Lincolnshire Safeguarding Adults Board

Annual Report 2024–2025

Protecting Adults • Promoting Wellbeing • Driving Change

AREAS IN RED ARE AWAITING NATIONAL DATA

Foreword - Independent Chair

As the Independent Chair of the Lincolnshire Safeguarding Adults Board (LSAB) I would like to welcome you to consider our annual report for 2024-2025. The report highlights the considerable work undertaken by all partners in delivering the Strategic Priorities of the LSAB together with how the board has fulfilled its duties as detailed within the Care Act 2014. The report additionally provides assurance of the work undertaken by the partnership in delivering the shared vision of the board of making Lincolnshire a place where adults feel safe, secure and may live free from abuse or harm.

I would wish to place on record my gratitude to the staff members of the LSAB who work tirelessly to coordinate and support the work of the board and the huge contributions made by partner agencies in supporting the work of LSAB.

Richard Proctor

LSAB Independent Chair.

The Lincolnshire Safeguarding Adults Board - LSAB

The main objective of Lincolnshire Safeguarding Adults Board (LSAB), as directed by the Care Act 2014, is to assure itself local safeguarding arrangements and partners act to help and protect adults in its area who:

- Have needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or at risk of, abuse or neglect
- As a result of those care and support needs is unable to protect themselves from either the risk of, or experience of abuse or neglect.

LSAB is a partnership body and has over 20 partner agencies as members. The Board sets direction and priorities, develops partnership working and holds partner agencies to account for the effective delivery of safeguarding arrangements across the County. The core partners are Lincolnshire County Council, the Lincolnshire Integrated Care Board and Lincolnshire Police.

Several Boards and sub-groups ran throughout the year looking at Strategic and Operational areas of safeguarding as well as specific issues such as Safeguarding Adult Reviews.

Locally, the Board has close working relationships with: Public Protection Board – a strategic coordinating group; Lincolnshire Safeguarding Children Partnership; the Safer Lincolnshire Partnership and Domestic Abuse Partnership.

Regionally and nationally the Board has strong working arrangements with the East Midlands Safeguarding Adults Network, the East Midlands Safeguarding Adults Board [SAB] Chairs Network and the National SAB Chairs Network.

Background to Board Development

In Lincolnshire, the Safeguarding Adults Board was established in 2010 in recognition of the need for all partner agencies to work together effectively to safeguard people that were at risk of harm, abuse and neglect.

The Care Act 2014 put this on a formal footing from the 1st of April 2015 and governance structures were put in place together with support arrangements. The governance structure was reviewed as part of the Peer Review in November 2017 and the support arrangements strengthened with the appointment of a Policy & Audit Officer.

Lincolnshire – Demographics

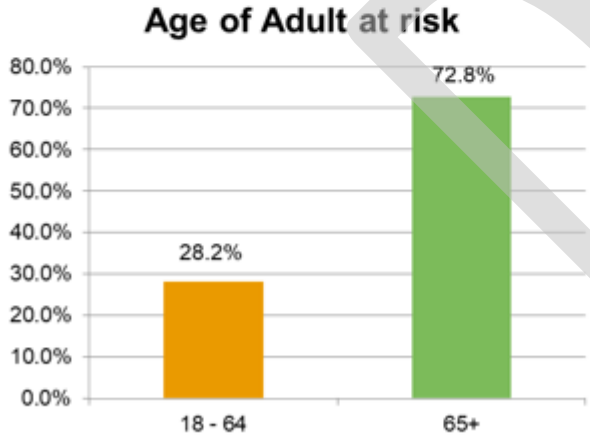
Lincolnshire is the 4th largest county in England covering an area of 5,921 sq. km. It is predominately rural, with some of its urban areas sitting within the highest levels of deprivation in the UK. These characteristics combined with a higher proportion of older residents gives us a population with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

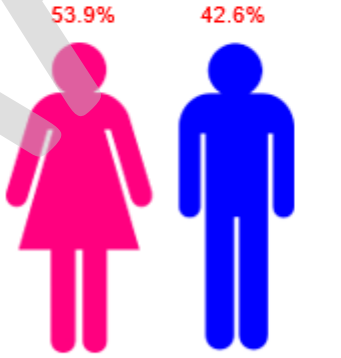
768,400
total population

51%
Female

49%
Male

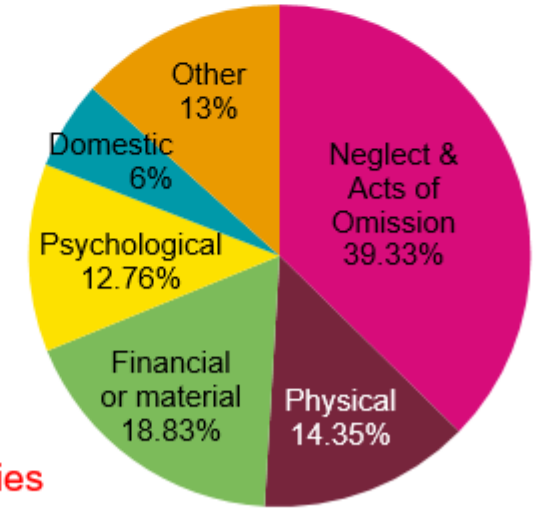
Safeguarding enquires data 2024/25





Nearly 60% of all safeguarding enquiries occurred in the victims own home

Types of Abuse 2021/22



Local Demographics

Lincolnshire is a largely rural County, and this poses challenges for effective and efficient delivery of services, with poor communication links both East/West and North/South. The population is 769,400, with a rapidly aging population in comparison to the national average. In addition, about 20% of Lincolnshire's inhabitants have long-term health problems or disabilities, limiting their day-to-day activities.

Vulnerable Groups

It is not possible to present a complete and definitive picture of the number of adults that may be at risk in Lincolnshire because some abuse or neglect may be hidden, despite the best efforts of local services to identify, assess, and support adults who are being harmed or are at risk of being harmed. However, the LSAB annually reviews data (both quantitative and qualitative) and other information such as the Joint Strategic Needs Assessments (JSNAs) carried out by the Health and Well-Being Board to gauge those specific groups deemed more vulnerable that need protection, such as:

- Adults with physical and sensory disabilities.
- Adults with Learning Disabilities and/or Autism.
- Adults experiencing Mental Ill-health;
- Adults frail due to age.

As in previous years the data has shown that risk settings are in a person's own home or care home/hospital setting, that the source of risk is mainly from family and care workers and that the majority of adults at risk are female and almost three-quarters of people at risk are over 65.

