Worcestershire Safeguarding Adults Board

Annual Report 2022/23

Worcestershire Safeguarding Adults Board

Final V2

Document Control

Contact: Worcestershire Safeguarding Adults Board Manager

Location: Worcestershire Safeguarding Adults Board website

Contributors to the development of the document

Name	Organisation
Keith Brown	WSAB Independent Chair
Sarah Wilks	WSAB SAR Manager and Board Coordinator
Sue Lawrence	WSAB CARM Project Lead
Jane Jones	WSAB administrator
Simon Davis	Worcestershire County Council
Sarah Cox	Worcestershire County Council
Claire King	Herefordshire & Worcestershire Health and Care NHS Trust
Sarah Dempsey	Herefordshire & Worcestershire Integrated Care Board
Deborah Narburgh	Worcester Acute Hospitals NHS Trust
Samantha Hammond	West Mercia Police
Caroline Mann	Worcestershire County Council
Lily box	Worcestershire County Council

Actions

Required Actions	Date
DRAFT V1 Presented to Chairs comments submitted by 24th August 2023. Draft 1 Updated	15th August 2023
Draft V2 Presented to Board	19th September 2023
Sign Off (no further comments following Board)	26th September 2023
Placed on website	October 2023
Updated (minor change)	May 2024

Contents

Chairs Foreword

The 2022/2023 Annual Report of the Worcestershire Safeguarding Adults Board (WSAB). reflects and represents the hard work that the Board and its members have undertaken in the past year. Whilst fortunately for most of us, living with covid 19 is not a daily concern, for those engaged in the health and social care sector, its impact remains. The pandemic pushed an already stretched system to the very edge. The shortage of staff in the health and social care sector is becoming one of the most acute problems and is a significant risk to the system. Whilst resolving this is beyond the scope and influence of a safeguarding board, it is a reminder that staff continue to face extreme pressure and our admiration for these colleagues remains undiminished.

I must acknowledge the skill and dedication of the Board staff and Board members who have worked in various subgroups and teams to effectively discharge the business of the Board and drive forward new initiatives and policies with the aim of improving the safeguarding of vulnerable adults in Worcestershire. Of note is the development of the Lead Professional agenda, with the introduction of the Complex Adult Risk Management (CARM) framework. We have seen some excellent work undertaken by staff, led by the newly appointed framework lead.

The Board also approved a new Self-neglect and Hoarding policy, produced using a collaborative approach with a range of stakeholders from the statutory and voluntary sectors. We are now focused on the introduction of an Adult Exploitation Strategy.

The WSAB continued to work closely with providers of services for people who are homeless or sleeping rough through the establishment of an Assurance Panel with representatives from across the sector and their advocates, who assess responses to the recommendations of the review.

As a Board we also commissioned two animated podcasts, looking at scams and executive function. These are freely available across the sector via YouTube and form part of our wider learning and development programme.

Please take time to read this annual report. It demonstrates how various agencies are committed to providing better outcomes for some of the most vulnerable people in our communities. A significant task and one that grows every year as we learn more about exploitation and vulnerability in our society. Alongside commending the practitioners and managers who strive daily to deliver their very best for society's benefit, I also want to thank councillors and members of health boards, alongside members of the local community who give of their time usually in an unpaid capacity to help shape and promote the services we all use and show incredible support for safeguarding issues. Together we really are stronger and make a more positive impact.

Professor Keith Brown
Independent Chair of Worcestershire Safeguarding Adults Board

1.0 Introduction

In line with the Care Act (2014) guidance on Annual Reports the purpose of this report is to:

- Clearly state what the Worcestershire Safeguarding Adults Board (WSAB) and its members have done to carry out its objectives and strategic plan.
- Set out how the Board is monitoring progress against policies and intentions to deliver its strategic plan.
- Provide information on Safeguarding Adult Reviews (SARs). Reporting on what has been done to act on the findings of completed reviews.

2.0 Background

2.1 Purpose of the Board

The WSAB's primary role is to provide assurance that local safeguarding arrangements are effective, and partners act to help and protect adults in its area who:

- *have needs for care and support (whether or not the local authority is meeting any of those needs) and;*
- *are experiencing, or at risk of, abuse or neglect; and*
- *as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect*

The WSAB's vision is to provide assurance that adults with care and support needs are safeguarded from abuse or neglect. Partners work together to ensure that these people are empowered and kept safe from abuse or neglect; where abuse sadly occurs the WSAB acts to ensure that partner organisations respond effectively and proportionately, whilst adhering to the outcome focused principles of Making Safeguarding Personal (MSP).

The work of the Board is underpinned by the six safeguarding principles as defined in the Care Act (2014) guidance which are:

- **Empowerment** - People being supported and encouraged to make their own decisions and informed consent.
- **Prevention** - It is better to act before harm occurs.
- **Proportionality** - The least intrusive response appropriate to the risk presented.
- **Protection** - Support and representation for those in greatest need.
- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse.
- **Accountability** - Accountability and transparency in delivering safeguarding.

2.2 Board Membership

The Board is made up of several key partner organisations in Worcestershire including:

- Worcestershire County Council Directorate of People
- West Mercia Police
- NHS Herefordshire & Worcestershire Integrated Care Board'
- Herefordshire & Worcestershire Health and Care NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- National Probation Service
- Regulatory Services
- Worcestershire Voices
- Representative from Worcestershire Housing Strategic Partnership
- Representative from Care Homes
- Representative from Independent Health Sector
- Representative from Carer reference group
- Representative from Advocacy Reference Group
- Representative from People with Lived Experience (PwLE)
- Lead Councillor for Adult Social Care
- Worcestershire County Council Directorate of Public Health
- Representative from Independent Health Providers
- Herefordshire and Worcestershire Fire and Rescue Service

2.3 Annual Budget and Financial Contribution

The annual budget is established through a financial contribution from statutory partners. The total partner contributions for 2022/23 was £134,450. The name of the agency and their contribution; shown as a percentage of the overall cost, is set out in table 2.1 below:

Table 2.1 – Financial Contribution by Statutory Partners

Agency Name	% Contribution
Worcestershire County Council	47.00
Herefordshire & Worcestershire Clinical Commissioning Group	41.10
West Mercia Police	11.90

The 2022/23 expenditure was £174,385 which is £39,935 over the total funding received. The majority of the overspend was predicted and covered through reserves, along with additional partnership funding from the South Worcestershire Community Safety Partnership and Public Health to develop a multi-agency response to the exploitation of adults with care and support needs. There was also an increase in projected salary costs due to the pay settlement and local changes in leave agreements.

The spend for 2022/23 can broadly be broken down under the following categories:

Staff and administration costs (including the Independent Chair)	£113,537
Special Projects (funded via reserves and other sources) • Exploitation Project (£6,613) • CARM Project Lead (£8,388)	£15,001
Sub-group and task-group spend	
• Case Review (Safeguarding Adults Reviews)	£15,229
• Case Review (Database)	£5,287
• Learning Development Practice and Communications	£8,710
• Reference Group * (2021/22 & 2022/23 payments)	£7,750
• Regional Assurance Framework	£4,665
• Policy Reviews	£1,167
• Business Mileage	£1,423
• Other (Insurance, communications, equipment, licenses)	£1250
• Network meetings	£366
Total Spend	£174,385

Following previous years of underspend, 2022/23 finished at £72,193, which is broken down into £48,894 from funding partners and £23,299 of carry forward from Public Health for the aforementioned exploitation work.

The carry forward into 2023/24 has been allocated to continue developing the work around, the Complex Adult Risk Management (CARM) framework and exploitation of adults, delivering the communication plan, policy reviews, alongside continuation of developing the rapid review SAR process and SAR development project work.

