Lincolnshire Safeguarding Adults Board Annual Report 2022 - 2023

LSAB

Making safeguarding personal

Ask

Listen

Offer Choice

Work Together

Independent Chairs Introduction

As the Independent Chair of the Lincolnshire Safeguarding Adults Board (LSAB) I would like to welcome you to consider our annual report for 2022-2023.

Following the undertaking of a joint needs assessment and analysis of the Lincolnshire Annual Safeguarding Return the board with its partners agreed its Strategic Priority areas as contained within our Strategic Plan. As you will observe from the contents of this annual report it has resulted in partners progressing significant pieces of Adult Safeguarding work in line with our Strategic Priorities.

One of the most exciting developments of this year has been the establishment of our "Keeping People Safe" Prevention Strategy 2023-2026. This strategy will help guide the prevention activities of the LSAB partnership with an ambition of working collaboratively with other statutory partnerships,organisations,communities,families,carers to promote individual well-being and help keep people safe by preventing safeguarding risks escalating. The delivery of the strategy is reliant on the commitment of the whole partnership, and it is a testament to the strength of our partnership that we have senior leaders from various sectors leading work in relation to the prevention priority areas.

I would wish to place on record my gratitude to the staff members of the LSAB who work tirelessly to coordinate and support the work of the board, in meeting both its statutory requirements under the Care Act and working towards the achievement of its Strategic Priorities.

Richard Proctor

Lincolnshire Safeguarding Adults Board

Independent Chair.

Lincolnshire – Demographics

Lincolnshire is the 4th largest county in England covering an area of 5,921 sq. km. It is predominately rural, with some of its urban areas sitting within the highest levels of deprivation in the UK. These characteristics combined with a higher proportion of older residents gives us a population with proportionally higher levels of safeguarding challenges and vulnerabilities than in most other areas of the UK.

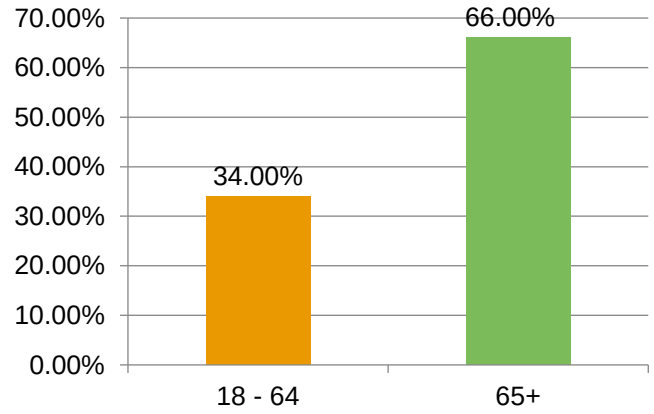
768,364
total population

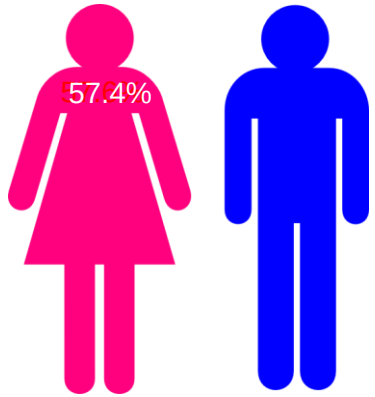
51%
Female

49%
Male

Safeguarding enquires data 2022/23

Age of adult at risk

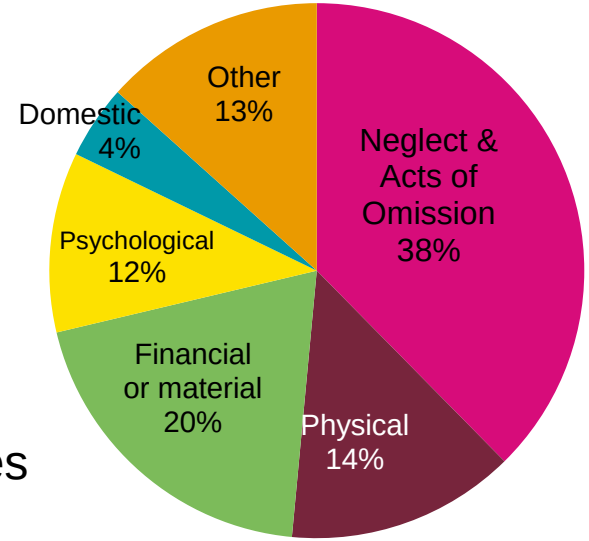




% of adult at risk by gender

Nearly 54% of all safeguarding enquiries occurred in the victims own home

Types of Abuse 2020/21



What does the Safeguarding Adults Board do?

The Lincolnshire Safeguarding Adults Board (LSAB) has a responsibility and a legal duty to ensure that Lincolnshire has effective multi-agency arrangements for safeguarding and preventing abuse for our most vulnerable adults.

The board has a statutory responsibility to have a three-year strategy that reflects identified areas of concern in Lincolnshire and to report back on its work each year in an annual report.

