Annual Report

Sandwell Safeguarding Adults Board - our journey

2024-2025

Sandwell Safeguarding Adults Board

ANNUAL REPORT
2024 - 2025

Contents

Appendices

1. FOREWORD FROM THE INDEPENDENT CHAIR

Welcome to the 2024/25 Annual Report for the Sandwell Safeguarding Adults Board.

I joined the Board as the Independent Chair most of the way through the 2024/25 year and so can take no credit for any of the achievements of the Board. Credit instead needs to go to the Partnership, the Business Team and my predecessor, Sue Redmond, whose (metaphorically) big boots I am trying to fill.

I have been made very welcome by both partners and the Business Team that supports the work of the Board. I have also been very struck by the commitment of all partners to the values and ambitions of the Board. Whilst this commitment is very strong, it is clear that, individually and collectively, the organisations that make up the Partnership and Board face capacity constraints that make delivering those ambitions more challenging.

One of the ways in which this is being mitigated in Sandwell is through strengthening the relationships with other partnership arrangements in order to both reduce duplication and recognise the synergy between the work of the Safeguarding Adults Partnership and the activity that is going on in areas such as Domestic Abuse, Community Safety and Safeguarding Children as well as the Health and Wellbeing Board. This approach is supported by a regular meeting of the 5 Board Managers and Chairs coming together to share areas for co-operation and joint learning.

This approach is increasingly common across the country and will help strengthen the work of the Board, particularly in relation to the commitment to continuous improvement and learning lessons from the work of others. This complements the learning that comes from SARS commissioned by the Board and through the Quality and Excellence sub-group.

A theme in 2024/25 that will continue into 25/26 is the need to work at multiple footprints. These include:

- At an individual level through personalised approaches that reflect the outcomes that individuals supported by the Safeguarding system want to see for themselves (Making Safeguarding Personal)
- The diverse neighbourhoods that make up the places where people live in Sandwell and which mean that we need to understand them and their residents to tailor our approaches to match their circumstances
- The Borough of Sandwell as the basis of our Board and the democratic structure that it relates to
- The wider regional and sub-regional footprints (West Midlands and Black Country) that reflect the operational arrangements of some organisations as well as the opportunities to collaborate and learn with and from others. In particular, the joint working across the Black Country has seen highly effective working at scale to make best use of resources and maximise impact through scale.

In addition, the Board will continue to take opportunities to learn from the national networks that support Board Managers and Board Chairs as well as the safeguarding arrangements of individual organisations.

The Board took advantage of West Midland Peer Review processes to hold a peer review in March 2025 having previously supported a Peer Review of another Safeguarding Adults Board (Coventry) in 2024.

The Strategic Plan was extended until 2025 to provide enough time to hold a development day to review the existing plan and set the strategic priorities for the following 3 years. This development day was held on 3rd April 2025 and the priorities set (Neglect, Self Neglect, Exploitation and Hearing People's Voice) build on work undertaken through the previous strategic plan in 2024 as well as reflecting priorities across the wider Black Country.

Richard Parry, Independent Chair

RDPARRY

2. SANDWELL AT A GLANCE

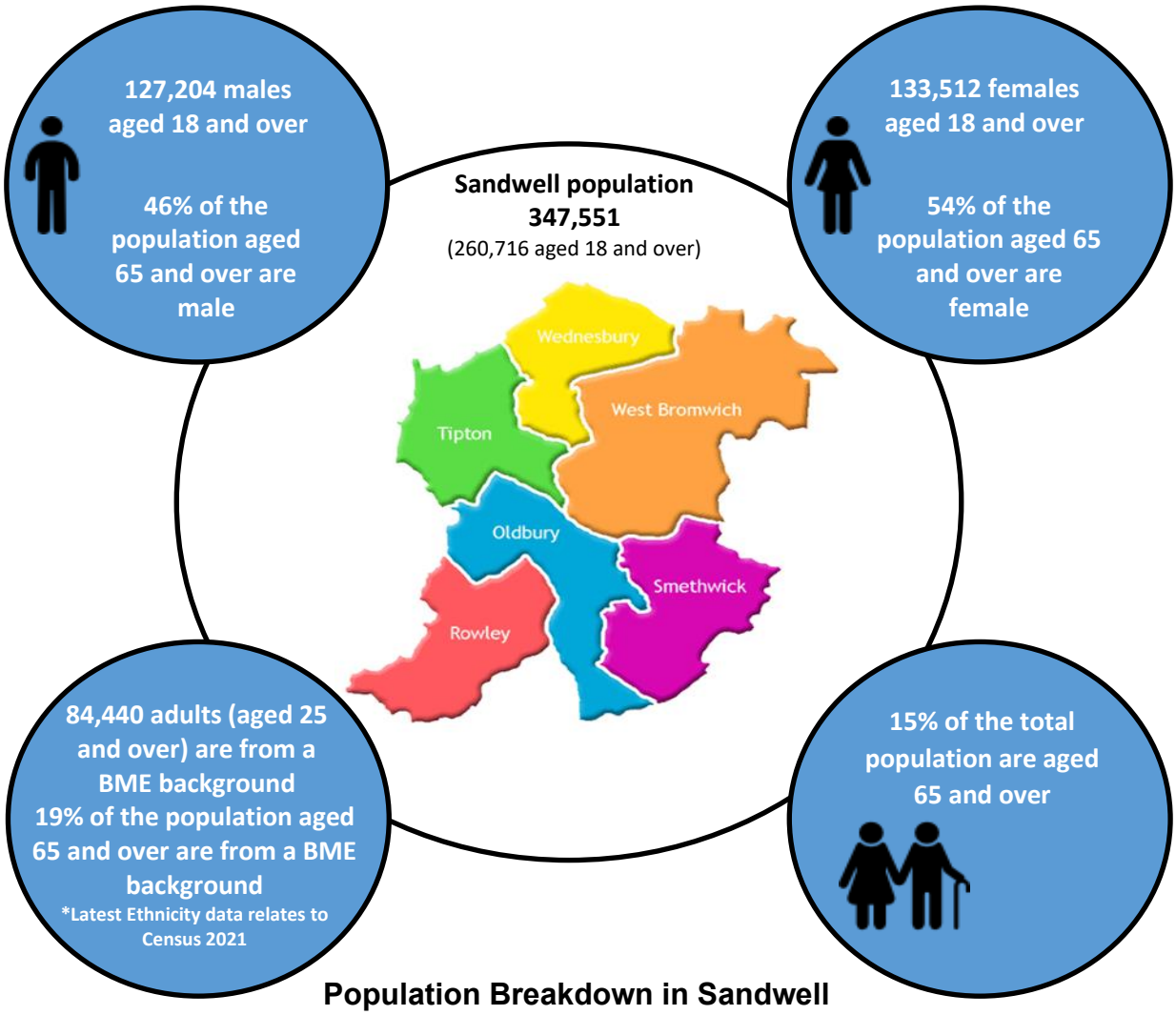
Sandwell covers 33 square miles

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 6% 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

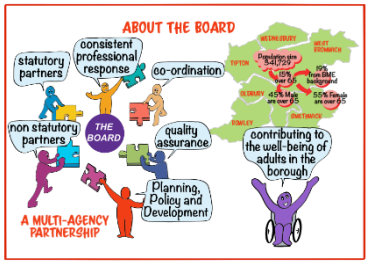
Data Source: Office for National Statistics – Mid-Year Population Estimates June 2023 / Census 2021, Dataset ID: RM032 - Ethnic group by sex by age

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. We continue to consider different ways of working, including hybrid meetings, and 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**

Agreement of Board Priorities 2025-28.

- Neglect
- Self-Neglect
- Listening to the voice of service users and frontline staff
- Exploitation

In addition, SSAB will continue to engage with the 5+ Statutory Boards to ensure effective working together and maximise opportunities to drive the priorities identified. In order to drive this work, SSAB has looked at its structures and subgroups as enablers with the focus on prevention.

Peer Review

Sandwell Safeguarding Adults Board participated in a peer review with Coventry Safeguarding Adults Board and Children's Partnership. This exercise was the first of its kind in the region and was a really positive experience. The findings from the report, including good practice and areas for development, are below. The full report and presentation can be found at Appendix 1.

Good Practice:

The Peer Review Team identified the following areas of good practice for Sandwell Safeguarding Adults Board:

- A clear Strategic plan which is clearly written and understandable.
- A well-resourced team indicating a commitment across the partnership to delivering positive outcomes.
- A clear understanding of strengths and areas for development across the partnership.
- A strong portfolio of visual resources to meet the needs of a broad range of people.
- A joined-up learning culture across the partnership which shares learning not only from SAR's but from other statutory reviews and also identifies areas of past learning with approaches to ensure this can be revisited and embedded.

Areas for Development

- Learning from SAR's could be complimented with a clear audit schedule which examines the quality of practice.
- The strategic plan would benefit from a multi-agency dataset and audit schedule to effectively understand progress against any identified work areas.
- It would be beneficial for SSAB to re-visit subgroup arrangements and ensure connectivity between groups.
- There needs to be a clear plan in terms of how areas for development, as identified in the self-assessment, will be taken forwards.
- SSAB may wish to consider co-ordination of engagement activity across the partnership.
- Opportunities for sharing learning of a 'peer review' approach regionally

Acknowledgements

Coventry Safeguarding Adults Board would like to extend their thanks to Sandwell for their involvement in the peer review process. It was a positive experience, and Coventry looks forward to taking some of the learning identified forward. Coventry would support the development of a peer review programme as identified in this report, across the West Midlands region.

