



A Message from the Independent Chair

It is a privilege to introduce the Annual Report for Leicestershire and Rutland 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 Leicestershire and Rutland. 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 SAB's priorities are delivered. There have been important areas of work undertaken in the year.

A high-level data dashboard has been agreed so that SAB partners are able to understand through a "temperature check" what this high-level data is telling us about where we need to explore and support frontline 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 is 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 emerging issues that have been identified. The SAB has agreed over the 2-year period 2023-2025 priorities of self-neglect, mental capacity and domestic abuse.

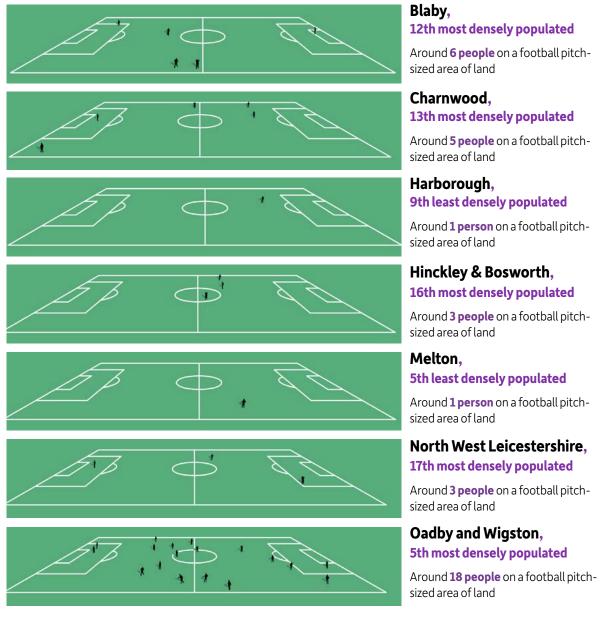
I would like to thank the Board Manager and the Team for efficiently and effectively managing the business of the Board. I would also like to acknowledge the work of the staff and managers across all statutory, voluntary and community partners who are committed to working together to keep people safe in Leicestershire and Rutland.

Seona Douglas

Local Context

The Census shows that, in 2021, the population of Leicestershire (not including Leicester City) rose from 650,600 in 2011 to 712,300. Across the 7 council areas in 2021, Blaby was home to around 5.6 people per football pitch-sized piece of land, Charnwood was 4.7 people, Harborough 1.2 people, Hinckley & Bosworth 2.7 people, Melton 0.8 people, North West Leicestershire 2.7 people, and Oadby and Wigston 17.5 people. More statistics regarding Blaby can be found here; for Harborough here; for Hinckley & Bosworth here; for Melton here; for Melton here; for North West Leicestershire here; and for Oadby and Wigston here.

As of 2021, of the East Midlands' 35 local authority areas our council areas are populated as follows:



The Census shows that, in Rutland, the population size increased by 9.7%, from around 37,400 in 2011 to 41,000 in 2021. This was higher than the increase for the East Midlands (7.7%). There was an increase of 31.2% in people aged 65 years and over, an increase of 4.0% in people aged 15 to 64 years, and an increase of 2.4% in children aged under 15 years. More statistics can be found here.



Rutland,

4th least densely populated

Around **1 person** on a football pitchsized area of land

The Safeguarding Adults Board

The Care Act 2014 stipulates that each local authority must set up a Safeguarding Adults Board (SAB). 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. A Safeguarding Adults Board must publish an annual report detailing what it has done during the year to achieve its main objectives and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action.

The work of the Safeguarding Adults Board is informed by the six key principles which underpin all adult safeguarding work, as set out in the Care and Support Statutory Guidance:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability.

The Leicestershire & Rutland Safeguarding Adults Board brings together organisations across the counties of Leicestershire and Rutland to oversee the multi-agency approach to safeguarding adults with care and support needs. The Safeguarding Adults Board:

- Sets how organisations should work together to safeguard adults with care and support needs
- · Provides multi-agency training and development resources to support good safeguarding
- Tests how well organisations are working together and the difference this is making
- · Reviews serious safeguarding incidents to identify improvements needed
- Uses learning and feedback to improve and develop how agencies work together to safeguard adults.

Safeguarding adults means helping adults at risk who need support from community care services to keep their independence, remain safe and exercise choice in their life. The Board partner agencies from the statutory, voluntary and independent sector come together to seek assurance that the persons thought to be at risk stay safe, are effectively safeguarded against abuse, neglect, discrimination, are treated with dignity and respect and enjoy a high quality of life.

The Independent Chair for Leicestershire and Rutland, Seona Douglas, is jointly appointed with the Leicester Safeguarding Adults Board.

The Safeguarding Adults Board members are made up of the following agencies:

LEICESTERSHIRE & RUTLAND SAB MEMBERSHIP		
	Leicestershire Police	
Criminal Justice	HMP Prisons	
	National Probation Service (NPS)	
Emargancy Carvicas	East Midlands Ambulance Service (EMAS)	
Emergency Services	Leicestershire Fire and Rescue Service (LFRS)	
	Leicester, Leicestershire and Rutland Integrated Care Board (ICB)	
Health	Leicestershire Partnership NHS Trust (LPT)	
	University Hospitals Leicester NHS Trust (UHL)	
Local Authorities (Leicestershire	Adult Social Care	
and Rutland)	Lead Member	
District and Borough Councils	Joint representative for all areas	
Government Department	Department of Work and Pensions	
Consumer Champions	Healthwatch	

The full membership of the partnership can be found on the Safeguarding Adults Board website: https://lrsb.org.uk/sab-membership-list

The engagement of all partners, at a Board and subgroup level, is monitored. If a partner agency does not attend a number of meetings, this is escalated to the Chair of the group. If the matter remains unresolved, it is further escalated to the Independent Chair. Details of attendance at Board meetings across 2023-24 and the governance of the Board and its subgroups are available at Appendix 1.

The Leicestershire & Rutland Safeguarding Adults Board is funded by contributions from the safeguarding partners. Further information about finance and the budget is available at Appendix 2.

This is the statutory annual report of the Leicestershire & Rutland Safeguarding Adults Board outlining the work it has carried out during 2023/24. For more information on how the Board works, please visit https://lrsb.org.uk/adults

Safeguarding Data

Leicestershire

Safeguarding Enquiries and Alerts

	2022/23	2023/24
Total number of concerns (alerts) raised	5005	1732
Total number of enquiries	494	796
Conversion rate of concerns to enquiries	10%	46%

Concluded Enquiries by Types of Abuse

(more than one type of abuse can be recorded against enquiries so percentages will not add up to 100%)

	2022/23	2023/24
% of completed enquiries which record – Physical Abuse	26%	28%
% of completed enquiries which record – Domestic Abuse	9%	11%
% of completed enquiries which record – Sexual Abuse	9%	6%
% of completed enquiries which record – Psychological Abuse	25%	25%
% of completed enquiries which record – Financial or Material Abuse	24%	24%
% of completed enquiries which record – Modern Slavery	<1%	<1%
% of completed enquiries which record – Discriminatory Abuse	<1%	<1%
% of completed enquiries which record – Organisational Abuse	7%	5%
% of completed enquiries which record – Neglect and Acts of Omission	41%	35%
% of completed enquiries which record – Self-Neglect	5%	2%



Making Safeguarding Personal

	2022/23	2023/24
% of incidents risk removed	39%	30%
% of incidents risk reduced	52%	67%
% of incidents risk remained	10%	3%
% of Making Safeguarding Personal outcomes achieved *fully or partly	93%	95%

There has been a big change in Leicestershire's figures for this year due to a change in recording (alerts) and a change in process (enquiries), and this is obvious when looking at their overall numbers as shown in the table above. For alerts, they were previously capturing any concern for welfare contacts in their figures, but this was thought to be incorrectly inflating their numbers. Leicestershire are now capturing only those contacts, where in the contact, the question 'are safeguarding adults issues indicated' is answered as Yes. For enquiries, halfway through 2023/24 the internal process was changed to open all enquiries after initial triage, which has caused an increase in enquiries reported.

