LSAB 2020/2021 ANNUAL REPORT

JUNE 2021

LEICESTER SAFEGUARDING ADULTS BOARD

Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Leicester

Safeguarding Adults Board

Annual Report
2020/2021

Report prepared and published pursuant to paragraph 4 of Schedule 2 of the Care Act 2014

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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

This year, for the first time, I am writing one foreword for the reports of both the Safeguarding Adults Boards for the Leicester, Leicestershire, and Rutland footprint. This reflects that, over the year, the boards have continued a process that had already begun. This was a move to greater shared activity and leadership of the safeguarding system, but all done while keeping a strong focus on the local populations of Rutland, Leicestershire and the city of Leicester and their distinct needs.

The context for this report is also unique and has had profound consequences for adult safeguarding and the role of the Safeguarding Adults Board. The pandemic started in the year covered by the 2019-2020 Annual Report. It impacted on everything the Safeguarding Adults Boards did for the whole of 2021-2022. Partnerships and local communities lived and worked through a year of high, often unpredictable demand and unprecedented situations. Serious incidents generally happen over a few days. As I write, our partnerships have been planning for, or responding to, the effects of the pandemic for eighteen months.

Partnership working has been strong during the pandemic. The government allowed some aspects of local councils' Care Act responsibilities to be 'eased' during a period in 2020. None of the three councils needed to enact these easements despite the very difficult context. An added layer of assurance from my external perspective lay with something that I felt was remarkably strong in Leicester, Leicestershire, and Rutland. The Local Resilience Forum for each area of England coordinates emergency responses. Work done by the national network of Safeguarding Adults Board chairs, showed how variable these structures were in their inclusion and prioritisation of adult safeguarding. This was not so in our area and particularly notable was the setting up of a Safeguarding Sub Cell in the Local Resilience Forum structure.

During the year, the two Safeguarding Adults Boards began to meet as one group on six weekly basis with a particular focus for each of our sessions. This agility came out of the pandemic but what it enabled was honesty, transparency, and shared approaches to complex problems. This open-ness will be important in the year ahead, as sadly, I think I anticipate as do all members of both Safeguarding Adults Boards, that harm – often unintentional - and neglect that happened during the pandemic, will emerge and our task will be to learn from it and prevent future occurrences wherever possible. The

statutory partners to the boards – Leicestershire Police, the NHS Clinical Commissioning Group, and the three local authorities, have met regularly and steered and owned the work of the Safeguarding Adults Boards. This leadership has extended to include regular joint sessions and priority setting with the Children's Safeguarding Partnerships, which can only benefit families and communities. Another first was that priority setting for the year was held jointly and included the naming of shared priorities, with transition pathways into adulthood for children and young people who have been exploited being the main joint area of work for 2021-2022.

I would like to thank everyone involved in all aspects of adult safeguarding over the last year. I would also want to recognise that it has been a time of loss and sadness and to offer condolences and best wishes to all those around our boards and in the communities of Leicester, Leicestershire, and Rutland, who have been affected

Fran Pearson
LSAB Independent Chair

1. 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 Safeguarding Adults Board 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	**National Probation Service (NPS), Leicestershire**	1
	Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company	1
	HMP Leicester	1
Emergency Services	**Leicestershire Police**	1
	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 (ASC)**	3
	Children's Social Care (CSC)	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

As a partnership, Leicester Safeguarding Adults Board 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 Safeguarding Adults Board, as are a number of our sub-groups (see appendix for 2020/21 structure chart). The day to day work of Leicester Safeguarding Adults Board is undertaken by the Subgroups. The Board Office supports the operational running of these arrangements on behalf of the multi-agency partnership.

2. SAFEGUARDING ADULTS IN LEICESTER

With a population of more than 330,000 Leicester is the 10th largest city in the UK. The mean age of Leicester's population is significantly lower at 34.8, than that of the East Midlands at 40 and England at 39.3 and it boasts the largest proportion of people aged 19 and under in the East Midlands. Information from 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.

