Worcestershire Safeguarding Adults Board

Annual Report 2021/22

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Chairs Foreword

Welcome to this 2021/22 Annual Report of the Worcestershire Safeguarding Board. and I am delighted to see via this report a summary of all the hard work that the board and its members have undertaken during my first year as Chair. Although for many of us in society the impact and effects of Covid 19 have begun to ease, there is still the legacy of loss that many experienced and it's also clear that the impact and effects of Covid 19 are still very acute in the health and social care sector, creating significant additional pressures on the system. I want to pay tribute to health and social care staff who are still bearing the brunt of higher workload pressures and coping with absence from colleagues due to illness - thank you.

I also want to acknowledge the hard work, tenacity and skill of the Board Staff and Board Members who have worked in various subgroups and teams to effectively discharge the business of the board. The number of new developments and projects that have been initiated whilst keeping the normal business moving along have been impressive. We have seen the development of the Safeguarding Adult Rapid Review process which significantly assists in ensuring that any learning from tragedies is out in the public domain as quickly as possible. This also helps the families as the length of enquiries is shortened so that they do not need to keep retelling their stories and experiences over protracted periods of time.

The board has also been able to resource new work in self-neglect. This is a complex area and we need to do far more to understand why individuals find themselves in situations where their own care is compromised. The ability of health and social care professionals to have a healthy professional curiosity is critical, as is the willingness to listen to the individual's story. I want to thank all involved with these initiatives; it really does make a difference.

As a board we also are committed to hearing from the communities we serve and to being as open as possible with them. To this end some of our priorities for the coming year will be to review our systems and procedures to see where we can improve, to work more effectively in partnership with all concerned and to be as open as possible in the way we operate.

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. This is a significant task and one that only seems to grow, partly due to demographic changes, but also as we as a society better understand the scale and complexity of safeguarding issues. We are fortunate to live in a society where abuse, coercion and harm are not tolerated or accepted. Therefore, I commend this report to you; it reflects the member organisations and their staffs' determination to ensure wherever possible that we can all live lives free from abuse, coercion and harm.

Professor Keith Brown

WSAB Independent Chair

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 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
- Worcestershire County Council Directorate of Public Health
- Representative from Independent Health Providers

2.3 Annual Budget and Financial Contribution

The 2021/22 annual budget for the Board was £125,524. 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

The 2021/22 expenditure was £132,561 which is £4,561 over the total funding received of £128,000. The overspend was predicted and covered through reserves and additional partnership funding from the South Worcestershire Community Safety Partnership to develop a multi-agency response to the exploitation of adults with care and support needs.

Alongside staff and administration, these contributions fund the cost of Safeguarding Adults Reviews (SARs) and support the delivery of objectives. The spend for 2021/22 can broadly be broken down under the following categories:

Staff and administration costs (including the Independent Chair)	£109,224
Special Projects (funded via reserves and other sources) • Exploitation Coordinator (temporary post) • WSAB Apprentice (temporary Post)	14,061
Sub-group and task-group spend	
• Case Review (Safeguarding Adults Reviews)	9,026
• Learning Development Practice and Communications	250
Total Spend	£132,561

In terms of the projected spend for the year, there was an under-spend of £34,000, in addition, £68,000 of carry forward from previous years gives a cumulative underspend figure of £102,000 for 2021/22. This has increased by £34,000 from the previous year due to receipt of funding from public health for year 2 of the Exploitation Officer post (£37,000); and the CARM Coordinator post funding not being used as a suitable candidate was not found (£27,000) which totals £64,000.

Other key factors contribute to the accrued underspend include:

- Modern apprentice was only in post for 9 months instead of 12 months
- Rapid Review process yielding cost savings in Case Review sub-group spend
- Expenditure decrease in Case Review subgroup due to virtual learning events being more cost effective and face-to-face events were not possible at times due to COVID-19 restrictions
- Database procurement is still ongoing

The carry forward into 2022/23 has been allocated to continue developing the work around, exploitation of adults, engagement of people with lived experience, delivering the communication strategy, policy reviews and rapid review SAR process.

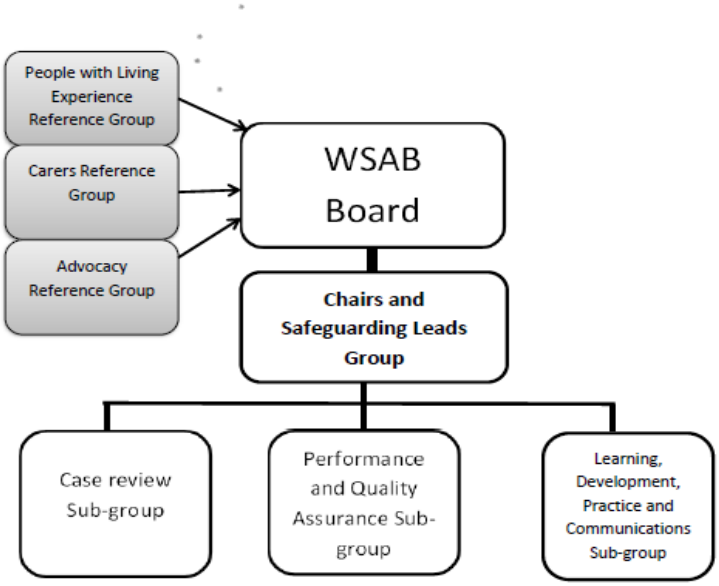
2.4 Delivery Model

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 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.

