Worcestershire Safeguarding Adults Board

Annual Report 2020/21

Worcestershire Safeguarding Adults Board

Final V1

Document Control

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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 Board Co-ordinator
Simon Davis	Worcestershire County Council
Sue Lawrence	Worcestershire County Council
Sarah Cox	Worcestershire County Council
Suzanne Hardy	Herefordshire & Worcestershire Health and Care NHS Trust
Ellen Footman	Herefordshire & Worcestershire Clinical Commissioning Group
Deborah Narburgh	Worcester Acute Hospitals NHS Trust
Samantha Hammond	West Mercia Police
Mary Nettle	People with Lived Experience Representative

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Chairs Foreword

Welcome to this 2020/21 Annual Report of the Worcestershire Safeguarding Adults Board. This is the first Annual Report I have been involved with since my appointment as Independent Chair of the Board and, as we are all aware, it reflects a period affected by the unparalleled issues of Covid 19. I therefore want to place on record both my sincere appreciation and my admiration for all those health and social care professionals who have worked through these difficult times to help protect and care for us all in society. In my opinion you simply do not get enough credit for all you do. You support us in moments of weakness and are there when we can cope no more. We as a society really owe you all so much for your kindness and support, especially during the past year when you have needed to wear PPE in often hot and uncomfortable conditions, and many of you have had to experience multiple traumas as you cared for so many who suffered with Covid 19 - thank you.

During the past year there has been an ever-growing focus on adult safeguarding throughout society as we understand more and more the scale and types of safeguarding issues we face. The WSAB has a responsibility to work with all agencies in Worcestershire to ensure its citizens are supported and protected from all forms of harm and abuse. This report demonstrates how the welfare agencies have worked together during the past year to deliver the best possible service to the citizens of Worcestershire. We don't - get it right all the time and that is why we conduct reviews, called Safeguarding Adult Reviews, to ensure we can all learn from situations where outcomes were not as we would have wished. Health and social care professionals work in some very demanding situations, sometimes at great personal cost, but we need to accept that we need to constantly challenge and review how we operate and deliver our services. The Worcestershire Safeguarding Adults Board has this as its key priority; to work with all agencies to ensure there is appropriate challenge and review so that we are continually improving all we do to safeguard adults.

This Annual Report provides a summary of how the various health and social care agencies within the Worcestershire partnership have worked to provide better outcomes for some of the most vulnerable people in our communities during the past year. Next year our intention is to find even better ways of engaging with the local community to explore ways to further improve safeguarding practices in Worcestershire, and I look forward to telling you about that in next year's report.

Finally, I want to record my sincere thanks and appreciation to both the WSAB team and the members of the board. You bring significant skill and wisdom to the board for the benefit of all – thank you.

Professor Keith Brown
WSAB Independent Chair

1.0 Introduction

Annual Review 2020 to 2021

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 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.

The application of the safeguarding principles supports a person-led and outcome focused approach to safeguarding, known as Making Safeguarding Personal (MSP). The WSAB plays a key role in ensuring that an MSP approach is embedded across all agencies within Worcestershire.

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 CCG'
- 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 Carer reference group
- Representative from Advocacy Reference Group
- Representative from People with Lived Experience (PwLE)
- Lead Councillor for Adult Social Care
- Public Health

Other organisations in the County providing services to adults with care and support needs continue to work in partnership with the Board to promote adult safeguarding and support the work of the sub-groups.

2.3 Annual Budget and Financial Contribution

The 2020/21 annual budget for the Board was £125,524. Alongside staff and administration, this funds the cost of Safeguarding Adults Reviews (SARs) and supports the delivery of objectives. The annual budget is established through a financial contribution from statutory partners. 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	45.90
Herefordshire & Worcestershire Clinical Commissioning Group	41.90
West Mercia Police	12.20

There was an under-spend for this financial year of £64,000. This figure includes the cumulative carry over of underspends from previous years. Last year's reserves were £66,000, so a decrease in reserves will be carried over into 2021/22. A much-improved figure on the £90K carried forward in 2018/19.

The accrued surplus funding is being used to offset any future SAR overspend, alongside supporting areas of work identified for additional development. To date funding has been allocated to develop work around exploitation of adults; developing the engagement of people with lived experience: policies review and a pilot to provide challenge to SAR decision making and develop rapid review process for SARs to enable us to share the learning in a more timely manner.

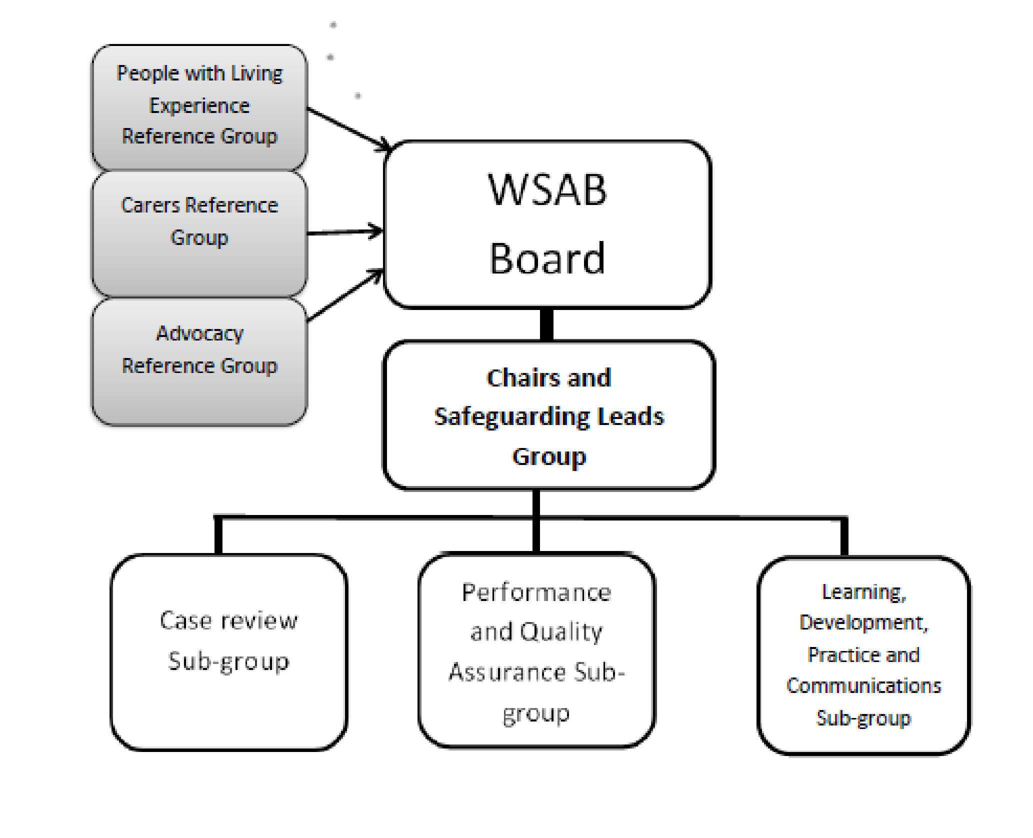
2.4 Delivery Model

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 developed, based on 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 represent the interests of people with care and support needs, their carers and families. There is a representative from each of these reference groups on the Board.

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 on a quarterly basis.

Fig 2.1 Board Structure



2.5 Business Objectives

There were three key objectives identified in the 2020 -21 business plan. These were:

Making the System Work

Continue to oversee the delivery of safeguarding requirements (meeting Section 42 criteria, (S42) Making Safeguarding Personal (MSP) and introduction of Liberty Protection Safeguards (LPS)), ensuring that learning is embedded across all services and that the pathways are understood.

Joint Working

Build on joint working with other Worcestershire Partnerships to ensure that adult safeguarding issues receive the appropriate strategic ownership and provision across all services.

Wicked Issues (for example. Complex Multi-Agency Issues)

Develop the WSAB ability to understand the 'wicked issues' which have the potential to have an impact on safeguarding adults with care and support needs.

Unfortunately, due to the impact of Covid 19 on Health and Social Care staff, it was agreed work in Sub-groups would be suspended for the first 6 months of the year. This meant the WSAB was unable to make as much progress as initially planned. However some limited progress was made and Table 2.2 gives a summary of the annual objectives and details or

achievements.

Table 2.2 - Achievements	
WSAB Objective	**Achievements**
1. Continue to oversee the delivery of safeguarding requirements (S42, MSP and LPS), ensuring that learning is embedded across all services and that the pathways are understood.	The website included a dedicated page for - safeguarding risks exacerbated by Covid-19, alongside links to support, during the lockdown. Details of the information published by the WSAB can be found here WSAB Covid-19 Information During the first lockdown the quarterly newsletter was published monthly to ensure information was shared in a timely way. The Adult Safeguarding Network continued to meet virtually during the pandemic. The Network focuses on sharing information on strength-based approaches and signposting toward early help. Presentations included information on suicide awareness and building resilience in teams. Representatives from the reference groups became more engaged in the work of the Board, including supporting a review of the SAR process to improve communication and working closely with the Learning Development Practice and Communication (LDP&C) sub-group to provide advice on information which goes out to the public. The Performance and Quality Assurance (P&QA) Sub-group completed a survey looking at how well MSP has been embedded in practice. The findings and recommendations from this are now being taken forward through the Board's Learning and Communication Strategy.
2. Build on joint working with other Worcestershire Partnerships to ensure that adult safeguarding issues receive the appropriate strategic ownership and provision across all services;	The new website is a shared platform with the Worcestershire Safeguarding Children Partnership. The WSAB identified funds to jointly pay for a coordinator post with the South Worcestershire Community Safety Partnership and Public Health to establish and develop joined up services for adults who are being exploited. The WSAB chair attended both the Worcestershire Strategic Housing Partnership and the Health and Wellbeing Board to share the findings of the Thematic SAR into Rough Sleeping. Emphasis was given on the recommendations which relate to these forums and Boards, including the requirement for them to provide future updates to the WSAB on their progress towards meeting these.

3. Develop the WSAB ability to understand the 'wicked issues' which have the potential to have an impact on safeguarding adults with care and support needs.	The task and finish group, established to oversee the development of a pathway for adults who are exploited project managed two initiatives on behalf of the WSAB: • The establishment of the above-mentioned coordinator post. • A research project undertaken by the University of Worcester to establish the extent of known exploitation and review the current pathways for accessing support. A virtual seminar was held with providers and interested parties to disseminate the findings of the Thematic SAR into Rough Sleeping. Attendees including those who provide homeless and rough sleeper services and other interested parties.

3 Review of Activities 2020/21

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 sub-groups. 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)

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 suspected that the adult has experienced serious harm.

Safeguarding Adult Boards (SABs) can also commission a review in other situations involving an adult with care and support needs. The WSAB only considers such reviews 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 sub-group 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 in order to prevent future harm or death from occurring.

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.

During 2020/21 there were 8 referrals requesting consideration for a SAR to be undertaken. A SAR was commissioned for 2 of these.

Of the remaining 6 referrals, 2 resulted in single agency actions being recommended; 3 required no additional actions and 1 decision is pending with the scoping meeting being held in April 2021.

6 SARs were completed and signed off by the Board during the year. Two have been published and can be found here; Rough Sleepers Thematic SAR and Mary SAR (executive summary). Three will be published May/June 2021

One was a joint Domestic Homicide review (DHR) and SAR which will be published at the end of 2021. It is a legal requirement that DHRs are signed off by the Home Office and unfortunately there is a back log for sign off at the Home Office.

Following the publication of the National Institute for Health and Care Excellence (NICE) Guidelines for Safeguarding Adults in Care Homes in February 2021 it is recommended that Safeguarding Adults Boards (SABs) should address issues relevant to Safeguarding in care homes as part of their Annual report. There were no SARs signed off during this period which involved a care home.

3.2.2 SARs: Changing Practice through Learning and Action

Action plans for each SAR are drawn up identifying where change in practice is required. The implementation and progress of the action plans are carefully managed by agencies and monitored the WSAB.

Areas for improvement identified in the 6 SARs completed during this year included.

Making safeguarding personal (MSP):

- To promote ‘thinking the unthinkable’ for professionals.
- Improving the effectiveness of the support for the person / families around the transition between Children’s and Adult services.
- Improve consideration on using advocacy where required.
- Improve engagement of individuals who decline support.

Multi-agency working / communication:

- Ensure Multi-agency meetings and lead agency/professionals are identified.
- Embed escalation processes in organisations

Mental capacity:

- Self-neglect, there is a need to consider whether mental capacity is a factor, therefore mental capacity assessments need to be carried out.
- A review and relaunch of the self-neglect policy, taking account of the above (along with other recommendations)

3.2.3 Annual Learning Event

It was decided prior to the Covid-19 pandemic that this year we would hold two half day events, one to engage with the providers of services for the homeless and rough sleepers, where we would disseminate findings from the Thematic SAR. The other with the residential and domiciliary care sector where we would share findings from previous SARs which were relevant to their service and practice.

Unfortunately, due to the impact of covid-19 the learning event for the care sector was postponed. However, following a postponement of the learning event for the Thematic SAR on Rough Sleepers, a virtual event was held in November. At the event the author of the SAR presented the findings and participants shared their views on how the recommendations should be taken forward, including how their organisation can support their implementation. There was also a presentation from a representative of a county task force set up to respond to rough sleeping during the lockdown. This included information on how they proposed to build on this work to prevent future rough sleeping.

3.2.4 Annual Assurance Statement

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.

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 and other SABs. The Performance and Quality Assurance (P&QA) sub-group now oversee a rolling annual programme for WSAB members to submit an update of their organisation's status on meeting safeguarding legislation and standards and any actions to address deficits. The P&QA sub-group assess these and report back to the Board as required.

3.2.6 WSAB Publications and Guidance

Policies which were required through the implementation of the Care Act are now in place. A process of reviewing these has been established; during 2020/21 the following guidance and leaflets were reviewed, and changes were made:

- Revised version of the West Midlands Adult Safeguarding Policy and Procedures
- Review of a local leaflet explaining Making Safeguarding Personal (MSP)

All the WSAB policies and procedures, including the above can be found here: Link to WSAB Policies and Procedures.

The WSAB also shared guidance published by several other organisations over the year which supports the work of SABs. These can be found by following this link: Link to Guidance for SABs

3.3 Organisational Contributions

Contributions from Statutory Partners who have supported the Business plan and meeting the priorities included:

Objective 1: Continue to oversee the delivery of safeguarding requirements (Section 42, MSP and LPS), ensuring that learning is embedded across all services and that pathways are understood.

- Worcestershire County Council (WCC)
  - reviewed safeguarding arrangements and allocated additional resources to manage the increase in safeguarding work.
  - extended the helpline support for partners to ensure that MSP is central to practice and embedded a protocol in the Adult Safeguarding Team to ensure best practice in the management of safeguarding concerns.
  - allocated additional resource to ensure the timely completion of high-risk Deprivation of Liberty Safeguards (DoLs) assessments.
  - increased support from link workers within the Adult Safeguarding and DoLs team to increase knowledge and confidence with safeguarding and MCA amongst social work teams.
  - begun preparation for the implementing of Liberty Protection Safeguards (LPS)
- The Herefordshire and Worcestershire Health and Care NHS Trust (HWH&CT)
  - undertook benchmarking against NICE MCA guidelines to identify areas for improvement which are being monitored by their Integrated Safeguarding Committee
  - it now has a separate lead for MCA & DoLS, which enables more support for staff on these complex areas of legislation.
- The Worcestershire Acute Hospital NHS Trust (WAHT)
  - undertook a survey on MSP across all its hospitals
  - promoted key messages and held a number of awareness events over the year
- Herefordshire and Worcestershire Clinical Commissioning Group (HWCCG)
  - as a commissioning organisation, seeks assurance from NHS commissioned services regarding the delivery of safeguarding requirements (S42, MSP, LPS). Assurance provided through governance processes. HWCCG Safeguarding Leads provide support, scrutiny, and challenge to the system.
  - Learning from serious incident reviews and SARs, along with other findings from inspections are monitored by the CCG to ensure that actions required are implemented and improvements sustained.

Objective 2: Build on joint working with other Worcestershire partnerships to ensure that adult safeguarding issues receive the appropriate strategic ownership and provision across all services.

- All partners continued to build links and processes with Worcestershire Children First
- HWCCG commissioned Safeguarding Supervision training for health safeguarding leads across the adult and children's workforce.
- CCG and Partners are engaged in a range of cross cutting work which impacts on Adults. For example, transitions from child to adult services, exploitation, rough sleeping/homelessness. Also reducing inequalities: through Learning Disabilities Mortality Review (LeDeR) and the Learning Disabilities Partnership Board; work around mental health and rough sleeping, or for asylum seeking young people /adults; to improve access to health services/support.
- All statutory partners are also represented and actively contribute to the work of the re-formed Worcestershire Domestic Abuse Partnership Board. They are also engaged in the work of the Multi-Agency Risk Assessment Conference (MARAC) and Drive schemes.

Objective 3: Develop WSAB ability to understand the 'wicked issues' which have the potential to have an impact on safeguarding adults with care and support needs. In particular:

Rough Sleeping

- A Homelessness Liaison Pathway Officer has been appointed across Health providers.
- Health partners Integrated Safeguarding Committee now receives a quarterly report from the Homelessness Pathway Officer to ensure oversight of activity and actions taken
- An alert system has been established for 'Rough Sleepers' or No Fixed Abode patients admitted into the HWCHT wards. This leads to the complex discharge coordinator undertaking a housing jigsaw referral to the relevant housing authority or housing services as appropriate
- Mobile phones are provided so that professional support can be maintained following discharge. (H&WCHT)
- Recommendations from the Rough-sleepers Thematic review, applicable to health are included as part of 'reducing inequalities' agenda, such as improving access to primary care and mental health services for rough sleepers

Exploitation

- Staff awareness campaigns have been promoted across WAHT and HWHCT on Modern Slavery and Human Trafficking guidance, Loan Sharks and Prevent
- Adult exploitation is already being explored by a multi-agency group which includes the -WSAB partners. The findings of this group will enable planning for the next phase of work on this issue.

Lead Professional

- WAHT undertook an internal review to look at the application of Respect and the use of MCA for patients with a learning disability
- Learning Disability Services at WCC are introducing a named social worker for all adults receiving support from this service.
- The Lead Professional is identified as part of the process when commissioning packages of care for people entitled to Continuing Health Care (CHC) funding,

Systemwide response to Covid 19:

- Fortnightly WSAB Covid Meetings were introduced as a response to the pandemic and included wider multi-agency partners from across the system. The meetings allowed early identification of emerging issues and themes, so that timely action could be implemented. In addition, the meetings highlighted what was working well across the system.
- The CCG and LA worked together to support the health and social care response to Covid 19.

4 Safeguarding Activity and Performance 2020/21

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.

Adult Social Care changed its reporting IT system from Framework I to Liquid Logic in November 2019. Whilst, the new categorisation options within Liquid Logic provide a wider set of data than has previously been available, it is therefore difficult to have a direct comparison to previous years on all of the data

4.2. The data

4.2.1 Number and Source of Concerns

The number of concerns reported during this business year shows a slight decrease compared to the previous year. (Table 4.1). The percentage of concerns reported which meet section 42 criteria has increased significantly to 27%, indicating that the level of awareness around what constitutes a safeguarding concern has improved. In addition, the number of cases that don't meet criteria, but where some level of enquiry has taken place is also now recorded.

Table 4.1 – **Concerns dealt with under safeguarding (Cases (incidents) Reported)** **Source: Safeguarding Adults Collection** (compared to the previous two years)			
	2018-19	**2019-20**	**2020-21**
Concerns Reported	**2202**	**3921**	**3283**
Section 42 applies (meets criteria)	**318**	**542**	**902**
Percentage of concerns reported where Section 42 Applies	**15%**	**14%**	**27%**

Data is also broken down into the number of individuals where concerns are reported. This not only helps manage any double counting of reported concerns (for example. where more than one person could report the same incident) but also provides an opportunity to understand more about the individual circumstances of the abuse.

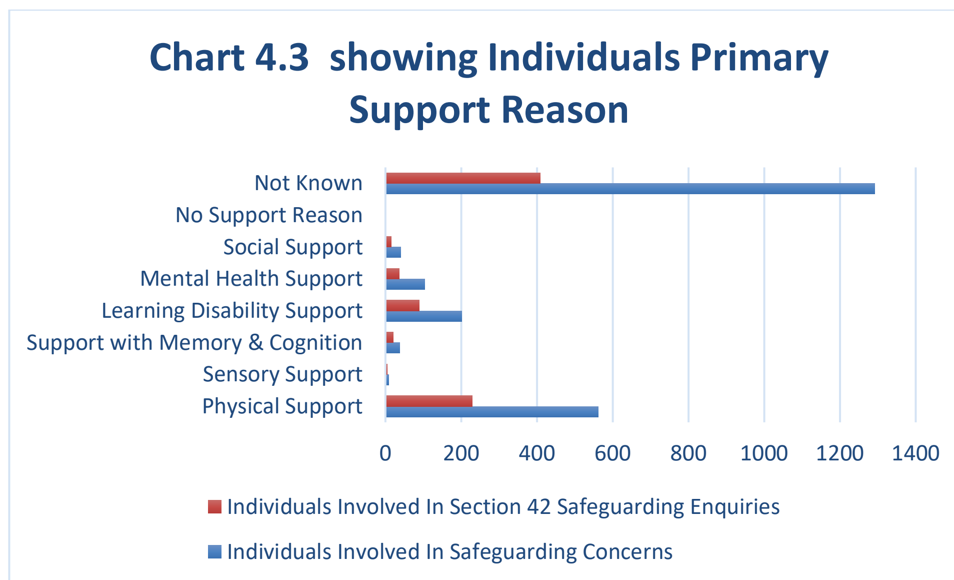
This data shows that a large proportion of concerns reported relate to the same person, particularly in those circumstances which meet the section 42 Criteria (Table 4.2).

Table 4.2 total concerns reported in 2020 to 2021 compared to total number of individuals where a safeguarding concern is raised		
	Concerns Reported	Individuals
Total Number of Safeguarding Concerns	3283	2248
Total Number of Section 42 Safeguarding Enquiries	902	804
Total Number of Other Safeguarding Enquiries	124	122
Percentage of concerns reported where Section 42 Applies	27%	35%

4.2.2 Individuals Primary Support Needs (Chart 4.3)

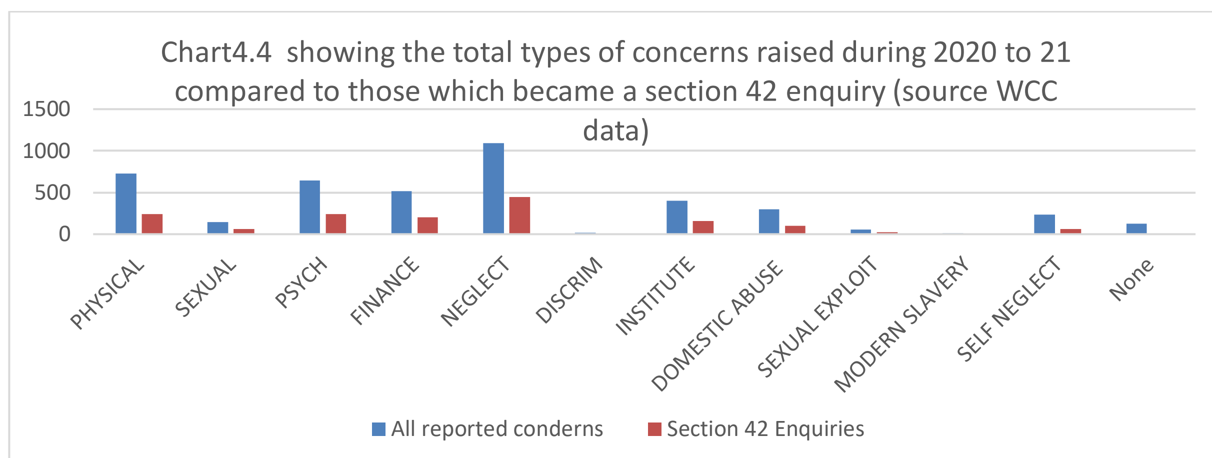
Of the 2248 individuals where a safeguarding concern was reported during the year, over half of their primary support need was not known (1292). Where the support reason was known one quarter (562) required physical support. The next two largest types of support were for people with a learning disability (202) and those individuals requiring mental health support (104).

Of those 804 individuals that went on to meet the section 42 safeguarding criteria, the proportions were similar. However whilst the primary support reason was unknown was still slightly over half (409) a greater proportion of those meeting the criteria were found to require physical support (229).



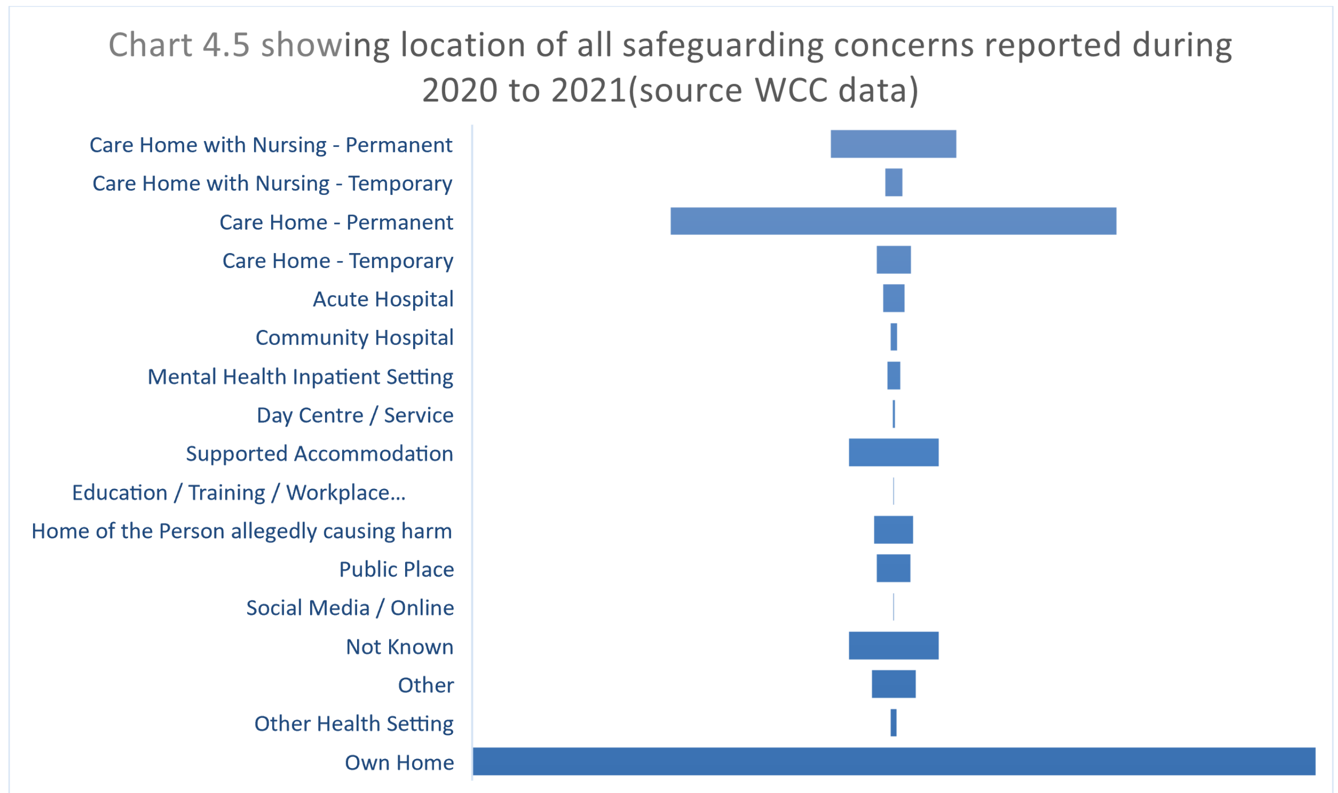
4.2.3 Type of abuse

In terms of all the safeguarding concerns that were reported during the year the highest number of concerns reported were for neglect, followed by physical, psychological, and financial abuse. This same pattern was emulated in those cases which went on to a section 42 enquiry (Chart 4.4).



4.2.4 Location of the safeguarding concern

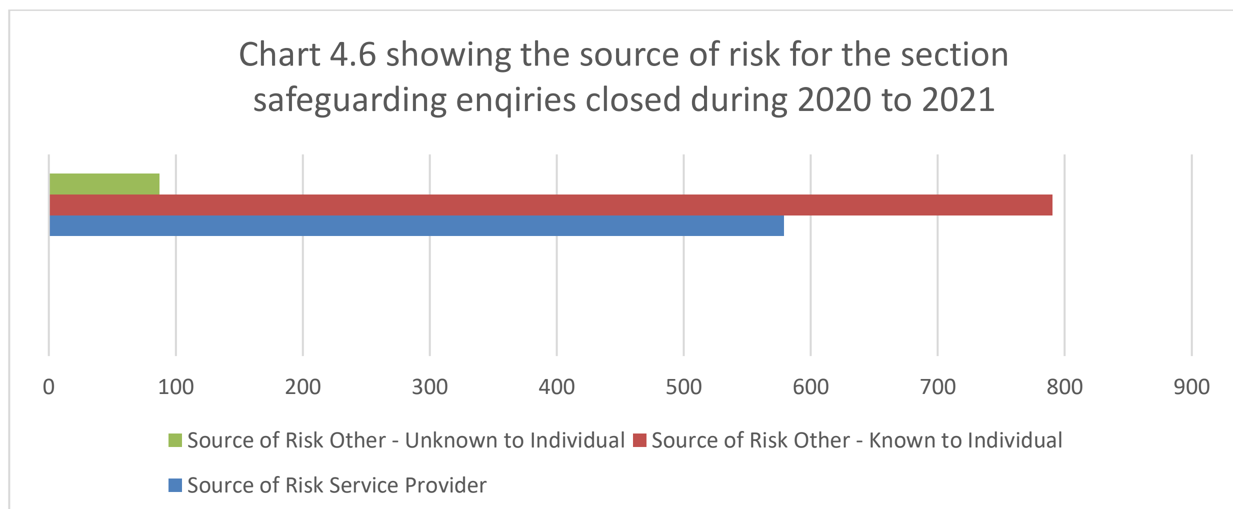
When examining the location where the safeguarding concern occurred for all the concerns reported, the highest level was in the person's own home followed by a care home or residential setting (Chart 4.5).



4.2.5 Source of Risk

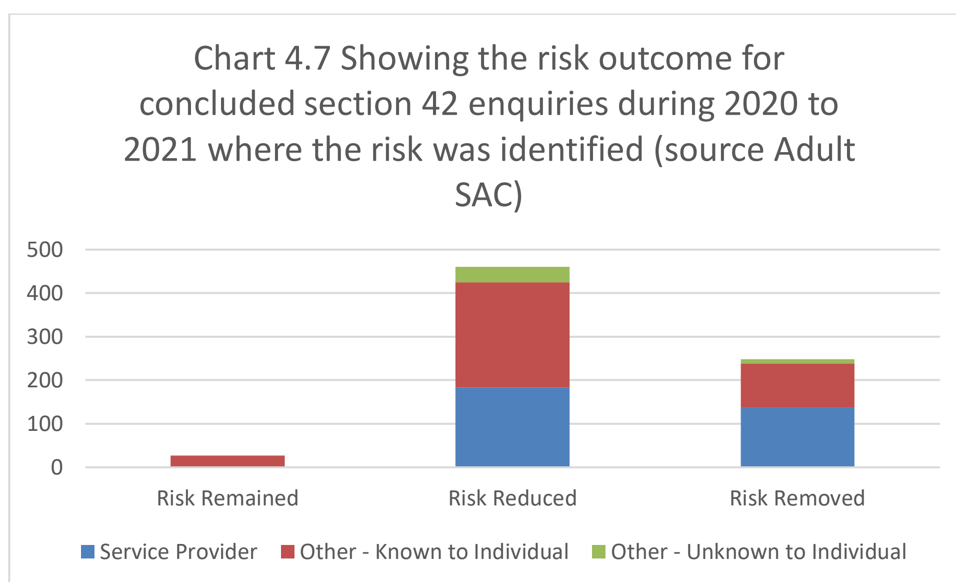
The following analysis is based on the 1456 section 42 enquires which were concluded or closed during 2020 to 2021.

In most cases the source of the risk was someone known to the person (chart 4.6)



4.2.6 Outcomes

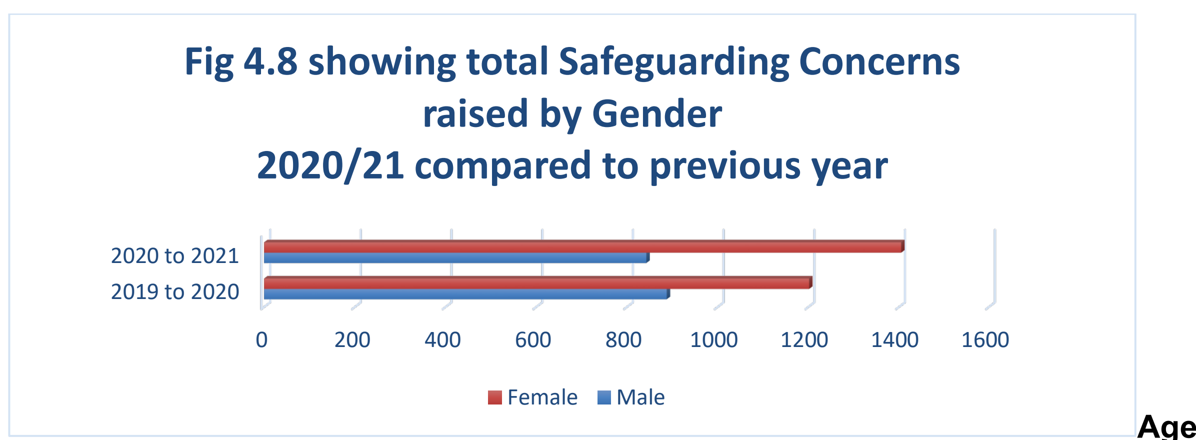
The national SAC now requires data to be collated on the impact of the work done to address the safeguarding concern. In terms of the section 42 enquiries which were closed during this year in most cases the risk was either reduced or removed (chart 4.7). in a small number (28 enquiries) the risk remained. The majority of these (26 cases) were where the source of risk was known to the person. Additional information shows that 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.



4.3 Demographic Profiles

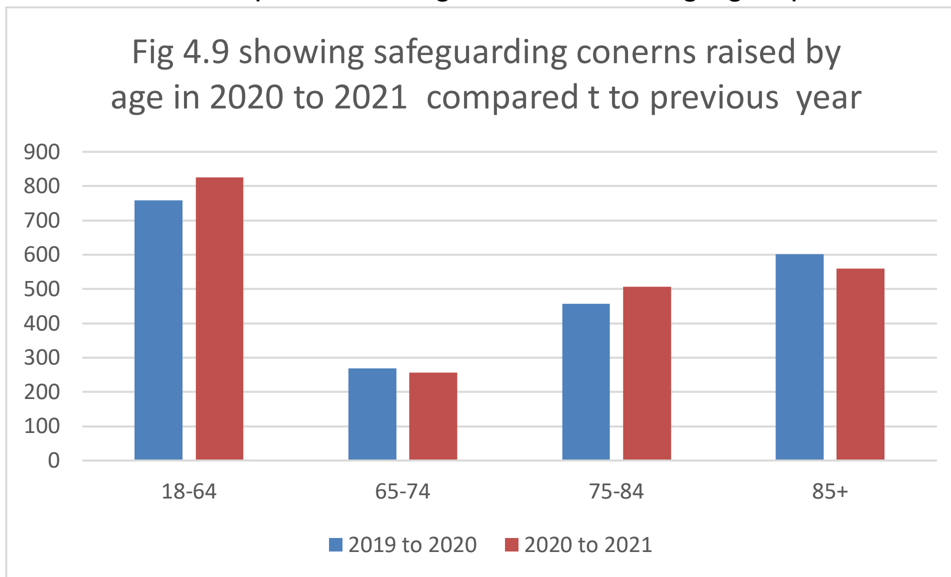
Gender

The number of Safeguarding Concerns reported and those which subsequently meet the safeguarding section 42 criteria is higher for women than for men, which follows the pattern of previous years (fig 4.8)

