HEALTH AND WELLBEING BOARD – WEDNESDAY, 2 OCTOBER 2013

SUPPLEMENTARY INFORMATION

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NHS England

The NHS belongs to the people

A CALL TO ACTION

Index

Foreword: NHS Call to Action

The NHS is 65 this year: a time to celebrate, but also to reflect. Every day the NHS helps people stay healthy, recover from illness and live independent and fulfilling lives. It is far more than just a public service; the NHS has come to embody values of fairness compassion and equality. The NHS is fortunate in having a budget that has been protected in recent times, but even protecting the budget will not address the financial challenges that lie ahead.

If the NHS is to survive another 65 years, it must change. We know there is too much unwarranted variation in the quality of care across the country. We know that at times the NHS fails to live up to the high expectations we have of it. We must urgently address these failures, raise performance across the board, and ensure we always deliver a safe, high quality, value-for-money service. We must place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing rather than treating illness. We also need to do far more to help those with mental illness.

There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS. Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health and care services.

This is not about unnecessary structural change; it is about finding ways of doing things differently: harnessing technology to fundamentally improve productivity; putting people in charge of their own health and care; integrating more heath and care services; and much more besides. It's about changing the physiology of the NHS, not its anatomy.

For these reasons, this new approach cannot be developed by any organisation standing alone and we are committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre, the Local Government Association, the NHS Commissioning Assembly, Health Education England, the Care Quality Commission (CQC) and NHS England want to work together alongside patients, the public and other stakeholders to improve standards, outcomes and value.

We are all committed to preserving the values that underpin the NHS and we know this new future cannot be developed from the top down. A national vision that will deliver change will be realised locally by clinical commissioning groups, Health & Wellbeing Boards and other partners working with patients and the public. That is why we are supporting a national 'Call to Action' that will engage staff, stakeholders and most importantly patients and the public in the process of designing a renewed, revitalised NHS. This is all about neighbourhoods and communities saying what they need from their NHS; it is about individuals and families saying what they want from their NHS. Above all, this is about ensuring the NHS serves current and future generations as well as it has served those in the past.

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Care Quality Commission

Alan Perkins,
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Health and Social Care Information Centre

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Chief Executive
Health Education England

Zoe Patrick,
Chair of the LGA Community Wellbeing Board
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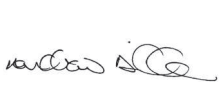

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The NHS belongs to the people: a call to action

Executive Summary

Every day the NHS saves lives and helps people stay well. It is easy to forget that only 65 years ago many people faced choosing between poverty if they fell seriously ill or forgoing care altogether. Over the decades since its inception the improvements in diagnosis and treatment that have occurred in the NHS have been nothing short of remarkable. The NHS is more than a system; it is an expression of British values of fairness, solidarity and compassion.

However, the United Kingdom still lags behind internationally in some important areas, such as cancer survival rates.[1] There is still too much unwarranted variation in care across the country, exacerbating health inequalities.[2] As the Mid-Staffordshire and Winterbourne View tragedies demonstrated, in some places the NHS is badly letting patients down and this must urgently be put right.

But improving the current system will not be enough. Future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's 65-year history.

The NHS has already implemented changes to make savings and improve productivity. The service is on track to find £20 billion of efficiency savings by 2015. But these alone are not enough to meet the challenges ahead. Without bold and transformative change to how services are delivered, a high quality yet free at

[1] Christopher Murray et al. (March 2013), "UK health performance: findings of the Global Burden of Disease Study 2010", The Lancet.

[2] For example, unwarranted variation in common procedures and in expenditure. See John Appleby et al. (2011), "Variations in health care: the good, the bad and the inexplicable", King's Fund and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".

the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.

In order to preserve the values that underpin it, the NHS must change to survive. Change does not mean top-down reorganisation. It means a reshaping of services to put patients at the centre and to better meet the health needs of the future. There are opportunities to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospitals. These include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. To do so, the NHS must harness new, transformational technology and exploit the potential of transparent data as other industries have. We must be ready and able to share these data and analyses with the public and to work together with them to design and make the changes that meet their ambitions for the NHS.

So this document is a 'Call to Action' – a call to those who own the NHS, to all who use and depend on the NHS, and to all who work for and with it. Building a common understanding of the challenges ahead will be vital in order to find sustainable solutions for the future. NHS England, working with its partners, will shortly launch a sustained programme of engagement with NHS users, staff and the public to debate the big issues and give a voice to all who care about the future of our National Health Service. This programme will be the broadest, deepest and most meaningful public discussion that we have ever undertaken.

Bold ideas are needed, but there are some options we will not consider. First, doing nothing is not an option – the NHS cannot meet future challenges without change. Second, NHS funding is unlikely to increase; it would be unrealistic to expect anything more than flat funding (adjusted for inflation) in the coming years. Third, we will not contemplate cutting or charging for core NHS services – NHS England is governed by the NHS Constitution which rightly protects the principles of a comprehensive service providing high quality healthcare, free at the point of need for everyone.

The Call to Action will not stifle the work that clinical commissioning groups and their partners have already accomplished. It is intended to complement this work and lead to five-year commissioning plans owned by each CCG. The Call to Action will also shape the national vision, identifying what NHS England should do to drive service change. This programme of engagement will provide a long-term approach to achieve goals at both levels.

The NHS belongs to all of us. This Call to Action is the opportunity for everyone who uses or works in the NHS to have their say on its future.

How is the NHS currently performing?

Quality at the core

Over recent years, the quality of NHS services has improved and, as a result, so has the nation's health. However, there is still too much unwarranted variation across the country. In England the Government measures the quality of care in five areas, collected together in the NHS Outcomes Framework. Each of these areas is discussed below.

Preventing people from dying early

As a nation we are living longer than ever before. Between 1990 and 2010, life expectancy in England increased by 4.2 years.[3] The NHS has made significant improvements in reducing premature deaths from heart and circulatory diseases but the UK is still not performing as well as other European countries for other conditions.[4]

Preventing disease in the first place would significantly reduce premature death rates. Early diagnosis and appropriate treatment of disease can also reduce premature deaths.

Around 80% of deaths from the major diseases, such as cancer, are attributable to lifestyle risk factors such as excess alcohol, smoking, lack of physical activity and poor diet.[5]

[3] Office for National Statistics (2011) http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-227587
[4] World Health Organisation (2013) http://data.euro.who.int/hfadb/
[5] World Health Organisation (2011) "Global Status Report on Non-communicable Diseases"

Enhanced quality of life for people with long-term conditions

Long-term conditions (LTC) or chronic diseases cannot currently be cured, but can be controlled or managed by medication, treatment and/or lifestyle changes. Examples of long-term conditions include high blood pressure, depression, dementia and arthritis.

Over 15 million people in England have an LTC. They make up a quarter of the population yet they use a disproportionate amount of NHS resources: 50% of all GP appointments, 70% of all hospital bed days and 70% of the total health and care spend in England.[6] People living at higher levels of deprivation are more likely to live with a debilitating condition, more likely to live with more than one condition, and for more of their lives.[7]

The NHS, working with local authorities and the new health and wellbeing boards, needs to be much better at providing a service that appropriately supports these patients' needs and helps them to manage their own conditions. Better management of their own conditions by patients themselves will mean fewer hospital visits and lower costs to the NHS overall, and more community-based care, including care delivered in people's homes

"BETTER MANAGEMENT BY PATIENTS WILL MEAN FEWER HOSPITAL VISITS & LOWER COSTS TO THE NHS OVERALL."

Helping people recover following episodes of ill health or following illness

Demand on NHS hospital resources has increased dramatically over the past 10 years: a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75.[8] A combination of factors, such as an ageing population, out-dated management of long term conditions, and poorly joined-up care between adult social care, community services and hospitals accounts for this increase in demand.

Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6% per year.[9]

New thinking about how to provide integrated services in the future is needed in order to give individuals the care and support they require in the most efficient and appropriate care settings, across health and social care, and in a safe timescale. For example, the limited availability of some hospital services at weekends has a negative impact on all five domains of the NHS Outcomes Framework: preventing people from dying prematurely; enhancing the quality of life for people with long-term conditions; helping people to recover from ill health and injury; ensuring people have a positive experience of care; and caring for people in a safe environment and protecting them from avoidable harm.

[6] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).
[7] The Marmot Review (2010), "Fair Society Healthy Lives".
[8] Royal College of Physicians (2012), "Hospitals on the edge? The time for action".
[9] Health and Social Care Information Centre
http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22Hospital+Episode+Statistics%2C+Admitted+patient+care+-+England%22&area=&size=10&sort=Relevance]

This is why the first offer in *Everyone Counts: Planning for Patients*, is to support the NHS in moving towards more routine services being available seven days a week. The National Medical Director has established a forum to identify how to improve access to more comprehensive services seven days a week which will report in the autumn of 2013.

NHS England recently announced a review of urgent and emergency services in England, which will also recommend ways to meet the objective of a seven-days-a-week service. Not only will this offer improved convenience for patients, full-week services will also improve quality and safety.

Patient experience

The UK rates highly on patient experience compared to other countries. A 2011 Commonwealth Fund study[10] of eleven leading health services reported that 88% of patients in the UK described the quality of care they had received in the last year as excellent or very good, ranking the UK as the best performing country. However, the data also show that the UK has improvements to make in the coordination of care and patient-centred care.

Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS. People from disadvantaged groups including the frail older population, some black and minority ethnic groups, younger people and vulnerable children, generally access poorer quality services and have a poorer experience of care (some also have lower life expectancies). This can be made worse by these groups having lower expectations of the experience of care and being less likely to seek redress. We must act to improve access and the quality of services for these less advantaged groups.

"EVERYONE WORKING IN THE NHS MUST STRIVE TO MAINTAIN AND IMPROVE ON THIS HIGH LEVEL OF PATIENT SATISFACTION AND EXTEND IT TO EVERYONE WHO USES THE NHS."

[10] Commonwealth Fund (2011), "International Health Policy Survey".

Patient safety

Although great improvements in patient safety have been made, the findings from the Mid-Staffordshire public inquiry set out starkly what can happen when safety is not at the heart of everything the NHS does. The NHS must work to ensure that all patients experience the safe treatment they deserve. Global healthcare expert Professor Don Berwick was recently asked by the Prime Minister to look into improving safety in the NHS and will report back with his findings later this year.

In addition to reducing harmful events, we must make it easier for staff to report incidents. In 2011, 1,325,360 patient safety incidents were reported to the National Reporting and Learning System,[12] of which 10,916 or less than 1% were serious. Despite this large number of reports we know we have not captured everything, and are working to make it easier for staff and patients to report incidents or near-misses. Learning from even largely minor incidents is important as it helps the NHS to avoid more serious incidents in the future.

Over the past 15 years, international studies have suggested that around 9 in 10 patients admitted to hospital experience safe treatment without any adverse events and our NHS is no different. But even these relatively low levels of adverse events are far too high. Of those people who do experience adverse events a third of them experienced greater disability or death.[11]

Health inequalities

Health inequalities is the term that describes the unjust differences in health, illness and life expectancy experienced by people from different groups of society. In England, as elsewhere, there is a so-called 'social gradient' in health: the more socially deprived people are, the higher their chance of premature mortality, even though this mortality is also more avoidable. People living in the poorest areas of England and Wales, will, on average, die seven years earlier than people living in the richest areas.[13] The average difference in disability-free life expectancy is even worse: fully 17 years between the richest and poorest neighbourhoods.[14] Health inequalities stem from more than differences in just income - education, geography, and gender can all play a role.

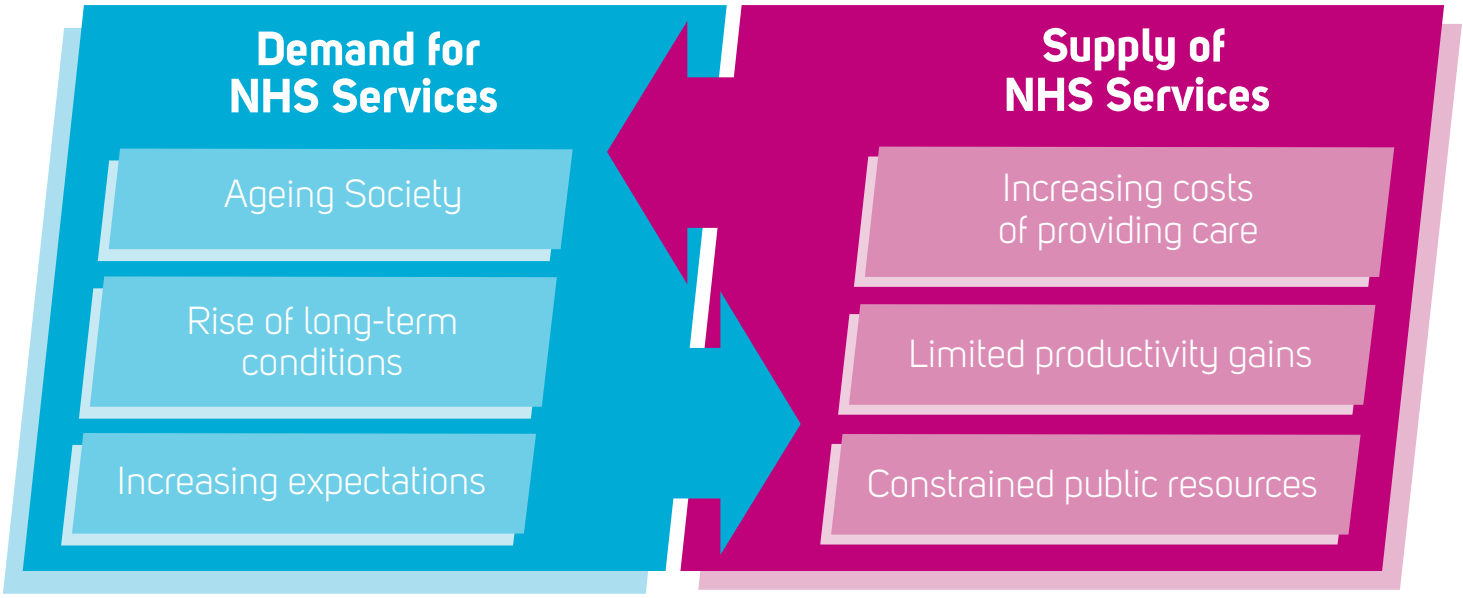
The NHS cannot address all the inequalities in health alone. Factors such as housing, income, educational attainment and access to green space are also important (the "wider social determinants of health"). In fact, it is estimated that only 15-20% of inequalities in mortality rates can be directly influenced by health interventions that prevent or reduce risk. If the NHS is to help tackle these inequalities we must work closely with Government departments, Public Health England, local authorities and other local partners to ensure the effective coordination of healthcare, social care and public health services.

[11] Charles Vincent, Graham Neale and Maria Woloshynowych (2001) "Adverse events in British hospitals: preliminary retrospective record review", British Medical Journal.
[12] National Patient Safety Agency (2012), "National Reporting and Learning System Quarterly Data Workbook" http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=135153
[13] The Marmot Review (2010), "Fair Society Healthy Lives"
[14] The Marmot Review (2010), "Fair Society Healthy Lives"

What challenges will the health and care service face in the future?

As the NHS strives to improve the quality and performance of current NHS services and to live up to the high expectations of patients and the public, we must anticipate the challenges of the future - trends that threaten the sustainability of a high-quality health service, free at the point of use. It is the potential impact of these trends that means that while a new approach is urgently needed, we must take a longer-term view when developing it.

Future pressures on the health service



Ageing society

People are living longer and while this is good news an ageing population also presents a number of serious challenges for the health and social care system:

- Nearly two-thirds of people admitted to hospital are over 65 years old.
- There are more than 2 million unplanned admissions per year for people over 65, accounting for nearly 70% of hospital emergency bed days.[15]
- When they are admitted to hospital, older people stay longer and are more likely to be readmitted.[16]
- Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older - the most intensive users of health and social care.[17]

Studies suggest that older patients account for the majority of health expenditure. One analysis found that health and care expenditure on people over 75 was 13-times greater than on the rest of the adult population.[18]

> "STUDIES SUGGEST THAT OLDER PATIENTS ACCOUNT FOR THE MAJORITY OF HEALTH EXPENDITURE."

Extra care housing: supporting older people to stay independent

Extra care housing is sometimes referred to as very sheltered housing or housing with care. It is social or private housing that has been modified to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home.

This 'retirement village' type of housing offers an alternative to traditional nursing homes, providing a range of community and care services on site. Compared with residence in institutional settings, extra care housing is associated with better quality of life and lower levels of hospitalisation, suggesting the potential for overall cost savings.[19]

[15] Candice Imison et al. (2011), "Older people and emergency bed use: exploring variation", King's Fund.
[16] Jocelyn Cornwell et al. (2012), "Continuity of care for older hospital patients: A call for action", King's Fund.
[17] Commission on Funding of Care and Support (2011), "Fairer Care Funding: The Report of the Commission on Funding of Care and Support".
[18] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[19] A Netten et al. (2011), "Improving housing with care choices for older people: an evaluation of extra care housing", Personal Social Services Research Unit.

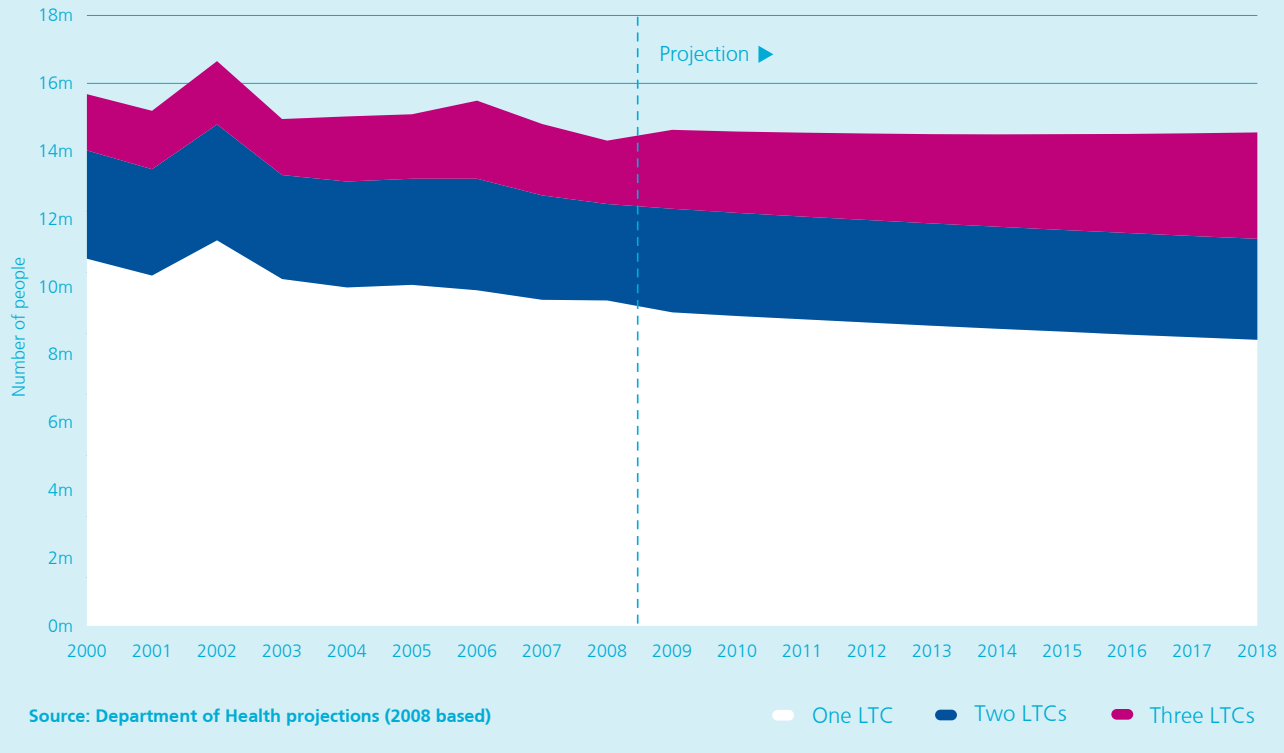
Changing burden of disease

People with one or more long-term conditions are already the most important source of demand for NHS services: the 30% who have one or more of these conditions account for £7 out of every £10 spent on health and care in England. Those with more than one long-term condition have the greatest needs and absorb more healthcare resources; for example, patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year. These multi-morbid, high-cost patients are projected to grow from 1.9 million in 2008 to 2.9 million in 2018.[20]

Patients with multiple long-term conditions must be managed differently. A hospital-centred delivery system made sense for the diseases of the 20th century, but today patients could be providing much more of their own care, facilitated by technology, and supported by a range of professionals including clinicians, dieticians, pharmacists and lifestyle coaches. They also need close coordination amongst these different professionals.

> "THE 30% WHO HAVE ONE OR MORE LONG-TERM CONDITION ACCOUNT FOR £7 OUT OF EVERY £10 SPENT ON HEALTH AND CARE IN ENGLAND"

Actual/projected numbers with one or more long-term conditions by year and number of conditions



Source: Department of Health projections (2008 based)

[20] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).

