LEICESTER SAFEGUARDING ADULTS BOARD

Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

ANNUAL REPORT

2021/22

Leicester

Safeguarding Adults Board

Annual Report

2021/22

Report prepared and published in accordance with paragraph 4 of Schedule 2 of the Care Act 2014

Report Date: June 2022

An easy read version of this document is in development and will be published on the Safeguarding Adults Board page of the Leicester City Council website

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Foreword

I am writing this foreword as my third and final year in the role of Independent Chair of the Leicester City and Leicestershire & Rutland SABs draws to a close.

I recently reflected on our journey over the last three years with the 'Statutory Partners' to the boards – the Police, NHS Integrated Care Board, and the Directors of the three local Adult Social Care services. We agreed that

- The two SABs work much more effectively together, whereas three years ago, their meetings and a number of their functions were separate
- The Statutory Partners, who the Care Act says are equally responsible for the SAB, work more closely together and have scheduled conversations about risks in the system, which in turn I have valued as chair because it helps set the context in which we work
- Links between the various strategic partnership boards that are required by law, are much stronger and the SAB members are clearer about what we contribute to issues that affect families and communities. The places where this linkage is strongest are in working between the adults' and children's safeguarding partnerships for LLR; and at a Police and Crime Commissioner committee called the Vulnerability Executive
- The two Safeguarding Adults Boards' approach to setting priorities based on data, is welcome. We are currently working on Hidden Harms and on Safeguarding in Care Homes.
- Shorter and more focused board meetings are allowing us to be more agile as a partnership. For example, we were the first partnership that I know of who tabled an urgent item on safeguarding risks associated with people arriving from Ukraine.
- There is an expectation that board members are open to scrutiny and are accountable. Alongside this, an inclusive culture has been developed thanks to everyone, and this culture means we shape the agenda so that all members are able to contribute
- Colleagues have worked together to create a comprehensive set of reports to the SABs on issues affecting the group of people with Learning Disabilities and Autism who have the most complex needs and are one of the groups of people we are most concerned about from a safeguarding perspective.
- One of the statutory functions of a SAB is to carry out Safeguarding Adults Reviews of people with care and support needs, when harm or neglect is suspected, and certain other criteria are met. Over the last three years we have become more effective at completing these reviews faster and writing for publication, using innovative approaches in some cases.

The report sets out the achievements of the board and of its partners. The Care Act guidance says that a Safeguarding Adults Board should be more than the sum of its parts and I think that the depth of items we have covered at the board and the actions carried out, show this in action.

I would like to thank everyone for your partnership, hard work and openness. The teams that support the board keep things working behind the scenes. Over the last year they have done a wide range of very

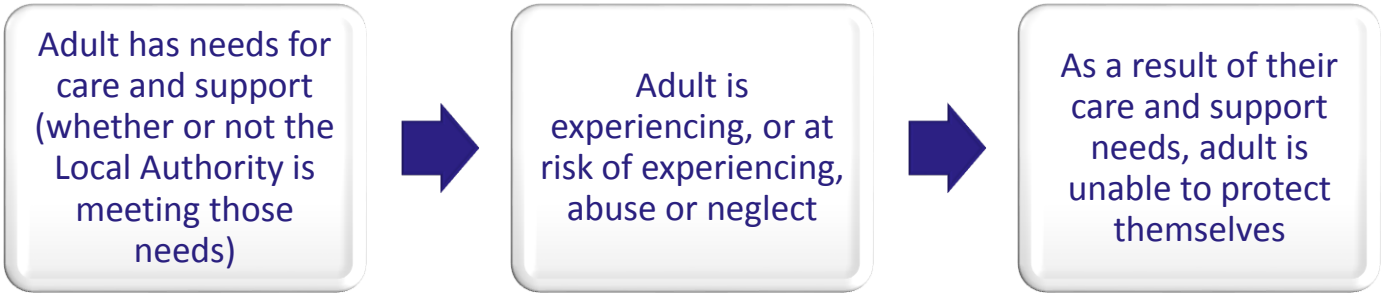
different tasks to promote learning, awareness and share their analysis of adult safeguarding data. This includes creating some really powerful adult safeguarding resources as well as overseeing review processes, including doing skilful and empathic liaison with families involved in reviews. Everyone on the board and in the various subgroups has been engaged with the board's work and I thank you all for your support and wish the very best to the next chair.