Leicester City 2019/20 Safeguarding Adults Data

Over the year the LSAB Board meetings have focused on several key areas these included:

A focus on the Transforming Care process during the July 2020 Board meeting where the results of an audit were explored.

- At the time of the audit 26 people had been identified as part of the Transforming Care process in Leicestershire since 2016, 18 had been subject to a safeguarding enquiry and, in some cases, there had been more than one enquiry for the person.
- Of the 18 safeguarding enquiries, 14 related to concern identified at the accommodation the person was living in, including care homes, supported living and in-patient units.
- Of the 18 safeguarding enquiries,
    - the outcome of 5 enquiries had been substantiated, 4 were unsubstantiated and the outcomes of the other 9 were either inconclusive or the enquiry had still been ongoing at the time of the audit.
    - 2 people had moved to alternative care provisions as a result of the outcomes of the safeguarding enquiries, and other outcomes had included staff dismissal, Police action, staff training and increased monitoring.
    - 4 of the enquiries had related to concerns which had occurred in care settings which were out of county and these were therefore undertaken by another local authority.
    - In 2 cases, the person had been subject to more than one safeguarding enquiry and 2 enquiries had related to unexplained injuries; this was of particular concern as due to the complex needs of most people reviewed, they required high levels of support and monitoring.

There was a focus on domestic abuse of adults with care and support needs at the September 2020 Board meeting and the following trends were discussed:

- Over the previous six months, the Police had continued to see isolated cases of very serious incidents of grievous bodily harm (GBH) against vulnerable adults. On a broader scale, there had been an increase in calls for service from those who had not been seen before.
- Leicester City Council had experienced a reduction in cases, but the numbers had now stabilised. There had been a change in the nature of what people were telling the service; more support was required rather than specific safeguarding work. Additional work had been undertaken by social workers to safeguard people with mental health needs.
- There had been a lull in safeguarding activity in UHL, but numbers had now returned to the level before Covid-19. It was stated that a new database had been introduced to improve tracking activity and there had been a greater awareness of elderly abuse. It was reported that the hospitals had spent more time with older people.
- Leicester City Housing had seen an increase in more severe domestic abuse cases during lockdown, although this had not been reflected in the number of homeless presentations. There had now been a significant increase in the number of homeless applications but those who accessed the service were not felt to be the most vulnerable. It was stated that information could be provided on care and support needs.

A follow-up discussion for Transforming Care took place at the December 2020 meeting, where members had noted that an understanding of how this represented across LLR would be beneficial.
The findings for Leicester City were very similar to those for the County.

- Across LLR, there were a total of 41 adults (26 in Leicestershire and 15 in Leicester City) who had been identified as being part of the Transforming Care cohort since 2016 and of this, 11 were placed out of county.
- Out of the 41 adults, there had been 33 safeguarding enquiries relating to 25 people.
- The main categories of concern were physical abuse, sexual abuse, financial abuse, neglect, psychological abuse and self-neglect.
- Of the enquiries, 25 had occurred at the accommodation the person was living in, including care homes, supported living and in-patient units.
- 8 of the enquiries had related to safeguarding concerns which had occurred in settings which were out of county. In some cases, there had been a degree of lack of clarity in terms of the outcome of the enquiry.
- Within the review of City cases, for 7 people in out of county placements there had been no reported incidents by the provider or safeguarding enquiries reported by the host authority. There was some concern around what might not have been reported to the funding authority

There was a focus on Prisons, Safeguarding and Covid-19 at the April 2021 meeting.

HMP Stocken summary:

- During 2020 there was no COVID 19 outbreak, however in January 2021 there was a COVID 19 outbreak lasting about 6-8 weeks. At its peak 200 prisoners and staff tested positive. The current “outbreak status” is likely to close in the coming days.
- During the pandemic the prisoner population have seen a fall in substance misuse, a fall in the levels of self-harm and prisoner violence, but a rise in mental health issues.

