Shropshire Partners in Care

Supporting social care providers in Shropshire, Telford & Wrekin

Safeguarding Adults Forum

January 2020

Keeping Adults Safe in Shropshire Network

Telford and Wrekin Safeguarding Partnership

NHS Telford and Wrekin Clinical Commissioning Group

a co-operative council

Telford & Wrekin Council

NHS Shropshire Clinical Commissioning Group

Shropshire Council

- ✓ **Consequence Management - Update on the Evacuation Plus Protocol (Alan Boyd and Sherry Woolgrove)**
- ✓ **Safeguarding Adult Collection 2018 - 19National and Local Comparison (Sarah Hollinshead-Bland)**
- ✓ **ReSPECT (Marion Kelly)**
- ✓ **Findings of the DNACPR Nursing Home Audit (Paul Cooper)**
- ✓ **Consultation – Seeking *Providers views on 'Provider Record for Alternative Actions to Raising a Safeguarding Concern Safeguarding'* (Emma Harding)**
- ✓ **Signposting - CPD Opportunities, Open Access Journal Articles and Events (Karen Littleford)**

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)

Forum Questions?????

Karen Littleford, Shropshire Partners in Care
klittleford@spic.co.uk
01743 860011

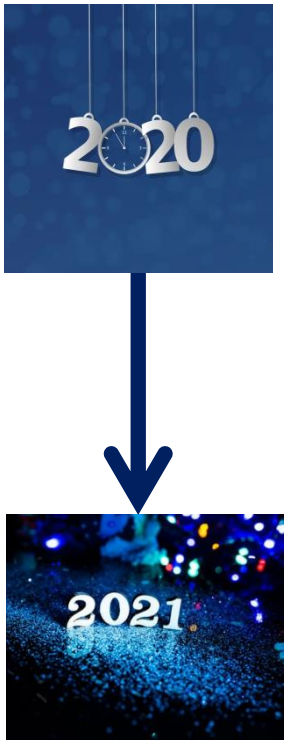
Ground Rules for Forum Meetings and Engagement with the Forum

Applicable during forum meetings and in any subsequent communication, including electronic:

- **Language** (appropriate)
- Maintain individuals **confidentiality**
- **Respect other forum members** right to voice their opinions
- Acknowledge **differences in opinions**
- **Contribute** to requests for **future agendas**
- Work to the forum Confidentiality Agreement
- Commit to partnership working in order to improve the experience of adults with care and support needs
- Commit to engage, share good practice and take appropriate action
- Be open to suggestions **'open, engaged and involved'**
- **Evaluate** individual forum meetings in order to contribute to overall project evaluation
- **Cascade information** within your organisation

Next Safeguarding Adults Forum

Date and Time of Next Meeting/s:



Wednesday 20th May, 2020
Shropshire Partners in Care,
Annscroft, Shrewsbury, SY5 8AN
9:30am-12:30am.

Thursday 1st October 2020 (Telford and Wrekin)
Wednesday 9th December 2020 (SPiC Offices, Annscroft)
Wednesday 24th March 2021 (Telford and Wrekin)

Register Your Interest:

Email Deborah Warman at SPiC – dwarman@spic.co.uk

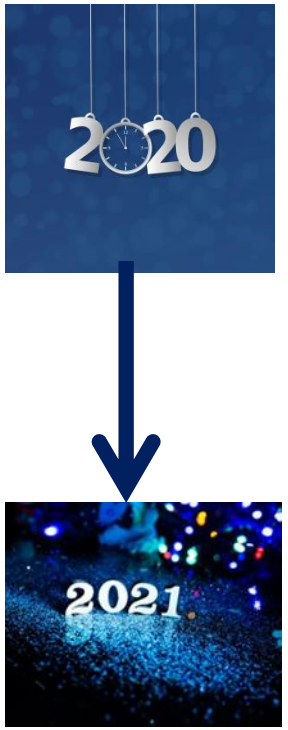
Shropshire Partners in Care

pixabay

Safeguarding Adults Funding

The Safeguarding Forum will be funded by SPiC for 2020 -2021.

To access previous presentations please click here



Consequence Management

Update on the Evacuation Plus Protocol

Alan Boyd (Resilience Manager, Telford and Wrekin Council)

Sherry Woolgrove (Civil Resilience Team Leader, Shropshire Council)

Telford & Wrekin COUNCIL

Shropshire Council

Background

- UXB Incident *(Unexploded Bomb)* at a local care home
- Major Fire at a Care Home in Cheshire East

Observed – the ***lack of a template plan*** covering ***extended*** evacuation in Care Homes.

The ***lack of understanding*** of the issues associated with extended evacuations.

