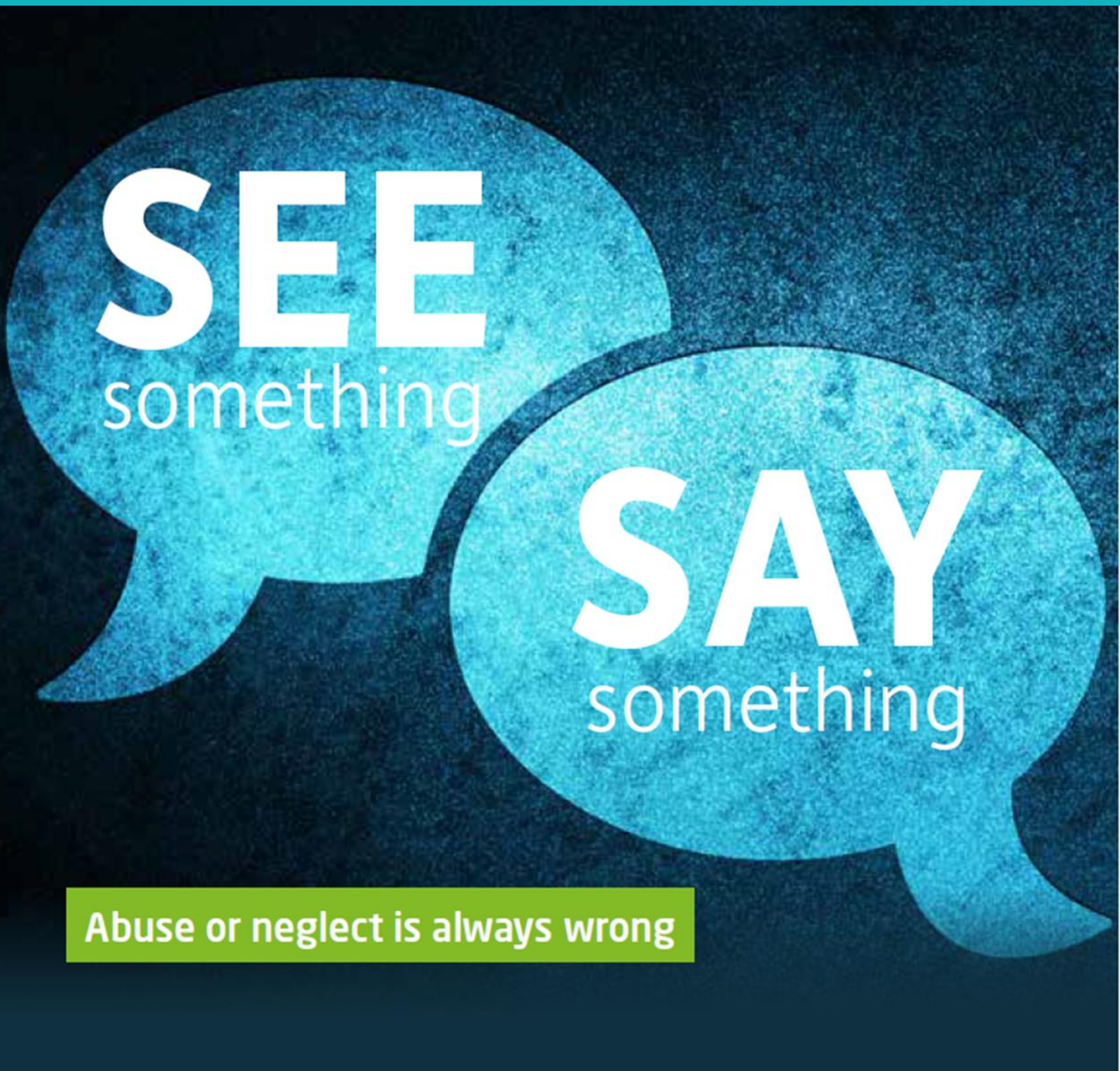
LEICESTER SAFEGUARDING ADULTS BOARD

Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

ANNUAL REPORT 2023/24



Leicester

Safeguarding Adults Board

Annual Report

2023/24

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

Report Date: June 2024

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.

Contents

A Message from the Independent Chair

It is a privilege to introduce the Annual Report for Leicester Safeguarding Adults Board (SAB) for 2023/24.

I am grateful to all partners for their contribution to the Board, and their ongoing support. It is important to lead the SAB in delivering its priorities as part of the continuous learning journey for all engaged in adult safeguarding, and the well-being of people in Leicester. As highlighted partners have been working hard to make a difference with and for people. They have continued to deliver services, provide care and support to people, and respond to the changing safeguarding needs and risks that occur in what can be described as challenging times for public services, and the effects post COVID-19. It would be fair to say this continued to impact upon people as seen by all partners.

The subgroups, and in particular the Chairs are owed much gratitude for their dedication and commitment to ensuring that the SABs priorities are delivered. There have been important areas of work undertaken in the year.

A high-level data dashboard has been agreed so that each SAB partners are able to understand through a "temperature check" what is this high level data telling us about where we need to explore, and support front line practitioners in their duties, and if issues occur with fluctuations, how we understand the reasons, and ensure all partners contribute to resolving any that may arise.

Mental Capacity remains an area of significant work as it's the responsibility of partners to be able to identify, and on occasions make decisions with regard to capacity in order to ensure safety and protection as required. Audit work, Safeguarding Adults Reviews and data, highlight this is an area of continuing development across all organisations. An area of particular interest has been domestic abuse of those over 60 + years and whether this is recognised in the same way as for the younger population. The SAB has worked with Durham University who have undertaken the research, and the SAB is currently considering the findings and will be developing actions which will be reported in the Annual Report for 24/25.