Meeting the dementia challenge: rapid diagnosis and referral

There are now 800,000 people living with dementia in the UK. By 2021, the number of sufferers is projected to exceed one million and dementia is estimated to cost the NHS, local authorities and families £23 billion a year. As the Prime Minister's 2012 Challenge on Dementia noted, diagnosis comes too late for many dementia patients and they and their families don't always get the care and support they need. This is in part because too little is known about the causes of this disease and how to prevent it, but some areas are leading the way in offering better care. In Stockport, Greater Manchester, local GPs are working with the Alzheimer's Society to increase diagnosis rates and provide post-diagnosis support. GPs have agreed a 'fast-track' referral process for suspected dementia patients that will also trigger support from Alzheimer's Society staff and volunteers. The scheme also sets out to improve the skills of clinicians to better recognise the early signs of dementia and increase early detection.[21]

Lifestyle risk factors in the young

We know that the risk of developing debilitating diseases is greatly increased by personal circumstances and unhealthy behaviours such as drinking, smoking, poor diet and lack of exercise, all of which contribute to premature mortality. If predictions are correct, and 46% of men and 40% of women are obese by 2035, the result is likely to be 550,000 additional cases of diabetes, and 400,000 additional cases of stroke and heart disease.[22] Although we understand the problem, we do not yet have enough evidence to be sure about what will facilitate sustainable weight loss and other associated behaviours. Working together with individuals, their families, employers and communities to develop effective approaches will be an extremely important task for the next generation NHS.

Rising expectations

Patients and the public rightly have high expectations for the standards of care they receive - increasingly demanding access to the latest therapies, more information and more involvement in decisions about their care.[23] If the convenience and quality of NHS services is compared to those in other sectors, many people will wonder why the NHS cannot offer more services online or enable patients to receive more information on their mobile telephones. Patients want seven-day access to primary care provided near their homes, places of work, or even their local shop or pharmacy. They also want co-ordinated health and social care services, tailored to their own needs. To provide this level of convenience and access, we need to rethink where and how services are provided.

[21] Alzheimer's Society (2012), "Dementia 2012".
[22] Y.C. Wang et al (August 2011), "Health and economic burden of the projected obesity trends in the USA and the UK," The Lancet.
[23] See for example Economist Intelligence Unit (2009), "Fixing Healthcare: The Professionals Perspective".

Increasing costs

The cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures than could ever have been envisaged at its inception. New drugs, technologies and therapies have made a major contribution to curing disease and extending the length and quality of people's lives. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable. It is of course a good thing that the NHS has more therapies at its disposal and can now diagnose and treat previously neglected illnesses. However, many healthcare innovations are more expensive than the old technologies they replace - for example, the latest cancer therapies[24] - which raises affordability questions. We must ensure that we invest in the technology and drugs that demonstrate the best value and this rigour must be extended throughout the system, evaluating not just therapies and technologies, but also different models of delivering health and care services.

Limited financial resources

The NHS is facing these challenges at the same time that the UK is experiencing the most challenging economic crisis since the 1930s and adjusting to an era of much tighter public finances. The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth.

Since it began in 1948, the share of national income that the NHS receives has more than doubled, an average rise of about 4% a year in real terms. As part of its deficit reduction programme the Government has severely constrained funding growth.

In addition, recent spending settlements for local government have not kept pace with demand for social care services. Unlike healthcare funding, social care funding is not ring-fenced; councils decide how much of their budget to spend on services based on local need. As a result, financially challenged local authorities have, in some locations, reduced spend on social care to shore up their finances. Reduced social care funding can drive up demand for health services, with cost implications for the NHS.[26] We therefore need to consider how health and care spending is best allocated in the round rather than separately in order to provide integrated services.

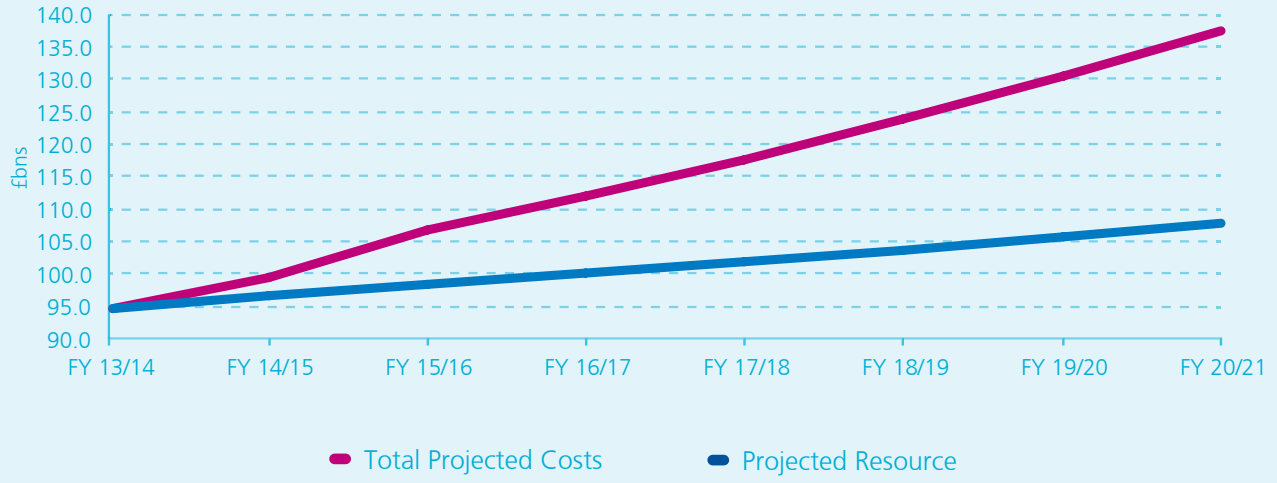
In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21). This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms.[25]

[24] Richard Sullivan et al (September 2011), "Delivering affordable cancer care in high-income countries", The Lancet Oncology.

[25] NHS England analysis.

[26] Research has found that spending on social care could generate savings in both primary and secondary healthcare and that increased social care provision is related to reductions in delayed hospital discharges and readmission rates. See Richard Humphries (2011), "Social Care Funding and the NHS: An Impending Crisis?," King's Fund and J Forder and JL Fernández (2010), "The Impact of a Tightening Fiscal Situation on Social Care for Older People", PSSRU Discussion Paper 2723, London, Kent and Manchester, Personal Social Services Research Unit.

Projected resource vs. Projected spending requirements



Source: NHS England

Limited productivity improvements

Measuring the productivity[27] of the NHS is methodologically difficult and hotly debated. The Office of National Statistics suggests that between 1995 and 2010 average productivity in the NHS grew at 0.4%, whilst in the economy as a whole it grew at a much faster rate of 2% over the same period.[28] Beneath this, NHS labour productivity levels have increased faster than equivalent rates in the wider economy by an average of 2.5% per year between 2007 and 2010.[29] This suggests that the NHS may not be using its capacity as efficiently as it could.

NHS productivity remains an unresolved debate. However, traditional productivity improvements will not be enough to plug the future funding gap. NHS England's analysis suggests that the overall efficiency challenge could be as high as 5-6% in 2015/16 compared to the current 4% required efficiency in 2013/14.[30] Improvements such as better performance management, reducing length of stay, wage freezes or better procurement practices all have a role to play in keeping health spending at affordable levels. However, these measures have been employed to deliver the so-called "Nicholson Challenge" of 4% productivity improvements each year, amounting to some £20bn in savings, and there is a limit to how much more can be achieved without damaging quality or safety. A fundamentally more productive health service is now needed, one capable of meeting modern health needs with broadly the same resources.

"THE OVERALL EFFICIENCY CHALLENGE COULD BE AS HIGH AS 5-6% IN 2015/16 COMPARED TO THE CURRENT 4% REQUIRED EFFICIENCY IN 2013/14."

[27] At its most basic productivity is the rate at which inputs (like labour, capital and supplies), are converted into outputs (like consultations or operations) and outcomes (such as good health) in order to improve quality of life.

[28] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[29] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[30] This is the challenge for the NHS after national action to constrain wages and other input costs. In recent years these have typically delivered c.1% per annum in savings which over the period modelled would equate to c.£8bn.

Seizing future opportunities

The future doesn't just pose challenges, it also presents opportunities. Technological, social and other innovations – many of which are already at work in other industries or sectors – can and should be harnessed to transform the NHS. These exciting opportunities have the potential to deliver better patient care more efficiently to achieve the transformation that is required, some of which are discussed below. These are not exhaustive and it is crucial that as a service we become better able to spot other trends and innovations with the potential to reshape health services.

A health service, not just an illness service

We must get better at preventing disease. In the future this means working increasingly closely with partners such as Public Health England, health and wellbeing boards and local authorities to identify effective ways of influencing people's behaviours and encouraging healthier lifestyles. The NHS has helped many people quit smoking (although there are still about 8m smokers in England), but has yet to develop similarly sophisticated methods for assisting people to improve their diet, take more exercise or drink less alcohol.

About 4% of the total health budget in England is spent on prevention and public health, which is above the Organisation for Economic Co-operation and Development (OECD) average,[31] but this will strike many as too little. We need to look at our health spending and how investment in prevention may be scaled up over time. It is not just about investment; partnering with Public Health England, working with health and wellbeing boards and local authorities and refocusing the NHS workforce on prevention will shape a service that is better prepared to support individuals in primary and community care settings.

[31] Department of Health (2009), "Public Health and Prevention Expenditure in England".

Giving patients greater control over their health

Developing effective preventative approaches means helping people take more control of their own health, particularly the 15 million people with long-term conditions. The evidence shows that support for self-management, personalised care planning and shared decision making are highly effective ways that the health system can give patients greater control of their health. When patients are involved in managing and deciding about their own care and treatment, they have better outcomes, are less likely to be hospitalised,[32] follow appropriate drug treatments[33] and avoid over-treatment.[34] Personalised care planning is also highly effective.[35] A major trial of Personal Health Budgets, a tool for personalised care planning, has shown improved quality of life and cost-effectiveness, particularly for higher needs patients and mental health service users.[36]

Manchester Royal Infirmary: home dialysis

Manchester Royal Infirmary has developed an innovative dialysis provision pathway, which allows patients to perform extended haemodialysis at home, rather than in hospital. This has delivered improved health and longevity, empowering patients through greater involvement, freedom and flexibility, and offers wider benefits of fewer medications and hospital visits resulting in substantial reductions in healthcare costs.[37]

Harnessing transformational technologies

The digital revolution can give patients control over their own care. Patients should have the same level of access, information and control over their healthcare matters as they do in the rest of their lives. The NHS must learn from the way online services help people to take control over other important parts of their lives, whether financial or social, such as online banking or travel services. First introduced to the UK in 1998, now more than 55% of internet users use online banking services.[38] A comparable model in health would offer online access to individual medical records, online test results and appointment booking, and email consultations with individual clinicians. Some of the best international providers already do this.[39] This approach could extend to keeping people healthy and independent through at-home monitoring, for example. These innovations would not only give patients more control, they would also make the NHS more efficient and effective in the way that it serves the public.

[32] JH Hibbard and J Green (February 2013), "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs," Health Affairs.
[33] Expert Patients Programme (2010), "Self-care reduces costs and improves health: the evidence".
[34] D Stacey et al. (May 2011), "Decision aids to help people who are facing health treatment or screening decisions", Cochrane Summaries and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".
[35] "RCGP Clinical Innovation and Research Centre (2011), "Care Planning: improving the lives of people with long term conditions".
[36] https://www.phbe.org.uk/
[37] NHS England (2013), "Catalogue of Potential Innovation".
[38] Office for National Statistics (2009), "e-society" (Social Trends 41).
[39] For example Kaiser Permanente and the Veterans Administration, both in the USA.

e-Intensive Care: a second pair of eyes

Guy's and St Thomas' NHS Foundation Trust, in London, has recently deployed a new e-Intensive Care Unit (ICU) to keep a 'second pair of eyes' on critically ill patients. Used in about 300 hospitals in the US, where studies have shown the system has reduced mortality rates and hospital stays, the eICU allows critical care specialists to remotely monitor patients using high-definition cameras, two-way audio and other instruments that keep track of vital signs. Not only does the system facilitate provision of 24/7 care, it also enables the most experienced specialists to spread their skills more widely and to help more patients with the greatest need.[40]

"THE NEW FRIENDS AND FAMILY TEST ASKS PATIENTS WHETHER THEY WOULD RECOMMEND THEIR HOSPITAL TO THEIR FRIENDS & FAMILY AND THE FIRST RESULTS WILL BE PUBLISHED ON NHS CHOICES IN JULY 2013"

Digital inclusion will have a direct impact on the health of the nation, and so innovation must be accessible to all, not just the fortunate. From April 2013, 50 existing UK online centres in local settings, such as libraries, community centres, cafes and pubs, are receiving additional funding to develop as digital health hubs where people will be able to find support to go online for the first time and use technology and information services such as NHS Choices to improve their health and wellbeing.

Exploiting the potential of transparent data

To support active patients the best quality data must be collected and made available. Dramatic improvements need to be made in the supply of timely and accurate information to citizens, clinicians and commissioners. Commissioners can use improved data to better understand how effectively money is being invested. For patients, more and better data will enable them to make informed decisions about their health and healthcare.

The new Friends and Family Test asks patients whether they would recommend their hospital wards or A&E department to their friends and family should they need similar care or treatment. Beginning in July 2013, the results will be published on the NHS Choices website. This is just one example of transparency which will for the first time allow citizens to compare NHS performance based on the opinions of the patients.

[40] Guy's and St. Thomas' NHS Foundation Trust, www.guysandstthomas.nhs.uk/news-and-events/2013-news/20130703-eICU.aspx

Moving away from a 'one-size fits all' model of care

A relatively small minority of patients accounts for a high proportion of health service utilisation and expenditure. This suggests an opportunity to manage patients, and help them manage themselves, more intelligently, based on an understanding of individual risk.

Healthcare is becoming more personal in other ways too. Recent biomedical advances suggest a revolution in medicine itself may be afoot that could enable clinicians to tailor treatment to individuals' specific characteristics. For instance, it has been proven that mutations in two genes called BRCA1 and BRCA2 significantly increase a person's risk of developing breast cancer. Individuals can now be tested for these mutations, allowing early detection and targeted use of therapeutic interventions. Similar progress is being made in understanding the biological basis of other common diseases. The health service needs to consider how to invest in this work and how it can most effectively be translated into everyday practice.

Risk-stratification in North West London

As part of the Inner North West London Integrated Care Pilot, patient information was combined across primary, secondary and social care providers to understand the impact of high-risk patients on services and expenditure. The data showed that the 20% of the population most at risk of an emergency admission to hospital accounted for 86% of hospital and 87% of social care expenditure. Yet despite this high concentration in expensive downstream services, only 36% of primary care resources were expended on these same patients.[41] This suggests that through better management of these patients in primary care many hospital admissions could be prevented and intensive social care support reduced, resulting in improved care with reduced costs.

Unlocking healthcare as a key source of future economic growth

All too often we think of health expenditure as solely a cost, but investment in individuals' wellbeing and productivity delivers vast benefits to society and the economy. Conversely, illness costs the UK economy dearly: in 2011, 131 million work days were lost due to sickness.[42] This translates into an annual economic cost estimated to be over £100bn whilst the cost to the taxpayer, including benefits, additional health costs and forgone taxes, is estimated to be over £60bn.[43]

In addition to preventing and relieving illness, the NHS has a central role in contributing to economic growth. The NHS is the largest single customer for the UK health and life sciences industries including pharmaceutical, biotechnology, medical devices and other sectors,[44] and Britain is recognised as a leader in biomedical research. We must consider how the NHS can work with industry partners to make sure that the health and life sciences continue to be a growing part of the UK economy.

[41] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[42] Office of National Statistics (2012), "Sickness absence in the labour market".
[43] Department of Health (2011), "Innovation, Health and Wealth".
[44] Department of Health (2011), "Innovation, Health and Wealth"

What's next?

This document discusses the key problems and opportunities that a renewed vision for the health service must address. In the next phase of work, we will analyse, with our key partners, the causes of these trends and challenges and share these more widely in order to begin to generate potential solutions. Some of these solutions may come from reviews that are already underway such as the Urgent and Emergency Care Review and the Berwick Review on improving safety in the NHS. Some solutions may be adapted from small-scale pilots or international models that can demonstrate success, but there is no doubt that new ideas are needed.

We cannot generate these new ideas alone. NHS England is committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, NICE, the Health and Social Care Information Centre, the Local Government Association,the steering group of the NHS Commissioning Assembly, Health Education England and the Care Quality Commission want to work in partnership with NHS England to understand the pressures that the NHS faces and to work together alongside patients, the public and other stakeholders to identify new and better ways to deliver health and care.

The NHS constitution stipulates that the NHS belongs to the people and so does its future. In keeping with this principle we will be working together with staff, patients and the public to develop new local approaches for the NHS. We need your help to ensure that the ideas identified are sustainable and respect the values that underpin the health service. To enlist your help, we are launching a nationwide campaign called *'The NHS belongs to the people: a Call to Action'*.

A call to action

A call to action is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. This programme will be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. The engagement will be patient - and public-centred through hundreds of local, regional and national events, as well as through online and digital resources. It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how services will improve.

The call to action aims to:

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future.
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures.
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans.
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 – 10 years.

What will happen with the data and views that are collected?

All data, views and information will be collected by CCGs and NHS England. This information will then be used by CCGs to develop 3-5 year commissioning plans, setting out commitments to patients about how services will be improved.

This information will also be used by NHS England to shape its direct commissioning responsibilities in primary care and specialised commissioning.

Information gathered in this way will drive real future decision making. This will be evident in the business plans submitted for both 2014/15 and 2015/16. These plans will signal service transformation intentions at both local and national level.

There is no set of predetermined solutions or options about which we are consulting. Bold, new thinking is needed and we will consider a wide range of potential options. However, there are three options that we will not be considering:

1. **Do nothing.** The evidence is clear that doing nothing is not a realistic option nor one that is consistent with our duties. We cannot meet future challenges, seize potential opportunities and keep the NHS on a sustainable path without change.

2. **Assume increased NHS funding.** In the 2010 spending review, the Government reduced spending on almost all most public services, although health spending was maintained. We do not believe it would be realistic or responsible to expect anything more than flat funding (adjusting for inflation) in the coming years.

3. **Cut or charge for fundamental services, or 'privatise' the NHS.** We firmly believe that fundamentally reducing the scope of services the NHS offers would be unconstitutional, contravene the values that underpin the NHS and - most importantly - harm the interests of patients. Similarly, we do not think more charges for users or co-payments are consistent with NHS principles.

How will the call to action engage people?

The call to action will offer a number of ways for everyone to engage with the development of a renewed vision for the health service including:

A digital call to action

Staff, patients and the public will be able contribute via an online platform hosted by NHS Choices. This platform will enable people to submit their ideas, hold their own local conversations about the future of the NHS and search for engagement events and other interactive forums.

'Future of the NHS' surgeries with NHS staff, patients and the public

Local engagement events will be led by clinical commissioning groups, health and wellbeing boards, local authorities and other local partners such as charities and patient groups. These workshop-style meetings will be designed to gather views from patients and carers, local partner groups and the public. We will also be holding events designed to capture the views of NHS staff, for instance, through clinical senates.

Town hall meetings

Held in major cities across the NHS, these events will engage local government, regional partners, business and the public. These regional events will give people who have not contributed locally a chance to participate in regional discussions.

National engagement events

A number of national events focusing on national level partner organisations to the NHS will be held. These will include Royal Colleges, patient groups and charities, the private sector and other stakeholders.

Conclusion

The NHS is one of our most precious institutions. We need to cherish it, but we also need to transform it. Future trends threaten its sustainability, and that means taking some tough decisions now to ensure that its future is guaranteed. We believe that by working together as a nation, we have a unique opportunity to transform the NHS into a health service that is both safe and fit for the future.

The NHS needs your help. Have your say.

Statement on the health and social care Integration Transformation Fund

Summary

1. The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand pressures on services. In this context the announcement of £3.8 billion worth of funding to ensure closer integration between health and social care was a real positive. The money is an opportunity to improve the lives of some of the most vulnerable people in our society. We must give them control, placing them at the centre of their own care and support, make their dignity paramount and, in doing so, provide them with a better service and better quality of life. Unless we seize this opportunity to do something radically different, then services will get worse, costs to taxpayers will rise, and those who suffer the most will be people who could otherwise lead more independent lives.

2. The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". We are calling this money the health and social care Integration Transformation Fund (ITF) and this note sets out our joint thinking on how the Fund could work and on the next steps localities might usefully take.

3. NHS England, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) are working closely with the Department of Health and Department for Communities and Local Government to shape the way the ITF will work in practice. We have also established a working group of CCGs, local authorities and NHS England Area Teams to help us in this process.

