WOKINGHAM BOROUGH COUNCIL

Safeguarding Adults Annual Report

2022/23

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Introduction

Safeguarding is a statutory responsibility of all Local Authorities and as such, is a strategic priority for Wokingham Borough Council and a core activity for Adult Social Care.

This annual report outlines the key performance indicators used to monitor activity for safeguarding adults in Wokingham. Analysis of performance is undertaken across the year and is used to influence strategic development.

Networks

Care Act 2014 requires all Local Authorities to form a Safeguarding Adults Board (SAB) to provide the strategic overview and direction for safeguarding, provide governance and quality assurance. This includes the commissioning of Safeguarding Adults Reviews (SAR) when a person has died or been significantly harmed and the SAB knows, or suspects, that the death resulted from abuse or neglect.

Wokingham Borough Council is a member of the West of Berkshire Safeguarding Adults Board; a tri borough Board in partnership with Reading Borough Council and West Berkshire Council alongside other key stakeholders including but not limited to; Thames Valley Police, Berkshire Fire & Rescue Service, South Central Ambulance Service, Berkshire Healthcare Foundation Trust, Royal Berkshire Hospital Foundation Trust, and the Berkshire West Clinical Commissioning Group.

The SAB has a Duty to public a strategic plan that sets out how it will meet its main objectives, and to publish an annual report detailing what the Board and its members have done during the year to implement its strategic plan.

Local Context

Within Wokingham Borough Council, Adult Safeguarding work takes places across all operational teams.

A single point of access for all safeguarding referrals is provided via the Adult Safeguarding Hub (ASH). This is a small team consisting of six practitioner staff, a manager, and an administrator. From February 2023 they have benefitted from the addition of a Referral Coordinator post, which is a fixed term post for 12 months to support with the increased referral rate.

The ASH triages all safeguarding referrals. Wherein they meet the criteria for Sec 42 intervention, the ASH staff undertake initial enquiries and interventions. A decision is then made as to whether ongoing work is required under the Sec 42 framework, in which case it is progressed to either a Level 1 Enquiry (delegated to another agency but overseen from the ASH), Level 2 Enquiry (allocated to another operational team) or Level 3 (most complex multiagency safeguarding work retained in the ASH). Practitioners in the ASH also work to agreed objectives aligned to local priorities and in line with the prevention agenda, where workload capacity permits.

Respective Heads of Service are responsible for the operational activity within their own services. Head of Adult Safeguarding & Care Governance has the strategic lead on safeguarding related matters and provides advice and guidance as a subject matter expert across other services.

Local activity in the context of the SAB priorities

The SAB Business Plan for 2022/23 set the priorities for the partnership as:

- Priority 1: To expand on learning in regard to self-neglect; to offer the partnership with resources to support them to achieve effective outcomes for individuals that self-neglect.

- Priority 2: To seek assurance that quality of health and social care services delivered in the West of Berkshire or those commissioned out of area for West Berkshire residents is monitored effectively and there is a proportionate response to concerns.

- Priority 3: The Board to review its Safeguarding Adult Review (SAR) process, in order to ensure that it is timely and good value for money.

- Priority 4: The Board will continue to carry out business as usual tasks in order to comply with its statutory obligations.

Operational Activity

	Concerns	S42 enquiries	Conversion rate of concern to S42 enquiry
2017-18	1232	478	39%
2018-19	1057	412	39%
2019-20	1279	471	37%
2020-21	1758	517	29%
2021-22	2253	668	29.6%
2022-23	2092	551	26%

The number of Adult Safeguarding concerns raised in Wokingham Borough during 2022/23 totalled 2092. At first glance, this looks like a reduction in the number of concerns being raised. However, there were two internal changes made during the year in relation to how the ASH managed referrals. These were directly in response to the exponential growth in referrals being received, and a need to manage these by ensuring 'out of scope' referrals were processed in a different way, enabling specialist resource to be focused on those referrals that were actually indicative of a concern of abuse or neglect.

1. From April 2022, referrals from SCAS and TVP that were clearly 'out of scope' (no indication of abuse or neglect) were recorded by way of a safeguarding consultation. This ensured a robust audit trail on decision-making, but lightened the administrative

burden of taking these into, and then straight out of, a Safeguarding framework. **There were 257 Safeguarding Consultations.**

2. From December 2022, the entry point to ASC for referrals from SCAS and TVP was changed, mindful that the very vast majority (85% plus) were not Safeguarding concerns, albeit labelled as such. This meant all of these referrals now go to the ASC Statutory Duty team in the first instance, being passed on to the ASH for a Safeguarding Concern to be raised where there are indicators of abuse or neglect. Based on average numbers over the preceding year, this would have accounted for a reduction in around **270 concerns.**

Has these internal changes not been made to streamline the way we were working the number of Safeguarding Concerns would have reached 2620 for the year, which would have equated to around 16% increase on the previous year. Flexibility to adapt to emerging trends has been vital in order to maintain operational delivery.

Internal Audit

During year 2021/22, the Adult Safeguarding service was audited internally as part of the approved Annual Internal Audit Plan. Based upon their review of the controls in place within Adult Safeguarding they concluded that controls were: *Substantially Complete and Generally Effective* with this being the 2nd highest out of 4 audit options. This was reported in the Annual Report for last year.

The audit confirmed 7 areas to work on in 2022/23, which were encompassed into the strategic plan for this year. In September 2022, as part of good practice and Audit Committee requirements, Internal Audit followed up on these areas of work to establish progress made. Evidence was provided in all areas, and the progress was signed off as complete.

Self-neglect

Self-neglect and hoarding are areas that continue to emerge nationally in relation to Safeguarding Adults Reviews (SARs). This area of practice is complex.

Adult Social Care has continued its relationship with *Hoarding Disorders UK* with the delivery of accredited training at Levels 1, 2 and 3. This has covered:

- Understanding Hoarding
- Engagement, Assessment & Safeguarding
- Therapeutic Interventions and Motivational Interviewing

Consistently positive feedback has been provided by delegates on these courses.

"The presentation of the material and general coverage of the disorder was delivered well and in an inclusive way".

"I found the interview really interesting, and it gave me a real insight in to how the hoarder feels when we try to support".

"I feel more knowledgeable about terminology – how to refer to peoples accumulated items rather than deeming it clutter".

"I now understand how neurodiversity can impact on hoarding disorders and feel equipped around ways to approach these situations differently".

For a number of years, WBC has had in place a *Self-Neglect & Hoarding Safeguarding Pathway Toolkit*, to help professionals analyse risk and determine which pathway for response is most appropriate. This year this has been acknowledged by the SAB and rolled out across the West of Berkshire to support multiagency responses to this complex area of work. WBC also created fictious cases, which were used to launch the tool across the area and to support application of it in practice.

