A Year in Review
How the Board Has Overseen and Led Safeguarding in Sandwell

Sandwell Safeguarding Adults Board

ANNUAL REPORT 2019-2020

Contents

Foreword from the Independent Chair

Six Principles of Safeguarding

- Empowerment
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The most important role in the community is ensuring adults are safe from abuse, exploitation and harm and that is why as part of the Care Act 2014 all Local Authorities were required to establish a Safeguarding Adults Board for their area to ensure that people who have care and support needs are protected.

This Annual Report looks at the work of the Sandwell Safeguarding Adults Board (SSAB) from March 2019 to March 2020 and details the work of the sub groups who do much of the work on the Boards behalf and highlights some of the Boards achievements over the past year.

The Board focused this year on the priorities including those suggestions from the Peer review and committed to a refreshed membership and approach. This year partners in Sandwell agreed to review the Board membership and ensure that senior decision makers from the statutory and voluntary and community sectors were at the table to discuss these most important issues. The year ahead will see further developments to how the board operates. Members were also committed to ensuring that learning from Safeguarding Adult Reviews into serious incidents was a priority. With the other Boards in Sandwell (Children's Community safety and Health and well-being) work was undertaken to look at all the reviews that had taken place across the partnerships into deaths and serious incidents to understand any common themes and to start to work together to embed the learning into all organisations. This work continues and remains the highest priority.

I welcome the closer working that has been developed with the voluntary and community sector and with Healthwatch. Working with both will enable the board to hear the views of people who use services to ensure that any developments are based on real experiences. The year ahead will develop this involvement further as well as hearing the voices of staff who work across these vital services. One of the roles for the Board is to identify measures that could help prevent abuse and harm and this work with the third sector will be key. The Board benefits from involvement with regional and national colleagues and the SSAB Board Managers role as Co-Chair of the regional Board managers network.

I would like to thank all partners for their commitment to the Board and the Chairs and members of the sub groups. Thank you too of course to the Board Manager and the Business unit whose work behind the scenes enable the Board to function. Finally thank you to all the staff who work in Health and social care supporting people and helping to keep them safe. As this reporting year ends and we are at the start of a pandemic even more heartfelt thanks to all who work in these services.

Sue Redmond, **Independent Chair**

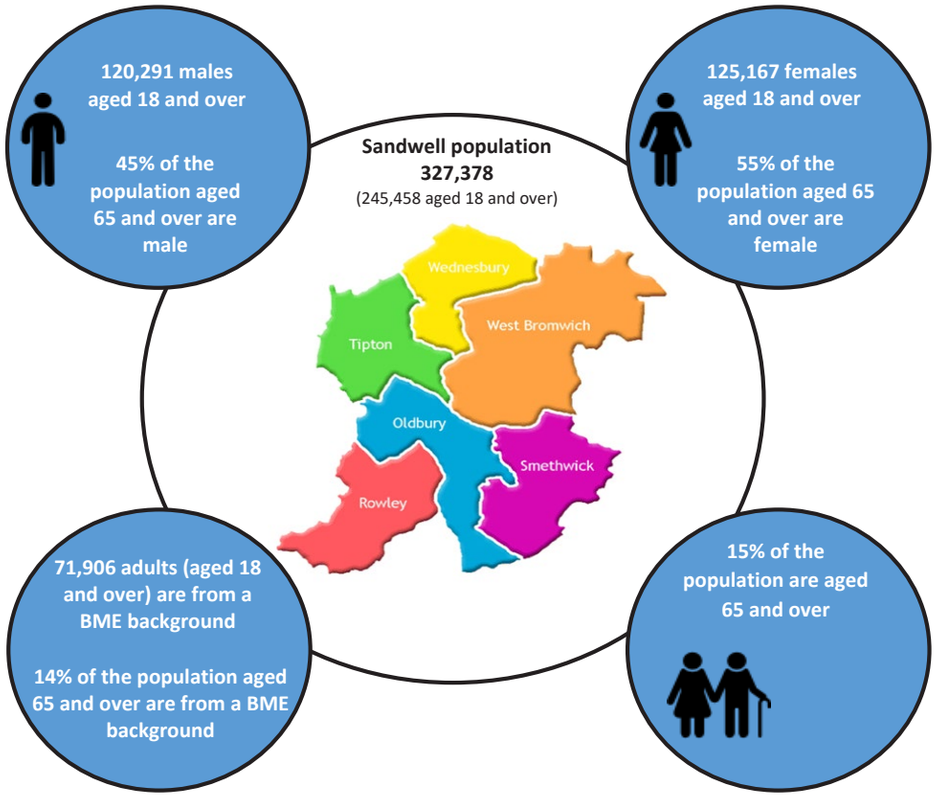
Sandwell at a Glance

Sandwell covers 33 square miles

Sandwell is made up of six towns (see below)

Sandwell has 24 Electoral wards

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



Population Breakdown in Sandwell

75% of the population are aged 18 and over

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

Data Sources: Office for National Statistics 2018 Mid-Year Estimates, 2011 Census, Table: DC2101EW - Ethnic group by sex by age

Sandwell Residents by Ethnic Group

(2011 Census)

White British 66%

White Other 4%

Mixed/Multiple 3%

Asian 19%

Black 6%

Other Ethnic Groups 2%

Data Source: 2011 Census, Table: DC2101EW - Ethnic group by sex by age

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.

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

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

www.sandwellsab.org.uk

SSAB Board Development

Summary and Update

In January 2019 SSAB held a Board Development Day including Board Members and Partners.

An outcome of this day was a commitment to refreshing Board Membership ensuring Board Membership comprised of senior members of representative organisations that can make decisions and commit resources.