Fran Pearson

LSAB Independent Chair

The Board

The main objective of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the following criteria:



Leicester's Safeguarding Adults Board (SAB) must seek to achieve this objective by coordinating and ensuring the effectiveness of each of its members in relation to adult safeguarding. We have a strategic role that is greater than the sum of the operational duties of our partners; we oversee and lead adult safeguarding across Leicester and are interested in a range of matters that contribute to the prevention of abuse and neglect.

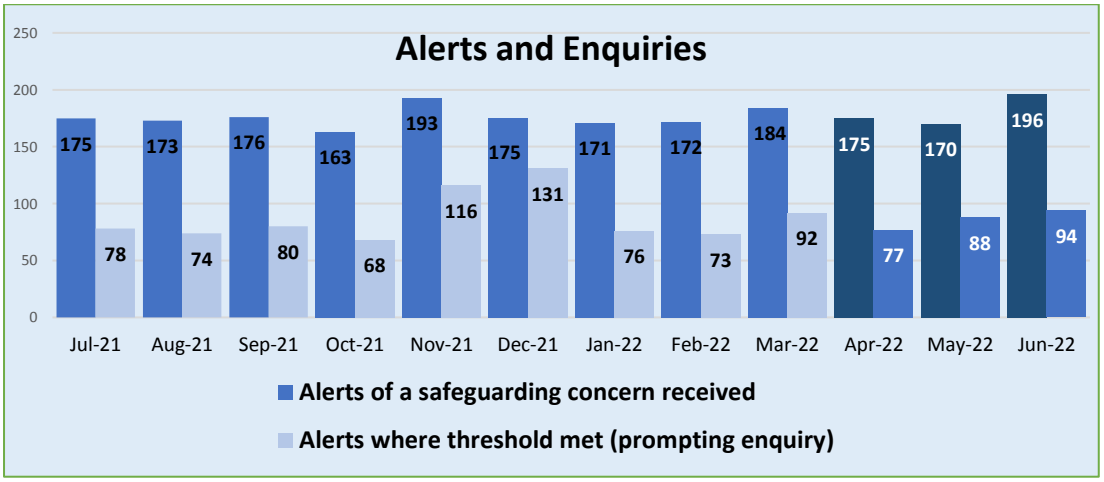
LEICESTER SAB MEMBERSHIP		
Criminal Justice	Leicestershire Police	1
	HMP Leicester	1
	National Probation Service (NPS)	1
Emergency Services	East Midlands Ambulance Service (EMAS)	1
	Leicestershire Fire and Rescue Service (LFRS)	1
Health	Leicester City Clinical Commissioning Group (CCG)	2
	Leicestershire Partnership NHS Trust (LPT)	1
	University Hospitals Leicester NHS Trust (UHL)	1
	NHS England	1
Local Authority	Adult Social Care	3
	Children's Social Care and Education	1
	Housing	1
	Community Safety	1
	Trading Standards	1
	Lead Member	1
Inspectorates	Care Quality Commission (CQC)	1
Consumer Champions	Healthwatch	1
Care Home Associations	East Midlands Care Association (EMCARE)	1

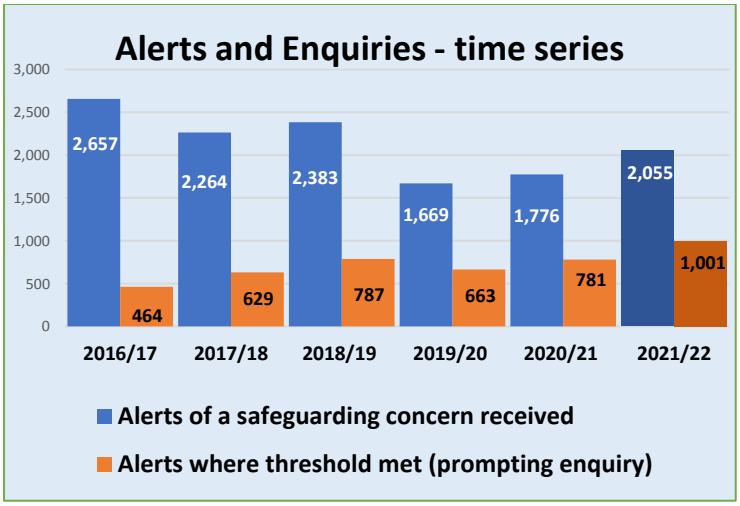
A SABs statutory partners are the Local Authority, the Police, and the Clinical Commissioning Group. As a partnership, Leicester SAB appoints an Independent Chair to oversee the work of the Board, provide leadership, offer constructive challenge, and ensure independence. To support consistency, alignment where appropriate, and a shared understanding of effectiveness across the two partnerships, our Independent Chair is shared with Leicestershire and Rutland SAB, as are a number of our subgroups (see appendix for 2021/22 structure chart). The day-to-day work of Leicester's SAB is undertaken by the subgroups. The board office supports the operational running of these arrangements on behalf of the multi-agency partnership.