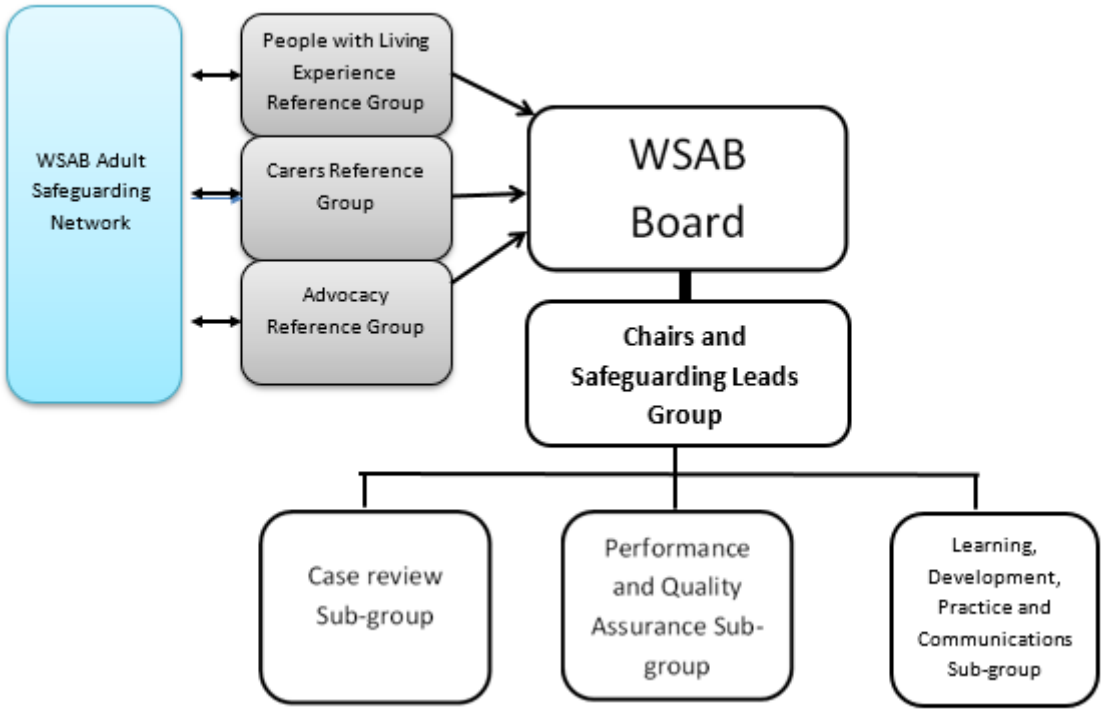
2.4 Delivery Model

Implementation of the Business Objectives is achieved through the work of the Board and its three sub-groups (Fig 2.1). Each year annual business objectives are identified though emerging themes from the data, findings from local and national SARs and Reviews, alongside a review of previous priorities.

Issues are also identified and raised at the Board via three reference groups, which facilitate the engagement of people with care and support needs, their carers and families with the work of the Board. There is a representative from each of these reference groups on the Board. They also link into a wider Adult Safeguarding Network.

The sub-groups develop individual implementation plans which outline the activities different stakeholders will undertake to ensure that the annual business objectives will be met. These are reviewed at Board on a quarterly basis.

Fig 2.1 Board Structure



2.5 Business Objectives

There the objectives identified in the 2022/23 business plan were:

Continuing to take forward work around Wicked Issues from previous business plans, particularly

- Exploitation
- Rough Sleeping
- The Lead Professional

Developing and Implementing a Communication Plan

Building Links with Herefordshire to support the development of the integrated Care System

Monitoring the impact of the difficulties in staff recruitment across the Health and Social Care system

There was also an objective to monitor the implementation of the Liberty Protection Safeguards, however this is currently on hold whilst we await further

government information

Table 2.2 gives a summary of the annual objectives and details or achievements.

Table 2.2 – Achievements	
WSAB Objective	**Achievements**
Continue to take forward work around 'wicked issues'	**Exploitation** A consultant was appointed to develop a strategy. The consultant held meetings with stakeholders and facilitated two workshops. One with voluntary sector representatives, the other with key stakeholders. A draft strategy has now been produced and is out for wider consultation with the ambition of it being signed off during the 2023/24 business year. **Lead Professional** The WSAB led on the development and implementation of a Complex Adult Risk Management (CARM) framework, which was launched in May 2022. (More details below in separate CARM section). **Homelessness and Rough Sleeping** The WSAB continued to work closely with providers of services for people who are homeless or sleeping rough. An assurance panel, which includes representation from these providers, assess responses to the recommendations of the Thematic Review into people who sleep rough. Minutes of the meetings can be found Link to WSAB Self-Neglect website page, along with a copy of the review and other information on working with people who are homeless or sleeping rough. In addition, the WSAB is currently reviewing its SAR process to ensure that there are clear expectations on the review process that needs to take place following any future deaths of Rough Sleepers. **Self-Neglect and Hoarding** The WSAB also signed off its updated Self-Neglect and Hoarding Policy. This revised guidance was produced through a collaborative approach, with a range of statutory and voluntary sector stakeholders, across Herefordshire and Worcestershire. It is for practitioners (both paid and voluntary) who have contact with people who persistently self-neglect, including those displaying hoarding behavior and people who sleep rough. Based on the approach of no wrong door, it clarifies the support pathway and introduces the concept of significant harm requiring a S42 enquiry. A copy of the policy can be found by following this WSAB Self Neglect Policy.
Developing and implementing a communication	Led by the Learning Development and Practice Sub-group the WSAB introduced its first comprehensive communication plan. This set out to

plan	raise awareness of safeguarding issues and the work of the Board over the year. Notable achievements include • the development of podcasts addressing areas identified through SARs which can be found by following these links WSAB Website Local Learning Resources Page • a successful safeguarding week with virtual sessions and a joint learning event with the 'Learning from Lives and Deaths of People with a Learning Disability and autistic people' panel (LeDeR) • the sharing of themed SAR learning Briefings, • a sustained awareness raising campaign on the CARM Framework and Self-Neglect and Hoarding Policy. • Refreshed Making Safeguarding Personal Leaflet Link to leaflet • Design of a demystifying safeguarding leaflet Link to leaflet The WSAB website was also subject to a redesign, in collaboration with carers, people with lived experience and professional. There is now an entrance point for each of these groups which takes them to the information they identified as that they are most likely to require the link to this page can be found here. Link to page Other pages on the website were also built to increase the level of information we provide on specific safeguarding issues.
Building Links with Herefordshire to support the development of the integrated care system;	With the introduction of the Integrated Care Board (ICB) and System (ICS) the footprint of the ICB and the Health and Care Trust expanded across both Herefordshire and Worcestershire. West Mercia Police's reach also covers these two counties, alongside Shropshire and Telford. Both the WSAB and Herefordshire Safeguarding Adults Board (HSAB) adopted a joint policy framework which sets out the approach for developing shared policies, where feasible. Link to Joint Policy
Monitoring the impact of the difficulties in staff recruitment across the Health and Social Care system	At the beginning of the year, in recognition of the difficulties which the Health and Care sector were experiencing in recruitment and retention of staff, the WSAB agreed to regularly monitor the situation, and receive regular updates on actions the sector were undertaking to address this concern. As the year progressed other issues also arose which impacted on this situation, including the industrial action which was taking place across the Health Sector. The WSAB received regular updates on how the sector were addressing this situation so that risks, particularly to safeguarding, were mitigated where possible.

Complex Adult Risk Management (CARM)Framework

The CARM framework, launched in May 2022, sets out a clear approach for multi-agency meetings when working with people with complex needs who are at risk of abuse or neglect but don't meet other social care or safeguarding criteria. Details of the framework can be found by following this Link. CARM document and information

The CARM was established in response to recommendations from Safeguarding Adults Reviews which advised that a Lead Professional needs to be identified in cases where there are multiple organisations involved and it is difficult to engage with the person. In October

2022 a Project Lead, was employed one day a week to help embed the framework.