The SAB has set its priorities for 2024/25 on the basis of the information provided through reviews of practice as part of the audit work undertaken, data collection, safeguarding adults' reviews, national feedback from reviews and immerging issues that have been identified. The SAB has agreed over 2-year period 2023- 2025 priorities of. mental capacity self-neglect and domestic abuse.

I would like to thank the Board Manager and the Team for efficiently and effectively managing the business of the Board. I would also like to acknowledge the work of the staff and managers across all statutory,

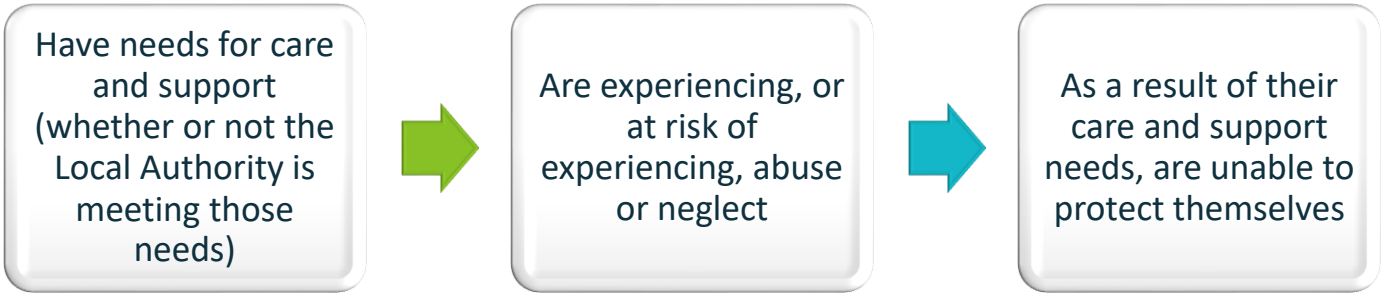
voluntary and community partners who are committed to working together to keep people safe in Leicestershire and Rutland.

Seona Douglas

LSAB Independent Chair

The Board

Under the Care Act 2014, the main objective of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners are acting to help and protect adults in its area who:



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
	HMP Leicester
	Probation Service
Emergency Services	East Midlands Ambulance Service (EMAS)
	Leicestershire Fire and Rescue Service (LFRS)
Health	Leicester, Leicestershire and Rutland Integrated Care Board (ICB)
	Leicestershire Partnership NHS Trust (LPT)
	University Hospitals Leicester NHS Trust (UHL)
	NHS England
Local Authority	Adult Social Care
	Children's Social Care and Education
	Housing
	Community Safety
	Trading Standards
	Lead Member
Inspectorates	Care Quality Commission (CQC)
Consumer Champions	Healthwatch
Care Home Associations	East Midlands Care Association (EMCARE)

Statutory partners of an SAB are the Local Authority (Leicester City Council), the Police (Leicestershire Police), and Health (Leicester, Leicestershire and Rutland Integrated Care Board). 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 most of our subgroups (see appendix for 2024/25 structure chart). The day-to-day work of Leicester's SAB is undertaken by the subgroups: Performance, Review, Learning and Development, Engagement and Communication, Audit, Policy and Procedure, VCS (Voluntary and Community Sector) Safeguarding Forum. The board office supports the operational running of these arrangements on behalf of the multi-agency partnership.

Safeguarding Adults in Leicester

During 2021 Leicester's population reached nearly 370,000 and Leicester was noted as the most densely populated local authority area across the East Midlands (Office of National Statistics, 2022)[1]. It is home to around 36 people per football pitch-sized piece of land.

According to the Office of National Statistics 'In the latest census, around 213,600 Leicester residents said they were born in England. This represented 57.9% of the local population'[2]. The 5 most common countries of birth for the population of Leicester in 2021 were England, India, South and Eastern Africa (other than Kenya, Somalia, South Africa and Zimbabwe), Poland, and Kenya.

In 2021, 43.4% of usual residents in Leicester identified their ethnic group as "Asian, Asian British or Asian Welsh" followed by 40.9% who identified themselves as "White", 7.8% as "Black, Black British, Black Welsh, Caribbean or African", 4.1% as "Other ethnic groups" and 3.8% as "Mixed or Multiple Ethnic Groups" (Office of National Statistics, 2022)[3].

Along with every local authority area across the East Midlands, the 2021 Census for Leicester saw a decrease in the proportion of residents who identified as being "disabled and limited a lot". This fall was from 11.5% of residents in 2011 to 8.8% of residents in 2021. Caution should be taken when making comparisons here between 2011 and 2021 because of changes in question wording and response options[4].

