



Safeguarding Adults Forum June 2024

Karen Littleford
Safeguarding Adults Lead
Partners in Care



The views expressed by the presenters are their own and not necessarily those of partner agencies.



Safeguarding Adults Forum Dates 2024/2025



Online – Zoom (9:30am - 12:30pm)

- Wednesday 11th September 2024
- Thursday 12th December 2024
- Thursday 20th March 2025

<https://www.partnersincare.org.uk/networking-events/meetings-forums-events/networking-meeting-for-trainers>



Agenda



Providers - How to carry out an Effective Safeguarding Adults Enquiry -

Duncan Henney, Assistant Team Leader, Adult Safeguarding, Telford and Wrekin Council

Adult Safeguarding Development Activities in Your Organisation –

Karen Littleford, Safeguarding Adults Lead, Partners in Care, Clare Shaw, Quality Manager, Bethphage and Jo Mear, Director of Care and Support, Condoover College Ltd.

Introducing the online home fire safety check tool and an update on Safe and Well visits -

Becky Castle, Team Leader- Prevention Team, Shropshire Fire and Rescue Service

Safeguarding Adults Reviews (SARS) and Domestic Homicide Reviews (DHR) update -

Shropshire Safeguarding Community Partnership and Telford and Wrekin Safeguarding Partnership, Karen Littleford, Safeguarding Adults Lead (Partners in Care)

Second National Analysis of Safeguarding Adult Reviews - Headlines, Recommendations and Findings -

Karen Littleford, Safeguarding Adults Lead, Partners in Care

Resources and Webinars -

Karen Littleford, Safeguarding Adults Lead (Partners in Care)



Providers - How to carry out an Effective Safeguarding Adults Enquiry.

Duncan Henney, Assistant Team Leader, Adult Safeguarding, Telford and Wrekin Council



Adult Social Care

Providers - Making an Effective Safeguarding Enquiry

Our Adult Social Care Charter

We will always promote independence

We will listen with empathy and understanding

You will know who to contact and we will always get back to you

Our conversations will be honest and personal to you, we won't just tick boxes

We will respect your decisions, be honest and open

Safeguarding is
Everyone's
Responsibility

Working together to enable people to Live Well and Independently in Telford and Wrekin

Protect
Care and Invest
to create a
better borough



Telford & Wrekin
COUNCIL

Local Authority Adult Safeguarding Duties

- **The Care Act 2014 sets out Local Authority Adult Safeguarding Duties:**

- **S42(1) eligibility met:**

Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.



- **A Local Authority must make enquiries, or ensure others do so, if it believes an adult is subject to, or at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by who**

When should an Enquiry be 'caused'

- Any employment responsibilities: allegations against staff may be best undertaken by an employer
- Who has best access to information: often this may be care provider
- Who has the necessary skills/knowledge: e.g. TVN, Meds Management, Hospital Safeguarding
- Has a crime been committed: if so, the police should lead the investigation

When is it not appropriate to cause an Enquiry

- Conflict of interest
- Lack skills knowledge
- Concerns that it will not be effective Enquiry
- Concerns about SG the adult
- Incompatible with own duties or would have an adverse effect

TELFORD & WREKIN SAFEGUARDING ADULTS S42 Enquiry

Date & Time of Referral:

Name of Referring Social Worker/professional:

Organisation/relationship to the person:

Contact details including secure email address:

Person Details			
Name:		DOB:	
Address:		NHS No:	
Telephone No:		LAS No:	
Email:			

GP Name & Address:	
Telephone No:	
NOR / Representative / Advocate & their views Address & Telephone No:	
Does the person lack capacity?	
Is a Mental Capacity assessment completed /available?	

[Section 42 Enquiry Referral Form by other agencies - Telford and Wrekin Safeguarding Partnership \(telfordsafeguardingpartnership.org.uk\)](https://telfordsafeguardingpartnership.org.uk)

Roles and Responsibilities

Causing Enquiry is distinct from requesting information/actions as part of an Enquiry conducted by the Local Authority

- Duty of Local Authority: be satisfied the agency identified is competent to do so; inform agency of the responsibility; set out the concern; inform who the Local Authority managing officer is and how to contact; agree **timescale**; ensure the Enquiry report addresses the concerns.
- Duty of Agency undertaking Enquiry: appoint officer to conduct Enquiry; agree a reasonable **timescale**; produce the Enquiry report

The local authority retains oversight and accountability for the S42 – and there to support the Enquiry

Objectives of a S42 Enquiry

- establish the facts
- ascertain the adult's views and wishes
- assess the needs of the adult for protection, support and redress and how they might be met
- protect from the abuse and neglect, in accordance with the wishes of the adult;
- make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect

[pg 14.94 Care and Support Statutory Guidance]

Conduct the Enquiry in line with principles of MSP

- Include the person in the Enquiry
- Be transparent about the process
- Obtain the persons wishes/feelings – what outcome do they want
- If advocacy is required, consider this from the start of the process
- Proportionate and least restrictive
- The conclusion of the Enquiry is shared with the adult or their representative



 Keeping Adults Safe in Shropshire Network

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is about putting the adult at the centre from the beginning to the end of every safeguarding concern. MSP is having a conversation led by the adult or their representative to find out what happened and what outcomes they want.

To Make Safeguarding Personal YOU WILL:

- If safe, share your concerns about abuse and neglect with the adult, ask what they want to change – agree who raises the safeguarding concern.
- Discuss risk and what needs to be done to make them safer now.
- Ask who they want to be told or seek the views of family or friends if they lack capacity to decide that.
- If they haven't got support and have substantial difficulty taking part in safeguarding think about an advocate
- Keep the adult involved – it's their life.

Six Safeguarding Principles

Empowerment

Prevention

Proportionality



Keeping Adults Safe
in Shropshire
Network

Adult Safeguarding means protecting an adults rights to live in safety, free from abuse and neglect. Its people and teams working together to prevent abuse or stop it when it's happening (DoH&SC, 2016:14.7). You can achieve this by following the **six safeguarding principles** that underpin all adult safeguarding work.