4. In '*Integrated care and support: our shared commitment*' integration was helpfully defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

5. Whilst the ITF does not come into full effect until 2015/16 we think it is essential that CCGs and local authorities build momentum in 2014/15, using the additional £200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and

2015/16, which must be in place by March 2014. To this end we would encourage local discussions about the use of the fund to start now in preparation for more detailed planning in the Autumn and Winter.

Context: challenge and opportunity

6. The ITF provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The ITF is an important opportunity to take the integration agenda forward at scale and pace – a goal that both sectors have been discussing for several years. We see the ITF as a significant catalyst for change.

7. There is also an excellent opportunity to align the ITF with the strategy process set out by NHS England, and supported by the LGA and others, in *The NHS belongs to the people: a call to action*[1]. This process will support the development of the shared vision for services, with the ITF providing part of the investment to achieve it.

8. The ITF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work CCGs and local authorities are already doing, for example, as part of the integrated care "pioneers" initiative and Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

Background

9. The June 2013 Spending Round set out the following:

2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8 billion pooled budget to be deployed locally on health and social care through pooled budget arrangements.

10. In 2015/16 the ITF will be created from the following:

£1.9 billion existing funding continued from 14/15 - this money will already have been allocated across the NHS and social care to support integration
£130 million Carers' Breaks funding.
£300 million CCG reablement funding.

[1] http://www.england.nhs.uk/2013/07/11/call-to-action/

c. £350 million capital grant funding (including £220m of Disabled Facilities Grant).
£1.1 billion existing transfer from health to social care.
Additional £1.9 billion from NHS allocations Includes funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill. Includes £1 billion that will be performance-related, with half paid on 1 April 2015 (which we anticipate will be based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in-year performance).

11. To access the ITF each locality will be asked to develop a local plan by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met. This plan will also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

12. Plans for the use of the pooled monies will need to be developed jointly by CCGs and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.

Conditions of the full ITF

13. The ITF will be a pooled budget which will can be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health;
- ensure a joint approach to assessments and care planning;
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached; and
- agreement on the consequential impact of changes in the acute sector.

14. Ministers have agreed that they will oversee and sign off the plans. As part of achieving the right balance between national and local inputs the LGA and NHS England will work together to develop proposals for how this could be done in an efficient and proportionate way.

Conditions of the performance-related £1 billion

15. £1 billion of the ITF in 2015/16 will be dependent on performance and local areas will need to set and monitor achievement of these outcomes during 2014/15 as the first half of the £1 billion, paid on 1 April 2015, is likely to be based on performance in the previous year. We will be working with central Government on the details of this scheme, but we anticipate that it will consist of a combination of national and locally chosen measures.

Delivery through Partnership

16. We are clear that success will require a genuine commitment to partnership working between CCGs and local authorities. Both parties need to recognise the challenges they each face and work together to address them.

- Finding the extra NHS investment required: Given demographic pressures and efficiency requirements of around 4%, CCGs are likely to have to re-deploy funds from existing NHS services. It is critical that CCGs and local authorities engage health care providers to assess the implications for existing services and how these should be managed;
- Protecting adult social care services: Although the emphasis of the ITF is rightly on a pooled budget, as with the current transfer from the NHS to social care, flexibility must be retained to allow for some of the fund to be used to offset the impact of the funding reductions overall. This will happen alongside the on-going work that councils and health are currently engaged in to deliver efficiencies across the health and care system.
- Targeting the pooled budget to best effect: The conditions the Government has set make it clear that the pooled funds must deliver improvements across social care and the NHS. Robust planning and analysis will be required to (i) target resources on initiatives which will have the biggest benefit in terms outcomes for people and (ii) measure and monitor their impact;
- Managing the service change consequences: The scale of investment CCGs are required to make into the pooled budget cannot be delivered without service transformation. The process for agreeing the use of the pooled budget must therefore include an assessment of the impact on acute services and agreement on the scale and nature of changes required, e.g. impact of reduced emergency activity on bed capacity.

Assurance

17. Local Health and Wellbeing Boards will sign off the plans, which will have been agreed between the local authority and CCGs. The HWB is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process. The plans will then go through an assurance process involving NHS England to assure Ministers.

Timetable and Alignment with Local Government and NHS Planning Process

18. Plans for use of the pooled budgets should not be seen in isolation. They will need to be developed in the context of:

- local joint strategic plans;
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term strategic plans as part of the NHS Call to Action)
- the announcement of integration pioneer sites in October, and the forthcoming integration roadshows.

19. The outline timetable for developing the pooled budget plans in 2013/14 is broadly as follows:

• August to October:	Initial local planning discussions and further work nationally to define conditions etc
• November/December:	NHS Planning Framework issued
• December to January:	Completion of Plans
• March:	Plans assured

Next Steps

20. NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of Funds
- Conditions, including definitions, metrics and application
- Risk-sharing arrangements
- Assurance arrangements for plans
- Analytical support e.g. shared financial planning tools and benchmarking data packs.

Carolyn Downs
Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

8 August 2013

NHS England Publications Gateway Ref. No.00314

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Leeds Safeguarding Adults Partnership

Annual Report 2012/13

Important Contact Details:

If any person needs to report a safeguarding adults concern they should ring:

- Adult Social Care: Contact Centre: 0113 222 4401 (Textphone for deaf and hard of hearing people 0113 222 4410)
  (Mon-Fri 8am – 6pm; except Bank Holidays)

- Adult Social Care: Emergency Duty Team: 0113 240 9536
  (Outside of the Contact Centre opening times)

If any person needs to report a crime:

- Non-emergency police number: 101

- In an emergency, dial 999

If any person would like advice in relation to a safeguarding adults concern, they may ring:

- Safeguarding Adults Partnership Support Unit Advice Line: 0113 224 3511
  (Office Hours, Mon-Fri)

If any person needs advice about a Deprivation of Liberty Safeguards (DoLS) concern, they may ring:

- Deprivation of Liberty Safeguards helpline: (0113) 295 2347
  (Office Hours, Mon-Fri)

If any person needs more information about Safeguarding Adults, Mental Capacity Act or Deprivation of Liberty Safeguards (DoLS) they can obtain further information from the Leeds Safeguarding Adults Partnership website:

- www.leedssafeguardingadults.org.uk

Foreword

Welcome to the Leeds Safeguarding Adults Partnership Board, Annual Report 2012/13.

The Board is a voluntary arrangement of statutory and non-statutory agencies that work together with the shared vision of making Leeds a place where adults at risk are protected from abuse, and the rights of people who are unable to make decisions for themselves are promoted and safeguarded.

This Annual Report provides an overview of the Board, its member organisations, its work-streams and achievements over the last 12 months.

I am pleased to be able to highlight significant achievements across our areas of responsibility:

- The trend for year on year increases in safeguarding adult referrals has not continued into 2012/13, which may suggest that awareness of safeguarding has become established and embedded in services that support adults at risk.
- Referrals for Deprivation of Liberty Safeguards (DoLS) are increasing each year, ensuring that more and more people are benefiting from these important legal safeguards.
- In the most recent Department of Health report[1], the use of Independent Mental Capacity Advocates (IMCAs) in Leeds is the highest in the country, ensuring people in Leeds are well represented when they lack the mental capacity to decide about certain important decisions.

The Annual Report provides much detail about the range of achievements. I am pleased with our progress, however we recognise that there is much more to be achieved, and to this end we have developed a Strategic Plan to help us work consistently towards our goals over the next 3 years. We have included a summary of our Strategic Plan within this report. However, the full document, together with the Business Plan for 2013/14 can be accessed from our website (www.leedssafeguardingadults.org.uk).

Dr. Paul Kingston,
Independent Chair of the Board

[1] Department of Health (2013) The Fifth Year of the Independent Mental Capacity Advocacy Service, 2011/12

Message from the Director of Adult Social Services and the Executive Member for Adult Social Care

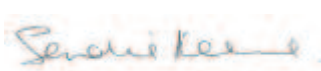
The Director of Adult Social Services is accountable to the elected members of the Council for ensuring the Safeguarding Adults Partnership Board works effectively to safeguard adults from abuse and to protect the rights of people without mental capacity to make particular decisions for themselves.

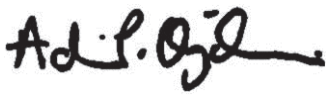
This report summarises our achievements, each of which reflects the commitment of the Board's members and their organisations to work collectively as partners across the city and towards our common goals.

This year, our achievements also reflect a new relationship of partnership with our neighbouring West Yorkshire Safeguarding Adults Boards. Over the last 12 months, Leeds has worked closely with the Safeguarding Adults Boards of Bradford, Calderdale, Kirklees and Wakefield to develop shared policy and procedures to safeguard adults from abuse and neglect. The new West Yorkshire Multi-Agency Safeguarding Policy and Procedures have been endorsed by the Social Care Institute of Excellence (SCIE) and were launched on the 1st April 2013. This achievement will aid those organisations that work across the West Yorkshire boundaries, and will provide significantly greater opportunities to learn and develop best practice across the region.

As we go forward into the next 12 months, we need to be mindful of how much can and has been achieved through close partnership working. The Annual Report provides an overview of our future priorities and includes the need to further develop our partnership working arrangements. This includes our local partners such as the Police, Community Safety and Leeds Safeguarding Children Board, in order to develop closer integrated practice, to share learning, and to ensure we coordinate our efforts in the best interests of those we all serve.

We are very much aware of the dedication of so many people who drive forward our vision of a safe community in Leeds. It is this that makes us confident that we can continue to develop our practice and extend our achievements each year. We would both like to take this opportunity to thank everyone across the partnership for their continuing efforts, achievements and support.





Sandie Keene
Director of Adult Social Services

Councillor Adam Ogilvie
Executive Member for Adult Social Care

Contents

1. Executive Summary

The Board is a voluntary arrangement of statutory and non-statutory agencies that work together to safeguard adults at risk of abuse and both promote and safeguard people's rights under the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

The Leeds Safeguarding Adults Partnership Board Annual Report 2012/13 provides an overview of the Board's achievements during the last 12 months and its strategic objectives going forward. This report demonstrates continuous improvement and development. Amongst the most significant achievements are the following:

- The Board in Leeds has worked with other West Yorkshire Safeguarding Adults Boards to develop West Yorkshire Multi-Agency Safeguarding Adults Policy and Procedures that were implemented on the 1st April 2013. This achievement marks a new relationship of working in partnership with other West Yorkshire Safeguarding Adults Boards.

- There were 3,438 safeguarding referrals during 2012/13, compared to 3,449 in 2011/12. After year on year increases, this may suggest that awareness of safeguarding adults has become increasingly embedded within services that support adults at risk.

- A new Board Bulletin is being published quarterly, that provides updates on developments in safeguarding, both locally and nationally.

- The Board has introduced Learning From Practice Events to share learning from practice with practitioners and to support the development of best practice.

- New questionnaires have been piloted to capture and learn from the experiences of adults at risk within the safeguarding process.

- Safeguarding adults training by Adult Social Care and NHS organisations alone has been provided to 14,307 people across Level 1 and Level 2 of our Training and Workforce Development Framework. In addition, 416 training opportunities were provided by the Safeguarding Adults Partnership Support Unit at Level 3 and Level 4.

- The Quality Assurance Framework has been implemented for safeguarding adults enabling Health and Social Care member organisations to sample safeguarding practice against agreed standards, supporting the development of targeted improvements.

- A Serious Case Review and a further four 'Learning the Lesson Reviews' have been completed during 2012/13, enabling the partnership to learn from, and continue to develop, its practice.

- According to a recent Department of Health report, during 2011/12 Leeds has the highest use of Independent Mental Capacity Advocates (IMCAs) in the country. Nevertheless the use of IMCA services during 2012/13 increased further by 15% (See page 21).

- A Transfer of Supervisory Body (Deprivation of Liberty Safeguards) Event was held on the 4th March 2013 to support the transfer of supervisory body responsibilities from NHS to Adult Social Care. Referrals for Deprivation of Liberty Safeguards (DoLS) have increased in Leeds from 98 to 122 (an increase of 25%) during 2012/13.

The Board has also developed a Strategic Plan for its work streams going forward. A summary of the Strategic Aims and Objectives is included in Section 6. The full document and the Board Business Plan for 2013/14 are published on the Leeds Safeguarding Adults Partnership website: www.leedssafeguardingadults.org.uk.

2. Leeds Safeguarding Adults Partnership Board 2012/13

2.1 The Board's Vision

The Board's Vision sets out the overarching aims of the Board.

Leeds Safeguarding Adults Partnership

The vision of the Leeds Safeguarding Adults Board is for the city of Leeds to be a place where:

all the citizens of Leeds, irrespective of age, race, gender, culture, religion, disability or sexual orientation live with their rights protected, in safety, free from abuse and the fear of abuse

The vision is one where no-one should have to tolerate or be exposed to abuse, neglect, or exploitation.

This means that as a Board, we need to work throughout the partnership, and with local communities to:

1. Prevent abuse from happening
2. Identify and report abuse
3. End any abuse that is occurring
4. Support people who have suffered abuse to recover and to regain trust in those around them

Our vision is also spurred by the knowledge that some people lack the mental capacity to make particular decisions about their own safety, health or wellbeing. We must be single-minded in our efforts to ensure that people have the protection to which they are entitled. We must work together to promote knowledge, understanding and use of the Mental Capacity Act, Independent Mental Capacity Advocates (IMCAs) and Deprivation of Liberty Safeguards (DoLS) that protect the rights and interests of all the people the Board serves.

2.2 Leeds Safeguarding Adults Board Structure and Governance

The Leeds Safeguarding Adults Partnership Board is a voluntary arrangement of statutory and non-statutory organisations. The Board includes senior representatives from:

- Leeds Adult Social Care
- NHS Airedale, Bradford and Leeds (Leeds Clinical Commissioning Groups, from 1st April 2013)
- Leeds Teaching Hospital NHS Trust

- Leeds Community Health Care NHS Trust
- Leeds and York Partnership Foundation NHS Trust
- West Yorkshire Police
- Leeds Community Safety
- Leeds City Council Environment and Neighbourhoods
- West Yorkshire Probation Service

A full list of current member organisations and representatives can be found on the Leeds Safeguarding Adults Partnership website www.leedssafeguardingadults.org.uk.

The Board has appointed Dr. Paul Kingston as the Independent Chair to the Board, providing for independent perspective, challenge and support to the Board in achieving continuous development. The Board is overseen by the Director of Adult Social Services.

The Board meets bi-monthly, its governance arrangements and functions are set out in full within the Board's 'Memorandum of Understanding', available to everyone on the Leeds Safeguarding Adults Partnership website.

The Board develops a Business Plan each year setting out is priorities and objectives, with dedicated sub-groups driving forward each work stream. The Board's Business Plans are available on the Leeds Safeguarding Adults Partnership website.

The Board is supported by the Leeds Safeguarding Adults Partnership Support Unit (LSAPSU) that is hosted within the Leeds City Council, Adult Social Care Directorate. The Unit provides support to the Board and its respective work streams, an Advice Service in relation to safeguarding adults concerns as well as providing Independent Case Conference Chairs and administrative support for Case Conference Meetings.

2.2.1 Funding Arrangements

During 2012/13 the costs of the Leeds Safeguarding Adults Partnership Board and its support unit was funded jointly and equally by Leeds City Council, Adult Social Care and NHS Airedale, Bradford and Leeds. From the 1st April 2013, NHS Airedale, Bradford and Leeds was replaced by Leeds Clinical Commissioning Groups. The following is the budget statement for the year 2012/13.

	2012/13 Budget £	2012/13 Actual £	2013/14 Budget £
Employees	455,990	458,583	100.6%
Premises	0	0	0
Supplies and Services	35,960	32,316	89.9%
Transport	1,230	2,471	200.9%
TOTAL EXPENDITURE	**493,180**	**493,370**	100.0%
Income from training	(6,000)	-6,190	103.2%
Contribution from Funding Partners	(487,180)	-487,180	100.0%
TOTAL INCOME	**(493,180)**	**-493,370**	100.0%

In addition to the figures shown above, the NHS made a one-off contribution of £10,000 towards projects during 2013/14. It is proposed that this money will contribute towards the costs of a Prevention of Abuse Campaign.

3. Our Work & Achievements

3.1 Safeguarding Adults

Safeguarding adults is a term used to describe “all the work which enables an adult [at risk] to retain independence, wellbeing and choice and to access their human right to live a life that is free from abuse and neglect” (ADASS: Safeguarding Adults 2005).

Safeguarding adults involves:

- organisations working together and with people to prevent abuse from occurring
- providing people with the support needed to end abuse
- protecting those people from abuse who do not have the mental capacity to decide about their own safety

The role of the Board is to achieve continual improvements in how issues of abuse are managed within Leeds. The various work streams of the Board are highlighted below, alongside a summary of their key achievements over the last 12 months.

3.1.1 Governance, Leadership and Partnership

The period of 2012/13 has been one of significant change for many organisations, not least for NHS Airedale, Bradford and Leeds as it has transitioned into the Leeds Clinical Commissioning Groups. The Board has maintained appropriate and effective representation of organisations during this period, and developed new induction arrangements for Board members affording them support in adopting and fulfilling their role.

The Board seeks to establish and build upon national learning. Following the publication of the Winterbourne View Hospital Serious Case Review in August 2012, by South Gloucestershire County Council, the Leeds Safeguarding Adults Partnership Board established a high level Task and Finish Group to review its findings and identify learning for Leeds. An action plan is being implemented in relation to four key areas: i) strategic commissioning, ii) safeguarding and protection, iii) legislative requirements and iv) individual placement, planning and review. More recently, in February 2013, the public inquiry into Mid Staffordshire NHS Foundation Trust, chaired by Robert Francis QC was published. The Board has requested and received information from its NHS partners about their responses to the Inquiry findings and recommendations.

A priority during 2012/13 has been to develop a Strategic Plan for the Board. The Board has to date produced a 12 month plan each year, setting out its priorities and objectives. The Board decided to develop a Strategic Plan setting out its aims and objectives for the next 3 years. In this way, it can maintain a focus on its longer term goals. To this end, the Leeds Safeguarding Adults Partnership Board held a Development Day in March 2013 to review the strategic direction of the Board. As a result, the principles: Empowerment, Protection, Prevention, Proportionality, Partnerships and Accountability were adopted as strategic aims and the Board has also set itself three year strategic objectives for each of its work streams.

One key objective of the Board is to focus on improving partnership working. A further Board Development Day is being planned for June 2013, which will be held jointly with the Leeds Safeguarding Children Board and the Safer Leeds Executive to identify potential opportunities for closer joint working. A summary of all the Board’s strategic objectives can be found in Section 6. The Board’s Vision and Strategic Plan is also available on the Leeds Safeguarding Adults Partnership website www.leedsafeguardingadults.org.uk.

3.1.2 Policy, Protocols and Procedures

During 2012/13 the Leeds Safeguarding Adults Partnership Board has worked closely with Bradford, Calderdale, Kirklees and Wakefield Safeguarding Adults Boards to develop joint West Yorkshire Multi-Agency Safeguarding Adults Policy and Procedures. These new policy and procedures have been reviewed and endorsed by the Social Care Institute of Excellence (SCIE).

The new policy and procedures were introduced on the 1st April 2013, alongside updated safeguarding guidance and templates. Briefing sessions have been provided for people in key safeguarding roles, updating them on the changes and the new Board Bulletin has been used to communicate key changes across agencies. The introduction of this regional approach marks the beginning of closer partnership working with other West Yorkshire Boards.

To support partnership working in Leeds, joint working protocols have been agreed between Adult Social Care and Leeds and York Partnership NHS Foundation Trust, clarifying responsibilities in relation to safeguarding coordination between the organisations.

The Board has produced Multi-Agency Risk Response guidance for situations where an adult at risk with mental capacity makes decisions that places themselves at risk. This guidance is not limited to circumstances of abuse, and may be relevant in some situations of self-neglect. The Board has also adopted the Risk Assessment & Management Tool (RAMT) from Adult Social Care, as an available resource for the partnership.

In addition the Board has produced new leaflets about safeguarding investigations for the person alleged to have caused harm and for service provider managers. The Board also reviewed and updated its Contesting Safeguarding Decisions procedures. Both these actions are part of the Board's commitment to ensuring the safeguarding process is fair and inclusive of all concerned.

3.1.3 Training and Workforce Development

During 2012/13 a new induction package for members of the Safeguarding Adults Partnership Board has been developed, training courses have been updated to reflect amendments to the safeguarding procedures and the findings of Serious Case Reviews, and training compliance figures agreed for partner organisations to work towards.

The Board's Training and Workforce Development framework has been developed to provide employees and volunteers with the knowledge and skills to fulfil their responsibilities to safeguard adults at risk. The training and workforce development framework provides for consistent content irrespective of the agency that is delivering the training.

Training is provided at four levels reflecting the various roles that employees and volunteers may fulfil within the safeguarding adults procedures[2].