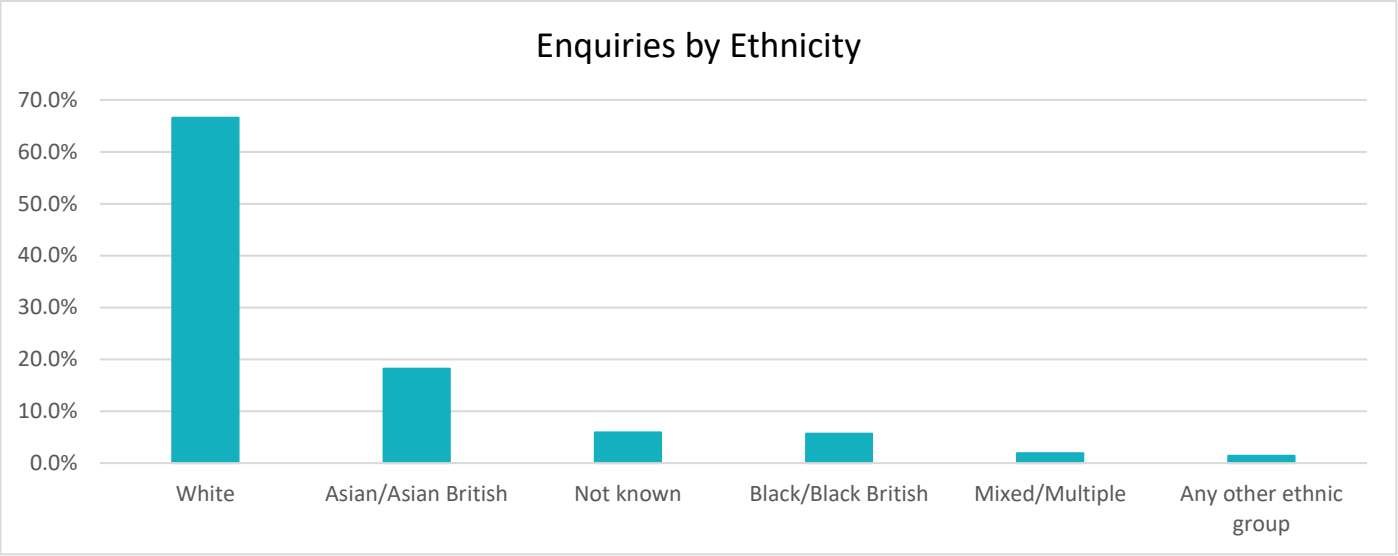
Just over half of the population of Leicester during 2021 were recorded as female (186,466) with just under half recorded male (182,115)[5]. 1,649 people recorded their gender identity as different from sex registered at birth with no specific identity given, 437 people identified as trans women, 496 people identified as trans men, and 328 people were recorded as 'all other gender identities'.[6]

[1] Office of National Statistics (2022) How the population changed in Leicester: Census 2021 https://www.ons.gov.uk/visualisations/censusareachanges/E06000016/
[2] Ibid
[3] Ibid
[4] For more context see Disability, England and Wales - Office for National Statistics (ons.gov.uk)
[5] Census 2021 - Population by single year of age and sex — Leicester Open Data
[6] Gender identity - Office for National Statistics (ons.gov.uk)

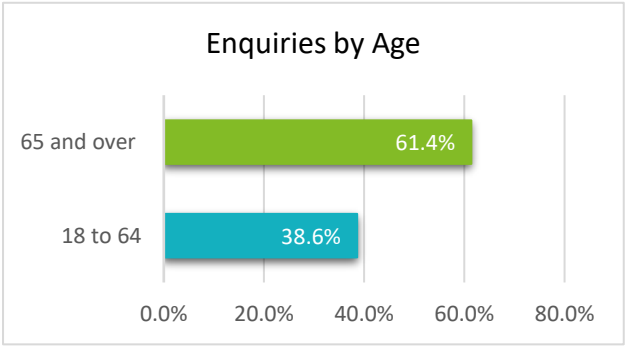
Safeguarding Adults Data for Leicester 2023/24

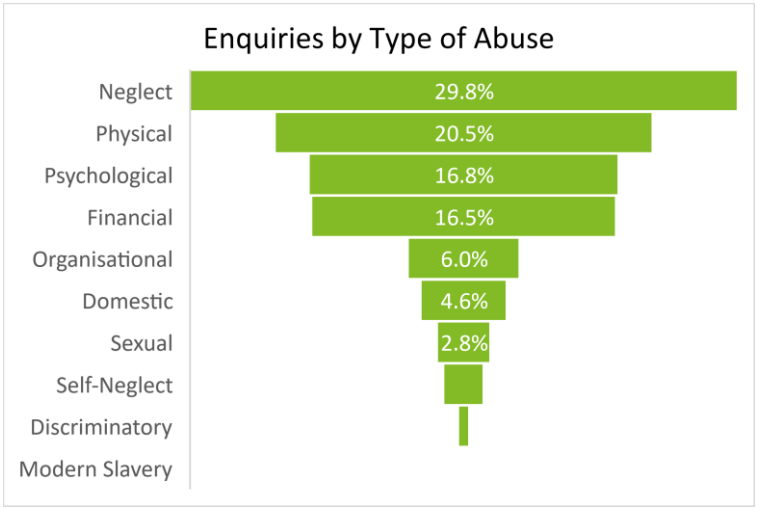
A safeguarding concern (known locally as an alert) is made to raise concerns that an adult is experiencing, or at risk of abuse or neglect. A concern may arise as a result of a disclosure, an incident, or other signs or indicators. A concern can be raised by anyone including the person at risk, family, friends, professionals, and other members of the public. During 2023/24 in Leicester a total of 2,259 concerns were made.

Where concerns require further investigation under Section 42 of the Care Act 2014, a safeguarding adults enquiry is initiated. This enables concerns to be addressed promptly, minimising risk. During 2023/24 in Leicester a total of 493 safeguarding adults enquiries were made. In 31% of incidents risk was removed, risk was reduced in 58% of incidents, and in 11% of incidents risk remained. Where risk remained, action plans were put in place. Making Safeguarding Personal[7] outcomes were achieved 88% of the time.



In **55.2%** of enquiries the abuse or neglect is reported to have taken place in the adult's own home.





[7] Making Safeguarding Personal (MSP) is a sector-led initiative which aims to develop an outcomes focus to safeguarding work; for more information see Making Safeguarding Personal | Local Government Association

Work has been undertaken to explore, understand and address disproportionality relating to ethnicity for S42 Safeguarding Enquiries in Leicester. The disproportionality in safeguarding activity across our diverse populations has been an area for further exploration. Data shows us that the setting of care influences the volume of safeguarding alerts and enquiries; we also know that our communities are differently represented in settings of care.

