Herefordshire Council

Title of report: Annual Report of the Herefordshire Adults Safeguarding Board (HSAB) 2023 to 2024

Meeting: Health and Wellbeing board

Meeting date: Monday 16 September 2024

Report by: Chair of the HSAB

Classification
Open

Decision type
This is not an executive decision

Wards affected
(All Wards);

Purpose
For the Health and Wellbeing Board (HWB) to receive the Annual Report of the Herefordshire Adults Safeguarding Board (HSAB). **It is a requirement of the Care Act 2014 that the HSAB annual report is sent to:**

- the chief executive and leader of the local authority which established the SAB
- any local policing body that is required to sit on the SAB
- the local Healthwatch organisation
- the chair of the local health and wellbeing board.

Recommendation
That:

a) **The Health and Wellbeing Board considers the HSAB Annual Report 2023/24 and discusses the effectiveness of the arrangements for safeguarding adults in Herefordshire.**

Alternative options
The Chair of HWBB could choose not to bring the report to the HWBB and circulate it for information.

Key considerations

1. Under the Care Act 2014 each local authority must set up a Safeguarding Adults Board (SAB). The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria for safeguarding.
2. A Safeguarding Adults Board has three core duties:

- It must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement, and the SAB must consult the local Healthwatch organisation. The plan should be evidence-based and make use of all available evidence and intelligence from partners to form and develop its plan.
- It must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adults reviews and subsequent action
- It must conduct any safeguarding adults review in accordance with Section 44 of the Act.

3. The HSAB Annual plan 23/24 covers the period 1 April 2023 to 31 March 2024. It outlines the progress of the partnership in delivering the priorities of the Strategic Plan 2023-2026.
4. The current priorities for the HSAB are:
   - Self-neglect - improving our response to understanding and managing self-neglect needs, making sure all agencies understand and respond to self-neglect.
   - Exploitation - addressing the safeguarding issues and challenges arising from criminal exploitation including 'cuckooing', sexual exploitation, modern slavery, county lines, human trafficking and financial exploitation.
   - Prevention - supporting initiatives and activities which prevent or reduce abuse and neglect and keep people safe.
   - Neglect and omission - understanding the profile of neglect and omission occurrences within the County and identifying approaches and resources to mitigate the impact.
   - Board effectiveness - ensuring the Board fulfils its statutory duties and is effective in its role of assurance of the safeguarding system
5. The Board has also decided to focus on:
   - Transitions for those moving from a child to an adult service, service to service or service to discharge in a safe and positive way.
   - Following the Thematic Review into adults with multiple and complex needs the Board has also been monitoring provision for those 'rough sleeping' in Herefordshire
6. In 23/24 five referrals for Safeguarding Adults Reviews (SAR) were received:
   - One did not meet criteria for review as the individual did not have Care and Support needs
   - During the triage meeting for one referral the Joint Case Review Group (JCR) identified extensive domestic abuse in the life of the individual, it was therefore decided that a joint Domestic Homicide Review (DHR) / SAR approach was most appropriate.
   - Three referrals for SAR's were scoped but did not meet criteria, however learning was identified. Examples of learning identified are –
     - recommendations parallel to those of the thematic premature deaths review
     - strengthening the Complex Adult Risk Management process
     - improving multi-agency practitioners' understanding of the Mental Capacity Act and duty to carry out assessments
     - lack of professional curiosity
     - poor recording

   All reviews have an action plan including multi-agency recommendations which are regularly updated.
7. The majority of the key performance data set out in the Annual report is from the national survey 2022/23. This shows that in the county 77.2% of service users 'felt safe' and

91.3% felt that the services provided made them feel safe. Both are a small increase on the previous year. The Board will continue to consider factors that are leading to 23% who do not feel safe. The Board does take assurance though from the number who said that services provided made them feel safe.

8. The Annual report includes an analysis of safeguarding concerns raised with partners. The number of concerns dropped by 34% but this is attributed to the changes that were introduced into the service whereby all referrals are triaged prior to being sent to the safeguarding team. This is ensuring that only safeguarding referrals progress which enables the safeguarding team to deal more effectively with those cases.
9. There is analysis of those subject to abuse. The majority were females (58%) and the most common location was 'own home' (47%). This demonstrates how important it is that communities remain vigilant when it comes to vulnerable adults and acting if they suspect any form of abuse.
10. Progress made by the Board and the sub groups is contained within the Annual Report. In general, the sub groups are delivering against the programme set out in the Business Plan but still face challenges related to the staffing capacity of partners.
11. In summary, whilst the partnership acknowledges there is more to do, it is working well and has re set the Business Plan and the work of the sub groups to make more progress in 2024/25.

Community impact

12. The report includes information on the effectiveness of the Talk Community programme in reaching out to communities and individuals.

Environmental Impact

13. There are no general implications for the environment arising from this report.

Equality duty

14. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to –

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

15. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. Our Health providers will be made aware of their contractual requirements in regards to equality legislation.

Resource implications

16. There are no resource implications associated with this report. The resource implications of any recommendations made by the HWB will need to be considered by the responsible body or the executive in response to those recommendations or subsequent decisions.

Legal implications

17. By receiving the report the HWBB assists the HSAB to meet its statutory requirements.

Risk management

18. There are no risk implications identified emerging from the recommendation in this report.

Consultees

None

Appendices

Appendix 1 – HSAB Annual Report 2023/24

Background papers

None identified.