Sandwell
Metropolitan Borough Council

Health and Adult Social Care Scrutiny Board

Monday 22 January, 2018 at 5.30 pm
In Committee Room 1, at Sandwell Council House, Oldbury

Agenda

(Open to Public and Press)

1. Apologies for absence.

2. Members to declare:-

   (a) any interest in matters to be discussed at the meeting;
   (b) the existence and nature of any political Party Whip on any matter to be considered at the meeting.

3. Minutes of the meeting held on 20 November 2017.

4. Sandwell Safeguarding Adults Board Annual Report 2016/2017.

5. Strategy to Reduce Infant Mortality in Sandwell.

J Britton
Chief Executive
Sandwell Council House
Freeth Street
Oldbury
West Midlands

Distribution:

Councillor E.M. Giles (Chair);
Councillor Ahmed (Vice-Chair);
Councillor Rouf (Vice-Chair);
Councillors Crompton, Downing, Goult, O Jones, Hevican, S Jones, Lloyd and Shaeen.

Agenda prepared by Stephnie Hancock
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This document is available in large print on request to the above telephone number. The document is also available electronically on the Committee Management Information System which can be accessed from the Council's web site on www.sandwell.gov.uk

Sandwell
Metropolitan Borough Council

Agenda Item 1

Health and Adult Social Care Scrutiny Board

Apologies for Absence

The Board will receive any apologies for absence from the members of the Board.

Sandwell
Metropolitan Borough Council

Agenda Item 2

Health and Adult Social Care Scrutiny Board

Declaration of Interests

Members to declare:-

(a) any interest in matters to be discussed at the meeting;

(b) the existence and nature of any political Party Whip on any matter to be considered at the meeting.

Sandwell Metropolitan Borough Council

Agenda Item 3

Minutes of the Health and Adult Social Care Scrutiny Board

20 November, 2017 at 5.30pm
at Sandwell Council House, Oldbury

Present: Councillor E M Giles (Chair);
Councillor Ahmed (Vice-Chair);
Councillor Rouf (Vice-Chair);
Councillors Downing, Goult, Lloyd and Shaeen.

Apologies: Councillors Crompton, Hevican and S Jones.

19/17 **Minutes**

Resolved that the minutes of the meeting held on 18th September, 2017 be approved as a correct record.

20/17 **Air Quality in Sandwell**

The Board received the draft Air Quality Action Plan for the borough for 2018-2023.

In accordance with the Environment Act 1995, the council had declared the borough an air quality management area in 2005, due to the annual mean concentration of Nitrogen Oxide being exceeded at a number of locations. As such the Council was required to have a plan which set out what action it would take to improve air quality in the area. The principle aim of the Plan was to secure reductions in Nitrogen Oxide concentrations and comply with the national air quality objective in the shortest possible timeframe.

The Cabinet had considered the draft Plan and agreed that a public consultation exercise be conducted to receive the views of statutory and non-statutory consultees. The views of the Scrutiny Board were now sought regarding the draft Plan and the proposed consultation process.

The Board was informed that many of the air pollutants resulted from the process of fuel combustion originating from a combination of domestic, commercial and industrial transport sources. Traffic pollution was now a major threat to health and a contributor to climate impacts. It was associated with adverse health impacts and early deaths and recognised as a contributing factor in the onset of heart disease and cancer. The most vulnerable in society were most at risk, including children and older people with heart and lung conditions. There was often a strong correlation with equalities issues, because areas with poor air quality were also less affluent. The annual health cost to society of the impacts of particulate matter alone in the UK was estimated to be around £16 billion.

Interventions to reduce levels of particulate pollution required a concerted action by a host of sectors with a vested interest in air quality management (environment, transport, energy, health, housing) at regional, national and international levels.

The council had already taken action in five key areas to reduce air pollution arising from vehicle emissions, these included:-

- Promoting health initiatives that supported sustainable transport and behavioural change.
- Reducing congestion and minimising transport emissions through traffic management and highway improvements.
- Implementation of guidance and policy, working in partnership with key stakeholders to improve air quality outcomes.
- Improved understanding of pollutant behaviour particularly at hot spot locations.
- Reviewed the council's impact on air quality through an assessment of its vehicle fleets, taxi licencing and employee vehicle use.

The 2018-2023 Plan set out three key priorities: -

- Priority 1 – Hot Spot Locations
  Seven hotspots had been identified in the borough and transport planning and traffic infrastructure management would be reviewed at each location to identify where additional resource was required.

- Priority 2 – Sustainable Transport Initiatives
  Walking, cycling, car sharing and public transport initiatives would continue to be promoted and additional health promotion campaigns would be undertaken to increase physical activity and the use of low emission vehicles.

- Priority 3 – Review what impact the council has on air quality and develop plan to reduce emissions from its activities.
  A full review of fleet vehicles, licensing activities and employee vehicle use would be carried out.

Under the Environment Act 1995 the Council was required to consult a number of public organisations and bodies representing local businesses. Local communities and existing neighbourhood groups would also be consulted.

From the discussion, questions and contributions of those present, the following issues were highlighted:-

- The Clean Air Act 1993 outlined measures to address pollution caused by industry, including permit regimes.
- There were five monitoring stations in the borough, two of which were near motorways.
- There needed to be a careful balance between building the economy through new industry and controlling pollution, however, there were also positive health effects from being employed.
- The government had challenged local authorities to look at creating a better infrastructure to support electric vehicles.
- For major planning Applications, the applicant was required to complete an air quality impact assessment.
- As Sandwell had so many town centres and local centres it was difficult to create exclusion zones for certain types of vehicle.
- Specific consultation would be carried out with residents of Birmingham Road, Oldbury.
- More work was to be done on specific strategies to tackle the emissions related to taxi vehicles.
- Complaints in relation to specific premises would be investigated as reported.
- More work was to be done with bus companies, in particular with regards to the Bearwood High Street area, which was one of the seven hot spots.

- Measures to reduce congestion on local motorways were the responsibility of Highways England.
- The government was moving towards stronger policies on emissions, however, this was taking time.
- Managed motorways and signalled entry points was one of the methods to address emissions levels.

Residents of Birmingham Road, Oldbury, present at the meeting raised the following concerns:-

- Despite diversions to alternative routes being in place, motorists were choosing to take Birmingham Road, which was resulting in more pollution that area.
- There was a lot of heavy industry surrounding the Road and residents believed this was impacting on their health.
- Measuring tubes for Nitrogen Dioxide seemed to have been moved.
- Measurements taken by Birmingham University and Friends of the Earth were different to those taken by the Council.

The Director – Prevention and Protection undertook to look into the issues raised by the residents.

Members remarked on the levels of physical inactivity in Sandwell and the added impact that poor air quality had on health. The Board felt that the Council should lead by example where possible in promoting measures to reduce air quality and recommended that free parking be offered to drivers of electric vehicles in Sandwell.

Resolved to recommend:-

(1) that the Director – Prevention and Protection carry out targeted consultation on the draft Air Quality Action Plan 2018-2023 with residents of Birmingham Road, Oldbury;

(2) that the Cabinet Member for Public Health and Protection liaises with the Council's representatives on the West Midlands Combined Authority to ensure that issues of air quality are addressed at a regional level;

(3) that free parking be offered to drivers of electric vehicles in Sandwell.

21/17 **Healthwatch**

The Board had invited representatives from Black Country Partnership NHS Foundation Trust's Child and Adolescent Mental Health Service (CAMHS) to report on how they had responded to Healthwatch Sandwell's report following its investigation into the experiences of young people who self-harm.

During 2015/16 Healthwatch Sandwell had been contacted by various people who shared their experiences of mental health services in Sandwell. These experiences were varied and related to different providers of care. Many experiences were negative, adding to already stressful situations. An engagement exercise with young people about their health and social care issues (reported in Healthwatch Activity Report 7, 30 June 2015) showed that 49% of issues raised were directly or indirectly related to mental health difficulties. Simultaneously parents of young people had contacted Healthwatch directly to share experiences of the difficulties they have had accessing appropriate and timely mental health care from primary, acute and social care.

Healthwatch reported that it had been difficult to ascertain actual figures of young people in Sandwell (or anywhere) who self harmed and available data did not relate specifically to self-harm as a stand-alone issue but to a wide range of mental health difficulties. In addition, the available data was based on engagement with services and concern was expressed about hidden numbers of people self-harming and not accessing the necessary support.

The investigation had included a survey reaching over 10,000 people, via partner organisations and social media. It was noted that only one of 17 schools contacted had responded. Given this poor response rate, it was acknowledged by Healthwatch that this limited the value of the findings. The first of the four recommendations therefore recommended that further research be undertaken to try to establish the scale of the issue in order to support the development of appropriate support services.

The report had been published in November 2016 and had made four recommendations:-

- Research into the prevalence of self-harm in Sandwell should be considered by appropriate organisations.

- A reduction in waiting times for appropriate care/support.
- Raise awareness of signs of self-harm in young people and where to signpost for help.
- Commissioners and providers of services to consider alternative service delivery that may be more appropriate and accessible to the audience.

The representatives present from CAMHS highlighted the following in their response:-

- CAMHS provided a range of services from universal to specialist services.
- Working with the local authority and commissioners, the Crisis Intervention Home Treatment Team had been remodelled and the Team now worked more closely with A & E departments to prevent hospital admission and instead provide intensive support in the home. This data could be looked at in relation to self-harm.
- The Sandwell BEAM service was due to be launched on 28th November, 2017. Led by the Children's Society, several agencies had come together to provide drop-in services for young people aged 5-18 who needed support with their mental health.
- There was an integrated pathway for young people presenting at GP surgeries with one document for professionals to complete to tell the young person's story.
- Specialist CAMHS teams were working with commissioners and looking at capacities, consent and legalities around self-referral pathways.

From the discussion, and questions and contributions of those present the following points were highlighted:-

- An online counselling service was provided by CAMHS, called Kooth and fliers had been sent to schools to promote this.
- Waiting times for referrals had been reduced to nine weeks.
- There was a triage system for urgent help.
- The CAMHS website had won an award.
- It was difficult to fully understand the levels of self-harm since some people used it as a coping strategy so did not feel they needed to approach support services.
- There were challenges in talking to schools since their focus was on delivering the curriculum.

- Commissioners had recently reviewed the new model and had concluded that a gold standard of service was being offered.
- Black Country Partnership NHS Foundation Trust, Birmingham Community Healthcare NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust were due to merge in the new year.
- Research showed that females internalised mental health issues whilst males externalised so it was necessary to look at behaviour indicators to identify risk.
- There had been a 40% increase since 2013 in young people presenting at A&E departments with mental health issues.
- Brook had been commissioned to set up young people's groups across Sandwell, which would assist in providing more data on prevalence of self-harm.
- The young person's voice was a central part in the CAMHS transformation plan.
- Austerity had created greater demands on services.
- A specialist social worker seconded to CAMHS from the Council had been withdrawn which had left a gap in service provision. The Executive Director Adult Social Care, Health and Wellbeing undertook to look into this.

The Board felt that promoting services and talking to young people was central to establishing the scale of the problem and seeking to address it. The Board felt that the Council had a role to play in promoting the services available to young people.

Resolved:-

(1) that an update on the merger of Black Country Partnership NHS Foundation Trust, Birmingham Community Healthcare NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust be submitted to the Board in early 2018;

(2) **to recommend** that the Council works with partner agencies in promoting the services available to support young people with mental health issues.

22/17 **Update on Delayed Transfers of Care**

The Board noted a presentation from the Executive Director – Adult Social Care, Health and Wellbeing on the Council's work with

partner organisations to reduce delayed transfers of care from hospital to home or an appropriate care setting.

Under the Improved Better Care Fund, the government had made around £11m available to local authorities to support the timely discharge of Sandwell residents from hospital. Sandwell and West Birmingham Clinical Commissioning Group and the Council were committed to building on the progress made in year one and two of the Better Care Fund and had agreed to align their respective commissioning duties to deliver improved health and wellbeing for the people of Sandwell. Both agreed that the best solution was to develop a placed based integrated care system that delivered better integration of general practice, out of hospital services, social care, primary, community services and specialist out of hospital care (physical and mental health services). However, this type of change was complex and the transition required careful management, including the development of a financial framework which created opportunities whilst reducing instability and managing risk.

A project had been established with the aim ensuring that a person was sent home or to the right care setting on the same day. Working on the principle of placed based commissioning, and Sandwell being the "place", a number of workstreams had been set up to deliver the project, focusing on the following areas:-

- low level support in the community to support prevention through targeted collective spend
- closer working with GPs
- working with community services
- co-ordinating services for residents in hospital outside of Sandwell
- partnerships with acute services

Currently Sandwell had the lowest delayed transfer of care amongst all authorities in West Midlands and was following a downward trajectory. However, the late reporting of data by Sandwell and West Birmingham Hospitals NHS Foundation Trust sometimes made it difficult to manage and this had been raised at the Health and Wellbeing Board and with the Trust.

If government targets weren't met then there was a risk that the funding would be lost or the government would step in and dictate how it was spent. In 2017/18 the funding had been committed to support adult services directorate as a whole and avoid the need for

cuts to be made, and to support the growth of services that would support timely discharge from hospital. The funding provided an opportunity to strengthen and further develop joint working with benefits for commissioners and providers.

23/17 **Work Programme Update**

The Board noted an update from the Chair and Vice-Chairs on their activities outside of the Board's meetings.

(Meeting ended at 8.08 pm)

Contact Officer: Stephnie Hancock
Democratic Services Unit
0121 569 3189

Sandwell Metropolitan Borough Council

Agenda Item 4

HEALTH AND ADULT SOCIAL CARE SCRUTINY BOARD

22 January 2018

Subject:	Sandwell Safeguarding Adults Board Annual Report 2016/2017
Contribution towards Vision 2030:	
Contact Officer(s):	Stephnie Hancock - Scrutiny Officer stephnie_hancock@sandwell.gov.uk

1 PURPOSE OF THE ITEM

Each year the Board receives Sandwell's Safeguarding Adults Board's annual report for consideration and comment. The Board's 2016/2017 Annual Report is now presented.

2 RECOMMENDATION

The Board is invited to consider and comment upon the annual report.

3 IMPLICATIONS FOR SANDWELL'S VISION

The work of the Sandwell Safeguarding Adults Board supports the Vision 2030, with clear and direct contributions to the following ambitions:

Ambition 2 – Sandwell is a place where we live healthy lives and live them for longer, and where those of us who are vulnerable feel respected and cared for.

Ambition 5 – Our communities are built on mutual respect and taking care of each other, supported by all the agencies that ensure we feel safe and protected in our homes and local neighbourhoods.

Ambition 10 – Sandwell now has a national reputation for getting things done, where all local partners are focused on what really matters in people's lives and communities.

Surjit Tour
Director – Monitoring Officer

Sandwell Safeguarding Adults Board

SSAB@SSAdultsBoard

ANNUAL REPORT 2016/2017
Executive Summary

The full version of the Annual Report and an Easy Read version is available on our website at **www.sandwell.org.uk** or by contact Lisa Roberts on **0121 569 5471**

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Foreword from the Chair

Welcome to Sandwell's Safeguarding Adults Board Executive Summary 2016-17.

Hello all,

Welcome to Sandwell's Safeguarding Adults 2016-17 Annual Report Executive Summary, which provides the Board and agencies with the opportunity to reflect on their achievements in 2016-17 and plans for the year ahead. It also gives us the opportunity to demonstrate the Board's fulfilment of its role and commitment to safeguard adults with care and support needs in the Borough of Sandwell.

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 continued to strengthen our relationship with Healthwatch who we have commissioned to promote and develop an infrastructure to enable effective service user involvement.

The Board now has its own website which can be found at;

www.sandwellsab.org.uk.

One of our key achievements for this year has been working in partnership with West Midlands Fire Service and Sandwell Council's Neighbourhoods and Communities Directorate. We have developed and launched a Hoarding Framework containing clutter images with ratings, clear guidance and a pathway. This has impacted on practice significantly and contributed to effective safeguarding in areas of high risk.

I am delighted to present this executive summary to you and I would urge you to read the full report at **www.sandwell.org.uk**

Eddie Clarke

Independent Chair,

Sandwell Safeguarding Adults Board

What's New

The SSAB have launched their own website

www.sandwellsab.org.uk

Contributions & Key Highlights

Service user experience & feedback on the safeguarding process:

Adult Social Care

We have a Safeguarding Questionnaire which is forwarded to customers at the final stage of S42 Enquiry.

Recording Making Safeguarding Personal (MSP) outcomes on adult social care records.

Case file record and safeguarding plan/enquiry form.

Case conference, actions

Domestic Abuse Strategic Partnership

The Identification and Referral to Improve Safety (IRIS) pilot in Sandwell and West Birmingham is progressing well and is successful regarding increased referrals. Sandwell and West Birmingham have adopted a 'unique' model of IRIS that essentially makes the most of existing services. This works well and shows that fidelity to the programme can be retained at the same time as molding it to local context and needs. Importantly, it has made a considerable difference to the safety and wellbeing of people living locally who are living with domestic violence and abuse.

West Midlands Ambulance Service is a responsive organisation with education and information on the Trust website which is available externally and the Safeguarding team works closely with Patient advice and liaison services Patient Advice and Liaison Services (PALS) and our Patient Experience team to collect and collate feedback from services users to feed into training, information, policies and procedures where appropriate.

Safeguarding achievements & the difference made:

West Midlands Fire Service

This year our Safe & Well checks were updated to include how 'safe' the individual feels using the Short Warwick- Edinburgh Mental Wellbeing Scale (SWEMWBS).

West Midlands Police

In November 2016 West Midlands Police (WMP) introduced new operational response principles (for all people contacting WMP, not just Vulnerable Adults), which included the introduction of a new grading policy to support the identification of the most suitable Primary (initial response) and Secondary (Investigation management and outcome) investigation resource.

Black Country Partnership Foundation Trust

The Trust safeguarding team produces quarterly and annual assurance reports to reflect adherence to safeguarding policies, procedures and best practice and incorporates the key priorities identified at the commencement of the financial year and in year emerging priorities.

Training:

Sandwell & West Birmingham Hospital Trust

Staff targeted to expand mandatory training with highlighted gap in knowledge. Currently level 2 is face to face and mandated at band 7 and above. The review indicates level 2 could be scenario based e-Learning ensuring staff can identify and raise safeguarding concerns/ Deprivation of Liberty Safeguards (DoLS). Level 3 class room based with a lesson plan to be aimed at a higher level of detail around legislation.

West Midlands Police

West Midlands Police have appointed two staff to work within the WMP Learning and Development department who have been commissioned to undertake a review of continuous professional development training (CPD), which will be used as part of a wider review of core training outlined above.

Sandwell & West Birmingham Clinical Commissioning Group

We have offered Bluestream online e-Learning training to all care homes across Sandwell & West Birmingham.

Continued with a rolling programme of training events including cross cutting initiatives such as PREVENT and Child Sexual Exploitation (CSE) – including holding a CSE conference.
We have actively participated in campaigns in partnership with Sandwell Safeguarding Adult Boards. The Prevent Strategy seeks to stop people becoming terrorists or supporting terrorism both in the UK and overseas.

Sub-Group Strategic Objectives 2016/17

Protection

Contribute and influence the strategic development of practice and undertake safeguarding adult reviews.

Quality & Excellence

Continue to focus on effective delivery and high quality processes.

Prevention

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

Sub-Group Contributions Key Highlights

Quality & Excellence

Safeguarding achievements & the difference made

- The Sub Group was relaunched with a new Chair, membership and lead officer to refocus on building the group and ensuring membership from all statutory partners.
- A fresh look at how the Board is assured about safeguarding referrals and looking at correlation with other agencies and highlighting any discrepancies
- Including the DoLS lead in the membership of the group to provide an insight to statistics and trends locally
- Participating in the development of an engagement strategy and an engagement group to ensure all activity is inclusive and reflective of the needs of Sandwell
- Ensuring Making Safeguarding Personal is embedded in practice.

Prevention, Learning & Development

Safeguarding achievements & the difference made

- Sandwell Safeguarding Adults Board (SSAB) dedicated website now live and being accessed
- Increased outreach activities exceeding our goal of 12 per year
- Provision of more e-Learning packages
- Successful conference, best practice forums and events
- Introduction of safeguarding briefs for agencies that do not require formal training but need an overall basic safeguarding awareness. An example of where this method has been used is volunteers

Protection

Safeguarding achievements & the difference made

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

Safeguarding Performance Data

Number of Concerns/Enquiries

Number of concerns

There has been a slight increase in the number of concerns received by the council during 2016-17 compared with 2015-16 (just over 1.5%). The analysis of the increase would suggest that the increase can be attributed to multiple categories of abuse within the same investigation and more than one concern in respect of the same person.

Number of enquiries

During 15-16 just under half of concerns progressed to enquiry, whereas during 16-17 just under a fifth progressed to enquiry. This reduction is a reflection of the change in the ASC recording system that enabled S42 enquiries to be monitored more accurately.

Since the Care Act, Safeguarding ASC have re-designed their social care systems to reflect the legislation and the definition of a S42 Enquiry and have made changes in their practice. Prior to the change in practice all concerns were being immediately progressed to S42/Investigation. Current practice ensures greater management oversight at the point at which a concern is raised enabling more effective solutions and signposting without the necessity to progress to a S42.

The data now collected more accurately reflects the operational picture with detailed work being undertaken at the point at which a concern is raised to establish the level of risk and/or whether it is a safeguarding concern or an issue for care management or other redirection meaning the number of actual enquiries undertaken are fewer in number but are complex safeguarding matters.

Concerns raised (commenced) within the period	**2015/16**	**2016/17**
Number of individuals with a concern	1686	1779
Number of concerns	2369	2408

Cases concluded within the period	**2015/16**	**2016/17**
Enquiries	1074	444
Concerns	2316	2408
% conversion rate	46%	18%

Concerns and enquiries by source of contact

Conversion rates for 2016-17 show that concerns raised by the general public quite often result in a section 42 enquiry, however, very few concerns raised by the NHS and the Police do. Work continues to be undertaken with all of our partners in uniformed services to clarify a common understanding of what constitutes a safeguarding concern as opposed to someone with additional support needs needing more robust support. It is of note that uniformed service colleagues have contact with adults with additional support needs during unsociable hours and on these occasions' opportunities to direct referrals appropriately may be more limited.

Conversion rate by source of concern	2016/17
Sandwell Council	16%
NHS	8%
Police	9%
Independent Sector	24%
General Public	38%
All other	18%

Concluded S42 enquiries by type of abuse

During 16-17 the majority of enquiries were due to safeguarding concerns relating to neglect or physical abuse. Over half of the enquiries during 16-17 had an abuse type of neglect and a quarter had an abuse type of physical.

In the table that shows types of abuse by location we can see that the highest numbers are represented in settings where the individual is living in their own home (community) which could include a shared living situation.

A high prevalence of physical abuse we can hypothesise relates to service user on service user assault. This may be linked to a significant learning disability or dementia where the intent is not to cause harm but rather an expression of an individual's communication.

Concluded S42 enquiries by type of abuse	2015-16	2016-17
Physical Abuse	437	114
Sexual Abuse	27	10
Psychological Abuse	85	24
Financial or Material Abuse	155	55
Discriminatory Abuse	2	0
Organisational Abuse	1	6
Neglect and Acts of Omission	391	230
Domestic Abuse	4	5
Sexual Exploitation	0	0
Modern Slavery	1	0
Self-Neglect	12	7
Total	1115	451

Concluded S42 enquiries by location

The highest number of enquiries related to S42 concerns are alleged to have taken place in the persons own home. This is closely followed the number of enquiries that were alleged to have taken place in a care home setting.

Concluded S42 enquiries by location	2015-16	2016-17
Own Home	493	211
In the community (excluding community services)	NA	3
In a community service	31	7
Care Home - Nursing	402	93
Care Home - Residential		90
Hospital - Acute	87	11
Hospital - Mental Health		15
Hospital - Community		7
Other	61	7
Total	1074	444

Sandwell Safeguarding Adult's Board Priorities 2017/18

Prevention, Learning & Development

- To continue to develop a specific campaign focus with the aim of continued improvement of awareness of Safeguarding and what 'to do' if you 'see something' with a considered focus on Prevention of Violence & Exploitation (PoVE)and community based campaigns
- Enable the identification of effective support to be delivered in a timely fashion including oversight of the provision of support to victims of violence and exploitation
- To facilitate a conference in October 2017 with a prevention focus considering 'What is adult Safeguarding?' and the range of support available to individuals where there may be concerns but they are not Safeguarding concerns

Quality & Excellence

- Relaunch the Sub Group with all statutory partners fully represented
- Develop a new performance framework to reflect quantitative and qualitative data required to assure SSAB of Safeguarding quality and processes and effective analysis of all data
- Support the development of a service user engagement forum and the engagement plan

Protection

- Care Act readiness – ensure local policies and procedures are re-written (where appropriate) in line with West Midlands guidelines and approved by the Board
- Launch the revised Safeguarding Adult Review Procedures and toolkit
- Review Position of Trust policies and procedures with partners

Conclusion

This Executive Summary gives a flavour of the full version of the Annual Report document with a focus on contributions, progress on agreed priorities for last year and the identification of agreed priorities for 2017-18.

To view the full version of the report please visit the SSAB website:

www.sandwellsab.org.uk

or contact:

Deb Ward
Sandwell Safeguarding Adult's Board Manager
Tel: **0121 569 5477**

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Sandwell Metropolitan Borough Council

www.sandwellsab.org.uk

Click paste the link below to watch our 2 minute film 'See Something, Do Something'
https://www.youtube.com/watch?v=I1f0WZEuKno

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 SANDWELL COUNCIL ON 0121 569 2266

Sandwell
Safeguarding
Adults
Board

SSAB@SSAdultsBoard

Sandwell Safeguarding Adults Board

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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 continued to strengthen our relationship with Healthwatch who we have commissioned to promote and develop an infrastructure to enable effective service user involvement.

The Board now has its own website which can be found at;

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One of our key achievements for this year has been working in partnership with West Midlands Fire Service and Sandwell Council's Neighbourhoods and Communities Directorate. We have developed and launched a Hoarding Framework containing clutter images with ratings, clear guidance and a pathway. This has impacted on practice significantly and contributed to effective safeguarding in areas of high risk.

I am delighted to present this report to you, which I hope you will use to raise awareness and identify issues that you can take forward in your own organisation as it is important that this is a "working document". Thank you to all of those who have contributed to supporting and protecting our most at risk adults in Sandwell.

Eddie Clarke

Independent Chair,

Sandwell Safeguarding Adults Board

The National Picture

The most significant advance in safeguarding adults for many years has been the Care Act 2014 which from 1st April 2015 set out a clear legal framework for how Local Authorities and other parts of the system should protect adults at risk of abuse or neglect. It gave Local Authorities new safeguarding duties. They must:

• lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens;

• make enquiries, or request others to make them, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed;

• establish Safeguarding Adults Boards, including the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy;

• carry out Safeguarding Adults Reviews when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them;

• arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

In addition, the Care Act 2014 has provided some new challenges during 2016-17 for Safeguarding Adults – new types of abuse – Self-neglect and Modern Slavery, allegations against people in positions of trust and the Local Authorities power to 'cause' enquiries.

Making Safeguarding Personal (MSP) remains a high priority as the approach that should be the foundation of all safeguarding activity and is embedded into the Statutory Guidance issued under the Care Act 2014. Making Safeguarding Personal enables safeguarding to be done with people, not to people. It focuses on achieving meaningful improvement to people's circumstances, rather than 'investigation'/'conclusion'. It utilises social work (and other professional) skills better than just 'putting people through a process' and concentrates on a real understanding of what people wish to achieve (and how), recording their desired outcomes and then seeing how effectively these have been met. Most importantly it enables practitioners, families, teams and SABs to know what differences have been made for people.

In July 2015 the Law Commission launched a Consultation Paper on Mental Capacity and Deprivation of Liberty Safeguards (DoLS). The Law Commission consider that there is a compelling case for replacing the DoLS, which is often perceived to be overly technical and legalised, not meaningful for disabled people and their families or carers, has failed to secure buy-in from health and social care practitioners and the most frequent and consistent criticism made about the DoLS has concerned the term "Deprivation of Liberty Safeguards" as it is viewed widely as unhelpful and it is suggested puts professionals off using the scheme.

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, an example of which is the current campaign 'See Something, Do Something'.

We continue to use our short film 'See Something, Do Something' as a standard tool in all of our training and the film has been adopted and used widely by our partners. This can also now be seen on our website.

www.sandwellsab.org.uk

Below is a quote from a Lay Member of the Board:

"The use of campaigns helps everybody understand in a clear way what safeguarding means and what we are all trying to do."

Currently, twelve agencies are represented on the Board - (see Appendix 2) 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 is supported by a small business team of Officers and a Board Operations 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 2016-17 the Sandwell Safeguarding Adult 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. Sandwell has lead in partnership with West Midlands Fire Service and Neighbourhoods on the development of both local and regional guidance including the use of Clutter Images on best practice when responding to hoarding.

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. There are strong links with all key Board's locally enabling joint development of agenda's including Prevention of Violence and Exploitation.

The focus for future development days could be common areas of safeguarding with our partners and developing our understanding of new areas of abuse as identified in the Care Act, and developing our partnerships and joint working with Sandwell Safeguarding Children's Board, the Health and Wellbeing Board and the Sandwell Safer Partnership Police and Crime Board.

Common areas of work with the Children's Board include adults aged 18 plus with additional support needs and their transition to adulthood.

Key policies including Hoarding Guidance and Self Neglect Guidance can now be found on the SSAB website @ **www.sandwellsab.org.uk**

A member's area will soon be added and Board Minutes will be accessed on there.

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

Key Achievements

Joint Board Development Day 28.04.16

Heads of Service, Senior Police representatives as well as Health Partners and others, all members of both Sandwell's Safeguarding Children's Board and Sandwell Safeguarding Adult's Board were present at a local event (the first of its kind in Sandwell) to look at key Safeguarding themes that impact on both adults with support needs and children in this area!

The identified priority areas were: Modern Slavery, Prevent, Transition and Vulnerable Young Adults and the Crisis Mental Health Concordat.

Some of the quotes received:

"Really informative day with lots of new information"

"Valuable opportunity to work together"

"Need to consider the impact of all of these issues more locally"

"An interesting and useful meeting"

Prevention Conference Making Safeguarding Personal/ Think Family 19.05.16

In May the Board supported a conference made up of a range of professionals from across all agencies with a focus on Prevention and the family as a whole. The day was structured with formal speakers and there was a series of dynamic workshops covering the following topics:

Making Safeguarding Personal

Sandwell Feel Good 6

Recovery Model and Personalised Solutions

The SCAMS Pub Quiz.

This event enabled the Board to evidence positive Prevention strategies, strong partnerships in action and showcase preventative work across the Borough.

"Valuable day learnt a lot" – Lay Member

"Interesting range of workshops, would have liked more time."

Appointment of Lay Member

SSAB appointed a second Lay Member to the Board this is a positive opportunity for an active member of the local community to act as a critical friend to the Board asking challenging questions and bringing a different and positive prospective to the work of the Board.

Launch of the Hoarding Pathway 06.10.17

Neighbourhood Services in partnership with West Midlands Fire Service and SSAB held a multi-agency conference to launch Sandwell and West Midlands Fire Service Hoarding Pathway! There were a range of speakers and presentations considering some of the challenges when working in this area.

Speakers included the West Midlands Fire Service and Hoarding Disorders U.K. The event was well attended and support by elected members.

Please use the link below to view the Hoarding Framework and Pathway:

http://www.sandwellsab.org.uk/wp-content/uploads/2017/03/Sandwell_Hoarding_Framework_final.pdf

Best Practice Events

Events enabling learning and sharing good practice were programmed in throughout the year!

They provide an opportunity for people to come together from a range of disciplines, share ideas and learn from each other.

Examples include:

28.06.16 - Safeguarding Event for the 'Ideal for All' Volunteers

06.09.16 - Safeguarding Event for the Hub

10.10.16 - Hate Crime Best Practice Event

Learning Pool

Joint commissioning with Children's Services and Domestic Abuse Partnership (DASP) enabled the commissioning of a learning management system and e-Learning platform offering a range of learning opportunities for staff in both directorates and effective use of resources including an expansion in the e-Learning programme available to staff in Adult Social Care.

See Something, Do Something Campaign and Community Engagement

Engagement in a range of events promoting a greater understanding of Safeguarding with members of the public and professionals, examples of this include stalls at all Sandwell Six Events, presentations at staff inductions for new Social Workers joining Sandwell MBC and support to the 'Dignitea' event hosted by Age U.K in support of National Dignity Day 2016.

Prevention of Violence & Exploitation Agenda

SSAB participated in an event/workshop which was organised by the Task and Finish group and strategic and senior managers from within Sandwell MBC and external partners (both statutory and voluntary) were invited. The event reflected the commitment from the four statutory partnership Boards to work together to prevent violence and exploitation in Sandwell, and focused on:

- Context and background
- Initial findings from scoping the evidence
- Identifying what current good practice looks like
- Encouraging shared dialogue and agreeing potential course of action.

The four key Boards identified below continue to work together to prioritise this agenda and have oversight of individual actions and themes that have been adopted by each Board.

- Health and Wellbeing Board
- Safer Sandwell Partnership Board
- Sandwell Safeguarding Adults Board
- Sandwell Safeguarding Childrens Board

The SSAB's theme is '**Support victims of violence and exploitation and enable their recovery**' and the actions are overseen by the work of the Protection Sub Group.

Regional Involvement

The SSAB has made representation at a number of regional events for example SCIE Safeguarding Event 18.03.16 with a focus on Making Safeguarding Personal (MSP) led by Clare Crawley from Department of Health enabling learning and effective sharing of good practice across the West Midlands region and engagement and the development of effective engagement action plans and partnerships.

Website

SSAB launched our own website at the end of March 2017!

www.sandwellsab.org.uk

Summary of Progress Against the Board's Priorities 2016-17

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 built on the 'See Something, Do Something' campaign in conjunction with our partners in Neighbourhood Services. The campaign continues to underpin much of the Board activity and supports activity linked to the Prevention of Violence and Exploitation Agenda (PoVE) and our key theme "supporting victims of violence and exploitation and enabling their recovery". Resources were developed as part of this campaign including leaflets, posters and a short film called 'See Something, Do Something' was produced and is still widely used in a range of settings. Childrens Services have also adopted the 'See Something, Do Something' campaign and jointly promote the use of the short film.
Engage the community in understanding their contribution to safeguarding.	SSAB continue to contribute 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. SSAB 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 2017. SSAB actively engaged in the Prevention of Violence & Exploitation agenda, with a focus on timely support to victims of violence with additional support needs. The SSAB held a prevention conference called Making Safeguarding Personal/Think Family 19.05.16

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…
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. SSAB have contributed to the joint needs analysis commissioned by the Health & Wellbeing Board scoping local preventative services.
Ensure Making Safeguarding Personal is at the forefront of all practice.	Practice has moved to an outcome based approach defined by people who are participating in Safeguarding Enquiries and the development of their Safeguarding Plans.

QUALITY & EXCELLENCE: Continue to focus on effective delivery and high quality processes	
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 continue to develop and refine our performance dashboard to reflect information that better enables us to understand the Sandwell picture. SSAB have committed to active involvement in regional programmes looking at core data.
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 (DoLS).	The supervisory body (the Council) reports to the Board twice a year.
Monitor the continued implementation of Making Safeguarding Personal and the impact for service users.	SSAB has contributed to the development of the Adult Social Care engagement strategy and tool kit considering some principles of effective engagement. We have agreed a development plan in partnership with Healthwatch supporting active engagement and involvement by a range of members of the public in Sandwell with and without support needs. Action plan with agreed outcomes has been finalised and development sessions with Healthwatch are planned and the impact and change will be reported on in the 2017/18 Annual Report.

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. SSAB actively contribute to the West Midlands Regional Editorial Group ensuring all relevant changes and developments to legislation are communicated effectively to all partners
Undertake Safeguarding Adult Reviews (SARs) as required – produce reports and action plans as a result.	There has been a detailed review of the SAR process involving partners through the vehicle of the Protection Sub Group including the referral process. SSAB are committed to organising an event to promote the effective application of the policy and ensure greater understanding of the grounds for and requirements for SAR's.
Develop action plans and promote and share learning identified by SAR's.	In April 2016 we shared key learning identified in a commissioned Serious Case Review(SCR) [commissioned pre Care Act] with a focus on 'Think Family'
Ensure a clear Position of Trust process in place across all agencies.	This is ongoing with a plan to use a regional framework with local operational guidance.

Case studies and Good Practice

Case Study 1

Detail of Concern
Mr H is a 55 year old gentleman residing in a residential home that specialises in supporting adults with mental health conditions.

The safeguarding team received a safeguarding concern relating to an incident where another resident Mr O, 'spat' at Mr H and 'lashed' out at him, scratching his eye. The safeguarding manager screening the referral noted from Mr H's records that previously there were historical similar concerns relating to the same resident causing harm.

Clear direction was provided by the safeguarding manager to the safeguarding worker, requesting for the necessary evidence to be gathered regarding the management of Mr O's behaviours via risk assessments and care plans and the required discussions to take place with Mr O's funding authority, CCG in relation to the presenting safeguarding incidents and to assess the adequacy of the current provision.

Findings
A number of visits were completed by the safeguarding worker, gathering information and establishing Mr H's views regarding the safeguarding incident and his wishes - primarily to "remain safe from harm". Mr H relayed his concerns around previous incidents and that he tries his best to keep himself away from Mr O.
The safeguarding concern was progressed to a formal S42 Enquiry and Case Conference. The first half of the conference was attended by Mr H fully involving him in the safeguarding process. Further, Advocacy representative was included in the given discussions at the case conference to ensure Mr H was fully understanding the concerns and decisions being made. Mr H spoke of the safeguarding incidents and expressed his views in wanting Mr O to keep away from him.

Outcomes
Additional funding, one to one was agreed by CCG colleagues following the given safeguarding discussions. Further, CCG professionals re-assessed Mr O and confirmed an alternative placement was required and this continues to be identified.

In the meantime, the Home's Manager has completed the necessary risk assessments regarding Mr O and ensured he has received an up to date medical and mental health assessment.

This case study has been selected as it demonstrates the safeguarding actions undertaken because of current and historical safeguarding concerns. The challenge presented to the safeguarding worker has been around the provider manager understanding the severity of each incident and taking the necessary action. Prior to the safeguarding worker's involvement, it seemed such incidents were formally reported and recorded for the adult harmed. However, there was little evidence of the manager progressing and requesting for a re-assessment of the adult causing the harm and implementing immediate measures following the completion of the risk assessment.

Further, the safeguarding activity demonstrates multi-agency working to safeguard the individual and ensuring the adult remained at the heart of the safeguarding process.

Case Study 2

Detail of Concern
JH is a 73-year-old gentleman who lived alone requiring support with some areas of his daily living. JH is known to be an alcoholic and was living in poor home conditions.

The safeguarding team received safeguarding concerns from 2013 to 2016, relating to financial abuse by a female 'friend'. Concerns were around the 'friend' persuading JH to give her his money, claiming to support him with shopping/ cleaning tasks, tending to visit on 'pay day' – when JH received his benefits. This 'Friend' had in the past had access to JH's visa card and accessed his funds without his permission.

The safeguarding concerns raised previously had not progressed further as JH had refused further involvement wanting to retain his 'friendship' even if at the expense of the friend stealing from him. JH was deemed to have capacity to make an informed decision around such. The safeguarding team received a further referral by the Floating Service in September 2016 advising that the 'friend' had taken JH's post office card and withdrawn half of his monies. It was being reported that it was the third time in two weeks that the card had to be stopped due to theft.

Findings
Following a safeguarding visit with JH's consent immediate steps were taken to cancel his pension card in order to protect his finances. However, as soon as the new card was issued the 'friend' would visit JH with alcohol and access his card. JH also admitted that he was being offered sexual favours during these visits.

The safeguarding worker and Floating Support worker discussed the concerns with JH including, concerns around the constant cycle of abuse which was directly affecting JH and his wellbeing, often leaving him with no money or food (food provided various times via the food bank). Following much discussions JH agreed that the abusive situation had to stop and agreed to consider Extra Care accommodation. The safeguarding worker assessed and confirmed that JH had the mental capacity to understand the concerns being relayed although at times would present confused due to his alcohol consumption. JH was clear in not wanting the Police involved, only wanting to be removed from the given situation and abuse.

Outcome
JH was supported into moving to his new accommodation and the safeguarding social worker visited him few weeks following the move. JH presented well in himself advising that he had settled well, eating and sleeping well (in bed as opposed to chair).

Once away from the abusive situation JH spoke to the safeguarding worker about his situation and realized how he had been manipulated by his 'friend'. JH relayed that he had thought there was no solution or 'way out' and expressed his gratitude in being supported to have control back over his life and have a 'quality' of life.

Partner contributions

1. Sandwell Metropolitan Borough Council

Service User Experience

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

How do service users give feedback regarding safeguarding processes?

We have a Safeguarding Questionnaire which is forwarded to customers at the final stage of S42 Enquiry.

How do you evidence your activity has made a difference?

Recording Making Safeguarding Personal (MSP) outcomes on adult social care records.

Case file record and safeguarding plan/enquiry form.

Case conference, actions

Can you identify your key safeguarding achievements for the year 2016/17?

- No waiting lists, concern is screened and responded to on the day of receiving referral.
- The principles of MSP and the Care Act has been embedded into our safeguarding practice.
- Closer partnership working with other agencies; CCG, Police, Ambulance Service, NHS Direct

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

- Case file Audits
- MSP outcomes – discussion with the Adult/representative throughout the safeguarding process
- Safeguarding plan/forms

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

- To continue to raise the awareness of Sandwell residents regarding safeguarding.
- To continue to raise the awareness of all professionals around how to keep Sandwell resident's safe from abuse and neglect and what to do when identifying abuse or neglect.
- To continue to work with other agencies e.g. Ambulance Service to ensure safeguarding referrals are 'appropriate' again raising awareness around safeguarding thresholds.
- To continue to share intelligence regarding care provider's and safeguarding via PEG forums (Pre-Escalation Group)
- Quality Assurance – to achieve quality assurance in practice and safeguarding case recording. Management team to progress with all teams effective case recording, ensuring safeguarding actions are recorded in a timely manner and evidence based recording.

Training

What training has been provided to staff?

Staff are informed of training that is accessed via e-Learning and the Learnwell website specifically the SSAB training module.

Training has included Modern Slavery,

Hoarding Event, Dignity and Respect in Care Settings, Safeguarding Awareness, Mental Capacity Overview.

Who (posts and responsibilities) has received training?

Social Workers Adult Social Care and front line workers in Adult Social Care.

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

Supervision
Team discussions
Group supervision/reflective practice
Case file audits

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?

Analyse statistics that may identify incorrect system recording regarding outcomes, e.g. person's mental capacity outcomes.

Identify trends – gender, ethnic groups, agencies' making referrals, nature and category of abuse, safeguarding outcomes.

How does your data assure the SSAB?

Analysis of the information presented and identification of further areas of development. Further explanations/narrative regarding practice and why statistics are as they are.

How do you evidence this has made a difference?

Details of reports are shared with the Safeguarding Team and other care management service areas. Identified learning and key areas for development shared with teams to make a difference to data for the next report.

Safeguarding Adult Reviews

Have you contributed to any SAR's?

Currently in the process re E.H.

What was the outcome?

An independent report is to be commissioned.

How was any identified learning shared?

We will participate in an agreed learning plan.

How would you evidence this intervention made a difference?

Through staff supervision and appraisals.

3. West Midlands Fire Service

Organisation:	West Midlands Fire Service (WMFS)
Completed by:	Gail Read
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2016 to 31st March 2017	
Governance Performance & Quality Communication & Engagement Learning & Development	Our team of vulnerable person's officers (VPO) work with individuals with multiple and complex needs and whilst reducing risk and vulnerability to fire our officers engage with a wide range of partners to identify and reduce other risk factors. WMFS has updated its safeguarding policy and alert process following a restructure and the introduction of The Care Act 2014. Following all serious and fatal fires, the service instigates its Serious Incident Review process, when the casualty was known to or in receipt of services from partners, this learning review is conducted with the involvement of those partners and seeks it identify recommendations for improvement in policy, process and practice across the system. The workforce is currently undertaking a Royal Society for Public Health level 2 qualification in 'understanding health improvement' Service User Experience: This year our Safe & Well checks were updated to include how 'safe' the individual feels using the Short Warwick- Edinburgh Mental Wellbeing Scale (SWEMWBS). Complex VPO cases have review dates set for revisit or telephone call. When multi agency case meetings are arranged by WMFS we aim to include the service user when possible or a suitable representative. The relationship building involved in complex VPO cases involves building rapport and trust with the individual to ensure their voice is heard and understood.
Work planned to contribute to Safeguarding Adults Board priorities 2017/18	
Governance Performance & Quality Communication & Engagement Learning & Development	During 2017/18 WMFS will undertake an extensive piece of work to further improve policy, process and practice in safeguarding. This will see the training of its workforce in relation to safeguarding. This will include specific themes e.g. MSP. The frontline workforce, operational personnel and vulnerable persons officers will over the coming months undertake training to deliver brief interventions which includes falls and will make appropriate referrals to services as a result. Service User Involvement: It is intended that data collected during Safe & Well checks using the Short Warwick- Edinburgh Mental Wellbeing Scale (SWEMWBS) will be available for Boards as part of future questions and answers returns to Board. WMFS Community members can be approached to seek feedback on the safeguarding process and to be part of focus groups via Communication & Engagement Sub Groups.

3. West Midlands Police

Organisation:	West Midlands Police (WMP) - Public Protection Unit (PPU)
Completed by:	T/DCI Chris Dowen
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2016 to 31st March 2017	
WMP operational structures to support delivery of their adult safeguarding responsibilities * Including how WMP makes Safeguarding personal	The Care Act 2014 created a clear legal framework for how Local Authorities and other parts of the health and care system should protect adults at risk of abuse or neglect. West Midlands Police (WMP), as a named member of the adult safeguarding arrangements outlined in the act, discharge their responsibilities through a range of interconnected strategic, tactical and operational activities. This report focuses on the principles of the Care Act, and does not cover wider adult safeguarding areas such as domestic abuse or sexual offences. West Midlands Police use the Association of Chief Police Officers (Now National Police Chiefs Council) definition of a Vulnerable Adult, which is: "any person aged 18 years or over who is or may be in need of community care services by reason of mental, physical, or learning disability, age or illness AND is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation". In November 2016 WMP introduced new operational response principles (for all people contacting WMP, not just Vulnerable Adults), which included the introduction of a new grading policy to support the identification of the most suitable Primary (initial response) and Secondary (Investigation management and outcome) investigation resource. For Vulnerable Adult investigations this equates to Primary investigations primarily being undertaken by Force Response resources supported by the WMP Public Protection Adults at Risk team as detailed below, and the secondary investigation being undertaken by a mix of the Adults at Risk Team and other WMP teams dependent upon the severity and nature of the incident. The Adults at Risk team have specific responsibility for investigations in the following areas: • Investigations where the suspected abuser is a person carrying out the role of 'carer' to the Adult at Risk • Adult at Risk suspicious deaths – if this is identified as a homicide then this is transferred to our Homicide Team, if there are associated criminal matters or it remains a coroner's file only then it remains with the Adult at Risk Team. • Investigations into allegation of sexual abuse where the victim is an Adult at Risk • Investigation of incidents where a pattern or sustained or repeat targeting of an 'Adult at Risk' has taken place. • Allegations of abuse/neglect or financial abuse where the victim and offender are Adults at Risk.

	The approach outlined above allows WMP to have a risk and harm based officers (Neighbourhood and Response), the Adults at Risk team, and other 3rd Sector Partners. The Adult at Risk team actively engages with Social Services, Commissioning Providers and other Partner Agencies to ensure there is a cohesive approach to Safeguarding running alongside investigations. This work is reviewed through the Safeguarding Adult Board arrangements. The Neighbourhood Policing Units for each area also manage a referral portal system which allows frontline officers within the area to identify an individual who needs help, support, and/or intervention from partner agencies. This work is not confined to adults who fit the above definition but covers the broader definition of 'vulnerability' adopted by WMP: "A person is vulnerable as a result of their situation or circumstances, they are unable to take care or protect themselves, or others from harm or exploitation".
WMP Adult Safeguarding - Key risks and challenges	**Partnership** The challenge of allocating optimal resources to the investigation and safeguarding of Vulnerable Adults in times of competing demands and austerity is one that will be recognised by all Strategic Partners, so is not one that will be recanted within this report. The focus will therefore be on the challenges that West Midlands Police and Partners can work together on. These present themselves in three elements: 1. Local Authority arrangements 2. Joint investigations 3. Development of Adult MASH **Local Authority Arrangements** West Midlands Police operates across seven Local Authority areas. All have different operating approaches, referral pathways, and partnership arrangements, and all of whom require information and support from WMP that is different to other Local Authority areas. In the case of Vulnerable Adults Safeguarding there is an opportunity to develop a consistent approach to all elements of the investigation and safeguarding activity that would benefit not only WMP but other partners such as the Care Quality Commission. **Joint investigations** The investigation of suspicious deaths, particularly in relation to Care Homes, provides an opportunity to develop an early intervention model for investigative pathways. This approach would allow WMP, the Care Quality Commission, other Investigative and Criminal Justice Partners, and local Safeguarding Boards to make early determination of the lead agency and investigative strategy for serious and complex cases, providing opportunities for early intervention, more collaborative working arrangements, and the potential for cost savings that could be reinvested into other areas of Vulnerable Adult work.

	Development of Adult MASH across the WMP area West Midlands Police is working with the Wolverhampton Safeguarding Board to assess the impact of developing a MASH (Multi Agency Safeguarding Hub) for Vulnerable Adults within the local authority area this could inform the work of other Boards within the region. Initial findings have been positive with an increase in referrals to WMP, and an increase in the investigations managed by the WMP PPU Adult at Risk team. If as predicted other Local Authorities in the West Midlands will seek to establish Adult MASH the funding for resources, for both WMP and Partners, will need to be considered carefully. **Vulnerable Adults** Trying to determine the key safeguarding risks for specific vulnerable adults is a complex undertaking that varies based upon the interaction between people and place: It is therefore difficult to quantify in terms of crime types, locations, or other environmental factors as crimes that present a risk to some vulnerable adults may not present a risk to others. The key safeguarding risk and challenges to citizens within the West Midlands area therefore is how each Adult Safeguarding partnership identifies individual vulnerable adults, and how effective any collaborative responses to support them are. The WMP response to the key safeguarding risks and challenges is outlined in the responses to questions 1 and 2 above. In a general sense we also flag the risk of radicalisation and exploitation. In particular sexual exploitation continues to pose a risk to citizens of the West Midlands, in particular due their vulnerability as 'Adults at Risk'.

WMP monitoring and auditing of our Safeguarding arrangements	West Midlands Police are monitored and audited externally by Her Majesty's Inspectorate of Constabulary (HMIC) through their PEEL (Police Effectiveness, Efficiency and Legitimacy) and Thematic Inspections, and also through the Independent Police Complaints Commission (IPCC) who investigate serious complaints made against Police Officers within England and Wales. This external auditing is supplemented by Peer Reviews undertaken by the other Forces, and Internal Audits and reviews undertaken by the WMP Strategy and Direction Unit, and the WMP Public Protection Unit Service Improvement team. This is supplemented at an operational level through Force and PPU Departmental Threat Review Meetings each morning and afternoon, and daily management and oversight of operational responses through the creation of investigative strategies and case management reviews. The information from the external and internal Audit and Inspection regimes, supplemented by effective practice identified from other force areas, has also been used to create the WMP Adults at Risk policy, which is in the final stages of review and sign off. WMP also partake in audits with all seven LSAB's where required. It is acknowledged that defining success and what good looks like is not always straight forward and that different inspection bodies and agencies have a different perspective on this. WMP are currently re-writing it's Adult at Risk policy. This policy will provide a clearer and updated framework for what good looks like internally.
Safeguarding Training	The interaction between the core and bespoke training delivered by West Midlands Police to our staff, and training delivered by the seven different Adult Safeguarding Teams and Boards across the WMP area is currently very complex. The creation of the new Adult Safeguarding Regional Group provides an opportunity to streamline this, and make efficiency savings. The WMP process in terms of Vulnerable Adults training, particularly how our core training integrates with partnership training, is an area currently under development. We do as an organisation collate learning from the Safeguarding Adult Reviews (SARs) and use that to inform Force Policies and practices, but a detailed mapping exercise needs to be completed to support the development of a learning plan that will ensure staff receive all relevant training for their role. It is hoped that this work will be completed through the Adult Safeguarding Regional Group during 2017/18 West Midlands Police have appointed two staff to work within the WMP Learning and Development department who have been commissioned to undertake a review of continuous professional development training (CPD), which will be used as part of a wider review of core training outlined above. Details of how many staff have received vulnerable adults training are not readily available as training of this nature can be delivered both as a standalone session, and as part of a wider input.

Engagement with Service Users	We work with Changing Our Lives, a local organisation that advocates for adults with learning disabilities , this includes supporting the role out of schemes such as the 'Safe Places' scheme. We manage our Counter Terrorism Prevent plan locally and collate and direct local Policing activity from with Sandwell Partnership Team, this includes attendance at local Prevent operational meetings with Partners and Channel meetings whereby bespoke safeguarding and mentoring of adults vulnerable to extremism is developed. The Sandwell Counter Terrorism Local Profile sets our Partnership priorities and key indicators and we provide a quarterly return is of our local Policing activities with partners towards our objectives and attendance at the newly established Contest board.
Key Safeguarding achievements	From a Vulnerable Adults perspective West Midlands Police are key stakeholders in the Safeguarding Board Group and Sub Groups, and the Safeguarding Adult Review processes, and use the learning, along with other information from external reviews such as HMIC PEEL Inspections, to design the policing response. This approach can be seen in the development of a draft Adults at Risk policy and the commitment to review our approach to Vulnerable Adults in 2017. We have recently begun to attend the Safeguarding Prevent Board meetings. We attend Sandwell New Arrivals Partnership meetings (SNAP) with our local authority colleagues and wider partners to identify the needs of the migrant community and understand subsequent vulnerability this creates in terms of individuals need, impact on community cohesion and service responses and capacity to meet growing need. This group tries to understand opportunities relating to early intervention and prevention but tries to understand impact on services in the following areas, Language and Communication, health and wellbeing, homelessness crime reduction and victim support and community development. A strategy and action plan is currently being developed. Sandwell Partnership team lead a very successful Hate Crime Partnership meeting, which includes overseeing the partnership operational delivery plan. This compliments national strategy regarding its aims and Safer Sandwell's approach and the activity of their group focuses on: Prevent Hate Crime and Hate Incidents by challenging attitudes and behaviours, Encourage reporting and ensure services are accessible, Ensure there are adequate support services for those who report a Hate Crime or Hate Incident and Ensuring robust action is taken in regards to the perpetrator(s). This group compliments the local Tension monitoring group, both of which report the Community Safety Planning Strategic Sub Group.

	Through local ASB case management by the Partnerships ASB Officer and locally implemented process control, we have close working relationships with the Local Authority ASB team and housing and referrals will be made when vulnerable individuals are identified in a timely way. Throughout WMP we also have the Mental Health Triage Team who respond to reports of mental health issues to ensure the most appropriate response and service is given at that vulnerable time by Police, Mental Health Nurses and Ambulance. Information sharing is fluid and the Sandwell Partnership Teams relationship with the MH Team is extremely close and positive. A member of the team is provided by Sandwell and this benefits the scheme in terms of continuity and local knowledge and relationships. In addition the team attend a Sandwell MH Partnership Forum with colleagues from the Trust set up by the Partnership team to work through challenges, opportunities, share learning, and work through repeat demand. This has seen sustained reduction in calls for service, and better working relationship moving forward through change processes and an early indicator re threat risk and harm of individuals who pose a risk to the public. This supports the work our Counter Terrorism colleagues regarding early indications regarding referrals for individuals vulnerable to extremism. Through attendance at the local Mental Health Legislation Group meeting we are also able to influence policy and procedure and work directly with commissioners. Work is commencing surrounding a partnership approach to houses of multiple occupancy (HMO) as they are increasing in volume and unregulated there is a partnership response to the challenge required, in order to overcome issues of vulnerability, poor housing conditions and vulnerable locations attacking crime/ASB and opportunity. Sandwell Partnership Team in Partnership with the Local Authority housing colleagues have created a monthly operation partnership group that tackles some of the issues relating to Rogue landlords, HMO's and the linked Forced labour and Modern day slavery issues. This group feeds into a new local Strategic group chaired by the local authority and attended by Sandwell Partnership team colleagues and Force Chief Inspector MDS Lead. Our partnerships team also attend a force led meeting chaired by the MDS force lead, the aims from this group are delivered locally through the partnership team. Work with the fire service and other statutory and third sector colleague's is well established and targeted work often delivered under the governance of the Strategic Sandwell Partnership police and crime board and the Community Safety Planning Group whose priorities include supporting the most vulnerable victims .

WMP Local context **1. How effective partnership working is in the area from WMP perspective** **2. How can the NPU support the priorities for the area**	Sandwell NPU has an identified SLT and Inspector lead for Vulnerable Adults. As part of this work the Sandwell Partnership Team are currently developing a Vulnerability Portfolio that focuses on Partnership working surrounding vulnerability whether adult/child or location. Some of the vulnerability work that we do currently with partners in this regard is below however this is not a definitive list. Previously the Sandwell Partnership team has not been directly involved with the Adult Safeguarding Partnership however as part of the Early intervention and Prevention agenda moving forward we would wish for our activities to compliment the work conducted within the Public Protection Unit and Community Safety arena. Currently the Vulnerability Officer oversees a joint referral portal system 'Sandwell Hub' that is administrated and owned by the Fire service. When frontline officers within the Sandwell area engage and identify an individual who needs additional help, support and/or intervention from partner agencies the officer will submit the details on the hub and they will then make a referral to the most appropriate agency(s). They can also discuss the individual with the Vulnerability officer if they need more specialist one to one guidance and advice and also look for opportunities for wider safeguarding having an understanding of local partners and processes. Also within our Vulnerability portfolio, we manage a process to identify any patterns of three absent reports within a 30 day period and this will then initiate an information package for our local Neighbourhood Team to take further action and attend the home address of the adult, to establish the cause of such concerns, enabling a more informed and partnership response to support and prevent future actions.
Work planned to contribute to Safeguarding Adults Board priorities 2017/18	
WMP 2017/18 activity	The West Midlands Police 'WMP2020 Change Programme', created following extensive consultation with our staff, the public, and Partners, is a radical overhaul of all aspects of business with people and technology at its heart. The first phase of changes was delivered in November 2016, and the second phase is now underway. The approach has six fundamental principles underpinned by a series of outcomes, all of which will either directly or indirectly support the activity of the Adult Safeguarding Board and Vulnerable Adults within the West Midlands area. The principles are: **1. "We trust our people"** **Outcomes Sought** • To improve organisational fairness in how we make decisions. • To increase the voice of staff in decision making. • To improve employee wellbeing and reduce sickness absence. • To improve the performance management of staff. • To deliver the People Deal including our Leadership Promise. • To develop effective workforce design and planning. • To attract and develop diverse and talented employees.

	2. "Information drives our actions" **Outcomes Sought** To increase information: • Access: So people can access information when they need it • Insight: So we understand issues more deeply • Foresight: So we can become more predictive • Security: So information is secure and managed ethically So it can: • Improve the experience of the public when using services • Help us collaborate across boundaries • Help us prevent crime / harm • Improve productivity and/or lowers cost • Increase staff motivation and satisfaction at work **3. Designed to Listen and Reassure (Involving the public and treating them fairly)** **Outcomes Sought** • To increase public participation in creating safe communities. • To increase public satisfaction with West Midlands Police Services. • To increase confidence in West Midlands Police. • To improve the fairness of West Midlands Police. • To design services to meet citizen need. • Understand whether the service design of local policing works. **4. Geared to Prevent Harm** **Outcomes Sought** • To prevent crime / harm • To increase prevention activity • To reduce offending, re-offending and improve rehabilitation • To reduce unnecessary demand for service • To increase partnership integration on outcomes and services **5. Responding at Pace** **Outcomes Sought** • To reduce demand • To increase productivity in the areas of contact, dispatch, responding, investigation, justice, intelligence, safeguarding, tasking and coordination and business enablers • To improve satisfaction of the public and colleagues with services • To improve our ability to prevent crime, protect the public and help those in need **6. Learn and Adapt** **Outcomes Sought** • To develop a sustainable operating model for learning • To apply research activity as part of the programme of change

Please provide any case study examples, relevant to Safeguarding Adults Board priorities, that can be included in the annual report
Police received anonymous information raising concerns about a vulnerable female being treated badly by a family. The female had been seen at all times of the day cleaning and looking unkempt. Enquiries located her where she initially disclosed she had been living with a family for a few years, however on reviewing the case Police identified a number of inconsistencies with the evidence provided. Therefore, the safeguarding was paramount. Through joint partnership working Adult Social Care now have involvement and following an appropriate assessment there is a care package in place.

4. Black Country Partnership Foundation Trust (BCPFT)

Service User Experience

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

Information is widely available to service users in the form of posters and staff support service users where there are safeguarding concerns. Where a service user does not have capacity to understand the concept, the information is shared verbally with their family/carer/nearest relative and they are signposted to the relevant information available from partners e.g. websites. A Mental Capacity Advocate would be considered if the service user does not have family/friend to support them.

How do service users give feedback regarding safeguarding processes?

There is currently no formal arrangement for service user feedback to occur. When it does take place, there is the opportunity to record it in the patient records and on the Trust incident reporting system which is utilised for all incidents including safeguarding concerns.

How do you evidence your activity has made a difference?

The outcome to safeguarding and case management is recorded on the Trust's incident reporting system.

Can you identify your key safeguarding achievements for the year 2016/17

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

The Trust safeguarding team produces quarterly and annual assurance reports to reflect adherence to safeguarding policies, procedures and best practice and incorporates the key priorities identified at the commencement of the financial year and in year emerging priorities.

What were your identified priorities for 2016/17 and what are your current priorities for the forthcoming year?

Recommendations from 2016/2017- all have been progressed.

1. Publicise the role and function of the Adult Safeguarding Team to promote safety and improve quality
2. Liaison with Local Authority colleagues to improve Safeguarding reporting and information sharing
3. Review the key work streams in line with emerging themes identified locally and nationally
4. Develop the role of the MCA/DoLS practitioner within BCPFT to support staff in the robust application of the MCA and DoLS
5. Improve training compliance across Safeguarding including PREVENT.

Recommendations for 2016/2017

1. Review the Safeguarding Adults Service Description and share across the Trust in order to raise awareness of the functions of the Safeguarding Adults Team. This will assist in managing the Trust's expectations of the Safeguarding Adults Team.

2. Review the work undertaken previously to provide support by operational staff to the Barnardo's Screening Tool group (BST) this will fulfil the requirement of the Trust to contribute to this group by providing mental health screening and mental health risk management expertise.
3. Continue to work with Local Authorities to agree what constitutes a Safeguarding referral to Local Authority and to reach an agreement in respect to feedback in response to alerts submitted. This will promote a consistency in respect to appropriate alerts being raised and timeliness of the response fed back to those concerns.
4. Continue to liaise with Local Authority colleagues via the Safeguarding Boards and make representations for clarity of requests relating to Section 42 enquiries. This will support staff in the Trust in respect to their roles and responsibilities should the Local Authority require the Trust to make enquires on their behalf
5. Review the Datix incident reporting system to enable 'reporters' to update the Datix report with progress information from Local Authority. This was undertaken in 2015/2016 but due to NHS mail transition work and subsequent Transformation of services, the latter which will be concluded in October 2017, the implementation was delayed.
6. Continue to conduct routine audits throughout the year, as per Safeguarding Adult Audit plan including the audit of DHR and SAR recommendation implementation. This will measure and inform capacity and demand and efficacy of the core activities and the services provided by the Adult Safeguarding Team.
7. Continue to monitor the MARAC workload. This will enable resource management associated with the Adult Safeguarding Team and to inform the Local Authority MARAC governance activity.
8. Follow up Sandwell MASH joint health economy proposal to increase staffing (both nursing and administration) to build resilience into the MASH team in order to provide mental health cover across all weeks of the year.
9. Review the MCA/DoLS work plan and embed consistency into the monitoring systems in place; and propose a resilience strategy in the event of sickness/absence
10. Work with the Regional Prevent Co-ordinator to ensure that appropriate, safe and effective arrangements are in place in relation to the Trust's PREVENT policy, training and evaluation.
11. Commence a review of the overarching Safeguarding Adult Training with a view to incorporating the required Level 3 Health WRAP (Workshop to Raise Awareness of PREVENT) within the Safeguarding Adult Training day.
12. Review the current modes of Safeguarding training to seek clarity on who is best placed and resourced to meet the training compliance demand.

Training

What training has been provided to staff?
Safeguarding Adults Levels 1,2,3 incorporating WRAP

Who (posts and responsibilities) has received training?

Up to Level 1
All Trust staff receive an awareness level of training.

Up to Level 2
Staff who may contribute to Safeguarding cases

Up to Level 3
Staff who may lead Safeguarding cases including case managers

How do you evidence this has made a difference to practice and understanding of safeguarding?
Datix system of reporting incidents enables the Safeguarding team to measure the effectiveness of training by reviewing the types of safeguarding alerts raised and the subsequent referrals that are made to Local Authority.

Performance Data

Do you complete the SSAB Performance Framework template?
BCPFT provide performance data relating to training including Safeguarding Adults and Mental Capacity Act.

How do you use the data you provide to the SSAB in the performance template?
BPCFT data is collected from a number of source documents and data recording.

How does your data assure the SSAB?
The Trust's information is scrutinised internally and fed into the Safeguarding and overarching governance process.

How do you evidence this has made a difference?
Incidents data and information from audits and monitoring visits is utilised to establish work and development priorities.

Work plan implementation demonstrates the difference that actions have made.

Safeguarding Adult Reviews

DHR 6	Overview report written-further external agency information requested
DHR 7	Awaiting delivery of action plan due to new provider
DHR 8	IMRs sent out April 2017 for completion

How was any identified learning shared?
Lessons learned are shared via the Safeguarding Forum, Lessons Learned report and through case studies in Safeguarding Training. Learning briefs communicated via divisional representatives at BCPFT Safeguarding Board.

How would you evidence this intervention made a difference?

Mechanisms are currently not in place and the forward plan for 2017/18 includes;

Seek evidence via the audit and evaluation of incident reports and referrals to Local Authority.

Instigate comprehensive pre and post course knowledge assessment processes for training.

Development and implementation of training post evaluation audits to be undertaken 3 months post training.

5. Sandwell & West Birmingham Clinical Commissioning Group

Organisation:	Sandwell & West Birmingham CCG
Completed by:	Michelle Carolan
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2016 to 31st March 2017	
Protection	Sub Group representation, including participation in SAR case consideration. Attended and organised Professionals Meetings regarding S42's and sub-threshold safeguarding. Undertaken S42 enquiries.
Protection & Prevention	We have shared learning with ASC Operational Team regarding safeguarding cases involving Learning Disabilities (LD) and Domestic Violence (DV). We have continued to build on the success of the monitoring of quality in care homes through the Quality Assurance Framework (QAF) We have improved the receipt of safeguarding referrals through the utilisation of our customer care team (Time2Talk).
Learning & Development	We have offered Bluestream online e-Learning training to all care homes across Sandwell & West Birmingham. Continued with a rolling programme of training events including cross cutting initiatives such as PREVENT and CSE – including holding a CSE conference. We have actively participated in campaigns in partnership with the Safeguarding Adult Boards.
Quality & Excellence	Provided an annual update to our Governing Body at the public section regarding the partnership work achieved through SSAB and continued to be active members of the Safeguarding Board to fulfil our statutory safeguarding responsibilities. We have embedded a safeguarding dashboard for provider services allowing continuity between Children and Adult Safeguarding and improving links across safeguarding. Implementation of a restorative supervision programme.

Work planned to contribute to Safeguarding Adults Board priorities 2017/18	
Quality & Exellence	Integrate Adult safeguarding into the wider safeguarding arena within the CCG. Continue to be active members of the Safeguarding Board to fulfil our statutory safeguarding responsibilities.
Protection/ Prevention	Develop an audit tool for key lines of enquiries for safeguarding, for primary care to use for all safeguarding requirements.
Learning & Development	Continue with a rolling programme of training events.
If not covered anywhere else on this form, please highlight any single or multi-agency work that your agency has been a part of that will contribute to improved outcomes for vulnerable adults	
Position of Trust cases, sharing information, incidents and referrals with ASC	

6. West Midlands Ambulance Service (WMAS)

Organisation:	West Midlands Ambulance Service
Completed by:	
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2016 to 31st March 2017	
WMAS – Priorities 2016/17 – Adult Safeguarding Boards	
WMAS operational structures to support delivery of their adult safeguarding responsibilities * Including how WMAS makes Safeguarding personal	The Care Act 2014 created a clear legal framework for how Local Authorities and other parts of the health and care system should protect adults at risk of abuse or neglect. West Midlands Ambulance Service Foundation Trust (WMAS), as a partner member of the adult safeguarding arrangements outlined in the act, discharge their responsibilities through a range of interconnected strategic, tactical and operational activities. WMAS worked with representatives of the Adult Boards to ensure our referral process is aligned to that of the Care Act and appropriately addresses some historic issues of inappropriate referrals. The following guidance was agreed by all Boards and is now current within WMAS. **Referrals to Adult Social Care** It is only appropriate to refer patients to Adult Social Care if the adult has care and support needs, AND either: • There is a concern that the adult needs additional support to live independently (Referral for Care Assessment) or • There is concern that the adult with care and support needs, is experiencing or at risk of neglect or abuse, and as a result of their care and support needs, they are unable to protect themselves. (Referral of Adult Safeguarding Concern) *An adult with care and support needs is a person over 18 years of age who:* Has a learning disability Has mental health needs including dementia or personality disorder Has a long term illness Misuses alcohol or drugs Is elderly and frail due to ill health, disability or cognitive impairment, and requires extra help to manage their lives and to be independent. Mental ill-health If a patient's mental health is in crisis (e.g. suicidal thoughts or actions, or taken an overdose) then these issues should be addressed by referral to the appropriate health professional for treatment (e.g. Emergency Department, Mental Health professional or GP). These circumstances should not be referred to Adult Social Care. If you have a general concern about the patient's mental ill health, consideration of appropriate safety netting should be made.

	Domestic Abuse: Adults experiencing domestic abuse should be referred to the Police. Adults with care and support needs experiencing domestic abuse should be referred to the Police and Adult Social Care (as an Adult Safeguarding Concern.) **Consent for referral - Adults** Consent from the adult must always be sought before a referral is made. If you judge that the adult lacks the mental capacity to consent to the referral you will need to make a "Best Interests" decision on behalf of the adult. There may be occasions when you need to report a concern without the adult's consent; for example: • If you suspect the adult is being coerced or bullied into refusing support • If waiting to get their consent would put them at further risk • If there is a risk of harm to the adult or others, • If it is necessary to prevent crime or if a crime may have • been committed, • If the adult lacks mental capacity to understand the risks they face • In these circumstances you must report your concern. The adult should always be told of your decision to report the concern and the reasons for this, unless telling them would put their safety, or the safety of others, at risk. The key issue in deciding whether to report a concern without their consent will be the level of risk of harm to the adult (or to any other adults who may have contact with the person or organisation causing the risk of harm.) **Children** ***If the safeguarding alert/care/welfare concern has any implications for children, present or not, then a separate safeguarding referral MUST be made for the children***
WMAS Adult Safeguarding - Key risks and challenges	**Partnership** WMAS has an agreement to attend at least one Board meeting a year and by invitation but we are happy to receive and note all minutes/papers and submit relevant documents when required. WMAS also partakes in providing information for IMR's, Short Reports, Briefs, DHR's and SAR's both at scoping panel meetings and via written reports. WMAS is also a member in the new Emergency Services Group which is scoping new ways of working and we are also on the PREVENT agenda. **Local Authority Arrangements** WMAS operates across the whole of the West Midlands where all localities require information and participation, but each locality has different operating approaches, referral pathways, and partnership arrangements from the other Local Authorities.

WMP monitoring and auditing of our Safeguarding arrangements	West Midlands Ambulance Service are monitored and audited externally by Care Quality Commission (CQC) who in their recent review deemed the service as outstanding. Lead commissioners regularly review our processes and Peer Reviews are undertaken by other Ambulance services. These are supplemented by Internal Audit Reports and regularly monitoring referrals. WMAS welcomes feedback from partner agencies and responds to adversity in a timely manner. WMAS also partake in audits with all seven LSAB's where required.
Safeguarding Training	WMAS have a dedicated Education and Training department who are responsible for the delivering and auditing of training. All WMAS staff members receive Safeguarding training, however the method and level of training varies depending on individual job roles. Training is delivered via mandatory workbooks, face to face and e-Learning packages. WMAS as an organisation collates and disseminates learning from SAR/DHR's and use that to feed into policies and procedures. WMAS Safeguarding team members attend multi agency training at a variety of levels. The Trust set a target of 85% and achieved an overall average of 91% for Safeguarding training. Emergency Operating Centre (EOC) staff achieved this target at 85.2%. Emergency and Urgent Care (EUC) and Resilience achieved 100% and Patient Transport Service (PTS) achieved 78.8%. There were challenges around PTS staff attending training, for example, figures for 2016/17 showed a reduction in Birmingham PTS University Hospital Birmingham and PTS Heart of England Foundation Trust at 67% and 80% respectively and PTS Stoke achieved the lowest at 34%. The Trust told us that they had made changes to management at PTS Stoke following the inspection, which would improve the Mandatory training attendance rates.
Engagement with Service Users	WMAS is a responsive organisation with education and information on the trust website which is available externally and the Safeguarding team works closely with Patient advice and liaison services (PALS) and our Patient Experience team to collect and collate feedback from service users to feed into training, information, policies and procedures where appropriate.
Key Safeguarding achievements	WMAS has been involved in a number of safeguarding vulnerable adult cases across the region and for the 2016/2017 period we have participated in 18 Safeguarding Adult Reviews and 19 Domestic Homicide Reviews. WMAS has made 21,386 Adult Safeguarding referrals to the relevant Local Authorities.
Work planned to contribute to Safeguarding Adults Board priorities 2017/18	
Quality Assurance	Safeguarding referral line and process to be audited to ensure a high standard both verbally and electronically, findings to be reported and monitored by the WMAS Safeguarding Team and reported to the appropriate Boards both internally and externally where necessary.

Training	Ensure Safeguarding training remains high on the agenda for all operational staff, is included in the yearly mandatory training workbook for all WMAS employees and awareness of current high profile cases/topics are disseminated to all staff via the weekly briefing and clinical times which are both available to all staff electronically.
Engagement	To streamline working practices around our engagement with partner agencies to build stronger working relationships. Ensure engagement with Child Death Overview Panel, SCR, DHR's, Board meetings continue taking place via a number of methods – submission of reports, case studies and attendance when required.
Adequate Safeguarding Referral Process	To ensure adherence to the Care Act – Working with Boards, genuine referrals sent to the correct partner agencies e.g. Mental Health, Social Services.

Please provide any case study examples, relevant to Safeguarding Adults Board priorities

Case 1

West Midlands Ambulance Service NHS Foundation Trust (WMAS) Initially received a 999 call to a care centre providing support to a range of patient needs, including dementia. WMAS were initially called for a 73 year old who was generally ill and dehydrated. A WMAS Double Crewed Ambulance (DCA) responded to the address given. The patient was found to be extremely septic and the care home staff could not give any explanation of what had happened or any history on the patient. The patient was on a reduced fluid and food intake but no nutrition or toilet charts had been completed or any documentation on her being unwell.

The concern was one of potential neglect.

The attending clinicians made a safeguarding referral via the WMAS referral line and this was then passed to the local Social Care Team and all concerns were also shared with the receiving hospital. The WMAS safeguarding team also highlighted this case to CQC due to the nature of the concerns raised and concerns for other residents in the care centre. Social care has opened an investigation which is currently on going and feedback has been received from CQC to confirm they are also investigating this case.

Case 2

West Midlands Ambulance Service (WMAS) initially received a 999 call for a patient who initially was reported to have abdominal pain and was 2.5 months pregnant. A rapid responsive vehicle was dispatched to the scene. The patient had a black eye and reported that her family do not know she is in a relationship or pregnant. Her partner is pressuring her to have an abortion but she does not want to but feels she has no choice due to her situation and religion.

A referral was made to the Local Authority and the Bharosa team (Bharosa is a domestic abuse service for ethnic minority women living in Birmingham) highlighting the concerns raised regarding the patient's, safety and current situation. All concerns highlighted to the relevant agencies immediately following the incident and the process of the referral system was discussed with the patient.

Update received from Bharosa team the patient has declined any support from them at the moment however the social care team have given her their number and arranged to call again in the future. If any further problems occur with health advised to contact GP and risk of harm to contact police.

Case 3

The patient is alcohol dependent, bulimic and suffers with depression. It was found that the patient has two children, one of adult age and one 16 year old who is having to look after the patient. Concerns that this is not appropriate due to the patient's mental state. The patient has also taken several overdoses in the past and has been into rehab but is very negative about trying to recover. The patient denied taking an overdose on this occasion but was under the influence of alcohol. The initial medical concerns of this patient were rapidly assessed and dealt with quickly. Patient was transported to hospital where all concerns were discussed with the receiving hospital and then a safeguarding referral was completed to alert social care to the concerns raised by the attending ambulance clinicians. The patient did not have capacity at the time of the incident so the attending ambulance crew acting in the best interests of the patient and provided rapid treatment and follow up care. The safeguarding issues noticed by the crew were passed to appropriate agencies (Both Adult and Children's Social Care in this case) for further investigation. All concerns were also shared with the receiving hospital.

Case 4

The patient was at her parents' house and stated she had been assaulted the previous evening by her husband and that this had happened before. The patient stated she had been physically assaulted by being punched and kicked in the abdomen, raped and was also 5 months pregnant but was now bleeding heavily.

The Local Authority teams are investigating this case as the patient currently has another child in care so were aware of the family history and are now investigating the new evidence whilst providing support to the family.

Case 5

West Midlands Ambulance service NHS Foundation Trust received a 999 call for a patient who suffers with MS who had slipped in the bath whilst being assisted by carers. The patient had been moved from the bath by her husband, the ambulance crew witnessed the patient's husband moving the patient in a very aggressive manner and throwing her onto the bed. The husband also continued to make comments and to verbally abuse the patient and would not let the patient speak for herself and followed the ambulance crew around and even back to their vehicle.

The concerns were around domestic abuse so the crew left the property and waited for the husband to leave to return to work and then proceeded to return to the address. The patient disclosed that her husband was always like this with her, frustrated and impatient although he had never hit her. The patient stated that he would not complete the paperwork for her to get extra help as it took too much time and also refused to attend counselling with her.

The attending clinicians also contacted the police to attend the home address due to the disclosure by the patient.

Police attended the scene and also referred the patient to the Local Authority for further support.

Case 6

West Midlands Ambulance Service (WMAS) initially received a 999 call for a patient who has dementia and was found in the street. The police were already in attendance with the gentleman who had been found in the street and taken to a nearby shop for his own safety. The gentleman did not know where he lived but after investigation it was found he lived in a care home but the carers were not even aware he was missing.

The patient was transported to hospital as a precaution due to him being confused and not knowing where he was or what had happened.

All safeguarding concerns were documented and shared with the relevant agencies either verbally (hospital, police) or via a safeguarding referral. Social care has launched an investigation into this case which is currently ongoing.

7. Sandwell & West Birmingham Hospital Trust

Organisation:	Sandwell and West Birmingham Hospitals
Completed by:	Clare Cotterill
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2016 to 31st March 2017	
WMAS – Priorities 2016/17 – Adult Safeguarding Boards	
Deprivation Liberty assessment and application and application of MCA	Deprivation of Liberty Safeguard (DoLS) applications on a monthly basis were low- after a scoping exercise the following issues were identified: • Medics were not demonstrating mental capacity – decision specific – New electronic data base will house a mandated field for capacity against principles of the Capacity Act • Nurses appeared to lack knowledge around DoLS - areas were identified and bespoke training made available by the Safeguarding lead. This training is rolled out alongside the training plan(see section below Safety Plan) • An Electronic Quest Module was developed to aid staff with ward based training • Vulnerable adult assessments have been included in admission documents for long stay patients thus supporting decision around DoLS. • A Consideration Chart has been devised and appears on ward staff notice boards and in the end of bed folder. The chart was devised in conjunction with governance and hospital legal firm 'Capsticks'. • Capsticks provided two training sessions around DoLS mandated and attended by band 7 and above.
Modern Slavery	• Activity highlights geographical priority in Sandwell. • Indications for modern slavery and the referral process for first responders (responsible for National Referral Mechanism reporting) have been included in the flow chart and added to our Safeguarding Policy • E-Learning modules to be explored over this financial year to raise further awareness
Prevent Agenda	• PREVENT policy is awaiting ratification • PREVENT referral form in use • Information leaflet designed • Representation at CHANNEL Panel Sandwell and NHS PREVENT exploring Birmingham connections • Representation at executive level requested • Scoping request completed as required • Attendance at NHS PREVENT Forums • PREVENT training included as part of the safeguarding agenda • Data shared with the CCG and NHS England
Policy Updates	• Safeguarding policy reflects updates to the Care Act with a flow chart for modern slavery and referral pathways for self –neglect • The PREVENT policy has been updated and is awaiting ratification – referral process in place

Work planned to contribute to Safeguarding Adults Board priorities 2017/18	
Safeguard Training metrics	• Training around the safeguarding agenda to be reviewed with a new strategy for levels and staff targets. Strategy to be reviewed by governance no later than early June 2017 • Staff targeted to expand mandatory training with highlighted gap in knowledge. Currently level 2 is face to face and mandated at band 7 and above. The review indicates level 2 could be scenario based e-Learning ensuring staff can identify and raise safeguarding concerns/DoLS . Level 3 class room based with a lesson plan to be aimed at a higher level of detail around legislation. • More of a focus around incidents related to modern slavery within the training. • To encourage staff to share information appropriately with safeguarding partners to achieve better outcomes for individuals (please see case study box) embedding knowledge through training review • To invite the Counter Terrorist Unit (CTU) to run a clinic for staff to discuss any concerns or confusion around the delivery of the PREVENT agenda
Deprivation Liberty and Application of MCA to practise	• To continue to embed knowledge supported by the review training metrics around DoLS with an outcome of increased referral's • To review the introduced assessment tool around vulnerable adults and offer ward based bespoke training as part of a safety plan (outlined in the box below) • Electronic patient records to mandate capacity assessment on admission for physicians • To review training metrics • To ensure attendance at Sandwell Adults Safeguarding Boards
Attendance at Safeguarding Boards	• Safeguarding lead to continue to serve Sandwell and Birmingham Operational Boards supporting delivery of strategic safeguarding agendas • Partnership meetings to be attended by the Corporate Executive Lead and deputy where appropriate • To continue to participate in work streams around SAR's and prevention strategies by participating in Prevention and Protection Sub Groups.
If not covered anywhere else on this form, please highlight any single or multi-agency work that your agency has been a part of that will contribute to improved outcomes for vulnerable adults	
The hospital have safety plan to improve aspects of care over a 3 year trajectory with capacity as the second standard. The Safeguarding Lead is the subject matter expert around this standard. Wards will audit as they join the roll out. Standards of capacity assessments, vulnerable adults page and numbers of DoLS will be recorded as an outcome. For more information please see link below https://connect2.swbh.nhs.uk/?s=safety+plan	
Please provide any case study examples, relevant to Safeguarding Adults Board priorities, that can be included in the annual report	

- 76 year old lady presented after falling out of an upstairs windows
- The lady was identified to have advanced dementia and on admission was deemed not to have capacity around health care needs. The subject was noted to have fractured neck of femur that required surgical intervention.
- Husband was only carer with no other family members.
- The police had been contacted and criminal investigation initiated
- Adult Safeguarding Sharing form was completed and shared and submitted to the Local Authority
- Patient was referred to IMCA to be part of decision making around surgery and discharge destination.
- Subject underwent surgery and remained on the ward whilst staff attempted to optimise mobility.
- Police informed partners that the fall had been accident due to the house windows being old and off see-saw design. The subject attempted to lean out the window to flower box underneath as she leant against the window to support her weight she had toppled out.
- Husband wanted to take his wife home. Whilst he admitted he had been struggling to cope he was not sure of how to access help and was fearful that she would be taken away
- Nurses observed the interaction between the patient and her husband. It was clear that her behaviour was more manageable with his presence and he appeared to be a memory that she could anchor herself to and she cried when he left the ward in the evening
- Twenty four hour care had been recommended but given police had closed criminal investigations a Best Interest Meeting was arranged. Following discussion it was agreed that home would be explored as the least restrictive option. Community dementia team were requested to support.
- Home visit was arranged and a therapist, social worker and IMCA attended
- IMCA raised a further safeguarding following this visit explaining she was concerned related to restrictions at the house and described that the husband had had a lock fitted to every window and that this was too restrictive
- Hospital staff discussed this with Safeguarding nurse and social worker and it was agreed that the action the husband took was proportional to the incident that occurred and we requested that the Fire Service undertook a home visit
- The Fire Service visited as requested and reported that they would not advocate for the removal of the locks given the age of the windows they felt there was a risk to others with reference to falling out the window and noted that the husband had taped the key to each window.
- The fire brigade therefore suggested that the bedroom could be relocated down stairs and the husband agreed to this
- The dementia team in the community raised awareness of the purpose and function of dementia cafes to improve understanding and offer opportunities
- The patient was discharged home with Package of care to support her physical needs and the dementia team to support emotional needs. With disciplines agreeing that this was the least restrictive option.

8. Domestic Abuse Strategic Partnership (DASP)

Organisation:	Domestic Abuse Strategic Partnership
Completed by:	Maryrose Lappin
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2016 to 31st March 2017	
WMAS – Priorities 2016/17 – Adult Safeguarding Boards	
To spot victims of domestic abuse early, especially working with NHS & CCG	**The IRIS programme** IRIS (Identification and Referral to Improve Safety) 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. A national IRIS evaluation found the programme has been invaluable in training GPs and other primary care staff in GP practices to recognise domestic abuse at the earliest opportunity and signpost victims to appropriate support services. The model is in the process of being implemented nationally. The Sandwell & West Birmingham IRIS GP project began as a 12-month pilot with 20 GP practices in April 2015 funded by the Sandwell Safeguarding Children's Board. Funding has since been agreed by Sandwell and West Birmingham Clinical Commissioning Group (SWBCCG) and the Safer Sandwell Partnership (SSP) to continue the IRIS programme for 2016/17 and 2017/18. The Sandwell IRIS programme was evaluated by the University of Birmingham in April 2016 which concluded: The IRIS pilot in Sandwell and West Birmingham is progressing well and is successful regarding increased referrals. "Sandwell and West Birmingham have adopted a 'unique' model of IRIS that essentially makes the most of existing services. This works well and shows that fidelity to the programme can be retained at the same time as melding it to local context and needs. Importantly, it has made a considerable difference to the safety and wellbeing of people living locally who are living with domestic violence and abuse. The recommendations outlined in the evaluation are: • General practice staff should not underestimate the value in providing information. • The giving of a leaflet can be empowering. A recommendation is that if this is all they have time to do, then do it. • Many women who were interviewed talked about the benefits of the Freedom Programme and it is recommended that this remains. • The AE (Advocate Educator employed by Black Country Women's Aid (BCWA) has made a palpable difference to people's lives and a recommendation is that as a person, she is commended.

- Sandwell and West Birmingham CCG IRIS pilot has made a difference to local people's lives that has been captured qualitatively in this evaluation. It is crucial that funding and support for the programme continues.

Comments from 2 domestic violence abuse victims who were helped by the IRIS GP project are contained in the University of Birmingham's IRIS evaluation report as follows:

"Participant: I was going through a lot of domestic violence from my husband… he was on the verge of murdering me. I went to my GP and told him what was happening and he referred me…
Interviewer: Why did you feel the need to say something?
Participant: Because he left the gas on in the house and he was going to kill me and enough was enough.

Another person said:
Thank goodness I told the doctor because I would have gone through another 15 years - I am sure of pure Hell - we are going to move and that is down to your information and your programme of support."

The Accident & Emergency Advocacy Pilot
The Accident & Emergency Advocacy Pilot is a two-year partnership project between Black Country Women's Aid (BCWA) and Sandwell & West Birmingham NHS Hospitals Trust which commenced in November 2015. The project is funded by the Hospitals' Charitable Trust. It aims to improve the early identification of and response to survivors of domestic violence and abuse within A&E departments as well as strengthen the integration of the Trust within local strategic responses to DVA. Two IDVAs (Independent Domestic Violence Advisers) are placed in A&E, offering victims a crisis response and referral to ongoing support, such as refuge or community advocacy.

One of the key aims of the pilot is to increase the visibility of domestic abuse in A&E and the wider Trust to gain a picture of the true impact of DVA on health services in Sandwell and West Birmingham. BCWA carried out an analysis of all high risk DVA cases heard at MARAC (Multi Agency Risk Assessment Conference) in 2015-16, cross-referencing those discussed with A&E attendances to scope the scale of the issue and identify patterns. This was the first study of its kind in Sandwell which revealed that high risk victims of DVA are 'frequent flyers' in A&E Departments. Key points from the data analysis found:

- 367 individuals were discussed at MARAC during the 12-month period
- 258 of these individuals had attended A&E within the same year, with multiple attendances which resulted in a total of 729 A&E visits across the 258 individuals
- Individuals had attended A&E between 1 and 35 times

Analysis of data from the pilot has also revealed that referrals into the A&E advocacy service were from a range of ethnicities. When attendances were compared with the most represented ethnic groups across A&E Advocacy and BCWA's overall services during the same period, the data revealed that different

	cohorts such as BME and older people appear more likely to access A&E than other routes. Analysis of 12 months before and after MARAC demonstrated a 64% overall reduction in A&E attendances following targeted support from Women's Aid and other MARAC agencies. Year 1 (Nov 2015 – October 2016) Key Achievements: • 117 individuals have been identified as victims in A&E, 41% of whom were previously unknown to any other service as DVA victims • The 117 individuals identified were found to be multiple attenders of A&E, and in a 12-month period had 474 attendances • 77% of those identified accepted ongoing support • All cases heard at Sandwell MARAC are now cross-referenced with A&E data and attendances reported in accordance with SafeLives best-practice guidance • Tagging and flagging of DVA victims on Trust databases is in development • Discharge information shared to GPs has been improved • A wide range of training has been delivered across A&E clinical and administrative staff, supporting the implementation of routine enquiry on DVA
Strengthen MARAC (Multi Agency Risk Assessment Conference)	Multi Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, children's services, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing information about a victim, representatives discuss options for increasing safety for the victim and turn these options into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim and ensure there is appropriate consideration of safeguarding children. Sandwell MARAC has been working hard to improve the way it works in the last three years, to ensure that there is effective safeguarding of victims who are at highest risk. An exercise to identify the outcomes achieved by Sandwell MARAC was completed through work with Safelives, a national organisation working on domestic violence and abuse, that help MARACs become more effective. This exercise found that victims discussed at Sandwell MARAC had a 72% reduction in police call outs and 61% had a total cessation of police call outs after MARAC. The average cost of police attendance to victims of DVA before MARAC was £1634 compared to £312 after MARAC, demonstrating reduced police costs. There was also a significant reduction in the severity of incidents that police attended after victims had received support from MARAC. This correlates with data from the Accident and Emergency Advocacy pilot, which shows a significant reduction in attendance at A&E by victims following intervention from MARAC agencies. 468 high risk victims of DVA were supported by MARAC in 2016-17. This is a 64% increase since 2013-14 when 286 victims were supported.

Commission and implement a voluntary behaviour change programme for perpetrators of domestic violence and abuse (DVA)	Sandwell MBC commissioned Fry Housing Trust to deliver a behaviour change programme for perpetrators of domestic violence and abuse (DVA). The Brighter Futures programme is a 10-week solution focussed behaviour change programme. It is a 2-year pilot project which started in October 2015. 51 perpetrators had completed the 10-week programme by the end of March 2017. The University of Birmingham have been commissioned to evaluate the impact of the Sandwell programme and will be reporting their findings in early summer 2017. **The following feedback from clients who have attended the Brighter Futures DVPP have been received:** 'gathered some important life skills to carry forward and help me achieve my goals, excellent understandable staff also' 'I found the course very good and it has helped me move forward with my life' "Well presented, friendly staff, have helped me look at myself in a positive way. Have helped me unlock the trigger points leading up to my actions" **The following feedback from stakeholders who have made referrals into the Brighter Futures DVPP has been received:** "I am writing to express my thanks for the support you have given both to me as a child protection social worker and to the parents I am working with, who are/ have been the perpetrators of Domestic Abuse. In relation to one particular female perpetrator, I have really noticed a change in her presentation and her person awareness is noticeably different. I attribute these changes to the work we are doing with her together. Thank you. Finally, thank you for working closely with me, both on this case and the other case we are aware of. I have really appreciated the partnership working."
Work planned to contribute to Safeguarding Adults Board priorities 2017/18	
DASP Delivery Plan 2017-18	DASP have developed a new 2017-2020 strategy to address domestic violence and abuse. This has 4 strategic priorities of Prevention; Provision; Protection and Partnership Working. There is a detailed delivery plan in place which takes forward the ambitions of the strategy. Partners are currently being consulted on the Strategy and Delivery Plan, prior to final sign off by DASP.

Sub-group contributions

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?

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 as is being able to present the information in a dashboard style performance framework that all main partners can contribute to

How do you evidence your activity has made a difference?

Feedback at forums and events – interaction with partners and other agencies and performance data tells us where referrals come from which we can hypothesise means and increased understanding of safeguarding in those areas.

As a Sub Group can you identify your key safeguarding achievements for the year 2016/17?

- The subgroup was relaunched with a new Chair, membership and lead officer to refocus on building the group and ensuring membership from all statutory partners.
- A fresh look at how the Board is assured about safeguarding referrals and looking at correlation with other agencies and highlighting any discrepancies
- Including the DoLS lead in the membership of the group to provide an insight to statistics and trends locally
- Participating in the development of an engagement strategy and an engagement group to ensure all activity is inclusive and reflective of the needs of Sandwell
- Ensuring Making Safeguarding Personal is embedded in practice.

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

The new ASC system provides data around the MSP agenda and its implementation so we can compare a range of data sets both regionally and locally to highlight any current trends

What were your identified priorities for 2016/17 and what are your current priorities for the forthcoming year as identified in the Strategic Plan?

2016/17

- A re-launch of the sub-group with all statutory partners fully represented.
- Self - assessment by partner agencies against the West Midlands self-audit standards
- Agreement of quantitative and qualitative data required to give the Board (SSAB) assurance of safeguarding quality and processes
- To monitor the appropriate use of the Deprivation of Liberty Safeguards (DoLS)
- Monitor the implementation of Making Safeguarding Personal and the impact for service users.
- Ensure the appropriate use of advocacy

2017/18

- To continue to add to the membership of the sub-group to ensure all statutory partners are fully represented
- Develop new performance framework dashboard to reflect a more qualitative data required to give the Board (SSAB) assurance of safeguarding quality and processes which will be more visual using tables and charts to highlight trends and less use of narrative.
- Support the development of service user engagement forum and engagement plan in order to monitor the implementation of Making Safeguarding Personal, ensure the appropriate use of advocacy and the impact for service users.
- Continue to monitor the appropriate use of the Deprivation of Liberty Safeguards (DoLS) based on the annual figures supplied and look at regional and national indicators in order to benchmark.

Training

What training has been provided to staff? N/A
Who (posts and responsibilities) has received training? N/A

Performance Data

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

Evaluation and feedback from practitioners and staff at forums or further training.

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?

Q&E identify any trends and scrutinise all performance data on a quarterly basis such as in terms of organisation or locality or even more general trends, and compare regionally and nationally to decide on appropriate action.

How do you evidence this has made a difference?

Board assured that statistics and practices are in line with national and regional guidelines.

Safeguarding Adult Reviews

Have you contributed to any SAR's? N/A

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

How do you evidence your activity has made a difference?

Attendance at community events and engaging with service users to obtain feedback

In 2016/17 the SSAB attended the following community events: Sandwell Council for Voluntary Organisations breakfast network meetings, Carers information event, Healthwatch consultation, Health Fun Day, Healthy Ageing event, Love is love as part of the Lesbian, Gay, Bisexual and Transgender (LGBT) week, Drop in Donuts and Discussion network day with Terence Higgins Trust and had a presence at all of the Sandwell Safer 6 meetings in each of the 6 towns across the borough.

As a Sub Group can you identify your

key safeguarding achievements for the year 2016/17?

- SSAB dedicated website now live and being accessed
- Increased outreach activities exceeding our goal of 12 per year
- Provision of more e-Learning packages
- Successful conference, best practice forums and events
- Introduction of safeguarding briefs for agencies that do not require formal training but need an overall basic safeguarding awareness. An example of where this method has been used is volunteers

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

We have received positive feedback at outreach events and activities and training and learning opportunities. Some examples of positive feedback received are below:

"I feel I know much more about safeguarding now" – Member of the public

"The hoarding framework is really helpful, I really like the clutter images they will help me determine risk" – Social Worker

What were your identified priorities for 2016/17 and what are your current priorities for the forthcoming year as identified in the Strategic Plan?

2016/17

- Develop a new campaign focus engaging all key partners and service users with a considered focus on prevention of violence and a community based campaign encouraging people to be good neighbours.
- Enabling the identification of effective support to be delivered in a timely fashion including oversight of the provision of support to victims of violence.
- Conference promoting staying safe, with links to prevention and building community involvement.
- Prevention of Violence & Exploitation Theme
- Scoping exercise identifying range of prevention work happening within statutory services, and wider community.
- Ensure Making Safeguarding Personal (MSP) is at the forefront of all practice.
- Be assured that the voices of victims of crimes and violence are heard giving due consideration to our adopted theme "support victims of violence and exploitation and enable their recovery".
- Be assured that access to appropriate advocacy ensuring support is given to victims of violence and exploitation to better enable their recovery.
- Use Best Practice Forums to develop learning
- Work with partners to ensure that there is collaboration on identifying learning and development needs and how they should be met
- Improved recording of learning and development activity and evaluation:
- Review data collection methods
- Increase the scope of data collection

2017/18

- To continue and develop a specific campaign focus with the aim of continued improvement of awareness of safeguarding and what to 'do' if you 'see something' with a considered focus on prevention of violence and a community based campaign encouraging people to be good neighbours
- Enable the identification of effective support to be delivered in a timely fashion including oversight of the provision of support to victims of violence
- To facilitate a conference in October 2017 with a prevention focus
- Continue to have oversight of our agreed POVE theme 'support victims of violence and exploitation and enable their recovery'
- Scoping exercise identifying a range of prevention work happening within statutory services and wider community. Mapping work to take place
- Work with partners to ensure that there

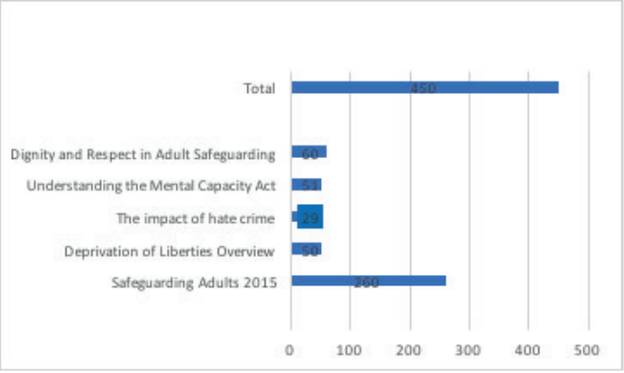
is collaboration on identifying learning and development needs and how they should be met
- Improved recording of learning and development activity and evaluation

Training

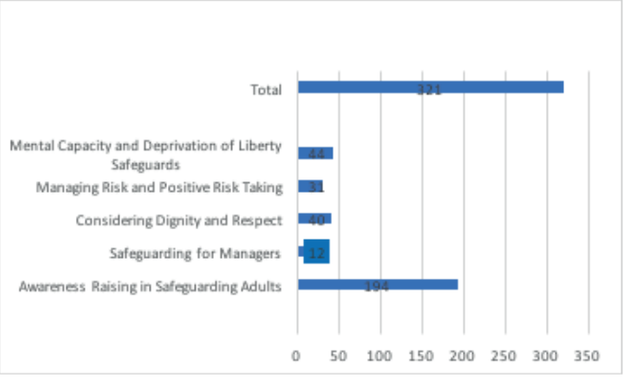
What training has been provided to staff?

- Face to face training in Awareness Raising in Safeguarding Adults, Safeguarding for Managers and Practitioners, Considering Dignity and Respect, Managing Risk and Making Safeguarding Personal was provided for all partners and agencies.
- E-Learning packages were also on offer.
- In addition to this several events were organised and extremely well attended

Safeguarding e-Learning 2016/17



Safeguarding Face to Face Training 2016/17



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

We undertake annual training needs analysis.

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.

Performance Data

How do you use the performance data?

Highlighting high prevalence areas and assurance that training and operational measures are embedded and working. Monitor training across the sector.

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

Identifying trends and fluctuations in statistics enables us to provide appropriate training and learning opportunities.

How do you evidence this has made a difference?

Forum feedback and training evaluation.

Safeguarding Adult Reviews

Have you contributed to any SAR's? N/A

What was the outcome? N/A

How was any identified learning shared?

This will be reflected next year

How would you evidence this intervention made a difference? N/A

Protection Sub Group

As a Sub Group can you identify your key safeguarding achievements for the year 2016/17

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

What were your identified priorities for 2016/17 and what are your current priorities for the forthcoming year as identified in the Strategic Plan?

- 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 2016)

Performance Data

How do you use the performance data?

The Protection Sub Group uses data to interpret any particular trends or areas of concern within Sandwell particularly with reference to types of abuse and demographic information.

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

The analysis of the performance data enables the Sub Group to identify in conjunction with all of the Sub Groups and Board members any potential gaps and areas that might require further development and understanding which informs the priorities agreed by the Board.

Safeguarding Adult Reviews

Have you contributed to any SAR's?

The SSAB commissioned two Safeguarding Adults Reviews in January 2016.

What was the outcome?

The SAR reports and action plans are awaiting approval of the SSAB.

How was any identified learning shared?

The Protection Sub Group lead will liaise with the Prevention Sub Group lead and SSAB business manager to identify the key learning and arrange best practice events and learning opportunities for Sandwell MBC and partner agencies.

How would you evidence this intervention made a difference?

With effect from 1 April 2016 there was a development regionally to the 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. The Sub Group continues to contribute to the repository and share learning both locally and across the region.

Review Position of Trust policies and procedures with partners

The Protection Sub Group will be adopting a high level Position of Trust (POT) document and will arrange a POT review for all partner agencies.

Ensure all paperwork is Care Act compliant including review of referral forms and safeguarding paperwork

The Protection Sub Group approved the Sandwell ASC Adult Safeguarding form (PAN1) in July 2016. The Section 42 investigation and Safeguarding plan were incorporated in to the LAS system (Sandwell ASC electronic system). The West Midlands Safeguarding Adults Self-

Neglect guidance was reviewed and localised to Sandwell.

The Protection Sub Group will continue to ensure Care Act compliance by all partners and ensure any updates to West Midlands procedures are effectively put into operation and all partners informed.

West Midlands Domestic Violence & Abuse Standards

The protection Sub Group accepted the Domestic Violence standards and continues to review documentation against them.

Strategic Plan

The Protection Sub Group have contributed to the review of the Strategic Plan and identified their priorities for 2017/2018 as:

- Care Act readiness and continue to ensure Care Act compliance by all partners and ensure any updates to West Midlands procedures are effectively put into operation and all partners informed
- Launch updated Safeguarding Adult Procedures and Toolkit
- Arrange for Safeguarding Adult Reviews to be undertaken when required and support learning to improve or change practice as a consequence
- Ensure a clear Position of Trust process is in place across all agencies

Safeguarding Performance Data 2016/17

This section details a range of data to demonstrate safeguarding activity in Sandwell.

Currently all this data is collected by Sandwell Metropolitan Borough Council (SMBC) and is used by the performance data team to inform local and national reporting.

One of the developing areas of work for SSAB with the support of the Quality & Excellence Sub Group is to develop a dashboard that enables contribution of relevant data from all partner agencies.

All data is scrutinised and used to inform the work of the Sub Groups of the Board and reviews of guidance and policy. Furthermore, it provides some of the assurance sought by the Board regarding the range of safeguarding activity, the story that it tells us, whether further analysis or understanding is required and what difference to the people with additional support needs of Sandwell all the activity is making.

Throughout this section of the report information is shown that enables us to consider key areas:

- Making Safeguarding Personal
- The numbers of concerns and enquiries that are received throughout the year, where they come from and analysis and explanation for the statistics
- We will look at the breakdown of referrals by age and gender
- Breakdown of referrals by type and location of abuse
- We will look at enquiries, timescales for completion and numbers going to case conference
- Mental capacity and DoLS

Making Safeguarding Personal Desired Outcomes Recorded

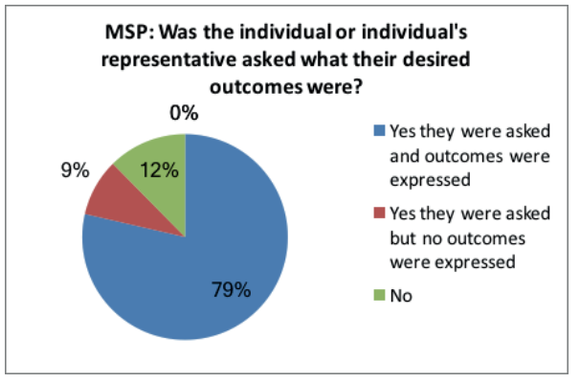
Analysis

In 2016/17 we can evidence (as in the tables below) that 88% of all individual's or the individual's representative were asked what they wanted to happen at the beginning of every enquiry. Some people were not able to specify what they wanted to happen and some of those people showing as 'not asked' may have lacked the capacity to determine what they wanted to happen with or without support.

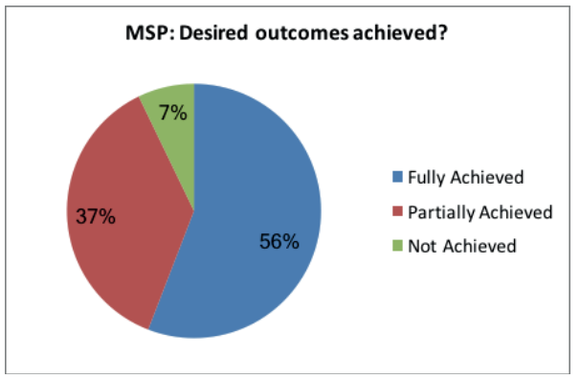
Within the current electronic recording system there is now a mandatory recording field requiring completion acting as a prompt for workers. This should mean that the quality of recording of whether people have been asked about their desired outcomes will improve. Operational Managers will continue to use supervision, practice development forums and management oversight to ensure that the quality of engagement and conversation with individuals in respect of their desired outcomes and options continues to improve.

There is no comparative data for 2015/16 as this is the first year we have been able to collect this data electronically as opposed to anecdotally. Going forward we will be better able to make comparisons and offer effective analysis as to any changes in the story the data tells us.

Making Safeguarding Personal Desire Outcomes Recorded



Making Safeguarding Personal Desired Outcomes Achieved Recorded



Number of Concerns/Enquiries

Number of concerns

There has been a slight increase in the number of concerns received by the council during 2016-17 compared with 2015-16 (just over 1.5%). The analysis of the increase would suggest that the increase can be attributed to multiple categories of abuse within the same investigation and more than one concern in respect of the same person.

Number of enquiries

During 15-16 just under half of concerns progressed to enquiry, whereas during 16-17 just under a fifth progressed to enquiry. This reduction is a reflection of the change in the ASC recording system that enabled S42 enquiries to be monitored more accurately.

Since the Care Act, Safeguarding ASC have re-designed their social care systems to reflect the legislation and the definition of a S42 Enquiry and have made changes in their practice. Prior to the change in practice all concerns were being immediately progressed to S42/Investigation. Current practice ensures greater management oversight at the point at which a concern is raised enabling more effective solutions and signposting without the necessity to progress to a S42.

The data now collected more accurately reflects the operational picture with detailed work being undertaken at the point at which a concern is raised to establish the level of risk and/or whether it is a safeguarding concern or an issue for care management or other redirection meaning the number of actual enquiries undertaken are fewer in number but are complex safeguarding matters.

Concerns raised (commenced) within the period	2015/16	2016/17
Number of individuals with a concern	1686	1779
Number of concerns	2369	2408

Cases concluded within the period	2015/16	2016/17
Enquiries	1074	444
Concerns	2316	2408
% conversion rate	46%	18%

Concerns and enquiries by source of contact

Conversion rates for 2016-17 show that concerns raised by the general public quite often result in a section 42 enquiry, however, very few concerns raised by the NHS and the Police do. Work continues to be undertaken with all of our partners in uniformed services to clarify a common understanding of what constitutes a safeguarding concern as opposed to someone with additional support needs needing more robust support. It is of note that uniformed service colleagues have contact with adults with additional support needs during unsociable hours and on these occasions' opportunities to direct referrals appropriately may be more limited.

Conversion rate by source of concern	2016/17
Sandwell Council	16%
NHS	8%
Police	9%
Independent Sector	24%
General Public	38%
All other	18%

Counts of individuals by age and gender

Within the Sandwell area there is a higher percentage of referrals received in respect of women, however this continues to be reflective of the National position and previous years within Sandwell.

There is no specific explanation as to why the referral rate is higher for males than females in the age group of 18-64 year olds., however, we can hypothesise that abuse involving 'resident on resident', 'patient on patient' involve more males with mental ill health.

There is no direct comparative data for 2015/16 due to the change in how data is collated.

Age and gender	Female	Male	Grand Total
18-64	49	81	130
65-74	25	22	47
75-84	57	38	95
85-94	70	18	88
95+	16	2	18
Grand Total	217	161	378

Counts of individuals by ethnicity

The ethnicity data continues to highlight the trend in Sandwell of the largest number of referrals being for an adult with White British background (86%). This represents an increase throughout the year.

In 2017-18 as part of the SSAB engagement strategy joint work will be undertaken with Children's Services focusing on building trusting relationships with faith communities enabling a more effective understanding of safeguarding with an ambition for more effective engagement with services for adults with additional support needs.

There is no direct comparative data for 2015/16 due to the change in how data is now collated.

Individuals with a concluded case during 16-17	People	%
White	324	86%
Mixed/Multiple	4	1%
Asian	24	6%
Black	25	7%
Other	1	0%
Total	378	

Concluded S42 enquiries by type of abuse

During 16-17 the majority of enquiries were due to safeguarding concerns relating to neglect or physical abuse. Over half of the enquiries during 16-17 had an abuse type of neglect and a quarter had an abuse type of physical.

In the table that shows types of abuse by location we can see that the highest numbers are represented in settings where the individual is living in their own home (community) which could include a shared living situation.

A high prevalence of physical abuse we can hypothesise relates to service user on service user assault. This may be linked to a significant learning disability or dementia where the intent is not to cause harm but rather an expression of an individual's communication.

Concluded S42 enquiries by type of abuse	2015-16	2016-17
Physical Abuse	437	114
Sexual Abuse	27	10
Psychological Abuse	85	24
Financial or Material Abuse	155	55
Discriminatory Abuse	2	0
Organisational Abuse	1	6
Neglect and Acts of Omission	391	230
Domestic Abuse	4	5
Sexual Exploitation	0	0
Modern Slavery	1	0
Self-Neglect	12	7
Total	1115	451

Concluded S42 enquiries by location

The highest number of enquiries related to S42 concerns are alleged to have taken place in the persons own home. This is closely followed the number of enquiries that were alleged to have taken place in a care home setting.

Concluded S42 enquiries by location	2015-16	2016-17
Own Home	493	211
In the community (excluding community services)	NA	3
In a community service	31	7
Care Home - Nursing	402	93
Care Home - Residential		90
Hospital - Acute	87	11
Hospital - Mental Health		15
Hospital - Community		7
Other	61	7
Total	1074	444

Timescales and completion of safeguarding activity

A third of concerns that progressed to an enquiry were concluded within 28 calendar days. A third of enquiries were ongoing for over 2 months. These were investigated by the Safeguarding lead to ensure that there were legitimate reasons for the enquiry taking this long. Examples could be ill health of the service user or difficulties in obtaining appropriate information and key individuals not being available to discuss key concerns in the immediate timescale (such as family members being on holiday).

Timescales: % of concluded S42 enquiries where the number of days from concern to end of enquiry falls within the following ranges	2015-16	2016-17
% concluded within 0-28 calendar days	59%	32%
% concluded within 29-60 calendar days	32%	33%
% concluded within 61+ calendar days	9%	35%

Concluded cases by final status of allegation

The increase in partially substantiated outcomes and fully substantiated outcomes is reflective of the rigour and conversation undertaken at the point at which concerns are raised meaning those that are progressed to enquiries are more robust and of a clear safeguarding nature meaning the allegations in the first instance are more likely to be substantiated or partially substantiated.

Final Status of Allegation	2015/16	2016/17	Comparative analysis
Investigation Ceased at Individuals Request	32 (3%)	10 (2%)	↓
Not Substantiated	225 (21%)	27 (15%)	↓
Inconclusive	174 (16%)	58 (13%)	↓
Partially Substantiated	98 (9%)	58 (13%)	↑
Fully Substantiated	545 (51%)	243 (55%)	↑
Other Conclusion	N/A	8 (2%)	

Concluded cases by mental capacity

A Mental Capacity Act (MCA) policy was devised in March 2016 to assist and enable ASC staff to appropriately assess MCA/Best interest decisions.

Audits completed on a regular basis by the Safeguarding Operational Manager ensure that MCA assessments are reviewed and guidance given where required.

These changes have improved staff's skill base in assessing MCA and offer robust guidance in complex cases.

Furthermore the electronic recording system now has a mandatory field for staff to record when assessments have been completed and if someone has/ has not got capacity which is reflected in the data below.

	2015/16	2016/17	Comparative Analysis
Mental Capacity Assumed	452 (42%)	187 (42%)	
Lacks capacity	435 (41%)	246 (55%)	↑
Don't know	27 (2%)	11 (2%)	
Not recorded	160 (15%)	0 (0%)	

SSAB strategic priorities 2017/2018

PREVENTION & LEARNING & DEVELOPMENT:

- To continue to develop a specific campaign focus with the aim of continued improvement of awareness of Safeguarding and what 'to do' if you 'see something' with a considered focus on PoVE and community based campaigns
- Enable the identification of effective support to be delivered in a timely fashion including oversight of the provision of support to victims of violence and exploitation
- To facilitate a conference in October 2017 with a prevention focus considering 'What is adult Safeguarding?' and the range of support available to individuals where there may be concerns but they are not Safeguarding concerns
- Support the prevention of violence and exploitation theme 'support victims of violence and exploitation and enable their recovery'
- Develop and map a range of preventative work within the community
- Work with partners to ensure that there is collaboration on identifying learning and development needs, how they should be addressed and delivered

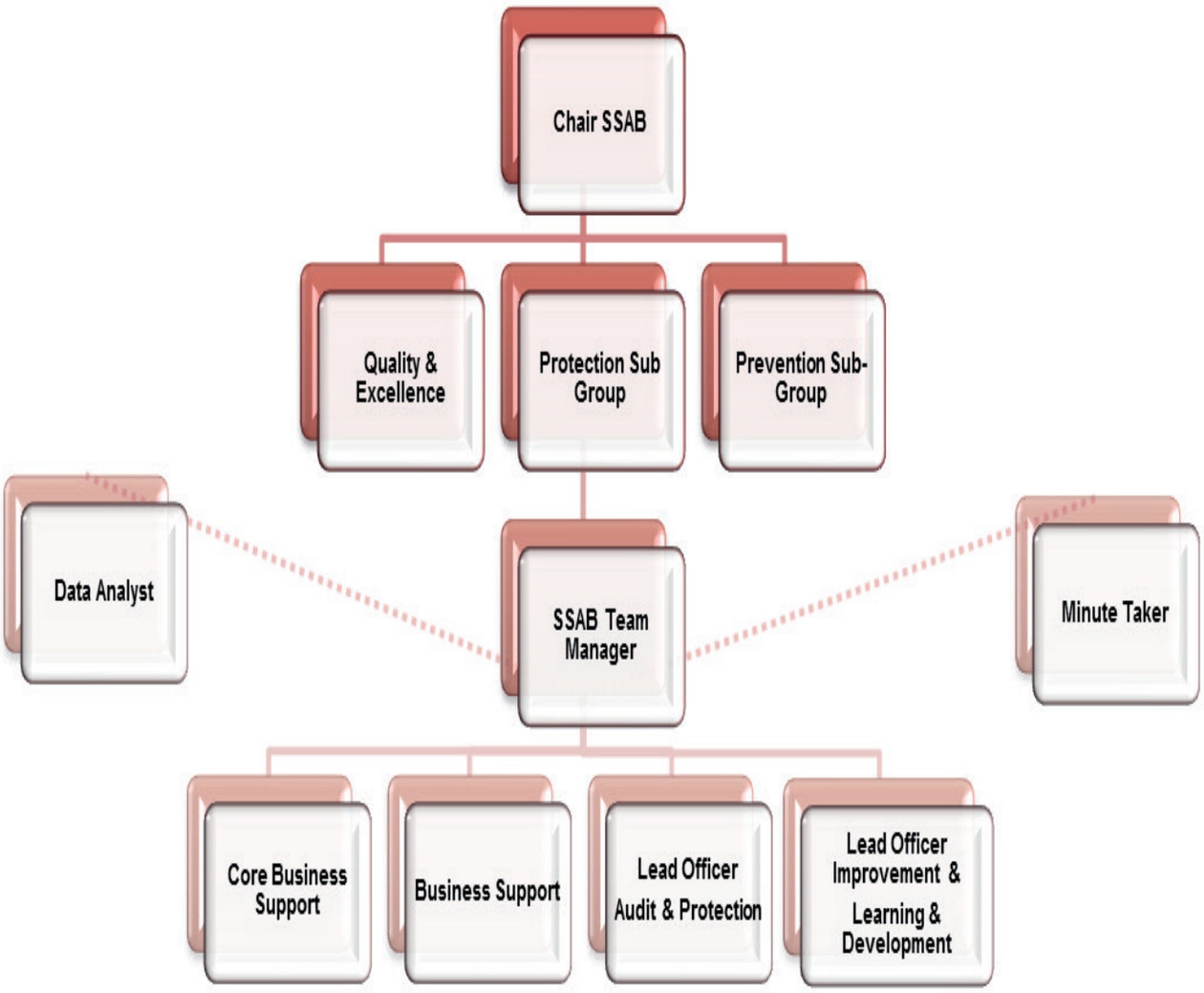
QUALITY & EXCELLENCE

- Relaunch the sub group with all statutory partners fully represented
- Develop a new performance framework to reflect quantitative and qualitative data required to assure SSAB of Safeguarding quality and processes and effective analysis of all data
- Support the development of a service user engagement forum and the engagement plan
- To monitor the appropriate use of the Deprivation of Liberty Safeguard's (DoLS)
- Monitor the implementation of Making Safeguarding Personal and the impact for service users, considering the appropriate use of advocacy

PROTECTION

- Care Act readiness – ensure local policies and procedures are re-written (where appropriate) in line with West Midlands guidelines and approved by the Board
- Launch the revised Safeguarding Adult Review Procedures and toolkit
- Review Position of Trust policies and procedures with partners

SSAB Board Structure 2016/17



Appendix 1 – Board Membership

Name	Job Title
Eddie Clarke	Independent Chair
Geoff Foster	Chief Executive CARES
Kay Murphy	Divisional Manager
Deb Ward	Safeguarding Adults Board Operations Manager
Ann Byrne	Lay Member
Ann Shackleton	SMBC - Cabinet Member
Clare Cotterill	Adult Safeguarding Nurse, South West Birmingham Hospital
Dave Bradshaw	Sandwell Rights and Equality
Davina Roberts	Lay Member
Debbie Talbot	South West Birmingham Hospital
Debbie Le Quesne	West Midlands Care Association
Elaine Kingston	IRIS Drug Treatment Team
Eva Rix	Black Country Partnership Foundation Trust
Gail Read	West Midands Fire Service
Julie Price	Black Country Partnership Foundation Trust
Kwado Owusu-Darko	Healthwatch
Mark Burnell	West Midlands Police - Head of Public Protection Unit
Michelle Carolan	Clinical Commissioning Group (CCG)
Michelle Fletcher	Area Housing Officer
Richard Baker	West Midlands Police
Sara Ward	Black Country Women's Aid
Stuart Lackenby	SMBC - Chief Operating Officer
Suki Sandhu	SMBC - Operational Safeguarding Team Manager
Viv Townsend	Head Dudley and Sandwell Probation - National Probation Trust

Appendix 2 – Sub Group Membership

Quality and Excellence Sub Group

Name	Job Title	
Sara Ward	Black Country Women's Aid	Chair
Sue Clark	Lead Officer – Safeguarding Adults Board	
Deb Ward	Operations Manager, Safeguarding Adults Board	Second Representative
Julie O'Toole	Age Concern	
Kwado Owusu-Darko	Health Watch	
Ross Bailey	SMBC	
Sonia Cookhorn	Senior Information Officer – SMBC	Second Representative
Kenneth Bennie	Team Manager Safeguarding Adults – SMBC	
Isolyn Clarke	Lead Practitioner – SMBC	Second Representative
Debbie Le Quense	West Midlands Care Home Association	
Barbra Maxwell	SMBC	
James Mellstrom	Data Analyst – SMBC	
Julie Winpenny	West Midlands Fire Service	

Prevention Sub Group

Name	Job Title	
Elaine Kingston	IRIS Drug Treatment Team	Chair
Sue Clark	Lead Officer	
Deb Ward	Operations Manager, Safeguarding Adults Board – SMBC	Second Representative
Anne Jones	SMBC	
Ann Taylor	Black Country Partnership Foundation Trust	
Barbara Maxwell	Learning and Development – SMBC	
Carol Hollis	Senior Learning and Development Officer – SMBC	
Debra Humphreys	Quality Officer – SMBC	
Denise Hooper	Neighbourhoods	
Gail Read	West Midands Fire Service	
Janette Beckett	Black Country Housing Group	
Joanna Luxmore-Brown	Adult Health Improvement Manager – SMBC	
Kate Houghton	West Midlands Fire Service	
Kathryn Wood	Trading Standards – SMBC	
Leona Bird	SCVO	
Lillie Abbott	West Midlands Fire Service	
Linda Francis	Senior Learning and Development Officer – SMBC	
Lisa Whitehouse	Sourcing Officer – SMBC	
Samantha Hall	SMBC	
Sandra Troth	Development Worker – SMBC	
Sue Lennon	West Midlands Home Care Association	
Tonia Flannagan	St Albans	
Susan Brookin	West Midland Fire Service	
WMAS	West Midlands Ambulance Service	
Simon McGarry	Healthwatch	
Michelle Carolan	Clinical Commissioning Group	
Samantha Jhall	SMBC	

Protection Sub Group

Name	Job Title	
Geoff Foster	Chief Executive CARES	Chair
Charmaine Stephens	Lead Officer – SMBC	
Michelle Moore	Lead Officer – Sandwell Safeguarding Adults Board	
Deb Ward	Operations Manager – Safeguarding Adults Board	Second Representative
Gail Read	West Midlands Fire Service	
Michael Fergus	Sandwell Probation	
Sara Ward	Black Country Women's Aid	
Elaine Newell	South West Birmingham Hospital	
Isolyn Clarke	Lead Practitioner – SMBC	
Kenneth Bennie	SMBC	Second Representative
Mario Ermoyenous	Black Country Partnership Foundation Trust	
Mark Beesley	Trading Standards Office – SMBC	
Mark Burnell	West Midlands Police	
Paul Hooton	South West Birmingham Hospital	
Marie Kelly	Clinical Commissioning Group	

Appendix 3 – Finance and Budget Information

The work of SSAB cannot be achieved without a dedicated budget and resources.
For 2016-2017, 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 2016- 2017 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.
- SSAB Website development and launch

Appendix 4 – Glossary of Terms

Abbreviation	Explanation
A&E	Accident & Emergency
AACE	Association of Ambulance Chief Executives
AE	Advocate Educator
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
ASB	Anti-Social Behaviour
BCPFT	Black Country Partnership Foundation Trust
BCWA	Black Country Women's Aid
BME	Black Minority Ethnic
BSAB	Birmingham Safeguarding Adults Board
CA	Care Act
CCG	Clinical Commissioning Group
CPD	Continued Professional Development
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
Datix	Electronic recording system
DASS	Director of Adult Social Services
DBS	Disclosure and Barring Service
DCA	Double Crewed Ambulance
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
DV	Domestic Violence
DVPP	Domestic Violence Perpetrator Programme
eL	e-Learning
EOC	Emergency Operation Centres
EUC	Emergency and Urgent Care services
FGM	Female Genital Mutilation
GP	General Practitioner
IDVA's	Independent Domestic Violence Advisers
IMCA	Independent Mental Capacity Advocate
IMR	Individual Management Review
IPCC	Independent Police Complaints Commission
IRIS	Identification and Referral to Improve Safety

IT	Information Technology
HMIC	Her Majesty's Inspectorate of Constabulary
HMO	Houses of multiple occupancy
KPI	Key Performance Indicator
LD	Learning Disability
LGBT	Lesbian, Gay, Bisexual and Transgender
LSAB's	Local Safeguarding Adult's Board's
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act (2005)
MDS	Modern Day Slavery
MSP	Making Safeguarding Personal
MH	Mental Health
NHS	National Health Service
NPU	Neighbourhood Policing Unit
PALS	Patient Advice and Liaison Services
PEEL	Police effectiveness, efficiency and legitimacy programme
POT	Position of Trust
PPU	Public Protection Unit
PTS	Patient Transport Services
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.
QAF	Quality Assurance Framework
SAB	Safeguarding Adults Boards
SAR	Safeguarding Adults Review
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SLT	Senior Leadership Team
SMBC	Sandwell Metropolitan Borough Council
SNAP	Sandwell New Arrivals Partnership meetings
SPOC	Single Point of Contact
SSAB	Sandwell Safeguarding Adult Board
SSCB	Sandwell Safeguarding Children's Board
SSM	Senior Strategy Meetings
SSP	Safer Sandwell Partnership
SWBCCG	Sandwell and West Birmingham Clinical Commissioning Group
SWBH	Sandwell West Birmingham Hospital
SWEMWBS	Short Warwick- Edinburgh Mental Wellbeing Scale
VPO	Vulnerable Person Officer
VTE	Venous Thromboembolism
WMAS	West Midlands Ambulance Service
WMASFT	West Midlands Ambulance Service Foundation Trust
WMCA	West Midland Care Association
WMP	West Midlands Police
WRAP	Workshop in raising awareness of PREVENT

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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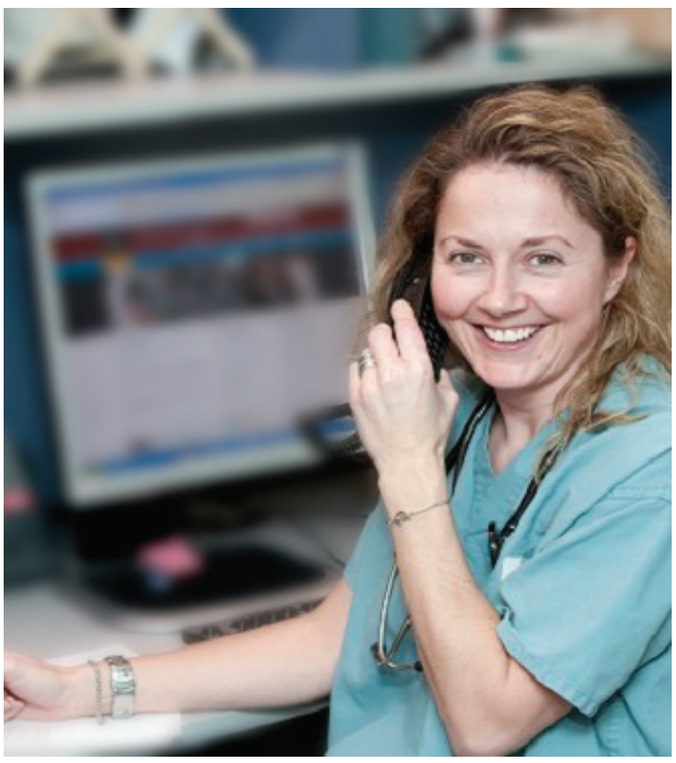
Who can I tell my concerns to?

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

In an emergency ring 999



Sandwell Metropolitan Borough Council

Agenda Item 5

REPORT TO
HEALTH AND ADULT SOCIAL CARE SCRUTINY BOARD

22 January 2018

Subject:	Strategy to Reduce Infant Mortality in Sandwell
Cabinet Portfolio:	Councillor Elaine Costigan - Cabinet Member for Public Health and Protection
Director:	Executive Director of Adult Social Care, Health and Wellbeing – David Stevens
Contribution towards Vision 2030:	
Contact Officer(s):	Valerie de Souza Consultant in Public Health 0121 569 3189 Valerie_desouza@sandwell.gov.uk

DECISION RECOMMENDATIONS
That Health and Adult Social Care Scrutiny Board: 1. Consider and comment upon the attached strategy

1 PURPOSE OF THE REPORT.

2 In late 2016/early 2017, a strategy was developed by Sandwell and West Birmingham Clinical Commissioning Group (SWBCCG) and Sandwell Local Authority to address infant mortality and stillbirths within the CCG. This report summarises the findings and recommendations of that report, and provides an update of the current position.

3 IMPLICATIONS FOR SANDWELL'S VISION

This strategy supports a number of ambitions within Sandwell's Vision 2030. It supports the ambition that Sandwell is a place where we live healthy lives and live them for longer, and where those of us who are vulnerable feel respected and cared for. It also supports our children to benefit from the best start in life.

4 BACKGROUND AND MAIN CONSIDERATIONS

1. Rates of stillbirth and infant mortality are higher in Sandwell and Birmingham than they are nationally.

2. Both stillbirth and infant mortality rates have decreased in Sandwell Local Authority in recent years.

3. Numerous risk factors are associated with infant mortality and stillbirth but this strategy highlighted the following as especially important:-

    - Smoking
    - Ethnicity
    - Infant Nutrition/Breastfeeding
    - Deprivation and Poverty

4. Four interventions were recommended within the strategy which were:-

    - Commissioning of a Family Support Nurse Service
    - Recruitment of Health Pregnancy Advocates (peer support system)
    - Supply of an enabling fund to assist health behaviour change
    - Health education and promotion to encourage healthy choices

5. All of the interventions were agreed in principal by both SWBCCG Governing Body and the Health and Wellbeing Board in early 2017 but are required to go through the SWBCCG prioritisation process.

5 THE CURRENT POSITION

The attached strategy outlines current services which are designed to reduce infant mortality, along with suggested modification to these and additional service which would reduce infant mortality in Sandwell.

6 CONSULTATION (CUSTOMERS AND OTHER STAKEHOLDERS)

Any changes to individual services have undergoing consultation and similarly planned changes/addition to services will include a period of stakeholder and resident consultation.

7 ALTERNATIVE OPTIONS.

Outlined in the attached strategy.

8 STRATEGIC RESOURCE IMPLICATIONS

Strategy has resource implications for individual organisations which provide and commission services which support reduction in infant mortality.

9 LEGAL AND GOVERNANCE CONSIDERATIONS

Considered by individual commissioner/provider organisation.

10 EQUALITY IMPACT ASSESSMENT

Considered by individual commissioner/provider organisation.

11 DATA PROTECTION IMPACT ASSESSMENT

Considered by individual commissioner/provider organisation.

12 CRIME AND DISORDER AND RISK ASSESSMENT

N/A

13 SUSTAINABILITY OF PROPOSALS

Considered by individual commissioner/provider organisation.

14 HEALTH AND WELLBEING IMPLICATIONS (INCLUDING SOCIAL VALUE)

Considered by individual commissioner/provider organisation

15 IMPACT ON ANY COUNCIL MANAGED PROPERTY OR LAND.

N/A

16 **CONCLUSIONS AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS**

To support the attached strategy.

17 **BACKGROUND PAPERS**

A STRATEGY TO REDUCE INFANT MORTALITY AND STILLBIRTHS IN SANDWELL AND WEST BIRMINGHAM

18 **APPENDICES:**

Summary of Infant Mortality Strategy for

David Stevens
Executive Director of Adult Social Care, Health and Wellbeing

A STRATEGY TO REDUCE INFANT MORTALITY AND STILLBIRTHS IN SANDWELL AND WEST BIRMINGHAM

A SUMMARY & UPDATE

ORIGINAL REPORT BY:

MATTHEW FUNG, SPECIALTY REGISTRAR IN PUBLIC HEALTH

ANDREW HARKNESS, DEPUTY CHIEF OFFICER PUBLIC HEALTH

SABA RAI, SENIOR COMMISSIONING MANAGER

SUMMARISED BY:

TANITH PALMER, SPECIALTY REGISTRAR IN PUBLIC HEALTH

HAZEL MALCOLM, SENIOR COMMISSIONING MANAGER

INTRODUCTION

In late 2016/early 2017, a strategy was developed by Sandwell and West Birmingham CCG (SWBCCG) and Sandwell Local Authority to address infant mortality and stillbirths within the CCG. This report summarises the findings and recommendations of that report, and provides an update of the current position.

For the purpose of this report, infant mortality is defined as:

"The death of an infant before his or her first birthday"[1]

And a stillbirth as:

"A baby born with no signs of life at or after 28 weeks' gestation"[2]

KEY POINTS

1. Rates of stillbirth and infant mortality are higher in Sandwell and Birmingham than they are nationally.

2. Although both stillbirth and infant mortality rates have decreased in Sandwell Local Authority in recent years, there has been an increase in Birmingham.

3. Numerous risk factors are associated with infant mortality and stillbirth but this strategy highlighted the following as especially important:
    - Smoking
    - Ethnicity
    - Infant Nutrition/Breastfeeding
    - Deprivation and Poverty

4. Four interventions were recommended within the strategy which were:
    - Commissioning of a Family Support Nurse Service
    - Recruitment of Health Pregnancy Advocates (peer support system)
    - Supply of an enabling fund to assist health behaviour change
    - Health education and promotion to encourage healthy choices

5. All of the interventions were agreed in principal by both SWBCCG Governing Body and the Health and Wellbeing Board in early 2017 but are required to go through the SWBCCG prioritisation process. Current service provision is covered in Figure 5.

[1] Center for Disease Control: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm "

[2] World Health Organisation: http://www.who.int/maternal_child_adolescent/epidemiology/stillbirth/en/ "

INFANT MORTALITY AND STILLBIRTH RATES

The death of a baby in pregnancy, at birth or after birth is a tragedy to parents, their families and their communities.

Nationally, there has been a gradual decrease in both stillbirths and infant mortality with the highest rates seen in both the youngest and the oldest mothers.

Sandwell and West Birmingham have some of the highest infant mortality rates in the country. Although these rates have been decreasing in Sandwell over the past three years, there has been an increase in infant mortality in Birmingham (Figure 1).

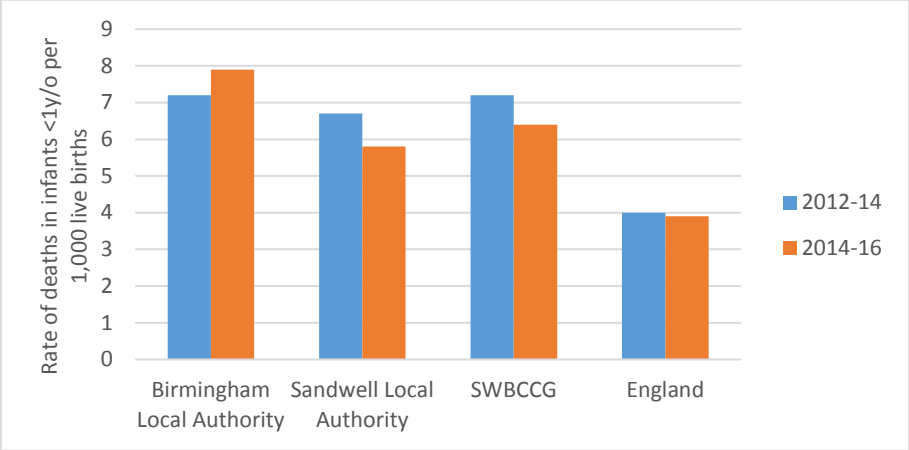


Figure 1. Average rates of Infant Mortality in Birmingham and Sandwell Local Authorities, Sandwell and West Birmingham Clinical Commissioning Group and England in 2012-2014 and 2014-2016

Stillbirth rates have decreased across SWBCCG but remain significantly higher than England. Stillbirth rates are similar in both Birmingham and Sandwell wards. Similar to the picture portrayed above, Sandwell's rates of stillbirth have decreased over recent years, whereas there has been an increase in Birmingham (Figure 2).

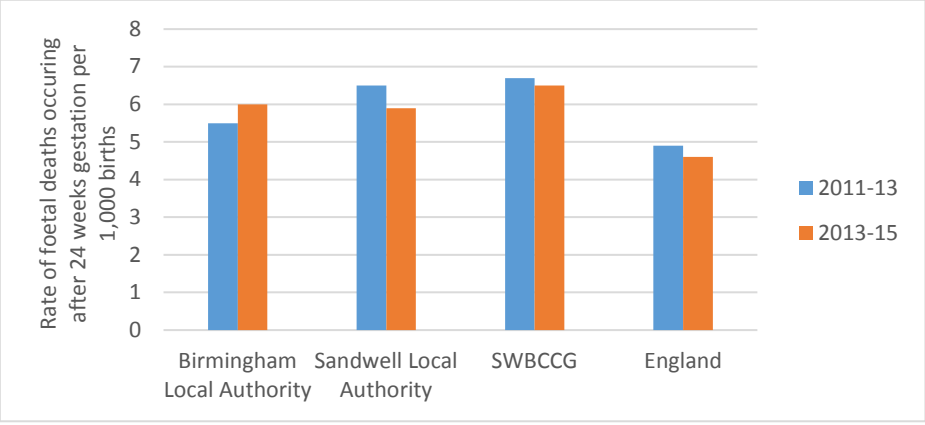


Figure 2. Average rates of Stillbirth in Birmingham and Sandwell Local Authorities, Sandwell and West Birmingham Clinical Commissioning Group and England in 2011-2013 and 2013-2015

This equated to 150 stillbirths and 147 infant deaths in SWBCCG in 2013-15.

RISK FACTORS ASSOCIATED WITH INFANT MORTALITY AND STILL BIRTH

There are numerous factors implicated in infant mortality and still birth and some of these can be modified to help lower the risk of both of these.

The Sandwell and Birmingham's Child Death Overview Panel identified the risk factors associated with infant mortality and stillbirth in the local area as outlined in Figure 3.

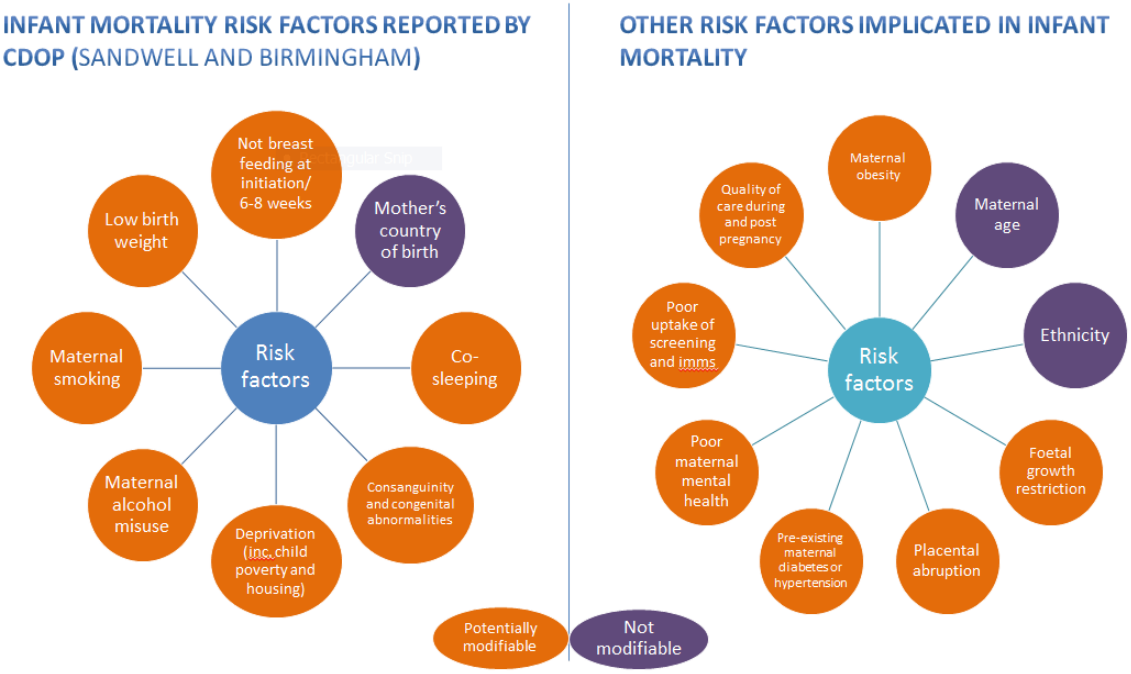


Figure 3. Modifiable and non-modifiable risk factors as identified by Sandwell and Birmingham's Child Death Overview Panel

Some of these risk factors are likely to have a strong and immediate impact on rates if death if they were modified/removed, whilst others would have less of an impact or may take considerably longer to effect change.

Of the risk factors outlined in Figure 1, key risk factors identified in the Infant Mortality Strategy are:

1. Smoking
2. Infant Nutrition and Breastfeeding
3. Deprivation and Child Poverty
4. Ethnicity

These are explained further here.

Smoking

Smoking is a risk factor strongly associated with stillbirths and infant mortality. Sandwell CDOP identified smoking as the most common risk factor in infant mortality in the local area.

Smoking in pregnancy accounts for approximately:

- More than 1 in 20 premature births
- Up to 1 in 5 cases of low birth weight in babies carried to full term
- More than 1 in 20 preterm-related deaths
- Up to 1/3 of sudden unexpected deaths in infancy (SUDI)

Maternal smoking in childhood is also associated with various child health and developmental issues.

Although a larger proportion of people smoke in SWBCCG than they do nationally, a smaller proportion of women were smoking when they delivered their babies in 2017/18 in SWBCCG than they were nationally [3]. Additionally, data would suggest that the numbers of women smoking at delivery has decreased over recent years in SWBCCG.

Despite this, only 1 in 20 women managed to successfully quit smoking in SWBCCG in 2015/16 and 851 women were recorded smoking in pregnancy across the region, demonstrating that more is needed to be done.

Infant Nutrition (Breast Feeding)

The benefits of breastfeeding to mother and baby are well documented. Evidence suggests that the risk of SUDI is smaller for breastfed babies.

In 2014/15[4], breastfeeding rates were considerably lower in SWBCCG than they were nationally:

- About 60% of women initiated breastfeeding in SWBCCG whereas 75% of women did nationally.
- Approximately a third of women were still breastfeeding at 6-8 weeks in SWBCCG compared to almost half nationally.

Deprivation and Child Poverty

In the West Midlands, evidence suggests that there is a link between deprivation and infant mortality (Figure 4) – the most deprived areas experience the highest levels of infant mortality including Sandwell, Wolverhampton, Birmingham and Stoke on Trent.

This finding is further supported by Sandwell CDOP, who found that the majority of infant mortality was seen in mothers who lived in the most deprived areas.

Despite this, deprivation is unlikely to be the sole cause of infant mortality, as rates differ amongst the most deprived areas in the region. In addition to this, a number of the risk factors associated with infant mortality/stillbirths are found more commonly in more deprived areas (e.g. smoking, bottle feeding).

[3] NHS Digital - Statistics on Women's Smoking Status at Time of Delivery, England - Quarter 1, 2017-18 https://digital.nhs.uk/catalogue/PUB30070

[4] More recent data was not available for the local area due to data quality issues

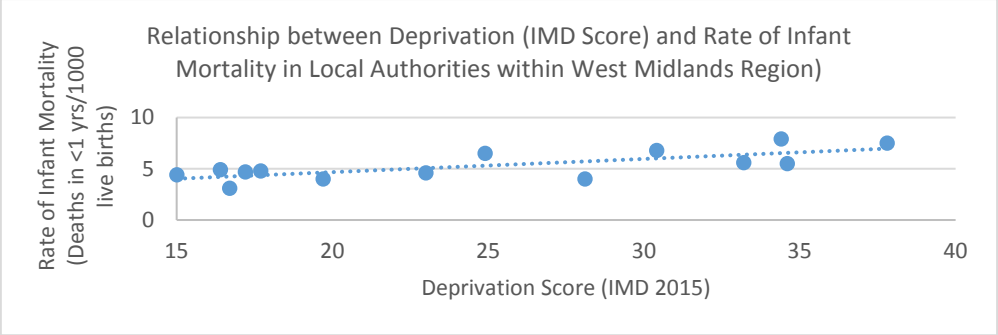


Figure 4. Graph showing the relationship between deprivation and infant mortality rates in the West Midlands

Ethnicity

Substantial inequalities in infant mortality rates are known to exist between white and ethnic minority groups in England and Wales.

In 2014, the infant mortality rates for babies of mothers born outside the UK are significantly higher than for mothers born inside the UK. The highest infant mortality rates were seen in babies of mothers born in Pakistan and Western Africa. Birmingham CDOP found that over half of infant deaths were in black and minority ethnic groups.

Evidence suggests that these differences are likely to reflect underlying factors such as differences in the mother's age, together with a range of other socio-demographic characteristics.

Any new intervention for infant mortality and stillbirths that is commissioned should be developed with due consideration to these factors.

RECOMMENDED INTERVENTIONS ARISING FROM STRATEGY

Following the analysis of data from a wide range of data including the CDOPs, Public Health England, and the NHS, the Infant Mortality Strategy outlined 4 recommended interventions to try and help reduce infant mortality and stillbirths in the area. These interventions were supported by NHS Outcomes framework, Public Health Outcomes Framework and SWB CCG operational plan and NHS England's Improvement and Assessment Framework (IAF).

The proposed interventions were as follows:

1. In Sandwell, Family Support Nurses (FSN) would deliver an intensive service, specific to the part of the pathway that the client is in, and appropriate to their needs up until the child reaches 2 years of age. After this point, clients would be transitioned to universal or universal+ health visiting. In West Birmingham, the vulnerable families pathway would provide additional health visitor led support to vulnerable women.

2. Healthy pregnancy advocates (HPA) would fit into the model by providing a consistent skilled peer-support through the antenatal period up until babies reach 1 year of age. After this point, HPA support would be withdrawn and clients would be transitioned back to the care of FSNs, vulnerable families health visiting, or universal health visiting services.

3. An enabling fund would provide additional scope for HPAs to support clients to make healthy choices through pregnancy which would assist with behaviour change.

4. Health education & promotion through social marketing/advertising would provide a universal offer to encourage healthy choices through pregnancy and early access to maternity services.

CURRENT POSITION OF INFANT MORTALITY SERVICES

This Infant Mortality Strategy went to SWBCCG's Governing Body in early 2017. The proposed interventions were agreed in principal, however it was advised that it would be required to go through the SWBCCG prioritisation process.

The strategy was also presented to Sandwell Health and Wellbeing Board.

Current initiatives and responsibilities are outlined in Figure 5.

Stage	*Lead Organisation*	*Initiatives currently in place*
Pre-conception	Local Authority Public Health	• Obesity Weight Management • Teenage Pregnancy Programme • Alcohol and Drug Awareness Programme • Low Birth Weight Strategy • Smoking Cessation
Pregnancy	Sandwell and West Birmingham Maternity Service /Sandwell and West Birmingham Clinical Commissioning Group	• Maternity Pathway which includes identification of high risk women and appropriate signposting/ immunisations and flu vaccination programme
	Sandwell MBC Public Health	• Best Start Programme • Ante-natal programme (which includes breastfeeding) • Perinatal Mental Health Clinic • CO_2 monitoring and BMI measuring • Smoking Cessation Service
Birth	Sandwell and West Birmingham Maternity Service / Sandwell and West Birmingham Clinical Commissioning Group	• Protocols for recording of infant • Perinatal Mortality Programme • Infant Breastfeeding Programme • 72 hour baby checks
Early Years	Local Authority Public Health	• Health Visiting Services • Children's Centres • 6 -8 week baby checks • Immunisation Programme

Figure 5. Table highlighting existing services and their corresponding Lead Organisations at each stage of pregnancy

More data is currently being collated and analysed to ensure effective monitoring of impacts and outcomes.