Over 50% of safeguarding alerts relate to people living in residential care homes – they are highly regulated services and care / interactions are more readily observed by others who might raise a concern.

Adults from White backgrounds are significantly more likely to receive care in this setting than Asian adults.

One alert in a care home may lead to several people becoming part of a safeguarding enquiry if the concern extends to other residents in that setting who are also at risk.

This will have an impact on the over-representation of White adults in safeguarding alerts.

However there remains more work to do, to ensure our communities understand what harm and abuse looks like and are confident to tell us about it.

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 2023/24 to 2024/25 are Self Neglect, Mental Capacity Act, and Domestic Abuse.

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 circumstances which meet the criteria. An SAB must (this is called a mandatory SAR) arrange for there to be a review of an adult with needs and support in its area if there is reasonable cause for concern about how organisations worked together to safeguard the adult where (1) the adult has died and we know or suspect that the death resulted from abuse or neglect or (2) the adult is alive and we know or suspect that the adult has experience serious abuse or neglect. An SAB can (this is called a discretionary SAR) arrange for there to be a review of any other circumstances involving an adult in its area with needs for care and support. The purpose of a review is to identify lessons to be learnt and to apply those lessons for the future.

During 2023/24 Leicester's SAB received one new referral but commissioned no new reviews. The LSAB's Review Subgroup was satisfied that all the referral received was an appropriate referral. 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 2023/24 SAR referrals, decisions, and outcomes is provided:

SAR REFERRALS AND DECISIONS 2023/24			
Referral Date	**Date Referral Considered by the LSAB Review Subgroup**	**Decision Made**	**Outcome**
September 2023	December 2023	Mandatory SAR criteria not met. Decision made not to undertake a discretionary SAR; needs for care and support demonstrated, suspected that the death resulted from abuse or neglect, but no concerns about how agencies worked together. Issues relating to individual agencies to be addressed outside of the SAR process.	No SAR

During 2023/24 Leicester's SAB concluded 2 SARs (details below) whist 3 remain outstanding. Publication meetings are progressing the publication of the two reviews concluded in 2023/24. The SAB has agreed to act on the findings of both reviews, with work due for completion throughout 2024 including:

Review 1

- Reviewing local guidance on sexual exploitation to ensure that this contains more detail on the range of early intervention support available, how to refer effectively to those services and when to utilise safeguarding or multi-agency risk management processes.

- Undertaking a multi-agency safeguarding audit of sexual abuse and exploitation of adults, including the use of Section 42 or Vulnerable Adult Risk Management (VARM).
- Exploring practical solutions to ensure relevant agencies involved with children and young people at high risk of sexual exploitation have access to a shared, up to date chronology and risk management plan that transfer across to adult safeguarding processes post-18.
- Receive assurance from spotlight checks that return home interviews are being completed in line with the local Joint Missing Protocol.
- Partners to produce guidance and available support re. emotionally unstable personality disorder (EUPD) and borderline personality disorder (BPD).
- Partners to consider how the role of the care coordinator can be strengthened in complex cases, in particular when multiple agencies are involved in supporting the individual.
- Receive assurance of the local arrangements for the identification of those who may require Section 117 Mental Health Act aftercare and the delivery of care plans by Leicestershire Partnership NHS Trust (in particular what oversight the Director of Adult Social Services and Integrated Care Board Chief Nurse have with regards to the efficacy of those arrangements.
- Make available to practitioners working with young people and adults at risk or experiencing exploitation details of the legal framework for assessing and providing treatment/care and support for complex needs and obligations owed to those in transitions from children to adult services.
- Discuss how to ensure that the trauma-informed care training each partner agency has commissioned delivers consistent messaging and promote the continuous improvement of trauma-informed practice across agencies, including targeting strategic leads in different agencies, commissioners, and housing teams.
- Receive assurance that there is sufficient clarity within section 256 / section 75 of the NHS Act (around delegated functions) agreement detailing delegated functions to protect against a gap in duties under the Mental Capacity Act, particularly where an assessment of executive capacity would need input from practitioners with expertise and experience in supporting adult victim survivors of sexual exploitation.
- Receive assurance that statutory expectations for transitions assessment and care delivery are complied with.
- Consider drafting local guidance to provide clarity on the different legal duties regarding assessment and care planning for young people in transition, including when an independent advocate should be appointed to support the young person, the role of leaving care personal advisor and which agency/team should lead on key assessment or care planning tasks.
- Promote the multi-agency safeguarding policies pathway for escalation of professional disagreement. This would benefit from a focus group with practitioners across the partnership to understand why the escalation policy is not consistently used currently to prevent drift or disputes being challenged in a timely manner. Consider what mechanisms exist to report high level disputes directly to the SAB to reduce reliance on Section 44 statutory duty but ensuring the SAB and strategic leaders still have oversight.
- Consider establishing a specialist multi-agency team for young people with emerging personality disorders, with appropriate psychiatric, psychological and social care practitioners, and access to expert legal advice to enable obstacles to be resolved in a timely way. In the interim, greater flexibility from commissioners is needed to identify support services with trauma-informed holistic support that are

able to agilely respond to periods of crisis. Where appropriate, additional support using powers under National Health Service Act 2006, Mental Health Act 1983 or Care Act 2014 should be jointly commissioned to ensure that a spectrum of accommodation-based support is available.
- Develop a local protocol to ensure effective communication and pragmatic care planning between agencies when inmates with care and support or mental health needs are discharged from prison, including risk management around transport on the date of release.