Level 1: Alerter – recognising and responding to abuse
Level 2: Referrer – when and how to refer abuse into the multi-agency safeguarding process
Level 3: Investigator – how to undertake an investigation into abuse or neglect
Level 4: Safeguarding Coordinator (and other specialist roles) – specialist training for people fulfilling other key roles

[2] Names of courses may be different during 2013/14 reflecting the terminology introduced by the West Yorkshire Multi-Agency Safeguarding Adults Policy and Procedures on the 1st April 2013.

Level 1 and Level 2 are provided by Adult Social Care to voluntary and independent sector organisations free of charge, the Adult Social Care: Business Support Centre can be contacted on 0113 247 5570 for information about available courses.

In addition, partner organisations will provide Level 1 and Level 2 training on an in-house basis. Within Adult Social Care and NHS organisations alone, 14,307 people have received training across Level 1 and Level 2 during 2012/13. This includes NHS staff who have been using e-learning as one of the methods to refresh their knowledge.

Level 3 and Level 4 training courses are provided by the Safeguarding Adults Partnership Support Unit. During 2012/13, 416 Level 3 and Level 4 training places were attended across the courses below:

Level 3 courses provided:	**Level 4 courses provided:**
The multi-agency procedures for professionals	Safeguarding training for trainers
Investigating allegations and disclosures	Safeguarding Coordinators Procedure Review
Writing the Investigating Officer's report	
Institutional abuse	

Significant work has been undertaken and continues to be made to update training materials so as to be consistent with the West Yorkshire Multi-Agency Safeguarding Adult Policy and Procedures introduced on the 1st April 2013.

3.1.4 Serious Case Review and Professional Practice

Serious Case Reviews

Where safeguarding practice gives rise to potential concerns about how agencies have worked together, the Leeds Safeguarding Adults Partnership Board will consider conducting a Serious Case Review. Work has commenced to update our procedures in light of recent learning. A Serious Case Review is used to identify learning that can be used to improve practice across the partnership. The report is written by someone independent of the Board; this helps ensure the findings are impartial and objective. A pool of independent authors has been created to facilitate such reviews. The Executive Reports are published on the Partnership website.

During 2012/13 a Serious Case Review was completed in relation to a young woman living in a health care setting. The findings were presented by the independent author to the Safeguarding Adults Partnership Board at an extraordinary Board meeting in December 2012. The Executive Summary will be published on the Leeds Safeguarding Adults Partnership website in the near future (www.leedssafeguardingadults.org.uk). Progress against the recommendations will be monitored, to ensure the learning results in improved practice in the future.

Learning the Lesson Reviews

Where safeguarding practice indicates potential learning, but a Serious Case Review is not considered appropriate, a Learning the Lessons Review may be used to learn from practice. Learning the Lesson Reviews are conducted by the individual agencies but their findings and the learning is shared with the partnership through the Serious Case Review and Professional Practice Sub-group. During 2012/13, four Learning the Lesson Reviews were undertaken, and work completed in order to be able to learn from related processes, such as Serious Incident Investigations. Procedures relating to Learning the Lesson Reviews are in the process of being updated in light of learning from their use.

Learning from Practice Events

Alongside the actions plans developed as part of Serious Case Reviews and Learning the Lessons Reviews, the Board has introduced Learning From Practice Events during 2012/13 to provide practitioners with opportunities to reflect on and develop best practice.

The first of these events, held in October 2012 was provided primarily for Safeguarding Coordinators and focused on issues of Choice, Capacity and Control. The event considered and responded to the Department of Health Consultations on Powers of Entry and the safeguarding clauses of the Care and Support Bill (now called the Care Bill). The session also provided for reflection on four anonymous cases in Leeds that highlighted potential learning for the Partnership.

The subsequent event in March 2013 focused on Institutional Abuse and additionally included health professionals, contract officers and the Care Quality Commission (CQC). The event focused on a national review of abuse experienced by adults with autism and learning disabilities at Winterbourne View Hospital. Additionally, there were presentations from CQC about their role and presentations in relation to new guidance introduced by the Association of Directors of Adult Social Services (ADASS) about inter-authority investigations.

3.1.5 Communication and Community Engagement

A priority for the Leeds Safeguarding Adults Partnership Board has been to use learning from people's experiences of safeguarding to improve practice.

During 2012/13 the Board has approved questionnaires to find out about the experiences of adults at risk within the safeguarding adults procedures.


Leeds Safeguarding Adults Partnership Board
Customer Satisfaction Questionnaire

Are you completing this form as a person acting in the best interests of the Adult at Risk (only select one option)
Are you completing this form on behalf of yourself

(Please select the most appropriate answer that applies to you for each question)

1. I feel safer now, as a result of safeguarding
2. My life is better, as a result of safeguarding
3. I felt included during the safeguarding investigation
4. People really took notice of what I said during the safeguarding investigation
5. I am happy with how you responded when the concerns were originally raised
6. People explained what was happening often enough

Strongly Disagree | Disagree | Neither Agree Nor Disagree | Agree | Strongly Agree

The questionnaires focus on both the experience of the safeguarding procedures and the outcomes of the process, for example, whether people felt listened to within the process and felt safer as a result of the support they received.

A pilot of the questionnaires has commenced and will be rolled out across the city in due course.

Learning from these questionnaires will be used to inform the development of practice and training.

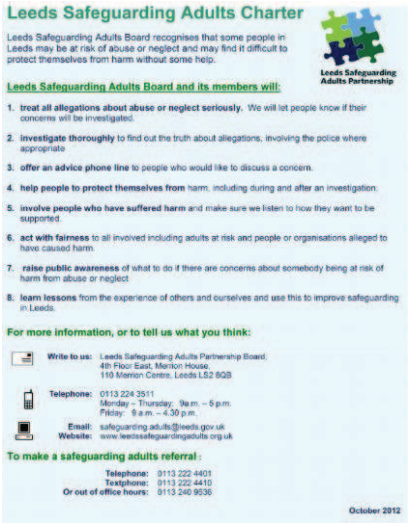
Other questionnaires are in the process of development in order to be able to learn from the experiences of everyone within the safeguarding adults procedures.

The Leeds Safeguarding Adults Partnership Board has also worked with Carers Leeds to organise an event to learn from the experiences of informal carers. This event was held on 30th November 2012 to coincide with Carers Rights Day. The event captured the needs of carers in the prevention of abuse and during responses to abuse.

Work has been undertaken to increase understanding of the need for advocacy to support people within the safeguarding adults procedures. This recognition has been built into service commissioning agreements for advocacy; helping to ensure people receive the support and representation they need.

The Leeds Safeguarding Adults Charter was updated during October 2012/13. It sets out eight key assurances as to how the partnership will respond to allegations or concerns of abuse (see over).

1. Treat all allegations of abuse seriously
2. Investigate thoroughly
3. Offer an advice phone line
4. Help people to protect themselves from harm
5. Involve people who have suffered harm
6. Act with fairness
7. Raise public awareness
8. Learn lessons



Leeds Safeguarding Adults Charter

Leeds Safeguarding Adults Board recognises that some people in Leeds may be at risk of abuse or neglect and may find it difficult to protect themselves from harm without some help.

Leeds Safeguarding Adults Partnership

Leeds Safeguarding Adults Board and its members will:

1. **treat all allegations about abuse or neglect seriously.** We will let people know if their concerns will be investigated.
2. **investigate thoroughly** to find out the truth about allegations, involving the police where appropriate
3. **offer an advice phone line** to people who would like to discuss a concern.
4. **help people to protect themselves from** harm, including during and after an investigation.
5. **involve people who have suffered harm** and make sure we listen to how they want to be supported.
6. **act with fairness** to all involved including adults at risk and people or organisations alleged to have caused harm.
7. **raise public awareness** of what to do if there are concerns about somebody being at risk of harm from abuse or neglect
8. **learn lessons** from the experience of others and ourselves and use this to improve safeguarding in Leeds.

For more information, or to tell us what you think:

Write to us: Leeds Safeguarding Adults Partnership Board, 4th Floor East, Merrion House, 110 Merrion Centre, Leeds LS2 8QB

Telephone: 0113 224 3511 Monday – Thursday: 9a.m. – 5 p.m. Friday: 9 a.m. – 4.30 p.m.

Email: safeguarding.adults@leeds.gov.uk
Website: www.leedssafeguardingadults.org.uk

To make a safeguarding adults referral :

Telephone: 0113 222 4401
Textphone: 0113 222 4410
Or out of office hours: 0113 240 9536

October 2012

Messages such as these are now shared within the Board's Quarterly Bulletin. Commenced in December 2012, the Bulletin conveys key messages from the Board as well as local, regional and national developments in safeguarding adults work. The Board's Bulletins can be located on the Partnership website www.leedsafeguardingadults.org.uk

3.1.6 Performance, Audit and Quality Assurance

A key priority of the Board is to continually improve standards of practice and outcomes for people within the safeguarding procedures. Throughout 2012/13 the Board has continued to actively develop its agreed standards and measures, and how it monitors practice. In this way the Board can identify areas of potential improvement to be addressed through its member organisations and Business Plan.

Development of the balanced score card has continued during 2012/13. The balanced score card involves four sets of measures used by the Board to monitor key performance issues. These are:

- Workforce capability and capacity
- Business processes
- Customer perceptions
- Value for money

Work has continued in relation to developing these last two domains. Customer satisfaction questionnaires have been developed and a pilot implemented. A value for money comparison with similar safeguarding units has also been undertaken during 2012; and a value for money review of training is planned for 2013/14.

The balanced score card is also informed by the Board's Quality Assurance Framework which was finalised in April 2012. This substantial piece of work establishes agreed standards for consistent safeguarding practice and allows the Board to assess practice against quality measures. Health and social care member organisations now sample safeguarding practice against these standards and report to the Board on the findings. Audit templates have been developed to support a time efficient audit process. With this mechanism in place, this will significantly enhance the ability of the Board and member organisations to identify those areas in need of improvement and to target efforts accordingly.

There is continuous monitoring of the safeguarding performance data leading to more detailed enquiries where required. This information in turn informs the balanced score card. This has included during 2012/13 an analysis in conversion rates from referral to investigation for different groups of service users to assure the Board as to equity of provision and response.

The Board has also completed a partner audit, assuring the Board that member organisations have the necessary provisions and arrangements in place to minimise the risk of abuse occurring within their organisation. Learning from this process has led to a review of how the partner audit is undertaken in future years, and plans are in place to integrate wider audit measures, such as those required by regulators and commissioners into the partner audit.

3.2 Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act 2005 was introduced to cover situations where someone is unable to make a decision because of the way their mind or brain works or is affected, for instance by illness or disability or the effects of drugs or alcohol. The Act is relevant to everyday decisions as well as major decisions about someone's property, financial affairs, health and welfare. It is an important safeguard, protecting the rights of people who lack mental capacity. The Act also introduces Lasting Powers of Attorney, Advance Decisions and Advance Statements, which provide a means by which people can plan for a time when they no longer have mental capacity to make decisions.

The Court of Protection and Independent Mental Capacity Advocates (IMCAs) were also introduced by the Act, to safeguard the rights of people who lack mental capacity when certain important decisions are made.

The Deprivation of Liberty Safeguards, often referred to as DoLS, were also introduced by the Mental Capacity Act. DoLS are a legal safeguard for people who cannot make decisions about their care and treatment when they need to be cared for in a particularly restrictive way. They set out a process that hospitals and care homes must follow if they believe it will be necessary to deprive a person of their liberty in order to deliver a particular care plan in the person's best interests.

More information about mental capacity, IMCAs and Deprivation of Liberty Safeguards (DoLS) can also be located on the Safeguarding Adults Partnership website: www.leedssafeguardingadults.org.uk

Mental Capacity Act In Practice

Iris is in her 90's and lived in her own home until last year when due to illness and falls she was admitted into hospital. Although she initially returned home to live with a package of support and the care of her family, as was her wish, she felt increasingly unable to live independently and asked to move into residential care.

After her move, Iris received the support she needed with various aspects of her care. However, she was concerned that she would be unable to manage her financial affairs in the future. Iris has times when she is confused and disorientated and wanted her family to be able to manage her finances for her when she was no longer able to do this herself.

Her granddaughter provided her with information about Lasting Powers of Attorney. Iris decided that she wanted a Lasting Power of Attorney for Property and Financial Affairs. Her granddaughter helped her to make these arrangements with a solicitor. This meant Iris would remain in control of her finances whilst she had the mental capacity to do so, but with the reassurance that when this changed, that those family members she nominated would be able to manage her finances for her in her best interests. This provided Iris with the peace of mind that she had the arrangements in place that she wanted for her future.

3.2.1 Mental Capacity Act Local Implementation Network

On the 1st April 2013, Leeds Adult Social Care became the Supervisory Body for hospitals (NHS and private) and registered care homes. This means that in circumstances where a hospital or care home believe it will be necessary to deprive a person of their liberty in order to deliver a particular care plan, they will need to apply to Leeds Adult Social Care for an assessment and authorisation. Prior to this NHS Airedale, Bradford and Leeds had been the Supervisory Body for hospitals.

During 2012/13 a task group was set up to ensure the seamless transition of responsibilities, and a Transfer of Supervisory Body (Deprivation of Liberty Safeguards) Event held on the 4th March 2013. This event involved 116 delegates, including managers of hospitals and care homes (i.e. Managing Authorities) as well as those involved in the DoLS assessment process.

The event included a range of informative presentations:

- Keynote speech provided by Sandie Keene, Director of Adult Social Services
- The Role of Managing Authorities, a legal perspective
- A Managing Authority Perspective
- The Role of Best Interest Assessors
- The Role of Independent Mental Capacity Advocates (IMCAs)

The afternoon included workshops for hospital and care home managers to explore through case scenarios, how to work with the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) to safeguard the best interests of patients/service users.

Work continues in relation to monitoring the quality of DoLS and Mental Capacity Act assessments and training is developed to promote best practice based upon the learning. Through the sub-group and its members, learning, best practice and developments in case law are shared. New information leaflets have been developed in relation to DoLS, and work is being undertaken to develop individualised ‘easy read’ information for those protected by DoLS.

For further information about Deprivation of Liberty Safeguards (DoLS) in Leeds, please refer to the DoLS activity report on Page 17 for further information.

Work also continues in relation to promoting use of Independent Mental Capacity Advocates (IMCAs) that support and represent those who lack mental capacity to make certain important decisions about their own care and welfare. The Mental Capacity Act Local Implementation Network works closely with Articulate Advocacy to monitor and promote use of IMCAs. For further information, please refer to the Independent Mental Capacity Advocate activity report on Page 20.

4. Activity Reports

4.1 Safeguarding Adults

This activity report provides a summary of key information about safeguarding adults activity during 2012/13. It includes information about:

- Safeguarding Referrals[3]
- Safeguarding Investigations
- Conclusions of Safeguarding Investigations

4.1.1 Safeguarding Referrals

Safeguarding referrals are incidents, concerns or allegations of abuse or neglect that are reported into the multi-agency safeguarding process.

Safeguarding referral numbers

There were 3,438 safeguarding referrals during 2012/13. Figure 1 illustrates that over the last 6 years the number of safeguarding referrals has significantly increased each year. However, this trend has not continued into 2012/13. Safeguarding adults referrals actually declined by 11 compared with 2011/12. This may suggests that awareness of safeguarding adults has become increasingly embedded within services that support adults at risk.

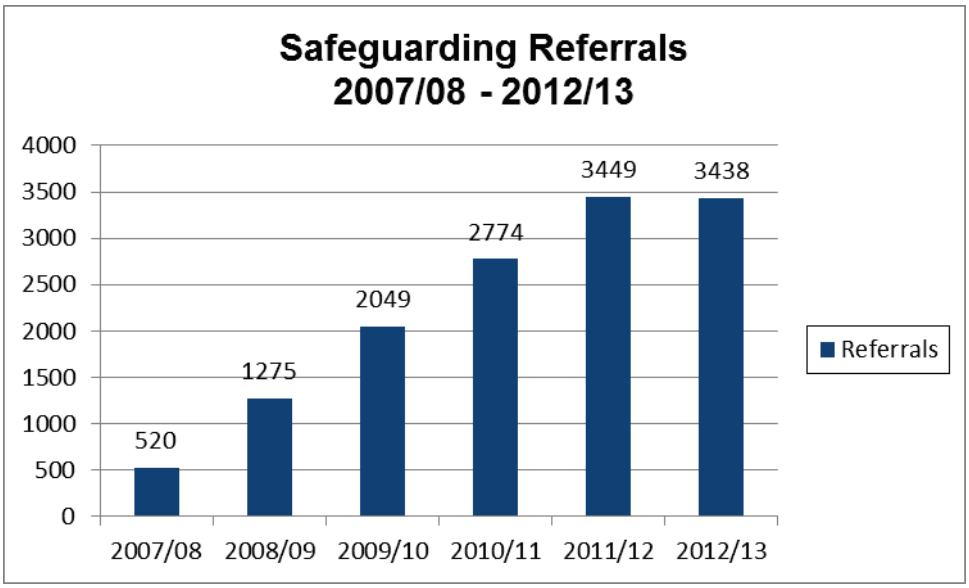


Figure 1: Safeguarding Adult referrals (2007/08 – 2012/13 (Source – ESCR database)

Safeguarding Referrals by Source

Safeguarding adult referrals are received from a broad and diverse range of sources. As illustrated in Figure 2, the largest proportion of referrals came from Social Care Staff (38%) and Health Staff (24%). Social care staff refers to people working within care management, residential, domiciliary or day care services or as personal assistants. Health staff includes primary/community health staff, secondary health staff and mental health staff.

However, a significant proportion of referrals come from housing organisations and the police, as well as friends and family members of the adult at risk.

[3] The term Referral is replaced by the term Alert within the West Yorkshire Multi-Agency Safeguarding Adults Policy and Procedures introduced 1st April 2013.

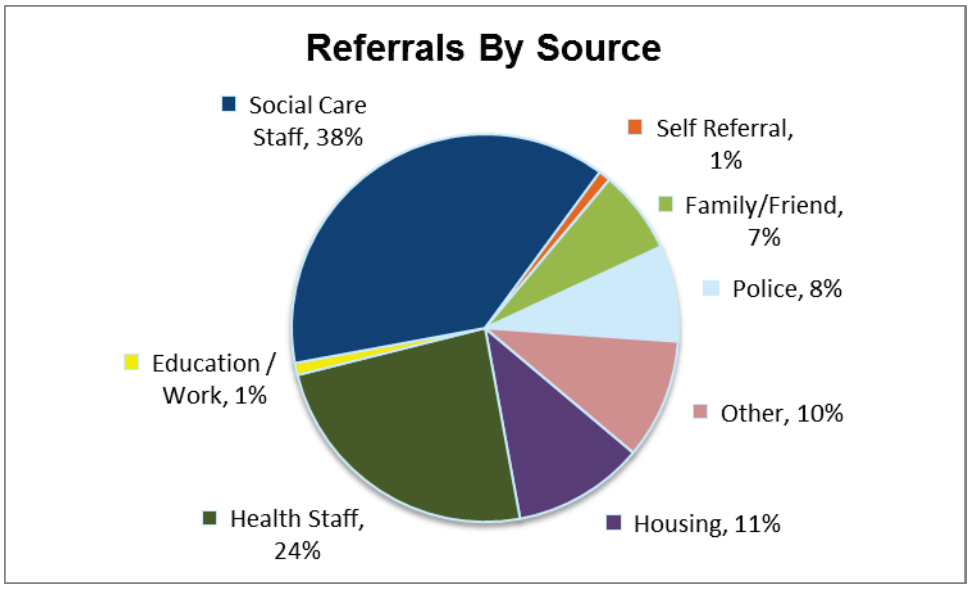


Figure 2: Safeguarding Referrals by Source (2012/13) (Source – ESCR database)

Safeguarding Referrals by Gender

During 2012/13 the majority of referrals concerned women, 59% and 41% concerned men as illustrated in Figure 3. This compares with 51% and 49% respectively in the 2011 census.

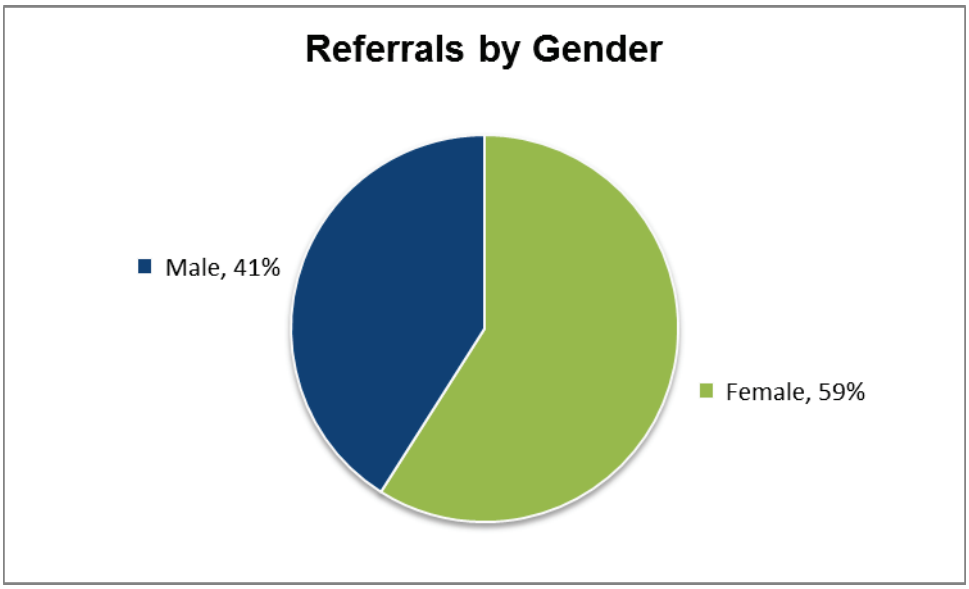


Figure 3: Safeguarding Referrals by Gender (2012/13) (Source – ESCR database)

Safeguarding Referrals by Ethnicity

The following table illustrates referrals according to the ethnic background of the adult at risk.

