Bi-Annual Report.

2 Critical Years in Review.

How the Board Has Overseen and Led on Safeguarding in Sandwell during a Pandemic.

Sandwell
Safeguarding
Adults
Board

BI-ANNUAL REPORT

2020 - 2022

Contents

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1. FOREWORD FROM THE INDEPENDENT CHAIR

The most important role in the community is ensuring adults are safe from abuse, exploitation and harm. This Annual Report looks at the work of the Sandwell Safeguarding Adults Board (SSAB) from March 2020 to March 2022, a particularly challenging time during a pandemic, and details the work of the sub groups who do much of the work on the Boards behalf and highlights some of the Boards achievements over the last 2 years.

During the pandemic (the period covered in this report). I have welcomed the closer working relationships that have been developed with all partners enabled by using Microsoft teams, and more frequent Members-from the statutory, voluntary and community sectors were at the table to discuss the most important issues including the impact of the pandemic on Safeguarding.

Members were also committed to ensuring that learning from Safeguarding Adult Reviews into serious incidents was a priority. With the other Boards in Sandwell work was undertaken to look at all the reviews that had taken place across the partnerships into deaths and serious incidents to understand any common themes and to start to work together to embed the learning into all organisations. This work continues and remains the highest priority.

The board are still committed to hearing the views of people who use services to ensure that any developments are based on real experiences. The year ahead will develop this involvement further as well as hearing the voices of staff who work across these vital services. One of the roles for the Board is to identify measures that could help prevent abuse and harm and this work with the third sector will be key.

The Board benefits from involvement with regional and national colleagues and the SSAB Board Managers role as Co-Chair Board managers network.

I would like to thank all partners for their commitment to the Board and the Chairs and members of the sub groups. And to the Board Manager and the Business unit whose work enables the Board to function. Finally thank you to all the staff who work in Health and social care supporting people and helping to keep them safe. As this reporting year ends the impact of the pandemic can still be felt, though restrictions have eased, even more heartfelt thanks to all who have continued to work in these services.

Sue Redmond, Independent Chair

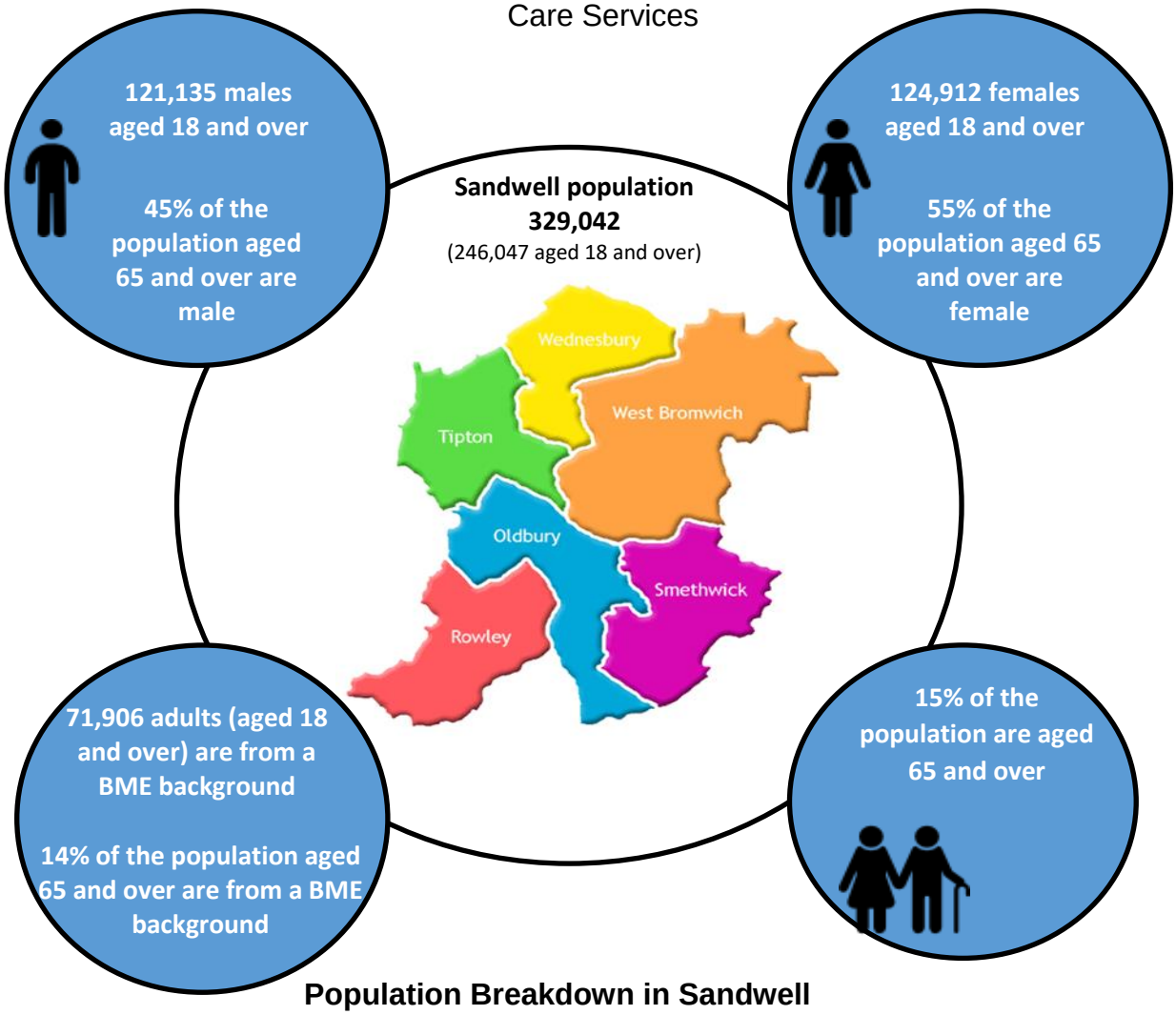
2. SANDWELL AT A GLANCE

Sandwell covers 33 square miles

Sandwell is made up of six towns (see below)

Sandwell has 24 Electoral wards

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



Population Breakdown in Sandwell

75% of the population are aged 18 and over

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

Data Sources: Office for National Statistics 2020 Mid-Year Estimates, 2011 Census, Table: DC2101EW - Ethnic group by sex by age

Sandwell Residents by Ethnic Group (2011 Census)

White British 66% White Other 4%
Mixed/Multiple 3%
Asian 19% Black 6%
Other Ethnic Groups 2%

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

3. ABOUT THE BOARD

The Board is a multi-agency partnership made up of statutory sector member organisations and other non-statutory partner agencies providing strategic leadership for adult safeguarding work and ensuring there is a consistent professional response to actual or suspected abuse. The remit of the Board is not operational but one of co-ordination, quality assurance, planning, policy and development. During this reporting period, the board have met virtually approximately every 6 weeks to ensure a robust working together response, to safeguarding during the pandemic.

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

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

SSAB BOARD DEVELOPMENT

Summary and Update

In October 2021 SSAB held a Board Development Afternoon including Board Members, Partners and sub group members. Please see illustration of the event below:

An outcome of this day was a commitment to board priorities, how we do business, working in partnership, continuing to learn from statutory reviews working across the system to include children's partnership and building on existing data. Attendees also identified the impact of COVID on resources, the priority to continue to make safeguarding personal and to hear what people are telling us.

Partners gave a further commitment to;

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

Agreement of Board Priorities 2020-22

1. Listen to the voice of service user and frontline staff
2. Develop more inclusive Performance Data
3. Work with all partners to look at Sandwell's "Front Door" including pathway, referrals and thresholds.
4. Specific Projects to be discussed with the four Statutory Boards which all focus on Prevention
5. Board Governance

4. WHAT IS OUR PERFORMANCE INFORMATION TELLING US 2020 – 2022?

WHAT IS OUR PERFORMANCE INFORMATION TELLING US FOR 2020-21?

Concerns concluded

3,566

50%

Conversion rate

Enquiries Concluded

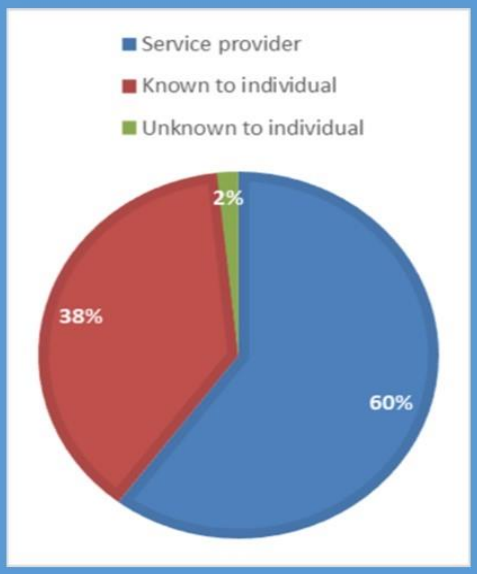
1,797

Concluded enquiries

58% female

42% own home

71% older people



98 % of people were asked what they wanted to happen as an outcome

94% Outcome fully or partially achieved

94% Risk reduced or removed

84% Care and support services that they received helped them to feel safe

WHAT IS OUR PERFORMANCE INFORMATION TELLING US FOR 2021-22?

Concerns concluded

3,035

39%

Conversion rate

Enquiries Concluded

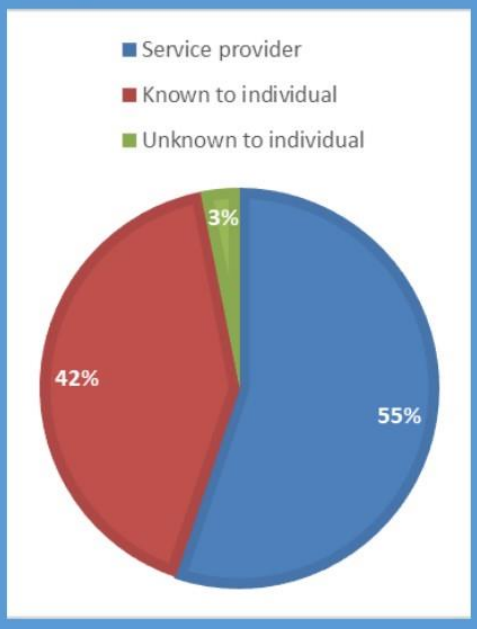
1,171

Concluded enquiries

61% older people

57% female

53% own home



99 % of people were asked what they wanted to happen as an outcome

97% Outcome fully or partially achieved

96% Risk reduced or removed

86% Care and support services that they received helped them to feel safe

We have looked at our data taking into account the previous year's data, regional data and national data for 2020-22 which will enable comparisons.

During this reporting period, the number of safeguarding concerns reported to Sandwell Metropolitan Borough Council (SMBC) as the lead agency for safeguarding adults, increased in 2020-21 and decreased in 2021-22. The conversion rate from concern to enquiry has overall decreased. Not all concerns raised become safeguarding investigations, other responses may have included signposting or a proportionate response that ensured an individual was safe. This demonstrates that the key messages delivered through social media and campaigns on how to report a safeguarding concern and what is safeguarding are being understood and acted upon. We can also see from the data the areas we need to continue to focus on.

We can see from our data who raises concerns, for example a family member, police, housing, hospital and other sources and we can see which of these concerns becomes a safeguarding enquiry.

Most concerns are raised by Social care staff (from within the Council or care agencies and care home settings) however the amount of concerns raised that then go on to become safeguarding enquiry continues to remain high from members of the public. For this reporting period of the 6% reported concerns from the public 44% of those concerns became active safeguarding investigations. This would suggest that the work around the See Something Do Something Campaign and helping communities to better understand safeguarding is having a positive impact.

Over the 2 year reporting period, we have seen an increase in the percentage of people subject to abuse in their own home in Sandwell, this is in line with the regional and national average and reflective of the pandemic, given that adults with needs for care and support spent more time at home (note the impact of lockdown) and many were unable to access previously provided services. This remains a priority for the Quality & Excellence Sub Group in terms of understanding the impact of neglect and financial abuse which are the primary types of abuse identified as happening in an individuals home. It is against this background that central government are launching a review into the prevelance of abuse in a persons own home during the COVID-19 pandemic. The activity of SSAB will be informed by and will inform this review process.

In addition, work has been undertaken with colleagues from the Domestic Abuse Strategic Partnership (DASP) to better support and enable professionals to consider domestic abuse when financial abuse has been identified. SSAB have sponsored a task and finish group with a focus on the prevelance of domestic abuse in the population of adults with needs for care and support living in Sandwell, comprehensive training has been developed and delivered in partnership with the Safeguarding team and Black Country Womens Aid (BCWA) have employed a specialist IDVA who's focus is to support professionals working with adults with needs for care and support and raise awareness and understanding of domestic abuse within this population. BCWA are active participants in the task and finish group, are supporting a mapping exercise looking at suitable and appropriate resources (for adults with needs for care and support) building on the recent needs assessment undertaken in Sandwell. SSAB plan to develop resources to support a specific campaign with a focus on domestic abuse and adults with needs for care and support under the broader campaign heading of 'See Something, Do Something'. This resource should be available by the end of 2022.

In the 18-64 age range 36% of people have long term care and support needs and have formal support funded by Adult Social Care (ASC) and 11% of individuals from within this age range are from a Black and Minority Ethinic (BME) background.

In the 75-84 age range 23% of people have long term care and support needs and have formal support funded by Adult Social Care (ASC) and 4% of individuals from within this age range are from a BME background.

Sandwell has consistently been able to demonstrate that citizens involved in a safeguarding investigation were asked what they wanted to happen as an outcome of involvement from professionals.

Over the 2 year reporting period f the number of people who expressed an outcome, on average 95% felt their outcome at the end of the safeguarding process was fully or partly met.

The Board receives data from SMBC about whether individuals and/or their representatives feel they are safer because of the help they received from people responding to the safeguarding concern and for this reporting period on average 95% of people said they felt safe and risk was removed, 85% said care and support services helped them feel safe. We acknowledge that this reporting period was unprecedented in terms of the impact of COVID-19 and that many people were also unable to access previously commisioned services.

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

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

Vulnerable Adults Risk Management (VARM) Data

Below is a table identifying a breakdown of VARM meetings including who called them, the themes and the reasons for concerns being raised. At the time of writing, there are 10 live VARM meetings at various stages of the process, 5 VARM meetings have been closed because the risks have been reduced or alternative pathways were persued. For example; safeguarding and rehabilitation, in one instance the citizen passed away before the VARM meeting happened.

In addition, there have been 6 VARM awareness sessions with 115 attendees. We are offering regular VARM awareness sessions on a monthly basis as well as, plans to develop chairing multi-agency meetings training.

Finally, there have been representatives from the Safeguarding Team, Housing Officers, professionals working in domestic abuse, West Midlands Fire Service and Colleauges at Cranstoun. Briefings have also been delivered at Town Task Meetings, the Blue Light Strategic Group and to a GP's forum. There are plans to develop a VARM champions scheme and a monthly newsletter is also published.

Agency Calling VARM Meeting	Lead Agency	Main reason for VARM	Second reason for VARM	Third reason for VARM	Key Themes
Sandwell Adult Safeguarding Team	Safeguarding Adults Team	Self-neglect	Hoarding	Mental Health	Self-neglect, hoarding, mental health
Adult Social Care Community Team		Self-neglect	Alcohol misuse		
Rowley Regis Neighbourhood Office	SMBC Local Rowley Regis	Alcohol	Self-neglect	Risk to others	Alcohol, self-neglect, inappropriate behaviour
Sandwell Hospital Team		Self-neglect			
Custom Care		Self-neglect	Drugs dependence	Alcohol dependence	Drugs and alcohol dependence, self-neglect
Social Worker, Floating Support					
Regis Medical Centre		Possible Neglect	Coercive control		Neglect and coercive control
Anti-Social Behaviour Town Lead Wednesbury		Referral received and toolkit sent			
Cranstoun		Mental Health Issues	Substance Misuse		Mental health and substance misuse
Sandwell Adult Safeguarding Team		Destitution / malnutrition	loss of income	risk of losing his home	

5. SUB GROUP CONTRIBUTIONS

Supporting the Board there are 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 receiving assurance reports and data
• Q&E undertook some high-level analysis of the outcomes of the self-assessment returns identifying what's working well and areas for improvement with all organisations. A detailed challenge event was due to be held in 2020, this was deferred due to the pandemic. SSAB to participate in further self-assessment using an updated self-assessment tool developed across the region in 2022-2023. A challenge event will follow in 2023.

Developed key lines of enquiry including:

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

The Quality and Excellence Sub Group also commissioned a number of task and finish groups with a focus on learning disability and autism and domestic abuse and the experience of adults with needs for care and support. In the autumn of 2022, there is a plan to look at the experience of older carers supporting adults with care and support needs linked directly to a SAR recommendation.
Quality and Excellence Sub Group works hard to ensure its membership is robust and reflective of the partnership and that they develop a context to the data.
Membership are committed to showing both qualitative and quantitative data enabling better understanding of a citizen's journey and ensuring voices are heard.

Protection, Prevention, Learning and Development Sub Group (PPLD)

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

- VARM awareness training
- Hate Crime
- Recognising Safeguarding as a volunteer
- Safeguarding in a range of settings

The group oversaw the operation of a VARM working group that delivered and implemented the VARM policy and procedure, the VARM toolkit, newsletter and e-learning. The VARM work was developed as a direct consequence of SAR recommendations with a focus on multiagency risk management. The VARM activity enables any professional who may have a concern about an individual to call a risk management meeting providing;

- the individual has capacity
- is at serious risk of harm
- there is a potential public safety risk
- a number of people share concerns

The focus of this sub group is to support a collaborative agenda ensuring that all activity within sub groups in connected maximising the opportunities to learn from SARs, develop resources, undertake focused pieces of work using a task and finish approach and minimising duplication. This has been particularly relevant during this reporting period where additional demands made on partners and stake holders were significant and necessitated smart ways of working with high impact.

Safeguarding Adult Review Standing Panel

Safeguarding Adult Review Standing Panel is a new group convened within the reporting period to consider referrals for SARs against the criteria. This group is chaired by a representative of the West Midlands Police (statutory partner on SSAB). Group members consider referrals against the SAR criteria, all key agencies are represented on this group. During the reporting period, they have considered 17 SAR referrals, 7 of which have been commissioned, 8 didn't meet the criteria and 2 are still on-going.

6. SUMMARY OF SUB GROUP PROGRESS 2020 – 2022

PREVENTION, PROTECTION AND LEARNING & DEVELOPMENT: Continue to raise awareness of adult abuse communicating effectively with all partners and members of the public	
What did we want to achieve	What did we achieve…
To develop a specific issue campaign.	• SSAB developed a range of resources in recognition of the pandemic. We produced resources for volunteers, to enable recognition of abuse. • We worked in partnership with other boards and systems across the West Midlands Region to produce regional flyers highlighting the risk of scams, with a focus on specific types of abuse including a range of languages. • Regularly updated the SSAB website to ensure all information was current and updated including COVID-19 guidance. • Participated in national Safeguarding Week on a virtual basis and continued to promote 'See Something Do Something'.
Specific Projects to be identified with a focus on Prevention	SSAB continues to develop a strong Prevention offer, promoting an inclusive understanding of Safeguarding and what it means to all and everybody's responsibilities. As a partnership we have continued to strengthen our links with the third sector particularly with reference to volunteers and how to help them understand and recognise Safeguarding for adults and children, this was key during the pandemic as a lot of activity with reference to food distribution and telephone calls were undertaken by volunteers. SSAB and Prevention Sub Group also considered different models of operating ensuring that systems were able to be responsive during the really challenging times, offering timely support and information as required. Prevention and protection sub group supported the activity of a range of task and finish groups including the learning disability and autism task and finish group (this went on to become an advisory group to SSAB) and the VARM task and finish group.
Listen to the voice of service user and frontline staff	The development worker charged with listening to the voice of service users and frontline staff continued to obtain views during the pandemic and lockdown. She did this by using surveys, telephone calls and liaising with 3rd sector organisations. People reported feeling anxious, missing some of the commissioned services, under pressure to learn new skills particularly with reference to staff who had to learn

	new ways of working using platforms. Hearing people's voices continues to be a priority for SSAB.
Develop a mandatory training offer	Using a competency-based framework adult safeguarding training is now mandatory for staff in a range of job roles and settings which can be used across the partnership. All training during this reporting period was either offered as e-learning or via a virtual platform. SSAB launched a VARM process in November 2021 and supported this with awareness raising training using a virtual platform. During the reporting period, there were also several learnings from SARs events led by authors using virtual platform. These were well attended and identified key learning.

QUALITY & EXCELLENCE: Continue to focus on effective delivery and high-quality processes	
What did we want to achieve	What did we achieve…
Continue to support the development of the Q&E Sub Group	The Chair continues to work hard to ensure the membership of the sub group is inclusive, and that data and intelligence is used to understand the nature of abuse in Sandwell and the relationship to changes made in practice. The sub group now have key lines of enquiry.
Develop more inclusive Performance Data **Continue to build on the performance framework and data set**	The data set continues to be reflective of the assurance required by Board Members. Partners contribute to the discussion about meaningful data and the dashboard continues to grow in line with the key lines of enquiry. The Q&E group reported the work of a number of task and finish groups particularly the learning disability and autism task and finish group, and the domestic abuse and adults with needs for care and support task and finish group. Both areas were high priority during the reporting period and all professionals involved achieved successes with reference to a supported vaccination programme for adults with learning disabilities and the distribution of accessible information and raising awareness of the impact of domestic abuse in respect of adults with care and support needs and the increased risk of hidden harm during the pandemic. SSAB has agreed in principal to commission some specific domestic abuse resources for Sandwell including a short 2 minute film and information about what good support looks like.
Develop a multi-agency self-assessment tool	Care Act Compliance Self Audit Tool developed and sent to partners for completion 2019. SSAB had planned to support a challenge event during 2020-2021 however, this

	did not happen because of the impact of the pandemic. The compliance audit tool continues to be reviewed and a challenge event will be planned for 2023.
Continue to understand the implementation of making safeguarding personal and the impact for service users	Continue to collect data that reflects citizens views particularly with reference to the impact of COVID-19 on people's lives.
Continue to work with all colleagues under the auspices of the 5 Boards arrangement as outlined in the partnership protocol.	SSAB continues to work in partnership with the other key statutory boards within the Borough; **Sandwell Safeguarding Adults Board** **Health & Wellbeing Board** **Sandwell Safeguarding Children's Partnership** **Safer Sandwell Partnership** **Domestic Abuse Strategic Partnership** **Children and Young People Strategic Commissioning Partnership** Work together to consider and develop cross cutting solutions for example, training and cross cutting priorities and who will lead on them.
Board Governance	SSAB has been refreshed and now reflects a senior and smaller membership. Board governance continues to be managed by key and statutory partners and the SSAB Independent Chair and a revised governance document has been written (Board Members Handbook) to reflect this.
Arrange for Safeguarding Adult Reviews to be undertaken as required, produce report and action plans and identify learning	• 17 SAR considerations during the reporting period • 2020 - Four SARs commissioned. One ongoing police investigation (so not able to progress). Five criteria not met • 2021 – Three SAR commissioned. Three criteria not met. • 2022 - One new SAR to date. Authors still to be commissioned. Further SAR referrals submitted throughout the reporting period and their progress and decision-making is being supported by Board Members, the SSAB Independent Chair, SAR standing panel and SSAB Operations Manager.

7. Task and Finish Groups

Local Task and finish groups have looked at:

- Domestic Abuse
- Learning Disability and Autism Advisory Group
- Embedding learning from statutory reviews.

National groups in which Sandwell SSAB have led include:

- The development of a national data toolkit to support all safeguarding adult boards with their assurance work.
- Safeguarding Front Door and good practice when shaping a safeguarding pathway.
- Developing a career pathway for partnership managers identifying clear competencies and opportunities for career progression.

8. WHAT ENGAGEMENT HAS LOOKED LIKE

Introduction

The safeguarding peer review undertaken in 2018 recommended a focus on

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

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

Work Undertaken March 2020 – March 2022

- Engagement Plan developed, including using social media
- Engagement has taken the form of telephone calls, Microsoft Teams or Zoom meetings, surveys and letters.
- Key themes identified examples include
  - The value of timely support
  - People missing service provision (day service)
  - The need to feel listened to
  - Support for informal carers
  - The importance of trusted relationships and the investment of time and opportunity to build those
  - The value of feedback

- Consolidation of key partnerships in particular with organisations who directly support adults with care and support needs has also enabled effective conversations with reference to increased opportunities (for example paid employment for adults with care and support needs)
- SSAB are exploring the opportunities to consider effective engagement across all the statutory boards within the Borough and within the West Midlands region

Future Engagement

The Covid-19 pandemic impacted engagement work March 2020 which includes the end of the reporting period. The engagement activity that was planned and largely face to face was converted as outlined above. Whilst we acknowledge face to face contact is the best option, in order to ensure duty of care platforms were used when appropriate. SSAB remains committed to effective engagement and supports risk management around the reintroduction of face to face contact now restrictions have eased. SSAB has also supported the development of resources that support engagement including short films. These will be reflected in our on-going work for 2023.

9. OUR LEARNING FROM SAFEGUARDING ADULT REVIEWS (SAR'S)

WHAT ARE SAFEGUARDING ADULT REVIEWS?

The Care Act 2014 introduced statutory Safeguarding Adults Reviews and mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

A Safeguarding Adult Review is a multi-agency process that considers whether serious harm experienced by an adult or group of adults at risk of abuse or neglect, could have been predicted or prevented. The process identifies learning that enables the partnership to improve services and prevent abuse and neglect in the future.

In 2020-2022 we have started seven reviews and considered a further eight which didn't meet the criteria and two are still on-going. At the beginning of the pandemic (2020) there was some small delay to progressing SARs whilst partners and business team members learnt to facilitate meetings and panel discussions using Microsoft Teams. At the time of writing this report (April 2022), there are 5 SARs awaiting publication, 2 ongoing SARs, 1 awaiting a criteria decision and 1 SAR referral currently with the police awaiting charging decision.

LEARNING

Two SAR's in progress have identified issues relating to mental capacity and effective risk management. Particularly in relation to a shared and common understanding of the risk both to an individual and others.
One SAR in progress involved numerous agencies and high risk, however, it is yet to be understood if the level of risk was appreciated by all agencies involved and whether that understanding could have prevented a tragic death.

Key Themes Identified

- **Absence of effective communication between all parties** - leading to confusion about who was taking things forward and who was responsible for what impacting negatively on the citizen who was then perceived as not working well with agencies

- **Nature and seriousness of risk not identified and/or effectively communicated to relevant parties** – there is evidence in one SAR currently being progressed that there was a significant risk posed to self and others by the citizens behaviour on an ongoing basis, however, when the immediate risk was managed there were no ongoing management strategies and one agency was left to manage the entire risk. In other SAR's there is evidence that the risk was not identified and therefore not shared appropriately with partners.

- **Evidence supporting inadequate consideration of mental capacity that was decision specific and timely** – evidence of generalised statements that a person lacks capacity with limited evidence of the thinking rationale or process to support that statement.

- **Missed opportunities** – evidence in ongoing SAR's are potential missed opportunities to engage more effectively with the citizen despite numerous people demonstrating best efforts to support individuals there is evidence that this support either lacked coordination, was not timely or was not presented in a way that promoted effective engagement with and for the citizen

- **A lack of understanding about the impact of drugs and alcohol on someone's capacity to make key decisions** – resulting in a lack of understanding of executive capacity and function, the impact of a cocktail of drugs and alcohol on capacity, an assumption that this is a lifestyle choice and a lack of consideration as to the components of self-neglect and what that looks like

Practice Changes

- **A practice change here is the introduction of the Vulnerable Adults at Risk management process and practice launched in Sandwell November 2021 and sponsored by SSAB. (see information in data section)**

- **Practice change as a direct consequence of a SAR recommendation was the development of a specific consultant role to support professionals have a better understanding of the impact of drugs and alcohol use on individuals and their capacity. A post holder was being recruited at the end of this reporting period.**

REGIONAL SAR LEARNING

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

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

Key themes identified;

- The impact of COVID-19 and different ways of working
- Understanding around mental capacity and its application
- Understanding risk and effective information sharing
- Considering the relationship between capacity and drug and alcohol use and ultimately self-neglect
- The impact of loneliness and isolation

National SAR Research Findings

A review of 231 cases Nationally undertaken by Professor Michael Preston-Shoot saw:

1. Self-neglect as the highest type of abuse recorded covering 45% of cases.
2. Neglect/abuse by omission more prevalent in older people.
3. Financial, physical abuse and self-neglect are more prevalent for males
4. Modern slavery/emotional abuse and psychological abuse more prevalent for females
5. Where causes of death were reported by the SARs, the most commonly mentioned were Sepsis, Heart and Vascular disease and Cardiac Arrest

These findings are mirrored in the Sandwell and Regional pictures.

10. KEY ACHIEVEMENTS

- Board members continued to meet on a more frequent basis using team's platforms
- Supported on-going priorities of listening to voice of citizens and front-line staff and heard directly from families about their COVID-19 experiences
- Engaged the Department of Work and Pensions in Safeguarding
- Reviewed and contributed to the Regional West Midlands Safeguarding Procedures
- Contributed to and co-chaired the Regional Uniformed Services Group
- Developed publicity material in a range of formats including easy read focusing on COVID-19 and risk. Particularly hidden harm and the potential for scams.
- Developed a learning disability and autism advisory group who supported the development of easy read material in relation to COVID-19 and vaccine programmes. Advisory group members also supported specialist vaccine clinics for adults with learning disabilities and complex needs ensuring adults with learning disabilities were vaccinated.
- Developed a key communication strategy with partners and all other statutory Boards within the Borough
- Added to SSAB e-Learning offer
- Developed and launched the VARM process
- Supported engagement activity using teams, zoom, telephone calls and surveys linking directly with 3rd sector services.
- Contributed to and lead on the West Midlands Association of Directors of Adult Social Services (ADASS) group
- Developed and contributed to a West Midlands Regional SAR Group
- Developed and contributed to training for SAR authors
- Led on SAR learning events
- Actively contributed to the National Board Managers Network including taking on chairing responsibilities and leading on a range of task and finish groups
- Developed robust relationship with Domestic Abuse Strategic Partnership ensuring the development of a relevant training offer to frontline social work staff
- Contributed to developing a core training offer to be made available across the partnership

11. PARTNER CONTRIBUTIONS

Learning disability advisory group

This is a multi-agency group including user lead organisations and the focus is on promoting best practice as it relates to adults with learning disability and cognitive impairment. Group members offered advice and guidance to other professionals, examples of this over the last 2 years include, supporting the establishment of specific COVID-19 vaccine clinics that were autism friendly and supported the needs of adults with learning disabilities (of note the clinic in Tipton), the provision of accessible information about COVID-19 and more recently information advice and guidance on sexual health and quality relationships. The advisory group also advises SSAB and has contributed to Safeguarding Adult Reviews where appropriate.

The action plan is attached as an appendix to this report.

Black Country Health Care NHS Trust

During 2020-2022 the services remain busy with staff capacity impacted seriously by Covid. Many frontline staff have been redeployed leaving deficits in mental health provision.

Incidents of domestic abuse have increased in severity and complexity with many victim trapped in unsuitable living conditions. For many incidences of domestic abuse the perpetrator can also be the victim and we have seen an increase in 'same sex' relationship abuse.

Self neglect and hoarding continue to be a key theme in community settings.

There has been an increase in cases whereby the hygiene standards within vulnerable people's homes have deteriorated significantly, mainly as a result of pets and a lack of ability to look after the animals.

Work within Prevent and Protect Sub Groups has continued with a focus on supporting Task and Finish groups for the most vulnerable during lockdown. The Adults with Learning Disabilities and Autism Task and Finish Group has been very pro-active in identifying difficulties in accessing care and support as well as being a valuable platform for sharing resources and support strategies. A great achievement was for all Partner Agencies to agree to use the same Patient Passport format which will offer consistency and continuity for adults with LD if acutely unwell. Another achievement was in working alongside Channel colleagues to help identify support pathways for young persons with ASD traits who have been directly affected by lockdown resulting in referrals to Channel due to ideologies they have expressed.

Work with SAR cases has also started again with a focus on supporting IMRs to continue to help identify learning and Learning Events are taking place again as a result of this.

Staff have remained busy despite remote working and remote working has facilitated an increase in productivity within some teams. Effective communication which is always the key to safeguarding has been strong with the ability to call multi agency meetings more urgently when risks emerge. Staff contact to the safeguarding team has remained high with response times being efficient and supportive in all areas of safeguarding.

Sandwell Metropolitan Brough Council (SMBC)

During 2020-21 the operational safeguarding team, like other services managed the challenges of the pandemic including an increased number of commissioner and provider failures, high volume of safeguarding caseloads open and managing the impact on our resources.

The year 2020-21 ended with a continuing commitment to ensure we have the right resources to manage the demands on the service and review our practice around provider related incidents applying an preventative perspective.

A summary of the challenges and achievements in 2021-22 from an operational safeguarding perspective is that we have reduced our open safeguarding enquiries, by half before the end of the financial year. At the end of the financial year, 2020-21 the Local Authority had 444 open

safeguarding cases open and active. At the of 2021-22, the Local Authority had 225 open safeguarding cases.

97% of enquiries concluded in the final quarter of 2021-22 resulted in the risk being reduced or removed and 92% of individuals reported that their desired outcomes were either fully or partly met.

There has been a rise in the number of referrals in 2021-22, compared to the previous year. In 2020-21 the operational duty safeguarding team manged and safely concluded, 2,255 contacts, in comparison to 2021-22, 4,099 contacts.

The challenge in managing this demand remains for the operational safeguarding team in the forthcoming financial year and work with partners and agencies is an indefinite activity in raising the awareness and understanding around what is 'safeguarding' as per the Care Act (2014) definition.

The operational safeguarding team's structure includes a full time equivalent Operational Manager, three full time equivalent Social Care Lead Officers (*one a seconded position*) and twelve full time equivalent social workers. The safeguarding team in 2021-22 has experienced a turnover of resource and the forthcoming challenge of short and long-term recruitment of experienced social workers continues to be progressed.

The emphasis for the operational safeguarding team this year has been focused mainly on reviewing our safeguarding process, improving practice and delivering on the outcome of the independent review.

An independent review was commissioned in late 2021 that focused on the following key areas: -

- The safeguarding process including decision making points
- Application of S42 Adult Safeguarding Criteria
- Application and use of the Mental Capacity Act
- Staff supervision and management oversight of safeguarding
- Frontline staff levels of knowledge and skill when working to safeguarding adults
- Implementation of Making Safeguarding Personal

Following the completion of the independent review and its recommendations an action plan was developed in response to the review and also learning to arise from in depth work by practice educators. The action plan had some key objectives, particularly on ensuring 1) effective management of the 'front door' contacts and referrals, 2) achieving safe caseloads for staff and 3) promoting effective professional safeguarding practice.

The objectives of the safeguarding action plan and outcomes achieved this year are as follows: -

- Sandwell Adult Safeguarding Procedures and Practice have been updated to include the 'Safeguarding and Quality of Care' guidance. This ensures that all low-level provider related incidents are triaged and progressed appropriately with the clear majority outside of the safeguarding pathway and passed to the Quality and Safety in commissioning.
- Managed workloads will continue to be monitored and reviewed. The safeguarding team were previously holding between 35-40 cases per social worker. With the introduction of alternative practice guidance, 'Safeguarding and Quality of Care' and more triage at the 'front-door', the operational safeguarding team hold between 15 and 20 cases. This enables managers to ensure 'quality practice' given the manageable numbers.
- The Principle Social Worker Lead, Practice Educators and the Learning and Development team are developing communities of practice in Sandwell. In addition, the Principle Social Worker is reviewing the supervision policy to ensure that staff/teams are appropriately supported.
- The introduction of VARM (Vulnerable Adult Risk Management), a 'multi-agency risk management' protocol was launched in November 2021. This encourages a shared approach to risk, owned by all necessary individual agencies and teams. VARM

awareness raising sessions have been undertaken with various professionals including, Housing Officers, Domestic Abuse representatives, Fire Service colleagues, Cranstoun etc.

Auditing and performance of safeguarding practice continues to be completed each quarter and reported to senior management and the Director, including any specific trends and actions in response to be undertaken. Sandwell Local Authority continues to participate in the regional safeguarding benchmarking data and Sandwell's conversion rate is reasonably in line with other neighbouring authorities, i.e. 39%. The operational safeguarding team provide membership to the SSAB's sub-groups and task groups to support and improve safeguarding practice to our Sandwell residents.

NHS Black Country and West Birmingham Clinical Commissioning Group (NBCWBCCG)

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

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

We continue to engage with SSAB via the relevant sub groups and we are represented on the board. We actively engage in identifying key themes and learning from SAR's and ensure that they are reflected in training that we deliver or commission. An example of this is training we commission for GP's where they are introduced to neglect and self-neglect as some of the themes with respect of safeguarding and the trainer linked the learning package to the themes identified in Adult A SAR commissioned by SSAB in 2018/19.

We have been an active partner in a significant amount of task and finish work and contribute regularly to the learning disability and autism advisory group. We actively participated in the VARM task and finish group and have supported conversations with GP's to help them understand the VARM process and get them involved in active risk management ensuring better outcomes for all and that people are better Safeguarded.

Finally, we actively contribute to a learning culture in Sandwell supporting learning from SARs and sharing learning from LeDer reviews.

We are also a statutory partner on SSAB.

Sandwell & West BIRMINGHAM Hospital Trust (SWBHT)

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

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

West Midlands Police (WMP)

The Adult at Risk Team investigate the following:

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

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

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

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

We now Chair the SSAB SAR Standing Panel to enable active participation in safeguarding adult review decision making and partnership working.

We actively participate in the West Midlands Uniform Services Group and work hard with partners to provide appropriate data and assurance across the metropolitan West Midlands footprint.

We actively contributed to the development of the VARM process and have participated and led in a number of risk management meetings involving adults with needs for care and support. We are also a statutory partner on SSAB.

Third Sector Representation

SSAB has third sector representation from Board Members however is committed to strengthening the working relationship. Members of the SSAB Business Team and the SSAB Operations Manager attended a third sector Health and Social Care Forum where we talked about the role of the Board, we actively contributed to board conversations with reference to stronger working relationships with the 3rd sector.

There has also been an ongoing conversation supporting the development of an early help partnership with adults who experience a range of impairments and who potentially have care and support needs.

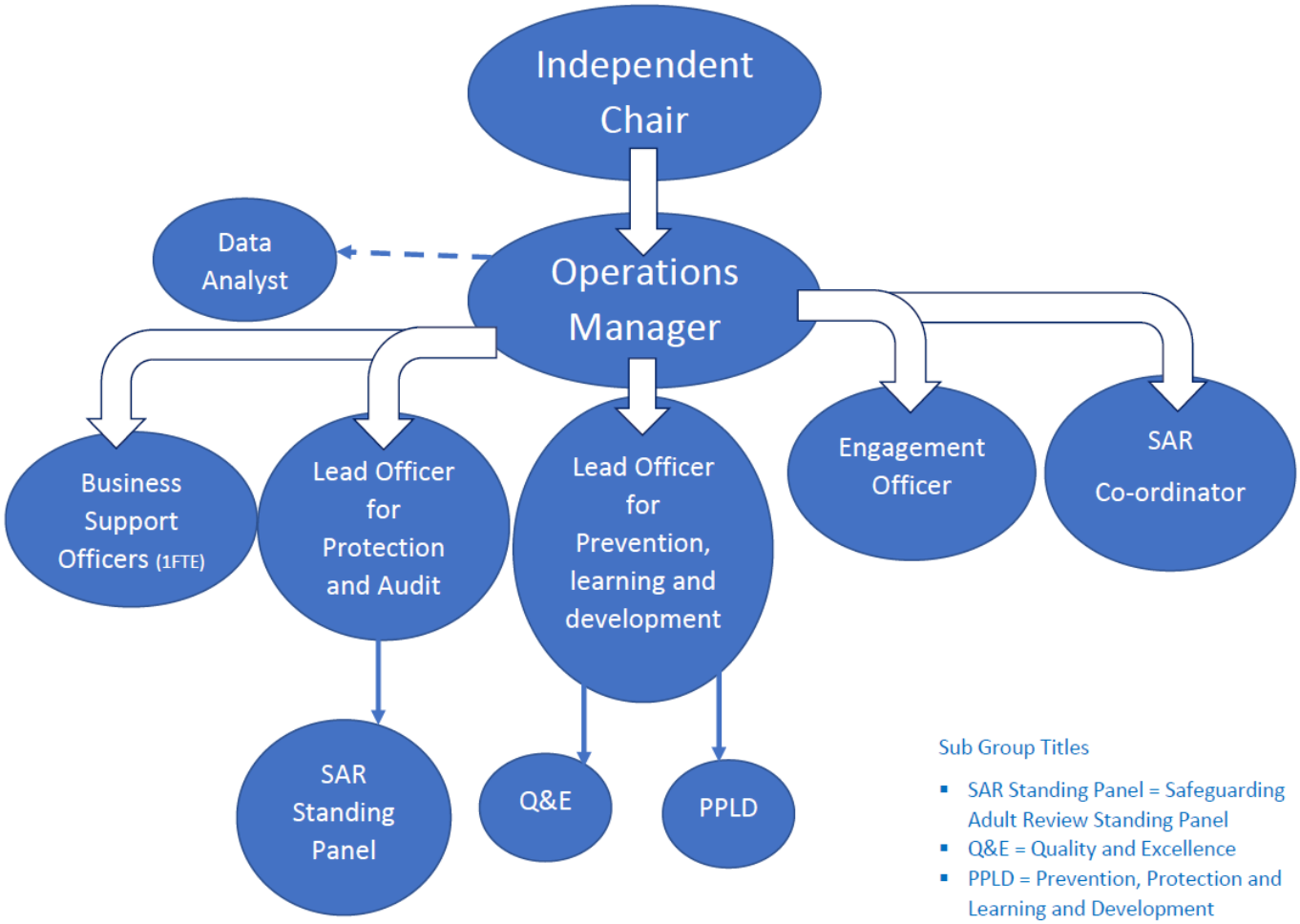
Healthwatch are committed to working in partnership to ensure the voice of the citizens of Sandwell are heard and that all activity is appropriately grounded in people's experience.

12. PLANNING FOR THE FUTURE

- Safeguarding Adult Reviews and taking forward the learning remains a priority. SSAB are going to plan an event with statutory review authors for October 2022. We hope this will be a hybrid event (some face to face and virtual attendance) with a focus on learning and what we can all do to support change.
- Building on the relationship with the 3rd sector, exploring a range of ways in which we can work together to strengthen the prevention offer and support a better understanding of safeguarding.
- Continue to develop specific issue campaigns maintaining a campaign focus under the broad banner of ‘see something do something’.
- Continue to work on effective relationships with all statutory boards in the borough, identifying key areas we can work together on minimising the risk of duplication and maximising impact.
- SSAB is planning a development session in June 2022 and this will be reported on in next years annual report.

Appendix 1

SSAB STRUCTURE



Sub Group Titles

- SAR Standing Panel = Safeguarding Adult Review Standing Panel
- Q&E = Quality and Excellence
- PPLD = Prevention, Protection and Learning and Development

APPENDIX 2

BOARD MEMBERSHIP

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

APPENDIX 3

FINANCE AND BUDGET INFORMATION

Sandwell Safeguarding Adults Board Budget 2020/2021 & 2021/2022

	2020 / 2021		2021 / 2022	
	Budget	% of Total Funding	Budget	% of Total Funding
Expenditure				
Employees	319,200		285,700	
Independent Chair	21,600		24,200	
SAR Case Review	43,600		43,600	
Training	10,000		10,000	
Legal	9,000		9,000	
Advertising & Publicity	3,000		3,000	
Other Expenditure	5,400		5,400	
One Off	13,300			
Total Expenditure	**425,100**		**380,900**	
Funding				
CCG Funding	(143,500)	33.76%	(143,500)	37.67%
West Midland Police	(17,200)	4.05%	(17,200)	4.52%
Other Fees and Charges	(100)	0.02%	(100)	0.03%
Sandwell MBC	(264,300)	62.17%	(220,100)	57.78%
Total Funding	**(425,100)**	**100%**	**(380,900)**	**100%**

The work of SSAB cannot be achieved without a dedicated budget and resources.
For 2020 - 2022, the financial contribution for the work of the Board came from Sandwell Council, Sandwell Clinical Commissioning Group, and West Midlands Police.

APPENDIX 4

Learning Disability & Autism advisory group action plan

(Draft 7) Learning
Disability Advisory Gr

APPENDIX 5

GLOSSARY

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

APPENDIX 5

FEEDBACK FORM

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

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

Sandwell Safeguarding Adults Board

100 Oldbury Road

Smethwick

B66 1JE

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

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

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

WHO CAN I TELL MY CONCERNS TO?

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

In an emergency ring 999