Progress to Date

Rude interruptions:

- Brexit
- General Election
- Flooding
- Local Incidents and Events

Ironbridge Cooling Towers Demolition

https://www.youtube.com/watch?v=4_WjB8lSC5g

Photo – Telford Live (2019)
Footage - Telford and Wrekin Council (2019)

Progress to Date

- L.A. Resilience Managers agreed a way forward

- Liaison –
  - Internal Commissioners
  - Home visit to a care home
  - Meeting with **M**ulti **D**isciplinary **T**eam
  - Meeting with T&W **E**mergency **D**uty **T**eam

Progress to Date

- Liaison –
  - Meeting with Telford and Wrekin My Options)
  - Cheshire East Council Resilience Unit to discuss lessons learned from the major fire at one of their Care Homes

Beechmere retirement complex was destroyed in a blaze (Image: Cheshire Fire and Rescue Service)

(Cheshire Fire and Rescue Service, 2019)

(Heath, 2019)

> **Apology to care home residents who lost everything in huge fire after they are sent council tax demands**

(Ryan and Parker, 2019)

Issues

- There is no plan for extended evacuations
- Limited training / exercising & discussion

Major Incident Management:

- Who is in charge?
- Link with other teams e.g. – MDT, Rapid Response, Brokerage etc.?
- Adult Social Care (ASC) Incident Management Structure?

Issues

- Not every Care Home has a Emergency Passport system
- Any Plans developed will be tweaked to reflect other types of care homes
- Links to electronic systems EMISS, Medication POD etc.

Issues

- Greater consultation needed:
  - Internal discussions within Local Authority
  - G.P.’s
  - Shropdoc
  - 111
  - Ambulance Service
  - CCG
  - etc.!

Reminder of what we are trying to achieve

Aim

Agree there is a need for standard Plan that support the Emergency Coordinating Team.

Aim – To ensure the Safety, Dignity and Comfort of the Residents

Objectives –

1. Identify the immediate needs of the Residents
2. The Additional Resources needed / available to support the Residents
3. Liaison with the Next of Kin
4. Alternative Accommodation
5. Transportation
6. Escalation of the incident – i.e. Hospitalisation

Outcome

For the staff at the Care Home:

1. A short aide-memoire plan (one double side of A4)
2. A Clear Escalation Process
3. A robust incident management response to support the staff
4. Training and awareness

Any Questions / Comments

Contacts:

Alan Boyd (Resilience Manager, Telford and Wrekin Council)

Email: Alan.boyd@telford.gov.uk

Telephone: 01952 381932

Sherry Woolgrove (Civil Resilience Team Leader, Shropshire Council)

Email: Sherry.Woolgrove@shropshire.gov.uk

Telephone: 01743 251785

References:

Cheshire Fire and Rescue Service (2019) *Fire at supported living complex in Crewe*. 08/08/2019. https://www.cheshirefire.gov.uk/news-events/incidents/ongoing-fire-at-supported-living-complex-in-crewe

Photos from the scene can be viewed here:
Cheshire Fire and Rescue Service (2019) *Fire at supported living complex in Crewe.* https://www.flickr.com/photos/cheshirefireservice/albums/72157710191482026

Heath, L. (2019) *Does the Crewe care home fire bring timber frame construction back into the spotlight?* Inside Housing, 22/08/19. https://www.insidehousing.co.uk/insight/insight/does-the-crewe-care-home-fire-bring-timber-frame-construction-back-into-the-spotlight-62922

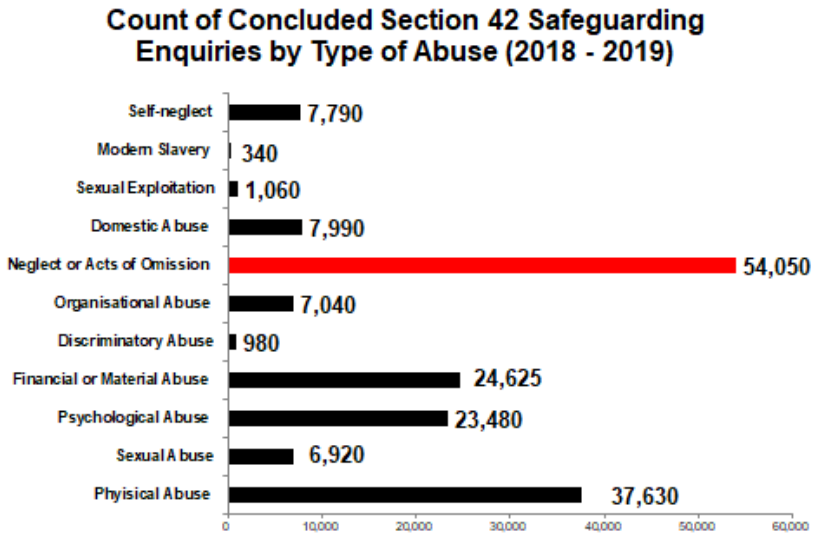
Ryan, B. and Parker, H. (2019) *Apology to care home residents who lost everything in huge fire after they are sent council tax demands*. StokeonTrentLive, 14:24, 28 AUG 2019. https://www.stokesentinel.co.uk/news/stoke-on-trent-news/apology-care-home-residents-who-3258801

Telford Live (2019) *Planning to watch the Cooling Towers demolition? What you need to know* https://www.telford-live.com/2019/12/planning-to-watch-the-cooling-towers-demolition-what-you-need-to-know/

Telford and Wrekin Council (2019) *Ironbridge cooling towers demolition.* 6 Dec 2019. https://www.youtube.com/watch?v=4_WjB8lSC5g