Ethnicity	White	Mixed	Asian or Asian British	Black or Black British	Other Ethnic Group	Not Stated
%	90%	1%	3%	2%	<1%	3%

Table 1: Referrals By Ethnicity (2012/13) (Source – ESCR database)

Approximately 7% of investigated referrals concern people from black and minority ethnic communities. This compares with a population of 15% in the 2011 census records.

Safeguarding Referrals By Referral Outcome

When a safeguarding referral is received, it is necessary to decide the most appropriate response. In 36% (1,213) of referrals it was initially decided that a safeguarding investigation was required as illustrated in Figure 3. This amounts to 31% (1,057) that were taken forward by Leeds Adult Social Care or Leeds Community Healthcare NHS Trust: Joint Care Management and 5% (156), were taken forward by Leeds and York Partnership Foundation NHS Trust.

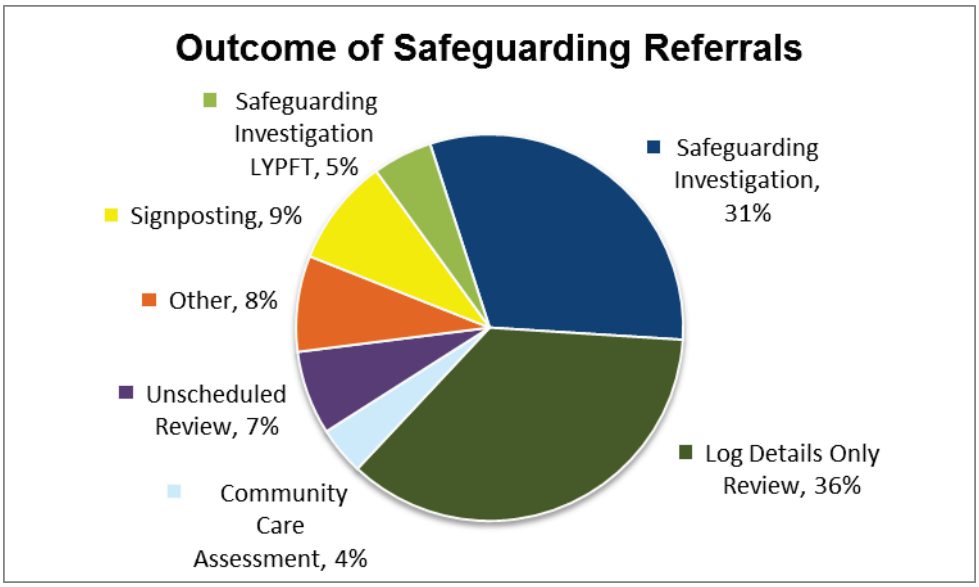


Figure 4: Safeguarding Referrals By Outcome (2012/13) (Source – ESCR database)

Although a safeguarding investigation is not always required, other forms of support may be, such as signposting/offering information and advice (9%), an unscheduled review of the person's support needs (7%) or a community care assessment (4%).

4.1.2 Safeguarding Investigations

In 2012/13, 1,183 safeguarding investigations were actually commenced. Additional work will have been undertaken in relation to investigations started but not completed in 2011/12.

Safeguarding Investigations by Client Group

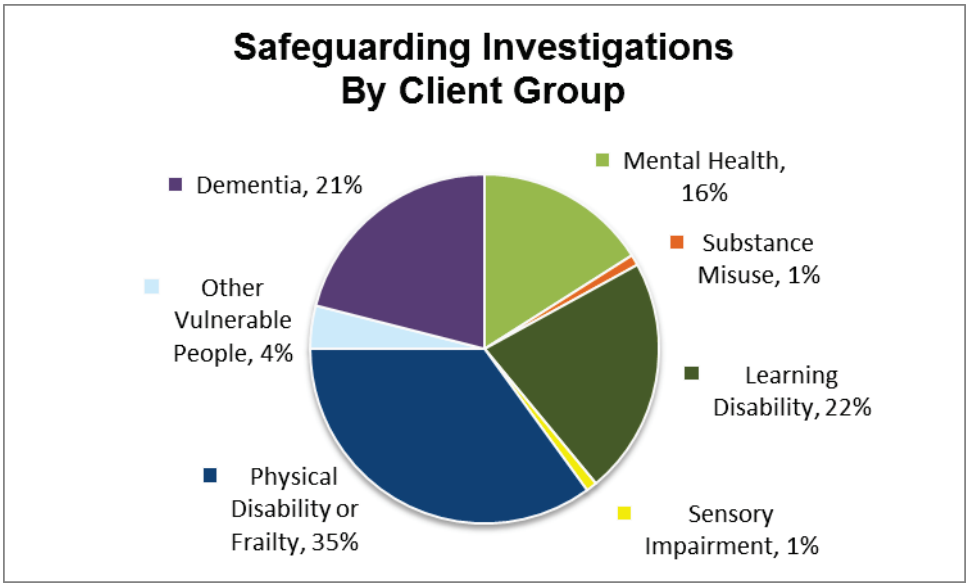


Figure 5: Investigated Referrals by Client Group (2012/13) (Source – ESCR database)

The highest proportion of investigations concerned a person with Physical Disability or Frailty (35%). This is followed by investigations involving a person with a Learning Disability (22%) and those involving a person with Dementia (21%).

Safeguarding Investigations by Type of Abuse

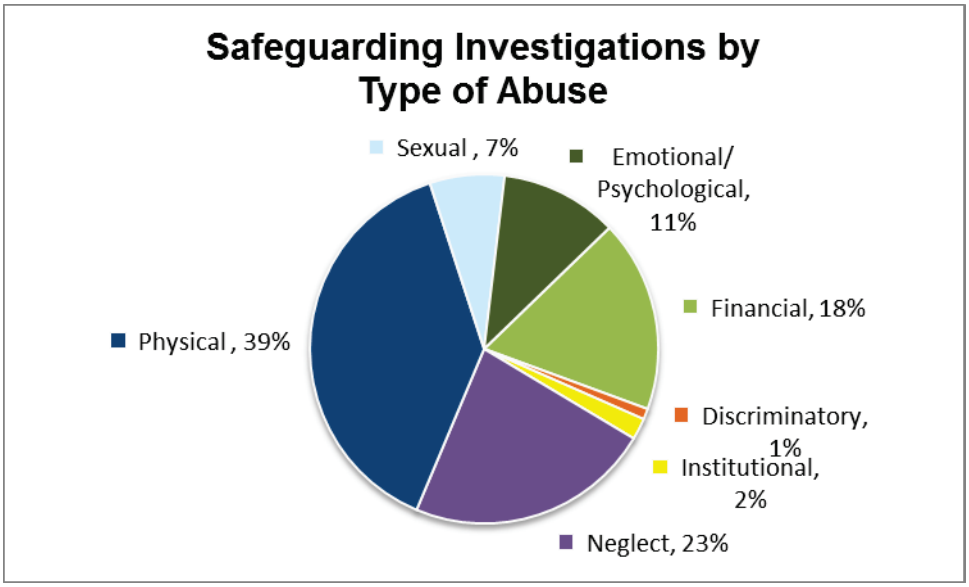


Figure 6: Safeguarding Investigations by Type of Abuse (2012/13) (Source – ESCR database)

Figure 6 illustrates that the most frequent form of abuse investigated is Physical Abuse (39%), followed by Neglect (23%) and Financial Abuse (18%). On many occasions however an investigation may concern more than one incident of abuse and more than one form of abuse.

Investigated Safeguarding Referrals – Type of Investigation

During 2012/13 the Leeds Multi-Agency Safeguarding Adults Procedures had 4 different types of safeguarding investigation as described on the next page[4]. This model provided for a proportionate response to be taken according to the nature of the alleged abuse and the circumstances within which it has arisen.

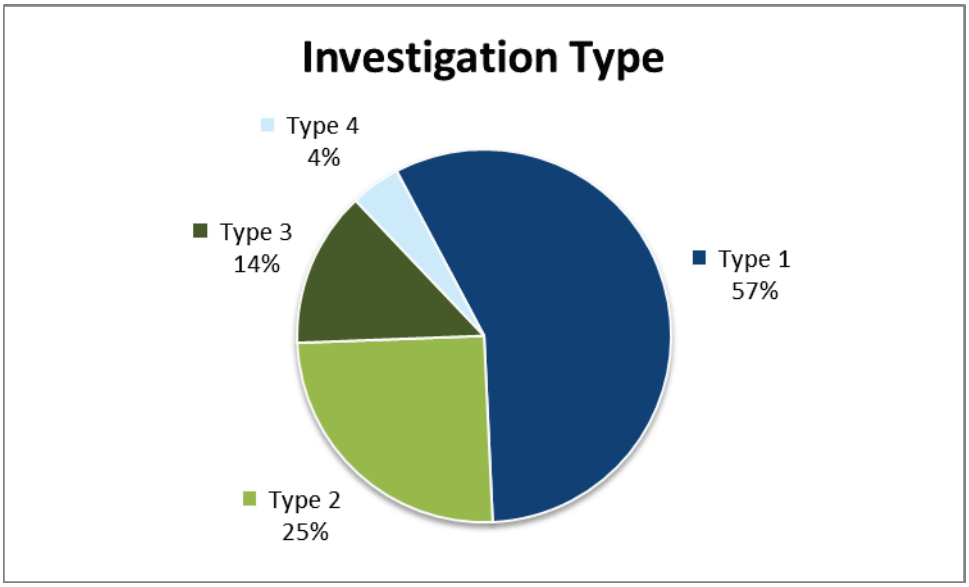


Figure 7: Investigations Type (2012/13)
(Source – ESCR database. Excludes 487 instances of unspecified data)

[4] The West Yorkshire Multi-Agency Safeguarding Adults Policy and Procedures implemented on the 1st April 2013 adopts an alternative but similar approach.

Type 1 Investigations were coordinated by Leeds Adult Social Care or an NHS organisation but investigated by the provider service. The majority of investigations during 2012/13 were undertaken as a Type 1 (57%).

Type 2 Investigations were undertaken by an Investigating Officer from Leeds Adult Social Care or an NHS organisation and focused on a review of care needs relating to the allegation/concern of abuse. These are the next most frequent form of investigations undertaken (25%).

Type 3 and Type 4 Investigations involved the most serious or complex situations, these were also investigated by Leeds Adult Social Care or an NHS organisation and required an independently-chaired, multi-agency case conference meeting to conclude them. These are the least frequent investigation types. Type 3 investigations relate to a single adult at risk (14%), Type 4 investigations concern more than one adult at risk (4%).

4.1.3 Conclusions of Safeguarding Investigations

During 2012/13, 817 investigations were completed. This will include some that were started in 2011/12.

Case Conclusions

A safeguarding investigation will gather evidence about the incident, allegation or concern. The decision based on this evidence, as to whether a form of abuse has occurred, is called the case conclusion. Case conclusions are decided 'on the balance of probabilities'. Figure 8 illustrates the four possible outcomes as established by the Health and Social Care Information Centre.

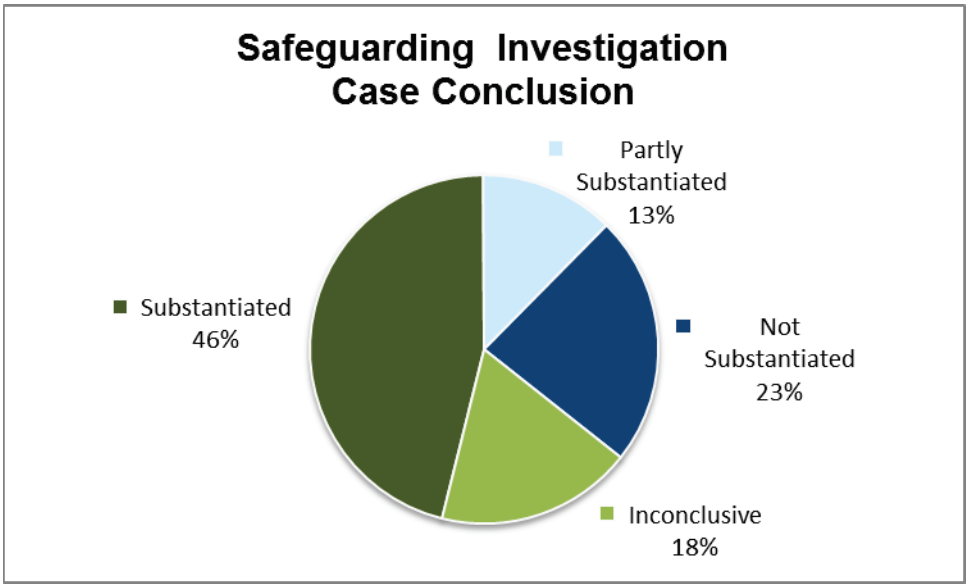


Figure 8: Safeguarding Case Conclusions (2012/13) (Source – ESCR database)

In 46% of occasions during 2012/13, the alleged abuse was found to be substantiated. In a further 13% of occasions the alleged abuse of the adult at risk was found to be partly substantiated. Partly substantiated means that there was more than one type of abuse investigated, and some types of abuse but not all, were substantiated. For example, the adult at risk was found to have been physically abused but the allegation that they were also financial abused was not substantiated.

Outcomes for the adult at risk

Outcomes for the adult at risk are those recorded at the conclusion of the investigation according to the criteria established by the Health and Social Care Information Centre. The most frequent outcome was 'increased monitoring' (52%) to keep the person safe. Other frequent outcomes were 'no further action' (18%) in relation to the adult at risk, however in some of these situations, actions may have been taken in relation to the person or organisation alleged to have caused harm. A 'move to increased/different care' and 'restriction/management of access to the person alleged to have caused harm' were both outcomes on 7% of occasions.

Outcomes for the person alleged to have caused harm

Outcomes for the person alleged to have caused harm are also recorded at the conclusion of the investigation according to the criteria established by the Health and Social Care Information Centre. The most frequent outcome was 'continued monitoring' (39%), 'no further action' (20%), 'management of access to the adult at risk' (6%) and 'disciplinary action' (5%).

Safeguarding Adults In Practice

Mike is in his early 20's, he attends college and lives at the family home with his mother and father. Mike has autism which means he has difficulty with social situations and needs support with some aspects of his life. One day, Mike tells his social worker about the problems he is having with his father. Mike reports that his father often tells him he is 'useless' and a 'waste of space'. Mike says his father gets very frustrated with him and has hit him on occasion. Mike is very upset and does not know what to do.

A safeguarding referral was made by the social worker. Mike chose to stay with a relative whilst the concerns were being investigated. The safeguarding investigation uncovered a range of difficulties that Mike was having at home. The deteriorating health of Mike's mother was adding to the stress of family life, and Mike's father had difficulty understanding and coping with his autism.

A case conference meeting was held to review the findings of the investigation and to consider how best to support Mike in the future. The meeting included Mike, his family and all the people involved in supporting Mike.

Mike decided he did not want to live at home anymore. A supported tenancy placement was found for Mike, where he is learning to develop his independent living skills and is gaining new friendships.

Mike continues to visit his mother regularly at the family home. He knows that he can be collected or go to a relative's home nearby if there are any problems when he visits. However, in this way he has managed to maintain contact with his mother and father without the pressures that have led to abusive incidents at home. Mike is pleased with these new arrangements.

4.2 Deprivation of Liberty Safeguards (DoLS)

The Deprivations of Liberty Safeguards, often referred to as DoLS, came into effect in 2009. They are part of the legal framework set out in the Mental Capacity Act 2005 to safeguard the rights of people who lack the mental capacity to make decisions for themselves. They set out a process that hospitals and care homes must follow if they think it will be necessary to deprive a person of their liberty, in order to deliver a particular care plan in the person's best interests.

It is a serious issue to deprive someone of their liberty and every effort should be made to prevent a deprivation of liberty occurring. However, there are some circumstances in which depriving a person of their liberty is necessary to protect them from harm, and is in their best interests.

What amounts to a deprivation of liberty occurring depends on the specific circumstances of each individual case. When there is a concern that a person is being deprived of their liberty, or will be if a particular care plan is followed, an assessment must be sought from the supervisory body.

During 2012/13, NHS Airedale, Bradford and Leeds was the supervisory body for hospitals, and Leeds Adult Social Care was the supervisory body for care homes. From 1st April 2013, Leeds Adult Social Care has become the supervisory body for both hospitals and care homes.

Upon receiving a request for an assessment, the supervisory body will coordinate six different assessments to ensure that the deprivation of liberty is in the person's best interests. If the authorisation is declined the hospital or care home must find alternative less restrictive ways to provide the treatment or care needed.

Leeds Deprivation of Liberty Safeguards (DoLS) Coordination Service

In Leeds a DoLS Coordination Service is provided that allows for a single point of contact for organisations, professionals and the public in relation to DoLS issues. If someone needs to seek advice, or request an assessment they can contact the service. The DoLS helpline can be contacted on (0113) 295 2347 (9am-5pm, Monday-Thursday; 9am-4.30pm Fridays (excluding Bank Holidays).

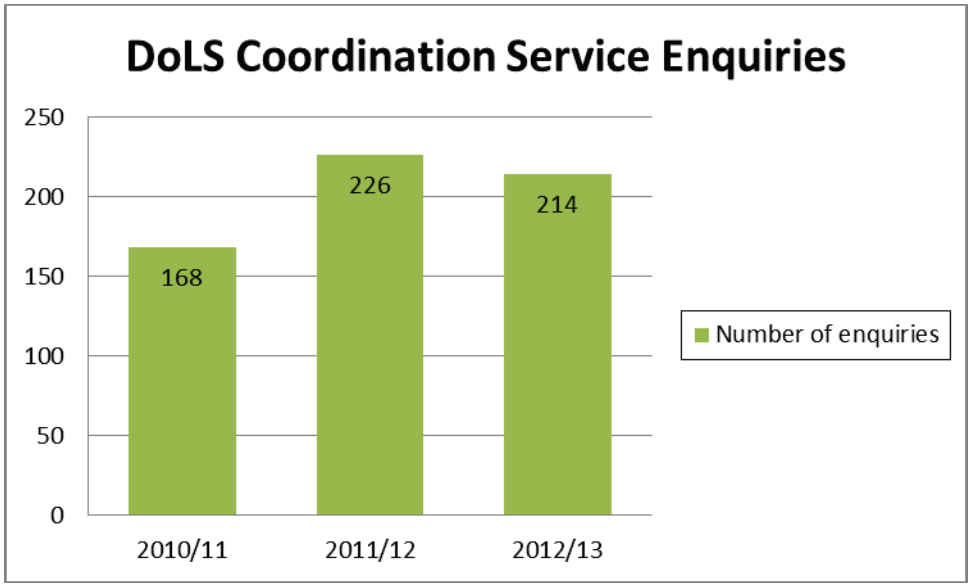


Figure 9: DoLS Advice Line Enquiries 2010/11–2012/13 (Source: DoLS Coordination Service)

The DoLS Coordination Service has continued to receive a high number of enquires. During 2012/13 a total of 214 separate enquiries were received, providing support to individuals and organisations across Leeds.

Use of Deprivation of Liberty Safeguards in Leeds

The table below illustrates the number of Deprivations of Liberty Safeguards referrals and authorisations in Leeds from 2010/11 to 2012/13.