The most common category of abuse in 2023-24 remained neglect and acts of omission.

In 75% of safeguarding enquiries, the individual (or their representative) was asked their desired outcomes, and these desired outcomes were fully or partly achieved in 95% of cases.

Most common category of abuse in 2023-24 remained neglect and acts of omission



75%
of individuals asked their desired outcomes in safeguarding enquiries

Cases where desired outcomes were fully or partly achieved

95%



"Think the worker is just fantastic. Really lovely way about her as well; you do feel that she listens and that she understands us as a family."

"The Social Worker has done a lot for us. She is the best social worker that we have ever had. Did not have to wait long at all. She is a very warm and friendly person, very easy to get on with. I enjoy her visits."

"I feel better about dealing with my mental health issues – my worker listened to me and has made a difference." "The worker was AMAZING. I don't know where I would be now without her. She went out of her way to help. She listened to what I needed... I really benefitted from the work and help she provided."

Feedback from people who use Leicestershire services

Rutland

Safeguarding Enquiries and Alerts

	2022/23	2023/24
Total number of concerns (alerts) raised	474	458
Total number of enquiries	56	51
Conversion rate of concerns to enquiries	12%	11%

Concluded Enquiries by Types of Abuse

(more than one type of abuse can be recorded against enquiries so percentages will not add up to 100%)

	2022/23	2023/24
% of completed enquiries which record – Physical Abuse	4%	14%
% of completed enquiries which record – Domestic Abuse	4%	3%
% of completed enquiries which record – Sexual Abuse	4%	3%
% of completed enquiries which record – Psychological Abuse	0%	3%
% of completed enquiries which record – Financial or Material Abuse	13%	22%
% of completed enquiries which record – Modern Slavery	0%	0%
% of completed enquiries which record – Discriminatory Abuse	0%	0%
% of completed enquiries which record – Organisational Abuse	0%	3%
% of completed enquiries which record – Neglect and Acts of Omission	75%	51%
% of completed enquiries which record – Self-Neglect	0%	0%



	2022/23	2023/24
% of incidents risk removed	17%	21%
% of incidents risk reduced	79%	79%
% of incidents risk remained	4%	0%
% of Making Safeguarding Personal outcomes achieved *fully or partly	75%	88%

The number of alerts and enquiries has remained stable.

Towards the end of 2022-23, Rutland started recording, where appropriate, more than one category of abuse against enquiries, whereas previously they would only record one. This approach to recording was embedded throughout 2023-24 and provides a true reflection of the abuse that occurred. The highest category of abuse remains neglect and acts of omission. There has been a further increase in financial abuse, with consecutive rises from 2021-22 to 2022-23 to 2023-24.

"Risk remained" in 0% of cases in 2023-24 and the percentage of Making Safeguarding Personal outcomes achieved rose to 88%.

There has been a further increase in financial abuse, with consecutive rises from 2021-22 to 2022-23 to 2023-24



00/0 Risk remained in cases during 2023-24



Making Safeguarding Personal outcomes achieved rose to





"Open and up front – clear communication, I had no difficulty understanding what was going on."

"They built my mother's confidence back up.
She didn't find it easy to accept help but she seemed to accept it off them, which was great."

"Can't think highly enough of them. They couldn't have done anything better. Really impressed. Good set up. I have heard people complaining about other Councils but I think we seemed to have cracked it here in Rutland. It was great."

Feedback from people who use Rutland services

Meeting our Strategic Priorities

The Leicestershire & Rutland Safeguarding Adults Board set a joint <u>Strategic Plan for 2020-2025</u> with the Leicester SAB in 2020 which provides the framework for forward priorities of the two SABs.

The strategic priorities are:

Core Priorities

- Ensuring Statutory Compliance carrying out the required functions of the SAB
- Enhancing Everyday Business of our partners

Developmental Priorities

- Strengthening User and Carer Engagement
- Raising awareness within our diverse communities
- Understanding how well we work together
- Prevention helping people to stay safe, connected and resilient to reduce the likelihood of harm, abuse or neglect

The Safeguarding Adults Board also sets Business Plans to progress work as part of the Strategic Plan. The work on these business plan priorities is embedded within the assurance, training, procedure and review work of the Safeguarding Adults Board, outlined further in the following sections of this report.

The business plan priorities for 2023-25 are Self-Neglect, Mental Capacity Act and Domestic Abuse. Further detail on these is provided later in the report.



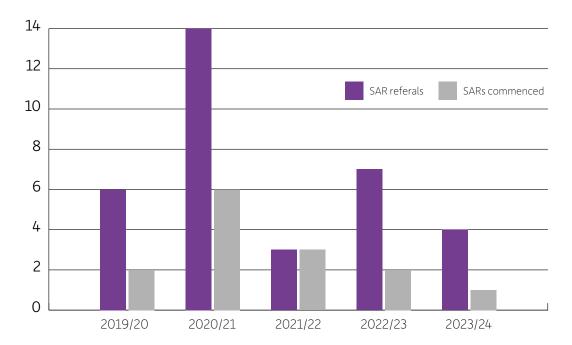
Core Priority 1: Ensuring statutory compliance

Safeguarding Adults Reviews

Safeguarding Adults Boards have a statutory duty under Section 44 of the Care Act 2014 to undertake Safeguarding Adults Reviews (SARs) into cases where individuals with care and support needs have been seriously harmed or died and abuse or neglect is suspected. When these reviews are undertaken they are focused on identifying how multi-agency safeguarding systems and practice can be improved in future.

During 2023-24, the Leicestershire & Rutland Safeguarding Adults Board had four referrals for Safeguarding Adults Reviews. It was identified that one of these referrals met the criteria for a review. With the other referrals, one case was initially referred as a potential Domestic Homicide Review (DHR) and then re-considered as a potential Safeguarding Adults Review but met the criteria for neither type of review, whilst the other two referrals came in just before the end of the financial year and will be considered early in 2024-25.

The chart below shows the number of referrals and Safeguarding Adults Reviews commenced (date case agreed to meet Safeguarding Adult Review criteria) each year for the past five years. In some cases, a Safeguarding Adults Review may have been referred in one year and commenced in the next year.



During 2023-24, the Safeguarding Adults Board continued work on four other Safeguarding Adults Reviews, with one review put on hold due to criminal processes.