The board has a statutory duty to carry out reviews of cases where an adult at risk has died or sustained serious abuse or neglect and there are concerns as to how board partner agencies worked together to protect that individual ensuring that lessons are learnt, and good practice is shared to ensure a more joined up partnership approach to safeguarding.

What is adult safeguarding?

Safeguarding adults means protecting their health, wellbeing and human rights, enabling them to live in safety, free from abuse, harm or neglect.

The aims of adult safeguarding are:

- To prevent abuse, neglect and harm
- To reduce the risk of abuse and neglect
- To focus on improving life for the person in question
- To address the cause of any abuse or neglect that occurs
- To support adults in making their own choices and having control in how they live
- Safeguarding adults should be person centred and outcomes focused.
- To increase public understanding so communities can play a role in safeguarding alongside professionals
- To provide advice, information and support about how to stay safe and how to raise a safeguarding concern

Adult safeguarding seeks to protect those who:

- Have care and support needs
- Are experiencing, or are at risk of, abuse or neglect
- Are unable to protect themselves from the experience or risk of abuse or neglect due to their care and support needs

- Categories and definitions of abuse

The six principles of safeguarding adults

Empowerment	People supported and encouraged to make their own decision and informed consent.
Prevention	It's better to take action before harm occurs.
Proportionality	Aim for the least intrusive response that is appropriate to the risk presented.
Protection	Provide support and protection for those in greatest need.
Partnership	Services should work with their communities to provide local solutions.
Accountability	Practices in safeguarding adults should be accountable and transparent.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is the approach that should be taken to all safeguarding work. The key principle of MSP is to support and empower each adult to make choices and have control about how they want to live their own life. It is a shift in culture and practice in response to what is now known about what makes safeguarding more or less effective from the perspective of the adult being safeguarded.

MSP is about having conversations with people about how responses to safeguarding situations can be made in a way that enhances their involvement, choice and control as well as improving their quality of life, well-being and safety. It is about seeing people as experts in their own lives and working alongside them to identify the outcomes they want.

MSP focuses on achieving meaningful improvements to people's lives to prevent abuse and neglect occurring in the future, including ways for them to protect themselves. People are individuals with a variety of different preferences, histories, circumstances and life-styles; so safeguarding arrangements should not prescribe a process that must be followed whenever a concern is raised, but instead take a more personalised approach.

The Lincolnshire Safeguarding Adults Board makes it clear throughout our policy, procedures, business plans and priorities that the aims of MSP must be embedded throughout all the work we do.

Making Safeguarding Personal

Ask

- Understand the situation from the person's perspective and gather the facts using a strength's-based approach.
- What are their views and wishes?
- What are they worried about?
- What do they want to happen? What outcomes would the person like to achieve?
- What's working well? Discuss the person's strengths and what helps them to be safe.
- What needs to happen next?

Listen

- Listen carefully to what they are saying.
- Consider how the person usually communicates and any tools that may assist them in this.
- Give the person time and space to share what they feel is important information.
- Listen with empathy and respect and without judgement.
- Try to record what the person is saying in their own words.
- Pay attention to non-verbal communication.

Offer Choice

- Empower them to make their own choices.
- Consider the person's capacity to make relevant decisions, when they may need support with this, and who can provide this support.
- Ask who they would like to be involved?
- Be open and honest about when consent is needed and when action may be taken without consent.
- Be clear about what safeguarding is, who will be involved and what information will be shared with who.
- Be honest about what can be achieved.

Work Together

- Build and maintain a positive relationship with the person and work in partnership with them to achieve their desired outcomes.
- Ensure the enquiry is conducted at the person's pace.
- Establish how the person, or their advocate, wants to be involved and agree how this will be achieved.
- Share information with the person at every stage and check what they would like to happen next at every stage.
- As the enquiry progresses, assist the person to review risks and rethink the outcomes if required.
- Discuss and agree when the outcomes have been met as far as possible and confirm when safeguarding support will end.
- Feedback, did we meet their desired outcome?

Strategic Priorities

The Boards overarching priority for 2022-2025

Prevention and Early Intervention

The areas of work we intend to focus on over the coming years can be defined into 3 areas

- Making Safeguarding Personal
- Learning and shaping future practice
- Safeguarding Effectiveness

Enablers

These are the tools and programmes we will use to deliver the focused work

Key Updates

Throughout 2022-2023 the Board enjoyed the full support from all partner agencies, those that are statutory, Local Authority, ICB and Police and those that we welcome as partners, such as all 7 district councils, agencies from the voluntary sector, all emergency services and care provider representation.

The collaborative work undertaken by all partners is far greater than the sum of its parts, creating a very positive culture of challenge, some new and innovative service models and very strong safeguarding teams.