"The Safeguarding Adults Board should assure itself that there is clear line of sight in each organisation at Chief Executive and Board level" (January 2018 Peer Review Recommendation)

Partners gave a further commitment to;

Developing a model of effective engagement with the citizens of Sandwell including the principles of co-production

An ambition to influence practice through learning from Safeguarding Adult Reviews (SAR's)

Agreement of Board Priorities 2019-20

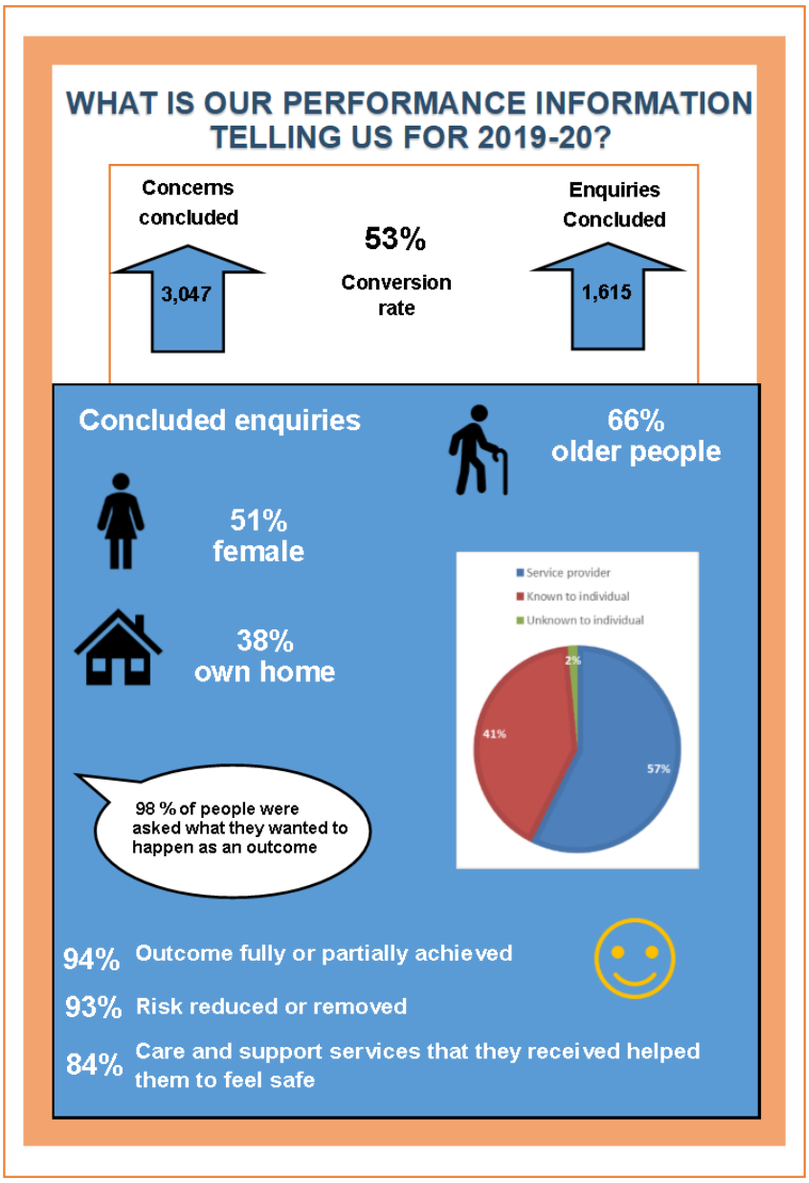
In June 2019 the refreshed SSAB met for the first time with a smaller, more senior membership including representation from the third sector.

Agreements reached included;

Membership and seniority appropriate and will enable effective decision making and partnerships

Priorities identified and agreed as;
1. Listen to the voice of service user and frontline staff
2. Develop more inclusive Performance Data
3. Look at Sandwell's 'front door' including Safeguarding pathway, referrals, criteria, and thresholds.
4. Specific Projects to be discussed with the four Statutory Boards which all focus on Prevention
5. Board Governance

What is our Performance Information Telling Us 2019-2020?



We have looked at our data taking into account the previous year's data, regional data and national data for 2018-19.

This year the number of safeguarding concerns reported to Sandwell Metropolitan Borough Council (SMBC) as the lead agency for safeguarding adults, has increased and the conversion rate from concern to enquiry has also increased. Not all concerns raised become safeguarding investigations, other responses may have included signposting or a proportionate response that ensured an individual was safe. This demonstrates that the key messages delivered through social media and campaigns on how to report a safeguarding concern and what is safeguarding are being understood and acted upon. We can also see from the data the areas we need to continue to focus on.

We can see from our data who raises concerns, for example a family member, police, housing, hospital and other sources and we can see which of these concerns becomes a safeguarding enquiry.
Most concerns are raised by Social care staff (from within the Council or care agencies and care home settings) however the amount of concerns raised that then go on to become safeguarding enquiry continues to remain high from members of the public. For this reporting period of the 6% reported concerns from the public 27% of those concerns became active safeguarding investigations. This would suggest that the work around the See Something Do Something Campaign and helping communities to better understand safeguarding is having a positive impact.

38% of abuse in Sandwell takes place in an individual's own home, this is in line with the regional and national average however for Sandwell this does represent a reduction in comparison to both last years reporting period and previous years. This remains a prioiritiy for the Quality & Excellence Sub Group in terms of understanding the impact of neglect and financial abuse which are the primary types of abuse identified as happening in an individuals home.

Identifying abuse where it happens in an individual's own home is challenging. Individual's may not in the first instance think they are being abused and we need to consider the impact of isolation and loneliness as these factors may make it harder for individuals to report abuse.
Furthermore work has been undertaken with colleagues from the Domestic Abuse Strategic Partnership (DASP) to better support and enable professionals to consider domestic abuse when financial abuse has been identified.

