Sandwell
Safeguarding
Adults
Board

SSAB@SSAdultsBoard

Sandwell Safeguarding Adults Board

ANNUAL REPORT 2017/2018

Sandwell Metropolitan Borough Council

Sandwell and West Birmingham Hospitals NHS Trust

Sandwell and West Birmingham Clinical Commissioning Group

Black Country Partnership NHS Foundation Trust

West Midlands Police

Contents

Foreword from the Chair

Welcome to Sandwell's Safeguarding Adults Board Annual Report 2017-18.

Hello all,

Welcome to Sandwell's Safeguarding Adults Board 2017-18 Annual Report, which provides the Board and agencies with the opportunity to reflect on their achievements in 2017-18 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.

The Board is proactive, lively and challenging with robust partnerships that were evidenced in our participation of Sandwell's Peer Review undertaken in January 2018.

The Peer Review team were positive about Operational Safeguarding and SSAB but identified the need for the Service User voice to be more visible.

The Board remains committed to the principle of empowerment and is keen to evidence good practice of Making Safeguarding Personal (MSP) The Board continues to maintain its own website and regularly posts new developments in safeguarding practice, policy and procedure. I would urge you to visit the website using the link below;

www.sandwellsab.org.uk.

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 safeguarding adults with additional care and support needs in Sandwell. I would like to take this opportunity to let you know that I will be retiring as the SSAB Chair in April 2018 and I wish to express my thanks for all of the support I have received and what we have achieved to date and wish you all the very best for the future!

Eddie Clarke
Independent Chair,
Sandwell Safeguarding Adults Board

Six Principles of Safeguarding

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnerships
- Accountability

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 this year has provided some new challenges 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 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, 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.

The Board continues to seek assurance in respect of The Learning Disabilities Mortality Review (LeDeR) programme which was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. It is being implemented at the time of considerable spotlight on the deaths of patients in the NHS, and the introduction of the national Learning from Deaths framework in England in 2017. The programme is led by the University of Bristol, and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

The programme has developed a review process for the deaths of people with learning disabilities. All deaths receive an initial review; those where there are any areas of concern in relation to the care of the person who has died, or if it is felt that further learning could be gained, receive a full multi-agency review of the death. Deaths subject to the current priority review themes (aged 18-24years or from a Black or minority ethnic background) receive multiagency review and expert panel scrutiny. At the completion of the review, an action planning process identifies any service improvements that may be indicated.

Locally the Black Country Partnership Foundation Trust (BCPFT) have coordinated a steering group which met in January 2018. Representatives from the steering group give updates on actions to the Protection Sub Group.

Partners will continue to work together to meet the agreed outcomes of the project and report on progress and findings to the SSAB.

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:

"I've never failed to be impressed by the commitment of the Board members and have become aware of the vital role that it serves in bringing together representatives from all the diverse professions"

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.

In January 2018 SSAB took part in a Peer Review. The Council invites a Peer Review which is a sector led improvement process to enable learning, development, focus on good practice and identify areas for potential improvement or considerations for doing things differently.

Throughout 2017-18 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.

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 has committed to have annual development days. There are strong links with all key Boards 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 of 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

Peer Review

In January 2018, the SSAB took part in a Peer Review.

Prior to the arrival of the Peer Review team, the team were provided with background documents as an evidence framework which included Annual Report, Strategic Plan, minutes from Board meetings, records of Scrutiny decisions and quality assurance documents and the team were asked by the Local Authority to consider the three questions below:

- **We currently deliver safeguarding intervention within 3 areas of the business are there improvements that you can suggest improving our operating model?**
- **Is the Councils' s42 decision making robust, how could it be improved?**
- **How could Sandwell MBC improve the ways in which Making Safeguarding Personal has been embedded into the practice of all statutory partners?**

The focus of this Peer Review was the work of the SSAB and Operational Safeguarding. The Peer Review team were in Sandwell from 23rd January to 25th January, during that time they met the SSAB Independent Chair, the Board Manager, the Chairs of the sub groups, members of sub groups, Board members and partners. Members of the Peer Review team asked questions in support of their key lines of enquiry and listened to all the feedback and information given to them by the participants.
In their summary, the Peer Review team said that "**Strong and clear leadership of the Safeguarding Adults Board with a wide range of partners enthusiastic and committed, with Eddie Clarke and Deb Ward clearly valued**"

Below are some of the comments taken directly from the presentation delivered by the Peer Review team:

The Peer Review team recommendations for the SSAB were:

- **The Safeguarding Adults Board should assure itself that there is clear line of sight in each organisation at Chief Executive and Board level**
- **The Board should further develop its challenge and scrutiny of each other's performance and accountability**
- **Develop a single view of priorities for Safeguarding Adults Board and ensure they reflect the emerging themes from local intelligence**
- **Build on the performance platform that you have created to share your practice with Peers across the region and look to extend the approach to effectively measure outcomes**

Prevention Conference Understanding Safeguarding 11.10.17

In October, the Board supported a conference made up of a range of professionals from across all agencies with a focus on Prevention and what do we mean by safeguarding. The day was structured with formal speakers and there was a series of presentations and exercises with a focus on the service user experience, mental capacity and the impact and application regarding decision making and the promotion of the Sandwell hub.

Quotes from attendees;

"It was a very interesting and informative session. The three key areas I will transfer back into my workplace are Mental Capacity, Discussions from the case study and the stories from the guest speakers"
The Enquiry Team

"My knowledge at the start of the conference was a rating of 2 and at the end it was 8. It was a brilliant speech by the gentlemen giving his recovery story. It was very moving, Thank you. The three key areas for me were the Sandwell Hub, Mental Capacity Act and sharing views and ideas with group"
Ideal for All

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.

Safeguarding Adults Review Event 14.02.18

Throughout 2017/18 the Protection Sub Group and Protection Lead Officers worked on writing and developing the Safeguarding Adults Review Policy and Procedure which included a clear referral pathway, scoping document and detailed policy. This was a complex piece of work and was approved by the Board in April 2017. The policy and procedure were formally launched at this event which was well attended by a range of professionals and included the dynamic use of theatre to explore challenging safeguarding scenarios.

Quotes from attendees;

"From today I am happy that I can improve my social work practice related Safeguarding investigations. It has been a very informative session. Very well presented, it was good to have such an interactive session.

Rating at the beginning of training was 5, rating at end 9"
ASC Health & Wellbeing

"Good information on Safeguarding adults and person-centred interventions. Very well delivered information and interactive sessions.

Rating at the beginning of training was 4, rating at end 8"
CCG

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:

- 17/08/2017 - Trading Standards – exploring the impact of SCAMS and financial abuse and effective resolution working in partnership with Trading Standards.
- 26/09/2017 - Tackling Violence and Exploitation Together – delivered in partnership with Health & Wellbeing Board and the Safer Sandwell Partnership & Crime Board.
- 19/10/2017 – Disability Hate Crime – how to report it and the impact on victims.

Community Outreach Events and Engagement

SSAB is committed to working in partnership with all stakeholders including members of the public. We attend community outreach events to ensure a high profile of the work of the Board and build on a community understanding of what constitutes safeguarding and how to report any concerns. In line with our ongoing campaign 'See Something Do Something' examples of activity involved are listed below. These provide a very real opportunity to engage with a range of people in a meaningful way. Concerns raised by members of the public continue to represent the area where the highest number of concerns are reported.

- 29/09/2017 – Safer Six at Blackheath
- 03/10/2017 – Safer Six at Oldbury
- 16/10/2017 – Safer Six at West Bromwich Town Hall and High Street
- 24/10/2017 – Safer Six at Wednesbury
- 30/10/2017 – Winter Warmth Event, Wesley Community Centre
- 07/12/2017 – Community and Faith Based Event
- 19/12/2017 – Terrence Higgins Trust Event

Prevention of Violence and Exploitation 26.09.17

SSAB participated in an event/workshop which was organised by the Task and Finish group. Both strategic and senior Managers from within Sandwell MBC and external partners (both statutory and voluntary) were invited to the event. 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 Children's 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.

The event was well attended and there was some helpful feedback collected, some examples of which are below;

Summary of Progress Against the Board's Priorities 2017-18

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 and engage the community in understanding their contribution to safeguarding.	SSAB continues to adopt a campaign focus and uses multi-media opportunities to promote 'See Something Do Something' and 'Safeguarding is Everybody's Business'. 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". 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 held a well-attended conference in October 2017 with a focus on 'What is Adult Safeguarding?'
Contribute to the development of the Prevention of Violence and Exploitation work including oversight of the provision of support to victims of crime with care and support needs.	SSAB has strengthened its partnership with the 4 Boards creating added value by utilising joint communication and engagement opportunities wherever possible. Each of the Boards are independent of each other but need to ensure that they take a whole family approach to setting their priorities and reporting performance where warranted. SSAB actively contribute to the Regional Uniformed Services Group in establishing agreed data sets from all emergency service partners that work across the West Midlands. SSAB are currently working with WMP to agree data and information in respect of victims of crime with care and support needs.

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.
Work with partners to ensure there is collaboration on identifying learning and development needs, how they should be addressed and delivered.	SSAB have commissioned a learning platform in partnership with Children's services to enable a robust learning and development offer, SSAB continues to work with partners both locally and across the region to understand and implement agreed competencies and a core training offer.

QUALITY & EXCELLENCE: Continue to focus on effective delivery and high-quality processes	
What did we want to achieve	What did we achieve…
Relaunch the sub group with all statutory partners represented	SSAB invited a new Chair to represent the Quality & Excellence Sub Group. The Chair has worked hard to ensure membership is reflective and appropriate and members understand the contribution they make to the work of the sub group.
To present both qualitative and quantitative data to the Board to give assurance of the safeguarding quality and processes.	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 and influence the development of a self-assessment audit tool against the West Midlands self-audit standards. The 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.
To monitor the appropriate use of the 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. SSAB continues to work with the 4 Boards to develop effective engagement and communication plans and will be further reported on in 2018/19 Annual Report.
Support the development of the service user engagement forum and the engagement plan.	Service User Engagement will be supported as a cross Board function and activity (developed as a specific project) and is no longer the sole responsibility of the Q&E Sub Group.

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.	SSAB undertook two Safeguarding Adult Review (SAR's) and developed action plans for both and identified key learning outcomes. In February 2018 SSAB held an event and launched the Safeguarding Adult Review Process and purpose. The event used theatre production to explore the key learning outcomes identified within the SAR's undertaken and the implications for practice.
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

Ms A is a 51-year-old lady who currently lives in a residential home that specialises for supporting individuals with a learning disability.

An alert was received by the safeguarding team from an anonymous source in relation to poor standard of care, neglect and physical abuse. There had been no previous concerns noted on the system historically or currently that related to similar circumstances.

Case direction was given to the safeguarding social worker by the safeguarding Manager to carry out an unannounced visit and speak to Ms A on her own, immediately assess the current situation and implement any measures as required to ensure her safety and that of other residents. Senior management at the provider were made aware and the staff that had been implicated were to be suspended pending investigation if after the visit this was felt to be appropriate. All relevant bodies were to be informed if it was felt there was a genuine concern.

Findings

On the first visit Ms A was found to be extremely underweight, wearing old and dirty clothing, barely able to speak and looked down at the floor the whole time, seeming unable to make eye contact.

West Midlands Police were immediately informed along with CQC, Contracts Team, CCG and other Local Authorities who had residents place there.

Police immediately took the lead, staff were suspended and all professionals were instructed to await further instruction from police before any further visits.

Once instructed by the police numerous visits were made by the safeguarding worker and a meeting with Ms A and her family was arranged. Strategy meetings were held in collaboration with Dudley MBC, Bristol City Council, Police and the CCG and case was taken to a S42. The provider changed the whole staff team at the residential unit following the strategy meeting.

Outcomes

In the two months since the alert was raised Ms A has become genuinely unrecognisable (unrecognisable is also the word every professional has used when they have reported back from visits), Ms A has put on over 6 kg in weight, is chatty, sociable and interactive. Ms A appears happy and is now wearing bright, clean outfits of her choice. Ms A is now going out on day trips and shopping trips and has been on holiday. All professionals involved along with family members have stated they are amazed at her transformation.

On the last visit the safeguarding worker made to Ms A they commented to her, "you look so well, what's changed?", not really expecting Ms A to be able to answer this, but she said, "new staff". When asked "what is different about the new staff?" she replied, "they are nice to me and help me".

The safeguarding case is still on-going due to a very long legal process with the provider. Police have ended their involvement and the safeguarding team continue to monitor the provider. Guarantees have been given that the outcome will be fed back to all professionals involved and none of the staff involved in the case will return to the home. Ms A and the other residents have since been observed and found to be relaxed and at ease in their home.

Case Study 2

Detail of Concern

Mr C is a 76-year-old gentleman who lives alone, he is supported with personal care via a domiciliary care agency which is privately funded.

An alert was received by the safeguarding team from the domiciliary provider as they were concerned that they had not been paid. Mr C seemed in arrears with many bills and his friend had informed them that Mr C had fallen prey to a 'sucker list' used by fraudsters who targeted vulnerable adults.

There had been no previous safeguarding alerts regarding Mr C. The safeguarding manager allocated the case to a safeguarding social worker and instructed them to visit Mr C and discuss the concerns and to liaise with police and trading standards and ensure finances were immediately secured if any irregularities were found. The worker was instructed to contact any utility companies and have arrears placed on hold until investigation completed.

Findings

On the initial visit Mr C was found to have no food in his home and had numerous outstanding bills that required urgent action. Mr C requested that his friend be contacted as he knew more about what was happening. The friend confirmed that Mr C was £8000 in debt and was being targeted by a 'sucker list' used by fraudsters to take advantage of vulnerable people. Mr C seemed to be confused and losing capacity and was unaware of what was happening around him and where his finances were going. On checking bank statements, large sums of money had gone from his account.

Outcome

The safeguarding social worker liaised with floating support to facilitate supporting Mr C in addressing all utility bill arrears. A bailiff letter was addressed as an emergency and after an assessment of Mr C's mental capacity was undertaken a referral was made to the council's appointeeship unit to manage finances. Safeguarding social worker liaised with police and trading standards and was subsequently informed that after a successful court case Mr C would be reimbursed by £65,000. The worker also managed to get electrics sorted at the property which immediately improved quality of living conditions.

Partner contributions

1. Sandwell Metropolitan Borough Council

Organisation:	Sandwell Metropolitan Borough Council (SMBC) Safeguarding Team
Completed by:	Suki Sandhu - Operations Manager Safeguarding & DoLS Service Area
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2017 to 31st March 2018	
Ensuring Making Safeguarding Personal is at the forefront of all practice.	We record and report on Making Safeguarding Personal (MSP) outcomes and test this through case file audits to ensure we can evidence that practice is person centred.
Protection	Adult Social Care (ASC) contribute to SAR's including making referrals when and where appropriate. ASC are represented at the Protection Sub Group.
Prevention	ASC actively engage and participate in the Prevention agenda.
Quality & Assurance	ASC produce quarterly performance data in partnership with the data team which is presented to the Quality & Excellence Sub Group and the Board and subject to robust scrutiny
Work planned to contribute to Safeguarding Adults Board priorities 2018/19 *Please outline how your agency intends to contribute to improving outcomes for **adults with care and support needs** over the coming year*	
Protection	Revised Safeguarding procedures and process for adult social care – improving on our approach regarding Making Safeguarding Personal (MSP) and good practice.
Quality Assurance	Quality assurance – advocacy, evidence based activity/recording.
Prevention	Multi agency working – work around safeguarding awareness with professionals at all levels – including front line

Please provide any case study examples, relevant to Safeguarding Adults Board priorities, that can be included in the annual report

*Case studies should clearly express the impact on **adults with care and support needs** and should be brief, no more than one or two paragraphs. Please include links to any relevant websites or online reports. You may also send us any images that support your case study.*

A 58-year-old lady who has had a diagnosis of a learning disability since childhood and has lived with her 95-year-old father throughout her life. The lady came to the attention of the Safeguarding team for the first time a year ago due to concerns that her father was in poor health and not coping with his caring responsibilities, respite was offered and accepted at this time but other agencies felt that it may be best for the lady to remain in residential care and not return to her father.

The lady returned home under a 'Working Agreement' in December 2017 (to promote transparency and collaborative working) and since this time there have been several low-level safeguarding concerns.

The safeguarding referral concerned bruises to the lady's arms and scratches to her face and forehead. A multi-disciplinary approach was utilised and identified that the care agency and day centre had seen the lady pinching herself, scratching herself and her father had informed them of a seizure like event. The father also liaised with the Local District nurse who visits weekly under the working agreement to support regular monitoring and take a lead role in arranging for further medical tests.

The lady will now be having neurological scans in 2018 and although this is one piece of work within a series which has been based upon a relationship based social work approach, the positive outcome is that the lady is receiving appropriate support with medical interventions and that there is a strong supportive network around both the lady and her father to support their right to live as a family, delay an increase in care needs and prevent social isolation.

2. West Midlands Fire Service

Organisation:	West Midlands Fire Service (WMFS)
Completed by:	Kate Houghton - Partnerships Officer
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2017 to 31st March 2018 *Please outline the work your agency has undertaken that has contributed to improved outcomes for **adults with care and support needs***	
Protection	WMFS has clear safeguarding procedures in place which inform all employees on what to do in the event of a safeguarding issue arising. In 2017/18 Vulnerable Persons Officers (VPO's) will be replaced with Complex Needs Officers who will trained to a higher level than VPOs to ensure those most vulnerable can be supported and encouraged in the most effective, collaborative and beneficial way. WMFS Serious Incident Review policy has been updated to improve internal and external learning from incidents that result in injury or death from fire. Recommendations are embedded into internal procedures and shared externally.
Work planned to contribute to Safeguarding Adults Board priorities 2018/19 *Please outline how your agency intends to contribute to improving outcomes for **adults with care and support needs** over the coming year*	
Prevention, Learning and Development	All staff have mandatory safeguarding and modern slavery training. Royal Society for Public Health training in health inequalities has been offered to all staff and all staff are aware of the organisation's safeguarding policy and how and when to make a referral. In 2017/18 all new entrants received Prevention Training as part of their initial induction training. This includes identifying risks and vulnerabilities to fire, extensive safeguarding training and how and when to make a referral.

3. West Midlands Police

Organisation:	West Midlands Police (WMP)
Completed by:	Chris Dowen - Detective Inspector

Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2017 to 31st March 2018

*Please outline the work your agency has undertaken that has contributed to improved outcomes for **adults with care and support needs***

2107/18 WMP Priorities

The following three areas were prioritised for 2017/18. Progress has been reported on quarterly to the Safeguarding Adults Board (SAB) through the WMP SAB Performance Report. (The draft 2018/19 priorities build upon these three areas and outlined at the bottom of this section)

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 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. 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.

Work planned to contribute to Safeguarding Adults Board priorities 2018/19 *Please outline how your agency intends to contribute to improving outcomes for **adults with care and support needs** over the coming year*	
2018/19 WMP Priorities (Draft)	The following draft priorities have been identified for 2018/19. They need to be reviewed and ratified by the SAB WMP representatives (Neighbourhood Policing Units (NPU) Commanders), and the Head of PPU before final sign off is agreed. The priorities are: 1. Develop the Force response to vulnerable adult abuse investigations and Intervention and Prevention activities 2. Develop the partnership response to vulnerable adult abuse investigations and Intervention and Prevention activities 3. Improve our understanding of vulnerable adult abuse priorities and "high demand" locations/vunerable adults
Assurance	WMP also complete an annual assurance statement that is shared with all safeguarding adult teams. In relation to WMP priorities the Strategic priorities are reviewed quarterly by the Thematic lead and reported on through the Performance report that is shared with all Safeguarding Adult Boards. Operational investigative activity is reviewed monthly between the Thematic Lead and the Detective Inspector responsible for the Adults at Risk team.
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 adults with care and support needs.	

The WMNow system is now live and available for West Midlands Police (WMP) Officers and Staff to use. It is a secure two-way instant messaging system to enable and develop community engagement with members of the public who have registered on the system.

There are partnership teams within the neighbourhood policing units which can assist with support and relevant information. This is also supported by two dedicated safeguarding Officers who support service users who are involved in investigations allocated to the WMP Public Protection Adults at Risk Team.

Training

Training packages are available and have been delivered to other organisations such as Care Home Associations on what to report and when.

There are many ways service users can give feedback to WMP. This includes:

- A public website
- Victim Right to Review process which is a formal request to review an investigation
- Contact under the statutory obligations set out in the Victims
- Serious Adult Reviews (SAR)

WMP continually review their investigations. This begins by a Triage system that is in place to establish if the matter is police related or if this would be better investigated by other means such as the Local Authority, Care Quality Commission or Coroners department. An investigating officer will make an assessment of the investigation at the start and conclusion of the investigation, which will be formally reviewed by their line manager and the Detective Inspector or Detective Chief Inspector. A person also has the right to review an investigation themselves or on behalf of their next of kin.

Training is delivered to new recruits through to accredited detectives, through a range of mediums, including the use of a video box presentation.

A new Policy has been created that provides guidance for all WMP staff on investigations relating to victims and witnesses with Care and Support Needs, which will be launched over the next 2 months. There are eLearning packages for the Care Act and Public Protection Unit (PPU) officers have mandatory training through the college of policing as well as on the Initial Crime Investigators Development Programme (ICIDP)

As an organisation, we also collate learning from the Safeguarding Adult Reviews (SARs) and use that to inform Force Policies and practices. This is a priority issue for the Adult Safeguarding Regional Group (Blue Light Services and Safeguarding Adult Board Team Managers Group). The matching of roles within WMP against a training matrix has been completed and will now be used by WMP and the SAB's to identify the training needs for delivery in 2018/19.

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. These two staff are supporting the Regional Training review/development.

West Midlands Police have reviewed the performance information provision with senior representatives of each Local Authority Safeguarding Adult Team to establish what information is most suitable for use within the Partnership to inform the impact of service delivery. This will be reviewed again during 2018/19 to refine the information provided by WMP and to WMP from the Safeguarding Adult Boards.

From a WMP perspective three separate analytical documents have been produced during 2017/18 in relation to demand, care homes and future threats, which are used to inform the strategic, tactical and operational response by WMP to adults with Care and Support needs.

Please provide any case study examples, relevant to Safeguarding Adults Board priorities, that can be included in the annual report

*Case studies should clearly express the impact on **adults with care and support needs** and should be brief, no more than one or two paragraphs. Please include links to any relevant websites or online reports. You may also send us any images that support your case study.*

Case Study One

A support worker employed by Adult Social Care was tasked with assisting a service user with finances and household tasks following bereavement of their surviving parent. The worker took advantage of her position taking out a £5,000 loan in the victim's name, diverting the funds for a holiday in the United States of America (USA). The worker opened a credit card in the victim's name and used it to purchase items for herself. They continued to steal from the victim by having access to online banking, making nearly 100 transfers. The total fraud and theft was £7,500, she was convicted of two counts of fraud and one count of theft and given a seven-month custodial sentence.

Case Study Two

The Victim was living in supported housing with 24-hour care. Two concerned members of the public witnessed the victim hitting one of the carers and the carer then proceed to push and kick the victim whilst he was on the floor she then looks around and kicks him a second time.

Offender stated she could not remember what had happened as she had a blackout following being hit by the victim. Guilty plea at court - • 6 weeks imprisonment, suspended for 12 months. • 3-month curfew with electronic monitoring 7pm to 7am.•

10 days rehabilitation• to pay victim services £115 and CPS £185"

4. Black Country Partnership Foundation Trust

Organisation:	Black Country Partnership NHS Foundation Trust (BCPFT)
Completed by:	Eva Rix Associate Director of Safeguarding
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2017 to 31st March 2018 *Please outline the work your agency has undertaken that has contributed to improved outcomes for **adults with care and support needs***	
Protection	Review of relevant policies. Development of Position of Trust policy and collaborative work with Human Resources.
Quality	Compliance with data gathering including sharing of Key Performance Data. Completion of safeguarding adult self-assessment. Refresh of the Deprivation of Liberty Safeguards (DoLS) policy and sourcing of DoLS eLearning. Increase in DoLS training compliance.
Prevention	Consistent use of the weekly Trust wide e-bulletin (available to all staff). Learning from case reviews in Safeguarding Link Worker meetings across the Trust. Consistent referral rates to the Local Authority of safeguarding concerns. Review and complete refresh of the in-house Level 3 Safeguarding training to include Prevent, domestic abuse signposting and modern slavery. Safeguarding signposting information available on the intranet.
Work planned to contribute to Safeguarding Adults Board priorities 2018/19 *Please outline how your agency intends to contribute to improving outcomes for **adults with care and support needs** over the coming year*	
Protection	Review the workload and expectations of the team to establish the most effective input and support internally and externally. Ensure that external reviews are administered through the newly developed Safeguarding Governance Process.

Quality	Ensure that there is consistent representation at internal and external safeguarding meetings, engaging more with clinical staff. Develop service improvement measures to monitor and audit the safeguarding system. Ensure relevant compliance and assurance reports are presented to Mental Health Act Legislation Group and Mental Capacity Act (MCA) practice is audited Mental Health Act (MHA) legislation group review and audit of application and practice, impact on compliance, training, service improvement, patient experience. To agree an audit plan in collaboration with the Safeguarding Boards and BCPFT divisions which is SMART (Specific, Measurable, Achievable, Realistic and Timely) and will impact on practice and safeguarding improvements.
Prevention	Review relevant safeguarding supervision policies and consider a mixed method of safeguarding supervision delivery including for example one to one, group and learning sets. Refresh the current training strategy to ensure it is fit for practice in line with national and local safeguarding drivers and KPIs (Key Performance Indicators)

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 adults with care and support needs.

The Trust has participated in three DHRs during the year.

Prevent training is now incorporated into the Level 3 Safeguarding Training and Level 1 Prevent Awareness is included within the Trust induction programme so all staff receive this training upon commencement of their employment.

Please provide any case study examples, relevant to Safeguarding Adults Board priorities, that can be included in the Annual Report

Case studies should clearly express the impact on and should be brief, no more than one or two paragraphs. Please include links to any relevant websites or online reports. You may also send us any images that support your case study.

A service user reported that her property had been targeted in a fire setting incident in a previous Borough of residence. She and her children were in the property at the time and the service user had subsequently moved location.

Actions taken- Practitioner spoke to Trust Safeguarding Lead who advised referrals to be made to Local Authority in respect of both the adult and children. The practitioner liaised with the MASH Social Worker who advised that the police are not pursuing the case any further at the request of service user. The practitioner referred the service user to the housing department for support and guidance regarding her accommodation options.

The service user subsequently made an informed decision to reside in her current location.

This was an excellent example of cross boundary/cross Borough working with the focus being on Making Safeguarding Personal and empowering the service user to make decisions the she felt were right for her and her children.

5. Sandwell & West Birmingham Clinical Commissioning Group (SWBCCG)

Organisation:	Sandwell & West Birmingham CCG (SWBCCG)
Completed by:	Marie Kelly - Designated Lead for Adult Safeguarding
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2017 to 31st March 2018 *Please outline the work your agency has undertaken that has contributed to improved outcomes for **adults with care and support needs***	
Protection	The organisation has participated in two SARs, developing stronger links with the Protection Sub Group. The recommendations will be cascaded across CCG member practices to ensure good practice is highlighted in relation to the recommendations made.
Prevention	The CCG has committed staff to undertake Learning Disabilities Mortality Review Programme (LeDeR) training to undertake a review of cases where a person has died whilst also have a learning disability. This will enable lessons learnt to be shared across the locality with all partners and embeds change if needed across the health economy. The CCG have also ensured that their website contains information for service users about safeguarding adults and contact details for anyone who may have concerns. There are also links to the SMBC website where there are further links to safeguarding, including links to policies and procedures The CCG also provide a Time2talk Service, where service users can provide any feedback, compliments or complaints. This service provides updates to the organisations Quality & Safety Committee enabling any actions or updates to be cascaded and shared appropriately. This committee has a direct link into the CCG Governing Body. The CCG actively encourages staff and member practices to utilise the Datix system to highlight any concerns, particularly in relation to safeguarding incidents. This enables any trends, training issues or concerns to be highlighted through the Quality & Safety committee.

Learning & Development	The joint SSAB/SSCB training brochure has been promoted and circulated across the organisation including member practices and has also been disseminated through the Chief Executives weekly news brief. The CCG also has an online level 2 safeguarding adult's module which staff complete on a 3-yearly basis and are encouraged to attend face to face training if deemed appropriate. The safeguarding team hosted a very successful multi-agency Female Genital Mutilation (FGM) conference in March which was very well evaluated. Work is continuing to gain momentum with the work around the CSE superhero campaign which the safeguarding team have been instrumental in developing, this highlights the risks identified particularly within the transition period for young people. The CCG has committed dedicated time for GPs and other clinical staff around learning lessons from DHR and SCRs for GPs and PREVENT awareness has been delivered at a recent organisational event. Sandwell and West Birmingham CCG has continued to fund the IRIS programme across 16 GP practices, where specialist domestic abuse training and support is available to enable practice staff to identify domestic abuse early and provide dedicated support to the victim through a designated specialist advocate linked to the practice.
Quality & Excellence	Provide an annual update to the organisations Governing Body at the public section regarding the partnership work achieved through the SSAB. Continue to be active members of the SSAB and Sub Group representation to fulfil statutory safeguarding responsibilities.
Work planned to contribute to Safeguarding Adults Board priorities 2018/19 *Please outline how your agency intends to contribute to improving outcomes for **adults with care and support needs** over the coming year*	
Accountably & Leadership	The CCG will continue to build strong links with the SSAB and the Sub Groups to ensure effective working together and safeguarding.
Learning	Additional funding for IRIS has been granted and the expansion of this programme across Sandwell will be undertaken during the planned year. Safeguarding adults training will continue to be actively promoted across the organisation and member practices. Lessons learnt around the recent local SAR's will be promoted at a safeguarding leads forum later in 2018. The GP safeguarding assurance toolkit will also be updated as required to share good practice around safeguarding adults.
Impact of abuse	The CCG will provide representation at the Prevention Sub Group which will ensure that all aspects and learning from abuse and SAR's are cascaded across the organisation. This will also ensure that the voice of the adult with care and support needs are firmly embedded across all partnership training.
Collaboration and Partnership	The CCG will continue to demonstrate its ongoing commitment to the work of the SSAB and the work of the Sub Groups.

Please provide any case study examples, relevant to Safeguarding Adults Board priorities, that can be included in the annual report

*Case studies should clearly express the impact on **adults with care and support needs** and should be brief, no more than one or two paragraphs. Please include links to any relevant websites or online reports. You may also send us any images that support your case study.*

(This is an ongoing case as the client still wants support)

A.M was referred to IRIS in November 2017 by her GP stating that a client has child contact issues between client and her ex-husband and needs support with this. The children are aged seven and eleven and have been emotionally affected by the domestic abuse they have witnessed. The client is experiencing mental abuse, verbal abuse and being isolated from friends and family. She also has a three-month-old baby with her new partner.

The Advocate Educator completed a Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and support plan with the client and she scored 10 on the DASH. The client was given information and a referral letter for a solicitor firm linked to the Black Country Women's Aid (BCWA) and was supported through the family courts. The client was afraid and nervous about being around her ex-husband at the two hearings and so being met at court and taken into a separate waiting room was very helpful to her. The Advocate Educator helped the client with decisions she had to make as the contact order was formulated and agreed upon. Both children were referred into BCWA children's team and supported by a specialised child support worker. Both children responded well to this intervention and were more settled and happier at home. The client has also been supported on an emotional level with visits every two to three weeks at the doctor's surgery where she feels safe and comfortable. These appointments were arranged after hours as the client worked full time and was only available after 5.30pm. The client is coming to terms with the abuse she experienced from her ex-husband and how to deal with the day to day contact due to the ongoing arrangements about contact with the children. Her confidence is improving and she has gone back to work following the end of her maternity leave. The client has expressed concerns about her new partner who appears to be controlling and not accepting of her children with her ex-husband. The Advocate Educator is continuing to work with the client to ensure that she is identifying any abuse abuse patterns with her new partner and correctly safeguarding her three children.

6. West Midlands Ambulance Service (WMAS)

Organisation:	West Midlands Ambulance Service (WMAS)
Completed by:	
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2017 to 31st March 2018 *Please outline the work your agency has undertaken that has contributed to improved outcomes for **adults with care and support needs***	
WMAS – Priorities 2017/18 – Adult Safeguarding Boards	
WMAS operational structures to support delivery of their adult safeguarding responsibilities *** Including how WMAS makes Safeguarding personal**	In 2017 / 2018 West Midlands Ambulance Service NHS Foundation Trust (WMAS) has continued to ensure the safeguarding of children, young people and adults at risk is a priority in accordance with the Working Together 2015 and the Care Act 2014. This report seeks to provide evidence of WMAS's commitment to effective safeguarding measures. The Safeguarding team works with the local Safeguarding Adult Boards (SAB's) The safeguarding team provide information and support to partner agencies for example safeguarding investigations, Safeguarding Adult Reviews (SAR's), Section 42 enquiries and Domestic Homicide Reviews (DHR's). Referral Process In July 2009, the Safeguarding Single Point of Contact (SPOC) was created. It was designed so that crews can make safeguarding referrals quickly and efficiently to a single point without the need for unnecessary paper trails and complex processes. All staff working within the SPOC have received training in safeguarding adults and children and PREVENT and receive ongoing education to ensure their knowledge is current. There is a dedicated telephone number which is staffed 24 hours a day, seven days per week; the SPOC is currently based within the Commercial Call Centre in Tollgate Staffordshire. Progress and Developments Safeguarding remains a high priority for WMASFT, there are regular items on the Learning Review and Governance groups. The last Care Quality Commission (CQC) inspection in June 2016 indicated the knowledge and awareness of safeguarding is embedded in the organisation, and the quality of referrals has increased dramatically year on year. The role of the safeguarding team is to ensure the Trust (from Frontline to Board) is kept up-to-date with national and regional documents, ensuring compliance against the statutory requirements, whilst taking care not to 'information-overload'. The Safeguarding Children Young People and Adults at Risk Policy and Procedure is due for review in May 2019.

SAR's

The aim of a Safeguarding Adults Reviews (SAR) is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame, it is to promote effective learning and improvement to prevent future deaths or serious harm occurring again. The aim is for agencies to work together towards positive outcomes for the adult and/or family involved.

Any learning identified for WMAS is taken to the WMAS Learning Review Group (LRG). By the end of 2017/2018 WMAS had been involved in 46 SAR's in total.

Safeguarding Communications

To communicate safeguarding topics a variety of methods are used. These include internal study days, Weekly Briefing Articles, Clinical Times and via learning review. In March 2015, the Safeguarding Team launched their safeguarding Website which gives all staff access to safeguarding information, including links and publications from each safeguarding board in the West Midlands. The Safeguarding team now have a Twitter account providing information to staff.

Professional Networks /External Stakeholders

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

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

From 2014/2015 WMASFT introduced a single Section 11 audit for all children's boards for 2014/2015 onwards and an adult Self-Assessment Framework (SAF) and a Learning disability SAF for all Adult boards. The feedback has proved to be excellent and reduced duplication of workload significantly**.**

	Quality Assurance The Safeguarding Team provide quality assurance to the Board via the Head of Organisational Compliance & Corporate and Clinical Effectiveness and the Director of Corporate and Clinical Services/ Deputy CEO. The Safeguarding team also produce section 11 audits as well as completing Safeguarding Adults Self-Assessment and Assurance framework for the Strategic Health authority along with a Learning Disability and Mental Health Self-Assessment. No areas were highlighted as less effective, the majority were rated as effective and some were rated as excelling. The Safeguarding Team have also undertaken a number of small audits with Local Authorities to ensure referrals are appropriate and address any areas which may require improvement. In 2017/2018 alongside the implementation of our Prevent Delivery Plan, we have also provided quality assurance through our Prevent Assurance Tool.
Safeguarding Training	**Board Assurance and Training** The safeguarding team provided a safeguarding session to the Trust Board (WMAS) on the 28 February 2018 which included Adult and Child Safeguarding and Prevent awareness. In 2017/2018 The WMAS Prevent Delivery Plan was formally signed off. This details the training levels and requirements for PREVENT and WRAP training. This has been a period of transition and following the recommendations of the Intercollegiate Document (2014) flexible learning opportunities have been offered via virtual learning (VLE) and the Mandatory Workbook. Safeguarding topics have been included in both the Weekly Briefings (internal staff bulletin) and Clinical Times internal publications All new staff attend a corporate induction which includes Safeguarding Level 1 training. Audits are planned for 2018/19 which will identify the effectiveness of the training and the learning opportunities. In April 2015, new online eLearning packages were developed in partnership with EduCare which included modules on adult safeguarding, child safeguarding and mental capacity. All staff within WMAS are required to complete their Mandatory Workbook available electronically and printed where required. This includes a 70-page section on safeguarding aligned to level 2 and Prevent, these include questions each year over the 3-year period. At the end of 2017/2018 **99.41%** of staff have completed Mandatory Update and **82.96%** have completed Mandatory Workbook so far (both of which included Safeguarding). These figures exclude new starters and staff on Maternity Leave.
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 Liaison Service (PALS) and our Patient Experience team to collect and collate feedback from services users to feed into training, information, policies and procedures where appropriate.

Key Safeguarding achievements	**Key Achievements** • Safer sleep leaflet – The Safeguarding Team have produced guidance to give parents advice on reducing the risk of Sudden Infant Death Syndrome (SIDS) through safer sleep, which is now on all front-line vehicles and will be shared with parents of children under 12 months. • WMAS are one of the first ambulance trusts to be selected to pilot CP-IS over coming months. • West Midlands Ambulance Service have consistently achieved Level 1 in our Prevent responsibilities evidenced in reporting via NHS England. • Introduction of Safeguarding app on Electronic Patient Record, which can be utilised by clinicians for advice. • The Safeguarding Team have undertaken a number of small audits with Local Authorities, with larger internal audits planned for quality of referral and staff knowledge checks. • The Safeguarding Team have continued to receive positive feedback around the engagement invested with Safeguarding boards, local authorities and other • agencies. • Introduction of a monthly 'Safeguarding Newsletter' covering a variety of safeguarding subjects such as Domestic Abuse, CSE and FGM • Increased engagement of Safeguarding Team with staff both face to face and via social media to enable discussion and advice.
Work planned to contribute to Safeguarding Adults Board priorities 2018/19 *Please outline how your agency intends to contribute to improving outcomes for **adults with care and support needs** over the coming year*	
	Priorities for 2018 / 2019 • Continue to invest in engagement with adult, children boards, CDOP's and other partner agencies, building on existing relationships. • Ensure focus remains on quality assurance, including further audits on staff knowledge and quality of referrals. • Continue collaboration with NHS England to deliver Prevent strategy, ensuring Level 3 WRAP training for frontline staff, targeted training for specific staff groups such as mental health triage car and engagement with local universities delivering Student Paramedic Programme. • Continue to embed lessons learnt from SCR's, DHR's, SAR's and CDOP's and share with wider organisation through the internal Learning Review Group (LRG and key staff communications).
Please provide any case study examples, relevant to Safeguarding Adults Board priorities, that can be included in the annual report *Case studies should clearly express the impact on **adults with care and support needs** and should be brief, no more than one or two paragraphs. Please include links to any relevant websites or online reports. You may also send us any images that support your case study.*	

Case 1

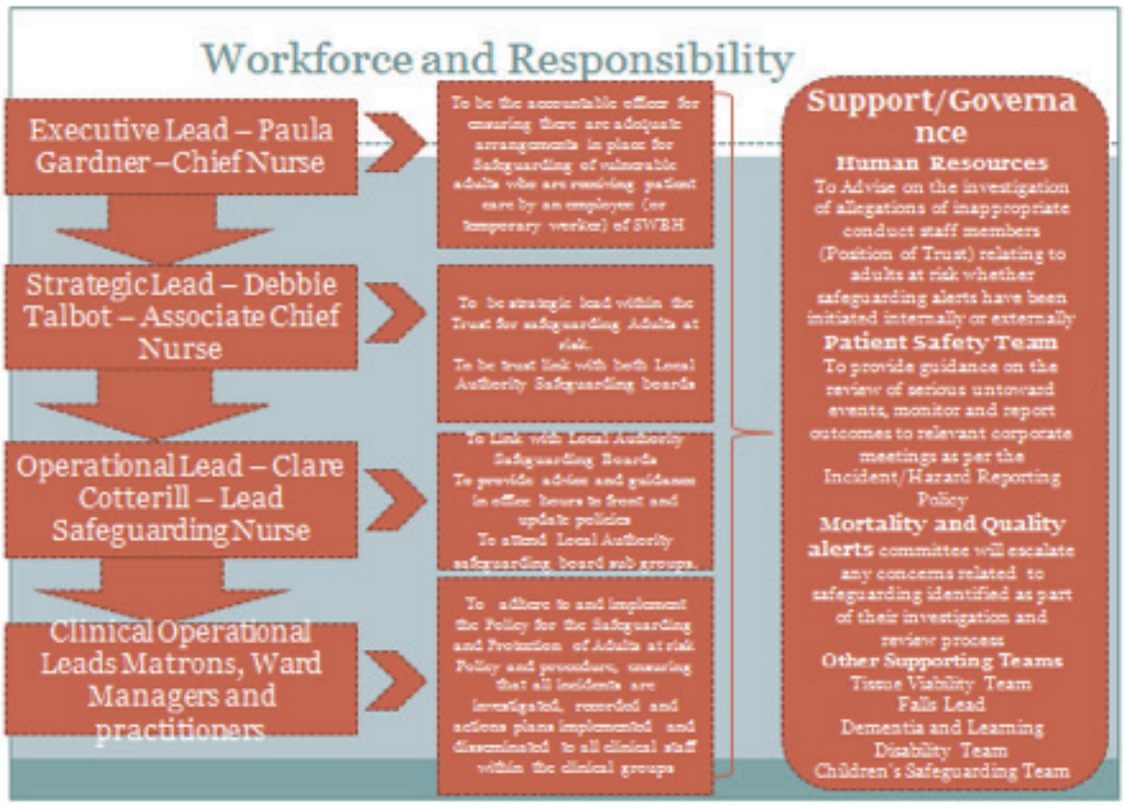
West Midlands Ambulance Service NHS Foundation Trust responded to an adult female who was experiencing a mental health crisis and had expressed thoughts of ending her life and that of her baby. Although the child's father resided within the property, it was alleged that father was the perpetrator of domestic abuse towards mother, and neither parent was meeting the needs of the child. Mother had also reportedly disappeared with child, and although child was kept warm, mother had no bottles or nappies for child to meet needs. WMAS conveyed Mother and Child to place of safety in conjunction with police and referral made to Local Authority where this progressed to section 47 enquiry.

Case 2

West Midlands Ambulance Service NHS Foundation Trust responded to a 999 call to an unconscious adult patient. On crew arrival, it became apparent the condition of the patient was due to illicit drug use. In the property were two young children under the age of three who were under nourished, in soiled nappies and clothing and were not having their basic needs met. Further resources including second ambulance and police requested. The immediate clinical needs of the adult and children were met and conveyed to hospital and referral to Emergency Duty Team made to provide intervention.

7. Sandwell & West Birmingham Hospital Trust

Organisation:	Sandwell and West Birmingham Hospitals (SWBH)
Completed by:	Clare Cotterill - Adult Safeguarding Nurse
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2017 to 31st March 2018 *Please outline the work your agency has undertaken that has contributed to improved outcomes for **adults with care and support needs***	
SSAB will continue to seek assurance with reference to organisational accountability and leadership in respect of Safeguarding Adults	SWBH have a clear safeguarding structure of accountability, the structure of which is outlined below. Any acute or ongoing concerns are escalated at quarterly safeguarding steering groups for executive review. Chief Nurse presents an annual report.



	Operational Adult Team is comprised of • Adult Safeguarding Lead and responsible for delivery and adherence to the care Act 2014 • Application Mental Capacity Act 2005 and Deprivation of Liberty Safeguards • Compliance with Modern Slavery Agenda • Compliance with Prevent Agenda • To Provide advice for staff
SSAB will continue to contribute to a learning culture and invest in training	• SWBH have a commitment to provide Adult Safeguarding training to its staff. • Training strategy in place for level 1, 2 and 3 related to vulnerable adults. This includes Prevent training. This is compliant with the intercollegiate document produced to give health care staff guidance. • Compliance target is 85%. Training and Targets are monitored by the care commissioning group and a financial penalty imposed if the organisation fails to reach its target. • SWBH will provide IMR reports for SARs where the organisation has been involved. • SWBH actively contribute/participate in SARs, reviews and disseminate learning • Safeguard incident reporting system in place.

SSAB will ensure there is a robust understanding amongst board members and all partners of all aspects of abuse and the impact on adults with care and support needs	• SWBH have both a strategic executive Lead and Operational lead (as outlined in structure) • Training strategy • SWBH attend steering groups that relate to Learning Disabilities and Prevent. • SWBH attend conferences and share updates via the organisations communication department. • Safeguarding Team publish a Safeguarding topic every 2 months that relates to Safeguarding. • SWBH have policies that relate to the following topics 1. Assessing Mental Capacity 2. Self-Harm Policy 3. Missing person policy 4. Falls policy 5. Mortality Review policy 6. Information Sharing policy 7. Adult Safeguarding Policy (Includes all categories of abuse) 8. Therapeutic and observational Policy (Includes risk assessment for focused one to one care)
SSAB will give a demonstrable ongoing commitment to continuing to work with 4 key boards	• SWBH attend Safeguarding Board and provide presentations. • SWBH attend SAR's, SSAB Sub Group and support events. • SWBH contribute to the SSAB Annual Report and offer assurance. • SWBH provide quarterly report for Certified Quantitative Risk Management
Work planned to contribute to Safeguarding Adults Board priorities 2018/19 *Please outline how your agency intends to contribute to improving outcomes for **adults with care and support needs** over the coming year*	
SSAB will continue to seek assurance with reference to organisational accountability and leadership in respect of Safeguarding Adults	• SWBH will be producing an independent Annual Report for the executive lead (Chief Nurse) to present at Board Meeting. • Quarterly steering group will continue to ensure concerns are escalated • SWBH will be participating in the leadership programme
SSAB will continue to contribute to a learning culture and invest in training	• SWBH training strategy has a 3-year trajectory. • CCG will continue to oversee this.

SSAB will ensure there is a robust understanding amongst board members and all partners of all aspects of abuse and the impact on adults with care and support needs	• SWBH will continue to attend steering groups, Board meetings and conferences. • Learning will be reflected in policies and disseminated to the work force. • Safeguard incident reports will be monitored and reviewed for trends. • Safeguarding team will continue to update information leaflets and training needs. • Safeguarding team will undertake regular audits of sample referrals to the Local Authority and application of the Mental Capacity Act. Results and gaps will be fed back to clinical areas and at safeguarding steering group to achieve service improvement.
SSAB will give a demonstrable ongoing commitment to continuing to work with 4 key boards	• SWBH will continue attendance at Board meetings • SWBH will continue to participate in SAR's group • SWBH will continue to provide an overview of Adult and Children's safeguarding within Clinical Service Quality Measures (CQRM) reports. The organisation will be represented at meetings.

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 adults with care and support needs

SWBH also serve Birmingham Safeguarding Board and are committed to risk enablement. This involves balancing wellbeing and risk. Educating the work force on positive risk taking which may for example lead to discharging a patient (with capacity) home. Having insight that they may fall but balancing risk with least restrictive care and meeting the person's outcomes. Understanding that senior management will support the right outcomes even if the person does come to harm.

Please provide any case study examples, relevant to Safeguarding Adults Board priorities, that can be included in the annual report

*Case studies should clearly express the impact on **adults with care and support needs** and should be brief, no more than one or two paragraphs. Please include links to any relevant websites or online reports. You may also send us any images that support your case study.*

Subject is a 67-year-old lady who attended the Emergency Department frequently. Most visits were due to alcohol intoxication and social problems. The patient had been exposed to sexual abuse and has had two violent marriages. The lady was recently financially abused by "friends" which was substantiated in a Local Authority investigation but no charges were brought against the perpetrator at the patient's wishes.

The Homeless Team assisted in finding her accommodation on numerous occasions but due to displaying violent and aggressive behaviour she would be evicted from the accommodation. Sandwell Housing discharged duty of care.

Numerous safeguarding referrals were completed along with referrals to alcohol services. The patient has full capacity and therefore safeguarding cases have been closed as she hasn't cooperated with alcohol services.

The patient was referred to SWBH Safeguarding Team by the Homeless Team after 29 Emergency Department visits within six months and concerns for her safety and vulnerability with no option to home her were escalating.

A Best Interest Meeting with the subject present and at the heart of the discussion was held. Professionals who attended included a social worker, past housing managers, alcohol services, complex discharge nurse, community liaison nurse, manager of the subject's previous tenancy in supported accommodation and SWBH Safeguarding Team.

During the meeting, it was discovered that the patient still had an open tenancy with a supported living organisation. The supported living organisation had submitted an application to the courts to end the tenancy. The judge had not agreed to this as it was felt there was not enough evidence. The patient could not return due to an active injunction after displaying aggressive behaviour.

The subject was informed of the severity of her behaviour and how vulnerable she was particularly when intoxicated and that she was in this situation due to her own actions which she understood. During the meeting, she was keen to accept alcohol support.

The housing solution agreed was that the subject would independently (with support of resources around the table) close her tenancy with the supported living organisation and search in the private sector for accommodation.

Social services offered to help her protect her money but the patient declined but continued to verbally report she was committed to sustaining from alcohol and therefore would be in a position where she could protect her own money.

Unfortunately, during this process, the patient left the ward and began to consume alcohol. Whilst the outcome was not optimum her right to make choices and Mental Capacity Act was adhered to. Multi agency working was commendable.

8. Domestic Abuse Strategic Partnership

Organisation:	Domestic Abuse Strategic Partnership (DASP)
Completed by:	Maryrose Lappin - Domestic Abuse Team Manager
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2017 to 31st March 2018 *Please outline the work your agency has undertaken that has contributed to improved outcomes for **adults with care and support needs***	
Protection	Domestic abuse is a significant issue both locally and nationally, and partners in Sandwell's Domestic Abuse Strategic Partnership (DASP) have continued to work hard in the last year to raise awareness; provide support to victims and families and challenge perpetrators. DASP has sought to increase reporting of domestic abuse, so that victims and their children can access the support they need at the earliest opportunity to prevent further harm and reduce the risk of homicide. Reports of domestic abuse to the police increased in 2017-18 by 7.4% compared to the previous year. **Support to victims and families** Black Country Women's Aid (BCWA) is commissioned by Sandwell MBC and the Safer Sandwell Partnership to provide specialist community-based support for victims of domestic abuse and sexual violence and their families. BCWA provide a range of bespoke support to victims, including advice & guidance, one-to-one casework and groupwork programmes for victims. They also provide refuge accommodation for victims of domestic abuse and their children. BCWA provided support to over 2,500 victims through this provision. 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, adult and 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. 572 high risk victims of domestic abuse were supported by MARAC in 2017-18, a 22% increase on the previous year. **Work with perpetrators** Sandwell MBC commissioned Fry Accord Housing Trust to deliver a pilot behaviour change programme for perpetrators of domestic violence and abuse (DVA) which operated from Nov 2015 till Sept 2017. 95 perpetrators completed the programme during that time. An evaluation by the University of Birmingham has indicated evidence of positive change for those who have completed the programme and identified that the programme was value for money. DASP have also worked with the West Midlands Police & Crime Commissioner and Children's Services to support the implementation of the My Time domestic

	violence perpetrator programme delivered by the Richmond Fellowship. This is a 30-week Respect accredited programme aimed at fathers who are perpetrators of domestic abuse and whose children are on child protection plans. The first cohort of men will complete the programme in the early months of 2018-19.
Prevention, Learning & Development	**Domestic Homicide Reviews** When someone dies because of domestic abuse, local Community Safety Partnerships are required to undertake a multi-agency review of the work undertaken by partner organisation with the victim, perpetrator and family. The purpose of Domestic Homicide Reviews (DHRs) are to identify lessons to help improve responses to victims and reduce the likelihood of future deaths from domestic abuse. Partners in the Safer Sandwell Partnership have undertaken substantial work in 2017-18 on DHRs and local reports have been published. A newsletter summarising the learning from DHRs highlights a number of lessons for local partner organisations. The information can be found at; http://www.sandwell.gov.uk/info/200324/domestic_abuse/2831/domestic_homicide_reviews One of the lessons from DHRs is the important role which health professionals can play in helping to identify victims of domestic abuse early and ensure they receive specialist support. DHRs have identified that there are often missed opportunities to do this and the IRIS domestic abuse programme with GPs in Sandwell and work undertaken in A&E is helping to address this. **The IRIS domestic abuse programme - GPs** 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. Funding support from SWBCCG has enabled work on the IRIS programme in Sandwell to continue to support the first cohort of 16 Sandwell GP practices in 2017/2018. The number of victims of domestic abuse identified by those GP surgeries and referred for specialist support has increased during the year. Additional money from the Safer Sandwell Partnership has enabled an additional advocate to be employed and a further 25 practices have expressed an interest in joining the IRIS programme across Sandwell. This should enable victims of domestic abuse to be identified at an earlier point, thus supporting recommendations in DHRs.

The Accident & Emergency Advocacy Programme

The Accident & Emergency Advocacy Programme is a partnership project between Black Country Women's Aid (BCWA) and Sandwell & West Birmingham NHS Hospitals Trust. The project has been funded by the Hospitals' Charitable Trust. It aims to improve the early identification of and response to survivors of domestic 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. During November 2015 - March 2017, 192 domestic abuse victims were identified and referred to appropriate support.

Multi-agency training on domestic abuse

Sandwell's Safeguarding Adults Board works closely with colleagues in other strategic partnership groups to ensure there is effective multi-agency training on a wide range of safeguarding issues. It is vital that frontline officers and managers in all organisations working with adults, children and families know how to recognise domestic abuse and know what to do to ensure victims and families are effectively supported. There is a range of domestic abuse training available on offer to partners, from introductory e-learning to improve awareness to face-to-face training on domestic abuse, forced marriage & honour based abuse, female genital mutilation, sexual violence, stalking, and learning from domestic homicide reviews. 612 officers attended training in 2017-18. Details of the training programme for 2018-19 and how to book can be found at;

http://www.sandwelllscb.org.uk/learning-development/training-booking/

Female Genital Mutilation

Work to address female genital mutilation (FGM) has continued to be undertaken by the Sandwell Stopping FGM sub group of the DASP. This group have produced the Sandwell policy and procedures to address Female Genital Mutilation. The procedures provide professionals, practitioners and anyone working with adults, children and young people with an understanding of FGM and what action they should take to safeguard girls and women who they believe may be at risk or have already undergone FGM.
http://www.sandwell.gov.uk/downloads/file/24516/sandwell_policy_and_procedures_to_address_female_genital_mutilation

The Sandwell Stopping FGM forum has active involvement from a wide range of community groups. These developments culminated in a Health and Wellbeing event in July 2017, supported by numerous partners, providing an ideal opportunity to raise awareness of FGM and community support which was available. This event was attended by approximately 150 people and it is anticipated that other events will be scheduled moving forward.

An event to raise awareness of FGM was held on International Women's Day this year (8th March 2018) which was well attended and well received.

Quality & Excellence	A multi-agency audit of domestic abuse was organised by the Safeguarding Children Board in February 2018. The audit examined 5 cases in detail, and explored many questions including: Is there sufficient focus on perpetrators; is there inappropriate blame placed on victims for the abuse; are the needs of children appropriately considered. The audit identified some excellent practice and some areas for improvement. The learning from the audit is here; http://www.sandwelllscb.org.uk/wp-content/uploads/2017/11/7-minute-briefing-DA-JTAI-Final.pdf
Work planned to contribute to Safeguarding Adults Board priorities 2018/19 *Please outline how your agency intends to contribute to improving outcomes for **adults with care and support needs** over the coming year*	
This is reflected in the overview as already referenced.	
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 adults with care and support needs	
This is reflected in the overview as already referenced.	
Please provide any case study examples, relevant to Safeguarding Adults Board priorities, that can be included in the annual report *Case studies should clearly express the impact on **adults with care and support needs** and should be brief, no more than one or two paragraphs. Please include links to any relevant websites or online reports. You may also send us any images that support your case study.*	
This is reflected in the overview as already referenced.	

9. 4 Boards

Organisation:	Statutory 4 Board Chairs Group (Health and Wellbeing Board, Sandwell Safeguarding Adults Board, Sandwell Safeguarding Children's Board, Safer Sandwell Partnership, Police and Crime Board)
Completed by:	Rachel Allchurch - Health and Wellbeing Board Project Officer, Tessa Mitchell - Business Manager – Community Safety and Resilience and Deb Ward - SSAB Operations Manager
Work undertaken to contribute to Safeguarding Adults Board priorities from 1st April 2017 to 31st March 2018 *Please outline the work your agency has undertaken that has contributed to improved outcomes for **adults with care and support needs***	
Prevention of Violence and Exploitation	Each statutory Board agreed to lead on identified work-streams within the Prevention of Violence and Exploitation (PoVE) umbrella. The 4 Boards designed and held a multi-agency learning event on tackling violence and exploitation together – to raise awareness of exploitation. Cabinet member workshop on PoVE took place on 7th March to brief cabinet members on the key themes for PoVE and the umbrella work-streams. PoVE pledges were completed by cabinet members and Directors as to how they would support PoVE and ACEs. Restructuring of the SSP (Safer Sandwell Partnership) into themes: Our priorities for 2018-19 are: • Prevent violence and exploitation • Reduce offending and organised crime • Solve problems in your neighbourhoods – including tackling crime and anti-social behaviour (http://www.sandwell.gov.uk/asb) • Protect and support vulnerable victims A PoVE Sub Group of the SSP will be established and a dedicated member of staff recruited to oversee this work-stream. HWB – will lead on the adverse childhood experiences, following the successful Adverse Childhood Experiences (ACEs) workshop held in July 2017, which was designed with other key agencies alongside the 4 Boards to raise awareness of ACEs and a work-shop to understand the prevalence of ACEs locally. SSAB Adult Abuse/self-directed violence. Modern Slavery, PREVENT, domestic abuse, youth and knife crime, gangs and organised crime and hate crime

	The 4 Board Managers have been building on formalising relationships to ensure a reflective infrastructure to capture agreed themes and priorities ensuring greater consistency and working together (development and agreement of the partnership protocol).
Work planned to contribute to Safeguarding Adults Board priorities 2018/19 *Please outline how your agency intends to contribute to improving outcomes for **adults with care and support needs** over the coming year*	
	The new Safer Sandwell strategy and work-plan 2018-2021 will be published making links to the PoVE work.
	Mid-way review of the Joint Health and Wellbeing Strategy to ensure safeguarding links are made.
	Supporting and influencing the Vision for 2030 work and the evidence framework to measure its progress.
	We plan to explore the short-term appointment of a graduate to support and coordinating the 4 Board programme and its specific themes.
	Sandwell has been chosen as a pilot for Homes First which will focus on the provision of accommodation for rough sleepers with targeted support covering a range of vulnerabilities – to start September 2018
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 adults with care and support needs	
Revamped ASB (Anti-Social Behaviour) process to focus more on the situational vulnerabilities	

Lay Member Contribution from Ann Byrne

"People say that you only really embed information when you've explained it to somebody else. Well, since taking on the role of lay member two years ago, I've explained my role to work colleagues so many times that I feel that I finally understand it myself! I'm the one who's not in the woods already – I don't work with adults with care and support needs as the full Board members do – so hopefully, I can see the forest. In context, when a group of professionals meet to discuss issues around safeguarding, I'm there to ask the 'silly questions' that others may not – 'What does that piece of jargon mean?'; 'Who is responsible for helping that person now then?' This does, I hope, help to add a little focus to discussions and perhaps to widen thinking about particular issues.

I've never failed to be impressed by the commitment of the Board members and have become aware of the vital role that it serves in bringing together representatives from all of the diverse professions involved in the care of adults in Sandwell who need that extra level of support. Most meetings start with a 'Good News Story' which is presented by one of the bodies represented there - and although I've found some of these to be presenting a far less than perfect outcome, they have probably been the most useful part of my induction into the world of adult safeguarding. They also mean that meetings start with a heavy dose of realism. I admit that it took a few meetings to work things out but as my confidence has grown, so has my ability to comment and sometimes challenge during meetings.

Although over the last year, my participation has been limited by my own health, I'm looking forward to becoming fully active in the role again. I'm particularly excited to be offered the opportunity to participate in safeguarding training and expect this to both strengthen my own understanding and my usefulness to the group. The chance to potentially become involved in delivering safeguarding training adds a new and more professional dimension to my role. It's never easy to juggle voluntary commitments with a full time job and I can understand why this role can be hard to fill. It is still, however, one decision that I am very glad to have made."

Sub-group contributions

Quality and Excellence Sub-Group

Service User Experience

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

N/A to group – however leaflets are available and information regarding the referral process for all partner organisations and the public.

How do service users give feedback regarding safeguarding processes?

N/A to group – however any feedback from operational safeguarding will be reflected in the performance dashboard presented to the Board quarterly.

How do you evidence your activity has made a difference?

Feedback at forums and events – interaction with partners and other agencies.

Compare safeguarding data with previous quarters and years.

Report back quarterly to other Sub Groups and Board.

As a Sub Group can you identify your key safeguarding achievements for the year 2017/18?

- Creation of new performance dashboard template.
- Creation of safeguarding self-audit tool for all partners and agencies.
- Hosting the annual SSAB conference alongside the Prevention Sub Group and celebrating the fantastic work achieved in the Borough.

What were your identified priorities for 2017/18 and what are your current priorities for the forthcoming year as identified in the Strategic Plan?

2017/18

- A re-launch of the Sub Group with all statutory partners fully represented.
- Develop a multi-agency audit template.
- Agreement of quantitative and qualitative data required to give the Board assurance of safeguarding quality and processes.
- Support the development of service user engagement forum and engagement plan.
- 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.

2018/19

- Continue to support the development of the Quality & Excellence Sub Group membership.
- New performance dashboard has been developed, however it continues to be reviewed and there is an intent to reflect qualitative data required to give the Board assurance of safeguarding quality and processes.
- To monitor the appropriate use of the Deprivation of Liberty Safeguards making comparisons regionally and nationally.
- Monitor the implementation of Making Safeguarding Personal and the impact for service users via the new service user engagement plan.
- Ensure the appropriate use of advocacy.
- Support the development of service user engagement forum and engagement plan.
- Involvement in the annual SSAB conference

Training

What training has been provided to staff?

SSAB face to face training in Awareness Raising in Safeguarding Adults, Safeguarding for Managers and Practitioners, was made available for all partners and agencies.

e-Learning was also updated to include the following packages:

- Safeguarding Adults for Non-Adult Services
- Domestic Abuse Awareness
- Child Sexual Exploitation
- Modern Slavery and Human Trafficking
- The Mental Capacity Act
- Hate and Mate Crime
- The role of the Social Worker in Adult Safeguarding
- Safeguarding for Adult Service Workers
- Self-Neglect
- Deprivation of Liberty Safeguards
- Introduction to Hoarding
- Safeguarding Adults
- Basic Safeguarding

Performance Data

Who (posts and responsibilities) has received training?

Available to all partners and agencies

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 trends and to provide 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?

The Board is assured that statistics and practices are in line with national and regional guidelines as reflected in the performance dashboard quarterly.

Prevention Sub Group

Service User Experience

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

Leaflets are available promoting the 'See Something, Do Something' campaign to promote awareness and give advice for the public on who to contact. There is also information available on both the Sandwell MBC website and the SSAB website on the referral process accessible to partners, organisations and the public.

How do service users give feedback regarding safeguarding processes?

Feedback is obtained at outreach events and activities and during training sessions.

How do you evidence your activity has made a difference?

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

In 2017/18 the SSAB attended the following community events:
Sandwell Council for Voluntary Organisations breakfast network meetings, we also

had a presence at all of the Sandwell Safer 6 meetings in each of the 6 towns across the borough as well as holding information stalls at the following events: Celebrate Sandwell Information Network, Sandwell Mental Health Peoples Parliament community place of safety, Tackling violence and exploitation together, AgeUK's Winter Warmth event, Community and faith based safeguarding event, National Hate Crime Week at Sandwell College and the Terence Higgins Trust – Healthy Christmas event.

As a Sub Group can you identify your key safeguarding achievements for the year 2017/18?

Increased outreach activities

Successful conference, best practice forums and events

Safeguarding briefs for agencies that do not require formal training but need volunteers etc to have an awareness.

Introduction of Train the Trainer training for Safeguarding awareness so organisations can have their own inhouse trainer to address safeguarding training backlogs.

Production of quarterly newsletters

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

Feedback at outreach events and activities and training and learning opportunities

What were your identified priorities for 2017/18 and what are your current priorities for the forthcoming year as identified in the Strategic Plan?

2017/18

- To adopt 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 identification of effective support to be delivered in a timely fashion including oversight of the provision of support to victims of violence
- Facilitate conference with a prevention focus to consider:
  - What is adult safeguarding
  - What is happening in Sandwell
  - Significant operational changes
  - Current campaigns
  - Key messages
- Scoping exercise identifying range of prevention work happening within statutory services and wide community
- Ensure Making Safeguarding Personal 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

2018/19

- To develop a specific issue campaign accessing all media options.
- Enable identification of effective support to be delivered in a timely fashion
- Embrace and promote Prevention of Violence theme
- Scoping exercise identifying range of prevention work happening within statutory services and wider community
- Host an annual conference
- Increase best practice events
- Relaunch Prevention sub group

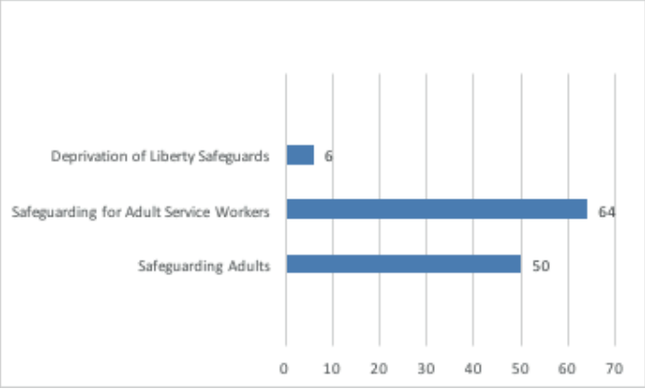
- Review Competency Framework and L&D
- Develop new eLearning and face to face training platform and booking service

Training

What training has been provided to staff?

- Safeguarding Adults for Non-Adult Services
- Domestic abuse Awareness
- Child Sexual Exploitation
- Modern Slavery & Human Trafficking – Core Skills
- The Mental Capacity Act
- Hate & Mate Crime
- The Role of the Social Worker in Adult Safeguarding
- Safeguarding for Adult Service Workers
- Self-Neglect
- Deprivation of Liberty Safeguards
- Introduction to Hoarding
- Safeguarding Adults

Safeguarding e-Learning 2017/18



eLearning was suspended from December 2017 due to the end of the learning providers contract. eLearning resumed with a new provider in April 2018.

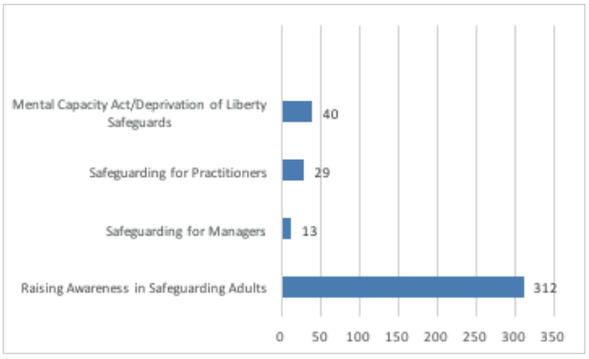
Safeguarding Face to Face Training 2017/18

Face to face courses

- Raising Awareness in Safeguarding Adults
- Mental Capacity Act/Deprivation of Liberty Safeguards
- Safeguarding for Practitioners
- Safeguarding for Managers

In addition to this several events were organised and extremely well attended.

Events;
Prevention Conference
Disability Hate Crime Event
Trading Standards Best Practice Event



Performance Data

Who (posts and responsibilities) has received training?

Available to all partners and agencies

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. Also, annual training needs analysis.

How do you use the performance data?

For 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?

By 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

Protection Sub Group

Service User Experience

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

When the SAR policies and procedures were re-written in 2016, this included for the first time a leaflet for families and an easy ready leaflet. Both have been reviewed again and will be available on the website soon. The SSAB website and websites of our partners includes information about safeguarding and about making safeguarding personal. Additionally, partners share information to service users in a variety of ways, at GP surgeries and hospital wards for example. Such information, includes Domestic abuse, Prevent and general Safeguarding. Safeguarding officers are available in many partner organisations where they can offer advice and support.

How do service users give feedback regarding safeguarding processes?

Our subgroup members have a range of ways of collating feedback including comments, compliments and complaints. There is also a duty of candour built into safeguarding incident reporting and complaints processes, direct feedback and surveys such as "friends and family surveys"; Patient Councils; Expert by Experience Meetings. Practitioners are encouraged through the Making Safeguarding Personal initiative that is promoted in Training, support calls and leaflets to seek the patient's/ service user's views.

How do you evidence your activity has made a difference?

Our subgroup members have a range of ways to learn about the quality of safeguarding activity; this includes escalation groups, quality and improvement groups. Some partners use comprehensive dashboards, dip sampling and case track reviews. Through patient's testimonies recorded during Multi-disciplinary meetings or review meetings with practitioners. The group also works collaboratively with the Prevention and Quality and Audit subgroups to learn more about community trends for example.

As a Sub Group can you identify your key safeguarding achievements for the year 2017/18

This year has included a substantial amount of SAR activity, with two being actively processed and a further one being considered. These activities require prompt responses to SARs group queries/IMRs participation in action plans, ensuring a proactive and partnership approach to learning. Furthermore, many DHRs are to be presented to the group so that we can ensure our SAR processes are robust and congruent with other processes. This process helps to develop learning and improve outcomes for people in Sandwell by reviewing internal processes and providing support to members.

Some partners also report a better understanding and application of MCA 2005 and wider understanding of risk enablement.

Reviews of relevant policies have also taken place across the group.

Most partners have a Safeguarding Adults Strategy and Audit plans and develop a culture that provides assurance that staff have the right knowledge to raise Safeguarding concerns and respond appropriately to safeguarding concerns.

Communication between Local Authorities and providers/ clinical groups to ensure that feedback is received by clinical teams about safeguarding referrals.

Consistent representation at internal and external safeguarding meetings with clear reporting frameworks. Some partners including BCPFT work alongside Seven Safeguarding Boards which impacts upon overall practice and safeguarding improvements.

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

Learning from the SAR's thus far has included a number of distinct changes; this includes: senior managers from SMBC and the CCG meeting on a weekly basis to discuss how best to work together to resolve complex situations which often involve hospital discharges. The group is well attended by a range of partners and this as such, there is multi- disciplinary participation at board meetings and sub groups. Some partners including SWBH Maintains a dashboard for DoLS applications Monthly audits and reports to the board in relation to risk assessments and applications.

The CCG has updated its safeguarding toolkit for GPs to include a more comprehensive adult focus and GPs are also encouraged to attend the quarterly safeguarding forums. WMPS have also circulated a new safeguarding policy which the subgroup was able to contribute to.

Most partners including BCPFT have a range of mandatory training which is audited and is well attended which helps to ensure best practice. Learning from internal auditing such as Datix reports (internal incident reporting system). Across partner organisations, Personal Development Reviews are undertaken for all staff and where relevant the individual's learning or support needs relating to Supervision can be evaluated.

What were your identified priorities for 2017/18 and what are your current priorities for the forthcoming year as identified in the Strategic Plan?

Care Act compliance – ensure local policies and procedures are written in line with West Midlands guidelines and agreed by the Board. This has been achieved to with policies and procedures to date and have been disseminated to partners. For example, the subgroup has sought to ensure that any new polices such as Self Neglect; or The Hoarding Pathway reflect requirements stipulated in the Care Act, particularly in terms of Care Act concepts of wellbeing. Such agreements have been further agreed at Board.

Safeguarding Adult Reviews (SARs) are undertaken as required, reports produced and action plans written and initiated as a result. Monitoring of Action Plans and providing the appropriate reassurance to board members that such outcomes have been met accordingly. This work also includes the co-ordination of all SAR referrals as required, including completion of West Midland repositories and the relevant learning from this repository. This also requires collaboration with the Prevention Sub-Group to ensure learning around such SARs.

The SAR policies, procedures, referral documents, templates, guidance and leaflets were all re-written early in 2017 with contributions from volunteers in the Protection Sub-Group. Most of the documents including the referral form, the IMR guidance, templates and Terms of Reference have been used in practice and all have been approved at board and are awaiting final publication to website.

The sub-group reviewed national guidance about Persons in Position of Trust Guidance to ensure understanding and scrutiny amongst partners. This will be taken to board in April 2017 and should be completed by July 2017. Further review is to be undertaken at regional level.

Going forward, we will need to have oversight of the multi-agency suicide and self-harm policy which is currently being developed locally. Sandwell MBC is currently working with Commissioners from partner organisations and with services user groups to this end and contributions from the Protection Sub Group has been offered. The group has also reviewed documents such as Self Neglect, as a new regional document was produced and which the group and board have agreed to adopt.

Terms of Reference have also been reviewed in line with GDPR.

Additionally, the sub-group is aware of Sandwell's inclusion in a new initiative called DRIVE which works with high risk Domestic

Violence Offenders. The sub-group has representation from Black Country Women's Aid and further updates will be sought.

Lead Safeguarding Nurse feeds into Safeguarding steering group and executive Board and participation at Board meetings and sub groups.

Training

What training has been provided to staff?

In October, a learning event took place, this was well attended and presented the outcomes and final reports from the two SARs which were commissioned in 2016. Staff in partner agencies such as the CCG and SWBH have also produced data to confirm numbers of staff training in safeguarding at levels 1,2 and 3 for target groups. Compliance is monitored by CCG and fines are imposed for targets below 85%. Other partners including BCPFT have mandatory safeguarding, MCA, DoLS and Prevent and training which is attended by between 92% and 98% of relevant staff; this helps to ensure best practice.

Prevent training is also mandated to identified groups in many partner organisations. The SSAB has produced a joint training catalogue with the Children's Safeguarding Board and this has also been disseminated to partners.

Who (posts and responsibilities) has received training?

Lead Officer for Protection Michelle Moore was seconded to the West Midlands Teaching Partnership and completed a teaching course and a PG research module. Seconded Lead Officer for Protection Charmain Stevens attended a suicide and self- harm course in Manchester; and Clare Cotterill (Lead Nurse SG- SWBH) and Marie Kelly- SWB CCG Assistant Designated Nurse Safeguarding Children) are in the process of completing an MA in safeguarding. The joint SSCB/SSAB training brochure has also been circulated to our partners.

How do you evidence this has made a difference to practice and understanding of safeguarding? Learning is shared in subgroup and then disseminated to team members; and teaching has also been delivered to student social workers from University of Birmingham. Sub-group partners also have a range of ways seeking such evidence such as: safeguarding audits and questionnaires; monitoring SG sharing forms and DoLS application's and in future, feedback will be sought in reference to the updated GP safeguarding assurance toolkit.

Performance Data

How do you use the performance data?

Both LeDer and DoLS are standing items for the subgroup. Communications with regional group have also taken place seeking a greater understanding of how different Local Authorities in the region are defining S42 enquiries as performance data suggests that SMBC has a Safeguarding conversion rate which is lower than local average.

Some partners use clinical effectiveness audit data collection and develop themes to implement such action plans. Performance data is summarised in Quality Assurance Reports with a list of Standards to be measured against. The Assurance Reports include progress and actions for the future with timescales. The reports are feedback to Safeguarding Quality Review Meetings and Clinical Quality Review meetings held by health commissioners, and progress is monitored CQC inspections in included organisations also gives direction; similarly, Peer reviews in other organisations offers independent scrutiny which helps to develop performance data.

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

The data helps the subgroup to better understand

how local people with care and support needs are kept safe, and how protections of liberty are in place. In short, improved operational practice across partner agencies.

How do you evidence this has made a difference?

In a number of ways including improved referrals and audits, quality review meetings and an increase in SAR referrals as overall understanding of the process increases, and learning from best practice is shared more readily amongst our partners.

Safeguarding Adult Reviews

The Subgroup has completed two SARs, has reviewed a third which was found not to meet the threshold, and has fed back final actions for a SAR that was commissioned by BSAB (CE). This has been collaborative with a range of sub group partners involved.

Have you contributed to any SAR's?
Yes

What was the outcome?
Areas for learning were identified for several of our partners, such learning outcomes have been actioned either in full or in part, with further reviews scheduled to reflect upon the longevity of such learning and practice change. This has included: Reviewed policies; and improved guidance and scrutiny from senior managers.

How was any identified learning shared?

The group has been actively involved with the learning outcomes in action plans and has audited and reviewed each action for robust scrutiny. This learning process is cascaded to staff in our partner organisations who have helped to ensure the learning from SARs are actioned. This is in addition to the Learning Event as described earlier. Partners use a range of additional communications including staff bulletins; intranet and newsletters.

How would you evidence this intervention made a difference?
Assurance Reports and audits of practice change have been completed.

This will also be revisited when a follow up document is sent to partners 12 months after action plans have been completed. This will ensure longevity of learning and improved operational practice.

Safeguarding Performance Data 2017/18

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.

The SSAB with the support of the Quality & Excellence Sub Group has developed a dashboard that enables contribution of relevant data from partner agencies, further work on this including the data set continues to be undertaken.

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:

- Adult Social Care Outcomes Framework (ASCOF)
- 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

Key findings of the 2018 Adults Social Care Outcomes Framework Survey

Each year SMBC in conjunction with NHS digital undertakes an annual survey of its long term social care service users, below are the findings for Sandwell;

1.1% of respondents did not feel safe at all.

2.9% felt less than adequately safe.

22.6% felt adequately safe but not as safe as they would like.

73.5% of respondents told us they did feel as safe as they wanted.

90.8% of respondents felt that the care and support services that they received helped them in feeling safe.

Making Safeguarding Personal Desired Outcomes Recorded

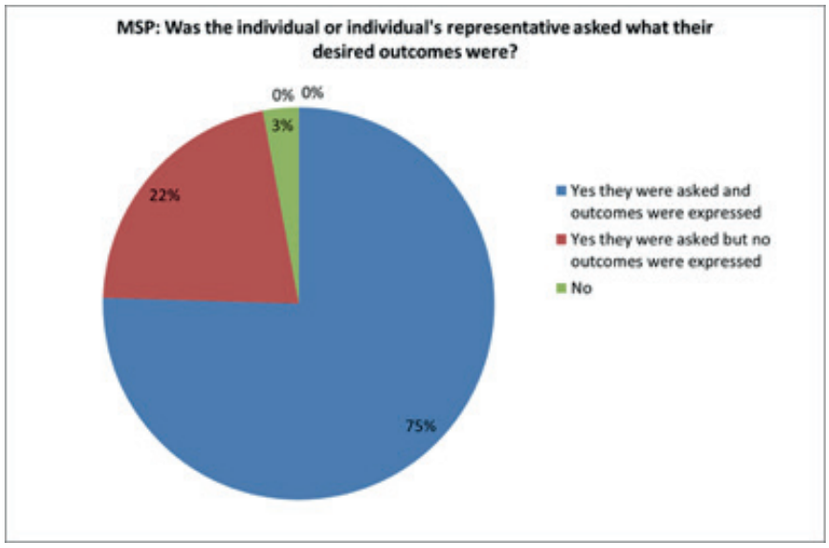
Analysis

In 2017-18 we can evidence (as in the tables below) that 97% of all individual's or the individual's representative were asked what they wanted to happen at the beginning of every enquiry meaning that only 3% of individuals were not asked. 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.

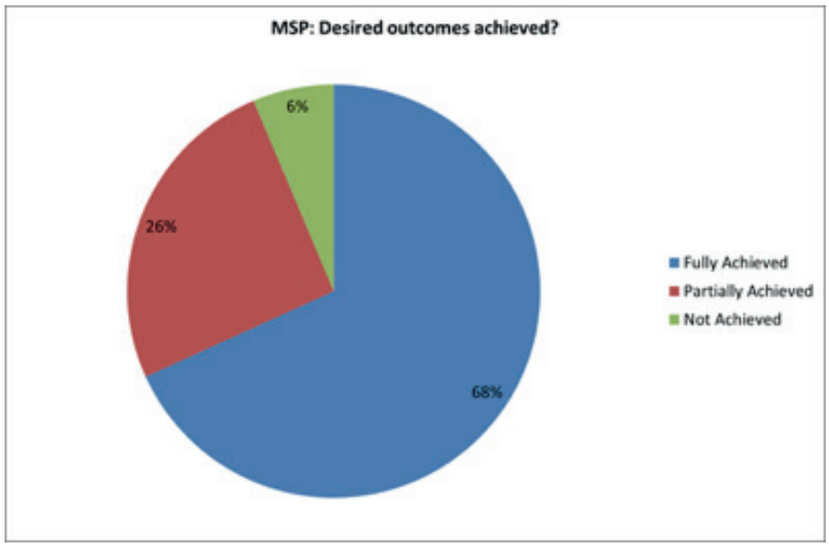
Within the current electronic recording system there is now a mandatory recording field requiring completion acting as a prompt for workers because of this change in practice we can now evidence that there has been an increase in the numbers of people being asked about their desired outcomes.

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.

Making Safeguarding Personal Desire Outcomes Recorded



Making Safeguarding Personal Desired Outcomes Achieved Recorded



Number of Concerns/Enquiries

Number of concerns and enquiries analysis

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.

During 2016/17 the average number of concerns per quarter was 602. The average number of concerns per quarter in 2017/18 was 627. Overall the numbers of individuals with a concern has gone down but the number of individuals experiencing multiple safeguarding concerns has increased. There was a 4% increase in the number of concerns received during 2017/18 compared to the previous year.

This data tells us that the safeguarding team and professionals are responding to increasingly complex safeguarding matters and ensuring that individuals with potentially increased risk are in receipt of a service.

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 requiring 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.

Total Concerns Raised (commenced)	2016-17	2017-18	Up/Down/Same
Number of individuals with a concern	1779	1704	Down
Number of concerns	2408	2506	Up

The data in the tables below relate to the number of concerns and enquiries during the period. The conversion rate shows the percentage of concerns that progress to a section 42 enquiry. When broken down by source of concern the information provides an indication as to where concerns maybe being raised inappropriately.

Cases concluded within the period	2016-17	2017-18	Up/Down/Same
Enquiries	444	545	Up
Concerns	2408	2545	Up
% Conversion Rate	18%	21%	Up

The percentage of concerns progressing to enquiry during 2017-18 was 21%, which is very like the previous year (18%).

Conversion rates for 2017-18 show that concerns raised by the public quite often result in a section 42 enquiry. The numbers of concerns raised by the NHS and the Police that were progressed to a section 42 have increased significantly in comparison to the previous year.

Work continues to be undertaken with all 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.

Conversation Rate by Source of Concern	2016-17	2017-18	Up/Down/Same
Sandwell Council	16%	24%	Up
Health	8%	14%	Up
Police	9%	28%	Up
Independent Sector	24%	25%	Up
Public	38%	33%	Down
All other	18%	18%	Same

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 what we know is people with additional care and support needs living in Sandwell are at higher risk of being abused in their own home.

In contrast if we look at ages 75 – 95+ we can see that females are at higher risk of abuse. We also know that in Sandwell care home settings whether residential or nursing are evidenced as the second highest location for abuse to take place therefore further scrutiny needs to be undertaken to understand the assumption that 18-64-year-old males are more likely to live in their own homes and that females 75+ are more likely to live in a care home setting.

Age and Gender 2017-18	2016-17 Female	2016-17 Male	2016-17 Total	2017-18 Female	2017-18 Male	2017-18 Total
18-64	49	81	130	75	96	171
65-74	25	22	47	30	15	45
75-84	57	38	95	69	32	101
85-94	70	18	88	79	29	108
95+	16	2	18	11	3	14
Total	217	161	378	264	175	439

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 (85%) although this is a 1% drop on the previous year. This continues to be an area of concern and concerns raised would not appear to be reflective of the population. SSAB will continue to seek assurance on this matter and highlight areas of good practice.

Individuals with a concluded case during 16-17	2016-17	2017-18
White	86%	85%
Mixed/Multiple	1%	1%
Asian	6%	6%
Black	7%	6%
Other	0%	1%

Concluded S42 enquiries by type of abuse

The table below shows the number of section 42 enquiries concluded during the period by the type of abuse.

There were 545 section 42 enquiries concluded in 2017-18. There were 182 enquiries concluded in quarter 4 which is higher than previous quarters during the year. This has had the effect of reducing the number of open safeguarding enquiries that are actively being worked on. At the end of March 2018, the number of open safeguarding referrals was 116 which is the lowest number seen during the year.

The most prevalent type of abuse remains as neglect and acts of omission. Sandwell works closely with the quality team to address issues around behaviour and managing the environment within a care home setting which can result in abuse for example, service user on service user assault. SMBC also has a multi-agency provider escalation process to address issues of poor practice which can result in providers no longer being worked with.

Concluded S42 enquiries by type of abuse	Total 2016-17	Total 2017-18	Up/Down/Same
Physical Abuse	114	156	Up
Sexual Abuse	10	21	Up
Psychological Abuse	24	74	Up
Financial or Material Abuse	55	76	Up
Discriminatory Abuse	0	10	Up
Organisational Abuse	6	11	Up
Neglect and Acts of Omission	230	248	Up
Domestic Abuse	5	6	Up
Sexual Exploitation	0	4	Up
Modern Slavery	0	1	Up
Self-Neglect	7	43	Up
Total	451	650	Up

Note: multiple types of abuse are recorded per enquiry.

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.

SSAB continues to seek assurance from the provider escalation process and the Quality and Excellence Sub Group have developed a quality assurance tool to be shared with partners and providers to enable organisations to consider in a proactive manner their evidence framework for safeguarding and identify areas for future work, this will be rolled out from October 2018.

Concluded S42 enquiries by location	2016-17	2017-18
Own Home	211	242
In the community (excluding community services)	3	16
In a community service	7	7
Care Home - Nursing	93	124
Care Home - Residential	90	103
Hospital - Acute	11	13
Hospital - Mental Health	15	18
Hospital - Community	7	15
Other	7	4
Total	**444**	**542**

Timescales and completion of safeguarding activity

During 2017/18 37% of enquires were concluded with 28 calendar days. This is a 5% increase on the percentage of cases concluded within a 28-day timescale in the previous financial year.

All cases when timescales were not met 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).

Percentage of concluded S42 enquiries where the number of days from concern to end of enquiry falls within the following ranges;

Timescales: % of concluded S42 enquiries where the number of days from concern to end of enquiry falls within the following ranges	2016-17	2017-18
% concluded within 0-28 calendar days	32%	37%
% concluded within 29-60 calendar days	33%	33%
% concluded within 61+ calendar days	35%	30%

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.

Concluded cases by mental capacity	2016-17	2017-18	Up/Down/Same
Yes, they lacked capacity	187	297	Up
No, they did not lack capacity	246	240	Down
Don't know	11	8	Down
Not recorded	0	0	Same

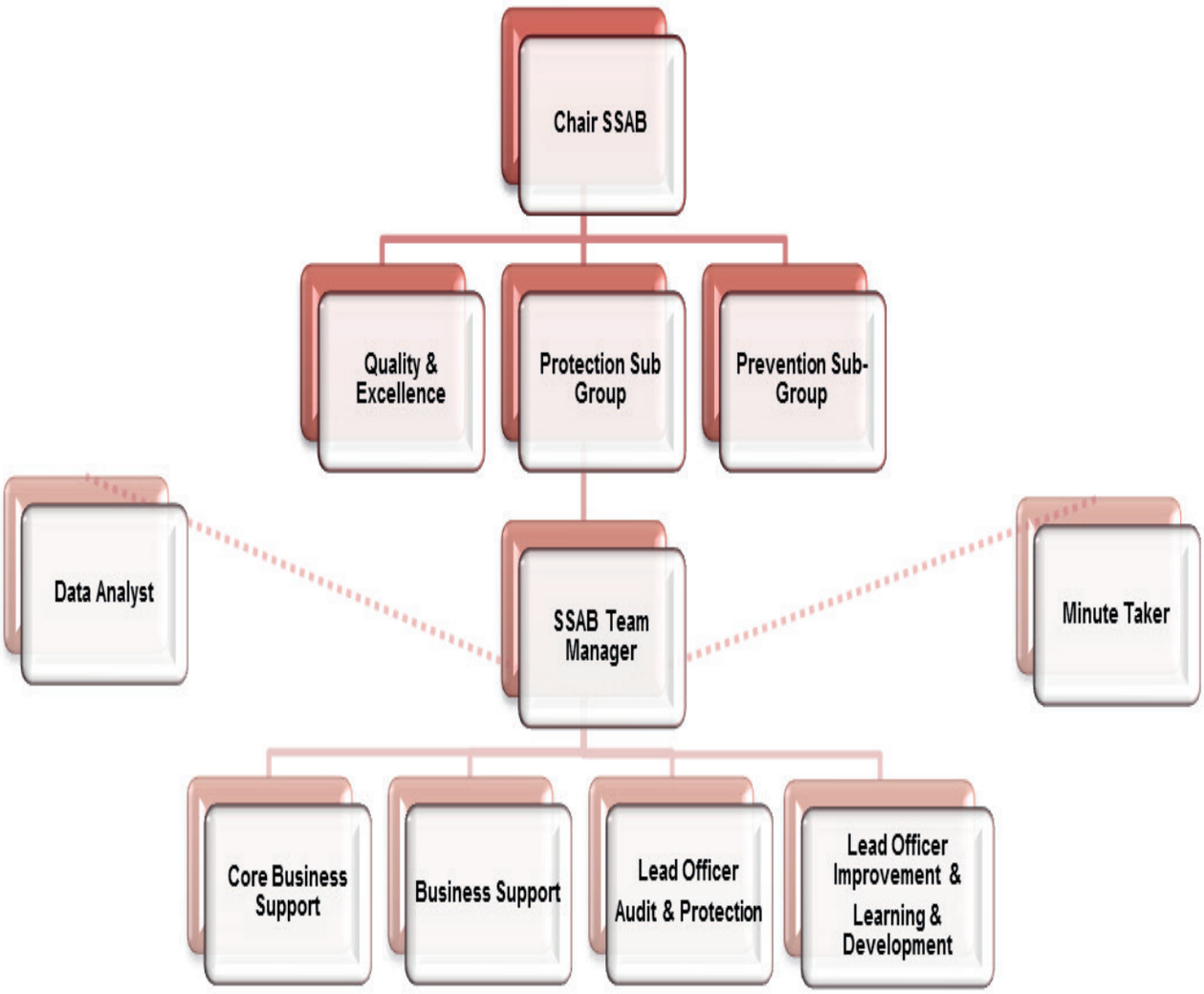
SSAB Strategic Priorities 2018/2019

PREVENTION & LEARNING & DEVELOPMENT:
• To develop a specific issue campaign accessing all media options including social media. Consideration to be given to exploring data to inform the nature of the campaign. • Undertake a scoping exercise with partners identifying a range of prevent work happening within strategy services and the wider community – mapping work to be undertaken. • Work with partners to ensure there is collaboration on identifying learning and development needs and how they should be met. • Review data collection methods with reference to learning and development. • Develop a mandatory training offer.

QUALITY & EXCELLENCE
• Continue to support the development of the Q&E Sub Group. • Continue to build on the performance framework and data set to ensure qualitative data is evidenced to provide assurance of quality of the safeguarding experience. • Develop a multi-agency audit tool. • Continue to understand the implementation of making safeguarding personal and the impact for service users. • Continue to work with all colleagues under the auspices of the 4 Boards arrangement as outlined in the partner protocol.

PROTECTION
• Continue to ensure local policies and procedures continue to be written and reviewed in line with the West Midlands procedures. • Launch the Safeguarding Adult Review Procedures. • Arrange for Safeguarding Adult Reviews to be undertaken as required, produce report and action plans and identify learning.

SSAB Board Structure 2017/18



Board Members

Appendix 1

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	Sandwell Advocacy
Debbie Talbot	South West Birmingham Hospital
Debbie Le Quesne	West Midlands Home Care Association
Eileen Welch	Clinical Commissioning Group
Elaine Kingston	IRIS
Eva Rix	Black Country Partnership Foundation Trust
Gail Read	West Midands Fire Service
Kwado Owusu-Darko	Healthwatch
Kate Houghton	West Midlands Fire Service
Keiron Broadbent	West Midlands Care Home Association
Mark Burnell	West Midlands Police - Head of Public Protection Unit
Marcia Whittingham	Sandwell MBC - Legal Service
Michelle Carolan	Clinical Commissioning Group
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 County 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	Sandwell MBC	
Sonia Cookhorn	Senior Information Officer – Sandwell MBC	Second Representative
Kenneth Bennie	Team Manager Safeguarding Adults – Sandwell MBC	
Isolyn Clarke	Lead Practitioner – Sandwell MBC	Second Representative
Debbie Le Quense	West Midlands Care Home Association	
Barbra Maxwell	Sandwell MBC	
James Mellstrom	Data Analyst – Sandwell MBC	
Julie Winpenny	West Midlands Fire Service	
Valerie DeSouza	Sandwell MBC	

Prevention Sub Group

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

Protection Sub Group

Name	Job Title	
Geoff Foster	Chief Executive CARES	Chair
Charmaine Stephens	Lead Officer – Sandwell MBC	
Clare Cotterill	Adult Safeguarding Nurse South West Birmingham Hospital	
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 2017-18, 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 2017- 2018 training programme.
- Miscellaneous.

Miscellaneous costs include:

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

Appendix 4
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
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence
DASP	Domestic Abuse Strategic Partnership
DASS	Director of Adult Social Services
Datix	Electronic recording system
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
LeDeR	Learning Disabilities Mortality Review Programme
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
SAF	Self-Assessment Framework
SAR	Safeguarding Adults Review
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SLT	Senior Leadership Team
SMART	Specific, Measurable, Achievable, Realistic and Timely
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