During 2022/23 there were a total of 38 referrals to CARM. Of these 16 were appropriate to progress to a CARM meeting and have safety plans in place. The remaining referrals were progressed through other pathways including, self-neglect, adult safeguarding and for social care assessments.

Issues which were sought to be addressed during the CARM planning meetings include access to mental health services, domestic abuse, homelessness and risk of eviction, substance misuse, the long-term management and support of self-neglect or hoarding.

Practitioners attending the CARM meetings include Housing, Police, Probation, District Councils, WCC Teams, Care Providers, NHS Acute Trust, District Nurses, Surgeries / Medical Practices, Voluntary Agencies, Health & Care NHS Trust and charities. A Lead Practitioner has been identified from these organisations in most of the CARM referrals. In the two which weren't the CARM project lead has ensured that they move forward.

The CARM project lead has also held a series of online briefings over the year explaining its purpose and process. The sessions are available to all organisations across the county and have been attended by 401 people.

3 Review of Activities 2022/23

3.1 Care Act Requirements

Care Act Guidance requires Safeguarding Adults Boards and the statutory partners to provide an account, through the Annual Report, of how they ensure that Care Act duties are both effective and meaningful, to ensure that local safeguarding systems and processes reflect the vision, principles, and requirements of the Act.

3.2 Work of the Board

Board processes are now well established and structures to engage with people who have experience of health and social care services, their carers and advocates are now in place through our different reference group. We also have an Adult Safeguarding Network group. This network is open to all sectors and services across the County that deliver services for adults with care and support needs. The network met twice virtually this year. Further information on the network can be found here Link to information on WSAB Safeguarding Network

3.2.1 Safeguarding Adults Reviews (SAR)

Mandatory SARs must be commissioned when:

- There is reasonable cause for concern about how services, worked together to safeguard an adult,

and

- The adult has died, and it is known or suspected that the death resulted from abuse or neglect

or

- The adult is still alive, and it is known or suspected that the adult has experienced serious harm.

Safeguarding Adult Boards (SABs) can also commission a 'discretionary SAR' in other situations involving an adult with care and support needs, where there are clearly identified areas of learning, practice improvement or service development which have the potential to significantly improve provision of care and support, and this cannot be achieved by other review procedures. The capacity of the SAR subgroup and agencies to manage such a review would have to be considered.

A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently, that could have prevented harm or a death from taking place to prevent future harm or death from occurring. It also highlights and seeks to share good practice.

The purpose of a SAR is to critically review whether:

- The services involved and establish whether they were provided in accordance with current policies, procedures, and professional standards.
- The policies and procedures enabled the services to work together to the benefit of the individual.

And importantly, if any matter had been completed differently the outcome would have been to the advantage of the individual.

3.2.2 SAR Methodologies

Rapid Review

This year the WSAB has continued to develop the Rapid Review process. The WSAB has adapted a process, initially introduced for Local Safeguarding Children's Partnerships, for working on reviews into the care and treatment provided to adults. Adhering to the requirements of the Care Act 2014, the process ensures representation from all agencies are involved at the earliest stage, along with the person, family, and carers, where possible. This facilitates more robust decision making on whether the SAR criteria are met and ensure that the learning is shared at the earliest opportunity. Concerns had been

raised regarding the number of SARs commissioned previously so, two independent consultants were commissioned to chair these meetings, providing challenge and support.

As a result, it has been possible to agree recommendations to improve systems and share learning more quickly and there has been a positive cost benefit with a saving of approximately 25% in comparison to following the original SAR protocol for all referrals.

3.2.3 SAR Referrals

During 2022/23 10 referrals were received by WSAB and the following decisions made:

- SAR criteria were not met in relation to five referrals.
- SAR criteria was met in three referrals. It was agreed that the rapid review process was appropriate for two of these, with the third being an extended SAR. The two rapid reviews are in progress. The extended SAR is awaiting author procurement.
- Two recent referrals have rapid review meetings pending.

3.2.4 SARs completed during 2022/23

Three mandatory SARs were completed and signed off by the Board at the end of March 2023.

- One mandatory Rapid Review SAR was published and can be found using the following link: Alison SAR
- One mandatory SAR was completed as a full SAR report, but only the executive summary will be published as soon as final engagement with the family has taken place.

One mandatory SAR was completed in the previous year but was awaiting publication due to a complaint which was not upheld This SAR involved a Care Home. Details of the SAR can be found using the following link: Dorothy SAR.

3.2.5 SARs: Changing Practice through Learning and Action

SARs seek to determine what the relevant agencies and individuals involved with the person's care and treatment might have done differently to prevent the harm or death. The reviews involve developing recommendations to promote effective learning and improvement actions. It is understood that professional practice occurs within the context and culture of the wider multi-agency safeguarding system, therefore, recommendations and associated action plans focus on improving the safeguarding system. Capacity within the team supporting the Board remains an issue, however, progress has been made in the monitoring process to ensure the assurance from subgroups and agencies that agreed actions are being progressed. The Board Business Support team are continuing to address this, and it remains a priority.

Areas for improvement identified in the three SARs signed off by the WSAB during this year included.

Making safeguarding personal (MSP) / CARM Framework:

- Improve engagement of individuals who decline support, engagement of CARM framework*.
- Importance of holistic approach.
- Professional curiosity particularly where the vulnerable person may be reluctant to engage.

Multi-agency working / CARM Framework:

- When considering individuals multiple and complex needs, ensure multi-agency approach to include lead professional, multi-agency meetings and jointly owned action plans*.

Mental Capacity & Self-Neglect:

- When considering mental capacity, a person's executive capacity should also be considered

*The Complex Adults Risk Management (CARM) framework launched in May 2022 seeks to address these issues and further briefings throughout 2022/23 have taken place

One multi-agency action plan, which encompasses the recommendations made for a SAR on 'Neil', has been signed off: Link to Neil Learning Brief

Six single agency action plans were also signed off during 2022/23

3.2.6 Annual Learning Event – Joint Event with the LeDeR

In 2022 the WSAB held a Joint annual learning with the Learning from Lives and Deaths Reviews (LeDeR) program. It was the first learning event for the WSAB which engaged people with lived experience (PWLE). The event explored the safeguarding experiences of people with learning difficulties and or disabilities, including findings from SARs and LeDeR reviews and provided an opportunity for participants to share their experience and concerns with service providers and commissioners of services.

The findings from the event were recorded via a graphic facilitator and an overview can be found on the WSAB website by following this link: WSAB Annual Learning Event 2022 Graphic Recording

Following the event, a Task Group was established to take forward the findings from this event, these include developing resources which can support the improvement of service provision such as:

- mapping services,
- designing checklists/quality standards for practitioners and service users

The Task Group also identified several concerns in the current pathways which present a potential risk to the safety of people with learning disabilities, which they shared with WSAB. These included:

1. **Allocation of a named Social Worker.**

Whilst there have been improvements over recent years, some people still don't have a named social worker, or they are changed frequently due to turn over in staff. This often means they are unsure of where to ask for help from resulting in a delay which can sometimes mean a risk increases.

*It is important to note that since the learning event this has been rectified and the team that supports people with learning disabilities is now fully staffed. Prior to this they ensured that there were systems and mechanisms to respond promptly to those who didn't have a named worker.

2. **Increase in professional distance**

The increase in online appointments and triage systems, particularly following covid, can create confusion and avoidance of asking for help. Many people with a learning disability find themselves sat waiting for a return call for a few hours, which can make it difficult for them to ensure that an advocate is with them when the call comes in. They also find that they are constantly repeating their story and are often not sure who to.