All four of these Safeguarding Adults Reviews were completed, with three published on our website during the year and one due to be published in April 2024. Further information about the reviews published in 2023-24 is available at Appendix 3. Leicestershire & Rutland Safeguarding Adults Board also adds its published reviews to the National Safeguarding Adults Review (SAR) Library developed by the National Network for Chairs of Adult Safeguarding Boards.

Of the six people considered as subjects of reviews agreed, on hold or under way during 2023-24:

- Four were female and two were male
- Four were White British, one of Asian ethnicity and one of White and Black mixed heritage
- One was aged over 65 and one was aged under 25.

Since 2020, the Leicestershire & Rutland Safeguarding Adults Board has conducted four Safeguarding Adults Reviews where the subject has been an adult with a Learning Disability and another review is underway. The Board has identified that this is an over-representation of people with a Learning Disability as subjects of Safeguarding Adults Reviews and has addressed this by:

- Establishing better and closer links between the local Safeguarding Adults Boards and the Transforming Care Team and LeDeR (Learning from lives and deaths People with a learning disability and autistic people) Team.
 - The Transforming Care Team delivered a presentation at Safeguarding Matters Live in June 2023 on the Dynamic Support Register (DSP), which is a pathway developed to provide support for individuals (all age) with a learning disability, autism or both who are deteriorating in their health and wellbeing whilst living in the community.
 - A formal Memorandum of Understanding between the Safeguarding Adults Boards and LeDeR has been agreed and implemented, to ensure that appropriate links are maintained as both have a statutory responsibility to complete reviews on the deaths of people with a learning disability and autistic people, where the criteria are met. These reviews can be completed as parallel processes and can provide an opportunity to share learning, data and offer opportunities for scrutiny and challenge.
- Working on establishing links with other groups whose focus is learning disabilities, such as the Learning
 Disability and Autism Collaborative, the Leicestershire Learning Disability Partnership Board and Rutland
 Learning Disability Partnership Board. These are partnership groups, which sit outside of the Safeguarding
 Adults Board governance structure, which have a learning disability remit and to where Safeguarding Adults
 Review learning could be fed in, allowing for a joined up, multi-disciplinary response to safeguarding adults
 with learning disabilities.
- Publishing a special issue of Safeguarding Matters in April 2023, with a focus on safeguarding adults with learning disabilities. It covered the following topics, which have been raised within local Safeguarding Adults Reviews:
 - Case Studies
 - The Voice of the Adult is Heard
 - Communication Passports
 - Being a Good Communicator
 - Addressing and challenging inappropriate language
 - Assessing Risk when essential care is not provided
 - Easy Read Resource What is an Annual Health Check
 - Easy Read Resource How to get a Health Check
 - Diagnostic Overshadowing
 - Mental Capacity
 - Easy Read Resource Consent and Capacity
 - My Role Primary Care Liaison Nurse (PCLN), Leicestershire Partnership NHS Trust (LPT)

Available to both practitioners and members of the public via our website, this resource encourages reflection on current practice, attitudes, blockers and solutions to supporting adults with learning disabilities to be safe and well.

- Disseminating to practitioners, in June 2023, a Learning Disability Week special Safeguarding Matters Digest with links to national resources from MENCAP and Change and local resources.
- Producing a local version of a short film created by Inclusion Gloucestershire entitled "<u>Was Not Brought</u>" which explains the importance of agencies recording whether a person "did not attend" or "was not brought" for their appointment. This message is brought to life by people who use services to explain the importance in noting this difference and why.

Other key areas of learning from the Safeguarding Adults Reviews during 2023-24 were:

- Understanding and application of the Mental Capacity Act (MCA), including in complex cases which have multiple factors such as learning disability, substance misuse, physical ill health, and domestic abuse
- Ensuring that multi-agency care and safety planning are discussed at the most appropriate multi-agency meeting, involving the appropriate professionals and the person, where possible
- Understanding of referral routes for services to ensure appropriate and timely referrals
- Safeguarding and the role of non-regulated services e.g., Personal Assistant (PA) service
- Understanding information sharing and issues of confidentiality and consent to share information with family members
- Understanding the impact of multiple risk factors
- The importance of taking a Whole Family approach, particularly when working with multi-generational households
- Understanding of pressure sores and recognition and management of these as a safeguarding issue, including when to seek medical support.

Action plans are in place to respond to and monitor areas of learning from reviews.

The Safeguarding Adults Board shared key messages from Safeguarding Adults Reviews through its quarterly <u>Safeguarding Matters newsletter</u> and <u>Safeguarding Matters Live events</u>, as well as the monthly Safeguarding Matters Digest emails. Safeguarding Matters has a wide reach, with over 2600 visits to the newsletter's webpage during 2023-24. To support workers to put learning from reviews into practice, the Board continues to use <u>7-minute learning briefings</u>. These concise documents are focused on encouraging reflection and development within teams and by individuals to develop practice in response to the learning.

East Midlands Peer Review

In 2022-23, Leicestershire & Rutland Safeguarding Adults Board were involved in an East Midlands regional review of Safeguarding Adults Reviews. It took advantage of work commissioned by Partners in Care and Health to provide evaluation and advice on safeguarding adults work. Learning from this process was delivered to the Leicester, Leicestershire & Rutland Safeguarding Adults Boards in 2023-24 and is influencing future work.

Second National SAR Analysis

Leicestershire & Rutland Safeguarding Adults Board provided data and information for the Second National Analysis of Safeguarding Adults Reviews. This has been commissioned by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) as Partners in Care and Health to support councils to improve the way they deliver adult social care and public health services. The analysis will cover reviews completed nationally between April 2019 and March 2023. The report will be published in late summer/autumn 2024.

Core Priority 2: Enhancing Everyday Business

Multi-Agency Safeguarding Procedures

Leicestershire and Rutland Safeguarding Adults Board works with Leicester Safeguarding Adults Board to maintain up-to-date multi-agency adult safeguarding policies and procedures across Leicester, Leicestershire and Rutland. These policies and procedures are hosted on our dedicated website called the MAPP (Multi-Agency Policies and Procedures) www.llradultsafeguarding.co.uk/.

Throughout 2023/24 these policies and procedures continued to be reviewed and updated in line with learning from reviews, audits, and best practice.

Updates were made to the following procedures:

- Deprivation of Liberty Safeguards
- Disclosure and Barring
- Domestic Abuse
- Female Genital Mutilation
- Forced Marriage
- · Guidance for Working with Adults at Risk of Exploitation: Cuckooing
- Independent Advocacy
- Mental Capacity
- Stage 2 Lead Agency Decision using Safeguarding Threshold Guidance whether to proceed to referral
- Thresholds
- Working with Adults Affected by Child Sexual Exploitation and Organised Sexual Abuse

A full list of new chapters and amendments made can be found on the 'Amendments' page of the Leicester, Leicestershire and Rutland Multi-Agency Policies and Procedures.

Individuals can receive alerts regarding procedure updates by registering with the MAPP. If they have any comments or feedback on the procedures, they can use the contact form.

Learning, Development and Training

The Safeguarding Adults Board continued to support up-to-date training in single agencies, including all key partners and many care providers, through providing a competency framework for adult safeguarding and disseminating learning from reviews and updates to procedure and legislation.