Some key pieces of work undertaken during 2022-2023 include:-

Prevention and Early Intervention

A focus on keeping people safe by mitigating safeguarding risks before they escalate. Priority areas for focus will include:

- Further improvement in the quality and safety of Residential and Nursing Care;
- Preventing and or limiting the impact of Pressure Sores (Across NHS and Independent sector providers);
- Tackling the Domestic Abuse of older adults (includes opportunity for joint working the other three statutory boards);
- Preventing Financial Abuse (includes opportunity for joint working with the other three strategic board);
- Safeguarding Adults with Complex Needs buy piloting phase two of the Team Around the Adult approach.

Prevention and Early Intervention

Work undertaken over throughout 2022 and into 2023 within the scope of prevention and early intervention includes:-

- **Prevention Strategy:** LSAB has updated its previous prevention strategy and developed a strategy for 2023-2026. Key areas of focus include further improvement in the quality and safety of residential and nursing care, preventing the impact of pressure sores, tackling domestic abuse of older adults, preventing financial abuse and safeguarding adults with complex needs by piloting phase two of Team Around the Adult.
- The Board is working closely with the newly formed Lincolnshire Domestic Abuse Partnership to combat elder abuse with a current key focus upon domestic abuse in older adults.

Learning and shaping future practice

To ensure that the learning from all our reviews and assurance activities is shared and embedded within partner agencies to reduce the risk of repeat incidents or causes of harm. Key areas of focus will include:

- Trailing innovative approaches to Safeguarding Adult Reviews (SAR's)
- Completing Assurance Activities to inform the continuous improvement of safeguarding practice across all partners
- Identification of themes and trends to drive training and awareness input both locally and nationally e.g. Professional curiosity, Mental Capacity
- Build on our ability to evaluate that system wide change has taken place as a result of the learning
- Supporting all stakeholders to improve the quality and impact of their safeguarding activity to improve the outcomes for adults who are abused
- Establish a constant cycle of learning and improvement at a local and national level

Safeguarding Effectiveness

Ensuring the effective operation and continuous improvement of the governance, scrutiny and business processes in place to support the board to work effectively. Key areas of focus will include:

- To develop a flexible and effective communications and engagement strategy, including a review of the LSAB Information and advice offer;
- Ensuring our Quality Assurance process is robust, identifying any challenges, sharing best practice and hearing the voice of the service user. This will incorporate the completion of the Local Assurance Framework by LSAB partners;
- Ensuring an effective risk/issues management process and the Boards policy and procedures including a review of the LSAB's risk register;
- Data collection and analysis to ensure our work is always based on evidence. This will include the development of an enhanced Assurance Dashboard for the LSAB Executive;
- Develop a service user and community engagement plan that will help us to further embed our co-production ambitions.

Safeguarding Effectiveness

- **Lincolnshire Assurance and Assessment Framework (LAAF)** A self-assessment audit in which 15 LSAB organisations completed, rating their effectiveness in a number of areas pertaining to adult safeguarding. This LAAF saw a tailored assessment for care home and domiciliary providers as well as a peer moderation element. Overall, most responses to the safeguarding standards were rated as effective.
- **Quality Assurance Programme:** LSAB plans to replace the LAAF with a quality assurance approach of peer-to peer site visits commencing in 2024.

Making Safeguarding Personal

Ensuring that all LSAB Partners can consistently evidence a Making Safeguarding Personal (MSP) approach to safeguarding practice. In particular:

- Partners can evidence that they have spoken to the person at risk prior to raising a safeguarding adult concern;
- That all partners will encourage the person at risk (or their advocate) to confirm what outcomes they wish to be achieved;
- That we will seek to achieve the outcomes expressed in a personalised way
- That partners will work together to keep people safe and prevent safeguarding risks from escalating.
- Implementation of the LSAB MSP action plan

Key Updates

Some key pieces of work undertaken during 2022-2023 include are detailed in the following pages along with updates on work areas from some of our partners:-

Trauma Informed Practice: As a result of the learning from TAA phase 2, LSAB have commenced a working group in collaboration with Lincolnshire Domestic Abuse Partnership (LDAP) and Lincolnshire Safeguarding Childrens Partnership (LSCP) to deliver a consistent approach to trauma informed practice across the partnerships.

Transitional Safeguarding: LSAB are collaborating with LSCP to develop a joint protocol on this area of safeguarding.

Policies and Guidance: During the reporting period, LSAB published its reviewed Policy and Procedures, its first Person in Position of Trust Protocol and Professional Curiosity Resource pack. LSAB continue to work on its Quality Incident Form aimed at supporting care homes and domiciliary providers.

Self-Neglect and Hoarding: LSAB's Self-Neglect Protocol is currently being reviewed, working closely with colleagues from public health on the Hoarding Protocol

Key Updates – cont'd

Team Around the Adult – Phase 2

A Task and Finish Group was established in April 2022 to progress a second phase of the TAA initiative initiated by the LSAB and Mental Health, Learning Disability and Autism Group (MHLDA). The Task and Finish Group operates under the oversight of LSAB Prevention Strategy.