Safeguarding Adult Collection 2018-19

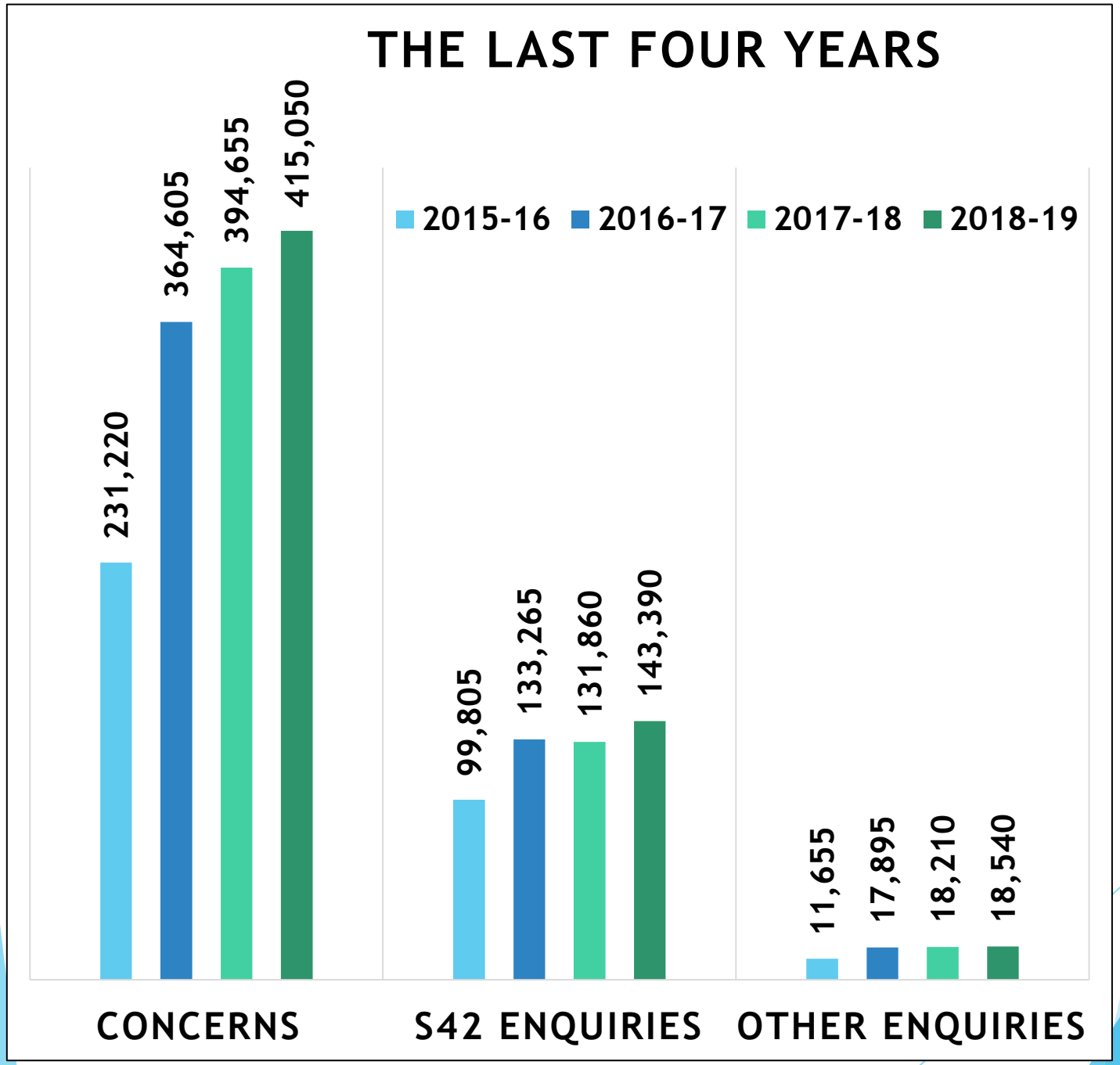
National and Local Comparison



NHS Digital (2019) *Safeguarding Adults, England, 2018-19*.10th December 2019. London: NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/annual-report-2018-19-england

Sarah Hollinshead-Bland

(Service Manager for Operations, Shropshire Council)



