Sandwell **Safeguarding** Adults Board

Annual Report 2018- 2019 Overview for Scrutiny Board

18.11.19



Overview



- Key Achievements
- Partners Contributions
- 4Boards Work
- Sub Group Contributions
- Abuse in Sandwell
- How do we know
 Safeguarding is Working?

- How do we know Policies & Procedures are Robust?
- Learning from Safeguarding Adult Reviews (SAR's)
- Strategic Priorities 2018-2019
- Future Plans



Key achievements

 Held a successful Conference with a focus on prevention attended by a wide range of professionals from all agencies;

"Thought that the use of "case studies" by South Staffs Water was very effective"

"I found it extremely useful"

People identified the conference was interactive and there was positive learning.

- The development of a safeguarding self-audit tool for all partners, subsequently adopted on a regional basis
- Supported a Graduate to undertake a project looking at the key themes and commonalities between SAR's, DHR's and SCR's

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Quarterly safeguarding operational data forwarded that primarily focuses on Adults operational work highlighting areas for ongoing work with partners around understanding of safeguarding thresholds.

Each year the Local Authority undertakes an annual survey of its long term social care service users to understand how safe people feel. In 2018 75% of people who use services said they feel as safe as they want to be.

SMBC

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Adults with care and support needs continue to be a high-risk group. The number of deaths and injuries from accidental domestic dwelling fires has decreased significantly. We consider that engagement with SAB partners through serious incident reviews, safeguarding adult reviews and referrals for Safe & Well Visits have contributed to this reduction.

We have:

Updated our domestic abuse policy

Introduced a modern slavery training package

Shared the approach taken to develop the Sandwell Hoarding framework across the metropolitan region.

Introduced Complex Needs Officers to work with people at risk



WMFS



- Review and complete refresh of the in-house Level 3 Safeguarding training to include Prevent, domestic abuse signposting and modern slavery.
- Actively involved in a DHR commissioned by Sandwell and have supported the process through to dissemination and roll out of the learning that came from the review.

BCPFT



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

'Thank you for support. It really was beneficial. Would not of coped by myself, really helped'

'Thank you for your support. I am glad my Practice Nurse asked'

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CCG

The Adult at Risk Team investigate the following:

- Position of Trust concerns involving a registered carer or an Adult with Care and Support needs.
- In ALL cases the victim needs to be an Adult with Care and Support needs.

Case Study

A young man with a significant physical impairment who is able to communicate his needs with head movement and using technology was being supported by a paid carer who failed to properly attend to his feeding tube meaning that stomach acid leaked on to his skin and he was subject to second degree burns. The victim was interviewed using 'achieving best evidence' principles and charges were authorised for ill treatment and neglect.



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WMP



- We attend SAR's, SSAB Sub Group and support events.
- We have a commitment to provide Adult Safeguarding training to its staff.
- We provide IMR reports for SARs where the organisation has been involved.
- Quarterly steering group will continue to ensure concerns are escalated



SWBHT



We are working positively with SSAB to profile work that continues to ensure adults with additional needs who are Domestic Abuse victims can access effective support from the adults' workforce and specialist organisations.

DASP



4Boards Work

- The 4 Board Managers have been building on formalising relationships to ensure a reflective infrastructure to capture agreed themes and priorities and agreement of the partnership protocol.
- Each statutory Board agreed to lead on identified work-streams within the Prevention of Violence and Exploitation (POVE) umbrella.
- SSAB makes an active contribution to the 4 Boards partnership.



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Sub Group Contributions

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

Quality & Excellence Sub Group

- Monitored the Boards performance using a Dashboard
- Developed, received, commented on and endorsed the West Midlands Care Act Compliance Audit for Safeguarding Adult Boards (adopted as a Regional tool) which helps members of SAB's audit their safeguarding arrangements using a common audit framework
- Focused on overlapping themes for both Prevention and Protection

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Sub Group Contributions

Protection Sub Group

- Agreed to review the local self-neglect guidance which includes a 'clutter rating' so that across the partnership there is a common understanding that supports a consistent approach
- Considered the impact of the new Homelessness Reduction Act 2017 and commented on safeguarding procedural updates to reflect homelessness and responses
- Commissioned a SAR, oversaw the writing of the report including engagement with frontline practitioners directly involved in the decision making



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Sub Group Contributions

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Prevention Sub Group

- Continued to develop promotional material advising people on how to report concerns
- Participated in a train the trainer programme engaging 6 key staff members in a training programme focusing on adult safeguarding
- Participated in the Sandwell Safer Six campaign meeting members of the public and professionals in all six towns raising awareness of adult abuse and how to report concerns and sharing the work of the Board
- Attend quarterly SCVO events building relationships with third sector partners
- Supported an annual conference with a Prevention theme that was well attended by multi-agency

What do we know about abuse in Sandwell?

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- The highest incidents of abuse relate to neglect and acts of omission
- Most reports relate to individuals in their own home
- In the 18 74 age bracket, the highest level of incidents occur in young males
- In the 75+ population that changes to women
- Most referrals are made by members of the community
- And it is those referrals that are more likely to warrant a formal safeguarding investigation
- Most referrals are in respect of individuals from a white British background

How do we know that Safeguarding works?

- 69% of safeguarding enquiries conclude within 60 days,
- 97% of the people asked told us what they wanted to happen as an outcome from their safeguarding process
- 93% got what they wanted
- There has been an increase in the diversity of types of abuse being reported, e.g. modern slavery

The 2019 Adult social care survey told us that:

- 75% of individuals reported that they feel as safe as they wanted
- 91 % felt that the care and support services they received helped them in feeling safe



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How do we know our policies Safeguarding and procedures are robust?

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- Protection Sub Group reviews local policies and procedures.
- Protection Sub Group Lead and SSAB Board Manager participate in and contribute to the West Midlands Editorial Group which has an annual work programme developing and reviewing key policies, examples of this include, West Midlands Safeguarding Procedures, Self Neglect Policy and Position of Trust Procedure and Practice, this informs local practice.
- West Midlands Policies and Procedures are also informed by the ADASS group for Policy and Procedures which in turn inform National direction and practice.
- Learning from SAR's

Learning from SAR's

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- 1 SAR was commissioned during 2018/19 and action plans formulated and progressed to change practice
- Key learning outcomes identified:
- A requirement for better communication including the need for better understanding of appropriate information sharing
- More effective and transparent risk assessments that are clearly recorded and communicated
- Understanding the impact on an individuals capacity to make decisions when using alcohol
- Understanding the relevance of information to the individual
- The importance of exercising professional curiosity when there may be perceived reluctance to engage with services
- The importance of person centred and strength based practice.

Strategic Priorities for 2018 - 2019

Building on the recommendations of the Peer Review January 2018 the below priorities have been identified. These will be reviewed at a Board Development Session planned for later this year.

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



Future plans

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- Review Board membership to ensure seniority of ownership and strategic direction.
- Review the function of the sub-groups to ensure they are fit for purpose
- Adopt a task and finish and project based approach e.g. agreement to review safeguarding pathways on a multiagency basis
- Focus on the voice of the citizen and appoint a development worker to develop networks and made this a Board priority
- Use of data to develop a deeper understanding of effectiveness in keeping people safe and undertake a selfassessment audit with partners and agree key lines of enquiry
- Enhance focus on Prevention