The existing Team Around the Adult remains unchanged and runs alongside Phase 2. To support the Task and Finish Group to achieve its goal of developing recommendations for improvement, a Multi-Agency Audit Group (MAAG) was established comprising representatives from Lincolnshire Police, Adult Care (LPFT and LCC), Housing (District Councils or Framework Housing), LPFT, LCHS and the VCSE sector.

The Group has been meeting since July 2022 to complete an audit of activity relating to the 40 individuals who were presenting most frequently to each of the four agencies (i.e. ten each from the Police, LPFT Crisis team, District Councils and LCC Emergency Duty team).

There has been great commitment to these meetings by sharing information and actively participating in meetings, fostering open discussions, professional curiosity, and constructive challenges.

Key Updates – cont'd

The MAAG work together with the Task & Finish Group. The former focus on what the person's situation is and how they were being supported, whilst the Task & Finish Group consider these findings to help determine priorities for change, improvement, and implementation.

Following the audit, if the individual's needs have not been met, the Team Around the Adult will support with the co-ordination and development of a multi-agency support plan which aims to empower the person to maintain their safety and well-being in the long term.

As a result of the audits to date, the Task and Finish Group have identified a need for co-ordinated and multi-agency access to multi-agency Trauma informed practice Training and resources, which the LSAB has agreed to develop in Lincolnshire alongside the other statutory Boards.

Plus, feedback and learning have been shared as part of the Self-Neglect Protocol Review, including the emerging findings associated with a frequent perception of 'non-engagement' and 'individuals not being ready for support'.

The final MAAG is scheduled for Tuesday 31 October 2023, by then activity relating to 35 individuals will have been audited. The Task and Finish Group will review the findings in their entirety to consider and agree next steps and further recommendations for improvement.

Partner Updates

Safer Lincolnshire Partnership

The Safer Lincolnshire Partnership (SLP) works collaboratively with the LSAB regarding the prevention of financial abuse (adults). The activity to support delivery falls under the SLP Crime and Disorder Core Priority Group (CPG). This CPG is currently tasked to deliver activity that aims to prevent online identity theft and to raise awareness of criminal traders. The LSAB consistently provides representation at the Core Priority Group and has worked with the Crime and Disorder Coordinator, and wider partners, to create communication and engagement packages. The coordinator provided evidence of scale and impact of the communication and engagement activity to the SLP Strategy Board in September 2023. It was agreed that preventative communication and engagement activity would move to business as usual. A copy the report submitted to the SLP Strategy Board is available upon request.

NHS
Lincolnshire
Integrated Care Board

Members of the Lincolnshire Integrated Care Board (LICB) safeguarding team actively contribute to delivering the work of the partnerships throughout the year, participating in the sub-groups, core priority groups, audit, rapid reviews, child safeguarding practice reviews, safeguarding adult reviews, domestic homicide reviews and specific task and finish groups as required. The Director of Nursing and Quality and Associate Director of Nursing and Quality for LICB provide leadership for safeguarding and attend the strategic boards in this capacity.

The LICB safeguarding team works alongside agency colleagues to support best safeguarding practice within care homes that promotes safe, compassionate, and dignified care to residents. In collaboration with LinCa workforce (Lincolnshire Care Association) and LCC mental capacity team we have continued to deliver the Safeguarding Ambassador programme with a total of 360 which is an increase of 75 ambassadors from last year.

The LICB is working with other system partners to support a system tissue viability and pressure ulcer prevention programme. This will require a number of sub-group arrangements due to the volume of work in this workstream for this and the subsequent reporting year which will include national wound care capabilities, review of wound care formulary and prescribing, review of pressure relieving equipment provision and use, digital wound management systems, policies and procedures, education and training.

The team ensures that NHS provider organisations provide a comprehensive service to safeguard individuals, through the provision of informed and evidence-based advice and training and through supervision for all professional disciplines.

The ICB plays a strategic role in ensuring Making Safeguarding Personal (MSP). Although the ICB do not work directly with adults, they ensure the voice of the adult is heard within the provider health services they commission.

- *Supported the development of the new Lincolnshire Assessment and Assurance Framework (LAAF)*
- *Supporting the development of the Quality Incident Form (QiF)*
- *Maintained the progress of the Ambassador programme unique to independent care sector to promote Safeguarding and Mental Capacity Act.*
- *Improved direct communication between support and management of SG by bringing representation from the LCC SG team into the monthly registered managers network meetings*
- *Delivering an annual conference for the independent care sector.*

- *Implementing the Patient Safety Incident Response Framework (PSIRF) work for pressure ulcer detection and management including Purpose-T tool across community and inpatient unit settings*
- *Robust mandatory training on the identification of types of abuse, support and supervision in reporting and beginning to address this when identified, debrief and reflection when cases referred to and handled by adult safeguarding team.*
- *Provide support for Palliative and End of Life Care patients and families who are subject to domestic and or financial abuse through counselling and welfare and benefits services.*
- *Bi-monthly safeguarding operational meetings for all senior clinicians to discuss referrals, themes, policy, audit and SARs*
- *Completed the local assurance framework*

At the University of Lincoln, we have taken the strategic priorities of the LSAB strategic plan into consideration as part of the development of our own safeguarding practice. The approach taken by the University in relation to Safeguarding reflects the overarching priority of the LSAB of Prevention and Early Intervention. We have developed teams within our Student Services department who are specifically focussed on this priority and have recently implemented a 'Student Success and Engagement Team' whose key aim is to identify students at risk of failure of their programmes which can identify safeguarding concerns and ensure the right support is in place. We have also created a new internal Sexual and Domestic Abuse service with trained specialist who can support and safeguard students impacted. This sits alongside other initiatives such as a University Police Officer and the development of an overnight mental health worker team.