Strategic Priorities

Prevention and Early Intervention

The LSAB is committed to proactively identifying and mitigating safeguarding risks before they escalate. This includes enhancing the quality and safety of residential and nursing care, addressing pressure sores across healthcare providers, and tackling the domestic abuse of older adults through collaborative work with other statutory boards. Financial abuse prevention and supporting adults with complex needs—particularly through the next phase of the Team Around the Adult approach—are also key areas of focus. The Board aims to embed learning from reviews and assurance activities across partner agencies to reduce repeat incidents and improve outcomes.

Making Safeguarding Personal (MSP)

MSP is a person-led, outcome-focused approach rooted in the Care Act 2014. It emphasises empowering individuals to make informed choices and be actively involved in decisions about their safety and wellbeing. LSAB partners are expected to demonstrate that they engage with individuals at risk before raising concerns, seek to understand their desired outcomes, and work collaboratively to achieve them. The Board has implemented an MSP action plan and developed training resources to support this cultural shift across agencies, ensuring safeguarding is tailored and respectful of individual needs.

Learning and Shaping Future Practice

Continuous improvement is central to LSAB's strategy. The Board is trialling innovative approaches to Safeguarding Adult Reviews (SARs) and conducting assurance activities to inform best practices. By identifying themes such as professional curiosity and mental capacity, LSAB aims to drive targeted training and awareness initiatives. A key goal is to ensure that learning leads to measurable, system-wide change, fostering a culture of reflection and improvement across all safeguarding partners.

Safeguarding Effectiveness

To ensure robust governance and accountability, LSAB is enhancing its internal processes and external engagement. This includes developing a dynamic communications strategy, strengthening quality assurance through the Local Assurance Framework, and refining risk management protocols. Data-driven decision-making is a priority, with plans to expand the Assurance Dashboard for the LSAB Executive. Additionally, the Board is

committed to co-production, aiming to embed the voices of service users and communities into all aspects of safeguarding work.

Further insight into these strategic priorities and ongoing initiatives can be found on the;

Lincolnshire Safeguarding Adults Board (LSAB) website

Reviews & Learning – 2024/25

Safeguarding Adults Boards (SAB) have a statutory duty to undertake Safeguarding Adults Reviews (SAR) when: "….an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult"

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

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

The Significant Incident Review Group for Adults (SIRGA) is a sub-group of the Lincolnshire Safeguarding Adults Board (LSAB) which under the Care Act 2014 is responsible for Safeguarding Adults Reviews (SARs).The group met monthly throughout 2024-2025 with good and engaged representation from across the partnership. The groups programme of work includes the process of recommending and commissioning SARs as well as assuring the LSAB that recommendations and associated actions have been addressed by the multi-agency partnership and individual agencies. Between April 2024 and March 2025, the group activity in relation to the SAR process is detailed below.

Serious Incident Notifications received 3
Reviews initiated 0
Reviews completed 0
Reviews published 0

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

LSAB Website.

Ongoing SAR A referral was made by Lincolnshire Partnership NHS Foundation Trust regarding a potential SAR following the death of a man, in his forties. The male was found dead in his property. The cause of death was not confirmed but suspected to be completed suicide.

The notification was discussed at the Significant Incident Review Group meeting in February 2024. Following consideration of the full multiagency information a recommendation was made to commission a statutory, discretionary SAR, under section 44 (4) of the Care Act (2014).

The Independent Chair agreed with the SIRG recommendation and approved the commissioning of an SAR.

The SAR process is near completion, and the report is in the process of being finalised

The Significant Incident Review Group for Adults – What else have we done 2024-25?

- Reviewed the improvement priorities contained within the second national SAR analysis and considered how they apply to Lincolnshire.
- Introduced 'safeguarding stories' into its meeting to showcase good safeguarding practice and what this meant for the adult concerned.

- Introduced partner presentations to increase understanding of the interface between member organisations.
- Updated the professional curiosity resource pack
- Developed guidance on MCA and executive functioning,

SAR Recommendations

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

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

The recording system enables thematic analysis to capture learning from notifications that do not meet the criteria for a SAR

What more will we do?

- Work with other strategic boards will continue to look at opportunities to align processes and share learning
- here will be continuous exploration of approaches adopted for future SARs to ensure learning is identified in a timely way
- Work will continue to evidence the impact of learning emerging from SARs and SAR notifications

Prevention and Early Intervention Strategy

The Lincolnshire Safeguarding Adults Board (LSAB) underscores the fundamental belief that no one should suffer abuse, exploitation, or neglect. Despite this, some individuals remain at risk due to varying levels of vulnerability. National legislation mandates that local authorities and their partners work together to protect people from harm. In Lincolnshire, this responsibility is fulfilled through statutory bodies such as the LSAB, the Domestic Abuse Strategic Partnership, and the Safeguarding Children's Partnership, which collaborate to improve outcomes for residents.

In 2020, LSAB launched its first Prevention Strategy, which emphasised the concept of "collective wellbeing" alongside targeted interventions. This strategy promoted joint working among organisations to enhance safety and wellbeing. Notable successes included the introduction of Safeguarding Champions in care settings, increased access to annual health checks for adults with learning disabilities, and improved support for individuals misusing substances through joint policies. The Team Around the Adult (TAA) initiative was particularly impactful, earning national recognition for its support of people with complex needs.

Building on these achievements, LSAB has now introduced its second Prevention Strategy. This updated strategy continues to be grounded in the six principles of adult safeguarding and the ethos of Making Safeguarding Personal, which prioritises listening to individuals and respecting their desired outcomes. The LSAB remains committed to working collaboratively with statutory partners, communities, and individuals to promote safety, wellbeing, and rights, and to prevent safeguarding risks from escalating.

The new strategy outlines clear prevention priorities and reaffirms Lincolnshire's stance against abuse, exploitation, and neglect. By fostering strong partnerships and maintaining a proactive approach, LSAB aims to further improve collective wellbeing and ensure that safeguarding efforts are person-centred, effective, and inclusive. The strategy reflects a continued dedication to protecting vulnerable adults and enhancing the quality of safeguarding across the county.

The following are updates on work undertaken through the period covered by this annual report.

Prevention

Financial Abuse

Programme Purpose and Definition

The work programme aimed to prevent financial abuse affecting adults in Lincolnshire, aligning with the definition provided in Section 42(3) of the Care Act 2014. Financial abuse includes theft, fraud, coercion regarding money or property, and misuse of financial assets. The work sought to build a comprehensive understanding of the issue and improve protective measures for those at risk, with reference to fraud at present.

Evidence Building and Data Analysis

Efforts were made to strengthen the evidence base around financial abuse by updating existing reports, cross-matching police and adult care data, and developing a problem profile. A heat map of fraud prevention resource requests was compiled, and opportunities for improved data collection were explored. These steps were intended to identify prevalence, trends, and barriers to effective data gathering across agencies.