Safeguarding Adults in Leicester

Information from the 2021 census notes that Leicester's population size has increased by 11.8% since 2011 to 368,600 making it the 19th largest local authority for total population in England and the most densely populated local authority in the East Midlands. 50.1% of Leicester's population is female whilst 49.4% is male. England has an aging population with more people than ever aged 65 and over recorded in the 2021 census (an increase of 20.1% since 2011). Leicester's population includes 43,500 people aged 65 or over, which is an increase since 2011 of 16.9%. Whilst awaiting the full results of the 2021 census we are reliant on information from the 2011 census for the remainder of our information. The 2011 census celebrates Leicester as one of the most ethnically diverse cities in the UK with the population being made up of people from the following ethnic groups: White (50.5%), Asian, Asian British (37%), Black/African/Caribbean/Black British (6%), Mixed/Multiple Ethnic Groups (3.5%), Other Ethnic Groups (3%). The population of Leicester is made up of 49.4% males and 50.6% females.

Safeguarding data for Leicester, collaged by Leicester City Council, Adult Social Care on behalf of the SAB demonstrates the scale of safeguarding activity across the city:





Additional national, regional, and local safeguarding adults data can be found on the NHS Digital website Safeguarding Adults Collection (SAC). In Leicester, alerts meeting the Care Act 2014 s42 threshold have increased substantially during 2021/22, in part linked to a number of care home enquiries. Looking to

2022/23 quarterly data from across the partnership is due at the Leicester, Leicestershire and Rutland (LLR) SAB Performance Subgroup, which will allow for ongoing benchmarking and further analysis.

During 2021/22 Leicester's SAB meetings have focused on several key areas, these included:

- How the SAB supports prisons in their safeguarding and consideration of what is appropriate oversight and governance around safeguarding in prisons for the SAB
- New Information Sharing Agreement (ISA) completed and signed off by key agencies
- An update on probation reunification
- Results of our multi-agency audit on neglect and older people
- Domestic abuse research project with Durham University
- Leicestershire Partnership NHS Trust report into in-patient incidents during 2021/22
- Findings from our multi-agency audit on transitions
- Consideration of system pressures
- Results of our multi-agency audit on neglect and older people

Meeting our Strategic Priorities

As a partnership, Leicester Safeguarding Adults Board outlined its strategic priorities in its five-year strategic plan which was published in 2020. Core priorities are ensuring statutory compliance and enhancing everyday business. Developmental priorities are strengthening citizen and carer engagement, raising awareness within our diverse communities, understanding how well we work together, and prevention (helping people to stay safe, connected, and resilient to reduce the likelihood of harm, abuse or neglect).

Our annual business plan priorities for 2021-22 included a shared priority with Leicestershire and Rutland Safeguarding Adults Board and local Safeguarding Children Partnerships to understand and respond to the impact of Covid-19 on safeguarding adults and children. Other priorities shared jointly with Leicestershire and Rutland Safeguarding Adults Board were Hidden Harm and Care Homes.