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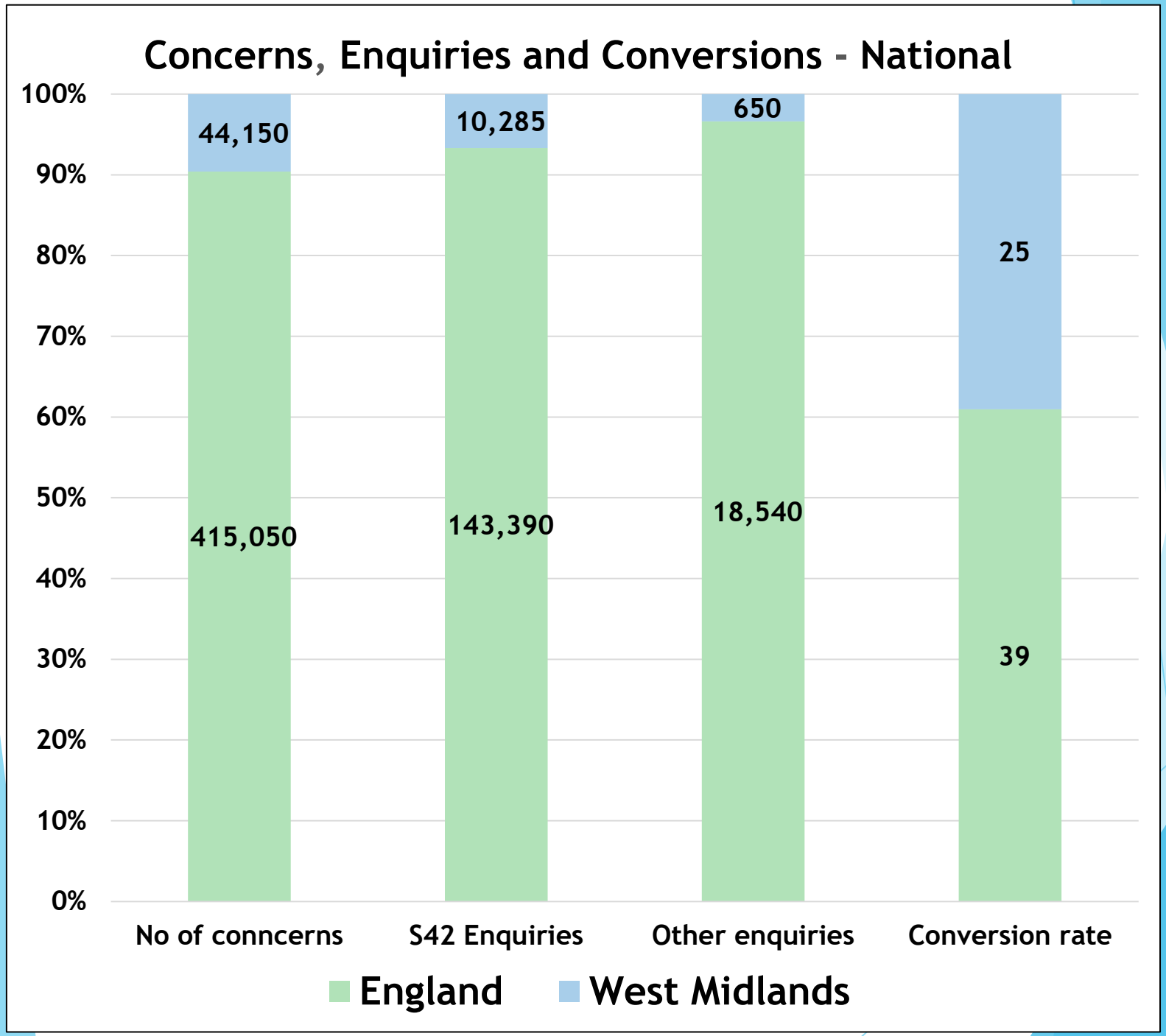