Community Awareness and Prevention Messaging

The programme delivered fraud prevention messages to communities through various engagement activities, including festivals, community talks, newsletters, and radio broadcasts. Although messaging mechanisms were in place, they were primarily focused on fraud rather than broader financial harm. The initiative aimed to prioritise vulnerable groups and ensure consistent public messaging.

Workforce Training and Support

Front-line workers received training and resources to help them identify financial abuse risks and communicate protective messages to clients. Activities included participation in national scams awareness programmes and fraud prevention conferences. The programme also promoted ambassador schemes to extend the reach of training and awareness efforts among professionals.

Capacity Building and Evaluation

Resources are available to support direct work with victims and those at risk of repeat victimisation. Partners were seeking to increase capacity to ensure availability of support for vulnerable people. Evaluation plans included both qualitative and quantitative measures such as training attendance, community engagement metrics, survey results, and feedback from support services. These assessments aimed to demonstrate improvements in knowledge, wellbeing, and community resilience against financial abuse.

Tackling the Domestic Abuse of Older Adults

Programme Purpose and Scope

The work programme focused on addressing domestic abuse (DA) affecting older adults, defined as individuals aged 65 and over. It aimed to enhance the collective wellbeing of this demographic through targeted prevention initiatives. The programme was developed under the oversight of Lincolnshire County Council and involved multiple stakeholders across community safety and adult safeguarding sectors.

Strategic Analysis and Data Integration

A series of analytical tasks were completed to inform the strategic direction of domestic abuse services. These included a strategic needs assessment, demand analysis, and a joint review of adult care and DA victim data. A dashboard was created to monitor trends and inform decision-making, supporting the review and refinement of the county's DA strategy.

Service Enhancements and Specialist Support

The programme introduced a dedicated Independent Domestic Violence Advisor (IDVA) role for older adults, ensuring tailored support for those at significant risk. It also explored the intersection of DA and dementia, establishing a task group to develop resources and guidance for professionals which includes piloting the resources and process with older adult LPFT area teams and also adult safeguarding teams within the county. Safe accommodation options were reviewed to ensure they met the needs of older adults, with plans for recommissioning and accreditation.

Awareness Campaigns and Professional Development

A communications plan was implemented to raise awareness among older adults and professionals. This included participation in national campaigns, webinars, and conferences. Collaborative efforts with third-sector organisations were initiated to co-produce training and engagement plans, aiming to reach underserved

communities and improve professional responses to DA, including quarterly workshops with businesses and LSAB contribute to online workshops for businesses re older adults

Evaluation and Future Considerations

The impact of the programme was assessed using both qualitative and quantitative data, including referral statistics, crime reports, training evaluations, and case studies. During this work potential areas were identified for future work, such as engagement with carers, hospitals, and faith groups.

Preventing and/or Limiting the Impact of Pressure Ulcers

Programme Aim and Structure

The programme aimed to reduce the occurrence and impact of pressure ulcers across NHS and independent sector providers. It focused on embedding prevention into care planning and delivery across hospital, residential, and nursing care settings. The initiative was structured around five key workstreams: Prevention, Communications & Engagement, Data & Intelligence, Standardising Care Delivery, and the Patient Safety Incident Response Framework (PSIRF).

Prevention and Standardisation Efforts

The prevention workstream undertook stakeholder mapping to guide targeted messaging for the public, informal carers, and health and care staff. Meanwhile, the standardising care workstream addressed risk assessment, care planning, equipment use, wound care practices, documentation, and staff competency. These efforts were designed to ensure consistent and effective care practices across all settings.

Data, Intelligence, and Safety Frameworks

The data and intelligence workstream focused on understanding the incidence of pressure ulcers and establishing a baseline for improvement. It considered benchmarking opportunities and aimed to develop mechanisms for monitoring and reporting progress. The PSIRF workstream integrated pressure ulcer reviews into broader patient safety incident responses, with a strong emphasis on learning and improvement.

Communications and Engagement Activities

Communications and engagement supported the other workstreams by facilitating awareness, training, and feedback. Surveys were launched to gather input from both the public and health and care staff, helping to shape future engagement strategies. The public survey also invited individuals to participate in co-production activities, enhancing community involvement in the programme.

Evaluation and Impact Measurement

Evaluation efforts considered reductions in pressure ulcer incidence, severity of reported incidents, safeguarding referrals, and staff understanding of prevention strategies. Challenges such as data gaps and duplications were acknowledged, particularly in settings like nursing homes. The programme planned to use confirmed datasets to establish improvement trajectories and meet reporting requirements, aligning with safeguarding board expectations.

Quality Improvement Plan

Reducing the percentage of adult safeguarding concerns that do not meet the criteria for a S.42 Enquiry

Current position

As discussed in the January 2025 update, this workstream has since been absorbed into the MSP task and finish group as it was identified there was duplication across both of the workstreams.

Meetings between LCC, ICB and EMAS as EMAS was one of the agencies that have the highest referrers for cases that do not meet the threshold for a delegated enquiry.

Work has been progressed as follows:

Update from EMAS:

- The Essential Education Programme for all frontline crews has been developed and delivered to EMAS educators. It will launch on 1st April 2025.

- Planning drop-in sessions to co-deliver and assess the quality of the sessions, with a focus on safeguarding referral quality. The sessions will include examples of strong and weak referrals and facilitate group discussions to analyse incorrectly completed referrals. Developing a pre-assessment questionnaire to assess learning over time.
- EMAS colleagues have visited crews in Lincoln. While the crews demonstrated strong knowledge, the new Essential Education Programme is expected to further enhance their skills.
- Met with a making safeguarding personal consultant working with Lincoln. The consultant expressed satisfaction with EMAS processes and will share a report after Board review.

Update from LCC:

- LCC confirmed its existing involvement in the regional board and will continue to collaborate with EMAS in that forum, ensuring a consistent approach to partnerships.
- A recent MSP consultant review of LCC will be shared with the Board. No new concerns emerged, and no direct recommendations were made for EMAS. The report primarily focused on existing data and ongoing known issues.
- The EMAS referral conversion rate has remained steady at 7.5% - 8% over the last three quarters. It is hoped that the regional approach and EMAS training will lead to increased rates in the future. Importantly, the rate has not declined.
- No significant concerns have been raised by LCC regarding EMAS referrals. LCC team has been reminded of the importance of sharing lessons learned with EMAS. Good feedback-sharing processes are in place.
- LCC maintains a positive and communicative working relationship with EMAS.
- Acknowledges that cultural shifts within EMAS will take time to reflect in measurable changes, given the organisation's size.

Based on the work that has been achieved and the systems and processes in place these meetings have now been stood down.