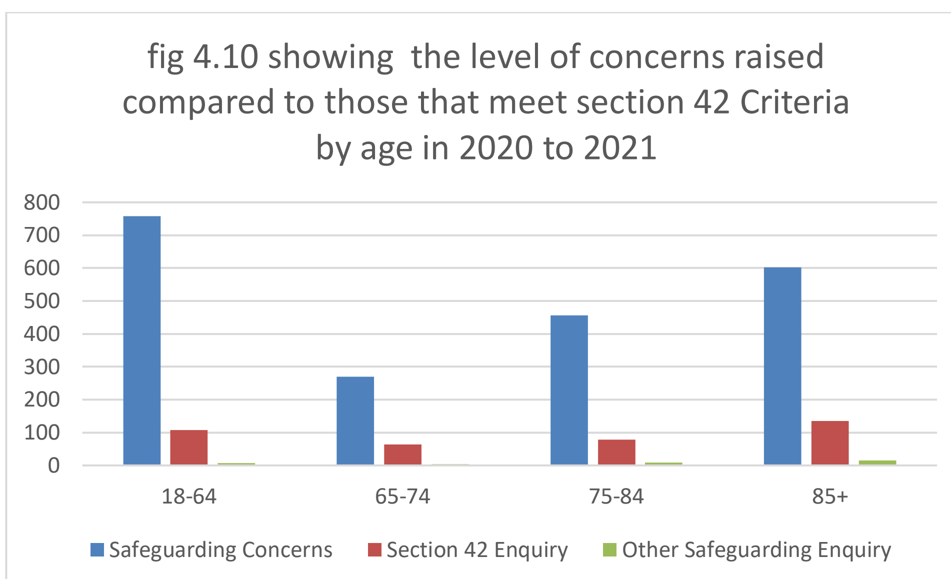


Age

As with previous years the age profile of concerns reported (fig 4.9) shows that there are more concerns reported amongst the 18 to 64 age group.

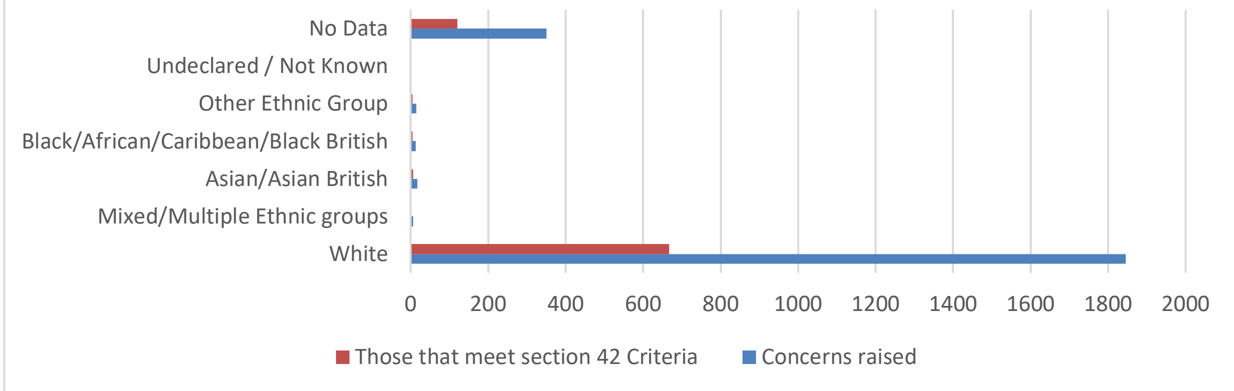


However, the number of those which meet the Section 42 criteria in this age group reduces significantly, with the over 85's having the highest level of concerns reported which meet the criteria (Fig 4.10).



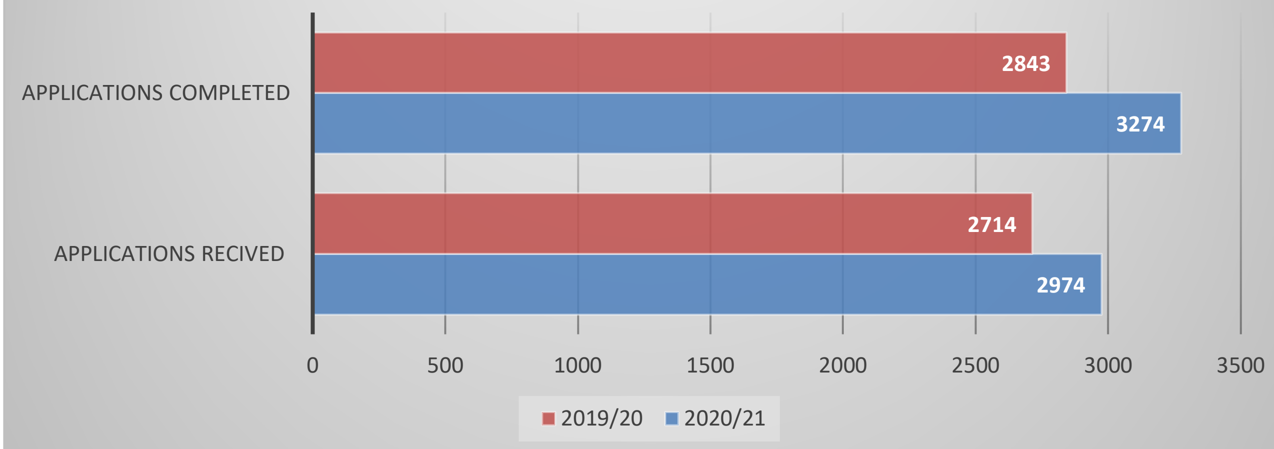
Ethnicity

Ethnicity also follows the same pattern as previous years. The majority of individuals involved with a safeguarding concern during 2020/21 were white (fig 4.11). The level of safeguarding concerns reported in other Black and Minority Ethinic (BAME) groups is 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.



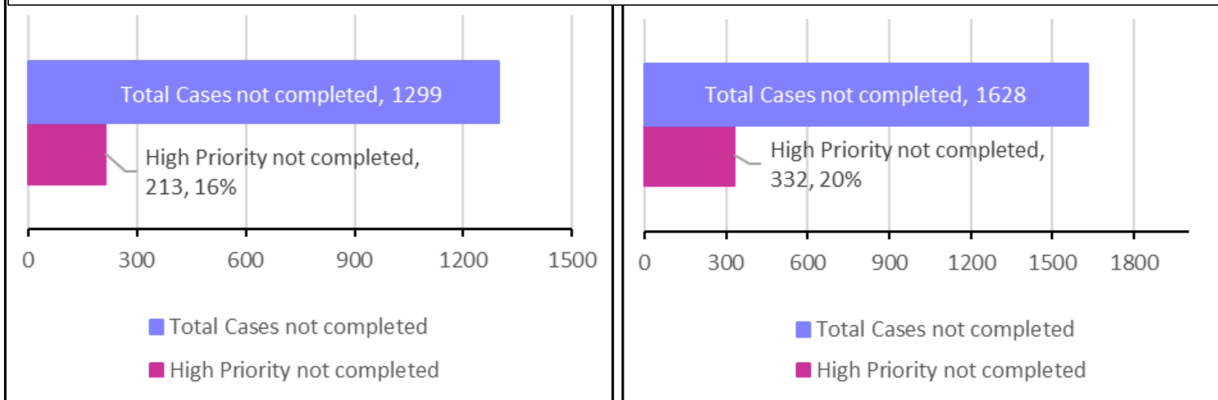
4.5 Deprivation of Liberty Safeguards (DoLS)

The total number of_Deprivation of Liberty Safeguards applications made during 2020/21 increased by 8.5% whilst the number of applications completed increased by 15%. (Fig 4.12). This improvement was due to additional resources being allocated to the DOLS teams enabling more assessments to be completed, alongside a concentrated effort on improving data quality.



Whilst there were 1299 assessments not completed during 2020/21, this was significanlty less than the prevous year where 1628 were not completed (Figs 4.13). Of those assessments not completed during 2020/21 only 213 (16%) were high priority cases, again a reduction compared to the previous year where 332 (20%) were high priority cases . The decrease was mainly due to more assessments being completed and also the outcome from the data quality exercise.

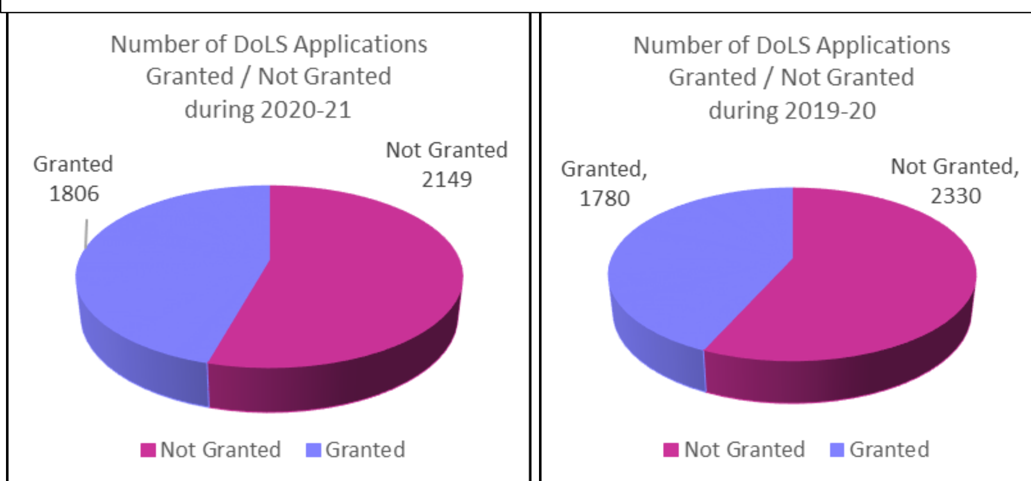
Fig 4.13 Number of DoLs cases not completed during 2020/21 (including high priority cases) compared to those completed in 2019-20



Proportion of Applications Granted or not Granted.

There were more DoLs applications ‘Not Granted’ than ‘Granted’ applications in both 2020/21 and 2019/20 (Fig 4.14). This is largely because many of these have their assessments discontinued once they are moved to a different place (i.e. hospital discharges, respite stays, deceased).

Fig 4.14 Number of DoLs applications granted and not granted during 2020/21 compared to those completed in 2019-20



5.0 Priorities for 2021/22

This year due to covid-19 the WSAB did not hold an annual strategy event to review priorities. Instead, given that businesses was placed on hold for a significant period, it was decided that the priorities from 2020/21 would be carried forward.

The priorities for the coming year are therefor:

Making the System Work

Continue to oversee the delivery of safeguarding requirements (S42, MSP and LPS), ensuring that learning is embedded across all services and that the pathways are understood.

Joint Working

Build on joint working with other Worcestershire Partnerships to ensure that adult safeguarding issues receive the appropriate strategic ownership and provision across all services;

Wicked Issues (for example. Complex Multi-Agency Issues)

Develop the WSAB ability to understand the ‘wicked issues’ which have the potential to have an impact on safeguarding adults with care and support needs.

KEY to Acronyms	
ASC	Adult Social Care
CSE	Child Sexual Exploitation
DoLS DHR GP	Deprivation of Liberty Safeguards Domestic Homicide Reviews General Practitioner (Doctor)
HWCCG	Herefordshire and Worcestershire Clinical Commissioning Group
HWHCT	Herefordshire and Worcestershire Health and Care Trust
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