Empowerment:

people being supported and encouraged to make their own decisions and give informed consent

Prevention:

it is better to take action before harm occurs

Proportionality:

the least intrusive response appropriate to the risk presented

Protection:

support and representation for those in greatest need

Partnership:

working with communities who have a part to play in preventing, detecting & reporting neglect and abuse

Accountability:

accountability and transparency in safeguarding practice

Department of Health and Social Care (2016) Care and support statutory guidance. London: Department of Health and Social Care. <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

Protection

Partnership

Accountability

Adult Safeguarding

Principles cards here <https://www.shropshiresafeguardingcommunitypartnership.co.uk/media/wxbcxbnc/01-making-safeguarding-personal-card.pdf>

Some key points

- **Effective Safeguarding Referral:** why are you sending – is it just for info or expecting an Enquiry to be triggered.
- **Usually, will relate to provision of care** e.g. falls, unexplained bruising, wound care; resident on resident abuse (an adult abusing another adult who is accessing your service)
- **Make sure you provide the required information on referral or Enquiry** e.g. care plans, risk assessment, falls plans, wound care plans, body maps etc.
- **Timely response** – there are timeframes for completing S42's (28 days)
- **Making Safeguarding Personal (MSP)** – capacity/consent, including the person, outcomes identified
- **Risk reduced** – have we made them safer as result; actions to reduce risk.
- **Your investigation;** perspective on outcome (substantiated; inconclusive etc)
- The local authority retains oversight and accountability for the S42



Adult Safeguarding Development Activities in Your Organisation –

Karen Littleford

Safeguarding Adults Lead, Partners in Care

Clare Shaw

Quality Manager, Bethphage

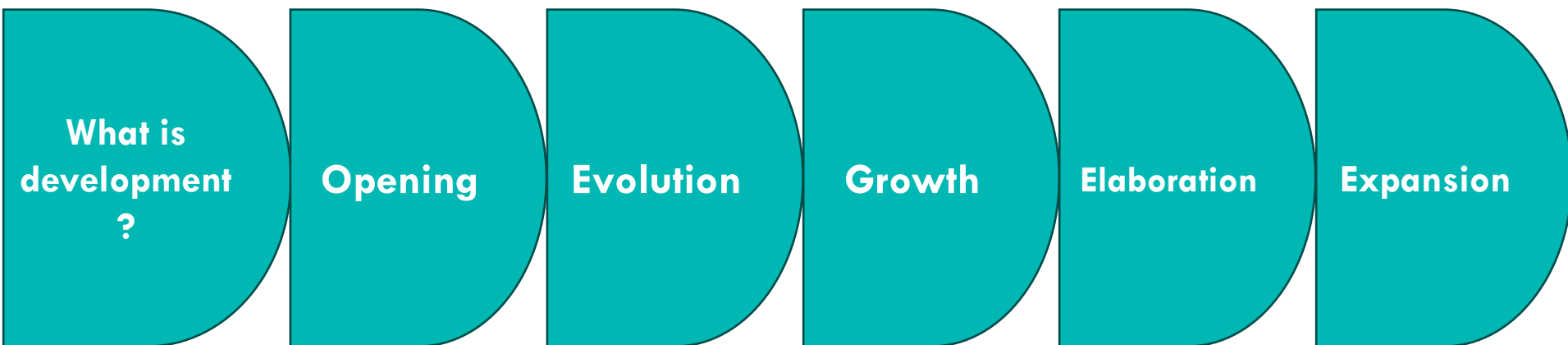
Jo Mear

Director of Care and Support, Condoover College Ltd.





Adult Safeguarding Development Activities in Your Organisation – What is ‘Development’?



What are Safeguarding Adults Development Activities in your organisation?

Policy review

- Involving staff in policy review

Introducing something new

- Safeguarding Supervision

Accessing learning events as part of your Continuous Professional Development

- Attend the Safeguarding Adults Forum to inform your development activity?

Working with your Board of Trustees or Senior Management Team

Having a targeted professional discussion

What are Safeguarding Adults Development Activities in your organisation?

Setting up a working group to address a specific subject

Involving adults who use your service to find out their views about 'safeguarding' and being safe

Do some co-production work (having conversations)

- Project with adults to address a specific area or subject

Carrying out an audit

- identify any themes or trends
- act on audit findings

Make a video/s about safeguarding subjects

Review local SAR's to see if there is any learning

What are Safeguarding Adults Development Activities in your organisation?

Commission bespoke training to address a specific need

Invite an external speaker for part of a team meeting

Write and distribute a 'briefing note'

Develop safeguarding champions

Revisit the 'Dignity' agenda

Sharing resources with your team

Setting up coaching or mentoring in your workplace

Use the resources on your Safeguarding Partnership website



Putting on an event/raising awareness of a subject via national days:

- Dignity Action Day (1st February every year)
- Hoarding Awareness Week (May every year)
- World Elder Abuse Awareness Day (June 15th every year)
watch the Hourglass [webinar](#)
- National Safeguarding Adults Week (18th-22nd November 2024) (Local events to be advertised)



Taking part in a National Consultation?

Have you contributed to consultations?



Department
of Health &
Social Care

DHSC - Duty of Candour - call for evidence as part of its review of the Duty of Candour across both health and social care (closed on 29th May 2024)



Home Office

Updating the domestic homicide review statutory guidance closes 1 July 2024 [here](#)



Development



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Safeguarding adults in practice

SCIE has developed the following resources to help social workers, local authority staff and their partners, chairs and members of Safeguarding Adults Boards, to meet their safeguarding duties under the Care Act 2014.

Feedback



Commissioning care



Quick guide for registered



Safeguarding adults for

3

<https://www.scie.org.uk/safeguarding/adults/practice/>



Safeguarding resources

Resources to support local areas' roles and responsibilities in keeping people safe.

<https://www.local.gov.uk/our-support/partners-care-and-health/safeguarding-resources>



Making Safeguarding personal

You can download a [series of tools to support Making Safeguarding Personal](#), measure effectiveness and improve safeguarding practice.

Making Safeguarding Personal

Transitional safeguarding resources



Telford and Wrekin
Safeguarding
PARTNERSHIP



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Training

Previous Seminars and Learning Events

Previous Seminars

Advocacy Awareness - took place on 25.01.24

This session was delivered by POHWER, a charity which helps people who, because of disability, illness, social exclusion and other challenges, find it difficult to express their views or get the support they need. POHWER provide statutory advocacy in Telford & Wrekin, and many other local authority areas across the country. The session covered the following topics:

- What is advocacy?
- Why is it needed?
- Who can benefit?
- Why is it needed?
- How to access it?