HMP Leicester summary:

- the experience at HMP Leicester was broadly similar with HMP Stocken. However, HMP Leicester is still having a turnover in the prison population as they are still servicing the courts which means prisoners will enter the prison and then relocate after 10-12 weeks.
- Prisoner violence and substance misuse has fallen, but levels of self-harm are similar to pre pandemic levels.
- The level of mental health issues is higher particularly when compared to similar settings in Nottingham and Lincoln.
- HMP Leicester experienced a COVID 19 outbreak in March 2020 affecting both staff and prisoners, however cases were generally low. Currently there are no positive cases for prisoners or staff. Communication between prisoners and family were largely done via phone with minimal physical visiting happening.

For more information about adult safeguarding, please visit our website www.leicester.gov.uk/lsab where you will find our introductory guide and our guide to the process of keeping adults safe from abuse and neglect in Leicester. Alternatively, call 0116 454 6270 to request a copy of these guides.

3. 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).

CORE PRIORITY 1: Ensuring statutory compliance – Leicester safeguarding adults reviews 2020/21
Safeguarding Adults Boards have a statutory duty under S.44 of the Care Act 2014 to undertake safeguarding adults reviews 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 2019/20 Leicester Safeguarding Adults Board concluded one Safeguarding Adults Review (SAR) and commissioned four. For the purposes of transparency, a table of SAR referrals, decisions, and outcomes during 2020/21 is provided:

SAR Referrals & Outcomes 2020/21

Referral Date	Date Case First Heard	Decision Made	Outcome
June 2020	June 2020	Mandatory SAR criteria not met. Decision made not to undertake a discretionary SAR as other processes are ongoing within agencies. The Group asked for a re-referral once the S42 enquiry has been completed if there is any suggestion of neglect.	No SAR
Oct 2020	Oct 2020	Mandatory SAR criteria not met. Decision made not to undertake a discretionary 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
Oct 2020	Oct 2020	Mandatory SAR criteria not met. Decision made not to undertake a discretionary 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
Nov 2020	Dec 2020	Mandatory SAR criteria not met. Decision made not to undertake a discretionary 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. A learning briefing from single agency learning reviews will be presented for discussion at a future meeting.	No SAR
Nov 2020	Dec 2020	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 were some concerns about how agencies had worked together. There is likely to be some useful learning from the review.	Discretionary SAR (2020/21 SAR 1)
Jan 2021	Feb 2021	Ongoing – the Review Subgroup had originally concluded that although the person had needs for care and support and it was suspected that the person died as a result of abuse or neglect, there was no concern over how agencies worked together. The SAB Independent Chair requested that more information be provided	Decision Outstanding

		before a final decision was made and the full information is expected to be ready during June 2021.	
Jan 2021	Feb 2021	Decision that a mandatory SAR should be carried out, based on needs for care and support, suspected neglect and concerns over how agencies worked together.	Mandatory SAR (2020/21 SAR 2)
Feb 2021	March 2021	Decision that a discretionary SAR should be carried out. The group agreed that the person had needs for care and support and that there were concerns about how agencies had worked together. Although the person has experienced serious abuse in the past, it is not clear whether the incident was related to abuse or neglect.	Discretionary SAR (2020/21 SAR 3)

The three of the four SARs commissioned during 2020/21 remain in progress.

2020/21 SAR 1: A decision to undertake a safeguarding adult's review for this case was agreed by the partnership in December 2020. Terms of reference have been agreed and agency reports have been requested with a return date of June 2021. Once we have received the agency reports, we will have a better understanding of the scale of the review which will enable us to determine the review completion timeline. The review will conclude during 2021/22.

2020/21 SAR 2: Initiated in February 2021, contracts with the independent reviewer are now in place with the review due for completion December 2021.

2020/21 SAR 3: Initiated in March 2021, contracts with the independent reviewer are now in place with the review due for completion January 2022.