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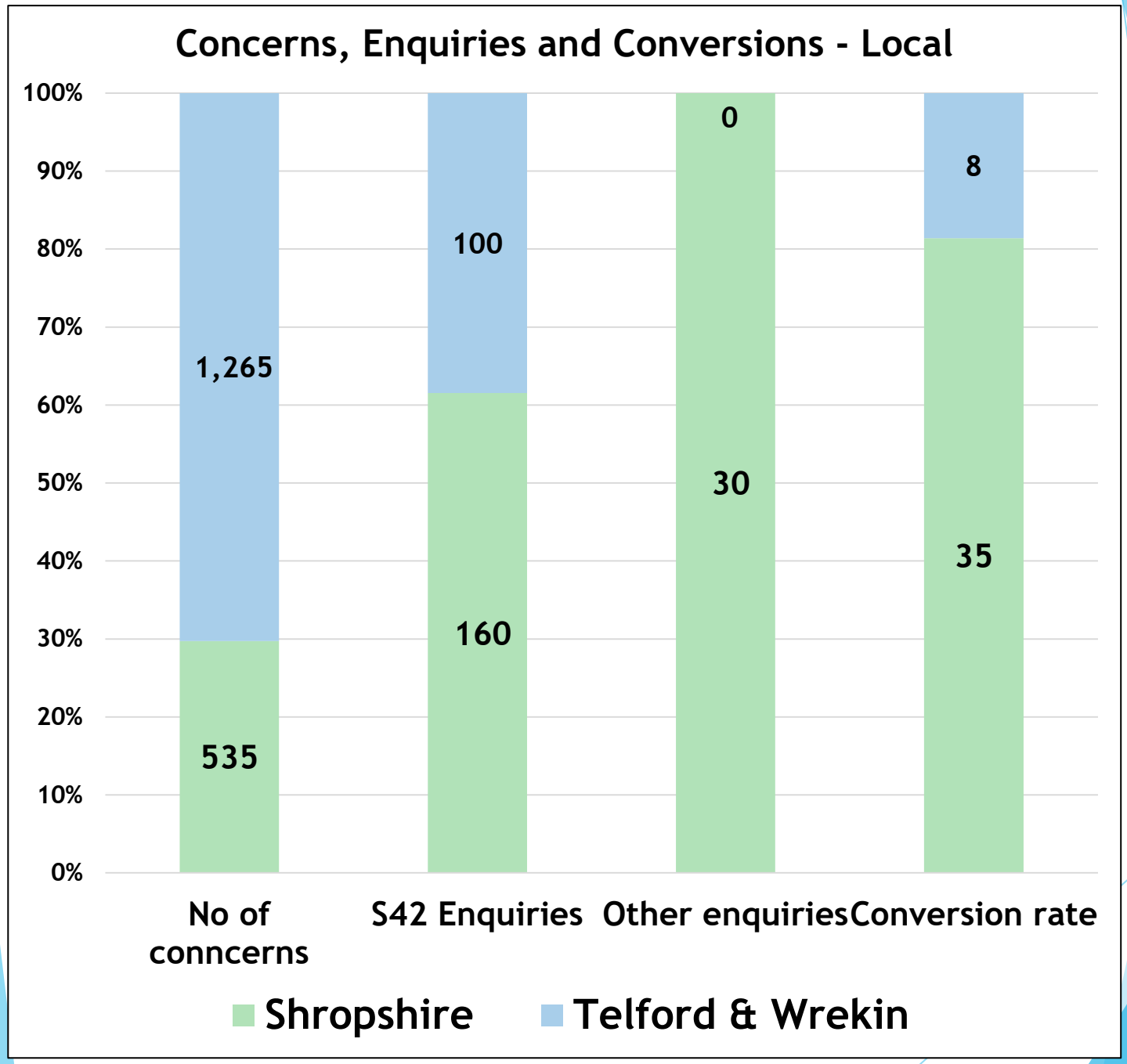