The use of the Quality Incident Form (QIF) - quality-incident-form-qif-.docx (live.com) which is in place for care home providers and home care providers is now part of the CHC and LCC quality monitoring indicators. The LCC safeguarding team also advice providers to complete the QIF when the criteria for a section 42 is not met.

Encourage safer recruitment initiatives across the Integrated Care System (ICS)

Current position

CareinLincs is the operational lead for this workstream as this is already part of his existing role for CareinLincs workforce.

A workforce strategy has been completed for social care titled " A Workforce Strategy for Adult Social Care in England". The Government have not yet agreed any of its recommendations as their main focus for the immediate future, is the development of Fair Pay Agreement which may support a number of the recommendations laid out in the Workforce Strategy for Adult Social Care.

CareinLincs are currently reviewing Lincolnshire's existing workforce strategy for the Adult Social Care Sector, Bridging the Gap. The aim is to develop a new strategy that looks to align itself to both the three clear deliverables of the NHS External Workforce Plan and also the three key deliverables found in the recent published Workforce Strategy for Adult Social Care. Timescale for completion is for an early draft for discussion to be submitted to the External Workforce Group at Lincolnshire County Council by June 25 and then a final document ready for circulation by the end of the of 2025.

Whilst providers have a responsibility to support international employees, LinCa have implemented a pastoral help desk and recruitment website: Resource Centre - Lincolnshire Care Association

A retention event has been held in March 2025, looking at funding streams to support social care workforce.

Along side this is consideration to the impact of the new proposed employment law: Government unveils significant reforms to employment rights - GOV.UK

LinCA is leading regionally on the support of International Recruitment.

DASS, at LCC leads the whole process for the East Midlands and LinCA oversees the pastoral support of all International Recruits across the region and is more specific to adult social care and seeking to support displaced individuals also.

Pastoral support for international recruits :: Lincolnshire One Workforce

This whole process is funded nationally by the use of government funding, and LinCA are now in the second year of the funding and doing some really important work as well in supporting Care Providers to understand their legal requirements to support Visa's

Improve the governance arrangements in relation to medicine management by care providers

Deputy Designated Nurse for Safeguarding Adults, Children and Looked After Children NHS Lincolnshire Integrated Care Board, was the operational lead for this workstream.

A task and finish group had been implemented with set terms of reference and six-weekly meetings to ensure the group maintained its momentum.

Five audit tools had been created in total to support medication governance in care homes. To date, the T&F group had agreed on all the audit tools. A care provider in the west of the county was piloting the tools to ensure they were fit for purpose; initial feedback had been extremely positive.

At a Skills for Care Event held in March 2025 for Quality Monitoring Officers across the Midlands and Eastern Region, the LCC Commercial team had provided a presentation on the work the team was doing to support the care home market in Lincolnshire. The work in relation to this Task and Finish Group had been shared, and there had been interest from a few attendees who asked whether we would be able to share our work.

The medication policy across care home settings, which had been shared at the last update, continued to be rolled out across the county. The figures showed that 93.2% of all Care Homes had accessed and used the Care Home Medication Policy, and a total of 20 Care Homes (6.8%) had declined to attend any of the 89 workshops. CareinLincs had delivered these workshops to support how to use the policy to its maximum. Additional work had been undertaken by the LCC Commercial team to support getting to 100%. A further attempt was being made to mop up the remaining care homes with another four workshops, but these dates had yet to be agreed with the facilitator.

It was proposed that the procedures would include the medication audit tools in the summer of 2025 when they were next due to be reviewed.

Each month, the Continuing Health Care (CHC) contracting team had been in receipt of Quality Incident Reports (QIR) from care homes that had a contract with the ICB. The data returns also included the number of incidents related to medicines. These returns were analysed by the CHC quality team and the ICB safeguarding team on a monthly basis. Any areas of concern were followed up by the CHC quality team.

Further increase the number of safeguarding champions in residential and domiciliary care.

Current position

LinCa is the operational lead for this work stream with the support of the ICB and DoLS team at LCC.

A training needs analysis has been completed by Care in Lincs which has confirmed there is still an appetite for the safeguarding ambassador programme. A review of the deliverables will take place and an agreement of any changes to the programme undertaken in order to ensure the Ambassador programme remains current.

The programme will be commissioned into 2025 and will be promoted by LinCA/CareinLincs when dates have been agreed with all the presenters.

Care Quality Commission (CQC) have supported a recent event in Lincoln and will replicate the same workshop in March to discuss changes and process that support providers to focus following the introduction of the new Single Assessment Framework by CQC.

The number of safeguarding ambassadors remains the same with the programme being delivered to 451 with a view to run another cohort in the summer 2025, subject to funding.

The next network meeting is being held in April 2025, with a focus on organisational abuse and making safeguarding personal. In the interim up to date information and any relevant guidance is shared by Care in Lincs newsletter.

Increase the number of employees who have completed the Skills for Care Care certificate

LinCa is already leading on this piece of work and has agreed to be the operational lead and will provide regular updates via this forum.

LinCahas shared the Government have announced a new Care Worker Pathway, which will replace the care certificate and will be replaced by a new Level 2 qualification. As is currently stands there is limited appetite by the providers unless it becomes mandated.

A training needs analysis has identified 1:4 providers are not participating but 80% are doing something similar which has been designed by Skills for Care, which is an Induction toolkit as part of the 90 days agenda: Please don't go! Why the first 90 days of employment are so important

The toolkit provides a plan and delivers a supportive and inclusive induction for new starters at all levels across all types of roles in adult social care.

Its emphasis the managers role in ensuring new starters are inspired and understand how to put expected standards and behaviours into practice. It also points out their role in noticing how staff are working during their induction period, identifying, and challenging any behaviour that is not in line with their expectations and supporting staff to succeed.

This toolkit will support managers to offer a robust induction to fully support new starters and ensure they create the right first impression.

The checklists at each stage provide lists of activities to consider with signposts to resources and templates which can tailor. It draws heavily on what providers across health and social care tell us works for them. Uptake of the new Care Certificate Level 2 Qualification remains very low due to a lack of easy access to central funding as well as the actual new qualification, not being a mandatory requirement to work.

Promotion of positive behaviour management across all settings

This piece of work has already been addressed in the Enhanced Health in Care Home (EHCH).

A pathway has been developed and shared across all care homes. The pathway was signed off via the EHCH by all partner agencies.

Individual cases where concerns are identified are to be escalated to the Service Quality Review then a strategy meeting will be convened with the relevant partners to ensure case by case is supported.

The behaviours of concern pathway is also part of the Lincolnshire Care Home Information pack which I have embedded but is in the process of being updated:

Minimise unsafe discharges from hospital

Deputy Director of Quality ICB is the operational lead for this workstream and has provided this update.