WBC took a leading role in making arrangements for National Safeguarding Adults Week in December 2022; a day was dedicated to learning about self-neglect and hoarding. The day started with a theoretical session from Suzy Braye followed by Jo Cooke from Hoarding Disorders UK sharing tools for working effectively with people who hoard, and then Royal Berkshire Fire & Rescue Service (RBFRS) running a session around self-neglect and fire risk. These sessions were attended by a total of 178 people.

National Safeguarding Adults Week

In November 2022 Wokingham Borough Council took the lead in arranging a series of events across the week in supporting the Ann Craft Trust Safeguarding Adults Week. A series of webinars was run across the week, open to all agencies and volunteers within the West of Berkshire. 14 events were run with around 400 people attending. Much of the material is available on the SAB website to ensure the learning can continue to be disseminated.

Allegations Management Framework

This process, known as PiPoT (Person in Position of Trust) deals with allegations against people working in positions of trust with children and vulnerable adults. For ease of understanding, it is the equivalent of the LADO (Local Authority Designated Officer) process in Children's Services.

The Wokingham Safeguarding service led on reviewing and revising this multiagency framework in 2022 and sought agreement from the Pan Berkshire Policy & Procedure subgroup to adopt it across the county. This was accepted, and resulted in a streamlined process, which is better understood, better aligned to the LADO framework, and ensures all core members are more accountable to the SAB.

The focus for 2023/24 will be on internal infrastructure for managing the framework.

Fire

During Autumn 2022 a piece of work focusing on risk assessment/management in relation to fire concerning adults with care and support needs was undertaken. The primary focus of this was around risk of emollients, wherein it was felt that the awareness raising that had taken

place a couple of years previously had probably becoming diluted amongst professionals and would benefit from a further targeted approach.

WBC worked with the RBFRS and other stakeholders across the West of Berkshire to support the development of literature raising awareness in this area, and also ensured this was disseminated locally.

Discussions around this led to reflection that fire risk around other pieces of equipment commonly used in Health & Social Care settings would also benefit from some awareness raising (e.g., oxygen, pressure mattresses, batteries for hoists etc.) and information about this was produced and circulated.

It was identified that the RBFRS *Adults at Risk Training*, was not being attended routinely by Adult Social Care staff and this became mandatory. The Safeguarding Service used National Adult Safeguarding week in November 2022 as an opportunity to engage with RBFRS to run some additional sessions on this and increase take up almost immediately, including via a bespoke session run specifically for commissioned providers in the Borough.

Adult Social Care and RBFRS have discussed the potential for a multiagency panel to monitor the highest risk situations involving vulnerable people – the feasibility of this continues to be considered.

Care Quality

A focus for this year has been on continuing to develop excellent relationships with commissioned services, in recognition of the vital nature of effective partnerships in driving up quality in services, delivering effective outcomes for customers and in preventing abuse and neglect from occurring.

At the end of the year 2022/23, 77 of the 136 providers in the Borough had had one or more of their services quality assured by the Care Quality team in the previous 18-month period. This incorporated 104 different audits when taking account of revisits (to measure improvement as part of quality monitoring) or where more than one service under the same provider was visited. At the end of Q4 2022/23, 73% of nursing homes in the Borough were rated good or outstanding by CQC and in respect of those rated Requires Improvement or Inadequate by CQC, issues had already been proactively identified by WBC and a collaborative relationship was in place to drive quality improvements. For the same period 90% of residential homes and 91% of domiciliary care agencies were rated good or outstanding by CQC.

A number of providers have been supported to achieve sustainable improvements with positive feedback received from those services. As an example:

"*I just wanted to thank you for working with me so well and supporting me and my clients over the last few years and especially during your visit for our annual quality audit. Your suggestions have helped us greatly in streamlining our service. I truly appreciate your professionalism and dedication to our clients. THANK YOU!".*

"Many thanks for sharing the updates really appreciate your process, which to me is very transparent".

Also, this year, the Care Quality Team has moved to delivering a regular programme of quality events for commissioned services. These run quarterly, alternating between a hybrid workshop type event, and an online targeted event with an external speaker. This is aimed at taking themes from Care Quality Audits and/or Safeguarding enquiries and disseminating learning and/or best practice across all providers in the Borough. These have received excellent attendance and feedback.

The first event in August 2022 was a hybrid event (virtual and in-person delegates), which 96 people attended. This covered a variety of topics including the Statutory Safeguarding framework, Restore2, a presentation from CQC on medication, the Data Security Protection Toolkit, and changes and penalties in relation to the DHSC Capacity Tracker.

In November 2022, the second event was an online one with 70 people hearing from an external speaker from the Royal Berkshire Fire & Rescue Service on fire safety.

The third event in February 2023 was another hybrid event, with 87 attendees This included a discussion around the findings of a Safeguarding Adults Review in another area of the country, a session on contractures, reviewing a webinar on "*Surveillance – a Rights Based Approach'* from the Restraint Reduction Network, a session on Covert Medication and a presentation from the BHFT Psychology Service for Older People.

Feedback from commissioned providers has demonstrated the value they place on these sessions:

"*I wanted to say that I am very pleased you and your team are organising these sessions, which are extremely valuable for me and my team".*

Feedback from another stakeholder in the Integrated Care Board (ICB) area said, "*What a lovely, inclusive, and well organised event! A massive well done. I work with 8 councils, all with different styles and approaches. It was so lovely that you were all so warm, supportive, and collaborative with the providers – I am sure that is really appreciated by them".*

Safeguarding Adults Reviews

Two Safeguarding Adults Reviews (SARs) were published for the Borough in 2021/22.

'Adam'

This SAR was published in May 2022. This SAR was the catalyst for the creation of a new *Joint Safeguarding and Criminal Investigations* Protocol. This protocol has been developed so that once a complex joint investigation has been instigated, there is clear, identified, senior oversight within organisations, to objectively support the operational teams regarding resourcing, information sharing and management of investigations.

'Louise'

This SAR produced learning around the Human Rights Act, Self-neglect, and the Mental Capacity Act 2005 and was used in conjunction with the learning from 'Steven' earlier in the year to inform work around revising Direct Payments processes, practice, guidance and training.

Domestic Abuse

The WBC Domestic Abuse Strategy 2021 to 2024 for the council can be found here.

Domestic Abuse has remained an area of priority for Adult Safeguarding during 2022/23. There has been good collaboration across Directorates to embed delivery against the Domestic Abuse Act 2021 and statutory guidance.

ASC have maintained an active presence on the Domestic Abuse Partnership Board, which was established in line with the new Duties under the Act in 2021. There are now established and solid interfaces between Adult Social Care, the Adult Safeguarding Hub, WBC Domestic Abuse Coordinator, and the Community Safety Partnership.

Grant funding has enable one member of staff in Adult Social Care to be trained as a qualified Independent Domestic Violence Advocate (IDVA), enhancing the support offer to victims/survivors of Domestic Abuse. This same member of staff will be further trained as an Independent Sexual Violence Advisor (ISVA) during the next financial year. Part of the output from this training will be their ability to be a subject matter expert and support responses across Adult Social Care.