The LSAB also commissioned four SARs during 2019/20. Of these four, one was concluded during 2020/21 (within 4 months from being commissioned) and is outlined below. The other three remain ongoing and are due to be completed during the first half of 2021/22.

2019/20 SAR 1: Commissioned in July 2019 with delays following due to COVID-19, this report is now nearing completion and will be tabled at the July 2021 meeting of the LSAB for final sign off prior to any publication.

2019/20 SAR 2: The LSAB determined to commission this review in February 2020, it was then put on hold due to COVID-19 and re-initiated in December 2020. The review is due for completion in August 2021.

2019/20 SAR 3: In October 2019 the LSAB Independent Chair approved a recommendation to undertake a SAR for this case. After a lengthy period agreeing the SAR methodology and arranging the contract, work began with the independent reviewer in July 2020. The review was originally due for completion in February 2021 but remains ongoing. A significant health partner was unable to contribute required information due to the impact of COVID-19, which led to additional delays. The review is due for completion in January 2022.

We publish our SARs throughout the business year and they can be found on the LSAB page dedicated to SARs on the Leicester City Council website.

2020/21 SAR 4: Commissioned and completed during 2020/21 this SAR will be published in 2021/22.

2020/21 SAR 4 Learning Summary "Martin"

Background

During 2019, Martin (a pseudonym has been used to protect anonymity) was discovered, deceased, in a park in Leicester. There is no indication that Martin's death resulted from abuse or neglect and there was no requirement under the Care Act 2014 to undertake a review of his death. Nonetheless, Leicester Safeguarding Adults Board (SAB) chose to undertake this review. It was thought that a review of Martin's circumstances prior to his death, focused on access to rehabilitation services after detoxification where there were pending criminal justice proceedings, would provide useful insights for future practise. By promoting effective learning and improvement action, Leicester Safeguarding Adults Board (LSAB), aims to prevent future deaths or serious harm occurring.

Findings

Case Finding 1: Organisations did not have access to a policy or guidance to support them in considering rehabilitation access for Martin. System Finding 1: There is no formal local policy or procedure to guide professionals in the situation where someone who has completed detoxification is ready to access alcohol or substance misuse rehabilitation services but has pending criminal justice proceedings. This meant that, for Martin, organisations adopted a blanket approach that they do not place anyone in rehabilitation until the outcome of the legal process is known.

Case Finding 2: Key organisations did not attend the Vulnerable Adult Risk Management (VARM) meeting set up to discuss the risks to Martin and to formulate strategies to manage those risks. System Finding 2: Key organisations did not prioritise attendance at the VARM meeting and did not provide information in advance of the meeting to contribute to discussion and risk management.

Recommendations

Recommendation 1: Multi-agency practice guidance should be produced to govern decision-making, and the role of organisations, when a person deemed ready to enter alcohol or substance misuse rehabilitation is awaiting a criminal justice charging decision. This should cover circumstances including: when rehabilitation should, and should not, be delayed; risk mitigation plans to manage risks to a person during any delay in accessing the planned rehabilitation placement.

Recommendation 2: The organisations who did not attend the VARM meeting should be asked to review their organisational response and provide assurance that it was in line with the LLR VARM policy, encompassing the points below and giving consideration to sharing any learning internally:

- Whether attendance should have been prioritised
- If attendance should not have been prioritised, whether information relevant to managing risks to Martin could have been shared in advance of the meeting to aid decision-making.