The Leicestershire & Rutland Safeguarding Adults Board's training co-ordination and delivery function is shared with the Leicester Safeguarding Adults Board to support consistent and effective partnership working. The name of the Leicester, Leicestershire & Rutland (LLR) subgroup was changed in order to reflect the broader focus on learning and development rather than simply training. The subgroup coordinates the production of training resources and the organising of events in support of our priorities and learning from reviews. A blended approach to learning is adopted, incorporating video resources and resource packs alongside online training

sessions. This allows for a wide reach. The June 2023 online Safeguarding Matters briefing was attended, at times, by over 370 delegates with the December 2023 briefing attended by, at times, around 400 people, while the Safeguarding Basic Awareness Powerpoint, aimed at people who may work in a voluntary capacity or staff requiring a basic induction to children's and adults' safeguarding, has been visited over 3800 times on the website.

During 2023-24, the subgroup:

 Produced a local version of a short film created by Inclusion Gloucestershire entitled "Was Not Brought" about the difficulties faced by those who need assistance to access doctors' appointments.



- Provided online Safeguarding Adults and Children: Basic Awareness training for people who work or volunteer with children and/or adults and may be in a position to spot safeguarding concerns, with a plan to deliver future sessions both online and in person.
- Redistributed and promoted the "Guidance for Working with Adults at Risk of Exploitation: Cuckooing" in response to the learning from the multi-agency cuckooing audit completed in 2022-23.
- Supported the production of a new addition to the <u>Building Confidence in Practice</u> suite of resources, with the Professional Curiosity for Supervisors and Managers resource being published in January 2024.
- Linked in with the Performance Subgroup to receive training compliance data. To receive further
 assurance that each partnership agency is compliant with the required training standards, the Learning &
 Development Subgroup will hear presentations from each agency over 2024-25 where they will showcase
 their training and share good practice. This will compliment the other regulatory processes agencies
 already have to provide evidence for assurance.
- Carried out an analysis of Mental Capacity themes from Safeguarding Adults Reviews completed in Leicester, Leicestershire & Rutland to inform the commissioning and content of Mental Capacity training.
 Edge Training, the commissioned provider, has agreed to weave in local learning from Safeguarding Adults Reviews and local procedures to personalise their standard course materials.
- Commissioned Mental Capacity Act (MCA) Training which covers the following areas:
 - Mental Capacity Act awareness
 - Mental Capacity Act in practice
 - Advanced Mental Capacity Act training
 - Self-Neglect and the Mental Capacity Act.

The subgroup has commissioned 24 sessions, with a mixture of online and in-person sessions over a 12-month period commencing from March 2024. It has commissioned 18 basic sessions (the fundamental principles to ensure practitioners are trained in the basics) and 6 advanced sessions. Each session will host 25 delegates with 25 sessions reaching 600 delegates. The training programme was advertised widely, including via the website and the April 2024 issue of Safeguarding Matters. Most of this training will take place over 2024-25 and so the impact will be considered in next year's Annual Report.

Resources

The Leicester, Leicestershire & Rutland Safeguarding Adults Boards provide numerous learning and development resources and these are available and promoted via the <u>Safeguarding Matters newsletter</u>, <u>Safeguarding Matters Live events</u>, Safeguarding Matters Digest emails and <u>YouTube Channel</u>. Further information is provided in Appendix 4.

Trainers' Network

The Leicester, Leicestershire & Rutland Safeguarding Adults Boards' Trainers Network is a forum that brings together individuals that deliver any learning and development activities relating to safeguarding adults. Individuals that complete the Train the Trainer course delivered by the Leicestershire Social Care Development Group (LSCDG) are invited to join the Network. During 2023-24, the Trainers Network did not meet but it will be relaunched in 2024-25, with two events being held, both online and in person.

Training Impact

During 2023-24, 60 additional people requested they be added to the Safeguarding Matters distribution list, with over 700 people now signed up.

"Very useful for updating practice."

"More training needed to boost staff confidence to raise safeguarding concern and know the appropriate action and approach to take."

"Very good, very informative and extremely educational."

"I found the session very informative across the board as it has given me a broader [view] of different contextual environments that I need to be aware of when engaging in my role."

Feedback from Safeguarding Matters Live events

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

Engagement

As in previous years, the Leicester, Leicestershire & Rutland Engagement & Communications Subgroup oversaw the Safeguarding Adults Boards' promotion of adult safeguarding during National Safeguarding Adults Week 2023 (20th-25th November). They produced a resource pack for organisations and partners.

They also supported four "See Something Say Something" campaigns in the financial year. These campaigns are two weeks long. The group provides assets and suggested messages to partners and stakeholders so that they can support the campaign from their social media platforms.



'What is Adult Safeguarding?' online information sessions have been regularly delivered to support those who work in Leicester, Leicestershire & Rutland, including to community members and groups. In 2023/24, 6 sessions were delivered and 109 people attended.



"I will review our Safeguarding Policy."

"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."

"I have a clearer idea about what actions I could take if I suspected someone was in trouble." "This training has given us a good insight into pointers to look out for which may highlight concerns to us. If this is the case, we would voice these concerns to our Manager."

Responses to the question "How will you use the information from this learning event?" following "What is Adult Safeguarding" session

During 2023-24, the Engagement & Communications Subgroup has:

- Developed a core safeguarding adults' message for all partners to use in their own publications
- Made links with communications leads in organisations to promote the "What is Adult Safeguarding" sessions via social media every quarter
- Developed an adult safeguarding survey which can be used at community events using a QR code and paper copies. The draft survey is currently being piloted by partners with people who use their services
- Adapted the Norfolk Safeguarding Adults Board's Older people and Domestic Abuse video, entitled "<u>Hidden Harms</u>", and launched this as part of Safeguarding Adults Week in November 2023.

HIDDEN HARMS

older adults and domestic abuse

Created by
Norfolk Safeguarding Adults Board
adapted to be used by
Leicester and Leicestershire &
Rutland Safeguarding Adults Boards

The group is currently working with the Making it Real group at Leicester City Council to co-produce a new Leicester, Leicestershire & Rutland Safeguarding Adults leaflet. The Making it Real Group is made up of people who draw on social care or who care for someone who does, as well as people who work in social care. Gaining advice from people with lived experience will help to produce a more user-friendly and accessible leaflet.

Developmental Priority 3: Understanding how well we work together

Quality assurance and service improvement

The Leicester and Leicestershire & Rutland Safeguarding Adults Boards use their <u>Quality Assurance Framework</u> to support assessment of whether local safeguarding arrangements for adults are effective and deliver the outcomes that people want.



Performance data

The Leicester, Leicestershire & Rutland Safeguarding Adults Boards' Performance Subgroup collects, manages and discusses performance data and intelligence relating to safeguarding adults across the partnership. A high-level dashboard has been developed to help the Safeguarding Adults Boards understand any fluctuation on the patch, and ensure action is taken to reduce risks or understand the practice that lies under the data to ensure partners meet their legal duties and to seek assurance about partnership working and impact. The core dashboard stays consistent, with metrics that underpin the business plan priorities added and reviewed as priorities change. Data is collated and discussed on a quarterly basis to identify performance challenges and potential areas of good practice so that, where necessary, action can be taken to learn from or to improve safeguarding experience and to identify data approaches.