Themes identified are as follows:

- No plan of care prior to discharge
- Medication errors
- Medication delayed
- Readmission to UTC following discharge
- Miscommunication with care homes
- Palliative care patient
- Delays in discharge lounge

- Transport delay
- Equipment delay
- Missed care

The ongoing work includes:

- The Home First Partnership (HFP) Group consisting of hospital, community, social care and ICB staff, brings together the actions of the operational teams involved in coordinating and expediting timely and safe discharge of patients from hospital. This has moved to monthly meetings with new TOR focusing on patient experience.
- Nursing and Quality represented at Flow Partnership weekly meetings with senior leadership.
- Discharge Coordinator training
- Digital Transformation – tracks all admitted patients throughout their hospital journey
- Response to learning identified as part of Patient Safety Learning Responses
- Implementing significant changes surrounding the time and method of discharging patients from hospital to care hone settings – review of discharge time and how this is communicated. New process for evening discharges at night authorised by duty clinical site manager as discharge at night is not routine practice.
- Review of close Discharge Lounge overnight with the exploration of alternative placements through LCHS services for those requiring out of hospital care.
- Implementation of a new discharge checklist procedure that includes medication, removal of cannula, communication with patient and relevant carers, medical equipment in place, referrals to primary care and documentation – actions generated from the HPF.

Data is analysed from the 'Inappropriate Discharge' forms / Health Provider Feedback (HPF) that are shared with the LICB clinical risk team by care home and home care providers. These concerns specifically pertain to those reported against LPFT and ULTH and LCHS.

A breakdown of the themes and the number of concerns submitted per calendar month throughout the year are seen in the table below:

Unfortunately, many care homes are not sharing the concerns with the LICB directly, instead opting to share them with the Commercial Team at Lincolnshire County Council resulting in the LICB learning about them second-hand when Lincolnshire County Council forward these on to us.

Impact and Evaluation

This is evident in the higher numbers in April and September 2024, where LCC shared a cohort of concerns that were reported to them only. However, the use of these forms are being promoted at the CareInLincs Registered Managers forums. Reluctancy still remains due the lack of feedback which has been escalated to the Clinical Risk team at the LICB.

The Lincolnshire County Council Safeguarding team are reviewing their data and intelligence as part of the reducing the percentage of adult safeguarding concerns that do not meet a section 42. They are scoping out available datasets to inform baseline position in terms of providers that are frequent reporters that do not meet a section 42.

This scoping work includes consideration of availability of benchmarking data. Once datasets have been confirmed and baseline position identified work will be undertaken through the task and finish groups to establish improvement trajectories.

Impact for adults will be considered in relation to:

- Numbers of safeguarding referrals
- Reduction in number of referrals that do not meet a section 42. This is subject to confirmation of available data and reporting.

- Social care staff have access to a pathway to support complex residents with change in their behaviours.
- Reduced number of mediation errors – need to unpick how this will be achieved.
- Health and care staff have improved understanding of how to manage a quality concern and are confident with the safeguarding process through uptake of training opportunities; sharing learning; and distribution of information. How uptake of training etc is captured will need to be determined dependent on the offer.
- Patients will be discharged safely in line with the Early Supported Discharge and Flow aims.

Key stakeholders are part of the above task and finish groups for each workstream.

Making Safeguarding Personal (MSP)

Programme Purpose

The MSP Prevention programme was designed to enhance safeguarding practices by ensuring that adults at risk are central to safeguarding processes. It aimed to reduce the number of safeguarding concerns that did not meet the criteria for formal enquiries and to improve the consistency of MSP practice across partner organisations.

Establishment of Assurance Structures

An MSP Assurance Group was proposed following a recommendation from the Executive Board in March 2023. This group was tasked with overseeing improvements in safeguarding training, referral decision-making, and overall MSP implementation. The group was expected to be operational by April 2024.

Training Review and Competency Assurance

The programme included a comprehensive review of safeguarding training across agencies. This involved identifying training offers at various levels (L1–L4), tracking attendance against workforce targets, assessing training quality and relevance, and ensuring competency through follow-up evaluations and feedback mechanisms.

Referral Decision-Making Improvements

Agencies were asked to review their safeguarding tools, guidance, and policies to support staff in making appropriate referrals. The presence of safeguarding leads for advice, pre-screening processes, and individual audits were emphasised. Multi-agency audits were also planned to ensure consistency and shared learning.

Quality Incident Form and Reporting Barriers

The Quality Incident Form (QIF) was already in place but required further review. Discussions with the Care Quality Commission (CQC) were ongoing to address barriers and clarify reporting thresholds. The aim was to improve the effectiveness of incident reporting and ensure alignment across agencies.

Targeted Work and Data Utilisation

Data analysis was central to identifying referral sources and improving conversion rates. Agencies were expected to use this data to refine their safeguarding processes and provide assurance measures. Specific attention was given to improving engagement with emergency services and other key partners.

Consistency in MSP Practice Across Organisations

Each LSAB partner organisation was tasked with identifying a senior responsible officer to lead MSP improvement plans. These plans were supported by a task and finish group and aligned with the broader MSP Action Plan. The goal was to embed MSP principles consistently across all safeguarding activities.

Training Uptake and Practice Assurance

Between August and November 2024, 74 individuals completed MSP e-learning and 11 attended virtual workshops. Agencies were expected to monitor training uptake, assess quality, and ensure staff understood and applied MSP principles. This included mental capacity and advocacy assurance in safeguarding processes.

Evaluation Framework and Benchmarking

An impact and evaluation plan was developed to benchmark progress and measure improvements. Quarterly data collection was proposed to track training attendance, referral conversion rates, and MSP engagement. National and regional benchmarking data were used to set performance targets and guide improvement efforts.

Voice of the Adult and Stakeholder Feedback

The programme emphasised the importance of capturing the voice of the adult in safeguarding processes. Agencies were asked to collect data on adult awareness, consent, views, and desired outcomes. Feedback was to be gathered through audits, questionnaires, and engagement groups to ensure safeguarding remained person-centred and responsive.

Learning and Shaping Future Practice

LSAB Multi-Agency Training

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

During 2024/2025 there has been significant focus on promoting the LSAB training offer to all partners with targeted work being undertaken in relation to Making Safeguarding Personal (MSP). This has included a full audit of agency uptake and feedback in relation to the MSP Training package and significant updates being made to the eLearning module which enhances knowledge around prevention, multi-agency working and when to raise a safeguarding concern. This work has also included the training team observing the safeguarding triage team within the local authority to understand the Section 42 process along with challenges that the team face around referrals that do not meet the criteria. The training offer has been widened to enhance practitioner knowledge when working with parental conflict and domestic abuse. There has also been an increase in the number of MSP workshops being delivered as significant promotion and focus has increased the demand for this course.