<https://www.telfordsafeguardingpartnership.org.uk/info/4/training-events/7/training/3>



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<https://www.partnersincare.org.uk/>



Partners in Care YouTube – Playlists



Partners in Care

@partnersincare8598 · 74 subscribers · 61 videos
Welcome to the Partners in Care YouTube channel. >

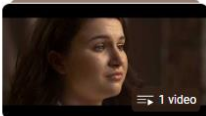


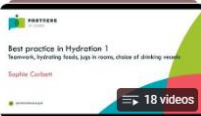


partnersincare.org.uk and 3 more links

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View full playlist
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-  18 videos
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View full playlist
-  9 videos
National Safeguarding Adults Week 2023
View full playlist
-  1 video
Information and Data
View full playlist

4S4JAgOLDtg/editing/images

<https://www.youtube.com/@partnersincare8598/playlists>

Closed cultures in social care: Guidance and questions to ask

Partners in Care
and Health



'Closed cultures' have been identified as a major risk to the wellbeing and human rights of people with care and support needs, who are unable to protect themselves from abuse or neglect, due to their care and support needs. The aim of this document is to provide guidance for the council workforce on identifying where a 'closed culture' may exist, or there may be a risk of one developing, in social care services for people with a learning disability and autistic people.

Partners in Care and Health (2024) *Closed cultures in social care: Guidance and questions to ask*. London: Partners in Care and Health.

<https://www.local.gov.uk/publications/closed-cultures-social-care-guidance-and-questions-ask>



References

Jersey Safeguarding Partnership Board (2024) *Making Safeguarding Personal*. Jersey: Jersey Safeguarding Partnership Board.

<https://safeguarding.je/safeguarding-adults/making-safeguarding-personal/>

Adult Safeguarding Development Activities in Bethphage

The settings



- Day opportunities
- Shared Lives (where people are offered support and accommodation in an individual's or family home. This can be a permanent placement or for short breaks)
- Supported living – some of these will be shared tenancies and some individual)
- Residential Care
- Small packages of support to people living with families or on their own

Long standing processes

- Recruitment processes – Safer Recruitment practices, values based questions, involving the people we support, DBS and reference checks
- Induction –robust induction including Care Certificate or self-assessment, essential training, Corporate Induction with focus on Speaking Up and EMT experiences, shadow shifts, observations, competencies including safeguarding, medication
- Ongoing supervisions, observations, PDR's, Team meetings, training, refreshed competencies

- System for recording incidents, accidents, complaints, concerns
- Annual feedback processes for the people we support, families and staff
- Schedule of service visits by SM's and AM's
- Comprehensive annual quality audit for all services
- Policy reviews and sharing
- Exit interviews

- PBS Team
- Person Centred Plans

Newer developments

- Use of Workplace
- Promotion of Upstander not Bystander – award, video, Workplace
- Safeguarding checklist for Board and EMT
- SeeHearSpeak Up service
- Revised supervision template
- Audit and sign off of safeguarding referrals

- Health Promotion and Improvement Lead
- Positive Culture Workshops
- Signed up to Restraint Reduction Network
- Improved agency induction process
- Stand Up and Speak Out sessions

Outcomes

- More comprehensive support plans for people with complex needs
- Increased awareness
- Evidence of continuous learning and reflection
- Increased confidence in reporting concerns
- Evidence of following best practice

Currently developing

- Safeguarding Learning Review meetings
- Safeguarding Debrief process
- Improved feedback surveys
- Shared Lives Have Your Say Meetings
- Including the experiences of people we support or staff experiences of speaking out at Corporate Induction
- Adding See, Hear, Speak up link to assistive technology