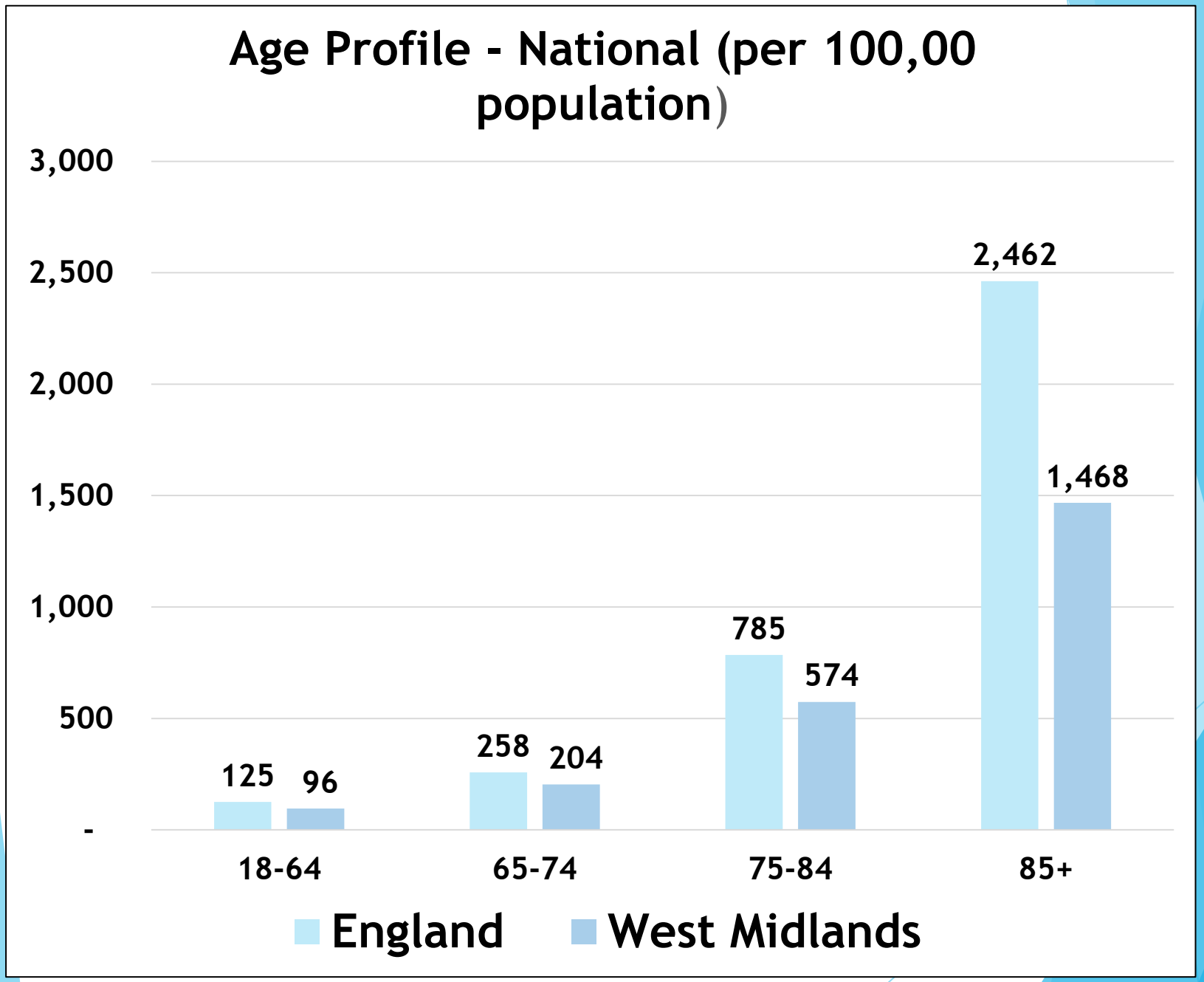
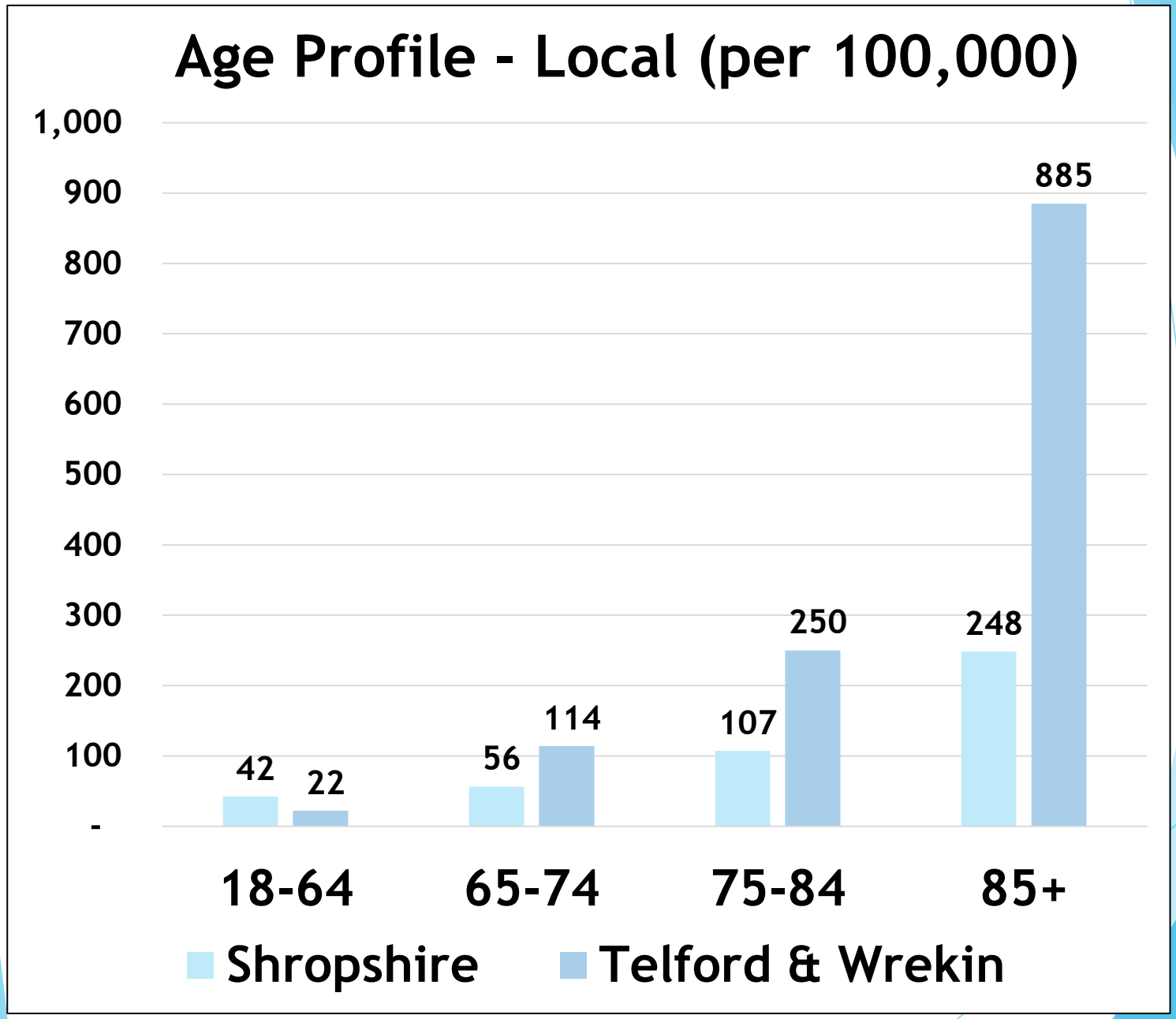