In addition to learning from our own local SARs, the LSAB Review Subgroup also considers learning from other SABs across the country. During 2020/21, reviews discussed by the group included:

Review	Learning Considered	Action Taken by LSAB
1.	Elderly female who was looked after in the home of her family (with some limited support from professionals) died in hospital and was found to have sustained 26 unexplained injuries, including a fractured nose and jaw, as well as old and new bruising to her face, arms and legs.	Detailed briefing received and discussed regarding the recommendation for consideration of an approach similar to the child death reviews, including context and current position. The position in Leicester established, with notable differences identified in how Leicestershire Police would have investigated and linked in with health. The Group was assured that current local processes would be robust enough to avoid the issues raised.
2.	The suicide of a young man with Autism Spectrum Disorder (ASD), learning difficulties and Obsessive-Compulsive Disorder (OCD) who was living in hotels and seeking provision of housing from the local authority.	Case and learning discussed, noting the themes locally and nationally. The report was passed on to the local Autism Strategy task and finish group Chair for comment and to recommend it incorporates any learning and considers any assurance that may be identified.
3.	The death of a woman in her forties, due to mixed drug toxicity. There was a complex interplay of factors in her life, and her presenting issues and vulnerability included: • Significant levels of domestic violence and coercive control • Poor mental health, including a history of depression and patterns of self-harm • Drug and alcohol dependency • Involvement in criminal behaviour leading to a short-term prison sentence • Periods of street homelessness and barriers in accessing housing provision.	Discussed at Review Subgroup and local factors highlighted, including around those who are vulnerable but have lifestyle challenges and do not comply with hostel settings. Referral made to the Local Audit group to consider if an audit into the issues could be carried out or whether case characteristics could be included in an existing planned audit.

CORE PRIORITY 2: Enhancing Everyday Business

The work of the Performance Subgroup, Joint Audit Group, Training Subgroup and Joint Policy and Procedures Subgroup. A local Safeguarding Adults Board must seek to achieve its objective is by 'coordinating and ensuring the effectiveness of what each of its members does' (Care Act 2014). 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.

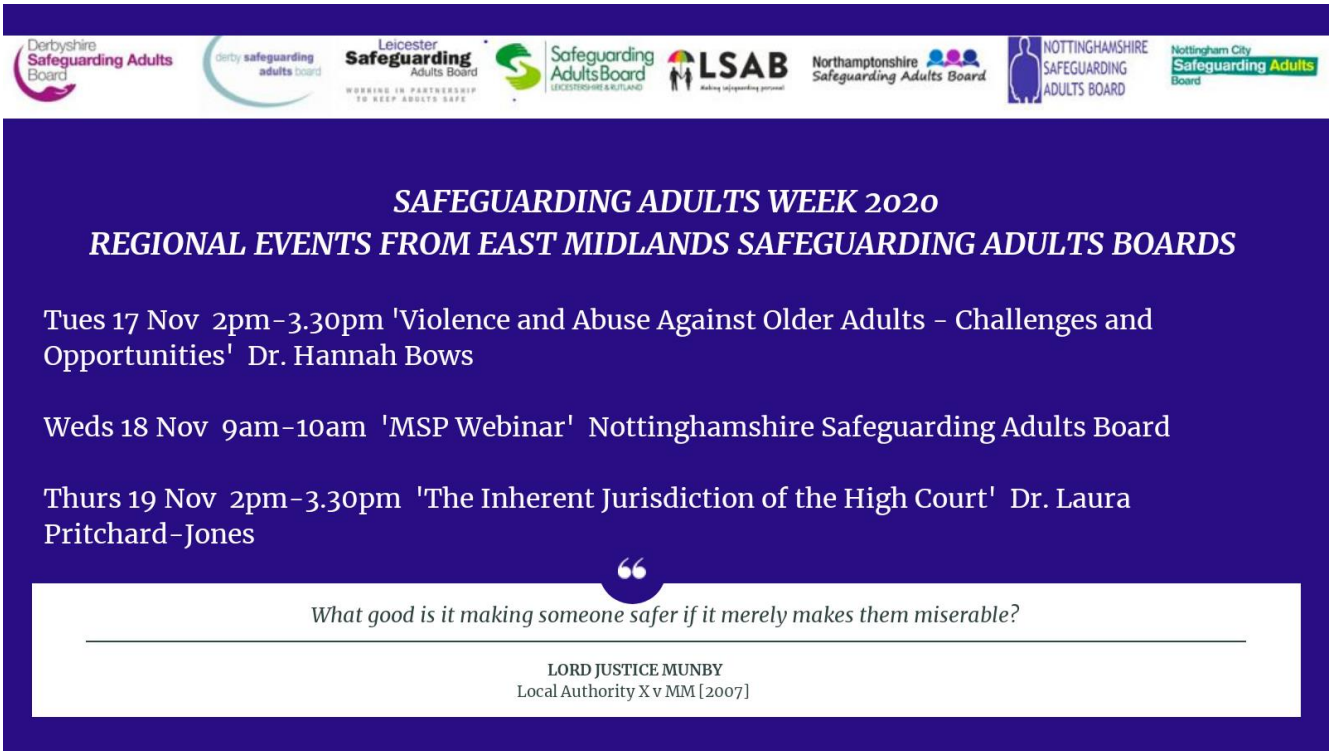
A new addition to our MAPP during 2020/21 was our multi-agency Guidance for Working with Adults at Risk of Exploitation: Cuckooing. Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation. This guidance seeks to provide front line professionals with a multi-agency framework to facilitate effective working with adults who are at risk due to 'cuckooing'.