**Introducing the online
home fire safety check
tool and an update on
Safe and Well visits.**

Becky Castle, Team Leader-
Prevention Team,
Shropshire Fire and Rescue
Service





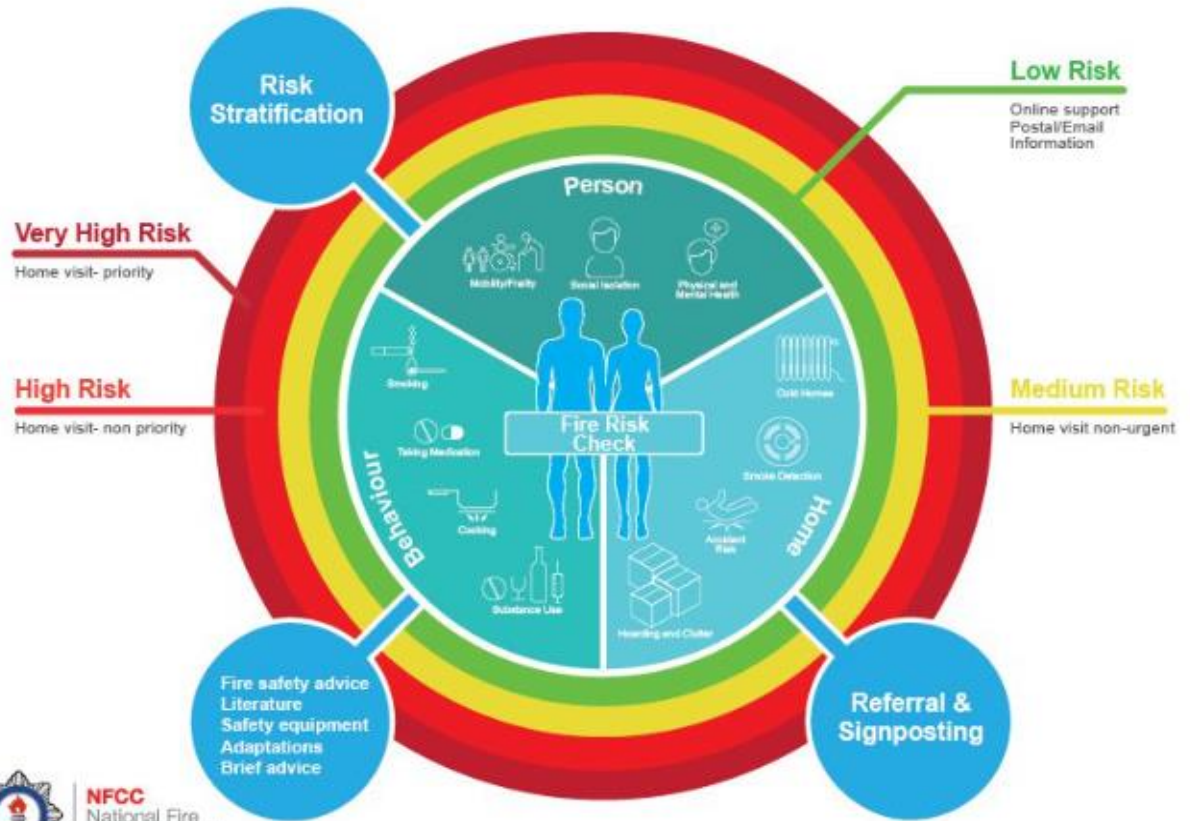
Shropshire
Fire and Rescue Service

**MAKING
SHROPSHIRE
SAFER**

Fire safety in the home and Online Home Fire safety check

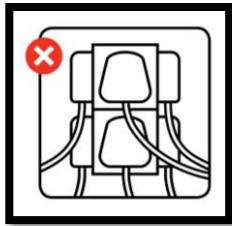


What makes
a person at
risk from
fire?





Of the 5 main causes of accidental fires, which is the highest proportion?



Electrical



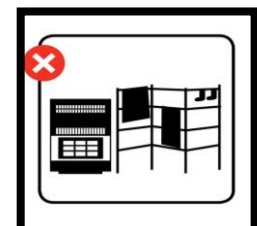
Candles



Cooking



Smoking



Heaters/
Chimney



Shropshire
Fire and Rescue Service

**MAKING
SHROPSHIRE
SAFER**

Online Home fire safety check (Online HFSC)
Scan this QR code to see how easy it is to complete....





www.safelincs.co.uk/hfsc/

If you want to do
test you can use
the postcode
SY1 2HJ

☰

Your Progress

- Property Location
- Assessment Type
- Relationship
- Property Ownership
- Property Type
- Number of Floors
- Smoke Alarms
- Room Details
- Tidiness / Clutter
- Heating
- Occupants
- Health Conditions
- Behaviours
- Previous Fires

Additional Steps

Once you have completed the initial assessment, additional steps and advice will appear here.

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NFCC
National Fire
Chiefs Council



Safelincs
Fire & Safety Solutions

Welcome to the online home fire safety check

This easy-to-follow home fire safety check has been developed through a partnership between the National Fire Chiefs Council (NFCC), Fire Kills and Safelincs. It will take you through your home one room at a time and the simple questions will help you spot fire risks as you go around your home.

The tool will offer tips and advice on the steps you can take to reduce those risks. At the end, you will receive a personalised fire safety action plan to help keep you and your household safe from fire.

Top tip



Fit smoke alarms

Top tip



Plan your escape route

Top tip



Get out, stay out and call 999

Property Address and Postcode:

SY1 2HJ

RESET

Please enter the address/postcode of the property you are completing this assessment for. By



How to complete your home fire safety check

To get the best advice from completing this online home fire safety check we recommend that you answer all the questions as honestly as possible and that you or someone on your behalf, goes into each room to complete the relevant section.



How long will it take?

This online home fire safety check should take around **15 minutes** to complete.



Did you know?

There are around 35,000 house fires and over 300 fire related deaths in Great Britain each year.

By following our tips and advice you can reduce the risk of a fire in your home.



Please note!

The advice given throughout this system is based on the answers that you have provided and should only be used as a



Part 1- Assessing risk

Part 1- Assessing fire risk

0-3	LOW
4-6	MEDIUM
7-19	HIGH
20+	VERY HIGH

Sections to be completed:

- Assessment type (self or partner)
- Relationship (eg carer)
- Property ownership
- Number of floors
- Smoke alarm status
- Room details
- Clutter levels
- Heating type
- Occupants- Living alone? Over 65 years?
- Health conditions- eg Mobility issues, Sensory impairment
- Behaviours- Smoking, Drinking alcohol, Medication
- Previous Fires



Part 2- Creating a Personal Action plan

Your Personal Action Plan

Based on the answers that you have given throughout the Home Fire Safety Check we recommend that you follow these fire safety tips and advice to help reduce the risk of a fire in your home.

Resources

Fire Escape Plans

If you don't have a fire escape plan, or you would like to know more about what to include in your fire escape plan, visit <https://fireengland.uk/fire-safety/how-protect-your-home#plan-your-escape>.

General Fire Safety

E-Bike & E-Scooter Fire Safety

- Don't leave your device charging unattended or when you're asleep
- Don't charge or store your battery in the hallway where it could block your escape
- Only use the correct charger for your battery
- Only buy e-bikes, e-scooters and batteries from trusted retailers and manufacturers
- Always follow the manufacturer's instructions. Don't attempt to modify or tamper with the battery
- Check for the CE or UKCA safety marking to make sure your battery and charger meet safety standards
- It is recommended that a professional carries out an e-bike conversion

Smoke Alarms

- Install at least one smoke alarm on each floor of your home – they are vital to give you an early warning if there is a fire
- It's important to test your smoke alarms at least monthly to check they are working [sign up to our free reminder service](#)

[Click here](#) for further fire safety advice for tenants.

Kitchen Fire Safety Advice



Safe and well visits

SAFE & WELL

Promoting fire safety, health & wellbeing in your home
Call **01743 260260** for your free visit!

Once we receive the referral, we can contact the individual with the details you have supplied and arrange a free Safe & Well visit. This is where we come to the home at a convenient time to see what we can do together to make you or the person you care for safer. We will fit free smoke alarms where required.

The individual still has the opportunity to decline the visit if they have changed their mind, or matters have changed.

The appointment normally lasts about 40 minutes and people can have another trusted person present with them if they wish to.



Safeguarding Adults Reviews and Domestic Homicide Reviews - Shropshire Safeguarding Community Partnership





Shropshire Safeguarding
Community Partnership

Learning from Case Reviews



Lisa Gardner



Since the Last Safeguarding Adults Forum

1

Domestic Homicide Review referral, however, the recommendation had to be deferred to await further information



2

Safeguarding Adult Review referrals. One did not meet the criteria as there was no concerns about how partner agencies worked together. The second is currently being scoped.



