

# Solihull Safeguarding Adults Board Annual Report 2022-2023



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## Purpose of this Report

The Care Act 2014 says that we must publish a report every year to say what we have done to achieve our main goals and how our members have supported us to do this. This report sets out who we are and what we have achieved between April 2022 and March 2023. There is also an easy-to-read version of this report available on the SAB website.

## About the Solihull Safeguarding Adults Board

The Care Act 2014 makes a Safeguarding Adults Board a statutory requirement. The job of Solihull Safeguarding Adults Board (SSAB) is to make sure that there are arrangements in Solihull that work well to help protect adults with care and support needs from abuse or neglect. Solihull Safeguarding Adults Board must ensure that safeguarding practice continues to improve the quality of life of adults in Solihull.

The Board is led by an Independent Chair appointed by the Local Authority. There are three members who must be part of the Board by law, which are:

Solihull Metropolitan Borough Council  
West Midlands Police  
Birmingham and Solihull Integrated Care Board.

Solihull SAB also has the following partners represented on its board representing our inclusive approach and long history of partners wanting to work together:

Age UK Solihull  
Birmingham & Solihull Mental Health Foundation Trust  
Care Quality Commission  
Coventry and Warwickshire Partnership Trust  
Healthwatch Solihull  
Private Care Sector  
Probation Service  
Solihull Action through Advocacy  
Solihull Carers Trust  
Solihull Community Housing  
University Hospitals Birmingham  
West Midlands Fire Service



## Message from the Independent Chair

I am delighted to be able to present Solihull's Safeguarding Adults Board's Annual Report for 2022-2023 on behalf of the Board. It has been a very demanding year for all safeguarding partners in Solihull, not least because in addition to managing the legacy across all services for Adults of Covid -19, all partners agencies represented on the Board have had to respond to the improvement demands resulting from the Joint Targeted Area Inspection of the Solihull Safeguarding Children Partnership and the National Review following the terrible murder of Arthur Labinjo-Hughes. As the Safeguarding Adults Board, we were mindful that Board colleagues working to safeguard children, needed both our wholehearted support, as well as our commitment to ensure that the strong partnership work that is so much a feature of how adult safeguarding is delivered across Solihull, was really responsive to any review recommendations which might have implications for the adult system. So, we have tightened our partnership working through the year, particularly strengthening the links with other partnership Boards working in Solihull and developing our shared focus on the quality of safeguarding practice.



The other key element of our work this year has been around the way we understand and report safeguarding risks, particularly any new and emerging risks. The annual report describes the changes made through the year to risk reporting and describes the impact that these changes have had to the way the Safeguarding Adults Board reports safeguarding risks through its risk register and the work of the sub committees.

As the Independent Chair of the Safeguarding Adults Board in Solihull I am very fortunate to be supported in the work of the Board by committed and dedicated partners across the partnership and particularly the Council, as the lead agency, and especially by the work of the Board manager and the Management Assistant who ensure throughout the whole year, that the very considerable volume of work associated with ensuring the Board achieves its priorities, is delivered. I cannot thank them enough because without their endeavours, the work described in this report, would not have been possible

Dr Sue Ross  
Independent Chair Solihull Safeguarding Adults Board

June 2023



# About Solihull

The population is 216,240

Projections suggest there are nearly

**4,000**

adults aged 18+, with a learning disability in Solihull



**51%**  
Female



**49%**  
Male



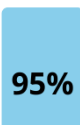
**21%**

of Solihull residents are 65 & over

Higher than West Midlands & England averages



\* **4.8%** of people did not answer the question



Same Sex at Birth

**0.1%** Different Sex at Birth (Unspecified)

**0.06%** Trans Woman

**0.06%** Trans Man

**0.02%** Non-Binary

**0.02%** Other



The Black, Asian and Minority Ethnic population increased by **72%** (+16,000) between 2011-21

It now accounts for **18%** of the Solihull population (38,600)

**71%**

of Solihull adults receiving long-term social care support are supported in the community

**76%**

of the working age population in Solihull are employed, in-line with the England average

**34%**



The ONS projects a 34% increase in the number of people in Solihull aged 85+, in the next 10 years

## SOLIHULL AT A GLANCE



Solihull has an area of **69** square miles and contains **17** electoral wards

There is an estimated

**7,100**



physically disabled people living in Solihull

Projections suggest that

**23,500** working age

adults in Solihull have a common mental health problem



Solihull residents have the highest average wages in the West Midlands and **12%** above the UK average

Projections suggest more than **3,400** people in Solihull, aged 65+, are living with dementia



In 2021 there were nearly

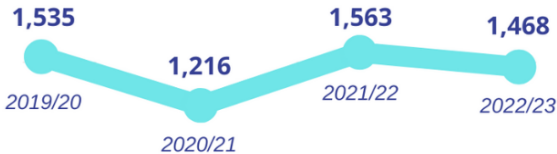
**20,000**

unpaid carers aged 5+ in Solihull, representing **10%** of the population

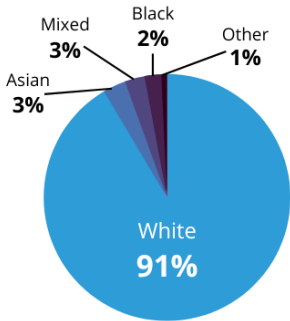
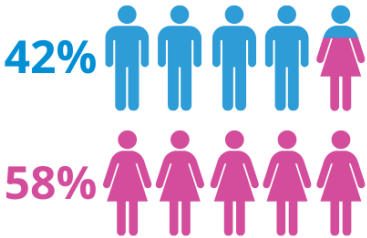
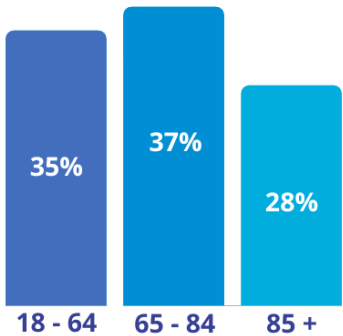
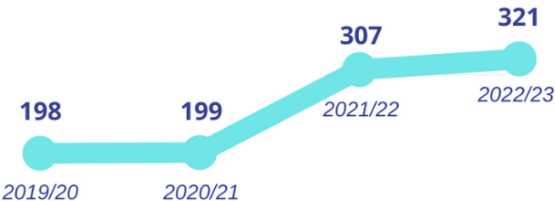
\*Data taken from [2021 Census](#)

# The Picture of Safeguarding in Solihull

## Concerns



## Enquiries



50 people did not declare their ethnicity

## Top 3 Types of Abuse



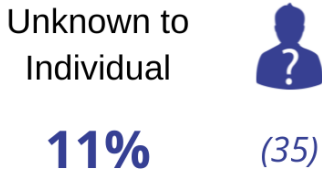
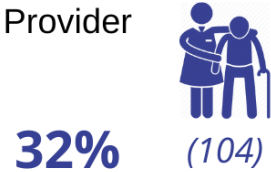
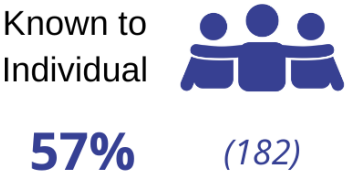
Neglect  
**26%**  
(135)



Physical  
**20%**  
(104)



Psychological  
**17%**  
(92)



## Asked What Outcome They Want



**83%**  
(272)

## Outcome Fully or Partly Met



**84%** (of those asked)  
(228)

## Risk Reduced or Removed



**60%**  
(199)

## Felt Safer after Safeguarding



**63%** (of those asked)  
(106)

\* All data is regarding enquiries commenced in 2022/23 unless otherwise stated

## What is the data telling us?

Safeguarding Concern and Safeguarding Enquiry numbers have not significantly changed when compared to the previous year 2021/22. The lower numbers in 2020/21 demonstrates a reduction in concerns being referred to the Local Authority at the beginning of the 2020 Covid-19 lockdown.

The 2021 Census data published recently tells us that the Black, Asian and Minority Ethnic population is now 18% and has increased by 72% since the last census in 2011. This information will support us with our 2023/24 priorities of understanding who Solihull's communities are and engaging with those communities as well as adults with lived experience of safeguarding, to understand what they need from an effective safeguarding response.

Approximately one third of safeguarding enquiries involve concerns regarding a care provider. We receive updates from Commissioning colleagues in Health and Social Care at each Board meeting to understand the work they do to support providers as well as addressing quality and safeguarding concerns with them as necessary.

Data measuring whether people are supported and encouraged to have their say about what they want from a safeguarding enquiry and whether it has made a difference to how safe they feel is largely positive. Most people are asked the outcomes they would like to see, and where they are not asked, the Board receives assurance that the reasons for this are appropriate, for example where a friend, family member or advocate has been approached because the person is unable to contribute. 63% of people asked if they feel safer after safeguarding responded that they do, with most of the rest of those asked reporting that they did not feel a difference. The Board receives assurances regularly that the reasons given for this are appropriate for example, the person did not feel particularly unsafe to begin with.



## The complexity of adult safeguarding

Safeguarding adults is complex because peoples' lives are complicated, and everyone's situation is different. Also, there are lots of different ways in which people can be abused or neglected. That's why our responses need to be personalised; different people may be involved in helping someone and partnership working is essential. As the diagram below demonstrates, safeguarding is everybody's business and everyone's responsibility, and organisations must work effectively with the person and with each other to achieve the best outcomes. There can be a wide variety of partners engaging with an individual, therefore effective communication and appropriate information sharing is important.



The SAB has a key role in ensuring safeguarding is happening effectively by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- ensuring safeguarding practice is not only guided by the Care Act (2014) but also wider statutory considerations including but not limited to the Mental Capacity Act (2005), Mental Health Act (1983), and Human Rights Act (1998)
- assuring itself that safeguarding practice is person-centred and outcome-focused
- working collaboratively to prevent abuse and neglect where possible
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area
- seeking feedback and views from local people on safeguarding arrangements and acting on these



# Board Priority and how it has made a difference

For 2022-23 we had 1 priority we wanted to focus on:

## **Oversight of quality and risk, with due consideration given to the long-term impact of Covid-19, considering the learning to date.**

The decision to have one priority focusing on quality and risk oversight was derived from discussions at the development session in March 22, where the board was acutely aware of the recent Joint Targeted Area Inspection of the Solihull Safeguarding Children Partnership and the national review of Arthur Labinjo-Hughes' murder. Service pressures being experienced by Board partners were also considered, as well as what safeguarding data was telling us about the impact of Covid-19 on safeguarding, the voices of survivors of abuse and neglect and the views of Solihull's communities.

The aim of focussing on oversight of quality and risk was to use the insights from Arthur's case, the JTAI findings and the changes resulting from the Covid-19 pandemic, to determine whether there were any risks or quality issues the Board had previously overlooked, as well as new risks or issues with the quality of safeguarding practice, emerging from the changes in response to Covid-19 and the learning from Arthur's case and the JTAI.

Subcommittee work would identify areas of risk requiring the board's attention and there would be opportunities to escalate areas of increasing risk for board response. Engagement with the public would give an indication of their key safety concerns and what impact Covid was having on people's lives. The impact of a focus on quality oversight was intended to be that audit and assurance work will identify good practice and areas of improvement that will inform the work of the board and subcommittees.

### **What we said we would do:**

- Receiving a quarterly report to Board with new and existing safeguarding risks and mitigations and any recommendations from the subcommittees.

### **What we did:**

- A focus on learning from the Safeguarding Children Partnership meant the subcommittees and board have identified new areas of risk with associated mitigating actions. A quarterly update on the risk register is received at Board including progress against mitigation of risks. The Board has been satisfied with subcommittee actions to mitigate risk but has also identified new risk areas requiring discussion at board.
- Further work is underway to achieve greater consistency across several of the multiagency boards in their approach to risk oversight and management, supported by the Council's risk team. This work is being overseen by the multiagency boards chairs and support officers who meet 6 monthly.

### **Impact:**

- New risk areas have been identified by subcommittees, relevant to their area of focus, with associated mitigations. Subcommittees review these at each meeting

and escalate matters to board as required. The risk register is reflective of the key risk areas for the board and progress of actions to mitigate, board is therefore sighted on key areas of risk and is able to hold focused and constructive risk discussions when it meets.

**What we said we would do:**

- Identification of new safeguarding risks that have emerged because of the direct and indirect impacts of Covid-19

**What we did:**

- Each Subcommittee and Board meeting focuses time on new safeguarding risks. These are either captured in the risk register with agreed mitigations, or in the board minutes with actions agreed to further scope the issue and feedback to board to support decision making.

**Impact:**

- The subcommittees and board have identified new risk areas captured in the risk register since the new approach was implemented in April 2022. The risk register is a dynamic and live document with progress towards mitigation presented at each board meeting, as well as risks to be escalated from subcommittee to board as required. This ensures information flows between the board and subcommittees and any areas for further action are identified and responded to.

**What we said we would do:**

- Making time for sharing safeguarding issues and concerns at Board meetings

**What we did:**

- There is a recurring agenda item on risks and issues, partners have used this opportunity to discuss areas of concern and agree actions.

**Impact:**

- Board partners are sighted and informed on issues arising locally and nationally for example board have discussed the local provider market, Integrated Care Board developments, cost of living impact and progress with exploitation reduction work in Solihull.

**What we said we would do:**

- Board Development Day discussions will focus on risks to the Board's ability to achieve its overall objective; ensuring arrangements in Solihull work well to help protect adults with care and support needs from abuse or neglect.

**What we did:**

- The board Development session in October 2022 considered progress to date on the board priority, agreed impact measures to support progress monitoring and had focussed time on self-neglect, an area identified by work nationally as requiring attention by SABs due to high numbers of cases reflected in SARs, indicating this as an area involving significant risks.

- SMBC's audit team looked at board oversight and management of risk and provided consultancy review findings to the board with recommendations on how to further improve. Recommendations and identified issues for the SAB included further improvement in terms of measuring impact of activity and aligning risk areas with the board's overall purpose as well as strategic objectives. These will be taken forward in the board's 2023-24 Strategic Plan and associated board and subcommittee workplans and risk register.

**Impact:**

- The impact measures agreed at the development session in October 2022 for the board objectives have been used to assure board of the impact of its work. The development session provided an opportunity for partnership working between Age UK and SMBC to problem solve where challenges to achieving improvements in self-neglect safeguarding practice were identified.
- The impact of addressing areas identified from the audit includes clarity of impact of board work, clear alignment of risk areas with board objectives and overall purpose and improvements to strategic planning and annual reporting going forwards.

**What we said we would do:**

- Horizon scanning for emerging risks to form basis of routine Board discussion.

**What we did:**

- An information report received at each board meeting provides board with summaries of key updates in legislation, policy and research as well as case reviews with national relevance. These reports drive local board activity to seek assurance of local preparedness to respond and adapt to new approaches and changes in policy etc.

**Impact:**

- The board agenda highlights key local and national issues with responses brought to board as required to provide assurance. Examples include agenda items on Solihull's response to homelessness following a NICE report on the subject, local systems pressures discussion following annual CQC state of care report publication, and oversight of a local secure hospital following Panorama investigation into Edenfield Centre hospital, Greater Manchester.

**What we said we would do:**

- A refresh of the Board's cultural approach to safeguarding highlighting leadership, accountability, assurance seeking, continuous improvement, the needs of Solihull residents, and openness and honesty as key.

**What we did:**

- The Board worked together to reflect on current cultural habits and what we wanted to maintain and improve and used this to develop a new statement on our cultural approach which has been added to the Memorandum of Understanding. It sets out clear expectations for SSAB members and organisations and identifies the outcomes expected from a culture of continuous

improvement and assurance seeking. We have used this as an ongoing reference to inform our approach to working with each other and with wider partners.

**Impact:**

- Partners have shared at board development sessions that they are able to raise matters at an early stage and their contributions are valued and respected. Partners agreed there are effective partner relationships existing outside the Board and partners can approach one another for informal discussion. One example is a recent meeting between Age UK and SMBC Adult Social Care to discuss self-neglect cases and agree a monthly meeting to focus on successful progression of such cases.

**What we said we would do:**

- Gaining agreement to the message(s) we want to put out as a Board, how we communicate and how we receive messages back.

**What we did:**

- Safeguarding Adult Review (SAR) Subcommittee is developing a communications plan for sharing learning from SARs, following the National Review recommendation to SSCP on this. A coordinated approach with SSCP has been discussed with Solihull Safeguarding Children Partnership (SSCP) Business Manager.
- Engagement and Prevention Subcommittee agree communications for key awareness days during the year, for example World Elder Abuse Awareness Day and Hate Crime Awareness Week.
- Coordinated joint working with partners within and across boards and partnerships on awareness days and on awareness raising campaigns e.g., exploitation reduction and 16 days of action on domestic abuse.
- Engagement and Prevention Subcommittee are leading on seeking views from communities on how safe they feel and what their key concerns are. Performance and Development Lead is visiting groups to share key safeguarding messages and listen to concerns of the public. Updates are presented at board on findings from engagement work to date and actions agreed.

**Impact:**

- A SAR communications plan will ensure clear and consistent messages are shared when a SAR is published and that learning is shared with everyone who needs to consider it, including organisations not involved in the SAR. Coordination with SSCP will also ensure consistency for partners in the type of messages they receive.
- Coordination across boards for awareness days has ensured a stronger impact of key messages and a broader audience reached. Recent examples include 16 days of action on domestic abuse where a joint communications plan was implemented by Community Safety Partnership (CSP), Solihull Safeguarding Adults Board (SSAB) and Solihull Safeguarding Children Partnership (SSCP).

Joint communications work was also undertaken by SSAB and SSCP and Exploitation Reduction Board (ERB) on exploitation reduction for businesses and the public. Joint work has started with Birmingham local authority to share the exploitation reduction communications across Birmingham given the cross-border work involved in exploitation cases.

- Updates to board on key concerns from Solihull's communities ensures board and subcommittees are clear on what communities are worried about. It also enables board to discuss and agree further action for the Engagement and Prevention Subcommittee in terms of reaching all communities and collating the work that is happening across organisations and partnerships to communicate this to staff and the public.

#### **What we said we would do:**

- Sharing learning and good practice regarding safeguarding from the subcommittee work into the Board.

#### **What we did:**

- Subcommittee updates to board now focus more on the impact of actions rather than solely on actions undertaken, considering feedback from the audit findings.
- The SAR subcommittee in Feb 23 received a practice briefing based on best practice with a case involving hoarding. This has been shared widely with practitioners, and SAR Subcommittee members will feed back on how this has been shared. It has also prompted SAR Subcommittee members to identify other good practice cases which the group will share as learning resources.
- Performance and Audit Subcommittee undertook a MCA/DoLS audit in Jan 23 and at the subcommittee examples of good practice and learning areas were shared. These cases will be used to develop a short staff briefing and will also be given to trainers to use as part of their training sessions.

#### **Impact:**

- Review of good practice cases highlight effective multi-agency working and analyse why things have gone well and the learning from this.
- A recent example of focus on good practice at board looked at the improvements made by a local provider following challenges during Covid-19 and an acknowledgement of the efforts of SMBC and ICB Commissioning as well as other partners in supporting the provider to make measurable and sustained improvement.

#### **What this means for the people we support**

Our work this year to achieve our priority means that we identify and mitigate for risks more robustly, so the 'safety net' is stronger for the people we support. The likelihood of a poor response or poor experience for someone being supported by us, is reduced. We are refining and developing our responses to the people we support as we identify improvement areas as well as learning from examples of best practice across the partnership.



## **Multi Agency Board Coordination**

During 2022-23 the Safeguarding Adults Board, Safeguarding Children Partnership, Community Safety Partnership, Health and Wellbeing Board, Domestic Abuse Partnership Board and Exploitation Reduction Board have been working to improve cross-board arrangements and coordination. Now the ICB Solihull Place Committee is fully established, we will be embedding this committee into these arrangements throughout 2023-24. The intended outcome from this work is that each board's work is effective and has impact and that capacity is organised to deliver our priorities.

Focus has been on development of:

- A plan on a page summary setting out the responsibilities and priorities of the boards
- An over-arching understanding of the risk registers across the boards
- A coordinated approach to multi agency audits
- A protocol setting out how the boards will work together to achieve improved coordination

Good progress has been made towards these goals, and work will continue in 2023-24 to embed multi-agency board coordination in everyday practice as well as identifying additional areas for improvement. This work is overseen by 6 monthly meetings of the board chairs and support officers, with a multi board event planned for 2023-24 to share progress with wider board membership and seek their feedback.

## **Subcommittee Progress**

Supporting the Board, we have five sub-committees which completed the following work so that people can live their lives free from abuse or neglect.

### **Policies & Procedures Subcommittee**

This subcommittee has developed and launched safeguarding best practice guidance with the local approach to risk enablement included, this provides a clear structure for professionals as to what is expected in terms of best practice. Adult Social Care Safeguarding Audits look at risk assessment as part of the audit, and any issues highlighted around risk assessment will inform whether the guidance is being used and is effective.

The subcommittee reviewed and refreshed the dispute resolution procedure during 2022-23 which sets out a clear process for resolving inter agency disputes. The SAB Business Manager is approached as needed with matters requiring resolution and these are escalated to the appropriate board member as necessary with quick and constructive responses received. On each occasion the relevant board member has responded quickly and has worked to resolve the issue raised.

The subcommittee's work on best practice guidance has been informed by regional developments e.g., West Midlands Police missing guidance, local learning e.g., the need to support professional understanding of coercive control, and effective tools already in place that have been adopted locally, e.g., screening tools for economic abuse and self-neglect. This ensures consistency in practice across the region, and demonstrates how learning from audits etc. is fed into developments of guidance, policy and procedure.

The focus now moves to how the tools are being used locally by partner organisations and how they are or are not supporting practice. P&P will follow up on this within the subcommittee and website analytics also provide an evidence base for how often resources are accessed. Further actions will be agreed as needed to embed safeguarding practice guidance, policy and procedure.

### **Engagement & Prevention Subcommittee**

The Engagement and Prevention Subcommittee have been engaging with Solihull's communities to understand current concerns and how these might lead to safeguarding considerations for the board. These largely focus on fears for individuals clinically at risk from Covid-19, and concerns around the cost-of-living crisis and the impact on opportunities for social contact, as well as on physical and mental health. The Engagement and Prevention Subcommittee has used this feedback and linked with other groups across the council to share information with the public and professionals on where to find help and support.

The group is sharing resources and support with communities as well as working to coordinate with other groups within the council to share consistent messages as widely as possible. Positive feedback has also been received regarding how well supported individuals felt during Covid-19 related restrictions and that individuals know where to ask for support if this was needed. This has provided assurance that the right support was available for people when they needed it.

The Performance and Development Lead has revived links with community groups that existed pre-Covid and has visited several groups to share key safeguarding messages and to hear their views and concerns. This has happened regularly during 2022-23 and will continue in 2023-24 meaning community groups are aware of the Board and its work and the Board is receiving feedback from communities.

### **Performance, Quality & Audit Subcommittee**

A refresh of the Quality Assurance Framework provided a clear structure for the subcommittee on where it needed to focus audit and assurance work, and the need for both dip sample and deep dive audits for quality assurance.

An audit schedule was developed for 2022-23 for the PQ&A Subcommittee and will be developed at the start of each year to ensure both dip sampling and deep dive audits are undertaken and provide assurance around quality of safeguarding work.

3 dip sample audits of safeguarding referrals have identified areas of single agency improvement which the subcommittee will oversee progress of.

A single agency audit of Mental Capacity Act and Deprivation of Liberty Safeguards has returned positive results and demonstrates good awareness and application of MCA across agencies with good oversight from those organisations on practice.

A deep dive audit on self-neglect as well as a Care Act Compliance and Section 11 Childrens regional audit across the West Midlands will yield results in May/June 23 and will provide further evidence of the quality of safeguarding practice, as well as compliance with Care Act duties.

Opportunities to joint work with other partnerships on audit and assurance focussed on exploitation and domestic abuse, reducing the impact on partners of multiple audits as well as

increasing the capacity of each board's business team by combining resources in a more focussed audit approach. This has been further strengthened by work improving cross-board coordination which includes audit and assurance coordination.

A multi board audit and assurance schedule has been developed this year and will be used during 2023-24 to support coordination of audit and assurance work across the boards, utilising opportunities for joint work and reducing the impact on partners.

The PQ&A has also reviewed the performance dashboard to consider what other data should be included; changes agreed are location of abuse which now provides additional context for where abuse is taking place which will help with targeted prevention messaging, ethnicity of adult at-risk meaning the subcommittee can identify whether the demographics reported in the safeguarding data reflect the census 2021 data, and large-scale enquiries and police investigations within care homes including people in a position of trust, which provides the group with oversight of quality and risk issues within provider services that might warrant a board response.

### **Learning & Improvement Subcommittee**

There have been several resources developed by the Learning and Improvement Subcommittee and Policy and Procedure Subcommittee with a focus on safeguarding best practice, risk assessment and engagement. This means there are resources available for staff to support their learning and development regarding safeguarding adults. The subcommittees are reviewing website analytics to understand how often resources are accessed, audit work will also support this as well as feedback from partners via the subcommittees. Where it is found that resources are not being used, further action will be agreed to promote and embed key messages.

The Learning and Improvement Subcommittee has progressed its focus on self-neglect with the aim of learning from best practice. The group have developed and promoted several resources based on best practice and agreed to commission self-neglect training for the partnership, this ran twice during 2022-23, was well attended on each occasion and was very positively reviewed. Evidence for the impact of the training will come from self-neglect audit scheduled for June 2023 by the P&A subcommittee.

### **Safeguarding Adult Review Subcommittee**

The SAR subcommittee has received 1 SAR referral this year and held discussions on other cases which ultimately did not warrant referral. Since the board's focus on SAR work, there has been an increase in referrals and discussions around whether cases met the criteria. This is a positive improvement meaning the SAR process is being considered more consistently across the partnership, and the SAR Subcommittee members are more confident and capable in discussing cases. The subcommittee has also worked with colleagues in the Community Safety Partnership to ensure links are made where it appears a case may need to be considered by both the SAR and Domestic Homicide Review (DHR) panel, and where there may be learning from DHRs for the SSAB.

The SAR subcommittee has reviewed a case of good practice in hoarding and developed a practice briefing promoting what can be learned from this case. This has been shared widely with practitioners across the partnership and is a positive way of sharing best practice and celebrating what we do well in Solihull. The board business team are also working with subcommittee members to collate further good practice examples as a resource for learning.

## Partner Contributions

Safeguarding Adults Board members have worked hard to implement the SSAB 2022-23 Strategy, here are just a few highlights of our partners' contributions:

### Statutory Partners:

**Solihull Metropolitan Borough Council** have continued to participate fully in the SSAB. As the lead partner for safeguarding adults, we have structures and processes in place to ensure that adults at risk are safeguarded effectively. This includes a dedicated Safeguarding Team Manager who is closely linked into SSAB activity. Solihull's Adult Social Care Directorate is committed to Making Safeguarding Personal (MSP), supporting and empowering adults to make choices and have control. This means a commitment to promoting equality and recognising and embracing diversity, ensuring everyone is treated fairly with access to information, advice, and support in an accessible format.

Key safeguarding activities undertaken to support SSAB priorities during 2022/23 included:

- Development and implementation of the Adult Social Care 5 Year Plan, that outlines our plans to enhance our safeguarding offer over the next 5 years.
- Continuing to closely monitor safeguarding performance through a weekly report to the Adult Social Care Directorate Leadership Team, and by providing performance information and commentary for the quarterly SSAB dashboard.
- Chairing three of the SSAB subcommittees.
- Facilitating refresher training provided for all safeguarding meeting chairs.
- Facilitating domestic abuse awareness training for front line staff, following the introduction of the Domestic Abuse Act.
- Continued development of our exploitation reduction offer, including securing additional resources for the dedicated Adult Exploitation Reduction Team
- Development of team engagement plans intended to elicit feedback from people with care and support needs and carers. These plans included mechanisms for feedback from people who experienced safeguarding processes. Further plans to develop this for 2023/24 are in development.
- We have also continued with routine practices to monitor quality of practice, including planned and ad hoc case audits. These identified consistently high standards of practice throughout the year.

**Birmingham and Solihull Integrated Care Board** have developed strong safeguarding oversight arrangements over the last year including the quality committee which provides assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The Chief Nurse and Deputy CEO have a lead role in co-ordinating the interface between Integrated Care Board and Solihull Safeguarding Adult Board arrangements. We continue to share the learning and development resources via our GP Safeguarding Network meetings, other forums and our newsletters. Our Deputy CEO has also presented to Solihull Safeguarding Adult Board regarding the Integrated care system and how this will work in practice. Now the Solihull Place Committee is fully

established, we will be ensuring this committee is embedded into the multi-agency board arrangements.

**West Midlands Police** officers attend calls for service where people are in need and ensure that they are appropriately safeguarded by attending officers. A dedicated officer ensures daily that appropriate referrals are sent to the right agency for onward support and advice and officers are regularly seeking new pathways to help support this area of business to ensure that the right support is put in place.

Structures around vulnerability and safeguarding are as such that incidents /events are reviewed daily, and any identified risk is dealt with promptly. Where long term intervention is required, meeting structures allow the progression of safeguarding with an escalation process, including the wider partnership in the Borough, where information is shared to assist with difficult cases.

## **Wider Partners:**

**Age UK Solihull** is strongly committed to safeguarding individuals in a way that supports them in making choices and having control in how they choose to live their lives. This has proven to be particularly challenging when dealing with increasing numbers of older people who self-neglect and/or hoard, and we have appreciated the support we get from Adult Social Care in addressing these often distressing situations.

We recognise that working closely with our partners in Solihull is a key component of this work in driving home the message that safeguarding is everyone's business. We are regular attendees at the Solihull Adult Safeguarding Board and recognise the role that we have in being both active participants and critical friends.

In addition, we have continued to chair the Engagement and Prevention Sub Committee and have valued the dedication and insight of our partners, including our voluntary sector partners, especially during the aftermath of the pandemic and the current cost of living crisis, both of which have impacted on organisations abilities to have as much face to face contact with individuals as they would have liked.

**Birmingham and Solihull Mental Health Foundation Trust** continue to prioritise safeguarding adults and children and works in partnership with local Safeguarding Boards.

- Additional resources have been approved to increase staffing capacity within the Safeguarding Team
- A new telephone system has been commissioned to improve caller experience to the BSMHFT Safeguarding Duty Line
- Think Family Approach and delivery plan is in place and a Think Family Launch is planned for June 23
- A safeguarding supervision policy is being developed
- 60 safeguarding supervisors have been trained and will provide reflective discussions sessions across the Trust
- Safeguarding Team has strengthened links with the Patient Safety Team and contributes to Terms of Reference for Serious Incidents



A review of safeguarding training compliance for adults and children has been implemented and additional sessions developed alongside encouraging staff to attend Partnership Multi – Agency Training

**Carers Trust Solihull** implemented refresher safeguarding training during 2022-23, following an internal safeguarding case file audit. Staff in separate teams working with adults' carers, parent carers, young adults, and young carers routinely share concerns over a single household. For example, when a worker visits an unpaid adult carer and identifies a potential safeguarding issue related to a young carer or another family member in the same home.

Given the different approaches to risk, mental capacity, observations, concerns and escalation, the digital training allowed all staff to step back, reflect on their practice, and think through how they might identify and refer a safe-guarding issue to a different team member and vice versa.

CTS also reviewed its Child Safeguarding and Adult Safeguarding Policies, amending, refreshing, and updating content to align best practices with the Solihull Adults and Children Safeguarding boards best practice; and refreshed Safeguarding reporting to the Trust' board of Trustees.

**Coventry and Warwickshire Partnership Trust** offer the learning disability and autism community services, as well as Brooklands inpatient facility along with the Talking Therapies service for Solihull. We also offer respite services for those children and adults with a learning disability.

The Safeguarding team are continuing to support staff in their safeguarding duties through advice and information sharing. We have significantly improved our Think Family Approach Safeguarding training compliance and supervision. We remain an active partner in the Safeguarding Partnership boards work and have completed the Section 11 / Care Act audit for the West Midlands and have a combined audit plan of CWPT and our Partnership board audits in place, including Solihull. This will help us to monitor safety and quality of service provision across the patch.

We have been eager to respond to the restoration agenda following Covid 19 and recognise the need to consider this in light of the economic challenges faced by patients and their families. We have also developed a Champions group of CWPT staff that carry the safeguarding messages to the teams.

**Healthwatch Solihull** is proud to be a member of the Board and subcommittees. Our role of listening to the public's experiences of health and social care give us a unique perspective for the Board. Our ability to hear quality and safety issues for adults with care and support needs across local services is an important role. We look forward to working with the Board in the year ahead in its priority to hear the experiences of individuals and support the Board in using this insight to drive improvement for Solihull residents.

**The Probation Service** are a member of the Safeguarding Adults Board and contribute to Board discussions and development sessions. They manage a statutory caseload of around 400 Solihull residents, primarily subject to post-custodial licence supervision or court-ordered community sentences. Some have been convicted for exploiting the vulnerability of others and our key aims including protection of the public. Few on the caseload meet the threshold for adult social care, but there is a trend toward an older prison population with emerging evidence that older long-term prisoners will have the health issues associated with someone ten years older than their chronological age. The Probation Service has supported with the provision of information for a Safeguarding Adults Review decision panel during 2022-23 and are committed to sharing the learning from this case within the organisation to help further develop the multiagency response to safeguarding adults. Undertaking of the Probation Service internal adult safeguarding training is mandatory for all staff.

**Solihull Action Through Advocacy** recognise positive partnership working is demonstrated at the SSAB amongst the statutory and independent / community sector. It enables an open and collaborative approach that provides the opportunity for the sharing of learning and good practice and fosters appropriate challenge. This helps to improve the quality of life of Solihull adults and includes those supported by SAAtA.

**Solihull Community Housing** Safeguarding delivery in SCH is overseen by SEDA (Safeguarding, Exploitation and Domestic Abuse) the internal strategic group that has oversight and assurance responsibilities. They provide regular reporting to the Executive Leadership Team on the work of the group and safeguarding outcomes. An annual assurance report is also presented to the SCH Board.

Key activities undertaken during 2022/23 included:

- Delivery of mandatory safeguarding training and enhanced training, such as domestic abuse training to front line teams
- Dissemination of key messages and learning identified by the Solihull Children and Adults partnerships from serious case reviews and audits to improve multi agency practice.
- Contributed to the review of multi- agency procedures around exploitation and the new Thresholds Guidance.
- Showcased best practice delivering webinars on the role of housing in tackling exploitation and enforcement against perpetrators of domestic abuse.

**University Hospitals Birmingham** Safeguarding Team support staff with education, training, clinical support, and supervision.

The Director of and Lead Nurses within Safeguarding and Vulnerabilities are proactive members of several of the SSAB's subcommittees and contribute to discussions within the meetings. UHB has proactively engaged with the work of the Board on oversight of quality and risk, with due consideration given to the long-term impact of Covid-19, considering the learning to date.

The Trust completes self-assessment tools for SSAB and formulates robust action plans to address any identified concerns, ensuring learning is embedded throughout the Trust. The action plans are monitored through the Trust's Safeguarding Board.

**West Midlands Fire Service** have taken action to strengthen safer recruitment including:

- An online statement reflecting the duty to safeguard and promote the welfare of children, young people, and adults with care and support needs is now on the WMFS' website.
- Commitment to safeguarding is in careers and job information on website.
- All internal and external job adverts now include a statement on safeguarding.
- Interview questions on safeguarding piloted by the Partnerships and Vulnerability Team and Crew Commander interviews.

The Level 1 Safeguarding Awareness eLearning has been developed and was implemented in November 2022. New content has been produced including case studies and video. The Safeguarding Oversight and Assurance Group started to receive quarterly reports on recommendations from safeguarding reviews in 2022. A safeguarding toolkit has been produced and implemented in 2022 on the WMFS intranet to embed good practice and promote use of the NHS Safeguarding App which is on all WMFS mobile phones.

## **Our Learning from Safeguarding Adult Reviews**

### **What are Safeguarding Adult Reviews?**

The Care Act 2014 introduced statutory Safeguarding Adults Reviews. A Safeguarding Adult Review takes place when agencies who worked with an adult who suffered abuse or neglect, come together to find out how they could have done things differently to prevent harm or a death. A SAR does not seek to blame anyone; it tries to find out what can be changed so that harm is less likely to happen in the future.

The law says SSAB must arrange a SAR when:

- There is reasonable cause for concern about how SSAB, its partners or others worked together to safeguard the adult; AND
- The adult died and SSAB suspects the death resulted from abuse or neglect, OR
- The adult is alive and SSAB suspects the adult has experienced significant abuse or neglect.

SARs are overseen by the SSAB, but as of March 2022, the detail on progress and considering referrals is managed by the newly formed Safeguarding Adult Review Subcommittee. The Subcommittee will provide regular updates to the Board and Independent Chair, who will retain overall responsibility for decision making around SAR criteria being met for a review, and the sign off of Safeguarding Adult Review reports and recommendations.

### **During 2022-23**

SSAB have received 1 referral for a Safeguarding Adults Review which was reviewed by a panel of representatives from organisations who are members of the Board. This referral did not meet the criteria for a review.

We have not completed any SARs during 2022-23 but we reviewed the impact of learning from 3 SARs: Rachel, Stephen and Paul.

To understand the impact of the Rachel SAR recommendations which focused on a case of exploitation, the SAB worked jointly with the Solihull Safeguarding Children Partnership and the Exploitation Reduction Delivery Group, to undertake an audit of cases involving exploitation across Childrens and Adult services. This was to understand how effectively the exploitation reduction procedures were embedded in practice and any areas for improvement. This audit showed us that although there is evidence of the procedures being used, they are not yet fully embedded across the multiagency partnership and there is more work to do to ensure the procedures are used consistently. Actions have been identified for the Exploitation Delivery Group to oversee which will address this, including a review of the Exploitation Reduction Strategy and procedures now that we are 3 years on from their introduction.

A review of the impact of the Paul SAR, which looked at Paul's experiences as a rough sleeper, involved targeted 1:1 meetings with individuals who have a lead role in working with homelessness and rough sleeping, as well as a group discussion to share the findings with those leads and determine any further improvement action required. The review findings were very positive and demonstrated that a lot of effort and energy from partner organisations with a role in reducing homelessness has created positive and effective partnership working at both the operational level working with individuals, and the strategic level looking at the effectiveness of SMBC's homelessness strategy. The SAB have agreed to receive an annual update on Solihull's response to homelessness to ensure they are sufficiently sighted on what is working well, emerging issues, and future plans.

A review of the impact of the Stephen SAR found a positive impact from the implementation of the recommendations. Policy and procedure implemented following the findings from the Stephen SAR are working well to support individuals and professionals in navigating complex support and care planning, commissioning, and safeguarding issues. Assurance and audit work has identified that in practice MCA policy and procedure is embedded in practice and where improvements were identified for some frontline teams, this will be followed up by organisational leads via action plan. A programme of audit for carers assessments is due to be implemented by SMBC Adult Social Care following the appointment of a Carers Lead in March 2023. Further updates on audit and assurance work will be shared with the Performance, Quality and Audit Subcommittee who will monitor progress of actions identified for improvement.

## **What is feedback telling us about our progress?**

The data from SMBC Adult Social Care tells us that for the most part (83% of the time), individuals are being asked what outcomes they would like to achieve as part of the safeguarding intervention. This is a similar percentage to 2021/22 indicating practice in this area is well embedded. Where individuals have not been asked, the Board has been assured that this is because the person was not well enough, had passed away during

the enquiry or did not identify any specific outcomes. Where the individual is asked, their outcomes are met or partly met 84% of the time. Again, this is similar to 2021/22 figures and the Board has been assured that where outcomes are not met, this is usually because they fell outside the remit of the safeguarding intervention. In 63% of cases, individuals felt safer following safeguarding intervention, this is also a similar result to 2021/22. Where individuals felt there was no difference in terms of how safe they felt, this was usually because they did not feel unsafe to begin with. This data provides evidence of the level of involvement individuals have in their safeguarding enquiries and demonstrates how making safeguarding personal is working in practice.

As part of the board's performance dashboard, the Performance and Development Lead for the board's business team contacts individuals who have been supported with a safeguarding issue, to talk about how they found the support and any feedback they would like to provide. This year 8 individuals have been contacted and their feedback has been very positive, with all individuals feeling they were fully involved and understood what was happening, that they were always or almost always listened to and that they were happy or quite happy with the result. Whilst we would like to be hearing from a larger number of individuals, and will be working on this during 2023-24, we are pleased with how positive the feedback received has been.

Healthwatch receive a lot of feedback from their community and speak to residents, families, and staff when they visit residential and nursing homes and supported living houses. Healthwatch have seen and heard about lots of positive examples of people receiving care and support in a way that suits them. Where Healthwatch hears about practice that doesn't meet the standards expected, they will raise this with the appropriate organisation or Board member to address. We are hoping to do further work with Healthwatch's support in 2023-24 to further understand the experiences and views of Solihull's communities.