UNIVERSITY OF LINCOLN

We have redeveloped our Safeguarding policy and re-set our Safeguarding training to identify themes and trends and to ensure a whole university approach to safeguarding. We have re-aligned our Safeguarding Teams within the organisations to ensure that the right support is given at the right time in relation to safeguarding concerns and that we work closely with partners outside the organisation to support individuals appropriately. The support of the LSAB and its partners is crucial to supporting the University in terms of its safeguarding practice.

During 2022 – 2023 ULHT have continued to work in partnership with the LSAB to ensure, where possible, that Adults in Lincolnshire feel safe, secure and free from abuse and harm.

The ULHT safeguarding adults' team have continued to expand and now have specialists in post covering not just safeguarding adults but now work with Dementia, Learning Disabilities, Autism and Mental Health ensuring that all our patients receive a high quality of care which is embedded in the six principles of safeguarding adults.

With a focus on Vulnerabilities the teamwork in a preventative model, empowering patients and making sure their voice is heard and their individual needs are addressed. A principle which is steeped in the ethos of making safeguarding personal.

Over the last 12 months we have strengthened our working with our voluntary partners such as Voiceability ensuring that we develop services based on client feedback (ASK) and more recently have undertaken a filming exercise with members of Voiceability (Listen / Work Together) to promote the services that ULHT can offer and raise the priority of reasonable adjustment for all our patients with additional support needs (Offer Choice).

Our priorities over the coming 12 months continue to align to the LSAB principles including the prevention and or limiting the impact of Pressure sores and continuing to identify domestic abuse on our older adults. We are working as a system to ensure that the knowledge of our professionals is heightened when looking after patients who have a learning disability and are on a journey to ensure that all staff within the trust complete the Oliver McGowan training.

Over the coming years we look forward to continuing to work in partnership with the LSAB taking into account the strategic plan and further protecting our vulnerable adults

NHS
United Lincolnshire Hospitals
NHS Trust

As part of our preparation for the recent CQC inspection it was identified that the understanding of safeguarding legislation and principles of good practice along with an increased understanding of the purpose and function of the LSAB would be areas of interest for the commission.

As recently agreed at our Operational Managers meeting, we will be launching a programme of reflective practice sessions between November 2023 and March 2024 to raise awareness of these topics.

The content of these workshops should be familiar to colleagues who routinely offer practice guidance to practitioners and mostly consists of information relating to safeguarding legislation, the principles of MSP and the function of the Lincolnshire Safeguarding Adults Board.

We have a safeguarding committee that is represented by all departments in our charity, with a lead trustee from our board. We review all safeguarding referrals to EMAS and to our local authorities, with an action plan for any referrals which fall short of our high expectation from our clinicians.

We have now incorporated practical safeguarding training into our medical simulations, to ensure that safeguarding is considered at all times.

The safeguarding lead reviews all national safeguarding cases and keeps up to date with any local cases, for discussion at our safeguarding committee meetings to implement any lessons learned and attend all meetings when we have made a referral of a patient. We audit our system annually to ensure that no safeguarding referrals are missed, and a report is presented to our board. We routinely work with our partners to ensure that any safeguarding risks are discussed and prevented at the earliest opportunity, sharing intelligence and information where appropriate.

The LCHS team strives to prevent abuse and promote early intervention to keep service users safe. The team attends the SQR meeting, promoting the escalation of poor practice concerns and maintain good relationships with the LCC contracting team.

Lincolnshire Community Health Services NHS Trust

Information is cascaded to LCHS staff to assist with recognition of potential risk and support and enhance working in partnership to improve patient care.

LCHS safeguarding team offer oversight and challenge for pressure ulcer reviews at internal LCHS steering group, thematic reviews and provide safeguarding response to section 42 investigations.

Safeguarding themes and incidents for learning are shared across divisions at the Safeguarding & Vulnerabilities Oversight Group meetings, and quality review of incidents is optimised as each division now has access to their own safeguarding dashboard assisting quality review within service lines.

LCHS Mandatory training updates include pressure sore prevention, domestic abuse in older adults, and recognition of financial abuse. LCHS Safeguarding Champions received an update on Fraud / Scamming, to be able to cascade details of this support to colleagues in practice. Working with Team Around the Adults Multi Agency Audit Group meetings has enabled LCHS to be able to raise concerns and discuss how partnership working can support service users with complex needs.