1

Domestic Homicide Review will be published shortly

2

Safeguarding Adult Reviews will be published shortly

1

Joint Safeguarding Adult Review and Domestic Homicide Review is ready for sign off by Partners

1

Domestic Homicide Review is ready for sign off by partners



Learning from Shropshire Safeguarding Adult Reviews

[About us](#)[Statutory case reviews](#)[Learning Briefings](#)[Learning from Shropshire Safeguarding Adult Reviews](#)

The Shropshire Safeguarding Community Partnership can also decide to publish the Review if it chooses. This will always be in discussion with the Adult in question (if they are able) and their family. All published Safeguarding Adult Reviews completed in Shropshire can be found on this page.

Last Updated: 13 May 2024 16:51 PM

Related Links

[> Safeguarding Adult Reviews](#)

Related Documents

- [> Mr. M Safeguarding Adult Review Learning Briefing](#)
- [> Lily Safeguarding Adult Review Learning Briefing](#)
- [> Mrs H Safeguarding Adult Review Learning Briefing](#)
- [> Mr I Safeguarding Adult Review Learning Briefing](#)
- [> Kim Safeguarding Adult Review Learning Briefing](#)
- [> Shropshire Carer Support Identifying And Supporting Carers Learning Briefing](#)
- [> SSCP Learning Briefing Preventing Fire Deaths](#)
- [> Mark Learning Briefing](#)
- [> Joan Learning Briefing](#)



Visit the SSCP website to find two Learning Briefings which relate to two individuals who were referred to the Business Unit for consideration for a SAR. Their deaths did not meet the criteria for a SAR however there was learning identified.

<https://www.shropshiresafeguardingcommunitypartnership.co.uk/about-us/statutory-case-reviews/learning-briefings/learning-from-shropshire-safeguarding-adult-reviews/>



Safeguarding Adults Reviews and Domestic Homicide Reviews – Update from Telford and Wrekin Safeguarding Partnership



**As the SAR's and DHR's are ongoing in Telford and Wrekin the information is not included in the online presentation. Once published you can read them here –
SAR's [here](#)
DHR's [here](#)**



Second National Analysis of Safeguarding Adult Reviews Headlines, Recommendations and Findings

Karen Littleford,
Safeguarding Adults Lead,
Partners in Care

About the individuals in 652 SAR's 2019-2023

- 82% of adults were deceased – the majority died from natural causes
- 44% female, 49% male, 7% other/not specified
- **Mental health (72%), chronic physical health (63%), substance misuse (46%), impaired mobility (27%) - all increased compared to the first national review**
- **47% lived alone, 30% in a group setting, 10% street homeless**
- **9% had experience of care as a child or young person**
- The **most common perpetrator was 'self' (76%)**; 28% were care providers and 28% were other professionals
- **Most abuse occurred in the home (44% own home)** but there were also cases in hospitals (9%), and care homes (20%)
- **6% of SARs featured resident on resident abuse**
- Many protected characteristics were not recorded: ethnicity, nationality, religion, sexuality

So What?

- The majority of SAR's were about **adults who died** - similar to the first National SAR analysis - how are we learning from cases?
- Male/female split similar to first national analysis.
- **6% of SARs featured 'resident on resident' abuse**
- Focused on transitional safeguarding (a DHSC requirement) - **9% had experience of care as a child.**
- **Most common perpetrator was self (76%)**

(Braye and Preston-Shoot, 2024)

Types of abuse/neglect

(from the 652 SAR's)

- **Marked increase in –**
 - Self-neglect (45% to 60%)
 - Neglect/abuse by omission (37% to 46%)
 - Domestic abuse (10% to 16%)
- **Moderate increase in –**
 - Sexual exploitation (2% to 4%)
 - Discriminatory abuse (1% to 2%)
- **Marked fall –**
 - Physical abuse (19% to 14%)
 - Psychological abuse (8% to 4%)
 - Organisational abuse (14% to 4%)

TYPE OF ABUSE / NEGLECT	%
Self-neglect	60%
Neglect/omission	46%
Domestic abuse	16%
Physical abuse	14%
Financial abuse	13%
Sexual abuse	6%
Criminal exploitation	5%
Psychological abuse	4%
Organisational abuse	4%
Sexual exploitation	4%
Discriminatory abuse	2%
Modern slavery	<1%
Other	10%

(Braye and Preston-Shoot, 2024)

Types of abuse/neglect

So What?

- **Even more self-neglect in the second analysis, significant rise from 45% to 60%**
- **Domestic abuse more of an issue, is this about Domestic Abuse Act, pandemic etc.?**
- **Fall in organisational abuse SARS – DHSC were asked to consider when neglect or acts of omission are actually organisational abuse. Asked DHSC to review definitions of organisational abuse.**
- **Certain types of abuse occurred in clusters: e.g. sexual abuse with sexual exploitation; physical with psychological and emotional abuse. Others occurred in isolation (e.g. self-neglect; neglect/omission).**

TYPE OF ABUSE / NEGLECT	%
Self-neglect	60%
Neglect/omission	46%
Domestic abuse	16%
Physical abuse	14%
Financial abuse	13%
Sexual abuse	6%
Criminal exploitation	5%
Psychological abuse	4%
Organisational abuse	4%
Sexual exploitation	4%
Discriminatory abuse	2%
Modern slavery	<1%
Other	10%

(Braye and Preston-Shoot, 2024)

Good practice themes

- ✓ **Compassion, kindness, care, empathy and sensitivity of professionals were all noted, along with commitment, dedication, professionalism, skill and diligence.**
- ✓ Examples of practitioners able to see beyond the presenting problem, and to find and respect the person beneath.
- ✓ Practitioners going above and beyond; able to 'think outside of the box' to find solutions, sometimes in the most challenging circumstances.
- ✓ Making safeguarding personal to the adult, shown in the ways in which practitioners/agencies had ascertained and paid attention to an individual's wishes and feelings.
- ✓ **Showing patience, persistence and tenacity in engaging with people who were reluctant to work with professionals; with personalised approaches to contact/meetings, home visits and other assertive outreach approaches.**
- ✓ Practitioners building trusted, trauma-informed relationships; using these to support at times of crisis and advocate for the individual, including to other services.

So What?

Direct work - A quarter of reviews (from 229 reviews) good practice risk assessment (31%), MSP was done well (29%), how sensitively abuse was recognised (23%), perseverance with the 'reluctant person' (22%), attention to needs - mental health needs, medical needs, health conditions (21%).