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 were three key objectives identified in the 2021/22 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.

These were carried over from the previous year due to the need for Health and Care Staff to prioritise their response to Covid 19.

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.	An audit of referrals into the Adult Social Care safeguarding team identified areas where training and awareness was required. This has informed the training and communication plans. It also identified possible ambiguity in some wording on the online referral form which will be addressed. Information from the data analyst provides assurance that there does not appear to be any areas of the County where abuse or neglect does not get reported from. The general distribution of the number of concerns reflects the population densities. Further mapping, looking at care facilities did not identify any areas with disproportionately high levels of concern that were not known about. Self-Neglect The WSAB undertook an extensive review of the Self-Neglect policy, which is now a 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, often combined with hoarding behaviour and including 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 link Link to Self Neglect Policy The Adult Safeguarding Network continued to meet virtually. Members of the network received regular updates on 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. Representatives from the reference groups continued to build on their input into the work of the Board. Initiatives they advised on included the production of two podcasts on the application of the Mental Capacity act and Best Interest decisions, which can be found by following this Link to WSAB Podcasts
2. Build on joint working with other Worcestershire	Continued to develop the WSAB website, undertaking a review with support from the reference groups.

Partnerships to ensure that adult safeguarding issues receive the appropriate strategic ownership and provision across all services;	The WSAB appointed an exploitation coordinator, hosted by West Mercia Police. This post is jointly funded by the WSAB. South Worcestershire Community Safety Partnership and Public Health. Continued to work with the Worcestershire Strategic Housing Partnership and the Health and Wellbeing Board to implement the recommendations from the Thematic SAR into Rough Sleeping. The WSAB is also working with the Worcestershire Safeguarding Children Partnership and other boards across the region to develop a regional multi-agency assurance framework. In the interim a limited assurance exercise was conducted across statutory partners.
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.	Exploitation The multi-agency exploitation task and finish group continued to meet and oversee the work of the Adult Exploitation Coordinator to establish a referral process for adults who are exploited. Lead Professional The WSAB provided the lead in the development of a Complex Adult Risk Management (CARM) framework. This 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. It has been established in response to recommendations from Safeguarding Adults Reviews which advised that a Lead Professional needs to be identified in such cases. Details of the CARM framework can be found by following this Link. .Link to information on CARM Framework 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 was established, which included representation from these providers, to assess the responses to the recommendations of the Thematic Review into people who sleep rough. A copy of the review can be found by following this Link to Thematic SAR

3 Review of Activities 2021/22

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 known or 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.

3.2.2 SAR Methodologies

Rapid Review

This year the WSAB introduced a 12-month pilot for a rapid review process. The concept of a rapid review was introduced for Local Safeguarding Children Partnerships and locally it was found to identify learning effectively and efficiently. WSAB has been working to adapt the process for adults, whilst ensuring compliance with the requirements of the Care Act 2014. The process builds on the scoping process by ensuring representation from all involved agencies at an early stage. This facilitates more robust decision making on whether the SAR criteria are met and the methodology of any mandatory or discretionary SAR undertaken. Concerns had been raised regarding the number of SARs commissioned previously so, a consultant was commissioned to provide challenge and support the development of the Rapid Review process.

Where it is agreed that a mandatory or discretionary SAR is required it has been possible, in some instances, to build on the scoping information by engaging the person or their family and following up on specific lines of enquiry to inform the SAR Overview Report.

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. 50% in comparison to following the current SAR protocol for all referral.

3.2.3 SAR Referrals

During 2021/22 6 referrals were received by WSAB:

- 1 referral was subsequently withdrawn by the referring agency.

- A decision was made that the SAR criteria were not met in relation to two referrals, with single agency actions agreed in response to one.

- A decision was made the SAR criteria were met in relation to three referrals and it was agreed that the rapid review process was appropriate. These reviews are in progress.

SARs completed during 2021/22:

One mandatory and one discretionary SAR were completed and signed off by the Board at the end of March 2022.

The discretionary SAR has been completed and a learning briefing has been published and can be found here Link to BS learning brief

Publication is pending for the mandatory SAR. This review concerned care provided within a care home setting. The findings have been shared with relevant commissioners, but general learning will be shared more widely with commissioners and service providers following publication.

One joint Domestic Homicide review (DHR) and SAR is still awaiting Home Office sign-off before publication can take place (approx. 12-18 month back-log due to COVID-19).However, dissemination of learning will be progressed.

3.2.4 SARs: Changing Practice through Learning and Actio

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 action. 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. Due to issues of capacity within the team supporting the Board there has been a delay in seeking assurance from subgroups and agencies that agreed actions have been progressed. This issue was exacerbated by SAR work being put on hold during Covid outbreaks to support the focus of safeguarding partners on operational delivery. The Board team are gradually addressing this, but it will take time to resolve.

Areas for improvement identified in the 2 SARs signed off by the WSAB during this year included.

Making safeguarding personal (MSP):

- To promote 'thinking the unthinkable' for professionals.
- 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
- Identify Lead Professional*

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**.

*The Complex Adults Risk Management (CARM) framework launched in May 2022 seeks to address these issues

** A review and relaunch of the self-neglect and hoarding policy took place in May 2022

Domestic Abuse in Older Couples:

- ensure that all domestic abuse and safeguarding adult training includes at least a reference to domestic abuse in older couples, especially where the abuse is happening as part of dementia where no previous abuse existed.

The SAR which involved a care homes also had recommendations that the following were addressed:

- commissioning and assuring safe placements within care homes
- To be more specific when describing the behaviour of an individual, rather than using generic labels such as ‘challenging’ or ‘difficult’
- Improving Carers Support

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

A new approach of an assurance panel has been adopted following the thematic Safeguarding Adult Review on people who sleep rough, as there are so many complex recommendations: Link to Thematic SAR into people who sleep rough

Work has been undertaken to test whether actions from a historic review were still in place and are being embedded in practice.

3.2.5 Annual Learning Event – Domiciliary and Residential Care Providers

This year’s annual learning event focused on sharing the findings of SARs which had learning for domiciliary and residential care home providers. The event was held virtually due to the risks of covid.

We targeted managers, trainers and safeguarding leads and focused on providing information on the following:

- the National Overview of issues emerging through sectors
- Overview of local SAR themes where Care Home or Domiciliary Care been one of organisations reviewed.
- Identifying good practice in the sector around the following areas:
    - Care Planning /Joint working
    - Having clear and accessible systems and processes
    - Application of the Mental Capacity Act and Deprivation of Liberty safeguards.
- Developing greater clarity around safeguarding systems including when and how to record and report

A copy of the presentations can be found by following this Link to Annual Learning event presentation.

3.2.6 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.

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

3.2.7 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 2021/22 the following guidance and leaflets were reviewed, and changes were made can be found by following these links:

- Assisted Suicide Policy
- Mental Capacity Act Policy
- Mental Capacity Act (MCA1) form
- Mental Capacity Act -Quality Assurance Self-Assessment Checklist
- Positions of Trust Protocol
- Quality Assurance Checklist for Safeguarding Adults Policies

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 to support the delivery of WSAB objectives include:

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 teams 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 the National Institute for Health and Care Excellence MCA guidelines to identify areas for improvement. These are being monitored by their Integrated Safeguarding Committee
    - 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 safeguarding 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.
- HWCCG 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 2021/22

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. It should be noted that there are differences in the recording of data in 2019-20 and subsequent years due to Adult Social Care changing the electronic social care record system.

4.2. The data

4.2.1 Number and Source of Concerns

Whilst the number of concerns reported during this business year has increased significantly in terms of reported incidents. (Table 4.1) a large proportion of concerns reported relate to people who have been the subject of concerns previously (Table 4.2)

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

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

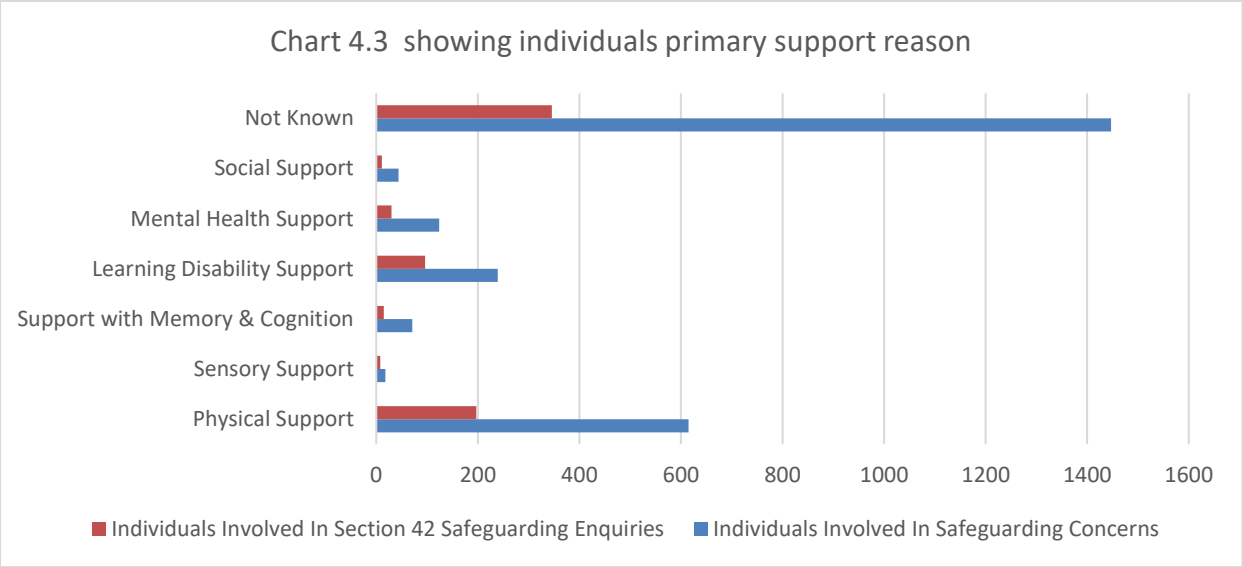
Table 4.2 total concerns reported in 2021 to 2022 compared to total number of individuals where a safeguarding concern is raised

	Concerns Reported	Individuals
Total Number of Safeguarding Concerns	4007	2558
Total Number of Section 42 Safeguarding Enquiries	793	703
Total Number of Other Safeguarding Enquiries	66	66
Percentage of concerns reported where Section 42 Applies	19%	27%

4.2.2 Individuals Primary Support Needs (Chart 4.3)

Of the 2558 individuals where a safeguarding concern was reported during the year, in over half of these people their primary support need was not known (1447). Where the support reason was known one quarter (615) required physical support. The next two largest types of support were for people with a learning disability (239) and those individuals requiring mental health support (124). (Chart 4.3)

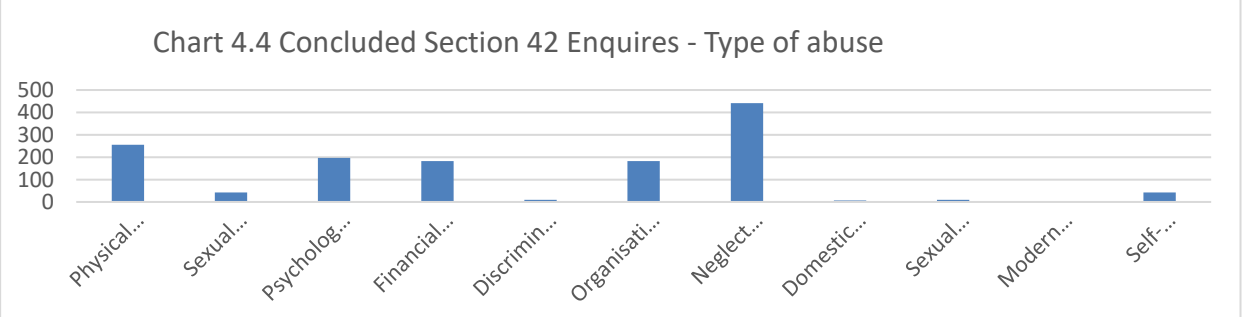
Of those 703 individuals that went on to meet the section 42 safeguarding criteria, the proportions were similar. (chart 4.3)



4.2.3 Type of abuse

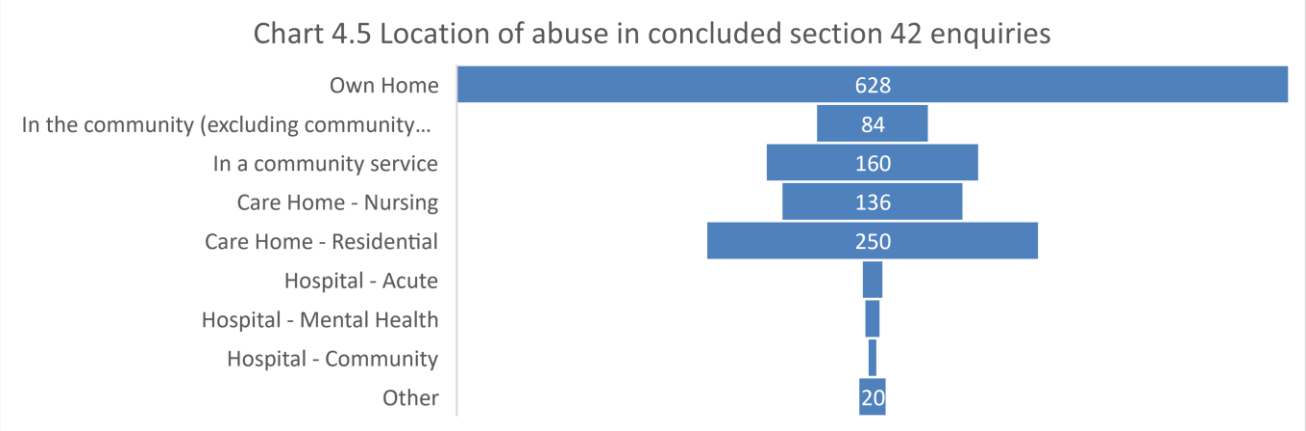
The following information relates to the data which Adult Social Care hold on concluded enquires for 2021 to 2022. The total concluded enquires which met section 42 criteria was 1369.

The highest number of concerns in the Section 42 enquiries which were concluded during the year was 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.



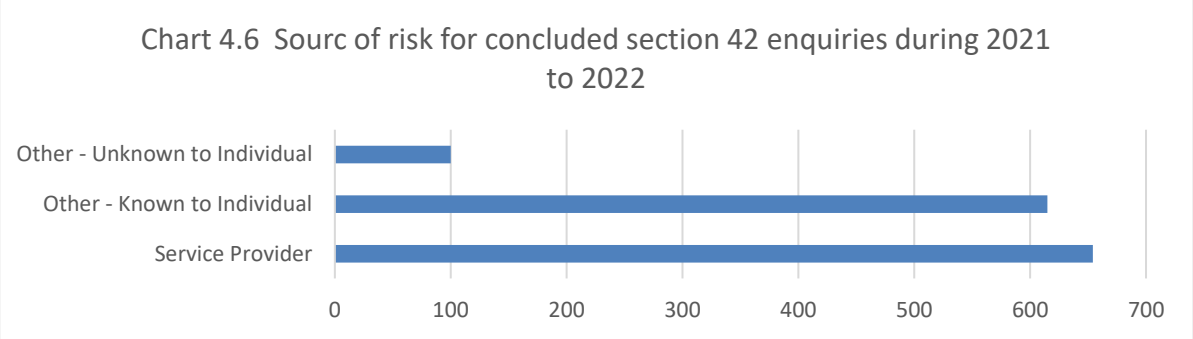
4.2.4 Location of the safeguarding concern

When examining the location where the concluded section 42 safeguarding enquiry occurred, the highest level was in the person's own home followed by a care home-setting (Chart 4.5).



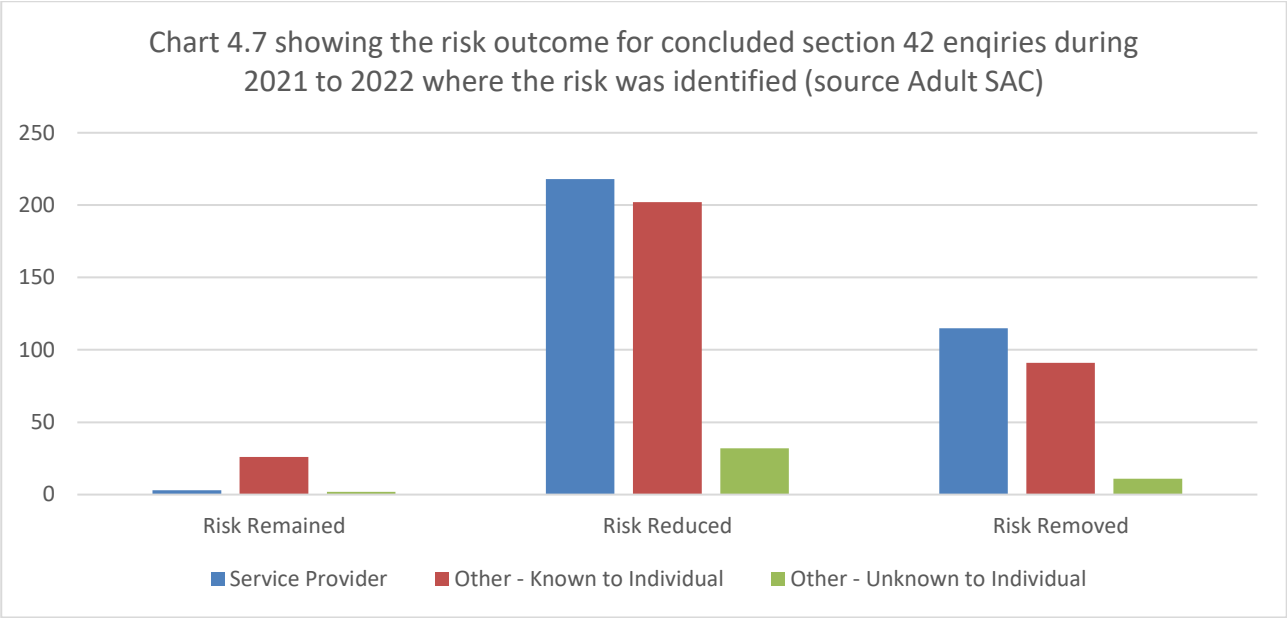
4.2.5 Source of Risk

In most cases the source of the risk was someone known to the person or by a service provider (chart 4.6)



4.2.6 Outcomes

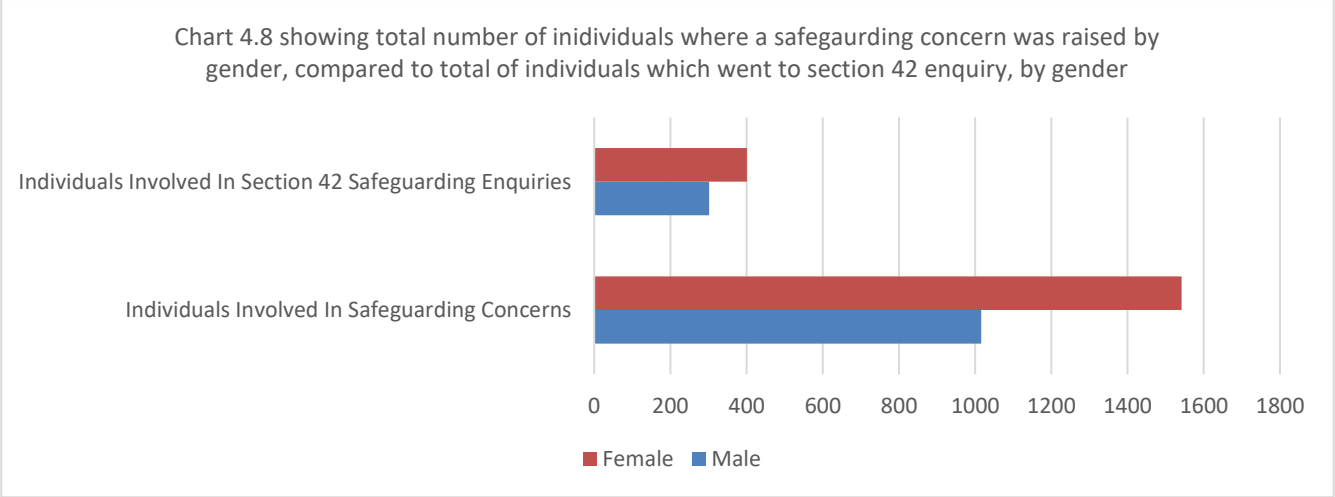
The national SAC now requires data to be collated on the impact of the work done to address the safeguarding concern. In terms of the section 42 enquiries which were closed during 2021/22 year in most cases the risk was either reduced or removed (chart 4.7). in a small number (31 enquiries) the risk remained. This is similar to the previous year and once again the majority of these (26 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.



4.3 Demographic Profiles

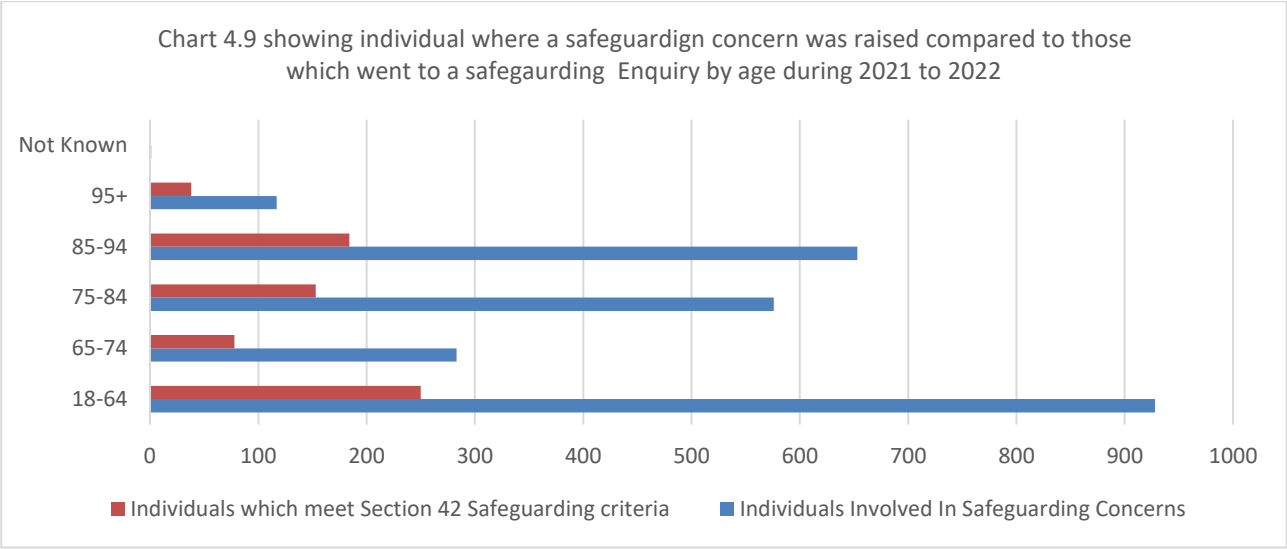
Gender

The number of individual cases where a Safeguarding Concern was reported, as with previous years, is higher for women than men. (Chart 4.8) More women than men subsequently meet the safeguarding section 42 criteria, however the differentiation is slightly reduced.



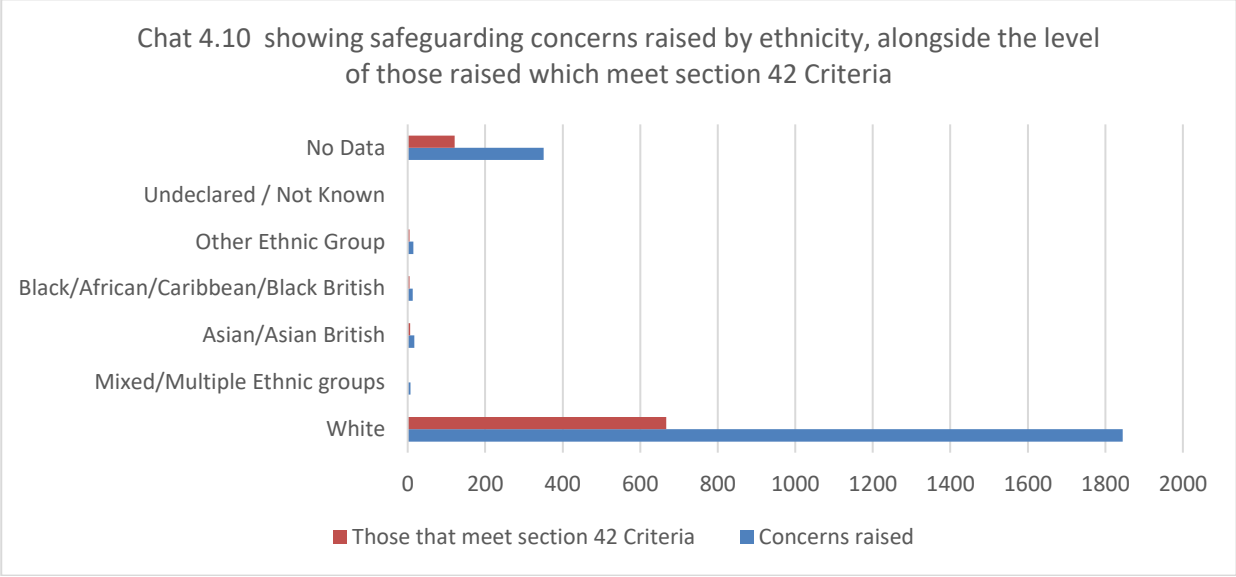
Age

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



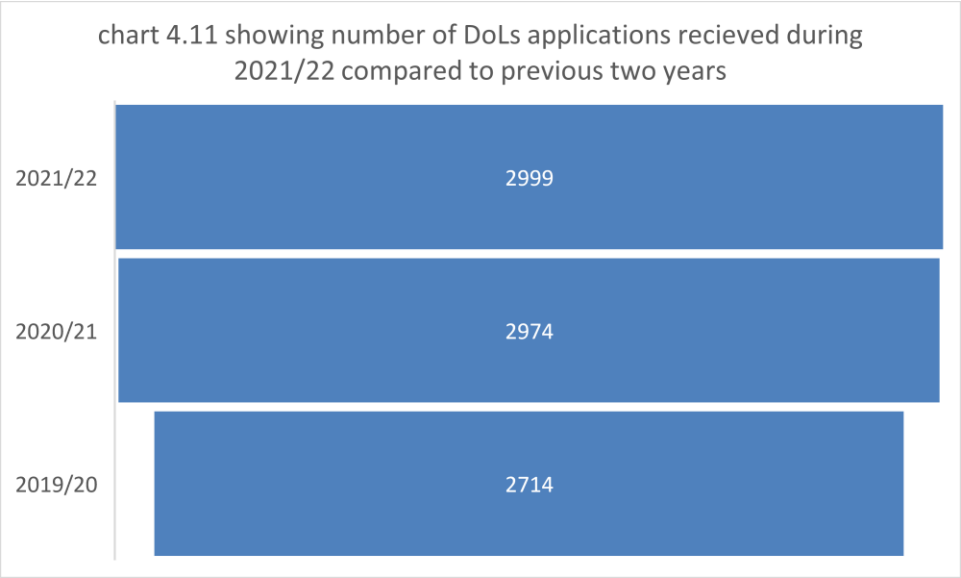
Ethnicity

Ethnicity also follows a similar pattern to previous years. Most individuals involved with a safeguarding concern during 2021/22 were white (chart 4.10). 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.

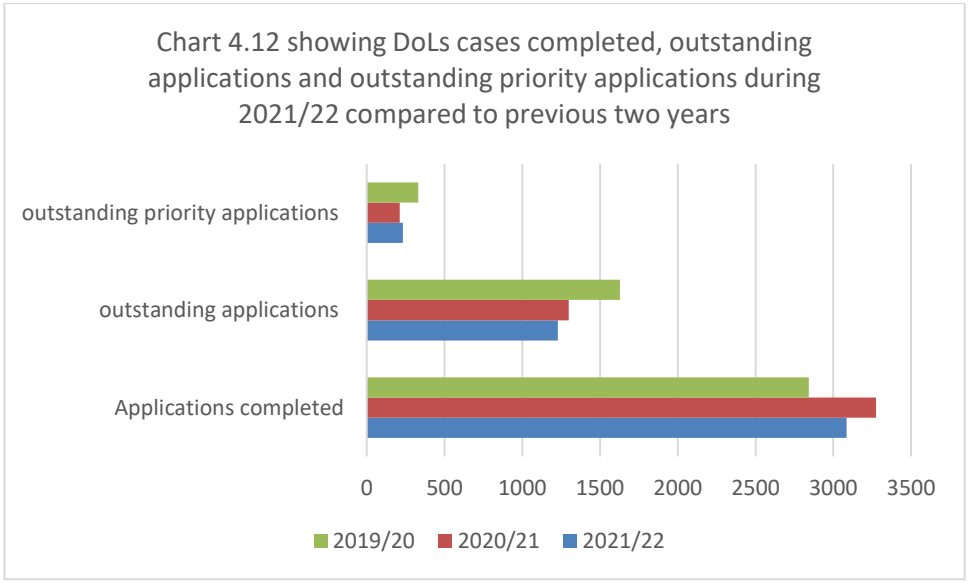


4.5 Deprivation of Liberty Safeguards (DoLS)

During 2021/22 there were only 25 more Deprivation of Liberty Safeguards applications made than the previous year. (chart 4.11).

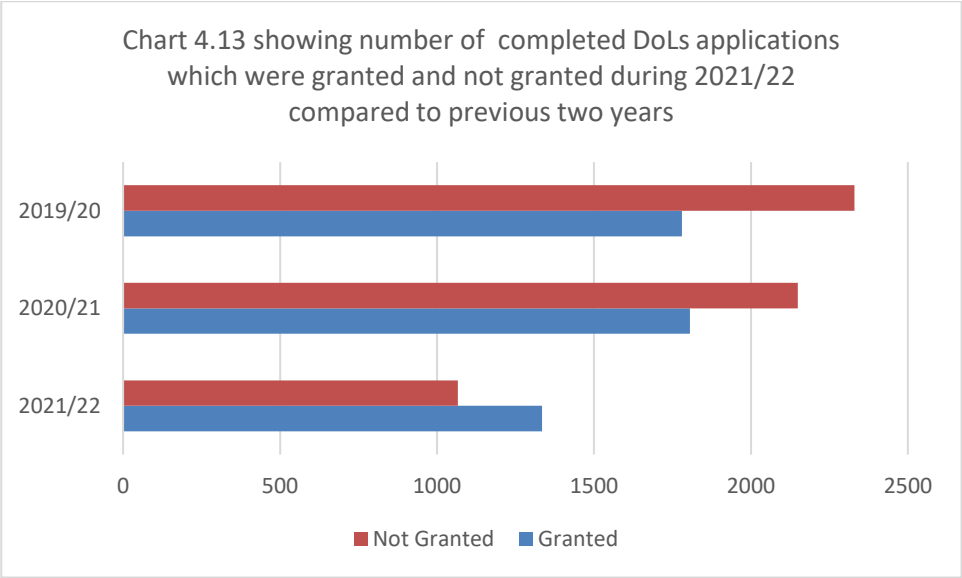


Whilst slightly less applications were completed during 2021/22 than the previous year, the number of oustanding applications, particulary those identified as priroity applicatons, are still lower than they were two years ago. (chart 4.12). This improvement was due to additional resources being allocated to the DOLS team enabling more assessments to be completed, alongside a concentrated effort on improving data quality.



Proportion of Applications Granted or not Granted.

Although the number of completed applications fell during 2021/22 the majority of applications were granted, which was not the case in the previous two years. (Chart 4.13)



5.0 Priorities for 2022/23

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, consolidation, or performance data. This informs the priorities for our Annual Business Plan.

The priorities which will be taken forward during 2022 to 23 include:

- Developing and implementing a Communication Plan
- Continuing to take forward the work around Wicked issues, particularly:
    - Exploitation
    - Rough Sleeping
    - the Lead Professional

- These will be supported by the introduction and implementation
- of a Complex Adults Risk Management (CARM) Framework and the revised Self-neglect and Hoarding Policy
- Building our links with Herefordshire to support the development of the Integrated Care System
- Monitoring the implementation of the Liberty Protection Safeguards
- Monitoring the impact of the difficulties in staff recruitment across the Health and Social Care Sector

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)
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