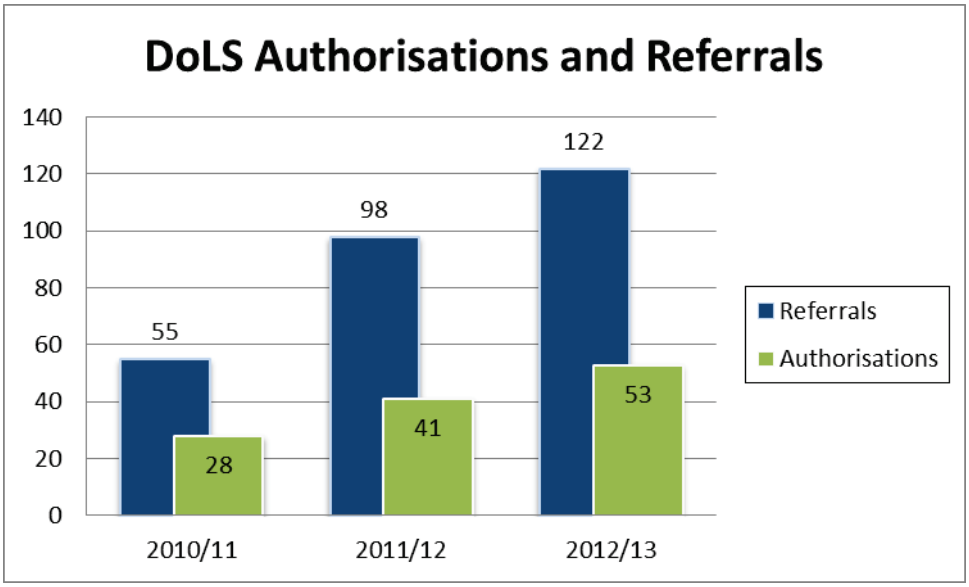


Figure 10: DoLS Referrals and Authorisations 2010/11-2012/13
(Source: DoLS Coordination Service)

Referrals for Deprivation of Liberty Safeguards in Leeds have continued to increase each year since they were introduced in 2009. There has been a 25% increase in referrals over the last 12 months and a 29% increase in authorisations. This indicates that awareness of when a DoLS needs to be considered has continued to increase and that more and more people each year are being protected by these important legal safeguards.

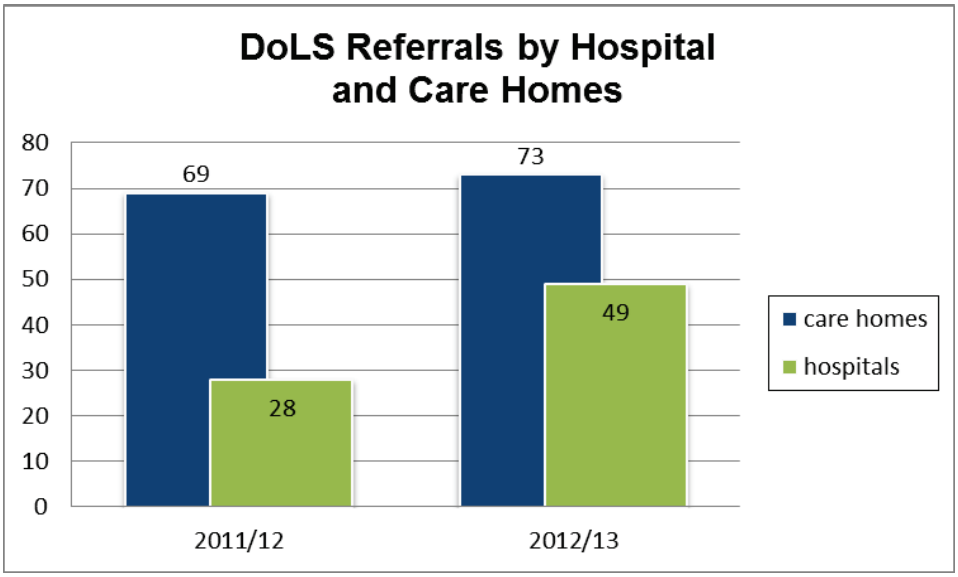


Figure 11: DoLS Referrals by Hospitals and Care Homes 2011/12-2012/13
(Source: DoLS Coordination Service)

Figure 11 above illustrates that the total increase in referrals during 2012/13 is largely due to a significant increase in referrals from hospital settings. This is an increase of 75% and evidences substantial work undertaken to promote awareness and use of DoLS in hospital settings in Leeds.

National Comparison

National comparison data for 2012/13 has not yet been published. However, information from the previous year is available[5]. The national increase in DoLS referrals from 2010/11 to 2011/12 was 27%, with an increase in authorisations of 28%. In Leeds during the same period the increase in referrals was 78%, with an increase in authorisations of 46%. This indicates that awareness and use of DoLS has increased above the national trend in Leeds during this period.

Deprivation of Liberty Safeguards (DoLS) In Practice

Richard is 92 years of age, he has dementia. Richard's wife died 2 years ago, after which he was supported and cared for by her family. Unfortunately, Richard was increasingly confused and disorientated due to his dementia and it was felt that it was no longer safe for him to live at home. Richard was very fit and active, but there were risks in the home for him, and he would wander in the local neighbourhood. Alongside the risk of getting lost, Richard was felt to be at considerable risk from busy roads nearby. It was proposed that Richard needed to move into a care home in order to receive appropriate support and a safe living environment.

Richard was assessed as lacking the mental capacity to make this decision; his views and wishes were taken into account, and his family involved in the best interests meeting that decided that the move was necessary for him to receive the support he needed.

Richard moved into a care home near his wife's family, but he was unhappy there. The environment was unfamiliar to him. Richard wanted to return home, he would say this to staff and family members, and he would try and leave when he could see an opportunity. The Care Home Manager could not let Richard just walk out of the care home due to the risk of getting lost and being hit by a car on the roads. The Care Home Manager was concerned that they may be depriving Richard of his liberty and so contacted the DoLS Coordination Service, who arranged for an assessment to be undertaken. The Deprivation of Liberty Safeguards (DoLS) was authorised, as the care arrangements were assessed as being in Richard's best interests. This ensured there were legal safeguards for Richard, not least a right to challenge the decision and a requirement to review his circumstances.

During this first review, Richard's daughter suggested that her father might be happiest if he were to move to the south coast. This is the area in which he had lived most of his life, and the area he talks most about. It was also the area to which she had also recently moved. An alternative care home placement was found for Richard on the south coast and the move was assessed to be in his best interests.

The care home, Richard's family, and the DoLS Coordination Service worked closely with local agencies to support the move. Richard was much happier and comfortable in the new care home. Richard had strong memories of the area and this made him feel at home. Staff were able to take him out to places that he knew from his past. After Richard had settled into his new environment the DoLS was reviewed. The DoLS was no longer felt necessary to keep him safe and to provide him with support and so the DoLS was removed.

Additional information about DoLS can also be accessed from the Leeds Safeguarding Adults Partnership website www.leedssafeguardingadults.org.uk

Please note, the Deprivation of Liberty Safeguards (DoLS) relate to a person receiving care and treatment within a hospital or care home. They do not apply to a person subject to detention under the Mental Health Act 1983.

[5] Health and Social Care Information Centre. Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) - Third report on annual data, 2011/12

4.3 Independent Mental Capacity Advocates (IMCAs)

Independent Mental Capacity Advocates (often called IMCAs) were introduced by the Mental Capacity Act 2005. IMCAs provide a form of statutory advocacy that helps to safeguard the rights of people who lack the mental capacity to make certain important decisions for themselves.

An IMCA can be appointed by an NHS body or the local authority for a person who has no one able to support and represent them and who lacks mental capacity to make a decision about either:

- a long-term care move
- serious medical treatment
- a care review
- deprivation of liberty safeguards
- safeguarding adults procedures (this may be possible in some circumstances, even if family, friends or others are already involved).

The role of an IMCA is not to make the decision on behalf of the person they are representing, but rather to represent them within the decision making process. An IMCA will be independent of the person making the decision. Their role includes:

- finding out the individual's views, feelings, wishes, beliefs and values
- providing them with support
- gathering information about the proposed decision
- providing the decision maker with information to inform the decision
- asking questions on the individual's behalf
- representing the individual during discussions about the proposed decision
- challenging decisions which appear not to be in the best interests of the person.

In Leeds, the Independent Mental Capacity Advocacy Service is provided by Articulate Advocacy. The Board works closely with Articulate Advocacy to promote understanding and use of IMCAs. With the benefits of this close working, use of IMCAs has continued to increase each year.

Table 2 below shows how many IMCA supported decisions were made in Leeds over the last 12 months (April 2012 – March 2013) and during the previous year (April 2011 – March 2012).

		LEEDS 11/12	LEEDS 12/13*	COMPARISON
		Number	Number	Increase from 2011/12 – 2012/13
Serious medical Treatment		67	74	10%
Accommodation		163	181	11%
DoLS		34	38	12%
Care Reviews		62	95	53%
Safeguarding		67	69	3%
Unknown		7	1	
Total		400	458	15%

Table 2: Use of IMCAs In Leeds 2010/11-2012/13 (Source – Articulate Advocacy) (* figures subject to audit)

The table shows that there have been 58 more IMCA supported decisions during the last 12 months, than in the year before. This is a 15% increase. There has been an increase in IMCA supported decisions for each of the areas in which IMCAs can be involved. The area of highest increase is Care Reviews (a 53% increase) which indicates an improved understanding of appropriateness of involving IMCAs in such decisions.

Some people may be supported by an IMCA on more than one occasion. In 2011/12, 322 people were supported by an IMCA, this increased to 385 people in 2012/13.

In addition to these figures, there have been 5 instances where the IMCA service has been commissioned to undertake the role of litigation friend. A litigation friend may be appropriate in circumstances where a person who needs to take legal action, lacks the mental capacity to do this themselves. Sometimes an IMCA is well placed to undertake this role in safeguarding the person's rights and interests. This is new for Leeds in 2012/13.

National Comparison

The Department of Health publishes information about the use of IMCAs in each local authority area. This information is not yet available for 2012/13 but the information for 2011/12 has been published. This gives an indication of how well Leeds is doing in promoting the use of IMCA services.

2010/11- 2011/12		NATIONAL % INCREASE	LEEDS % INCREASE
Serious medical Treatment		5%	74%
Accommodation		6%	29%
DoLS		18%	31%
Care Reviews		34%	210%
Safeguarding		2%	6%
Total		9%	39%

Table 3: Comparison of IMCA supported decisions nationally with those in Leeds 2010/11-2011/12
(Source – Articulate Advocacy and Department of Health[6])

The table shows that IMCA referrals have been increasing at a much higher rate in Leeds (39%) than the national average (9%). This rate of increase is higher for each type of decision involving an IMCA.

Overall during 2011/12, Table 2 also shows that Leeds had 400 IMCA supported decisions. This was the highest number in the country. Leeds also had the highest number of IMCA supported decisions in the country for each decision type (except for Deprivation of Liberty Safeguards).

Findings:

The IMCA service has a very important role in representing and protecting people's rights when certain key decisions are made for them. The support of an IMCA helps ensure that the person's 'best interests' stay at the centre of the decision making process. In Leeds the use of IMCAs is continuing to increase each year, and hence more and more people are benefiting from this support.

For further information, the Mental Capacity Act Code of Practice provides information about the role of an IMCA. This can be obtained from the Leeds Safeguarding Adults Partnership website www.leedssafeguardingadults.org.uk

The Articulate Advocacy Annual Report is also available, providing additional useful information. It can be accessed on the Articulate Advocacy website www.leedsadvocacy.co.uk

[6] As reported within Department of Health 2013 report, The Fifth Year of the Independent Mental Capacity Advocacy Service 2011/12. Information supplemented by Articulate Advocacy in relation to omitted IMCA decision type data for Leeds within this document.

Independent Mental Capacity Advocacy In Practice

Betty is in her 70's and lived in her own home until she had a stroke. The stroke caused her such mobility issues that she was unable to leave her bed. It was proposed that she should move into a nursing home in order to receive the care and support that she needed at that time. Betty was assessed as lacking the mental capacity to decide about this move, and so an IMCA was appointed to represent her interests in the decision making process. Due to her current circumstances, it was agreed that the move was in her 'best interests'.

When Betty later had a care review, an IMCA was instructed to represent Betty again. Betty had wanted to maintain the tenancy for her home but having moved into the nursing home it was proposed that she give this up.

The same IMCA that previously worked with Betty was involved again and highlighted to the social worker how keen Betty was, and always had been, to return home to live independently. The IMCA asked whether this possibility could be re-assessed. The social worker arranged for her care and support needs to be assessed. This included an occupational therapy involvement to assess Betty's abilities and needs within different environments.

The IMCA interviewed all those involved with Betty and produced a report drawing together everyone's opinions and considerations. The report was given to the social worker, who held a Best Interests meeting. The IMCA's report and the assessments were reviewed together. All those involved agreed that Betty could, in her current health, now return to live in her home with the support of telecare and a comprehensive support package.

Betty had been unable to make the decision herself. However, the IMCA was able to make sure everyone was focused on Betty's wishes, and this helped enable her to return to live at home when this was in her own 'best interests' to do so.

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5. Annual Statements of Board Member Organisations

5.1 Leeds City Council: Adult Social Care

During 2012/13 Adult Social Care has continued to develop practice in relation to safeguarding and Mental Capacity Act practice. Key achievements include:

Adult Social Care has sought to develop the provision of expertise and leadership of front line operational practice, developing its 10 Senior Practitioner posts into Safeguarding Risk Manager positions. Safeguarding Risk Managers have an enhanced role providing mentoring and performance monitoring of both safeguarding and risk assessment/management practice. Best Practice Panels are also currently being developed to provide additional support and expertise in complex cases. These will be introduced in 2013, enabling social work teams to seek additional practice guidance in challenging cases, in order to meet the needs of services users.

Adult Social Care has been working to prepare for and operationalise the changes introduced by the adoption of regional safeguarding adults procedures from April 2013. This has included significant revisions of the safeguarding activity plans on the Electronic Social Care Register (ESCR), whilst also incorporating the new data reporting requirements of the Health and Social Care Information Centre from the 1st April 2013. ESCR has also been developed during 2012 to provide for more effective recording in relation to service providers, enabling low level concerns to be captured that can be used to help indicate and prevent the development of more significant concerns.

In view of Adult Social Care adopting the recording system currently used by Calderdale Council in 2014, Adult Social Care has been working with Calderdale Council to develop the system to be able to meet the needs of operational practice in Leeds.

Forums have continued to be regularly held between Adult Social Care practitioners and the police safeguarding unit in order to share learning and develop partnership approaches to joint working. Initial discussion have been held about developing more integrated working models of practice with the police, such as Multi Agency Safeguarding Hubs (MASH) that have been adopted in some parts of the country. Such opportunities for closer inter-agency working will be further explored in 2013/14.

During 2012/13 significant work has been undertaken to prepare for the transfer of supervisory body functions for hospitals from NHS partners to Adult Social Care. From 1st April 2013 Adult Social Care is the supervisory body for Deprivation of Liberty Safeguards (DoLS) in both hospitals and care homes. This change was marked by an event in March, hosted by Adult Social Care for hospital and care home managers, to inform and develop good practice across Leeds. The DoLS Coordination service continues to provide advice and the coordination of assessments for the city.

5.2 NHS Airedale, Bradford and Leeds (NHS ABL)

Leeds Clinical Commissioning Groups (CCGs) from the 1st April 2013

2012/13 has been a year of great change in the commissioning arm of the health service. From April 2013 NHS Airedale, Bradford and Leeds (the Primary Care Trust (PCT)) ceased to exist. Three Clinical Commissioning Groups (CCGs) in Leeds have assumed many health commissioning functions. The safeguarding team will continue to work across the whole of

Leeds and continues to strive to ensure that the citizens of Leeds receive safe and effective care and treatment.

Another major change for 2013/14 is the transfer of the Supervisory Body hospital applications under the Deprivation of Liberty Safeguards (DoLS) to the local authority. In 2012/13 NHS ABL and Leeds City Council have worked together to ensure a smooth transition of this function. CCGs will retain responsibility for commissioning healthcare which is compliant with the Mental Capacity Act (MCA) and DoLS and ensure that healthcare providers meet their statutory responsibilities to patients who lack capacity to consent to care and treatment.

The Francis report into Mid Staffordshire NHS Foundation Trust and the Winterbourne View Hospital reports provide health commissioners with significant challenges. CCGs will continue to address the recommendations in these reports.

Some of the adult safeguarding achievements for 2012/13 are listed below:

- Following the Winterbourne View Serious Case Review, NHS ABL has ensured that all patients receiving care out of area have been reviewed to ensure they are receiving safe and effective care and where possible have been moved closer to home, in line with the LSAPB Winterbourne View Action Plan.
- The implementation of the NHS ABL Safeguarding Adults Commissioning Policy which describes the safeguarding roles and responsibilities of staff and sets safeguarding standards for all commissioned providers.
- Delivery of adult safeguarding, MCA and DoLS training to over 1000 staff in primary care (GPs and their practice staff, community dental, community pharmacy and ophthalmology staff).
- There has been a significant rise in the number of DoLS applications. This indicates a much greater awareness of the safeguards amongst hospital staff.
- NHS ABL has undertaken an audit of DoLS Mental Capacity and Best Interest assessments and addressed issues raised, including providing further specific local training for Best Interest Assessors.

5.3 Leeds Teaching Hospitals NHS Trust (LTHT)

Leeds Teaching Hospitals continues to grow, develop and review the safeguarding adults service.

Safeguarding Quality Assurance:

- LTHT provides information on safeguarding activity to NHS Commissioners, Leeds Safeguarding Adult Partnership Board and national bodies e.g. Care Quality Commission.
- Over the last year safeguarding alerts to the Trust adult safeguarding team continue to average at 40 a month.
- New Nursing Care Standards were launched in March 2013; these are related to previous Essence of Care Standards and the new Compassion in Practice initiative launched by National Commissioning Board Chief Nursing Officer, Jane Cummings in December 2012.
- A Lead Practitioner for Learning Disability has been appointed to provide robust clinical leadership in the care of patients with a learning disability.

Safeguarding Training:

- There are 15,199 staff at LTHT, over 75.5% have been trained at alerter level (level 1) in adult safeguarding. There is also additional higher level training being delivered to managers (Level 2).

Safeguarding Partnership Working:

- LTHT has full engagement with the multi-agency process and as such contributes to all stages of relevant safeguarding investigations and all the sub-groups of the Safeguarding Adult Board.
- LTHT have been active in the Serious Case Review process having now participated in 3 Serious Case Reviews. Action planning following these are underway and on target.

MCA/DoLS

- The Mental Capacity Act 2005 is now an established component of LTHT mandatory training and induction for all relevant patient facing staff. The training is delivered at 2 competency levels and includes content on the use of restraint and Deprivation of Liberty. Over the past year 3000 staff have been trained, including more detailed DoLS specific training.
- In addition to the mandatory training, the MCA Co-ordinator regularly develops and delivers bespoke packages of education and guidance for specific staff groups and specialties.
- LTHT MCA Co-ordinator also runs an advice service across the Trust, giving an average of 15 pieces of case specific advice per month in addition to more general MCA enquiries.
- There is a newly developed specific MCA and DoLS intranet site with a range of guidance available to staff across the Trust.
- DoLS and Restraint Policy and procedures have been written.
- A central LTHT DoLS administration service has been developed which will ensure that as a Managing Authority the standard of practice is consistent regarding DoLS Safeguards and procedures across all in-patient areas.
- LTHT continues to work on systems to promote and record the use of safeguards within the Mental Capacity Act, such as Lasting powers of Attorney (Health and welfare), Advance Decisions to Refuse Treatment.

The above range of activity has led to significant successes over the past year:

- Marked increase in the number of IMCA referrals from LTHT staff for serious medical Treatment.
- Increase in number of DoLS applications from last year, as well as applications coming from wards who previously have not considered the use of these safeguards.
- MCA issues are now increasingly imbedded into Trust wide procedures and assessments - e.g. nursing assessments, care plan documentation, discharge processes.

5.4 Leeds and York Partnership NHS Foundation Trust (LYPFT)

During 2012-13 LYPFT Safeguarding has had to meet a number of additional challenges as Leeds mental health services merged with the York and North Yorkshire services that previously came under the North Yorkshire PCT. We are now a much larger organisation with an even greater diversity of client groups and services all of which expect the same high quality response from our Adult Safeguarding team.

Along with our partner agencies we have also responded to national concerns in regard to vulnerable adults reviewing our practice and evaluating standards of care in response to Francis, Winterbourne and Savile.

LYPFT is a now a main partner in three Safeguarding Adults Boards; Leeds, York and North Yorkshire, each with variations in policy, procedure and language. Although these are relatively minor variations they still present us with some challenges when we are trying to emphasise consistency across what is now a much larger and more widespread workforce. This work has been on-going whilst maintaining our quality response to the, still growing, workload of alerts/referrals involving our Leeds service users.

Key Developments:

We have refined our data capture and recording processes assisted by an in depth independent review of adult safeguarding practice which highlighted these as priority areas for development. A new IT systems within LYPFT is currently being rolled out which will systematically link incident reporting to safeguarding, generating automatic alerts where appropriate.

We have continued to build on the developments to our classroom and eLearning training programme. At 80%+ of all staff trained to Level 1, we are closing in on our target of 100%.

The LYPFT Safeguarding Standing Support Group, which came into being in April 2012 is now established as the main governance forum within the organisation for child and adult safeguarding. Chaired by the Deputy Chief Executive this is a high level meeting which ensures that safeguarding matters are at the top of the organisation's agenda.