A key development of the year has been the introduction of a new Trauma Informed Practice eLearning course which was co-designed with Lincolnshire Domestic Abuse Partnership and in collaboration with partners across Adults and Children's services. This work is the start of developing a trauma informed practice training offer which will include a new face to face course due to commence in 2026.

Additionally, work has been undertaken to respond to challenges around non-attendance at training. This has including strengthening reports which are shared with training leads and requesting partners act where staff are identified as repeat non-attenders. This has led to a drop in the percentage of non-attendance instances from 19.6% in June 2024 to 13.4% in March 2025.

Free Voluntary Sector Briefings continue to be delivered jointly with the Safeguarding Children Partnership. These briefings are held online, quarterly. This year, a wide range of topics were covered including Exploitation and Safer Recruitment. There were two sessions which highlighted learning from adult reviews which included a briefing focusing on self-neglect and hoarding, 44 professionals attended representing 24 organisations including Age Uk, local care homes, Dementia support services and YMCA. The March session focused on learning from safeguarding reviews and professional curiosity, 45 professionals attended representing 33 organisations including St Barnabas Hospice, Lincolnshire, Nottinghamshire Air Ambulance, and Diocese of Lincoln.

Evaluations continue to be collected following all training completions which provide an overview of positive feedback and suggested developments. There has also been a wider focus on measuring the impact of training courses via 3-monthly follow-up evaluations.

Where new courses are introduced, feedback is reviewed regularly to respond to any developments needed. This has included encouraging staff to take regular breaks when completing the trauma informed practice training, additional links to videos being provided at the end of the course and a disclaimer about the length of the eLearning. We are also considering potentially separating the current module into two modules so that staff across different roles are accessing the relevant level of content. Feedback from this course has however been mostly positive and has included:

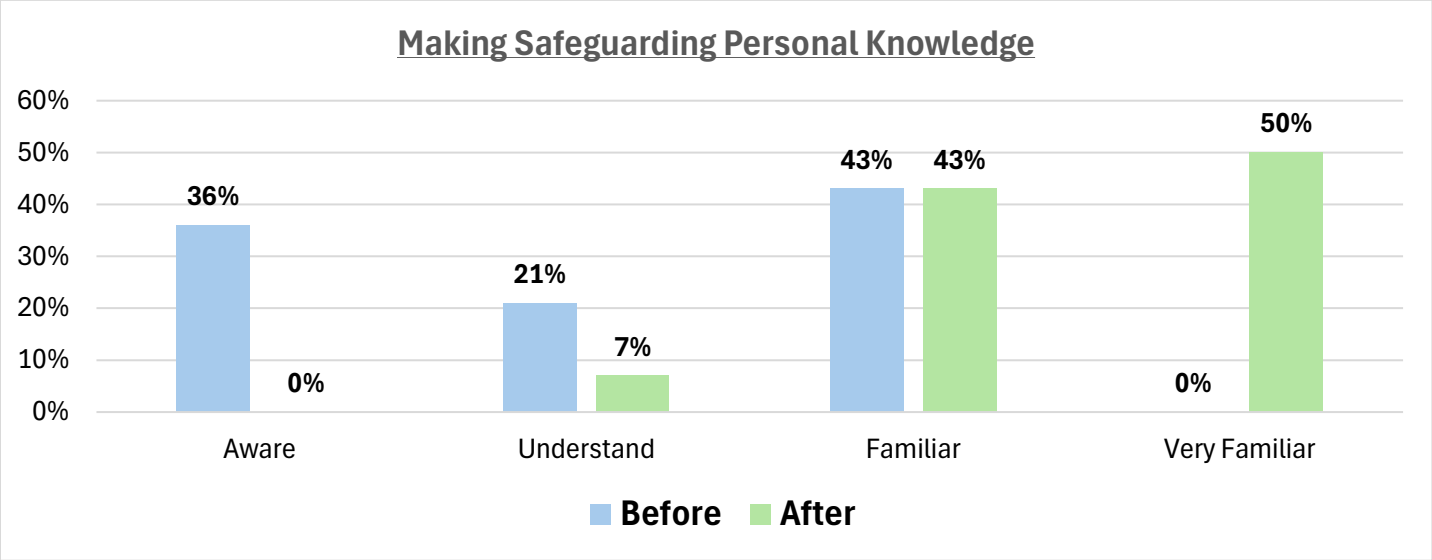
"I can't think of any improvements, it was informative engaging and useful - what we have needed for a long time. "

"It is essential for understanding and supporting people who may have experienced trauma. It has taught me the importance of creating a safe empathetic environment that prioritises trusts and avoids more trauma. The trauma recovery model was very helpful, and I will use this in my work. "

"This training has been more in depth than other similar training and I feel better informed."

"The training has increased my awareness on how to interact to gain best outcomes."

Staff are also asked to identify whether their knowledge has increased on completion of all courses. This example provided highlights an improvement in knowledge for all staff following completion of the Making Safeguarding Personal eLearning and Virtual Workshop.



The training uptake continues to be popular and attendance at some training courses has increased since the last report. This is in response to the promotional and targeted work undertaken by the training team.

Across the year overall attendance at workshops and face to face events totals 290, an increase of 85 attendees in comparison to 2023-24.

Virtual Workshops	**Workshops**	**Increase from last year**	**Attendees**	**Increase**
Making Safeguarding Personal	13	+4	156	+61
Recognising and Supporting Parents in Parental Conflict	11	+1	3	-10
Face to Face	**Courses**	**Increase**	**Attendees**	**Increase**
Domestic Abuse in Practice	25	+13	123	+45
Child to Parent Carer Abuse	Currently being reviewed and updated to reflect Lincolnshire process.			
Recognising Disguised Compliance (New addition for Adults services this year)	12	+3	8	-8
TAC Young Carers Workshop	Currently being reviewed and updated.			

Enrolment on e-learning courses has also increased overall since the last report with 14,389 courses being completed, an increase of 2,932. This is in response to the promotional and targeted work undertaken by the training team and the widening of the training offer to include additional courses and content. New courses that have been developed or made available this year are highlighted in green. There are some courses which show a drop in numbers, the training offer is mapped across a 6-year period and therefore different courses are more popular each year dependent on whether new staff start the pathway or existing staff follow the gradual yearly format.