The Safeguarding team strive to ensure all updates from local and national reviews are included in training and supervision and include themes of making safeguarding personal and professional curiosity. Audit of current practice in relation to Mental capacity assessments and DOLS applications is completed across Community Hospital Division and is planned to be completed within Community Nursing Service Users in the future.

All DASH screened by the safeguarding team for quality improvement and safety planning. The LAAF was submitted to share transparent working with the LSAB, and LCHS look forward to future close partnership work with the LSAB.

NKDC holds meetings of the Vulnerable Adults Panel (VAP) to discuss cases that are referred by NK staff or external organisations. Although the details of these cases may differ, they often involve instances of domestic abuse. The purpose of the VAPs is to bring together all relevant agencies to collaborate and determine the best course of action to support the individual or individuals involved in the referral. The NKDC VAP can evidence that the outcomes achieved were consistent with the vulnerable adult's requests. In addition to the VAP meetings, NKDC actively participates in both the DASH and MARAC meetings.

NKDC has completed the LSAB LAAF audit. Additionally, the safeguarding procedures of NKDC's contracted partners are reviewed every two years. NKDC ensures that all its staff and council members receive mandatory safeguarding training via the LCC e-learning portal.

Contractors working with NKDC are required to undergo a safeguarding review every two years. This review assesses the suitability of the company's safeguarding documents and policies. To ensure awareness of proper safeguarding practices, contractors must also send company representatives to attend an NK Safeguarding Briefing.

At NKDC, we have adopted the county-wide approach to safeguarding. This means that all our staff, members, and contractors are given the same advice through formal training sessions and awareness updates. We make it clear that any person who is at risk must be informed that the information they share will be passed on to the relevant professional services, such as our safeguarding team or the police. There is no discretion in this matter, and it is expected that staff will discuss any concerns with their line manager or the safeguarding team.

NKDC actively supports all LCC campaigns aimed at raising awareness of safeguarding issues.

Reviews & Learning – 2022-23

We said we would ensure that the learning from all our reviews and assurance activities is shared and embedded within partner agencies to reduce the risk of repeat incidents or causes of harm

Safeguarding Adults Boards (SAB) have a statutory duty to undertake Safeguarding Adults Reviews when:

"….an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult"

SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The purpose of the review is to identify learning that can be used to improve outcomes for others, it is not to find fault and apportion blame.

Reviews & Learning – 2022-23 cont'd

The Significant Incident Review Group for Adults (SIRGA) is a sub-group of the Lincolnshire Safeguarding Adults Board (LSAB) which under the Care Act 2014 is responsible for Safeguarding Adults Reviews (SARs).

SIRGA manages the process of recommending and commissioning SARs as well as assuring the LSAB that recommendations and associated actions have been addressed by the multi-agency partnership and individual agencies. Throughout 2022 and into 2023, the Board has :

- Progressed one safeguarding adult review – SAR Anthony, which is expected to complete and be published by late Autumn 2023. As the SAR has progressed, the group has worked together on all proposed recommendations, ensuring that key learning is cascaded in a timely way.
- received and considered five Significant Incident Notifications, which upon further investigation did not meet the criteria for a Safeguarding Adults Review. In two of the notifications learning identified from single agency processes was presented and discussed at a subsequent SIRGA meeting .

All published reports, executive summaries and learning bulletins can be found on the board website by following the link below.

LSAB Website

Reviews & Learning – 2022 – 23 cont'd

Ongoing SAR – Anthony

A referral was made by Lincolnshire Community Health Services NHS Trust in February 2022 following the death of a man, in his sixties in the hospital. The male was part of a family where there were complex dynamics, he was believed to have a learning difficulty, there were concerns around the conditions within his home, which he owned and around self-neglect.

The notification was discussed at the Significant Incident Review Groups meeting, where it was decided that the criteria for a SAR had been met.

Information gathering from partners has taken place and as the SAR has progressed, the group has worked together to identify emerging themes and agreed recommendations, ensuring that key learning is cascaded in a timely way throughout the review process.

The report has been written and it is expected that this will be published in the late autumn of 2023.

Ongoing SAR – Anthony. What is the learning?

The learning that emerged from this review highlighted the importance of:

- Identification and escalation of safeguarding concerns
- Professional Curiosity
- Practitioners' knowledge of executive functioning
- The multiagency response to self-neglect
- Discharge planning

There was good practice identified in relation to:

- Professional tenacity of professionals in ensuring Anthony received the care needed
- The practice of some professionals in undertaking assessments of capacity

Reviews & Learning – 2022 – 23 cont'd

What have we done?

- Learning has been taken forward through a reflective partnership event applying the learning from the review to the Self-Neglect Protocol.
- The process of the review to date has been quality assured using the Lincolnshire Safeguarding Adults Review Policy and Toolkit, which includes the SCIE quality markers.