The Performance Subgroup is responsible for ensuring that Leicester Safeguarding Adults Board has a clear quality assurance framework. It delivers a range of business as usual matters, including management of the performance data and intelligence, a programme of assurance activity, and the production of an annual assurance statement (which includes the results of the annual local Safeguarding Adults Assurance Framework). Throughout 2020/21 the Performance Subgroup was temporarily stood down in response to COVID-19. In its place, the main LSAB board meeting was held on a six-weekly basis. This approach enabled flexibility and a quick response to issues that arose during the pandemic but meant that we did not have a Safeguarding Adults Assurance Framework (SAAF) or annual assurance report this year. The Performance Subgroup is being reinstated for 2021/22 and will become a Leicester, Leicestershire and Rutland Subgroup.

Our Joint Audit Sub Group undertakes multi-agency safeguarding adults audits across Leicester, Leicestershire and Rutland. The process brings together practitioners to give a multi-agency view on practice in safeguarding cases to identify areas of good practice and areas for learning and improvement. During 2020/21 the LSAB received the findings of a 'Mental Capacity Act and Safeguarding' audit as well as 'Neglect and Older People' audit.

Multi-Agency Training: Section 14.139 of the Care Act Statutory Guidance notes 'Each SAB should… promote multi-agency training and consider any specialist training that may be required. Consider any scope to jointly commission some training with other partnerships…'. The LSAB Training Subgroup leads this work on behalf of the partnership, in line with our Training Strategy.

During 2020/21 the Training Subgroup moved from being a Leicester only Subgroup to a Leicester, Leicestershire and Rutland Subgroup. The Training Strategy will be refreshed during 2021/22 to reflect this. The group oversees the production of our LLR quarterly newsletter Safeguarding Matters, our LLR Trainers Network, it also has governance for the Mental Capacity Act forums run in the city for care home providers, as well as the LLR Trainers' Network. During 2020/21 the group commissioned and facilitated basic and enhanced MCA training across the partnerships in preparation for Liberty Protection Safeguards (LPS) being implemented during 2021/22. The group also oversaw an online programme of events for Safeguarding Adults Week including East Midlands regional events involving Domestic Abuse and Older People, and Inherent Jurisdiction.



Feedback included *"Thanks so much! Great presentation by the way and very easy to understand for those of us not working in the legal arena!"*

DEVELOPMENTAL PRIORITIES 1, 2, and 4: Strengthening Citizen and Carer Engagement; Raising Awareness within our Diverse Communities; and Prevention (helping people to stay safe, connected and resilient to reduce the likelihood of harm, abuse or neglect).

Throughout 2020/21 the LSAB Engagement Subgroup facilitated online 'What is Adult Safeguarding?' sessions for Leicester communities. A total of 65 people attended these sessions and feedback included.

