

Safeguarding Adults Forum

January 31st 2018

Agenda

Introduction from safeguarding adults forum organisers (*Karen Littleford*)

Introduction to the Forum & Agreements (*Karen Littleford*)

Learning from the analysis of the 27 London Safeguarding Adults Review's (*Paul Cooper*)

Update on Safeguarding Adults Board Websites & Phone Numbers (*Karen Littleford*)

Good capacity assessments: how to and how *not* to do an assessment of capacity (*Marion Kelly*)

Record Keeping (Themes and Trends Across our Patch) (*Kathy George*)

NICE - Sepsis: Risk stratification tools (*Kathy George*)

‘Making Waves’ for Dignity.



Staff from the Social Care and Health sector in Shropshire and Telford and Wrekin attending a Safeguarding Adults Forum organised by Shropshire Partners in Care, Shropshire and Telford and Wrekin Clinical Commissioning Groups and Local Authorities prepared to mark National Dignity Action Day (February 1st 2018) by ‘Making Waves’ for Dignity.

Kathy George, Telford and Wrekin CCG said “We want to encourage everyone to participate and celebrate dignity by joining in with us by creating a wave as a signal of our support” so we did!

Click the link to watch the video on twitter

<https://twitter.com/SPICnews/status/958717771298328576>

Introduction to the Forum & Agreements



**Karen Littleford,
Safeguarding Adults Lead,
Shropshire Partners in Care**

The purpose of the Safeguarding Adults Forum is to promote awareness of good practice concerning safeguarding adults, including the application of the Mental Capacity Act, the Deprivation of Liberty Safeguards and the Prevent agenda
(SA Forum ToR, 2018)

Engagement with the Forum

Communication outside of forum meetings:

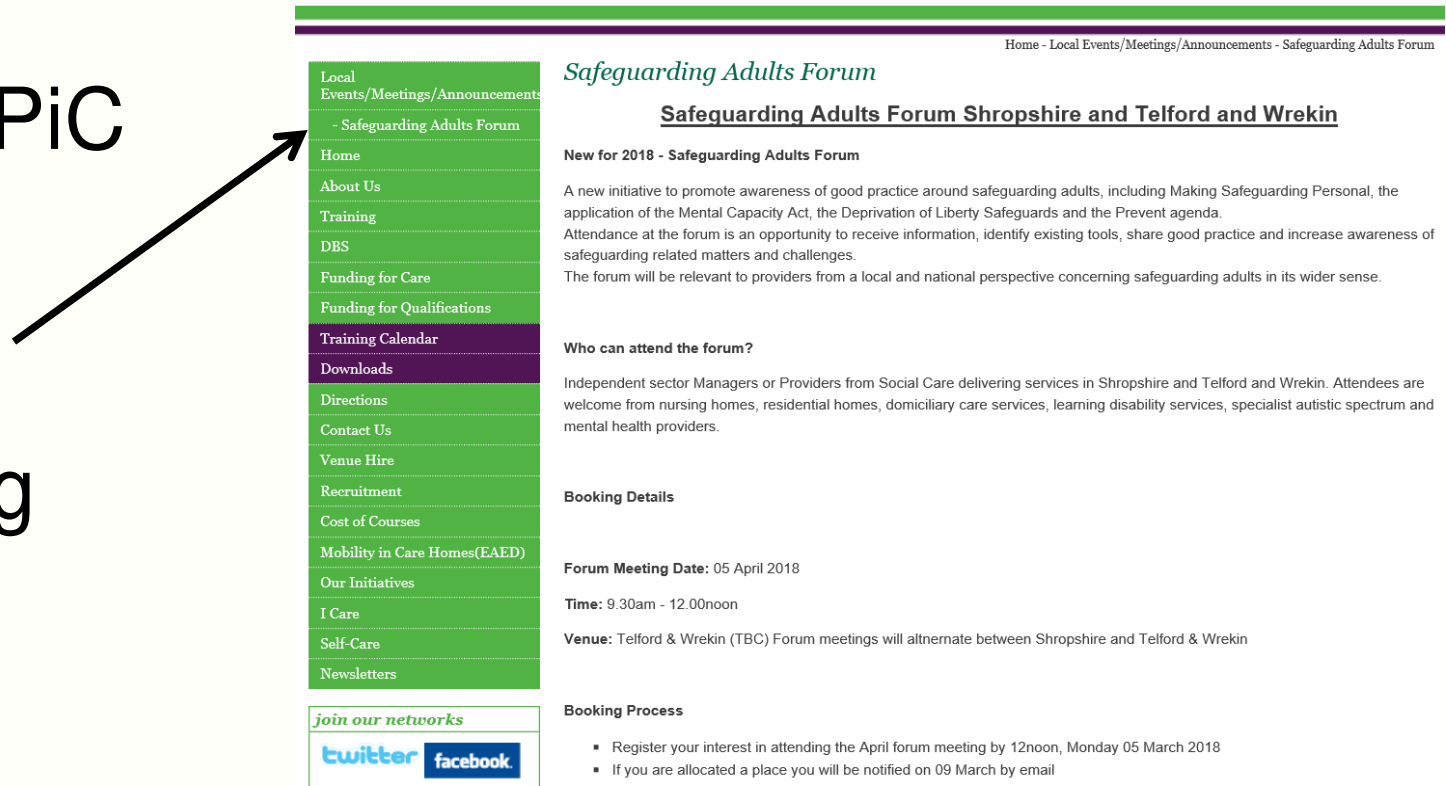
Visit the SPiC website to access signposting Materials