Self-Assessment

During 2022-23, the safeguarding partners and specific relevant agencies carried out a self-assessment audit of their safeguarding effectiveness. Safeguarding Adults Assurance Framework (SAAF) returns were fully analysed and presented to the Leicester and Leicestershire & Rutland Safeguarding Adults Boards during the 2023-24 business year. The majority of partner agencies provided some evidence that they were effective across all areas in the assessment. Where agencies judged themselves as not meeting the standard for being 'fully effective' against an area of assessment, additional information was required to indicate how they plan to achieve full effectiveness and by when.

A Safeguarding Adults Assurance Framework audit was not completed in 2023-24. A further process is being produced for the business year 2024-25. This will be focused on frontline staff and managers in partner agencies.

To enhance the process, it has been agreed to undertake Safeguarding Adults Assurance Framework self-assessments using different methodologies to obtain safeguarding assurance from agencies. A survey of frontline staff and managers is planned. This will enable the Safeguarding Adults Board to obtain assurance of the impact of recommendations and actions resulting from safeguarding reviews and multi-agency audits.

Audits

The Leicester and Leicestershire & Rutland Safeguarding Adults Boards carried out two multi-agency audit processes during 2023/24. The audit process brings together safeguarding leads from different agencies to give a multi-agency view on practice in safeguarding cases in order to identify areas of good practice and areas for learning and improvement. The audits focus on particular themes or parts of the safeguarding process. Practitioners are invited to give a frontline perspective on cases.

Thresholds Audit

The first audit focused on thresholds for access to services. The theme was selected as a result of continued learning from local Safeguarding Adults Reviews (SARs) and because the application of thresholds is a key multi-agency process. It looked at people's cases that met and did not meet safeguarding threshold criteria. The scope of the audit was 6 months from 1st July 2022 to 1st January 2023.

The audit demonstrated that thresholds are being applied appropriately 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 Safeguarding Adults Board Thresholds audit carried out in 2016. Practice has improved, with more consistent use of the thresholds as a tool to support decisions around people's care.



Learning	Action and Outcome
In some cases, it was not clear from the recording what the rationale was for a threshold decision.	Leicester Adult Social Care had, and Leicestershire Adult Social Care were in the process of, updating their forms with clearer prompts for practitioners and a clear link to the Thresholds Guidance. Leicestershire's form has since been updated.
In terms of the category of abuse recorded, it was recognised in more than one agency's audits 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.	Awareness raising was carried out in relation to the category of domestic abuse and the relationship between the people involved in the safeguarding enquiry.
In relation to Making Safeguarding Personal, carers and loved ones could be prioritised more as part of discussions, when appropriate, particularly around outcomes, and them being fully involved in this.	This should be in line with best practice and the priorities set out in the <u>LLR Carer's Strategy 2022-2025</u> .
There can be difficulties in gaining a person's views when safeguarding enquiries and health transfers take place concurrently, particularly in community settings.	Awareness raising was carried out to highlight that it is not solely the responsibility of the Local Authority to establish a person's wishes and views, under 'Making Safeguarding Personal'. There is a systems responsibility to ensure that we "Make Safeguarding Personal".
There remains a lack of confidence in relation to mental capacity assessments and recording.	The learning from the audit was fed into the Learning & Development Subgroup who have commissioned Mental Capacity training.
It is important to provide feedback to referring agencies about cases that do not meet the threshold. Without formal feedback, agencies can be left with open safeguardings on their system.	Rutland Adult Social Care has a letter that they use. Leicester Adult Social Care and Leicestershire Adult Social Care are considering how they will provide formal and timely feedback to referring agencies.

Mental Capacity Audit

The second audit focused on mental capacity. An audit on this theme was undertaken by the Subgroup in September 2019 and it was agreed that a repeat audit would be beneficial, as mental capacity is still a consistent theme in Safeguarding Adults Reviews (SARs). It is also a business plan priority. Cases were selected from safeguarding enquiries where there was a documented capacity assessment on the enquiry. The scope of the audit was 12 months from 1st April 2022 to 1st April 2023.

Where mental capacity assessments were completed, good practice was identified by all auditing agencies, with some examples of proportionate capacity assessments, practitioners being persistent and joint assessments being carried out by agencies. Overall, when the Mental Capacity Act was followed, it led to better outcomes in respect of the safeguarding enquiries.

Learning	Action and Outcome
It was noted that all agencies can complete capacity assessments but it is sometimes wrongly assumed that this is the remit of Local Authority practitioners. Additionally, it needs to be clear that assessments are decision specific and require an assessment for each decision that has to be made.	The learning from this audit was fed into the
Where the mental capacity assessment was not completed, this was sometimes attributed to practitioner oversight or gaps in knowledge and sometimes to recording issues. A proportionate capacity assessment should always be completed at the outset of any safeguarding enquiry, where doubts about capacity arise. In assessing capacity, information needs to be given to the person around the whole safeguarding process.	Learning & Development Subgroup, which has commissioned multi-agency MCA training for access across the partnerships and is establishing an MCA Community of Practice that will bring staff together for MCA learning and development.
The rationale around practicable steps taken is sometimes lacking detail.	Agencies are to promote the need for more detailed recording around practicable steps taken to include clear rationale. Practitioners should be documenting in records what they have considered and used – for example, different communication methods.
Safeguarding enquiries where family members/carers have Power of Attorney can be complicated.	The Procedures Subgroup is creating a procedure regarding "Working with People who have Lasting Power of Attorney", including key points for practitioners and how to check if there is a valid Lasting Power of Attorney in place. This is due to be published in early 2024-25.
The use of advocacy is not well embedded in safeguarding practice.	Awareness raising will be carried out regarding the importance of advocacy in safeguarding enquiries and the fact that, from 1st April 2024, the charity POhWER will provide all types of statutory advocacy on behalf of Leicester, Leicestershire and Rutland.

Learning from audits leads to recommendations and actions that are progressed and monitored. The learning is disseminated and informs changes required at both a system and practice level.

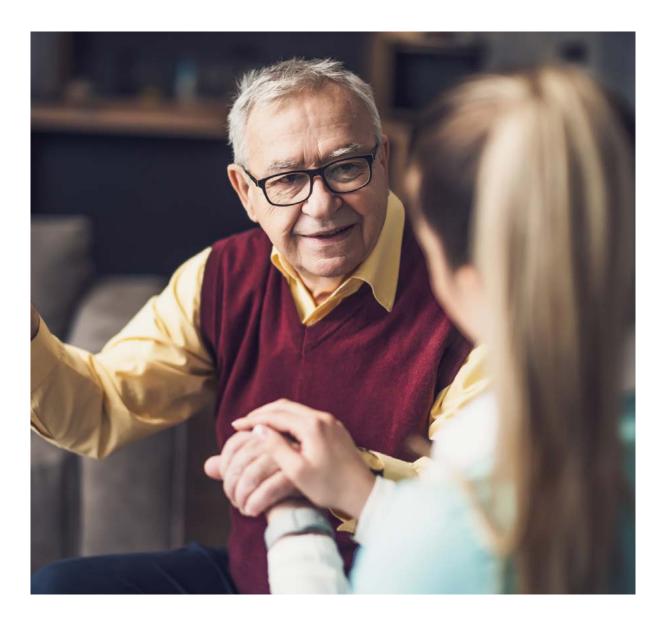
Other assurance work

Right Care Right Person

The Leicester and Leicestershire & Rutland Safeguarding Adults Boards have considered the local implications of "Right Care, Right Person" (RCRP). This is a collective national approach from the Home Office, Department of Health & Social Care, the National Police Chiefs Council, Association of Police and Crime Commissioners and NHS England which aims to ensure that individuals in mental health crisis are seen by the right professional.

