Worcestershire Safeguarding Adults Board

Annual Report 2023/24

Worcestershire Safeguarding Adults Board

Final V1

Document Control

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Location: Worcestershire Safeguarding Adults Board website

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Actions

Required Actions	Date
DRAFT V1.1 Presented to Operational Board	13th August 2024
Draft V2 Presented to Board	26th September 2024
FINAL V1 Sign Off	26th September 2024
Placed on website	26th September 2024

Contents

Chairs Foreword

Welcome to the 2023/24 Annual Report of the Worcestershire Safeguarding Adults Board (WSAB). It reflects the hard work that the board and its members have undertaken in the past year on behalf of the citizens of Worcestershire. Covid 19 is no longer a daily concern to most of us yet the pressures in the health and social care system remain, especially with waiting lists and backlogs. I also mentioned last year - and it warrants repeating - that staffing is becoming a major issue. We as society need to value and respect more significantly the role that health and social care workers undertake on our behalf, often caring for the most vulnerable members of our society. Although it is a highly rewarding role, it is physically demanding and often involves shift work which is hard to adapt to. We must as a society recognise, value and pay appropriately in order to ensure we get the best quality care.

I'm delighted to report that the work of the Complex Adult Risk Management (CARM) framework has gone from strength to strength, making a significant impact on the most vulnerable members of our community. It has progressed the work of the lead professional, ensuring that services are provided those often hardest to reach.

The animated podcasts, looking at the issues surrounding fraud and scams and tackling the difficult issue of executive function and dementia, are now well used throughout Worcestershire, and indeed throughout the UK. They are available on our website through this link, Local WSAB resources

During the past year we have also been able to develop an Exploitation Strategy. This was a major piece of work which included significant consultation within the sector. It was felt best for the ongoing governance of this work for it to sit within the Community Safety Partnership, and we will continue to work with them to ensure the policy is fully implemented.

The board also continues to manage the Safeguarding Adult Review (SAR) process and there has been significant activity in this area over the past year. It is a major task to coordinate, deliver and act on the recommendations of SAR's and I am grateful to the SAR subgroup who undertake this work with such skill and dedication each year. Indeed, I wish to acknowledge and thank all the board staff for their hard work and commitment during this past year. They are a constant source of energy, dedication and good will without which the running of this board would be almost impossible.

During this past year we also ran a highly successful annual learning event focused on working with carers. This was such a valuable time as we listened to differing voices and insights. We will endeavour to ensure that we maintain this during the coming year. We were also very active during the National Safeguarding Week delivering webinars and materials, and I have been able to speak several times on local BBC radio about safeguarding issues, particularly fraud and scams.

I trust you find this annual report both interesting and inspiring as we offer an insight into how we as a board attempt to ensure that services to vulnerable members of the community are effectively and safely delivered. Once again, I want to thank councillors and members of other health boards who give of their time, often in an unpaid capacity, with a desire to serve the local community. Society needs committed people, willing to serve in these roles to help us deliver the very best services. I particularly want to pay tribute to those volunteers in our community who help run food banks, debt advice agencies, advice centres, tea clubs and general community activities. These people make an enormous contribution to the richness of all our lives, and I especially want to thank you all.

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 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
- Young Solutions
- 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
- 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 2023/24 was £138,497. 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
Herefordshire & Worcestershire Clinical Commissioning Group	41
West Mercia Police	12

The 2023/24 expenditure was £170,183 which is £31,686 over the total funding received. The majority of the overspend was predicted and covered through reserves, along with additional partnership funding from Public Health. This funding was used to develop a multi-agency response to the exploitation of adults with care and support needs alongside the Complex Adult Risk Management framework. There was also an increase in projected salary costs due to the pay settlement.

The spend for 2023/24 can broadly be broken down under the following categories:

Staff and administration costs (including the Independent Chair)	£125,3625
Special Projects (funded via reserves and other sources) • Exploitation Project • CARM Project Lead	£22,171
Sub-group and task-group spend	
• Case Review (Safeguarding Adults Reviews)	£15,773
• WSAB Website and annual costs	£1,496
• Learning Development Practice and Communications	£25
• Reference Group	£3,500
• Business Mileage	£482
• Other (Insurance, communications, equipment, licenses)	£927
• Network meetings	£447
Total Spend	£170,183

As with previous years there was an underspend. In 2023/24 it was £44,338.

. The carry forward into 2024/25 will be allocated to continuing the Boards priorities of:

- Implementation and embedding into practice a Learning Framework from SARs
- Continue to build and support partnership links to implement the exploitation strategy

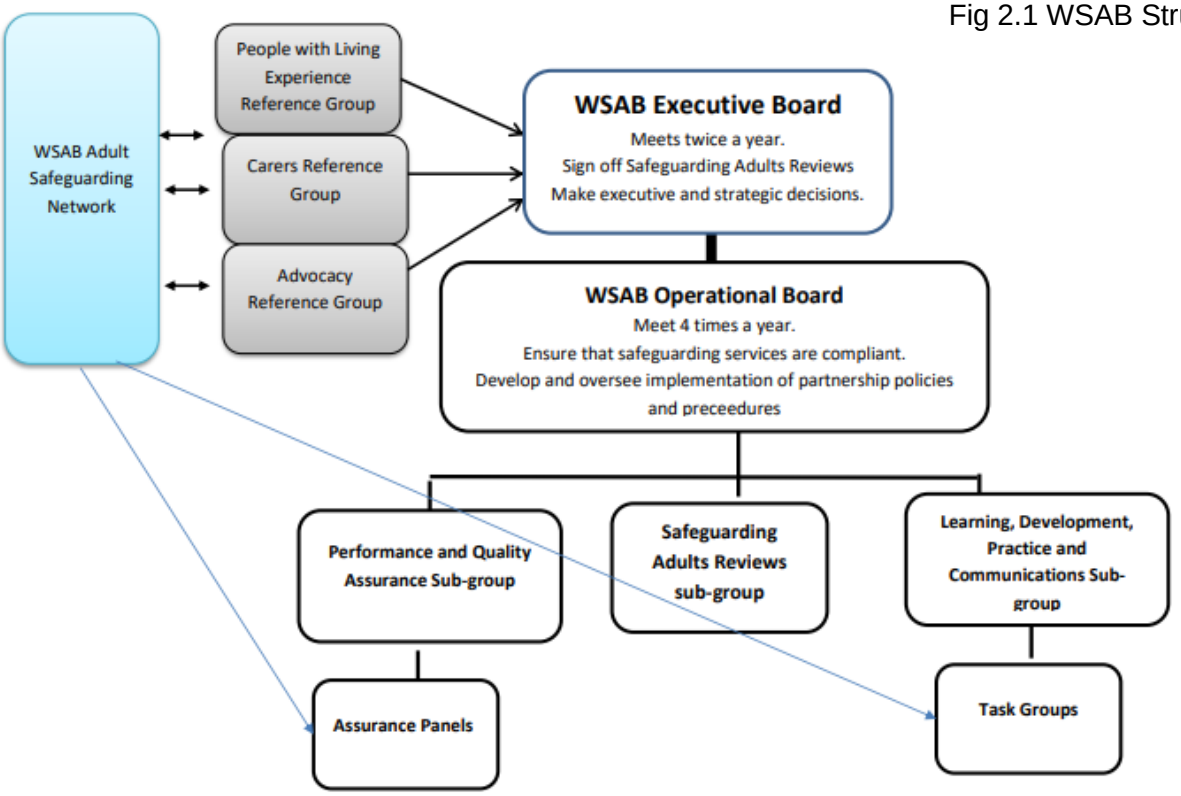
2.4 Delivery Model

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 WSAB Structure



2.5 Business Objectives

The objectives identified in the 2023/24 business plan are set out in the table 2.2 below, which also gives a summary of their delivery progress and achievements.

Table 2.2 – Achievements

WSAB Objective	Achievements
1. Further development of the SAR and Rapid review process	The SAR and Rapid Review process is still in development. However, there has been a delay in progressing actions due to the number of SAR referrals received which take precedence. The following areas were identified as key areas of focus as part of this development. • **Engagement of people with lived experience in the process** The WSAB is currently piloting different approaches to ensure that people and their families have meaningful engagement in the SAR process • **Development of a shared learning framework** The framework has now been agreed and a template is in place. This will be implemented over the next business year. • **Development of an assurance approach which links into the learning framework.**

	Now the learning framework is in place the WSAB will build on its current assurance processes to ensure that they align with the framework. • **Implementing any associated changes to policies and procedures** In progress.
2. Further development and embedding of the Complex Adult Risk Management (CARM) framework	A survey was undertaken and the findings from this have enabled the WSAB to better understand those areas where more work was required to embed the framework. Over the last business year, the project lead continued to raise awareness of the CARM framework across all sectors and establish clear links with key stakeholders to ensure the needs of the people who are referred are met. As part of this work, they have also developed a risk assessment framework and an escalation process was established and agreed by the WSAB.
3. Implementation of the Exploitation strategy	Following consultation with a wide range of stakeholders from across the statutory, independent, and voluntary sector a draft strategy has been produced. Progress has been made in taking forward the pathways for protection of victims and pursuit of perpetrators. A risk assessment process is also being designed along with alignment to the CARM framework as part of the referral pathway. The ambition was for the WSAB to sign it off during the business year. However, following strategic discussions, it was agreed that governance should sit within the community safety domain. The WSAB will continue to work with them to support the implementation of this strategy, with a particular focus on the Protection element.

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 social care or safeguarding criteria.

Details of the framework can be found by following this Link. CARM document and information

The CARM framework was established in response to recommendations from Safeguarding Adults Reviews. These reviews found that there had been some good multi-agency working but this was patchy at times. They also found that a lead practitioner was not always identified resulting in a lack of coordination and poorer outcomes for the adult.

In October 2022 a Project Lead, was employed one day a week to help embed the framework. This was increased to two days a week from August 2023.

During 2023/24 there were a total of 81 referrals to CARM. Of these 52 were appropriate to

progress to a CARM meeting. This is a 113% increase in referrals and a 225% increase in referrals that progressed to CARM. This evidences that awareness amongst practitioners about CARM has increased with more appropriate referrals being made. Since the launch of CARM in May 2022 there have been a total of 125 referrals.

The CARM framework has provided practitioners with a tool to enable multi-agency working which enhances outcomes for adults. These have included:

- Increased support networks.
- Delays in evictions.
- Access to mental health services.
- Support to register with GP's.
- Access to & Support for substance dependency.

CARM Case Study

Person A is a 51-year-old man, who was referred to the CARM framework from a local voluntary sector homelessness service. He had a range of needs, including mental health issues, poor physical health and substance misuse. Services found it difficult to meaningfully engage with him, he regularly missed appointments, was intermittently rough sleeping, and had recently been evicted from temporary accommodation due to his behaviour. He stated that he saw no point to having health appointments as he had no home and was frustrated that he continually had to repeatedly answer the same questions.

A range of organisations were working with him and came together through the CARM framework, including homeless and housing services, the substance misuse service, mental health, GP and the hospital. Working together they have supported him in finding temporary accommodation, accessing rehabilitation, managing his health appointments and sorting out his benefits. This multi-disciplinary approach has enabled a consistent approach, with a clearly identified lead professional who regularly engages with him and keeps the other services updated. This has facilitated speedy decision making and given greater flexibility in how and who support is provided. As a result, engagement with Adult A has greatly improved and he agreed to move to a residential rehabilitation service which is going well.

3 Review of Activities 2023/24

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 firmly in place through our active reference groups and our networking group.

Over the last year the WSAB has sought to ensure the processes for overseeing the implementation of SAR learning and recommendations is robust and meaningful. Alongside embedding monitoring processes through the sub-groups, we have also developed our assurance process to ensure people with lived experience have a voice and opportunity to influences meaningful change to processes and services. For further information see section 3.2.9 on Collaboration and Co-Production.

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

The WSAB continued to utilise and develop the Rapid Review process, which was an adapted process from the Children's arena. Adhering to the requirements of the Care Act 2014, the process also includes representation and information gathering from all agencies who are/have been involved with the person, family, and carers, where possible.

This facilitates more robust decision making on whether the SAR criteria are met and ensures that the learning is shared at the earliest opportunity. Following concerns raised regarding the number of SARs commissioned previously, two independent consultants have continued to chair these meetings, providing challenge and support.

This is an emergent process to ensure results continue, especially around recommendations improving systems and sharing learning more quickly for further safeguarding prevention. There continues to be a positive cost benefit with a saving of approximately 40% in direct comparison of Rapid Review and Full SAR.

3.2.3 SAR Referrals

During 2023/24 13 referrals were received by WSAB and the following decisions made:

- SAR criteria were not met in relation to eight referrals.
- SAR criteria was met in one referral. It was agreed that the Rapid Review process was appropriate and is currently in progress.
- SAR criteria was not met in one referral; however, a discretionary SAR was agreed due to crucial multi-agency learning.
- Two recent referrals are gathering further information as other processes/reviews may be running parallel.
- One recent referral has a triage meeting pending

3.2.4 SARs completed during 2023/24

Four mandatory SARs were completed and signed off by the Board at the end of March 2024.

- One mandatory SAR was completed as a full SAR report, but only the executive summary published, it can be found using the following link: Ruth SAR - Executive Summary

- Three mandatory Rapid Review SARs were published and can be found using the following links: Peter - RR SAR, Joseph - RR SAR and John - RR SAR

*Two learning briefs were published following two SAR referrals that did not meet the SAR criteria, but crucial learning was extrapolated from the Rapid Review Meetings, they can be found using the following links: Dee Learning Brief and Adult M.

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 Complex Adult Risk Management
- Explore and record with a person at the time of initial contact what their preference on methods of future contact are.
- 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*.
- Promote the use of the Cuckooing/Home Invasion agreement
- Promotion of agencies sharing specific risk/s presented by a person

Mental Capacity & Self-Neglect:

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

- Secondary mental health services and substance misuse services to work together to provide a service to those persons with co-occurring conditions

Information Sharing / Care Homes / Caring Role:

- Importance of clarifying relationships
- Passport style 'This is Me' document to be available to visiting professionals
- Promote Shared Care Records

* One multi-agency action plan, which encompasses the recommendations made for a SAR on 'David' (2019), was also signed off.

3.2.6 Annual Learning Event –Working with Carers

Each year during safeguarding week the WSAB hold a learning event which focuses on any reoccurring themes which have emerged through SAR learning and recommendations. This year the focus was SARs which have identified a need to listen to carers and ensure that they have access to appropriate support.

The event was open to both carers and representatives from health and social care, with the emphasis being on listening to carers, sharing their experience and working with them to look at ways in which advice and support could be improved. There were also presentations on key themes which have arisen through the reviews, including

- Understanding the application of legal frameworks
- Listening to carers
- Providing support and training to carers

The presentation from the event can be found by following this link: WSAB annual learning event 2023 Listening to Carers presentations

3.2.7 National Safeguarding Week.

The WSAB utilise National Adult Safeguarding Week each November to raise awareness and promote information and training on key adult safeguarding themes, amongst professionals and practitioners, alongside the local community. This year the WSAB shared details resources developed locally through co-production. This included:

- leaflet for co-designed with carers to help them consider whether concerns they may have been quality issues or safeguarding and explaining the respective pathways for reporting them. Link to demystifying safeguarding leaflet
- A locally developed podcast where the WSAB Chair explains executive function: Link to executive function podcast

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. In 2023 the WSAB signed up to a regional framework which covers both Adults and Children's safeguarding. Locally organisations completed this through an online template in December 2023. The responses from this audit are now being reviewed

3.2.9 Collaboration and Co-Production

As part of its approach to Making Safeguarding Personal (MSP), the WSAB continue to build on its commitment to working collaboratively with People with Lived Experience and the services that support them, ensuring that there is meaningful representation and input into the work of the board. A key part of this work is the use of assurance panels which oversee the implementation of recommendations from SARs.

Assurance panels are established when there are reoccurring themes emerging through SAR recommendations or the SAR has complexities which would benefit from a collaborative approach. Each of these panels have representation from relevant specialist organisations who, working alongside people with lived experience, review the responses to recommendations and assess whether they will improve future practice.

This approach not only allows greater transparency but is also provides a framework though which people with a vested interest in an area of practice can challenge current approaches and influence change. Panels in place during 2023/24 include.

- Rough sleeping and homelessness
- Carers
- Dorothy SAR panel

Representatives from the panels are requested from our reference groups and/or network. This network is open to all sectors and services across the County that deliver services for adults with care and support needs, and they provide an additional route to engage with people with lived experience. The network met twice virtually this year. Further information on the network can be found here Link to information on WSAB Safeguarding Network

3.2.10 WSAB Publications and Guidance

Following the changes to the board's delivery model (see section 2.4) the WSAB reviewed its constitution. Details of the revised constitution can be found by following the link below:

- WSAB Constitution V9 December 2023

i) Policies, guidance, and strategies

Below are links to policies and strategic guidance were updated during this business year:

- WSAB Communication and Engagement Strategy Final V2
- Missing Person Guidance consideration for residential care and domiciliary care V2.
- Joint Policy development WSAB and HSAB updated FINAL V2
- Position of Trust Protocol Final Version 2.1

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

- Link to WSAB Policies and Guidance

ii) Briefings

The WSAB also published briefings and information to support the learning from Safeguarding Adults Reviews. These set out a summary of the learning found in relation to a specific theme. They include links to SARs where this is a feature, alongside links to useful resources. These briefings can be found by following the links below:

- WSAB Professional Curiosity Briefing 2023
- WSAB Demystifying Safeguarding Leaflet
- Mental Capacity Act and Executive Function Links to SARs V2

iii) Website and Podcasts

The WSAB has continued to develop its website to ensure that information is readily available for both professionals and members of the public. The information includes pages which supports recommendations from national good practice or learning from local SARs. Examples of informaiton added this year include:

- Development of a page focusing on cuckooing Link to WSAB cuckooing page
- Information on scam awareness and prevention Link to WSAB Scams Page
- Fire Safety advice and good practice Link to WSAB Fire Safety guidance page

Over the last few years, the WSAB have also produced some Mental Capacity Act podcasts, 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. 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: Further Development of the SAR and Rapid Review Process

All statutory partners have been engaged in the development of this process and actively engage in the SAR sub-group, which is responsible for developing the SAR protocol, and its supporting frameworks. In addition, when a SAR referral is made they provide information in a timely manner and learning from any subsequent review is shared across their organisation. Specific practice in relation to this includes

- The police help facilitate contact with the next of kin as required.
- Health organisations systematically share learning from SARs at their integrated safeguarding committee and have systems in place to ensure that it is disseminated across their organisation.
- Adult Social Care have
    - introduced quarterly sessions to discuss learning from statutory reviews
    - Practice standards now also include learning from SARs
    - introduced a new model of safeguarding that puts Making Safeguarding Personal central to the process.
    - introduced a new serious incident framework which aligns with the SAR process

Objective 2: Embedding of the Complex Adult Risk Management Framework

The CARM framework is now becoming part of all sectors working practice, including statutory partners, and is reflected in the level of referrals and attendance of practitioners at meetings. Examples of actions taken to support this embedding of the framework include:

- The police have worked to ensure the framework is now used within the MARAC toolkit and it is regularly discussed at police tasking and management meetings.
- Adult Social Care have ensured that the framework is clearly referenced in their processes and have supported its implementation across all services, particularly as part of the early response and triage process.
- The Integrated Care Board (ICB) have actively promoted the CARM framework with primary care providers, including GP's and frontline practitioners.
- The ICB now have a section within their own assurance framework to ensure that that practice managers are aware of the CARM and promoting it in practise.
- The Acute Hospital Trust and Health and Care trust have developed strong links between the CARM project lead and their safeguarding leads.

- The Health and Care Trust now include information on the CARM as part of their Level 3 Safeguarding training and ensure that it is promoted widely across their organisation.

Objective 3 Implementation of the Exploitation Strategy

Although the Exploitation Strategy has not yet been signed off statutory partners have still maintained a focus on ensuring that it can move forward. All organisations have continued to deliver training and raise awareness on exploitation. Other activities to support this agenda include:

- The WSAB have worked closely with Adult Social Care and the Police to develop clear the pathways for victims and perpetrators
- They are also systematically reviewing data and now share intelligence with the CARM project lead when required.
- Within Adults Social Care the new model of safeguarding now facilitates the collation of patterns and themes, including exploitation.
- The Health and Care Trust have introduced a sexual safety policy, which includes exploitation and the procedures for dealing with any cases.

4 Safeguarding Activity and Performance 2023 to 2024

4.1 Care Act (2014)

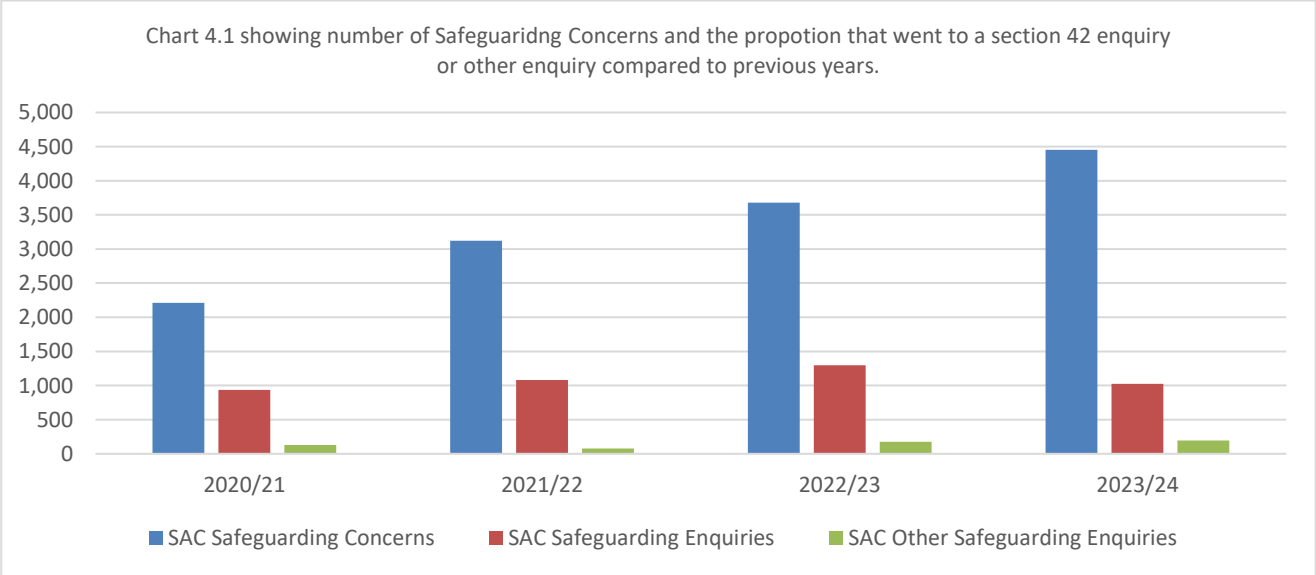
The data in this report is based on the definitions of safeguarding criteria as set out in the Care Act (2014).

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. Please note some data between 2021 and 2022/23 will slightly differ to that used in previous annual reports due to changes in the methodology. The data has been updated to reflect this change.

4.2. The data

4.2.1 Number and Source of Concerns

A total of 4,454 safeguarding concerns were raised during 2023/24, continuing the increase seen in previous years. However, the proportion which meet the criteria for a safeguarding enquiry saw a slight decrease compared to the previous year. (chart 4.1)



The concerns reported involved 2639 individuals (Table 4.2) and the section 42 criteria was met for 877 of these individuals, 190 individuals were reviewed under 'other safeguarding enquiries.

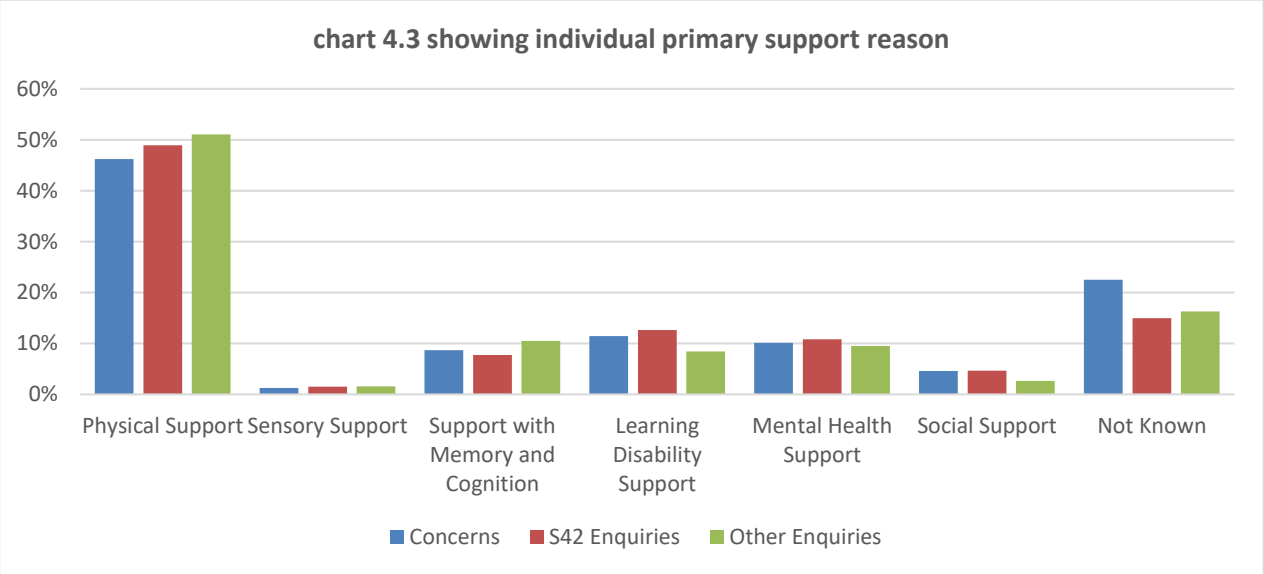
In percentage terms one third of individuals where there was a concern was reported met the Section 42 safeguarding criteria. This is a reduced rate from last year where 43% met the criteria.

Table 4.2 total concerns reported in 2023 to 2024 compared to total number of individuals where a safeguarding concern is raised		
	Total Number	Individuals
Total Number of Safeguarding Concerns	4454	2639
Total Number of Section 42 Safeguarding Enquiries	1209	877
Total Number of Other Safeguarding Enquiries	195	190
Percentage of concerns reported where Section 42 Applies		33%

4.2.2 Individuals Primary Support Needs (Chart 4.3)

Of the individuals where a safeguarding concern was raised during the year, in just under half their primary need was for physical support.

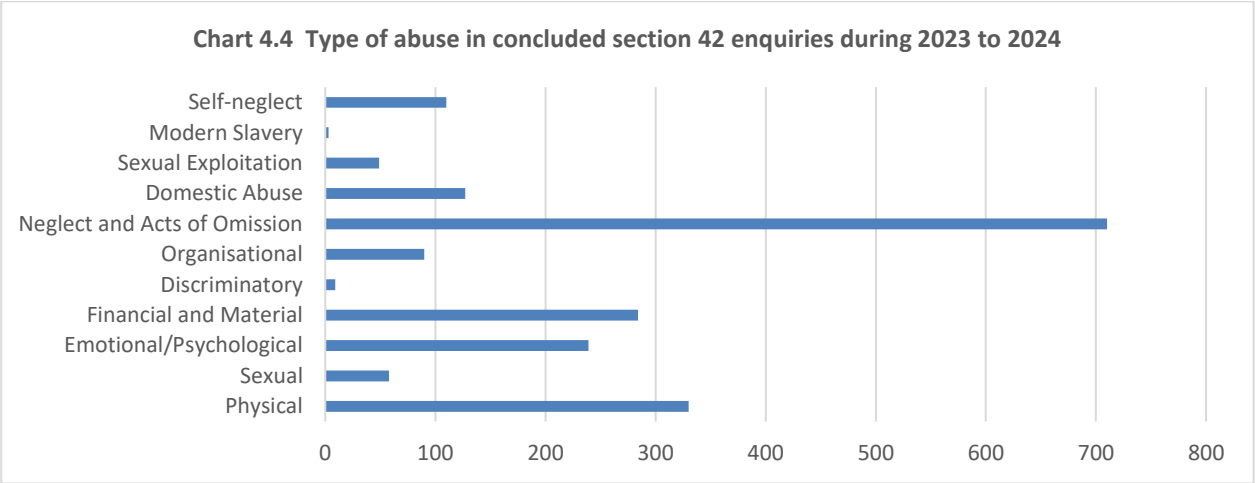
Of those individuals that went on to meet the section 42 safeguarding criteria, the proportions were similar. (chart 4.3)



4.2.3 Type of abuse

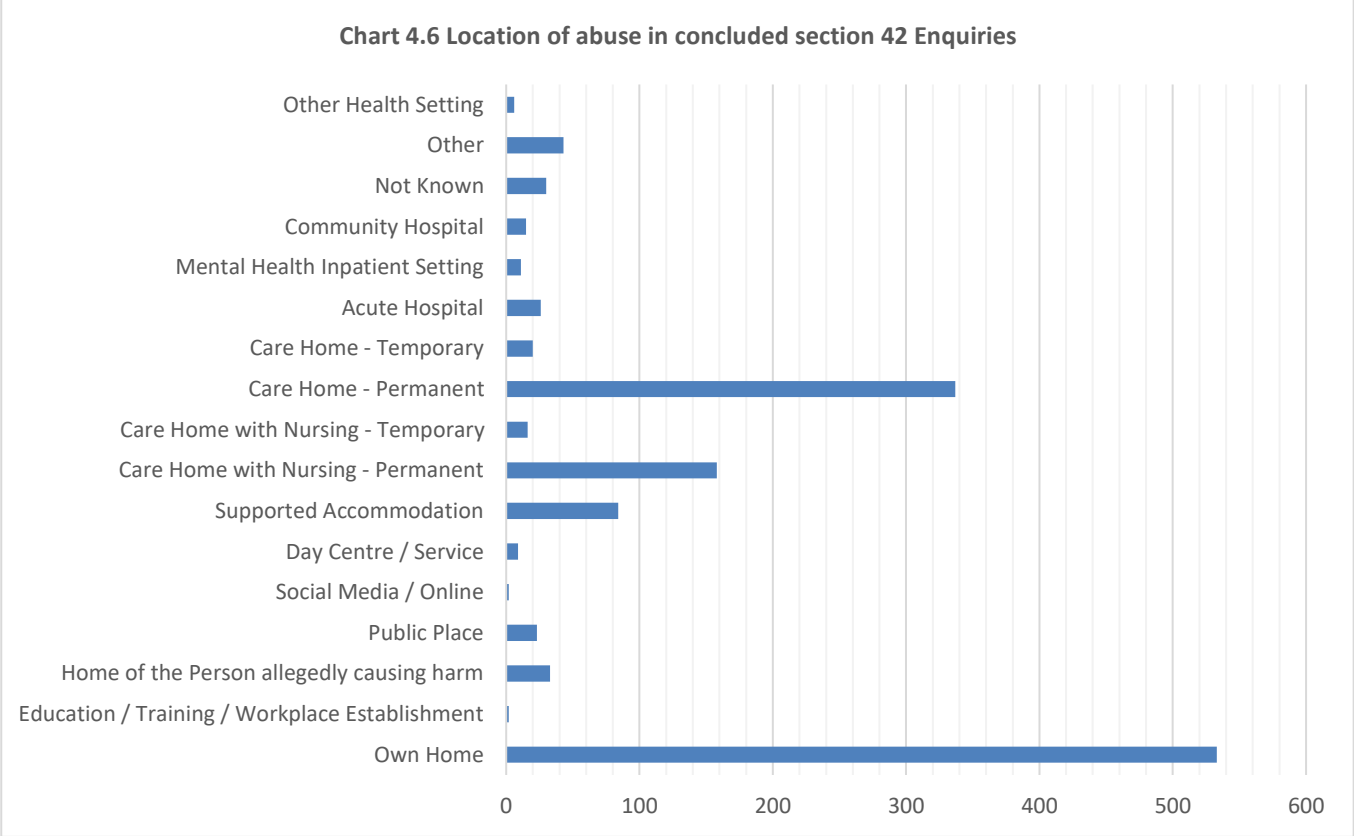
The following information relates to the data which Adult Social Care hold on concluded enquires for 2023 to 2024.

In terms of the types of abuse, as with the previous year, 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 again is similar to the previous year.



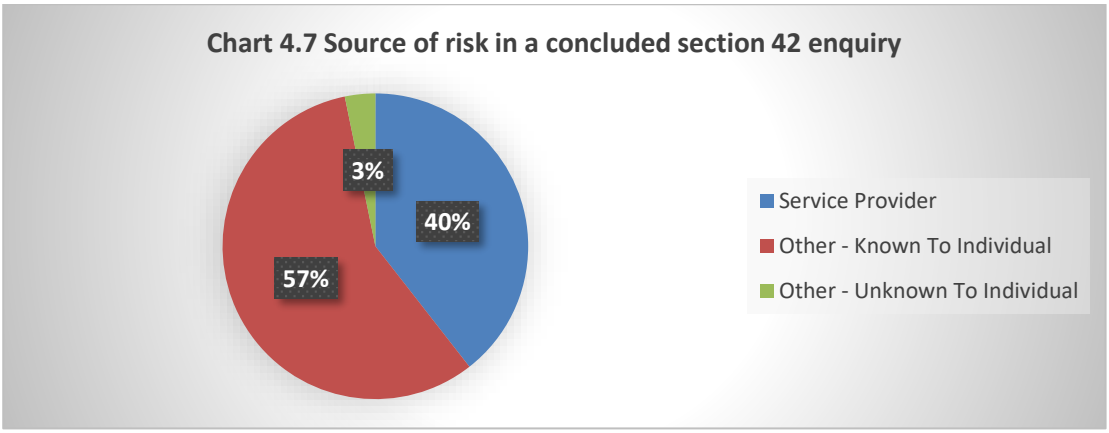
4.2.4 Location of the safeguarding concern

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.

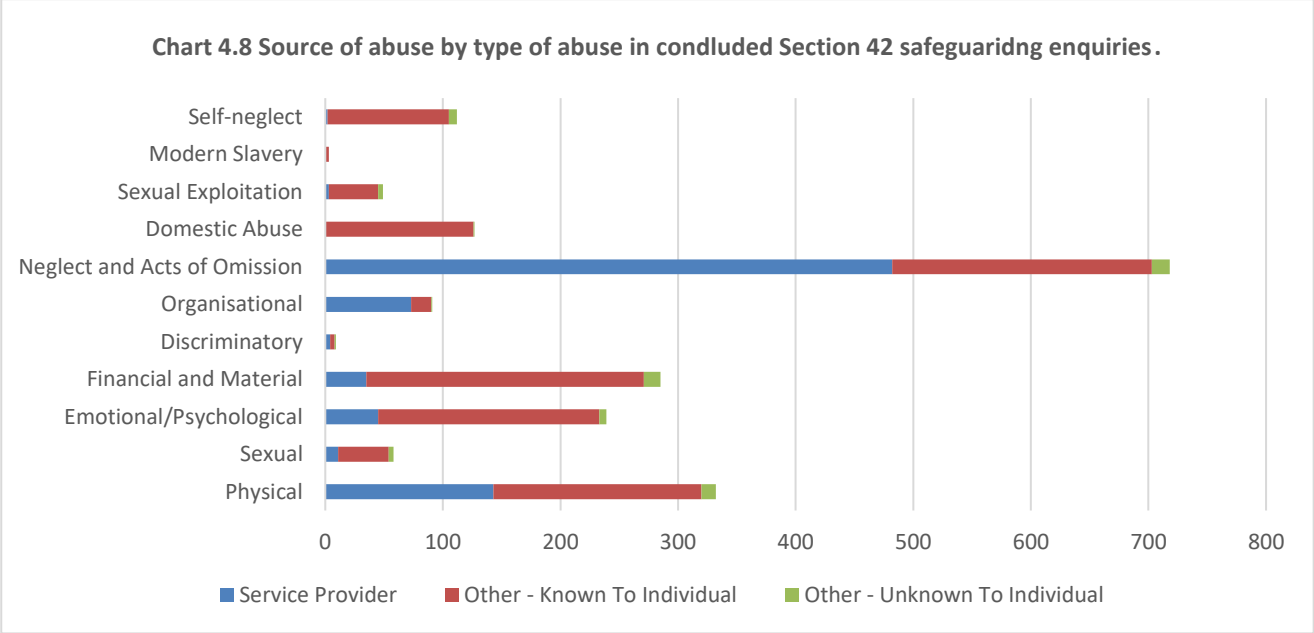


4.2.5 Source of Risk

In over half the cases (57%) the source of the risk was someone known to the person and in 40% it was someone working for a service provider (chart 4.7). Again, this is similar to the previous year.

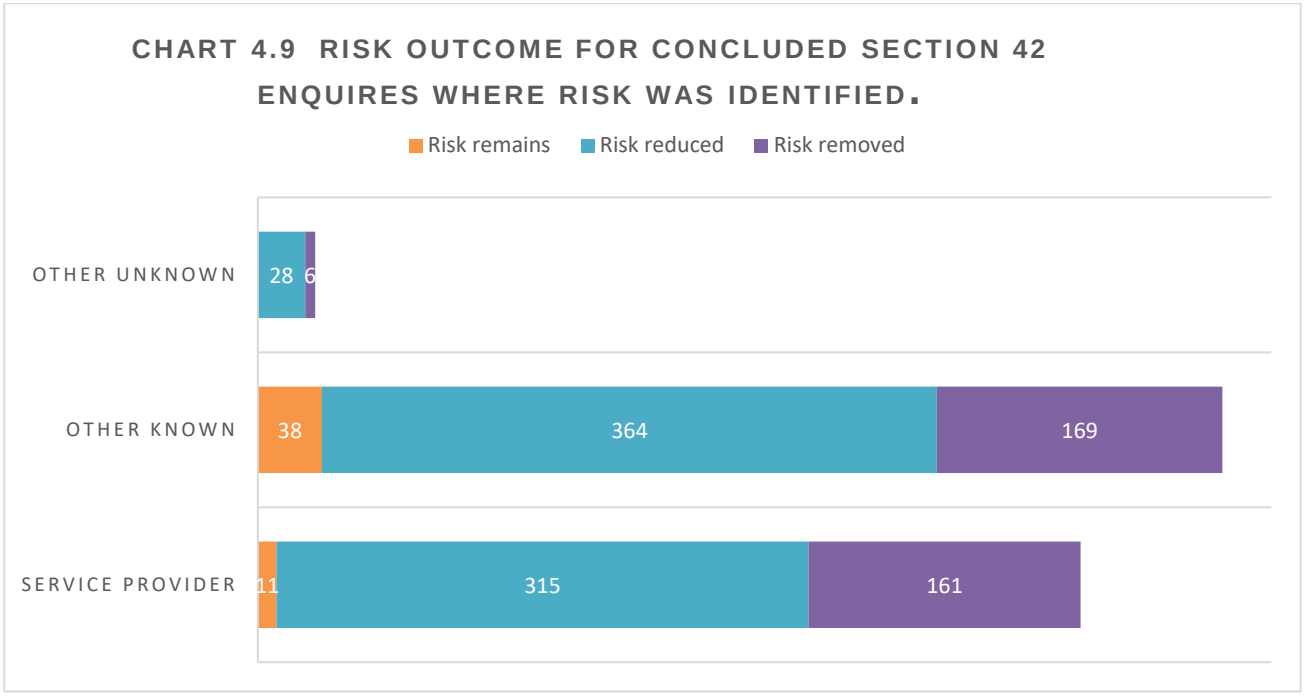


When this information is broken down further, examining the different types of abuse (chart 4.8), the main source of risk in cases of neglect and acts of ommission, alongside organisaitonal buse are sevice providers However, in most other types of abuse the source is someone known to the individual.



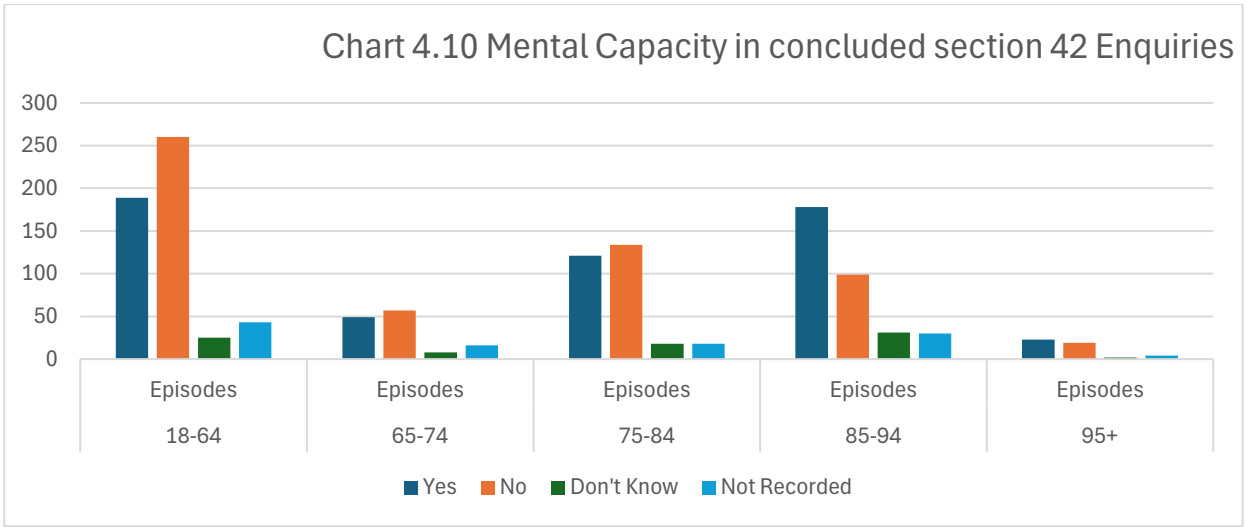
4.2.6 Outcomes

In section 42 enquiries closed during 2023/24 the risk was either reduced or removed in the majority (chart 4.9). In a small number (49 cases) the risk remained. This is similar to the previous year and once again, the majority of these 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 be respected. However, advice and support will have been provided to the person.



4.2.7 Mental Capacity

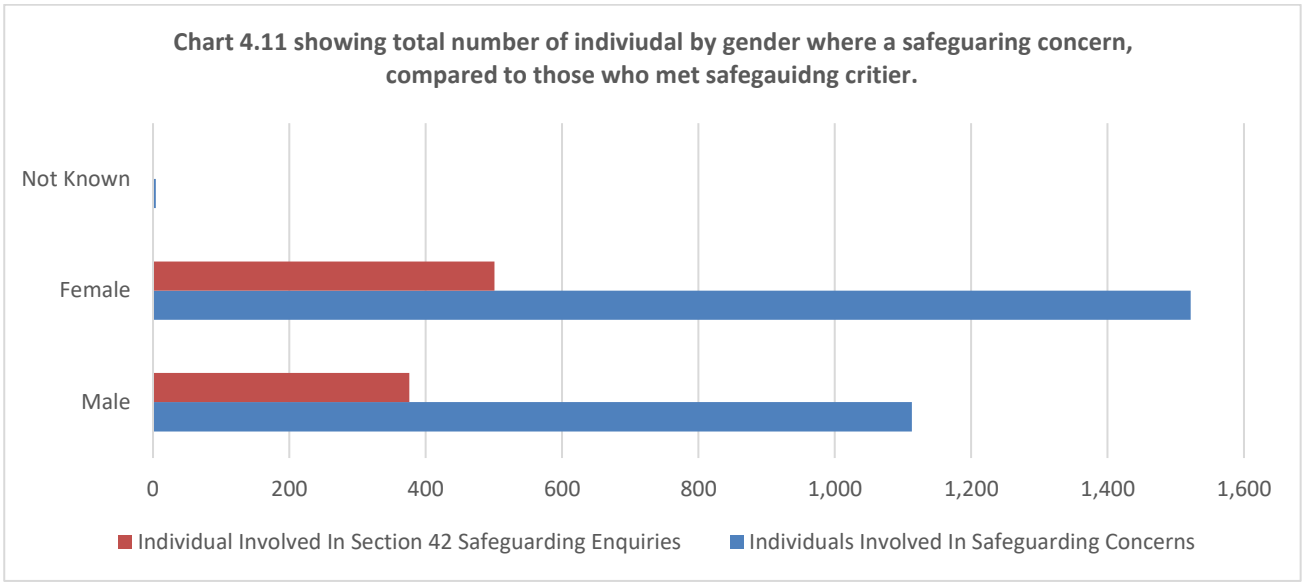
In most concluded section 42 enquiries the person was assessed as having mental capacity. However, the numbers assessed as having capacity began to decline in people 65 years old and older. This changes again when people reach 85, when the majority were assessed as having capacity. All those assessed as not having mental capacity were supported through an advocate or family member.



4.3 Demographic Profiles

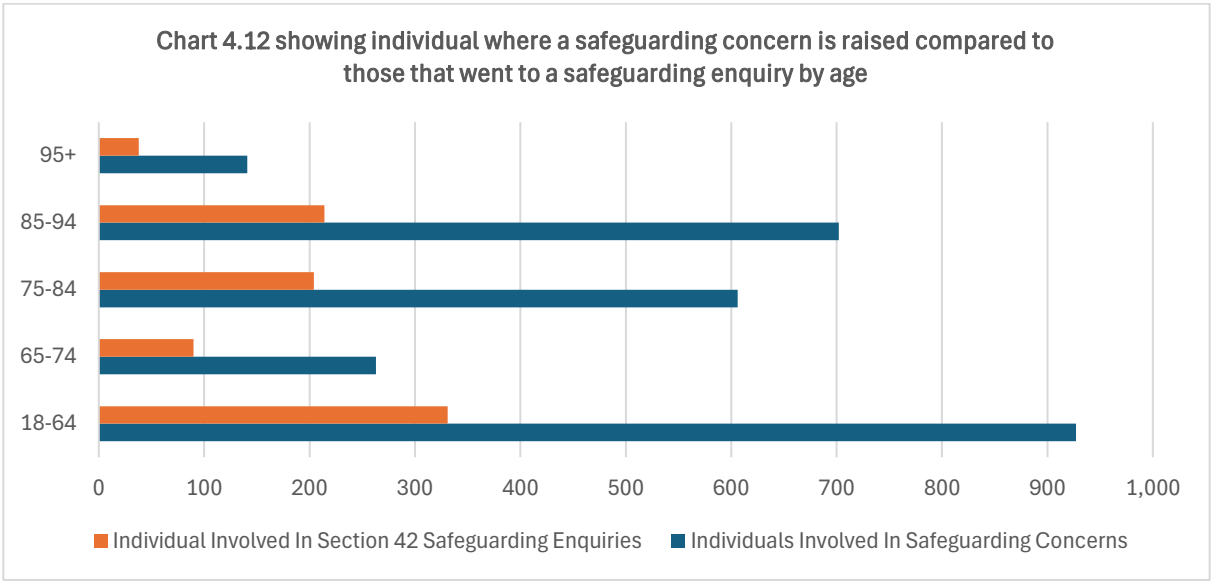
Gender

The number of individual cases where a Safeguarding Concern was reported is higher for women than men. (Chart 4.11) which is similar to previous years. More women than men also subsequently meet the safeguarding section 42 criteria, however the differentiation is slightly reduced.



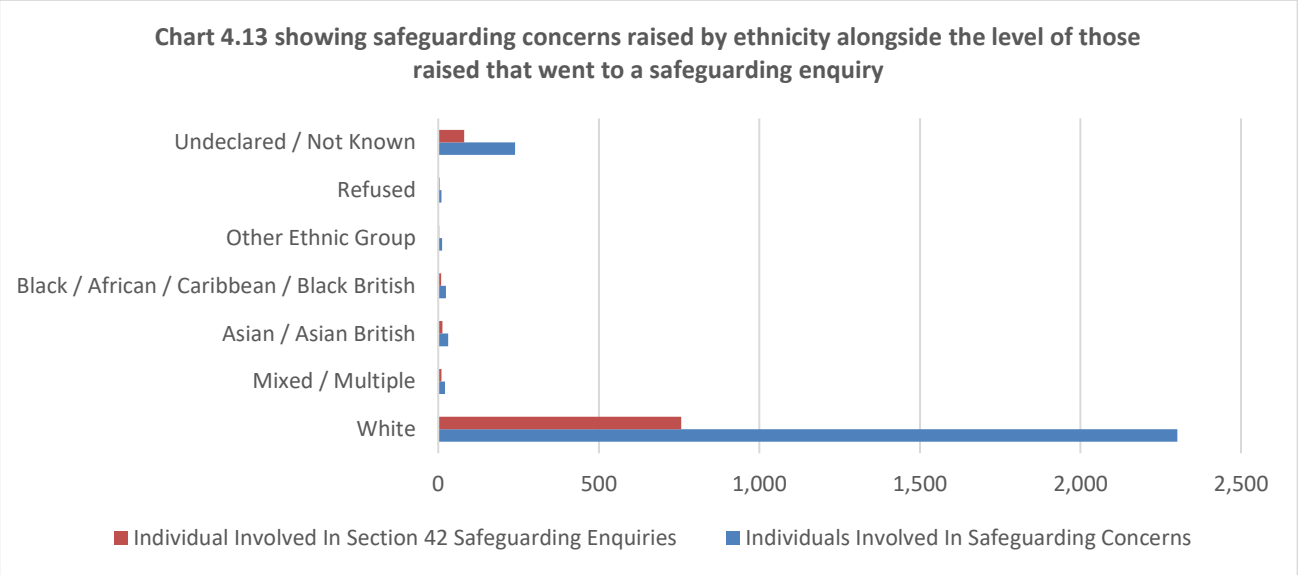
Age

The age profile of concerns reported and enquiries again mirrors that of previous years (chart 4.12), with more concerns being in the 18 to 64 age group. Again, it reduces in the 65 to 74 age group, but sees an increase in the next two bands (75-84 and 85-94) reducing significantly in the 95 plus.



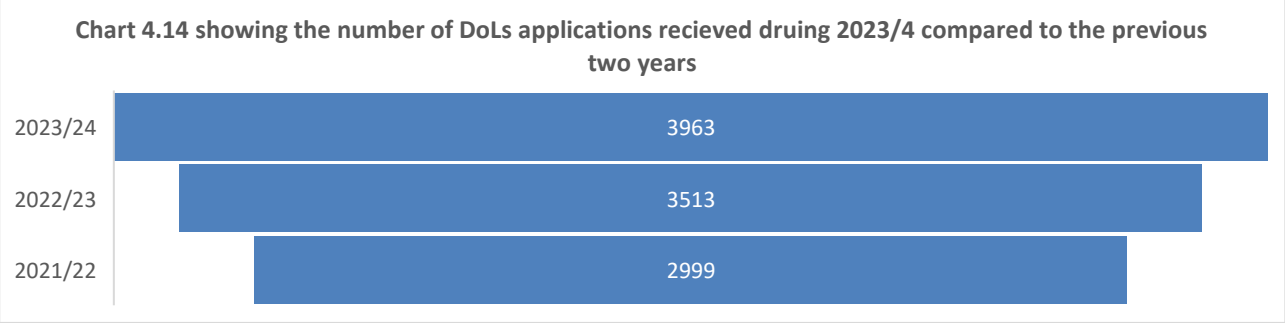
Ethnicity

Again, ethnicity follows a similar pattern to previous years. Most individuals involved with a safeguarding concern during 2023/24 were white (chart 4.13). 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.

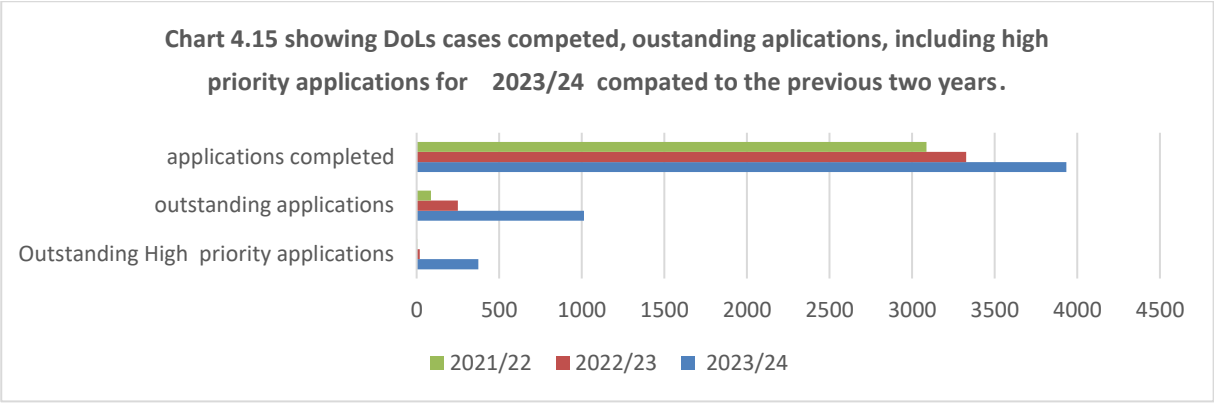


4.4 Deprivation of Liberty Safeguards (DoLS)

There was an increase Deprivation of Liberty Safeguards applications received during 2023/24, which follows a similar pattern to previous years. (chart 4.14).

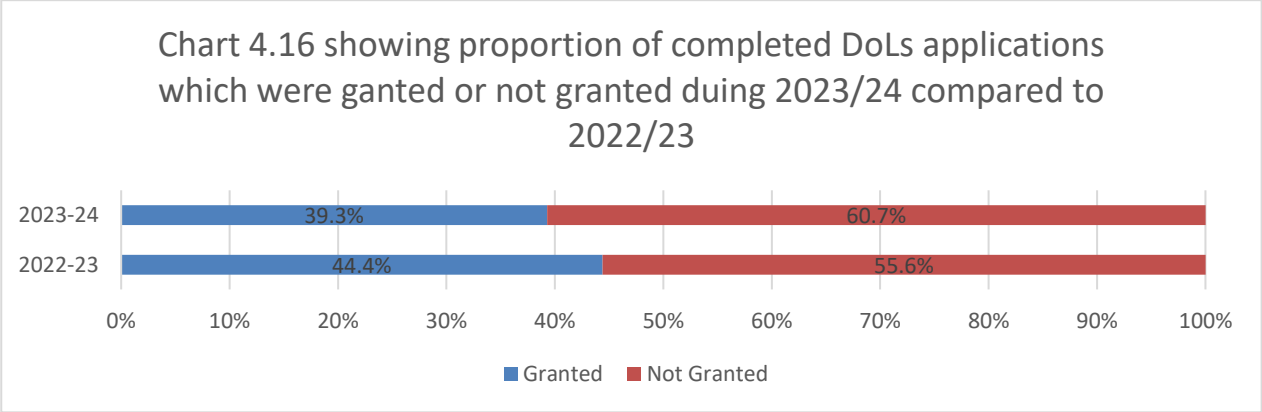


At total of 3933 applications were completed druing 2023/24(chart 4.15). The number of applications completed during the year is higher than previous years. Whilst the number of outstanding applications including high priority applications, is also higher for 2023/24 than previous years this is because an initiative was established within the DOLs team to check old referrals that have been waiting a long time and close them down if appropriate.

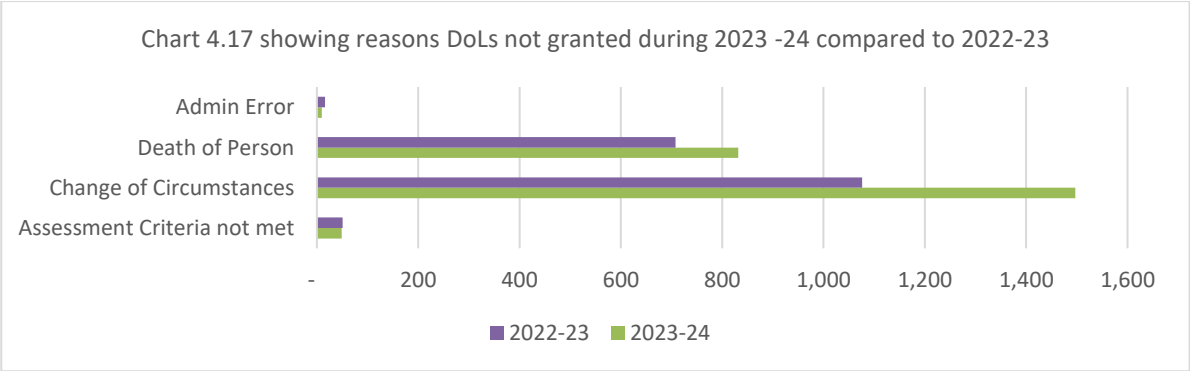


Proportion of Applications Granted or not Granted.

Of the 3,933 applications completed during 23/24 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 4.16).



The reasons applications are not granted are recorded under four categories, which can be found in chart 4.17 below. The largest category both this year and last year was due to changes in circumstances, this was followed by the death of the person. Changes in circumstances can include the person regaining capacity, returning home, moving to a care home, being admitted to a hospital or transferred to another hospital. The initiative to address outstanding waiting list and referrals will have had an impact on the increased level of DoLs not begining granted during 2023/24.



5.0 Objectives for 2024/25

Each year the WSAB holds a Strategy Day to evaluate the impact of activities over the last year. It also looks at any emerging issues identified through SARs, feedback via network members and other forums, events and collaborative work, or performance data. This informs the priorities for our Annual Business Plan.

The objectives which will be taken forward during 2024 to 2025 include:

1. Implement the Learning Framework to ensure that SAR learning is embedded in practice and is underpinned by clear a communication plan which includes the sharing of good news and practice. Areas of focus should include:

    - professional curiosity
    - Safeguarding rights

2. Continue to build links with other partnership to support the delivery of shared objectives including:

    - implementation of the Exploitation Strategy with the CSPs and/or SCP
    - developing a shared approach to implementing the recommendations of Domestic Homicide Reviews with the Domestic Abuse Partnership
    - Working with the Children's Partnership and Herefordshire SAB in establishing a robust assurance approach for reviewing the organisational assessments submitted through the regional assurance tool.

3. Implement the new actions identified in the Quality Assurance Framework, in particular:

    - Reviewing the themes identified by organisations through the regional assurance tool

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