Core Priority 1: Ensuring statutory compliance

Safeguarding Adults Boards have a statutory duty under S.44 of the Care Act 2014 to undertake safeguarding adults reviews (SARs) in cases which meet the criteria. The purpose of a review is to identify lessons to be learnt and to apply those lessons for the future. During 2021/22 Leicester's SAB concluded two SARs (commissioned in previous years) and commissioned two new reviews which remain ongoing. The Review Subgroup was satisfied that all the referrals received were appropriate referrals. This provides a level of assurance that partners are aware of our statutory duty in relation to SARs and are making referrals in line with that duty. For the purposes of transparency, a table of 2021/22 SAR referrals, decisions, and outcomes is provided:

SAR REFERRALS AND DECISIONS 2021/22			
Referral Date	**Date Case First Heard**	**Decision Made**	**Outcome**
January 2021	February 2021	August 2021 following additional information being received. Mandatory SAR criteria not met. Decision made not to undertake a non-mandatory SAR; needs for care and support demonstrated, suspected that the death resulted from abuse or neglect but no concerns about how agencies worked together. Ongoing support and work with single provider as no multi-agency concerns identified.	No SAR
April 2021	June 2021	Decision that a discretionary SAR should be carried out. The group concluded that it was suspected that the person did have care and support needs and that there was likely to be interagency learning and an opportunity to consider a potential COVID-19 impact within the review.	Discretionary SAR under S44(4)
June 2021	July 2021	Decision that a mandatory SAR should be carried out, based on the adult's needs for care and support, suspected abuse and neglect, and concerns over how agencies worked together.	Mandatory SAR under S44(1)
February 2022	March 2022	Mandatory SAR criteria not met. Decision made not to undertake a non-mandatory SAR; needs for care and support demonstrated but no evidence that the death resulted from abuse or neglect; also no concerns about how agencies worked together.	No SAR

Details of the two SARs completed in 2021/22 are outlined below:

SAR 1: 'Robert'

This report was not published at the family's request.

Overview

Robert (pseudonym used to protect anonymity) died by suicide. There was no indication that Robert died as a direct result of abuse or neglect and no requirement to undertake a review of his death. Nonetheless, after careful consideration, the Leicester Safeguarding Adults Board (LSAB) chose to undertake a safeguarding adults review under section 44(4) of the Care Act 2014. At the request of Robert's family, the review has not been and will not be published. Here learning is outlined but case detail remains limited.

Robert was a dependent drinker with vulnerabilities relating to physical and mental health as a result of his alcohol consumption. In the months leading up to his death by suicide, there is an indication he may have begun to self-neglect. In the three months preceding his death, Robert had multiple contacts with a variety of agencies including regular 'blue light' services. For example, he attended the local emergency department, and required short inpatient admissions on five occasions. He was also a regular attendee at his GP practice; however his engagement with community alcohol services was limited. At the time of his death by suicide Robert was in breach of a Non-Molestation Order and awaiting sentence.

Findings

Unlike reviews of a similar nature nationally, this review did not find that Robert's alcohol use was considered by organisations to be a 'lifestyle choice' or that there was a lack of understanding of the Mental Capacity Act 2005 or the Care Act 2014. However, this review did find a lack of a coherent response in supporting Robert, with no one agency taking the lead in coordinating an approach.

Whilst potentially not meeting the criteria for Vulnerable Adult Risk Management (VARM), Robert was clearly at risk of self-harm and suicide and practitioners would have likely benefitted from structures and systems in place which supported effective multi-agency working with people experiencing suicidal ideation.

This review also found that when agencies were focused on Robert and his needs and vulnerabilities, they were less likely to consider him as a potential perpetrator of domestic abuse. Conversely, when the main focus of agencies was on reducing the risk Robert posed to his wife and children as a perpetrator of domestic abuse, support or rehabilitation options available for Robert were not considered. In Robert's case, coordinated support including the city perpetrator programme, substance misuse services, support to address mental and physical ill health, or to find alternative accommodation, may have in turn reduced the risk that Robert posed to his wife and children as well as to himself.

The review found that the following factors were positive in relation to effective information sharing within and between agencies:

- Co-location

- Access to the same records / recording systems
- Automatic referrals which do not rely on workers to action
- Referrals which require input from practitioners, but which are then sent and received via an automated system (i.e. 'at the push of a button')
- An understanding of each other's roles and responsibilities

Recommendations:

1: It is recommended that all case findings from this review are shared with individual organisations, to provide them with an opportunity to assure themselves that these case findings are not reflective of wider systems issues within the organisation. Any wider systems issues identified by individual agencies, to be fed back to the LSAB Review Subgroup.

2: It is recommended that all systems findings and identified potential gaps in service provision noted in this review, are shared with relevant organisations and commissioning bodies for their knowledge and consideration.