SPiC Website -

<http://www.spic.co.uk/>

Safeguarding Adults Forum page

<http://www.spic.co.uk/local-events/safeguarding-adults-forum>



Home - Local Events/Meetings/Announcements - Safeguarding Adults Forum

Safeguarding Adults Forum

Safeguarding Adults Forum Shropshire and Telford and Wrekin

New for 2018 - Safeguarding Adults Forum

A new initiative to promote awareness of good practice around safeguarding adults, including Making Safeguarding Personal, the application of the Mental Capacity Act, the Deprivation of Liberty Safeguards and the Prevent agenda. Attendance at the forum is an opportunity to receive information, identify existing tools, share good practice and increase awareness of safeguarding related matters and challenges. The forum will be relevant to providers from a local and national perspective concerning safeguarding adults in its wider sense.

Who can attend the forum?

Independent sector Managers or Providers from Social Care delivering services in Shropshire and Telford and Wrekin. Attendees are welcome from nursing homes, residential homes, domiciliary care services, learning disability services, specialist autistic spectrum and mental health providers.

Booking Details

Forum Meeting Date: 05 April 2018

Time: 9.30am - 12.00noon

Venue: Telford & Wrekin (TBC) Forum meetings will alternate between Shropshire and Telford & Wrekin

Booking Process

- Register your interest in attending the April forum meeting by 12noon, Monday 05 March 2018
- If you are allocated a place you will be notified on 09 March by email
- To register your interest please contact Deborah Warman at SPiC on 01743 860011 or email dwarman@spic.co.uk

Local Events/Meetings/Announcements

- Safeguarding Adults Forum

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Self-Care

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Forum Questions

**Karen Littleford, Shropshire
Partners in Care**

klittleford@spic.co.uk

01743 860011

Learning from SARS: A Report for the London Safeguarding Adults Board

Paul Cooper

**Head of Adult Safeguarding
Shropshire Clinical Commissioning Group**

Link to Report

<http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf>

LEARNING FROM SARs:

A REPORT FOR THE LONDON SAFEGUARDING ADULTS BOARD

SUZY BRAYE AND MICHAEL PRESTON-SHOOT

18th July 2017

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Safeguarding Adults Boards must arrange a SAR when:

- An adult in its area dies of abuse or neglect, whether known or suspected **AND**
- There is concern how the SAB or member agencies or those with relevant functions worked together to protect the adult

- An adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Safeguarding Adults Boards “free to arrange” a SAR when:

