Sandwell Safeguarding Adults Board

SSAB@SSAdultsBoard

ANNUAL REPORT 2017-18
Executive Summary

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

Sandwell Metropolitan Borough Council

Sandwell and West Birmingham Hospitals NHS Trust

Sandwell and West Birmingham Clinical Commissioning Group

Black Country Partnership NHS Foundation Trust

West Midlands Police

Contents

Foreword from the Chair

Six Principles of Safeguarding

empowerment

prevention

proportionality

protection

partnerships

accountability

Welcome to Sandwell's Safeguarding Adults Board Executive Summary 2017-18.

Hello all,

Welcome to Sandwell's Safeguarding Adults 2017-18 Annual Report, which provides the Board and agencies with the opportunity to reflect on their achievements in 2017-18 and plans for the year ahead. It also gives us the opportunity to demonstrate the Board's fulfilment of its role and commitment to safeguard adults with care and support needs in the Borough of Sandwell.

We continue to work in partnership to ensure we work effectively to better protect adults at risk of harm (people with support needs).

The Board maintains its commitment to working with adults at risk from harm to ensure that they continue to be at the centre of all planning and decision making.

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

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

The Board remains committed to the principle of empowerment and is keen to evidence good practice of Making Safeguarding Personal (MSP)

The Board continues to maintain its own website and regularly posts new developments in safeguarding practice, policy and procedure. I would urge you to visit the website using the link below;

www.sandwellsab.org.uk.

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

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

Eddie Clarke
Independent Chair,
Sandwell Safeguarding Adults Board

Contributions & Key Highlights

This section of the Annual Report highlights work undertaken by partner agencies to evidence their contribution to the Safeguarding Adults Board priorities during the period of 1st April 2017 to 31st March 2018

Sandwell Metropolitan Borough Council (SMBC) - Adult Social Care (ASC)

To ensure Making Safeguarding Personal is at the forefront of all practice we record and report on Making Safeguarding Personal outcomes and test this through case file audits to ensure we can evidence that practice is person centred.

ASC contribute to Safeguarding Adult Reviews including making referrals when and where appropriate and ASC are represented at the Protection Sub Group.

ASC actively engage and participate in the Prevention agenda.

ASC produce quarterly performance data in partnership with the data team which is presented to the Quality & Excellence Sub Group and the Board and subject to robust scrutiny.

West Midlands Fire Service (WMFS)

WMFS has clear safeguarding procedures in place which inform all employees on what to do in the event of a safeguarding issue arising.

In 2017/18 Vulnerable Persons Officers (VPO's) will be replaced with Complex Needs Officers who will trained to a higher level than VPOs to ensure those most vulnerable can be supported and encouraged in the most effective, collaborative and beneficial way.

WMFS Serious Incident Review policy has been updated to improve internal and external learning from incidents that result in injury or death from fire. Recommendations are embedded into internal procedures and shared externally.

West Midlands Police (WMP)

The following three areas were prioritised for 2017-18. Progress has been reported on quarterly to the SAB through the WMP SAB Performance Report.

Local Authority Arrangements

West Midlands Police operates across seven Local Authority areas. All have different operating approaches, referral pathways and partnership arrangements all of whom require information and support from WMP that is different to other Local Authority areas. In the case of vulnerable adults safeguarding there is an opportunity to develop a consistent approach to all elements of the investigation and safeguarding activity that would benefit not only WMP but other partners such as the Care Quality Commission.

Joint investigations

The investigation of suspicious deaths, particularly in relation to Care Homes, provides an opportunity to develop an early intervention model for investigative pathways. This approach would allow WMP, the Care Quality Commission, other Investigative and Criminal Justice Partners and local Safeguarding Boards to make early determination of the lead agency and investigative strategy for serious and complex cases, providing opportunities for early intervention, more collaborative working arrangements and the potential for cost savings that could be reinvested into other areas of vulnerable adult work.

Development of Adult MASH across the WMP area

West Midlands Police is working with the Wolverhampton Safeguarding Board to assess the impact of developing a MASH (Multi Agency Safeguarding Hub) for vulnerable adults within the Local Authority area. Initial findings have been positive with an increase in referrals to WMP and an increase in the investigations managed by the WMP PPU Adult at Risk team. If as predicted other Local Authorities in the West Midlands will seek to establish Adult MASH the funding for resources for both WMP and Partners will need to be considered carefully.

This section in the Annual Report outlines areas highlighted by partner agencies of how they intend to contribute to the Safeguarding Adults Board priorities during 20181-19

Black Country Partnership Foundation Trust (BCPFT)

BCPFT will endeavour to:

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

Sandwell & West Birmingham Clinical Commissioning Group

The CCG will endeavour to:

- The CCG will continue to build strong links with the SSAB and the Sub Groups to ensure effective working together and safeguarding.
- Additional funding for IRIS has been granted and the expansion of this programme across Sandwell will be undertaken during the planned year.
- Safeguarding adults training will continue to be actively promoted across the organisation and

member practices.

- Lessons learnt around the recent local SAR's will be promoted at a safeguarding leads forum later in 2018. The GP safeguarding assurance toolkit will also be updated as required to share good practice around safeguarding adults.
- The CCG will provide representation at the Prevention Sub Group which will ensure that all aspects and learning from abuse and SAR's are cascaded across the organisation. This will also ensure that the voice of the adult with care and support needs are firmly embedded across all partnership training.
- The CCG will continue to demonstrate its ongoing commitment to the work of the SSAB and the work of the Sub Groups.

West Midlands Ambulance Group (WMAG)

WMAG will endeavour to:

- Continue to invest in engagement with adult, children boards, CDOP's and other partner agencies, building on existing relationships.
- Ensure focus remains on quality assurance, including further audits on staff knowledge and quality of referrals.
- Continue collaboration with NHS England to deliver Prevent strategy, ensuring Level 3 WRAP training for frontline staff, targeted training for specific staff groups such as mental health triage car and engagement with local universities delivering Student Paramedic Programme.
- Continue to embed lessons learnt from SCR's, DHR's, SAR's and CDOP's and share with wider organisation through the internal Learning Review Group (LRG and key staff communications.

In this section, there are some example of how partner agencies evidence the training that offer

Sandwell & West Birmingham Hospital Trust

- SWBH have a commitment to provide Adult Safeguarding training to its staff.
- Training strategy in place for level 1, 2 and 3 related to vulnerable adults. This includes Prevent training. This is compliant with the intercollegiate document produced to give health care staff guidance.
- Compliance target is 85%. Training and Targets are monitored by the care commissioning group and a financial penalty imposed if the organisation fails to reach its target.
- SWBH will provide IMR reports for SARs where the organisation has been involved.
- SWBH actively contribute/participate in SARs, reviews and disseminate learning.
- SWBH have a safeguard incident reporting system in place.

Domestic Abuse Partnership (DASP)

- GP's IRIS (Identification and Referral to Improve Safety) is a general practice domestic violence training, support and referral programme for primary care staff. It is targeted prevention for female patients aged 16 and above experiencing current or former domestic abuse from a partner, ex-partner or adult family member. IRIS provides care pathways for all patients living with abuse as well as information and signposting for male victims and for perpetrators.
- Funding support from SWBCCG has enabled work on the IRIS programme in Sandwell to continue to support the first cohort of 16 Sandwell GP practices in 2017/2018.
- Sandwell's Safeguarding Adults Board works closely with colleagues in other strategic partnership

groups to ensure there is effective multi-agency training on a wide range of safeguarding issues.

- There is a range of domestic abuse training available on offer to partners, from introductory e-learning to improve awareness to face-to-face training on domestic abuse, forced marriage & honour based abuse, female genital mutilation, sexual violence, stalking, and learning from domestic homicide reviews. 612 officers attended training in 2017-18. Details of the training programme for 2018-19 and how to book can be found at;

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

Highlighted below are examples of single and/or multi-agency work that partner agencies have been part of that will contribute to improved outcomes for adults with care and support needs

4 Boards

The 4 Board Managers have been building on formalising relationships to ensure a reflective infrastructure to capture agreed themes and priorities ensuring greater consistency and working together (development and agreement of the partnership protocol).

Each statutory Board agreed to lead on identified work-streams within the Prevention of Violence and Exploitation (POVE) umbrella.

The 4 Boards designed and held a multi-agency learning event on tackling violence and exploitation together – to raise awareness of exploitation.

Cabinet member workshop on PoVE took place on 7th March to brief cabinet members on the key themes for PoVE and the umbrella work-streams. PoVE pledges were completed by cabinet members and Directors as to how they would support PoVE and ACEs.

There has been a restructuring of the Safer Sandwell Partnership into themes:
4 Board priorities for 2018-19 are:

- Prevent violence and exploitation
- Reduce offending and organised crime
- Solve problems in your neighbourhoods – including tackling crime and anti-social behaviour (http://www.sandwell.gov.uk/asb)
- Protect and support vulnerable victims

West Midlands Police (WMP)

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

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

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

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

Sandwell and West Birmingham Hospital (SWBH)

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

Lay Member

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

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

Case Studies

Case Study 1

Detail of the Concern
Ms A is a 51-year-old lady who currently lives in a residential home that has a specialism for supporting individuals with a learning disability.

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

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

Findings
On the first visit Ms A was found to be extremely underweight, wearing old and dirty clothing, barely able to speak and looked down at the floor the whole time, seeming unable to make eye contact. West Midlands Police were immediately informed along with CQC, Contracts Team, CCG and other Local Authorities who had residents place there.

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

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

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

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

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

Case Study 2

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

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

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

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

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

Sub-Group Strategic Objectives 2017-18

Prevention

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

Protection

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

Quality & Excellence

Continue to focus on effective delivery and high quality processes.

Sub-Group Contributions Key Highlights

Prevention, Learning & Development

- SSAB continues to adopt a campaign focus
- Increased outreach activities and strengthening partnerships with 4 Boards
- Successful conference and events
- Provision of e-Learning and a jointly commissioned platform with Children's Services

Quality & Excellence

- The subgroup was relaunched with a new Chair, membership and lead officer to refocus on building the group and ensuring membership from all statutory partners
- Further development of the performance dashboard
- The development of a quality assurance self-assessment tool to be used by partners that has influenced and shaped the development of a similar regional tool across the West Midlands

Protection

- Strengthened existing partnerships
- Launched the Safeguarding Adult Procedures ensuring they are operationalised
- Successfully undertaken two Safeguarding Adult Reviews Procedures, identified learning and progressed action plans

Safeguarding Performance Data

Number of Concerns/Enquiries

Number of concerns/enquiries

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

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

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

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

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

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

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

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

Work continues to be undertaken with all our partners in uniformed services to clarify a common understanding of what constitutes a safeguarding concern as opposed to someone with additional support needs requiring more robust support. It is of note that uniformed service colleagues have contact with adults with additional support needs during unsociable hours and on these occasions' opportunities to direct referrals appropriately may be more limited.

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

Concluded S42 enquiries by type of abuse

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

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

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

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

Note: multiple types of abuse are recorded per enquiry.

Concluded S42 enquiries by location

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

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

Concluded S42 enquiries by location	2016-17	2017-18
Own Home	211	242
In the community	3	16
(excluding community services)	7	7
In a community service	93	124
Care Home - Nursing	90	103
Care Home - Residential	90	103

SSAB Strategic Priorities 2018/19

Prevention, Learning & Development

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

Quality & Excellence

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

Protection

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

Conclusion

This Executive Summary gives a flavour of the larger Annual Report Document with a focus on contributions, progress on agreed priorities for last year and the identification of agreed priorities for 2018-19.

For a more detailed account then please reference the full report which is available on the SSAB website:

www.sandwellsab.org.uk

or contact:

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Copy the link below to watch our 2 minute film 'See Something, Do Something'
https://www.youtube.com/watch?v=l1f0WZEuKno

SEE SOMETHING DO SOMETHING – SAFEGUARDING IS EVERYONE'S BUSINESS
IF YOU ARE CONCERNED THAT AN ADULT WITH CARE AND SUPPORT NEEDS IS AT RISK OF ABUSE OR NEGLECT CALL SANDWELL COUNCIL ON 0121 569 2266