NHS Digital (2019)

Age Profile - National (per 100,00 population)

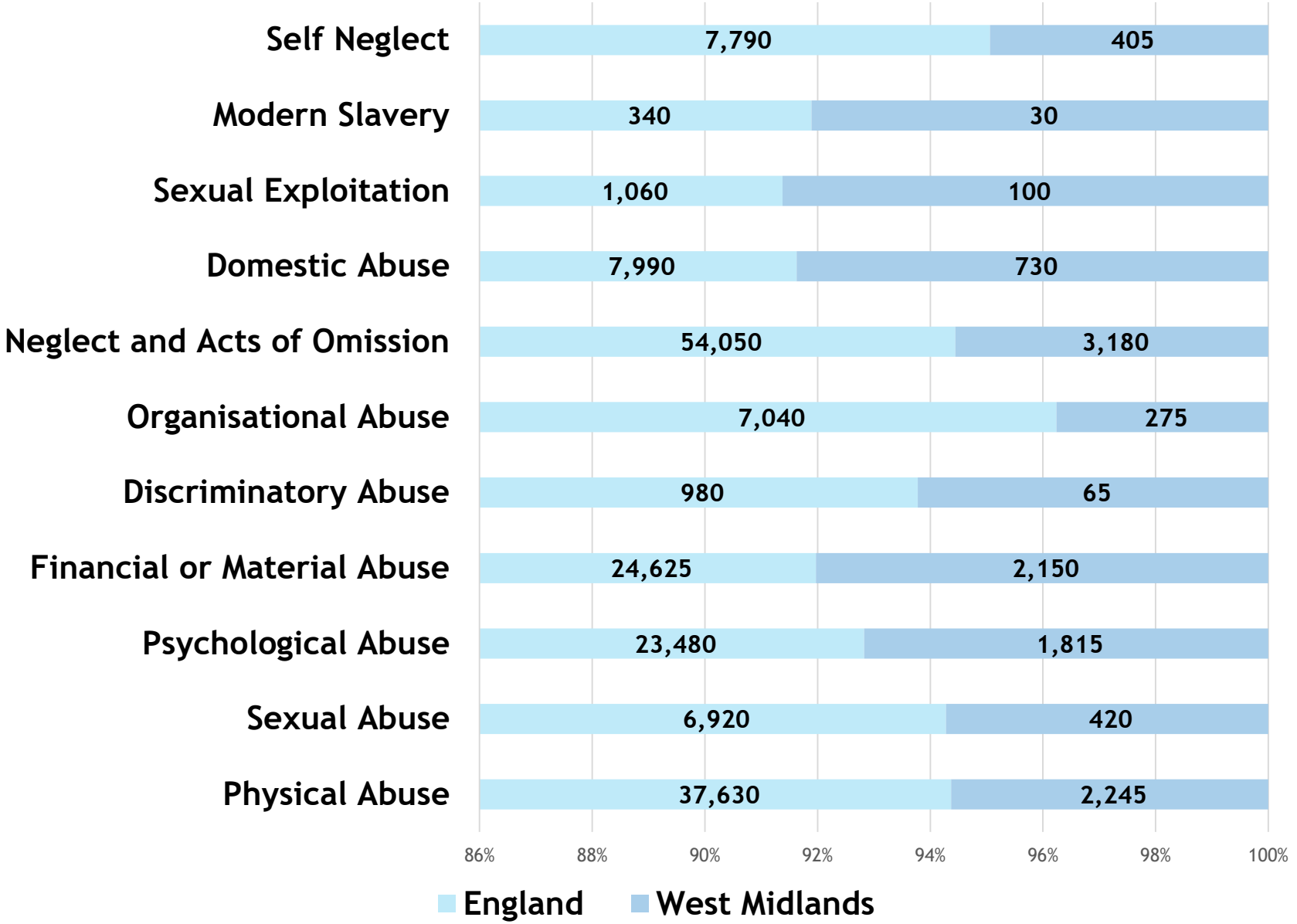


NHS Digital (2019)



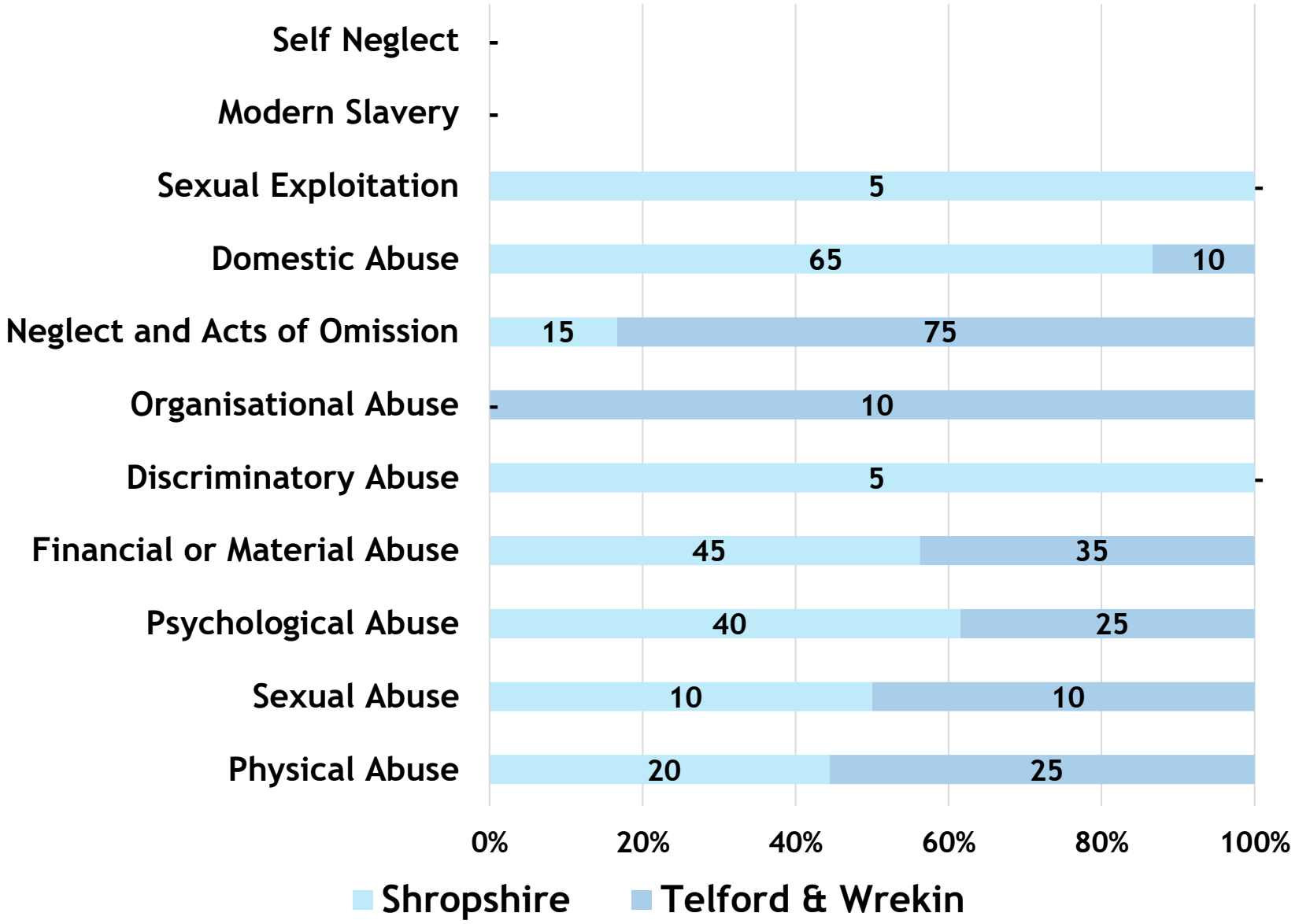
NHS Digital (2019)