- The SAB feels it would provide useful learning from “near misses”
- Situations where the arrangements worked especially well.
- Any other circumstances of the SAB’s choosing

SAR Requirements - the SAB must:

- Publish each SAR's Terms of Reference^{14.166}
- “Determine locally” the modus of SAR^{14.170}
- Complete within 6 months^{14.173}
- Consider publication of the report^{14.179}
- Publish findings & actions in Annual Report^{14.177}

Summary of London Report

- Looked at 27 SARS from 30 London Boroughs
- From April 2015 to April 2017
- Ethnicity in majority not included
- **50% SARS were of people in residential care. 58% in Hull Review**
- **Organisational Abuse** – highest category [9]
- Self neglect – 2nd highest category [7]
- In 75% of the cases the adult died

“**Organisational abuse** is the mistreatment, abuse or neglect of an adult by a regime or individuals in a setting or service where the adult lives or that they use. Such abuse violates the person’s dignity. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

A number of inquiries into care in residential settings have highlighted that organisational abuse is most likely to occur when staff:

- ❖ receive little support from management;
- ❖ are inadequately trained;
- ❖ are poorly supervised and poorly supported in their work;
- ❖ receive inadequate guidance;

Or where there is:

- ❖ Unnecessary or inappropriate rules and regulations;
- ❖ Lack of stimulation or the development of individual interests;
- ❖ Inappropriate staff behaviour, such as the development of factions, misuse of drugs or alcohol, failure to respond to leadership;
- ❖ Restriction of external contacts or opportunities to socialise.”

Methodology Used

- Chronology and IMR [9]
- SCIE systems model [6]
- Hybrid or custom built [12]
- Period under review ranged 2 weeks to several years
- When adult still alive [0] were involved
- For those deceased 50% involved family
- Other 50% declined

Major Findings

- When discoverable only 2 completed within recommended 6 months
- Length of report varied from 2 to 98 pages
- Number of recommendations varied from 3 to 39
- Only 8 published
- 21 reports involved issues of capacity
- MCA most frequent learning area for direct practice

Four Learning Domains from the Review

- Quality of direct practice by workers
- Agency factors that affect practitioners
- Inter professional and inter agency practice
- SAB's governance role

Quality of Direct Practice by Workers

- **Missing or poor capacity assessments**
- Absence of Best Interest decision process
- Poor risk assessment – escalating risks
- **Making Safeguarding (MSP) failings from both ends**
- Poor involvement of family
- No curiosity about and context of behaviours
- Lack of assertive engagement
- Focus upon relationship

Agency Factors that Affect Practitioners

- Records: case records not clear or missing; technology shortcomings
- Safeguarding literacy
- Lack of management oversight and challenge
- Resources
- Supervision biased towards targets not needs
- Organisational policy
- Legal literacy
- Culture
- Market features/contracts/placement monitoring

Inter Professional and Inter Agency Practice

- Parallel working with no coordination or MDTs
- Information not shared - practice and policy
- Lack of single system information sharing
- Service thresholds impede referrals
- No whole “think family” working
- Safeguarding policy and referral scrutiny
- Legal literacy lack of knowledge of powers within MDT

What Care Homes Did Do Well

- Personalised care - positive choices to remain in care home during final phase of life
- Care Home staff had best knowledge of the person
- Example of a care home working closely with a surgery to introduce named GP scheme

Practice improvements required [1]

- Lack of personalised care – preferences
- Policy to restrict who could raise a concern
- Processes to manage assaults
- Lack of challenge to other professionals
- Poor info given to care homes
- Lack of advocacy when patient has no family
- Institutional responses

Practice improvements required [2]

- Lack of supervision
- Information exchange at transfer/referral (necrosis)
- LD patient passports not shared
- Safeguarding Literacy [16 SARS]
- 2 Care Homes very defensive during SAR
- Lack of nutritional log - detect deterioration
- Infection control

Recommendations [1]

- MCA use and knowledge
- Pressure ulcer management protocols and training
- Improve information to homes on admission
- Personal handling and lifting training
- Care plan audits
- IPC inspection and audits

Recommendations [2]

- Assaults from other residents  safeguarding
(please refer to local safeguarding adults guidance on this issue)

[Shropshire](#)

[Telford and Wrekin](#)

- Better support for assaulted staff
- Training on sexuality and consent
- Sufficient discharge medication
- Documented handovers
- GPs and community staff to write in notes
- Better access to Health Action Plans (LD)
- Implement Night checks schedule

Local Implications- What Do We Want To Do Next????