All of the concerns that are raised and dealt with are representative of the Sandwell population.
In the 18-64 age range 35% of people have long term care and support needs and have formal support funded by Adult Social Care (ASC) and 11% of individuals from within this age range are from a Black and Minority Ethinic (BME) background.

In the 75-84 age range 29% of people have long term care and support needs and have formal support funded by Adult Social Care (ASC) and 4% of individuals from within this age range are from a BME background.

Sandwell has consistently been able to demonstrate that citizens involved in a safeguarding investigation were asked what they wanted to happen as an outcome of involvement from professionals. Of the number of people who expressed an outcome 94% felt their outcome at the end of the safeguarding process was fully or partly met.

The Board receives data from SMBC about whether individuals and/or their representatives feel they are safer because of the help they received from people responding to the safeguarding concern and for this reporting period 73.5.% of people said they feel as safe as they want to and 84% said care and support services helped them feel safe.

We continue to monitor as part of safeguarding practice whether as a consequence of intervention the risk posed to the individual was reduced or removed. Risk enablement is a fundamental approach to making safeguarding personal.

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

Summary of Progress Against the Board's Priorities 2019-20

PREVENTION & LEARNING & DEVELOPMENT: Continue to raise awareness of adult abuse communicating effectively with all partners and members of the public	
What did we want to achieve	What did we achieve…
To develop a specific issue campaigns.	Promoted publicity material in the five community languages predominant in the Sandwell Borough Participated in national Safeguarding Week and local outreach events. Agreed the extension of the See Something Do Something Campaign with the potential to commission three short films focusing on whole family, domestic abuse and modern slavery.
Specific Projects to be identified with a focus on Prevention	SSAB is developing a strong Prevention offer, as a partnership we have strengthened our links with the third sector and continue to build on an ambition to take an inclusive approach to safeguarding and craft in partnership with the third sector and 'early help' offer for adults that is place based. SSAB and Prevention Sub Group also continues to look at systems and ensuring that partnerships are effective across systems including when safeguarding referrals come in through Sandwell's front door.
Listen to the voice of service user and frontline staff	To support SSAB in its commitment to ensuring partnership work reflects both the views of staff and citizens of Sandwell the SSAB Business Team has recruited to the post of Development Officer with a focus on Engagement. This has included a range of projects including, 'What does co-production look like?', accessible information and an opportunity for citizens to tell their story and identify their priorities and outcomes. In the coming year this work will inform the boards priorities
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.

QUALITY & EXCELLENCE: Continue to focus on effective delivery and high-quality processes	
What did we want to achieve	What did we achieve…
Continue to support the development of the Q&E Sub Group.	The Chair continues to work hard to ensure the membership of the sub group is inclusive, and that data and intelligence is used to understand the nature of abuse in Sandwell and the relationship to changes made in practice. The sub group now have key lines of enquiry.
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. Partners contribute to the discussion about meaningful data and the dashboard continues to grow in line with the key lines of enquiry. On 26.11.2019 SSAB, Sandwell Council and Clinical Commissioning Group (CCG) representatives participated in a regionally based task and finish group looking at what does good look like? 'for dashboards and what key information should be included? This information has been well received across the region and has shaped data templates and data collection.
Develop a multi-agency self-assessment tool.	Care Act Compliance Self Audit Tool developed and sent to partners for completion 2019. Challenge Event to be established in 2020 to consider scrutiny of data including all partner learning.
Continue to understand the implementation of making safeguarding personal and the impact for service users.	Continue to collect data that reflects citizens views on how safe they feel including whether as part of their safeguarding investigation what they wanted to happen happened, or if it didn't there is a clear explanation as to why it didn't happen, for example, a citizen may want a member of staff in a care agency to lose their job as a consequence of a safeguarding concern this may not be a legitimate outcome of the safeguarding investigation but the citizen would need to feel safer as a consequence of the investigation. SSAB's work on engagement is further expanded upon later in the report.
Continue to work with all colleagues under the auspices of the 4 Boards arrangement as outlined in the partnership protocol.	SSAB continues to work in partnership with the other key statutory boards within the Borough; **Sandwell Safeguarding Adults Board** **Health & Wellbeing Board** **Sandwell Children's Safeguarding Partnership** **Safer Sandwell Partnership** **Domestic Abuse Strategic Partnership** Work together to consider and develop cross cutting solutions for example, training, and within the latter part of the reporting period contributed to the set up and running of the Executive Place Group which supports a cross partnership agenda and place-based approach.
Board Governance	SSAB has been refreshed and now reflects a senior and smaller membership. Board governance continues to be managed by key and statutory partners and the SSAB Independent Chair and a revised governance document has been written (Board Members Handbook) to reflect this.

PROTECTION: Contribute and influence the strategic development of practice and undertake safeguarding adult reviews.	
What did we want to achieve	What did we achieve…
To ensure local policies and procedures continue to be written and reviewed in line with the West Midlands Policies and Procedures.	All policies and procedures are now Care Act compliant including additions and amendments to the Care Act in line with West Midlands procedures. This is reflected in operational activity. SSAB actively contribute to the West Midlands Regional Editorial Group ensuring all relevant changes and developments to legislation are communicated effectively to all partners.
Arrange for Safeguarding Adult Reviews to be undertaken as required, produce report and action plans and identify learning	SAR 2 - criteria met, Author commissioned SAR 3 - criteria met, Author commissioned SSAB being supported by Legal Services to obtain relevant information. Further SAR referrals submitted throughout the reporting period and their progress and decision-making is being supported by Board Members, the SSAB Independent Chair, the Protection Sub Group and SSAB Operations Manager.