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?

2024 – 2025

Concerns concluded

1285

38%

Conversion rate

Enquiries Concluded

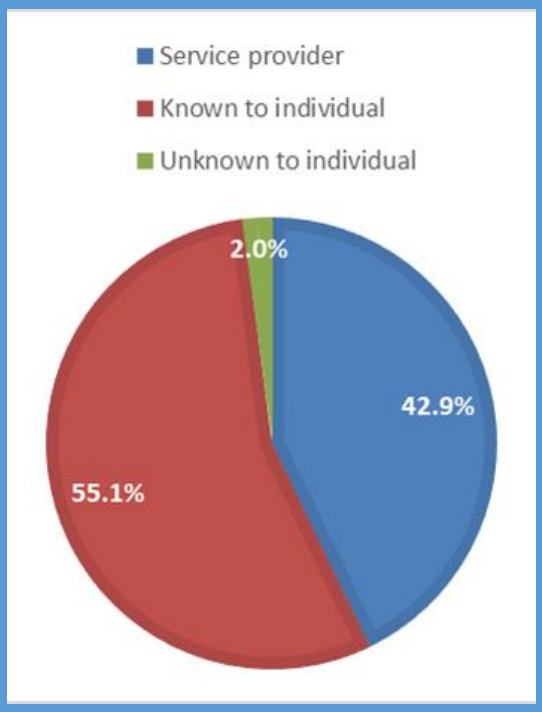
490

Concluded enquiries

58% older people

52% female

57% own home

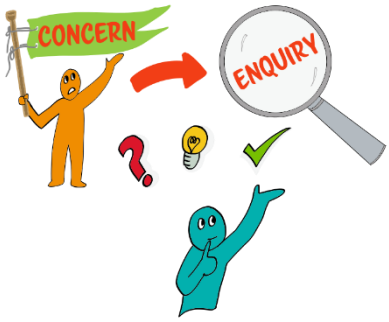


97 % of people were asked what they wanted to happen as an outcome

98% Outcome fully or partially achieved

96% Risk reduced or removed

85% Care and support services that they received helped them to feel safe



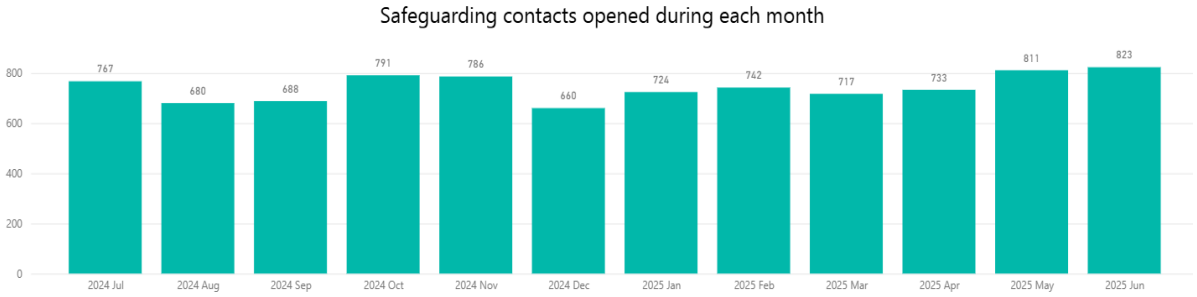
We consider that everyone should have the right to live a life that is free from harm, abuse, and any form of exploitation. Our commitment to safeguarding the citizens of Sandwell in need of our support has never been stronger in ensuring safety in the system. These efforts are also intended to move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

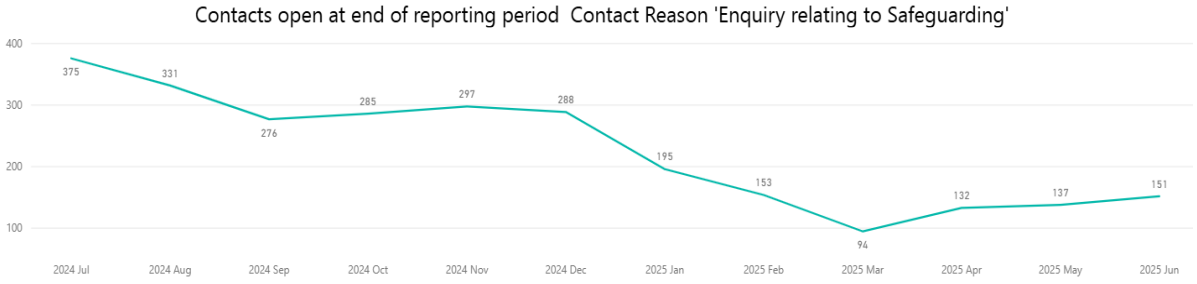
Sandwell's Adult Social Care data pack continues to provide the needed insights to inform our efforts in ensuring safety in the Sandwell Place and system.

During the period **1 July 2024 – 30 June 2025** there were **9,209 contacts** completed that were initially recorded as an enquiry relating to safeguarding. Of which, **1,988 (22%)** were deemed to be a **safeguarding issue.** Of which **63% progressed to a new safeguarding** referral and 33% were linked to an existing safeguarding referral.

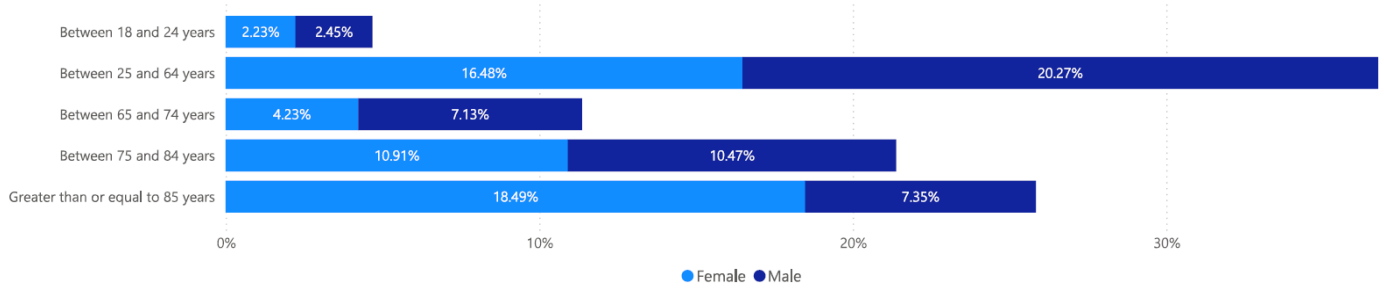
Most of the contacts resulted in advice and information, signposting or no further action. There were **1,924 (21%) contacts** that resulted in signposting during the year, most being resolved by the Quality and Safety Team.

Safeguarding contacts received & how many open at the end of each month
Contact reason 'Enquiry relating to Safeguarding'

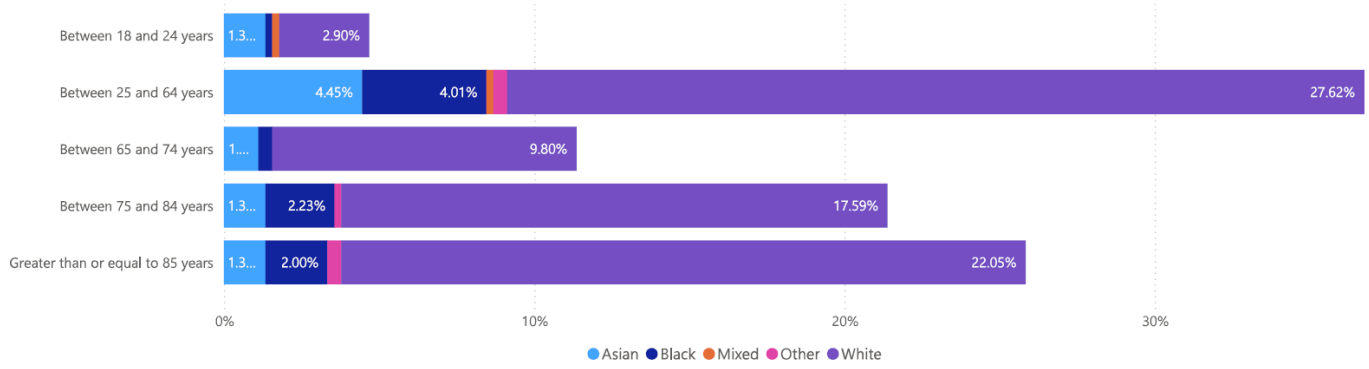




Concluded Section 42 enquiries by gender and ethnicity

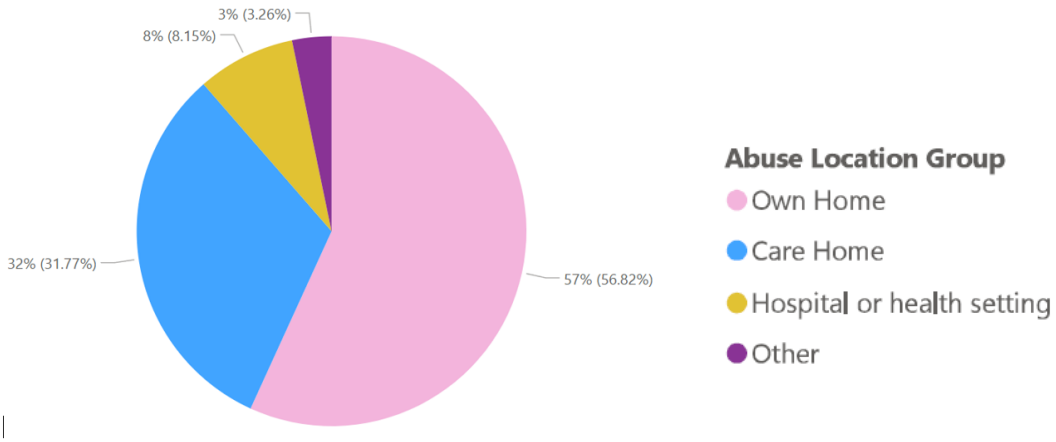


The above table focusses on gender and shows that within the working age population, males represent a higher proportion of safeguarding enquiries. We can hypothesize that this may be because working age males are more visible and therefore more likely to be referred.



