Sandwell Metropolitan Borough Council *Delivering Scorecard Priorities through successful scrutiny*

Agenda Item 4

Health and Adult Social Care Scrutiny Board

16 February 2017

Sandwell Safeguarding Adults Board Annual Report 2015-2016

The Board will receive a presentation from the Chair of Sandwell's Safeguarding Adults Board and the Board's Business Manager on its Annual Report 2015-2016.

Sandwell
Safeguarding
Adults
Board

SSAB@SSAdultsBoard

Sandwell Safeguarding Adults Board

ANNUAL REPORT 2015/2016

Sandwell Metropolitan Borough Council

Sandwell and West Birmingham Hospitals NHS Trust

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Foreword from the Chair

Welcome to Sandwell's Safeguarding Adults Board Annual Report 2016.

Hello all,

It has been another busy year for the board continuing to embed the principles of the Care Act in all safeguarding training and operational activity.

We continue to work in partnership to ensure we work effectively to better protect adults at risk of harm (people with support needs).

The board maintains its commitment to working with adults at risk from harm to ensure that they continue to be at the centre of all planning and decision making.

We have strengthened our relationship with Healthwatch who are working with us to promote and develop an infrastructure to enable effective service user involvement.

The board is committed to the development of its own website enabling easier access for all. This will be operational from autumn 2016.

The board has participated in an internal audit conducted by SMBC looking at our internal processes and accountability and evidenced that there is a robust framework in place that provides substantial assurance to all. This is a positive outcome.

I look forward to the forthcoming year and the on-going work of the Safeguarding Board including the active campaigns and ensuring that the citizens of Sandwell are involved in raising the profile of safeguarding and making Sandwell a safer place to live.

This year we have included a feedback form in the Annual Report and I would encourage you to complete it and include any suggestions you may have for future content.

Eddie Clarke

Independent Chair,

Sandwell Safeguarding Adults Board

Legal Framework

- a quick reminder

Who is an adult at risk?

"An 'adult at risk' is defined as an adult (a person aged 18 or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is, or may be unable to take care of him or herself, or unable to protect him or herself."
Department of Health Guidance 2013

- Local Authorities have a statutory duty to have Safeguarding Adults Boards;
- Local Authorities have a statutory duty to make, or cause to be made, Section 42 enquiries when it is thought that an adult with care and support needs in its area, may be at risk of abuse or neglect;
- Safeguarding Adult Reviews are mandatory when certain triggering situations have occurred and the parties believe that there is cause for concern over the way relevant parties worked together to safeguard an adult, and boards will have the discretion to undertake reviews in other circumstances;
- Agencies have a duty to co-operate over the supply of information;
- Local Authorities have a duty to fund advocacy for assessment and safeguarding for people who have substantial difficulty in being involved in the process and do not have anyone else to speak up for them;
- Existing duties to protect people's property when in residential care or hospital are reaffirmed; this could include pets.
- There is a duty of candour on providers of health or adult social care about failings in specified circumstances, and a new offence will be created of supplying false or misleading information, in the case of information they are legally obliged to provide.

Work of the Board

The Sandwell Safeguarding Adults 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 examples of which is the current campaign 'See Something, Do Something' and the short film used to further promote this campaign and enable everybody's understanding of safeguarding.

This film is used as a standard tool in all of our training and has been adopted and used widely by our partners.

Below is a quote from one of our partner's that has used the short film in their training;

"I have just shown the video clip.

You could have heard a pin drop in the room! I asked for feedback- these are some of the words used – powerful, hard hitting, contextual, get use of agencies and neighbour in the scenario – not the 'usual people' that are associated with providing care which makes it more striking and real.

Thanks for letting me use it!"

The film can be viewed by going to:

https://www.youtube.com/watch?v=l1f0WZEuKno

Currently, twelve agencies are represented on the board - see Appendix 1 for a list of board members. It is agreed that the Care Quality Commission will attend and report on their activity at one board meeting a year. The board also has the support of a Cabinet member who attends meetings whenever possible and the previous post holder participated in various adult safeguarding events.

The board meets quarterly to oversee progress and to develop and monitor multi-agency strategies, practices and standards.

The board is supported by a small business team of Officers and a Board Business Manager. In addition to this professional advisers and safeguarding leads assist in the delivery of the board's business.

The Partnership accesses a large network of health and social care providers from statutory, voluntary and private sectors, to promote the welfare of adults at risk.

Throughout 2015-16 the Sandwell Safeguarding Adults Board was represented on the West Midlands Editorial Group.The safeguarding policies and procedures of the group are used by all agencies and have been adopted by all 14 Safeguarding Adult Boards in the West Midlands region. All documentation has been reviewed and revised to reflect the new government legislation and guidance.

Regional guidance has been developed in the areas of Self Neglect, Safeguarding Adult Reviews and Positions of Trust. Work was undertaken to ensure that all the documents are both Care Act and Making Safeguarding Personal compliant. This is to secure a consistent approach to safeguarding adults across the West Midlands region.

The Sandwell Safeguarding Adults Board is well established and provides strategic leadership

for adult safeguarding work and seeks to ensure there is a consistently high standard of professional response to situations where there is actual or suspected abuse.

The board also oversees the effectiveness of the arrangements made by individual agencies and the wider partnership to safeguard adults from abuse.

The board has four meetings a year and would aim to have annual development days.

The focus for future development days would be common areas of safeguarding with our partners and developing our understanding of new areas of abuse as identified in the Care Act.

Minutes of Sandwell Safeguarding Adults Board meetings are not currently included on the Sandwell Council website; however, the SSAB are developing their own website and all minutes and documentation will be available upon completion of the website. Target date for completion is December 2016.

All current safeguarding forms can be downloaded using the link below:

http://www.sandwell.gov.uk/downloads/download/1359/safeguarding_adults_forms_guidance_policies_and_procedures

One Serious Case Review (now called Safeguarding Adults Reviews) was commissioned and undertaken during 2014/15. The final report has been presented to the Protection sub-group of Sandwell Safeguarding Adults Board completed July 2016 and an action plan will follow along with a programme of review and best practice events.

Summary of progress against the Board's priorities 2015/16

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…
Improve local understanding of adult safeguarding.	Sandwell Safeguarding Adults Board adopted the 'See Something, Do Something' campaign in conjunction with our partners in Neighbourhood Services. This campaign was launched at our Prevention Conference in October 2015. Resources were developed as part of this campaign including leaflets, posters and a commitment to producing a short film.
Engage the community in understanding their contribution to safeguarding.	Sandwell Safeguarding Adults Board contributed to the Safer Six Campaign, visiting towns within the region, holding information sessions and discussing how to report concerns for both members of the public and professionals. Sandwell Safeguarding Adults Board made a commitment to develop a service user engagement strategy; this will be scoped out over the forthcoming year in partnership with Healthwatch with an operational target of October 2016.
Undertake a scoping exercise and community mapping identifying the range of prevention work currently being undertaken within the community and statutory services.	Mapping and scoping exercise still to be undertaken. Revised deadline to be agreed.

QUALITY & EXCELLENCE:	
What did we want to achieve	What did we achieve…
Continue to focus on effective delivery, high quality processes and services improving the way we work with adults at risk of harm in Sandwell.	We now have a performance dashboard for all partners on the board to contribute to. This requires further development and is subject to active review.
Contribute to the development of a self-assessment audit tool against the West Midlands self-audit standards.	Audit tool to be developed. However contributions are being made to a regional audit tool.
To present both qualitative and quantitative data to the board to give assurance of the safeguarding quality and processes.	The new performance dashboard provides quantitative data to the board. Qualitative data is now also shared at the board on a quarterly basis by all partners and the service user experience is included in the commentary that supports all data collection.
Monitor the appropriate use of Deprivation of Liberty Safeguards.	The supervisory body (the Council) reports to the board twice a year.

PROTECTION: Contribute and influence the strategic development of practice and undertake safeguarding adult reviews.	
What did we want to achieve	What did we achieve…
Care Act Readiness – ensure local policies and procedures are reviewed in line with West Midlands guidelines and agreed by the board.	All policies and procedures are now Care Act compliant including additions and amendments to the Care Act in line with West Midlands procedures.
New SSAB Forms produced in line with Care Act requirements – disseminated and used by all partners.	The Concern and Section 42 form were launched in October 2015 and are in use. A review of all forms was undertaken in February 2016 including all partners and the forms are being updated and relaunched in accordance with agreed amendments. A revised Concern form is now in use. Work on the paperwork reflecting investigations and plans continue to be undertaken and are due for completion October 2016.
Undertake Safeguarding Adult Reviews (SARs) as required – produce reports and action plans as a result.	Undertaken one SAR to date, awaiting publication. Reviewing the SAR referral process and working with partners to determine appropriate reporting.
To ensure that a Designated Adult Safeguarding Manager (DASM) is in place in all core agencies.	The need for a specific role is no longer a requirement of the Care Act; however, each agency has a responsibility to have their own position of trust procedures. A local audit exercise to be planned for 2016/ 2017.

Case studies and good practice

Safeguarding Case Studies – Good Practice

The Safeguarding Audit process has enabled management to review cases and identify both learning points and areas of good practice. Below are two examples that identify evidence of good practice:

Case Study 1 - Mr H

Mr H (named for the purpose of the case study)

Detail of Concern

Received in January 2016, raised by close family members concerned about Mr H being 'emotionally and psychological abused' by a 'female friend'. Concerns related to the friend being an alcoholic and drug user, using Mr H's property as a drinking den, exploiting, influencing and financially abusing him – being intoxicated in the early hours of the morning.

Findings

The worker demonstrated good practice:

Contact was made with the referrer and concerns were clarified.
An unannounced visit was made to see Mr H.

Using the principles of Making Safeguarding Personal (MSP) Mr H's wishes and feelings were sought.

Mr H's capacity to understand the concerns and risks being raised was assessed.

The worker respected the referrer's confidentiality yet being very clear with Mr H about the concerns being raised. The worker raised the specific concerns regarding financial abuse and Mr H was clearly able to explain each scenario advising that he had loaned money that was paid back. The worker was able to take a holistic approach to assessing the safeguarding concern and noted Mr H's concerns around his feelings of isolation.

Outcome

The incident of 'emotional and psychological' abuse was not substantiated and closed within reasonable timescales. The worker demonstrated not only 'Making Safeguarding Personal', including Mr H's views and wishes but also illustrated professionalism and the ability to have clear and direct discussions that given the detail of the concern referred by close family members is challenging in itself. Mr H was referred to day services to assist him to reduce the risk of social isolation.

Case Study 2 – Ms S

Ms S (named for the purpose of the case study)

Detail of Concern

This was received by the team from Sandwell Hospital in November 2015. The concern related to Ms S, resident of H Residential Home when she attended the hospital with carer as she had a right arm injury, bruising to the shoulder area and a dislocated shoulder.

Findings

The worker demonstrated quality practice for the following reasons:

- Concern appropriately progressed to S42 Enquiry and recordings provide clear reasoning behind the given decision.
- A series of visits to the Home to gather information and maintained regular telephone/email updates with the Home's Manager.
- Evidence of working together with the Home Manager – direction and clarity by the worker in requesting the manager took the lead in the S42 Enquiry.
- Evidence that immediate action undertaken by the Home Manager, suspending the member of staff that later resulted in dismissal given the evidence found of poor and unsafe practice that was being undertaken.
- Evidence of the worker liaising with other professionals, Police and Quality Team.
- Evidence of the worker liaising with family representative –Ms S known to have mental health issues.
- Evidence of Case Conference – confirming outcomes of the enquiry and highlighting actions/recommendations for the Home to put in place to ensure the safety and wellbeing of Ms S and all residents.

Outcome

The incident was substantiated in that the findings of the enquiry confirmed poor quality of care provided by a member of staff that resulted in the staff's dismissal. As a result further risk assessments and measures were put in place by the Home's Manager to manage the wellbeing of all residents.

Partner contributions

1. Sandwell Metropolitan Borough Council

Service User Experience

What information is available to service users regarding the safeguarding process?

Adult Social Care utilise the information that is provided on the Safeguarding Adults website – which is inclusive to the leaflets that are also available from the SSAB.

How do service users give feedback regarding safeguarding processes?

On completion of the Safeguarding Process – the worker will provide either the person, advocate or family member/friend a copy of a questionnaire so that they can express the quality of their experience of the safeguarding journey.

ASC has also incorporated MSP into the safeguarding process. This also allows an opportunity for the service user to state what they wish the outcome of the safeguarding process to be.

How do you evidence your activity has made a difference?

There are a number of ways in which ASC seek to assess the effectiveness of the Safeguarding input into cases:-

- *The Making Safeguarding Personal process allows the ASC to assess whether the outcomes that the service user identified at the start of the process were achieved and therefore puts the individual at the centre of the process.*
- *The Operations Manager via an in-house tracker database ensures that ASC monitor repeat incidents as well as trends identified. This data is used to ensure that the Safeguarding Team work robustly with the Quality Team and other officers to ensure that there is a coordinated approach when dealing with Safeguarding concerns.*

Can you identify your key safeguarding achievements for the year 2015/16?