With support from Leeds Adult Social Care, LYPFT will be gaining direct access to Electronic Social Care Records (ESCR or its equivalent). This will enable a more seamless exchange of safeguarding information between LYPFT and partner organisations.

LYPFT will be harmonising internal operating instructions for safeguarding adults for all staff in the organisation ensuring a consistent response to alerts across all areas. These will recognise the language and practices of Leeds, York and North Yorkshire safeguarding adults Boards and recognise the changes and developments brought about by the inauguration of the West Yorkshire regional safeguarding adults procedures.

5.5 Leeds Community Healthcare NHS Trust (LCH)

In Leeds Community Healthcare NHS Trust (LCH) the last 12 months has been an exciting and challenging time as we progress to becoming a Foundation Trust. June 2012 saw the appointment of a full time Named Nurse for Safeguarding Adults with a clear remit to advance safeguarding practice across the Trust. The integration with safeguarding children and looked after children service has progressed to co-location of the joint team. This has led to the development of a safeguarding vision statement with objectives to deliver a cohesive service focussing on valuing staff, quality, value for money and partnership working. The results so far have been shared training events, sharing ideas and shared learning.

The safeguarding adults work plan has completed actions across all 10 work streams. Incidents logged with safeguarding adults concerns are reported on a quarterly basis to both the Operational Group and Joint Adults and Children Safeguarding Committee. Learning from these incidents and from the Winterbourne View Serious Case Review has led to the

development of a guidance leaflet for LCH practitioners to support working together in care homes; to identify and report safeguarding concerns, including those which fall below the threshold for referral into multi-agency procedures.

Mandatory training at safeguarding adults alerter level and for Mental Capacity Act has now moved to national e-learning programmes for all clinical staff. Senior clinical staff are receiving face-to-face training to safeguarding adults referrer level to increase the level of knowledge across all clinical practice and embed safeguarding into all clinical contacts. LCH now has three trained Best Interests Assessors who are actively contributing their skills in the Deprivation of Liberty Safeguards work across the city. We have over 50 MCA Champions who are dedicated to sharing their increased knowledge and experience and work is continuing to map their locations across the organisation and identify any gaps in services.

The next 12 months will continue to be challenging with structural changes within the Trust, however the safeguarding team will maintain their commitment to be active partners in increasing the profile and supporting the work of the Leeds Adult Safeguarding Partnership Board and the broader safeguarding agenda.

5.6 West Yorkshire Police

The Leeds District Safeguarding Unit has continued to develop and now encompasses both Child and Adult Safeguarding in Leeds. Since the last report the unit now incorporates the Public Protection Unit which manages the Registered Sex Offenders in Leeds.

Staff in the unit have worked hard to foster good relations with our counterparts in Adult Social Care and there is a regular meeting with Senior Practitioners from ASC This has developed into a forum to discuss case studies and develop joint good practice.

Comprehensive vulnerable adult training has been rolled out for front line police officers in Response, Neighbourhood Policing Teams and CID. The aim of the training is to raise awareness of vulnerability issues, to highlight instances where a crime may have been committed and also to signpost the work done by other agencies in helping vulnerable people. This training is now completed but further refresher training is planned. Staff from the Leeds District Safeguarding Unit has also given vulnerable adult inputs to groups of GP’s in four specially arranged training events.

In March, West Yorkshire Police hosted a master class on financial abuse. This was arranged in response to the sharp increase in cases where carers or relatives have abused their position of trust and fraudulently obtained money. The event was well supported by partners from ASC, Mental Health and Trading Standards as well as interested parties from the police. The Leeds District Safeguarding Unit has recently secured a series of successful prosecutions against individuals who have committed this kind of offence and there are several on-going investigations.

Some of the Leeds Senior Practitioners from Adult Social Care and Mental Health practitioners have conducted training in the Mental Capacity Act and Deprivation of Liberty Safeguards for the Leeds District Safeguarding Unit staff so that we could gain a better understanding of how these assessments are made. Assistant Chief Constable Geoff Dodd has recently been appointed ACPO lead on Mental Health issues and is keen to make improvements in key areas such as management of missing from home incidents involving mental health patients. He will shortly be setting up a working group to look at potential areas for improvement.

Leeds District Safeguarding is looking forward to developing further in the next 12 months and is looking to exploit opportunities to develop joint training with partners. The next 12 months will hopefully see the unit move from Millgarth and Weetwood stations to the new police station at Elland Road.

5.7 West Yorkshire Probation

West Yorkshire Probation Trust in Leeds contributes to Adult Safeguarding by supervising a range of adult offenders in the community, many of whom have been convicted of serious crimes against victims, some of whom may be regarded as 'vulnerable'. Our primary mechanism for managing those deemed most serious is MAPPA (Multi Agency Public Protection Arrangements) which place a statutory duty on partner organisations to cooperate in the management of High Risk offenders living in the community.

By their nature these offenders tend to be those who have committed the most serious violent offences, or who have convictions for serious sex crimes and assaults. Supervision will typically include restrictions and monitoring, residency at an approved premise and possibly exclusion from certain areas of the city.

Probation interventions through accredited programmes also have an impact on vulnerable adults by seeking to mitigate future risk through group based programmes that aim to reduce the likelihood of reoffending. Programmes aimed at reducing domestic violence, such as our Safer Relationships course and the Sex Offender Treatment Programme are nationally accredited and available for offenders who fit the criteria. These programmes have good rates of success.

As one of the few agencies working directly with perpetrators, Probation's contribution to helping to protect vulnerable adults is one of helping to build good assessments of risk and, through effective partnership and close supervision, the management of risk.

5.8 Safer Leeds

Safer Leeds had identified Safeguarding and vulnerability as a strategic priority for the partnership over the past 12 months and has actively engaged with safeguarding vulnerable adults agenda on a number of fronts. The most notable development comes from the statutory requirement on the partnership to undertake domestic homicide reviews which came into effect from April 2011. Leeds currently has two Domestic Homicide Reviews underway and this has resulted in joint working with both the Safeguarding Adults and Children teams to:

- Draw upon the learning from Serious Case Reviews and Learning Lessons Reviews.
- Have strong collaboration and joint working between the Safer Leeds Partnership and the Safeguarding Vulnerable Adults team in a Domestic Homicide case where the victim was also deemed to be a vulnerable adult.
- Working with the Safeguarding teams to establish a process for Domestic Homicide Reviews which mirror the Serious Case Review processes for vulnerable adults and children.

The secondment of a Probation Officer and Prison Officer into the Domestic Violence Team to develop a programme of work with male perpetrators of domestic violence means that vulnerable adults who choose to remain in relationships are being more effectively supported.

Leeds Anti-Social Behaviour Team (LASBT) is a multi-agency team, comprising of staff from Leeds City Council, Leeds ALMO's, West Yorkshire Police, Victim Support and West Yorkshire Fire Services Arson Taskforce. Central to LASBT's policies and procedures is a commitment to ensure the service operates with a strong customer focus, underpinned by a need to identify vulnerabilities and risk factors faced by both victims and alleged perpetrators, to ensure referrals to support, interventions and risk management conferences (MARAC's) meet their needs.

Leeds Anti-social Behaviour Team (LASBT) staff have a clear responsibility to undertake a vulnerability/risk assessment with victims and alleged perpetrators. Using matrices initially developed by the Home Office but developed locally to include an assessment of alleged perpetrators, matrices seek to clarify existing known vulnerabilities, identify potential vulnerabilities, safeguarding issues and risk factors, existing support provision and gaps. LASBT staff will typically refer vulnerable individuals into a range of support services including, Adult Social Care, Children's services, ALMO Independent Living teams, Sustain, Signpost and a wide range of generic support providers as necessary. More recently, work has also been done with our police partners to identify repeat and vulnerable victims of anti-social behaviour, through police reporting mechanisms.

West Yorkshire Police and LCC Adult Social Care have recently reached an agreement to formalise the arrangements for the provision of appropriate adults for arrested vulnerable adults within Leeds. The new arrangements will ensure that appropriate adults will have a consistent knowledge, competence and experience in dealing with all custody and vulnerability issues.

The Leedswatch Service works closely with Adult Social Care, to deliver the 1st response for the Care Ring Service. This involves the deployment of officers to vulnerable adults following the trigger of a Care Ring alarm pendent. When arriving at an alarm, officers will undertake a risk assessment to determine the type of response required. This could involve contacting emergency services, next of kin, or other designated adult. The officer, will remain with the vulnerable person providing reassurance, until help arrives.

5.9 West Yorkshire Fire and Rescue Service (WYFRS)

West Yorkshire Fire and Rescue Service believes that everyone has the right to live their life free from abuse and neglect regardless of race, gender, disability, age, sexual orientation, religion and belief, gender reassignment, marriage and civil partnerships, and pregnancy and maternity. The service acknowledges that safeguarding children and vulnerable adults is "everybody's business" and is committed to playing an active role in safeguarding work.

The agreed reporting structure as set out in West Yorkshire Fire and Rescue Services Policy, is for quarterly activity reports to be presented to the Corporate Diversity Board, and an annual report presented to Management Board.

Since the new policy went live, 80 safeguarding cases have been referred through to the safeguarding units. The Safeguarding policy is now well embedded into West Yorkshire Fire and Rescue Services working practices.

5.10 The Arms Length Management Organisations (ALMOs)

Aire Valley Homes, East North East Homes and West North West Homes, provide housing on behalf of Leeds City Council. All three of the Leeds ALMOs have specialist teams in place to support tenants at risk. Achievements during 2012/13 are significant and widespread, and include the following:

Aire Valley Homes

- The Independent Living Support Team (ILST) was established in March 2012
- There are 4 Safeguarding Lead officers.
- A safeguarding procedure for adults and children with guidance notes has been developed and is available to all staff.
- A Safeguarding Awareness Training package has also been updated. It is interactive; it contains video clips of typical scenarios that raise the importance and the need for all staff to be conscious of safeguard 'alerts' and to know what to do.
- Safeguarding Awareness Training forms part of the induction of new employees.
- The Financial Inclusion Team has been expanded to deal with tenants who are being impacted on by the Welfare Reform changes. The team meets periodically with adults and children's services to share good practice and to keep under review how we can work together most effectively.

East North East Homes

- A robust safeguarding and alerter package is in place, and 650 staff and contractors were trained between January and June 2012; 99.7% of people rated the training good or very good.
- A Cause for Concern Card has been developed to enable staff to capture their concerns on an easy to complete card that is shared with line managers to report.
- East North East Homes is involved in Leeds City Council's Lead Officer Safeguarding Group to share good practice and help shape the future development of safeguarding across the council.
- The team works closely with safeguarding Adults and Children in developing an understanding of what constitutes a safeguarding referral.
- Improved awareness and the quality of reported information from staff and teams has enabled better assessment of support needs and risks.

West North West Homes

- Fourteen Safeguarding Champions have been established to support colleagues to be alert to potential safeguarding issues and to make appropriate safeguarding children and adult referrals. The Safeguarding Officer will monitor referrals and meet with Safeguarding Champions bi-monthly to discuss and update practice.
- Safeguarding Champions have undertaken the LSAPB 'Training the Trainer' course and provided Level 1 training to 135 staff since September 2012.
- A bi-monthly safeguarding case study is sent to Safeguarding Champions who disseminate it to their staff teams to be discussed within staff training.
- A safeguarding awareness pack has been developed for new employees. This includes a video case study, useful contacts list, a guidance poster, and the safeguarding children and adult policies.
- Each week the Safeguarding Vulnerability Officer attends a team meeting to carry out safeguarding training. This approach has received very positive feedback.

5.11 Care Quality Commission (CQC)

The Care Quality Commission's (CQC) responsibility regarding safeguarding is to ensure that CQC uses its regulatory powers to ensure that risks to people, who receive services that are regulated by CQC, are minimised. CQC powers will be used promptly and in accordance with CQC frameworks for judging compliance with the regulations outlined in the Health and Social Care Act 2008 and the Commission's enforcement policy.

In Leeds this work continues in three ways. Firstly, CQC meets regularly with commissioning and safeguarding officers from Leeds City Council and NHS Leeds. The purpose of these meetings is to share information about services which may pose a risk to people's safety. Secondly, outside of these meetings partnership agencies may refer concerns that have been brought to their attention to CQC. Commission inspectors may respond by undertaking inspections in order to ascertain whether or not the service is complying with national standards and if not, determine the action that needs to be taken to address this. In addition, there are occasions when inspectors identify incidents that mean people may be at risk. In these circumstances inspectors will make a safeguarding adult referral. Thirdly, inspectors are also involved in meetings convened by Leeds Adult Social Care Services to consider actions necessary to either investigate concerns raised and/or to ensure the safety of vulnerable people who receive services that are regulated by CQC.

CQC records the number of safeguarding matters, being brought to its attention and that occur within regulated settings. That is to say that we receive concerns from service users' relatives, the provider and/or partner agencies such as the police or the local authority. There are also incidents that may have been observed by inspectors. Over the past year 2012-13, we have noted 312 incidents in regulated services in Leeds. Of these, the vast majority (257(82%)) are incidents that have been classified as matters of concern and about which the local authority safeguarding team was already aware. The remainder (55) were new alerts to the Commission and only a small proportion (9(16%)) of these were considered to be new matters that required referral to the local safeguarding authority for investigation.

This suggests that there is greater awareness of safeguarding in the health and social care community in Leeds and provides assurance that appropriate action is being taken, when these incidents are brought to the attention of CQC.

This year has been one of considerable change for CQC. The Commission has strengthened its regulatory approach in the light of the events at Winterbourne View, and more recently the findings of the Francis report Inquiry into Mid Staffordshire NHS Hospital. Throughout the year Commission has been engaged in a consultation with partner organisations and the public about its strategic approach to regulation.

In February 2013, when the Francis report was published, CQC Chief Executive David Behan said: "Robert Francis's report is a defining moment for everyone involved in healthcare. People were badly let down by the NHS and those responsible for healthcare regulation and supervision. Our thoughts are with the families who have suffered. This kind of long term failure must not happen again.

"We agree with Robert Francis that the NHS should maintain a positive patient-focused culture throughout.

"CQC's purpose is to make sure hospitals provide patients with safe and acceptable standards of care, underpinned by an open culture and effective leadership. The primary

responsibility for delivering quality care lies with the leadership of hospitals, care professionals, clinical staff and those who commission the care.

“No system can guarantee that there will *never* be failings. Regulators and supervisory bodies must be much better at identifying and challenging poor care and in working together to improve people’s experiences of care. And boards, managers, care staff and commissioners must take responsibility. And we must all listen to patients.”

The findings of the report, and ministers’ statements at that time set clear objectives for CQC which strengthen the Commission’s role as regulator. CQC will continue to operate as a single, unified regulator across health and social care. CQC has progressed with the recommendations of the Report with respect to appointing a Chief Inspector of Hospitals and proposes to appoint a chief inspector of social care and support, and a chief inspector of primary care and integrated support. This work will continue into 2013 and is reflected in the Commission’s strategy for 2013 – 2016.

The Commission’s priorities remain to:

1. Respond swiftly to concerns that suggest providers are not complying with the regulations and failing to safeguard the people for whom they have responsibility.

2. Ensure that all social care providers, independent health care providers and NHS trusts are inspected. Inspections continue to be unannounced, unless there are specific reasons for this not to be the case.

3. Review from a national perspective health and social care issues of public concern.

6. Going Forward

6.1 Strategic Aims and Objectives

The Board has also developed a Strategic Plan for its work going forward. This includes Strategic Aims and Strategic Objectives. These Strategic Aims and Strategic Objectives will be carried forward within each year's Business Plan.

6.1.1 Strategic Aims

The Board's Strategic Aims describe the principles that the Board adopts in its practice. They describe the values to be achieved by the Board in the course of meeting its objectives. The Board and its sub-groups are committed to the following:

I. Empowerment

Working to support people to manage risk in their own lives, with professionals supporting their decision making at each stage of the safeguarding adults procedures.

II. Protection

Working to ensure safeguarding adults procedures serve to end abuse and that decisions are made in line with the Mental Capacity Act.

III. Prevention

Working to gain reassurance of all partner organisations that prevention is a core element in the delivery, commissioning and development of services.

IV. Proportionality

Working to ensure the safeguarding adults procedures are used in appropriate circumstances and as a proportional response to concerns being raised.

V. Partnership

Working to develop joint working practices between organisations that promote coordinated, timely and effective responses for the adult at risk and other parties, and makes the best use of skills and resources.

VI. Accountability

Working to engage with and be responsive to the needs of all stakeholders necessary to promote the Board's Vision, including adults at risk, carers, service providers and the wider community. This includes working in ways that achieve effective, respectful, fair and valued outcomes for all the people the Board serves.

6.1.2 Three Year Strategic Objectives

The Board's three year objectives for 2013/14–2016/17 are set out here, aligned with the various work streams of the Board. Each year, when the Business Plan is agreed for the next 12 months, it will include various elements of these objectives. This will help to focus on longer term goals that need to be worked towards over more than one year.

Governance, Leadership and Partnership

Strategic Objectives:

- ❖ Multi-Agency Safeguarding Hub (MASH) type models of operational practice have been explored and considered.
- ❖ Effective working relationships of the Board has been sustained and developed, ensuring appropriate representation, membership and links to wider networks/Boards are embedded.
- ❖ Strategic links and key shared workstreams have been identified and included as relevant into the Board Business Plan. For example, shared agendas relating to:
    - Leeds Safeguarding Children Board
    - Safer Leeds Executive
    - Radicalisation (Prevent/Channel partnership work)
    - Homelessness and adults at risk
    - Substance misuse and adults at risk

Policies, Protocols and Procedures

Strategic Objectives:

- ❖ There is a full range of policy, procedures and guidance in place that provides a framework within which organisations can work together effectively to respond to abuse and neglect, and reflects developments in national guidance and legislation, as well as national/regional/local learning, and new approaches to safeguarding.

Training and Workforce Development

Strategic Objective:

- ❖ The training and workforce framework strategy incorporates local/regional and national policy, procedures and learning, and meets the needs of stakeholders involved in the safeguarding process.

Serious Case Review and Professional Practice

Strategic Objectives:

- ❖ Serious Case Review and Learning the Lesson Review procedures reflect best practice as established through local/regional and national learning as well as any relevant legislation.
- ❖ Effective systems have been developed and maintained to share the learning within Leeds from Serious Case Reviews and Learning the Lesson Reviews occuring both locally and nationally.

Performance, Audit and Quality Assurance

Strategic Objectives:

- Measures and processes effectively capture the outcomes of safeguarding adults work (such as improved levels of safety, improved sense of wellbeing, reduced levels of risk, successful achievement of outcomes desired by adults at risk).
- There is consistent recording and reporting of safeguarding information across partner organisations in Leeds, enabling sharing of intelligence at both a strategic and operational level.

Communication and Community Engagement

Strategic Objectives:

- Systems and resources have been developed that raise public awareness and understanding of safeguarding adults work.
- Adults who have experienced, or are at risk of abuse and neglect, shape and influence the development of safeguarding practice.
- All stakeholders who experience the safeguarding process have opportunities to inform and influence the development and improvement of that process.

Mental Capacity Act Implementation

Strategic Objectives:

- Where mental capacity cannot be presumed in relation to adults who need care or support services, mental capacity is formally assessed and subsequent decisions are reached in line with the Mental Capacity Act.
- All required Independent Mental Capacity Advocates (IMCA) instructions are made as required.
- Deprivation of Liberty Safeguards (DoLS) practice is in line with national requirements.
- The number of people who are assessed as lacking the mental capacity to make decisions about their safety and who have representation in the safeguarding process (from an advocate, friend or family member) is audited and any required improvement plans implemented.

6.1.3 Board Business Plan 2013/14

The Board Business Plan sets out the detail of the Board's continuous work programme. This includes information about how these identified priorities will be taken forward during 2013/14.