In addition, this table focusses on ethnicity. This information demonstrates that the number of safeguarding concerns for each identified ethnic group is not reflective of the Sandwell population. There will be a range of barriers preventing and/or not enabling referrals to be made. These require further exploration and action.

Abuse by location



Most abuse often occurs in a person's own home representing 57% and the alleged perpetrator is either a family member or a paid carer. When abuse occurs in a care home at 32%, the alleged perpetrator is usually a paid carer. Of 8% of abuse which occurs in a hospital or health setting, the alleged perpetrator and source of risk is usually a health care worker.

Impact and Continuous Improvement

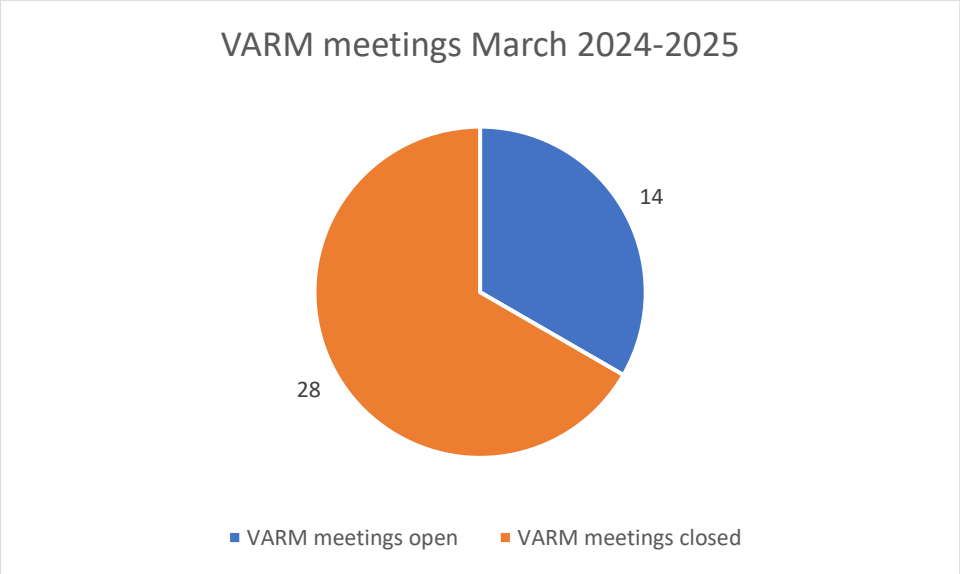
Our data highlights significant progress in reducing outstanding safeguarding contacts. The number of open contacts at the end of each month has steadily **decreased from 560 on 1 April 2024 to 151 on 30 June 2025**. This demonstrates the effectiveness of our improved processes in managing demand and ensuring timely interventions.

Commitment to Safeguarding Excellence

Sandwell's strong performance in **Making Safeguarding Personal (MSP)** reflects the dedication to **ensuring individuals are active participants in decisions about their safety and well-being**. By embedding a **person-centred, risk-aware approach**, the evidence supports that statutory responsibilities are being met, and citizens are being **empowered to feel safer, supported, and heard** in the safeguarding process.

Vulnerable Adults Risk Management (VARM) Data

Below is a table identifying the themes highlighted by VARM meetings. During this reporting period March 24 to March 25 there have been 42 VARM meetings held. At the time of writing, there are 14 open VARM meetings at various stages of the process. In addition, 28 VARM meetings have been closed because the risks have been reduced or alternative pathways were pursued.



<u>VARM Awareness raising</u>

March 2024 – March 2025 - There were 8 planned awareness sessions, 2 were cancelled because of low attendance so 6 VARM awareness sessions were held with 50 attendees. We continue to offer booked VARM awareness sessions on a bi-monthly basis. These are advertised and promoted through the VARM newsletter and the VARM working group.

<u>Chairing Multi-Agency meetings</u>

Chairing multi-agency meetings training has continued to be delivered during this period. This again is promoted via newsletters, the learning platform and the VARM working group. 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 have launched the Sandwell Hoarding Improvement Partnership and VARM is being used in some circumstances where hoarding is identified as the risk to try and progress and support all including the person described as exibiting hoarding behaviours to work more effectively together and priotise relationship building and actions.

Case Study

Miss S lives alone in a high rise block of flats in the borough, the fire service have been able to support with ensuring and advocating for lift repairs, the ICB requested an urgent GP visit as Miss S' mobility is poor and her adhema of her legs is significant. As a consquence, Miss S agreed to district nurses visiting to support her with dressings and a hoarding expert was able to support Miss S to agree to small changes with support that made a big difference to how she was able to live in her home.

In addition we have participated in a VARM peer review with Derbyshire Safeguarding Adults Board. We each observed three of each other's VARM meetings and although a relatively small sample, some initial findings for Sandwell are identified below:

Chairing: Empathetic, operationally informed

Multi-Agency Involvement: Mixed – some strong, one would have benefitted from additional attendees e.g. care agency, Police, GP.

Adult Involvement: In some meetings this was absent; however in one meeting the person's mum was included at every possible opportunity.

Risk Management: Clear identification, with escalation focus

Meeting Structure: One meeting lacked structure and clarity

Learning Themes: Voice of adult, structure, agency engagement, capacity clarity

Positive Practice: Trauma-informed, empathetic, creative engagement

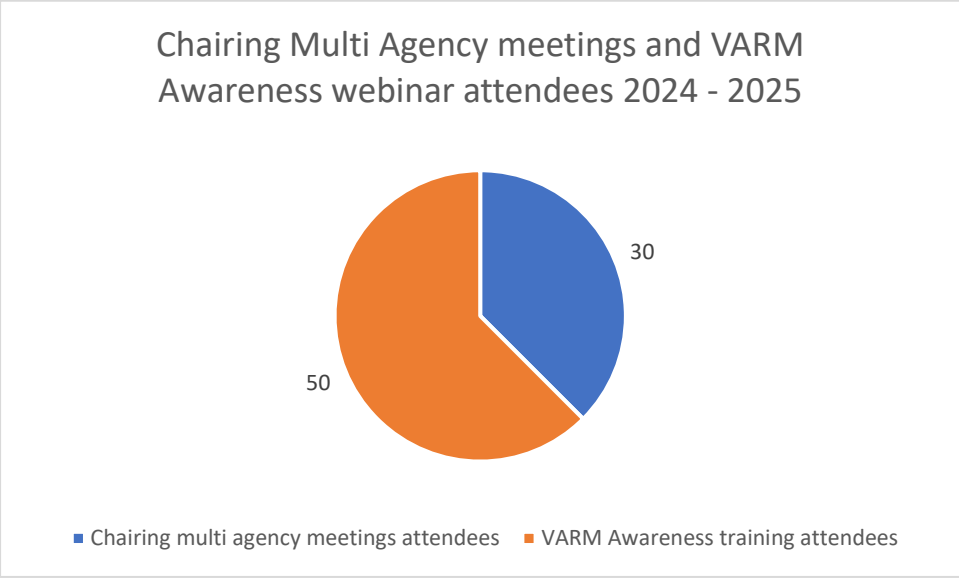
The VARM Working Group will take forward the identified learning from the peer review and develop an action plan and work plan for 2025/2026, including identified priorities and review activity. This will be reported on in next year's annual report.

Sandwell Safeguarding Adults Board expresses its thanks to Derbyshire Safeguarding Adults Board for their involvement in the peer review and the learning identified. We learn better together.

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 Safeguarding, Domestic Abuse Lead, 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.

The VARM service provides consistency, inclusivity, compassion, communication and empowerment. For our vulnerable adults VARM becomes more than a service - it becomes a lifeline.

(SWBH NHS Trust)

- Powerful.
- Working together so that the family and citizen voice is heard.
- The team show commitment.
- I feel listened to
- I am clear on the plan and information and can make corrections if needed

(Citizen actively involved in a series of VARM meetings)

Sandwell's VARM provides an invaluable opportunity to bring service users and support services together to problem solve complex situations, and to ensure support is provided to some of our most vulnerable residents.

(Housing)

The VARM process in Sandwell is exemplar, Deb leads with pride and compassion, this has resulted in really supporting our citizens that need a helping hand at a time of crisis. I have learnt a lot from the VARMs and have been welcomed into this space with warmth. (DWP)

Learning On One Page (LOOP)

Vulnerable Adult Risk Management (VARM) case study

Sandwell Safeguarding Adults Board

Background

*** is a White British man in his 70s who lives in his own home in Sandwell. He experiences poor mental health and has a diagnosis of Aspergers.