Safe Care at Home Review

The Safe Care at Home Review was published in June 2023. This is a joint review led by the Home Office and Department of Health and Social Care (DHSC) into the protections and support for adults abused, or at risk of abuse, in their own home by people providing their care. In light of some of the issues raised in this national review, the Leicester and Leicestershire & Rutland Safeguarding Adults Boards agreed to partnership agencies assessing themselves against the 8 Key Findings. It was felt that this would provide a local overview, identifying good practice and challenges to address in light of the review. It was acknowledged that agencies may already be addressing the issues; however, the Safeguarding Adults Boards needed to understand the gaps and decide if there were actions for them or specific organisations. The agencies assessed themselves against each area and provided a Red, Amber, Green (RAG) rating. The Safeguarding Adults Boards agreed how to monitor any amber and red rated areas. In 2024-25, they will be seeking partners' assurance regarding their progress.



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

Annual Business Plan Priorities

The Leicestershire & Rutland Safeguarding Adults Board worked with the Leicester Safeguarding Adults Board to identify <u>shared priorities for 2023-25</u>. These priorities were identified as a result of local and national learning.

The annual Business Plan was replaced with a two-year-plan to allow time to embed the outcomes of the key deliverables and, subsequently, analyse the impact of these outcomes.

The work on these business priorities was embedded within the assurance, training, procedure and review work of the partnership outlined further in the other sections of this report. Updates on this joint business plan are provided throughout the business year to the Boards.

Self-Neglect:

Seek assurance that local safeguarding partners are working together to effectively safeguard adults who self-neglect.

Rationale (as of 2023-24):

- Safeguarding Adults Reviews have been or are being undertaken by Leicester SAB and Leicestershire and Rutland SAB as well as nationally, which have highlighted key learning in relation to self-neglect.
- There is a cross-over between our Mental Capacity Act priority and self-neglect.

What we did:

- Continued work to replace the current Leicester, Leicestershire & Rutland (LLR) Vulnerable Adult Risk Management (VARM) Guidance with refreshed and rebranded LLR Self-Neglect Guidance and templates. A Task & Finish Group has been working on this update. The learning points from a Leicestershire & Rutland Safeguarding Adults Review and the Leicester, Leicestershire & Rutland Safeguarding Adults Boards' Multi-Agency Cuckooing Audit, completed in 2022-23, have been fed into the process. The learning from the Multi-Agency Self-Neglect Audit will also inform the new guidance (see below).
- Planned a Leicester, Leicestershire & Rutland Safeguarding Adults Boards' Multi-Agency Self-Neglect Audit, which will take place in April 2024. A Vulnerable Adults Risk Management (VARM) audit was completed by the Multi-Agency Audit Subgroup in 2018. The results from that audit will be compared with those from the 2024 audit and learning will be fed into the work around the LLR Self-Neglect guidance. Both Section 42/Safeguarding Self-Neglect and VARM cases will be audited. Additional agencies, who do not sit on the Audit Subgroup, will be invited to attend, including POhWER (Advocacy Service), Environmental Health, Housing, Leicestershire Fire & Rescue Service (LFRS) and Turning Point (Drug and Alcohol Service). This will ensure that the views/expertise of agencies which are often involved in selfneglect cases are provided during the audit process.
- Continued to monitor, on a quarterly basis via the core dataset, the number of concluded enquiries where self-neglect is recorded as the type of abuse. Further work is being undertaken to capture business plan priority metrics, which will not be solely data driven work.

Outcomes and Impact:

Learning from local reviews and audits has indicated that there are some issues around the thresholds for the current VARM process. Consequently, there will be more in the new local Self-Neglect Guidance about risk levels and different types of services, with a view to ensuring each individual receives the right type of intervention. Another issue identified is the escalation process in practice proving not to be effective; therefore, it needs to be revised. It is acknowledged that the launch of the new guidance has been delayed; this is mainly due to the complexity of addressing all identified issues around this complex form of abuse which differs from the other forms of abuse because it does not involve a perpetrator. Once the guidance has been finalised, it will be relaunched. Learning and development events and resources will support the relaunch.

Mental Capacity Act:

Seek assurance that local safeguarding partners are using the Mental Capacity Act to effectively safeguard adults where appropriate.

Rationale (as of 2023-24):

- Local Safeguarding Adults Reviews and audits over last few years have identified MCA learning including around:
 - Best Interests
 - Advocacy
 - Recording of decisions and that assessments have been carried out
 - Complexity of co-existing conditions
 - Fluctuating capacity
 - Role of parents and carers / listening to them / sharing information with them (with permission)
 - Lack of understanding of the process by frontline workers and whose responsibility it is to carry out assessments
- Need for more suitable resources to support frontline practitioners in their daily practice in recognising the situations where a person's mental capacity is in question
- Demystifying the process

What we did:

- Completed a Leicester, Leicestershire & Rutland Safeguarding Adults Boards' Multi-Agency Mental Capacity Audit in October 2023 (see the section on Developmental Priority 3 for further information).
- Commissioned Edge Training to provide MCA Training specific to the learning needs of the Safeguarding Adults Boards (see the section on Core Priority 2 for further information).
- Started to consider how to establish an MCA Community of Practice which will bring staff together for MCA learning and development.
- Delivered presentations on the Mental Capacity Act in Practice at the December 2023 Safeguarding Matters Live Event and to the Leicester, Leicestershire & Rutland Safeguarding Children Partnerships/ Safeguarding Adults Boards Voluntary & Community Sector Forum in February 2024.

• Received a report from University Hospitals of Leicester NHS Trust (UHL) on the management of Deprivation of Liberty Safeguard (DoLS) applications.

Outcomes and Impact:

A lot of work has been implemented during 2023-24; it has been informed by national and local learning from reviews and quality assurance processes.

As this is a 2-year priority, the realisation and impact of this work will become evident in 2024-25 and will be reported in next year's Annual Report. Feedback from the commissioned training will be evaluated in terms of the focus of future work and how skills and knowledge levels are influenced. It has been agreed that staff benefit from live case examples about implementing theory into practice so this will be a key focus moving forwards regarding the MCA Community of Practice, with a plan to offer "Lunch and Learn" sessions. Learning around the Mental Capacity Act will be shared with the Safeguarding Children Partnerships as mental capacity assessments should be completed, where required, with individuals aged 16+.

Domestic Abuse:

Understand local response to domestic abuse in older people and safeguarding adults.