Sub-group contributions

Supporting the Board we have three Sub Groups who completed the following work so that people can better live their lives free from abuse and neglect.

Quality and Excellence Sub-Group

• Monitored the Boards performance using a Dashboard receiving assurance reports and data

• Circulated West Midlands Care Act Compliance Audit Tool (WMCACT) to all partner organisations represented at SSAB. This common audit framework is a self -assessment tool enabling organisations to determine what they do well relating to adult safeguarding and areas for improvement.

• Q&E undertook some high-level analysis of the outcomes of the self-assessment returns identifying what's working well and areas for improvement with all organisations. A detailed challenge event will be held in 2020

Developed key lines of enquiry including:

- Training
- Location of abuse person's own home and factors that contribute to that
- Conversion Rate

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.

Membership are committed to showing both qualitative and quantitative data enabling better understanding of a citizen's journey and ensuring voices are heard.

Protection Sub Group

This Sub Group has a positive representative membership. It now has a new Chair from West Midlands Police and all members actively contribute to key decision making particularly with reference to Safeguarding Adult Reviews and identified learning.

During the reporting period four SAR's have commissioned and one did not meet the criteria. Although not completed key highlights include;

• Inappropriate management and/or lack of recognition of risks

• Lack of understanding of decision making and mental capacity

• The need to establish clear systems to ensure multi-agency working remains effective

Prevention Sub Group

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

- Mental Capacity Act
- Safeguarding in a range of settings
- Hate Crime

The Prevention Sub Group works in partnership with the Quality & Excellence Sub Group ensuring the data informs campaign planning and Outreach work. Themes are reflected in the Newsletters and trends are identified.

In addition, SSAB continues to develop its links with the third sector, this is reflected in Board Membership and in projects undertaken on behalf of the Board. The SSAB Operation Manager and Prevention Lead attended a third sector Health and Social Care Forum where we talked about the role of the Board, adult safeguarding and undertook an exercise using mentimeter to establish participants understanding of adult safeguarding and ways in which they felt the SSAB could assist them in their tasks.

Learning & Development Sub Group

The Learning and Development Sub Group have looked at how training is delivered, what partners offer. Changes have been made to the programme for 2020/21 to reflect the views voiced via the training needs analysis and as a result the Board will offer more e-Learning and Best Practice Events as it as opposed to formal face to face training (face to face will still be available on a quarterly basis instead of monthly)

The sub group have adopted the regional Competency Framework which gives everyone a level playing field in deciding levels and content of training versus job roles.

Training figures and needs have been analysed and the group are collaborating with Sandwell Children's Safeguarding Partnership (SCSP). Safer Sandwell Partnership (SSP) and Domestic Abuse Strategic Partnership (DASP) to offer a collaborative training offer with a mix of face to face and eLearning. The group have identified areas which will see training opportunities realised in the 2020/21 period.

A combined catalogue and training platform was initiated and collaborative workplan was created for the 2020/21 period.

The L&D Sub Group also takes forward the learning identified from SAR's often using Best Practice events with case studies to highlight key learning. The sub group has also identified opportunities with partners to ensure that key learning from SAR's is also taken forward across the partnership. For example, the CCG commissioned some training for GP's on safeguarding and the trainer used examples with reference to engagement and missed opportunities from a SAR commissioned by SSAB. Furthermore, the sub group is researching how to better embed this learning into practice.

What Engagement Has Looked Like

Introduction

The safeguarding peer review undertaken in 2018 recommended a focus on

''Work with local communities and people who use services to ensure that your customer journey reflects Making Safeguarding Personal and your ambition around asset-based approaches."

In response to the above recommendation SSAB Operations Manager created a development worker post within the SSAB Business Team to develop engagement strategy and work incorporating the principles of co-production and reflecting SSAB's priority to;

"Listen to the voice of service user and frontline staff".

Work Undertaken July 2019 – March 2020

- Engagement Plan developed
- A program of outreach activities undertaken involving individual users and community groups to ensure a diverse range of engagement and opportunity
- Face to face conversations have also been undertaken with adults with care and support needs, family members where appropriate and frontline staff from a range of settings
- Key themes identified examples include
    - The value of timely support
    - The need to feel listened to
    - Support for informal carers
    - The importance of trusted relationships and the investment of time and opportunity to build those
    - The value of feedback
- Consolidation of key partnerships in particular with organisations who directly support adults with care and support needs has also enabled effective conversations with reference to increased opportunities (for example paid employment for adults with care and support needs)
- SSAB are exploring the opportunities to consider effective engagement across all the statutory boards within the Borough and within the West Midlands region

Future Engagement

The Covid-19 pandemic impacted engagement work March 2020 which includes the end of the reporting period. The engagement activity and plan will need to be reviewed to reflect and understand this impact ensuring that people can still be heard and listened to and safe.

Our Learning from Safeguarding Adult Reviews (SAR'S)

WHAT ARE SAFEGUARDING ADULT REVIEWS?

The Care Act 2014 introduced statutory Safeguarding Adults Reviews and 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.

In 2019-20 we have started two reviews and considered a further four and three of those will progress to full reviews. Of the three that are being progressed terms of reference have been agreed and authors identified. The two reviews in progress have been delayed at the end of this reporting period because of Covid-19.

LEARNING

Two SAR's in progress have identified issues relating to mental capacity and effective risk management. Particularly in relation to a shared and common understanding of the risk both to an individual and others.

One SAR in progress involved numerous agencies and high risk, however, it is yet to be understood if the level of risk was appreciated by all agencies involved and whether that understanding could have prevented a tragic death.