Course	Total	Change	Course	Total	Change	Course	Total	Change
Introduction to Safeguarding Everyone in Lincolnshire	2402	-309	Mental Capacity Act - Basic Awareness	470	+113	Domestic Abuse Supporting and Understanding Men Who Experience Domestic Abuse	181	+83
Tackling Exploitation and Modern Slavery in Lincolnshire	2014	+611	Domestic Abuse DASH	467	+96	Self-Neglect	162	+1
Domestic Abuse Awareness - Short Course	1507	-240	Deprivation of Liberty Safeguards (DoLS)	357	+92	Equality, Diversity and Inclusion for Employees	146	+146
Friends Against Scams E-Learning	1347	+343	FGM (Abuse linked to faith or belief)	282	+78	Dementia Awareness	144	+24
Zero Suicide Alliance Training	1177	+558	Domestic Abuse MARAC & MOP	273	+2	Mental Health Awareness	125	+12
Introduction to Safeguarding Adults	520	+32	Radicalisation and Extremism	267	-175	Refresher Safeguarding Adults	124	+48
Making Safeguarding Personal – Prerequisite	503	+153	Parental Domestic Abuse, Substance Misuse and Parental Mental Illness	215	+215	Domestic Abuse The Importance of Language in Domestic Abuse	121	+26

The largest increases are seen across eLearning which focuses on exploitation, suicide and making safeguarding personnel, which have been key focuses of the board. The largest drop is seen in the Introduction to safeguarding everyone eLearning course, which is an introduction to safeguarding themes, this drop is likely linked to the format of the training pathway, and the wider engagement and completion of other courses is more beneficial to staff in terms of maintaining a wider understanding of safeguarding across the board. A drop has also been highlighted on Radicalisation and Extremism eLearning; this is likely due to the course being supplementary to the mandatory Prevent training available outside of our training offer which is to be prioritised by all services.

Course	Total	Change	Course	Total	Change	Course	Total	Change
An Introduction to Trauma Informed Practice	47	+47	Domestic Abuse in Practice Prerequisite	206	-59	Modern Slavery and Trafficking	116	-32
Understanding the Impacts of Hate Crime	109	-67	Domestic Abuse Safe Accommodation	72	+72	TAC Young Carers Short Course	48	+5
Domestic Abuse and Disabilities in Adults and Children	92	+92	LGBTQ+ Awareness	67	+6	Operation Encompass in Lincolnshire	45	+45
Understanding Healthy Parental Relationships and its Impact on Child Outcomes	89	+89	Understanding Animal Welfare in Violent Homes	66	+66	Quality Incident Form	40	-4
Specific Conditions in Social Care	81	-23	Transition to Adulthood as A Child In Care	59	+59	Recognising and Supporting Parents in Parental Conflict Pre-Requisite	17	+17

Safeguarding Effectiveness

Throughout 2024-2025 the Board has continued to benefit from the full and active support of all partner agencies. This includes our statutory partners—the Local Authority, Integrated Care Board (ICB), and Police—as well as our valued partners from across the wider safeguarding landscape. All seven district councils, voluntary sector agencies, all emergency services, and care provider representatives have played a vital role in shaping our collective approach.

The collaborative work undertaken by all partners has consistently demonstrated that our impact is far greater than the sum of our individual contributions. This strong partnership has fostered a positive culture of constructive challenge, encouraged the development of innovative service models, and strengthened our safeguarding teams across the county.

Over the past year, this spirit of collaboration has enabled us to respond effectively to emerging challenges, adapt to changes in national policy, and maintain a relentless focus on improving outcomes for adults at risk. Our Board has continued to champion best practice, share learning, and drive forward improvements in safeguarding across all sectors.

Some key pieces of work undertaken during 2022-2024 include:

Professional Curiosity Resource Pack - Update & Learning from SAR Anthony: The Professional Curiosity Resource Pack has been revised to incorporate key lessons from the Safeguarding Adult Review (SAR) for Anthony. This pack is designed to help practitioners develop the skills to look beyond the obvious, ask probing questions, and challenge assumptions when working with adults at risk. It encourages staff to be “respectfully nosey,” triangulate information from multiple sources, and reflect on their own biases. The resource is intended for use in team meetings, supervision, and individual development, and includes scenarios, top tips, and guidance for managers.

Survey & Assurance: A survey was completed by partner agencies to assess how professional curiosity is being embedded across the partnership, ensuring that the approach is not just theoretical but actively practiced.

National Guidance Adoption: The Board has also adopted national guidance on professional curiosity, aligning local practice with best practice standards.

Executive Functioning Guidance - SAR Anthony Recommendation: As a direct recommendation from SAR Anthony, new guidance on executive functioning has been developed collaboratively with relevant partners. Executive functioning refers to the cognitive processes that enable individuals to plan, focus attention, remember instructions, and juggle multiple tasks. The guidance helps practitioners identify when difficulties in executive functioning may impact an adult’s ability to safeguard themselves, make decisions, or engage with services. It also outlines practical support strategies and the importance of considering executive functioning in capacity assessments.

Self-Neglect Guidance - Ongoing Development & ULTH Lead: The self-neglect guidance continues to evolve in response to SAR Anthony, with United Lincolnshire Hospitals Trust (ULHT) taking the lead. The guidance provides a multi-agency protocol for identifying and responding to self-neglect, which includes behaviours’ such as hoarding, poor personal hygiene, and refusal of care. It emphasises the need for proportionate, person-centered responses and multi-agency collaboration.

Transitional Safeguarding - Joint Work with LSCP: Transitional safeguarding is a developing area focused on improving the experience of young people moving from children’s to adults’ services. LSAB has supported the Lincolnshire Safeguarding Children Partnership (LSCP) in joint work to ensure smoother transitions, recognising that young people’s needs do not change overnight at 18. This work aims to bridge gaps in support and ensure continuity of care and safeguarding for vulnerable young people in Lincolnshire.

Voluntary Sector Briefings - Ongoing Collaboration: In partnership with LSCP, LSAB continues to deliver quarterly briefings for the voluntary, community, faith, and social enterprise (VCFSE) sector. These sessions cover key safeguarding themes, including self-neglect and professional curiosity, and are designed to support those working in the third sector to recognise and respond to safeguarding concerns. Presentations and resources are shared to build sector-wide capacity.

Second National SAR Analysis - SIRGA Review & Large-Scale Enquiries: Under the Significant Incident Review Group for Adults (SIRGA), partners have reviewed national improvement priorities from the second

national analysis of SARs. Lincolnshire's position was assessed, leading to a review of LSAB's policy on Large Scale Enquiries complex cases involving multiple adults or organisational abuse. This ensures local practice reflects national learning and is robust in responding to systemic safeguarding issues.

QA Model - New Assurance Model: Partners have approved a new Quality Assurance (QA) model to replace the Lincolnshire Assurance and Assessment Framework (LAAF). The new model incorporates self-audit, peer review, and crucially, the voice of the adult, ensuring that assurance activities are more reflective, inclusive, and focused on outcomes for those at risk.