The same grant funding has been used to fund a bespoke service via Hourglass to increase support for older victims/survivors of Domestic Abuse, one of the groups who had been previously identified as under-represented in this area. Hourglass promote safer ageing and a fairer society, with a focus on elder abuse. They have:

- Raised awareness in the Borough.
- Attended community events such as WBC's White Ribbon campaign.
- Supported the development of key pathways into local Domestic Abuse services.
- Supported individuals through monthly peer-support groups.
- Attended the Domestic Abuse Partnership Board and Domestic Abuse Networking Group.
- Delivered six pop up clinics to raise awareness at supermarkets, libraries, and the Charity & Community Hub.
- Delivered presentations to a variety of organisations.
- Provided safer ageing workshops at various events.
- Received a total of 28 clients referred for support.
- Positive outcomes reported:
    - more informed
    - more confident in how to proceed
    - feels listened to and supported.
    - improved independence and confidence
    - improved resilience and wellbeing
    - decreasing feelings of loneliness and isolation

Consideration of referral to Hourglass is now an integral feature of all Adult Safeguarding interventions where the victim/survivor is an older person.

Development of staff confidence and competence around working with this complex area of practice remained a priority, as ever, this year and a variety of new targeted training was delivered to support this:

- Honour Based Abuse and Forced Marriage
- Improving Responses to Older Victims/Survivors of Domestic Abuse
- Gaining a Better Understanding and Awareness of Domestic Abuse within Black and Minoritized Communities
- Understanding the Additional Challenges and Barriers Faced by Male Victims/Survivors of Domestic Abuse
- Substance Misuse and Domestic Abuse
- Sensory Awareness for Domestic Abuse Practitioners
- Domestic Abuse and Housing
- Domestic Abuse and Money Matters
- Elder Abuse – Financial Abuse and Office of the Public Guardian
- Domestic Abuse and Travellers
- Domestic Abuse Crime Prevention
- Impact of Imprisonment on Families Affected by Domestic Abuse
- Digital Stalking and effects on victims/survivors of Domestic Abuse
- Vicarious Trauma and Overload
- Critical Awareness of 'victim blaming', why it's harmful and what you can do about it.
- How Domestic Homicide Reviews can be used as mechanism for change.

Building on the work started the previous year, a provider of DASH-RIC training was sourced and commissioned to design and deliver a bespoke course of this nature across Adults and Children's Services. This has been rolled out. Feedback from the initial sessions has been very positive and joint training in this way is enabling front line staff to achieve broader learning and also develop their networks.

The Adult Safeguarding Hub has continued to attend MARAC (Multiagency Risk Assessment Conference for high-risk cases) and MATAC (Multi-Agency Tasking and Coordination process of identifying and tackling serial perpetrators of domestic abuse perpetrators) meetings, ensuring effective ASC representation.

The Safeguarding service has continued to develop effective relationships with Police colleagues, including in particular the Domestic Abuse Investigation Unit (DAIU) to support collaborative working.

<u>Deprivation of Liberty Safeguards (DoLS)</u>

In October 2022, the DoLS team was moved from sitting within the Prevention and Short-term service to sit under the umbrella of the Safeguarding Service. This brought it in line with the model most commonly used across other Local Authorities in England and enhances the focus of that team on oversight and scrutiny of the safeguards.

Towards the end of the financial year, we received confirmation that the much-anticipated introduction of the Liberty Protection Safeguards was being delayed "*beyond the life of this Parliament"* by Government and thus the focus of this team has shifted from preparation for the legislative change, to ensuring robustness against the current legislation and enhancement of the current offer.

Quality Assurance Framework (QAF) for Adult Safeguarding.

One of the major achievements for the year has been the development and implementation of the QAF for Adult Safeguarding. This quality assurance framework enables us to evidence whether the right things are being done, for the right reasons and in the right way, and enables us to use this information to secure greater impact and effectiveness. The framework is used by Adult Social Care to:

- evidence and gain assurance that Safeguarding arrangements in Wokingham are effective.
- identify priorities and make decision on how to improve Safeguarding practices.
- hold partners and stakeholders to account for their Safeguarding work through providing feedback on their own involvement as part of a multiagency approach.
- support stakeholders to be innovative and improve Safeguarding arrangements.
- help the Authority be more accountable to residents.

The framework facilitates:

- monitoring of qualitative and quantitative performance covering prevalence, nature of abuse, activity, effectiveness of responses, Making Safeguarding Personal.
- annual self-assessment of Safeguarding arrangements to provide assurance of areas that are effective and how to act on areas requiring improvement.
- early identification of risks to enable early intervention and mitigation.
- gaining a holistic view of Safeguarding arrangements so we can recognise and learn from good practice and identify areas that need improvement.
- being open and transparent about risk and things that require improvement.
- identifying priorities to feed into the strategic plan and the SAB.
- supporting and evidencing continuous improvement over time.

The framework has strengthened or introduced a range of measures targeted at quality assurance. These are split into two categories; those that are embedded in 'business as usual' and undertaken as a matter of course within the Adult Safeguarding pathway itself or 'usual' practices within teams, versus those that take place outside those processes, to give objective oversight.

Within business as usual	**Objective oversight and quality assurance**
Operational 'live' oversight/support of Enquiry Officer by SAM (Safeguarding Adults Manager) on every open enquiry.	Routine audits of completed Safeguarding work by senior manager. 5% - concerns 10% - initial enquiries and enquiries
Management sign off on all decisions on Safeguarding cases at every stage;	Targeted thematic audits. Rolling programme of quarterly audits targeting

Concern, Initial Enquiry and Enquiry. This means no decisions are made in isolation.	different areas of practice relating to Safeguarding. e.g., Q4 Mental Capacity.
Underwriting of sign off on all enquiries completed in teams outside of the Adult Safeguarding Hub, to ensure specialist oversight and consistency.	Performance data.
Safeguarding cases are an agenda item on supervision.	SAR learning events.
Safeguarding is an agenda item in team meetings.	SAR reflective sessions.
	Safeguarding Champions forum.
	Safeguarding surgery for practitioners.
	Annual review of training.
	Lived Experience group.
	Secret Shopper.
	Complaints/compliments.

The focus for 2023/24 will be to embed all areas of this framework and have it operating seamlessly by the end of the year.

Transitional safeguarding

Transitional safeguarding is about recognising that the needs of young people do not change or stop when they reach 18, although many of the laws and services supporting them might. It is about safety in a more general sense, not just statutory safeguarding interventions. Many young people who received a service through children's services (for example the Early Help and Prevention service), will not meet the criteria for Adult Services intervention.

This can mean that an adolescent engaged in 'county lines' may find they receive a criminal justice response rather than being recognised as a victim of criminal exploitation. A young adult experiencing sexual exploitation may not be eligible for a safeguarding response unless they have identified care and support needs in line with the Care Act. A young person subject to a child protection plan may find support stops abruptly as they turn 18, despite their experiences of maltreatment leaving them just as a vulnerable as a child leaving care who would be entitled to ongoing support.