How do you evidence that your activity has made a difference?

ASC monitor the statistical information around MSP data through the year to seek to ensure that the service user remains at the heart of the process.

What were your identified priorities for 2015/16 and what are your current priorities for the forthcoming year?

2015/2016

- *To work with partners to implement the Care Act 2014.*
- *Devising the new process/ procedures to be in line with the Care Act 2014.*
- *To create a MSP action group to embed the principles into practice.*

2016/2017

- *To continue to embed the MSP principles in practice.*
- *To create 'one form' to record information around the Safeguarding cases from concern to closure.*
- *To devise an audit tool in line with the Care Act 2014.*
- *To continue to audit Safeguarding cases bi monthly across ASC (Community, Mental Health and Safeguarding) and disseminate the learning.*
- *To continue to monitor trends in Safeguarding to ensure that ASC takes a coordinated approach when dealing with complex cases.*
- *To ensure that staff are trained in line with new areas of Safeguarding.*
- *To prepare for the Peer Review in 2016.*

Training

What training has been provided to staff?

ASC ensure that they promote the training provided by the SSAB – Managers/ Practitioners training on Safeguarding, Mental Capacity training and Deprivation of Liberty Safeguards (DoLS).

Over the 2015/2016 training has also been provided on the following:-

- *Alongside Birmingham Council two days of training was provided on Community DoLS.*
- *Training has also been provided on Modern Slavery and Forced Marriages.*
- *An in house training event was also provided on the Mental Capacity Assessments.*
- *Training on the provision of IMCA.*

Who (posts and responsibilities) has received training?

The training identified above was open to all staff in Adult Social Care, however, specific emphasis was placed on the Safeguarding Team and the leads for the Community Teams.

How do you evidence this has made a difference to practice and understanding of safeguarding?

The training provided is subsequently monitored in supervision/appraisals by the relevant line managers to ensure that learning from events attended are embedded into practice.

The Audit process also allows ASC to monitor the effectiveness of training in practice but also allows ASC to monitor any gaps in learning and develop or commission new training where required.

Performance Data

Do you complete the SSAB Performance Framework template?

ASC provide the SSAB data for the performance framework.

How do you use the data you provide to the SSAB in the performance template?

The data set that is provided to the SSAB is utilised to assess both the good practice that is present in the council but also enables ASC to identify any areas of learning and develop action plans in relation to these areas. The information supports areas for development.

How does your data assure the SSAB?

The data provided to the board identifies the key statistical information, this has been useful as a basis for discussion and will form a basis for the Q&E Sub-group to consider and request additional assurance and information in specific areas.

How do you evidence this has made a difference?

ASC seek to present case studies in the performance report that highlight the difference that the Safeguarding Process has made to individual cases.

ASC provide extensive data in the performance report – which displays both good practice and learning areas – ASC also provide information on actions that they will be taking on specific areas of concern. Subsequent performance reports provide evidence of the actions taken and outcomes of such.

Safeguarding Adult Reviews

Have you contributed to any SAR's?

There were no SAR's in 2015.

What was the outcome?

n/a

How was any identified learning shared?

n/a

How would you evidence this intervention made a difference?

n/a

2. West Midlands Fire Service

West Midlands Fire Service continue to be active participants in the activity of the Sandwell Safeguarding Adults Board and its sub-groups particularly in Prevention and Protection.

Practical examples of the West Midlands Fire Service engaging in the prevention agenda include direct work with social landlords improving the safety of properties and completing safe and well checks in people's homes ensuring the risk of fire or outbreak of fire is better managed by occupants and to provide additional support by referring to other agencies as required. This contributes to the 'one door' approach in identifying people that are at risk or need additional help.

In addition the West Midlands Fire Service continues to develop a portal which ensures that all referrals are actioned and signposted appropriately to all relevant agencies.

The Sandwell Hub that is funded by Public Health and managed by West Midlands Fire Service was re launched in May 2015. There are over 40 agencies that use the Hub and the numbers of referrals are steadily increasing. There has been an increase of 40% in the number of referrals in the last 12 months.

- In Sandwell Local Authority Area the Crews carry out Safe and Well Visits – many of which are the result of the referrals from partner agencies.

- In 2015/16 WMFS had 120 Vulnerable Person Officers (VPO) cases in the Sandwell Area.
- People seen by the VPOs in that year presented with the following issues:
    - 38 Hoarders (an increase from 26 last year)
    - 30 smoking issues or careless disposal of cigarettes
    - 25 with mobility problems that would delay their exit in the event of a fire
    - 32 people had dementia or a mental health issue (an increase from 21 last year)
    - Other cases involved heavy alcohol use, drug taking, leaving items on the cooker, candles, squatters and unsafe storage of oxygen cylinders

- Many of the cases above had multiple issues and all increase the risk of fire or serious injury. This is especially so when we have cases that involve hoarding, careless disposal of cigarettes and alcohol use in the same case.

- The case numbers above are only those that are considered to be complex and referred to a VPO. There are many more cases that are dealt with by a Crew either during a Safe & Well Visit or following an incident.

- The top 4 areas of the Borough where cases were referred are:
    - West Bromwich – 38
    - Oldbury – 23
    - Smethwick – 16
    - Tipton – 16

The Fire Service have engaged with and sought help from Partners to reduce the risk of those in need and undertook to train agencies and Partners to identify the risks and how to refer their service users for safety checks.

When a Serious Incident i.e. Fire Death or serious injury occurs the Command undertakes its own Review, where agencies involved are invited to discuss lessons learnt which are shared with the Safeguarding Board.

3. West Midlands Police

West Midlands Police were subject to an independent inspection by Her Majesty's Inspectorate of Constabulary (HMIC) in July 2015 Police effectiveness, efficiency and legitimacy programme, (PEEL) vulnerability inspection, was in relation to the Force's effectiveness, efficiency and legitimacy to keep people safe and reduce harm.

The report was published in December 2015 and made a number of recommendations which were accepted by the Force. An improvement plan was drawn up to address the issues highlighted within the report and recommendations are being progressed under the governance of the Assistant Chief Constable and a Detective Chief Superintendent.

Service User Experience

WMP have a comprehensive internal and external communications strategy which incorporates the WMP website (**www.west-midlands.police.uk**) that not only provides the public with general information regarding organisational communication and information, but includes hyperlinks to local geographic areas, including Sandwell Local Policing Unit (LPU) so that localised, specific safeguarding information and police contacts can be accessed 24 hours a day.

WMP conduct victim satisfaction surveys to assess the service that both victims of crime and members of the public have had when in contact with the Force. This is to enable the organisation to improve, enhance and develop our performance and processes. In addition to this the Force conducts single agency audits in relation to the Force's compliance to the "victim's code", which is a Home Office directive. This is to ensure that all victims receive tailored support to cope, recover and be protected from revictimisation. The results of such audits are fed back to the Local Policing Units to identify opportunities to improve the victim's experience.

Key Safeguarding Achievements 2015 - 2016

Over the last reporting year WMP has seen an increase in the volume of cases (crime and non-crime vulnerable adult investigations) that have been reported in relation to vulnerable adult abuse. The Force recorded **734** crimes which had a vulnerable adult offence type marker between April 2015 and March 2016, which was **12%** higher than the previous year's **656** reports. Of those recorded **60** offences occurred within Sandwell Local Authority area, where the police were identified as the lead agency. During the same period there were **102** non crime numbers obtained in relation to vulnerable adults within Sandwell. WMP received **1998** calls for service from Nursing and Care homes within the Force area, of which 303 calls were made from Nursing and Care homes within Sandwell.

Sandwell has also seen an increase in the volume of cases (crime and non-crime domestic abuse investigations) that have been reported in relation to domestic abuse. Sandwell recorded **2168** crimes which had a domestic abuse offence type marker between April 2015 and March 2016, which was **17%** higher than the previous year's **1853** reports. During the same period there were **4339** non crime numbers obtained in relation to domestic abuse over this same time period, which was **4%** higher than the previous year's **4183** reports. Of the recorded crime there were **869** positive outcomes for victims of domestic abuse within the local authority area which equates to **40%.**

The increase in reporting supports the investment WMP has made into the vulnerability portfolio, both in relation to resource and training. This has resulted in officers and staff recognising this type of crime and ensuring that incidents are recorded and investigated appropriately. It also reflects that the public have greater confidence in the police response when reporting such incidents.

Training

The Force has invested heavily in a structured learning and development training programme for all areas of vulnerability. WMP officers and staff have completed comprehensive training inputs in relation to vulnerability on designated training days and safeguarding inputs form part of initial Police training. Sentinel is WMP response to increase the awareness of vulnerability and learning and development is a key strand in raising awareness for all front line staff.

WMP employees are also required to complete 'E-learning' packages that are provided through the National Centre for Applied Learning technologies (NCALT) system. An example of this is Detective Inspector Mark Burnell (Adult at Risk Team) in conjunction with learning and development has produced an e-learning package that is in the process of being delivered across the Force to ensure that all front line staff are aware of their safeguarding obligations in relation to the Care Act. This is in addition to bespoke training being delivered to contact centre staff to understand the Care Act and what is expected as a WMP response.

Tailored training events have also been delivered to Adult Safeguarding Managers across the seven Local Authority area's to provide an overview of "Criminal Threshold". This training also includes an understanding of the Police procedures when pursuing prosecutions.

Performance Data

WMP provide quarterly data returns to the board, enabling the sharing of police information to enhance multi-agency discussion. This data is in relation to:

1. Vulnerable Adult total recorded crime
2. Vulnerable Adult total recorded non crime
3. Offences where there is a disability marker in relation to an Adult
4. Missing Adult data
5. Police attendance at both Nursing and Care homes within the Local Authority area.

WMP has a Daily Management process where performance information is shared and critical incidents are raised, allowing the Force to respond effectively and efficiently deploying appropriate resources to match calls for service. This has resulted in times of high demand for additional resource to be flexed across the Force to support the variety of teams within the Public Protection Unit. The Service Improvement Team within public protection also collates data which sits within Force systems in relation to reported crime / non crime and outstanding offenders. This data is presently in a monthly document to ensure that the risk around reported incidents are monitored and appropriate resources are allocated to match demand.

Safeguarding Adult Reviews

WMP recognise the importance of learning attributed to SARs, DHRs, and SCRs, and as such have invested in a dedicated Force Review Team. The team are responsible for all aspects of work related to statutory reviews. Learning from SARs, DHRs, and SCRs is now routinely embedded across all themes of Force wide training delivered to all WMP staff regardless of role or rank, and is a theme that continues in future Sentinel and supervisor training. Learning that results in recommendations for WMP are tracked by way of a recommendation tracker governed by the Crime Governance Board, this is chaired by ACC Foulkes. Progress on the completion of recommendations is accountable to Crime Governance Board and features as an agenda item on a quarterly basis. Over the last reporting year there have been no requests from Sandwell Local Authority in relation to potential SAR's that occurred within the Local Authority area. In context WMP's Force Review Team have supported the initial scoping of four SAR's across the region.

WMP priorities for the forthcoming year are still awaiting to be set by the Police and Crime Commissioner but the Force continues to be focused on preventing crime, protecting the public and helping those in need. Priorities will continue to be focused on violence, vulnerability and prevention.

4. Black Country Partnership Foundation Trust

The BCPFT Adult Safeguarding Team

This year saw significant changes to the Black Country Partnership NHS Foundation Trust (BCPFT) adult safeguarding team in that its membership (5 staff) was almost entirely replaced due to retirements and staff movements from September 2015 onwards.

The team has used its "fresh eyes" to identify where improvements are necessary and possible, generating a number of actions in the categories of:

- Quick wins – issues that can be resolved promptly
- High risks – matters which need immediate attention
- Long standing – issues for which remedies have proved elusive

Increased reporting of safeguarding adults concerns

As a NHS Trust we have seen an increase across the year in the reporting of adult safeguarding concerns and a number of possible reasons for this have been identified including:

- Implications of the Care Act including removal of the threshold for reporting of "significant harm" and focus on "making safeguarding personal" may have increased those events now recognised as requiring a safeguarding response
- Increased staff training in safeguarding adults levels 2 & 3: has in all probability raised staff awareness of adult safeguarding
- The facility to record safeguarding concerns on DATIX (the trust risk management & reporting system) became available from October. This may account for the 11% increase in reporting in the second six months of the year.

Improved learning from Safeguarding Adults Reviews (SAR)

The Trust Safeguarding Forum has increased its membership to include senior professional and operational managers and safeguarding team representatives now attend divisional Quality & Safety meetings to feedback on adult safeguarding in general and on lessons learnt from Safeguarding Adult Reviews in particular.

Information for patients

Adult safeguarding information for patients has been improved by development of an accessible/easy read poster developed with Speech & Language Therapy Colleagues.

