Annual Report

Safeguarding;

the picture in Sandwell

2023-2024

Sandwell Safeguarding Adults Board

ANNUAL REPORT
2023 - 2024

Contents

Appendices

1. FOREWORD FROM THE INDEPENDENT CHAIR

The most important role in the community is ensuring adults are safe from abuse, exploitation and harm. This Annual Report looks at the work of the Sandwell Safeguarding Adults Board (SSAB) from April 2023 to March 2024, a year of mixed challenges including hybrid working and a move back to some face to face Board meetings which all have really appreciated.

Within this report, details of the work of the sub groups and task and finish groups who do much of the work on the Board's behalf will be evidenced, in addition, some of the Board's achievements over the last year will also be highlighted.

I continue to welcome the closer working relationships that have been developed with all partners enabled by using Microsoft Teams, and the reintroduction of some face to face Board meetings. The Partnership continues to work together to ensure people in Sandwell are safe and challenge each other to support the development of quality assurance information, sub groups with strong chairs and clear direction and a robust relationship with the other statutory boards in the borough.

Members continued to be committed to ensuring that learning from Safeguarding Adult Reviews was a priority. A learning event with authors and workers was undertaken in March 24, and this event is referenced in more detail in this report. The Safeguarding Adults Board sponsors a task and finish group looking at how to better take forward learning from all statutory reviews, including Safeguarding Adult Reviews. The membership of this group reflects all key partners across the system and the third sector. This group can influence learning materials and supports all key partners in focussing on how to better embed learning. Across the region and nationally, Sandwell Safeguarding Adults Board actively participated in a regional development session and subsequent report looking at what good looks like when responding to self-neglect. This will be addressed in next year's report.

The board members are still committed to hearing the views of people who use services to ensure that any developments are based on real experiences and there is evidence of this work in this report. The year ahead will further develop this involvement as well as hearing the voices of staff who work across these vital services. One of the roles for the Board is to identify measures that could help prevent abuse and harm and this work with the third sector will be key in driving this forward.

The Board benefits from involvement with regional and national colleagues and the SSAB Board Manager's role as Co-Chair of the Board Managers Network and regional task and finish groups.

As this reporting year ends, my tenure as SSAB Independent Chair is also ending. I have worked in Sandwell for six years and am pleased to be able to welcome Richard Parry, who I am confident will continue to drive the positive, creative and impactful work of the Board. I would like to thank all partners for their commitment to the Board, the Chairs and members of the sub groups. Final thanks to the Board Manager and the Business unit, whose work enables the Board to function, and to everyone for the valuable work you do together, in supporting people and helping them to keep and feel safe in Sandwell.

Sue Redmond, Independent Chair

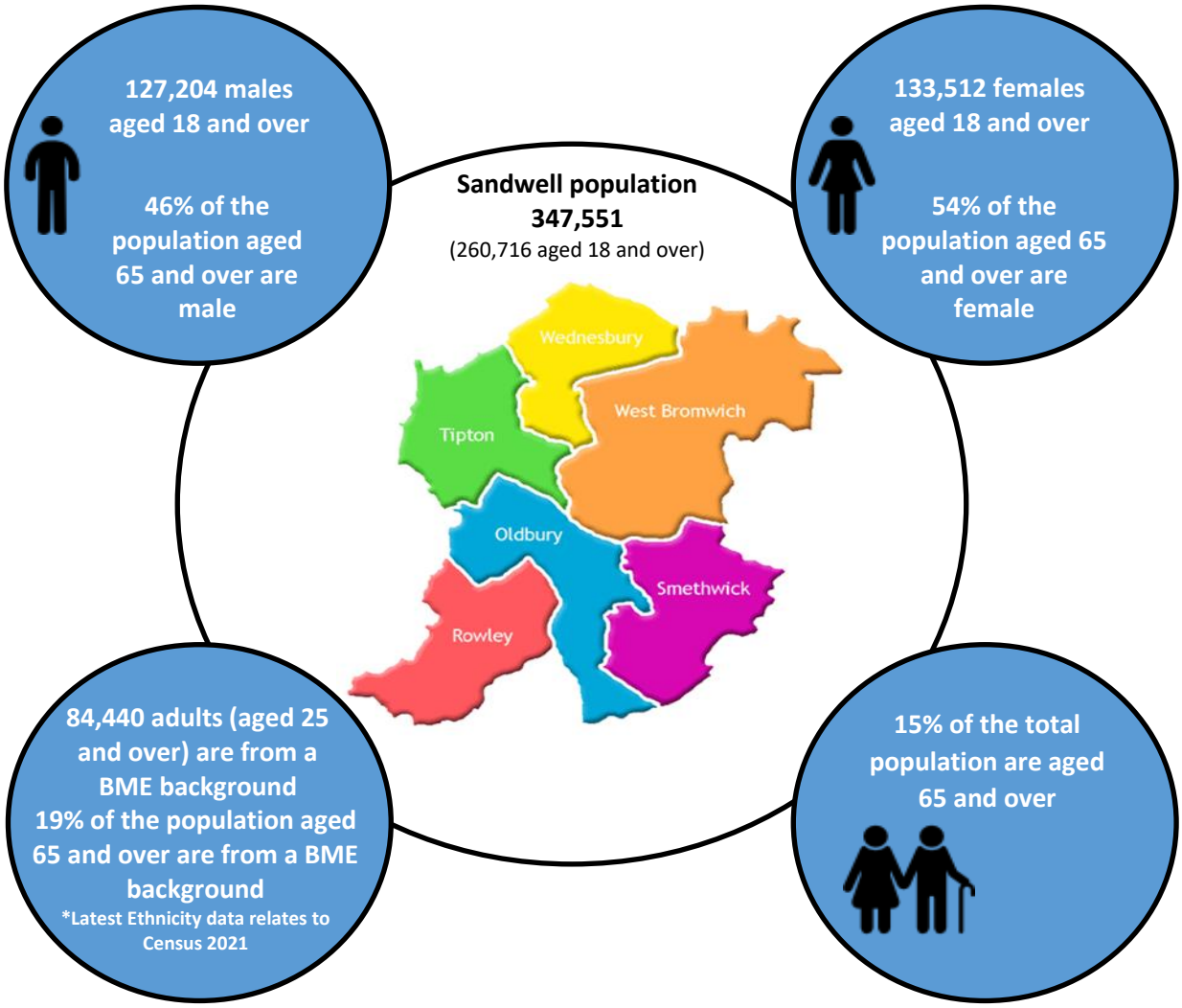
2. SANDWELL AT A GLANCE

Sandwell covers 33 square miles

Sandwell is made up of six towns (see below)

Sandwell has 24 Electoral wards

In Sandwell 15% of the population are aged 65 or over and 5% of this population use Adult Social Care Services



Population Breakdown in Sandwell

75% of the population are aged 18 and over

20% of the adult population (aged 18 and over) are age 65 and over

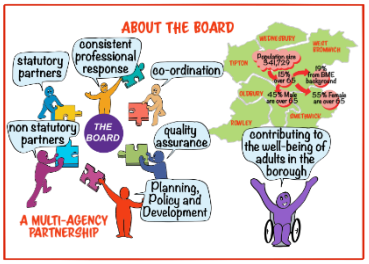
Data Source: Office for National Statistics – Mid-Year Population Estimates June 2023 / Census 2021, Dataset ID: RM032 - Ethnic group by sex by age

Sandwell Residents by Ethnic Group

White British 52% White Other 5%
Mixed/Multiple 4%
Asian 26% Black 9%
Other Ethnic Groups 4%

Data Source: Office for National Statistics – Census 2021 - Population by ethnic group, 2021, local authorities in England and Wales.

3. ABOUT THE BOARD



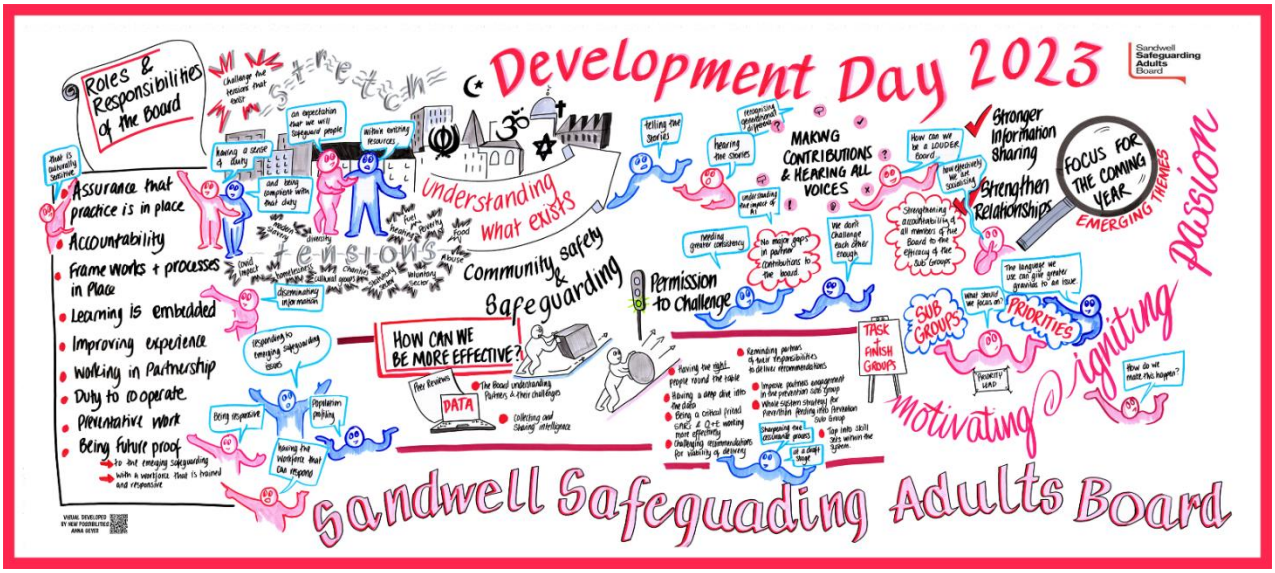
The Board is a multi-agency partnership made up of statutory sector member organisations and other non-statutory partner agencies providing strategic leadership for adult safeguarding work and ensuring there is a consistent, professional response to actual or suspected abuse. The remit of the Board is not operational but one of co-ordination, quality assurance, planning, policy and development. During this reporting period, the Board has met both virtually on TEAMs and face to face approximately every 8 weeks and we had a face to face development day that was independently facilitated and discussed below. Considering different ways of working, including hybrid meetings, continues to ensure a robust working together response to safeguarding.

The Board contributes to the partnership's wider goals of improving the well-being of adults in the borough and promotes and develops campaigns, an example of which is the current campaign 'See Something, Do Something'.

Sandwell Safeguarding Adults Board (SSAB) continue to use the short film it made 'See Something, Do Something' as a standard tool in training and the film has been adopted and used widely by partners. This can also now be seen on the SSAB website; **www.sandwellsab.org.uk**

SSAB BOARD DEVELOPMENT

Summary and Update - In November 2023, SSAB held a Board Development afternoon including Board Members, partners and sub group members. Please see an illustration of the event below:



An outcome of this day was a continued commitment to the board priorities and activity identified above; Sub-groups, strengthen relationships, stronger information sharing, assurance that practice is in place, accountability, community safety and safeguarding, with our biggest priority being assurance. The commitments identified above will inform the development of the updated Sandwell Safeguarding Adults Board (SSAB) strategic plan to be undertaken in the Spring of 2025 and reported on in next year's annual report. Sandwell Safeguarding Adults Board Independent Chair formally submitted her notice at the development day, giving all Board members an opportunity to raise with her any questions, with the Chair also giving a commitment to remain in post until a new Independent Chair was appointed. At the SSAB Board meeting on 3rd October 2024, Board members agreed to extend the priorities outlined below until the next Board Development Day on 3rd April 2025 to support a transition for the new Chair and a meaningful Board Development Day.

Partners gave a further commitment to;
An ambition to influence practice through learning from Safeguarding Adult Reviews (SARs)

Agreement of Board Priorities 2022-24. Extended until April 2025:

1. Listen to the voices of service users and front-line staff
2. Develop more inclusive performance data
3. Work with all partners to look at Sandwell's "Front Door" including pathway, referrals and thresholds
4. Specific projects to be discussed with the Five + Statutory Boards which all focus on prevention
5. Board Governance

STRATEGIC PLAN

Our Strategic Plan 2022—2024: What we will do

We will continue to work on our website to ensure it is accessible and contains the information people want.	Understand what is happening in care homes provision in Sandwell as a priority those homes that have no CQC rating. Hear about peoples experience who live there and hear from employees who work there. Project plan to be developed.	Safeguarding Adult Review action plans will be developed in partnership using a task and finish approach and agencies will be held to account for their actions.	Seek assurance around the Health and Social Care—Integrated Care systems and how we are working together effectively to minimise duplication and maximise opportunity.
Continue to involve and engage with citizens and partners maximising opportunities using existing systems and link to specific workstreams.	Undertake a baseline audit with partners using the care act compliance audit tool in September 2022. Update SSAB on progress and establish a challenge event in the spring of 2023.	The embedding learning multi-agency task and finish group (this is an across the system group) will undertake audit activity to ensure learning and changes are being made.	SSAB will work with other statutory boards to agree key priorities and who will lead on them.
Undertake work using a multi-agency Task & Finish approach exploring the effectiveness of the current Safeguarding Pathway in Sandwell outlining areas for improvement and recommending alternative models.		Progress and difference made will be reported to SSAB as a standing item.	Set clear project plans for all activity and ensure outcomes of domestic abuse and adults with needs for care and support task & finish group and the learning disability and autism advisory group are appropriately reported.

Our role is to help and safeguard adults with care and support needs by:

- Seeking assurance that local safeguarding arrangements are in place as defined in the Care Act.
- Assuring that safeguarding practice is person-centred and outcome focused.
- Working collaboratively to prevent abuse and neglect where possible.
- Ensuring that agencies and individuals work in a timely and proportionate manner where abuse or neglect has occurred.
- Seeking assurance that safeguarding practice is continually improving.
- Concerning ourselves with a range of issues which may impact on people with care and support needs.

Our Structure:

- Board with an Independent Chair
- Safeguarding Adult Reviews Standing Panel
- Quality & Excellence Sub-Group/Prevention Sub Group
- Themed Task & Finish Groups

Our Responsibilities:

- Publish Strategic Plan: our 1-year ambition.
- Publish Bi-Annual/Annual Report which includes what we have achieved.
- Complete Safeguarding Adults Reviews when adults die or are seriously injured as a result of abuse/neglect.

Strategic Priority 1
Listening to the voices of people who use services and front-line practitioners

Ambition: That we promote co-produced solutions and work in partnership with adults with care and support need and their families and support, enable and promote what good looks like in Safeguarding.

Strategic Priority 2
Develop more inclusive Performance Data

Ambition: To develop an assurance framework, audit programme and narrative that provides robust assurance to the partnership that adults with care and support needs in Sandwell are safe. Use key information and activity to identify future priorities.

Strategic Priority 3
Embedding learning from Safeguarding Adult Reviews

Ambition: recommendations from Safeguarding Adult Reviews commissioned are meaningful and achievable and are a lever for positive change.

Strategic Priority 4
Board Governance

Ambition: SSAB membership continues to be made up of senior members who can make decisions on behalf of their organisations and the partnership. Board governance continues to be managed by key and statutory partners and the SSAB Independent Chair and a revised governance document has been written (Board Members Handbook) to reflect this.

4. WHAT IS OUR PERFORMANCE INFORMATION TELLING US?

2023 – 2024

Contacts completed

9280

Concerns concluded

773

27%

Conversion rate

Enquiries Concluded

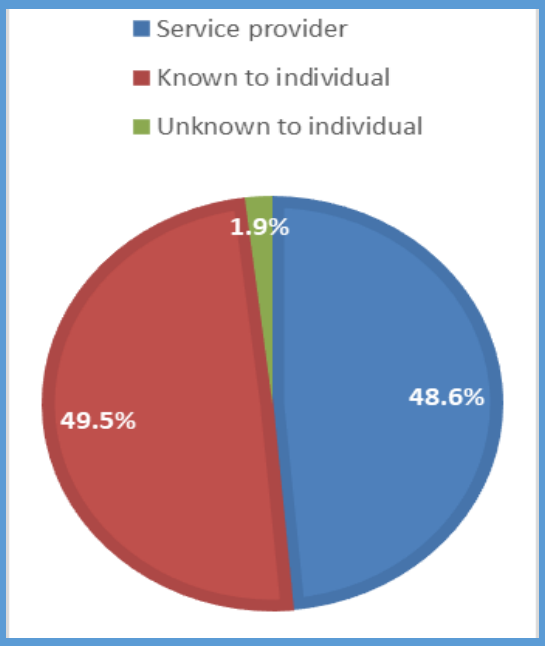
210

Concluded enquiries

56% older people

59% female

58% own home

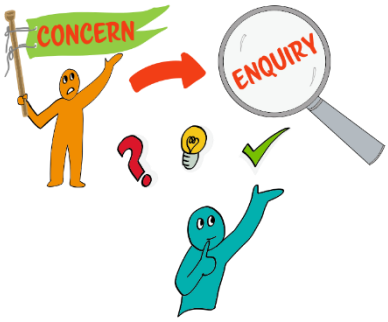


96 % of people were asked what they wanted to happen as an outcome

93% Outcome fully or partially achieved

95% Risk reduced or removed

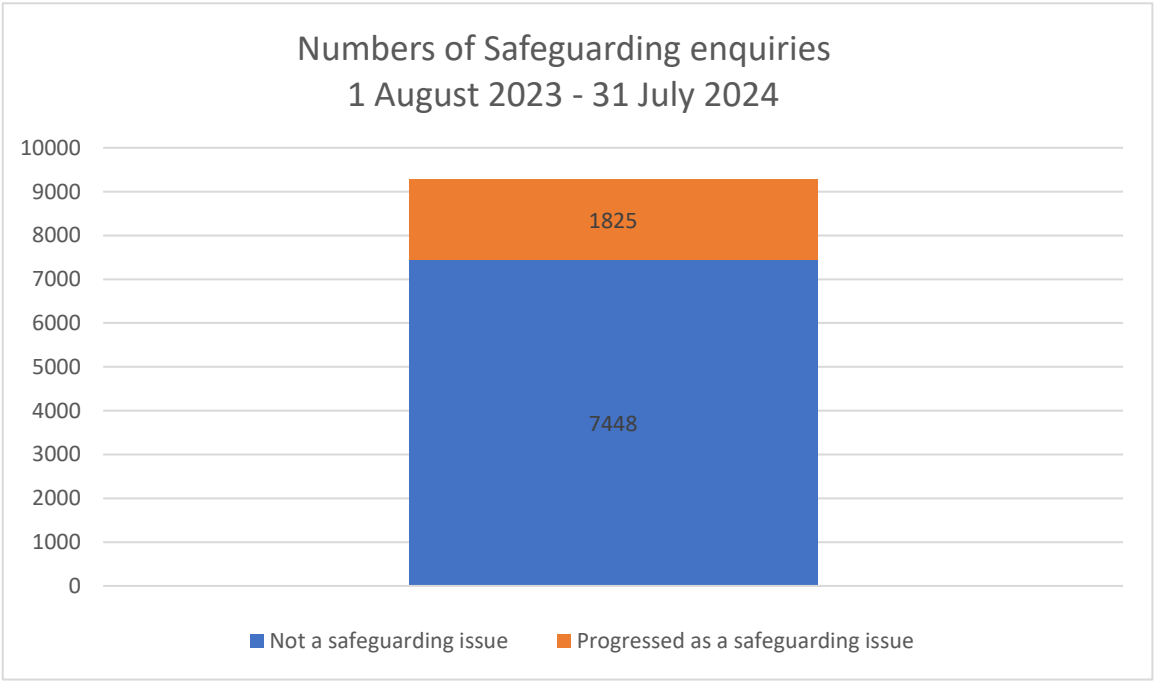
84% Care and support services that they received helped them to feel safe



We consider that everyone should have the right to live a life that is free from harm, abuse, and any form of exploitation. Our commitment to safeguarding the citizens of Sandwell in need of our support has never been stronger in ensuring safety in the system. These efforts are also intended to move us closer to a future where citizens in Sandwell can feel safe and protected.

Sandwell's Adult Social Care data pack continue to provide the needed insights to inform our efforts in ensuring safety in the Sandwell Place and system.

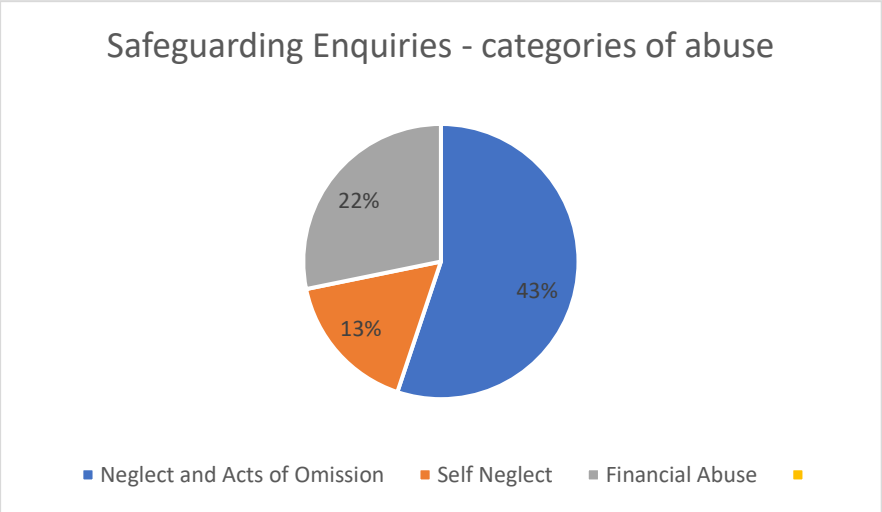
During the period 1 August 2023 to 31 July 2024 there were 9,280 contacts completed that were initially recorded as an enquiry relating to safeguarding. Out of these, 7448, representing 80.3% were found to be 'not a safeguarding issue' with only 1825 representing 19.7% progressed as a safeguarding issue. Most of the contacts resulted in advice and information, signposting or no further action.



There were 2,076 contacts that were signposted during the year. As a result, we have considered that the future development of the operational service should include proposal for developing a mechanism for efficient quality assurance of low-level quality concerns enabling a direct reporting between providers and commissioning units within adult social care. We believe that this would significantly reduce the steps in the current customer journey and ensure service efficiency while creating capacity for the operational adult safeguarding to respond to complex demand.

During the reporting period, the number of safeguarding concerns concluded was 773 and the number of section 42 enquiries concluded for all categories of abuse was 210 representing 27% conversion rate. The conversion rate is an improvement from last year's position of 25% arising from the data between the safeguarding concerns and enquiries concluded during the 2022-23 period.

Pertaining to the category of abuse, 43% of safeguarding enquires relate to neglect and acts of omission. A quarter of enquiries are related to financial abuse at 22% with self-neglect being the least of all abuse types at 13%.



Most abuse often occurs in a person's own home representing 41% and the alleged perpetrator is either a family member or a paid carer. When abuse occurs in a care home at 26%, the alleged perpetrator is usually a paid carer. Of 16% of abuse which occurs in hospital, the alleged perpetrator and source of risk is usually a health care worker.
The current data continue to show positive increasing trends in performance in adult safeguarding which is consistent with current sustained efforts towards system improvements and changes in the culture of practice. The number of Contacts open at the end of the reporting period with the Contact Reason being 'Enquiry relating to Safeguarding' have continued to decrease month on month. In terms of risk outcomes, 98% of the enquiries concluded by the fourth quarter of 2023/24 resulted in the risk either being reduced at 64% or removed at 34% with only 2% of risk remaining and 95% overall across the reporting year. This among other factors demonstrates that we are doing very well as an authority in ensuring safety in the system.

Similarly, Sandwell is committed to following 'Making Safeguarding Personal' principles outlined in the Care Act. For each enquiry concluded in the period, the data shows that 95% of the individuals or their representatives were asked about their desired outcomes. Of the enquiries where the individual did expressed their desired outcomes, the data demonstrates that 93% were either fully achieved(76%) or partially achieved (17%).

From the data, it is noted Sandwell adult safeguarding is performing quite high in these indicators and is among the top in the midlands region for asking MSP questions showing our seriousness and commitment in placing wellbeing at the centre of our safeguarding efforts.

Sandwell is also performing well nationally, on Adult Social Care Official Figures (ASCOF) indicators 4A & 4B, the proportion of people who use services who feel safe and the proportion of people who use services who say that those services have made them feel safe and secure, respectively. The last reporting data shows that Sandwell's performance is around 84%.

Vulnerable Adults Risk Management (VARM) Data

Below is a table identifying the themes highlighted within VARM meetings. From 2021, when the process was launched, there have been 91 VARMs held. At the time of writing, there are 33 live VARM meetings at various stages of the process. This represents over 100% increase on the last reporting period which shows that the proess is being successfully embedded in practice. In addition, 58 VARM meetings have been closed because the risks have been reduced or alternative pathways were pursued.

In addition, there have been 12 VARM awareness sessions with 112 attendees in March 2023 – March 2024. We are offering regular VARM awareness sessions on a monthly basis. Chairing multi-agency meetings training sessions were launched in October 2022 and at the time of writing this report, there have been 22 attendees across 7 sessions March 2023 – March 2024. More sessions were scheduled however, some were cancelled due to low attendance. This training is now mandatory within Adult Social Care.

The VARM process supports the embedding of multi agency working, enabling all professionals to raise concerns regardless of the organisation they work for, providing the VARM criteria are met. Key to this work are strength based approaches, working directly with families and individuals to reach an agreed understanding of the identified risks and a plan (again with agreement from individuals and/or family members) on how to manage and mitigate those risks. This practice has been identified as good practice across the region, particularly when dealing with self-neglect and, further promoting the VARM process forms the basis of a recommendation of a Domestic Abuse Related Death Review (DARDR) within the borough.

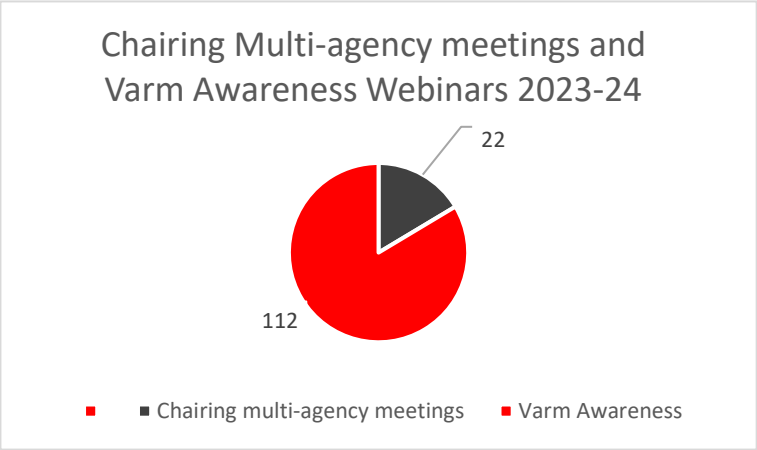
The themes and trends identified with the VARM data have enabled real consideration as to the development of best practice in response to self-neglect and, where appropriate, hoarding. Sandwell SAB were involved in a West Midlands regional event shaping and promoting best practice with reference to self-neglect and risk management and SAB are considering developing a co-prodiuced hoarding partnership approach and a robust training offer, in partnership with the third sector. The progress in this work will be reported in the Annual Report 2024-2025.

VARM themes
High risk
Challenges re engagement
Self neglect and the escalation of risk
Harm outside the home, exploitation, home invasions and financial abuse, including ‘risky relationships’
Hoarding with some links to self neglect
Anti-social behaviour and potential for criminalised outcomes

VARM referrals continue to be made, referring agencies vary but include West Midlands Police, West Midlands Fire Service, Housing, Community Teams, Cranstoun and Neighbourhood Officers. Where high risks are identified within Adult Social Care, leads are offered attendance at weekly risk surgeries as well as support to convene VARM meetings, as appropriate. There is also a weekly, multi-agency discussion including Health partners, Housing colleagues and Homeless Services representatives, looking at a range of options and management strategies for high risk vulnerable adults. Health partners, with safeguarding lead responsibilities, are key in this space, supporting registration with GPs, for individuals who may not be registered and engaging with GPs to ensure an attendance or involvement in VARM meetings, where requested. Below is some key training data, reflecting the impact of VARM Awareness training that continues to be offered and Chairing multi-agency meetings. It is of note that this year (during this reporting period), bespoke

arrangements were made with hospital staff, ensuring that they had access to a range of VARM Awareness training at different times and dates, enabling workers on different shifts to attend the training. The impact has ensured awareness of this multi-agency way of working and risk management amongst ward staff, community matrons and district nurses.

VARM Training Data



Below is an example of some key learning from a VARM. Please see the Learning On One Page (LOOP). It is important to note that the story described below was not a static story; however, the VARM process enabled and supported people to work together to better safeguard the individual, whilst proactively involving key partners and families. The learning identified within this scenario is transferable to a range of other high risk situations and can be used as a tool to revisit cases as risks change and, potentially, escalate as well as decrease.

Please see the quotes below from professionals involved in a range of VARMs.

For the NHS, VARM is an important referral pathway for its patients that do not meet the threshold for adult safeguarding. The VARM process provides a space for professionals to assess risk and produce personalised plans, providing safety netting. This is often achieved for citizens with vulnerabilities that were previously hidden to services. The process encourages a collaborative partnership approach, this promotes effective communication sharing and gathering. This triangulates and unites agency responses to the assessed risk, improving outcomes to the vulnerable service users.

I felt that it was all good to begin with, although I did raise a safeguarding for both which went to adults but no one from adults came to the meeting? I don't think we got very far with either of them to be honest…the issue never improved with her property, and then it came to a standstill altogether. Only a small number of professionals attended.

The Vulnerable Adults Risk Management Framework has strengthened partnership working and information sharing. The framework includes and empowers Sandwell's vulnerable citizens.

"The VARM process in Sandwell is a really useful framework which supports professionals to identify and manage risks in specific circumstances. The VARM process brings multi-agency professionals together and facilitates effective information sharing and promotes synergy between professionals. In addition, the VARM process creates an environment where creative thinking and problem solving is encouraged and valued and gives professionals access to specialist advice from other agencies.

The VARM process in Sandwell ensures a person centred and holistic approach to safeguarding and encourages all relevant agencies/professionals to consider ways in which their service can maximise opportunities to engage with and offer support to the individual at the centre of the VARM.

In my experience thus far, the VARM process in Sandwell works very well and is an important asset to both the public and professionals "

Learning On One Page (LOOP)

Vulnerable Adult Risk Management (VARM) case study

Sandwell Safeguarding Adults Board

Background

*** is a White British man in his 40s who lives in his own home in Sandwell. He experiences poor mental health and has a diagnosis of schizophrenia. He also has an acquired brain injury (ABI). The VARM process was initiated in February 2024 due to concerns re financial abuse and exploitation. ***'s mental health and personal hygiene were also deteriorating, highlighting a risk of self-neglect. Agencies involved in the VARM process including adult social care, housing, mental health services and CPN, anti-social behaviour team, police, floating support and the modern slavery team.

*** did not feel able to participate directly in the VARM process as, because of his experiences whilst living in his home, he struggles to trust people.

J, who is ***'s mum, is a huge advocate for *** and attended the risk management meetings to ensure both her voice, and the voice of her son, were heard. J described *** as a very creative and well-presented man, who valued his family and friends, but she acknowledged some of ***'s relationships had deteriorated because of the abuse he experienced.

*** is perceived as vulnerable by individuals within his neighbourhood who targeted him, stole from his property, and pressurised him into parting with money (considerable sums). They expected to enter his home at all hours, removed property from his household and sold it, keeping the money.

What did not go so well?

- J felt frustrated at the lack of pace in terms of actions (these concerns had been longstanding).
- Members of the team around the adult were hopeful of criminal justice routes.
- Key capacity assessments were not timely as additional trusting relationships needed to be built.
- Initially, there was a lack of understanding from some agencies about the impact of the abuse and potential exploitation. As VARM meetings progressed, this understanding changed.
- VARM meetings are ongoing, and we are working to engage *** in the meeting space and sharing his views.

Good practice

- The social worker was patient and took time to build trust with ***. This meant a lot to *** as he struggles to trust people and initially would not let the social worker into his home.
- The social worker built on an existing positive relationship with J and enabled J to be heard and mum built a more trusting relationship with ***.
- Professionals worked together well and shared information and owned risk.
- Housing prioritised property allocation to enable a move to a suitable property near his mum's address.
- Police colleagues ensured there was a marker on the new property and provided support on the day of the move, enabling *** and family to feel safe.
- Police encouraged mum to report offences where she had been threatened and intimidated.
- Anti-social behaviour team considered a range of Public Protection orders to afford further protection to ***.
- Adult Social Care supported costs incurred in relation to the property move.
- Professionals felt galvanised.

Key Learning Themes

The following four factors are all important in ensuring that the best possible outcomes are achieved for *** and others who may have similar experiences.

- **Trauma Informed knowledge and practice; understanding of context of people's lives**
- **Honesty in professional relationships**
- **Person centred practice (Making Safeguarding Personal)**
- **A consistent worker or team to build trust (and a commitment to making a difference)**

Please take a moment to reflect on the information provided within this LOOP. If you would like further information in relation to VARM, please email: safeguarding_SSAB@sandwell.gov.uk or, visit the VARM pages on the SSAB website: https://sandwellsab.org.uk/safeguarding-policy-and-procedures/vulnerable-adults-risk-management-varm/

5. SUB-GROUP CONTRIBUTIONS AND PROGRESS 2023-2024

Supporting the Board are three sub-groups who completed the following work so that people can better live their lives free from abuse and neglect.

PREVENTION, PROTECTION AND LEARNING & DEVELOPMENT:

Continue to raise awareness of adult abuse, communicating effectively with all partners and members of the public

The Prevention, Protection and Learning & Development sub group has a clear work plan developed on a multi-agency basis with a focus on accessible and appropriate training, ensuring all partners and the third sector have access to safeguarding training and learning events. There is subject specific training including;

- VARM awareness training
- Hate Crime
- Recognising safeguarding as a volunteer
- Safeguarding in a range of settings
- Specific projects, including the Care Home project

The group oversaw the operation of a VARM working group that delivered and implemented the VARM policy and procedure, the VARM toolkit, newsletter and e-learning. The VARM work was developed as a direct consequence of SAR recommendations with a focus on multi-agency risk management. The VARM policy, procedure and toolkit are currently being reviewed and the sub group will have oversight of that activity.

The focus of this sub group is to support a collaborative agenda ensuring that all activity within sub groups is connected, maximising the opportunities to learn from SARs, develop resources, undertake focused pieces of work using a task and finish approach and minimise duplication. This has been particularly relevant during this reporting period where additional demands made on partners and stakeholders were significant and necessitated smart ways of working with high impact.

What did we want to achieve	What did we achieve…
To develop a specific issue campaign.	• The Prevention sub group became a virtual group in 2023 with task and finish activity for the priorities set for 2023/24. In 2023 a new updated website was developed to host information for both professionals and the public. We also continued to share information via social media and quarterly newsletters as well as raising safeguarding awareness at various events and engagement opportunities. We continue to be involved with information networks to ensure our safeguarding message has as far a reach as possible. • The prevention sub group also ensured that all VARM information was reported and available on the SSAB website. • Sub group members participated in a Care Homes project, talking to people with lived experience, family members and professionals about the experience of living in a care home, what informed their decision

	making and what is and is not working. A film identifying findings is available to view at: https://youtu.be/_mDfQsopZ0Y?si=uhBZs0kwARyXr5cU
Specific projects to be identified with a focus on Prevention	SSAB continues to develop a strong Prevention offer, promoting an inclusive understanding of safeguarding and what it means to all and everybody's responsibilities. As a partnership, we have continued to explore how to better strengthen our links with the third sector and smaller organisations as they work in community settings and safeguard people every day. SSAB and the Prevention sub group also considered different models of operating, ensuring that systems were able to be responsive during the really challenging times, offering timely support and information as required. The Prevention sub group supported the activity of a range of task and finish groups including the learning disability and autism task and finish group (this went on to become an advisory group to SSAB) and the VARM task and finish group. All projects identified in the strategic plan will be reported to Board on an ongoing basis and outcomes reported as part of the development day in November 2023.
Listen to the voices of service users and front-line staff	The Engagement Officer continues to work on projects where hearing the voice of citizens and front-line staff is key. In some of the projects highlighted in this report, we have seen direct feedback from citizens, particularly with reference to the relationship event and in the impact statement provided, in response to Safeguarding Adult Reviews.
Develop a mandatory training offer	Using a competency-based framework, adult safeguarding training is now mandatory for staff in a range of job roles and settings which can be used across the partnership. Some training during this reporting period was offered as e-learning or via a virtual platform. However, SSAB supported a face to face SAR Learning event in March 2024 which is referenced below. Additional training data is included in this report.

QUALITY & EXCELLENCE:
Continue to focus on effective delivery and high-quality processes

The Quality & Excellence sub group continues to monitor performance, receiving assurance reports and data from some partners. Using the data, the group reports on themes and trends to SSAB and key lines of enquiry are then agreed and established. In addition, the sub group supports the monitoring of, and learning from, SAR action plans and plans to develop an audit programme using the assurance framework.

- Q&E have developed a work plan and work programme which includes:
  - Peer Reviews, reflecting on information gathered as part of a Care Act compliance audit
  - An audit programme
  - Comprehensive data set
  - What good assurance looks like

They have influenced the response to carers, ensuring that the needs of older carers, supporting adults with care and support needs, are considered, this is linked directly to a SAR recommendation.

The Quality and Excellence sub group works hard to ensure its membership is robust and reflective of the partnership and that they develop a context to the data. Members are committed to showing both qualitative and quantitative data, enabling better understanding of a citizen's journey and ensuring voices are heard.

What did we want to achieve	What did we achieve…
Continue to support the development of the Q&E Sub Group	The Q&E Sub Group continues to work with board members to develop good quality assurance and data sets. Throughout this reporting period, the sub group has supported the development of a quality assurance framework identifying priority areas for audit (including self neglect). The sub group now has a clear work programme, a new chair from the ICB and has advertised internally for a new deputy chair.
Develop more inclusive Performance Data **Continue to build on the performance framework and data set**	The data set continues to be reflective of the assurance required by Board members and key assurance information is provided in response to specific requests of Board members and/or the independent chair of SSAB. SSAB works closely with the other statutory boards in the borough and supports a collective response to assurance and data. Partners contribute to the discussion about meaningful data and the dashboard continues to grow in line with the key lines of enquiry. The Q&E sub group reported the work of a number of task and finish groups particularly the Learning Disability and Autism Advisory Group, and the domestic abuse and adults with needs for care and support task and finish group. Both areas were high priority during the reporting period and all professionals involved achieved successes, including the development of the 'It happens to us too' film highlighted earlier in this report.

Develop a multi-agency self-assessment tool	A Care Act Compliance Self Audit Tool was developed and sent to partners for completion in September 2022. The compliance audit tool continues to be reviewed and a peer review will be planned for Spring 2025.
Continue to understand the implementation of Making Safeguarding Personal and the impact for service users	Effective engagement means that we will continue to collect data and information that reflects citizens' views. Some of these are illustrated within this report.
Continue to work with all colleagues under the auspices of the 5 + Boards arrangement as outlined in the partnership protocol.	SSAB continues to work in partnership with the other key statutory and non-statutory boards within the borough; Sandwell Safeguarding Adults Board Health & Wellbeing Board Sandwell Children's Safeguarding Partnership Safer Sandwell Partnership Domestic Abuse Strategic Partnership Sandwell Children and Families Strategic Partnership Harm Outside The Home Board Youth Justice Board We will work together as board managers to consider and develop cross cutting solutions for example, training and cross cutting priorities and who will lead on them. There have been a number of new chairs to all the partnerships and, as a system, we need to work at embedding the principles of working together and ensuring new chairs continue to sign up to the agreed protocol.
Board Governance	This remains a strategic priority. SSAB has been refreshed and now reflects a senior and smaller membership. Board governance continues to be managed by key and statutory partners and the SSAB Independent Chair and a revised governance document has been written (Board Members Handbook) to reflect this. Governance and priorities to be reviewed at the SSAB Development session planned for Spring 2025 and this will be reported on in next year's report.

SAFEGUARDING ADULT REVIEW STANDING PANEL

To focus on the statutory function of SSAB, to apply rigour to the criteria application, work together to identify and embed learning.

The Safeguarding Adult Review Standing Panel is a sub-group convened to consider SAR referrals. This group is chaired by a representative of Sandwell & West Birmingham Hospitals NHS Trust. Group members consider referrals against the SAR criteria. All key agencies are represented on this group.

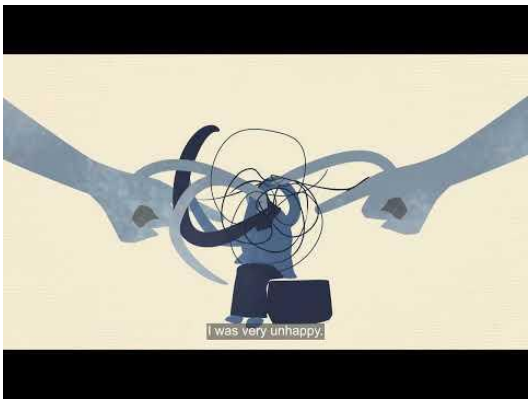
Arrange for Safeguarding Adult Reviews to be undertaken as required, produce reports and action plans and identify learning	Within this reporting period, April 2023 – March 2024, the SAR Standing Panel have delivered on board responsibilities. The Panel have published 1 review within the reporting period. In addition, 1 is awaiting publication, 2 reviews are progressing. A new referral has recently been agreed to meet the threshold for a SAR. Additional to this, the group is contributing and participating in a joint learning review commissioned by DASP and SSAB. This case did not meet the criteria for a DHR or SAR. The SSAB are committed to learning and improving outcomes for a vulnerable citizen. The promotion of collaborative and partnership working is a strategic priority for the board. The panel continues to progress and focus on embedding learning and measuring service improvement. The panel is working closely with Quality & Excellence to measure agency success.

6. Task and Finish Groups

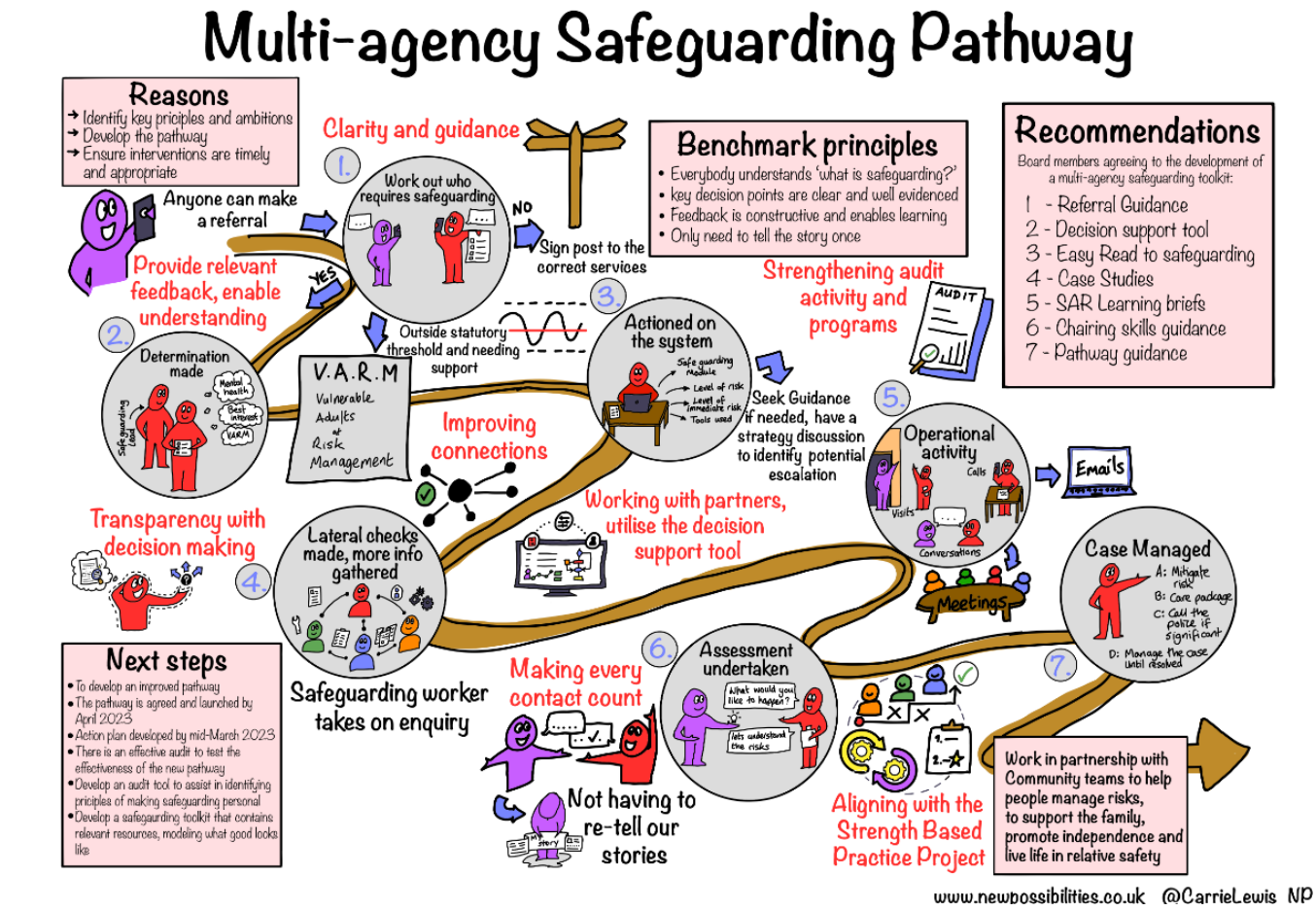
Local Task and Finish groups have looked at:

- Domestic Abuse
- Safeguarding Pathway
- Learning Disability and Autism Advisory Group
- Embedding learning from statutory reviews
- VARM Working Group
- Hoarding Working Group
- All Age Exploitation Strategy Task & Finish Group

Work has been undertaken with colleagues from the Domestic Abuse Strategic Partnership (DASP) to strengthen links and enable all professionals to consider risk through the lens of domestic abuse and the impact on adults with needs for care and support. Risks associated with domestic abuse have been highlighted through the VARM process and SSAB commissioned a short film called 'It happens to us too' which you can view below. This film was developed by a multi-agency task & finish group, including domestic abuse providers. This group has now been aligned with the Domestic Abuse Strategic Partnership (DASP) to further strengthen partnership working and ensure robust governance.

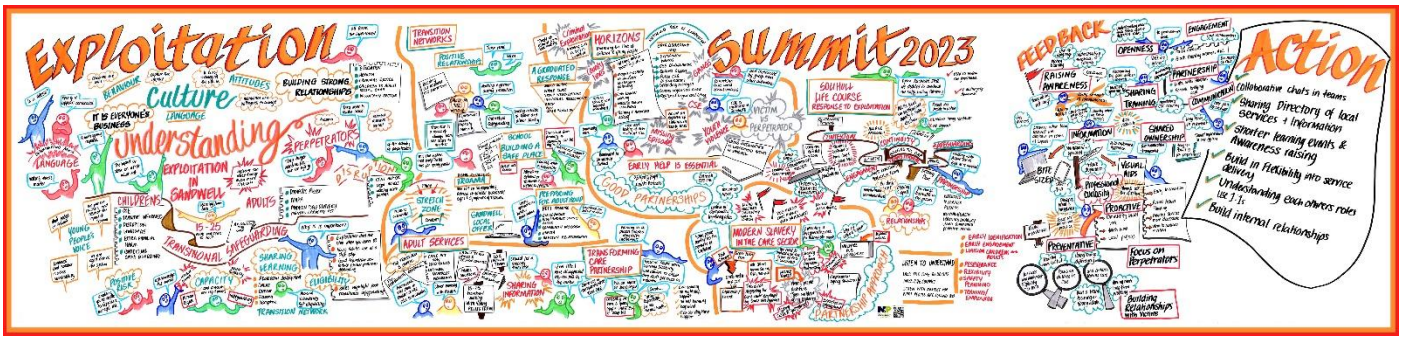


Having worked with Adult Social Care (ASC) and The Social Care Institute for Excellence (SCIE), the Safeguarding Pathway task and finish group is now being led and progressed by ASC, ensuring effective and robust links are made with their internal project work considering the customer journey and the front door. This change will ensure an effective, coordinated response that puts the customer at the heart of all work and improves the experience for the citizens of Sandwell. The Board remains committed to supporting coordinated approaches and will continue to seek assurance that the work undertaken will reflect the benchmark principles outlined below and improve the experience for citizens.



(n.b all data correct at time of report writing)

In October 2023, SSAB led on an Exploitation Summit, involving partners and representatives from the Children's Trust, Adult Social Care and the Third Sector. Please see the graphic below, which identifies activity and agreed priorities.



As an outcome of this event, and developing a greater understanding of both Children's and Adults' working priorities, challenges and opportunities, it was agreed that an All Age Exploitation Strategy would be developed. Work has begun on this strategy, including harm outside the home, which has the endorsement of SSAB, the 5+ Boards and the Exploitation Board (now known as Harm Outside the Home Board), supported by the Children's Trust.

National and Regional groups in which Sandwell SSAB have led include:

- The development of a national data toolkit to support all safeguarding adult boards with their assurance work
- Safeguarding Front Door and good practice when shaping a safeguarding pathway
- Developing a career pathway for partnership managers identifying clear competencies and opportunities for career progression
- The development and publication of a safeguarding film-based toolkit for Emergency Services https://www.safeguardingwarwickshire.co.uk/images/downloads/West_Midlands_Emergency_Services_Toolkit.pdf

7. WHAT OUR ENGAGEMENT HAS LOOKED LIKE

SUMMARY OF ENGAGEMENT APRIL 2023 - MARCH 2024

This year there has been the wonderful possibility of returning to face to face engagement which we have done with a bang. However, consideration was given to how we do so to ensure engagement with as many individuals as possible as well as focusing on the questions we ask. This year we therefore have had the following priorities;

- To ensure our literature is in community venues following the removal during the pandemic.
- To be visible in the community raising the profile of Safeguarding.
- To develop regular opportunities to listen to individuals in the community.
- To focus engagement to respond to the board's question regarding care homes within Sandwell.
- To support the work of sub - groups and Task and Finish groups to ensure the voice of individuals are heard.

TOP THREE ENGAGEMENT THEMES

GP Services	Individuals experiencing challenges accessing a doctors appointment continues to be raised frequently in conversations. Particularly around appointments being full 5 or 10 minutes after surgeries open at 8am and reluctance of using online booking systems
Cost of Living	Individuals finding increasing energy, food and care costs challenging to meet. Individuals expressing the need to monitor their heating usage and finding other ways to keep warm such as blankets and accessing community venues.
Waiting Lists	Individuals have expressed the concerns about the impact of delays in consultant appointments, treatment and operations. Living with pain whilst waiting for a hip or knee replacement or believing delays have affected their chances of recovery from cancer.

Care Home conversations with family members and professionals

Why are social care and continuing healthcare funding reviewed separately?

Help us find the right provider for our loved ones. Don't rush us, we know you need hospital beds, but we can't find somewhere right overnight.

"Training does not prepare them for certain situations they face"

"There is a lack of suitable placements for deaf individuals"

OUTCOMES

21 Community Chat Sessions

3 monthly Community Chats are now held across Sandwell in community venues.
Bi monthly chat held at Willow Gardens extra care.
These sessions offer the opportunity to listen to individuals' stories and where appropriate signpost to relevant services.

Attended 5 Outreach Events Connecting with over 300 individuals

Large outreach events such as fayres and fun days allow us to meet a large group of individuals and raise awareness within the community with the SEE SOMETHING, DO SOMETHING message as well as hear individual experiences and direct individuals to consultations. These events were used to speak to individuals about their experiences of care homes in Sandwell.

Attended 5 Public Events

Attended Healthwatch Guided by you events across the 6 towns. Engaging with approximately 80 individuals.

Future Engagement

All engagement activity continues to be face to face going forward, unless we are making reasonable adjustments to enable individuals to participate and share their views. SSAB remains committed to effective engagement and wishes to use a variety of methods to suit as many individuals as possible. SSAB have also supported the development of resources that support engagement including short films. These will be reflected in our on-going work for 2024-2025. There are lots of examples of different ways of engaging within this report, which we will continue to build on.

8. OUR LEARNING FROM SAFEGUARDING ADULT REVIEWS (SARS)

WHAT ARE SAFEGUARDING ADULT REVIEWS?

The Care Act 2014 introduced statutory Safeguarding Adults Reviews, mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

A Safeguarding Adult Review is a multi-agency process that considers whether serious harm experienced by an adult or group of adults at risk of abuse or neglect, could have been predicted or prevented. The process identifies learning that enables the partnership to improve services and prevent abuse and neglect in the future.

The activity undertaken and reviews commissioned by the board have produced recommendations for the board and partnership agencies.

These recommendations have informed new services and practice development, an example of this includes the Vulnerable Adults Risk Management Framework, improving multi agency working and information sharing, improving outcomes for individuals that do not meet a safeguarding threshold but have identified vulnerabilities. These vulnerabilities include self-neglecting behaviours and substance misuse.

The Safeguarding Adult Review recommendations have identified gaps and improvements within single agencies and multi-agency working. The board and the panel members have reflected on recommendations which have developed a focus on agency governance structures which the board continue to progress to better ensure robust and realistic improvements.

The outcome of these reviews has provided an opportunity for the key characteristics and themes to be identified. The themes are listed below

- Effective working together and what good looks like
- Identification of risk and escalation
- Mental capacity and the appropriate application of the legislation

Understanding the themes supports the board to seek assurance that learning and changes are being imbedded and that outcomes are being monitored in quality and excellence. This continues to be a focus for both the Safeguarding Adult Review Panel and Quality and Excellence members.

The Safeguarding Adult Reviews have contributed to and supported a SSAB learning event with the support of the theatre company to explore the identified learning.

The SSAB provide partners with access to training, examples include Vulnerable Adult Risk Management framework and chairing meetings.

The SSAB supports interventions with task & finish and advisory groups, examples include the LD Advisory Groups. These forums support progress with recommendations and provide multi agency improvement work plans. These groups also provide platforms for case studies that often progress to board.

Learning identified has informed Quality & Excellence and will contribute to the multi-agency audit plan and performance data requests.

Within this reporting period, the Panel have published 1 review within the reporting period. In addition, 1 is awaiting publication, 2 reviews are progressing. A new referral has recently been agreed to meet the threshold for a SAR.

SAR Learning Event – 18th March 2024 – We See You, We Hear You!

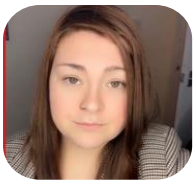
With a focus on:

- **Person centred thinking and strength-based approaches**
- **Diagnostic overshadowing**
- **Substance misuse and self-harm**
- **How to empower and work in partnership with people who have unpaid caring responsibilities (family members)**

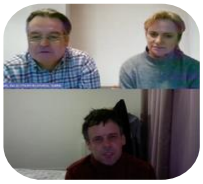
In 2024, the SSAB Business Team and Safeguarding Adults Board has continued to develop the use of impact statements and learning tools to support the powerful delivery of key messages underpinning practice changes and learning for all. On 18th March 2024, the SSAB held a multi-agency SAR learning event that engaged positively with families and individuals with lived experience, identifying key learning and resource development. Please see some of the hard-hitting films and statements below.

Family contributions to the SAR Learning Event

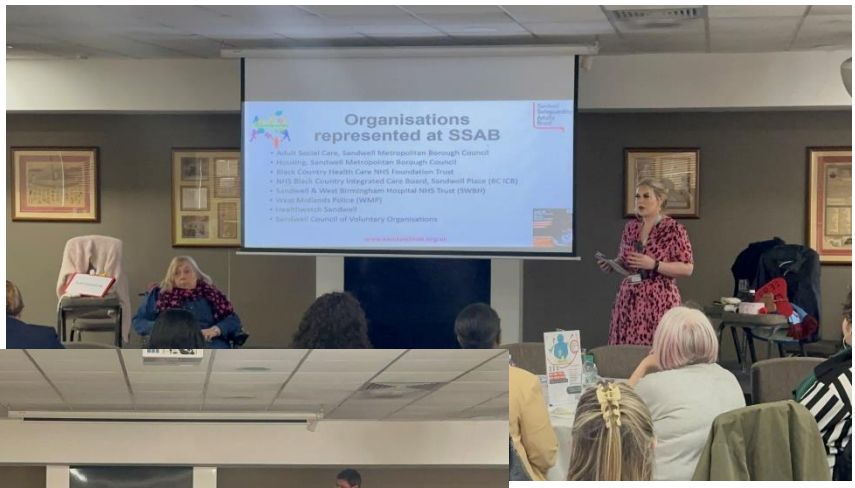
Sharon's story
Sharon shares her view of what didn't work for her nephew, when he needed support.



Caragh's story
Caragh talks about her late sister, Shannon, what didn't work, what she would like to see happen and the impact on the whole family.



Diagnostic overshadowing
This conversation helps us understand what diagnostic overshadowing is, and means, and why it is important that we are alert to it when thinking about adults with needs for care and support and good healthcare.



The pictures above show a range of activity taking place and people working together and hearing families' stories and the impact the loss of their loved ones has had on them individually, and as a family. In order to further explore themes and impact, the SSAB commissioned a theatre group who acted out scenarios based on real SARs in Sandwell, identifying challenges that were faced by all and supporting conversations about what could happen differently in the future. Both the theatre presentations and hearing directly from families made this event extremely powerful and impactful. Some people, including family members, were distressed on the day but appropriate support was offered and all involved acknowledged the impact the session had and supported the ongoing commitment to change.

Practice Changes in Sandwell

- Clear and transparent risk assessment tools
- The introduction of risk management surgeries by Adult Social Care
- The introduction of screening tools and risk assessments to better enable appropriate support to be provided to adults who may use drugs and alcohol

National SAR Research Findings 2019-2023

- All 136 Safeguarding Adults Boards responded with details of completed published and unpublished SARs
- 652 SARs in the sample (+ 23 unpublished reviews not shared)
- 60% feature self-neglect
- Self-neglect the most frequent type of abuse or neglect reviewed

Some Findings on the SAR Process

- Still a lack of focus on “protected characteristics”
- Still some evidence of misunderstanding of the mandates in section 44
- Insufficient use of reviews completed previously by the SAB, or by other sabs, meaning that we are starting again rather than building on prior learning and its impact on practice improvement and service development
- Unclear how the quality markers are informing sab decision-making about reports
- Not all reports focus on answering the question “why?”
- Insufficient focus on the national context within which adult safeguarding is situated
- Evidence that COVID disrupted timescales
- Parallel processes (inquests, criminal proceedings) have caused delay

9. KEY ACHIEVEMENTS

- Board members continued to meet in a hybrid manner, some face to face and some over TEAMs
- Supported on-going priorities of listening to the voices of citizens and front-line staff
- Engaged and built positive working relationships with the Department of Work and Pensions in Safeguarding
- Reviewed and contributed to the Regional West Midlands Safeguarding Procedures
- Contributed to and co-chaired the Regional Uniformed Services Group
- Reviewing SSAB's publicity materials and continuing to develop accessible resources.
- The Learning Disability and Autism Advisory Group have taken on a specific project, looking at carers' responsibilities and support available.
- Developed a key communication strategy with partners and all other statutory Boards within the borough
- Added to SSAB e-Learning offer
- Further developed, and monitored the VARM process, ensuring it is embedded in practice. Agreed a Peer Review framework and begun the process of reviewing all documents
- Continued to develop key learning resources for learning from SARs
- Contributed to robust working arrangements across all statutory partnerships in Sandwell
- Supported a range of face to face engagement activity, with reference to specific projects for example, people's experience and understanding of living in a care home, which is reported on in this report
- Contributed to and led on the West Midlands Association of Directors of Adult Social Services (ADASS) group
- Developed and contributed to a West Midlands Regional SAR Group
- Developed and contributed to training for SAR authors
- Led on SAR learning events
- Actively contributed to the National Board Managers Network including taking on chairing responsibilities and leading on a range of task and finish groups
- Developed a robust relationship with the Domestic Abuse Strategic Partnership ensuring the development of a relevant training offer to front-line social work staff
- Contributed to developing a core training offer to be made available across the partnership
- Developing an effective response to hoarding, adopting co-produced Sandwell Hoarding Improvement Partnership. This is referenced in our future plans
- Sandwell Safeguarding Team was nominated for a national award and won! This will be reported on in next year's annual report 2024-2025.

10. PARTNER CONTRIBUTIONS

Learning Disability and Autism Advisory Group

This is a multi-agency group including user led organisations and the focus is on promoting and developing best practice as it relates to adults with a learning disability and/or autism. Group members offer advice and guidance to other professionals, examples of this over the last year include shaping recommendations for safeguarding adult reviews, supporting the provision of topic specific accessible information, exploring the effective use of communication passports. The advisory group also advises SSAB and has contributed to Safeguarding Adult Reviews where appropriate.

Sandwell Metropolitan Borough Council (SMBC)

The Operational Safeguarding Team comprises of twelve (12) establishment social workers, two (2) advanced practitioners, a team manager, and an Operational Head responsible for the day-to day operations of adult safeguarding activities within the team and across the Adult Social Care space.

We practice in a way which puts the individual at the centre known as ‘Making Safeguarding Personal’.

On the back of an Improvement Plan for Safeguarding instituted in 2021 which was recorded as achieved in 2024, the Operational Adult Safeguarding service is dedicated to intensifying our efforts in protecting and promoting the safety and wellbeing of citizens in Sandwell. Our current road map outlines major goals and initiatives that will guide our actions and strategies going forward. The forward plan is also a demonstration of our commitment to making a positive impact in the lives of those who are experiencing and or is at risk of experiencing abuse or neglect.
Our forward plan is ambitious, however, with the support and commitment from our citizens, families, partners, and teams, we are confident that we can make considerable difference in keeping people safe in line with their desired outcomes.

Sandwell is committed to promoting safeguarding practice. We do this by:

- Contributing to work of SSAB by providing representation at the relevant subgroups and participating in the development, implementation, and review of the SSAB Policies, Procedures and Practice Guidance
- Provide a strategic and operational lead for safeguarding practice, representing Sandwell at local and regional forums to share and learn from good practice.
- Ensuring that all adult social care staff are aware of the safeguarding procedures and that safeguarding is seen as everybody’s business.

Sandwell is committed to continuous improvement of our safeguarding practice. We do this by:

- Reviewing and auditing our safeguarding practice, including participation in the SSAB audit framework.
- Ensuring that our staff are well informed, well trained and can adapt to changes with the adult safeguarding arena.
- Reflecting on feedback from those we work through Making Safeguarding Personal. This helps us to look at what works well and what needs to improve.
- Implementing learning from Safeguarding Adults Reviews and Domestic Homicide reviews.
- Participating in the annual Quality Assurance Framework led by SSAB, which seeks assurance in relation to the quality of our safeguarding practice.

Sandwell is committed to partnership working to deliver the best outcomes for the adults we work with. We do this by:

- Holding regular meetings with CQC and our Contracts and Commissioning Unit to share information relating to our providers.
- Holding regular meetings with the ICB to review medication errors within provider services and other areas of practice improvement.
- Working with the Council's Domestic Abuse Team to ensure that we support those who have experienced domestic abuse and sexual violence.
- Involvement in the strategic and operational MARAC (multi-agency risk assessment conference) meetings.
- Involvement in the Multi-Agency Town and Tasking and MAPPA (Multi-agency public protection arrangements) meetings.
- Holding our weekly high-risk surgeries and individualised Vulnerable Adult Risk Management (VARM) Panel. This is our multi agency high risk panel which brings together agencies regularly to support high risk cases and practice and ensuring that robust measures and support are in place to address concerns and promote wellbeing.
- Taking part in the Sexual Exploitation and domestic abuse sub-groups, focussing on those who are at the highest risk of sexual exploitation in Sandwell.
- Being involved in the Slavery and Human Trafficking Operational Partnership (SHOP) and holding regular multi agency meetings to review our work relating to Modern Slavery, Human Trafficking and Sexual Exploitation.
- Meeting regularly with the Police to promote joint working and good practice through the SSAB.
- Attending community-based drop ins to increase engagement with teams.
- Supporting providers when managing multiple safeguarding enquiries through a supportive approach.

NHS Black Country Integrated Care Board (BC ICB)

The Black Country ICB Primary Care Safeguarding Self- Assessment Tool was launched in 2023 and disseminated to all Sandwell GP Safeguarding Leads and Practice Managers. The tool has been developed to support our local Black Country GP health economy to fulfil statutory safeguarding responsibilities and enable an opportunity ahead of any CQC Inspection to review current safeguarding practice, identify any risks and gaps, as well as highlight good practice and areas requiring improvement. The exercise also supports the Place Safeguarding teams to identify good practice and themes and areas within Primary Care, where further support may be required.

A Safeguarding Learning Log developed by the ICB Safeguarding Team/ Named GPs for use in Primary Care was launched in 2023. The tool supports GPs and Primary Care staff in recording details of any Adult /Child safeguarding training, education or learning opportunities completed over a three-year period to demonstrate acquisition and up to date knowledge, skills and competencies. This should prevent the need to repeat learning where individuals move organisations and support to demonstrate up to date relevant competence, knowledge and skills when individuals move to a similar role in the same area of practice. This information will also inform personal development (PDP) and where relevant revalidation requirements.

The ICB continued to support the implementation of an IRIS system wide response to DA within primary care across the Black Country.

Commissioning of a podcast relating to 'unconscious bias' and professionals asking the question about domestic abuse as highlighted as a recommendation from Domestic Homicide Review Learning.

Domestic abuse training delivered to training leads within WMAS to ensure that any callouts to potential victims of domestic abuse were asked direct questions about this, ensuring appropriate response were given and sign posting into support services.

Commissioning and purchasing of domestic abuse resources for primary care to promote disclosures of domestic abuse.
Commissioning of Level 3 Safeguarding Adult Training for Black Country Nursing Home staff.

2023-4 saw the launch of the Tier 1 Oliver McGowan online and taught training for Health Professionals. This has been added as a requirement to ICB staff and is being implemented in all Providers across the Black country. The training was developed to ensure that staff in all health settings have sufficient knowledge and skill to adapt care to meet the needs of those patients with learning disabilities and autism.

In February 2023, His Majesties Government published an Independent Review of Prevent, which precipitated changes to Prevent guidance and imposed new Prevent duties on the National Health Service and other public bodies. To ensure that the Black Country Integrated Care Board was working in accordance with these new guidelines, the Associate Director of Nursing for Safeguarding and Partnerships, commissioned an independent review of their Prevent response. The review endorsed the draft Policy developed by the ICB with support from the National Home Office Prevent Team and made recommendations to support the implementation of the policy. The policy will be due for ratification in June 2024, along with a comprehensive implementation plan.

During 2023-4 the following policies were reviewed, updated, and ratified: Supervision Policy; Safeguarding Adults Policy; Domestic Abuse Policy; Managing Allegations.

Learning from statutory reviews is cascaded in a variety of formats and coordinated at place and Safeguarding Partnership Level. These include Newsletters, 7-minute briefings, forums, formal training sessions, leaflets and pod casts. As reviews conclude and are published (where applicable) a presentation on key learning and assurance in relation to recommendation implementation comes to the Safeguarding Assurance Group. Learning is also woven into training and events commissioned or delivered by the ICB.

A series of events for Primary Care staff were delivered during 2023-4 focusing on key learning from reviews including Domestic Homicide Reviews, the role of the Named GP and CQC preparedness.

The Designated Nurse for Safeguarding Adults has been involved in a project working with Black Country Probation Service supporting the Women's Trauma Informed Community Healthcare Project. The aim of the project is to allow easier access to Women's Healthcare Services, for hard-to-reach females. The project aim is to provide a nurse led clinics held at Black Country Women's Aid site within Sandwell, where Probation staff are co-located providing services and further information, around cervical screenings, breast screenings, prostate examinations, sexual health, HIV testing, and the menopause. Birmingham University are currently undertaking a formal evaluation of the project and in January 2024 won the Kathy Biggar trophy with the Butler Trust.

During 2023-24, the ICB have led on the completion of 19 LeDeR reviews in Sandwell, of which 15 were initial reviews and 4 focussed reviews.
Initial reviews are completed for all notifications. However, some reviews are escalated to a focused review. Focused reviews are completed at the following

- Ethnic Minority background
- Autism without LD
- Under the Mental Health Act
- Where an initial review is highlighting additional learning

The Serious Violence Duty which came into effect in January 2023 and requires the implementation of effective information sharing systems, this is to enable subsequent joint multi-agency development of services to prevent harm through violence. In response to this Black Country ICB have:

- Establishment of the SVD steering group
- Engagement of all key partners
- Specific work to improve the health data contribution as part of the future strategic needs assessments and service planning.
- Development of health Business Intelligence dashboard
- Regular reporting on this element of statutory compliance via the ICB Quality & Safety Committee.

During 2023-4, a threat to the Non-Pregnancy FGM clinic was identified due to lack of planned funding, a business case was developed to support a 3 year funding schedule and a new set of key performance indicators were developed.

West Midlands Police (WMP)
As the local commander, I take active responsibility as the police lead attending the Safeguarding Adults Executive Group and Safeguarding Adults Board to ensure the joint delivery of the strategic plan and discussing issues outside the board when a more dynamic approach to risk is needed. I have ensured that an appropriate escalation model was implemented for such urgent cases. Sub-groups of the board are also supported with police representation and work continues to ensure that we have a multi-agency data set including police data that allows for strategic decision making and intervention.

I work closely with the Adult Care Abuse Investigation Team (ACAIT) in West Midlands Police (WMP) to understand the themes and strategic issues in order to inform and update our partnership work towards delivering the strategic plan.

ACAIT continue to give victims of abuse a 'voice'

During the period April 2023 - March 2024 WMP obtained 10 Positive Outcomes for Sandwell criminal cases as follows:

- 2 x Theft/Fraud (both Conditional Cautions)
- 4 x Care Worker Ill Treat/Neglect (all Cautions)
- 3 x Assaults (2 x Common Assault and 1 x Actual Bodily Harm all Cautions)
- 1 x DBS offence (Charged)

All of WMP investigations are person-centred, regularly working with intermediaries to assist in enabling victims to fully understand the process and achieve their best evidence. ACAIT work collaboratively on a daily basis with partners including the CQC, Coroner's Office, Adult Social Care and Sandwell Hospital Trust to prevent and detect abuse and neglect of the most vulnerable in our society.

Following a report from LEDER at our Safeguarding Adults Board (Learning from lives and deaths of people with a learning disability and autistic people) it was recognised that more understanding was needed with a particular gap in gender and ethnic minority information. As a result, I instigated a process via WMP Force Review Team to ensure that where police attended a death and the deceased is identified by officers as either being autistic or having learning disabilities a referral to the local authority safeguarding adult review coordinators would be made. This supports our strategic plan in relation to inclusive performance data and learning from Safeguarding Adult Reviews.

As senior responsible officer for the implementation of Right Care, Right Person (RCRP) in WMP, I ensured briefings into the Adults Safeguarding Board and Executive throughout the implementation of this approach. The first two phase went live in February 2024 ('Concern for Welfare' and 'AWOL/Walk out of Healthcare facilities'). These briefings allowed partnership feedback to be considered in order to safely implement the national RCRP agreement locally and has seen a high level of reassurance achieved to ensure our communities remain safeguarded through this new approach.

As lead for Sandwell Community Safety Partnership and chair of this board I am able to ensure that the work across thematics in safeguarding and community safety is coordinated with a particular focus on Domestic Abuse and Modern Slavery, that can so often also impact on vulnerable adults in our communities.

Third Sector Representation

SSAB has third sector representation from Board Members however is committed to strengthening the working relationship. Members of the SSAB Business Team and the SSAB Operations Manager attended a third sector Health and Social Care Forum where we talked about the role of the Board, we actively contributed to board conversations with reference to stronger working relationships with the third sector.

There has also been an ongoing conversation supporting the development of an early help partnership with adults who experience a range of impairments and who potentially have care and support needs.

Healthwatch Sandwell

Healthwatch Sandwell are committed members of the Sandwell Safeguarding Adults Board and have been involved in the development of the board's strategic plans.

We also work together with SSAB Development Officer with Community Chat coffee mornings. This initially started at Cape Hill Asda and has expanded to the South Staffs Water Community Hub with a plan to develop this work in other towns.

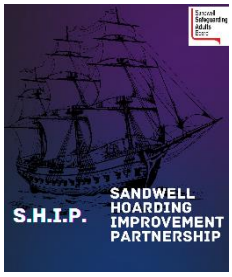
Our relationship with other partners of the board is valued, demonstrated by the level of discussion, scrutiny and learning that is fundamental to how the board functions. Feedback that Healthwatch Sandwell has provided on behalf of citizens has been taken seriously and acted upon. The board are focused on listening and getting better outcomes for vulnerable citizens, and advocates that the person is at the centre of the safeguarding process.

Healthwatch Sandwell continue to be a conduit in supporting the work of the board in promoting that “safeguarding is everyone’s business – see something do something” - by sharing information, newsletters, training events and citizens stories through our web site and other social media platforms.

11. PLANNING FOR THE FUTURE – EXCITING OPPORTUNITIES!

- SSAB have appointed and welcome a new Chair, Richard Parry. You will hear more from Richard, and we are really excited to be working with him and continuing to build on work and direction developed so far
- SSAB plan to review the strategic priorities and strategic plan at our Board development session in the spring of 2025
- Safeguarding Adult Reviews and taking forward the learning remains a priority. SSAB continue to plan learning events throughout 2023-24 and we have featured an analysis and contributions from our March 2024 learning event in this report. We are now moving towards more face to face events which enable greater networking opportunities and learning.
- SSAB and the other statutory boards in Sandwell continue to support the development of an All Age Exploitation Strategy which was an action that came out of the Exploitation Summit featured in this report. A multi-agency group continues to meet to progress this work
- Continue to develop specific issue campaigns maintaining a campaign focus under the broad banner of 'see something do something'. SSAB is currently developing animated learning tools telling people's stories and focusing on risk management
- Continue to work and build on effective relationships with all statutory boards in the borough, identifying key areas we can work together on minimising the risk of duplication and maximising impact. All key documents (with reference to the Five+ boards partnership) have been available on relevant websites since 03.07.23. In addition, the documents will be reviewed and meetings have welcomed the new chairs

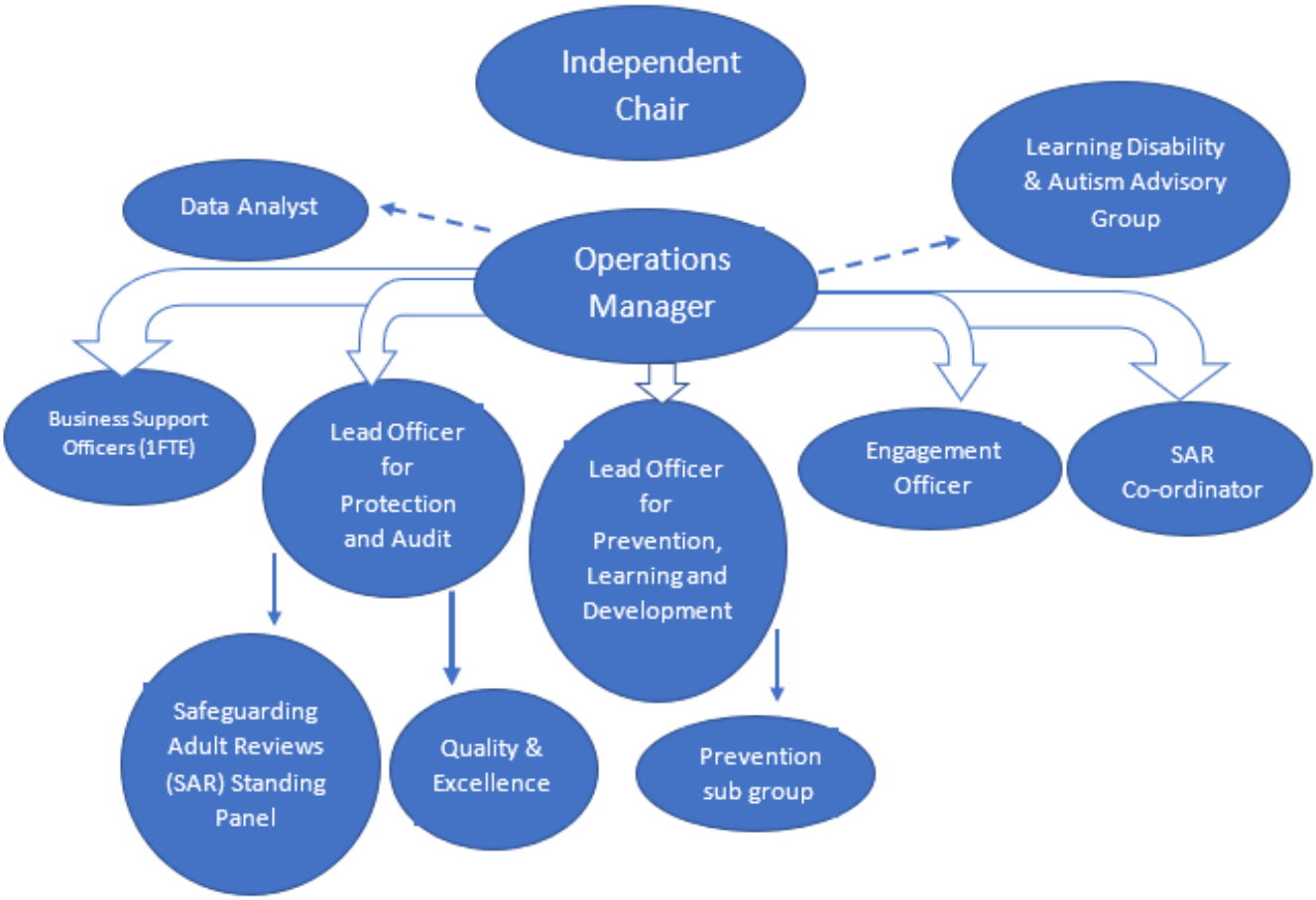
- SSAB have commissioned Ian Porter to work with Sandwell and people who exhibit hoarding behaviours, to develop a **S**andwell **H**oarding **I**mprovement **P**artnership



Please see Ian in action on the BBC and some key learning and messages from a person who exhibits hoarding behaviours **https://youtu.be/yAsopd1GuUE?si=4nYVRDbgIzOJSOAX**

APPENDIX 1

SSAB STRUCTURE



APPENDIX 2

BOARD MEMBERSHIP

Black Country HealthCare NHS Foundation Trust
NHS Black Country Integrated Care Board, Sandwell Place
Healthwatch Sandwell
Sandwell Safeguarding Adults Board Operations Manager
Sandwell Safeguarding Adults Board Independent Chair
Sandwell Adult Social Care
Sandwell & West Birmingham Hospital NHS Trust
Sandwell Council of Voluntary Organisations
West Midlands Police

APPENDIX 3

FINANCE AND BUDGET INFORMATION

The work of SSAB cannot be achieved without a dedicated budget and resources. For 2023 - 2024, the financial contribution for the work of the Board came from Sandwell Council, Black Country Integrated Care Board and West Midlands Police.

	2023 / 2024	
	Budget	**% of Total Funding**
Expenditure		
Employees	251,553	
Independent Chair	13,815	
SAR Case Review	40,200	
Training	10,000	
Legal	4,000	
Advertising & Publicity	3,000	
Other Expenditure	9,000	
One Off		
Total Expenditure	**331,568**	
Funding		
ICB Funding	(140,000)	36%
West Midland Police	(17,695)	4.6%
Other Fees and Charges	(0)	0%
Sandwell MBC	(226,000)	59%
Total Funding	**(383,695)**	**100%**

APPENDIX 4

GLOSSARY

Abbreviation	Explanation
ADASS	Adult Directors of Social Services
AP	Advanced Practitioner
ASC	Adult Social Care
BC ICB	Black Country Integrated Care Board
BCWA	Black Country Women's Aid
BME	Black and Minority Ethnic
LSDASP	Domestic Abuse Strategic Partnership
DHR	Domestic Homicide Review
GP	General Practitioner
ICB	Integrated Care Board
IDVA	Independent Domestic Violence Advocate
IMR	Independent Medical Review
IRIS	Identification and Referral to Improve Safety
LD	Learning Disability
MASH	Multi Agency Safeguarding Hub
NHS	National Health Service
Q&E	Quality and Excellence
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
SMBC	Sandwell Metropolitan Borough Council
SSAB	Sandwell Safeguarding Adult Board
SWBHNT	Sandwell West Birmingham Hospital NHS Trust
VARM	Vulnerable Adults Risk Management
WMAS	West Midlands Ambulance Service
WMASFT	West Midlands Ambulance Service Foundation Trust
WMCACT	West Midlands Care Act Compliance Audit Tool
WMP	West Midlands Police

APPENDIX 5

FEEDBACK FORM

Can you please help by providing us with feedback on the content of this report and your opinion on our future priorities?

Please use the link or QR Code to access an online form.

https://forms.office.com/e/yE7QmXQBYS

Sandwell Safeguarding Board Annual Report Feedback (2023/4)

Or you can contact the SSAB Operations Manager, Deb Ward deb_ward@sandwell.gov.uk:

Talk with me on Microsoft Teams

WHO CAN I TELL MY CONCERNS TO?

To make a referral ring the Enquiry Team on 0121 569 2266

In an emergency, ring 999