3. **Waiting lists for Diagnosis Assessments.**

Whilst people are waiting for assessments and diagnosis, they are often not receiving formal support, which can increase the risk of exploitation as well as mental health issues. During this wait they also do not have access to any additional benefits, which can make them anxious and isolated.

3.2.7 National Safeguarding Week.

Over recent years the WSAB have actively delivered local events during the National Safeguarding Week each November. The week has been used to get key messages out to professionals and practitioners about the services, resources and policies which can support them in safeguarding the adults with care and support needs that they work with. This year we focused on the role of the Self-Neglect and Hoarders Policy and the Complex Adults Risk Management (CARM) Framework, which included the CARM project lead holding a series of briefing sessions.

3.2.8 Annual Assurance Statement

Statutory member organisations of SABs are required to undertake an annual assurance review of how they have worked to meet the Care Act requirements and deliver the Board's priorities. Initially, following the introduction of the Care Act, statutory partners assessed themselves against a set of standards and provided evidence to support these statements. The Performance and Quality Assurance (P&QA) sub-group provide oversite of this process.

Over the years this approach has been adapted to avoid repetition and duplication as many organisations must provide similar information to their regulatory bodies for their internal quality frameworks along other SABs where there are wider boundaries (e.g the ICB covers two counties). In 2023 the WSAB signed up to a regional framework which covers both Adults and Children's safeguarding. Locally organisations will complete the online template in the Autumn of 2023, and this will be reviewed and inform the 2024/5 improvement plan. A report on the outcomes of this will be provided in next year's annual report.

3.2.9 Collaboration and Co-Production

As part of its approach to Making safeguarding Personal (MSP), the WSAB have continued to build on its commitment to working collaboratively with People with Lived Experience and the services that support them. Representatives from the reference groups continued to build on their participation into the work of the Board. Alongside continued involvement into the design of promotional and learning material, there has been greater engagement of reference group representatives in the assurance role of the WSAB.

i) Assurance Panels

Building on the Assurance Panel approach, adopted to oversee the implementation of the Thematic SAR into Rough Sleeping recommendations, additional assurance panels and theme groups were established during 2022/23 to assess the response to recommendations in other SARs. Panels have been established to examine responses from reoccurring themes including Multi-Agency Working, Self-Neglect and Carers. The assurance panels membership draws on expertise from the sector and people with lived experience, providing a framework through which they can challenge current approaches and influence change.

ii) Review of PWLE approach

During the year the WSAB, though the Learning Development Practice and Communication (LDP&C) sub-group, undertook a review of its approach to engaging People With Lived Experience (PWLE) in its work. This has developed organically, with the lead on how to undertake this work being driven by participants. Whilst there were no concerns regarding the approach, the WSAB wanted to identify any areas which could be built on and improved. Following the review, several recommendations were identified which will inform an improvement plan to be taken forward over the next business year.

A key part of this improvement plan is developing the role of the Adult Safeguarding Network. Following the end of lockdown this Network resumed in-person meetings, which have been well received. At these meetings the WSAB provide regular updates on the work of the WSAB, alongside presentations on services, organisations and policies which play an important role in adult safeguarding. Following the review of the PWLE approach this network will also provide a valuable link to their service users, who through their

support, will provide further input into the work of the WSAB.

Details of the network, along with presentations from the meetings, can be found by following this Link to WSAB network page.

3.2.10 WSAB Publications and Guidance

i) Policies and Guidance

During 2022/23 the WSAB adopted a Complex Adult Risk Management Framework. Details of the framework along with other information to support and advise the process can be found by following this link: WSAB CARM Framework

The Self-Neglect Policy was also reviewed and updated in response to recommendations and learning from several Safeguarding Adults Reviews. This revised guidance was produced through a collaborative approach, with a range of statutory and voluntary sector stakeholders, across Herefordshire and Worcestershire. Based on the approach of no wrong door, it clarifies the support pathway and introduces the concept of significant harm requiring a S42 enquiry. Details of the Policy can be found by following this link: WSAB Self-Neglect and Hoarding Policy

Details of all the WSABs Policies and Guidance can be found on the following page : Link to WSAB Policies and Guidance

ii) Guidance and Briefings

Alongside the publication of Safeguarding Adults Reviews the WSAB also published a series of briefings based on common themes. These set out a summary of the learning found in relation to the theme, including links to relevant SARs, alongside links to useful resources. Links to the briefings can be found by following the links below:

- Self-Neglect Briefing
- Mental Capacity)

In addition, we also produced and published some information documents explaining the purpose and process of undertaking a review. These can be found in the introduction of the following page: Information on SARs

iii) Podcasts

The WSAB have also been producing a series of podcasts looking at the Mental Capacity Act. Designed in collaboration with people with lived experience, they aim to provide an overview of the legal frameworks and provide advice on things to consider when applying them. At the end of last year, we published two on the Mental Capacity Act and Best Interest Decisions. We also produced a podcast advising on Scams and how to prevent them. All these podcasts can all be found on the following page : Link to WSAB Podcasts

3.3 Organisational Contributions

Contributions from Statutory Partners to support the delivery of WSAB objectives include:

Objective 1: Developing and implementing a WSAB communication plan

All partners have supported this objective ensuring that information produced by the WSAB is disseminated across their organisation in a timely way. This has included

- Sharing information on new or revised polices and the CARM framework, including briefings and details of training events
- Sharing briefings produced by the WSAB, including the daily briefings for Adult Safeguarding Week.
- The Acute Trusts intranet A-Z now contains a link to the WSAB website.

Objective 2: Taking forward the work around 'wicked issues' focusing on

Rough Sleeping

- The Integrated Care Board (ICB) Homelessness Liaison Pathway Officer has a clear workplan in place with priorities around supporting people to live independently and mental health and wellbeing.
- The ICB Mental Health Collaborative is well established and delivering against its plan
- Health organisations and the County Council are committed to delivering the recommendations in the Thematic SAR on Rough Sleeping and steady progress is being made.
- Adult Social Care are reviewing and revising their recording of data to ensure that they can better capture the number of rough sleepers and homeless referred to their services.
- The Acute Trust are ensuring that they have robust data on rough sleepers and the homeless and regularly review the Homelessness Liaison Pathway work.

Exploitation

- All partners have been actively engaged in the development of the Exploitation Strategy
- Adult Social Care have reviewed their safeguarding model, including how they capture data so that they can identify patterns and trends, including identifying exploitation.
- The Acute Trust, acknowledging their unique position to identify people who have been exploited, now have a named professional meeting where they regularly review people from key groups who are at risk from modern slavery
- West Mercia Police have drawn on their experience in other areas to support,

advise and share good practice or learning in relation to exploitation, including ensuring we that all areas adopt the forces definition and sharing their specialist training with other organisations.

Lead Professional

- All organisations have actively supported the implementation of the CARM framework, including sharing the briefings and encouraging staff to attend the information session provided by the WSAB
- Adult Social Care and WAHT have also delivered internal briefing sessions and training to ensure that staff are aware of the framework and its approach.
- The ICB are planning to measure how well the framework has been embedded across primary care
- The H&W H&C Trust have identified a Named Nurse to work with the CARM project lead to ensure that the relevant level of mental health support is available for each individual subject to a CARM referral.

Self-Neglect

- Following the publication of the revised Self-Neglect and Hoarding policy by the WSAB Adult Social care have reviewed their internal self-neglect pathway to ensure that the policy can be effectively implemented.
- Health organisations are actively monitoring the implantation of the policy and ensuring that it is reviewed through their governance processes

Objective 3 Supporting wider issues, risks and the WSAB development

All sectors have provided regular reports on how they are managing the risk in recruitment and retention of health and social care staff across the sector. Action taken to mitigate this risk include:

- Offering supplements to difficult to recruit posts (ASC)
- Changing terms and conditions, including the introduction of new benefits (ASC)
- Recruitment drives and raising awareness of the work across education establishments

The industrial action across the health sector further impacted on this risk, particularly at the WAHT. The Trust and ICB provided regular updates on actions being undertaken to monitor and address the risks.