The posters are titled "Say no to abuse and keep safe" and provide pictorial advice on what to do when you are concerned or afraid.

Posters are used in both inpatient and outpatient areas.

Mental Capacity Act & Deprivation of Liberty Safeguards (MCA & DoLS)

A new post was recruited to in January and the new MCA & DoLS Practitioner based within the adult safeguarding team undertook a scoping of the current trust arrangements and practice within the trust.

The scoping revealed where a number of improvements to systems and processes could be made to strengthen the monitoring, reporting and assurance in this area to the trust, commissioners, regulators and Local Authorities that these matters are safely, effectively and legally managed.

Conclusion

A great deal has changed and been improved within the BCPFT adult safeguarding team in the last year so the priority for 2016/17 will be to consolidate those improvements and embed new practices.

The small team can work more effectively by:

- Managing expectations improve systems/ processes, auditing practice and continue to work with partners in a spirit of cooperation and understanding of the pressures that all safeguarding teams are under.

Specific actions for the team for 2016-17 include:

- Conduct routine audits of advice calls at points throughout the year and include this measure for comparison and demand management in future Annual Reports
- To implement the MCA & DoLS Practitioner work plan to include drafting of policies, establishment of systems/processes and improving staff training
- Increase safeguarding training capacity by preparing named nurses for safeguarding to deliver training
- Develop the "Safeguarding Link" role within teams and services to enable them to become first point of contact in their area for adult safeguarding advice and support
- Improve safeguarding information and guidance available to staff on the trust intranet

5. Sandwell & West Birmingham Clinical Commissioning Group

Service User Experience

What information is available to service users regarding the safeguarding process?

- All information is published on Sandwell & West Birmingham Clinical Commissioning Group (SWB CCG) Website
- Sandwell Safeguarding Adults Board (SSAB) leaflets and booklets were circulated within campaigns
- Links to SSAB promoted on SWB CCG communications such as Twitter
- SSAB information circulated within primary care for further cascading with their citizens

How do service users give feedback regarding safeguarding processes?

SWB CCG has an internal customer team called Time2Talk which is a one stop shop for customer concerns or complaints. Anyone is able to contact the team including:

- Local Authority
- GPs
- Service Users
- Provider Services

How do you evidence your activity has made a difference?

All information received by the Time2Talk team is analysed and discussed in the Quality and Safety Committee and Learning from Experience Group. Assurance is then provided to the Governing body on Safeguarding activity and learning.

Can you identify your key safeguarding achievements for the year 2015/16?

- Developed a comprehensive training programme for CCG staff and general practice
- Developed and distributed a Safeguarding Adults leaflet
- Raised safeguarding agenda with the Governing Body
- Successfully bid for additional non-recurring funding to support the Safeguarding Adults agenda
- Took the chairmanship of the Quality and Excellence sub group
- As a result of chairmanship of the Quality and Excellence sub group

successfully hosted a joint medication errors in safeguarding event with Sandwell Safeguarding Adults Board (SSAB).
- Mental Capacity Act (MCA) Health project team engaged with Safeguarding leads within Sandwell Metropolitan Borough Council (SMBC) to help influence national guidance and policies.
- Created a MCA resource pack for all GP practices.
- Shared all local leaflets, guidance and policies from Birmingham Adults Safeguarding Board with GP practices and SSAB.

How do you evidence that your activity has made a difference?

- Incident and complaints reporting with a focus on safeguarding.
- Information sharing with partner agencies
- Clinical Quality Review meetings with commissioned services with safeguarding as a themed agenda item.
- Commissioning for quality and innovation (CQUIN) with a focus on Safeguarding with two main providers throughout the year.
- Raised General Practice awareness.
- Clearly promoted safeguarding leads throughout the CCG and General Practice.
- Set up a bi-monthly meeting with SMBC safeguarding leads to review activity levels and exchange feedback.
- Actively responded to section 42 requests and made recommendations to improve services and practice.

What were your identified priorities for 2015/16 and what are your current priorities for the forthcoming year?

2015/16 Priorities:
- Continue to be active members of the Adult Safeguarding Board and sub groups, to fulfil our safeguarding responsibilities as a statutory partner.
- Developing a safeguarding dashboard for provider services allowing continuity between Children and Adult Safeguarding.
- Within the Adult Safeguarding Board remit participate in Safeguarding Adults Reviews (SAR) ensuring lessons learnt are embedded into practice.
- Working closely with services to ensure Making Safeguarding Personal is embedded in practice.
- To hold a workshop within the CCG on the implications of the Care Act.
- Provide training to all Governing Body Members on Safeguarding Adults and the Care Act.
- Developing a process for monitoring quality through a ratings process across Birmingham and Sandwell Care Homes in conjunction with Local Authorities.
- Actively participate in campaigns in partnership with Safeguarding Adult Boards.
- To work jointly in delivering the Crisis Care Concordat action plan.
- Review and update local policies and procedures in line with the Care Act 2014.
- Highlight gaps in the applications of Deprivation of Liberty authorisations within Care Homes and support with practical training.
- In line with guidance develop the role of the Designated Adult Safeguarding Manager (since been removed from guidance).
- Continue to engage with other stakeholders to ensure effective safeguarding arrangements are in place across each local health community
- Continue with a rolling programme of training events including PREVENT, PVVP, FGM, Domestic Violence and Forced Marriage.

2016/17 Priorities:
- Further develop safeguarding adult training.
- Continue to participate in SSAB activities and campaigns.
- Conduct safeguarding assurance visits with provider services.
- Continue to monitor and gain assurance of safeguarding activity with provider services.
- To further develop the leadership roles for safeguarding adults within SWB CCG.
- Develop practical pathways for preventative measures for front line staff.

- Develop an interactive performance base training programme for primary care.
- Develop a self-assessment audit tool for primary care.

Training

- All staff, Governing Body members and GP practices received Adult Safeguarding level 1 (100 GP sites and 170 CCG staff).
- Basic PREVENT awareness.
- Face to face.
- Safeguarding Level 2 update for Continuing Healthcare Staff – 15 people.
- Safeguarding Adults level 3 update for Continuing Healthcare staff and Safeguarding Adult leads - 10 people.
- Safeguarding Adults level 3 update for GP - 160 people.
- MCA/DOLs GP - 100 people.
- Individual Management Review (IMR) Training for Continuing Healthcare Managers and Adult Safeguarding Leads – 14 people.
- All Governing Body members, Safeguarding Adults Awareness.
- FGM training.
- Care Act awareness training for clinical staff within SWB CCG
- Child Sexual Exploitation (CSE) conference.

Adult Safeguarding Leads:

- NHS Executive Leadership programme for Safeguarding Adult Leads.
- Adult Safeguarding under the Care Act and its Interface with Domestic Abuse.
- Adult Safeguarding Investigations and Adult Reviews.
- Train the Trainer Workshop to Raise Awareness of PREVENT (WRAP).
- Regional Safeguarding conference with workshops.
- Making Safeguarding Personal Workshops hosted by BSAB.
- BSAB partnership workshops, including domestic abuse and coercive control.
- BSAB practitioner forums.

How do you evidence this has made a difference to practice and understanding of safeguarding?

- Increased contact with SWB CCG Safeguarding Leads for support and advice regarding safeguarding adults.
- Feedback from Time2Talk team with complaints and incidents.
- Bi monthly meeting with SMBC looking at activity.

Performance Data

Do you complete the SSAB Performance Framework template?

Yes.

How do you use the data you provide to the SSAB in the performance template?

To inform practice and activity with SWB CCG.

How does your data assure the SSAB?

Provides evidence of a robust process within SWB CCG and its commissioned providers.

How do you evidence this has made a difference?

- Increased contact SWB CCG Safeguarding Leads for support and advice regarding safeguarding adults.
- Feedback from Time2Talk team with complaints and incidents.
- Bi monthly meeting with SMBC looking at activity.

Safeguarding Adult Reviews

Have you contributed to any SAR's?

None have been commissioned.

What was the outcome?

N/A

How was any identified learning shared?

N/A

How would you evidence this intervention made a difference?

N/A

6. WEST MIDLANDS AMBULANCE SERVICE

General Overview

The Referral Process

In July 2009 the Safeguarding Single Point Of Contact (SPOC) was created. It was designed so that crews can make safeguarding referrals quickly and efficiently to a single point without the need for unnecessary paper trails and complex processes. All staff working within the SPOC have received training in safeguarding adults and children and Prevent.

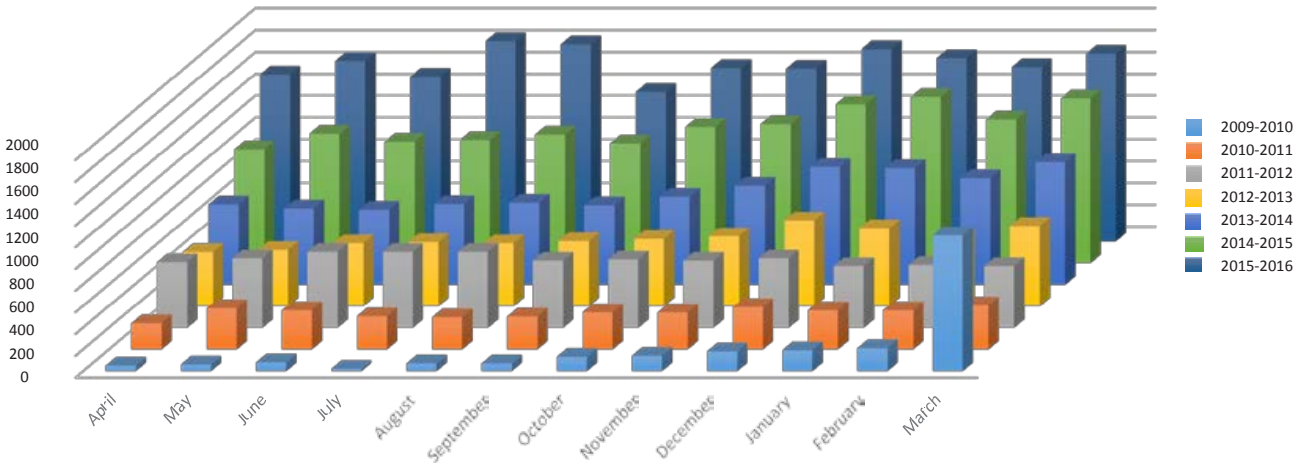
There is a dedicated telephone number which is staffed 24 hours a day, seven days per week; the SPOC is currently based within the Commercial Call Centre in Tollgate Staffordshire.

The SPOC staff ask a pre-determined set of questions. The system used, the referral forms, and questions asked were updated in October 2015 following a consultation with key stakeholders across the region. These are continually reviewed to ensure the questions meet the needs of our partner agencies throughout the region. The referral process is aimed at providing accurate and succinct information in a timely fashion that does not delay operational crews from attending life threatening emergencies, but at the same time elicits the correct information required to ensure a robust referral is made when there is a need to protect a member, or members, of the public.

The SPOC staff will refer onwards the alert to the appropriate services in line with a robust referral process.

Currently the recording system is not able to differentiate the categories of referral but it is planned to be able to do this in the year 2016.

Adult Safeguarding Referrals WMAS made



Domestic Homicide Review (DHR)

The Home Office definition for a Domestic Homicide Review (DHR) is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

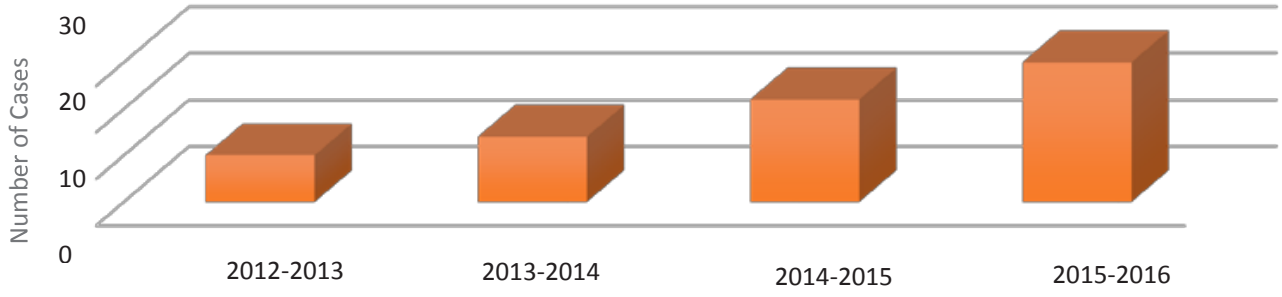
(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself,

(c) As part of safer partnerships all areas are required to carry out reviews of all domestic homicides. As predicted the number of requests for domestic homicide reviews is increasing as more areas activate their review process. WMASFT ensures that all reports are completed in a timely manner and to a high standard.

(d) By the end of 2015/2016 WMAS had been involved in 88 DHR's in total.