## **Our social media and website**

### **Twitter - [@SolihullSAB](https://twitter.com/SolihullSAB)**

We use Twitter to keep our followers up to date with what SSAB are doing, to share safeguarding messages and to promote best practice guidance and support organisations who are safeguarding adults. We support several awareness days across the year by promoting key messages around awareness raising and where to go for support.

We also link up with the partner organisations' communications plans for the sharing of key messages, for example the Violence Reduction Partnership, and local and national voluntary organisations as we recognise that the reach and therefore impact is much greater from these accounts. We also join up with the Council's twitter account for some elements of communication and promotion which has a large following of almost 24,000 followers.

Some topics we tweeted about in 2022-23 included:

- Exploitation and key resources to support exploitation reduction
- World Elder Abuse Awareness Day
- National Safeguarding Week



- Hate Crime Awareness Week
- Carers Week
- 16 days of activism against domestic violence
- Suicide prevention
- LGBT+ History Month

We're really pleased that our Twitter presence has increased in the past year, and we now have 1070 followers, which means our messages are reaching an increasing number of people and organisations.

**Website** - [safeguardingsolihull.org.uk/ssab](https://safeguardingsolihull.org.uk/ssab)

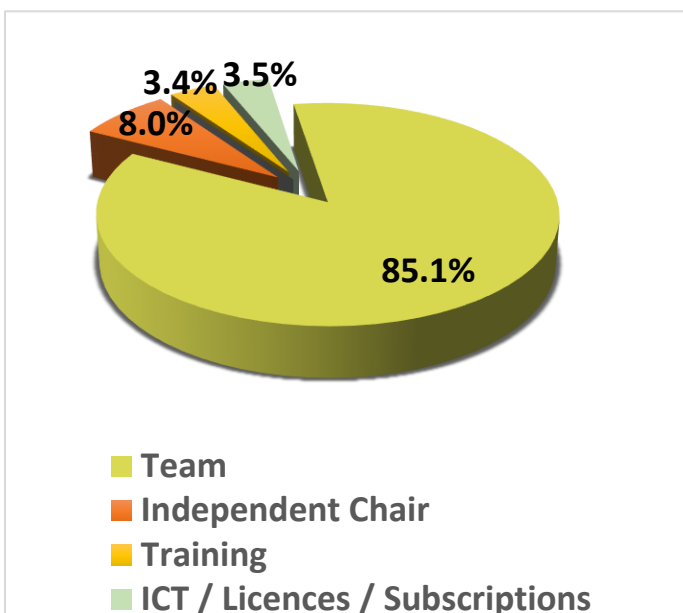
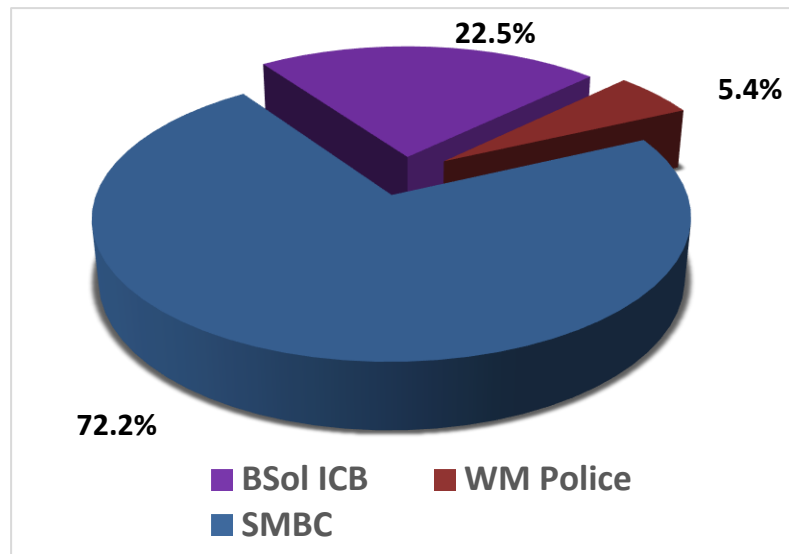
Our joint website with Solihull Childrens Partnership is where we hold information about the board, our training offer for the multiagency partnership, and resources for professionals to support their practice. It also includes joint learning resources developed with Solihull Safeguarding Children Partnership and the Domestic Abuse Partnership Board, and joint communications to support exploitation reduction, which were developed with Solihull Safeguarding Children Partnership and SMBC Adult Social Care's Exploitation Reduction Lead. We keep the website under regular review to ensure it continues to be easy to navigate and that it contains up to date information and resources.



# Financial Summary 2022-23

In 2022-23 we had a gross budget of £255,703. This budget comprises contributions from Solihull Metropolitan Borough Council Adult Social Care, West Midlands Police, and Birmingham and Solihull Clinical Commissioning Group.

In addition to the financial funding, Board partners also support the board by chairing sub committees and have delivered exploitation reduction training to the partnership.



The budget covers the costs associated with the running of the Board, including its Independent Chair and Business Team. It also covers a discreet training offer and supports the Boards Engagement approach and publicity. It also includes ICT related costs including licences and subscriptions. This year we have not had any SAR's requiring funding.

Expenditure in 2022-23 totalled £244,173 which gave an underspend against budget of £11,530. This underspend will be carried forward as Reserve and can be used for commissioning Safeguarding Adult Reviews, any project work, additional training need, improvements, or future variances.

## What's next for 2023-24?

Towards the end of 2022-23 the Board came together to agree the priorities for 2023-24. The priorities for Solihull Safeguarding Adults Board will be:

**To understand who Solihull's communities are and use this to improve the accessibility and quality of safeguarding information as well as service development.**

**To understand from Solihull's communities and those with lived experience of safeguarding, what they need from an effective safeguarding response.**

**A robust response to financial abuse.**

The strategic plan 2023-24 will set out further detail on how the Board intends to deliver on these priorities.





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