The VARM process was initiated in January 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 included adult social care, safeguarding, police, floating support and the modern slavery team.

*** initially did not feel able to participate directly in the VARM process, however, as he grew in confidence and trusted people, and the VARM meetings were moved face to face in a local to him venue, he chose to become very actively involved in his VARM meetings.

*** struggled to understand and appreciate risk, despite presenting as articulate. Much later in the process, capacity assessments determined that *** lacked capacity in a range of areas. *** is perceived as vulnerable by specific individuals within his neighbourhood who targeted him and to whom he gave money (considerable sums). *** was always offered what felt to him, like really plausible explanations as to why money was needed by an individual and he struggled to understand why the person he knew could have anything but honourable intentions as he felt that he was protecting the individual.

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 team around *** worked together well to engage with *** and meetings were always ended with a positive observation.
- Professionals worked together well and shared information and owned risk, including undertaking capacity assessments.
- All participants adopted a strength based and person centred approach, even when progress felt slow and repetitive.
- Police colleagues engaged positively in the VARM process and contributed to building trusting relationships, including sharing appropriate information with ***.
- Adult Social Care supported costs incurred in relation to property repairs.
- Professionals felt galvanised.
- ***'s attendance at his VARM meetings changed how all partners viewed and understood ***'s presentation and values.

What did not go so well?

- VARM members 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 completed but these took a significant amount of time, and the significance of the outcome was not immediately understood by all partners.
- 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.
- The risk of exploitation and financial abuse remained high throughout the activity. Although there were mitigations, this risk did not really decrease.

Key Learning Themes

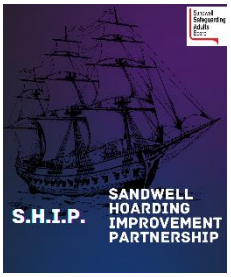
The following five factors are all important in ensuring that the best possible outcomes are achieved for *** and others who may have similar experiences.

- 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)
- It was important to continue to motivate and work with all team members, including ***, reminding them of the purpose of working together and outcomes desired.

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:

Click on the image above to watch this short VARM animation.

Sandwell Hoarding Improvement Programme: Launch & Ambition



The Sandwell Hoarding Improvement Programme (S.H.I.P.) has been developed in order to:
(i) Develop a peer support network
(ii) More effectively support citizens who exhibit hoarding behaviours
(iii)To develop skills and communities of good practice within the borough of Sandwell and to model good practice across the Black Country region and wider West Midlands

Hoarding is increasingly viewed as an anomaly in terms of mental health 'disorders' i.e. It is the only mental health condition which requires a community-based response, one that is, overall, sadly lacking across the UK. Consequently, the support offered to people who exhibit hoarding behaviors is often disjointed, ineffective, further stigmatizing and, for the most part, unfit for purpose.

In order to begin to address this untenable position, Sandwell Safeguarding Adults Board commenced planning conversations in September 2024 with a view to developing an improvement program which would focus on the following key ambitions in the first instance:

(i) To increase the hoarding literacy (knowledge and skills bases) of the multi-agency workforce across Sandwell and, subsequently, the Black Country.
(ii) To significantly improve the support to Sandwell citizens who exhibit hoarding behaviors.
(iii) To develop a number of sustainable improvement initiatives which would then be assimilated into a revised framework e.g. the development of a network of psychosocial intervention and support groups across the district.

Subsequently, the Sandwell Hoarding Improvement Programme (S.H.I.P.) was launched in November 2024 via an initial event designed to:
(i) Challenge people's perceptions of 'hoarding in order to change the associated narrative.
(ii) Explore some of the multi-agency/systemic issues in relation to the provision of support for people who exhibit hoarding behaviours.
(iii) Outline the main components of the programme, which also included the development of a multi-agency improvement vehicle i.e. the establishment of bi-monthly Hoarding Improvement Partnership (H.I.P.) symposia which would also act as a conduit for so-production initiatives via the inclusion of a corpus of 10-15 citizens who exhibit hoarding behaviours.

65 professionals attended (representing over 20 organisations/services/teams) and the initial momentum garnered was impressive. This led to the design and delivery of 2 multi-agency foundation training workshops in December 2024 and the organisation of a sequence of six Hoarding Improvement Partnership (H.I.P.) symposia scheduled throughout 2025. The inaugural H.I.P. symposium took place in January 2025 and was followed by a second event in March.

The evaluations of both initiatives was very impressive and subsequent training workshops took place in February (which included 2 co-morbidity/co-condition-specific training events) and April.

Reports of significant practice improvements and impacts were received from both

professionals and peers (people who attend the psychosocial intervention and peer support group facilitated by Kaleidoscope) and the spread and reach of the S.H.I.P. initiative began to reach the other three Black Country districts.

This led to the planning and design of the first Black Country Regional Hoarding conference which was scheduled to take place during National Hoarding Awareness week in May 2025. On the back of these conference planning sessions, initial Black Country-wide discussions began to focus on the possibility of a region-wide revision of the current hoarding framework later in the year.

In addition, the potential for developing a network of psychosocial intervention and peer support groups across Sandwell was discussed at the March H.I.P. symposium and received enthusiastic support. It was agreed to formalise an approach to this development during the Summer with a view to establishing 1-2 additional support groups by the end of the year.

The structure, process and outcomes/impacts of the Sandwell Hoarding Improvement Programme have been communicated across the Black Country footprint via a number of means including the design and dissemination of an e-bulletin: S.H.I.P.PING News.
Please see the video of our conference below. We are continuing to work on the improvement aspect of the S.H.I.P. including exploring the role of a hub/panel to provide appropriate advice and guidance to a range of professionals and an ongoing learning and development programme that will be reported on in next year's annual report.

Click on the image above to watch this short film

Hoarding Conversation

Sandwell Hoarding Improvement Partnership (S.H.I.P.) was launched in November 2024. Listening and building relationships with individuals who have hoarding behaviours is key to ensuring the success of this work. Through attending Kaleidoscope Plus Group - 'Your Space, Your Way' 15 Individuals have shared their stories and experiences. Clear themes from this engagement are reflective of the training and experiences shared by Dr Ian Porter.

Its not rubbish! It means something

Individuals spoke about a lack of understanding of how much something may mean to them. "All my clothes were hand me downs, new clothes mean so much to me" "Allowing someone to lend one was horrible, I physically worried"

Building Relationships

Individuals have spoken of past negative experiences with professionals. Trust and a non-judgmental attitude is essential. "Don't judge us ...get to know us rather than looking down your nose... show some respect you're in my home ".

Shame & Isolation

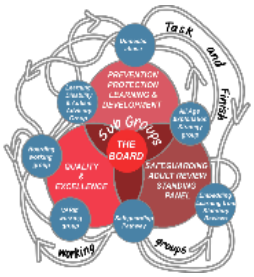
The impact of others not coming into your home or hiding your hoarding behaviours significantly impacts on relationships. "We have friends who we tried to tell but 'you're not one of those are you?' ended the conversation". "My daughter didn't come into my home for 3 years, before I would have hated for her to see how bad it got... now she helps me maintain everything. My house will never be tidy but it's safe". "If I was rich I would be called a collector, it's the size of my house that makes me a hoarder". "I hate anybody coming to my house...I'm ill for days before they come".

Anxiety & Overwhelm

Some individuals have resigned their self to their situation not changing feeling stuck and overwhelmed with the amount of work needed to find space. "I wouldn't know where to start, I want to but it's everywhere". "I feel low so go out and buy something then come back and feel worse".

Appreciation

Individuals have spoken of there appreciation of empathic, respectful support that "sees me as a person and doesn't judge" "She lets me choose what stays and what goes". "She supported me all the way and didn't give up on me".



6. SUB-GROUP CONTRIBUTIONS AND PROGRESS 2024-2025

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. SSAB and Prevention Sub Group also continues to look at systems and ensuring that partnerships are effective across systems including safeguarding.

There is subject specific training including;

- VARM awareness training
- Hate Crime
- Recognising safeguarding as a volunteer
- Safeguarding in a range of settings
- Hoarding Inside Out training
- Hoarding Co-morbidities training

The group continues to oversee the operation of the VARM working group, its role in informing practice and policy and procedure review.

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. **See Something Do Something 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. • As part of the 2025 Board development and strategy document a new sponsor for the prevention sub group

	was agreed and the workstreams and task and finish groups are being progressed. Our future plans include strategic direction and activity linked to the new Board priorities which are reported on in the Future Plans section of this report. We continue to support the See Something, Do Something Campaign, this includes reviewing its ongoing effectiveness.
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 2025.
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.

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

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 Subgroup continues to work with board members to develop good quality assurance and data sets. Throughout this reporting period, the subgroup has supported the development of a quality assurance framework identifying priority areas for audit (including self-neglect). The subgroup now has a clear work programme, a new chair from the ICB and also has a deputy chair who also chairs the SAR standing panel strengthening the assurance links and activity between the two groups.
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. Q&E now has access to real time data using Power BI. 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 recirculated in May 2025. The outcomes and analysis will be reported on in next year's annual review.

Board Peer Review	The Chair of the Q&E sub group participated in the first West Midlands Board Peer Review. Coventry Children and Adults Partnership undertook a review of Sandwell's Safeguarding Adults Board and Sandwell used the same tool to review the Coventry Children and Adults' Partnership. It was a positive experience and it will be reported on in 2026's Annual Report.
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. They have come together to support the system, continued to meet and signed the reviewed protocol. The 5 Boards system is supporting the delivery of Trauma Informed Leadership Training in September 2025 to involve all system leaders, including elective members.