Number by year of new Domestic Homicide Reviews



Progress and developments

Safeguarding remains a high priority for WMASFT, there are regular items on the Learning Review and Governance groups. The last CQC inspection in 2013/2014 indicated the knowledge and awareness of safeguarding is embedded in the organisation, and the quality of referrals has increased dramatically within the last year. The role of the safeguarding team is to ensure the Trust (from Board level to frontline) is kept up-to-date with national and regional documents, ensuring compliance against the statutory requirements, whilst taking care not to 'information-overload'. Both the Adult and Children and Young Persons Safeguarding policies were updated in January 2013. The updated versions are due for release in May 2016.

Commissioning for Quality and Innovation (CQUIN) – Safeguarding referrals

In 2015/2016 WMAS had a Safeguarding CQUIN which required WMASFT to identify 10 safeguarding concerns per quarter, five adults and five children's. By 2015-2016 Q4, 40 cases had been identified and Q4 data was submitted in April 2016. No learning was identified during this process but feedback on referrals was highlighted as an area which required development.

Professional Networks /External Stakeholders

The Safeguarding Team attends forums and groups to benchmark and share best practice and lessons learned, such as:

- National Ambulance Safeguarding Networks.
- Designated/Named Safeguarding Regional Groups.
- Local Safeguarding Adults Boards
- Local Safeguarding Children's Boards
- Safeguarding Board sub-groups
- Regular engagement by WMASFT with Regional Safeguarding Leads and attendance at relevant conferences to ensure regional and national agendas is reflected within WMASFT and that WMASFT contributes to this developing work.

Quality Assurance

The safeguarding team provides quality assurance to the board via the Deputy Director of Nursing Quality/Medical Director. The Safeguarding team also produces section 11 audits as well as completing Safeguarding Adults Self-Assessment and Assurance framework for the Strategic Health authority along with a Learning Disability and Mental Health Self-Assessment. No areas were highlighted as less effective, the majority was rated as effective and some were rated as excelling.

Patient Safety Conference

WMASFT hosted the 4th National Ambulance Clinical and Patient Safety Conference which the safeguarding team contributed to and hosted the National Ambulance Safeguarding Group. This event was in Partnership with WMAS, the College of Paramedics and AACE (Association of Ambulance Chief Executives). The safeguarding team led a series of workshops and the event was very positively received. The National Ambulance Safeguarding Group delivered three safeguarding sessions.

Care Quality Commission

An unannounced CQC inspection took place in January 2014 and WMASFT were graded as compliant for safeguarding. In June 2016 the CQC are due to inspect WMASFT in the planned Ambulance Inspection program.

Additional work-streams – Domestic Abuse, Female Genital Mutilation (FGM)

Sitting within the safeguarding agenda are closely linked areas that WMASFT have been working on to ensure education and awareness is provided to all staff through a partnership working approach. Extensive engagement with representatives from the above areas have assisted in developing some excellent resources for WMASFT staff to ensure that all members of the community, and in particular those from known vulnerable groups; continue to receive the highest level of care from our staff.

Domestic abuse was included in the 2014-2015 mandatory training for all clinical staff. This will also be complimented by a domestic abuse question set for the WMASFT Safeguarding Referral line enabling staff to appropriately refer concerns. Close ties with the the Police forces in the West Midlands have also been developed for reporting domestic abuse.

		Safeguarding and Care Concern Referrals Made	999 Calls	111 Calls	PTS Activity	Total Activity	% Total (Number of Referrals against activity)	West Midlands average for month
Q1	Apr-15	93	5,831	5976	5323	17,130	0.54%	0.78%
	May-15	127	5,993	6053	5093	17,139	0.74%	0.88%
	Jun-15	98	5,736	5028	5541	16,305	0.60%	0.80%
Q2	Jul-15	129	6,188	5164	5863	17,215	0.75%	0.92%
	Aug-15	119	6,157	5913	5414	17,484	0.68%	0.91%
	Sep-15	115	5,870		5645	11,515	1.00%	1.13%
Q3	Oct-15	116	6,111		5855	11,966	0.97%	1.17%
	Nov-15	112	6,038		5356	11,394	0.98%	1.21%
	Dec-15	111	6,514		5609	12,123	0.92%	1.29%
Q4	Jan-16	128	6,728		5433	12,161	1.05%	1.27%
	Feb-16	101	6,105		5382	11,487	0.88%	1.29%
	Mar-16	141	6,710		5806	12,516	1.13%	1.20%
					Average %		0.85%	1.07%

7. Sandwell and West Birmingham Hospital Trust

Our Organisation

Sandwell and West Birmingham Hospitals is an integrated care organisation. The Trust employs approximately 7.500 people, 60 volunteers and facilitates teaching for approximately 460 nursing midwifery and 603 medical students across the disciplines.

The organisation is responsible for the care of 530,000 local people from North West Birmingham and all towns within Sandwell. This care is delivered at several sites: City Hospital, Sandwell General Hospital, Rowley Regis care hubs, Leasowes, Midland Eye Centre. The Trust delivers care to in patient paediatrics and performs most general surgeries. Stroke services based at Sandwell General Hospital, Sickle Cell and Thalassemia services at City. Academic Departments include Cardiology, Rheumatology, ophthalmology and neurology.

Activity

Approximately:

5,500 women gave birth

564,500 attended outpatient clinics

176,500 attended emergency department at Sandwell or City or the eye hospital

38,479 admitted as in patients

82,295 operations 47,500 as Day Cases

Listening and acting on the voice of citizens

- Trust board open to the public.
- Dedicated website for staff guidance and to support and guide service users.
- Patient and specialist dementia surveys.
- Displays on ward boards.
- Robust PALS and complaint service.
- Introduction domestic abuse nurse in ED area.
- Two case studies per quarter have been submitted to the CCG making safeguarding personal.
- Introduction extended/open visiting-Sign up to Johns Campaign – audited and feedback through dementia lead nurse.
- Improved quality care for patient requiring 1:1 supervision chaired by TDA cited in Lord Carter report. Improved assessment monitoring and activity.

Assurance

- Monthly integrated performance collation and review.
- Completion of safeguarding quarterly and annual reports presented at safeguarding steering groups.
- Dedicated website to safeguarding. All staff given guidance on safeguarding procedures and training matrix.
- Employment of Adult Safeguarding Nurse.
- Employment dementia lead.
- Employment LD Nurse allowing both acute sites access to bedside expertise.
- Re launch 10/10 safety framework checklist – Work closely with assessment areas implementing rapid improvement to ensure basic safety measures are assessed at the front door. Inclusion of:
    1. Positive Patient Identification
    2. Mental capacity
    3. Vital Signs
    4. Medicines
    5. Pain Control
    6. MRSA Screening
    7. Pressure ulcer/falls
    8. VTE (Venous Thromboembolism)
    9. Nutrition
    10. Lifestyle
- Participation in audit harms (safety thermometer).
- Monthly audit related consent and DNARCPR.
- Robust complaint procedures – Newly appointed Safeguarding lead.
- Legal Department –Newly appointed safeguarding lead to build relations.
- Supportive HR department – Newly appointed safeguarding lead to build relations.
- Related safeguarding policies to be reviewed updated as planned.

- Mandatory training matrix in place.
- All volunteers within the trust undertake an advanced DBS and those allocated to paediatrics and maternity undertake level 2 safeguarding training.
- Development of PREVENT policy outlined. Training incorporated to level safeguarding training to capture band 7 and above audience. PREVENT leaflet developed. Adult safeguarding Nurse has developed good relation with police representation and awaits vetting to participate in the channel panel.
- Activities, incidents, issues and patients are kept on Adult Safeguarding Central Log.
- Robust systems for complaints and incident reporting.

Identify Key Safeguarding Achievements for 2015/16

Case exampes/CPD

The organisation has successfully achieved adult Safeguarding CQUIN. Requirement was 2 case studies to be submitted per quarter.

Partnership working

- Organisation executive lead/deputy to attend partnership meetings.
- Adult Safeguarding Nurse to commit to work streams to benefit the organisation.
- Good relations with PREVENT police representation and application to channel panel.
- Organisation makes regular Twitters and contribution to SSAB media Network Channels.
- Frontline staff aware of policies and procedures to safeguarding patients.

Gaps and Priorities

- As an organisation it can be a challenge to implement work stream ideas as it stretches across two geographical areas Sandwell and Birmingham which gives potential for conflicting management.
- It can be challenging to feel board is progressing with action plans if sub boards are poorly attended.
- Newly appointed safeguarding team relations with each other and outside agencies require to be established.
- To embed and empower local managers to review deprivation liberties and safeguarding issues in line with new work force structures.
- To update related policies safeguarding, deprivation liberties, mental health policy.

Training and Performance Data

- Training matrix reviewed to target staff groups.
- Level 1 training – Leaflet given at induction and attached to payslips periodically and when guidelines updated.
- Level 2 training- Class room based and attendance expected on a 3 yearly basis.
- PREVENT is incorporated into this morning or afternoon class room teaching again targeting against a workforce band 7 and above. Lower bands are not excluded. PREVENT returns submitted for Home office use each quarter.
- PREVENT leaflet now compiled/updated sent to all managers via staff comms to be given out on induction and attached to pay slips to target level 1training for band 7 and below.
- Adult Safeguarding maintain dashboard highlighting all referrals. Trends and concerns are reviewed in patient safety committee with executive presence and at quarterly steering group chaired by the chief nurse.
- Trends are also reviewed as part incident reporting with any significant harm being table topped and learning identified.

8. DOMESTIC ABUSE STRATEGIC PARTNERSHIP

The Domestic Abuse Strategic Partnership (DASP) has worked to consolidate and further strengthen our collective response to domestic violence and abuse. DASP has sought to increase reporting of DVA, so that victims can access the support they need at the earliest opportunity in order to prevent further harm and reduce the risk of homicide.

Reports of DVA to the police have been increasing locally, regionally and nationally. During 2015-16, there were 6539 DVA crimes/ incidents in Sandwell reported to the police. This is a 13% increase compared to 2014-15 and a 34% increase compared to 2012-13. Approximately 66% of those cases were screened by the multi-agency Domestic Abuse Screening Team in the MASH (Multi-Agency Safeguarding Hub) and advice and support then offered by appropriate organisations to those victims and their families, depending on the level of risk identified. The number of high risk cases of DVA increased slightly from 450 in 2014-15 to 460 in 2015-16. All of these cases were considered by the MARAC (Multi Agency Risk Assessment Conference) and a safety plan put in place to reduce the risk to the victims and their families.

Sandwell Council provided funding for Sandwell Women's Aid (SWA) to support victims of domestic abuse and sexual abuse. Additional Domestic Abuse Advocates (DAAs) were recruited in early 2015 to work in Sandwell's six towns. The DAAs provide support to victims and their families in localities and work with other agencies to provide an effective community co-ordinated response to DVA at a local level. SWA continued to provide emergency accommodation to victims fleeing domestic abuse through refuges, safe houses, specialist provision for BME victims and floating support. Sandwell Council and SWA were successful in securing funding from central government to provide extra refuge places and dispersed accommodation for victims of domestic abuse. Nine new bed spaces of medium/low risk accommodation were provided. This enabled a smoother transition of victims from high risk to medium risk accommodation, enabling high risk/ high need accommodation to be used by more families in real crisis.

A successful domestic abuse awareness raising event, "Faces of domestic abuse – perspectives on victims, children and perpetrators" took place on 10th March 2016. The event incorporated the Sandwell launch of the West Midlands DVA standards (***WM domestic violence and abuse standards | Sandwell Council***) which DASP worked with regional partners in the West Midlands to develop. The standards aim to provide a framework for organisations to develop their professional practice, improve services, shape future services and deliver the right response across all settings and sectors.

The standards formed the basis of the event and were incorporated into a performance which enabled professionals to identify with the complexities within families and challenged existing approaches to ensure better outcomes. DASP worked with SWA and a professional actor who told the life story of a real character of Sandwell whose own life experience depicted experiences of intergenerational violence and abuse. This powerful emotional performance left the audience with the challenge of a fresh approach to supporting individuals and families.

Presentations were also heard from Fry Housing Trust on Sandwell's Brighter Futures voluntary perpetrator programme which started in October 2015 and from SWA on children and domestic abuse. In addition, the Chair of DASP gave the audience an overview of its work.

A key development this year has been the commissioning of a voluntary perpetrator programme on a 2-year pilot basis. Fry Housing Trust has been funded by Sandwell Council to deliver a behaviour change programme with DVA perpetrators. Referrals to the programme can be made by partner agencies or by perpetrators themselves. Parallel support to victims is funded by Safer Sandwell Partnership and delivered by SWA. The programme is being evaluated by the

University of Birmingham to inform and shape future work with domestic abuse perpetrators on a local and regional level.

Whilst GPs and health professionals are well placed to identify domestic abuse at an early point and direct victims and perpetrators for help and support, they need further training and support to undertake this role. Sandwell & West Birmingham Clinical Commissioning Group secured funding from the Sandwell Safeguarding Children's Board for a pilot IRIS project (Identification and Referral to Improve Safety) in GP surgeries in 2015-16. IRIS is a general practice domestic violence training, support and referral programme for primary care staff. It is targeted prevention for female patients aged 16 and above experiencing current or former domestic abuse from a partner, ex-partner or adult family member. IRIS provides care pathways for all patients living with abuse as well as information and signposting for male victims and for perpetrators. Approximately 20 GP surgeries were identified to work as part of the pilot and training has taken place with those surgeries during the pilot period. The University of Birmingham produced a positive evaluation of the IRIS pilot, capturing powerful feedback from survivors regarding the value and importance of this work.

Since the implementation of the IRIS pilot, there has been an increase in the number of victims referred for support to Sandwell Women's Aid (SWA) and MARAC (Multi Agency Risk Assessment Conference) from the IRIS GPs. Future funding for this project is being explored for 2016-17.

During the year, SWA and Sandwell & West Birmingham Hospitals Trust (SWBH) also secured funding to enhance the response to DVA in Accident & Emergency Services and refer victims of domestic abuse for appropriate support. There has also been an increase in the number of victims referred by A&E for specialist support.

Work to address female genital mutilation (FGM) has been undertaken in the last year. The West Midlands Police and Crime Panel undertook a review of FGM in the West Midlands and made a number of recommendations to ensure consistency in dealing with FGM; encourage reporting and provide support to girls and women who are victims and potential victims. Training on FGM has been delivered to over 100 officers across a number of agencies during the year and further training will be delivered over the next year. A problem profile on FGM will be commissioned to further improve our collective understanding of the scale and nature of the risk of this hidden crime in Sandwell in order to target work with specific communities.

During the year, two Domestic Homicide Reviews (DHRs) were published and these can be accessed at ***www.sandwell.gov.uk/domesticabuse***. The DHR Standing Panel has worked to ensure that all the recommendations from these DHRs were implemented and lessons learnt from DHRs were included within the DASP training programme.

DASP priorities are:

- Spot victims of domestic abuse earlier, especially working with NHS & Clinical Commissioning Group.
- Strengthen MARAC (Multi Agency Risk Assessment Conference).
- Ensure support to victims of all forms of domestic abuse is made more visible and more locally accessible.
- Develop victim services and provide support to vulnerable people harmed by DVA including female genital mutilation (FGM), "honour" based violence (HBV) and forced marriage (FM).
- Target perpetrators of Domestic Violence & Abuse; Forced Marriage; Honour Based Violence and Female Genital Mutilation.
- Learn from Domestic Homicide Reviews how to improve practice and reduce risks and threats to victims.
- Commission and implement a voluntary behaviour change programme for DVA perpetrators.
- Raise awareness of domestic abuse (including FGM) through campaign.

7.Sub-group contributions

1. Quality and excellence sub-group

Service User Experience

What information is available to service users regarding the safeguarding process?

All partner organisations have access to safeguarding information that they share with customers; this includes leaflets, referral forms that explain the process, face to face interviews and feedback questionnaires.

How do service users give feedback regarding safeguarding processes?

At the study event below we received live feedback at the end of the session:

We have since been approached to roll this out to individual care homes. With reference to safeguarding processes practitioners establish with service users their desired outcomes at the beginning of the process, revisit that throughout the process and ensure they have feedback on whether desired outcomes have been met at the end of the process. This information is captured on the recording system managed by adult social care and in questionnaire format. Multi agency audit tools are still to be developed and this is a priority for the sub-group.

How do you evidence your activity has made a difference?

Feedback at forums and future events.

As a Sub Group can you identify your key safeguarding achievements for the year 2015/16?

Study day targeting medication errors referred through to safeguarding.

How do you evidence that your activity has made a difference?

Data recorded on the performance dashboard under 'types of abuse' during April, May and June 2015 shows acts of neglect and omissions as 106 events with 22 acts where the alleged perpetrator was known to the individual and during the months of January, February and March 2016 after the training and study day these incidents which would include medication mismanagement are shown as significantly reduced and represented as 51 incidents with 5 acts where the alleged perpetrator was known to the individual.

Prior to the session SSAB data showed medication errors at 11% prevalence. Re-running of data will show if there has been a reduction in referrals.

The level of reporting in these areas raised a significant concern; the Operations Manager alongside the Quality Team devised a short training event at West Midlands Care Association meeting on the 2 February 2016.

What were your identified priorities for 2015/16 and what are your current priorities for the forthcoming year as identified in the Strategic Plan?

2015/16 Finalise the Q&E report to ensure continuity of data for all partners.

2016/17 Improve the report to showcase more qualitative data.

Training

What training has been provided to staff?

One day open session for all care homes and domiciliary care agencies in Sandwell covering core aspects of safeguarding.

Who (posts and responsibilities) has received training?

n/a

How do you evidence this has made a difference to practice and understanding of safeguarding?

All training is practice based and provides practitioners with an opportunity to reflect on their own practice and change it. There is a key drive to ensure that making safeguarding personal is a reality and clients are at the centre of all decision making. A multi-agency audit tool is in development and this will enable us to more effectively evidence that training has directly impacted upon changes to practice.

Performance Data

How do you use the performance data?

For highlighting high prevalence areas and assurance that training and operational measures are embedded and working.

How does the data assure the SSAB that the right priorities are identified?

How do you evidence this has made a difference?

SSAB highlighted the concern regarding the high levels of referrals regarding medication errors. The Quality and Excellence group in conjunction with partners devised some specific training to highlight the issue and mitigate against any subsequent risk.

Safeguarding Adult Reviews

Have you contributed to any SAR's?

No SAR's were commissioned in 2015.

What was the outcome?

n/a

How was any identified learning shared?

n/a

How would you evidence this intervention made a difference?

n/a

2. Prevention learning and development sub-group

A multi-agency training needs analysis was undertaken during May 2016 which both reflected on the previous year and highlighted future needs with the following results:

Awareness Raising in Safeguarding Adults, Safeguarding for Managers and Practitioners, Considering Dignity and Respect, Managing Risk and Making Safeguarding Personal were the highest scorers for organisations training priorities.

Forced Marriage and Honour Based Violence, Mental Capacity and Care Act, Scamming and Domestic Abuse also scored highly.

Factors that influenced attendance were based on whether course were certificated, the length of the course and the course content.

Negative factors included problems booking onto training, training not being available when organisations needed it and training not covering what is needed.

Number of staff needing Safeguarding training

Three quarters of staff working in organisations who work with adults at risk receive Safeguarding training this is provided either on a face to face basis or e-Learning .

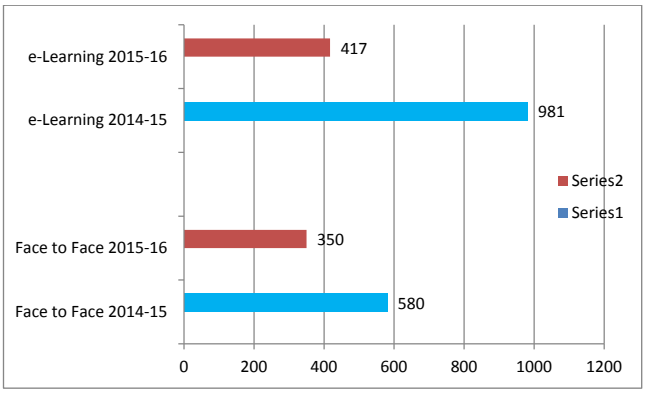
Challenges

Courses being cancelled at short notice due to poor attendance. Booking is problematic and organisations find it easier to table e-Learning. There is evidence to suggest that

organisations may be unaware of the SSAB training catalogue and have requested a yearly calendar of dates.

Training Comparisons

There has been a substantial drop in the take up for both face to face and e-learning. Evaluation shows the choice of training venue and booking system to be an issue. Future training venues will be in a central location with popular courses holding sessions across the six towns of Sandwell. The SSAB will be using Learning Pool as a booking system for future training. This should eradicate previous problems.



E-Learning

Six topics are available on the SSAB e-Learning site: Safeguarding Adults Awareness, Dignity and Respect, Forced Marriage, Hate Crime, Mental Capacity Act and Deprivation of Liberty Safeguards.

The e-Learning needs further promotion. This will be achieved by advertising on the quarterly newsletters, flyers given out at outreach events and distributed to appropriate agencies. Other advertising opportunities will also be investigated. This could include promotional leaflets identifying all training opportunities and direct representation at team meetings, regional learning events and Sandwell based community activities.

Engagement and Prevention activity

During 2015-16 the SSAB participated in the following events and activities promoting the work of the board and the 'See Something Do. Something campaign:

- Safer Six Town Events.
- SSAB held a market stall at each of the six towns of Sandwell Safer Six Event.
- Childrens Social Care Inductions.
- Mince Pie Coffee Morning.
- Dignitea Day.
- Prevention Conference.
- Open Days at Residential Homes.
- Creation of a SSAB Twitter account.
- Production of quarterly newsletters.

In addition the sub-group and head office have undertaken work to commission and develop a website for the board to be launched early 2017.

2015-16 Aims

- Implement a tendering exercise to ensure SSAB commissions good quality training providers.
- The tendering exercise was undertaken successfully and has been repeated for the next years training ensuring the most updated information is available.
- Ensure the Care Act is embedded in all training.
- The Care Act and the MCA are highlighted in the commissioning of all training.
- Work with partners to integrate principals of Making Safeguarding Personal.
- A MSP working group has been set up with information leaflets about to be produced and MSP is highlighted as a theme in the commissioning of training.
- Participate in community events to promote the boards training.
- The SSAB business team have had a presence at several events including the Safer Six campaign covering the 6 towns of Sandwell.
- Build upon the mailing lists developed in 2015 to produce a comprehensive community wide database giving access to a huge community network for marketing and information purposes.

Feedback from participants of SSAB training:

The evidence suggests that a challenge to people taking up the SSAB training was the booking system. Therefore the SSAB took the decision to use 'Learning Pool' for both e-Learning and booking for face to face sessions. Upon application of this

system the SSAB will review the number of people accessing training and scrutinise feedback.

Feedback suggested that some of the training didn't meet all requirements. We have rectified this by undertaking a training needs analysis and ensuring that the areas identified are now included in the available training. Examples of this include 'Positive Risk Taking' within the Managing Risk training and 'Chairing Case Conferences' in both Managing Risk training and Considering Dignity and Respect in Adult Safeguarding training.

The board is also keenly aware of different working patterns for staff and therefore training is offered on a flexible programme basis to ensure as many staff as possible have the opportunity to access appropriate training.

In sourcing new training providers the SSAB participated in a rigorous tendering exercise ensuring clear specifications, standards and identified outcomes. The trainers that have been subsequently commissioned had to evidence a high standard and an ability to meet the training specification.

7.3 Protection sub-group

Regionally with effect from 1 April 2016 there is in development a regional SAR repository enabling all to look at published SAR's and consider a range of methodologies. The repository may also assist in identifying common themes and trends across the region.

West Midlands Domestic Violence & Abuse Standards

To look at the Safeguarding Adult policy and procedures and ensure they reflect the DV Standards. Each of our partners should make reference to the above in their Policy and Procedures. This will be reviewed and form part of the work programme for the Protection Lead Officer.

Review of forms

A review was undertaken with all partner agencies in February 2016. The concern form has been amended to reflect all appropriate risk assessments, rationale for decision making and location of abuse. The Section 42 Form and Safeguarding Plan are to be combined as one form and are still being developed. The updated concern form was launched July 2016.

Amendments to the Care Act

Current annotated guidance has been circulated to sub group members.

All Boards policies and procedures to be audited to ensure they are still Care Act compliant and reflect updated guidance published March 2016.

West Midlands Police

West Midlands Police are updating their safeguarding policy and The Protection Sub-group have contributed and commented on the policy document.

Position of Trust Policy and Procedure

Position of Trust is being looked at locally and partners have their own policies. Representatives of the sub-group are contributing to regional developments.

Serious Case Review

- One SCR report completed with action plan. This is awaiting publication.

Strategic Plan

The Protection Sub Group have contributed to the review of the Strategic Plan and identified their priorities for 2016/2017 as:

- Review operational practice and forms (timescales September 2016).
- Ensure all agencies have a Position of Trust Lead and associated policy and process for further development 2016/2017.
- Undertake an analysis of SAR's or lack of SAR's to ensure continued developments in practice and feel assured as a Board (timescale April 2016).

8. Safeguarding performance data

Number of concerns

Throughout the year 2015/16 there has been an increase in concerns but an overall reduction in the numbers of enquiries which was the same during 2014/15.

This reduction of cases progressing to enquiry was anticipated following the introduction of the new procedures adopted that are in line with the Care Act 2014 with a focus on making safeguarding personal social workers and allied professionals work in partnership with adults with additional support needs agreeing and identifying outcomes at the beginning of a safeguarding process which has led to concerns raised being addressed satisfactorily prior to enquiry in line with service users desired outcomes.

The Operational Safeguarding Manager continues to monitor the findings of Adult Social Care case file audits and learning has been disseminated to all frontline Social Workers in terms of what cases should be progressing to a Section 42 enquiry ensuring that there is a consistent practice across all frontline practitioners.

Number of enquiries

The number of safeguarding concerns over the last year has increased to 2242 which is an increase of 279 on the previous year's figure of 1963. Operational staff have identified that the reporting of 'self-neglect cases' has been noted as one of the contributing factors to this.

Furthermore, there is a greater awareness amongst professionals and agencies of safeguarding and reporting 'all' incidents from medication errors, unexplained bruising to clear physical or verbal abuse.

Not all of these concerns progressed to enquiries. This evidences the need to continue to work with partners in developing a comprehensive understanding of what is a safeguarding concern.

Since 1st September 2015 management began to monitor the nature of the incoming concerns on a daily basis – looking for trends in concerns received. Out of the 588 concerns received during this reporting period 84 Medication errors have been reported which equates to 14% of concerns received and a further 45 cases (7.6%) of service user on service user assaults (from the 1November 2015 to 31December 2015).

The level of reporting in these areas raised a significant concern; the Operations Manager alongside the Quality Team devised a short training event at West Midlands Care Association meeting on the 2 February 2016 to raise awareness around the current numbers of medication failures that are received by the safeguarding team. Using case studies to demonstrate how this could be reduced.

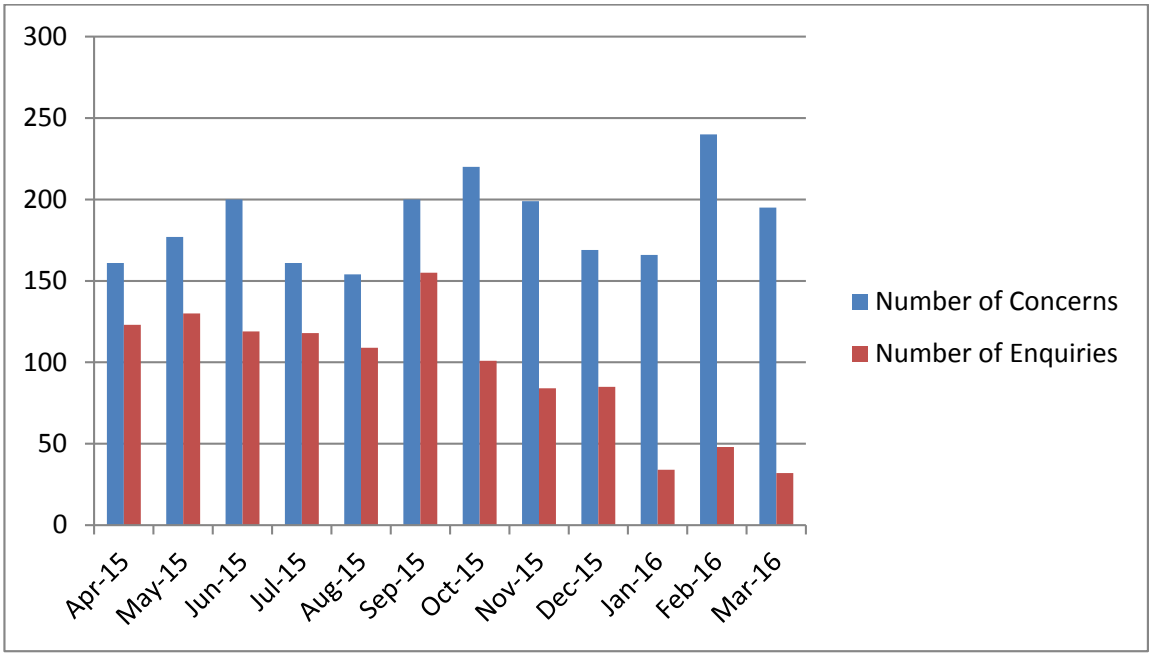
Furthermore, training was jointly delivered by the CCG and SSAB on 1 April 2016 to providers focusing on the impact of medication errors and effective reduction this included an overview of safeguarding, case studies and a presentation on medication regimes and side effect.

Safeguarding concerns/enquiries commenced in period

The data in this section relates to concerns or enquiries which commenced during the reporting period. Note that S42 enquiries are a subset of concerns.

Activity	2014/15	2015/16	Comparative analysis
Number of concerns	1963	2242	↑
Number of concerns (average per month)	164	187	↑
Number of enquiries	1233	1069	↓
Number of enquiries (average per month)	103	89	↓

Number of concerns/enquiries commenced by month



Commentary

Concerns and enquiries by source of contact

The decrease of concerns progressing to enquiries continues to be reflected across all of the 'concerns and enquiries by source of contact'.

From April 2015 to March 2016 the percentage of concerns and enquiries has decreased. The period between July 2015 and September 2015 shows an increase in the number of concerns reported and enquiries investigated. There has been a change in Social Work practice. Social Workers are identifying risks earlier in the process using a robust risk analysis with management oversight meaning that fewer concerns are progressing to the enquiry stage and they are being responded to in an appropriate manner at the concern stage.

There is no comparable available data for the previous year however, for the next reporting period of 2016/17 comparative data for the same time period will be collated to assist in determining whether the proposed hypothesis can be supported and whether further trends analysis is needed.

Concerns and enquiries by source of contact

	2015/16 Number of Concerns	2015/16 Number of Concerns Converted into Enquiries	2015/16 Enquiries/ Concerns (%)
Sandwell council	287	130	42
NHS	814	304	37
Police	59	19	32
Independent sector	1297	605	47
General public	92	48	52
All other	65	32	49

n.b Multiple categories of abuse can be identified within the same enquiry and are reflected in the figures.

Counts of Individuals by Gender

Within the Sandwell area there is a higher percentage of referrals received in respect of women, however this is reflective of the National position and this trend has continued during 2015/16 as it did through 2014/15.

Male 2014/15	Female 2014/15	Total 2014/15	Comparative Data
366	601	967	↓
Male 2015/16	**Female 2015/16**	**Total 2015/16**	**Comparative Data**
328	484	812	↓

Commentary

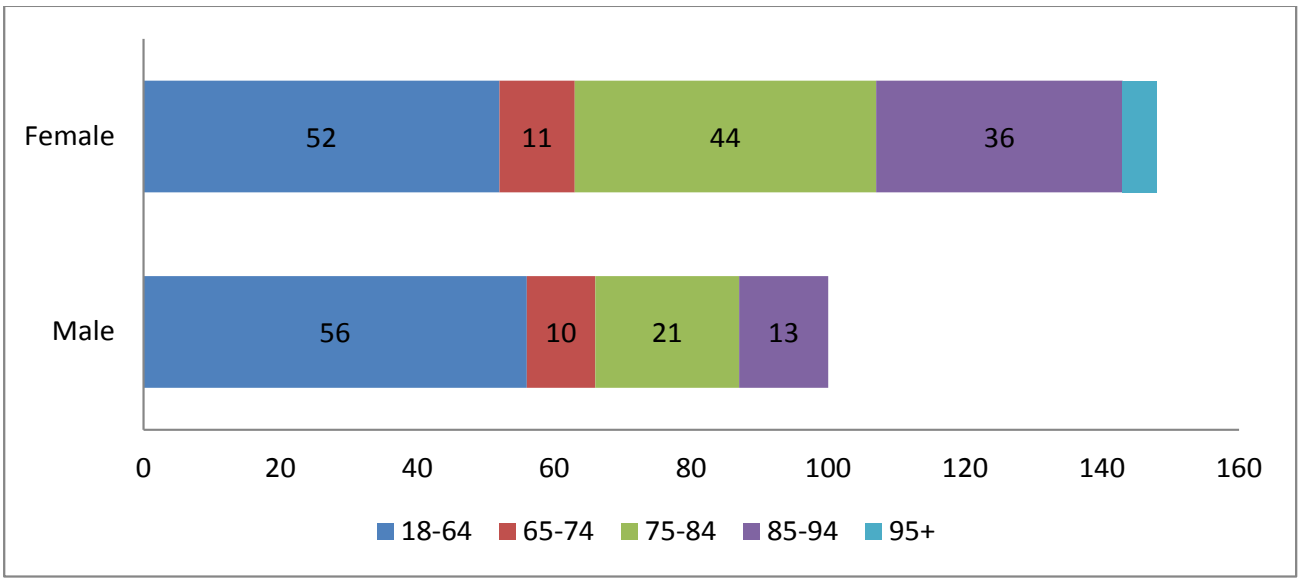
Demographics

The data shows that for 2015/16 there was an overall reduction in referrals for both men and women with the majority of enquiries being made for women between the ages of 18-64 or 74-85 years of age.

Due to more sophisticated data collection we can evidence that the referral rate for males between the age of 18-64 has increased throughout the year 2015/16. We are unable to compare last years' data however we will be able to continue to scrutinise the data now collected to assist in determining any specific trends in this area.

There is a continued trend in Sandwell of the largest number of referrals received being for an adult with a White British background (84%) rather than any other ethnic group. The 2011 Census identified that the Ethnic Breakdown of Sandwell as being 65.8% of the population as White British and 34.2% are from other ethnic groups. Given the statistics the SSAB may need to consider how we can target information on safeguarding for the 'hard to reach communities'.

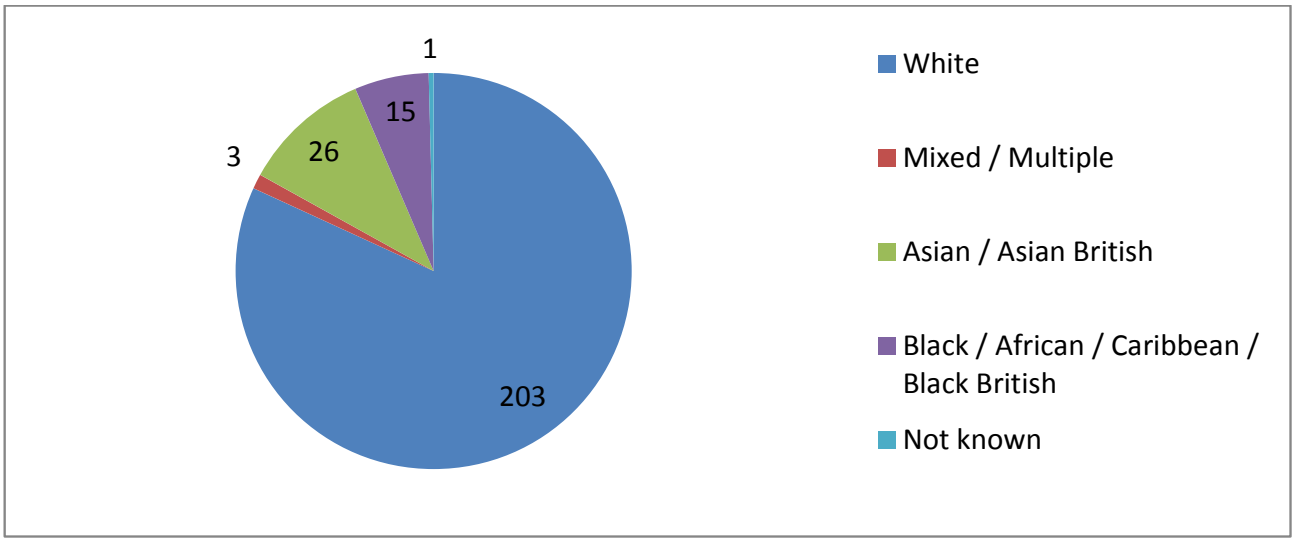
Gender by Age Groups



n.b these are not percentage values but are a count of gender within age brackets.

Ethnicity

The ethnicity pie chart continues to highlight the trend in Sandwell and the largest number of referrals continuing to be for an adult with White British background (84%) This represents an increase throughout the year.



Commentary

Concluded cases by type of abuse

Multiple categories of abuse can be identified within the same enquiry and are reflected in the figures. The highest type of abuse during 2015/16 is shown to be physical abuse with 'other-known to individual' being the source of risk which was the same in 2014/15.

'Neglect & acts of mission' where the source of risk is identified as 'social care support' was the second highest type of abuse through both 2014/15 and 2015/16.

We understand this increase to reflect circumstances of individuals who are living in shared occupancy or residential settings and may be assaulting one another either intentionally or as an expression of distress or anxiety.

There are now four additional categories of abuse that we are gathering intelligence on which is shown in the table below for 2015/16. These will be scrutinised and reported on in future reports.

Concluded cases by type of abuse

Concluded cases by type of abuse additional categories 2015/16

	Source of Risk					
Type of abuse	**Social Care Support 2014/15**	**Other - Known to individual 2014/15**	**Other - Unknown to individual 2014/15**	**Social Care Support 2015/16**	**Other - Known to individual 2015/16**	**Other- Unknown to individual 2015/16**
Physical Abuse	147	412	10	112	313	12
Sexual Abuse	4	38	14	1	24	2
Psychological Abuse	50	90	6	18	62	5
Financial & Material Abuse	50	196	40	34	114	7
Discriminatory Abuse	2	0	0	0	1	1
Organisational Abuse	4	1	0	0	1	0
Neglects & Acts of Omission	347	91	8	309	78	4
Totals	**604**	**828**	**78**	**474**	**593**	**31**

Source of Risk			
Type of Abuse	**Social Care Support 2015/16**	**Other - Known to individual 2015/16**	**Other - Unknown to individual 2015/16**
Domestic Abuse	0	4	0
Sexual Exploitation	0	0	0
Modern Slavery	0	1	0

Self-Neglect	0	12	0
Totals	0	17	0

Counts of enquiries by location and source of risk

Location of abuse

The data shows us that the highest amount of referrals in both 2014/15 and 2015/16 came from individuals in 'care homes' where the source of risk was identified as being social care support. In the other reporting categories the data in both 2014/15 and 2015/16 shows that in 'hospitals', 'peoples own home', 'community services' and 'other' the highest amount of referrals came from individuals where they knew the alleged abuser.

The Local Authority manages provider related concerns via its escalation panel and commissioning.

Location and Source of Risk						
	Social Care Support 2014/15	**Other - Known to Individual 2014/15**	**Other - Unknown to Individual 2014/15**	**Social Care Support 2015/16**	**Other - Known to Individual 2015/16**	**Other - Unknown to Individual 2015/16**
Care Home	345	222	8	257	154	7
Hospital	1	81	9	2	74	4
Own Home	238	393	43	208	301	13
Community Service	8	35	1	7	25	0
Other	7	75	7	7	51	5
Totals	599	806	68	481	538	29

Timescales and Completion of Safeguarding Activity

There has been a reduction of cases progressing to enquiries and this was anticipated following the introduction of the new procedures that are in line with the Care Act 2014.

The Operational Safeguarding Manager continues to monitor the findings of ASC case file audits, learning has been disseminated to all front line social workers in terms of what cases should be progressing to a Section 42 Enquiry ensuring that there is a consistent practice across all front line practitioners.

Strategy Discussions

In 90% of the cases received the team have met the target of having strategy discussions and confirm concern outcomes within five working days of receipt; this is slightly lower than during 2014/15 which was 96.5%.

Given the initial level of work required during the early stages of receiving a referral, i.e. completing a visit, meeting the representative/individual to discuss the concerns and not solely relying upon information gathering via telephone, it is suspected that delays at strategy will occur.

Safeguarding Enquiries completed within 20 working days

The percentage of Safeguarding Enquiries being completed within 20 working days during has increased to 60% during 2015/16 compared to 2014/15 where it was 48.7%.

The delays in progressing cases is deemed to be a feature expected in dealing with some safeguarding cases – there are a number of contributing factors for such as:- other partners completing a section 42 enquiry, the complexity of cases, as well as criminal matters which may need to take precedence over the safeguarding case.

The Safeguarding management team monitor the progress of all open cases on a weekly basis; this in turn ensures that they are able to assist in reducing any inappropriate delays in progressing any cases.

Concluded enquiries that went to case conference

The number of cases that went to case conference during 2015/16 was 30 in comparison to 68 in 2014/15.

The safeguarding team continue to progress 'complex' enquiries to a case conference involving all required professionals to devise the safeguarding plan.

Case conference within 20 working days

A case conference being held within 20 working days of receiving the concern during 2014/15 was 50% which has reduced by over half during 2015/16 to 23%.

It is however noted that some delays can be directly attributed to operational challenges identified when trying to co-ordinate appropriate attendance at case conferences. Operational staff are working hard to ensure that there are no inappropriate delays in the process.

Case details of concluded Section 42 enquiries

The data in this section relates to section 42 enquiries that have concluded in the reported period.

Activity	2014/15	2015/16	Comparative Analysis
Number of enquiries concluded in period	1483	1074	↓
% with a strategy discussion within 5 working days of concern	96.5%	90%	↓
Average time from concern to enquiry start date	-	-	-

% of safeguarding enquiry investigations completed within 20 working days	48.7%	60%	↑
Concluded enquiries that went to case conference	68	30	↓
% with a case conference within 20 working days	50%	23%	↓
Average time from concern to enquiry end date (median)	Not Available	37 days	-

Final status of allegation

The final status of allegation with the highest percentage is '*fully substantiated*'. During 2015/16 this figure has increased to 51% in comparison to 2014/15 where it was 36% .A hypothesis for this is a development within practice that clearly identifies the process and risk identification at the point of enquiry and investigation meaning there is a clearer understanding from practitioners about the point at which an investigation proceeds to an enquiry.

Concluded cases by final status of allegation

Final status of allegation	2014/15	2015/16	Comparative Analysis
Investigation Ceased At Individuals Request	93 (6%)	32 (3%)	↓
Not Substantiated	424 (29%)	225 (21%)	↓
Inconclusive	257 (17%)	174 (16%)	↓
Partially Substantiated	175 (12%)	98 (9%)	↓
Fully Substantiated	534 (36%)	545 (51%)	↑
Other Conclusion	N/A	-	-

Commentary

Mental Capacity

The data shows that the number of individuals that are 'assumed to have mental capacity' has increased during 2015/16 to 42% compared to 35% in 2014/15.

ASC seek to improve 'staff awareness on MCA

- *A Practice Forum on MCA was completed for all SW staff for the 13th January 2016*
- *A MCA policy has been devised in March 2016 to assist and enable staff to appropriately assess MCA/ Best interest decisions.*
- *Audits completed by Safeguarding Operational Manager and Team manager ensure that MCA assessments are reviewed and guidance given where required.*

It is anticipated that these changes will continue to improve staff skill base in assessing MCA and offer robust guidance in complex cases.

Independent Mental Capacity Advocate (IMCA) – referral numbers

	2014/15	2015/16	Comparative Analysis
Sandwell IMCA	82	100	↑
RPRs	54	61	↑
TOTAL	136	161	↑

	2014/15	2015/16	Comparative Analysis
Males	56	64	↑
Females	63	71	↑
Ineligible	3	1	↓
TOTAL	122	136	↑

Concluded cases by mental capacity

	2014/15	2015/16	Comparative Analysis
Mental capacity assumed	497 (35%)	452 (42%)	↑
Lacks capacity	624 (42%)	435 (41%)	↓
Don't know	36 (2%)	27 (2%)	-
Not recorded	326 (22%)	160 (15%)	↓

Deprivation of Liberty Safeguards

Activity	2014/15	2015/16	Comparative Analysis
Number of DoLS referrals	452	839	↑
Number of active cases at end of quarter	NA	1976	-

*Active cases snapshot data was not collected in 2014/15, in the way that it is collected now.
All data abstracted from dashboards submitted to Sandwell Safeguarding Adults Board on a quarterly basis.

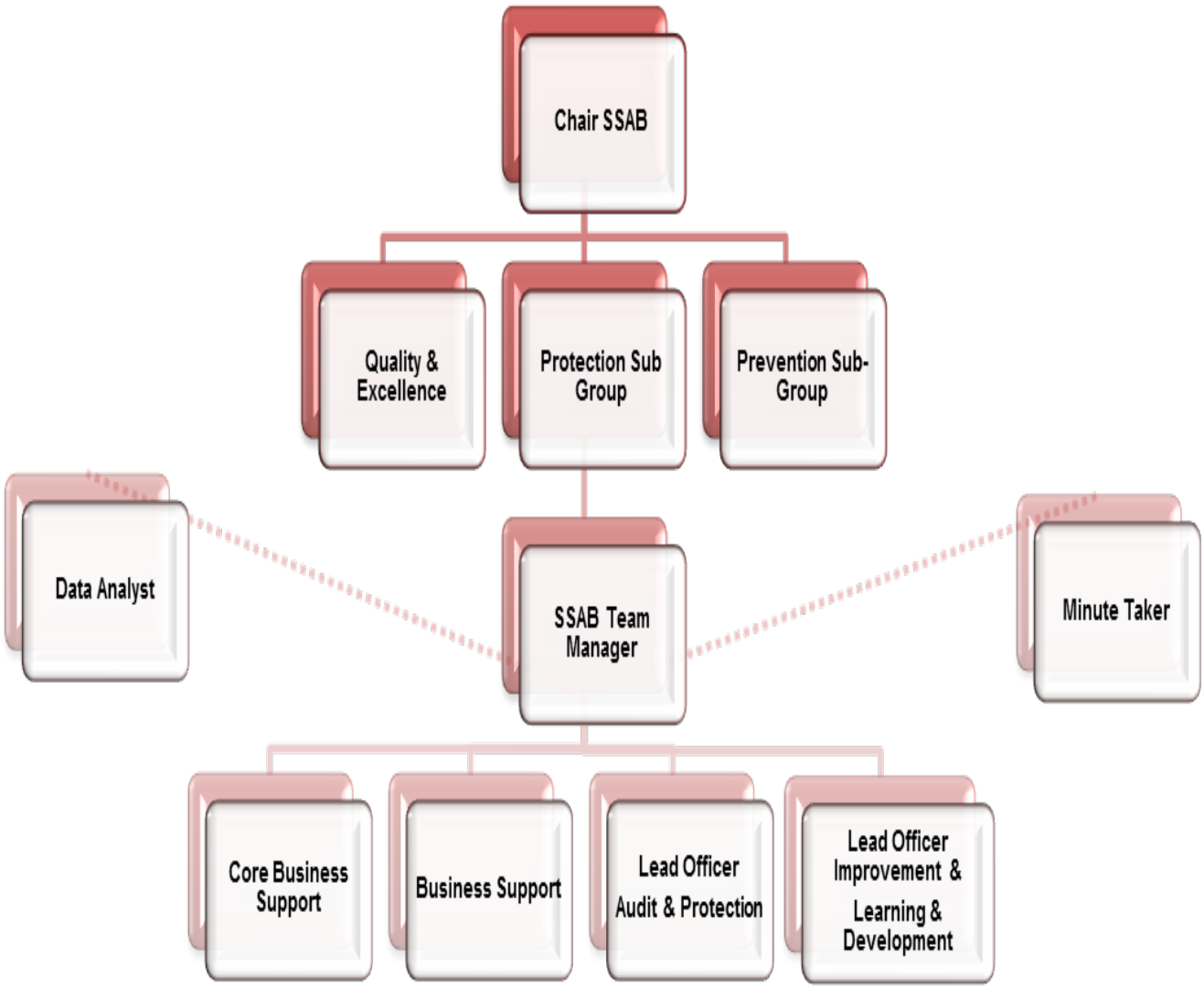
9. SSAB strategic priorities 2016/2017

PREVENTION & LEARNING & DEVELOPMENT:
• Facilitate a campaign with Sandwell Safeguarding Children's Board and Domestic Abuse Safety Partnership building on the Think Family model. • Host a conference promoting Making Safeguarding Personal. • Develop and map a range of preventative work within the community. • Develop a service user engagement plan in partnership with Healthwatch by December 2016. • Write and promote a learning and development strategy. • Annual board development day April 2016. • Develop a website for the board by the end of 2016.

QUALITY & EXCELLENCE
• Work with partners to develop a self-assessment audit tool to enable us to review and consider the quality of practice. • Develop an effective data set on reported deaths both expected and unexpected. • Ensure making safeguarding personal is imbedded in practice.

PROTECTION
• Review the SAR process and ensure all agencies refer cases appropriately. • Review Position of Trust policies and procedures with partners. • Ensure all paperwork is Care Act compliant including review of referral forms and safeguarding paperwork.

SSAB Board Structure



Appendix 1 – Board Membership

Name	Job Title
Eddie Clarke	SSAB Independent Chair
Deb Ward	Sandwell Safeguarding Adults Board Business Manager
Alison Hodgson	Deputy Chief Officer for Quality, Clinical Commissioning Group (CCG)
Michelle Carolan	Quality and Safeguarding Lead Nurse, Clinical Commissioning Group (CCG)
Clare Cotterill	Senior Sister, Priory 5, Sandwell & West Birmingham Health Trust (SWBH)
Debbie Talbot	Lead for Optimal Wards, Sandwell & West Birmingham Health Trust (SWBH)
Dave Bradshaw	Project Co-ordinator at Sandwell Advocacy, Sandwell Homes
Michelle Fletcher	Oldbury Area Manager, Sandwell Homes
Debbie Lequesne	Association Chief Executive West Midlands Care Association
Geoff Foster	SSAB Vice Chair , SSAB Protection sub-group Chair, CARES
Jayne Leeson	SSAB Prevention sub-group Chair, Changing Our Lives
Julie Winpenny	Partnership Officer, West Midlands Fire Service
Kay Murphy	Divisional Manager – Brokerage, SMBC Adult Community Services
David Stevens	Head of Adult Social Care, Service Director, SMBC Adult Community Services
Kwado Owusu-Darko	Director, Health Watch
Lisa Thacker	Compliance Manager, Care Quality Commission
Lynn Campini	Home Support Manager, Alzheimer's UK
Mark Burnell	Head of Public Protection Unit West Midlands Police
Matthew Ward	Chief Superintendent, West Midlands Police
Permjeet Panesar	CEO, Rights and Equality Sandwell
Satinder Purewal	PA/Office Manager, Rights and Equality Sandwell
Simon Reeves	Deputy Director of Service Delivery, BCPFT
Tabetha Darmon	Associate Director, Safeguarding, BCPFT
Viv Townsend	Senior Manager, National Probation Services
Ann Byrne	SSAB Lay Member

Appendix 2 - Case study from SWBHT

1. **Please describe the safeguarding concern (include how the safeguarding concern was identified; assessed - what tools were used; how the patient was involved and if the concern progressed to a referral to the Local Authority (MASH).**

Question	SWBH Answer	Weighting (Max score)	SA Score
1.1 Provide a clear anonymous description of how the safeguarding concern presented, including historical, background information if known.	Patient presented to Emergency Department from home on the 1.1.16 following a seizure. The subject was a known epileptic whom complained of headaches and the partner who was present reported multiple falls. Patient was referred for CT scan and the result revealed chronic subdural's. These findings were discussed with QE and conservative management agreed. The patient on presentation was confused. Bloods supported dehydration and a blood film sodium was low which could attribute to confusion. SALT review sought as patient appeared to have difficulty swallowing.	4	4
1.2 How the safeguarding concern was identified? - Include a description of the assessment made and use of tools.	On examination the patient was found to appear unkempt. Multiple bruises were recorded on a body map. Patient appeared nutritionally challenged and weighed 37.7kg BMI of 15(MUST Tool). Red marks were recorded around the neck that dissipated within 12 hours of admission and bruises to the upper torso that remained. Ambulance crew recorded that the partner who was present had reported the bruises/marks were an attempt to restrain the patient during a seizure. Safe guarding referral was made on arrival to ED. Social services allocated a key worker to the case who referred the case to the police.	4	4

1.3 Describe the circumstances leading to presentation, significant others involved with vulnerable adult and known factors that may impact on the assessment of need.	The patient had multiple falls, bruises located on upper torso and recorded on a body map. Chronic subdural confirmed by CT and fluctuating GCS. Capacity assessment deemed patient unable to make decisions. The patient was transferred to a ward for rehydration, monitor bloods and then discharge planning, Self-neglect/neglect case required full MDT meeting and strategy. DOLs to be considered. Await police outcome. 7.1.16 police followed up report and as patient remained confused they were unable to pursue an investigation but logged the concern.	3	4
1.4 Describe the rationale for decision making.	Patients only recorded contact in the notes as NOK was the partner. Patient unable to make decisions. IMCA referral made to ensure best interest decision on the 08.01.16 DOLs implemented on the 13.01.16 Transferred To MFFD on the 29.1.16 Capacity assessed by social work department on 12.2.16 (patient remained unable to make a decision) 12.2.16 Decision taken to discharge to an EMI bed with above agency involvement.	4	4
1.5 Demonstrate how vulnerable adult's voice/ feedback was sought understood and responded to.	As above Involvement with voice ability IMCA Including input where possible with patient and partner and optimal medical care	4	4
1.6 Indicate if referral was made to the LA and what happened once the referral was made. Please indicate if you have followed up on the referral.	24 hour care EMI bed for prolonged assessment.		
1.7 If the concern did not progress to a referral to the LA describe in detail how the concern was managed and the outcome.	N/A		N/A

2. Describe how effective partnership work was achieved and how any barriers were identified and managed (e.g. information sharing, multi-agency working and partnership, professional challenge, use of escalation policy, communication with patient and their family/carers).

Question	SWBH Answer	Weighting (Max score)	SA Score
2.1 Description of what went well and how this is evidenced. Was it "best practice" and if not – why not? – If it is recognised as best practice, why is it considered so and what is the evidence.	Patient safety maintained and safe discharge facilitated with support of the MDT team Capacity assessments were completed.	4	4
2.2 How did you work with your other partners – how did you exchange information and keep in touch?	Good MDT involvement. This is reflected in good communication and achieving a good outcome	4	4
2.3 What information was shared and how did it influence the process?	Clinical and safety information through best interest meeting as well as structured formal referral processes	3	3
2.4 When this went well, describe the process and what caused the positive outcome?	A shared goal to achieve safe discharge. Early referrals and capacity assessment	3	3
2.5 Describe any specific barriers in this process and how they were addressed. Reflection of why barriers occurred.	Ambulance crew and ED given suspicion on presentation could have contacted the police. It was unclear reliability of partners contribution	1	1
2.6 Indicate the impact of any non-engagement of partners upon the adult and how this gap in service delivery was addressed.	It did not appear that the patient had any insight or interest in partners presence or not.	1	1

3. Was the child/adult given an opportunity to express their wishes or feelings – what did they say? and how was this captured? And how were their wishes used to influence the process?

Question	SWBH Answer	Weighting (Max score)	SA Score
3.1 Demonstrate how the voice of the adult was obtained and represented. How was this incorporated into the care package to address the identified needs?	IMCA referral report indicated 24 hour continuing care following best interest meeting	5	5
3.2 If the child was pre-verbal – what other observations did you make	N/A	5	N/A

3.3 Supporting information to give assurance that the vulnerable adult had an opportunity to provide an account and/or express wishes/ feelings. E.g. child seen alone, age appropriate asked for their account of circumstances, interpreter used, use of play therapy, and observation of child's behaviour, demeanour and interaction with primary care giver.	IMCA referral made following two detailed capacity assessment. Patient involved in all meetings.	5	4
3.4 What was obtained from this and what response was given from practitioner.	N/A	5	N/A
3.5 How was this documented?	In medical notes Formal referral	3	3
3.6 If it was not taken into account, why not?		5	5

4. What was the outcome for the child/adult? And what were their and their family's or advocate's views on the outcome?

Question	SWBH Answer	Weighting (Max score)	SA Score
4.1 What happened? What difference did this make to the vulnerable adult? How do you know it made a difference? E.g. Did the child's behaviour change, was there feedback from a vulnerable adult on how they feel?	It is unclear whether this did change the outcome. Involvement of IMCA service ensured all avenues of needs and wishes were investigated supported by social work, therapy and nursing teams	5	5
4.2 Were adult Safeguarding proceedings initiated to provide protection for adult	Safe guarding referral made by ED on patient's arrival. Aspect for discussion/ learning – could the police have been involved any earlier. DOLS initiated as patient was restricted not requiring 1:1 care when confusion failed to improve.	3	5
4.3 What support was given to Parents to safely meet the needs of the vulnerable child?	N/A	N/A	N/A

4.4 What support was given to the family/carer to safely meet the needs of the vulnerable adult?	N/A 24 hour care – no recorded family	4	4
4.5 Was a conversation had with parents/carers? What did they say?	Partner was informed and updated of situation by both police and nursing teams.	4	4

5. Please reflect on your practice in this case (you may use the attached Gibbs (1988) reflective model or a similar model to do this – see below)

Question	SWBH Answer	Weighting (Max score)	SA Score
5.1 What were you thinking/ feeling?	It is felt that the police may have been involved earlier.	3	4
5.2 What was good and bad about this experience?	Safeguarding referral and DOLS implemented appropriately. IMCA requested appropriately and capacity and best interest	4	4
5.3 What sense can you make of the situation?	Police presence on admission could have been considered	3	4
5.4 What else could you have done?	As above	2	3

Appendix 3 – Finance and budget information

The work of SSAB cannot be achieved without a dedicated budget and resources.

For 2015-2016, 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 2015 - 2016 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.

Appendix 4 – Internal audit report and outcome

An audit of adult safeguarding was completed as part of the approved Internal Audit Plan for 2015/16:

The objective of our audit is to deliver reasonable assurance on the adequacy and application of the internal control system.

Scope and objectives of audit work

Our audit considered the objectives and the potential risk to the achievement of those objectives.

Objectives Reviewed	Potential Risks
To review the governance arrangements of the Sandwell Safeguarding Adult's Board.	That the organisation does not have internal safeguarding policies and procedures. That groups or committee is not accountable for safeguarding adults in the organisation. That the organisation does not have a lead director for the implementation of this work and a senior representative on the safeguarding adults' board. That representative has clear lines of accountability and feedback for this aspect of their work within their organisation.
Limitations to scope of audit:	Limited to the functions and control of the Adult Safeguarding Board.

Overall Conclusion

Our audit provides **substantial assurance** over the adequacy of the controls reviewed as part of the process to mitigate risks to an acceptable level.

Glossary of terms

Abbreviation	Explanation
A&E	Accident & Emergency
AACE	Association of Ambulance Chief Executives
Agewell	An over 50's initiative to influence positive changes in policies & services for and on behalf of older people
AGM	Annual General Meeting
ASC	Adult Social Care
BCPFT	Black Country Partnership Foundation Trust
BSAB	Birmingham Safeguarding Adults Board
CA	Care Act
CCG	Clinical Commissioning Group
CQC	Care Quality Commission www.cqc.org.uk
CQIN	Commissioning for Quality and Innovation
CSE	Child Sexual Exploitation
DA	Domestic Abuse
DASP	Domestic Abuse Strategic Partnership
DASS	Director of Adult Social Services
DBS	Disclosure and Barring Service
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
DV	Domestic Violence
eL	e-Learning
FGM	Female Genital Mutilation
GP	General Practitioner
IMCA	Independent Mental Capacity Advocate
IT	Information Technology
HMIC	Her Majesty's Inspectorate of Constabulary
KPI	Key Performance Indicator
LD	Learning Disability
MASH	Multi Agency Safeguarding Hub

Abbreviation	Explanation
MCA	Mental Capacity Act (2005)
MH	Mental Health
NHS	National Health Service
PEEL	Police effectiveness, efficiency and legitimacy programme
POT	Position of Trust
PPU	Public Protection Unit
PVVP	Preventing violence against vulnerable people
Prevent	The Prevent Strategy, launched in 2007, seeks to stop people becoming terrorists or supporting terrorism both in the UK and overseas.
SAB	Safeguarding Adults Boards
SAR	Safeguarding Adults Review
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SMBC	Sandwell Metropolitan Borough Council
SPOC	Single Point of Contact
SSAB	Sandwell Safeguarding Adult Board
SSCB	Sandwell Safeguarding Children's Board
SSM	Senior Strategy Meetings
SWBHT	Sandwell West Birmingham Hospital Trust
VPO	Vulnerable Person Officer
VTE	Venous Thromboembolism
WMAS	West Midlands Ambulance Service
WMASFT	West Midlands Ambulance Service Foundation Trust
WMCA	West Midland Care Association

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 Safeguarding Adult Board Manager, Deb Ward on 0121 569 5477 to give verbal feedback.

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

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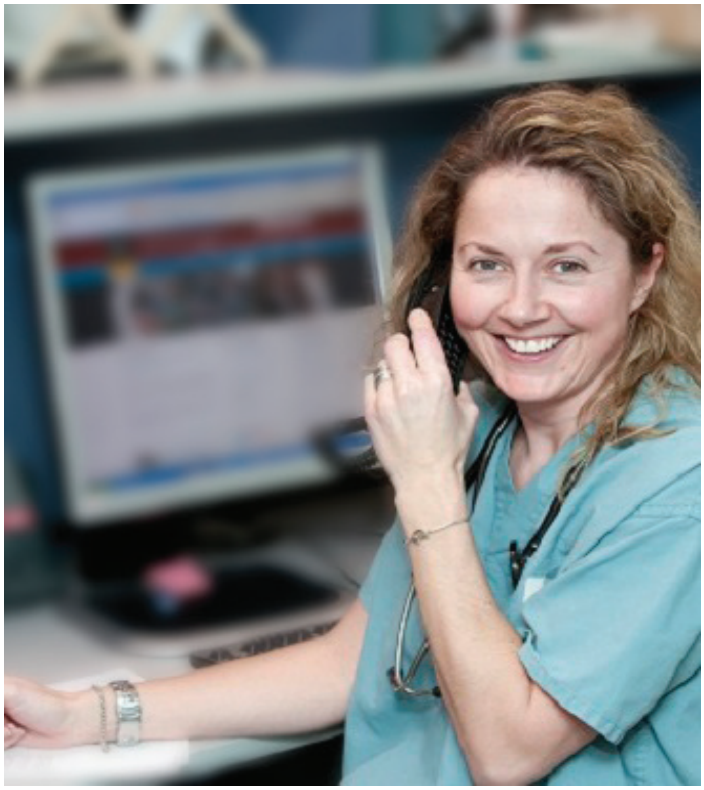
Who can I tell my concerns to?

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

In an emergency ring 999



SEE SOMETHING DO SOMETHING – SAFEGUARDING IS EVERYONE'S BUSINESS

If you are concerned that an adult with care and support needs is at risk of abuse or neglect call Sadwell Council on ***0121 569 2266.***