- Do any of the issues strike a chord?
- Would any of the recommendations apply to your service?
- How could learning from SARS improve your service
- What themes and trends analysis takes place in your service

Learning from SAR's - New for March 2018



Providers Children Safeguarding Integration All resources Training Consultancy

Home / Safeguarding adults / Safeguarding Adults Reviews (SARs) / Safeguarding Adults Reviews library

Safeguarding Adults Reviews (SARs)

Safeguarding Adults Reviews library

The Safeguarding Adults Review (SAR) library will contain reports and associated resources to support those involved in commissioning, conducting and quality assuring SARs.

Safeguarding Adults Reviews (SARs) are a statutory requirement for Safeguarding Adults Boards (SABs). SARs can inform adult safeguarding improvement. They can identify what is helping and what is hindering safeguarding work, to tackle barriers to good practice.

Commissioned by the Department of Health, this library is being developed jointly by Research in Practice for Adults (RiPfa) and Social Care Institute for Excellence (SCIE), working closely with colleagues from the sector.

The Safeguarding Adults Reviews (SARs) library will be up and running by March 2018.

Overview of the SARs library project

Details about the project, including frequently asked questions and how to get involved.

> Overview > Frequently asked questions



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

Update on Safeguarding Adults Board Websites & Phone Numbers (Shropshire)

Karen Littleford

**Safeguarding Adults Lead
Shropshire Partners in Care**



Keeping Adults Safe
in Shropshire
Board



Telford & Wrekin

**Safeguarding
Adults Board**



Keeping Adults Safe
in Shropshire
Board

Access

Search 'Keeping Adults Safe in Shropshire Board'

<http://www.keepingadultssafeinshropshire.org.uk/>

The screenshot shows the homepage of the Keeping Adults Safe in Shropshire Board website. At the top is a dark blue navigation bar with the following menu items: Home, What we do, About abuse, News and events, Learning resources, People's stories, and Get in touch. To the right of the menu is a search bar with the placeholder text 'Search for...' and a 'Search' button. Below the navigation bar is the main header area, which includes the organization's logo and name on the left. A large, semi-transparent blue diagonal graphic covers the right side of the header, featuring a yellow button that says 'Report a concern'. Below the header is a 'Latest news' section. The first news item is titled 'Preventing Abuse in Shropshire' and includes a green map of Shropshire. To the right of the news section are two images: one showing two hands clasped together, and another showing an elderly person sitting on a bench in a park-like setting.



Access

Search 'Telford Safeguarding Adults Board'

<http://www.telfordsafeguardingadultsboard.org/sab/about>



[Home](#) | [About](#) | [What is adult abuse](#) | [How to report adult abuse](#) | [Professionals, carers and health workers](#) | [FAQ's](#)

[About us](#)

About us

What is the Telford & Wrekin Safeguarding Adults Board (TWSAB)

Safeguarding adults and reducing the risk of harm to individuals in our communities requires effective co-ordination. The [Care Act 2014](#) requires local authorities to set up a Safeguarding Adults Board (SAB) in their area, giving these boards a clear basis in law for the first time. The [Care Act 2014 Guidance](#) provides further detail on how this should be achieved.

The objective of a SAB is to help and protect adults who have needs for care and support, who are experiencing or are at risk of abuse or neglect, and as a result of their needs are unable to protect themselves from abuse or neglect. This is whether or not the adult is having their needs met or they meet the local authority's eligibility criteria for care and support services.

TWSAB Meetings

The Board is chaired by Andrew Mason, Independent Chair and is comprised of the following partners:

Reporting a Safeguarding Adults Concern

Shropshire (new number)

First Point of Contact

0345 6789044

Telford and Wrekin

Family Connect

01952 385385 - select option 3

Good capacity assessments: how to and how *not* to do an assessment of capacity

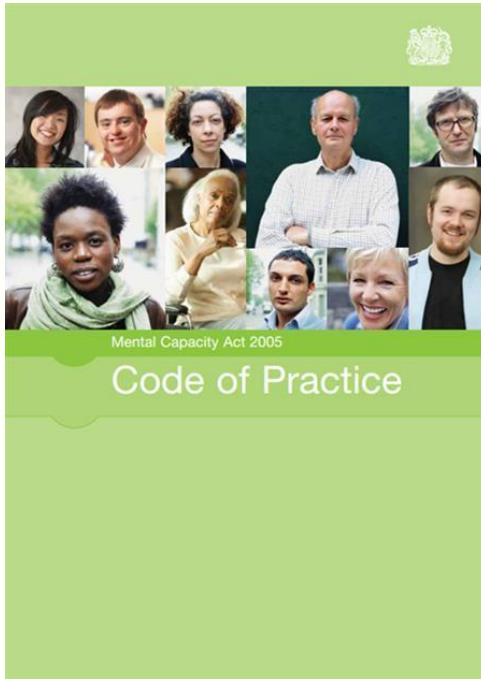
Marion Kelly

**Trainer and Development Officer
Shropshire Partners in Care**

Good capacity assessments: how to and how *not* to do an assessment of capacity

A good example of a mental capacity assessment was provided to forum members.

A less robust example of a mental capacity assessment was provided for comparison.



NHS
Shropshire
Clinical Commissioning Group



NHS
Telford and Wrekin
Clinical Commissioning Group

Shropshire Multi-Agency Mental Capacity Act Guidance

The Shrewsbury and Telford Hospital **NHS**
NHS Trust

Shropshire Community Health **NHS**
NHS Trust

The Robert Jones and Agnes Hunt **NHS**
Orthopaedic Hospital
NHS Foundation Trust

POhWER
advocacy, making your voice heard



Shropshire Mental Capacity Assessment Tool

This document is to be used when a formal two stage assessment of capacity needs to be made (e.g. a new care plan, a move into residential care, consent to treatment or discharge from hospital)

Name:	Date of Birth:
Address:	Care First No:
Stage One Diagnosis that there is an impairment of or disturbance in the functioning of the mind or brain? (Without this diagnosis a person cannot lack capacity).	
Decision to be made:	
Stage Two Functional assessment of capacity to make the recorded specific decision only. Tested in the following four areas, a failure in any area constitutes a lack of capacity for the specific decision.	
a. Record how you have tested whether the person can understand the information, the questions used, how you presented the information and your conclusion.	
b. Record how you tested whether the person could retain the information and your conclusion.	
c. Record how you tested whether the person could use and weigh the information and your conclusion.	
d. Record your findings about whether the person can communicate the decision?	
e. Conclusion (including any further input needed). Record the outcome of the assessment.	
Completed by: _____	

Record Keeping

Themes and Trends Across our Patch

Kathy George

**Named Nurse, Adult Safeguarding
Telford and Wrekin CCG**

Record Keeping

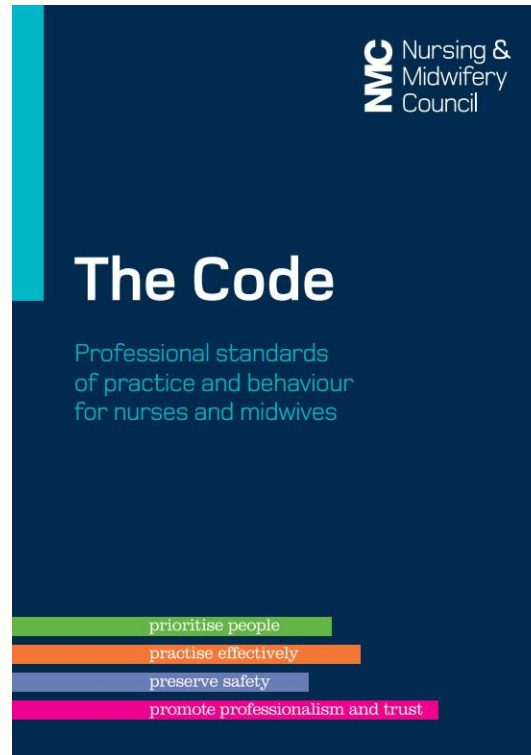
- Care Quality Commission
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17



Regulation 17(2)(c)

- 17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;
- **Records relating to the care and treatment of each person using the service must be kept and be fit for purpose. Fit for purpose means they must:**
- **Be complete, legible, indelible, accurate and up to date, with no undue delays in adding and filing information, as far as is reasonable. This includes results of diagnostic tests, correspondence and changes to care plans following medical advice.**
- **Include an accurate record of all decisions taken in relation to care and treatment and make reference to discussions with people who use the service, their carers and those lawfully acting on their behalf. This includes consent records and advance decisions to refuse treatment. Consent records include when consent changes, why the person changed consent and alternatives offered.**
- Be accessible to authorised people as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe. This applies both internally and externally to other organisations.
- Be created, amended, stored and destroyed in line with current legislation and nationally recognised guidance.
- Be kept secure at all times and only accessed, amended, or securely destroyed by authorised people.
- Both paper and electronic records can be held securely providing they meet the requirements of the Data Protection Act 1998.
- Decisions made on behalf of a person who lacks capacity must be recorded and provide evidence that these have been taken in line with the requirements of the Mental Capacity Act 2005 or, where relevant, the Mental Health Act 1983, and their associated Codes of Practice.

Nursing and Midwifery Council (NMC)



<https://www.nmc.org.uk/standards/code/>

The Code – Professional Standards

- **3.** Make sure that people's physical, social and psychological needs are assessed and responded to
- **8.** Work cooperatively
- **10.** Keep clear and accurate records relevant to your practice
- **13.** Recognise and work within the limits of your competence

NICE - Sepsis: Risk stratification tools

Kathy George

**Named Nurse Adult Safeguarding
Telford and Wrekin CCG**

Recognising a Deteriorating Condition

Think Sepsis -
National Institute for
Health and Care
Excellence (NICE)

Sepsis: Risk Stratification Tools

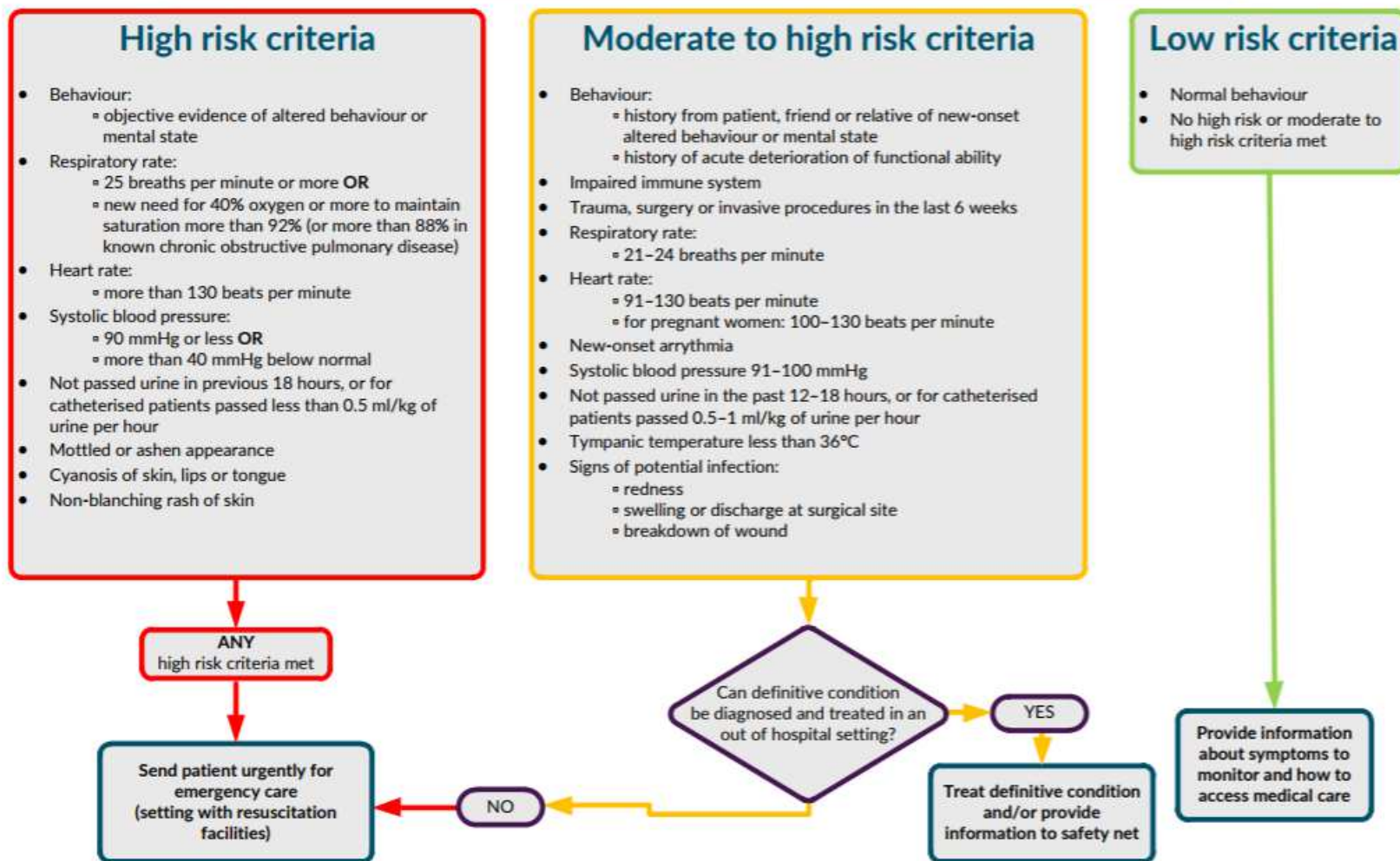
Sepsis Risk Stratification Tool:

People aged 18 years and over out of hospital

Link

www.nice.org.uk/guidance/ng51/resources/algorithms-and-risk-stratification-tables-compiled-version-2551488301 (Page 10)

Sepsis risk stratification tool: people aged 18 years and over out of hospital



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NICE National Institute for Health and Care Excellence

What Do We Need to Consider ?

Observe, Record and Report

- Behaviour
- Respiratory Rate
- Heart Rate
- Blood pressure
- Urine output
- Appearance - skin, cyanosis swelling, wound discharge etc.

Safeguarding Adults Forum Evaluation

Future Dates:

5th April - 9:30-12noon (Telford & Wrekin venue)

18th July - 9:30 – 12noon (Shropshire venue)

19th December - 9:30-12noon (Telford & Wrekin venue)

Save the date – 14th June 2018

Joint Safeguarding Adults Boards Prevention Event to mark World Elder Abuse Awareness Day (WEAAD).

We are pleased to announce Professor Michael Preston-Shoot will be speaking about working with adults who self-neglect and Mental Capacity (learning from Safeguarding Adults Reviews).

Thursday 14 June 2018 from 9:30am – 1:30pm at Oakengates Theatre @ The Place, Limes Road, Oakengates, Telford, TF2 6EP.

World Elder Abuse Awareness Day is commemorated each year in June to highlight the often silent suffering of older people. People across the world will voice their opposition to the abuse and neglect of older people. The joint Safeguarding Adults Boards in Shropshire and Telford and Wrekin event will focus on preventing the abuse of all adults with care and support needs.

This is a free event, co-ordinated and run jointly by the **Keeping Adults Safe in Shropshire Board (KASiSB)** and **Telford & Wrekin Safeguarding Adults Board (TWSAB)**. Booking Essential further information on how to reserve your place will follow shortly.