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.

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

During the period of 2024-2025 the Sandwell Safeguarding Adult Board have commissioned a total of 2 safeguarding adult reviews.

The SAR Panel subgroup is well attended and has wide representation from partners. Statutory partners include Health (integrated care board), Local Authority and Police. Additional to this the panel is enriched by contributions from Acute Health, mental health specialist, housing and Women's Aid.

The SAR panel discuss and debate both methodologies and key lines of enquiries to ensure that SARs are person cantered and sensitive to the persons friends and living relatives.

In all cases friends' family are encouraged to participate in the review. Methodologies utilised have included practitioner forum events. Staff have been empowered to speak openly in a safe space.

Relatives have been given a platform to share their story.

Strategic Priority 2 Develop more inclusive Performance Data

Themes from local and national SARs are presented at SSAB development days and in other multiagency forums. This data is shared with Quality and Excellence subgroups.

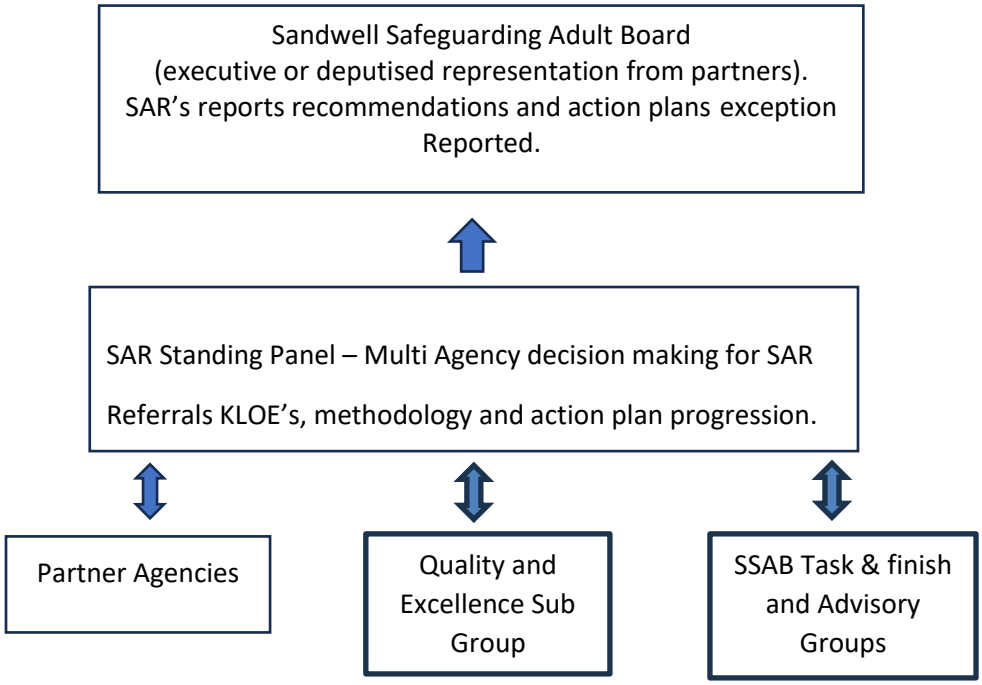
Strategic Priority 3 Embedding learning from Safeguarding Adult Reviews

Recommendations are translated to individual agency action plans. Agencies are requested to update panel members on progression of action to inform service improvement and partnership working. Information and themes are shared with colleagues in the quality and excellence subgroup to support audit planning and data sharing.

The SSAB were proud to host a Conference in 2024, sharing the learning from themes identified in SARs.

Strategic Priority 4 Board Governance

SAR Governance



Looking forward 2025 -2026

The SAR panel are keen to support the SSAB with next year's priority by continuing to include participation of families, cares, friends and frontline practitioners in reviews, ensuring recommendations are responsive to their input.

Share Learning and support awareness of the VARM.

To be committed to support agencies to learn and shape improved services to respond to the needs of Vulnerable Adults.

7. Task and Finish Groups

Sandwell place Task and Finish groups have looked at:

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

Examples of work undertaken by the task and finish groups

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 are supporting DASP to explore and implement VARM within the domestic abuse arena.

Learning Disability and Autism Advisory Group

Members of this group include a range of professionals that support learning disabled adults and adults with autism, both within hospital and community settings. The purpose of the group is to support a community of best practice, share ideas, address challenges, provide assurance to SSAB and inform and share best practice in Sandwell.

Examples of assurance include information and data on adults in long term hospital settings including when they were last seen, when they were reviewed and any updates to care plans.(give a data example)

This group has championed the use of communication passports in a range of settings advocating for them to be used, seen, updated and shared on systems, this has been particularly successful in hospital setting supported by specialist learning disability nurses.

The advisory group has also contributed to SAR recommendations where the SAR involves a learning-disabled citizen

VARM Working Group

This group continues to have oversight and governance of the VARM process, to date it has

- Supported and contributed to the review of the VARM procedure
- Continues to support the champions network
- Contributes to the VARM training offer and newsletter
- Supported the Peer review process
- Considers barriers and opportunities

Hoarding Working Group

The Hoarding working group is multi agency and includes colleagues from across the Black Country, it supports and drives

- The Sandwell Hoarding improvement partnership (SHIP)

- The quarterly symposiums bringing together professionals and Sandwell citizens who exhibit hoarding behaviours to promote improvement, practice change and develop best practice in Sandwell
- There is a current review of the hoarding framework with a focus on improvement which will be reported on in next years annual report and the launch and development of the SHIP you can read about in this report.

Click on the image above to watch this short film.

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
- Regional preparing for adulthood community of practice group, showcasing good practice, developing and informing practice and horizon scanning re key issues
- SSAB have also contributed to a national group on cuckooing as a form of abuse under the exploitation umbrella and resources to support best practice.

8. WHAT OUR ENGAGEMENT HAS LOOKED LIKE

SUMMARY OF ENGAGEMENT APRIL 2024 - MARCH 2025

This year "Listening to the voice of people who use services and front-line practitioners" continued to be one of the boards strategic priorities. The focus of engagement this year included;

- To be visible in the community raising the profile of safeguarding.
- To embed community chats within the community. Allowing individuals to get to know us and what we do.
- To attend voluntary sector meetings to engage and share messages with a variety of organisations across Sandwell.
- To support the workstreams and task and finish groups of the board to ensure the voice of individuals are heard.
- To use training spaces as opportunities to engage with frontline practitioners.
- To contribute to the commissioning teams engagement as part of the pre-tendering process for Healthwatch Sandwell and Carers Service. As well as promoting any other opportunities for citizens to have their say.
- Safeguarding Adults week was an opportunity to focus engagement with over 250 individuals being engaged.

OUTCOMES

37 Community Chat Sessions

3 monthly Community Chats are now held across Sandwell in community venues.

These sessions offer the opportunity to listen to individuals' stories and where appropriate signpost to relevant services. Individuals not knowing about services available to them is a frequent concern during sessions. **79** individuals signposted to services

Consultations

Supported Individuals to participate and signposted to 8 consultation activities

Attended 8 Outreach Events
Connecting with over 250 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.

TOP ENGAGEMENT THEMES

The Key themes from engagement with individuals in Sandwell reflect many of the broader national conversations across the country that also resonate locally in Sandwell.

Accessing 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. ***"The doctors are lovely when you get to see them, but first you have to get to them"***
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. Waiting lists for specialist mental health support and diagnoses causes some individuals to deteriorate while waiting ***"it just keeps gets worse, you feel like you can't get out of the hole"***
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. ***"They leave me alone in the library, I can have a cuppa, sit and watch my DVD player and don't have to put my heating on".*** Many individuals have spoken positively of support received from the voluntary sector such as food banks and activities to prevent isolation.
Challenges facing care providers & professional carers	Care providers have spoken about the challenges of recruiting and retaining staff. The real worry of increase to minimum wage and National Insurance contributions on sustainability ***"If council rates don't increase significantly we just won't balance the books".*** Carers have spoken about the challenges of the job particularly if you rely on public transport. ***"We don't get paid between calls it's okay when calls are close but some are far, in the summer I just walk to be quicker". "Some clients are nice but some don't understand why you are late if you miss a bus between calls".***
Carer Support	Carers feel the physical and emotional strain of caring. They often do not feel they have the right or enough support with the challenges they face. Often I meet individuals with their own health needs that are still caring for others. They feel trapped between their own needs and those they caring for. ***"I don't want or need someone to talk to or benefit advice, I need someone to sit with him a couple of hours a week so I can get out of this house, everyone happy to refer you somewhere else".***
Digital Exclusion	For many older individuals there is a feeling the world is changing to fast, ***"I feel like I have been left behind. They needed to wait to bring all this in you lot understand it, we're to old".*** The difficulties faced if you do not have a smart phone and can follow links sent by text messages to appointments have been highlighted to me.

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. This has been reflected in this report and continues to be a priority for SSAB 2025-2028. There are lots of examples of different ways of engaging within this report, which we will continue to build on.