What more will we do?

- Deliver a learning event to cascade the learning from this review and the wider body of knowledge of research and practice.
- Development of an "easy read" version of the report
- Development of a learning bulletin
- Reflect the learning from the review in the professional curiosity resource pack
- Reflect the findings of the review in the Lincolnshire Self-neglect Strategy and the Safeguarding Adults Board Strategic Plan.
- Share a range of learning materials around executive functioning

How will we know the earning has impacted practice?

- Peer review and site visits as part of the new assurance framework will provide quantitative evaluation
- Include patient stories that reflect the key areas of learning as a standing agenda item at the meetings of SIRGA to provide qualitive evaluation
- Scrutinise individual agency audit feedback

Reviews & Learning – 2022 – 23 cont'd

- **Learning from SARs – a thematic approach**
- Throughout 2020 and 2021 three notifications were submitted to SIRGA for consideration as a Safeguarding Adults Review (SAR) and two were additionally submitted to the Lincolnshire Domestic Abuse Partnership (LDAP) for consideration for a Domestic Homicide Review (DHR). Although none of the cases met the statutory criteria for a SAR or DHR similarities in cases were noted and it was agreed that a joint thematic non – statutory review would be undertaken. The joint thematic review was completed in the period 2022-2023.
- **What is the learning?**
- The learning emerging from this review highlighted the importance of:
- Raising professional awareness of the completion of DASH risk assessments when professionals fail to engage service users
- Considering whole households in assessment practice
- Consideration of how disability may impact on engagement
- Responding effectively to individuals with complex needs including those who lack executive function of capacity
- Professional curiosity

Reviews & Learning – 2022 – 23 cont'd

.**What have we done?**

- The SAB has asked each agency for evidence of how the learning has been taken forward in relation to awareness raising related to DASH risk assessment and assessment practice
- The learning through the thematic review has been developed into an action plan with agreed actions, the progress of which is monitored at each monthly meeting of SIRGA
- A learning bulletin based on the review has been developed and circulated across the partnership
- SIRGA have developed a pool of learning and development material on executive functioning
- LDAP have commissioned a "tool kit" to support practitioners when working with domestic abuse and those living with dementia/cognitive impairments which will be shared across the partnership

What more will we do?

- Develop a 7-minute briefing to promote the professional curiosity resource pack
- The complex needs section in the policies and procedures will be reviewed .

How will we know the learning has impacted practice?

- Peer review and site visits as part of the new assurance framework will provide quantitative evaluation
- Include patient stories that reflect the key areas of learning as a standing agenda item at the meetings of SIRGA to provide qualitive evaluation

Reviews & Learning – 2022 - 23 cont'd

SAR Recommendations

All safeguarding adult reviews commissioned by the LSAB come with recommendations from the independent reviewing author. These recommendations charge the LSAB and its partners with improving systems to try and prevent similar significant issues occurring in the future.

The recommendations are monitored by SIRGA through to completion and the impact on the experience of service users is assessed through the SAB assurance framework.

SARs in Rapid Time learning and development

The SARs In Rapid Time is a programme of training funded by DHSC and delivered by SCIE.

The training focuses on a model for completing Safeguarding Adult Reviews in rapid time and offers a process and tools to support SABs to produce learning of practical value to on-going improvement work. A number of SAB and SIRGA members have attended the training, and the approach is included in the upated Lincolnshire Safeguarding Adults Review Policy and Toolkit

Reviews & Learning – 2022 – 23 cont'd

SAR Quality Markers.

Safeguarding Adult Review (SAR) Quality Markers are a tool to support people involved in commissioning, conducting and quality-assuring SARs to know what good looks like. Covering the whole process, they provide a consistent and robust approach to SARs.

The Quality Markers are based on statutory requirements, established principles of effective reviews and incident investigations, as well as practice experience and ethical considerations.

The SAR Quality Markers assume the principles of Making Safeguarding Personal, as well as the Six Principles of Safeguarding that underpin all adult safeguarding work (Empowerment; Prevention; Proportionate; Protection; Partnership; Accountable). These principles therefore permeate the Quality Markers explicitly and implicitly. The Lincolnshire Safeguarding Adults Review Policy and Toolkit has been updated to reflect the revised SCIE quality markers.

Analysis of Safeguarding Adults Reviews

This report commissioned by the Care and Health Improvement Programme (CHIP) presents the findings of the first national thematic analysis of published and unpublished safeguarding adult reviews (SARs) in England since implementation of section 44, Care Act 2014.

When published in 2021, LSAB conducted a benchmark exercise against the reports proposed sector led improvement priorities. LSAB continues to use this resource to support ongoing improvement of the SAR process.

LSAB Multi-Agency Training

The LSAB multi-agency training is an effective way of bringing together professionals from different agencies to gain a better understanding of each other's roles and responsibilities for safeguarding and how this can make a positive difference to frontline practice.

The training team have continued to adopt a hybrid delivery model, which includes a mixture of face-to-face, virtual, and online learning. Feedback from practitioners and partners supports this model of delivery.