Since Covid 19 the WSAB also saw a steady increase in safeguarding referrals. Actions to address this include:

- ASC are developing a new safeguarding model to address the increase in demand. This will require additional funding which has been allocated.
- The WAHT safeguarding team ensured that the workload had clear priorities so that they could ensure they met legal and statutory duties during periods of increased activities.
- The ICB worked with Primary Care Trusts providing educational sessions to ensure referrals were appropriate and submitted correctly

- WMP actively raised awareness across their personnel to ensure that referrals were appropriate, this included providing information on other agencies to sign post to where section 42 criteria aren't met.

4 Safeguarding Activity and Performance 2022/23

4.1 Care Act (2014)

The data in this report is based on the definitions of safeguarding criteria as set out in the Care Act (2014).

Data for this section is obtained from Adult Social Care (ASC) Safeguarding Adults Collection (SAC) which is submitted to NHS Digital by all areas across England and Wales

4.2. The data

4.2.1 Number and Source of Concerns

The number of concerns reported during this business year (Table 4.1) saw a slight decrease on the previous year, which saw a significant increase.

Table 4.1 – Concerns dealt with under safeguarding (Cases (incidents) Reported) (compared to the previous two years)

	2019-20	2020-21	2021-22	2022-23
Concerns Reported	**3921**	**3283**	**4007**	**3912**
Section 42 applies (meets criteria)	**542**	**902**	**793**	**1309**
Percentage of concerns reported where Section 42 Applies	**14%**	**27%**	**19%**	**33%**

The concerns reported involved 2519 individuals (Table 4.2) and the section 42 criteria was met for 1114 of these individuals, 189 individuals were reviewed under 'other safeguarding enquiries.

In percentage terms there was an increase of 10% of concerns reported which met Section 42 criteria.

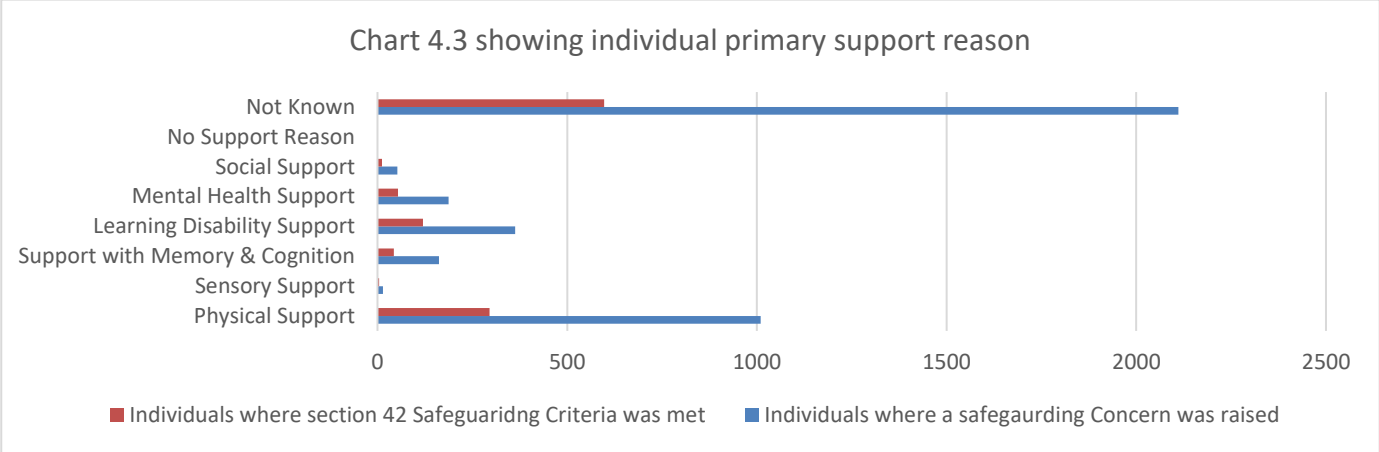
Table 4.2 total concerns reported in 2022 to 2023 compared to total number of individuals where a safeguarding concern is raised

	Concerns Reported	Individuals
Total Number of Safeguarding Concerns	3912	2519
Total Number of Section 42 Safeguarding Enquiries	1309	1114
Total Number of Other Safeguarding Enquiries	197	189
Percentage of concerns reported where Section 42 Applies	33%	43%

4.2.2 Individuals Primary Support Needs (Chart 4.3)

Of the individuals where a safeguarding concern was raised during the year, in over half of these people their primary support need was not known (1423). Where the support reason was known most required physical support (648). (Chart 4.3)

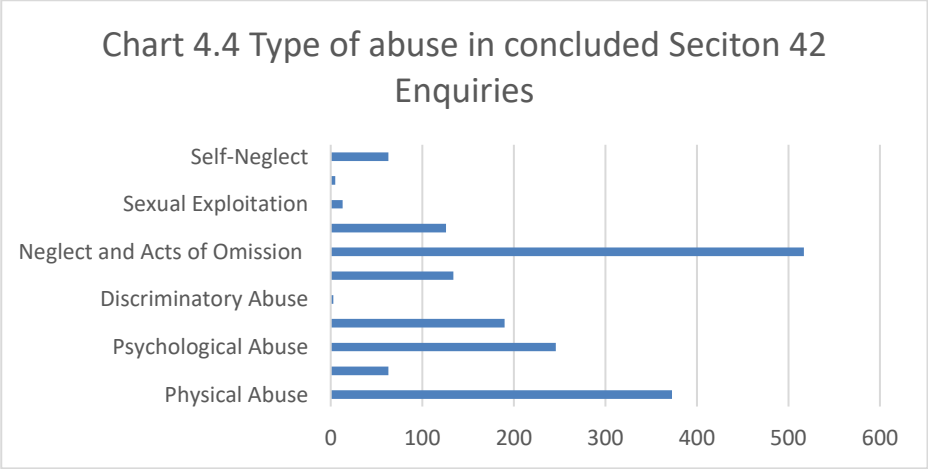
Of those individuals that went on to meet the section 42 safeguarding criteria, the proportions were similar. (chart 4.3)



4.2.3 Type of abuse

The following information relates to the data which Adult Social Care hold on concluded enquires for 2022 to 2023. The total concluded enquires which met section 42 criteria during 2022/23 was 2174.

In terms of the types of abuse, the highest number of concerns in the Section 42 enquiries which were concluded during the year were for neglect and acts of omission. This was followed by physical, psychological, financial and organisational abuse (Chart 4.4), which is similar to previous years.