Rationale (as of 2023-24):

 Safeguarding Adults Reviews, Domestic Homicide Reviews and audits have been undertaken by Leicester SAB and Leicestershire and Rutland SAB, which have identified case specific learning in relation to safeguarding adults and domestic abuse in older people. A research project is being undertaken to better understand systems issues and our local response to older people experiencing domestic abuse who also come under safeguarding adults.

What we did:

- Supported a Domestic Abuse and Safeguarding Research Project, entitled "Perpetrators of Domestic Abuse Against Older Adults: Characteristics, Risk Factors and Professional Responses", carried out by Durham University.
- Adapted a short video, produced by Norfolk Safeguarding Adults Board, for Leicester, Leicestershire &
 Rutland about Domestic Abuse in Older People, entitled "<u>Hidden Harms</u>". It is now available on the LLR
 SABs YouTube Channel and has been widely promoted.
- Carried out awareness raising in relation to the category of domestic abuse and the relationship between the people involved in the safeguarding enquiry.

Outcomes and Impact:

The final draft of the "Perpetrators of Domestic Abuse Against Older Adults: Characteristics, Risk Factors and Professional Responses" report was presented to the Safeguarding Adults Boards at the end of 2023-24. Local partners are now considering the implications for their single agencies. The Safeguarding Adults Boards will then identify where a collective response, actions and monitoring are required.

Priorities moving forwards

The Leicestershire & Rutland Safeguarding Adults Board is developing a new joint Strategy for 2024-2027 with the Leicester Safeguarding Adults Board. The Strategy provides the framework for forward priorities of the two Boards.

The three priorities in the Business Plan for 2023-25 are:

Self-Neglect

Mental Capacity Act

Domestic Abuse

For each of these areas, we have set out our rationale for prioritising the topic, and presented the key deliverables, leads, activities, impact measures and timescales. This will enable us to monitor progress and secure assurance that our actions are making a positive difference to the lived experience of adults with care and support needs. The <u>Joint Leicester, Leicestershire & Rutland Safeguarding Adults Board Business Plan for 2023-25</u> is published on our website.

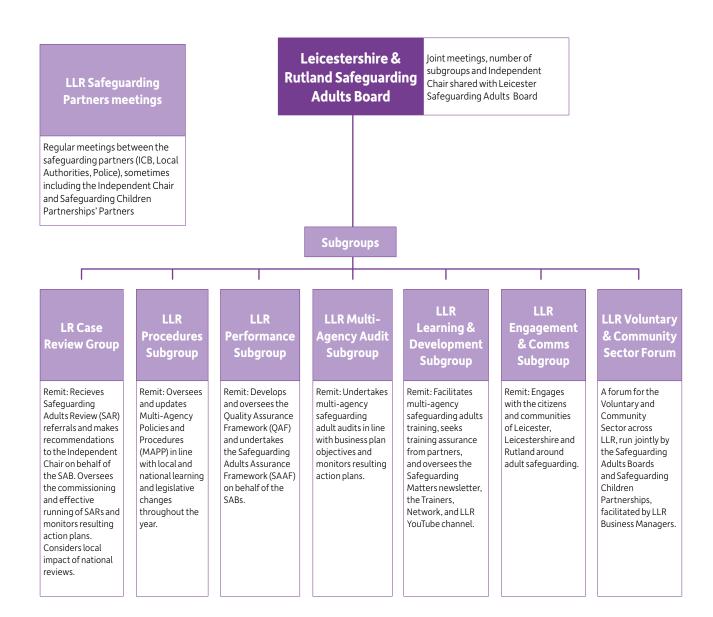
The Safeguarding Adults Board will also work to continue to meet its statutory responsibilities and continue to develop its approach to learning and improving safeguarding of adults.

Appendix 1 – Leicestershire & Rutland Safeguarding Adults Board and its subgroups

The table below provides details of agencies that are represented on the Leicestershire & Rutland Safeguarding Adults Board and their attendance at Board meetings in 2023-24. It may be that the Lead Officer delegated attendance to another officer.

	Attendance at meetings					
Agency	June 2023	August 2023	September 2023	December 2023	January 2024	March 2024
Leicestershire Adult Social Care	✓	✓	✓	✓	✓	✓
Rutland Adult Social Care	✓	✓	✓	✓	✓	✓
District and Borough Councils	Apologies	Apologies	✓	Apologies	✓	Apologies
Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB)	√	√	1	✓	√	√
Leicestershire Partnership NHS Trust (LPT)	✓	✓	✓	✓	✓	✓
University Hospitals Leicester NHS Trust (UHL)	✓	✓	√	✓	✓	✓
East Midlands Ambulance Service (EMAS)	Apologies	✓	√	1	1	1
Leicestershire Police	✓	✓	✓	1	✓	✓
HMP Prisons	✓	✓	✓	✓	✓	✓
National Probation Service (NPS)	✓	✓	1	Apologies	✓	Apologies
Leicestershire Fire and Rescue Service (LFRS)	1	✓	√	✓	✓	✓
Department of Work and Pensions	✓	Apologies	Apologies	Apologies	Apologies	Apologies
Healthwatch	✓	1	✓	Apologies	√	✓
Leicestershire Lead Member	✓	√	✓	✓	Apologies	✓
Rutland Lead Member	✓	√	✓	✓	√	✓

The structure chart below demonstrates the governance of the Board and its subgroups.



Appendix 2 – Finance

The work of the Safeguarding Adults Board is supported by the Leicestershire & Rutland Safeguarding Partnerships Business Office that also supports the Safeguarding Children Partnership and carries out Domestic Homicide Reviews. The Safeguarding Adults Board is funded by contributions from its partners.

A single funding arrangement for the Safeguarding Adults Boards and Safeguarding Children Partnerships for 2020 onwards has been agreed between the statutory partners for the Safeguarding Adults Boards and the Safeguarding Children Partnerships for Leicester, Leicestershire & Rutland. At that time it was also agreed how the contributions would be split across the two.

The contributions from partners for the Leicestershire & Rutland Safeguarding Children Partnership and Safeguarding Adults Board as a whole for 2023/24 can be seen below alongside contributions for the previous year:

	2022/23	2023/24
Leicestershire County Council	£119,266	£119,266
Rutland County Council	£50,367	£50,367
Leicestershire Police	£97,500	£97,500
Leicester, Leicestershire & Rutland Integrated Care Board (LLR ICB)	£97,500	£97,500
Total income for SCP and SAB	£364,633	£364,633

Overall expenditure across the Safeguarding Children Partnership and Safeguarding Adults Board for 2023/24 was £356,749.

Expenditure for the Safeguarding Adults Board was apportioned as follows:

Total Expenditure	£132,275	£150,478
Case Reviews	£6,975	£4,320
Engagement	£O	£75
Operating Costs	£4,540	£6,076
Support Services	£O	DE
Independent Chairing	£5,418	£9,997
Staffing	£115,342	£130,010
	2022/23	2023/24

Staffing costs increased as a result of the agreed Leicestershire County Council pay award (as the staff are hosted by this Local Authority). The cost of the Independent Chair was lower in 2022-23 because there was a vacancy for part of the year. Expenditure on Safeguarding Adults Reviews decreased due to the number of reviews already being in an advanced stage and alternative methodologies being used, as appropriate. As a result of the above factors and gaps in filling vacancies on the team, a reserve has built up over time of £95,350. This amount has been held due to a potential increase in costs and has meant that partners have not been asked for an increase in contributions; however, this surplus will eventually be used. All partners will be expected to ensure that the Leicestershire and Rutland Safeguarding Adults Board is self-sufficient.