"This was really interesting and useful"

"I am more confident now at spotting the signs of abuse and neglect and know the importance of early intervention"

"To support adults, I will be working with to be able to identify the risk and the support they need."

"Continue doing my volunteering role knowing that the info is still current"

"Both in my volunteering role as well as away from that. I know who to notify if I sense there is risk of some form of abuse."

In addition, an easy read version of our 'What is Adult Safeguarding?' document has been produced, published on our SAB webpage, and promoted via Engagement Officer's Twitter account.

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

The group also led on our local engagement side of national Safeguarding Adults Week 2020. In addition to facilitating a 'What is Safeguarding?' session there were also Hate Crime awareness sessions with Leicestershire Police's Hate Crime Officer, and the Policy and Procedures Subgroup promoted their 'Cuckooing in the Context of Adults Safeguarding' via a webinar.

An article was published in Age UK's Engage Magazine, providing an overview of what safeguarding adults is and how people can make contact.

Leicestershire Police also ran a Facebook live event on Preventing Financial Abuse against Adults. The figures after a week the event took place shows that the event:
- Reached 16,000 unique people
- 7,000 people have watched the video, with 142 viewers watching live
- There were 2,000 Thru Plays (this means people watched a significant portion of the video)
- 163 people liked, shared and commented on the post
- Our average viewer was female aged 45 – 54

DEVELOPMENTAL PRIORITY 3: Understanding How Well We Work Together

Mental Capacity Act Audit: Positive practice for Leicester City Council included evidence of consideration of practicable steps (such as best time of day) and perseverance in completing Mental Capacity Act assessments and there was evidence of multi-agency working in completing assessments (joint visits). For LPT there was evidence and recognition of issues around fluctuating capacity and also that lessons learned within the enquiry were taken forward with staff for wider learning. For UHL good practice included development of guidance to support staff in seeking consent to care, and also appropriate use of the Best Interest process.

Issues identified across the partnership included presumption of capacity, consideration of whether advocacy for the person is required and clearly reqcorded, assessing workder need to feel confident to discuss what they are worried about with the person in order to be able to assess their understanding of the risks within the siuation, legal literacy of workers, when the person has been assessed as lacking capacity to understand a decision within a safeguarding enquity there should still be evidence of trying to ensure their voice is heard in line with Making Safeguarding Personal principles.

Safeguarding Mental Capacity Act guidance has been developed across Leicester, Leicestershire and Rutland, with 'How To' guides available to support practitioners with their MCA assessments. In addition, the Training Subgroup has commissioned basic and enhanced MCA training for the partnerships.

Neglect and Older People Audit: Having received the findings of the neglect and older people multi-agency audit, recommendations being taken forward by the partnerships include:

- Facilitating multi-agency workshops to promote the work of advocacy providers.
- Facilitating multi-agency training around safeguarding adult's strategy meetings.
- Consideration is being given to updating multi-agency policies and procedures relating to how outcomes are recorded (we will be taking a regional view on this in the first instance).
- Highlighting with providers the issues identified (family intervention when this is impacting on the person's care, refusal of care) around older people and neglect (this will be taken forward via the LLR Trainers' Network).
- The Performance Subgroup to consider repeat referrals.
- On-going work (guidance and workshop) in response to audits around 'Transforming Care' which is relevant to the issue identified around safeguarding in private hospitals.

4. LOOKING TO 2021/22

Looking to 2021/22 we have developed our annual business plan jointly with Leicestershire and Rutland Safeguarding Adults Board. It will soon be published alongside our strategic plan, on the 'plans, reports, and strategies' page of our web pages.

Business Plan priorities for 2021/22 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.
- Increase in domestic abuse in safeguarding adults cases and across services. Increase in number of alerts relating to Psychological abuse.
- Other areas of concern include self-neglect and individuals with mental ill-health and/or learning disabilities.

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 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.

5. APPENDIX A: 2020/21 LSAB STRUCTURE CHART