

Solihull Safeguarding Adults Board Annual Report 2025-2026



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Purpose of this report

The Care Act 2014 requires safeguarding adults boards to 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 2025 and March 2026. There is also an easy-to-read version of this report available on the SSAB [website](#) .

About 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 who have, or may have, 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 - Voluntary, Community, Faith and Social Enterprise (VCSFE) Sector representative
- Birmingham & Solihull Mental Health Foundation Trust
- Care Quality Commission
- Coventry and Warwickshire Partnership Trust
- Healthwatch Solihull
- Independent 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 pleased to present the Annual Report of Solihull's Safeguarding Adults Board (SSAB) for 25/26. In doing so, I can confirm that the Board has continued throughout the year, led by the Council, with its statutory partners, to be well supported by agencies across Solihull. As Independent Chair, my focus is always to ensure, whatever organisational changes and pressures exist throughout the year, across those agencies, that safeguarding adults remains the highest priority across the safeguarding system for which we hold responsibility. This year the Board has had the benefit of the Care Quality Commission's (CQC) inspection findings about adult safeguarding, as highlighted in their inspection of Adult Social Care, and were pleased to note CQC's recognition of both the strength of the safeguarding partnerships, and their recognition of timely, co-ordinated and appropriate responses to safeguarding concerns. The overall inspection outcome awarded of "good" for Adult Social Care services, reflects the dedication, commitment and hard work of the Council officers and elected members and our congratulations go to them for making that result possible. Their sound underpinning of safeguarding practice by the local authority is at the heart of the co-ordinated safeguarding partnership work, supported and overseen by the Board, and we are fortunate in Solihull that this is so effectively managed and led by the local authority.



In January this year we published the first Safeguarding Adult Review in Solihull that has been conducted for several years. The review called "Anne", for confidentiality purposes, particularly relates to the sad circumstances of a woman in Solihull who died in a fire in her own home. As a partnership we were able to commission an experienced reviewer, Fiona Bateman, to carry out this review who was able to show links in her findings to deaths by fire of vulnerable individuals in other parts of the UK and thus make recommendations for learning, not just for agencies across Solihull, but regionally and nationally also. This enables our SAB to contribute to the learning and to the work in this and in other ways, of the regional work of Safeguarding Adult Boards across the West Midlands and also the national safeguarding work, through my membership of the Safeguarding Chairs network.

2 years ago we determined, as a Board to focus on a smaller number of Board priorities each year, in order to concentrate the limited, dedicated resources of the Board on specific and clear reportable outcomes. This year has seen real progress on both Board priorities; our community engagement and communication with the changing communities of Solihull and on the focus and effectiveness of safeguarding training and staff development, in recognition that the skills of our staff across the partnership, are our key asset. The quarterly newsletter for professionals and the horizon scanning information report delivered to every Board meeting demonstrate that we take seriously our responsibilities as a SAB to communicate key matters that effect safeguarding at every level from Board members to practitioners. The annual report summarises the work on both priorities and significantly has influenced our choice of priorities for 26/27 which again are restricted to 2 key priorities in order to ensure dedicated focus but absolutely represent our continued ambition to provide the best possible safeguarding services for the people of Solihull.

The population is 221,242

Projections estimate there are

4,000

adults aged 18+, with a learning disability in Solihull



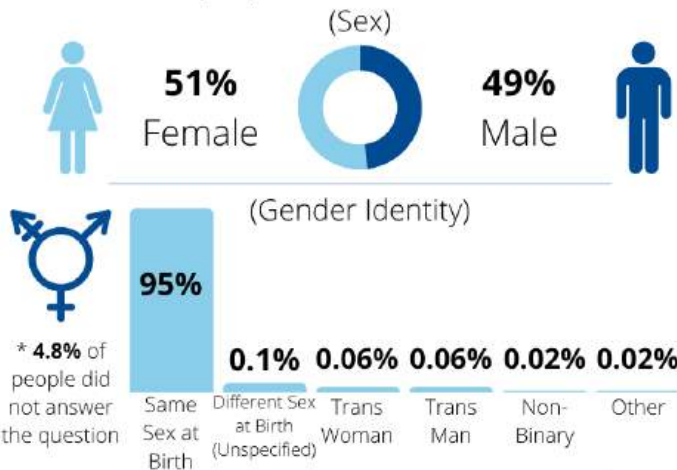
The Black, Asian and Minority Ethnic population increased by **72%** (+16,000) between 2011-21

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

69%

of Solihull adults who received long-term social care support during 2025/26 were supported in the community

Projections estimate more than **3,600** people in Solihull, aged 65+, are living with dementia



21%

of Solihull residents are 65 & over

Higher than West Midlands & England averages

77%

of the working age population in Solihull are employed, compared to 76% for England

SOLIHULL AT A GLANCE



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

40%



In the next 10 years (2026-36) the Solihull population aged 85+ is projected to grow by 40%

33,300



Solihull adults (18+) are disabled under the Disability Act. 14,000 are limited in their day-to-day activities

23,800 working age adults in Solihull have a common mental health problem



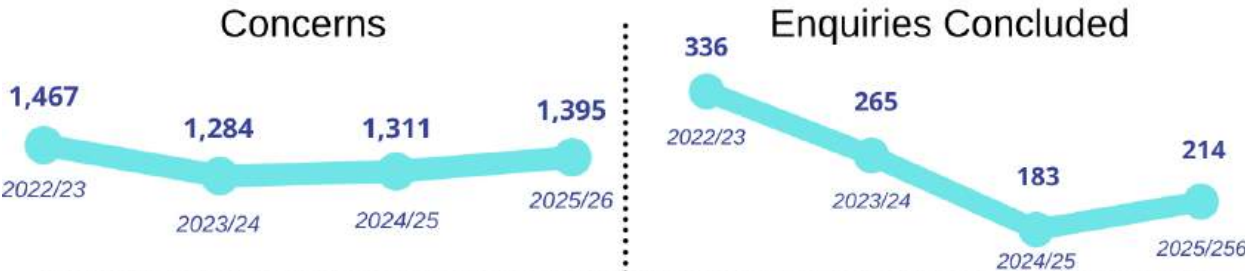
Solihull residents have the highest average wages in the West Midlands and **20%** above the UK average



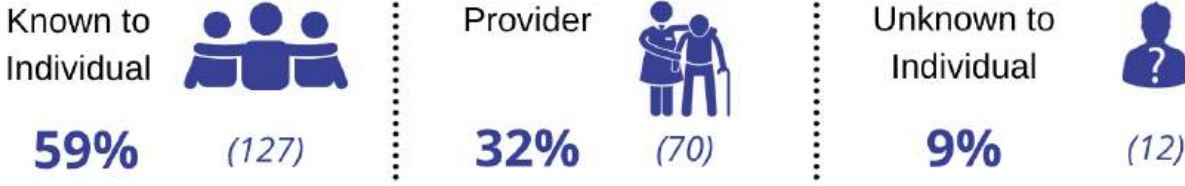
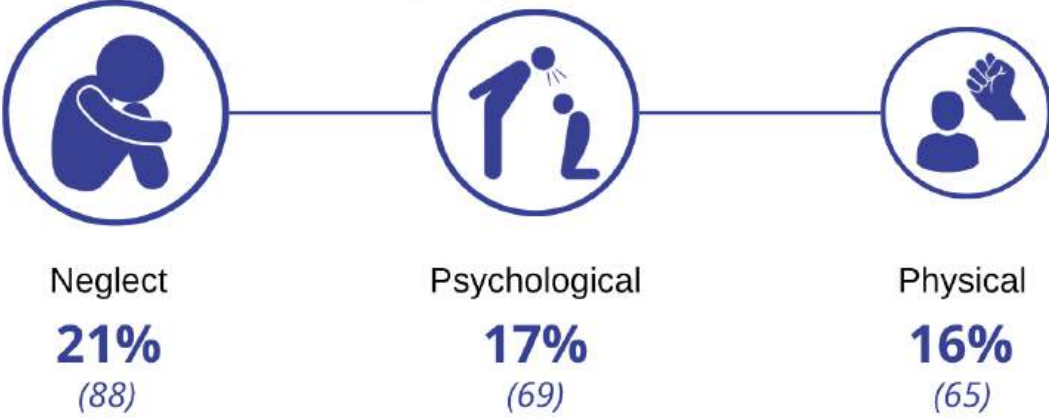
In 2021 there were nearly **20,000** unpaid carers aged 5+ in Solihull, representing **10%** of the population

*Data taken from [2021 Census](#)

The picture of safeguarding in Solihull



Top 3 Types of Abuse



* All data is regarding s42 enquiries concluded in 2025/26 unless otherwise stated

What is data telling us?