Review 2

- SAB partners need to be assured that the learning from this case is integrated into the commissioning and operation of services in LLR for women involved in the criminal justice system who have complex needs.
- Provide system-wide MCA support and guidance to enhance the skills of practitioners working with people who may lack capacity and use drug and alcohol.
- Ensure that relevant stakeholders understand the harmful impact of short-term prison sentencing of women within the criminal justice system.
- Consider the lack of housing support for the cohort of women with dual diagnosis in very high-risk circumstances.

In addition to learning from our own local SARs, Leicester SAB's Review Subgroup also considers learning from other SABs across the country and considers local impact and action required. During 2023/24 reviews considered by the group included:

- 'Aziza' SAR from Bournemouth, Christchurch and Poole SAB in relation to mental health, suicide and students.
- 'Beverley' SAR from West Sussex Safeguarding Adults Board in relation to organisational neglect and complex cases. Four national reports where self-neglect was a theme were also discussed.
- 'Adult H' SAR from Rochdale Borough Safeguarding Adults Board, following the death of a Zimbabwean man who was subject to deportation and who had untreated HIV.
- 'Brenda' SAR from Swindon Safeguarding Partnership, following the death of a 75-year-old woman. Issues explored including mental ill health, mental capacity, self-neglect, and poor home environment.
- 'Joshua' SAR from Lewisham Safeguarding Adults Board (LSAB) with learning surrounding the death of a 35-year-old Black man, who was experiencing a mental health crisis when he died following restraint by Metropolitan Police officers.
- 'Sandra' SAR from the West of Berkshire Safeguarding Adults Board, following the death of a 65-year-old woman who had long term health conditions, including poor mobility, obesity and orthopaedic problems. Issues around professional curiosity, risk management, complex cases and agency participation at multiagency strategy discussions.
- 'Adult P' SAR from Norfolk Safeguarding Adults Board, following the death of a man in his 30s who had a back injury and suffered with other physical health issues, with a history of falls, mental ill health, drug and alcohol use. A focus on community alarms.

Action taken locally having considered these reviews from other SABs included:

- Work with local universities, including exploration of their links with the SAB.
- Featuring learning in the local Safeguarding Matters Live (local multi-agency learning and development) presentations.

- Promoting learning across individual agencies within the partnership.
- Re-issuing the local Professional Curiosity (professional curiosity and professional curiosity for managers and supervisors) resource packs across the partnership.
- Consideration of local provision of community alarms.

Leicester SAB also provided data and information for the second national analysis of Safeguarding Adults Reviews: April 2019 – March 2023. Recommendations from this national report have been published by the Local Government Association and the full report will be published later in 2024, at which point the Review Subgroup of LSAB will be consider its learning in more detail along with any actions required locally.

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 2023/24 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 chapter replaced
- Working with Adults Affected by Child Sexual Exploitation and Organised Sexual Abuse chapter updated throughout and should be re-read
- Thresholds chapter updated
- Domestic Abuse chapter updated
- Independent Advocacy chapter updated
- Mental Capacity chapter updated
- Disclosure and Barring chapter updated
- Female Genital Mutilation chapter revised throughout
- Forced Marriage chapter reviewed and extensively updated
- Guidance for Working with Adults at Risk of Exploitation: Cuckooing chapter updated
- Working with People who have Lasting Power of Attorney added

A full list of new chapters and amendments made can be found on the 'amendments' page of the MAPP. The policy and procedures website was accessed by a minimum of 6,500 users during 2023/24, demonstrating a wide reach across the partnership. To measure impact more fully, a frontline survey is being carried out during 2024/25.

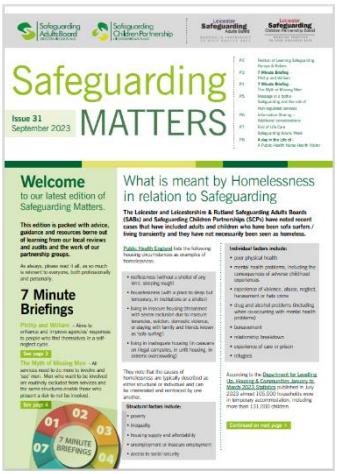
Training: The joint Leicester, Leicestershire and Rutland Safeguarding Adults Boards and Safeguarding Children Partnerships newsletter for staff 'Safeguarding Matters' was published throughout 2023/24 reaching 700 people, and Safeguarding Matters Live (a live version of the newsletter presented via MS Teams) was run in June 2023 and December 2023 with attendance from up to 510 and 550 multi-agency delegates respectively. The Learning and Development Subgroup has also overseen weekly briefings, a trainers' network, and the SABs' YouTube channel with new additions including:

- Was Not Brought which explains the importance of agencies recording whether a person 'did not attend' or 'was not brought' for their appointment.
- Hidden Harms – Domestic Abuse Against Older People
- A selection of videos about Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR): DNACPR Consultations (what they are and how to use effectively in end of life planning); What DNACRP means and how important it is to understand and use it correctly; What to do if you are concerned about a DNACRP recommendation.
- What is Adult Safeguarding? Information Session

The group has promoted awareness of our local 'Guidance for Working with Adults at Risk of Exploitation: Cuckooing' which was developed in 2020 alongside a video to accompany the original launch of the guidance. This followed the findings of a multi-agency agency audit which recognised that local agencies were responding well to cuckooing but there was limited awareness of this local guidance which may have proved helpful to organisations if they had known about it.

In line with business plan objectives for 2023/24 the Learning and Development Subgroup commissioned Mental Capacity Act (MCA) training with 24 sessions to be run across the locality during 2024/25 reaching a planned 600 delegates. The training will cover MCA awareness, MCA in practice, self-neglect and the MCA, and advanced MCA training.