3: Local partner agencies to assure themselves that practitioners are aware of the 'trilogy of risk' as well as the need for a 'whole family' approach to safeguarding adults and children.

4: It is recommended that this review is shared with relevant local strategic bodies for awareness and information, including Leicester Health and Wellbeing Board and the LLR Suicide Audit and Prevention Group.

5: EMAS to provide an overview of the EMAS SPOC role, including contact details, to SAB members for promotion within their organisations (action completed during the review).

6: For consideration to be given locally to the development of structures and systems across LLR which facilitate the multi-agency management of individuals experiencing self-harm and/or suicidal ideation (i.e. similar to the VARM guidance but for self-harm/suicide).

Impact:

Adult Social Care's front door duty teams across Leicester, Leicestershire and Rutland now have an email address to enable them to request additional information in regard to East Midlands Ambulance Service (EMAS) referrals. Where there are queries which are not urgent, or if a member of the duty team needs to speak to someone directly, they are able to contact the EMAS regional safeguarding lead. Feedback from duty teams is that this has been positive. Adult Social Care also now have quarterly meetings with EMAS safeguarding adults lead to discuss themes, any concerns around referrals, service development, and training plans. These meetings have been very positive.

SAR 2: 'Mrs Moyo'

This report has been published on our web pages alongside previous reviews.

Overview:

Mrs Moyo (a pseudonym) is a black woman of African heritage. She was in her sixties at the time of the incident and lived in a council property with her son Joseph who is a black man of African heritage and Muslim religion. Both are English speakers, with no communication or language adjustments required.

Mrs Moyo was supported through Adult Social Care due to her physical health needs. She was provided with domiciliary calls twice daily. Mrs Moyo has another son, Aaron and she also received support from him and his wife, Jasmin.

Mrs Moyo's son Joseph had a history of psychotic episodes that was induced by his use of illicit substances. At the time of the assault, Joseph was not engaged with AMHS but was under licence to probation, having been released from prison where he had been serving a sentence for supplying class A drugs.

In the six-week period leading up to the assault, Mrs Moyo's son and daughter in law, had been in contact on nine occasions with Adult Social Care; Probation; NHS 111; ambulance service; police and mental health services, concerned about Joseph's deteriorating behaviour and of Mrs Moyo's wellbeing.

On the day of the assault, Joseph began a prolonged and sustained assault to his mother, punching, kicking and trying to strangle her. Mrs Moyo managed to call the police. Mrs Moyo was taken to hospital where she received treatment for soft tissue injury and a nasal fracture. Joseph was arrested and subsequently detained for psychiatric assessment under the Mental Health Act 1983 and then recalled to prison.

Findings:

The findings in this review are many varied and can be read in full via the published review.

There were opportunities for preventative intervention that may have made a difference to the events that followed. These include the importance of a shared understanding of Joseph's mental health needs, his relapse indicators, and risk assessment; understanding the nature of carer roles and significant others and incorporating this into assessments; the need to improve communication between probation and adult mental health services; the importance of GP registration and where a person is not registered with a GP the need to consider the impact of this within discharge planning.

There were also findings focusing on the responses to escalating concerns. The chronology of events demonstrated that there was a high volume of calls from family within a short period; concerns about Joseph's presentation mirrored features of past relapse; there were unexplained inconsistencies: Mrs Moyo's assertions that all was well did not fit with Aaron and Jasmin's recurrent concerns and their description that she was fearful of Joseph.

Recommendations:

1. Procedural Development, Monitoring and Review: Leicester's Strategic Offender Management MAPPA Board should use learning from this review to inform their strategic plan for 2021-2022, specifically, the action to improve publicity, pathways and gateways into mental health services. The Strategic Offender Management MAPPA Board should seek to develop mechanisms to strengthen partnership working between AMHS and Probation pre-sentence, pre-release, and post-release. This Board should also seek assurance on the quality of the release plans and that registration with a community GP is a component within the release plan.

2. Procedural Development, Monitoring and Review: Learning from this review should be shared with the relevant Home Office departments (Her Majesty's Prison and Probation Service and Domestic Abuse). The learning should be used to influence national policy and guidance on the need for information sharing and joint work between AMHS and Probation at key junctures in the offender pathway: pre-sentence (including Fast Delivery Reports), pre-release, and post-release.