9. 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, weekly risk surgeries undertaken in partnership with safeguarding, and weekly meeting reviewing all the high risk VARM cases, this meeting includes partners which enables effective information sharing and progress chasing, the Vulnerable Adults Risk Management Framework continues to improve and support 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 chairing of both of these subgroups continues to be supported by partners enabling effective working relationships between both subgroups contributing to greater assurance. The SAR standing panel and SSAB business team continue to review the effective contributions to SAR action plans, this has been greatly enhanced by agencies being invited to personally deliver and explain their progress on action plans on a one to one basis with the chair and lead officer rather than in a group setting. This will be reported on a more detail, in next year's annual report.

SSAB continue to ensure and be assured that we continue to learn from SARS with a range of events and resources developed and feedback on impact.

The SSAB provide partners with access to training, examples include Vulnerable Adult Risk Management framework and chairing meetings, safeguarding e- Learning and the Mental Capacity Act.

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, there have been 2 SARS commissioned they continue to be progressed, and a further 2 SARS published. Please see the links to the report on Shannon's life and her untimely death and a thematic report involving adults with multiple impairments. Please take the time to read these reports and listen to family's accounts. All outstanding work linked to the completion of additional Safeguarding Adult Reviews will be reported in next year's annual report as it will fall within that reporting period.

Shannon's report

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.

Thematic SAR

Practice Changes in Sandwell

- Clear and transparent risk assessment tools
- The introduction of risk management surgeries by Adult Social Care
- Weekly risk management meetings involving partners to review all risks and progress chase VARMS.

The National SAR Research Findings 2019-2023 remain as identified below and reported on last year, however the context is still relevant.

- 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

In order to address the above findings, the National Board Managers and Chairs Network have established 4 workstreams. Sandwell and representatives of the Safeguarding Adults board have been involved in shaping and contributing to the workstreams below:

1. Review the components of the four domains for SAR Analysis and consult with SAR Reviewers, SAB Chairs and SAB Business Manager and where appropriate practitioners in respect of components of positive practice

2. Develop a template for the components of positive practice in response to all types of abuse and neglect – those that are generic and those that are specific to particular types of abuse

3. Produce a progress briefing to the National Chairs Network 9/6/25 and ensure there is continuous collaboration with other workstreams

4. Pilot activity to be undertaken with a small cohort of SABs to review impact of positive practice resource(s). These areas are still to be identified, and the outcome of this National work will be reported on in the annual report 2025-2026.

10. KEY ACHIEVEMENTS

- Sandwell Safeguarding Adults Board participated in a peer review with Coventry, the first review of this kind within the West Midlands Region this has been reported on in this report
- Board members continued to meet in a hybrid manner, some face to face and some over TEAMs. April board development session was face to face and included colleagues and partnership managers from across the Black Country footprint
- 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 welcomed new members, and adult social care are now well represented in this space. Group members continue to contribute to best practice initiatives
- Developed a key communication strategy with partners and all other statutory Boards within the borough
- Continue to add to SSAB e-Learning offer
- Further developed, and monitored the VARM process, continuing to ensure it is embedded in practice. Participated in a Peer Review with Derbyshire and are reviewing the VARM training offer and toolkit
- Continued to develop key learning resources for learning from SARs
- Explored and used a range of different SAR methodologies enabling clear outcomes and effective learning
- Contributed to robust working arrangements across all statutory partnerships in Sandwell and identified priority leads
- 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 including panning regional learning events
- Developed and contributed to a West Midlands Regional SAR Group
- Developed and contributed to training for SAR authors
- 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. SSAB business team are supporting the exploration and use of VARM within the domestic abuse arena. This will be reported on next year's annual report.
- 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 this report, and we will continue to report on the ongoing development of a now Black Country wide effective response to hoarding and conference
- Sandwell Safeguarding Team was nominated for a national award and won! A really positive achievement for the safeguarding team and Sandwell. The team have made a real difference in safeguarding adults; this has been acknowledged and received national recognition! Well done Team.

11. 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)

<u>Strategic Priority 1</u>
Listening to the voices of people who use services and front-line practitioners.

- Black Country Integrated Care Board's complaints procedure reflects and promotes the Parliamentary and Health Service Ombudsman's six principles for remedy:
    - Getting it right
    - Being customer-focused
    - Being open and accountable
    - Acting fairly and proportionately
    - Putting things right
    - Seeking continuous improvement.

- The views and opinions of the patients for whom we commission services for are vital in helping us deliver the best healthcare to our communities. We are committed to providing accessible, equitable, effective services and welcome views about those we provide and are responsible for commissioning. We actively encourage feedback through public participation groups and routinely monitor patient experience feedback with service providers, in joint engagement meetings and through systems such as Quality Concerns. We place a high priority on the handling of complaints, and we recognise that suggestions, constructive criticisms, and complaints, can be valuable aids to improving services and informing service redesign.

- We are confident that we have a clear complaints policy that signposts members of the public to the correct points of contact when the ICB is not the provider of care for a complaint. The ICB's Time2Talk team manages all complaints and Ombudsman investigations that are directed to the ICB. The team oversee all formal complaints relating to ICB service responsibility and signposts other enquiries to commissioned providers in the first instance to encourage local resolution as outlined within the NHS Complaints Regulations. In addition to this there is a robust interface between public complaints, the ICB Time 2 Talk Team and safeguarding professionals.

- In additional to this BC ICB continue to commission a variety of services that seek to support vulnerable children, young people, and adults. One such service is the Identification and Referral to Improve Safety (IRIS) programme within Sandwell and across the broader Black Country footprint. This domestic abuse training and advocacy service within primary care promotes disclosures of domestic abuse with clear pathways for support and advocacy for victims. Case studies are included within each quarterly report submitted by Black Country Women's Aid to demonstrate the impact of the service and the outcomes that are expressed by the individuals who use the service.

Strategic Priority 2

Develop more inclusive Performance Data

- Black Country ICB continue to monitor the data available which includes.

    1. IRIS referrals,
    2. LeDeR data,
    3. FGM Clinic data and outcomes,
    4. Learning from Level 3 safeguarding training for primary care,
    5. Learning from Level 3 safeguarding training within nursing homes across the Black Country.

- This enables the ICB to quality assure the internal process and commissioning of services to ensure that it is delivers the outcomes required to ensure that we have a skilled workforce to safeguard those living within Sandwell who may be vulnerable to abuse. The safeguarding dashboards shared with our NHS providers also enables the ICB to have oversight of training and supervision as part of the contractual monitoring of services.

Strategic Priority 3

Embedding learning from Safeguarding Adult Reviews

- Learning from statutory reviews including SARs is cascaded in a variety of formats and coordinated at place and through Safeguarding Partnership routes. These have included Newsletters, 7-minute briefings, forums, formal training sessions, leaflets, conferences, workshops, and pod casts. As reviews conclude and are published (where applicable) a presentation on key learning and assurance in relation to recommendations are shared across the Black Country at the Safeguarding System Oversight Group (SSOG), where key members from the ICB and NHS providers attend to further cascade learning. In addition to this the ICB also ensure that any training and event opportunities also include this wider learning. The safeguarding team have oversight of internal and multi-agency audits which demonstrate the effectiveness of this learning and to provide assurance to the Safeguarding Adult Board and Children's Safeguarding Partnership that this is embedded within practice.

Strategic Priority 4

Board Governance

- Black Country ICB has a strong presence at the Sandwell Safeguarding Adult Board (SSAB). The Associate Director for Safeguarding & Partnerships is a member of the Executive Committee as well as a Board member. The Designated Nurse for Adult Safeguarding is also a SSAB member, as well as chair of the Quality & Excellence sub-group and Vice Chair of the Sandwell Safeguarding Adult Review Panel. The ICB are also members of the Embedding Learning Task & Finish Group, Domestic Abuse Task and Finish Group, Learning Disability and Autism Advisory Group as well as active participants at the Vulnerable Adult Risk Management meetings and working group.

Case Study example of clear governance

During October 2024 BC ICB Sandwell Place Safeguarding Team submitted a Safeguarding Adults Review (SAR) referral in respect of a 32-year-old gentleman who was residing in a 24-hour care placement. BC ICB identified that this young male had experienced serious harm due to neglect and there were concerns that agencies had not worked together effectively to safeguard him. In December 2024 Sandwell SAR Standing Panel unanimously agreed that the criteria for a SAR had been met. Subsequently, BC ICB Sandwell Place Safeguarding Team undertook work in conjunction with other agencies to improve this young man's quality of life. Including, sourcing a new 24-hour care placement which could meet his specific needs, collaborating with him to develop a person-centred plan, ensuring he had access to appropriate resources and assisting agencies in achieving a coordinated approach to meeting his needs. As a result of this work this gentleman now has an improved quality of life and agencies now have a better understanding of his wishes and feelings and continue to collaborate with him to achieve his goals.

How will the ICB contribute to the SSAB priorities for 2025/28?

Black Country ICB continue to strengthen their contribution as a statutory partner of the Sandwell Safeguarding Adult Board priorities.

Neglect/Self Neglect

- In September 2024, the Black Country ICB Health Neglect Workstream commenced, this work is supported by Adult and Children's Designated Nurses from each place. The aim of this work is to consider the impacts of systemwide neglect and self-neglect from a health perspective. Three initial objectives were to:
- Improve identification and response to neglect and self-neglect.
- Establish a clear escalation process for Was Not Brought/ Did Not Attend concerns.
- Develop protocol to support children, young people, and adults where neglect of medical conditions exists.

Work within this forum continues to develop at pace and the aspiration of this work includes:

- A review of place partnership neglect strategies, consider inclusion of a framework for when to initiate neglect response.

- Include child sexual abuse and parental mental health neglect overlap in strategies and pathways.

- Reinforce neglect and self-neglect message at all opportunities including supervision.

- Consider and review use and effectiveness of WeCan/ GCP2 tools and associated screening tools and identify method of improving compliance with these tools to evidence neglect. Assess tool training compliance and improve (a need from WTTSC 2023).

- Ensure robust health input as part of the multi-agency response to neglect/ self-neglect within place-based partnerships.

- Workstream to function as a conduit for sharing of best practice and learning around neglect/ self-neglect.

- Workstream to advocate for aligning a single Black Country wide process over a 2-to-5-year period to avoid duplication, alleviate resources and evaluate effectiveness and impact of the neglect response for children and adults.

- Share learning and initiatives related to neglect from FFCP across places to start the embedding of ideas.

Hearing People's Voices

- The ICB continue to capture the voice of service users in all its commissioned services.

Exploitation

- An exploitation 'grab guide' has been developed and disseminated to all community pharmacies across the Black Country to raise awareness of this vital safeguarding 'front door', where people being exploited may attend to access support including dressings and emergency contraception, rather than presenting to more visible services such as Urgent Treatment Centres, Emergency Departments or Primary Care services.

- A planned bi-annual exploitation event is being held in September around AI and online exploitation/ abuse for partners to access. The last event in hosted in 2024 attracted ninety-nine health partners across the Black Country and evaluated positively.

West Midlands Police (WMP)

West Midlands Police have continued to support SSAB priorities this year and remain a committed member of the Executive Group, the Board and subgroups.

Officers often come across members of the public with vulnerabilities in our community and make consent-based referrals into Sandwell Police Partnership Team seeking additional support. Our dedicated Vulnerability Officer then assesses and triages the information and refers to the agency or service best placed to support the vulnerable person.

This is supported by the work of Adult Care Abuse Investigation Team (ACAIT) who continue to give victims a 'voice'. During the period April 2024 - March 2025 positive outcomes for Sandwell residents have included two care workers charged with ill treatment/neglect and one person charged with grievous bodily harm with intent. All of our investigations are person-centred, with intermediaries regularly assisting to enable our victims to fully understand the process and achieve their best evidence.

ACAIT work collaboratively with partners including the CQC, Coroner's Office, Adult Social Care and Sandwell Hospital Trust to prevent abuse and neglect of the most vulnerable in our society.

Case Study

Sergeant David Eeles went above and beyond this year by gaining the trust of a very vulnerable male in the community. The victim is in his 70's and experiencing Asperger's, was self-neglecting and was a victim of significant long standing (12 years) Financial abuse and exploitation. Professionals understood him to be trauma-bonded to the perpetrator as he believed they were a victim of crime and abuse. This led to him being conflicted given the differing views of the professionals working with him. He did not trust the police or even himself and these were huge barriers to agencies being able to safeguard him. The situation escalated to the victim being in debt, his physical and mental health had deteriorated to the point where he was begging on the street, using food banks and searching bins for food.

Sergeant Eeles worked extremely hard to gain the victims trust by professionally and constructively building a relationship with him on listening, plain and gentle challenge, and a presentation of factual based information. He was empathetic and prepared to take actions of support including sharing his works mobile number with the victim letting him know it would be ok to call him. This led to the victim acknowledging he was being abused, that he was frightened to withhold money and did want things to change. These were huge steps noted by all given the many years that this case had been ongoing. Partners gave hugely positive feedback to WMP as a result of Sergeant Eeles successful intervention. It was agreed that police would issue the perpetrator with a Community Protection Warning to prevent them from asking the victim for more money.

Unfortunately, the police could not initially locate the perpetrator to serve the notice. However, they were able to demonstrate to the victim over the course of many meetings that the information the perpetrator had given him was false and a fraud investigation was commenced. The suspect was arrested a short time later in February 2025, where they stated that they had been given money freely. They were bailed with conditions not to contact the victim or attend his address, which was initially successful in safeguarding him.

The multi-agency work continued with the victim subsequently having been deemed not to have capacity and with the help of a court order, was moved by the Local Authority with police assistance (after initially refusing to leave his address) to a respite residential home, pending a full court hearing. The victim is now fully safeguarded and thankfully has had no further contact with suspect.

WMP were pleased to be part of the Board Development Day in April 2025 resulting in new priorities being set to reflect the current context in the Borough. Police colleagues will continue to support the progress of all four priorities by working in partnership to make Sandwell Safer for vulnerable people in our communities. Chief Superintendent Madill is the executive sponsor for the Exploitation priority and will be working with tactical leads to deliver against this vital work, ensuring connection to Child Safeguarding and Community Safety who also have similar priorities with an aspiration towards and effective and embedded all age exploitation plan for the Borough.

Sandwell & West Birmingham Hospitals NHS Trust

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

The Safeguarding Team work closely with the Patient Experience Team. In the last 12 months the Trust has developed with service users and carers, 'Getting to know me' and 'all about me' posters. The aim is to understand individuals' who live with or are experiencing cognitive impairment.

To support this individualised care, the Trust has introduced a "Critical Companion" pathway. This pathway allows identified carers to have,

- Extended visiting,
- Stay overnight,
- Free car parking
- Discount at the organisation's food outlets.

The hospital has introduced Patient Safety Incident Response Framework (PSIRF). The introduction of this framework changes how the NHS respond to incidents and has four key aims,

- Compassionate engagement and involvement of those affected by patient safety incidents including service users and their families.
- Application of a range of system-based approaches to learning.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

The Trust has a dedicated complaints team, concerns raised are responded to in an open and transparent way, gaps are identified and action plans developed.

To capture the voice of staff the Trust undertakes regular NHS surveys, responses are collated and shared with employees. The organisation employs speak up guardians which is just one pathway to allow staff to raise concerns.

In response to safeguarding incidents the Adult Safeguarding Team support staff debriefs and plan to introduce Safeguarding supervision in our emergency department.

Strategic Priority 2: Develop more inclusive Performance Data

The Adult Safeguarding Team maintain a dashboard of safeguarding concerns.
During the last financial year, the Trust has employed 2 Learning Disability Nurses who provide a liaison service, supporting both service users and their families. Easy Read information library has been created.
Learning Disability dashboard has been created to mirror the safeguarding dashboard which provides extensive data.
To support patient experience, interpreting services and language line is available to support staff with leaflets in a range of languages.

Strategic Priority 3: Embedding learning from Safeguarding Adult Reviews

The Adult Safeguarding Team participate in the SAR process; frontline practitioners attend the SSAB's embedding learning work stream.
A newsletter is produced by the Safeguarding Team on a quarterly basis. Learning from SARs are presented at quality improvement half days (QIHD). The QIHD have a monthly hot topic, that are

shared Trust wide. During the last year both learning from LeDeR reviews and a patient subject to a SAR review have been presented. This has been presented at Trust board.

Strategic Priority 4: Board Governance
During the last financial year, the Trust has introduced a new governance structure and seen the introduction of a Safeguarding Quality Assurance meeting and Joint adults and children's operational meeting. Information exception reported to Vulnerable Persons Group chaired by our Chief Nursing Officer.

Case Study

Female in her late 30s diagnosed with cancer requiring lifesaving treatment which she had previously declined due to pregnancy,

The pregnancy resulted in a still birth. The spouse exhibited controlling behaviour and prevented his wife receiving cancer treatments. Wife indicated that she did want to explore treatment but was expected to follow her husband's instruction. The lady's husband reported after the death of his unborn baby he did not have confidence in the care and held a strong believe in the healing power of prayer.

The couple have an additional 8 children that reside in the house. Safeguarding Adults, Midwives, Children's team, police, legal team and Local Authority worked together with consultants, arranging for an appointment at a different hospital. Treatment was commenced and the family supported.

SSAB Priorities for 2025 - 2028

- Neglect
- Self - Neglect
- Hearing Peoples Voices
- Exploitation

The Trust are committed to support the SSAB with the priorities agreed, work continues to ensure that we hear the voice of the person and that a think family approach is embedded and adopted. There is a Trust Patient Experience Group that capture the voice of patients, carers and families to ensure this is incorporated into service planning and delivery.
Adult Services continue with a commitment to identify and action Self – Neglect, Neglect and Exploitation.

To strengthen delivery,

- We are working with partners to explore VARM and groups of individuals including homeless population and addiction,
- Ensure staff are aware of a clear referral process for those patients affected
- Introducing a new safeguarding training strategy.
- As a Trust we will continue to participate in workstreams with our partners identified by the board.

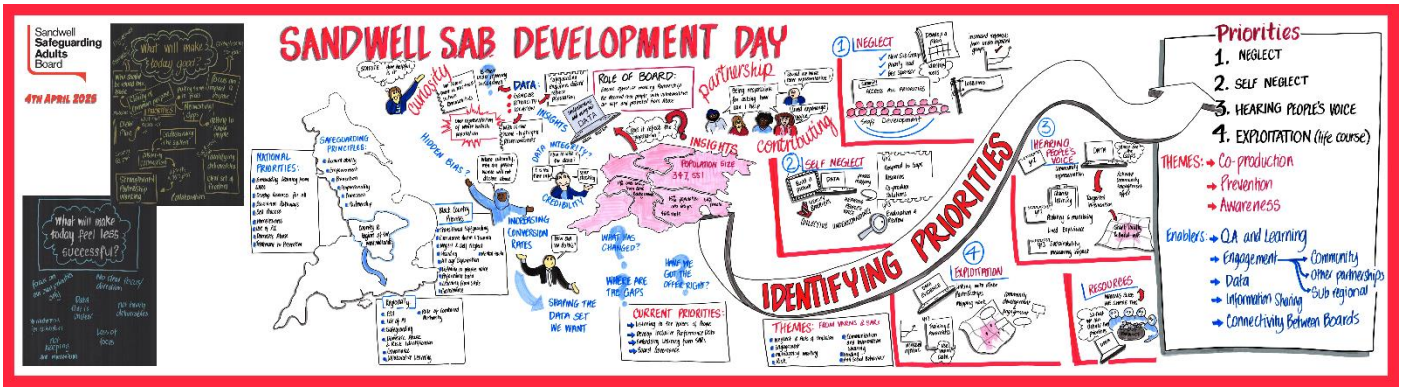
Healthwatch Sandwell
Healthwatch Sandwell are committed members of the Sandwell Safeguarding Adults Board and have been involved in the development of the board's strategic plans.

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 at this time 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.

12. PLANNING FOR THE FUTURE – EXCITING OPPORTUNITIES!



In April 2025 SSAB came together to plan and identify the priorities for the next 3 years! We also invited colleagues from other areas of the black country so we could identify common priorities cross the black country footprint. Partners who share the footprint are supporting SSAB to work across the black country footprint where appropriate and the above graphic demonstrates our place-based work and drivers, our West Midlands wide work, our Black Country wide priorities and opportunities to work together better and lastly our national footprint. As well as generating lots of exciting and better coordinated opportunities the above also gives a sense of Sandwell Safeguarding Adults Board reach and influence. Really positive impact for the citizens of Sandwell, our partnerships and Sandwell place. In addition, there are also the identified points below

- SSAB have appointed and welcome a new Chair, Richard Parry. Richard has introduced himself in the forward of this report, he has successfully overseen Sandwell Safeguarding Adults Board meetings during this reporting period, and supported are Board development day in April where we identified our new priorities 2025-2028.

- SSAB have reviewed and agreed the new strategic priorities and strategic plan for the Board 2025 – 2028, these are commented on in this report

- Safeguarding Adult Reviews and taking forward the learning remains a statutory priority. SSAB continue to plan learning events throughout 2024-25. 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 reviewed and are available on relevant websites.

- SSAB have launched the Sandwell Hoarding improvement partnership, and we have commented on this in this report. We continue to support the ambition to support a peer support network in every town in Sandwell, we currently have 3 effective networks who will receive ongoing support, supervision, resources and tools from the Hoarders Helping Hoarders in the Northwest all free to Sandwell and the wider Black Country footprint.

- SSAB will drive the new priorities through a series of task and finish and subgroups, we have Board sponsors for neglect, self-neglect and exploitation and a real opportunity to drive change and continue to demonstrate best practice, many thanks to all who continue to contribute and drive the work of SSAB

- Take forward the action plans from both of the peer reviews that SSAB participated in

APPENDIX 1

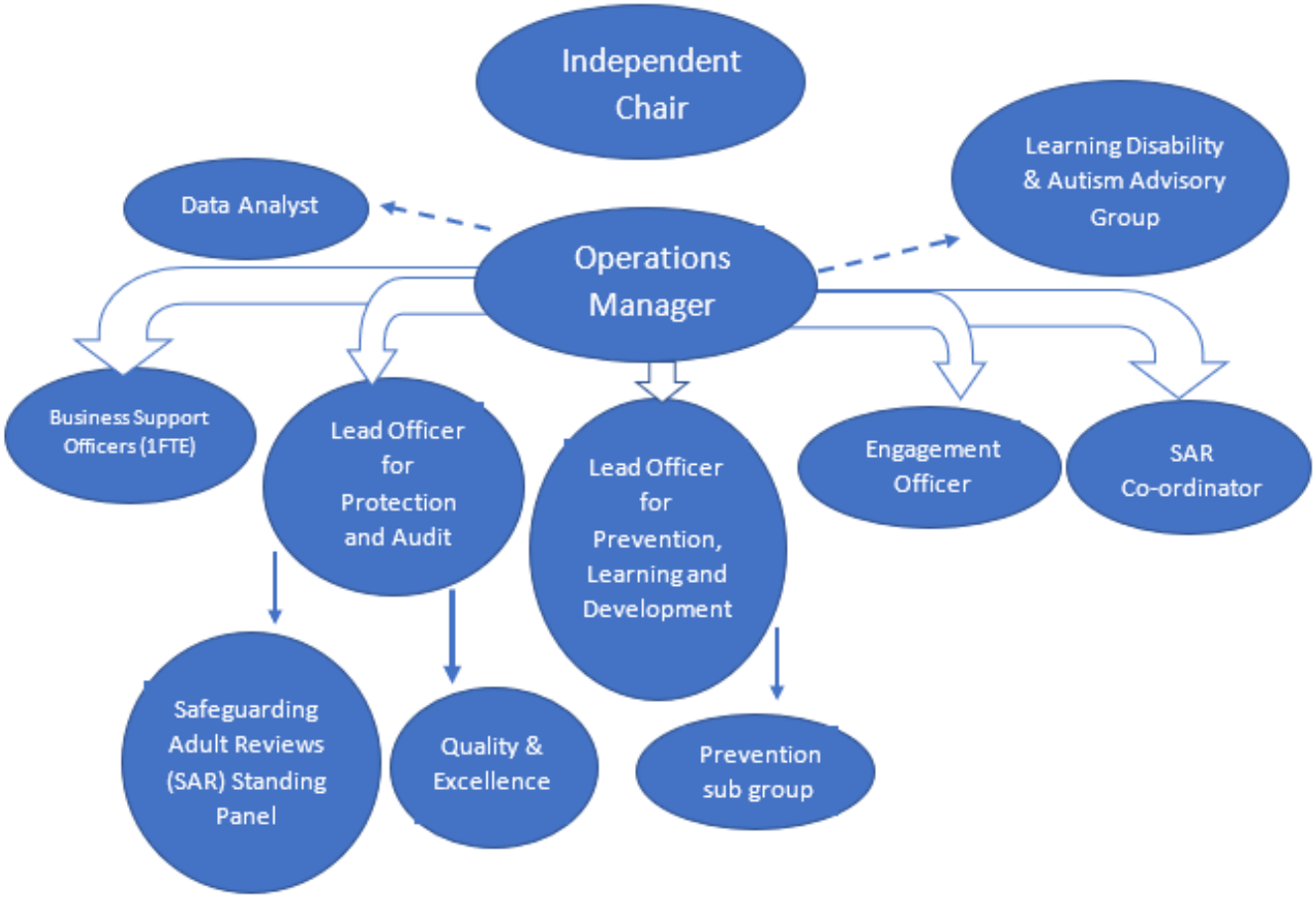
Peer Review Report and Presentation

Final Coventry Peer Review report 9.10.24

SSAB Peer Review final presentation 24.2

APPENDIX 2

SSAB STRUCTURE



APPENDIX 3

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 4

FINANCE AND BUDGET INFORMATION

The work of SSAB cannot be achieved without a dedicated budget and resources. For 2024 - 2025, the financial contribution for the work of the Board came from Sandwell Council, Black Country Integrated Care Board and West Midlands Police.

	2024 / 2025	
	Budget	**% of Total Funding**
Expenditure		
Employees	289,700	
Independent Chair	25,100	
SAR Case Review	40,200	
Training	10,000	
Legal	9,000	
Advertising & Publicity	3,000	
Other Expenditure	4,200	
Overheads	30,200	
Total Expenditure	**411,400**	
Funding		
ICB Funding	(143,500)	
West Midland Police	(17,200)	
Other Fees and Charges	(100)	
Sandwell MBC	(250,600	
Total Funding	**(411.400)**	**100%**

APPENDIX 5

GLOSSARY

Abbreviation	Explanation
ACAIT	Adult Care Abuse Investigation Team
ADASS	Adult Directors of Social Services
BC ICB	Black Country Integrated Care Board
BME	Black and Minority Ethnic
CQC	Care Quality Commission
DARDR	Domestic Abuse Related Death Reviews
DASP	Domestic Abuse Strategic Partnership
DWP	Department of Work and Pensions
FFCP	Families First Contact Point
FGM	Female Genital Mutilation
GP	General Practitioner
ICB	Integrated Care Board
IRIS	Identification and Referral to Improve Safety
LD	Learning Disability
LeDeR	Learning from lives and deaths of people with a learning disability and autistic people
LOOP	Learning On One Page
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	multi-Agency Risk Assessment Conference
MSP	Making Safeguarding Personal
NHS	National Health Service
PSIRF	Patient Safety Incident Response Framework
Q&E	Quality and Excellence
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
SHIP	Sandwell Hoarding Improvement Programme
SHOP	Slavery and Human Trafficking Operational Partnership
SMBC	Sandwell Metropolitan Borough Council
SSOG	Safeguarding System Oversight Group
SSAB	Sandwell Safeguarding Adult Board
VARM	Vulnerable Adults Risk Management
WMP	West Midlands Police
WWTSC 2023	Working Together to Safeguard Children 2023

APPENDIX 6

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/JkqbZyKw5T

Sandwell Safeguarding Board
Annual Report Feedback

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