The SABs also worked with the local safeguarding children partnerships to develop and launch a new 'building confidence in resource pack' focusing on professional curiosity for managers and supervisors.



Performance: Returns from the Safeguarding Adults Assurance Framework (SAAF) undertaken across the partnerships during 2022/23 were analysed by the Performance Subgroup at the start of the 2023/24 business year. A staff survey audit was agreed for 2024/25 and work began on drafting questions for this piece of assurance, exploring the safeguarding adults awareness and knowledge of the local workforce.

A quarterly dataset and narrative were collated and analysed by the group throughout 2023/24, with a high-level dashboard reported into the Leicester, Leicestershire and Rutland SABs. The group achieved its business plan objectives by ensuring that metrics included self-neglect, mental capacity act, and domestic abuse.

Work has begun on an annual assurance report that will be presented to the SABs during 2024/25.

Multi-Agency Audits: During 2023/24 the multi-agency audit subgroup undertook two audits: thresholds and Mental Capacity Act. The methodology for these audits included involvement of practitioners to capture their views.

Threshold multi-agency audit questions were:

1) Have the thresholds been applied as per the LLR SAB Thresholds Guidance? How was this evidenced?
2) How were the views of the person established? Was advocacy needed and, if so, was it considered? If the threshold was met, is there evidence that the person's outcomes were addressed?
3) Did the person consent to the enquiry starting? Were the Mental Capacity Act (MCA) and Best Interests all considered? How was this evidenced?
4) If the threshold was not met, are the reasons for this decision clearly evidenced? Were risks addressed and how?
5) If the case did not meet the threshold, was the referrer informed of the decision?
6) Was there any disagreement about the threshold decision? If so, were escalation procedures used?

The audit found that in terms of the category of abuse recorded, it was recognised that domestic abuse is sometimes being incorrectly categorised as another kind of abuse – for example, physical abuse or sexual abuse. This is not as common when a current spouse is involved, but practitioners can get confused when the perpetrator is an ex-partner, co-habiting partner, or another family member. The group recommended that awareness raising is carried out in relation to the category of domestic abuse and the relationship between the people involved in the safeguarding enquiry and that the impact of this would be measured by the number of domestic abuse reports as monitored by the Performance Subgroup.

Overall, the audit demonstrated that thresholds are being applied correctly and this is being documented. Thresholds are being used consistently and are seen as a useful tool by practitioners. Trends and themes are being picked up. This is leading on to further pieces of work. Repeated low level incidents are being acknowledged and, when they indicate a concern, they are being escalated for action. Enquiries and reviews continue even when a case does not meet the threshold criteria for Section 42. Learning that has emerged is acted on and disseminated. The results of this audit are more positive than those identified in

the previous multi-agency SAB Thresholds audit carried out in 2016. Practice has improved, with more consistent use of the thresholds as a tool to support decisions.

Mental Capacity Act multi-agency audit questions were:

1) What was the specific capacity issue being considered?

2) What evidence did the practitioner have to support their concerns about the lack of capacity? What was the rationale for concerns / doubting capacity?

3) What practical steps did the practitioner take to support the person to be the decision-maker?

4) Who completed the Mental Capacity Assessment? Were they the most appropriate person to do this?

5) Was the Mental Capacity Act followed in terms of the capacity assessment?

- Did they identify a mental disorder?
- Was the four-step process followed?
- Did the person
    1. Understand information given to them
    2. Retain that information long enough to be able to make the decision
    3. Weigh up the information available to make the decision
    4. Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.
- Was the mental disorder linked to the four-step process (causative nexus)?

6) Is there evidence in the enquiry to suggest that capacity is linked to an unwise decision?

7) If applicable, is there evidence of a Best Interests decision process as part of the enquiry?

The audit identified the following key learning:

- Whilst all agencies can complete capacity assessments, it is sometimes wrongly assumed that this is the remit of Local Authority practitioners.
- The rationale around practicable steps taken is sometimes lacking detail. Practitioners should be documenting in records what they have considered and used – for example, communication methods.
- Where the mental capacity assessment was not completed, this was sometimes attributed to practitioner oversight or gaps in knowledge and sometimes to recording issues.
- Safeguarding enquiries where family members / carers have Power of Attorney can be complicated. It is not always clear what kind of Power of Attorney a family member / carer has, i.e. for health and welfare or property and finances. Use of the Office of the Public Guardian (OPG) 100 is not always evident.

- It was identified in the previous Multi-Agency Audit, completed in 2019, that '*Assessing workers need to ensure that consideration of whether advocacy for the person is required is clearly recorded,*

in line with the Safeguarding duty defined in the Care Act'. This audit also demonstrated that the use of advocacy is not well embedded in safeguarding practice.

Recommendations and an action plan have been put in place with the potential for a future audit to measure impact by reviewing safeguarding enquiries where a Power of Attorney is involved.

Good practice identified included that there was good evidence of the rationale for completing an assessment and there was a clear link between the person's medical diagnosis and how this could affect their decision making; practitioners were persistent and carried out joint assessments, to include relevant clinical expertise. They looked at capacity based on specific decisions and also initiated the escalation procedure, when required; a proportionate capacity assessment was demonstrated and, despite the challenges of carrying out a capacity assessment within a hospital environment, practicable steps were taken, with consideration of the time of day and the timing of pain medication. The audit found that overall, when the Mental Capacity Act was followed, it led to better outcomes in respect of the safeguarding enquiries.

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

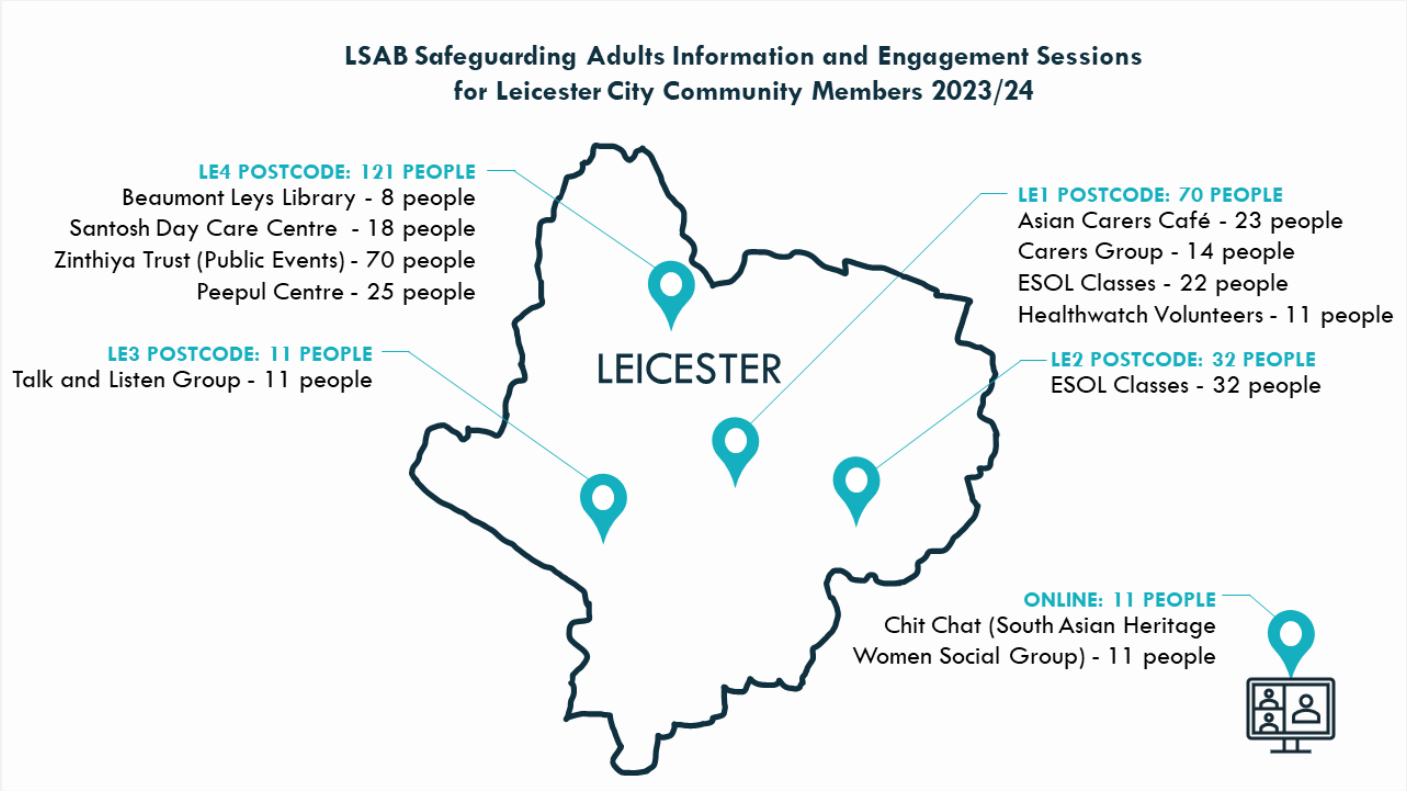
Engagement and Communication: Local safeguarding adults data suggests that since at least 2019/20 there has been an over-representation of people from White communities in comparison to the total adult population of Leicester for adult safeguarding. Since 2021 the Leicester Safeguarding Board Office has been delivering 'What is Adult Safeguarding?' information session on-line for residents in Leicester. Since February 2023 these sessions have been delivered by Leicester, Leicestershire and Rutland Safeguarding Board Offices for residents across Leicester, Leicestershire and Rutland. The sessions have been delivered on MS Teams and are a maximum of one hour long. In 2023, 7 information sessions took place attended by 127 delegates and at the start of 2024, 2 sessions took place with 38 delegates. These sessions continue to run throughout 2024/25 and are attended by members of public, volunteers, and staff from voluntary organisations. Evaluation of the sessions to date has included the following feedback:

It's important to have an idea what is adult safeguarding, so that you can be aware of it."

"[I will] Be more attentive to the possibility of Adults in need of care and support on my daily basis"

"Makes me more mindful of safeguarding in my role just to make sure I'm picking up on things when I talk to people in my role."

Throughout 2023/24 the Leicester Engagement Officer has also facilitated information and engagement sessions across Leicester. In total, 245 people attended these sessions, the majority of which were held in person at locations across the city:



Feedback from these sessions was positive with attendees noting that they felt the sessions had been useful and informative. We heard that the term 'neglect' was not always easy to understand and so the sessions have been updated to provide additional explanation around this type of harm. Participants were also interested in financial abuse from family members and how this would be responded to, including positive steps that could be taken that would not alienate a person's family. The importance of Making Safeguarding Personal (MSP) was often discussed in these sessions.

Since March 2022 the SABs have been running a 'See Something Say Something' media campaign which takes place four times a year for two weeks. Assets and messages are circulated to partners who support in raising awareness of adult safeguarding. Social media messages provide links to our 'See Something Say Something' animations on our YouTube channel which focus on stories of adult safeguarding, domestic abuse, neglect and 'cuckooing'.