Nationally, transitional safeguarding is still an emerging area of interest, which is now starting to gain some traction. As a concept, it seeks to better align services for children and adults and encourage a culture of partnership to respond better to the changing needs of adolescents and young adults. These can for example, including improved responses to young people at risk of sexual exploitation at the point of transition,

During this year we have started the dialogue around this area of challenge, engaging colleagues from the Community Safety Partnership, Adult Social Care, Children's Services, Health, and Police/Probation in helpful conversations. There has been a shift towards more recognition of the 'cliff edge' for this group and of the need to explicitly include young adults and vulnerable adults in the thinking around contextual safeguarding matters in general.

A lot of work has been undertaken over the year by Children's Services around reviewing and revising their *Exploitation and Missing Process* (EMRAC). This has been seen as the entry point for starting to make some changes around transitional safeguarding and there is a broad

acceptance that this multiagency process/panel could be used proportionately going forwards to also oversee a small cohort of 'vulnerable adults' who meet the criteria. As the year closes, key staff from ASC are starting to attend the monthly panel in order to gain an overview of any young people approaching adulthood and to consider whether (and if so, when, and how) these young people should transition into adult services.

This will be a focus for 2023/24.

Annual Performance data and analysis 2022-23

Safeguarding activity - Concerns and enquiries

The information in this report comes from the Safeguarding Adults Collection (SAC) for the period 1 April 2022 to 31 March 2023. The figures below relate to adults at risk for whom safeguarding concerns were raised and where enquiries were started during the year. A safeguarding *concern* is where a local authority's Adult Social Care service is notified by someone (i.e. a professional, family member or carer) who is worried about the adult at risk being neglected or abused.

An *enquiry* is where a *concern* is progressed to a formal investigation stage. In 2022-23, 551 enquiries were started during the year. The 'conversion rate' is the ratio of enquiries to concerns. The conversion rate for Wokingham during 2022-23 was 26.3% which means for every 100 concerns that were raised, there were 26 s42 enquiries that were started. Table 1 shows Safeguarding activity for Wokingham in the past 4 years.

Table 1 – Safeguarding activity, 2020-23

	Concerns	S42 enquiries	Individuals who had a S42 enquiry	Conversion rate of concern to S42 enquiry
2019-20	1279	471	400	37%
2020-21	1758	517	439	29%
2021-22	2259	668	585	30%
2022-23	2092	551	470	26%

Table 2 – Safeguarding activity benchmarking data, 2021-22

2021-22	Concerns	s42 enquiries	Other safeguarding enquiries	Conversion rate of concern to all safeguarding enquiries
Wokingham	2260	670	*	30%
West Berkshire	1660	705	*	42%
Reading	2970	400	*	13%
Slough	1440	195	20	15%
Bracknell	900	110	10	13%
Windsor and Maidenhead	1885	385	*	20%
England	541535	161925	22590	34%
South East	97730	34715	1785	37%

At first glance, this looks like a reduction in the number of concerns being raised upon the previous year. However, there were two internal changes made during the year in relation to how the ASH managed referrals. These were directly in response to the exponential growth in referrals being received, and a need to manage these by ensuring 'out of scope' referrals were processed in a different way, enabling specialist resource to be focused on those referrals that were actually indicative of a concern of abuse or neglect.

1. From April 2022, referrals from SCAS and TVP that were clearly 'out of scope' (no indication of abuse or neglect) were recorded by way of a safeguarding consultation. This ensured a robust audit trail on decision-making, but lightened the administrative

burden of taking these into, and then straight out of, a Safeguarding framework. **There were 257 Safeguarding Consultations.**

2. From December 2022, the entry point to ASC for referrals from SCAS and TVP was changed, mindful that the very vast majority (850% plus) were not Safeguarding concerns, albeit labelled as such. This meant all of these referrals now go to the ASC Statutory Duty team in the first instance, being passed on to the ASH for a Safeguarding Concern to be raised where there are indicators of abuse or neglect. Based on average numbers over the preceding year, this would have accounted for a reduction in around **270 concerns.**

Has these internal changes not been made to streamline the way we were working the number of Safeguarding Concerns would have reached 2620 for the year, which would have equated to around 16% increase on the previous year. Flexibility to adapt to emerging trends has been vital in order to maintain operational delivery.

There are always variances in conversion rates across Local Authorities and it is very difficult to compare these in any meaningful way, due to different ways of working regionally and nationally. In Wokingham, we have focused in closely on the legislation and the statutory guidance, to ensure that in terms of converting *concern* to *enquiry* we are strictly applying this three stage test at sec 42(1) of the Care Act 2014 to identify whether our statutory *Duty* to apply the framework in triggered, whether we wish to use our *Powers* to use the framework, or whether we are diverting out into an alternative, more appropriate framework. This enables us to be proportionate and also transparent, ensuring that we are not in fact, doing enquiries (and perhaps exchanging information without consent or without a clear legal gateway) 'disguised' as triaging a concern.

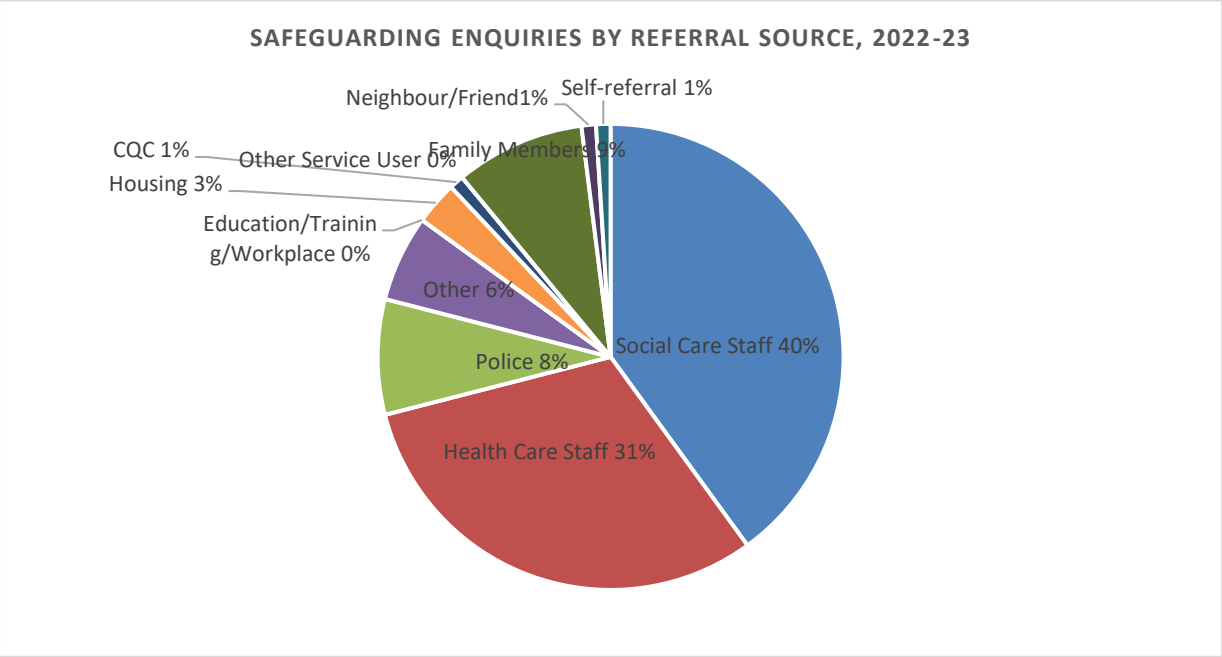
More robust application of decision-making in this context will explain the slight reduction in conversion rate upon the previous year. However, it should be noted that dealing with SCAS and TVP referrals in a different way effectively means the data becomes incomparable to that in previous years.

Source of safeguarding enquiries

As with previous years, most enquiries in 2022-23 came from social care and health care staff. Social care staff category includes LA and independent sector staff from domiciliary, day care and residential care staff.

In 2022-23, 40% of enquiries came from social care staff which is a decrease from 41% last year and 31% came from health staff which is an increase from 23% last year. However, this might not be a true representation of the categories as the number of enquiries from category 'Other' has decreased from 13% last year to 5% this year. The percentage of self-referrals and referrals from family members, friends, or neighbours in 2022-23 was 11% which is an increase from 10% in 2021-22. The earlier comment on the impact of dealing with SCAS and TVP referrals in a different way also applies here; as a significant number of those no longer entered the Safeguarding pathway at all, from late in Q3 onwards, this will render a comparison around source of referrals on the previous year(s) unhelpful.

Figure 1 – Safeguarding enquiries by referral source, 2022-23



The table below shows comparison of source of referrals for safeguarding enquiries over the past 4 years.

Table 3 – Safeguarding enquiries by referral source, 2020-23

	Referrals	2019-20	2020-21	2021-22	2022-23
Social Care Staff	Social Care Staff total (CASSR & Independent)	211	204	276	218
	Of which: Domiciliary Staff	36	44	53	37
	Residential/ Nursing Care Staff	105	82	125	97
	Day Care Staff	15	2	4	13
	Social Worker/ Care Manager	30	49	73	44
	Self-Directed Care Staff	8	1	1	4
	Other	17	26	20	23
Health Staff	Health Staff - Total	93	136	155	172
	Of which: Primary/Community Health Staff/South Central Ambulance service	59	113	145	157
	Secondary Health Staff	25	12	5	7
	Mental Health Staff	9	11	5	8
Other sources of referral	Self-Referral	11	5	5	4
	Family member	68	40	51	49
	Friend/ Neighbour	11	9	7	8
	Other service user	1	0	0	0
	Care Quality Commission	12	5	12	6
	Housing	11	9	9	18
	Education/ Training/ Workplace Establishment	1	0	0	2
	Police	26	30	66	46
	Other	26	79	87	28
	Total	**471**	**517**	**668**	**551**

Individuals with safeguarding enquiries

Age group and gender

The table below shows age groups for individuals who had a safeguarding enquiry in the previous four years. Majority of enquiries (63%) were for individuals aged 65 and over.

Table 4 – Age group of individuals with safeguarding enquiries, 2020-23

Age band	2019-20	% of total	2020-21	% of total	2021-22	% of total	2022-23	% of total
18-64	146	36%	163	37%	179	31%	169	36%
65-74	43	11%	36	8%	76	13%	56	12%
75-84	92	23%	88	20%	155	26%	124	26%
85-94	95	24%	120	27%	148	25%	93	20%
95+	22	5%	26	6%	24	4%	25	5%
Age unknown	2	0%	6	1%	3	1%	3	1%
Grand total	344		439		585		470	

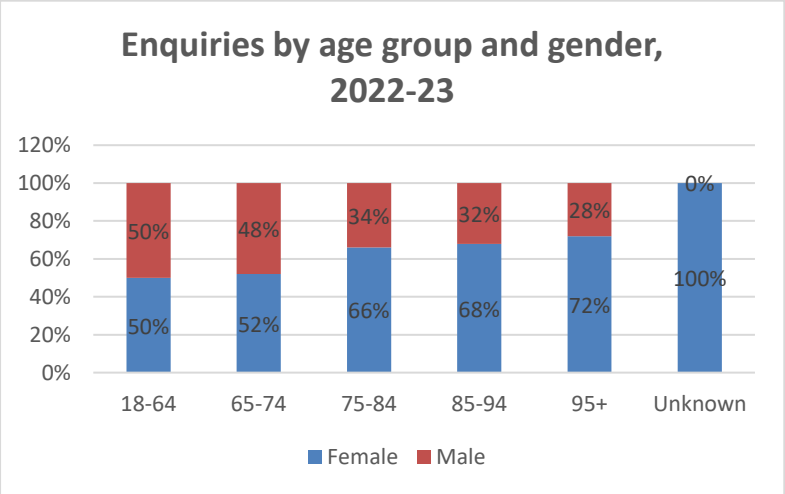
As with previous years, more women were the subject of a Section 42 safeguarding enquiry than males. 59% of safeguarding enquiries started in 2022-23 were for females which is an increase from 57% last year. There was no increase in the number of enquiries for females in the 85-94 age band which was 68% in 2021-22 and 68% in 2022-23.

Table 5 – Age group and gender of individuals with safeguarding enquiry, 2022-23

Age group	Female	Male
18-64	83	84
65-74	29	27
75-84	82	42
85-94	63	29
95+	18	7
Unknown	3	0

The chart below indicates that likelihood of abuse increases with age for women.

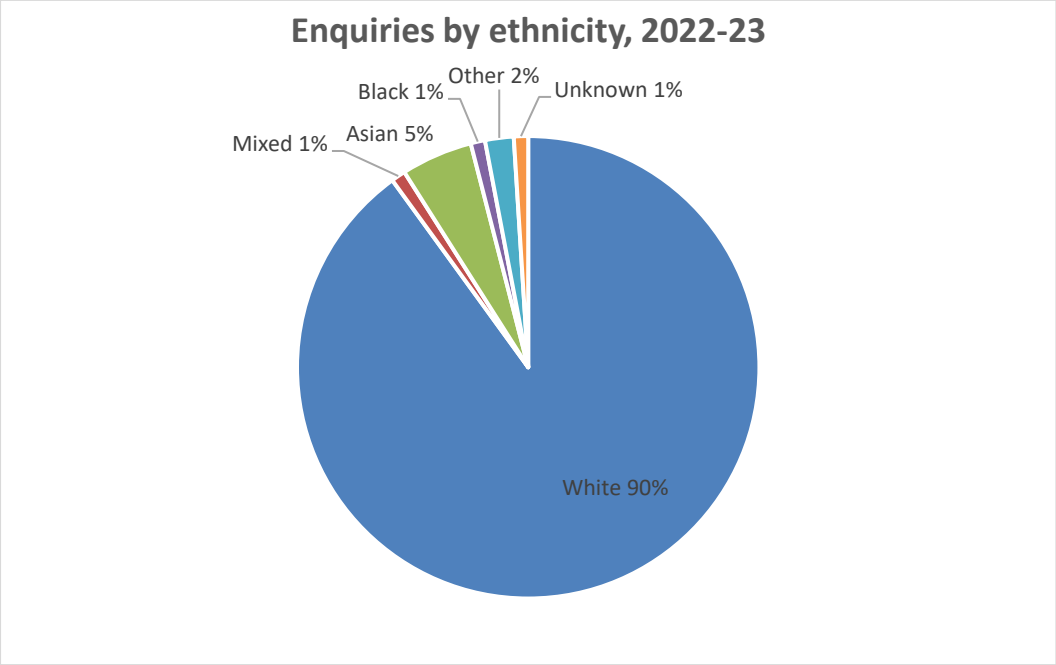
Figure 2 – Safeguarding enquiries by age group and gender, 2022-23



Ethnicity

Ninety percent of all individuals who had a safeguarding enquiry were of white ethnicity. However, 1% did not have any ethnicity recorded which might not give a true representation of the categories.

Figure 3 – Ethnicity, 2022-23



Primary support reason

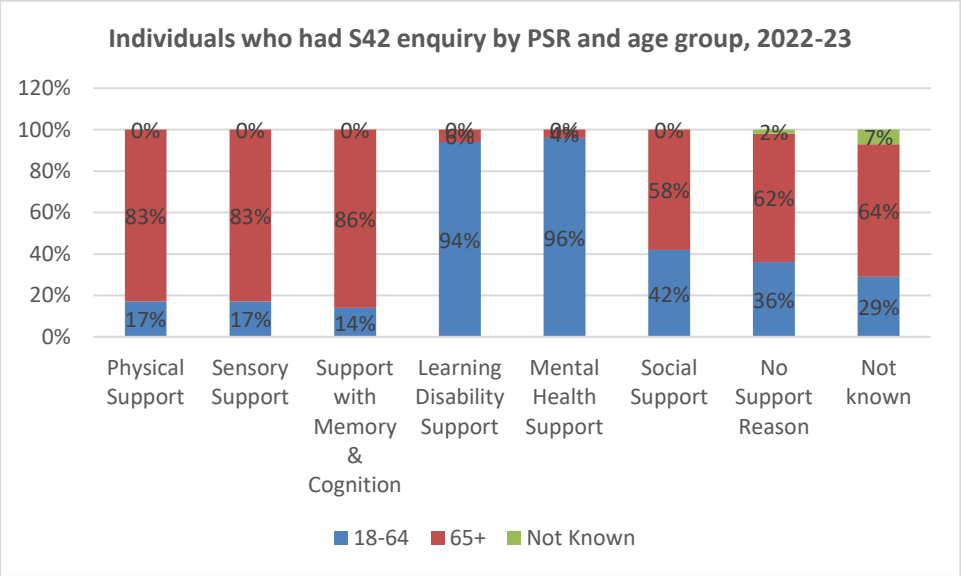
Table 6 below shows breakdown of individuals who had a safeguarding enquiry by primary support reason. As with previous years, majority of cases the primary support reason was physical support (42%) followed by learning disability support (13%) and support for memory and cognition (11%). 20% of cases did not have a support reason as they were not receiving any social services support at the time of the safeguarding incident.

Table 6 – Primary support reason, 2020-23

Primary support reason	2019-20	% of total	2020-21	% of total	2021-22	% of total	2022-23	% of total
Physical support	166	42%	196	45%	270	46%	198	42%
Sensory support	10	3%	12	3%	19	3%	12	3%
Support with memory and cognition	38	10%	49	11%	69	12%	51	11%
Learning disability support	69	17%	59	13%	79	14%	62	13%
Mental health support	27	7%	34	8%	26	4%	27	6%
Social support	8	2%	9	2%	6	1%	12	3%
No support reason	81	20%	79	18%	105	18%	94	20%
Not known	1	0%	1	0%	11	2%	14	2%
	400		439		585		470	

The chart below (figure 4) shows enquiries broken down by age group and primary support reason. Individuals who had physical support were more likely to be aged 65 and over whereas those who had a primary support reason of learning disability were mostly in the 18-64 age group. Wokingham has a high number of people with a learning disability living in the Borough, compared to nationally, including as a result of Norwood's Ravenswood Village being situation in the Borough.

Figure 4 - Individuals who had safeguarding enquiry by PSR and age group, 2022-23



Case details for concluded enquiries

Type of alleged abuse

The table below shows enquiries by type of alleged abuse in the last four years.

As with previous years, majority of the allegations were for neglect accounting for 43% of all recorded risks followed by physical abuse at 26% and emotional abuse at 19%. While the shifts in abuse categories from year to year remain mostly insignificant there are a couple of notable exceptions. Neglect has increased from 35% last year to 40% in 2022-23 and this is

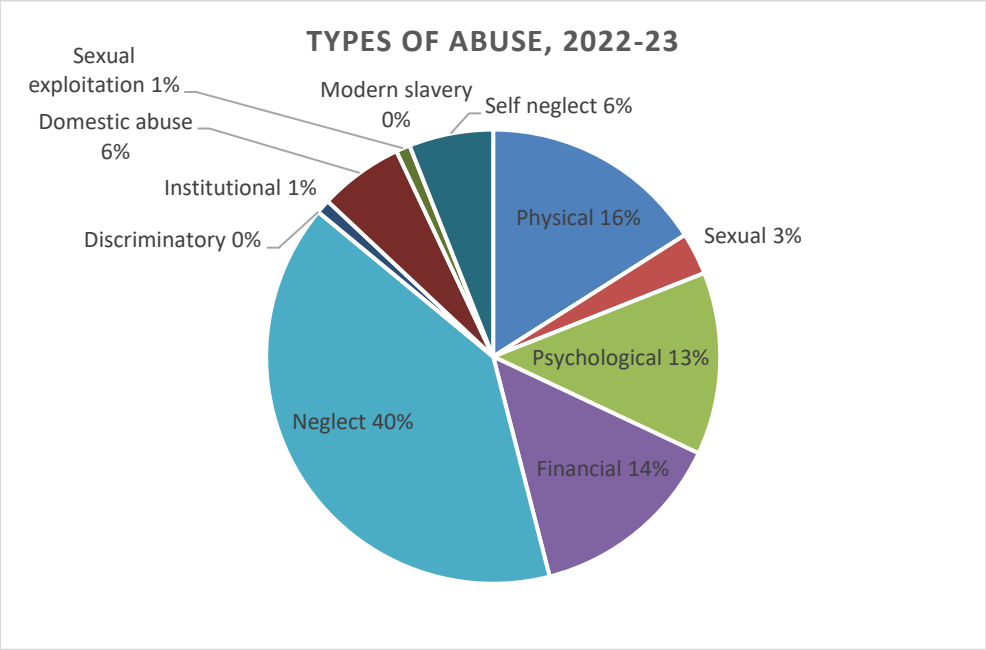
now lower than the national figure of 43% in 2021-22. Physical abuse decreased from 18% last year to 16% in 2022-23. Emotional abuse remains the same as last year was 14% and this year is 14%.

This will be a result of targeted training at ASH staff and greater accuracy in recording categories of abuse. Staff are now clear that concerns around pressure ulcers, will be recorded as alleged neglect rather than physical abuse, and (unwitnessed) falls within jury will be recorded as alleged neglect, rather than physical abuse as any harm will be caused by (passive) omission that an active physical action. There is also greater accuracy around recording concerns related to medication; wherein missed doses (with harm) are recorded as neglect, and the category of physical abuse is reserved for allegations of active abuse such as use of medication for chemical restraint.

Table 7 – Type of abuse, 2020-23

Concluded enquiries	2019-20		2020-21		2021-22		2022-23		% England 2021-22
Physical	116	20%	130	17%	157	18%	115	16%	26%
Sexual	22	4%	28	4%	30	3%	18	3%	5%
Emotional/Psychological	98	17%	110	14%	124	14%	96	13%	19%
Financial	93	16%	103	13%	117	14%	103	14%	18%
Neglect	156	27%	288	37%	303	35%	292	40%	43%
Discriminatory	3	1%	5	1%	1	0%	1	0%	2%
Institutional	12	2%	23	3%	8	1%	9	1%	8%
Domestic abuse	43	7%	46	6%	72	8%	41	6%	9%
Sexual exploitation	4	1%	9	1%	5	1%	8	1%	1%
Modern slavery	1	0%	2	0%	4	0%	1	0%	0%
Self-neglect	36	6%	32	4%	38	4%	45	6%	9%

Figure 5 – Type of abuse, 2022-23



Location of alleged abuse

The home of the adult at risk accounted for 49% of the risk locations. This is lower than the national figure for 2021-22 when 51% of alleged abuse took place in the individuals home. Residential and nursing care homes accounted for 35% between them, which is broadly in line with the national data when combined for the two settings. There is no acute hospital or mental health hospital(s) in the Borough, which explains the zero figures against those (the small numerical figures are likely related to concerns that were opened on the system, before the worker recognised the referral needed to be sent to Reading Borough Council as host Authority for the Royal Berkshire Hospital and closed it down as they rediverted it).

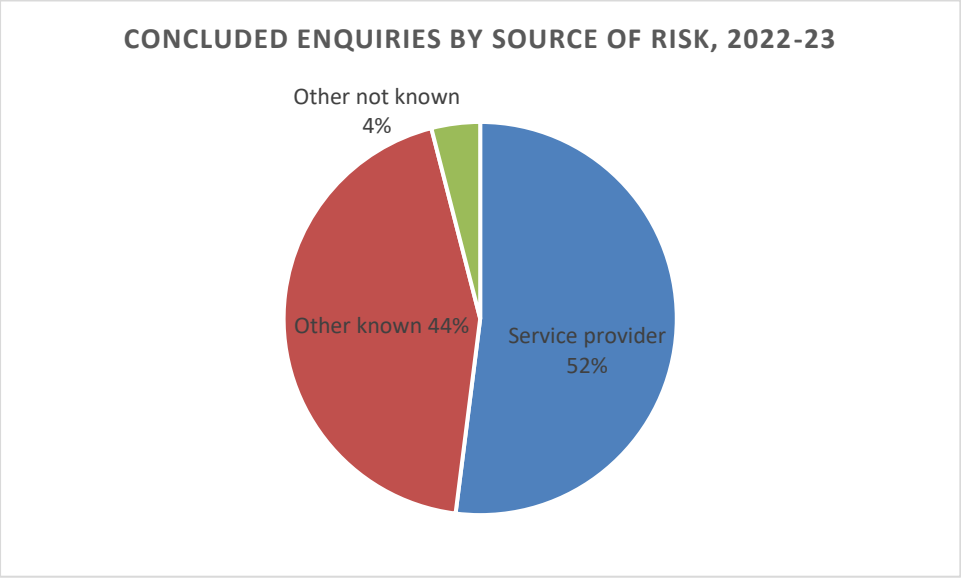
Table 8 – Location of alleged abuse, 2022-23

Location of abuse	2022-23	%	England 2021-22
Own Home	259	49%	51%
In the community (excluding community services)	24	5%	4%
In a community service	35	7%	3%
Care Home - Nursing	77	14%	10%
Care Home – Residential	112	21%	24%
Hospital - Acute	2	0%	4%
Hospital – Mental Health	1	0%	3%
Hospital - Community	7	1%	1%
Other	16	3%	6%

Source of risk

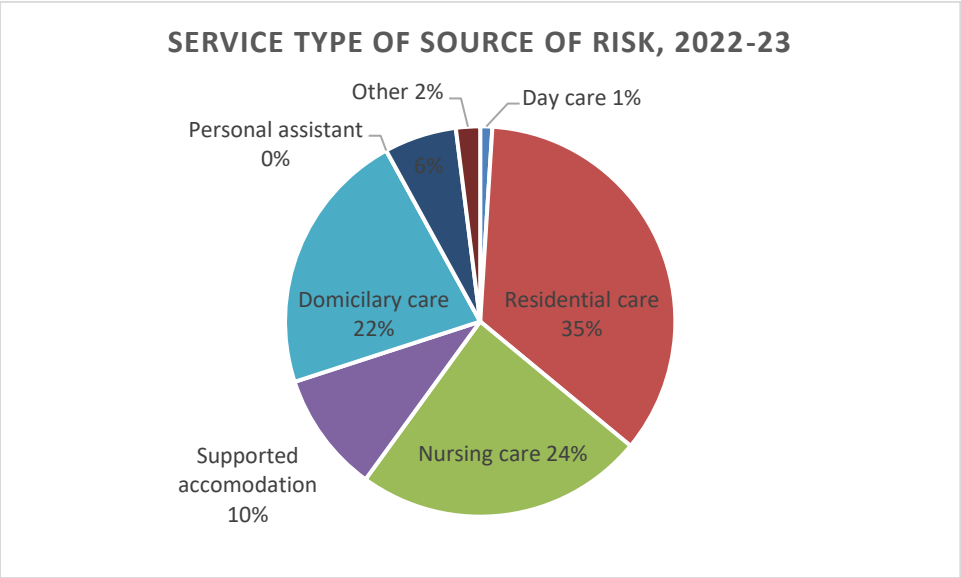
In 52% of cases, the source of risk was a service provider. Service provider refers to any individual or organisation paid, contracted, or commissioned to provide social care services regardless of funding source and includes services organised by the council and residential or nursing homes that offer social care services. This category includes self-arranged, self-funded and direct payment or personal budget funded services. Health or social care staff who are responsible for assessment and care management do not fall under this category.

Figure 6 – Concluded enquiries by source of risk, 2022-23



The chart below shows a breakdown of service provider category. Where the source of risk was a service provider, 59% of residential and nursing care staff reported as the alleged abuser. Domiciliary care staff accounted for 22% of this category.

Figure 7 – Breakdown of source of risk service provider by service type, 2022-23



Action taken and result.

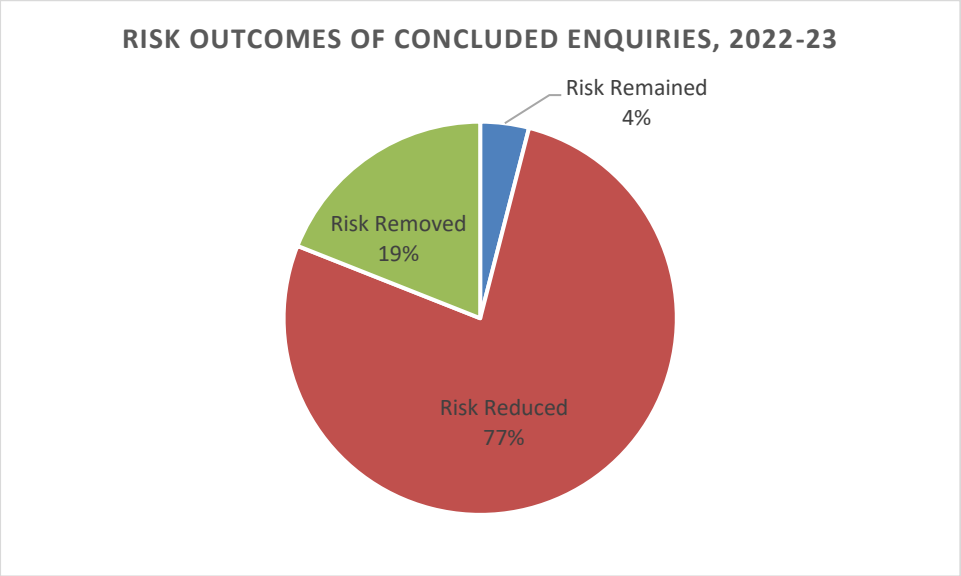
The table below shows risk assessment outcomes for concluded enquiries. In 79% of cases, a risk was identified, and action taken.

Table 9 – Concluded enquiries by risk assessment outcomes, 2022-23

Risk assessment outcome	Total
Risk identified and action taken	406
Risk identified and no action taken	8
Risk - Assessment inconclusive and action taken	6
Risk - Assessment inconclusive and no action taken	5
No risk identified and action taken	36
No risk identified and no action taken	17
Enquiry ceased at individual's request and no action taken	33

The chart below shows concluded enquiries by result in cases where a risk was identified. In majority of cases, the risk was reduced or removed. In 4% of cases, the circumstances causing the risk was unchanged and the risk remained.

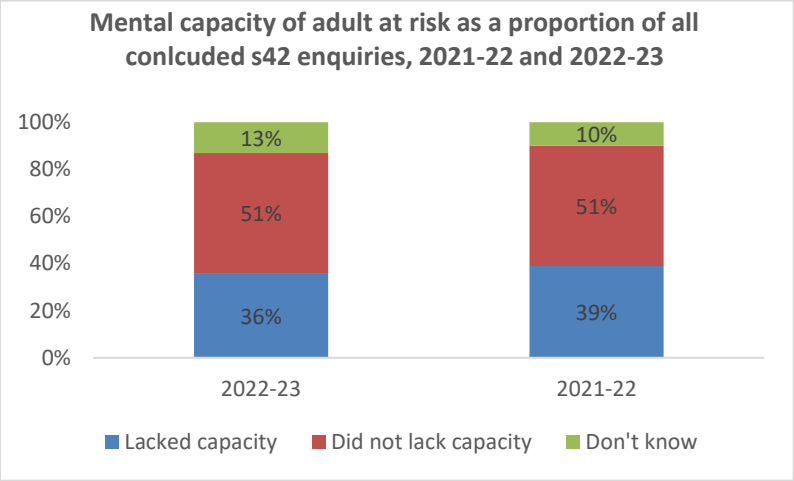
Figure 8 – Risk outcomes of concluded enquiries, 2022-23



Mental Capacity and Advocacy

The chart below shows mental capacity of individuals involved in concluded enquiries. 36% of individuals who had an enquiry concluded in the year lacked capacity.

Figure 9 – Mental capacity, 2021-23

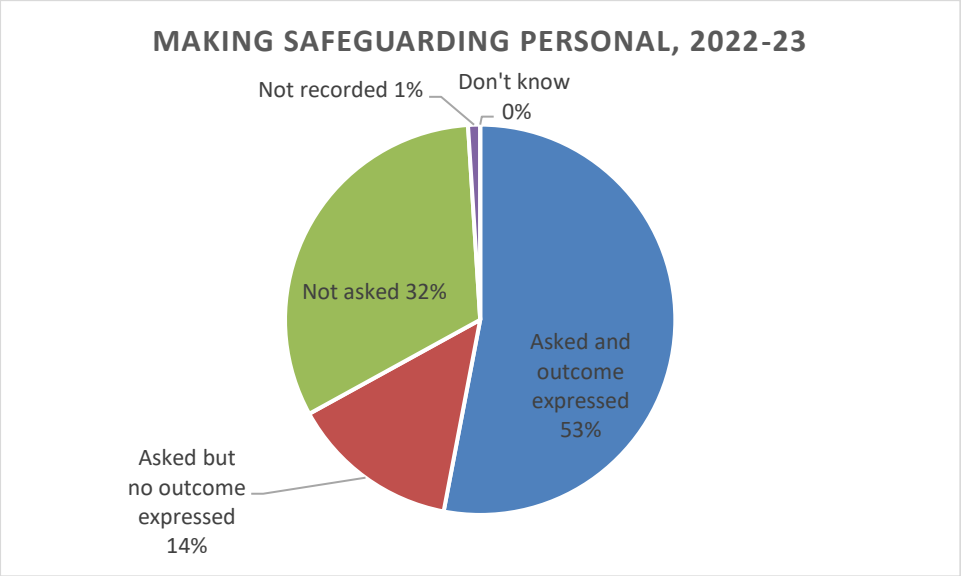


Where the adult at risk lacked capacity, in 93% of cases they were supported by an advocate, family or friend which is above the national figure for England in 2020-21 which was 79%.

Making Safeguarding Personal

Making safeguarding personal is a person-centred approach and is about having conversation ns with people about how to respond in safeguarding situations to enhance involvement, choice and control as well as improving quality of life, well-being, and safety. Of the enquiries concluded in 2022-23, 67% of people or their representatives were asked what their desired outcomes were and in 53% of these cases, outcomes were expressed.

Figure 10 – Making safeguarding personal, 2022-23



Where outcomes were expressed, in 65% of those cases the desired outcomes were fully achieved, in 29%, the desired outcomes were partially achieved and in 3% of the cases none of the expressed outcomes were achieved.