Shortcomings: key themes

- Professional culture and negative attitudes: risky/distressed behaviour viewed as 'lifestyle choice', attention-seeking, noncompliance/engagement. Resignation & low expectation of change.
- Safeguarding that was not personalised; adults with communication needs, learning disabilities, neurodiversity and mental health needs left out of decisions/discussions about their support.
- Failure to recognise the significance of repeated patterns of engagement followed by disengagement. Some agencies lacked flexibility in their expectations/approach for engagement.
- Transition for young people to adult services lacked coordinated assessment and planning, leading to a reduction in support.
- Multiple SARs noted shortcomings in relation to risk; **absence of risk assessment was common.**
- **Uncertainty about when and how to share information without consent; and examples of where key information had not been shared with other agencies as it was viewed too sensitive.**
- SARs show there is a significant lack of mutual understanding about the roles, powers and duties of different agencies with regards to safeguarding.

So What?

From a deep dive into 229 of the 652 SARS

more comments about practice shortcomings, **risk management (82%) was the biggest shortcoming, risk not addressed.**

Lack of attention to MCA 58%

Lack of professional curiosity (44%).

Transitional safeguarding lacking

Organisational features - 23% staff lacked training in key skills needed.

National legal, policy & financial context

- Positive impact of the “everyone in” response to COVID-19 – example of what can be achieved with a funded national policy initiative
- **22% of SAR’s commented of shortcomings from the pandemic: the impact on services, poverty, unemployment, loss of routine, loss of social contact, and reduced access to support**
- **Economic context, legal frameworks, national policy and commissioning** all featured as having negative impacts
- **Interconnected features** compounded the difficulties: **responses to the pandemic alongside the impact of austerity and available legal powers; changes to NHS or social care policy in the context of austerity**
- **Deterioration in people’s lived experience - the impact of welfare benefit rules, e.g. the bedroom tax, the impact of poverty and inequality on disabled people and on people from minority groups**
- **The absence of an adult safeguarding power of entry in England**, unlike in Wales and in Scotland

Features of the national context	% of SARs
Covid-19 pandemic	22%
National economic context	8%
Legal powers and Duties	7%
Health/social care policy	5%
National commissioning	3%
Statutory guidance	2%
Immigration policy	<1%
Regulation of services	<1%

(Braye and Preston-Shoot, 2024)

Reference and Resources

Reference:

Preston-Shoot, M. and Braye, S. (2024) *Second National Analysis of Safeguarding Adult Reviews*. London: LGA, Adass, Partners in Health.

Resources –

Chief Social Worker for Adults, Research in Practice, the Association of Directors of Adult Social Services British Association of Social Workers, Care and Health Improvement Programme, Local Government Association and the NWG Network (no date) *Bridging The Gap Transitional Safeguarding And The Role Of Social Work With Adults*. London: Chief Social Worker for Adults, RiP, ADASS BASW, CHIP, LGA and NWG Network.

https://assets.publishing.service.gov.uk/media/60b108a88fa8f5489192fdb3/dhsc_transitional_safeguarding_report_bridging_the_gap_web.pdf

The full analysis report is due to be published in June 2024.

Partners in Care and Health (2024) *Analysis of Safeguarding Adults Reviews: April 2019-March 2023 (Executive Summary)*. London: LGA, ADASS, Partners in Care and Health.

https://www.safeguardinglewisham.org.uk/assets/2/analysis_of_safeguarding_adult_reviews_-_april_2019_-_march_2023_executive_summary.pdf

Briefings:

- Briefing for practitioners: Second National Analysis of Safeguarding Adult Reviews [here](#)
- Briefing for senior leaders and SAB members: Second National Analysis of Safeguarding Adult Reviews
- Briefing for elected members: Second National Analysis of Safeguarding Adult Reviews [here](#)
- Briefing for SAB chairs and business managers: Second National Analysis of Safeguarding Adult Reviews [here](#)
- Briefing for individuals and their families: Second National Analysis of Safeguarding Adult Reviews [here](#)
- Briefing for authors of Safeguarding Adult Reviews: Second National Analysis of Safeguarding Adult Reviews [here](#)



Webinars, Policy, Guidance, Resources and Reports

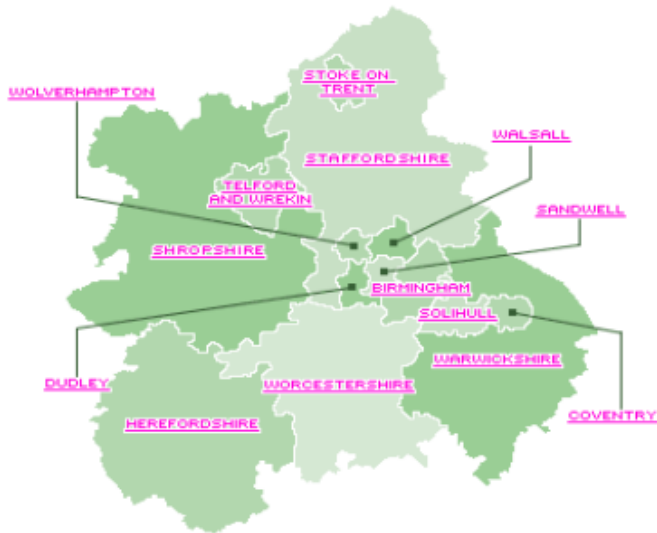


[This Photo](#) by Unknown Author is licensed under [CC BY-SA](#)



Adult Safeguarding:

Multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands.



Access

Shropshire Safeguarding Community Partnership website

<https://www.shropshiresafeguardingcommunitypartnership.co.uk/procedures/adult-safeguarding-procedures-and-guidance/>

Telford and Wrekin Safeguarding Partnership website

<https://www.telfordsafeguardingpartnership.org.uk/info/7/partner-agency-information/8/policies-procedures-pathways>

Version: 3.0

Date of issue: 9th April 2024

Document owners: West Midlands Adult Safeguarding Editorial Group

Self-neglect Guidance Shropshire

Updated Local Procedure and Good Practice Guidance to be added to Shropshire Safeguarding Community Partnership website at the end of June 2024.

Soft launch so it will replace the current guidance for Shropshire but there will be events later in the year looking at the document in more detail.



Shropshire Safeguarding
Community Partnership

Responding to Self-Neglect in Shropshire: Local Procedure and Good Practice Guidance



Date Completed	
Status	
Date of Approval	
Approving Body/Group	
Revised	
Due for review	

What is Adult Safeguarding?



Safeguarding is everybody's business

New Shropshire Adult Safeguarding Leaflet

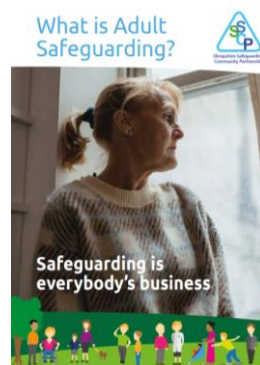
Regarding the print file – some printers may need a slightly different format set in what is called 'printers pairs'. But the actual set up for printers varies, with the print file you should have what you need i.e. 'bleed and trim marks'.

Available on the SSCP website

<https://www.shropshiresafeguardingcommunitypartnership.co.uk/partnership-priority-areas/adult-safeguarding-and-protection-practice/>

Review of Public Awareness Resources (Shropshire)

- [Making Safeguarding Personal Card](#)
- [What Is Adult Safeguarding Leaflet](#)
- [What Is Adult Safeguarding Leaflet Print Version](#)
- [Here](#)
- Posters x 4 online [here](#) and hard copies available (from Partners in Care)



Animations

- **Hidden Harms - Domestic Abuse and Older Adults** (Shropshire and Telford and Wrekin) [here](#)
- **What To Do About Self-Neglect** (Shropshire and Telford and Wrekin) [here](#)
- **Domestic Abuse: It Happens To Us Too (to be released summer 2024)**
- Domestic Abuse: It Happens To Us Too Hard Subtitles
- Domestic Abuse: It Happens To Us Too BSL
- **Shropshire Tricky Friends 2022 BSL** [here](#)
- Shropshire Tricky Friends with Subtitles [here](#)
- Tricky Friends Ukrainian Shropshire [here](#)

What else would you like to be available in Shropshire? Drop me an email karen.littleford@partnersincare.org.uk



MCA Webinar 7 - Mental Capacity, Sex and Relationships

- Do you want to discuss the thorny issue of sex and relationships in care settings when mental capacity is in doubt?

A webinar with Lorraine Currie, Independent Mental Capacity Consultant



When? July 3rd, 11:00am-12:30pm

Cost: £18 per Partners in Care member (£25.00 non-member)

Book here: <https://www.partnersincare.org.uk/training-courses/mca-dols/mca-and-dols-webinars>

Watch previous webinars here –

<https://www.youtube.com/playlist?list=PLR7h4BzDDmvRKI8NFFtHQiRe4-HB3hRT1>

The screenshot shows a YouTube video player interface. The video title is "Film - In the Shadows of the Institution". The video thumbnail features a person with a large, spiky, orange mask. Below the video player, the channel name "Partners in Care" is visible, along with "58 subscribers", "Analytics", and "Edit video" buttons. There are also icons for likes, comments, shares, and a "Promote" button. To the right of the video player, a playlist titled "Partners in Care Mental Capacity an..." is shown, listing five previous webinars with their respective durations and thumbnails.



On hold due to election

Cuckooing will become a criminal offence, May 15, 2024

An amendment initially tabled by Sir Iain Duncan Smith and backed by 50 cross bench MPs is being accepted and will make the crime punishable by up to five years in prison.

Introducing the amendment in Parliament, Victims and Safeguarding Minister Laura Farris said: 'When it comes to cuckooing, although there are a range of current offences that can be applied, the government has listened carefully to concerns about weaknesses in the existing legal framework. And so, new clause 94 provides for a bespoke criminal offence to tackle cuckooing.

'This offence criminalises the control, whether exercised by means of coercion or otherwise, over a person's home for the purpose of using it as a base to commit specified criminal activity.

<https://justiceandcare.org/news/cuckooing-will-become-a-criminal-offence-after-campaign-from-justice-and-care-and-partners/#:~:text=And%20so%2C%20new%20clause%2094,to%20commit%20specified%20criminal%20activity>.



Useful webinar recording from the DBS Spring 2024 Conference about referral and transferable Harm and Reporting to DBS



Transferable Harm and Reporting to DBS:
<https://watch.wave.video/fDxxvpzx8q6E4Ud>

[Harmful behaviour outside of the workplace and should this be referred to the DBS?](#)



Watch all the events from the Disclosure and Barring Service Spring Conference [here](#)

- **Welcome from DBS Chairman and Chief Executive:**
<https://watch.wave.video/itVQhCj2ER2qGlwD>
- **Digital DBS - Embracing technology to enhance our services:**
<https://watch.wave.video/WuTA1b7peipW5tZh>
- **Digital Q & A (Live with Barry Topham):** <https://watch.wave.video/oja7rC4TObnMJbw4>
- **Transferable Harm and Reporting to DBS:** <https://watch.wave.video/fDxxvpzxC8q6E4Ud>
- **Myth Busting the DBS Check Process:** <https://watch.wave.video/JXzd728p6AAWeGTv>
- **Using our DBS Update Service to keep DBS certificates up-to-date:**
<https://watch.wave.video/PiPsMwfDxALz8ydC>
- **Providing the information needed to make a balanced safeguarding decision:**
<https://watch.wave.video/jbJQfb7Qq61mnrzl>
- **An Introduction to Basic DBS Checks:** <https://watch.wave.video/7pDHrKzQIUbvHphh>



Learning lessons in design and delivery of Care Home research

The NIHR local clinical research networks have recently funded several projects expanding research within underserved communities with high health needs. One of the projects that has been funded is exploring the opportunities and challenges of conducting clinical research in care homes. It is led by Dr Annabelle Long from the University of Nottingham. This piece of work aims to produce practical advice and support to help encourage future research in care homes enabling better care and quality of life for the people who live there.

It would be great if you would consider completing this survey as well as promoting it to your care home sites. **It is open to people who work in a care home, live in a care home, have a family member who lives in a care home or conduct research in a care home environment in the UK.** This piece of work is really important to help care homes be included as sites for delivering research, therefore your opinion matters.

The survey takes 10 minutes to complete and consists of up to 23 questions access here - <https://forms.office.com/Pages/ResponsePage.aspx?id=7qe9Z4D970GskTWEGCkKHIY-nJEL89BFmJjTD8y4JZtUQTQySzNYUUpVMkJCTjhWMkpENU5SUUVOMyQIQCN0PWcu>



Sharing Effective References and Conduct Information

A Better Hiring Toolkit

In collaboration with:



Providing
References - see
Better Hiring
Institute Toolkit.
Endorsed by Telford
and Wrekin
Safeguarding
Partnership and
Shropshire
Safeguarding
Community
Partnership as well
as Partners in Care.

<https://www.betterhiringinstitute.co.uk/industry-best-practice/health-social-care>



Department
of Health &
Social Care

**Guidance (replaces previous guidance)
Safeguarding adults protocol: pressure ulcers
and raising a safeguarding concern
Published 16 January 2024 updated 5th March**

These documents help practitioners and managers across health and care organisations to provide caring and quick responses to people at risk of developing pressure ulcers. The guidance offers a process for the clinical management of harm removal and reduction where ulcers occur, considering if an adult safeguarding response is necessary. The guidance also outlines how the appendices should be used if a concern is raised:

- appendix 1: adult safeguarding decision guide
- appendix 2: body map
- appendix 3: concern proforma

Pressure ulcers, which are largely preventable, cause distress to individuals and their families and create financial pressures for the NHS. While the treatment of pressure ulcers is mainly clinical, prevention is a shared responsibility.



Appendices 1 to 3: adult safeguarding decision guide, body map and concern proforma

Published 16 January 2024

Contents

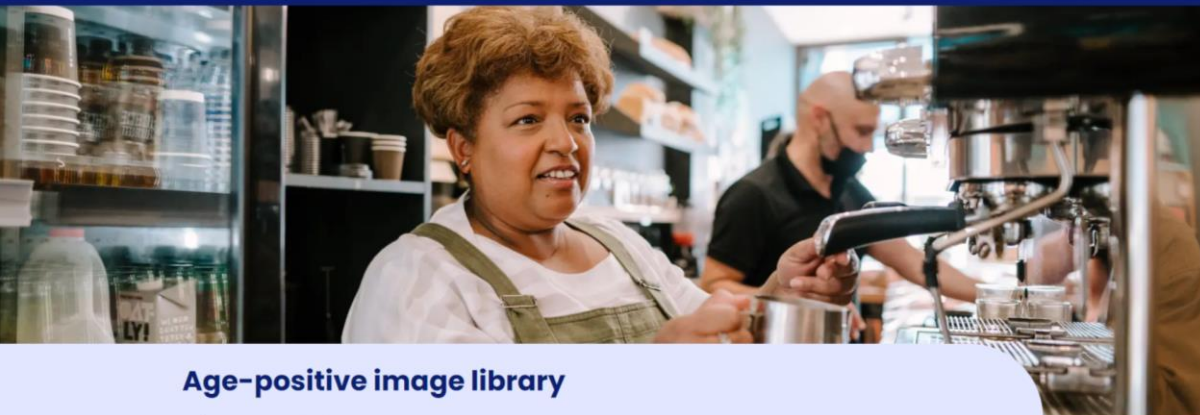
Appendix 1: adult safeguarding decision guide.....	
Appendix 2: body map	
Appendix 3: adult safeguarding concern proforma regarding pressure ulcers.....	

Guidance:

<https://www.gov.uk/government/publications/pressure-ulcers-how-to-safeguard-adults/safeguarding-adults-protocol-pressure-ulcers-and-raising-a-safeguarding-concern#safeguarding-concern-assessment-guidance>

Appendices:

<https://www.gov.uk/government/publications/pressure-ulcers-how-to-safeguard-adults>



Age-positive image library

We've created the first free library showing positive and realistic images of over 50s.

The photos show a more realistic depiction of ageing – to help challenge stereotypes of older people. The library, which contains over 3,000 images and is regularly updated, is available for anyone to use for free.

Want to create your own personalised collection of photos? Make an account below.



Centre for Ageing Better Image Library is Moving!

Now accessed on the campaign website

https://www.agewithoutlimits.org/image-library?utm_source=Image+Library+Users+Feb+2024+legitimate+interest&utm_campaign=cf4e5f68a2-LI+image+library+update&utm_medium=email&utm_term=0_-cf4e5f68a2-%5BLIST_EMAIL_ID%5D





MCA Cards

Have you seen
the updated 5 +
3 cards?


<https://www.shropshire.gov.uk/media/23231/mca-5and3-card.pdf>

Mental Capacity Act 2005

Remember to use the 5 and 3 to assess capacity

5 Principles to guide you

- 1) Presume capacity
- 2) Do all you can to support decision making
- 3) Do not decide someone lacks capacity just because they make an unwise decision
- 4) If a person lacks capacity for a decision you must act in their best interests and
- 5) You must aim to choose the less restrictive option



3 Questions to help you



- 1) Can the person do all the following?
 - Understand the information relevant to a decision
 - Retain the information long enough to make a decision
 - Use and weigh the information to make a decision
 - Communicate their decision - by any means possibleIf at least one of these requirements can't be met - you must ask:
 - 2) Does the person have an impairment or disturbance in the functioning of mind or brain?
If so
 - 3) Is this the reason that they cannot make the decision?

Best Interests Decision Making - applies when the person lacks mental capacity.

Decision Making – Statutory Checklist	Questions for Decision Makers
<ul style="list-style-type: none">• Do not discriminate - avoid assumptions based on age, disability, behaviour etc• Consider all relevant circumstances• Consider the person's past and present wishes, feelings, beliefs and values• Involve the person in the decision making• Might the person regain capacity, does the decision need to be made now?• Consult others e.g. family and friends, care providers, other professionals• For life sustaining treatment, do not be motivated by the desire to bring about the person's death	<ul style="list-style-type: none">• Are you certain you have provided all possible support for the person to make their own decision?• Is there a Lasting Power of Attorney (LPA) or Deputy appointed?• Is the decision within the LPA/Deputy's power to make?• Is there an Advance Decision to Refuse Treatment?• Have you involved an Independent Mental Capacity Advocate (IMCA) i.e. in all un-befriended decisions about serious medical treatment or change of accommodation; in certain safeguarding situations; and in some care reviews?• Are you certain about the available options and which are less restrictive?

Best Interests Decision Making does not replace Care Act duties

For training requirements contact:
Joint Training Team
Tel: 01743 254 734
E-mail: joint.training@shropshire.gov.uk
<https://shropshire.gov.uk/joint-training>





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