Safeguarding concern numbers in Solihull have remained stable, with 1,395 concerns recorded in 2025/26, in line with previous years. Over the same period, 214 safeguarding enquiries were concluded, compared to 183 in 2024-25 however this figure remains lower than levels seen in previous years. This change may reflect effective decision-making at the front door, ensuring safeguarding enquiries are proportionate and focused on cases where they add value in improving safety.

Safeguarding enquiries involve adults across all age groups, with 45% of enquiries supporting adults aged 18–64 years. This demonstrates that safeguarding is relevant across adulthood, not solely within older age groups. The data also shows that safeguarding enquiries involve people of a wide range of backgrounds, with most adults identifying as White (89%), while smaller proportions are from Asian, Black, Mixed and Other ethnic backgrounds. While this broadly reflects the local population profile, people from ethnic minority backgrounds remain underrepresented in safeguarding activity in Solihull. This highlights the continued importance of targeted work to ensure equitable access to and engagement with all communities for safeguarding support.

Neglect remains the most common type of abuse identified within safeguarding enquiries, accounting for 21% of cases, followed by psychological abuse (17%) and physical abuse (16%). This reinforces the need for early identification of risk, effective oversight and good quality care planning, particularly for people who rely on others to meet their care and support needs. Most safeguarding enquiries relate to individuals known to the adult, accounting for 59%. In just under one third of safeguarding enquiries (32%), the source of risk was a care provider. The Board continues to receive assurance from Health and Adult Social Care Commissioning colleagues that the quality and safeguarding concerns within provider settings are actively monitored and addressed. In addition, local multi-agency audit activity relating to care provider referrals provides assurance that concerns are being raised appropriately, the quality of referrals is robust, and adults are receiving timely support, including being signposted to appropriate organisations for ongoing support.

The data also demonstrates positive practice in terms of Making Safeguarding Personal. Most people were asked what outcomes they wanted from the safeguarding process (84%), and where outcomes were identified, 95% were fully or partly met and nearly three quarters of people who were asked, reported feeling safer following safeguarding intervention (72%), with others reporting no change for valid reasons, such as not feeling unsafe at the outset. In over half of cases, the identified risk was reduced or removed, providing assurance that safeguarding activity is making a meaningful difference to people's safety and wellbeing. Where risks remained, Adult Social Care audits provide assurance that immediate risks had been appropriately mitigated, and that longer-term work was ongoing. This was particularly evident in cases of exploitation, where sustained multi-agency support was in place to address the longer-term risks.

CQC assessment of safeguarding arrangements

In March 2026, the Care Quality Commission (CQC) published its local authority assessment of Solihull Metropolitan Borough Council's adult social care arrangements. Adult Social Care was rated "Good", providing independent assurance about how the Council meets its Care Act duties, including how it works with partners to keep adults safe. The assessment considered the effectiveness of safeguarding arrangements across the system, including the role of Solihull Safeguarding Adults Board (SSAB).

What is working well

The CQC found that safeguarding systems, processes and practices in Solihull are operating at a good standard, with evidence that adults are supported to feel safe and to understand and manage risk in ways that are meaningful to them. This reflects a continued focus on Making Safeguarding Personal, ensuring that safeguarding work is outcome-focused and centred on what matters to people.

The assessment highlighted effective partnership working to respond to safeguarding concerns and local safeguarding risks. Information sharing was found to be timely and appropriate, supporting a coordinated multi-agency response when concerns are raised. This aligns with the statutory role of the SSAB in coordinating and assuring the effectiveness of safeguarding arrangements across the partnership.

The CQC also recognised that safeguarding activity in Solihull is underpinned by a shared commitment across partners to protecting adults from abuse and neglect while supporting their rights, independence and wellbeing. This provides important external assurance on the strength of the local safeguarding system and the collaborative approach overseen by the SSAB.

Areas for continued focus

While the overall safeguarding standard was assessed as good, the CQC identified that there is a need for ongoing system-wide focus on consistency and sustainability in safeguarding practice. This includes maintaining timely responses to concerns and ensuring learning from safeguarding activity continues to inform practice across partners.

With the publication of the Anne SAR in January 2026, the SSAB will seek assurance from partners of systemic learning from the review, as well as multi-agency audits, and other review activities, to drive continuous improvement in systems, processes, and practice.

SSAB will use its 2026–27 priorities to strengthen its focus on prevention, aiming to stop harm before it occurs. This means working closely with local communities, tailoring approaches to meet different needs, and recognising that safeguarding issues can present differently across communities.



Board priorities and how they have made a difference

For 2025-26 we had 2 priorities:

Priority 1: Effectively engage with Solihull communities and use feedback to drive continuous improvement in safeguarding practices, leading to better outcomes for adults at risk.

What we said we would do

- Create a clear communications and engagement plan that explains what we are doing to raise awareness, how we have worked with communities, and the difference this has made. This plan will support the actions in the Multi-Agency Board's development plan.
- Ask local communities what matters most to them about safeguarding adults. Their views will help us set our priorities for 2026–27.
- Work with organisations to check how they are raising awareness of adult safeguarding and how they share public feedback with the SSAB, so we can work together to improve any gaps.
- Work closely with Community and Voluntary Action (CAVA) to help strengthen and maintain our engagement with local groups.
- Link our engagement activities with national campaigns and record key actions on the SSAB dashboard.
- Show communities how their feedback has been used so they can see the impact of their contributions.
- Use evidence of what works to improve our communications and engagement, making sure our approach stays relevant and effective.
- Plan a Year 2 event bringing together voluntary groups, businesses, community members, and faith leaders to share safeguarding information, raise awareness, and gather ideas for the 2026–27 plan.
- Ensure key professionals work together to support adults who are rough sleeping or at risk of homelessness. They will agree clear pathways, appoint leads for quick escalation, and meet when needed to check the arrangements are working well.

What we did

- We created an engagement calendar to plan the events SSAB would attend throughout the year to promote safeguarding awareness in Solihull. During the year, we delivered safeguarding presentations to a range of community groups, and we asked communities how safe they felt, how they would seek help, and what would improve their understanding. This feedback directly

informed changes to how we share safeguarding information, helping communities understand when and how to get help.

- Communities told us they needed information in different languages and accessible formats. In response, we introduced an accessibility tool on the SSAB website, enabling documents to be read aloud and translated so more people can access safeguarding information in ways that meet their needs.
- Communities told us they value face-to-face engagement, clear information and real-life examples to help them understand safeguarding. In response, we have offered this approach widely to support more community groups across Solihull.
- Feedback from Solihull Faith Forum leads identified varied levels of safeguarding understanding across communities. A faith representative has joined the SSAB Engagement and Prevention (E&P) Subcommittee, strengthening safeguarding messaging across local faith networks.
- Since July 2025, representatives from CAVA and the wider Voluntary, Community, Social, Faith and Enterprise (VCSFE) sector have attended the SSAB Engagement & Prevention (E&P) subcommittee. They have shared information about their services and supported joined-up working and consistent community messaging.
- The Adult Social Care Community Development Team now shares information on local events, enabling SSAB representatives to attend and raise safeguarding awareness directly with communities
- All engagement activity and community feedback are recorded on the SSAB safeguarding performance dashboard, allowing the Board to monitor reach, identify gaps and ensure no communities are overlooked.
- Partners regularly update their communities on how feedback has shaped safeguarding work, helping build trust and spread consistent messages.
- Partners are working together to plan a joint safeguarding awareness event in 2026–27, bringing voluntary organisations, businesses, and community and faith leaders together to raise awareness and share key safeguarding information across Solihull.
- SSAB met with the Rough Sleeping and Homelessness Team to better understand safeguarding needs for people experiencing homelessness and shared practical resources, including safeguarding information, self neglect guidance and clear escalation tools to support frontline work.

Impact for the people we support

- More people can access safeguarding information in formats that meet their needs, including translated and accessible options.

- Community and faith organisations are better connected to safeguarding support and know how to raise concerns
- Safeguarding messages are more consistent across local organisations and community groups
- Feedback from communities is actively shaping Board activity, improving how safeguarding information is shared.
- Professionals supporting people who are homeless or rough sleeping have clear guidance and pathways to safeguard adults at risk.
- Clearly demonstrating how community feedback has been used has strengthened trust between communities and safeguarding partners.



Priority 2: Further improve the impact of staff learning and development activities to deliver improved safeguarding practices and outcomes for adults at risk.

What we said we would do

- Coordinate with the cross-board action to develop a proportionate all-age learning and development offer for 2025-26, ensuring all staff are aware of available opportunities. Set a target for multi-agency training attendance and work together to achieve the necessary improvements.
- Seek assurance from statutory partners on training implementation and impact, working together to address any gaps.
- Focus the multi-agency offer on learning from SARs, CSPRs and DARDRs (formerly DHRs) and use a variety of resources e.g. case studies, fact sheets, 7-minute briefings, bite size training focused on headline messages.
- Review the safeguarding resources, information and advice available on the SSAB website and statutory partners websites to identify further improvements to impact, accessibility and usage, particularly focusing on preventative information and advice as a key component of helping people keep themselves safe.

- Set a target for evaluation form completion and record this on the SAB dashboard. Follow up with a sample of participants to assess the long-term impact of training.
- Conduct case file audits linked to training topics to establish evidence of learning in practice.
- Use staff feedback and evidence from audits to continuously improve the training offer and address any emerging issues or gaps.

What we did

- A comprehensive multi-agency training offer was delivered, informed by learning from Safeguarding Adult Reviews, audit findings and performance data, ensuring that training content addressed identified areas for improvement. This included continued cross-board collaboration, with an all-age learning offer developed in partnership with the Safeguarding Children Partnership to promote consistency across safeguarding systems.
- A jointly hosted Practice Learning Forum achieved high attendance across agencies, supporting shared understanding and reflective discussion. Engagement with specialist learning was strong, with a webinar on fire safety and hoarding being delivered to 80 attendees.
- Flexible access to learning was supported through on-demand resources, including 7-minute briefings and recorded webinars hosted on the SSAB website.
- To strengthen assurance and effectiveness, the Board introduced a 3-month post-training evaluation to assess the extent to which learning is applied in practice. Completion rates are monitored through the SSAB dashboard, alongside standard post-training feedback. Evaluation findings, audit evidence and attendance data were reviewed throughout the year and used to inform planning for the 2026–27 training programme.
- The Board also aligned learning with quality assurance activity. Multi-agency audits were designed to reflect key training themes such as Mental Capacity and Making Safeguarding Personal, supporting consistency and enabling evidence of learning being reflected in safeguarding practice.
- In response to capacity pressures, the training offer was reduced by 50% compared with the previous year, to focus on core learning needs while avoiding unnecessary expenditure. Attendance data and feedback were used to identify barriers to participation and explore potential solutions, including staff preferences for training formats, greater promotion of bite-size learning, and the proposal of a reserve attendee system to minimise unused training places.

Impact for the people we support

- Evidence gathered during the year shows that learning and development activity is supporting safeguarding practice, which contributes to safer and more effective responses for adults at risk.
- Feedback from practitioners demonstrates that training is helping to strengthen multi-agency working, risk assessment and professional curiosity, with examples of learning being applied directly to safeguarding situations. The introduction of a 3-month evaluation has provided early insight into how learning is sustained over time, including practitioners sharing learning within teams and applying it to their practice.
- Multi-agency audits provide additional assurance that learning and guidance are being reflected in practice, including consideration of protected characteristics, diversity, race and culture. Audit findings indicate that the quality of safeguarding practice is influenced by training and guidance delivered through the Board's learning programme.
- Access to resources through the SSAB website supports practitioners to refresh their knowledge when needed, helping to maintain consistent safeguarding approaches across the system. Together, these arrangements provide growing assurance that learning activity is contributing to more informed, coordinated and person-centred safeguarding practice, supporting adults to be safeguarded and supported.

Multi-agency board coordination

Solihull Safeguarding Adults Board worked with Solihull Safeguarding Children Partnership, Community Safety Partnership, and Health and Wellbeing Board to improve cross-board coordination to ensure effective and impactful work. Focus areas included:

- Enhancing board and partnership communications.
- Maintaining a 'plan on a page' outlining key multi-agency boards, their purposes, and priorities.
- Ensuring strategic plans directly connect to the impact on Solihull children, young people, and adults.
- Providing key information for new and existing board members through a Partnership Information Pack.

This work is overseen by biannual meetings of board chairs and support officers. A multi-board event in January 2026 shared progress, sought feedback, and identified improvement areas for 2026-27, including identifying a new priority to strengthen our commitment and approach to addressing all forms of inequality and division, including the development of an anti-racist strategy within this.



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

The group ensures local safeguarding policy and guidance are kept up to date and develops new resources to meet partnership needs, including responding to national legislative and guidance changes, and learning from SARs.

Promoting awareness and access to safeguarding information

The subcommittee reviewed newsletter and website analytics, which showed an increase in newsletter open rates compared with the previous quarter. Updated SSAB online safety materials were confirmed as live on the website and actively promoted.

National resources on online safety and scams, shared by West Midlands Police, were agreed for adoption to support both professionals and members of the public. The group also agreed to promote a romance fraud awareness campaign developed by the Metropolitan Police and West Midlands Police. In addition, partners received and agreed to share the West Midlands ADASS Directory for safeguarding and wellbeing services across their organisations.

Embedding equality, diversity and inclusion

The subcommittee gave focused attention to ensuring that equality, diversity and inclusion (EDI) considerations are reflected in locally developed safeguarding guidance. Work progressed during the year on the development of an EDI checklist, supported by engagement with Solihull Metropolitan Borough Council's Equality and Diversity Officer. A final version of the checklist was agreed, providing a consistent prompt to support EDI considerations when creating or updating guidance.

Assurance and effective use of guidance

Partners discussed the effectiveness of existing Position of Trust guidance and its use in practice. It was noted that cases are considered several times each year and that the guidance, alongside advice from the Adult Social Care Safeguarding Team Manager, continues to support proportionate decision-making in individual cases.

Engagement & Prevention Subcommittee

This group focuses on raising awareness, working with communities, and helping people know how to get support if they are worried about themselves or others.

Working with partners and communities

The group heard from a range of organisations to improve shared understanding of local support services and to strengthen partnership working. This included support from CAVA and the VCSFE as well as public-facing services like Citizens Advice Bureau and West Midlands Police. Partners worked together to share clear and consistent safeguarding messages across Solihull. This included joint online safety advice and information about fraud and scams to help keep communities safe.

Engagement activity and events

Partners shared information about engagement activities taking place across the borough. This helped to keep the SSAB Engagement Calendar up-to-date and ensured that events could be attended by SSAB to share preventative messages, and feedback from the public was used to inform future work.

Engagement Event

The group explored plans for the delivery of a joint engagement event in 2026–27, exploring what this approach will look like and how different organisations could contribute to support this event.

Understanding safeguarding data

The group reviewed key safeguarding data including referral trends and information about protected characteristics. This helped the group to understand how safeguarding awareness can continue to be strengthened within communities and where more targeted support may be needed.

Listening to the community

Feedback from partner organisations and local people played an important role in shaping the group's work. This included learning from a self-neglect survey, which helped improve understanding of community needs, encourage a more empathetic approach, and clarify how people can raise concerns about friends, neighbours, or family members.

Improving prevention and early help

The group discussed Multi-Agency Risk Management Guidance, supporting partners to know how to raise concerns with other agencies when they are worried about an adult.

Showing how feedback leads to change

The group received an Engagement Assurance Report from the SSAB Performance and Development Lead, which showed how SSAB listens to people with lived experience and uses their feedback to shape safeguarding priorities and improve practice.

Performance, Quality & Audit Subcommittee

The Performance, Quality & Audit Sub-Committee provides assurance to the Board by reviewing safeguarding data, undertaking audits, and overseeing quality improvement work.

Safeguarding performance reports

Throughout the year, the group reviewed regular safeguarding reports using the new interactive performance dashboard. This helped to identify trends, emerging concerns and areas requiring focus, which supported our priorities for action.

Using learning to plan audits

Performance data and learning from previous local audits informed the groups audit planning for the year, ensuring they focused on local improvement priorities, emerging themes, and the Board's priorities.

Tracking audit actions

The group endorsed summary reports from audits they have jointly completed which identified learning and good practice; and practice briefings were developed to share this learning widely. Recommendations from the audits were tracked through the SSAB Audit Action Plan, which was shared with partners to support oversight, actions and accountability.

Partners also agreed to share learning from their own internal audits to strengthen openness and share learning across the partnership. Learning from the Care Act Compliance Audit was reviewed, reflecting on learning and positive feedback, including key strengths and areas for development.

West Midlands Fire Service partner referral data

The group reviewed safe and well visit referral data from West Midlands Fire Service, and will use learning from a local Safeguarding Adults Review (SAR) to improve referral patterns and multi-agency working.

Planning audits

To maintain a proactive approach, the group agreed to use future meetings to continue to shape audit plans, prioritising areas requiring immediate focus and developing a longer-term schedule to address identified priorities.

Learning & Improvement Subcommittee

This group supports the Board by making sure learning is shared, training is effective, and safeguarding best practice is embedded for frontline staff.

Learning from audits

At the start of the year, the group reviewed the 2024–25 Audit Summary Report. This brought together examples of good practice and areas for improvement from completed audits and helped shape the training offer for 2025-26. In addition, the group considered practical actions to support frontline staff in response to identified learning, such as sharing resources through organisational communications channels.

SSAB multi-agency training

Throughout the year, partners reviewed attendance at SSAB multi-agency training and the evaluation feedback following training sessions. This helped us to explore ways to reduce non-attendance as well as providing reassurance that training was improving staff safeguarding practice. To better understand the longer-term impact of training, the group also developed a three-month post-training evaluation form.

Flexible learning options

The group explored the development of a bite-size learning resource, responding to requests from the Engagement & Prevention Sub-Committee, to improve understanding for frontline staff and developed a 7 minute guide on neglect and self-neglect.

Trauma-Informed Approach

Regular updates were received on the implementation of a Trauma-Informed Approach in Solihull, including progress on the Train-the-Trainer programme, plans for multi-agency training delivery and themed workshops, and the development of a supporting strategy and audit tool. Partners were encouraged to take part to ensure a consistent and compassionate approach was used across organisations in Solihull.

SSAB website and newsletter analytics

The group reviewed the analytics at each meeting to better understand what information professionals are accessing. Actions were agreed to promote resources that were being used less often, through newsletters and messages from the SSAB.

Staying informed about new risks

Horizon scanning formed an important part of the group's work, with partners sharing emerging policy developments, national safeguarding issues, and local issues, enabling timely discussion and information sharing across the partnership.

Learning from wider forums also informed discussions, including the Safeguarding Learning Forum run jointly by SSAB and Solihull Safeguarding Children Partnership (SSCP) and the Race and Racism Conference organised by SSCP.

Safeguarding Adult Review (SAR) Subcommittee

The group considers whether new Safeguarding Adult Review (SAR) referrals meet the SAR criteria and makes recommendations to the SSAB Independent Chair. It also oversees the progress of commissioned SARs, the implementation of learning, and considers relevant SAR learning from other areas.

Managing Safeguarding Adult Reviews

During 2025–26, the subcommittee oversaw progress on the Anne Safeguarding Adult Review (SAR). This included agreeing the scope and approach, overseeing the request and receipt of Individual Management Reports, and supporting engagement with the family. The subcommittee reviewed and agreed the final draft SAR report, with minor amendments, for presentation to the SSAB, and monitored progress against the associated action plan, noting that actions were underway and some had been completed.

The subcommittee also agreed the learning summary for publication, supporting transparency and wider dissemination of learning.

Screening and decision-making on SAR referrals

The subcommittee considered one SAR referral during the year. The referral was reviewed against the statutory SAR criteria, with agreement that the criteria were not met at that stage, subject to reconsideration should further relevant information emerge.

Learning from local and national reviews

The subcommittee reviewed learning from local assurance activity and national SARs completed by other Safeguarding Adults Boards, including SARs focused on abuse, exploitation and the misuse of direct payments. Learning from these reviews was discussed,

with representatives agreeing to share reflective questions and key messages within their organisations and across partnership learning forums.

An assurance report was received from Adult Social Care regarding oversight of direct payments, following discussion of national SAR learning. The subcommittee noted the assurance provided on local oversight and escalation arrangements.

Improving SAR quality and inclusivity

Reflective discussions took place on the Anne SAR process, identifying strengths to replicate and opportunities for improvement. Partners recognised the value of using a rapid-time SAR methodology, supporting timely identification of learning and improved efficiency.

The subcommittee also considered thematic learning on race, ethnicity and culture, agreeing to review and update local SAR guidance to better embed consideration of race, racism and racial bias within the SAR process. SAR best-practice materials were updated to ensure clearer consideration of how an adult's protected characteristics may influence their experiences of services and safeguarding practice.



Partner contributions

Safeguarding Adults Board members have worked hard to implement the SSAB 2025-26 Strategy, here are just a few highlights of our partners' contributions:

Statutory partners:

Solihull Metropolitan Borough Council

Over the course of 2025/26, Adult Social Care has strengthened how we engage with Solihull communities and how we use feedback to shape safeguarding practice. We have continued to embed lived experience feedback into our assurance processes, with auditing managers routinely contacting individuals and families following safeguarding enquiries to understand their experience and the extent to which outcomes were achieved. This has helped us build a more consistent picture of what "good" looks like from the perspective of the people involved, and it has informed improvements in how we communicate, involve people in decision making, and explain safeguarding processes.

Targeted engagement has been a key feature of the year. To address under representation within safeguarding data, the SSAB Business Team has spent time with

community groups that support residents from diverse ethnic backgrounds, particularly older Asian communities. As a result, safeguarding information has been translated into key community languages, and accessibility features have been added to the SSAB website to support wider reach and understanding. Alongside this, SSAB has developed an engagement calendar to track activity and is preparing a “You Said, We Did” update to demonstrate how community insight is shaping our work.

Data and performance insight continue to guide our priorities. Further development of our quarterly dashboards has strengthened our understanding of who is raising concerns, the profiles of adults at risk, and conversion rates to Section 42 enquiries. Audit activity has provided assurance that referrals from providers are appropriate and of good quality, and exemplar practice is being shared to build consistency across the system. Safeguarding decision making has remained timely throughout the year, with strong performance against the 72-hour decision expectation and no waiting list for Section 42 enquiries. Together, these elements demonstrate meaningful engagement, improved accessibility, and a consistently responsive safeguarding front door.

Adult Social Care has continued to strengthen the quality, reach, and impact of learning and development to improve safeguarding practice across the system. This year saw a refreshed training offer, including new resources launched during National Safeguarding Adults Week. Evaluation and attendance data are now routinely reviewed to ensure that training is accessible, relevant, and targeted, and learning from Safeguarding Adult Reviews, audits, and national research directly informs updates to the training programme.

The Solihull Social Care Academy continues to provide a comprehensive ASC learning and development offer, with an updated brochure setting out clear pathways for practitioners, managers, and specialist roles. This is complemented by monthly newsletter articles promoting development opportunities across Adults and Children’s Services. A significant development this year has been the introduction of a Trauma Informed Approach training programme. This includes a universal Tier 1 e learning module to be completed by the end of March 2026 and a more in depth Tier 2 face to face programme for roles where trauma informed practice is essential. This is aimed at strengthening reflective, relational, and psychologically informed practice across the workforce.

We continue to focus on ensuring that learning translates into everyday practice. Case file audits, reflective supervision, and the Safeguarding Leaders network all support this, alongside deep dive reviews through DLT which have recently focused on enquiry timeliness, complexity, and escalation. Across the year, practitioners have reported increased confidence in identifying deterioration, managing behaviours that challenge, and responding to self-neglect and exploitation.

Birmingham and Solihull Integrated Care Board

The NHS Birmingham and Solihull Integrated Care Board (ICB) supports safeguarding through its commissioning, quality assurance, and system leadership role across health services.

In relation to SSAB Priority 1 (Community Engagement and Using Feedback), the ICB has strengthened how it captures and responds to feedback from people with lived experience, families, and carers. This includes ongoing work with the Capturing Change

project and routine analysis of complaints to identify themes and risks. GPs and providers continue to gather patient feedback, with further work underway to improve engagement with harder-to-reach communities.

In relation to Priority 2 (Staff Learning and Development), the ICB has enhanced safeguarding assurance by focusing on how training is applied in practice. This is supported by reflective learning within GP Safeguarding Network meetings, helping clinicians embed learning and improve safeguarding outcomes.

These actions support continuous improvement in safeguarding practice and outcomes across the system. Despite significant changes within the safeguarding team over the past 12 months, the ICB has remained committed to supporting the adult safeguarding agenda and maintaining strong partnership working.

West Midlands Police

Public Protection Unit

West Midlands Police have a well embedded Organisational Learning Process which gathers learning from statutory reviews, internal audits and debriefs in order to continuously improve the way the organisation responds to incidents, and manages investigations, involving Adults at Risk. A new West Midlands Police Multi-Agency Referral Form (MARF) has been developed to support consistent high-quality referrals into Adult Social Care and to support signposting to other third sector support agencies where safeguarding concerns and support needs are identified.

Local

Vulnerability Officer processes all adult Multi Agency Referral Forms (MARFs) for Solihull Local Policing Area (SH LPA) and as part of this role has regular contact with the partner agencies that makes referrals to. This can involve phone calls, attending teams' meetings, joint training sessions etc. These working relationships ensure that any learning can be shared and acted on.

Engagement and Comms Officer has contact with partner agencies as well as various community groups as part of the role so emerging themes, concerns, safeguarding gaps etc can be shared.

The vulnerability and engagement officers attend the bi-monthly Solihull Learning Disability Partnership Board. This is chaired by the Adult Social Care Directorate and two service users, who themselves have learning disabilities and use their experiences to help and represent others.

The vulnerability and engagement officers attend the bi-monthly Solihull Learning Disability Partnership Board. This is chaired by the Adult Social Care Directorate and also two adults with lived experience, who themselves have learning disabilities and use their experiences to help and represent others.

The vulnerability and engagement officers visit the Solihull Action Through Advocacy office about 4 times a year and have regular contact. This is a charity with funding from SMBC that helps vulnerable adults with things such as housing, medical appointments, filling in forms, education, benefits, shopping. Where they give inputs to people and staff around things like cuckooing, crime prevention etc.

An officer attends our Multi Agency Adult and Child Exploitation (MAACE) meetings for vulnerable adults. A lot of these are generated as a result of police attended incidents. The PC also conducts single and joint visits to vulnerable adults and adults who have been reported missing on multiple occasions.

Partnership Inspector has regular contact with SMBCs Community Safety Partnership in various meetings and settings on the topics of vulnerability and safeguarding.

Neighbourhood Policing Teams have various interactions with vulnerable adults during visits to places such as Park View Day Centre, which is a day centre for adults with learning and/or physical disabilities.

Patrol Crime Team (PCT), Neighbourhood Policing Teams and Licensing officer work, often alongside SMBC, re. closure orders for cuckooing, Sandstar, Modern Day Slavery, Organised Immigration Crime etc.

Partnership Inspector as the LPA lead for Missing Operational Group (MOG) and Solihull Missing Operational Group (SMOG) is to review every child and adult who has come to harm whilst missing from SH LPA. This could include suicidal ideations, rape, assault, exposure due to cold etc. Feedback any failings or learning opportunities to officers and their supervisors, identify trends on teams and then feedback to MOG.

Priority 2: Further improve the impact of staff learning and development activities to deliver improved safeguarding practices and outcomes for adults at risk.

Public Protection Unit

Guidance was developed for the new Adult MARF process and shared with all frontline and investigative staff who will have responsibility for completing the MARF. Additionally, WMP have commissioned a training package which is in development through L&D – the package will be mandatory for all staff and will detail how to identify and respond to safeguarding concerns. This is a follow up to a force-wide Vulnerability training programme delivered in 2023. Safeguarding and Vulnerability is prominent in the training programme for new officers.



Wider partners:

Age UK Solihull play a vital role in Solihull in identifying vulnerable people and assessing their need for safeguarding support. Of the 234 vulnerable people identified in 2025-26, 79 of them were brought to the Safeguarding Lead by Age UK Solihull staff, mostly those working in the community, with 48 of those identified through the Community Advice Hubs.

93 of the 234 identified were the subject of MARAC discussions and 63 were referred to Age UK Solihull by the Police, demonstrating the strength of multi-agency working in identifying and supporting vulnerable people. Of these 26 were referred into the Local Authority for safeguarding support. Our reflections on the year note that self-neglect continues to be on the rise and that mental health concerns remain a significant contributory factor, present in nearly 30% of cases.

Birmingham and Solihull Mental Health Foundation Trust

Over the past 12 months, BSMHFT has taken a number of steps to strengthen its contribution to the SSAB's strategic priorities.

In relation to Priority 1, BSMHFT has continued to maintain a strong operational presence within Solihull through its community-based teams, enabling close engagement with local populations and a better understanding of emerging safeguarding needs. Information sharing has been a key mechanism for engagement and improvement; safeguarding updates, learning from practice and training opportunities are routinely disseminated across the organisation via internal communication channels such as the intranet and concise "7-minute briefings." This ensures that frontline staff remain informed and responsive to both local and organisational safeguarding priorities.

In addition, the safeguarding team provides accessible support to clinical services through a dedicated duty and advice telephone line and email, facilitating timely guidance on complex cases. Our team also takes a proactive, data-informed approach by monitoring incident reports to identify themes, trends and potential hotspot areas. This intelligence is then used to target support and intervention where it is most needed, supporting continuous improvement in safeguarding practice and contributing to better outcomes for adults at risk.

In relation to Priority 2, BSMHFT has focused on strengthening the impact and responsiveness of safeguarding learning and development. Training compliance is actively monitored to ensure staff are meeting required standards, and this is complemented by regular feedback from service areas into the internal Safeguarding Management Board meetings, helping to assess the effectiveness and relevance of learning activity. Building on this, the safeguarding team has developed a flexible programme of internally delivered, topic-specific training sessions, including areas such as self-neglect, financial abuse, sexual safety and Person in a Position of Trust (PiPoT). These sessions can be tailored and delivered to individual teams in response to identified need, including where themes have emerged from incidents or safeguarding concerns. This targeted and adaptive approach supports the translation of learning into practice, helping to improve staff confidence, decision-making, and ultimately safeguarding outcomes for adults at risk.

Carers Trust Solihull

Over the past year, Carers Trust Solihull secured a new carers contract to continue delivering adult carers support in the borough. This involved significant changes to the service offer, particularly a greater emphasis on community outreach after December 2025, with a range of adult drop-in, awareness-raising, and thematic groups, as well as planned campaigns, to reach underrepresented carer groups.

The number of active adult carers registered with the Carers Trust continued to rise.

- Young adult carers up by 65 to 511, a rise of 12%
- Adult carers up by 127 to 2,884, or 4.6%
- Parent carers up by 204 to 1,029, or 20%
- And carers reluctant to give their identity up from 47 to 511, 10%.

To meet the growing demand for information and advice, CTS has entered into a partnership with Bridgit Care to deliver an AI-powered online information and advice service to all carers in the borough. During the configuration of Bridgit, to ensure it provides Solihull carers with appropriate answers, carers, staff, and volunteers were involved. Importantly, it was necessary to develop safeguarding pathways and policies for any carer chat entered into the Bridgit system that might raise a concern. Learning from other local authority areas where the programme is running, CTS established a digital referral system using Bridgit, following normal CTS safeguarding processes. The occasions when this has been a cause for concern in Bridgit's rollout in other local authority areas have been minimal, but it is intended that Bridgit will not simply duplicate known carers but, in time, extend the number of currently hidden carers known to CTS in the borough. Therefore, ensuring safeguarding processes are embedded and assured was important.

Through 2025, the profile of adult carer (over 18 years) safeguarding saw:

- 10 unique carer safeguarding referrals, an increase of 43%
- 72 safeguarding interactions by staff with carers, an increase of 63%

However, these rises are from a low base in 2024 and do not necessarily reflect a trend. (For example, activity during the Covid lockdown period was significantly higher.)

- 80% of contact was by phone
- 10% by email
- 5% face-to-face
- 43% involved supervised Carers Practitioner action
- 41.7% safeguarding officer supportive action
- 12.5% led to a Cause for Concern

The highest-volume wards for safeguarding activity were Chelmsley Wood, Smith's Wood, and Kingshurst & Fordbridge.

As the carer cohort in the borough ages, and the cared-for suffer from more chronic end-of-life or other illnesses associated with longer life, we are seeing many carers facing isolation. It is too early to determine how the new outreach, digital, and existing information and advice packages will help to identify and mitigate the frequency of safeguarding concerns. CTS's role in these cases, as well as in those that avoid escalation, is to support carers in relieving the pressures that can lead to safeguarding referrals. This year, the preventative support included a range of individual support

packages, contacts and sessions, relaxation activities, workshops, support, and contingency plans.

CTS continues to provide refresher safeguarding training arising from internal safeguarding case file audits. Staff in separate teams working with adult carers, parent carers, young adults, and young carers routinely share any concerns they identify within a single household. The mobilisation of the new service has led to new workers and volunteers joining, and they have all received appropriate safeguarding training as part of their induction into new roles or into the service.

Coventry and Warwickshire Partnership Trust (CWPT) continue to be an active partner in Solihull Safeguarding Adults Board. Our services are Brooklands Hospital, providing inpatient care for those with learning disability and Autism who have Mental health illness, this includes some provision for young people and four forensic wards for those referred through a criminal justice process. We also offer Learning Disability and Autism Community services for Solihull and Primary Care mental health support through Talking Therapies for the Solihull community.

This has been a busy year for CWPT, with the developments below:

- Working in partnership with the board, with attendance and engagement in subgroups and development days,
- All safeguarding policies have been reviewed and ratified and a process of reviewing future policies has been put in place.
- The Safeguarding Team have reviewed their supervision offer and documentation in line with policy and approach and offering multi-disciplinary group sessions as part of the strength-based sessions.
- Safeguarding supervision training was attended, so that all staff in the safeguarding team and many of the Champions Group have and can demonstrate recognised enhanced skills.
- The Safeguarding Team has supported their Champions Group, who meet virtually on a quarterly basis, to embed safeguarding messages across the Trust. Speakers have included an update on Prevent, Fire Safety and The Com (online safety for children and young people). A Champions briefing of all newsletters, updated legislation, training and policy is shared on a weekly basis.
- A Sexual Safety Working Group has been meeting regularly and have written a package which will be delivered in 2026/27 on sexual assault and abuse to support staff to ask the question and understand necessary and appropriate actions.
- The safeguarding team have benchmarked themselves against all core standards of CQC and put actions in place to strengthen areas identified for development.
- A competency framework for new staff in the safeguarding team has been developed and embedded.

Healthwatch Birmingham and Solihull is pleased to continue serving as a member of the Solihull Safeguarding Adults Board and its subgroups. Our statutory role in gathering and representing the views and experiences of local people using health and social care services provides a valuable perspective, particularly in highlighting issues relating to the safety and quality of care for adults with care and support needs.

Over the past year, we have continued to champion the voices of Solihull residents, supporting learning, reflection and improvement across the safeguarding system. We

welcome the opportunity to continue working collaboratively with the Board in the coming year, helping to ensure that lived experience informs practice and contributes to positive outcomes for adults at risk in Solihull.

The Probation Service supervises approximately 200 Solihull residents subject to statutory sentences, with a clear focus on protecting the public, reducing reoffending, and enabling sustainable rehabilitation. Professional relationships, underpinned by structured interventions and evidence-based practice, are central to this delivery and support effective risk management alongside long-term behavioural change.

Safeguarding is integral to all aspects of practice. Practitioners are trained to identify, assess and manage risks of serious harm, including risks to vulnerable adults, in line with national policy and legislative requirements. Mandatory Adult Safeguarding training has been fully completed across the service and is embedded within the Probation Professional Register, ensuring sustained competence, professional accountability, and ongoing development.

The service has directly supported the delivery of local safeguarding priorities by strengthening engagement with Solihull partners and communities and systematically using feedback from multi-agency activity to drive continuous improvement. This has resulted in more effective information sharing, clearer referral pathways, and more timely identification and support for adults at risk.

Focused investment in staff learning and development has further enhanced safeguarding practice. By embedding learning within supervision, case management and quality assurance processes, the service has improved the consistency and quality of professional decision-making, strengthened risk management, and delivered demonstrable improvements in safeguarding outcomes.

The Probation Service remains committed to collaborative partnership working and to the effective implementation of the Sentencing Act 2026. Practitioners are being supported through structured guidance, training and governance to apply legislative changes consistently, with partner agencies actively engaged to ensure a coordinated and system-wide approach to safeguarding and public protection.

Solihull Action Through Advocacy (SAAtA) supports some of the most vulnerable adults in the community, including people with learning disabilities and autistic people. Advocacy plays a vital role in ensuring that individuals' voices, wishes, and feelings are heard and represented throughout the safeguarding process, particularly those who do not have loved ones who are able to support them.

Through active involvement with the Solihull Safeguarding Adults Board (SSAB), SAAtA contributes from an independent advocacy perspective that helps strengthen safeguarding practice across the partnership. SAAtA values the positive and collaborative working relationships between statutory agencies, health services, and the voluntary and community sector. This partnership approach supports open discussion, shared learning, and the development of good safeguarding practice, helping to improve safeguarding outcomes and the quality of life for adults in Solihull.

SAAtA also Chairs the Engagement and Prevention Sub Committee, where advocacy plays an important role in promoting inclusive engagement and ensuring that the

experiences of vulnerable adults inform local safeguarding priorities. The Sub-Committee provides opportunities for partners, including voluntary sector organisations, to share information, identify emerging issues, and coordinate consistent approaches to prevention and safeguarding. Through this work, SATa helps ensure that the lived experiences of people who use advocacy services continue to influence safeguarding practice and service development across Solihull.

Solihull Community Housing

In 2025/26, Solihull Community Housing concluded a pilot scheme 'Every Contact Counts' where a group of staff and contractors undertook additional checks when visiting tenants' homes. This included identifying and reporting concerns for adults such as additional needs, poor living conditions, damp and mould, hoarding behaviour or frailty. This was a successful pilot and will be rolled out to wider staff during 2026/27.

In February 2026, SCH recruited a new Safeguarding Coordinator to ensure safeguarding is strongly embedded into policy and practice.

SCH supported West Midlands Police and Council colleagues during 'Mischief Week', which includes Halloween and Bonfire Night. With the clocks going back and the nights getting darker, we see increases in incidents such as burglaries, firework misuse, youths congregating and nuisance callers. To ensure a safer environment for all, we focused on checking in with our most vulnerable tenants, ensuring spaces around our properties and estates were safe and well-maintained, and offered reassurance.

Home invasion exploitation is a vital piece of work undertaken by Neighbourhood Services. SCH worked alongside police and other agencies and used vulnerability data to identify higher-risk households and carry out reassurance visits to make sure people felt safe and supported.

Our new Hoarding Peer Group launched on 19th February. Hoarding causes issues to SCH particularly around compliance and fire hazards but hoarding also impacts the tenant's life. This fresh new approach through the peer group aims to help people to help themselves, build trust, and share lived experiences, working through small management steps through to long-term behavioural change.

SCH continue to strengthen, year on year, our existing Safeguarding Portal to ensure staff are able to access multi-agency procedures and referral forms at speed. This includes referrals to our in-house Mental Health Support and Advice Officer. All staff are required to complete mandatory safeguarding training. This year, we also introduced a new mandatory training module 'Preventing radicalisation and response to terrorism'. SCH ensure that key safeguarding messages and learning from audits and case reviews are disseminated throughout the organisation through team meetings and monthly core briefs.

University Hospitals Birmingham supports the work of the Solihull Safeguarding Board by providing a robust and responsive safeguarding service. The Trust overall includes 4 hospitals, as well as community and sexual health services for the citizens of Solihull. The Director and Lead Nurses for Safeguarding continue to be proactive members of the SSAB's board and subcommittees

To improve services UHB strives to capture the voices of adults to ensure that improvement plans remain focussed on the needs of those most in need. A comprehensive programme of training, supported by supervision and advice lines, is provided by the safeguarding team to support staff in their safeguarding practice

Key activities undertaken during 2025-2026:

- Ensured key messages and learning identified by the Solihull Children and Adults partnerships from serious case reviews and audits to improve multi agency practice have been disseminated throughout the Trust through a programme of site based and focussed Safeguarding and Vulnerabilities meetings.
- Training needs analysis (TNA) is reviewed annually and updated, along with our education and training packages to ensure training is responsive to service need, accessible and relevant for practitioners. Mandatory training is supplemented by ward visits, communications, and intranet support. This includes a suite of 7-minute briefings which have been developed in response to clinical incidents, statutory reviews, and safeguarding topics
- The safeguarding team have provided an in-reach model of safeguarding, to support all clinical areas and all staff groups.
- Daily support to Emergency departments across all our hospital sites to provide education, training, supervision, and operational support.
- Safeguarding policies and procedures have been updated to reflect current practice locally and nationally.
- We have remained committed to improving staff knowledge and understanding of domestic abuse, neglect and self-neglect
- We have safeguarding champions across all our hospital sites spreading the safeguarding message with champions training days throughout the year
- A robust audit schedule is in place, auditing an understanding of adult safeguarding, Deprivation of Liberty Safeguards (DoLS) and MSP to ensure staff understand the principles and how they are applied in practice.

West Midlands Fire Service

Revised Serious Incident Review (SIR) procedures have now been implemented, extending the scope to encompass both fire risk and broader vulnerability factors. This enhanced approach supports the more effective identification of safeguarding concerns and strengthens multi-agency collaboration. WMFS continues to make an active contribution to multi-agency review processes, including Safeguarding Partnerships, and is further developing arrangements to ensure that learning is systematically captured, shared, and embedded within practice.

WMFS has developed a Power BI dashboard that provides Safeguarding Adults Boards (SABs) with access to data on Safe and Well referrals made by partner agencies, supporting enhanced analysis and oversight.

Work is ongoing to establish a structured internal audit and quality assurance programme, promote consistent reporting of findings, and strengthen the evidence base demonstrating the impact of safeguarding activity on practice and outcomes for children, young people, and adults at risk.



Rough sleeping and homelessness

SSAB receives an annual update on homelessness and rough sleeping to understand the associated safeguarding risks for adults with care and support needs.

During 2025/26, demand for homelessness support in Solihull remained high but stable compared to previous years (2,879 households compared to 2,981 in 2024/25), with increasing complexity of need. This sits within a wider national and regional context, where homelessness levels in England are at near-record high levels and demand continues to rise, alongside comparatively elevated rates of temporary accommodation use in the West Midlands. This is reflected in rising rough sleeping, with 148 individuals identified compared to 128 in the previous year, indicating increased risk among the most vulnerable. Despite this, performance demonstrates a strong focus on prevention and early intervention, with improved outcomes and reduced use of temporary accommodation.

The proportion of households where homelessness was prevented or relieved increased to 56.35%, reflecting effective early support and reducing the likelihood of crisis situations, rough sleeping, and associated safeguarding risks. Use of temporary accommodation reduced by 14% over the year, including a reduction in families in temporary accommodation, which is a positive indicator of system effectiveness.

However, some challenges remain. Lengths of stay in temporary accommodation have increased, particularly for families, which can impact health, wellbeing, and stability. In addition, rough sleeping numbers have increased, including a rise in new individuals presenting reflecting wider regional trends continued inflow and increased complexity of need.

People experiencing homelessness and rough sleeping are more likely to face multiple disadvantage, including poor mental health, physical ill health, substance use, and trauma. This cohort represents a group with potentially heightened safeguarding risk and requires coordinated, multi-agency responses. Increasing complexity, combined with

housing pressures, can make sustained engagement and recovery more difficult to achieve.

There is strong evidence of effective partnership working across housing, Adult Social Care, health services, Police, Probation, and the third sector. This includes:

- A coordinated multi-agency approach through the Homelessness Forum
- Targeted support for individuals with complex needs, including through the Homeless Outreach Prevention and Engagement HOPE Panel
- Strengthened prevention activity, including domestic abuse support and tenancy sustainment
- Continued reduction in the use of unsuitable accommodation

These arrangements support early identification of risk, timely intervention, and improved safeguarding outcomes. Any challenges in securing consistent engagement from partner agencies will be escalated to SSAB meetings, which offer a mechanism to understand barriers and reinforce commitment to coordinated multi-agency responses.

The Homelessness and Rough Sleeping Strategy continues to provide a clear framework for partnership working, with a focus on prevention, reducing rough sleeping, improving access to settled housing, and strengthening wellbeing and resilience.

Overall, while demand and complexity continue to present challenges, there is a clear and coordinated system response in Solihull, with improving performance in key areas and a continued focus on reducing safeguarding risk and improving outcomes for individuals.



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 apportion blame; it tries to find out what can be changed so that harm is less likely to happen in the future.

Section 44 of the Care Act (2014) 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

The SSAB also has a discretionary power to arrange a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

The Safeguarding Adult Review Subcommittee considers SAR referrals against the criteria and oversees progress on live reviews. The Subcommittee provides quarterly updates to the Board and Independent Chair, who retains overall responsibility for decision making around SAR criteria being met for a review, and the sign-off of Safeguarding Adult Review reports and recommendations.

SAR Activity 2025-26

Referrals

In the past year, SSAB received one referral for a Safeguarding Adults Review. A panel of representatives from partner agencies reviewed the case thoroughly. After detailed discussions with the panel and the SSAB Chair, it was determined that the case did not meet the criteria for a SAR.

Anne SAR published

SSAB published a short summary of the [Anne SAR](#) 30 January 2026. Anne sadly died in a house fire at her home, and following a decision that the mandatory SAR criteria were met, the SAR was commissioned to understand how fire safety awareness and practice can be improved to better safeguard adults who hoard. The SAR made five recommendations, and an action plan is in place to ensure the recommendations are achieved. The SAR Subcommittee monitors progress against the action plan at its quarterly meetings.

A key area of learning from the SAR highlighted the importance of involving West Midlands Fire Service (WMFS) where fire risks are identified. Although support such as Safe and Well checks was available, referrals were not being made consistently. In response, the SSAB worked with WMFS to raise awareness across partner agencies, including targeted visits to organisations to share SAR learning and promote the role of WMFS in safeguarding. Recorded webinars, videos and written resources have been developed to provide ongoing learning for staff.

The impact of this activity is being monitored through increased scrutiny of referral levels to WMFS to ensure appropriate and timely use of Safe and Well checks. In addition, regional Self-Neglect and Hoarding guidance is being updated collaboratively across the West Midlands to strengthen frontline practice, and work is underway to develop a hoarding pathway in Solihull to provide clarity for staff and the public on what support is available for adults who exhibit hoarding behaviour and how to access this.

Recognising the importance of this learning, the SSAB has set a priority for 2026–27 to strengthen coordinated safeguarding responses for adults who exhibit hoarding behaviours. This will focus on improving multi-agency working to ensure timely, joined-up interventions that reduce risk and improve safety, including fire safety.

What is feedback from adults with lived experience of safeguarding telling us about our progress?

84% of individuals are asked about their desired outcomes during safeguarding interventions, with 95% of these outcomes met or partly met, consistent with 2024/25. In 72% of cases, individuals felt safer after intervention, an increase from 63% in 2024/25. 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.

The Performance and Development Lead contacted ten people or their relatives, for feedback on their safeguarding experience in 2025/26. This is a significant increase on the one person who was contacted in 2024/25. As part of our focus during 2025/26 we wanted to increase the number of individuals we received feedback from, so it is great to have achieved this and reflects the support from social workers in Adult Social Care who sought consent from the adults they supported. Our approach is to only talk to people where we are assured by the social worker that it is a safe and suitable time for the person, and for some individuals who had initially agreed to talk to us, we learned from their social workers that it was no longer appropriate. All feedback is shared with the relevant organisations to support continuous improvement in safeguarding practice.

Positive experiences of the safeguarding process included people reporting a sensitive and supportive approach from the social worker, people receiving clear and regular updates on actions being taken, communication needs being met, feeling in control of what was happening, and being treated with dignity and respect. These experiences reflect the principles of making safeguarding personal and demonstrate examples of safeguarding best practice.

Where feedback was not entirely positive, this reflected people's disappointment when evidence of alleged abuse could not be identified, thresholds for prosecution had not been met, or prevention and early intervention opportunities were felt to have been missed. SSAB has set a priority for 2026/27 around ensuring clear, accessible information and advice so every adult can get the safeguarding support they need. Strengthening prevention and early intervention approaches will form part of the work to achieve this priority.

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.

Our website and newsletter

Website - safeguardingsolihull.org.uk

Our joint website with Solihull Safeguarding Children Partnership provides information about the board, training offers, and resources for professionals. It includes joint learning resources and communications to support exploitation reduction, developed with partners. The website is regularly reviewed to ensure ease of navigation and up-to-date content.

Newsletter

Our quarterly newsletter reaches 900 professionals, delivering updates on local and national policies, practices, and resources. It covers key safeguarding topics, including Equality, Diversity, and Inclusion, Learning and Development opportunities, and progress from our Board and Subcommittees, empowering professionals to implement best practice and support continuous professional development.

SSAB NEWSLETTER

Solihull Safeguarding Adults Board
Protecting Adults Together

ISSUE 55 | May 2026

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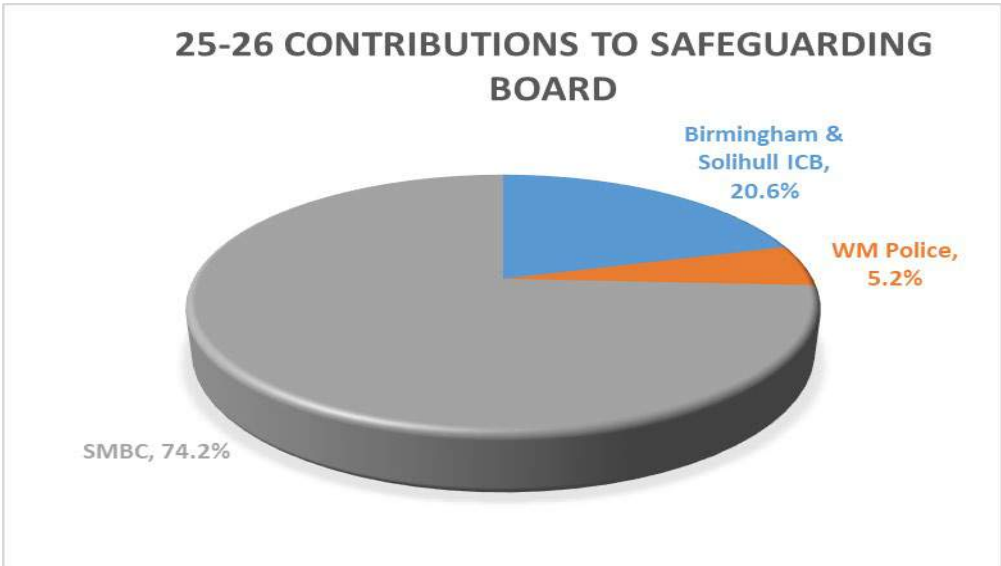

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Financial summary 2025-26

In 2025-26 we had a gross budget of £278,129 This budget comprises contributions from Solihull Metropolitan Borough Council Adult Social Care, West Midlands Police, and Birmingham and Solihull Integrated Care Board.

In addition to the financial funding, Board partners also support the board by chairing sub committees and supporting task and finish group work.



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 Board’s Engagement approach and publicity. It also includes ICT related costs including licences and subscriptions. This year we have had a SAR review this was funded from the annual budget.

| Expenditure | 25/26 | Percentage |
|----------------------------|----------|------------|
| Team | £242,431 | 88.8% |
| Independent Chair | £17,504 | 6.4% |
| SAR Lead Reviewer | £5,525 | 2% |
| Training | £5,651 | 2.1% |
| ICT/Licences/Subscriptions | £1,984 | 0.7% |
| | £273,095 | 100% |

Expenditure in 2025-26 totalled £273,095 which gave an underspend against budget of £5,034

What's next for 2026-27?

Towards the end of 2025-26 the Board came together to agree the priorities for 2026-27. The priorities for Solihull Safeguarding Adults Board will be:

Priority 1: Safeguarding support that everyone can access.

Ensuring clear, accessible information and advice so every adult can get the safeguarding support they need.

Priority 2: Coordinated safeguarding support for adults who exhibit hoarding behaviours.

Improving multi-agency working so adults who exhibit hoarding behaviours receive timely, coordinated safeguarding responses that reduce risks and improve safety, including fire safety.

The strategic plan 2026-27 will set out further detail on how the Board intends to deliver on these priorities.





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