The Engagement and Communication Subgroup has also developed surveys to engage with people. Their current survey is to find out how much people know about what adult safeguarding is and how to access support. The survey can be found using this web link or by scanning this QR code:

The SABs are currently working with Leicester City Council's Making it Real group to co-produce a new Leicester, Leicestershire and Rutland Safeguarding Adults leaflet.

Whilst there remains an over-representation of people from White communities in comparison to the total adult population of Leicester in relation to adult safeguarding concerns and enquiries, there has been a reduction of 4.5% in concerns and 4.3% in enquiries, showing a demonstrable impact of the SAB's work.

Leicester Safeguarding Adults Concerns by Ethnicity	2021/22	2022/23	2023/24
White	67.2%	64.9%	62.7%
Mixed/Multiple	1.9%	1.8%	2%
Asian/Asian British	18.2%	18.1%	19.7%
Black/Black British	4.7%	5.6%	5.5%
Any other ethnic group	0.9%	1.6%	1.5%
Refused	0%	0%	0.1%
Not known	7.1%	8%	8.6%
Total Individuals: Concerns	1,071	1,094	1,631

Leicester Safeguarding Adults Enquiries by Ethnicity	2021/22	2022/23	2023/24
White	70.9%	70.9%	66.6%
Mixed/Multiple	1.6%	1.3%	1.9%
Asian/Asian British	16.3%	16.4%	18.2%
Black/Black British	3.6%	4.7%	5.7%
Any other ethnic group	0.8%	0.6%	1.4%
Refused	0%	0%	0.2%
Not known	7%	6%	5.9%
Total Individuals: Enquiries	471	464	422

Developmental Priority 3: Understanding how well we work together & Developmental Priority 4: Helping people to stay safe, connected and resilient to reduce the likelihood of harm, abuse or neglect

See annual business plan priorities which have been agreed over two years 2023-2025 therefore the Annual Report details the progress to date.

Annual Business Plan Priority: Domestic Abuse

The core dataset now includes 10 domestic abuse focused items including concluded safeguarding adults enquiries by type of abuse – domestic %.

Partners are asked to provide, on a quarterly basis, an answer to the following question: "What safeguarding activity has your organisation been involved in this quarter for Domestic Abuse and what impact has this had?"

A first of its kind research project has been undertaken with Durham university focusing on safeguarding adults enquiries and domestic abuse in older people. Findings were presented to the SABs where LLR domestic abuse board and community safety partnership chairs were also invited. The research will be published during 2024/25.

Annual Business Plan Priority: Mental Capacity Act

Core data now considers what proportion of people undergoing a safeguarding adults enquiry were assessed as lacking capacity to advise their Making Safeguarding Personal (MSP) outcomes.

2023/24				
What proportion of people undergoing an enquiry were assessed as lacking capacity to advise their Making Safeguarding Personal outcomes?	Q1 35.2%	Q2 28.3%	Q3 23.8%	Q4 31.8%

Leicester city adult social care continues to reinforce via their Safeguarding Adults Mandatory Training the importance of consideration of the adult at risk capacity at the outset of a safeguarding adults concern being raised and throughout an section 42 enquiry. They have recently commission a rolling programme of Mental Capacity Act training via the Edge Training provider which will be mandatory for any practitioner who may undertake MCA as part of their role. As part of their training offer around MCA they are developing some bespoke MCA training modules on specific areas of more complex decision making which will be aimed at our experienced Level 3 Social Workers.

Partners are asked to provide, on a quarterly basis, an answer to the following question: “What safeguarding activity has your organisation been involved in this quarter for the Mental Capacity Act and what impact has this had?”

A multi-agency audit focusing on mental capacity has been completed and findings and recommendations presented to the SABs.

A thematic analysis of MCA learning from local and national reviews was undertaken by the Learning and Development subgroup and presented to the SABs.

Multi-agency MCA training for 600 delegates has been commissioned for access across the partnership with training targeting practitioners and also managers with a view to build confidence in MCA in leaders across the system.

MCA has been a focus at the LLR SABs and SCPs Voluntary and Community Sector (VCS) Safeguarding Forum held via MS Teams.

During 2023/24 there was a delay in establishing an MCA community of practice which will bring staff together for MCA learning and development and this work is now progressing throughout 2024/25.

Self-Neglect

Self-neglect is now a focus in performance and assurance activity and is monitored within the core data set.

Partners are asked to provide, on a quarterly basis, an answer to the following question: “What safeguarding activity has your organisation been involved in this quarter for self-neglect and what impact has it had?”

Due to additional learning identified to inform the Vulnerable Adults Risk Management (VARM) and self-neglect guidance, revised timelines have been agreed with the SABs for completion of the self-neglect objective during the 2024/25 business year.

Finances

LSAB 2023/24 Contributions	
Police	£51,850
ICB	£51,850
Leicester City Council	£66,200
MCA Training Grant	£5,000
Use of Reserves	£1,138
Total	**£176,038**

LSAB 2023/24 Spend	
Independent Chair	£9,997
Board Office Staffing	£142,460
Case Reviews	£14,750
Engagement and Comms	£0
Procedures	£3,400
Training	£5,000
Miscellaneous	£431
Total	**£176,038**

Looking to 2024/25

Our business plan for 2023/24 was a two-year plan and continues into 2024/25. It is published alongside our strategic plan, on the 'plans, reports, and strategies' page of our web pages. During 2024/25 our priorities will continue to focus on Self-Neglect, Mental Capacity Act, and Domestic Abuse.

If you have difficulties accessing or viewing this annual report, please email LSAB@leicester.gov.uk.

Appendix I: 2024/25 Leicester SAB Structure Chart

Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE