Annual Report

How the Board has overseen and led on safeguarding in Sandwell, preparing for the challenge.

2022-2023

Sandwell Safeguarding Adults Board

ANNUAL REPORT

2022 - 2023

Contents

Appendices

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 2022 to March 2023, a year of mixed challenges including hybrid working and a move back to some face to face Board meetings which all have really appreciated.

Within this report, details of the work of the sub groups and task and finish groups who do much of the work on the Board's behalf will be evidenced, in addition, some of the Board's achievements over the last year will also be highlighted.

I continue to welcome the closer working relationships that have been developed with all partners enabled by using Microsoft Teams, and the reintroduction of some face to face Board meetings. The Partnership continues to work together to ensure people in Sandwell are safe and challenge each other to support the development of quality assurance information, sub groups with strong chairs and clear direction and a robust relationship with the other statutory boards in the borough.

Members continued to be committed to ensuring that learning from Safeguarding Adult Reviews was a priority. A learning event with authors and workers was undertaken in March 23, and this event will be referenced in more detail in this report. The Safeguarding Adults Board sponsors a task and finish group looking at how to better take forward learning from all statutory reviews, including Safeguarding Adult Reviews. The membership of this group reflects all key partners across the system and the third sector.

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 members 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 in driving this forward.

The Board benefits from involvement with regional and national colleagues and the SSAB Board Manager's role as Co-Chair of the Board Managers Network.

As this reporting year ends, the impact of the pandemic can still be felt, though restrictions have ceased. I would like to thank all partners for their commitment to the Board, the Chairs and members of the sub groups. Final thanks to the Board Manager and the Business unit, whose work enables the Board to function, and to everyone for the valuable work you do together, in supporting people and helping them to keep and feel safe in Sandwell.

Sue Redmond, Independent Chair

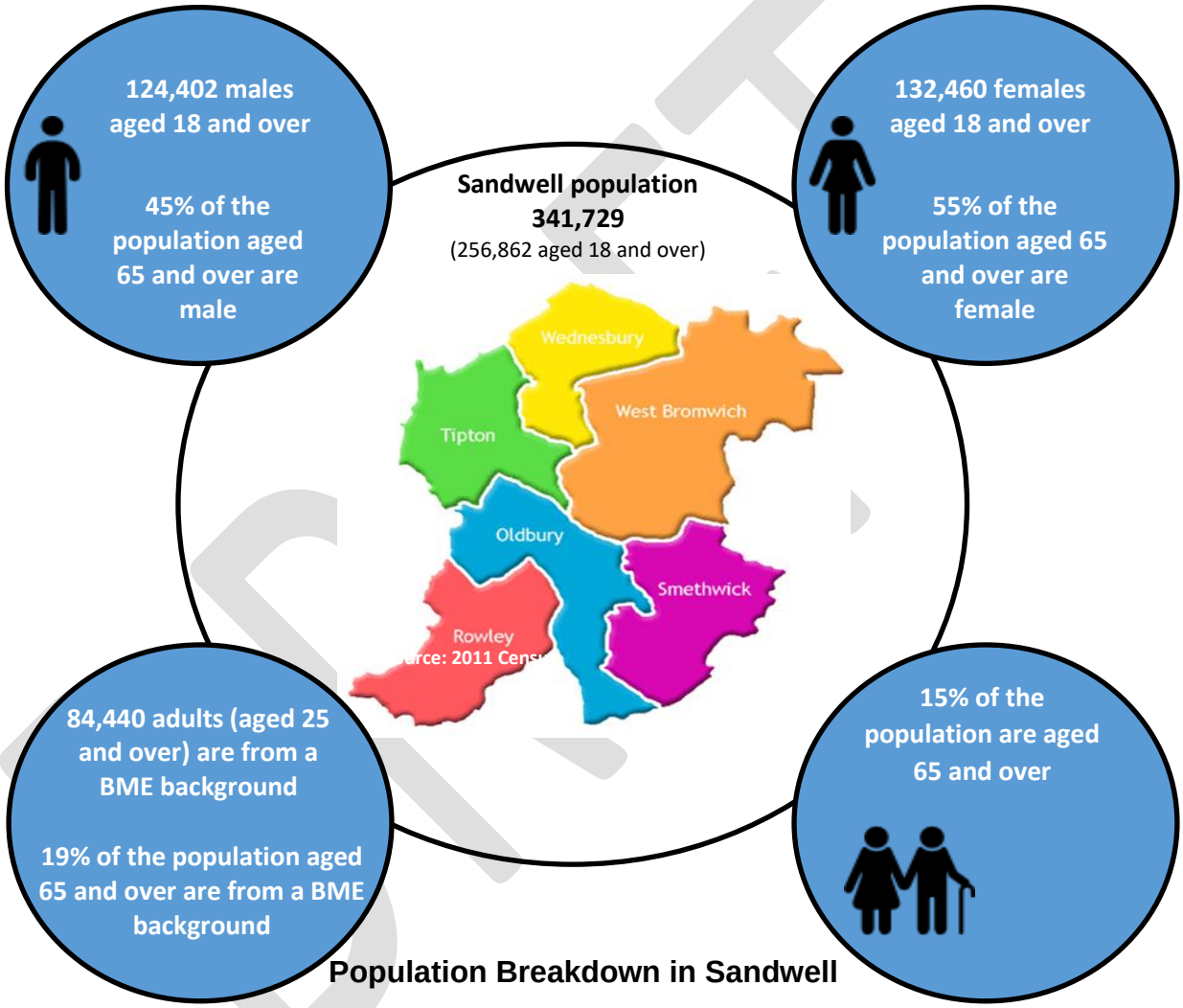
2. SANDWELL AT A GLANCE

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

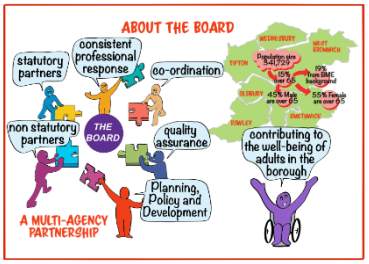
Data Source: Office for National Statistics – Mid-2021 Estimates of the population / Census 2021, Dataset ID: RM032 - Ethnic group by sex by age

Sandwell Residents by Ethnic Group

White British 52% White Other 5%
Mixed/Multiple 4%
Asian 26% Black 9%
Other Ethnic Groups 4%

Data Source: Office for National Statistics – Census 2021 - Population by ethnic group, 2021, local authorities in England and Wales.

3. ABOUT THE BOARD



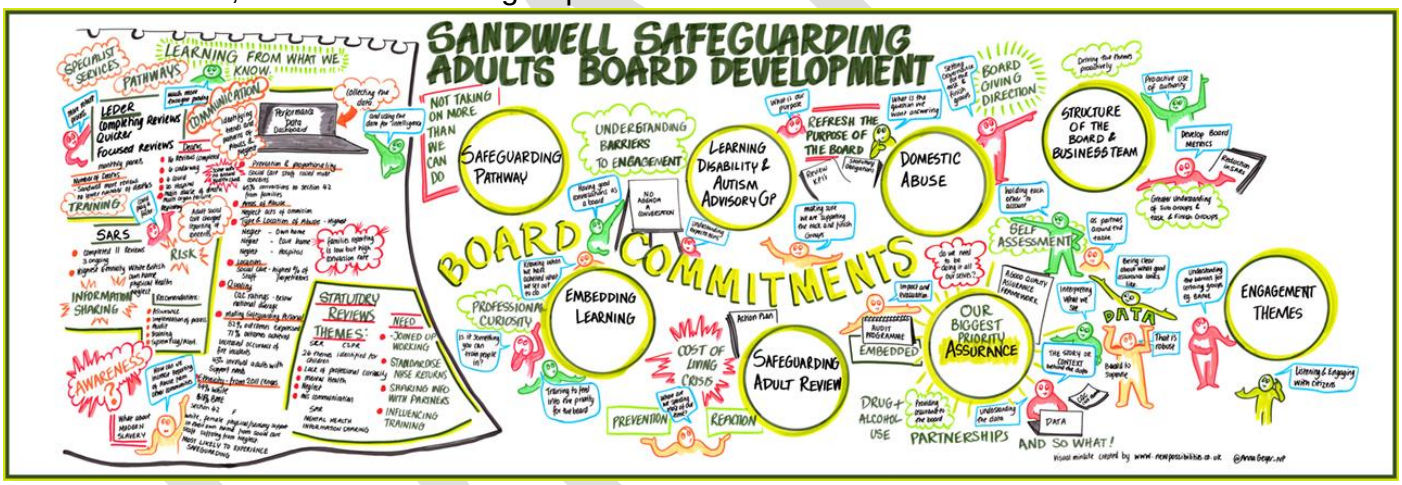
The Board is a multi-agency partnership made up of statutory sector member organisations and other non-statutory partner agencies providing strategic leadership for adult safeguarding work and ensuring there is a consistent, professional response to actual or suspected abuse. The remit of the Board is not operational but one of co-ordination, quality assurance, planning, policy and development. During this reporting period, the Board have met virtually approximately every 8 weeks to ensure a robust working together response to safeguarding.

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 June 2022 SSAB held a Board Development afternoon including Board Members, Partners and sub group members. Please see an illustration of the event below:



An outcome of this day was a commitment to the board priorities and activity identified above; Safeguarding Pathway, Embedding Learning, Learning Disability & Autism Advisory Group, Domestic Abuse, Safeguarding Adult Reviews, Structure of the board and business team and Engagement Themes, with our biggest priority being assurance. The commitments identified above inform the development of the Sandwell Safeguarding Adults Board (SSAB) strategic plan.

Partners gave a further commitment to;
An ambition to influence practice through learning from Safeguarding Adult Reviews (SARs)

Agreement of Board Priorities 2022-24:
1. Listen to the voices of service users and front-line 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 Five + Statutory Boards which all focus on prevention
5. Board Governance

STRATEGIC PLAN

Our role is to help and safeguard adults with care and support needs by:

- Seeking assurance that local safeguarding arrangements are in place as defined in the Care Act.
- Assuring that safeguarding practice is person-centred and outcome focused.
- Working collaboratively to prevent abuse and neglect where possible.
- Ensuring that agencies and individuals work in a timely and proportionate manner where abuse or neglect has occurred.
- Seeking assurance that safeguarding practice is continually improving.
- Concerning ourselves with a range of issues which may impact on people with care and support needs.

Our Structure:

- Board with an Independent Chair
- Safeguarding Adult Reviews Standing Panel
- Quality & Excellence Sub-Group/Prevention Sub Group
- Themed Task & Finish Groups

Our Responsibilities:

- Publish Strategic Plan: our 1-year ambition.
- Publish Bi-Annual/Annual Report which includes what we have achieved.
- Complete Safeguarding Adults Reviews when adults die or are seriously injured as a result of abuse/neglect.

Strategic Priority 1
Listening to the voices of people who use services and front-line practitioners

Ambition: That we promote co-produced solutions and work in partnership with adults with care and support need and their families and support, enable and promote what good looks like in Safeguarding.

Strategic Priority 2
Develop more inclusive Performance Data

Ambition: To develop an assurance framework, audit programme and narrative that provides robust assurance to the partnership that adults with care and support needs in Sandwell are safe. Use key information and activity to identify future priorities.

Strategic Priority 3
Embedding learning from Safeguarding Adult Reviews

Ambition: recommendations from Safeguarding Adult Reviews commissioned are meaningful and achievable and are a lever for positive change.

Strategic Priority 4
Board Governance

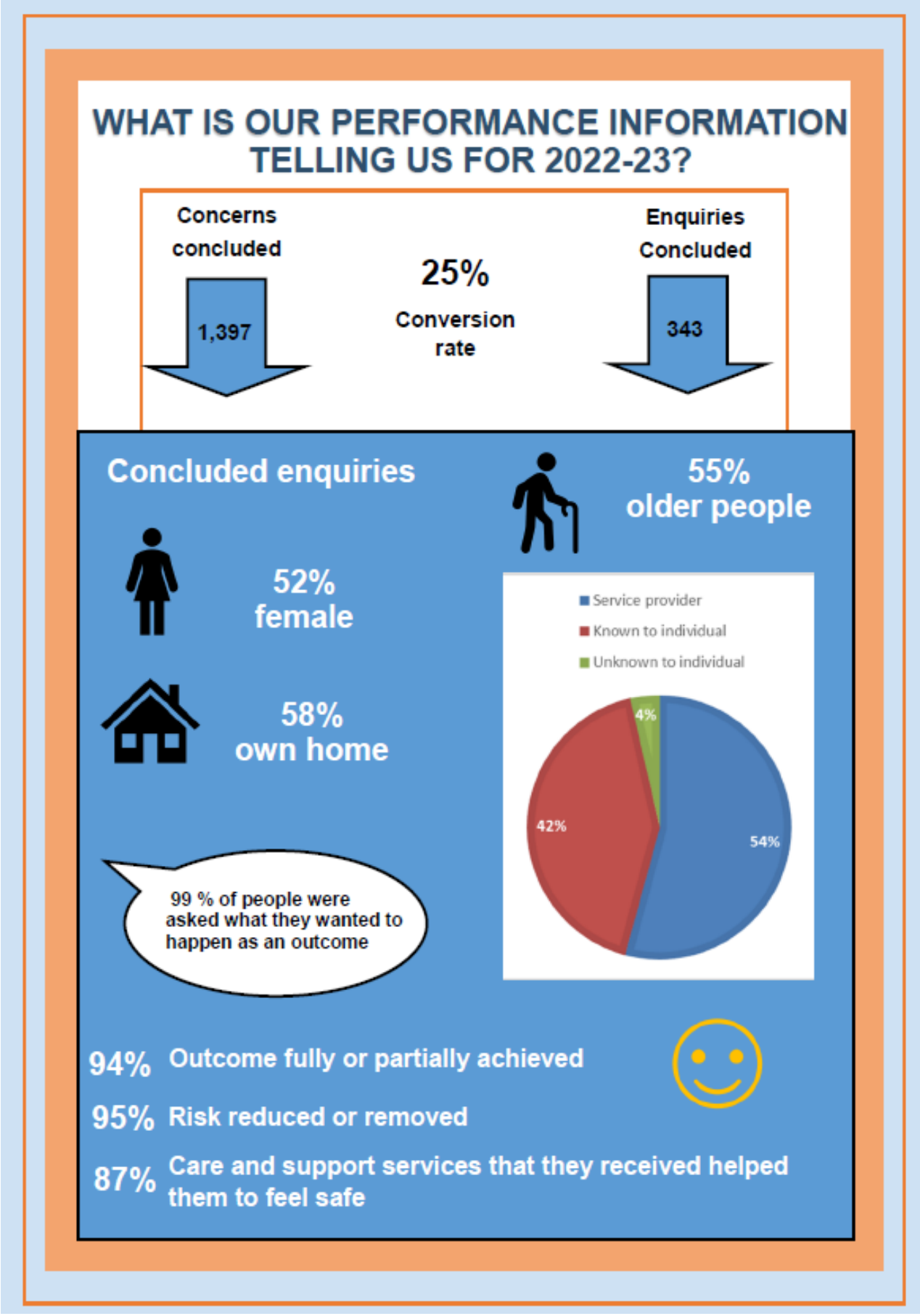
Ambition: SSAB membership continues to be made up of senior members who can make decisions on behalf of their organisations and the partnership. Board governance continues to be managed by key and statutory partners and the SSAB Independent Chair and a revised governance document has been written (Board Members Handbook) to reflect this.

Our Strategic Plan 2022—2024: What we will do

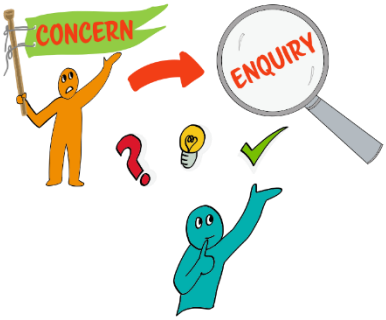
We will continue to work on our website to ensure it is accessible and contains the information people want.	Understand what is happening in care homes provision in Sandwell as a priority those homes that have no CQC rating. Hear about peoples experience who live there and hear from employees who work there. Project plan to be developed.	Safeguarding Adult Review action plans will be developed in partnership using a task and finish approach and agencies will be held to account for their actions.	Seek assurance around the Health and Social Care—Integrated Care systems and how we are working together effectively to minimise duplication and maximise opportunity.
Continue to involve and engage with citizens and partners maximising opportunities using existing systems and link to specific workstreams.	Undertake a baseline audit with partners using the care act compliance audit tool in September 2022. Update SSAB on progress and establish a challenge event in the spring of 2023.	The embedding learning multi-agency task and finish group (this is an across the system group) will undertake audit activity to ensure learning and changes are being made.	SSAB will work with other statutory boards to agree key priorities and who will lead on them.
Undertake work using a multi-agency Task & Finish approach exploring the effectiveness of the current Safeguarding Pathway in Sandwell outlining areas for improvement and recommending alternative models.		Progress and difference made will be reported to SSAB as a standing item.	Set clear project plans for all activity and ensure outcomes of domestic abuse and adults with needs for care and support task & finish group and the learning disability and autism advisory group are appropriately reported.

4. WHAT IS OUR PERFORMANCE INFORMATION TELLING US?

2022 – 2023



We have looked at our data taking into account the previous year's data, regional data and national data for 2022-23 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, decreased. The conversion rate from concern to enquiry has decreased overall. Not all concerns raised became 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.

In the working age population (18-64), 26% 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 population 75-84 age, 18% 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.

During the reporting period, the number of people who expressed an outcome, on average 94%, felt their outcome at the end of the safeguarding process was fully or partly met.

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 became a safeguarding enquiry.

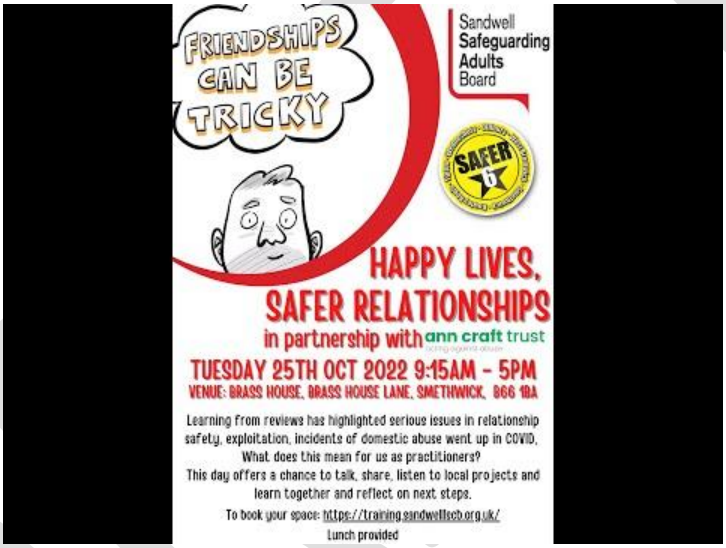
Most concerns were raised by Social Care staff (from within the Council or care agencies and care home settings), the amount of concerns raised that then went on to become safeguarding enquiries were also raised by Social Care staff. For this reporting period, of the 46% reported concerns from Social Care staff, 33% of those concerns became active safeguarding investigations. The work around identifying what is and what is not a concern is having an impact, linked to the 'See Something, Do Something' campaign and staff are feeling empowered to report concerns. VARM Awareness sessions and the VARM multi agency meetings will have informed people's understanding of when to report a safeguarding concern. SSAB continues to work with partners to support an active conversation around risk management and the link to safeguarding.

Over the reporting period, the data tells us that 58% of people are abused in their own home. This is in line with the national picture and central government plan to undertake a review which will be reported on in more detail next year. Understanding the nature of the abuse and the factors contributing to it, remains a priority for SSAB and the Quality & Excellence sub group and informs our assurance framework. SSAB remain committed to hearing the experiences of citizens with needs for care and support in Sandwell, this is also reflected in the Safeguarding Pathway work which we can expand on for future plans. SSAB, along with other statutory boards, remain concerned about the impact of the cost of living crisis and the impact that will have on individuals in respect of exploitation, financial abuse and self neglect.

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 prevalence 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 Women's Aid (BCWA) have employed a specialist IDVA whose 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 and 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 2023.

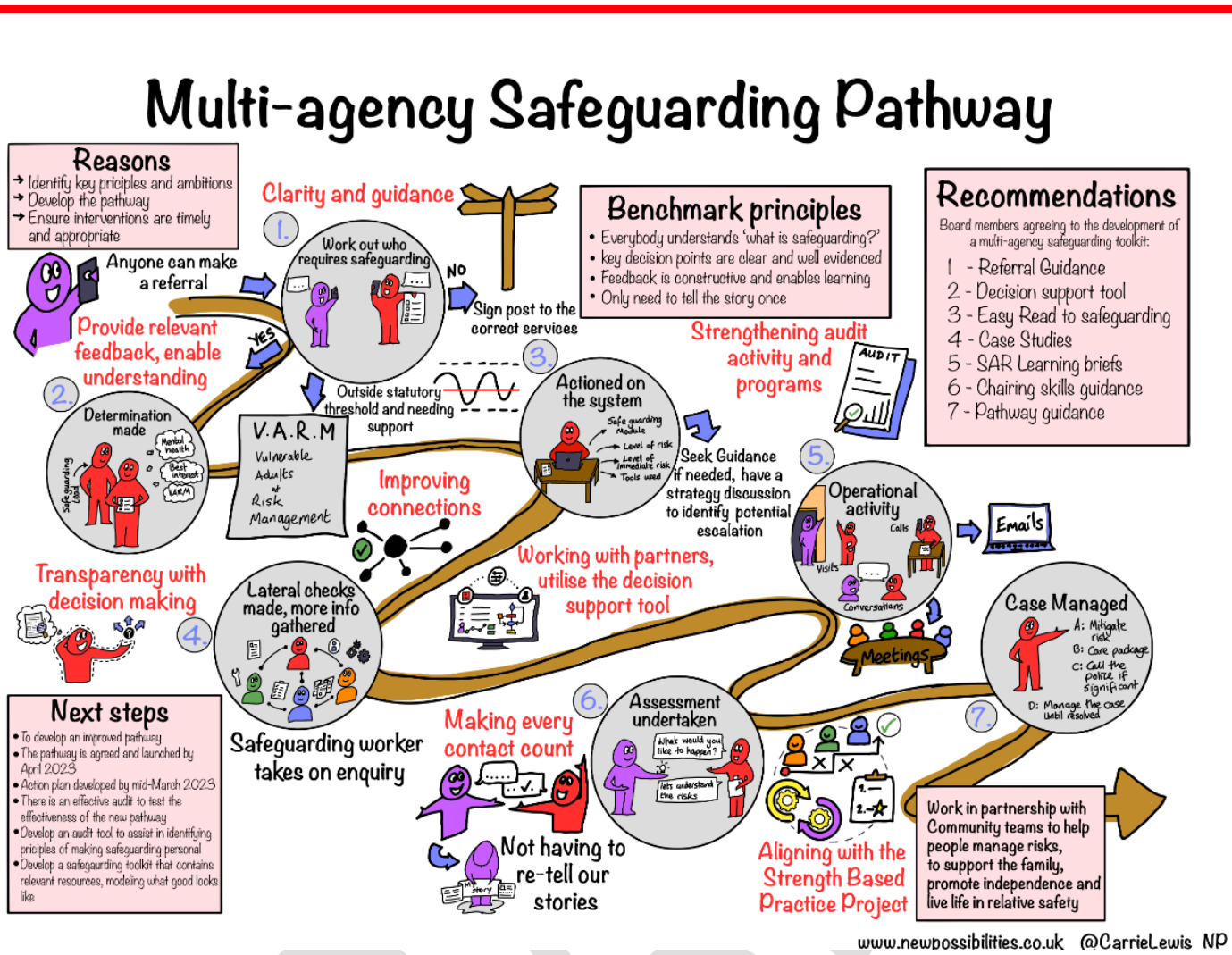
In partnership with the Ann Craft Trust, SSAB ran two events in September and October 2022 with a focus on relationships and what good looks like for young people and adults with needs for care and support. We plan to run a program of these events as they were well attended and valued by all partners.



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. For this reporting period, on average 95% of people said they felt safe and risk was removed, 87% said care and support services helped them feel safer.

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 fundamental to making safeguarding personal. SSAB are sponsoring work looking at a Safeguarding pathway using a task and finish methodology that includes all key partners. Pro-active work with risk is key in the VARM work outlined below and links to risk management tools and safeguarding toolkit being developed.

(Please see draft pathway on next page).



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

Vulnerable Adults Risk Management (VARM) Data

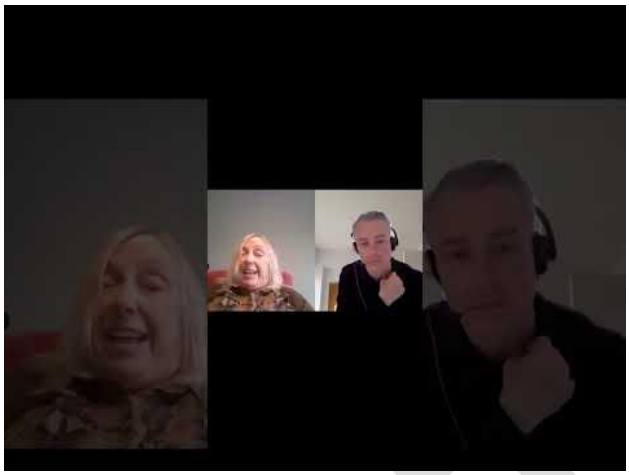
Below is a table identifying a breakdown of VARM meetings including who called them, the themes and the reasons for concerns being raised. At the time of writing, there are 16 live VARM meetings at various stages of the process. 24 VARM meetings have been closed because the risks have been reduced or alternative pathways were pursued.

In addition, there have been 9 VARM awareness sessions with 97 attendees in March 2022 – March 2023. We are offering regular VARM awareness sessions on a monthly basis. Chairing multi-agency meetings training sessions were launched in October 2022 and at the time of writing this report, there have been 28 attendees across 4 sessions March 2022 – March 2023. More sessions were scheduled however, some were cancelled due to low attendance. This training is now mandatory within Adult Social Care.

Finally, there have been representatives from the Safeguarding team, housing officers, professionals working in domestic abuse, West Midlands Fire Service and colleagues at Cranstoun at VARM meetings and Learning and Development opportunities. VARM briefings have also been delivered at Town Task Meetings, the Blue Light Strategic Group and to a GP's forum. The VARM champions scheme continues to be developed and a six weekly newsletter is also published.

The VARM process supports the embedding of multi agency working, enabling all professionals to raise concerns regardless of the organisation they work for, providing the VARM criteria are met. Key to this work are strength based approaches, working directly with families and individuals to

reach an agreed understanding of the identified risks and a plan (again with agreement from individuals and/or family members) on how to manage and mitigate those risks.



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		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			Self-neglect
Custom Care		Self-neglect	Drugs dependence	Alcohol dependence	Drugs and alcohol dependence, self-neglect
Regis Medical Centre		Possible Neglect	Coercive control		Neglect and coercive control
Anti-Social Behaviour Town Lead Wednesbury		Referral received and toolkit sent			
Cranstoun	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	Destitution / malnutrition, loss of income, risk of losing home
Young Adults Team		Criminal Exploitation			Criminal Exploitation, Physical Impairment
Cranstoun	Cranstoun	Housing Issues	Health Issues		Housing and health issues
CSWT West Bromwich		Risk of Coercive control	Drug dependence		Risk of coercive control and drug dependence
Cranstoun / Blue Light Project	Cranstoun	Dependent Drinker	Homelessness, financial issues	Health problems	Dependent drinking, homelessness, financial issues and health problems
Black Country Healthcare NHS Foundation Trust	BCHNHS Trust	Excessive Alcohol use	Self -neglect	Physical health needs	Excessive alcohol use, self-neglect, physical health needs
SMBC Hospital Trust	SMBC Hospital Trust	Unintentional self-neglect	Health deterioration	Medical errors	Unintentional self neglect, health deteriation and medical erros
Young Adults Team		Criminal exploitation	Risk of harm		Criminal exploitation and risk of harm
Neighbourhoods / Rowley Regis	SMBC Local Rowley Regis	Hoarding	Health Issues	Risk of fire	Harding, fire risk to self and others and health issues

Neighbourhoods / Rowley Regis	SMBC Local Rowley Regis	Hoarding	Risk of fire	Risk to others	Hoarding, fire risk to self and others
Adult Social Care/ Wednesbury	ASC / Wednesbury	Financial coercion / abuse	Physical threats of violence		Finanancial coercion and financial abuse, threats of violence
NHS – LD Service OT		Hoarding	Risk of fire	Poor living conditions	Hoarding, fire risk, poor living conditions
Cranstoun / Blue Light Project	Cranstoun	Unsuitable housing	Health Issues		Unsuitable housing, health issues
CSWT West Bromwich	SMBC	Risk of Coercive control	Drug dependence		Risk of coercive control, drug dependence
Cranstoun / Blue Light Project	Cranstoun	Rough sleeper	Drug dependence		Rough sleeper, drug dependence
Black Country Health Foundation Trust	BCHFT	Self-neglect, poor diet, physical health needs	Excessive alcohol consumption	Risk of fire / harm to others	Self-nelgect, poor diet, physical health needs, escessive alcohol consumption, risk to ohers
CSWT West Bromwich	West Bromwich Social Work Team	Risk of homelessness			Risk of homelessness
SMBC Hospital Team		Unintentional self-neglect	Medical errors	Health deterioration	Unintentional self-neglect, medical erros, health deterioration
Neighbourhoods / Rowley Local	Neighbourhoods	Hoarding	Risk of fire		Hoarding, fire risk to others
Neighbourhoods / Rowley Local	Neighbourhoods	Hoarding	Risk of fire		Hoarding, fire risk to others In block
ASC / Wednesbury		Financial coercion / financial abuse	Criminal exploitation	Threats of violence from others	Financial coercion / financial abuse, criminal exploitation, threats of violence from others
ASC / Smethwick		Homelessness			Homelessness
ASC / Wednesbury		Health issues	Risk of fire to others	Risk of eviction	Health issues, risk of fire to others, risk of eviction
CSWT / West Bromwich		Risk of harm or death due to alcohol abuse	Relationship issues		Risk of harm or death due to alcohol abuse, relationship issues
CSWT / Wednesbury		Domestic abuse	Alcohol abuse	Health issues	Domestic abuse, alcohol abuse, health issues
CSWT / Rowley Local		Excessive alcohol consumption	Health issues	Risk of fire to others	Alcohol dependence, health issues, risk of fire to others
Hospital 2 Town Team		Alcohol abuse	Self-neglect	Medication issues	Alcohol abuse, self neglect, medication issues

5. SUB GROUP CONTRIBUTIONS AND PROGRESS 2022-2023

Supporting the Board are three sub groups who completed the following work so that people can better live their lives free from abuse and neglect.

PREVENTION, PROTECTION AND LEARNING & DEVELOPMENT:
Continue to raise awareness of adult abuse, communicating effectively with all partners and members of the public

The Prevention, Protection and Learning & Development sub group 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;

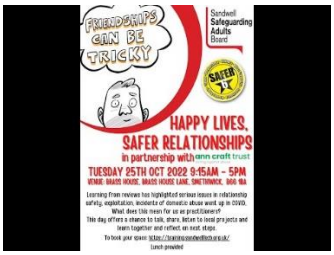
- VARM awareness training
- Hate Crime
- Recognising Safeguarding as a volunteer
- Safeguarding in a range of settings

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 multi-agency 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 is connected, maximising the opportunities to learn from SARs, develop resources, undertake focused pieces of work using a task and finish approach and minimise duplication. This has been particularly relevant during this reporting period where additional demands made on partners and stakeholders were significant and necessitated smart ways of working with high impact.

What did we want to achieve	What did we achieve…
To develop a specific issue campaign.	• Participated in National Safeguarding Week on a virtual basis and continued to promote 'See Something, Do Something'. • SSAB developed a range of resources and questionnaires supporting the work of task and finish groups and actively participated in Sandwell Safer 6 campaign, where we worked in partnership with West Midlands Fire Service to raise awareness of fire related risks. • SSAB worked with the Ann Craft Trust to deliver two face to face learning opportunities looking at the impact of domestic abuse on women with needs for care and support and exploring what a good relationship looks like.

	 • The prevention sub group also ensured that all VARM information was reported and available on the SSAB website. • This sub group was relaunched in 2023.
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 explore how to better strengthen our links with the third sector and smaller organisations as they work in community settings and safeguard people every day. SSAB and the 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. The Prevention 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. The Sub group also has oversight of the Safeguarding Pathway task and finish group. All projects identified in the strategic plan will be reported to Board on an ongoing basis and outcomes reported as part of the development day in November 2023.
Listen to the voices of service users and front-line staff	The Engagement Officer continues to work on projects where hearing the voice of citizens and front-line staff is key. In some of the projects highlighted in this report, we have seen direct feedback from citizens, particularly with reference to the relationship event and in the impact statement provided, in response to Safeguarding Adult Reviews.
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 continues to support this with awareness raising training using a virtual platform, and virtual training on Chairing multi agency meetings which is now mandatory for Adult Social Care managers. During the reporting period, there were also several learning from SARs events led by authors using a virtual platform. These were well attended and identified key learning.

QUALITY & EXCELLENCE:
Continue to focus on effective delivery and high-quality processes

The Quality & Excellence sub group continues to monitor performance, receiving assurance reports and data from some partners. Using the data, the group reports on themes and trends to SSAB and key lines of enquiry are then agreed and established. In addition, the sub group supports the monitoring of, and learning from, SAR action plans and plans to develop an audit programme using the assurance framework.

- Q&E have developed key lines of enquiry including:
  - Training
  - Location of abuse (a person's own home) and factors that contribute to that
  - Conversion Rate

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.

The 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. Members are committed to showing both qualitative and quantitative data, enabling better understanding of a citizen's journey and ensuring voices are heard.

What did we want to achieve	What did we achieve…
Continue to support the development of the Q&E Sub Group	The Q&E Sub Group continues to work with board members to develop good quality assurance and data sets. Throughout this reporting period, the sub group has supported the development of a quality assurance framework identifying priority areas for audit and has undertaken with board partners a Care Act compliance self-assessment audit. Most responses were received in September 2022 and analysis has been completed re self-assessment ratings submitted by partners. A peer challenge event is still to be organised to enable further exploration of what good looks like and areas for development as identified in the self-assessment. The sub group now has key lines of enquiry and a new chair and deputy chair, senior officers in the Integrated Care Service and Black Country Healthcare Foundation Trust.
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 and key assurance information is provided in response to specific requests of Board members and/or the independent chair of SSAB. SSAB works closely with the other statutory boards in the borough and supports a collective response to assurance and data. 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 sub 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 including; a supported vaccination programme for adults with learning disabilities, 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 principle 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	A Care Act Compliance Self Audit Tool was developed and sent to partners for completion in September 2022. The compliance audit tool continues to be reviewed and a peer review will be planned for late 2023.
Continue to understand the implementation of making safeguarding personal and the impact for service users	Effective engagement means that we will continue to collect data and information that reflects citizens' views.
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 Sandwell Children and Families Strategic Partnership We will work together to consider and develop cross cutting solutions for example, training and cross cutting priorities and who will lead on them. The revised protocol was agreed in March 2023 and can be found as appendix 4 to this report.
Board Governance	This remains a strategic priority. 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.

SAFEGUARDING ADULT REVIEW STANDING PANEL

To focus on the statutory function of SSAB, to apply rigour to the criteria application, work together to identify and embed learning.

The Safeguarding Adult Review Standing Panel is a sub group convened to consider SAR referrals. This group is chaired by a representative of Sandwell & West Birmingham Hospitals NHS Trust. Group members consider referrals against the SAR criteria. All key agencies are represented on this group.

Arrange for Safeguarding Adult Reviews to be undertaken as required, produce reports and action plans and identify learning	• 1 SAR referral submitted, still to be considered SARs previously reported on were progressed throughout the reporting period with 3 final reports being approved by Board Members including 1 SAR being published. Christine SAR There is a program of future publications throughout 2023 and SAR action plans are being developed to ensure recommendations from all SARs are taken forward and embedded in practice changes.

6. Task and Finish Groups

Local Task and Finish groups have looked at:

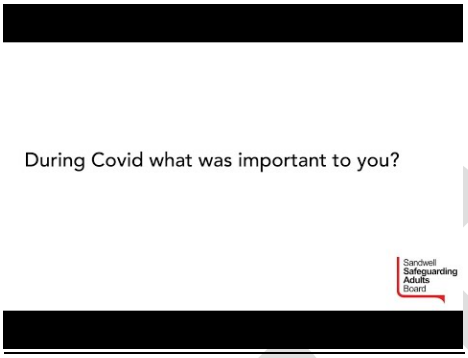
- Domestic Abuse
- Learning Disability and Autism Advisory Group
- Embedding learning from statutory reviews
- Safeguarding Pathway

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
- The development and publication of a Non-engagement toolkit

7. WHAT ENGAGEMENT HAS LOOKED LIKE

April 2022 was the start of face to face engagement following the lockdowns and restrictions of the Covid 19 pandemic. Therefore, our first piece of engagement was to listen to individuals' experiences of this time and their hopes for the future.



Work Undertaken March 2022 – March 2023

- Increased use of Social Media through our networks with front facing services to reach out to individuals
- Engagement has taken the form of outreach events, visiting established groups, telephone calls, drop in sessions, Microsoft Teams meetings and surveys.
- Targeted engagement to support Task and Finish groups.
- Engagement Practitioner Guidance produced.
- The groundwork for a large piece of engagement work regarding care homes due to commence April 2023.
- A new monthly drop in session in the Smethwick area.
- Key themes identified, examples include
    - The long-term impact of Covid 19 particularly on mental health, long term medical conditions, and primary health services
    - People feeling relief that restrictions ended with enjoyment and appreciation of face to face support groups
    - The feeling that lots of support and services have disappeared following Covid 19
    - The pressures of recruiting care staff
    - Support for informal carers
    - The importance of face to face contact to build trusted relationships
    - The value of feedback

- Throughout the year we have listened to over;
    - 50 individuals with care and support needs and carers
    - 25 organisations and council departments individually
    - 60 organisations through multi agency meetings.

Future Engagement

The majority of engagement activity will largely be face to face going forward, however the positives of digital engagement, particularly for professionals, means it is important we continue to explore and develop online opportunities. SSAB remains committed to effective engagement and wishes to use a variety of methods to suit as many individuals as possible. SSAB have also supported the development of resources that support engagement including short films. These will be reflected in our on-going work for 2023.

8. OUR LEARNING FROM SAFEGUARDING ADULT REVIEWS (SARS)

WHAT ARE SAFEGUARDING ADULT REVIEWS?

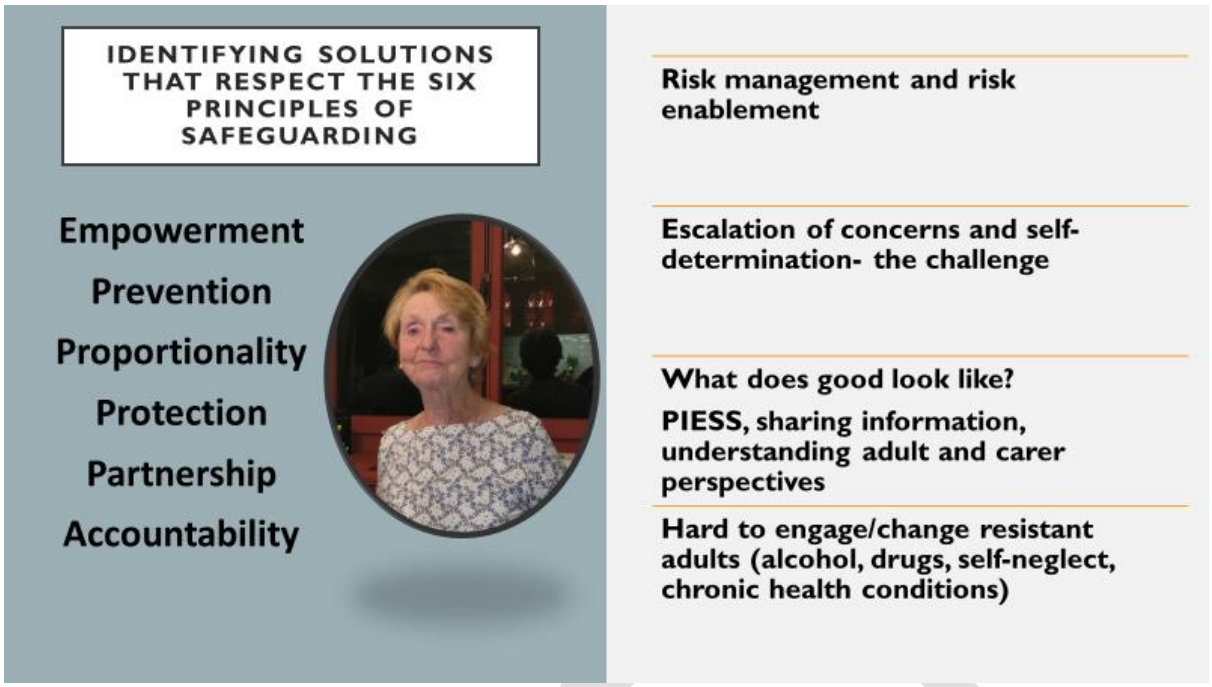
The Care Act 2014 introduced statutory Safeguarding Adults Reviews, mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

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 2022-2023 we have had 1 SAR referral. At the time of writing this report (April 2023), there are 2 SARs awaiting publication, 1 ongoing SAR, 1 awaiting a criteria decision and 1 SAR referral currently with the police awaiting charging decision. Christine SAR has been published during the reporting period.

LEARNING FROM ALL SARS UNDERTAKEN IN SANDWELL (Some of which fall outside of this reporting period)

- 1 SAR in progress has 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
- 1 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
- **SAR learning event** 13.3.23 identified the need to:
    - Work together
    - Apply the six principles of safeguarding to safeguarding practice
    - Understand the impact of unconscious bias and barriers to effective decision making
    - Appropriately apply the Mental Capacity Act



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 citizen's 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 SARs, 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 SARs 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.

Impact Statements

In 2021, the SSAB business team and safeguarding adult review authors started to co-produce impact statements in partnership with families who had lost a loved one. These have been a really powerful tool when using learning, reminding us all that safeguarding adult reviews are about real people who had families, loved ones and lives that were valued. Please note the selection of powerful comments and quotes below:

"It's very hard to read about the events leading up to your own mother's/sister's death. We are struggling emotionally with the whole thing. You get stuck in a loop of "*if I'd done x at y point, then things would've been better.*"

Kim was a great kid; so loving… a mommy's girl. She grew up to have three children and was a good mom. I was so proud of her.

She started using drugs around the age of 26 and her life would never be the same again. She lost her home, her children and herself.

"I wish I could've kept Jeff at home, but I was struggling to cope, needed help."

"I remember saying, very shortly after my mother died and we were having discussions in the family about complaints and inquiries, "*I can tell you right now what the response will be; lack of information sharing, and the phrase 'lessons will be learned' will appear somewhere in the official response*". And we're here, just under ten months later, and that's basically what's happened.

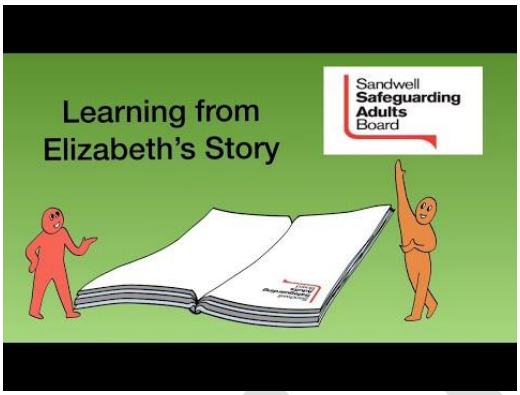
My only hope is that those who continue to serve their community and 'choose' to carry on with their careers take heed and provide the best level of care and support possible. One day it may be their relative lying in that bed needing help and compassion.

I am the one left feeling that I 'failed' to protect Richard, 'failed' to ensure he got the treatment and help he deserved to enable him to carry on with his life. It should not be that way.

"The learning event which was held recently clearly highlighted the fact that Richard was an individual in his own right and deserved to be treated the same as anyone else. It identified what worked well between the agencies (in my opinion – not a great deal, but I'm biased), what could have been done better and what the failings were."

"It hasn't been the same since Jeff has gone and I haven't been right since. I haven't felt right since he died, and I believe Jeff's death is my fault. I don't want anyone to go through what Jeff went through. I want the SAR to make sure this doesn't happen to anyone else!"

Elizabeth's Story is an animated short film where the circumstances of the young woman's death met the SAR criteria. This resource is being used as a learning tool, enabling learning from this SAR to be easily understood, embedded and used to influence change. Further resources are currently being developed to support this learning.



Practice Changes in Sandwell

- Clear and transparent risk assessment tools
- The introduction of risk management surgeries by Adult Social Care
- The introduction of screening tools and risk assessments to better enable appropriate support to be provided to adults who may use drugs and alcohol

REGIONAL SAR LEARNING

During the reporting period, the 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
- Developed 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

Key themes identified;

- 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 exploitation and modern slavery

National SAR Research Findings

A further review has been commissioned. This will be reported on in next year's annual report.

9. KEY ACHIEVEMENTS

- Board members continued to meet on a more frequent basis using Teams platforms, hybrid working and some face to face events
- Supported on-going priorities of listening to the voices of citizens and front-line staff
- 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
- Reviewing SSAB's publicity materials and continuing to develop accessible resources.
- The Learning Disability and Autism Advisory Group have informed SAR learning outcomes where the SAR relates to an adult with a learning disability and support the development of best practice in the borough.
- Developed a key communication strategy with partners and all other statutory Boards within the borough
- Added to SSAB e-Learning offer
- Developed, launched and monitored the VARM process, ensuring it is embedded in practice
- Developed key learning resources for learning from SARs
- Contributed to robust working arrangements across all statutory partnerships in Sandwell
- Supported a range of face to face engagement activity, with reference to specific projects for example, people's experience and understanding of living in a care home, which will be referenced in more detail in next year's annual report 2023-24.
- Contributed to and led 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 a robust relationship with the Domestic Abuse Strategic Partnership ensuring the development of a relevant training offer to front-line social work staff
- Contributed to developing a core training offer to be made available across the partnership

10. PARTNER CONTRIBUTIONS

Learning Disability and Autism Advisory Group

This is a multi-agency group including user led organisations and the focus is on promoting and developing best practice as it relates to adults with a learning disability and/or autism. Group members offer advice and guidance to other professionals, examples of this over the last year include shaping recommendations for safeguarding adult reviews, supporting the provision of topic specific accessible information, exploring the effective use of communication passports. The advisory group also advises SSAB and has contributed to Safeguarding Adult Reviews where appropriate.

Black Country Health Care NHS Foundation Trust

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.

The Chief Nurse Officer continues to act as the Executive Lead for Safeguarding, supported by the Associate Director of Safeguarding acting as the strategic lead for safeguarding providing oversight, leadership to the BCHFT Safeguarding Team. The operational management of the Team is led by the Interim Head of Safeguarding supported by Specialist Lead Nurses.
The Associate Director for Safeguarding is a core member of the SSAB and is also the Chair of the Quality & Excellence sub group. BCHFT safeguarding team continues to be well represented and has continued to engage with all sub-groups at both operational and strategic levels, contributing to the key priorities of Sandwell Safeguarding Adults Board. The offer of the safeguarding bulletins, newsletters, 7-minute briefings, and publications of Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews (SARs) have also been included within the Trust Learning Lessons library and shared widely with staff across the Trust.
With the development of the new BCHFT safeguarding service, as of December 2022, the visibility of the safeguarding team across clinical areas within the Trust has increased to support clinical staff with daily safeguarding practice. BCHFT has also continued to comply with the Care Act (2014) by having in place Lead Named Nurse for Adults working with the Trust Mental Capacity Act Lead to ensure the Trust fulfils its legal duty to safeguard adults at risk from harm or abuse, also supported by an Associate Named Nurse. The BCHFT safeguarding team has continued to provide advice and practical support for a wide range of safeguarding issues relating to adults and children who may be at risk of abuse either deliberately or by acts of omission.

BCHFT have achieved the following:

1. Ensured safeguarding is embedded within the new reporting and serious incident management systems, as well as patient records, safeguarding alerts, tracking and monitoring of statutory reviews and learning. Work has started to implement the safeguarding statutory review tracker onto Ulysses.
2. The Associate Director for Safeguarding and BCHFT Team has continued to improve partnership working with the SSAB Partners to support the progression of SSAB priorities.
3. Built up a positive learning culture refraining from a blame culture within the Trust and to support learning and ensuring lessons learnt,
4. pertinent to safeguarding are cascaded effectively throughout the Trust
5. Developed a Single Agency Audit planner to support and identify quality improvement within safeguarding practice and outcomes for Adults at risk of abuse.
6. Developed a robust internal Safeguarding Committee to oversee and provide governance and assurance to demonstrate how we are discharging our safeguarding duties.
7. Within 2022-2023 there will be more of a focus on the inclusion within the Trust Ulysses function as a way to ensure the Trust is capturing Making Safeguarding Personal, encompassing having meaningful discussions with patients and service users which are person led, about how best to respond to individual safeguarding concerns. All of this information will be used to provide assurance and we will continue to work positively as a SSAB partner.

Sandwell Metropolitan Borough Council (SMBC)

There has been a significant change in the Safeguarding team in recent months; as part of that change we are reviewing safeguarding policy and procedures alongside pathways with partners.

We continue to monitor the improvement plan that was enacted in December 2021. Several recommendations were made, and progress has been evidenced particularly in relation to team culture, safe caseloads and risk management.

Looking forward

A paper was presented to SSAB in June 2023 presenting the findings of the report and the improvements we are striving to achieve.

Due to the changes support was initially provided via community team managers, however the impact and risk to continuity for the whole service meant that an interim re-design was required to reduce backlogs and provide consistency to permanent and agency staff members.

As of July 2023 a re-design was agreed at DMT with the introduction of 4 Advance Practitioners (AP's) this has proved to be a successful plan, having reduced the backlog of contacts and duty so that the team is now positioned to effectively manage all daily contacts and duty situations. Urgent/high risk cases are allocated on the day.

We are working closely with the team, performance colleagues and community teams to address the demand and capacity. Progress is being made to reduce the demand, including changes to frontline practice that has comprised of an interim re-design with the introduction of an advance practitioner role. Procedures have been reviewed to align with community and hospital ensuring that Making Safeguarding Personal and Section 42 enquiry is embedded within all social work teams. We have noted improvements in timely Section 42 decision making and increased numbers.

We are in the process of working with learning and development to develop and up to date training programme for all frontline practitioners; surgeries are also available with the Safeguarding management should managers and practitioners have any queries.

Ongoing internal audits of adult safeguarding contacts, concerns and enquiries commenced in April 2023. There is elements of good practice and overall learning to take forward; particularly in relation to case recordings and copy/pasting of emails. A new case recording policy was launched, with training sessions led by the practice educators, we are looking to deliver a second round of training over the next 12 months.

We continually work with learning and development colleagues to discuss learning requirements for frontline practitioners and managers, the audits do support those discussions. Further training opportunities will include:

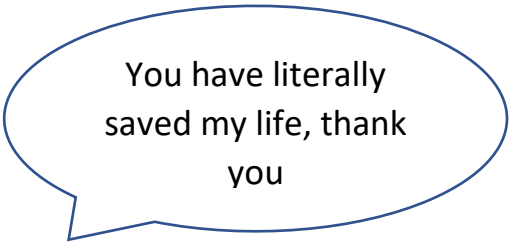
- Mental Capacity Act
- Forced Marriage
- Exploitation
- Case Recording
- Supervision
- Safeguarding

The Safeguarding overall review of safeguarding also aligns with the work that commenced as part of the safeguarding adults board in relation to safeguarding pathways; we will continue to work with partners to align the re-design of safeguarding team through effective communication not only internally but externally also.

NHS Black Country Integrated Care Board (BC ICB)

NHS reforms and the creation of ICBs in July 2022 required the transfer of statutory responsibilities/ due diligence around safeguarding processes and maintenance of business as usual and ensuring Partnerships were maintained and partners informed. In addition, the ICB have agreed internal governance for safeguarding and safeguarding training for new Board members. Achievements include:

- Contributing to the Joint Forward Plan and ensuring safeguarding was referenced throughout in terms of priorities and planned work and commissioned services.
- Continue to develop the work of Liberty Protection Safeguards and well as the development of work in line with the Serious Violence Duty, working with Sandwell LA partners and the West Midlands Violence Reduction Partnership.
- Continuation of level 3 safeguarding adult training for primary care clinicians as well as other ICB staff.
- Continued funding for the Identification & Referral to Improve Safety (IRIS) programme of domestic abuse, advocacy and support within primary care and ensuring that the ICB have a consistent approach to early identification of abuse across the Black Country.



- Support the continuation of funding of the FGM clinic for non-pregnant women.
- The commissioning and development of the One Health Care Record and the implementation and roll out across health and LA partners.

Further achievements can be found in Appendix 6.

For the coming year we will continue to build on these priorities as well as Commissioning level 3 safeguarding adult training for nursing home staff across Sandwell and the wider Black Country.

The BC ICB regularly undertake public consultations to ensure the wishes and feelings of service users are considered when making decisions and designing services around their care. Adults with care and support needs are included in end-of-life arrangements and advanced care planning where possible/appropriate. Section 42 enquiries completed with the CHC/ICB team include making safeguarding personal to ensure that the adults voice is heard.
We also have a team who listen to concerns or complaints raised by all key stakeholders in confidence. They provide information and advice to help offer a resolution and signpost to the right department where necessary. The team can also pass on any compliments to the relevant team or person. This information enables the organisation to learn from patients' experiences and make improvements to local services.
SAR recommendations and learning from SARs is overseen by the Designated Nurse for Adult Safeguarding, who is a member of the SSAB. The action plan is regularly updated and monitored through the Sandwell SAR standing panel and internal ICB governance processes.
SAR learning has also been reflected in level 3 adult safeguarding training, contribution to local pathways and procedures as well as influencing internal policies and procedures. Learning is also shared through the GP Safeguarding Leads forum, 7-minute briefings and podcasts.
The ICB has undertaken a thematic analysis of statutory reviews across the Black Country, highlighting 3 key areas as priorities, including the implementation of shared care record to improve information sharing across health and social care. Review of safeguarding communications to complement the learning and development offer, as well a focus on supervision, implementing a new supervision policy and monitoring this through provider dashboards
As part of the SAR action plan for the ICB, various audits have been included within the audit plan. Evaluations and feedback is regularly sought from the GP Safeguarding Leads and following the delivery of level 3 and level 4 training for GP staff.
The ICB have also a schedule of audits to demonstrate learning from reviews.
The ICB will be able to contribute IRIS data, training data from primary care and nursing homes as well as other assurance data to the SSAB in future.
The ICB Sandwell safeguarding team provide quarterly safeguarding forums where GPs are provided with updates on areas such as the VARM process, mental capacity, rights of the nearest relative in respect of mental health assessments, as well as learning from SARs and DHRs. This also informs the Level 3 safeguarding adult training provided for primary care staff.
There is also a GP safeguarding toolkit which is being updated, this is a tool for self-assessment of general practice systems and processes to determine whether GP practices are currently up to date with safeguarding requirements. Safeguarding Adult Reviews undertaken in Sandwell and the UK have highlighted a number of recommendations regarding systems and procedures undertaken in general practice. This includes flagging vulnerability, adult at risk, child at risk/families at risk, families in which there is domestic abuse as well as other medically held information that could have informed multi-agency working if shared appropriately.
Black Country Integrated Care Board (BC ICB) are currently updating the ICB website, which will advise service users and the wider public about the various safeguarding processes across the Black Country. This will also include the details of the various Designated Safeguarding Professionals and their roles and responsibilities.
Safeguarding Partnerships' website links are included on the BC ICB Safeguarding page. We continue to engage with our local communities using resources that are flexible and inclusive. We

provide information on a range of platforms including our Facebook, Twitter, and Instagram accounts, @NHSinBlkCountry. These include written word, videos and images. The designated team ensure that Primary Care have all the up to date information leaflets and contact numbers for adult safeguarding during quality visits to GP practices and key lines of enquiry used as part of this visit, includes ensuring that safeguarding information is visible in the practice.
BC ICB is committed to ensuring that its staff are skilled and enabled to deliver on the priorities outlined. We offer a range of training including; Level 3 adult safeguarding training for primary care and continuing healthcare (CHC) staff which is aligned to the intercollegiate document. In addition, mental capacity training has been offered to all CHC staff. The ICB complete post training evaluations to demonstrate the effectiveness of the training.

Sandwell & West Birmingham NHS Trust (SWB)

- We attend, participate and chair SAR Standing Panel and support events
- Accident and Emergency have access to independent domestic violence advocates that are based in the department. The service provides Trust wide advise.
- 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 all staff.
- We have attended VARM Awareness training.
- 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.
- The Trust has a clear governance structure, with a vulnerable adult operation group that meets monthly, exception reporting to a Vulnerable Persons Strategic Group chaired by the Chief Nursing Officer, executive Lead for safeguarding.
- SWB will continue to attend multi agency steering groups, Board meetings and conferences.
- Learning will be reflected in policies and disseminated to the workforce via modalities including the 'WeLearn' programme and Quality Improvement half days.
- 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.
- The Trust is developing a Safeguarding Strategy, content includes Safeguarding and Vulnerable Adults inclusive of Oliver McGowen training package.

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 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 third 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 Sandwell
Healthwatch Sandwell are committed members of the Sandwell Safeguarding Adult Board and have been involved in the development of the boards strategic plans. We are active members of SAR Standing Panel (originally the SAR Protection subgroup) working together with multi-disciplines to discuss findings of serious safeguarding cases, integral to improving learning and preventing incidents happening in the future through development of new policies.

We also work together with SSAB Development Officer with Community Chat coffee mornings. This initially started at Cape Hill Asda and has expanded to the South Staffs Water Community Hub with a plan to develop this work in other towns.

Our relationship with other partners of the board is valued, demonstrated by the level of discussion, scrutiny and learning that is fundamental to how the board functions. Feedback that Healthwatch Sandwell has provided on behalf of citizens has been taken seriously and acted upon. The board are focused on listening and getting better outcomes for vulnerable citizens, and advocates that the person is at the centre of the safeguarding process.

Healthwatch Sandwell continue to be a conduit in supporting the work of the board in promoting that “safeguarding is everyone’s business – see something do something” - by sharing information, newsletters, training events and citizens stories through our web site and other social media platforms.

11. PLANNING FOR THE FUTURE

- Safeguarding Adult Reviews and taking forward the learning remains a priority. SSAB continue to plan learning events throughout 2023-24 and we have featured an analysis and screenshot from our March 2023 learning event in this report. We are now moving towards more face to face events which enable greater networking opportunities and learning. We are planning a learning event with reference to Adults with Learning Disabilities and their families in November 2023 at which we have Elaine Clarke (sister of the late Clive Treacey) and Beverley Dawkins OBE (SAR independent reviewer and the author of the death by indifference report).

Death by indifference: 74 deaths and counting: a progress report 5 years on

- SSAB and the other statutory boards in Sandwell are also supporting an Exploitation Summit to be held on 18.10.23 (National Modern Slavery Day.) Both of the above dates will be reported on, in next year's annual report.
- Build on the relationship with the third 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'. SSAB is currently exploring an animation project identifying the experience of needs of Adults with needs for care and support & domestic abuse.
- Continue to work and build 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. All key documents (with reference to the Five+ boards partnership) have been available on relevant websites since 03.07.23.
- SSAB is planning a development session in November 2023 and this will be reported on in next year's annual report.

APPENDIX 1

SSAB STRUCTURE

APPENDIX 2

BOARD MEMBERSHIP

Black Country HealthCare NHS Foundation Trust
NHS Black Country Integrated Care Board, Sandwell Place
Healthwatch Sandwell
Sandwell Safeguarding Adults Board Operations Manager
Sandwell Safeguarding Adults Board Independent Chair
Sandwell Adult Social Care
Sandwell & West Birmingham Hospital NHS Trust
Sandwell Council of Voluntary Organisations
West Midlands Police

APPENDIX 3

FINANCE AND BUDGET INFORMATION

The work of SSAB cannot be achieved without a dedicated budget and resources.
For 2022 - 2023, the financial contribution for the work of the Board came from Sandwell Council, Sandwell Integrated Care Board and West Midlands Police.

	2022 / 2023	
	Budget	**% of Total Funding**
Expenditure		
Employees	277,125	
Independent Chair	20,987	
SAR Case Review	43,600	
Training	12,000	
Legal	9,000	
Advertising & Publicity	3,000	
Other Expenditure	5,400	
One Off		
Total Expenditure	**371,112**	
Funding		
ICB Funding	(143,420)	36.55%
West Midland Police	(17,520)	4.46%
Other Fees and Charges	(0)	0%
Sandwell MBC	(231,560)	58.99%
Total Funding	**(392,500)**	**100%**

APPENDIX 4

BOARDS
SANDWELL STATUTORY
FIVE BOARDS PARTNERSHIP

5Boards Protocol
March 2023.docx

APPENDIX 5

GLOSSARY

Abbreviation	Explanation
ADASS	Adult Directors of Social Services
AP	Advanced Practitioner
ASC	Adult Social Care
BC ICB	Black Country Integrated Care Board
BCWA	Black Country Women's Aid
BME	Black and Minority Ethnic
LSDASP	Domestic Abuse Strategic Partnership
DHR	Domestic Homicide Review
GP	General Practitioner
ICB	Integrated Care Board
IDVA	Independent Domestic Violence Advocate
IMR	Independent Medical Review
IRIS	Identification and Referral to Improve Safety
LD	Learning Disability
MASH	Multi Agency Safeguarding Hub
NHS	National Health Service
Q&E	Quality and Excellence
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
SMBC	Sandwell Metropolitan Borough Council
SSAB	Sandwell Safeguarding Adult Board
SWBHNT	Sandwell West Birmingham Hospital NHS 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 6

BC ICB key safeguarding achievements for the year 2022/23

NHS reforms and the creation of ICBs in July 2022 required the transfer of statutory responsibilities/ due diligence around safeguarding processes and maintenance of business as usual and ensuring Partnerships were maintained and partners informed. In addition, the ICB have agreed internal governance for safeguarding and safeguarding training for new Board Members.

- Contributing to the Joint Forward Plan and ensuring safeguarding was referenced throughout in terms of priorities and planned work and commissioned services.

- Continue to develop the work of Liberty Protection Safeguards and well as the development of work in line with the Serious Violence Duty, working with Sandwell LA partners and the West Midlands Violence Reduction Partnership.

- Continuation of level 3 safeguarding adult training for primary care clinicians as well as other ICB staff.

- Support the continuation of funding of the FGM clinic for non-pregnant women.

- The commissioning and development of the One Health Care Record and the implementation and roll out across health and LA partners.

- The commissioning and development of learning resources for primary care and wider ICB staff, which included commissioning two podcasts pertaining to child to parent abuse and the rights of the nearest relative in respect of mental health assessments.

- The completion of an FGM resource film for professionals.

- Continued funding for the Identification & Referral to Improve Safety (IRIS) programme of domestic abuse, advocacy and support within primary care and ensuring that the ICB have a consistent approach to early identification of abuse across the Black Country. The feedback from users of the service reported:

'you have literally saved my life, thank you'

"The support I received was just what I needed to move forward and make the decisions that needed to be made, I know that I would not have got here on my own and just having someone to talk things through with really helped, I am so grateful for all of your help and advice".

'Thank you for all your support'. It is so good that I could visit my GP and get this support.

APPENDIX 7

FEEDBACK FORM

Can you please help by providing us with feedback on the content of this report and your opinion on our future priorities?

Please use the link or QR Code to access an online form.

Sandwell Safeguarding Board Annual Report Feedback

https://forms.office.com/e/JkqbZyKw5T

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

Talk with me on Microsoft Teams

WHO CAN I TELL MY CONCERNS TO?

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

In an emergency, ring 999