3. Procedural Development: LPT need to assure that their policies (and application of those policies) for Did Not Attend and Discharge, take adequate account of circumstances when a patient is not registered with a GP i.e.

- Reasonable attempts are made to support service users to register with a GP.
- Lack of GP registration is factored into risk assessment and,
- Risk assessment is used to inform proportionate communications with other agencies, family and carers, in line with information sharing guidance.

It is important that all agencies play a role in encouraging people to register with a GP. The contribution of the Leicester City CCG in providing guidance and raising awareness of access routes to register with GPs, will assist in this.

4. Staff Support: LSAB and its constituent agencies, should use learning from this SAR to inform training and supervision, in relation to safeguarding and domestic abuse:

- Reinforcing the value of multi-agency collaboration
- Recognition of carers and significant others within assessments, including consideration of assets, protective factors, stress factors and risks.
- Fundamentals of a robust risk assessment; understanding and working with barriers to disclosure (including safe enquiry).

Impact:

There have been some national and local changes since the scope period that are relevant to the learning. In summary:

- National development between NHS and National Offender Management Service to improve support and monitoring of offenders on release.
- National reforms of the Probation service through the reunification programme. Probation practitioners will work in both HM Prisons and in community settings which should aide continuity of care plans and the flow of information.
- Locally, the Strategic Offender Management MAPPA Board is working to improve partnership working between probation and mental health services.

- Leicestershire NHS Partnership Trust has opened a Crisis Mental Health Hub at the Mental Health Unit were people and their families can self-refer for urgent mental health support to a central access point by telephone.
- Adult Social Care is strengthening processes and training for staff within their Contact and Response team.
- Leicester City CCG have provided guidance and raised awareness of access routes to register with GPs.

In addition to learning from our own local SARs, the Leicester SAB's Review Subgroup also considers learning from other SABs across the country and considers local impact and action required. During 2021/22 reviews considered by the group included five reviews in relation to self-neglect:

- Suffolk SAB 'Mr. B'
- Leeds SAB 'Mr and Mrs A'
- Gloucestershire SAB 'Ted'
- Worcestershire SAB 'RN'
- Sandwell SAB 'Anne'

Four national reports where self-neglect was a theme were also considered. Approaches to SARs where self-neglect is involved was discussed in detail by the group. As a result, a local resource supporting the consideration of SAR referrals where self-neglect is a feature was produced and is now used to support the group's decision-making. In addition, our local self-neglect guidance was spotlighted in our local 'Safeguarding Matters' publication in order to brief practitioners across Leicester, Leicestershire and Rutland.

Norfolk's SAR on Cawston Park Hospital was considered by the Review Subgroup and also by the main Board.

Core Priority 2: Enhancing Everyday Business

Policies and Procedures: Leicester Safeguarding Adults Board works with Leicestershire and Rutland Safeguarding Adults Board to maintain up to date inter-agency adult safeguarding policies and procedures across Leicester, Leicestershire and Rutland. These policies and procedures are hosted on our dedicated policy and procedures website called the MAPP (Multi Agency Policies and Procedures). Throughout 2020/21 these policies and procedures continued to be reviewed and updated in line with learning from reviews, audits, and best practice.

Updated chapters include:

- Deprivation of Liberty Safeguards - This chapter was amended to add the note in the scope box regarding the timetable for the introduction of Liberty Protection Safeguards.
- Types and Patterns of Abuse and Neglect - Section 6.4, Financial or material abuse has been amended to include additional information about abuse by deputies and also action against fraud.
- Stage 2: Lead Agency Decision using Safeguarding Threshold Guidance whether to proceed to Referral - Section 5, Roles and Responsibilities has been updated to include information about reporting suspected crimes to Leicestershire Police.
- Safeguarding Adults Reviews - A link was added to Local Guidance and Templates, where additional SAR guidance has been added.
- Quick Reads and Audios - A quick read and audio summary about Ordinary Residence has been added.
- Publication of our LLR Multi-Agency Overarching Safeguarding Information Sharing Agreement and Guidance which covers children and adults.
- Sexual exploitation and organised sexual abuse.
- A guide to multi-agency meetings to help practitioners identify the appropriate route to explore and address concerns about the welfare of adults.
- A set of guides to support workers to assess the mental capacity of people they work with.

Training: Safeguarding adults multi-agency training has been provided throughout 2021/22 in line with business plan objectives. Training for Mental Capacity Act was rolled out across LLR, well established Mental Capacity Act forums have continued to run across the city for care home providers, a trainers' network has been facilitated across LLR, and weekly briefings and quarterly newsletters have been published and circulated.

The SAB training subgroup is now LLR and has launched its YouTube channel, the first video developed and published is the 'Tricky Friends' animation for adults with learning disability and autism. This was followed by our 'See Something Say Something' awareness-raising video. A financial abuse task and finish group was set up in response to a previous multi-agency audit, and videos for practitioners were developed including interviews with the Office of the Public Guardian (OPG). A PowerPoint resource pack on 'Professional Curiosity' has also been produced and published in response to learning from our reviews.

Developmental Priorities 1 & 2: Strengthening User and Carer Engagement & Raising awareness within our diverse communities

A resource pack was developed for Safeguarding Adults Week, November 2021 and shared across the partnership and with Voluntary and Community groups.

Throughout 2021/22 'What Is Adult Safeguarding?' briefings were facilitated to local community members and groups.

An easy read version of our 'What is Adult Safeguarding?' document was been produced, published on our SAB webpage, and promoted via social media.

Printable safeguarding information has been developed and published on our SAB webpage in English, Urdu, Punjabi, Hindi, Gujarati and Bengali.

Our "See Something Say Something" awareness campaign and video - explaining what adult safeguarding is - has been promoted with the video having reached over 1,000 views. The Engagement Subgroup is working to split this longer video into three shorter ones to make them more accessible on social media.

Developmental Priority 3: Understanding how well we work together

Multi-Agency Audits: The SAB carried out two multi-agency audits during 2021/22 and also received the results of one multi-agency audit conducted during 2020/21.

The older people and neglect audit found:

- It was good practice that local systems automatically notify the contracts team when a safeguarding alert is recorded involving a service provider.
- In almost all cases, there was evidence of the principles of Making Safeguarding Personal
- In almost all cases, the risks to the person had been reduced within the enquiry safeguarding of young adults including transition from children's services.

The transitions audit found:

- Safeguarding thresholds were applied appropriately and the principles of Making Safeguarding Personal were applied well in almost all cases.
- Where cases had not met the criteria for safeguarding there was evidence of other actions taken to address risk.

- Many of the cases related to people who were placed from other areas and in most information had not been shared with Leicester, Leicestershire & Rutland agencies.
- Transitions of individuals from children to adult services was not always robust.
- Safeguarding enquiries were not always closed at an appropriate point, particularly when police processes were underway.
- The Police were not always involved when a potential crime had been carried out.

The strategy meetings audit found:

- In almost all cases the right organisations were being involved in strategy meetings and the principles of Making Safeguarding personal were evidenced.
- Meetings were not taking place in the timescales set out in local procedures and separate conversations were taking place between smaller groups of partners.
- The differences and processes around strategy meetings and strategy discussions caused confusion for practitioners, which led to processes not being followed.

The strategy meetings audit included interviews with practitioners to understand approaches which helped clarify the learning and will be used in future audits.

The findings from these audits have been disseminated to practitioners and are being taken forward as follows:

- Information sharing across areas to be raised with regional and national networks to improve this.
- Learning regarding transitions was fed into the scoping of the SABs work on transitional safeguarding planned for 2022/23.
- Local Authorities have reviewed how outcomes of safeguarding enquiries are recorded to support clarity of understanding and appropriate closure of these enquiries.
- Strategy Meetings and discussions guidance is being reviewed to make terminology and processes clearer and will be communicated to practitioners across organisations.

The SAB reviewed its approach to the Safeguarding Adults Audit Framework (SAAF) assessment of individual agencies safeguarding approaches and sent this out to be completed at the start of 2022/23 to focus on specific priorities and concerns of the SAB.

Developmental Priority 4: Helping people to stay safe, connected and resilient to reduce the likelihood of harm, abuse or neglect

The work of the hidden harm priority below alongside the developmental priority of raising awareness within our diverse communities above have contributed to this priority.

Business Plan Priority: Responding to COVID-19

Leicester SAB alongside Leicestershire and Rutland SAB held reflection sessions jointly with the Safeguarding Children Partnerships to give partners the space to reflect on positives and negatives from working through the pandemic. Key points included:

- Prisons in the area have assessed impacts on prisoners and listened to prisoners as they adapted to the impact and response to Covid-19 and considered safeguarding within this.
- Concern regarding remaining hidden harm in care homes when they are under pressure. The SAB needs to have a collective view of concerns across care homes to ensure safeguarding concerns do not go unreported.
- Pressure on capacity is not just in care homes, but also the domiciliary care sector, which could impact on the ability in the system to identify and respond to safeguarding matters

- There are large backlogs in various parts of the system including for routine treatment and discharge from hospital which will increase pressures even once Covid appears to have passed.
- There are additional pressures of impacts of the pandemic for example social issues impacting on mental and physical health - more complex cases, more rapidly deteriorating,
- The impact of mandatory vaccination for care staff is not yet known, but expected to reduce the capacity in the system further.
- Partners need to continue to hear and be advocates for those we work with.
- Partners need to continue work together, to identify and respond to strategic safeguarding concerns and to support a resilient workforce going forwards.

The majority of these points were identified towards the end of the year and influenced the forward business plan priories for 2022/23.

Business Plan Priority: Hidden Harm

- A domestic abuse research project with Durham University, funded by the Home Office was run throughout 2021/22 with findings to be presented in 2022/23.
- Training for Mental Capacity Act has been rolled out across Leicester, Leicestershire and Rutland.
- A multi-agency audit regarding transitions has been completed and work is being taken forward to address the learning identified.
- An awareness campaign “See Something Say Something” was launched during safeguarding adults week (November 2021).
- ‘What is Adult Safeguarding?’ sessions have been run in the city for residents throughout 2021/22.
- ‘Safeguarding Stories’ an animation has been developed to support community and professionals’ understanding of safeguarding adults, abuse, and neglect.
- Training for managers around supporting professional curiosity in staff and knowledge of local escalation policy has been scoped and will be run throughout 2022/23.

Business Plan Priority: Care Homes

- A multi-agency audit on care homes was facilitated, with findings to be presented to the SAB during 2022/23.
- NICE safeguarding in care home guidance was considered at Board during 2021/22. Contracts and commissioning teams across the Local Authority and the Clinical Commissioning Group subsequently reviewed this guidance and provided assurance to the SAB.
- The training subgroup has undertaken a review of how we link in with care homes and are now developing a summary sheet of what support is available via the SABs.
- Escalation procedures have been reviewed in line with NICE guidance.

Looking to 2022/23

Looking to 2022/23 we have developed our annual business plan jointly with Leicestershire and Rutland Safeguarding Adults Board. It has been published alongside our strategic plan, on the 'plans, reports, and strategies' page of our web pages.

Business Plan priorities for 2022/23 build on the 2021/22 priorities and are as follows:

1. Hidden Harm

Rationale:

- Local and national SARs identify people "hidden in plain sight" as a recurring theme for improvement.
- We are concerned that that during Covid-19 services have less physical contact with and 'eyes on' people to fully understand their needs and circumstances, in addition some informal care arrangements that support safeguarding of individuals may not be functioning as they were with restrictions in place.
- Specific areas of concern include self-neglect and individuals with mental ill-health and/or learning disabilities, and individuals from black and other diverse backgrounds.

Focus will be on community culture shift across practitioners and public to: Help people to a) see concerns b) have confidence to want to respond and c) respond.

2. Care Homes

Rationale:

- A number of issues in care homes regarding quality of care and safeguarding have become apparent during Covid-19 lockdowns with increase in safeguarding alerts relating to care homes and care homes closing. Closure of care homes and lack of capacity in the system increases risk around safeguarding. As care homes open up for visitors more people are seeing those in care homes, and therefore potential for more concerns to be raised.

In addition to the priorities identified for 2022/23 the SABs will continue to operate business as usual to improve safeguarding of adults with care and support needs and meet its statutory obligations. The Review Subgroup will pilot a 'rapid review' scoping approach for SARs and the Training Subgroup will review the current training strategy to cover Leicester, Leicestershire and Rutland as well as work with the Local Implementation Network (LIN) regarding Liberty Protection Safeguards (LPS). The Performance Subgroup will finalise the updated performance framework.

Appendix I: 2022/23 Leicester SAB Structure Chart

Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE