

Appendix 1.



# Annual Report

## 2022-23



## Contents

	Page
Foreword	2
Strategic priorities	
Priority 1: Prevention	3
Priority 2: Communications and engagement	6
Priority 3: Operational effectiveness	7
What does safeguarding look like in Herefordshire?	8
How the Board works to deliver results	13
What the sub groups have delivered this year	15
<ul style="list-style-type: none"><li>• Performance and quality assurance</li><li>• Policies and procedures</li><li>• Training and workforce development</li><li>• Joint case review</li></ul>	
Business Plan – what we will deliver 22/23	22
Appendix 1 – Meeting attendance	22
Appendix 2 – Budget	23

---

## Foreword

Once again thank you for taking the time to read this annual report and your continued interest in safeguarding adults in Herefordshire.

Herefordshire's Safeguarding Adults Board (HSAB), comprises senior leaders from a range of commissioners and provider agencies who include, but not exclusively, the health sector, the Police, the Fire Service, the Local Authority Adult Social Care, and Public Health and representatives of the voluntary and community sector and residential care providers.

My role is independent of these organisations and my duty as Chair is to ensure that the Board is given adequate assurance that we are all delivering safe services, and that Board Members hold each other to account for this. This is my final year as Chair in Herefordshire and I know my successor will continue to receive the full support of the committed membership of the Board.

I reflected in the annual report 2020 – 22 our emergence as a society from the Coronavirus pandemic. This has shown the need to understand the longer-term impact on the health and well-being of local people, and specifically for those with care and support needs how safeguarding responses may need to adapt.

During the current reporting year we started to see the emergence of societal and financial pressures relating to the cost of living crisis. There will again be a need to understand how this might change the nature of adult safeguarding both locally and nationally. These might include the risks of the lack of availability of care and support packages for those who need them, and where financial pressures on families may manifest in risk to individuals.

Herefordshire continues to hold system wide conversations to embed strategic approaches to support those who face multiple and complex needs. The Board continues to work closely with the Health and Well-Being Board to ensure strategic commitment and joint working in this regard.

The adult social care 'front door' continues to see high numbers of referrals for people who do not have care and support needs, but do have vulnerabilities in their lives. Work is underway in Herefordshire to bring granularity of understanding of these needs, and how to support people to access services to address these vulnerabilities needs to be better understood across agencies in Herefordshire.

The Board has not commissioned any safeguarding adult reviews during this reporting year. The Board has drawn on national learning from the area of child protection and has introduced a process of adult themed 'rapid reviews'. During the reporting year the Board received 8 referrals, none of which met the criteria for a safeguarding adults review, but seven of which were subject of the rapid review procedure. This means that even though cases did not meet the statutory review criteria learning was identified in these cases which positively influences local procedures for agencies working with adults.

In April 2023 the Board revised and started work on its new strategic plan 2023 -26, which is a strong commitment to delivering against all of the above elements.

Finally I would wish to place on record my thanks to those dedicated professionals, volunteers, families and communities who work daily and tirelessly to keep our most vulnerable residents free from abuse and neglect.

A handwritten signature in black ink, appearing to read 'Ivan Powell', written in a cursive style.

**Ivan Powell**  
**Chair of Herefordshire's Safeguarding Adults Board**

## Strategic priorities

### Introduction

The strategic plan for 2019-22 was approved previously and includes a yearly business plan. This forms the foundation for the work of the sub groups to deliver the desired outcomes to safeguard the citizens of Herefordshire.

Whilst developing the strategic plan to deliver safeguarding activity from 2023 it was agreed that the existing business plan would extend for another year.

The business plan is developed to enable the Safeguarding Adult Board to carry out its functions as set out in legislation and guidance. This includes ensuring the safeguarding of adults in the following circumstances:

- (a) Has needs for care and support (whether or not the authority is meeting any of those needs),
- (b) Is experiencing, or is at risk of, abuse or neglect, and
- (c) As a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it.

The way in which a SAB must seek to achieve its objective is by coordinating and ensuring the effectiveness of what each of its members does to safeguard vulnerable adults. HSAB achieves this through scrutiny, challenge, learning and support. The key outcomes and actions in this plan are designed to help us demonstrate **Strong Partnership**, which is an essential part of ensuring strong and effective working together to safeguard vulnerable adults.

## Priority One: Prevention

<p><b>To ensure Herefordshire residents receive quality, person centered services, safeguarding responses are proportionate and people avoid reoccurrence of abuse</b></p>	
<p><b>Business plan 22/23</b></p>	<p><b>Action</b></p>
<p>Talk Community (TC) programme provides appropriate safeguarding signposting for the community</p>	<p>The TC programme needs to demonstrate that safeguarding is one of the golden threads running through its work.</p>
<p><b>Progress:</b>  All TC staff have received training in safeguarding and are able to recognise and respond to safeguarding concerns. They are able to signpost residents as necessary.  All volunteers within Hubs and Community Groups are actively encouraged to undertake training.  All the providers delivering the Holiday Activity Fund must provide their safeguarding policy during the application process and ahead of appointing them to deliver the activity.  A “vulnerability and exploitation” session was delivered to all HAF providers by the Police and Crime Commissioner trainer. This cohort are also encouraged to undertake the Local Authority Designated Officer training for managing allegations involving staff.</p>	
<p>Assurance of quality of care and safeguarding in care homes</p>	<p>Consider the work of the Care Home Support network</p>
<p><b>Progress:</b>  Our primary aim is to ensure its commissioned adult, children's and young peoples' social care providers deliver a good quality service to the people of Herefordshire. We continue to deliver an assurance program through robust quality assurance processes that evaluate and support services to improve.  Quality assurance will be delivered in alignment with Herefordshire Council's People's values of which the six principles are:</p> <ul style="list-style-type: none"> <li>• <b>People:</b> treating people fairly, with compassion, respect and dignity</li> <li>• <b>Excellence:</b> striving for excellence, and the appropriate quality of services, care and life in Herefordshire</li> <li>• <b>Openness:</b> being open, transparent and accountable</li> <li>• <b>Partnership:</b> working in partnership and with all our diverse communities</li> <li>• <b>Listening:</b> actively listening to, understanding and taking into account people's views and needs</li> <li>• <b>Environment:</b> protecting and promoting our outstanding natural environment and heritage for the benefit of all</li> </ul> <p>Our services should also continue to:</p> <ul style="list-style-type: none"> <li>• provide high quality and safe care, that really focuses on person centered outcomes for each and every individual,</li> <li>• evidence and demonstrate through practice that they are safe and well led,</li> <li>• provide opportunity for adults, children and young people to participate in and to be connected to their communities wherever they are,</li> </ul>	

- to respond to the changing landscape of funded care for our Herefordshire Service users, supporting the provision of assurance and driving improvement in quality, in commissioned services, by bringing together safety, effectiveness and take into account the voice of those that receive care.

Using the above principles as a foundation the Quality and Review team will seek core assurances in the following ways:

- Provider self-assessment / desk top review of core assurances,
- Officer visit to each location,
- Collaborate and receive feedback from all stakeholders,
- Supporting with service improvement plans where necessary

A quality review for each commissioned service will be undertaken on a stretched annual rolling basis and may at times be unannounced.

The reviews will demonstrate compliance with the service specification and ensure that they are focused on delivering the outcomes set out within contract terms.

A written report will be shared with the provider.

Those who have previously been safeguarded are empowered to resist abuse in the future or to seek support quickly

Policy and procedures sub group to create a “Staying Safe” leaflet for those who have previously been safeguarded

**Progress:**

Herefordshire Safeguarding Adults Board has a page of resources for members of the public

Transitional safeguarding: criminal and sexual exploitation

CSC to provide quarterly report to Board in respect of statutory duties care leavers (18-25 yrs old).

**Progress:**

Working with partner agencies the Herefordshire Child Exploitation and Missing Strategic Group (that reports to the Herefordshire Safeguarding Children Partnership (HSCP) continues to address the transition arrangements for vulnerable young adults who are at risk of exploitation as they transition into adulthood.

A young person may have received support from children’s services because they have been exploited or at risk of exploitation as a child. However, when a young person turns 18 years old, they may not be aligned with adult care and support provision and in some cases may not qualify for care and support needs in accordance with the Care Act 2014. With the possible risk of the individual being ‘floated off’ without support, that potentially puts that young adult in danger.

Herefordshire is looking to ensure transition arrangements for those at risk of exploitation is appropriate and individuals are supported post 18th birthday. Provision is already in place for those adults that have care and support needs and are at risk of exploitation. Likewise any adult can be supported by the criminal justice services, e.g. police, or the Community Safety Partnership, via multi-agency tasking and co-ordination activity, if they are identified as being at risk, or of being exploited. However, the intention is to strengthen the transition arrangements during 2023/24.

Representatives from the Community Wellbeing Directorate, the Childrens and Young People Directorate, HSAB and HSCP continue to meet to develop the transition arrangements and it

continues to be a priority piece of work to implement for both the HSAB and the HSCP during 2023/24.	
<p>Tackling sleeping and homelessness</p> <p>Statutory agencies to be held to account by The Board</p>	<p>HSAB to lead on MHCLG rough sleeping and homelessness next phase and implement the principles of ADASS / LGA Adult Safeguarding and Homelessness – A Briefing on Positive Practise.</p> <p>The street based link worker model will report activity into the PAQA sub group of the Board.</p>
<p><b>Progress:</b></p> <p>Herefordshire Council is working in collaboration with a wide variety of Community, Voluntary, and Faith Sector and statutory partners to ensure that bespoke packages of support are offered to all who are facing or experiencing homelessness, and this also extends to those who are recovering homelessness in the form of floating support being offered when someone has moved into their own property.</p> <p>There are a number of multi-agency meetings happening frequently to discuss specific cases and also plans currently being implemented to review strategy in line with guidance and initiatives from Centre For Homelessness Impact, Homeless Link and DLUHC (formerly known as MHCLG).</p> <p>As a local authority, we have joined the MEAM network, which helps to shape the character and culture within organisations in the county and seeks to make services accessible to people who need them. This process involves co-designing and co-producing with experts by experience and involving people who have lived experience of homelessness in any form wherever appropriate.</p> <p>Two new projects are planned:</p> <ul style="list-style-type: none"> <li>• Taking a census of women’s experiences of homelessness in the county and this will feed into a national pilot (more information available upon request).</li> <li>• A review of the national Ending Rough Sleeping Data Framework and seeking to apply this in Herefordshire to improve our offer of support and ensure that services are appropriately working towards sustainable recovery.</li> </ul>	

## Priority Two: Communications and Engagement

<p><b>To ensure that Herefordshire residents can recognise safeguarding concerns and know what to do</b></p> <p><b>To deliver the messages from the board and recognise the voice of those we safeguard</b></p>	
<b>Business plan 21/22</b>	<b>Action</b>
Build personal and community resilience	Build strong links with the local authority Talk Community programme
	Herefordshire residents are alerted to and prevented from the effects of scams
<p><b>Progress:</b></p> <p>The Board ensures that all community messages are shared with the Talk Community Programme and any relevant feedback is fed back to the Board.</p> <p>The Talk Community Team have included resources on this within their directory: <a href="#">Scams - Talk Community Directory</a></p>	
Service user involvement	Continue to develop the work already commenced of service user feedback through Healthwatch
	Expand the work to include service user feedback via commissioned advocacy service
	Promote the use of the newly introduced feedback form through social work practitioners
<p><b>Progress:</b></p> <p>Difficulties continue in engaging with those who have been safeguarded, the amended feedback form did not provide any greater levels of engagement and therefore Healthwatch (as our preferred resource) were unable to pursue the feedback.</p> <p>Discussions continue with the advocacy service.</p> <p>This subject has become a key part of planned direction for the Board on the Strategic Plan 2023-26.</p>	

### Priority Three: Operational Effectiveness

<b>To ensure safeguarding knowledge, processes, systems and structures are embedded across all agencies</b>	
<b>Business plan 22/23</b>	<b>Action</b>
Single agency assurance reporting to Exec	Assurance reporting from single agency is scheduled in to the business cycle of HSAB.
<b>Progress:</b> Regular opportunities are presented at both Executive and Strategic Board for individual agencies to update members on matters arising	
Ensure learnings from multi-agency audits and reviews are shared across the partnership	Develop approaches to achieve timely dissemination of messages from reviews and audits, with single agency partners taking responsibility and contributing to this. Details to be included in sub group work plans
<b>Progress:</b> Learning from audits and reviews are shared with the HSAB training and workforce development sub group and are built into practitioner forums and training materials. Seven minute learnings are widely disseminated. Work has commenced this year to better evidence the impact of the learning on professional practice.	
Continue to embed Making Safeguarding Personal across partner organisations	Safeguarding journey and working with risk
<b>Progress:</b> MSP continues to be a focus for the Board, audits have been conducted and findings evidence that although MSP is embedded into statutory agencies, understanding across the wider sector requires improving.	
Ensure Mosaic records accurately reflect both safeguarding referrals and activity	Improve understanding of Section 42.1 and 42.2 activity
<b>Progress:</b> HSAB representatives have been working actively both locally and regionally to develop new guidance and legal understanding	

## What does safeguarding look like in Herefordshire?

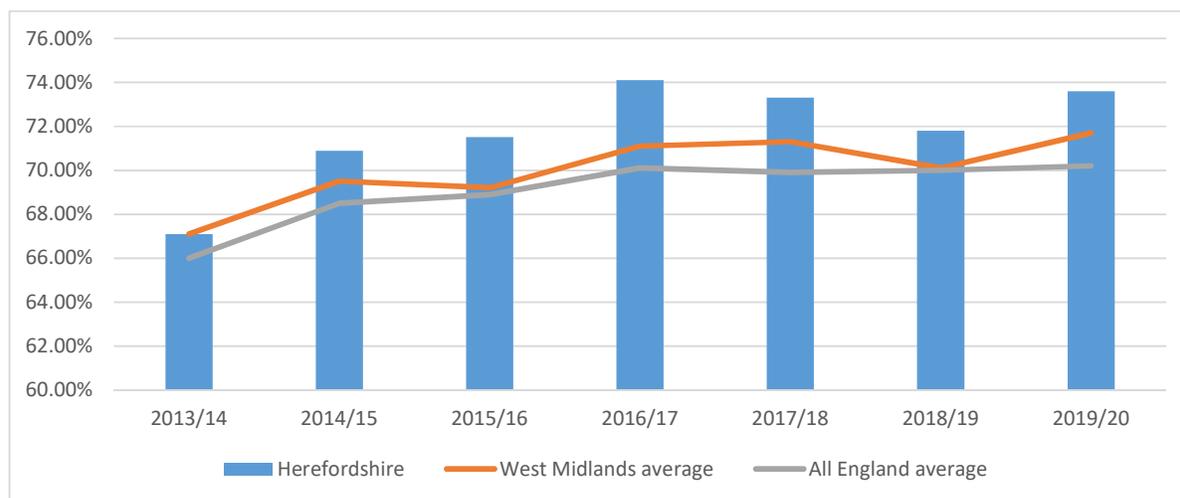
Every year the local council takes part in a survey, commissioned by the government, collecting multi-agency performance data and asking individuals about their experience of care.

Some key highlights are:

### Proportion of people who use services who feel safe

Safety is fundamental to the wellbeing and independence of people using social care, and the wider population. Feeling safe is a vital part of service users' experience and their care and support.

4a	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Herefordshire	67.10%	70.90%	71.50%	74.10%	73.30%	71.80%	73.60%
West Midlands average	67.10%	69.50%	69.20%	71.10%	71.30%	70.10%	71.70%
All England average	66.00%	68.50%	68.90%	70.10%	69.90%	70.00%	70.20%

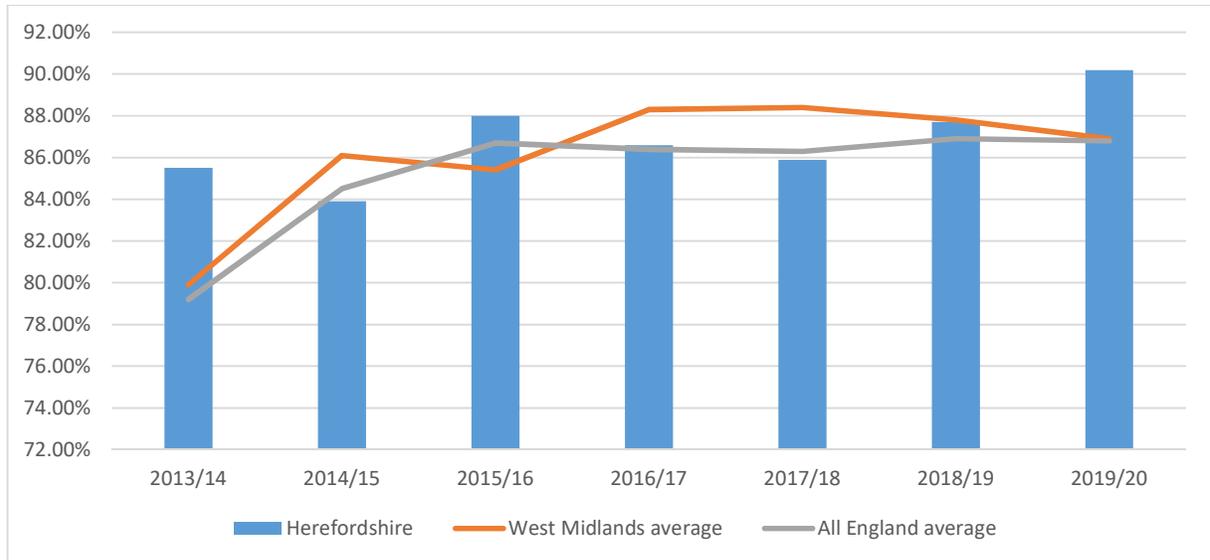


### Proportion of people who use services who say that those services have made them feel safe and secure

The measure below reflects the extent to which users of care services feel that their care and support has contributed to making them feel safe and secure.

4b	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Herefordshire	85.50%	83.90%	88.00%	86.60%	85.90%	87.70%	90.20%
West Midlands average	79.90%	86.10%	85.40%	88.30%	88.40%	87.80%	86.90%

All England average	79.20%	84.50%	86.70%	86.40%	86.30%	86.90%	86.80%
---------------------	--------	--------	--------	--------	--------	--------	--------

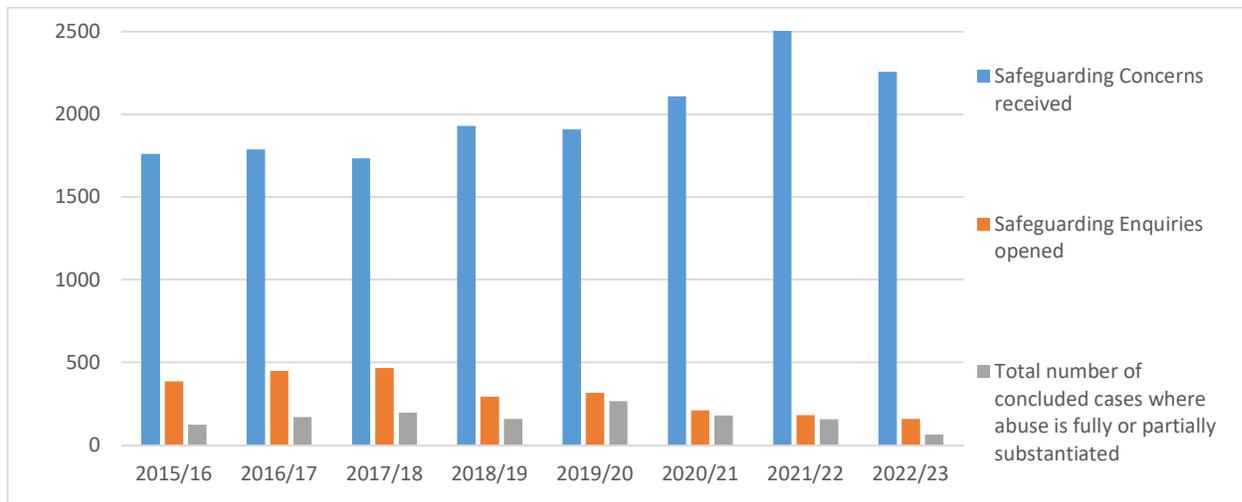


Due to Covid 19 these measure have been voluntary for the years 2021-21 and 2021-22 therefore no updates available

The following graphics relate to circumstances where safeguarding concerns were raised. All of this data is from the Local Authority information systems as, has been previously reported, limited information is available from partner agencies to support the safeguarding agenda.

### For the year 2022-23

#### About the concerns regarding abuse that have been raised



The number of concerns raised has decreased over this reporting period by around 12%.

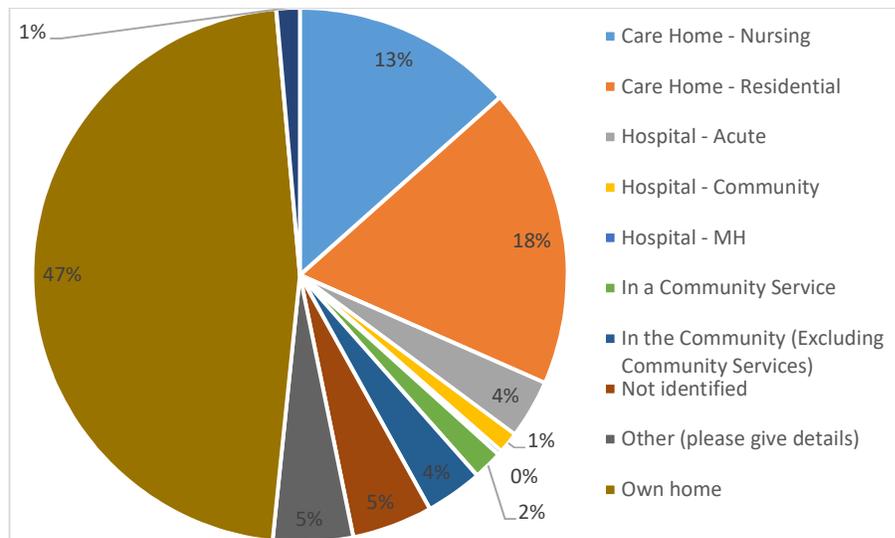
42% of individuals involved in safeguarding concerns were male



58% of individuals involved in safeguarding concerns were female

60% of the individuals involved in safeguarding enquiries were aged of 65 or over

**Where abuse has occurred**

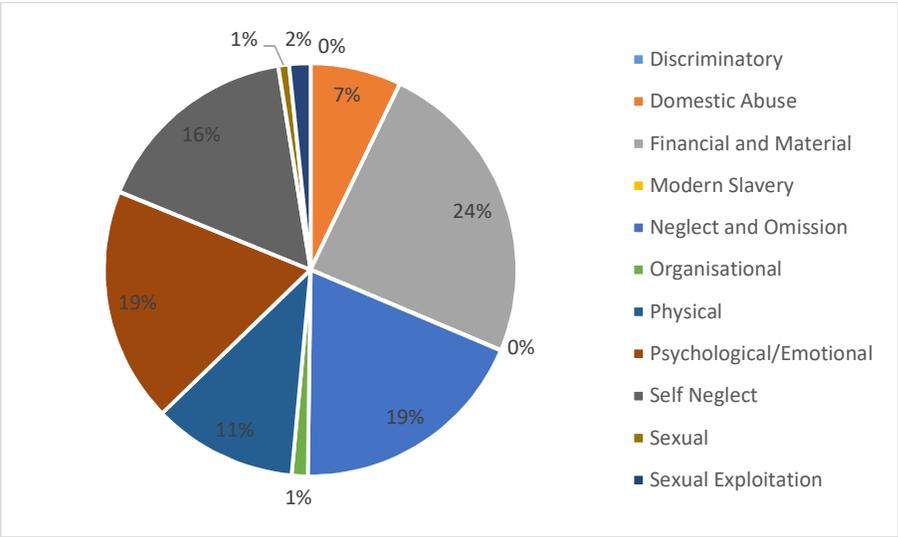


The diagram above depicts the location of the concern at the time of this being raised with the local authority.



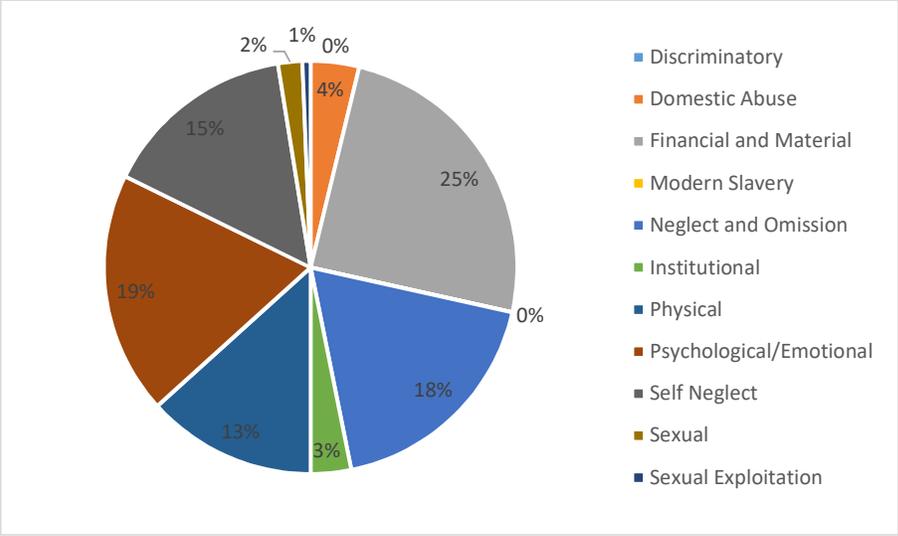
Once again the largest number involve those in their own home (47%).

The most common type of abuse that people suffer from in their own home is Financial and Material (25%) followed by Psychological and Emotional (18%)



The diagram above depicts the location of the concern at the time of this being raised with the local authority.

**What type of abuse has been reported?**



Self-neglect and Neglect and Omission were the most commonly reported types of abuse for the past two years. Historically Psychological and Emotional had been prevalent. Work needs to be undertaken to understand why these types of abuse are increasing.

**Source of risk**

The “source of risk” was personally known to the individual in 41% of 2022-23 concluded safeguarding enquiries.



## Mental Capacity



In 2022-23 safeguarding enquiries that were completed people lacked mental capacity in less cases (52) than had mental capacity (84). This is in line with previous years

## Advocacy

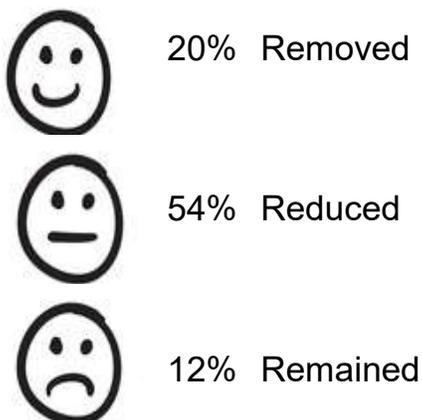
Where the person was assessed as not having capacity in 2022-23, there were 33% such service users which is similar to the previously reported figure.

## Making Safeguarding Personal

In 2022-23 76.2% of people or their representatives were asked what they wanted to outcome of their safeguarding enquiry to be. This is significant decrease on last years reported figure of 94.6%. Some analysis will be required to understand why this figure is declining.

Outcomes were partially or fully achieved in 75% of concluded safeguarding enquiries in 2022-23. This is comparable to last year's figure of 77%.

The number of concluded enquiries were it was assessed that the risk of abuse or neglect for the person was



## How the Board works to deliver results

The Board brings together representatives from:

- Herefordshire Council social care and public health teams
- Herefordshire and Worcestershire Integrated Commissioning Board (responsible for the purchase of health care)
- Wye Valley NHS Trust and Herefordshire and Worcestershire Health and Care NHS Trust (health care providers)
- Healthwatch
- West Mercia Police
- National Probation Service
- West Midlands Ambulance Service NHS Foundation Trust
- Hereford & Worcester Fire and Rescue Service
- Members from provider and voluntary services

This multi-agency approach ensures that all partner organisations work cohesively, using the same information and communicate consistent messages to provide the strategic direction for the work undertaken on their behalf.

It is the task of the Strategic Board to agree the priorities for the year, in consultation with Healthwatch and the community and to inform the executive group of these.

Sub groups develop work plans which contain the activity required to deliver the priorities. Each sub group chair is responsible for reporting successes, developments and any barriers to progress to the executive.

## What the sub groups have delivered this year

### Performance and quality assurance

Terms of reference:

This group is responsible for data quality, audit and effective information systems to meet current and future expected national and local data reporting requirements and enable performance to be managed and reasonable assurance secured on the quality of local safeguarding.

#### **Update from the Chair: Jez Newell, Designated Safeguarding Nurse, Herefordshire and Worcestershire ICB**

Attendance has improved over the last 12 months. Quoracy has been achieved at every meeting that took place. One meeting was cancelled in January 2023 due to the chair being unavailable and no stand in coming forward.

The consistent attendance by the statutory agencies has been a valuable addition to the work PAQA is doing.

PAQA continues to request a consistent representation by a Local Authority data analyst to support the provision of available data for PAQA and for advice on the structural elements of PAQA work. Review of non-statutory partners attendance is an ongoing element of PAQA discussion it still remains an area which requires improvement. However, thanks must go out to all agencies as it is recognised that pressure across the entire system continues to have significant implications for PAQA's attendance, but attendance this year has improved.

Evaluation of Safe Voice has not been possible due to the lack of service user participation within this project. Liaison with Healthwatch has continued but the uptake continues to be very low. For "Safe Voice" as a project, Information sharing has proved to be a considerable challenge for this work stream and there is no progress to report.

Audits completed this year are Making Safeguarding Personal and an assurance request on how services manage service users who are difficult to engage. This audit was labelled "Assertive Outreach". Participation and the quality of the assurance was good for this audit. While service users were engaged with services the "assertive" approach worked well with ongoing follow up and engagement continuing. A follow up audit after discharge from a service would be useful to explore how the same service users were coping.

PAQA also received an Audit completed by West Midlands Ambulance Service on safeguarding notifications and referrals from their service. The notification nature of WMAS referrals was still evident with information giving, rather than a formal referral, to other agencies (safeguarding) being the majority of the referrals audited.

PAQA also conducted a Safeguarding Adult Reviews assurance exercise for the Joint Case Review Group. This required assurance from all involved agencies. Assurance was received from the agencies that submitted returns and individual agencies' learning was noted.

PAQA aspires to use the findings from local (Rapid Reviews), regional and national SARs and other adult safeguarding reporting mechanisms to underpin its future audit work. Safeguarding data has been presented at the PAQA meetings. Currently this is only Social Care safeguarding data and other agencies are unable to provide data to the meetings.

How data is used for the work that PAQA needs to do still requires clarity around the multiagency approach and what benefits can be accrued from data provided. Assurance was also obtained around how direct payment safeguarding risks are monitored. Although the assurance was limited, there were mechanisms in place at assessment and review to obtain a view of the safeguarding risk, if apparent, for individuals who are often low profile with regard to local services.

As previously referred to, consistent multi agency attendance is required for PAQA to be consistent in its aims and objectives that are presented through the work plan. A change of emphasis to learning from SARs and other adult safeguarding learning methods is intended to give the HSAB PAQA sub group clear direction in the work that it is required to do.

The work plan for 2023/24 is being finalised.

Closer links with the HSAB Training & Workforce Development Subgroup are intended to bring some coterminous aims and objectives that are synchronised to produce consistent outcomes for all partners in adult safeguarding and HSAB.

### **Policies and procedures**

Terms of reference:

Work is undertaken jointly with Worcestershire (we have many partners working across both Counties). We have a working protocol that has been signed off by both Boards.

During 2022/23 a multi-agency consultation on the Information Sharing Protocol was initiated and the document updated as a result.

### **Joint training and workforce development**

Terms of reference:

This group is responsible for agreeing and maintaining Herefordshire's competency framework and provides evidenced assurance that partner agencies are meeting the requirements of the framework.

The group has particular responsibility to promote and facilitate multi-agency development opportunities for all practitioners, including disseminating learning from case reviews. By undertaking such activities, the group seeks to empower the workforce to be skilled and confident in adult safeguarding.

### **Activity in 2022/23**

Following the formation of the HSAB Training and Workforce Development Sub-Group in 2020 (this was previously a joint child and adult training development group), the group is now more established, with regular attendance from partner agencies and greater clarity about the group's role and purpose.

The agreed approach to workforce development and training for HSAB is to support a multi-agency Competency Framework, which details the level of training required for each role. Agencies are encouraged to share resources and, where appropriate, offer spaces on their

safeguarding courses to other organisations. In 2022/23, the HSAB Professional Competency Framework was reviewed and re-launched. This offered partner agencies greater clarity about training and professional competence expectations, and their role and responsibility in promoting a skilled and competent workforce.

During this annual report period, group members supported the dissemination and embedding of the Complex Adults Risk Management Framework, the HSAB Self-Neglect and Hoarding Policy and Practitioner Guidance, and learning from the Thematic Review of Pre-Mature Deaths of Adults. To support dissemination of learning in these areas, a number of learning briefings were produced and widely disseminated:

- Professional Curiosity
- Trauma-informed Practice
- Routine Domestic Abuse Enquiries
- Self-Neglect (briefing to support publication of HSAB Self-Neglect and Hoarding Policy and Practitioner Guidance)
- Complex Adults Risk Management (briefing to support publication of the CARM Framework)

A few time-limited training courses were also commissioned by partners and offered as multi-agency training, to address specific needs:

<b>Mental Capacity Act and Self-Neglect.</b> Commissioned by the Council.	11 attended
<b>Mental Capacity and Acquired Brain Injury</b> Commissioned by the Council.	22 attended
<b>Trauma-informed practice</b> Commissioned by the Council	164 attended
<b>Domestic Abuse Courses (West Mercia Women’s Aid)</b> <ul style="list-style-type: none"> <li>• Stalking and Harassment – 29</li> <li>• Domestic Abuse and Older People – 21</li> <li>• Domestic Abuse and Rural Context – 29</li> <li>• Working to Address Housing Issues – 10</li> <li>• Violence Against Women and Girls – 12</li> <li>• Understanding Domestic Abuse and Trauma – 6</li> </ul> Commissioned by the Community Safety Partnership.	107 attended
<b>Curiosity Saves Lives – Multi-agency Domestic Abuse Training</b> Commissioned by the Community Safety Partnership.	96 attended
<b>Fabricated and Induced Illness</b> Commissioned by the NHS ICS	167 attended
<b>Delivering Substance Use Interventions with Adults</b> Delivered by Herefordshire Recovery Service – Turning Point	37 attended
<b>Exploitation and Vulnerability</b> Delivered by West Mercia Police vulnerability trainers	65 attended

*Impact of multi-agency training courses:*

*“I attended the Mental Capacity and Self Neglect training on Friday of last week, it was one of the best training sessions I’ve been on. As a result of the training, I’ve already contacted Social Care regarding us undertaking an assessment on a lady who has an ABI and is losing weight rapidly.” – Feedback from a training delegate who works as a registered nurse supporting adults with acquired brain injury.*

In addition, the annual White Ribbon Domestic Abuse Conference was held in November 2022, which this year was on the theme of Violence Against Women and Girls.

Three Practitioner Forums were organised during this reporting period, with good attendance and engagement from a range of partner agencies. One of these Practitioner Forums, in November 2022, was dedicated to Adult Safeguarding Week and included awareness raising of the Complex Adults Risk Management Framework, Trauma-Informed Practice, and learning from a Thematic Review commissioned by HSAB into pre-mature deaths of adults. Topics included in other Practitioner Forums included adult self-neglect, hoarding and fire safety awareness.

*Feedback from Practitioner Forum Delegate Feedback:*

*“I found the diverse agenda interesting enabling me to understand other sectors of adult safeguarding.”*

*“well thought out; interesting and informative; relevant”*

It has been difficult to provide assurance of staff competencies across the multi-agency workforce, as the professional competency framework was only agreed in January 2023, and the HSAB self-assessment will be completed in 2023. Partner agencies have, however, fed-back to through T&WD on general assurance of staff competencies. This resulted in a gap identified in adult safeguarding training for the voluntary sector that will be addressed through the provision of e-learning in 2023/24.

Finally, the safeguarding partnerships website, which hosts information about HSAB, was re-designed and re-launched in September 2022. The new website has a more engaging look and feel, and is easier for practitioners to navigate to access guidance and resources.

## **Joint Case Review (JCR)**

Terms of reference

The Joint Case Review Sub Group (JCR) is accountable to the Herefordshire Safeguarding Partners, Herefordshire Safeguarding Adults Board and Herefordshire Community Safety Partnership.

Safeguarding Children and Young People in Herefordshire have a legal duty to undertake reviews of serious child safeguarding cases (Local Child Safeguarding Practice Reviews

LCSPR's) where children have died or suffered serious harm, the criteria for such reviews is set out in Working Together 2018

Herefordshire Safeguarding Adults Board. The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. The criteria for such reviews is set out in the Care Act 2014 (See Care Act Guidance 2016)The Chair of HSAB has the responsibility for decision making about whether to conduct a review in individual cases.

Herefordshire Community Safety Partnership. Overall responsibility for establishing a review rests with the local Community Safety Partnership (CSP) Statutory Guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act)1.

### **Joint Case Review Group-Annual Report Submission**

#### **Heather Manning - Chair**

Some agencies work across more than one local authority area and work with different safeguarding adult boards, community safety partnerships and safeguarding children partnerships. Partner Agencies represented at JCR, have responsibilities in respect of Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs) and Child Safeguarding Practice Reviews (CSPRs). It is important that the Partnerships and Boards were cited on the overall themes from all reviews and any cross-cutting learning or issues within the system in Herefordshire. Therefore, the JCR Chair, with agreement of the Herefordshire Safeguarding Adult Board (HSAB), Herefordshire Safeguarding Children Partnership (HSCP) and Herefordshire Community Safety Partnerships (CSP), provides one report per quarter on behalf of the JCR Subgroup.

### **Safeguarding Children**

During reporting period 1st April 2022-to 31<sup>st</sup> March 2023, the Joint Case Review Group (JCR) received two referrals for Rapid Review scoping, however the meetings were both held in Q1 2023-2024

There have not been any child safeguarding practice reviews commissioned during this reporting period.

One statutory review was published during this period however this was a Serious Case Review and not a Child Safeguarding Practice Review as it was commissioned prior to Working Together 2018.

There was a significant delay in completion and publication of this SCR due to parallel processes and the Partnership agreed for only the executive summary to be published.

SCR Louise – published November 2022

Serious injuries which were sustained by Louise in June 2019, who was 18 months old at the time. The injuries caused had a life changing impact on Louise. When the injuries occurred, Louise was being cared for by her mother's partner at the mother's address. Prior to the incident, there were concerns about domestic abuse and child neglect.

#### Identified Learning Opportunities

- Framework of need and pathways – To ensure that there is a joint understanding and agreement in the application of thresholds of all levels of need and that referral pathways are clear and understood. That both Child in Need and Child Protection Plans and processes are robust, outcome focused and clearly understood and owned by all agencies.
- Multi Agency Safeguarding Hub – to develop one access point, that there is robust and consistent management oversight. That the functions are collaborative and there is a clear and understood collective responsibility. To ensure that information is effectively shared to make effective and safe decisions including in domestic abuse cases.
- Neglect – The multi-agency responsibility to identify and respond to all aspects of neglect. To include educational and emotional neglect and the effects of nondependent alcohol use by parents and the impact of these on children.

Key areas of partnership activity that HSCP should seek assurance on –

- Application of thresholds, to be undertaken by multi-agency audit.
- Escalation and professional disagreement policy.
- Neglect.
- Safeguarding of children in mental health services.

Further considerations –

- Training on the cycle of change and motivational interviewing.
- Escalation and professional disagreement.
- Recognition and prevention of abusive head injury in infants.

Positives and further implementation –

- The engagement of agencies in this review has been very positive, there has been a real demonstration of agency reflection to enable learning.
- The GP practice have held two internal learning events as a result of this case and their engagement in the discussion events for this process was excellent. As a result of internal discussion, they have introduced a template of safeguarding prompt questions which are asked when any adult presents with low mood, depression or is prescribed anti-depressant medication. This was recognised as good practice and should be communicated to other GP practices.

#### **Domestic Homicide Reviews (DHR)**

During reporting period 1st April 2022-to 31<sup>st</sup> March 2023, JCR has received one referral for a DHR is currently undergoing a scoping exercise, work has concluded or continued for five open reviews.

Two DHR's completed in the previous year have now been approved by the Home Office. All recommendations have been completed. Two DHR's have been completed and sent to the Home Office following sign off at the Community Safety Partnership (CSP).

Recommendations have been approved and action plans are in place to address these. The remaining review is awaiting the outcome of the court proceedings prior to completion and presentation to the CSP.

### **Safeguarding Adults Reviews (SARs)**

During reporting period 1st April 2022-to 31<sup>st</sup> March 2023, the Joint Case Review Group (JCR) has received 7 referrals for Rapid Review scoping. Whilst none have met the Care Act 2014 criteria for a full Safeguarding Adult Review (SAR) learning and recommendations have been drawn from the scoping returns and rapid review meetings.

Examples of learning identified are -

- consideration for professionals recognising carers' and offering carer's assessments
- professional curiosity continue to be lacking in many practitioner/professional interactions with adults who do, or may have, care and support needs
- recognition of domestic abuse in relation to older people and their families and a lack of community awareness
- ensuring that the right people are invited to multi-agency meetings

SAR Dorothy was a Worcestershire review published in March 2023. 'Dorothy' had previously been a Herefordshire resident so Herefordshire services were part of this review.

Dorothy was 77 years old when she sadly died following a fall that occurred in the care home where she lived in Worcestershire. The fall was as a result of an altercation with another resident.

The admission to a care home and the incident took place during the Covid-19 pandemic and it was recognised that the impact of the pandemic was significant in finding a care home for Dorothy.

Points for strengthening practice, and recommendations were made and included agencies across both Herefordshire and Worcestershire, particularly in relation to commissioning out of area care and support services.

### **Oversight and follow on from last year**

Extensive multi-agency work has been undertaken to ensure all the learning, both single, and multi-agency, from Rapid Reviews and case reviews, has been brought together to ensure recommendations have clear SMART actions assigned, and that all agencies are clear on the learning required within their own agency.

Learning briefings, and presentations have been shared at the Practitioner Forums to raise awareness of the learning recognised at all Rapid Reviews and full case reviews. Evidence for the effectiveness of learning from reviews remains a challenge. Performance data, audit activity and scrutiny from the Independent Scrutineer is now more robust. The Quality and Effectiveness sub-group (HSCP) and the Performance and Quality Assurance sub-group (HSAB) are working towards a resolution regarding the data and audit activity in 2023-2024.

(Please note that all names used in this report are pseudonyms and not the true names of the individual)

## **What HSAB will deliver 22-23**

The outgoing Independent Chair held a development session in February 2023 which was attended by all usual Board members plus additional agencies including registered providers and other commissioned services.

Following presentations of data, learning from audits and reviews and other initiatives currently being proposed it was agreed that the priorities for the next three years would be:

### **Self-neglect,**

- To improve our response to understanding and managing self-neglect needs, making sure all agencies understand and respond to self-neglect

### **Exploitation**

- To address the safeguarding issues and challenges arising from criminal exploitation including cuckooing, sexual exploitation, modern slavery, county lines, human trafficking and financial exploitation.

### **Prevention**

- To support and promote initiatives and activities which prevent or reduce abuse and neglect and keep people safe

### **Neglect and omission**

- To understand the profile of neglect and omission occurrences within the County and develop resources to mitigate.

### **Board Effectiveness**

- To ensure that the Board fulfils its statutory functions and is effective in its role of assurance of the safeguarding system.

A copy of the Strategic Plan can be found on the Safeguarding Boards website:

[Home Page - Herefordshire Safeguarding Boards and Partnerships](#)

## Appendix 1

### % Meeting attendance

<b>Meeting and Frequency</b>	<b>Strategic Partnership Board Meets 4 x yr</b>	<b>HSAB Executive Group Meets 4 x yr</b>	<b>Performance and Quality Assurance Meets 8 x yr*</b>	<b>Training and Workforce Development Meets 6 x yr</b>	<b>Joint Case Review Meets 4 x yr</b>
<b>Agency</b>					
<b>Community Wellbeing</b>	4	3	4	3	4
<b>Healthwatch</b>	3	N/A	1	N/A	N/A
<b>Hereford &amp; Worcester Fire &amp; Rescue Service</b>	1	N/A	1	N/A	4
<b>Herefordshire and Worcestershire Health and Care Trust</b>	4	4	6	4	4
<b>Herefordshire ICB</b>	4	4	6	4	4
<b>HVOSS</b>	0	2	N/A	2	N/A
<b>Lead Member</b>	3	N/A	N/A	N/A	N/A
<b>National Probation Service</b>	0	N/A	N/A	N/A	0**
<b>Public Health</b>	0	N/A	N/A	N/A	3
<b>West Mercia Police</b>	4	4	6	6	4
<b>Wye Valley NHS Trust</b>	4	N/A	6	5	4
<b>Turning Point</b>	N/A	N/A	N/A	2	N/A

\*2 meetings cancelled / postponed due to other matters arising

\*\* Whilst not attending business meetings NPS do attend review meetings when required



## Appendix 2

The Partnership Team, which is a multi-agency funded team, oversees the work of the Board and its sub groups.

The unit is funded as follows:

AGREED BUDGET FOR 2021-22		%
Children's and Families	133,569	35.3
Community Wellbeing	103,000	27.3
Integrated Care Board	80,190	21.2
Police	53,510	14.2
<b>TOTAL GROSS BUDGET</b>	<b>378,099</b>	<b>100.0</b>

Contributions from statutory partner agencies

**Note:** This total contribution is for the support of the Herefordshire Safeguarding Adults Board, Herefordshire Safeguarding Children's Partnership and the Community Safety Partnership



Herefordshire Safeguarding Adults Board  
Council Offices  
Hereford HR4 0LE

Email: [admin.sbu@herefordshire.gov.uk](mailto:admin.sbu@herefordshire.gov.uk)  
Tel: 01432 260100