The Learning System, Enable, provides multi-agency access to all Adult and Children Safeguarding and Domestic Abuse courses. All partners continue to encourage staff and volunteers to access the training.

The Voluntary Sector Briefings continue to be delivered jointly with the Safeguarding Children Partnership and are an excellent opportunity for us to promote the training courses available to the voluntary sector.

Evaluations are collected following all training completions and provide an overview of positive feedback and suggested developments. The comments provided later, demonstrate this and are taken from across the training pathway.

Where developments are identified within evaluations, the training team work to respond accordingly, in the examples provided all courses have been updated to respond to the feedback or are in the process of being reviewed.

Staff completing training are asked to identify whether they feel that their knowledge has increased after completing the training courses offered. One example highlights that all 43 staff who completed the Quality Incident Form eLearning identified that their knowledge had improved.

LSAB Multi-Agency Training – Participants Comments

"Hearing people from professions other than my own. Discussing the case from the various viewpoints but also considering all ways that "Ben" could be helped and thinking outside the Safeguarding box - Confirmation that as a Dentist I, we, are in a position to help"

Dentist – Making Safeguarding Personal

"some of the links did not work"

"The slides were a bit slow and I wasn't sure if more information was going to appear on the page."

Domestic Abuse – Short Course

"Some of the type was difficult to read due to being faint and small font. Even when I expanded the page."

"I thought the beginning few slides were confusing. More information on notes than outlined visually"

Quality Incident Form

"Clarifying the difference between a safeguarding concern and a quality concern and the different processes and procedures in place for recording and reporting these."

Independent care Sector – Quality Incident Form

"Demonstrated the importance of keeping the person at the center of decision making."

Community Care Officer - Making Safeguarding Personal

"Talking about identifying victims of stalking and also looking and completing DASH risk assessment . I was interested to learn about escalation of risk in relation to domestic abuse- specifically- 8 stages of homicide timeline"

LCC – Adult Services – Domestic Abuse in Practice

LSAB Multi-Agency Training

The Multi-Agency training data for this period is provided here. The training uptake continues to be very popular and attendance and enrolment on e-learning courses continues to increase year on year.

Virtual Workshops	**Workshops**	**Attendees**
Making Safeguarding Personal	5	46
Recognising and Supporting Parents in Parental Conflict	11	1
Domestic Abuse Risk Indicators & Barriers *(Replaced by Domestic Abuse in Practice July 2022)*	4	15
Controlling, Coercive Behaviour & Stalking *(Replaced by Domestic Abuse in Practice July 2022)*	4	10
Face to Face	**Courses**	**Attendees**
Domestic Abuse in Practice *(Commenced October 2022)*	7	32
Child to Parent Carer Abuse	3	11
Recognising Disguised Compliance	8	8
TAC Young Carers Workshop	4	3

LSAB Multi-Agency Training

The Multi-Agency training data for this period is provided here. The training uptake continues to be very popular and attendance and enrolment on e-learning courses continues to increase year on year.

eLearning Course	Completed
Introduction to Safeguarding Everyone in Lincolnshire	1503
Domestic Abuse Awareness - Short Course	952
Tackling Exploitation and Modern Slavery in Lincolnshire	886
Friends Against Scams E-Learning	700
Zero Suicide Alliance Training	63
Introduction to Safeguarding Adults	361
Understanding Domestic Abuse	191
Mental Capacity Act - Basic Awareness	261
Domestic Abuse DASH	163
Domestic Abuse MARAC & MOP	159
Radicalisation and Extremism	327
Self Neglect	74

eLearning Course	Completed
Refresher Safeguarding Adults	106
Deprivation of Liberty Safeguards (DoLS)	194
Modern Slavery and Trafficking	137
FGM (Abuse linked to faith or belief)	157
Statutory and Mandatory Training: Mental Health, Dementia and Learning Disabilities	33
Understanding the Impacts of Hate Crime	150
TAC Young Carers Short Course	10
Domestic Abuse in Practice Prerequisite	144
Mental Health Awareness	53
Making Safeguarding Personal – Prerequisite eLearning	178
Statutory & Mandatory Training: Mental Health, Dementia & Learning Disabilities	31
Quality Incident Form	43

There have been 6870 Adult eLearning courses completed during the period 1st April 2022- 31st March 2023

LSAB's financial resource allocation and deployment for 2022 onwards are set out below.

Finance

Income

	£
LCC – ASC	45,000
Lincolnshire Clinical Commissioning Group	45,000
Lincolnshire Police & Crime Commissioner	45,000
	135,000
Expenditure	
Staff costs/fees	135,000
	135,000

Human Resources

1 x	Independent Chair *
1 x	Deputy and Chair SIRG(A) *
1 x	Business Manager
1 x	Audit and Policy Officer
1 x	Administrator
1 x	Training Officer

* Engaged under contract for employment for fixed terms as per Memorandum of Understanding (MOU)