During the year it was brought to the attention of the WSAB that nationally there had been a rise in sexual abuse against people with a learning disability. Whilst the data which is reported nationally does not give a breakdown of type of abuse against support needs the

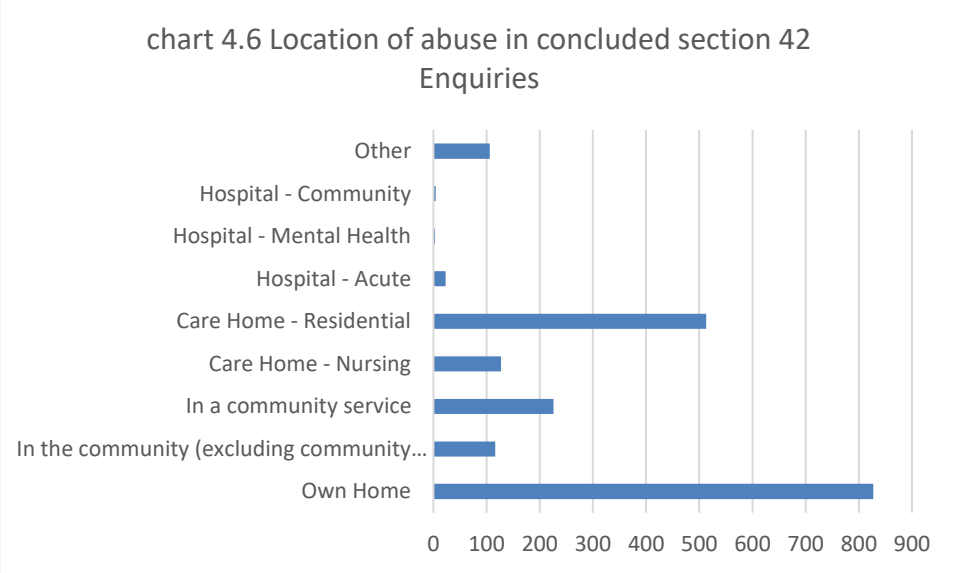
Performance and Quality Assurance Sub-group are reviewing this information and found a similar rise locally between 2020 and 2022 (Table 4.5). The WSAB will continue to monitor this and consider causes, along with ways to address this.

Table 4.5 Safeguarding involving sexual abuse for people with a learning disability Concern Reported and Enquiries

	2020		2021		2022	
Primary Support Reason	**Concerns**	**Enquiries**	**Concerns**	**Enquiries**	**Concerns**	**Enquiries**
Learning Disability Support	**10**	**5**	**28**	**10**	**31**	**17**

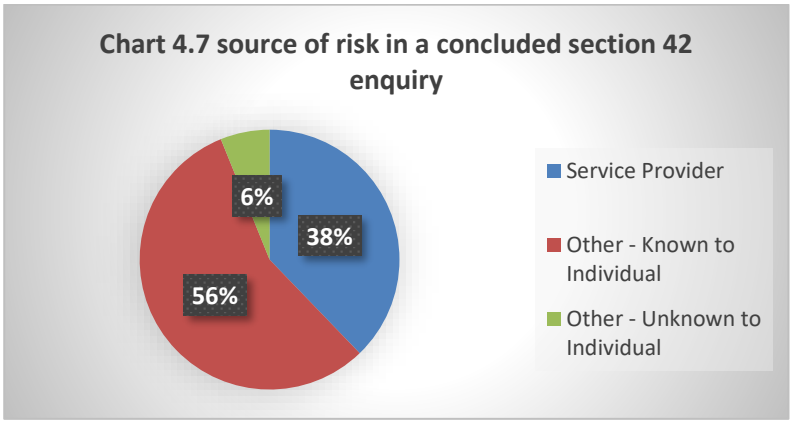
4.2.4 Location of the safeguarding concern

Most concluded section 42 safeguarding concerns took place in the person's own home, followed by a care home-setting (Chart 4.6). Again, this is similar to previous years.



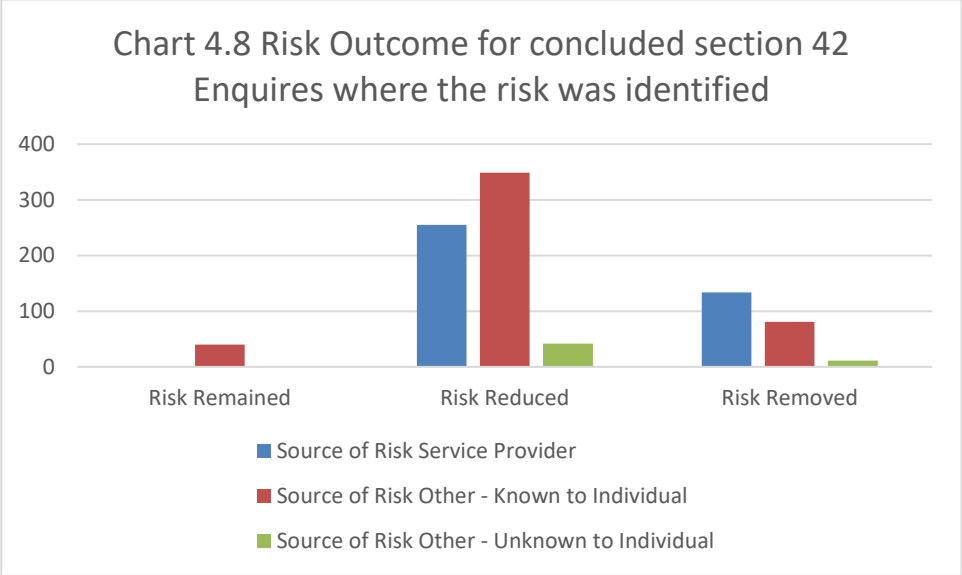
4.2.5 Source of Risk

In over half the cases (56%) the source of the risk was someone known to the person and in 38% it was someone working for a service provider (chart 4.7).



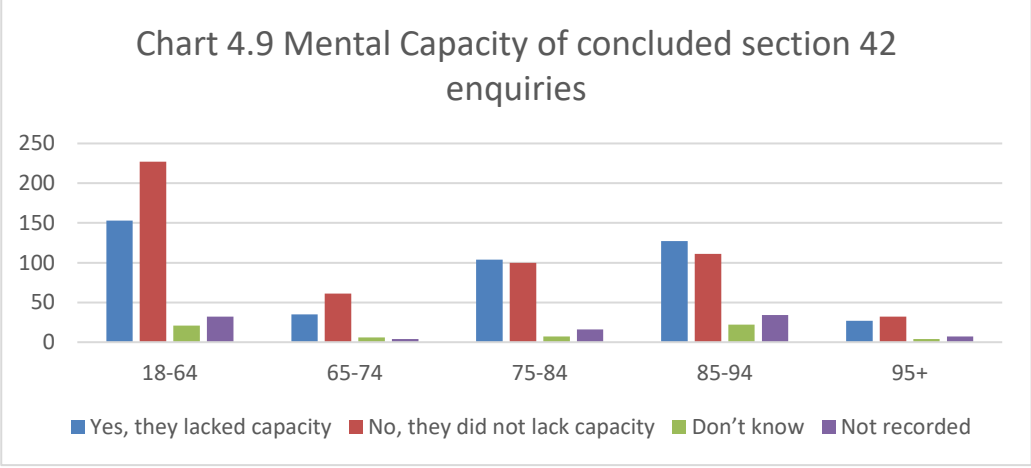
4.2.6 Outcomes

In terms of the section 42 enquiries which were closed during 2022/23 in most cases the risk was either reduced or removed (chart 4.8). In a small number (41 cases) the risk remained. This is similar to the previous year and once again the majority of these (40 cases) were where the source of risk was known to the person. In most of these cases this was because the person at risk asked for no further action to be taken. Reasons for this can be complicated, particularly where the source of risk is a family member. Making safeguarding personal requires that the wishes of the person are respected. However, advice and support will have been provided to the person.