Appendix 3 – Safeguarding Adults Reviews completed in 2023-24 by Leicestershire & Rutland Safeguarding Adults Board

Safeguarding Adults Reviews are published on our website for 1 year and are available <u>here</u>.

Past reviews are still available and accessible via the National Safeguarding Adults Review (SAR) Library.

SAR*	Publication Date	Synopsis	Learning
SAR "Nigel"	26.04.23	Nigel died as a result of Covid-19 when he was 38- years-old. He had cerebral palsy, a learning disability and autism. He required 24-hour support and a wheelchair to mobilise. Nigel lived with his parents and attended a Day Centre. At the time of his death he was being treated for swallowing problems and, as a result, he had experienced significant weight loss. At the time of his death his Body Mass Index (BMI) was 9. He had also developed pressure ulcers.	Lesson 1: Not all professionals were aware of communication passports. Lesson 2: There is no evidence of professionals maximising opportunities to discuss and explain the best interest principle to parents. Lesson 3: Professionals allowed parents to continue to make decisions for Nigel instead of consulting the Mental Capacity Act. Lesson 4: Detailed records must be kept of best interest decisions; this is not only good professional practice but necessary should a decision or decision making process be later challenged or reviewed. Lesson 5: The professional was not appropriately supported to progress safeguarding concerns. Lesson 6: The referral process that the Day Centre followed did not provide staff with enough information to ensure that they understood the options available to them if their concerns remained, or Nigel deteriorated post the referral being submitted. Lesson 7: Weight management and onward specialist referrals, where weight has been identified as a concern, are a priority. Lesson 8: Nigel's care and support was not coordinated by any lead professional. Lesson 9: The role of the Learning Disability Primary Care Liaison Nurse is not widely known amongst professionals within the agencies and organisations who support adults with learning disabilities.

SAR*	Publication Date	Synopsis	Learning
SAR "Claire"	14.02.24	Claire is diagnosed with Down's Syndrome, a learning disability and osteoarthritis. Claire lived with, and was cared for, by her sister and niece. She was taken to hospital suffering dehydration, and a grade 4 pressure wound which had caused sepsis and required surgery. The pressure wound was so severe it resulted in Claire being an inpatient at the hospital for a number of weeks, and Claire still required nursing thereafter. The criteria for this review were met as whilst Claire, an adult with needs for care and support, has thankfully not died, it is believed that she would have, had she not arrived in hospital when she did.	Question 1: How can GP surgeries in the local area assure LRSAB that Learning Disability Review templates are fit for purpose and include the individuals' 'lived experience'? Question 2: How can partner agencies assure LRSAB that professionals are understanding of the impact of language, are using positive language when referring to a disability or a person with a disability, and are addressing inappropriate language if used by carers and/or family members? Question 3: How can LRSAB be assured that all organisations are promoting advocacy services and empowering their practitioners to know when and how to seek advocacy services? Question 4: How can LRSAB be assured that professionals from all services do not deny a person with learning disabilities the equal right to be heard by having conversations with family members or carers instead of with the individual directly? Question 5: How can LRSAB be assured that professionals understand and consider diagnostic overshadowing when working with service users? Question 6: How can LRSAB ensure that professionals, and carers in the area, can easily access information which will help them understand what support is available to carers? Question 7: How can LRSAB ensure that professionals from all services are aware that referrals can be made to the fire service for a safety check? Question 8: How can partner agencies assure LRSAB that professionals from all services understand how to make a safeguarding referral to Adult Social Care? This must take into consideration any high turnover of staff and use of agency staff.

SAR*	Publication Date	Synopsis	Learning
SAR "Angela"	21.03.24	Angela was in her early 30's at the time of her tragic death. Angela had a long history of mental health problems, a learning disability, alcohol and drug addiction. Professionals had longstanding concerns regarding Angela's vulnerabilities particularly regarding intimate and peer relationships.	1. Understanding and Application of the Mental Capacity Act in complex cases which have multiple factors such as learning disability, substance misuse, physical ill health, and domestic abuse. 2. Understanding the person's lived experience, including the impact of a learning disability. 3. Ensuring that multi-agency care and safety planning is discussed at the most appropriate forum e.g., strategy meeting/case conference under S.42 of the Care Act or Vulnerable Adults Risk Management (VARM) as Angela had been deemed to have capacity, living in a way that was significantly harmful, and reluctant to engage. 4. Safeguarding and role of non-regulated services e.g., Personal Assistant service. 5. Family and carers – understanding information sharing and issues of confidentiality and consent to share information with family members. 6. Multiple risk factors – domestic abuse including coercive and controlling behaviour, exploitation, and substance misuse were present in her life and her relationships. Whilst efforts were made to discuss these issues and concerns with Angela (and at times she was incredibly open), her learning disability and fluctuating capacity affected her understanding of the impact of these issues and risky behaviours. 7. Weight management – Angela, although described as always very slim, had an extremely low body weight. Where there are concerns about low body weight, these need to be monitored and action taken if necessary. Adults with a learning disability should have an Annual Health Check regardless of their capacity.

^{*}Safeguarding Adults Reviews can be labelled using codes and acronyms, as agreed with family members where possible.

Appendix 4 – Learning & Development Resources

The <u>LLR SABs' YouTube channel</u> continues to develop a bank of safeguarding videos and other resources that can be utilised by partners for learning and development – for example, in single agency training and supervision. It is used to share local and national learning content, especially that which aligns with the Safeguarding Adults Boards' Business Plan priorities.

As in previous years, during 2023-24, two print issues of the <u>Safeguarding Matters newsletter</u> were published, with a focus on disseminating learning from reviews and audits and promoting procedural updates. The April 2023 issue was a special issue on Safeguarding Adults with Learning Disabilities.

Following the successful launch of <u>Safeguarding Matters Live</u> in 2022-23, two events were held in June 2023 and December 2023. These are live online briefings for all staff across the children and adults multi-agency partnerships. They share learning from reviews and audits, procedure and guidance updates, and resources to support practice. The slides from the events are made available via our website and sessions are available to watch on the YouTube Channel. Topics covered in 2023-24 included trauma-informed practice; the Dynamic Support Pathway; mental capacity; and developing awareness of unconscious bias.

The Safeguarding Matters Digest is a monthly email, which is used to disseminate local and national safeguarding information in a concise and regular format. In June 2023, a Learning Disability Week special digest was disseminated with links to national resources from MENCAP and Change and local resources, including a link to the Tricky Friends video.

The Safeguarding Matters newsletters and Live PowerPoints and videos are available via our website and YouTube channel. Individuals can request to be added to the distribution list so that they are informed of publication and event dates by emailing lrspbo@leics.gov.uk. The Safeguarding Matters Digest is disseminated via email to those that have signed up to receive it. To be added to the distribution list, individuals can email lscpb@leicester.gov.uk.