The Board Business Plan 2013/14 is available on the Safeguarding Adults Partnership website: www.leedssafeguardingadults.org.uk

Appendix A: Representation of Board Member Organisations

April 2012 to March 2013 [7]

Organisation	Invitee	Membership Status	April 2012	June 2012	Aug. 2012	Oct. 2012	Dec. 2012	Feb. 2013
Leeds Adult Social Care	Sandie Keene, Director of Adult Social Services	Ex-Officio Accountable Officer					✓	
Independent	Dr. Paul Kingston, Independent Chair	Chair	✓	✓	✓	✓	✓	✓
Leeds Adult Social Care	Dennis Holmes, Deputy Director, Strategic Commissioning	Full member	✓	✓		✓		
	Michele Tynan, Chief Officer	Full member			✓		✓	✓
	Maxine Naismith, Head of Service (also MCA LIN sub-group chair)	Deputy	✓	✓	✓	✓	✓	✓
	John Lennon, Chief Officer	Full member	✓		✓			
	Julia Suddick, Head of Service, Access & Inclusion	Deputy				✓	✓	✓
NHS Airedale, Bradford and Leeds	Diane Hampshire, Head of Safeguarding/Senior Designated Nurse	Full member	✓		✓	✓	✓	✓
	Luke Turnbull Designated Nurse – Adult Safeguarding	Deputy		✓	✓	✓	✓	✓
Leeds Teaching Hospitals NHS Trust	Al Sheward, Divisional Nurse Manager	Full member		✓	✓	✓	✓	
	Jill Asbury Divisional Nurse Manager	Full member						✓
Leeds Community Healthcare NHS Trust	Sam Prince, Director of Operations	Full member	✓				✓	✓
	Susan Lines, Head of Service	Deputy		✓	✓			
Leeds and York Partnership NHS Foundation Trust	Michele Moran, Chief Operating Officer and Chief Nurse, Deputy Chief Executive	Full member						
	Norman McClelland, Associate Director of Nursing	Full member	✓ (Deputy)	✓ (Deputy)				✓
	Steve Wilcox, Lead Clinician for Safeguarding Adults	Deputy			✓			
	Richard Hattersley Safeguarding Adults Manager	Deputy				✓		
West Yorkshire Police	Richard Jackson, Chief Superintendent	Full member		✓	✓	✓	✓	✓
	Julie Sykes, Detective Chief Inspector (also SCR&PP sub-group chair)	Deputy	✓		✓			

[7] Excludes the extraordinary Board Meeting on 5th December 2012 held to consider the findings of the completed Serious Case Review, see Page 6. Observers not recorded.

Organisation	Invitee	Membership Status	April 2012	June 2012	Aug. 2012	Oct. 2012	Dec. 2012	Feb. 2013
	Mark Griffin, Detective Chief Inspector	Deputy						✓
West Yorkshire Probation Service	Kevin Ball, Operations Manager	Full member		✓				✓
Leeds City Council Environment and Neighbourhoods	Liz Cook, Chief Officer, Statutory Housing	Full member						
	John Statham, Strategic Landlord Manager	Deputy					✓	✓
	Megan Godsell Housing Policy Manager	Deputy			✓			
Leeds City Council: Community Safety	Munaf Patel Head of Safeguarding and Localities	Full member				✓		✓
	Michelle de Souza Domestic Violence Manager, Community Safety	Deputy		✓				
West Yorkshire Fire & Rescue Service	Ruth Cornellison Area District Manager	Full member						✓
	Chris Lawton Assistant District Manager	Full Member	✓		✓			
Policies, Protocols and Procedures sub-group (PP&P)	Chair: Kieron Smith, LSAPSU	Full Member	✓	✓	✓	✓	✓	✓
Training and Workforce Development sub-group (TWFD)	Chair: Wendy Kelvin, NHS Airedale, Bradford and Leeds	Full Member	✓	✓	✓	✓		
	Chair: Anna Edgren-Davies Leeds Teaching Hospital NHS Trust	Full Member						✓
Serious Case Review & Professional Practice sub-group (SCR&PP)	Chair: Julie Sykes, West Yorkshire Police (also organisation deputy)	Full Member	✓		✓			
	Chair: Emma Mortimer LSAPSU (also organisation member)	Full Member						✓
Performance, Audit and Quality Assurance sub-group (PA&QA)	Chair: Rachel Gregson, Leeds and York Partnership Foundation NHS Trust	Full Member	✓	✓				
	Chair: Gareth Flanders Leeds and York Partnership Foundation NHS Trust	Full Member				✓	✓	✓
	Vice Chair: Richard Graham Adult Social Care	Deputy			✓		✓	
Communication and Community Engagement sub-group (C&CE)	Chair: Hilary Paxton, LSAPSU (also organisation member)	Full Member	✓	✓	✓	✓	✓	✓
Mental Capacity Local Implementation	Chair: Maxine Naismith, Leeds Adult Social Care (also organisation deputy)	Full Member	✓	✓	✓	✓	✓	✓

Organisation	Invitee	Membership Status	April 2012	June 2012	Aug. 2012	Oct. 2012	Dec. 2012	Feb. 2013
network (MCA LIN)								
Leeds ALMOs	Steve Hunt, Chief Executive, ENE Homes	Associate member						
Leeds Safeguarding Children Board	Bryan Gocke, LSCB Manager	Associate member						
LCC: Children's Services	Sarah Sinclair, Deputy Director Commissioning	Associate member						
	Carol Carson, Head of Service, Safeguarding	Associate member						
Voluntary Sector	Paul Belbin Development Manager, Gipsil	Associate member			✓		✓	✓
	David Smith Deputy Chief Officer, VAL	Deputy			✓			
Advonet	Annie French Manager: A4MHD	Co-opted member		✓				
	Philip Bramson Manager: A4MHD	Co-opted member						
Link / The Alliance of Service Experts	Joy Fisher, Alliance Chair	Co-opted member	✓	✓	✓			✓
	Emma Stewart	Deputy	✓	✓	✓	✓		✓
Care Quality Commission	Rod Hamilton, CQC Compliance Manager	Co-opted member	✓	✓		✓	✓	✓
Crown Prosecution Service (CPS)	Lizzy Mills, Equality, Diversity & Community Engagement Manager	Co-opted member						
Trading Standards Service	David Lodge, Trading Standards Officer	Co-opted member						
Leeds City Council Legal Services	Gerry Gillen, Corporate Lawyer,	Ex-officio member	✓	✓	✓	✓		✓
Leeds Safeguarding Adults Partnership Support Unit (LSAPSU)	Hilary Paxton, Head of Safeguarding Partnership Unit (also C&CE sub-group chair)	Ex-officio member	✓	✓	✓	✓	✓	✓
	Emma Mortimer, Safeguarding Adults Partnership Manager (also SCR&PP sub-group chair)	Ex-officio member	✓		✓	✓		✓
	Jayne Ogier, Board Minute Taker	Ex-officio member	✓	✓	✓	✓	✓	✓

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June 2013

Leeds Safeguarding Adults Partnership

Board Business Plan 2013/2014

Version:	June Board 2013
Ratified by:	Leeds Safeguarding Adults Partnership Board
Author:	Sub-group chairs group
Date issued:	June 2013
Review date:	Reviewed and updated for each Board meeting

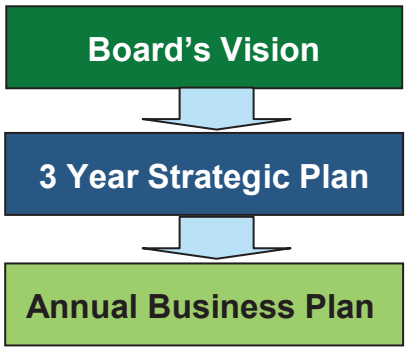
The Leeds Safeguarding Adult Partnership Board Business Plan 2013/14

The Board Business Plan details specific objectives to be addressed during 2013/14. The Board Business plan is designed to promote the Board's Vision and 3 Year Strategic Plan as described below:

Board's Vision – sets out the overall vision of the Board and the outcomes it wants to achieve for the citizens of Leeds.

3 Year Strategic Plan – establishes key areas of development required to achieve the Board's vision; providing direction and continuity to each year's Business Plan.

Annual Business Plan – provides a detailed plan of specific key actions, supporting actions and target timescales required over a 12 month period, in order to achieve the Board's Vision and Strategic Plan.



The Boards Vision and Strategic Plan can be located on www.leedssafeguardingadults.org.uk

The Board Business Plan sets out specific objectives within each of the identified work streams:

- Governance, Leadership and Partnership
- Policies, Protocols and Procedures
- Training and Workforce Development
- Serious Case Review and Professional Practice
- Performance, Audit and Quality Assurance
- Communication and Community Engagement
- Mental Capacity Act Local Implementation Network

Achievements against the Business Plan are reported to each Board meeting.

The Board Business Plan may need to be added to or amended during the course of the year in order to reflect continuous learning and competing priorities, and will include actions in progress from the previous Business Plan.

In the event that any individual, group or organisation feels that the Safeguarding Adult Partnership Board Business Plan omits important aspects of safeguarding that needs to be developed, they can write to the Chair of the Leeds Safeguarding Adult Partnership Board, detailing their recommendations. Any such recommendations will be given due consideration by the Chair of the Safeguarding Adult Partnership Board for inclusion into the Board's Business Plan.

Chair of the Safeguarding Adults Partnership Board
c/o Safeguarding Adults Partnership Support Unit,
4th Floor East,
Merrion House,
110 Merrion Centre,
Leeds,
LS2 8Q

Or email at: lsab.chair@leeds.gov.uk

Key Action	Start Date	Strategic Aims	Supporting Action(s)	Target Board Date	Progress Rating	Explanatory notes in relation to Progress Rating (inc. Actual Date of Completion)
1. Governance, Leadership and Partnership						
1.1 Hold a Joint Board Development Day with Children's Safeguarding Board and Safer Leeds Executive, in order to identify and plan for shared work streams	April 2013	Partnership	Development day held to identify shared agenda	June 2013	**Green**	
		Partnership	Board Chairs to agree objectives and work streams for approval by respective Boards	October 2013	**Green**	
1.2 Produce an Annual Report for 2012/13 detailing achievements and priorities as a Board.	April 2013	Accountability	Annual Report approved.	June 2013	**Green**	
1.3 Undertake workshops that promote close working practice between criminal and safeguarding adult investigations.	April 2013	Partnership	Learning disseminated and integrated into training.	October 2013	**Green**	
1.4 Review responses of member organisations to the Francis report and consider need for additional actions as a Board.	April 2013	Accountability	Summary of responses presented to Board.	October 2013	**Green**	
1.5 Review practice within Leeds against the learning from the Winterbourne View Serious Case Review.	April 2013	Accountability	Report to Board.	December 2013	**Green**	
1.6 Review governance arrangements and membership of the Board (including GP representation) ensuring these reflect the requirements of the Care Bill and other relevant guidance/legislation.	April 2013	Accountability	Arrangements captured in the Board's Memorandum of Understanding or successor document.	February 2014	**Green**	
1.7 Support regional approaches for more effective engagement of the DWP in the safeguarding adults	April 2013	Partnership	Advise the Board on progress.	February 2014	**Green**	
1.8 Explore potential and benefits of adopting an Multi-Agency Safeguarding Hub type model of practice in Leeds	April 2013	Partnership	Task group to be established. Report to the Board on findings.	February 2014	**Green**	

White	Green	Blue	Amber	Red
Unable to commence: Awaiting other action	**Progress towards milestone / timescale on track**	**Milestone Achieved**	**Timescale not met**	**Milestone delayed by more than 3 Board dates**

PP & P – Policy, Protocols and Procedures
T & WFD – Training and Workforce Development
SCR & PP – Serious Care Review and Professional Practice

C & CE – Communications and Community Engagement
PA & QA– Performance, Audit and Quality Assurance
MCA LIN – Mental Capacity Act Local Implementation Network

Key Action	Start Date	Strategic Aims	Supporting Action(s)	Target Board Date	Progress Rating	Explanatory notes in relation to Progress Rating (inc. Actual Date of Completion)
2. Policies, Protocols and Procedures						
2.1 Review and update the Advocacy, IMCA and Safeguarding Policy	April 2013	Empowerment	Policy revised in partnership with MCA LIN	August 2013	**Green**	
2.2 Develop, in partnership with the C&CE sub-group, an easy read Fact Sheet aimed at people alleged to have caused harm, informing them of the safeguarding procedures	April 2013	Empowerment & Accountability	Easy read version of safeguarding investigations: person alleged to have caused harm to be developed	October 2013	**Green**	
2.3 Produce guidance on Service User Towards Service User Abuse	April 2013	Protection & Proportionality	Draft guidance presented to Board	October 2013	**Green**	
2.4 Finalise LTHT/ASC protocol in relation to safeguarding coordination responsibilities	April 2013	Partnership & Accountability	Protocol reported to Board	October 2013	**Green**	
2.5 Review investigating institutional abuse guidance, addressing wider issues of abuse occurring within the context of health or social care provision.	April 2013	Protection	Draft guidance to be presented to Board	February 2014	**Green**	
2.6 Developing supporting guidance relevant to financial abuse.	April 2013	Prevention & Protection	Draft guidance presented to Board.	February 2014	**Green**	
2.7 Work with West Yorkshire Boards to support the development of a joint approach to safeguarding thresholds.	April 2013	Proportionality	Joint approach approved by the Board	Timescale to be agreed regionally	**Green**	
3. Training and Workforce Development						
3.1 Review the current Partnership safeguarding adults training needs.	April 2013	Protection	Training Needs Analysis Conducted	October 2013	**Green**	
3.2 Develop a peer to peer network with the aim of improving the quality of training on offer through peer observation, resource sharing and pooling, training	April 2013	Partnership & Protection	Training content audits and reviews of materials against changes to	October 2013	**Green**	

White	Green	Blue	Amber	Red
Unable to commence: Awaiting other action	**Progress towards milestone / timescale on track**	**Milestone Achieved**	**Timescale not met**	**Milestone delayed by more than 3 Board dates**

PP & P – Policy, Protocols and Procedures
T & WFD – Training and Workforce Development
SCR & PP – Serious Care Review and Professional Practice

C & CE – Communications and Community Engagement
PA & QA– Performance, Audit and Quality Assurance
MCA LIN – Mental Capacity Act Local Implementation Network

Key Action	Start Date	Strategic Aims	Supporting Action(s)	Target Board Date	Progress Rating	Explanatory notes in relation to Progress Rating (inc. Actual Date of Completion)
skills and support. The group will also facilitate the sharing of learning from cases and practice across the partnership.			procedures. Report to Board on case learning inclusion.			
3.3 Review the Partnership Training Framework	April 2013	Accountability & Protection	Conduct a review based on the response to the Training Needs Analysis	February 2014	Green	
3.4 Aggregate and monitor all current training provision across the Partnership and provide an overview to the Board.	April 2013	Protection & Prevention	Report provided to Board detailing training provision	February 2014	Green	
3.5 Review the Partnership's current approach to charging for training.	April 2013	Accountability	Review policy, provide proposals for change if required to the Board	February 2014	Green	
4. Serious Case Review and Professional Practice						
4.1 Review all existing policies and procedures in relation to establishing Serious Case Reviews.	April 2013	Accountability	Revised policy, procedures and guidance presented to Board	August 2013	Green	
4.2 In liaison with PA & QA Sub-group develop a framework for regular monitoring of agreed outcomes emanating from SCR Action Plans.	April 2013	Protection & Prevention	Framework developed and presented to Board.	August 2013	Green	
4.3 Develop clear criteria, procedures and templates for Learning the Lessons Reviews.	April 2013	Accountability	Draft criteria and procedure presented to Board	October 2013	Green	
4.4 Provide regular updates to Board of progress in relation to Serious Case Review and Learning the Lesson Reviews being undertaken	April 2013	Protection & Prevention	Updates provided.	February 2014	Green	

White	Green	Blue	Amber	Red
Unable to commence: Awaiting other action	Progress towards milestone / timescale on track	Milestone Achieved	Timescale not met	Milestone delayed by more than 3 Board dates

PP & P – Policy, Protocols and Procedures
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Key Action	Start Date	Strategic Aims	Supporting Action(s)	Target Board Date	Progress Rating	Explanatory notes in relation to Progress Rating (inc. Actual Date of Completion)
5 Performance, Audit and Quality Assurance						
5.1 Balanced Scorecard: Provide information as requested by the Board to assess the value of the proxy indicators and continue looking for national benchmarking	April 2013	Proportionality & Accountability	Advise the Board on progress to identify benchmarks and proxy measures in order to provide clarification to clarifying their potential value to the Board	August 2013	**Green**	
			If approved, monitor the indicators and provide a report to the Board	December 2013	**Green**	
5.2 Partner Agency Self-Assessment: Refresh the current self-audit template, implement and analyse the results	April 2013	Prevention & Accountability	Report provided to the Board advising of findings and recommendations.	October 2013	**Green**	
			On the basis of recommendations made, take any further appropriate action as directed by the Board	February 2014	**Green**	
			Presentation of subsequent Partner Audit (annually).	TBC	**Green**	
5.3 Information/data sharing– all partner agencies (notably ASC and NHS) to address access and recording	April 2013	Partnership & Accountability	Update the Board on progress as appropriate.	August 2013	**Green**	

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issues – in particular in relation to ESCR and ensure that the requirements of safeguarding are taken into account in the development of the new Client Information System presently due for implementation in 2014			On the basis of recommendations made, take any further appropriate action as directed by the Board.	TBC	Green	
5.4 Balanced Scorecard: Undertake a review of the balanced score care to ensure alignment with West Yorkshire procedures and statutory reporting requirements to ensure that the balanced score card continues to meet the Boards requirements for performance and quality assurance information	April 2013	Accountability	Report provided to the Board advising of findings and recommendations regarding the alignment of the West Yorkshire procedures and the Score card	August 2013	Green	
			On the basis of recommendations made, take any further appropriate action as directed by the Board	December 2013	Green	
5.5 Quality Assurance Framework – finalise framework, implement and evaluate findings, making recommendations to the Board as appropriate to improve practice (this will ensure that domain 3 of the Balanced Scorecard can be populated)	April 2013	Protection & Accountability	Report provided an update to the Board on implementation – action taken and further action planned	August 2013	Green	
			Subsequent report following implementation of the Quality Assurance Framework provided to the Board.	December 2013	Green	
			¼ report to be presented at	TBC	Green	

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			subsequent meetings, with assurance that the west Yorkshire procedures and the QA framework fully aligned and any necessary changes to the QAF are identified and implemented.			
5.6 Balanced Scorecard Finalise data collection and baselines for the Customer Perception domain	April 2013	Empowerment & Accountability	Run and assess a pilot implementation using lessons learned to fully implement the customer perception survey across all areas of safeguarding and review of approach to ensure it is fit for purpose.	October 2013	**Green**	
			Review of questionnaires in use and providing information for the customer perception dimension of the balanced scorecard,	February 2014	**Green**	
5.7 Balanced Scorecard– Review the scorecard to confirm that all parts can be and are being populated by activity performance data, monitoring of the Quality Assurance Framework and associated quality assurance audits or other sources.	April 2013	Protection & Accountability	Report to the Board	August 2013	**Green**	
			6 monthly report to Board on progress	February 2014	**Green**	

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6. Communications and Community Engagement						
6.1 Agree strategic objectives of a prevention of abuse campaign, and the approach required to achieve these objectives	April 2013	Prevention	Actions and objectives established and agreed	October 2013	**Green**	
6.2 Agree and implement process to capture views of key stakeholders at the end of each safeguarding episode, routinely share the learning with the TWF&D subgroup and PP&P subgroup of learning.	April 2013	Empowerment & Partnership	A) Process implemented for Adults at risk	December 2013	**Green**	
			B) Process implemented for Service providers	February 2014	**Green**	
			C) Process implemented for Relatives/informal carers	February 2014	**Green**	
			D) Process implemented in relation to case conference meetings	February 2014	**Green**	
6.4 Publicise preventative measures contained within Mental Capacity Act e.g. Last Power of Attorney, and Advanced decisions aimed at professionals and public	April 2013	Prevention & Empowerment	Advise on and make publicly available advisory information produced by MCA LIN Sub-group. Commencement of partnership campaign	October 2013	**Green**	Also see Action 7.2
6.5 Improve the accessibility of information in line with the EIA Screening	April 2013	Empowerment	Updates through sub-group chairs report	December 2013	**Green**	
6.6 Work with ASC and NHS commissioners to ensure that they understand advocacy needs within safeguarding and that these are reflected in both the advocacy commissioning strategy and the service specifications for individual advocacy providers.	April 2013	Empowerment	Update to Board on work with advocacy commissioners and providers in preparation for new contract.		**Blue**	New collaborative advocacy arrangements in place from April 2013.

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7. Mental Capacity Act Local Implementation Network						
7.1 MCA LIN maintains an overview of partner MCA/DoLS audits, performance and activity measures.	April 2013	Accountability & Prevention	Issues highlighted to Board as required.	August 2013	**Green**	
7.2 Develop, in partnership with the C&CE Sub-group, a leaflet(s) 'planning for your future in Leeds' e.g. advice on Lasting Powers of Attorney and other safeguards	April 2013	Empowerment	Provision of information	August 2013	**Green**	
7.3 Produce DoLS annual report 2012/13	April 2013	Accountability	Final report presented to Board	October 2013	**Green**	
7.4 Develop a joint approach with Children's Services to ensure that the MCA is fully implemented within Children's Social Care and its relevant partners.	April 2013	Accountability, Protection & Partnership	Expand membership of the MCA/LIN	October 2013	**Green**	
7.5 Undertake targeted work with identified providers and CHC teams to raise awareness, develop knowledge and skill sets in order to ensure that contract and statutory compliance in relation to the MCA is embedded.	April 2013	Accountability	Provision of training, support and information. Plus monitoring mechanism and revision of MCA/LIN membership	December 2013	**Green**	
7.6 Continue to monitor the resource impact and activity in relation to the transition of the transfer of supervisory functions from NHS to ASC	April 2013	Accountability & Protection	Issues highlighted to Board as required.	February 2013	**Green**	

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