4.2.7 Mental Capacity

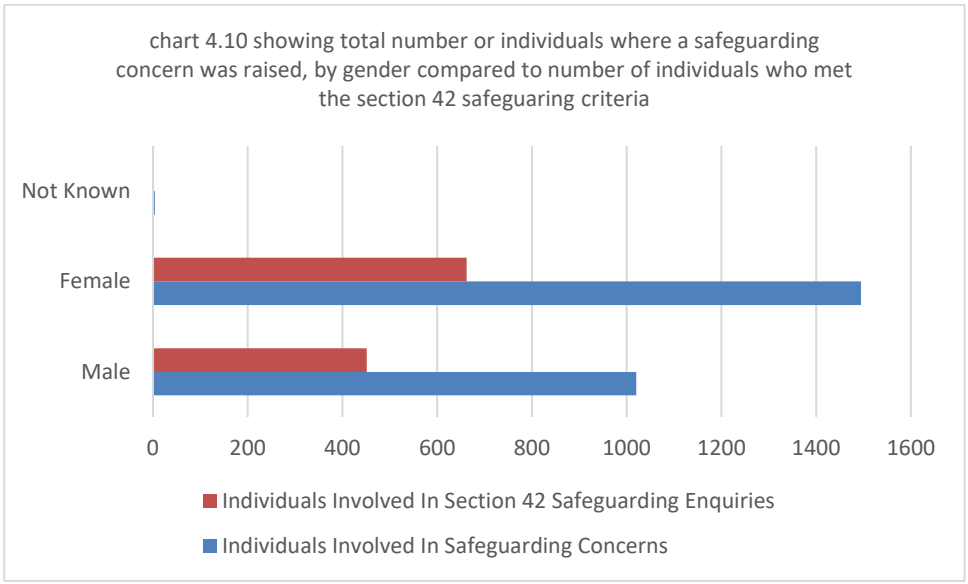
In most concluded section 42 enquiries the person was assessed as having mental capacity. However, the numbers assessed as having capacity declined from the 75 year age groups onward (chart 4.9) with a slight increase in those over 95. Of those who were assessed as not having mental capacity all were supported through an advocate or family member.



4.3 Demographic Profiles

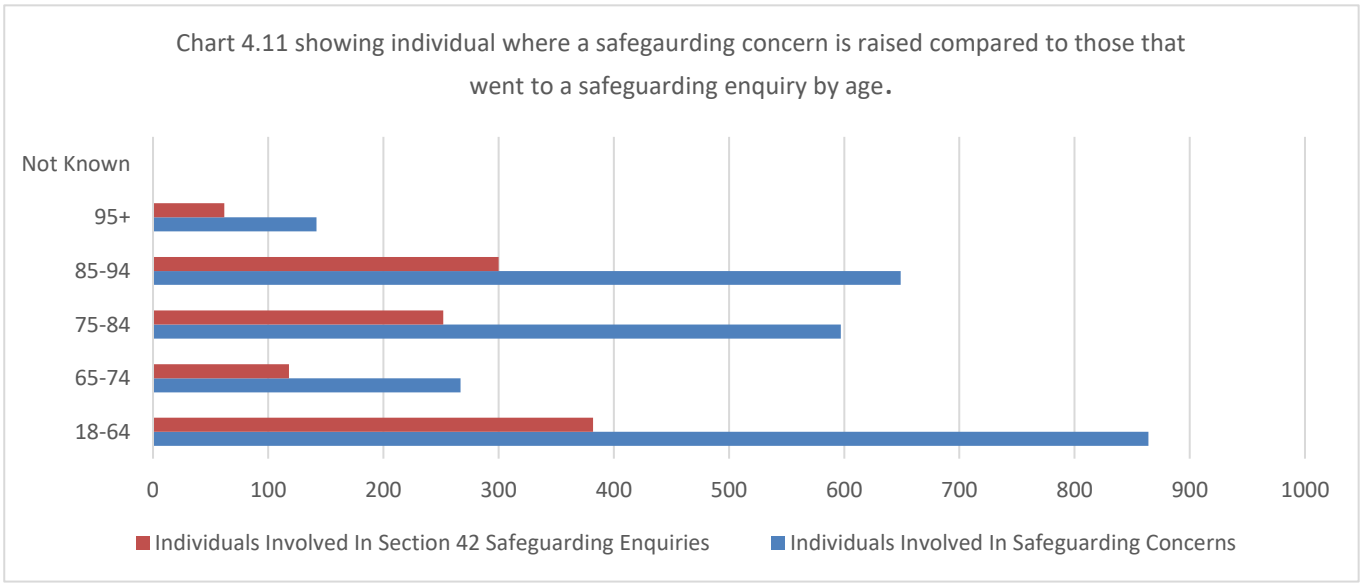
Gender

The number of individual cases where a Safeguarding Concern was reported, as with previous years, is higher for women than men. (Chart 4.10) More women than men also subsequently meet the safeguarding section 42 criteria, however the differentiation is slightly reduced.



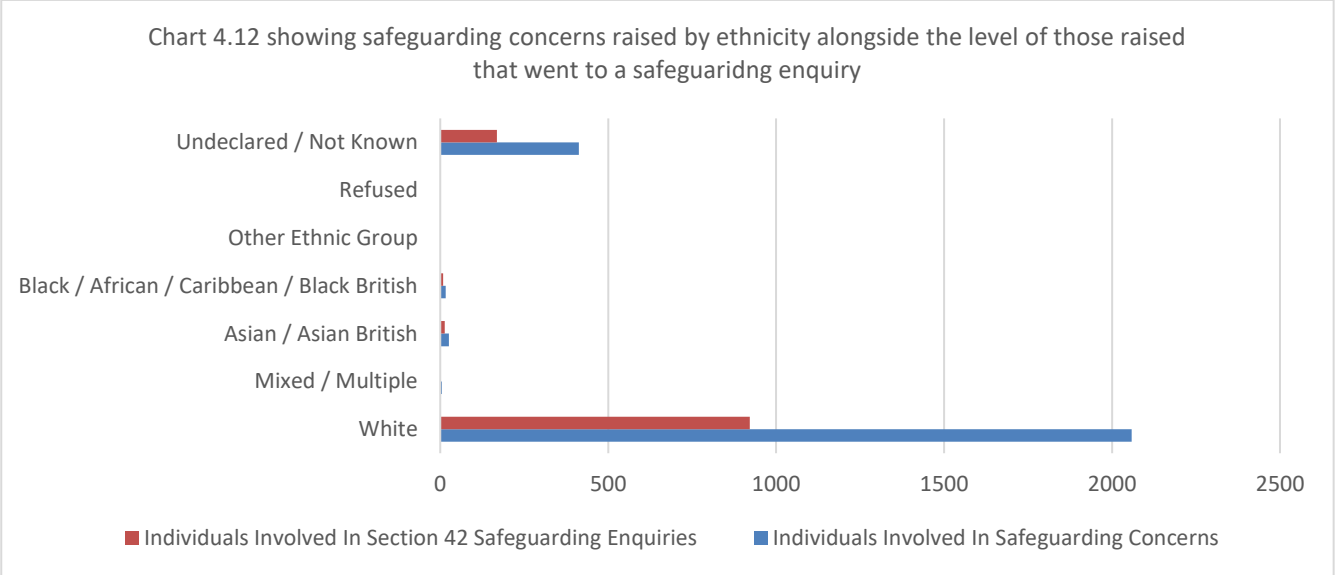
Age

As with previous years the age profile of concerns reported (chart 4.11) shows that there are more concerns reported amongst the 18 to 64 age group.



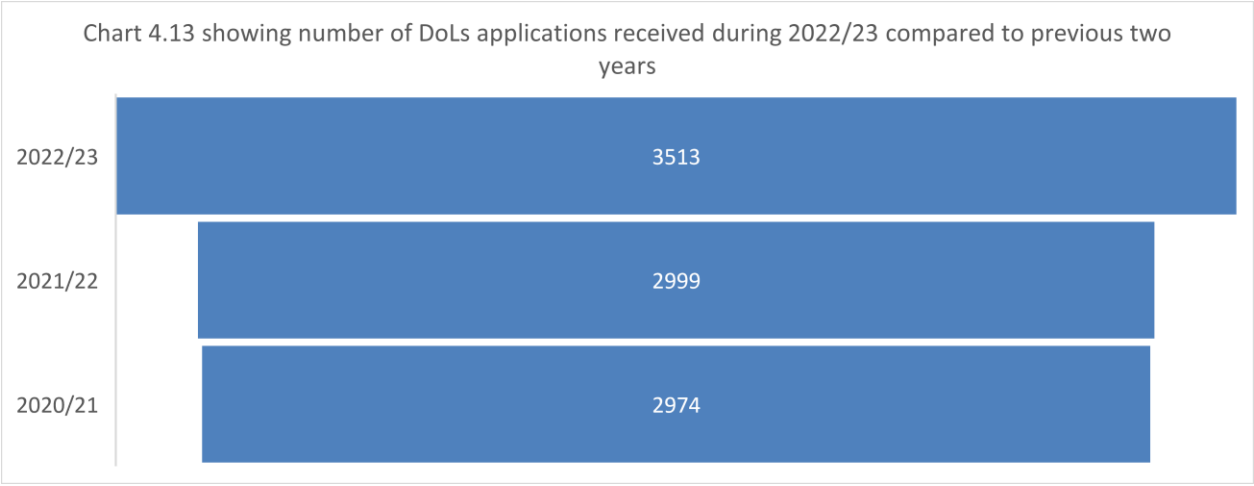
Ethnicity

Again, ethnicity follows a similar pattern to previous years. Most individuals involved with a safeguarding concern during 2022/23 were white (chart 4.12). The level of safeguarding concerns reported in other Black and Minority Ethinic (BAME) groups is once again lower than the level of BAME groups identified as living across the county in the last census. This lower level could be due to underreporting within these communities. However, there is also a relatively significant number where the ethnicity is either not recorded or not stated. In which case there may be some inaccuracies in recording amongst this group.

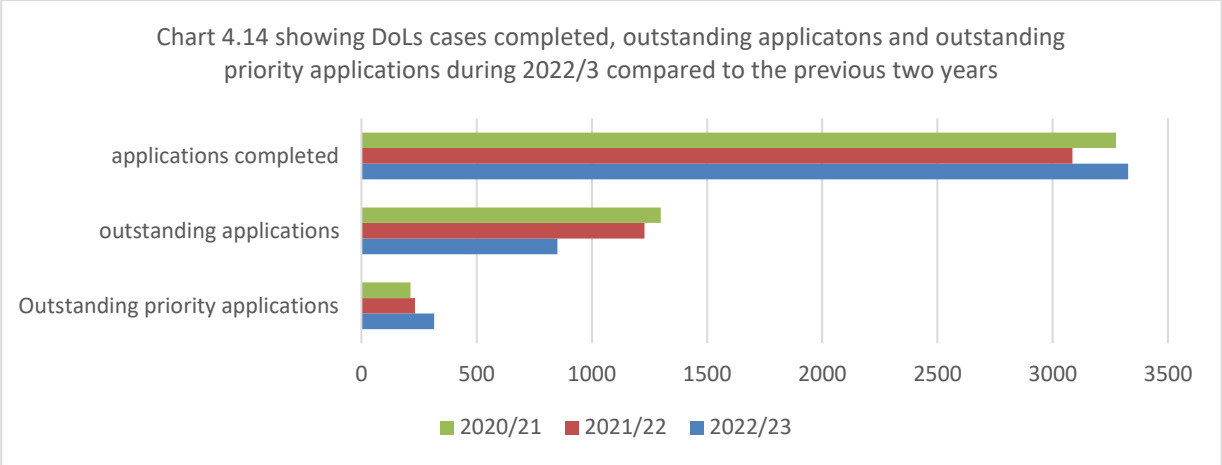


4.4 Deprivation of Liberty Safeguards (DoLS)

During 2022/23 there was an increase Deprivation of Liberty Safeguards applications made than the previous two years. (chart 4.13).

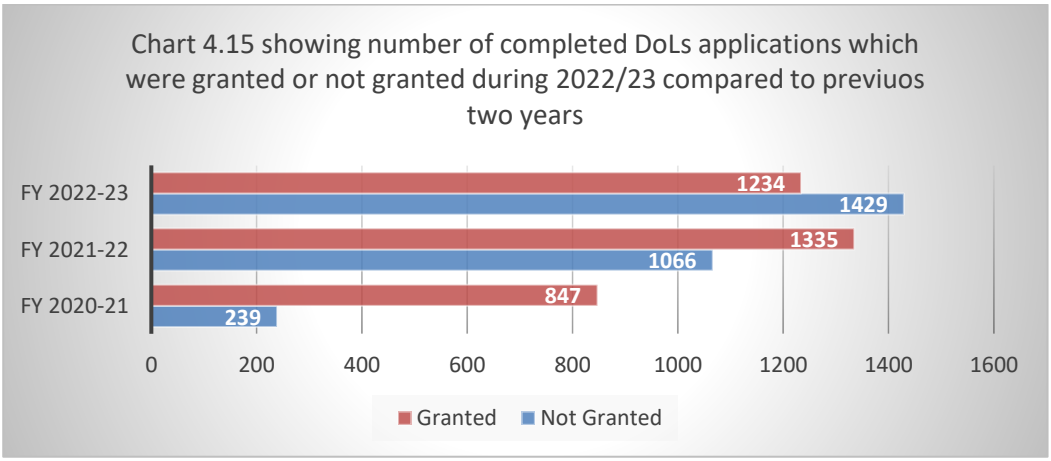


At total of 3327 applications were completed druing 2022/23. The number of oustanding applications, are lower than the previous two years. (chart 4.14). However, the number of outstanding priority applications have slightly increased compared to previous years.



Proportion of Applications Granted or not Granted.

Of those applications completed during 2022/23 the proportion which were granted or not granted has shifted in comparison to previous years, with the proportion not being granted being higher, whereas in previous years the numbers granted were higher. . (Chart 4.15)



5.0 Priorities for 2023/24

Each year the WSAB holds a Strategy Day to evaluate the impact of activities over the last year and look at any emerging issues identified through SARs, feedback via out Network member and residents, events and collaborative work, or performance data. This informs the priorities for our Annual Business Plan.

The priorities which will be taken forward during 2023 to 2024 include:

1. Further development of the SAR and Rapid Review process following the recommendations from the assessment currently being undertaken. This should include.

    - Clarity on how we engage people with lived experience in the process.
    - Development of a shared learning framework for dissemination of learning and good practice from the SARs
    - Implementing any required changes to polices and strategies.
    - Development of an assurance approach which links into the learning framework.

2. Further development and embedding of the Complex Adult Risk Management (CARM) framework*.
3.
4. Implementation of the Exploitation Strategy*

(*both the above should include recommendations on managing the manifestation and impact of domestic abuse)

These objectives have been used to complete the Annual Business Plan and inform the work streams of the relevant subgroups.

KEY to Acronyms	
ASC	Adult Social Care
CSE	Child Sexual Exploitation
DoLS	Deprivation of Liberty Safeguards
DHR	Domestic Homicide Reviews
GP	General Practitioner (Doctor)
H&WB	Health and Wellbeing Board
HWICB	Herefordshire and Worcestershire Integrated Care Board
HWHCT	Herefordshire and Worcestershire Health and Care Trust
ICB	Integrated Care Board
LPS	Liberty Protection Safeguards
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NHS	National Health Service
P&QA	Performance and Quality Assurance Sub-group
PH	Public Health
PwLE	People with Lived Experience
SAB	Safeguarding Adults Boards
SAC	Safeguarding Adults Collection
SAR	Safeguarding Adults Review
S42	Section 42 Care Act 2014 (Criteria)
WCC	Worcestershire County Council
WAHT	Worcestershire Acute (NHS) Hospital Trust
WMP	West Mercia Police
WSAB	Worcestershire Safeguarding Adults Board
WSCB	Worcestershire Safeguarding Children's Board
WSCP	Worcestershire Safeguarding Children's Partnership
WSHP	Worcestershire Strategic Housing Partnership