Key Themes Identified

- **Absence of effective communication between all parties** - leading to confusion about who was taking things forward and who was responsible for what impacting negatively on the citizen who was then perceived as not working well with agencies
- **Nature and seriousness of risk not identified and/or effectively communicated to relevant parties** – there is evidence in one SAR currently being progressed that there was a significant risk posed to self and others by the citizens behaviour on an ongoing basis, however, when the immediate risk was managed there were no ongoing management strategies and one agency was left to manage the entire risk. In other SAR's there is evidence that the risk was not identified and therefore not shared appropriately with partners
- **Evidence supporting inadequate consideration of mental capacity that was decision specific and timely** – evidence of generalised statements that a person lacks capacity with limited evidence of the thinking rationale or process to support that statement.

- **Missed opportunities** – evidence in ongoing SAR's are potential missed opportunities to engage more effectively with the citizen despite numerous people demonstrating best efforts to support individuals there is evidence that this support either lacked coordination, was not timely or was not presented in a way that promoted effective engagement with and for the citizen
- **A lack of understanding about the impact of drugs and alcohol on someone's capacity to make key decisions** – resulting in a lack of understanding of executive capacity and function, the impact of a cocktail of drugs and alcohol on capacity, an assumption that this is a lifestyle choice and a lack of consideration as to the components of self-neglect and what that looks like

In a nationwide audit report (Learning for the police from Safeguarding Adult Reviews: Quarter 4 briefing) released January 2020 a number of police forces including West Midlands Police considered the learning themes identified within 45 SAR's, this is further broken down as 42 deaths and 3 cases of significant harm. The 42 deaths were categorised as;

- 10 cases of homicide
- 5 deaths in house fires
- 5 suicides (1 relating to abuse)
- 2 unclear

In this national piece of research 17 of the SAR's considered were found to reflect a key theme of self-neglect.

A perceived refusal on behalf of the citizen to look at any support or action that would change their condition or situation, yet their condition often presents a high level of risk to self and others (Social Care Institute of Excellence 2018).

Self-neglect can often come with specific risks for the individual. Hoarding for example, a prominent feature of self-neglect, can increase the risk of fire within the home.
It is important that the police refer specific risk, such as the risk of fire, to the individual agency, rather than relying on other agencies to identify risk and share appropriately* (this was a key issue in an ongoing SAR in Sandwell)

** Learning for The Police from Safeguarding Adult Reviews Quarter 4 Briefing*

REGIONAL SAR LEARNING

During the reporting period SSAB Operations Manager and Lead Officer have participated in and contributed to the development of a Metropolitan West Midlands Safeguarding Adults Review Group. We have developed;

- A regional SAR referral process
- A regional SAR process including an in-depth understanding of a range of appropriate methodologies
- Standardised paperwork ensuring all partners have a common understanding of the process and how to trigger it
- Contributed to the development and application of SAR quality markers
- Contributed to national discussions on the development of a national SAR library enabling effective sharing of information and learning across the region and a national footprint
- Contributed to discussions with reference to a commissioning framework for authors enabling appropriate skill development and costs
- Considered key themes evident in SAR learning across the region

Key themes identified;

- Understanding around mental capacity and its application
- Understanding risk and effective information sharing
- Considering the relationship between capacity and drug and alcohol use and ultimately self-neglect
- The impact of loneliness and isolation

Key Achievements

- Board membership refreshed and met under new arrangements
- Agreed Board Priorities
- New governance arrangements and members handbook written and agreed
- Engaged the Department of Work and Pensions in Safeguarding
- Reviewed and contributed to the Regional West Midlands Safeguarding Procedures
- Contributed to the Regional Uniformed Services Group
- Updated on Learning from SAR, Domestic Homicide Reviews (DHR), Learning Disabilities Mortality Reviews (LeDeR) & (CSPR) in Sandwell, 2018 to 2020
- Developed publicity material in the five principle languages of the Sandwell Borough
- Developed a key communication strategy with partners and all other statutory Boards within the Borough
- Added to SSAB e-Learning offer
- Delivered Safeguarding training to frontline staff and providers
- Supported a range of Engagement Events including a presence at staff briefings and the Sandwell Six Towns Event
- Contributed to and lead on the West Midlands Association of Directors of Adult Social Services (ADASS) group
- Developed and contributed to a West Midlands Region SAR Group
- Developed and contributed to training for SAR authors
- Held a SSAB Business Team Away Day looking at areas for development and good practice
- Developed robust relationship with Domestic Abuse Strategic Partnership ensuring the development of a relevant training offer to frontline social work staff
- Contributed to training to frontline staff on the Liberty Protection Safeguards

Partner contributions

Black Country Health Care NHS Trust

During 2019/2020 the Safeguarding Department welcomed the effective and positive contribution of a Specialist Safeguarding Practitioner, employed to support the Safeguarding agenda across both the Adult and Children's teams which has further underpinned the application of Think Family and will also provide resilience to Sandwell Multi-Agency Safeguarding Hub (MASH), which previously had only one practitioner from the Trust supporting the Mental Health and Learning Disability function.

Significant work has taken place to strengthen the governance assurance process within the organisation with the Safeguarding and Governance Assurance Unit Leads firming up the reporting schedule and the management of partner information requests such as DHR, SAR and Section 42 enquiries. As a direct consequence of this work, clinicians, divisional leads and senior executives of the Trust are more actively engaged with the culture of safeguarding, further promoting that Safeguarding is Everyone's business. The Head of Adult Safeguarding is also an active participant in quality and safety meetings, the review of Route Cause Analysis and Assurance reports which enables Safeguarding principles to be embedded into front line practice and improve the outcomes for patients and service users and we completed the Care Act Self-Assessment Audit Tool and contributed to high level analysis.

Active participation in partner meetings, MARAC, Channel Board Subgroups was demonstrated throughout the year, with positive contributions made to the working groups considering the business of the Safeguarding Partnerships and how agencies could actively and effectively support this.

The coming year will see the following;

- Black Country Partnership National Health Service NHS Trust merged with Dudley and Walsall Mental Health Trust in April 2020. The new Trust 'Black Country Healthcare NHS Foundation Trust' will focus its efforts on building the new organisation. The Safeguarding Department will confirm its structure and business plan to ensure that patients and service users receive the best possible service to remain safe and free from harm, abuse and neglect. This will be supported by reflecting on current practice level activities and drawing the best from both areas and making them exceptional, aligning where safe and possible to do so Safeguarding policies and procedures taking into account there are regional variations in contract monitoring and some of this policy alignment work will be done within the Sustaining and Transformation Partnership/Integrated Care System (STP/ICS) work.
- Further monitor and audit the Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) paperwork to ensure that best practice is being followed. Where areas for strengthening are noted, support will be tailored to respond to this.
- Review of current attendance and contribution to partner agency meetings to ensure that the new organisation effectively uses its resources, avoids oversight or duplication of effort and keeps safety, well-being and person-led principles central to all its activity.

Sandwell Metropolitan Borough Council (SMBC)

Safeguarding adults is one of the highest priorities for Sandwell Council continuing to aim for a high-quality service that keeps people safe from harm.

We have continued to:-

- focus on people and the outcomes they want, valuing the difference that is made;
- provide collaborative leadership – we have supported integration and holding partners to account – key to cross agency engagement and effectiveness.
- make sure that concerns are addressed proportionately, and we do not miss the very real serious concerns.
- Work with Commissioning and Contracts Management, sharing safeguarding intelligence around internal/external providers.

The performance of the Safeguarding Operational Team is regularly checked and audited. Each quarter the Performance Team will continue to produce a safeguarding dashboard that presents safeguarding data, including sources of referrals, categories of abuse, locations of abuse, outcomes for Adults, the number of Concerns and Section 42 Enquiries, ethnicity/age/gender of Adults referred etc.

Key priorities for the future

- To ensure all agencies and partners fully understand and agree on the definition of abuse under the Care Act (2014) legislation.
- Ensure quality data on the use of the Mental Capacity Act is collected and analysed to monitor its usage and identify any areas for concern (usually undertaken via audits)
- SSAB to continue to support and have a safeguarding training and development strategy, that audits, delivers and monitors attendance/completion.

Sandwell and West Birmingham Clinical Commissioning Group (SWBCCG)

We listen to the voice of the service user which include the following who are or were suffering from domestic abuse.

The joint SSAB/SCSP training brochure has been promoted and circulated across the organisation including member practices, this has also been disseminated through the Chief

Executives weekly news brief.

We continue to engage with SSAB via the Protection Sub Group and Quality & Excellence Sub Group. We actively engage in identifying key themes and learning from SAR's and ensure that they are reflected in training that we deliver or commission. An example of this is training we commission for G. P's where they are introduced to neglect and self-neglect as some of the themes with respect of safeguarding and the trainer linked the learning package to the themes identified in Adult A SAR commissioned by SSAB in 2018/19.

We were also actively involved in a regional task and finish group looking at effective data sets for dashboards and what good assurance looks like. This included the production of a set of data standards and examples of group dashboards across the region and we completed the Care Act Self-Assessment Audit Tool and contributed to high level analysis.

Sandwell & West BIRMINGHAM Hospital Trust (SWBHT)

140 Sandwell patients attending Sandwell & City Hospitals were referred to the Accident & Emergency Independent Domestic Violence Advocate (IDVA) service for support to address domestic abuse.

- We attend SAR's, SSAB Sub Group and support events.
- We contribute to the SSAB Annual Report and offer assurance.
- We comply with the Care Act 2014
- We have a commitment to provide Adult Safeguarding training to its staff.
- We provide Independent Medical Review (IMR) reports for SARs where the organisation has been involved.
- We completed the Care Act Self-Assessment Audit Tool and contributed to high level analysis.
- Quarterly steering group will continue to ensure concerns are escalated
- SWBH will continue to attend steering groups, Board meetings and conferences.
- Learning will be reflected in policies and disseminated to the work force.

West Midlands Police (WMP)

The Adult at Risk Team investigate the following:

• Position of Trust concerns involving a registered carer or an Adult with Care and Support needs.

• In ALL cases the victim needs to be an Adult with Care and Support needs.

• The offences team investigates matters of abuse: Physical, Sexual (excluding Domestic Abuse) and Financial abuse and all Suspicious deaths, unless identified as a Homicide.

• The team are dedicated Investigators, not Safeguarding officers, this is the responsibility of all staff.

We now Chair the SSAB Protection Sub Group as well as send a representative to the sub group to enable active participation in safeguarding adult review decision making and partnership working.
We actively participate in the West Midlands Uniform Services Group and work hard with partners to provide appropriate data and assurance across the metropolitan West Midlands footprint.
We completed the Care Act Self-Assessment Audit Tool and contributed to high level analysis.

Third Sector Representation

SSAB has third sector representation from Board Members however is committed to strengthening the working relationship. Members of the SSAB Business Team and the SSAB Operations Manager attended a third sector Health and Social Care Forum where we talked about the role of the Board, adult safeguarding and undertook an exercise using mentimeter beginning a constructive conversation about how to more effectively work together to promote a broader understanding of safeguarding across a range of organisations working within the sector.

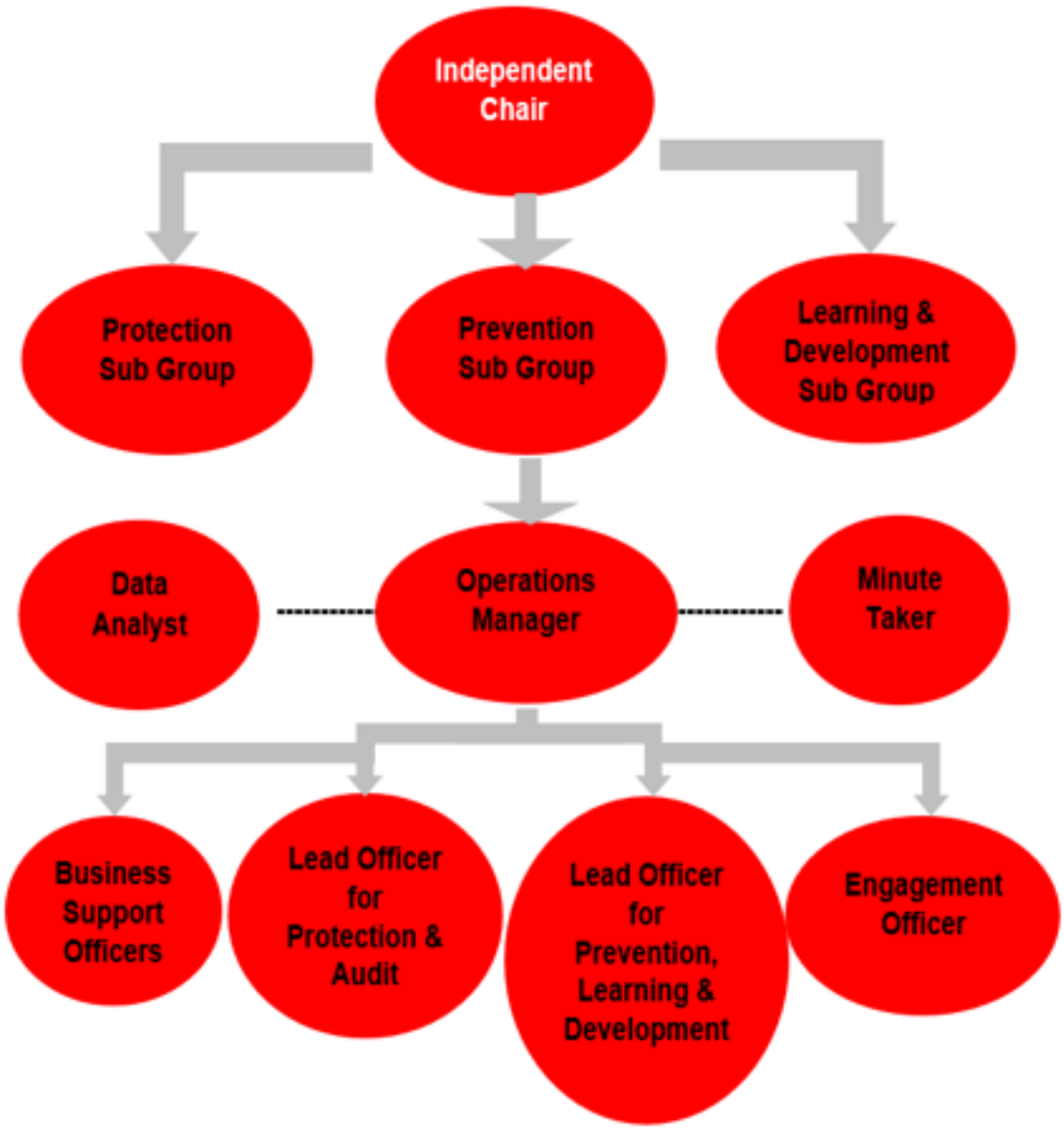
There has also been an ongoing conversation supporting the development of an early help partnership with adults who experience a range of impairments and who potentially have care and support needs. Healthwatch are committed to working in partnership to ensure the voice of the citizens of Sandwell are heard and that all activity is appropriately grounded in people's experience.

Strategic Priorities for 2020 - 2021

- Listen to the voice of service user and frontline staff
- Develop more inclusive Performance Data
- Look at Sandwell's 'front door' including Safeguarding pathway, referrals, criteria, and thresholds.
- Specific Projects to be discussed with the 4Boards which all focus on Prevention
- Board Governance

Appendix 1

SSAB Structure



Appendix 2

Board Membership

Black Country Partnership Foundation Trust
Clinical Commissioning Group
Healthwatch
Safeguarding Adults Board Operations Manager
Safeguarding Adults Board Independent Chair
Sandwell Adult Social Care & Health & Wellbeing DAS
Sandwell & West Birmingham Hospital Trust
Sandwell Council of Voluntary Organisations
West Midlands Police

Appendix 3

Finance and Budget Information

The work of SSAB cannot be achieved without a dedicated budget and resources.
For 2019-20, the financial contribution for the work of the Board came from Sandwell Council, Sandwell Clinical Commissioning Group, and West Midlands Police.

SSAB's core budget has four constituent parts:

- Independent Chair - two days a month
- SSAB staff salaries and expenses
- Funding to deliver the 2019- 2020 training programme
- Miscellaneous.

Miscellaneous costs include:

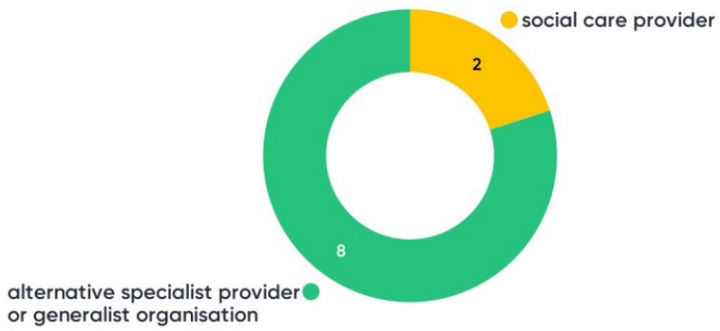
- Board Member training and development
- Venue, hospitality and other costs for sub group meetings, learning events (outside the training programme) and other multi agency group meetings
- Costs for printing and distribution of leaflets and posters etc
- Safeguarding Adult Reviews
- Website maintenance and support costs.

Appendix 4

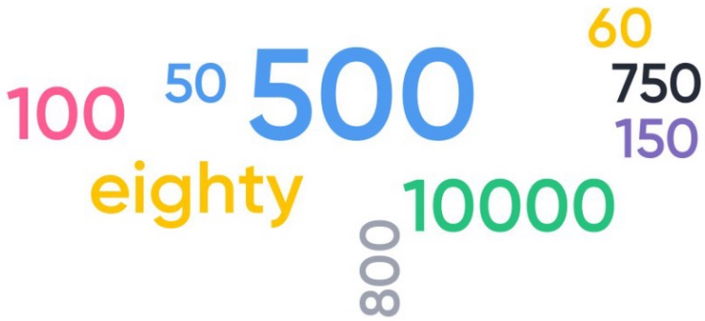
Mentimeter

Sandwell Safeguarding Adults Board working with Sandwell's voluntary and community sector

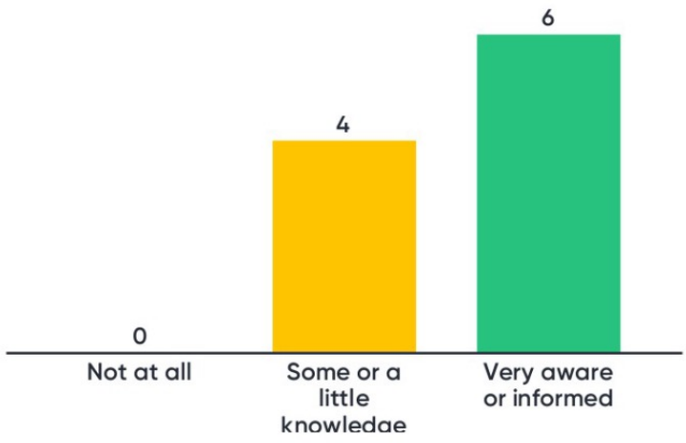
Is your organisation principally a:
i) health care provider
ii) social care provider
iii) alternative specialist/generalist org



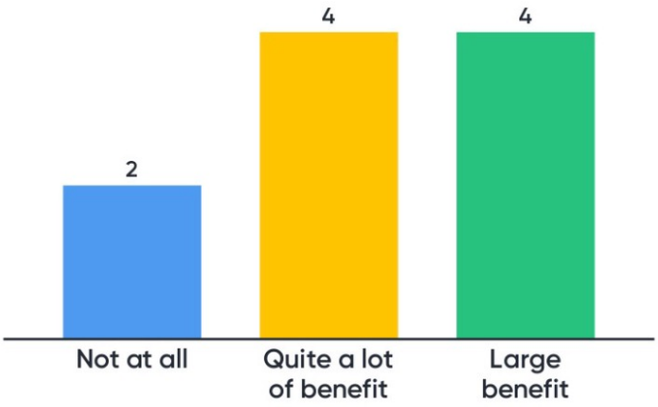
Approx. how many adults in your community or client group who you might consider vulnerable do you reach/engage/support each year?



How informed/aware do you feel about the activity of the SSAB?



To what extent does your org benefit from SSAB support to keep members of the community/service users safe & improve quality of life?



What is the most helpful way in which the SSAB helps you keep people in your community/service users safe and improve their quality of life?

Training	Information and support	Safeguarding Awareness Training
Training	Information and training	Safeguard training for all staff/volunteers.
Process Driven	Useful work with safegustding team re information a s support	Information and training

Appendix 5

Glossary

Abbreviation	Explanation
ADASS	Adult Directors of Social Services
ASC	Adult Social Care
BCPFT	Black Country Partnership Foundation Trust
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
CSPR	Child Safeguarding Practice Reviews
DASP	Domestic Abuse Strategic Partnership
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
GP	General Practitioner
IDVA	Independent Domestic Violence Advocate
IRIS	Identification and Referral to Improve Safety
LeDeR	Learning Disabilities Mortality Review Programme
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act (2005)
NHS	National Health Service
SAB	Safeguarding Adults Boards
SAR	Safeguarding Adults Review
SMBC	Sandwell Metropolitan Borough Council
SSAB	Sandwell Safeguarding Adult Board
SCSP	Sandwell Children's Safeguarding Partnership
SSP	Safer Sandwell Partnership
STP/ICS	Sustaining and Transformation Partnership/Integrated Care System
SWBCCG	Sandwell and West Birmingham Clinical Commissioning Group
SWBHT	Sandwell West Birmingham Hospital Trust
WMAS	West Midlands Ambulance Service
WMASFT	West Midlands Ambulance Service Foundation Trust
WMCACT	West Midlands Care Act Compliance Audit Tool
WMP	West Midlands Police

Appendix 6

Feedback form

Can you please help by providing us with feedback on the content of this report?

You may wish to print off this page and return this in the post to:

Sandwell Safeguarding Adults Board
100 Oldbury Road
Smethwick
B66 1JE

Or, alternatively contact the Sandwell Safeguarding Adult Board Admin Support on **07388858414** to give verbal feedback.

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

To improve the report next year can you please specify what information or areas you would like included:

_____

_____

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Who can I tell my concerns to?

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

In an emergency ring 999