QIF (Quality Improvement Framework) - Ongoing Effectiveness Review: The Quality Improvement Framework (QIF) is regularly reviewed in collaboration with partners to ensure its effectiveness. This framework underpins continuous improvement in safeguarding practice, supporting agencies to identify strengths, address gaps, and share learning.

PPET (Policy, Practice, Education and Training) - Joint Sub-group with LSCP: LSAB has joined the well-established LSCP PPET sub-group, creating a joint forum for developing, reviewing, and maintaining safeguarding policy, practice, education, and training. This collaboration strengthens co-board working, ensures consistency across children's and adults' safeguarding, and supports shared learning and development.

Rough Sleeping

Purpose and Context

The Lincolnshire Homelessness Partnership produced an assurance report in response to a government directive issued in May 2024, which required Safeguarding Adults Boards to seek assurance on homelessness and rough sleeping. The report aimed to demonstrate that effective arrangements were in place across Lincolnshire to meet statutory responsibilities and protect vulnerable adults at risk of homelessness. It outlined the strategic context, including national commitments to tackle homelessness and the local ambition that homelessness should be rare, brief, and non-recurring.

Approach and Governance

The partnership had implemented the Lincolnshire Homelessness and Rough Sleeper Strategy in January 2023, focusing on five priorities supported by multi-agency collaboration. The Housing, Health and Ageing Well Delivery Group worked to integrate housing with health and social care, while the Lincolnshire Safeguarding Adults Board assumed oversight of rough sleeper assurance. The report confirmed that governance arrangements were strengthened to ensure scrut*iny and continuous improvement in safeguarding practices.*

Local Safeguards and Protocols

The report highlighted statutory duties under the Homelessness Reduction Act 2017, including early intervention and the duty to refer by public authorities. It described local mechanisms such as Vulnerable Adults Panels and the Team Around the Adult process, which addressed complex cases through multi-agency collaboration. Protocols for severe weather, prison release, care leavers, hospital discharge, and individuals with no recourse to public funds were reviewed or developed to ensure consistent safeguarding responses.

Delivery and Achievements

During 2024/25, the partnership achieved several milestones, including expanding health support for homeless individuals, publishing protocols, and piloting a new referral process with Probation. It secured Rough Sleeper Accommodation Programme funding, reviewed specialist accommodation needs, and re-established operational and strategic groups to improve multi-agency working. Data collection frameworks were introduced to monitor homelessness trends, and rough sleeper numbers were tracked monthly, showing seasonal fluctuations and ongoing challenges.

Challenges and Future Actions

The report acknowledged gaps such as limited immediate-access accommodation, insufficient mental health support, and barriers to move-on housing. It emphasised the need for assertive outreach, improved communication between agencies, and flexible engagement with individuals deemed non-engaging. Key actions for 2025/26 included increasing accommodation supply, enhancing mental health access, improving move-on options, and strengthening system-wide collaboration to reduce rough sleeping across Lincolnshire.

Conclusion

The Lincolnshire Safeguarding Adults Board has demonstrated commendable commitment and collaboration throughout 2024–2025, delivering impactful initiatives across prevention, learning, and safeguarding effectiveness. From the expansion of multi-agency training and the introduction of trauma-informed practice to the strengthening of strategic partnerships and the development of innovative safeguarding models, the Board's work has clearly advanced the safety and wellbeing of adults at risk. The proactive approach to financial abuse, domestic abuse of older adults, and pressure ulcer prevention reflects a deep understanding of local needs and a drive to embed learning into practice. These achievements are a testament to the dedication of all partners and the Board's strategic leadership.

However, the report also highlights that safeguarding is a continually evolving landscape, and there remains significant work to be done. The absence of completed or published Safeguarding Adults Reviews this year, despite serious incident notifications, underscores the need for timely learning and system responsiveness. Challenges such as data gaps, training non-attendance, and the complexity of multi-agency coordination persist and require ongoing attention. The Board's commitment to co-production, embedding service user voice, and refining assurance frameworks is encouraging, but these efforts must be sustained and expanded to ensure safeguarding is truly person-centred and effective. As pressures on services grow, the Board must continue to innovate, challenge, and adapt to ensure that adults in Lincolnshire are protected and empowered.

LSAB Financial Situation

The Lincolnshire Safeguarding Adults Board (LSAB) is funded through contributions from its three statutory partners: Lincolnshire County Council (Local Authority), Lincolnshire Integrated Care Board and the Office of the Police and Crime Commissioner (OPCC). These contributions are essential to supporting the Board's statutory duties under the Care Act 2014, as well as its strategic priorities aimed at protecting adults at risk across the county. The Board remains grateful for the continued financial support and commitment from these partners, which enables the delivery of safeguarding initiatives, multi-agency training, and assurance activities.

In recent years, the Local Authority has absorbed a significant financial overspend to ensure the Board's work could continue uninterrupted. This support has been critical during periods of increased demand and programme expansion, particularly as LSAB has developed new strategies around prevention, trauma-informed practice, and safeguarding effectiveness. While this has demonstrated the Local Authority's dedication to adult safeguarding, it has also highlighted the need for a more sustainable funding model that reflects shared responsibility across all statutory partners.

To address this, LSAB has undertaken a comprehensive review of its operations and is now streamlining its services to align with the increased financial contributions from the Police, OPCC, and Local Authority. This includes refining programme delivery, prioritising high-impact initiatives, and enhancing efficiency across its support functions. The Board is confident that these changes will ensure long-term financial sustainability while maintaining the quality and reach of its safeguarding work. This collaborative approach reinforces the shared commitment to protecting vulnerable adults in Lincolnshire and delivering meaningful outcomes through a well-resourced and accountable partnership.

Final words from the Chair

This report provides clear evidence of the work undertaken in delivering both the strategic aims of the board together with its statutory requirements as per the Care Act 2014.Whilst acknowledging the many challenges our partner agencies face in respect of increasing demand and financial pressures, my view is we will continue as a board to improve outcomes for "adults at risk" if we continue to work together.

Richard Proctor Independent

Chair- LSAB

Abbreviations Used in LSAB Annual Report 2024–25

Abbreviation	Meaning
LSAB	Lincolnshire Safeguarding Adults Board
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
SIRGA	Significant Incident Review Group for Adults
JSNA	Joint Strategic Needs Assessment
MSP	Making Safeguarding Personal
MCA	Mental Capacity Act
IDVA	Independent Domestic Violence Advisor
LPFT	Lincolnshire Partnership NHS Foundation Trust
PSIRF	Patient Safety Incident Response Framework
ICS	Integrated Care System
CQC	Care Quality Commission
QIF	Quality Incident Form / Quality Improvement Framework
VCFSE	Voluntary, Community, Faith, and Social Enterprise sector
LAAF	Lincolnshire Assurance and Assessment Framework
QA	Quality Assurance