ways of delivering our business so that the Board is better positioned to reduce future calls on resources in recognition of the pressures that partner agencies will be facing in the future.

1.5 What was planned?

Ensure that all service providers of all partner agencies, regardless of their agency status, are clear they have the same safeguarding responsibilities for vulnerable adults (e.g. voluntary sector and private organisations).

What action did the Board take?

Developed an Engagement Strategy which includes the voluntary and independent sector and service providers

Through 'Safeguarding Matters', staff across both adult and children's workforce are updated on changes to procedures /legislation /research and guidance.

The Safeguarding Adults Trainers Network meets twice a year and receives regular updates as above in order to disseminate information to front line staff and service users.

What has been the impact?

Anecdotal evidence of the use of 'Safeguarding Matters' seems to support the view that the stakeholder group continues to grow and engage in the Safeguarding Agenda. Whilst there is no direct evidence that this has led to increased referrals to the Local Authorities it may be one of many contributory factors to the year on year increase in referral rates.

What developments and improvements are required in the future?

Embedding the engagement strategy within the Subgroups' work and the Board's structure is a priority moving forwards. We will continue to refresh the membership of the communication and Engagement Subgroup to ensure there is relevant expertise and focus on mapping relevant groups to engage with.

2.1 What was planned?

Clarify the scope of the SAB in terms of both universal/early intervention safeguarding practice and safeguarding of vulnerable adults

What action did the Board take?

Develop positive and two way links between the SAB and other agency work streams looking to improve universal/early intervention including Safer Communities initiatives 'Deprivation of Liberty' Safeguards and the development of Keep Safe places.

What developments and improvements are required in the future?

Redefine the scope of the SAB in the constitution document following further government guidance on making the Board functions statutory.

Safer Communities to provide progress report on the vulnerability work stream.

2.2 What was planned?

Incorporate learning from single and multi-agency investigations, including Serious Case Reviews (SCRs) and Significant Incident Learning Processes (SILPs), into the work of agencies and the SAB.

What action did the Board take?

The publication 'Safeguarding Matters' has shared learning on a variety of issues including Winterbourne View and the abuse of adults with learning disabilities,; and Keeping the Child in Focus. These messages were also reiterated at a SCR Learning event in January 2013, and attended by 127 participants.

Mental Capacity (MCA) and Risk Assessment was the subject of a conference held in August 2012 attended by 120 staff.

Progress on the development of a Learning Framework that offers a variety of review methodologies to provide a proportionate response and learning opportunity.

What has been the impact?

The SCR Learning event attended by 127 frontline practitioners from a variety of agencies across Leicestershire & Rutland who work with children, young people and adults was positively evaluated. 70% of the participants rated the presentations and overall learning event "useful" or "very useful. Participants were committed to taking the learning back to their organisations.

Feedback from the MCA conference led to consideration within the Joint procedures group of a multi-agency risk assessment tool. However it was decided that existing processes such as the Morgan Risk Assessment, the Care Pathway and guidance within the Multi Agency Policy and procedures offered more flexibility.

What developments and improvements are required in the future?

Use 'Safeguarding Matters'/ Learning conferences/ website / Trainer's Network to disseminate information.

Review effectiveness and scope of training in relation to practice issues identified by review processes (See Learning and Development Subgroup Report).

2.3 What was planned?

Ensure Practice and Procedural Guidance is fit for purpose.

See Procedures Subgroup Report.

3.1 What was planned?

Develop robust monitoring systems that allow the Board to understand trends in Adult Safeguarding activity and identify gaps.

What action did the Board take?

During the year, the Board introduced and further developed performance score cards for agencies. The data is reported quarterly and significant issues are flagged and reported to the Executive Group and Board. Audits have been carried out to test the effectiveness of agencies' safeguarding work.

What has been the impact?

Please see section 9 Performance Overview.

What developments and improvements are required in the future?

Work will continue this year to further refine the Performance Management Framework and capture the voice of service users and practitioners.

3.2 What was planned?

Secure an effective training and development strategy that enables managers and staff to effectively implement safeguarding and ensure that training is effective.

What Action did the Board take?

During 2012/13 the Leicestershire and Rutland SAB have continued to support the strategy that has been in place since September 2011 of in house delivery of Alerter and Referrers training with the support of the Training Alerter Programme delivered by the Leicestershire Social Care Development Group (LSCDG), a Training Manual and Trainers Network. Investigating and Managing the Process courses are delivered by the Ann Craft Trust (commissioned by the SAB).

As the training strategy has been in force since September 2011 the Safeguarding Effectiveness Group set up a Safeguarding Adults Training Effectiveness Task and Finish Group to establish the current position regarding delivery of training both single and multi-agency.

What was the impact?

The Trainers Network has met twice this year with attendance, of on, average 35-40 people from a diverse workforce, offering the opportunity to share lessons from reviews and national issues; and also to consider creative ways of developing learning opportunities.

A total of 70 practitioners attended the two day Investigation Course which ran 5 times throughout the year with very positive evaluations: “Made you think”, “Increased confidence”, “Useful having the police and mental health perspectives.”

The one day ‘Managing the Process’ course ran twice with 22 participants again receiving positive comments: “Exploring how process works and problem solving obstacles”; “Positive emphasis on Information Sharing.”

What developments and improvements are required in the future?

See Safeguarding Adults Training Effectiveness Task and Finish Group report.

4.1 4.2 4.3 4.4 What was planned?

Develop an adult safeguarding engagement strategy that secures the involvement of service recipients.

Gain assurances that residents within Leicestershire and Rutland are instrumental in the safeguarding of vulnerable adults.

To develop more effective communications pathways with managers and staff..

The profile of the SAB is raised.

What action did the Board take?

Communications & Engagement Subgroup formed.

Design of a new Safeguarding Adults logo.

The Communications and Engagement Subgroup devised a new brand identity for the Board. ‘‘Safeguarding Matters’’, a new publication for practitioners, was created which is sent out via a comprehensive distribution list.

Links with training networks have been strengthened to ensure that information and learning from reviews is embedded within courses. The work of Subgroups has been mapped to ensure their priorities are reflected in activity and communications is now a standing item on each agenda.

What was the impact?

The impact of this developing area of work is, at this, early stage purely anecdotal in increasing awareness of Safeguarding Adults issues. Staff are referencing ‘Safeguarding Matters’ in supervision, team meetings and training. Any direct link to improved practice and service delivery may come through future auditing.

What developments and improvements are required in the future?

Further develop effective communication pathways to and from the Safeguarding Boards at all levels (locally, regionally, voluntary, community and independent sectors and throughout all levels of partner agencies). Another next step is holding an event in September 2013 to understand and map the engagement mechanisms and links which already exist in Leicestershire and Rutland.

Revise and maintain public awareness of safeguarding being “everyone’s business.”

Publish ‘‘Safeguarding Matters’’ on a regular bi-monthly basis with special editions as required.

Further website development and maintenance as an important part of the strategy.

Review the processes used to deal with the media issues relating to SCRs, SILPs and on-going raising awareness.

7. Progress made against joint Priority 5: Family and Community

Strengthening multi-agency working to prevent harm and abuse

What was planned?

To have clarity regarding the extent to which safeguarding is addressed within specific priority areas:

- Domestic Violence
- Adult Mental Health
- Drugs and Alcohol
- Child Sexual Exploitation

What action did the Board take?

In relation to domestic violence, the Board endorsed the roll out of the Co-ordinated Action Against Domestic Abuses (CAADA) DASH, a tool to help frontline practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.

In relation to Mental Health, a Mental Capacity and Risk Assessment conference was held in August 2012 attended by 120 staff and gave participants the opportunity to discuss the complexities of assessing mental capacity and its impact.

In relation to Drugs & Alcohol, the Safeguarding Effectiveness Group (SEG) commissioned a dual agency audit into drugs and alcohol services by Swanswell and Children & Young Person's Services. For more information see Section 8.2 SEG Subgroup report.

In relation to Child Sexual Exploitation, a separate Subgroup was created. For more information see Section 8.8 CSE Subgroup Report.

A number of multi-agency events have been held with themes including safeguarding and the Mental Capacity Act see Section 8.7 SAB Training Effectiveness Task and Finish Group report for more information. The Board has also supported training in relation to 'Think Family'.

The Board has supported the work of Supporting Leicestershire Families. This programme was set up by the county and district councils, the police, NHS and other agencies to work together to improve support for more than 3,000 families across the county.

The family support workers work directly with vulnerable families to support them to achieve better outcomes and turn their lives around. They plan to work together to intervene earlier with the aim of transforming the lives of these families, by reducing intergenerational cycles of debt, poverty, violence, and worklessness.

What has been the impact?

The effectiveness of services to children, young people and their families where any of the above risk factors has been identified has been monitored.

The LSCB Section 11 Audit (Part 2: Targeting Front line practitioners) was conducted in 2012. The results of the audit showed that awareness of the complex problems faced by families was high. The question was asked if staff would know what to do to ensure the child or young person was protected. Only 3.5% of respondents (3) stated they would not know what to do in cases of alcohol, drug misuse or mental ill health. Nobody stated that they would not know what to do in cases of Domestic Abuse. 82% of respondents stated they would know how to recognise the signs of possible Child Sexual Exploitation (CSE).

The feedback from the LSCB/SAB SCR/SILP Learning Event held in January 2013 showed that learning about key areas was being embedded. The event evaluation reported as follows: Some groups noted the importance of the 'Think Family' approach: "Think Family' being jointly owned and valued; "Adult workers to consider needs of children and children workers to consider needs of adults" and "Consideration of children discussed at every adult safeguarding conference". Others noted the importance of linking up: "Links between children in care teams and transitions team, adults + Adulthood" and "Transitions from child to adult care to be seamless, more co-working options". One participant went so far as to suggest: "Re-structure of social care to integrate adult and children's services."

What developments and improvements are required in the future?

The SEG Audit Group will commission further audits to include these risk factors.

Review procedures to ensure relevance to practice.

Ensure training is offered to include these areas.

An annual report from Supporting Leicestershire Families will be requested.

Include these issues in editions of ''Safeguarding Matters'.

What was planned?

Develop communication pathways to and from the Safeguarding Boards by:

- Ensuring the Board constitution and Terms of Reference reflect the agreed governance structure.
- Further develop the relationships with Joint Action Groups (JAGs) and Community Safety groups.
- To put in place a communication and engagement plan that enables effective relationships between the Safeguarding Boards and:
    - Key strategic bodies such as the Health & Wellbeing Board, Children's Trust Clinical Commissioning Groups and Community Safety Partnership
    - Partner agencies – particularly senior leaders
    - Front line staff
    - Service users and communities of Leicestershire and Rutland.

What action did the Board take?

The LSCB and SAB Constitution and the Terms of Reference for the Boards and Subgroups were reviewed to ensure they were relevant and fit for purpose.

The Board received the report from the Community Safety Partnership which had reviewed the work of the JAGs.

The Communication and Engagement Subgroup approved the Communication Strategy and the Engagement Strategy. 'Safeguarding Matters' was launched in February 2013. For more information see Section 8.3 Communication and Engagement Subgroup Report.

An audit of the arrangements joining the LSCB and SAB was conducted in December 2012. This included questions relating to communication. The feedback was presented at the Board Development Day on 11th January 2013.

What has been the impact?

Feedback from the survey, conducted in relation to the Joint Working Arrangements and Conjoined Meetings between November 2012 and January 2013, was generally positive in relation to improved communication. For example, in response to one of the questions: "Are there any other advantages you would like to highlight?" some of the responses included:

- "Allows networking across both areas of specialism. Improved time management as meetings where separate run consecutively."
- "Much better understanding of 'Think Family'. Also, improved working relationships across adults and children. Better understanding of roles and responsibilities."
- "Networking is an advantage."

What was planned?

To consider the extent of join up with Leicester City Boards in relation to:

- **Procedures**
- **Training**
- **Communication and Engagement**

What action did the Board take?

The following groups are managed on a sub-regional basis:

- The Joint Leicester, Leicestershire & Rutland (LLR) LSCB Procedures & Development Subgroup - See Section 8.4 for more information.
- The Joint Leicester, Leicestershire & Rutland Safeguarding Adults Procedures & Practice Subgroup - See Section 8.5 for more information.
- Leicester, Leicestershire & Rutland Training and Development Task and Finish Group- See Section 8.6 for more information
- The Leicester, Leicestershire & Rutland Safeguarding Adults Training Effectiveness Task & Finish Group - See Section 8.7 for more information.
- Leicester, Leicestershire & Rutland Large Publication Group – this group manages the process of publishing Serious Case Reviews, Domestic Homicide Reviews and other major learning process across the sub-region.

The Communication and Engagement Subgroup continues to be Leicestershire & Rutland but communication takes place where necessary with partners in Leicester City.

The Leicester, Leicestershire & Rutland (LLR) Joint Executive meets bi-annually to ensure strategic matters are discussed and aligned across the sub-region.

What has been the impact?

The sub-regional management of the Subgroups has assisted in achieving consistency across the local authorities. The on-line procedure manuals reflect the consistency of practice between the three authorities.

The appointment of the LLR Project Development Officer for developing the strategy for LSCB training has resulted in a consistent approach to safeguarding children training across the sub region.

What developments and improvements are required in the future?

More effective communication across the sub-region is necessary to ensure consistency of approach for partner agencies who span the sub-region, and for all partners. This is particularly the case as regards setting thresholds for service provision.

More involvement of children, young people and adult service users in the work of the Safeguarding Boards is essential.

An agreed process for accessing early help and safeguarding children and young people services between the local authorities (thresholds) needs to be finalised.

Leicester, Leicestershire & Rutland Large Publication Group will manage the publication of any Serious Case Reviews, Domestic Homicide Reviews and other major learning process across the sub-region.

What was planned?

Agree process for managing Domestic Homicide Reviews (DHRs)

What action did the Board take?

The Board continued with work across the SAB & LSCB to develop working processes regarding the effective management of DHRs.

Two Domestic Homicide Reviews (DHRs) were initiated by Community Safety Partnerships and managed through the Serious Case Review Subgroups.

What has been the impact?

Two DHRs are being concurrently conducted.

What developments and improvements are required in the future?

The two Domestic Homicide Reviews (DHRs) will be published in 2013/14. Learning arising from the process will be identified and will be incorporated in a review of the procedures for DHRs after their publication. An evaluation and learning event is planned as part of the publication of each the DHRs.

8. Reports from Subgroups

8.1. Serious Case Review Subgroup

Role of the Subgroup

The Serious Case Review Subgroup is a conjoined Subgroup of the Leicestershire & Rutland Local Safeguarding Children Board and Safeguarding Adults Board.

Meetings are held monthly. LSCB and SAB Subgroups meet separately with a third section where joint LSCB and SAB issues are discussed.

There are two Chairs for these meetings who are assistant directors from Children's and Adults Social Care who chair the conjoined section on an alternate basis.

The Serious Case Review Subgroup monitors the progress of all case review processes, e.g. Serious Case Reviews (SCRs) and Significant Incident Learning Processes (SILPs).

In addition, by arrangement with the Community Safety Partnerships in Leicestershire and Rutland, Domestic Homicide Reviews (DHRs) are also managed by the group.

A Serious Case Review is required by government when a child or young person has been seriously harmed as a result of abuse, and a number of different organisations have been involved. The case must meet the criteria as set out in Chapter 8 of 'Working Together 2010'.

Adult serious case reviews are currently voluntary processes but are regularly considered by the group when a serious incident occurs.

In both cases a report is produced with recommendations for change if improvements can be made and lessons can be learnt. The final reports are published in due course and are anonymised to ensure no individual child adult or family can be identified.

What did we do?

During the year 2012/2013noSerious Case Reviews were completed by the Leicestershire and Rutland LSCB and Safeguarding Adults Board, two Domestic Homicide Reviews commenced and a Significant Incident Learning Process (SILP) was undertaken by the Safeguarding Adults Board.

The Subgroup monitors the progress of recommendations arising from Serious Case Reviews, Domestic Homicide Reviews and other review processes through Master Action Plans.

The actions are monitored at each monthly meeting to ensure progress is being made and that change is implemented within agreed timescales.

Consideration will be given to requesting that the Safeguarding Effectiveness Group (SEG) monitor the effectiveness of any changes through single or multi-agency audit. If changes are needed to Policy or Procedure these are passed to the Development and Procedure Subgroups for consideration across Leicester, Leicestershire and Rutland.

'Working Together 2013' introduces changes around the type and nature of SCRs and other learning and review processes and the proposed Social Care Bill will put Safeguarding Adults reviews on a statutory footing. The SCR subgroup set up a LLR task and finish group to develop a Learning Review Framework that will give guidance on decision making as to the type of review to be undertaken.

What has been the impact?

The Subgroup meetings continue to be well attended and contribution is effective and productive. During the year the LSCB SCR Subgroup monitored the completion of actions relating to four reviews. The SAB SCR Subgroup monitored the completion of actions relating to three reviews which were undertaken in previous years.

The learning from these reviews included:

- Streamlining the processes between the Coroners' Office and the Safeguarding Boards where Serious Case Reviews are undertaken in order to ensure bereaved families have a better understanding of both processes.
- Ensuring that the learning points from SCRs and other review processes are disseminated through multi-agency training events. This was achieved through the SCR Learning Events held in January 2013. The learning events were designed to encourage agency attendees to incorporate learning into their own development planning.
- Ensuring robust practice guidance is in place which enables Independent Reviewing Officers to assess, challenge and effectively progress the work tasks of Child Protection plans.
- The introduction of a multi-agency protocol for supporting and debriefing staff involved in cases where children have been significantly harmed or died.
- Revised arrangements for obtaining information and undertaking checks were introduced to allow other professionals to be aware of other agencies involved in a case.

What developments and improvements are required in the future?

The SCR Subgroup will ensure that learning from local and national review processes (SCR, SILP, DHR, and CDOP) is incorporated into the practice of the Boards and partner agencies to secure improved outcomes for children and adults in need of safeguarding.

The SCR Subgroup will continue to manage reviews of cases on behalf of the Boards. During the year, greater consideration was given to receiving details of individual agency reviews and considering the impact to Leicestershire and Rutland of Serious Case Reviews that had taken place elsewhere in the UK.

The Learning Review Framework will be adopted across LLR.

8.2. Safeguarding Effectiveness Group

Role of the Subgroup

The Safeguarding Effectiveness group is a joint Subgroup of both the Local Safeguarding Children Board and the Safeguarding Adults Board. The group aims to lead on the monitoring of practice across partner agencies and seeks to identify whether or not the required actions following national or local recommendations from reviews have been implemented and to assess the impact and effectiveness of such recommendations and changes.

The key areas for monitoring include:

- Effectiveness of organisations' implementation of their duties in relation to safeguarding.
- The effectiveness of recommendations from Serious Case Reviews (SCRs) and Significant Incident Learning Processes (SILPs).

- Effectiveness of Training
- The effectiveness of joint working across children's and adult's services of the whole family / think family approach, and the
- The core data set provided by the Board member organisations

The SEG met for a total of eight times throughout the year as well as a number of task and finish groups to progress the work.

What was planned?

During 2012-13 the group focused its time on: Audits, Training effectiveness, the development of the Performance scorecard and the monitoring of the Master Action Plan of serious case review outcomes.

What action did the group take?

During the year the Boards introduced and further developed the LSCB and SAB Performance Score Cards. These are a system designed to collect and report on the performance of member agencies in their work to Safeguard Children and Adults in need of Safeguarding. The performance is reported quarterly to the Safeguarding Effectiveness Group (SEG). The group Chairs then report significant issues to the Executive Group and the Safeguarding Boards.

The Safeguarding Effectiveness Group (SEG) has undertaken audits that test the effectiveness of elements of agencies safeguarding work. During the year these audits have resulted from Serious Case Reviews and other Review processes.

These have included audits looking at the provision of drugs and alcohol treatment and Child Protection Strategy Meeting Audit, Safeguarding Adults – Multi Agency Case Audit.

A Section 11 audit was also undertaken, testing the experiences and knowledge of front line staff and supervisors against the perceptions of agency performance obtained from their management in a previous Section 11 audit.

In addition, a large scale Safeguarding Audit was undertaken by the Safeguarding Adults Board. Agencies were asked to produce action plans on how they would ensure full compliance in areas where they reported they were not fully compliant.

This is being followed up in the current year by a 'reality check' audit with front line staff and supervisors.

What has been the impact?

The Boards have been assured on the effectiveness of multi-agency safeguarding arrangements across the adult and Children's arenas.

The changes brought about by implementing recommendations from local and National reviews have been audited for effectiveness and shown to be fit for purpose.

For the Section 11 audit there were replies from 100 individuals in Rutland and a geographical area of Leicestershire. This has resulted in actions to ensure that messages from reviews are embedded with school staff and that issues relating to self-harm are better understood by staff.

What developments and improvements are required in the future?

Work will continue this year to further refine the Performance Framework, using both qualitative and quantitative information, and capturing the voice of both the service user and front line practitioners.

A reference group has been established with a good cross representation of agencies across Leicestershire and Rutland. The group had agreed seven main categories of performance to monitor:

1. Prevent and identify maltreatment.
2. The child's experience of their 'journey' through the safeguarding system protects them from harm.
3. Protecting Vulnerable Adults suffering, or likely to suffer, significant harm.
4. Proactive targeting of specific participant groups for themed work or close monitoring.
5. Embedding learning across organisations and practitioners,
6. Achieving the standards required nationally,
7. Partner organisations working effectively together to ensure safeguarding.

These categories are broken down into quantifiable statements that each agency will report against, and these statements will be approved by the Reference Group by the end of June 2013.

Each member agency will then be provided with a Service Level Agreement detailing what data they are required to provide against this framework and the reporting schedule for the current financial year.

These reports will then feed into one single Safeguarding Adults and Local Safeguarding Children Board's dashboard to monitor and manage activity across Leicestershire and Rutland.

8.3. Communications and Engagement Subgroup

Role of Subgroup

The primary role of the Communications and Engagement Subgroup is:

- To promote the work of the Local Safeguarding Children Board (LSCB) and Safeguarding Adult Board (SAB) in Leicestershire and Rutland
- To ensure children, young people and adults in need of safeguarding are fully and meaningfully involved at all levels in the planning, design, implementation, monitoring and evaluation of work undertaken by the LSCB and SAB.

What was planned?

To develop and action a Communications and Engagement Strategy

What action did the Group take?

Published 'Safeguarding Matters' on a regular bi-monthly basis

Designed a new Safeguarding Adults logo

Website development

What has been the impact?

'Safeguarding Matters' has been distributed to both the adult and children's work force across the statutory, voluntary and independent sector.

Communication and engagement is a standing item on all the Board Subgroup agendas so there is no shortage of articles and themes for each edition.

What developments and improvements are required in the future?

Further develop effective communication pathways to and from the Safeguarding Boards at all levels (local, regional, voluntary, community and independent sectors and throughout all levels of partner agencies) with an Engagement Event planned for September 2013.

Revise and maintain public awareness of safeguarding being "everyone's business".

Publish 'Safeguarding Matters' on a regular bi-monthly basis with special editions as a when required.

Further website development and maintenance.

Review the processes used to deal with the media issues relating to SCRs, SILPs and on-going raising awareness.

8.4. Joint LLR LSCB Development and Procedures Subgroup

Role of the Subgroup

The Leicester, Leicestershire and Rutland (LLR) LSCB Development and Procedures Subgroup is the principal strategic group which co-ordinates and delivers the function of developing policies and procedures for safeguarding and promoting the welfare of children in Leicester, Leicestershire & Rutland.

The LLR Development and Procedures Subgroup met on three occasions throughout the year. Attendance at meetings was about 50 % with an average of 7 members from different agencies attending. Most members attended at least one meeting, with LSCB staff, Head of Service/Safeguarding and the Probation Trust attending all meetings.

Members are represented by the following agencies:

- Leicestershire Police
- Clinical Commissioning groups in the city and counties
- Leicestershire & Rutland Probation Trust
- Leicestershire Partnership Trust
- University Hospitals of Leicester Social Care services in the city and counties
- Local Safeguarding Board Business offices in the city and county

Task and Finish Groups were formed to progress a number of issues including the revision of the Multi-Agency Referral Form (MARF) and Report to Child Protection Conference Templates for agency partners and GPs; and revision of procedures such as the Appeals by Parents / Carers and Children against Child Protection Conference decisions Private Fostering, and Children Moving Across Boundaries.

The coming year will be dominated by ensuring that changes from 'Working Together 2013' are incorporated into the procedures. This will include issues such as Single Assessment, Thresholds and the Learning & Improvement Framework.

8.5. Joint LLR SAB Procedures and Practice Subgroup

Role of the Subgroup

The Safeguarding Adults Boards of Leicester City, Leicestershire and Rutland Joint Procedures and Practice Subgroup drive the development of Procedures and Practice Guidance.

Meeting bi-monthly, the group drive the development of Procedures and Practice Guidance within safeguarding by identifying, scoping and developing new initiatives in response to:

- Government publications
- New research findings
- Recommendations from Serious Case Reviews and other reviews/audits of practice
- Significant issues raised about the operation of current practice

What was planned?

- The revision and production of the Leicester, Leicestershire & Rutland procedures and practice guidance
- The revision of the Information Sharing agreement
- The development of a thresholds document
- Discussion regarding the development of a Multi-Agency Risk Assessment Tool

What action did the Group take?

Reviewed the pan East Midlands SCIE Procedures

Revised the information sharing agreement

Leicester City pilot of the Thresholds document

Reviewed a variety of risk assessment/management tools and agreed not to have one multi agency document but use the variety of tools already available

What has been the impact?

Working towards congruent processes across LLR.

What developments and improvements are required in the future?

Publish revised SAB procedures on the new website

Regular review of procedures to ensure compliance with legislation, policy and best practice.

8.6. Joint LLR LSCB Training and Development Task and Finish Group

Role of the Sub-group

In March 2011 the Leicester and Leicestershire & Rutland LSCBs confirmed their positions regarding the future delivery of safeguarding training and ratified the proposed Training Learning and Development Strategy.

The strategy requires the Leicester and Leicestershire & Rutland LSCBs to support partner agencies in the development of multi-agency training, whilst not being the responsible body for delivering the training. The Leicester and Leicestershire & Rutland LSCBs will be responsible for the effective monitoring and

evaluation of the quality, scope and effectiveness of any training provided and will each submit an annual report demonstrating assurance that the training delivered meets agreed standards for the relevant bodies.

This multi-agency group is accountable jointly to the Children's Trusts / Commissioning Board and the two Local Safeguarding Children Boards. The Group has overall responsibility for the strategic direction of Safeguarding Learning in line with the Current Training Strategy. This Group is made up of representatives of key partner agencies, who can help to commit resources to the multi-agency programme in order to meet the essential requirements.

The Group has the following responsibilities:

- Overview and support of the implementation and administration of the Leicester, Leicestershire & Rutland Training, Learning and Development Strategy (September 2011). This strategy applies to all staff who require Children's Safeguarding Learning.
- Overview and consideration of work undertaken by LLR Project Development Officer, (whose primary role is to support the implementation of the Training Strategy).

The group has a particular responsibility for supporting the delivery of the multi-agency programme:

- To consider and endorse draft strategic documents, prior to formal endorsement by Boards / Children's Trusts and Commissioning Boards.
- Astrategic overview and coordination of work undertaken by the Interagency Training Coordinator in relation to event programming, booking, administration and programme/event monitoring.
- To meet on a regular basis to oversee and review safeguarding learning, training and development across the partnership.
- To disseminate key messages about safeguarding learning, training and development.
- To support and actively implement the Quality Assurance processes, in line with any current version of Working Together.
- To support the work of the Trainers Network.

The Group also shares views, current themes and practice issues that are relevant to safeguarding learning, development and training. They make recommendations to formal LSCB Safeguarding Effectiveness groups and LSCBs in respect of actions needed to meet learning needs which cannot be wholly fulfilled by training opportunities.

What action did the Group take?

On-going liaison and work to develop and implement the Training Strategy has developed and strengthened existing relationships and allowed for new working relationships with key partners to be developed. This in turn will have supported and strengthened multi agency working by the development of the programme and priorities for safeguarding learning. Specifically this has included:

- Undertaking a priority needs analysis for the multi-agency programme and developing a process for tracking and audit purposes which will support the Quality Assurance process. This also links in with tracking how recommendations from SCRs and business plan priorities are met.
- Development of a multi-agency programme which includes a flagship course of Effective Partnership working for Level 3 staff.
- Development of the 'golden threads' (5 identified themes / areas for consideration) as key in all multi-agency training, which includes consideration of multi-agency working, listening and

responding and roles and responsibilities for all learning within all delivered training events (proportionate to roles and responsibility).

- Re-establishing the Trainers Network to offer support to all staff who deliver or have involvement with development of Safeguarding learning.
- Regular mail-outs of resources and information to staff, managers and safeguarding trainers.
- Development of Best Practice Guidance for safeguarding learning.
- Review of first year of multi-agency programme, planning and development for 2013/2014.
- On-going support and commitment to provision of Level 2 training to PVI sector.
- Quarterly evaluation reports and analysis of multi-agency training programme.
- Strengthening inter agency partnerships in relation to safeguarding learning, by regular formal meetings of the group, and contact with Project Co-ordinator and Project Officer
- Re-establishing the Trainers Network to offer support to all staff who deliver or have involvement with development of Safeguarding learning. This offers development opportunities, consistency and a forum to communicate key LSCB/Safeguarding messages.

What was the impact?

For multi-agency training, the quarterly evaluation report provides evidence that is accessible and used by the LSCB and also by partner agencies; this quarterly reporting allows for learning to be measured; but also this will provide data in relation to uptake, attendance and venues. The new infrastructure and tracking systems for the multi-agency programme will allow for contributions by partners and priorities to be tracked and measured.

For 2012-13, data is available for the multi-agency programme including the numbers of staff trained, sectors and also increase in skills, knowledge and confidence.

Evaluation indicates good take up and increase in skills, knowledge and confidence for those staff who attended the multi-agency programme. This was also evidenced by a good response and maintenance of this Knowledge, skills and confidence at the 3 month evaluation stage.

Over 600 practitioners received multi-agency learning via the programme last year. It is also acknowledged that there will be many other multi agency learning events across children and adult services which have taken place.

The primary focus of the training group is to support practitioners in the workforce to have the skills, knowledge and confidence required to undertake their roles and responsibilities in relation to safeguarding.

The continued development of this process has also allowed for partners to work to their strengths and areas of expertise and has the potential to model interagency training developed by a multi-disciplinary team, which models good practice and will enhance the learning experience.

There is now a system for audit and tracking how the SCR recommendations are met and we can review and provide this information to SEG.

The priorities are now formally lodged and approved by SEG, which means that there is synergy between the work of SEG and training officers.

This work and processes will continue to be reviewed and developed. However, we are now able to focus resources on priority areas and also adopt a broader approach of acknowledging different types of learning

– rather than just training – which can be underpinned and ensured by the use of the proposed competency framework.

On-going issues and next steps

- Development of joint adult and children's trainers network event, to promote common themes and learning for safeguarding trainers.
- Further analysis of evaluation methods, and consideration of focus groups to look at effectiveness of partnership working.
- Promotion of specific themes and areas, i.e. DV and parental mental health, to be included in multi-agency training programme, and also considered (proportionality) at all levels for the workforce.
- Planning and developing a formal process for audit and quality assurance for the next year, which should provide guidance and consistency for safeguarding learning, via a competency framework.
- The development of the Quality Assurance Framework and Competency Framework will give all partners clear guidance in terms of the expectations and scrutiny that the LSCB will determine. However there has been an approach of consultation and development work with many of the partners, in order to seek advice on the Competency Framework and look at implementation.

8.7. Joint LLR SAB Training Effectiveness Task and Finish Group

Role of the Subgroup

The Safeguarding Adults Board through the Safeguarding Effectiveness Group (SEG) has the responsibility to seek assurance as to the effectiveness of both single and multi-agency Safeguarding Adults Learning.

The aim of the Group was to produce a report for the Board on current training provision across the partnership, with a proposal to endorse partnership requirements for training linked to a revised competency framework including reporting requirements.

How we get there:

What was planned?

- To compile a questionnaire - scoping current provision and how it is delivered
- Review competency framework updating terminology, legal requirements and support managers to identify which competencies apply to their staff
- Publish the competencies and requirements on website and 'Safeguarding Matters'
- Establish reporting requirements to the SEG
- Develop the Board's framework for evaluation and effectiveness
- Make recommendations for future work e.g. audit tools.

What action did the Group take?

Before work was undertaken on the competency framework and effectiveness strategy, a survey was undertaken to give an overview of the training and learning being provided across the partnership.

The Task and Finish Group members have progressed work in the following areas:

- Surveyed Questionnaire to identify the range of training delivered
- Reviewed the Competency Framework to guide learning, evidence practice and support managers
- Developed a competency log
- Developed best practice principles in the commissioning, delivery and evaluation of learning opportunities
- Developing with the LSCB an effectiveness strategy of quality assurance

What has been the impact?

Agreement across LLR and closer links with the Safeguarding Children's Boards

What developments and improvements are required in the future?

- Analysis of survey results
- Implementation of the revised competency framework
- Support the role of training/learning commissioner in commissioning development opportunities that meet the competencies and best standards of delivery
- Support training/learning delivery through updates on legislation, policy and SCRs Ensure training is linked to Business Plan priorities SAB procedures and lessons from reviews

8.8. Child Sexual Exploitation Subgroup

Role of the Subgroup

The Child Sexual Exploitation Subgroup was established as an LLR joint operational CSE, Trafficking & Missing meeting to improve understanding of sub-regional issues and good practice to improve the safeguarding of children and young people and reduce the numbers of missing incidents.

What was planned?

Following completion of the CSE Project in March 2012, recommendations from that project, a recommendation from the Police, and the influence of a number of relevant government reports and guidance, the LSCB agreed to the formation of a Leicester, Leicestershire & Rutland (LLR) Subgroup to safeguard children in these categories, identify and manage related issues and progress solutions effectively.

What action did the Board take?

A subgroup was formed and the first bi-monthly meeting took place in August 2012. Financial support was given for a Business Analyst to assist in establishing an effective data collection process across all agencies.

What has been the impact?

Bringing together key agencies across Leicester, Leicestershire & Rutland to avoid duplication of effort and focus expertise into the activities of the subgroup. Overseeing changes to policy, procedure and joint protocols.

The Police formed a team of police officers to deal specifically with these issues and work closely with other LLR partners.

The Police led on the production of the 2012 Joint protocol 'Children and Young People who Run Away or go Missing from Home or Care' providing guidance for parents, carers and professionals. This was launched at an LLR event to 150 managers in February 2013. The Subgroup was able to react promptly to an ACPO definition change in respect of Missing persons by reviewing the above protocol with plans to re-launch it in June 2013.

Improved linking to private children's homes to ensure that they are supported to work within (LLR) protocols and networking with other authorities to ensure best practice of child placements into the area. The Subgroup produced the 'LLR CSE, Trafficking & Missing draft Strategy and Action Plan' along with a 'Subgroup Communication Strategy' and submitted articles for the new publication ''Safeguarding Matters''.

Prompt completion of the Office of the Children's Commissioner's Formal Inquiry into CSE in Gangs and Groups year 2 dataset requests.

In Leicestershire, the Safeguarding & Improvement Unit (SIU) has the operational lead and this includes: monitoring cases involving CSE, trafficking and missing; raising awareness of the issues amongst colleagues and partner agencies; offering consultation to practitioners; and developing processes and practice.

Since the roll out of the LSCB CSE procedure and practice guidance in July 2011 over 90 CSE strategy meetings have been held chaired by the SIU. Further analysis is required but this work appears to be having an impact. The evidence suggests there is now earlier identification of issues, more successful earlier disruption and offers of help, improved outcomes and improved identification of perpetrators.

The SIU also managed the Return Project, a listen and support service aimed at children going missing from home,that was piloted in NW Leicestershire. A report was produced detailing how the Project has been effective in its impact in reducing local missing episodes and recommending the endorsement of the method being rolled out more widely This is still progressing.

What developments and improvements are required in the future?

On-going work with the police, health and others partners to collect data on these issues to inform practice guidance and identify intelligence and emerging trends and to inform targeting of resources.

To continue to make recommendations to the LLR Executive about services required to address the issues and inform commissioning decisions.

To continue to review and react appropriately to National, Government and research publications and guidance in order to better safeguard children and reduce incidences exposing them to harm.

8.9. Safeguarding Children - Voluntary Community Sector (VCS) Reference Group

Role of the Subgroup

The Leicester and Leicestershire/Rutland LSCB VCS Reference Group works on behalf of the VCS, acting as a conduit for communication between the LSCBs and the VCS. The Group is proactive in engaging the involvement of the VCS in the work of the LSCBs and has identified the following responsibilities:

- To represent VCS perspectives to the LSCBs and identify VCS representatives to attend LSCB Subcommittees as appropriate.
- To seek the views of the VCS and raise awareness of the work of the LSCBs.
- To raise the awareness of the LSCBs in relation to the work of the VCS.
- To identify appropriate safeguarding resources available to the VCS.
- To create and maintain appropriate links with other VCS networks.

The Group meets bimonthly with a total of 9 different VCS groups represented with additional efforts being made to expand membership.

What was planned?

The following Outcomes have been taken from the VCS Reference Group 2012/2014Action Plan. The broader achievements of the Group have also been highlighted to further demonstrate the contribution of the Group to each priority.

Action Plan Outcome 1 – '*Agencies within the LSCB are aware of VCS services and the contribution the VCS can make to the Safeguarding Children & Young People agenda.'*

Action Plan Outcome 2 - *'Agencies within the VCS are aware of the LSCB and their responsibilities to safeguard children & young people within LSCB procedures and guidance.'*

Action Plan Outcome 3 -*'A resource library is identified, developed and maintained and made easily accessible to the VCS ensuring this includes: CSE, Domestic Abuse and Abuse through Technology.'*

Action Plan Outcome 4 - *'A monitoring framework is established to enable the Reference Group to identify increased access to safeguarding training across children and adults services..'*

Action Plan Outcome 5 - *'Increased awareness by VCS groups/organisations of the Safe Network Standards and role of the Safe Network Champion.'*

Action Plan Outcome 6 – 'The LSCB Reference Group has supported both the VCS and statutory partners within the LSCB to reflect and learn from experiences of complex cases, SCRs, 'stuck' cases and professional challenge over safeguarding issues.'

Action Plan Outcome 7 -*'The LSCB VCS Reference Group has an established membership that is representative of the sector.'*

Action Plan Outcome 8 - *'The LSCB VCS Reference Group has a clear action plan in place that is linked to the business plans of the L&R and L Boards. The action plan is regularly monitored and reviewed and is up-dated annually'.'*

Action Plan Outcome 9 - '*Review LSCB action plans to ensure alignment of Reference Group Action Plan.'*

What action did the Group take?

- Action plan developed and reviewed against LSCB Business plan and Risk Register priorities.
- An audit of current membership, attendance and identification of gaps in representation and proactive steps taken to encourage broader membership; invitations sent to Federation of Muslim organisations, PREVENT Leicester, Swanswell, New Futures, Future Minds and The Aquoon Centre.
- Providing VCS input through regular attendance at Leicestershire/Rutland and Leicester LSCB's Executives, Communications and Engagement and other relevant sub-groups.

- Reporting on activities and key achievements to LSCB Executive Groups via the LSCB Managers and Deputy Chair of the VCS CYP Reference Group; including information from Annual Workforce Data Profiles and Inter-Agency Training Evaluation Report.
- LSCB features and SCR bulletins added to CWM website (with links to VAL website). Also included in CWM e-Briefings, 'Safeguarding Matters' Newsletter and CWM Newsletters (Rutland).
- Continued development of the Safe Network Champion, supporting the VCS (Rutland). Raising awareness of Safe Network Standards and promoting the use of 'Safe Network' training.
- Learning from SCRs and SILPs disseminated via CWM to the Group members and passed onto the wider VCS as well as own organisations. Learning also detailed on CWM website (accessible to all) and shared via the e-briefings (Rutland).
- Identification and collation and review of relevant and new resources, creating online links on the CWM website and to other websites.
- Support and promotion of safeguarding training programmes through CWM website, newsletters and e-bulletins.
- Production of a Disclosure & Barring Service Leaflet.
- Discussions with the Board Office relating to the sharing of information between with the Safeguarding Adults Board in respect of work with the VCS and the possibility of setting up a Safeguarding Adults VCS.
- Promotion of CYP Safeguarding Agenda to groups working with adults.
- Presentations to the group to raise awareness of safeguarding issues in Madrassas, Disclosure and Barring Service – presentation delivered by Safe Network and PREVENT .

What has been the impact?

Where possible, the Group has taken proactive steps to develop awareness of the need to consider the role of the VCS within Adults Safeguarding; whilst recognising the need to promote children's safeguarding as part of the Adult's agenda. As the steps taken have largely been in the form of broader discussions, advice and support, it is premature to assume that the actions of the Group have had a direct impact on the improving the effectiveness of the SAB. However, the Group feels confident that a contribution has been made in respect of raising awareness of the role of the VCS and broader safeguarding considerations for professionals working with adults.

The work demonstrates that the VCS Reference Group is working towards the following areas of improvement:

- Improving information sharing and awareness in relation to the needs and contribution of the VCS.
- Increasing VCS access to up to date information relating to latest LSCB developments.
- The Action Plan helps to guide the work of the Group and ensures a proactive approach is taken in supporting both LSCBs and the VCS.

- Actively promoting the sharing of key safeguarding information to the sector, raising awareness by using effective communication methods managed by the CWD Project Team
- The availability of free resources is also communicated on a regular basis and key messages are cascaded through training sessions.
- Broadening membership of the Group enables sharing information more widely.

What developments and improvements are required in the future?

By raising awareness of local VCS services, supporting learning from safeguarding issues and aiming to establish a membership that is representative of the sector, the Group is working towards the following areas of improvement:

- Improving VCS awareness of the Safe Network and supporting VCS groups to establish robust auditing and standards for Safeguarding.
- Increasing VCS awareness of learning from key safeguarding issues.
- Improving VCS representation on the Group.
- Supporting the LSCB to review risks in line with the VCS and to use broader techniques.
- To identify resources to deliver key training.
- To undertake a snapshot survey of the sector to identify improved learning through SCRs.

8.10. Leicester, Leicestershire & Rutland Children's Executive

Role of the Subgroup

The Leicestershire and Rutland Executive group of the LSCB and the Leicester City LSCB executive group meet jointly twice a year.

During the year the group have discussed the following issues:

The CDOP annual report, LLR Procedures & Development Group work, the Signs Of Safety Approach, Safeguarding Training Arrangements, the new Working Together Performance Framework and Managing Individual Cases. The group also share/update on the Serious Case Reviews the two Boards are working on at thetime (if any).

Other topics of discussion have included updates on CSE across LLR, and the Domestic Violence Risk Assessment Tools used across LLR.

Outcomes from the discussion are fed into the Individual Executive Groups and/or Subgroups for discussion and development.

8.11. Child Death Overview Panel

The duties undertaken by the Leicester, Leicestershire and Rutland (LLR) Child Death Overview Panel are as outlined in chapter 5 of 'Working Together to Safeguarding Children (2013)'. The child death overview process has been established within LLR since February 2009. 'Working Together to Safeguarding Children (2006)' outlined the duties of the Local Safeguarding Children Board (LSCB) to undertake a review of any child death resident within its area. 'Working Together to Safeguarding Children (2013)' re-emphasized the need to ensure a process is in place to undertake this work. Leicestershire Partnership Trust is commissioned to provide and co-ordinate the CDOP process and undertake scene visits for unexpected child deaths.

The remit of the child death overview process is to co-ordinate a systematic review into the death of any child between 0 and 18 years of age (the review does not include stillbirth notifications).

All notifications are received by the Child Death Review Manager who co-ordinates the initial response. Within LLR there is a team of 7 Named Nurses who contribute to rotational cover to undertake a home visit for unexpected deaths. As part of the visit the nurses will discuss the CDOP process with the family and provide them with an opportunity to raise questions they may wish the panel to answer. The nurses will also provide initial information about sources of support the family may wish to access. The nurses are then invited to attend the case discussions that are held prior to the case being presented to the CDOP panel. The nurses provide cover during office hours (9am – 5pm) Monday to Friday (excluding bank holidays).

The CDOP Panel meets 6 weekly and comprises representation from:

- Leicestershire Constabulary Child Abuse Investigation Unit
- Leicester City Council Education and Children's Services Department
- Leicestershire Children and Young Peoples Services
- Rutland Children and Young Peoples Services
- Leicestershire Partnership Trust
- University Hospitals of Leicester NHS Trust
- Community Paediatricians
- Designated Paediatrician
- Designated Nurse for Safeguarding
- Public Health
- Lay Member LSCB
- Chair

During 2012/2013 the panel met on 8 occasions and completed reviews on 53 cases. Data submitted to the Department for Education showed that in the review of cases undertaken and the learning identified LLR CDOP are comparable with other CDOP nationally (the latest statistical release is available on the Department for Educations website).

The highest number of notifications still remains those under 1 year of age.

In order to ensure lessons identified within the panel review are disseminated, in addition to panel members ensuring the learning is taken back to their relevant organisations, the Child Death Review Manager attends a number of key meetings including the Stay Safe Development Group, the respective SCR Sub Committees, the Suicide Audit Prevention Group, the Perinatal Mortality Review Meeting and the Infant Mortality Steering Group.

During 2012/2013:

- Work has been progressed on establishing a shared process with the LSCB (through the training officer) to ensure learning is captured and disseminated
- Multi agency training has been undertaken to provide an update on the process and share learning

- Guidelines regarding thermoregulation management have been reviewed following case review
- Work is still on-going with local organisations regarding 'cardiac death in the young'

  a conference is being hosted in November at which CDOP will be making a presentation
- The panel received an update on learning from SCRs and SILPs that have been undertaken in order to identify any links/learning with current CDOP cases

A number of cases have also helped to set the priorities for 2013/2014, which include:

- Working with partners to strengthen the process for ensuring families are offered appropriate bereavement support
- LLR CDOP would also like to host a regional forum in 2014 to try and establish links for sharing learning on a regional perspective
- Establishing stronger links with the CCGs

The LLR CDOP annual report will be submitted to the LSCB in November and will provide a more detailed account of the activity of CDOP and the priorities identified.

9. Performance Overview

9.1. Safeguarding Children - Leicestershire

Leicestershire Children and Young People's Service- Contact, Referral and Assessment 2012/2013

There were 14,741 contacts recorded between April 2012 and March 2013, an increase of approximately 1% compared to the previous year, with the number of referrals recorded in the period reducing by 3% to 6,165.

The percentage of referrals going on to initial assessment (NI 68) was 84.5% in 2012/13, an increase from 71.6% reported for 2011/12. This indicator is defined as the total number of initial assessments completed as a percentage of the total number of referrals completed; referrals and assessments may not necessarily relate to the same case.

The percentage of initial assessments carried out within 10 working days (NI 59) between April 2012 and March 2013 was 57.2% compared to 48.8% in 2011/12.

The percentage of initial assessments escalated to core assessments in 2012/13 was 43.1% for the year. The percentage of core assessments completed within 35 working days (NI 60) was 79.5% compared to 70.4% in 2011/12.

There were 1,201 section 47 enquiries recorded in 2012/13, with 662 children considered at an initial child protection conference in the year. This compares to 1,242 section 47 enquiries and 804 children considered at initial child protection conferences in 2011/12.

Child Protection

There were 393 current child protection(CP) plans at 31st March 2013 which is a decrease of 25% compared to 524 plans current at 31st March 2012.

The majority of CP plans at the end of March 2013 continue to be recorded with multiple categories of abuse. The combined category with the highest number of plans was emotional abuse/physical abuse which represented 25% of all plans. The most common category of abuse either alone or combined with others was emotional abuse which is included in 62% of plans.

All 297 children with CP plans for 3 months or more at 31st March 2013 (100%) had been reviewed within timescales (NI 67), compared to 97.8% at 31st March 2012.

Of the 536 CP plans that commenced between April 2012 and March 2013, 63 (11.8%) concerned children that had previously been subject to a CP plan or registration (NI 65). This compares to 14.0% for 2011/12.

Of the 667 CP plans that ended between April 2012 and March 2013, 31 (4.6%) had been at least 2 years in duration (NI 64). This compares to 3.7% for 2011/12.

Of children with a child protection plan at 31st March 2013, the largest age group was age 0 to 4, representing 42% of all children with CP plans, followed by age 5 to 9 at 28% and age 10 to 15 at 23%. 48% of children with CP plans at the end of March 2013 were male, with 47% female and 5% unborn.

Of the children with a child protection plan at 31st March 2013, 55 (14%) were from minority ethnic groups compared to 8% of the Leicestershire population age 0-17 recorded in the 2001 Census.

Children in Care

There were 435 children recorded on Frameworki (the Leicestershire case management system) as in care on 31st March 2013 which is an increase of 61 (16%) compared to 373 at 31st March 2012.

Of the children in care at 31st March 2013, 61 (14.0%) were from minority ethnic groups compared to 8% of the Leicestershire population age 0-17 recorded in the 2001 Census.

The largest age group of children in care at 31st March 2013 was age 0 to 4 (31.0%) although only slightly higher than the group aged 10 to 15 which represents 30.8% of the total care population. 19.5% were age 5 to 9 and 18.6% were aged 16 and over.

Of the 435 children in care at 31st March 2013, 25 (5.7%) had experienced 3 or more placements during the previous 12 months (NI 62). This compares to 8.3% reported for 2011/12.

Of the 110 children and young people in care aged under 16 who had been in care for at least 2.5 years at the end of March 2013, 72 (65.5%) had been in the same placement for at least 2 years (NI 63). This compares to 62.5% reported for 2011/12.

Figure 1: Leicestershire County Council - Contact, Referral & Assessment Information

Leicestershire - Contact, Referral and Assessment Information					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Number of contacts to Children's Social Care (include referrals)	3819	3827	3491	3604	**14741**
Number of referrals to Children's Social Care	1723	1352	1588	1502	**6165**
Number/Percentage of referrals going onto Initial Assessment	1462	1204	1205	1337	**5208**
	84.9%	89.1%	75.9%	89.0%	84.5%
Percentage of Initial Assessment carried out within 10 working days	914	734	650	679	**2977**
	62.5%	61.0%	53.9%	50.8%	57.2%
Number of Initial Assessments escalated to Core Assessments	557	560	538	592	**2247**
	38.1%	46.5%	44.6%	44.3%	43.1%
Number of Core Assessments carried out within 35 working days	469	415	424	479	**1787**
	84.2%	74.1%	78.8%	80.9%	79.5%
Number of strategy discussion meetings	350	332	344	357	**1383**
Number of S47 enquiries	327	296	283	295	**1201**
LADO referrals	113	68	55	73	**309**

9.2. Safeguarding Children - Rutland

The number of contacts recorded between April and March 2013 was 631. This is a 21% (523) increase on the previous year. 63% (378) went onto referral, compared to 60% (327) in 2011/12.

The percentage of referrals going on to initial assessment (NI 68) was 71% as at the end March 2013, compared to 78% the previous year.

The percentage of initial assessments carried out within 10 working days (NI 59) between April 2012 and March 2013 is 96.3% compared to 80.4% for the same period in 2011/12.

The percentage of initial assessments that progressed to a core assessment was 15% between April 2012 and March 2013, compared to 36% the previous year. The percentage of core assessments completed within 35 working days (NI 60) was 96.3% at the end of the year. This was a significant improvement on the previous year at 57%.

The numbers of section 47 enquiries recorded was 86; this is a 31% (125) decrease on the previous year.

Child Protection

There were 23 current child protection plans at 31st March compared to 15 the previous year. This is an increase of 53%. The largest category of abuse for CP plans at the end of March 2013 was neglect, which represented 56.5% of all plans. Of the children with a CP plan for 3 months or more at 31st Mar 2013, all been reviewed within timescales (NI 67).

Of the 24 CP plans that ended during the year, none had been at least 2 years in duration (NI 64 – 0%). Performance for the previous year was also 0%.

Of children with a child protection plan at 31st Mar 2013 95.7% were White British compared to 80% the previous year. 57% of children with CP plans at the end of March 2013 were male, with 39% female and 4% unborn.

Children in Care

There were 31 children in care on 31st Mar 2012. This was a similar trend to that of 2011/12 with 29.

Of the children in care at 31st Mar 2013, 3 (10%) were from minority ethnic groups compared to 5.7% of the Rutland population recorded in the 2011 Census. (This % includes all ethnic groups other than White British)

The largest age group of children in care at March 2013 was age 5 to 9 which represents 29% of the total care population, with 25% aged 0 to 4, 23% age 16 and over and 3% age 10 to 15.

Of the 31 in care at 31st Mar 2013, 1 young person (3.2%) had experienced 3 or more placements (NI 62). This compares to 3.4% reported for 2011/12.

Of the children in care for at least four weeks at 31st Mar 2013, all (100%) had received statutory reviews within timescale (NI 66). Performance for the year before was also 100%.

64.3% of the children looked after at 31st March 2013 for 2.5 years or more had remained in the same placement for at least 2 years (NI63). This was an increase on the year before with 46.7%.

Figure 2: Rutland Peoples Service- Contact, Referral and Assessment & LADO

Rutland Peoples Service- Contact, Referral and Assessment & LADO					
Rutland	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Number of contacts to Children's Social Care (include referrals)	156	180	143	152	**631**
Number of referrals to Children's Social Care	86	107	83	102	**378**
Number of Referrals including domestic abuse incidents	9	11	7	9	**36**
Number of referrals made by EDT/Out of Hours Team	4	2	6	1	**13**
Number/Percentage of referrals going onto Initial Assessment	65	57	59	80	**261**
	75.6%	31.7%	71.1%	78.4%	**64.2%**
Number/Percentage of Initial Assessment carried out within 10 working days	62	57	55	77	**251**
	95.4%	100.0%	93.2%	96.3%	**96.2%**
Number/Percentage of Initial Assessments escalated to Core Assessments	2	10	10	19	**41**
	2.6%	17.5%	16.9%	23.8%	**15.2%**
Number/Percentage of Core Assessments carried out within 35 working days	26	30	29	33	**118**
	100.0%	100.0%	100.0%	89.2%	**97.3%**
Number of strategy discussion meetings	37	12	9	27	**85**
Number of S47 enquiries	29	12	9	26	**76**
LADO referrals	5	2	2	6	**15**

9.3. Safeguarding Adults - Leicestershire

Safeguarding Adults - Safeguarding referrals 2012/13 from Leicestershire County Council

Total Referrals

There were a total of 1341 referrals (leading to investigation) received by the Adults and Communities Department during 1/4/2012 and 31/3/2013. Compared to 2011/12 this is a 28% increase.

Total referrals have steadily increased quarter by quarter from 282 in Q1 to 424 by Q4 of 2012/13. Comparing Q4 to Q1 this is approximately a 50% increase.

Community / Residential Referrals

Of the 1341 referrals, 842 (63%) were where location of alleged abuse was in a residential or nursing care home, whilst 461 (34%) were where location of alleged abuse was in the community. There were 38 referrals (9%) where location of abuse was not recorded.

Comparing this to 2011/12, 765 referrals (73%) were where alleged abuse was in a residential or nursing home whilst 269 (26%) was where location of alleged abuse was in the community. 1% of the referrals in 2011/12 were where location of alleged abuse was not recorded.

This shows that the proportion of referrals in the community is rising. Since 2011/12, the number of community referrals has risen by 71% whilst the number of residential referrals has risen by 10%.

Outcome of Referrals

In 2012/13, 1273 referrals were completed, which represents 95% of total referrals, whilst in 2011/12 only 85% of the referrals were completed by the end of the reporting period.

Of the 1273 completed referrals, 53% were substantiated or partially substantiated. This compared to 59% in 2011/12 and 51% in 2010/11.

Of the 861 completed residential referrals, 60% were substantiated or partially substantial compared to 65% for 2011/12 and 58% for 2010/11. Of the 378 completed community referrals, 41% were substantiated or partially substantiated compared to 42% in 2011/12 and 43% in 2010/11.

General profile

Of the 1341 referrals received:

- 47% where the victim had a physical or sensory disability,
- 32% where the victim had mental health needs,
- 21% where the victim had a learning disability, and
- Less than 0.5% was where the victim had substance misuse problems.

Of the referrals received in 2012/13:

- 31% were relating to people aged 18-64,
- 8% were relating to people aged 65-74,
- 24% related to people aged 75-84,
- But the majority, 37%, related to those aged 85 or over.

Of the 1341 referrals received, the majority, 38%, related to neglect, followed by 34% relating to physical abuse.

Source of referrals for majority of referrals was residential care staff accounting for 33%, followed by 12% for other and 8% for family member.

There has been a continuing shift in the balance of community and residential referrals over the course of the past year, reversing the previous trend evident in 2011/12. There has been a steady growth in the number of community referrals in 2012/13, and at the same time it appeared for much of the year that residential referrals had peaked following rapid growth in 2011/12. However, residential referrals rose again significantly in the final quarter of 2012-13 and early indications are that this trend is continuing into the current year. The increase in the number of completed referrals is likely to relate to recording issues, due to the impact of restructuring in 2011/12. Overall, there were no significant changes overall in referral outcomes across either community or residential settings.

The most significant change in terms of referral profiles relates to the category of abuse. There has been an increase in referrals related to neglect from 31% to 38% with a corresponding decline in the referrals related to physical abuse from 43% to 34%.

Despite the efforts to improve the quality of residential care there are still increasing numbers of safeguarding referrals arising from unacceptably poor standards of care relating to issues such as nutrition, administration of medication, moving and handling and, in particular, falls.

More work is needed to understand patterns of repeat referrals from residential providers and to evaluate the effectiveness of intervention designed to improve care standards.

The work on defining thresholds for safeguarding investigations is now nearing completion and can therefore be applied to an audit of concern for welfare referrals in order to provide assurance regarding community safeguarding referrals, and to inform the wider corporate work streams relating to vulnerability.

Figure 3: Safeguarding Referrals to Leicestershire Adult Social Care

Safeguarding Adults - Referrals by Agency - Year to Date (Reporting Frequency – Quarterly)					
	Q1	**Q2**	**Q3**	**Q4**	**Full Year**
Number of Referrals					
	279	262	326	424	**1341**
Outcome					
Substantiated	118	50	64	149	**538**
Partly Substantiated	22	8	7	37	**136**
Not Substantiated	44	31	72	117	**347**
Not Determined/ Inconclusive	39	30	15	65	**252**
Primary Client Type					
Phys. Disability / Frailty / Sensory Imp.	120	108	162	215	**635**
Mental Health Needs	83	92	97	137	**424**
Learning Disability	76	60	66	70	**277**
Substance Misuse	0	2	1	2	**5**
Other Vulnerable People	0	0	0	0	**0**
Primary Age Group					
18-64	106	94	98	108	**423**
65-74	15	19	29	37	**106**
75-84	52	53	83	118	**318**
85 +	106	96	116	161	**494**

Safeguarding Adults - Referrals by Agency - Year to Date (Reporting Frequency – Quarterly)					
	Q1	**Q2**	**Q3**	**Q4**	**Full Year**
Type of abuse					
Physical	125	93	114	132	**484**
Sexual	14	15	27	17	**73**
Emotional / Psychological	18	29	24	33	**115**
Financial	33	41	37	45	**170**
Neglect	90	95	130	200	**539**
Discriminatory	2	1	0	2	**6**
Institutional	11	12	2	11	**36**
Not Known	3	6	5	1	**3**
Source of Referral					
Primary Health Care	22	34	47	49	**163**
Secondary Health Care	7	13	13	17	**49**
Adult Mental Health Setting	1	2	7	4	**15**
Residential	132	77	73	145	**443**
Day Care	3	5	4	6	**18**
Social Worker/Care Manager	19	24	24	29	**107**
Self-Directed Care Staff	4	0	0	0	**4**
Domiciliary	7	7	12	27	**57**
Other Care Workers	8	13	21	25	**71**
Self	3	4	7	5	**24**
Family Member	24	31	32	20	**110**
Other Service User	0	0	2	1	**3**
Friend/Neighbour	2	1	3	7	**14**
Care Quality Commission	9	5	7	9	**30**
Housing	3	5	1	11	**21**
Education	3	0	14	1	**18**
Police	3	7	5	10	**28**
Other	22	28	44	56	**164**
Not Known	7	6	10	2	**2**
Protection Plans					
Adult Protection Plans accepted	120 (92)	54 (34)	83 (56)	164 (121)	**596 (423)**
Adult Protection Plans not accepted	79 (33)	51 (19)	70 (13)	181 (50)	**578 (197)**
Could not consent	24 (15)	14 (5)	5 (2)	23 (15)	**99 (54)**
Repeat Referrals					
No of Repeat Referrals	53	17	50	54	**261**

9.4. Safeguarding Adults - Rutland

This report contains information for 2012/13. Information in respect of 2011/2012 was not collected in a format that would be suitable to compare year on year trends.

Total Referrals

There were a total of 59 referrals (leading to investigation) received by the Adults Team during April 2012 and March 2013.

Community / Residential Referrals

Of the 59 referrals, 29 (49%) were where location of alleged abuse was in a residential or nursing care home, whilst 30 (51%) were where location of alleged abuse was in the community.

Outcome of Referrals

Of the 59 completed referrals, 54% were substantiated or partially substantiated.

General profile

Client type breakdown of referrals:

- 31% where the victim had a physical or sensory disability,
- 10% where the victim had mental health needs,
- 14% where the victim had a learning disability, and
- 41% none recorded

Age breakdown of referrals:

- 31% related to people aged 18-64,
- 0% related to people aged 65-74,
- 20% related to people aged 75-84,
- but the majority, 44%, related to those aged 85 or over.

Of the 59 referrals received, the majority, 37% ,related to neglect, followed by 19% relating to physical abuse.

The Source of referrals for the majority of referrals (where recorded) was residential care staff and Social Care Staff which accounted for 36%.

There is a drive to improve the number of not known and not recorded entries (Primary Client Type and Source of Referral) through training, procedure development and the location of a qualified Social Worker on the Duty Team.

Not all the referrals required a Protection Plan. Where there is more than 1 similar referral in a residential home a Protection Plan can be produced for the residential home rather than the individual.

In over half of the total number of closed cases the allegation was substantiated at least in part. In 19 cases the allegation was unsubstantiated and 5 cases were inconclusive.

People with physical disabilities/sensory impairment/ frailty continue to be the client group most prevalent in safeguarding investigations, reflecting the fact that this is the largest client group within adult services. 6 had mental health issues and 8 were people with learning disabilities. In keeping with the statistics from Q3 the most prevalent form of abuse in Q4 was neglect.

Figure 4: Safeguarding Adults - Referrals 2012-13 to Rutland County Council

Safeguarding Adults - Referrals by Agency - Year to Date (Reporting Frequency – Quarterly)					
	Q1	**Q2**	**Q3**	**Q4**	**Full Year**
Number of Referrals					
	40	21	52	59	**172**
Referral by type					
Community	8	10	9	3	
Residential	10	11	4	4	
Unknown	0	0	0	0	
Outcome					
Substantiated	1	11	26	24	**62**
Partly Substantiated	0	0	6	8	**14**
Not Substantiated	2	3	7	19	**31**
Not Determined/ Inconclusive	0	0	4	5	**9**
Primary Client Type					
Phys. Disability / Frailty / Sensory Imp.	2	7	18	18	**45**
Mental Health Needs	1	1	6	6	**14**
Learning Disability	0	6	8	8	**22**
Substance Misuse	0	0	0	0	**0**
Other Vulnerable People	0	0	0	0	**0**
Primary Age Group					
18-64	2	9	13	18	**42**
65-74	0	0	0	0	**0**
75-84	0	1	4	12	**17**
85 +	1	4	15	26	**46**
Type of abuse					
Physical	1	6	9	11	**27**
Sexual	0	1	3	3	**7**
Emotional / Psychological	0	3	9	9	**21**
Financial	0	8	11	14	**33**
Neglect	2	6	17	22	**47**
Discriminatory	0	0	1	1	**2**
Institutional	0	4	7	8	**19**
Not Known	0	0	0	0	**0**
Source of Referral					
Primary Health Care	0	0	0		
Secondary Health Care	0	0	0		
Adult Mental Health Setting	0	0	0		
Residential	0	5	10		
Day Care	0	0	0		

Safeguarding Adults - Referrals by Agency - Year to Date (Reporting Frequency – Quarterly)					
	Q1	**Q2**	**Q3**	**Q4**	**Full Year**
Social Worker/Care Manager	1	3	9		
Self-Directed Care Staff	0	0	0		
Domiciliary	0	0	0		
Other Care Workers	0	0	0		
Self	0	0	0	0	
Family Member	0	1	2	4	
Other Service User	0	0	0	0	
Friend/Neighbour	0	0	0	0	
Care Quality Commission	1	4	5	5	
Housing	0	0	0	0	
Education	0	0	0	0	
Police	0	0	0	0	
Other	0	0	0	0	
Not Known	1	1	6	2	
Protection Plans					
Adult Protection Plans accepted	0	6	9	10	**25**
Adult Protection Plans not accepted	3	5	8	7	**23**
Could not consent	0	3	13	12	**48**
Repeat Referrals					
No of Repeat Referrals	0	11.00%	20.00%	25.71%	

9.5. Deprivation of Liberty Safeguards 2012-2013

Background

The Deprivation of Liberty Safeguards (DoLs) is a later addition (2007) to the Mental Capacity Act (2005). It provides a legal framework for the deprivation of liberty of people who lack the capacity to consent to arrangements made for their care or treatment but who need to be deprived of liberty in their own best interests, to protect them from harm. The Safeguards apply to people over the age of 18, whose care/treatment is being delivered in a registered care homes or hospital ,and thas not been authorised already under the provision of the Mental Health Act 1983.

The purpose of the DoLs is to safeguard the rights of vulnerable adults living in care homes or who are in hospital, from arbitrary decisions being made to deprive them of their liberty and to provide a robust and transparent framework in which to challenge the authorisation of DoLs.

DoLs came into force on the 1st April 2009. Care homes and hospitals, (managing authorities) must seek authorisation from Supervisory bodies (Currently PCT and local authorities) in order to lawfully deprive a person of their liberty. Where a request for a Standard authorisation for DoLs is made, the supervisory body is responsible for arranging a number of assessments to determine whether the authorisation is to be granted. Where any assessment is negative the authorisation cannot be granted.

Partnership Agreement

The delivery for the DoLs service is currently provided under a Partnership Agreement between three local authorities in Leicester, Leicestershire and Rutland. This service is currently hosted by Leicestershire County Council; this arrangement will expire on the 31st March 2014. The local authorities take over supervisory responsibility from Health in April 2013.

Transition of PCT responsibility to Local Authority

With effect from April 1st 2013 the NHS responsibilities for DoLs will transfer to the local authorities. The basis for this transfer is set out in the DoLs Funding Transfer Fact Sheet published by the DoH on 24.9.12. This means that the local authorities become the supervisory bodies for people subject to a deprivation of liberty in NHS settings and NHS organisations only retain the role of a managing authority.

Service Delivery

Referral Rates

Since the safeguards were first introduced there has been a year-on-year increase in the number of applications for DoLs. The DoLs service has taken a proactive approach since 2009 to ensure heightened awareness and ownership of the DoLs Safeguards. The general indicator, which has been validated by the DoH, is that higher referral figures are an indicator that the legislation is understood.

Figure 5: DoL Referral Rates across Leicestershire and Rutland since 2009/10

Referral Rates across Leicestershire and Rutland since 2009/10				
Supervisory Body	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Leicestershire	213	419	463	488
Rutland	15	17	21	43
PCT - Leicestershire County and Rutland	93	96	75	73
Totals	321	532	559	604

Figure 6: DoL Referral Rates across Leicestershire and Rutland 2012 - 2013

Referral Rates across Leicestershire and Rutland 2012 - 2013					
Supervisory Body	**Q1**	**Q2**	**Q3**	**Q4**	**Total Referrals**
Leicestershire	105	120	127	136	488
Rutland	12	14	10	7	43
PCT - Leicestershire County and Rutland	15	20	14	24	73
Totals	132	154	151	167	604

Figure 7: DoL National Referral figures 2012-2013

National Referral figures 2012-2013	
Local Authority	**Referrals**
Leicestershire	**488**
Buckinghamshire	**365**
Hampshire	**289**
Essex	**259**
Leicester City	**244**
Derbyshire	**215**

In 2011/2012 Leicestershire DoLs Service received 463 (Figure 5) referrals, this amounted to the highest DoLs referral rate in the country. The next highest rates were: Buckinghamshire (261) and Derbyshire (236).This trend continues. However, there are significant increases in some areas e.g. Buckinghamshire (365) (Figure 7)

The DoH endorses this trend and views it as an indictor of heightened awareness and local ownership of the Safeguards.

The National PCT figures for 2012/13 (not shown) see considerable variance with Leicestershire and Rutland (73) compared with Mid Essex (113) Hull and North East Lincolnshire (0).

The NHS transfer is likely to mean approximately 80 combined additional sign offs per annum for Leicestershire and Rutland.

Locally, referral rates continue to rise (Figure 5 and 6). Approximately 60% of the current referrals amount to repeat referrals for persons who have been subject to a number of authorisations. It is also thought that in part, the use of short authorisations may account for the higher than average referral rate. Observations indicate that shorter authorisations may be used during first use of DoLs/Hospital cases or where there are outstanding issues that may impact on a person's Best Interests. Further work needs to be completed in the light of the number of shorter authorisations utilised by the, Assessor/Supervisory Bodies.

The DoLs service holds referrer data that evidences which care homes and hospital request DoLs assessments. Where appropriate, this information is shared with Safeguarding and Compliance teams.

During 2011/12, referral rates have decreased within hospital settings The conversion rates, (that is a referral which results in an agreement to a Standard Authorisation) in 2011-12 were 68% County, 65% City and 9.5% Rutland. These figures were highlighted recently within a BBC News article. In part, the conversion rate is accounted for by the higher than average number of renewals undertaken.

Partnership Working

The DoLs Service has been working closely with the Safeguarding, Compliance teams and Partner agencies such as the Continuing Health Care (CHC) teams in order to ensure that any themes or concerns identified by the BIA's are feedback and action taken.

Following advice from the DoH to avoid any periods of unlawful deprivation, a renewal Chaser System has been implemented and a leaflet is due to be piloted to further support the Managing Authorities in avoiding periods of unauthorised deprivation.

Training

The Leicestershire Social Care Development Group (LSCDG) commission basic MCA and DoLs training. This is aimed at Care Providers. Front line professionals can attend, although they would also need to undertake a more detailed training course to enable them to undertake complex Best Interest /MCA assessments.

Due to the potential training gap identified for practitioners, each agency has organised their own MCA training, the content of the training varies across agencies.

As identified in the recent CQC report, Mental Capacity Act and DoLs Training are central to awareness and ownership of the Safeguards by Care Homes/Hospitals and other professionals.

10. Looking Forward

The business plan for 2013/14 lays out the key improvement objectives that will underpin our work and sets out the actions that will be taken to address the priorities. There is an emphasis on ensuring that we are more explicit about the outputs, outcomes and impact that the Boards intend to achieve. We believe this will strengthen our ability to quality assure, performance monitor and risk manage the work of the Boards and their impact on safeguarding service delivery and on safeguarding outcomes for children, young people and adults.

The priorities in this Business Plan have been identified against a range of national and local drivers including:

- National policy drives to strengthen safeguarding arrangements and the roles of LSCBs and SABs including revisions to 'Working Together', a move to statutory status for Safeguarding Adults Boards and the outcomes of the Winterbourne View review
- Recommendations from regulatory inspections
- The outcomes of Serious Case Reviews (SCRs) and Serious Incident Learning Processes (SILPs) emerging from both national and local reports
- Evaluations of the impact of previous Business Plans and analysis of need in Leicestershire and Rutland
- Priorities for action emerging from Quality Assurance and Performance Management arrangements operated by both Boards
- Responses to the views of stakeholders including the outcomes of engagement activities
- Best practice reports issued by Ofsted, ADCS and ADASS

Having considered these matters, members of the Boards have identified 3 key priorities for work over the next three years. These priorities are to:

- Improve the effectiveness and impact of the Safeguarding Boards
- Secure confidence in the operational effectiveness of the Safeguarding Partner Agencies and Services through robust Quality Assurance and Performance Management of Safeguarding
- Improve the effectiveness of Communications and Engagement

The Plan will be implemented during a period of major challenge. Many agencies in the partnerships that form the two Boards are undergoing major organisational and structural changes whilst facing reductions in available resources. In addition, we are developing new strategic arrangements such as the creation of Health and Well-Being Boards and new approaches to commissioning and providing services.

Safeguarding is everyone's business. Never has it been more critical for LSCBs and SABs to show strong, robust and effective leadership in securing the safeguarding and well-being of our communities.

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