Types of Abuse - National



NHS Digital (2019)

Types of Abuse - Local



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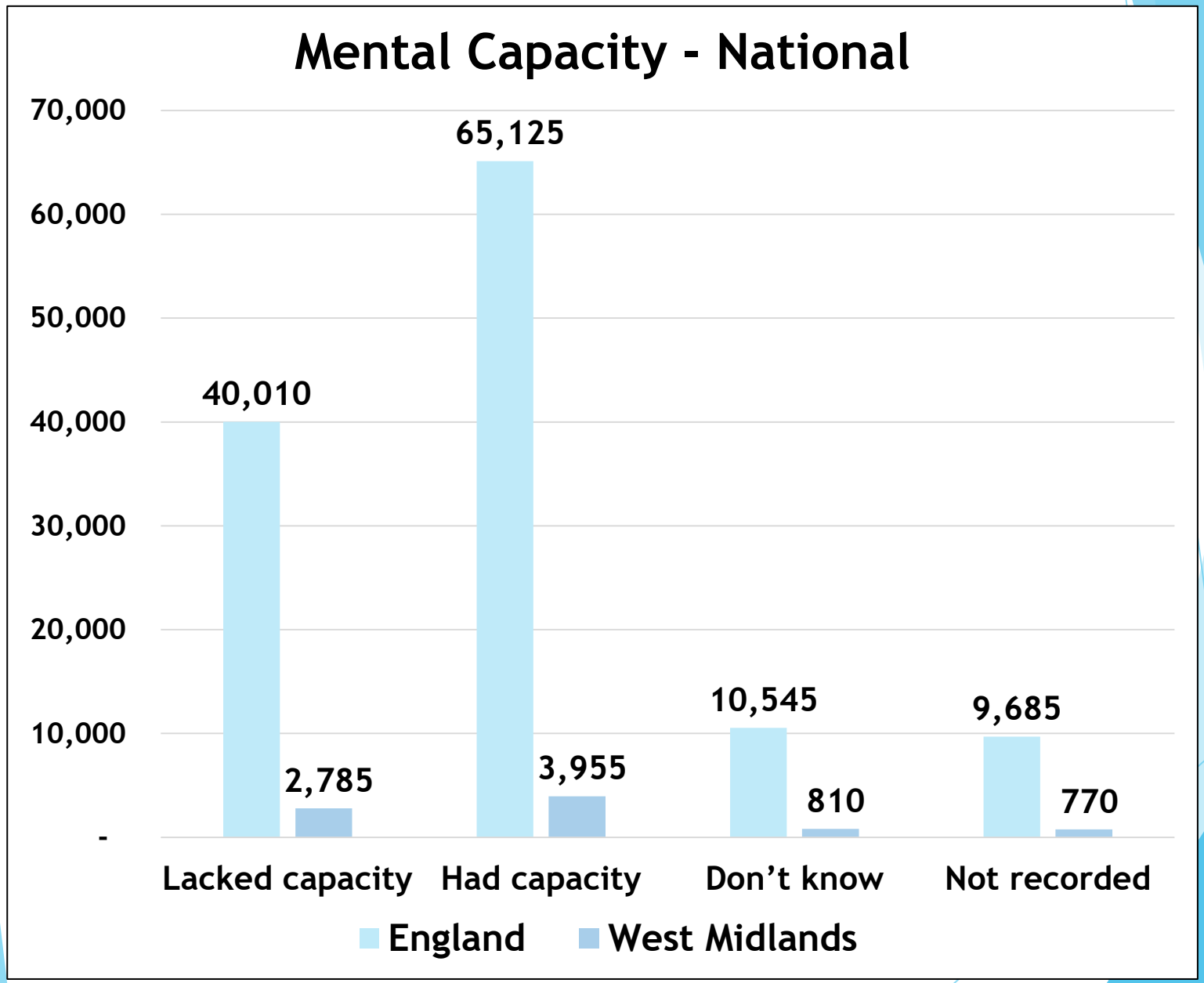

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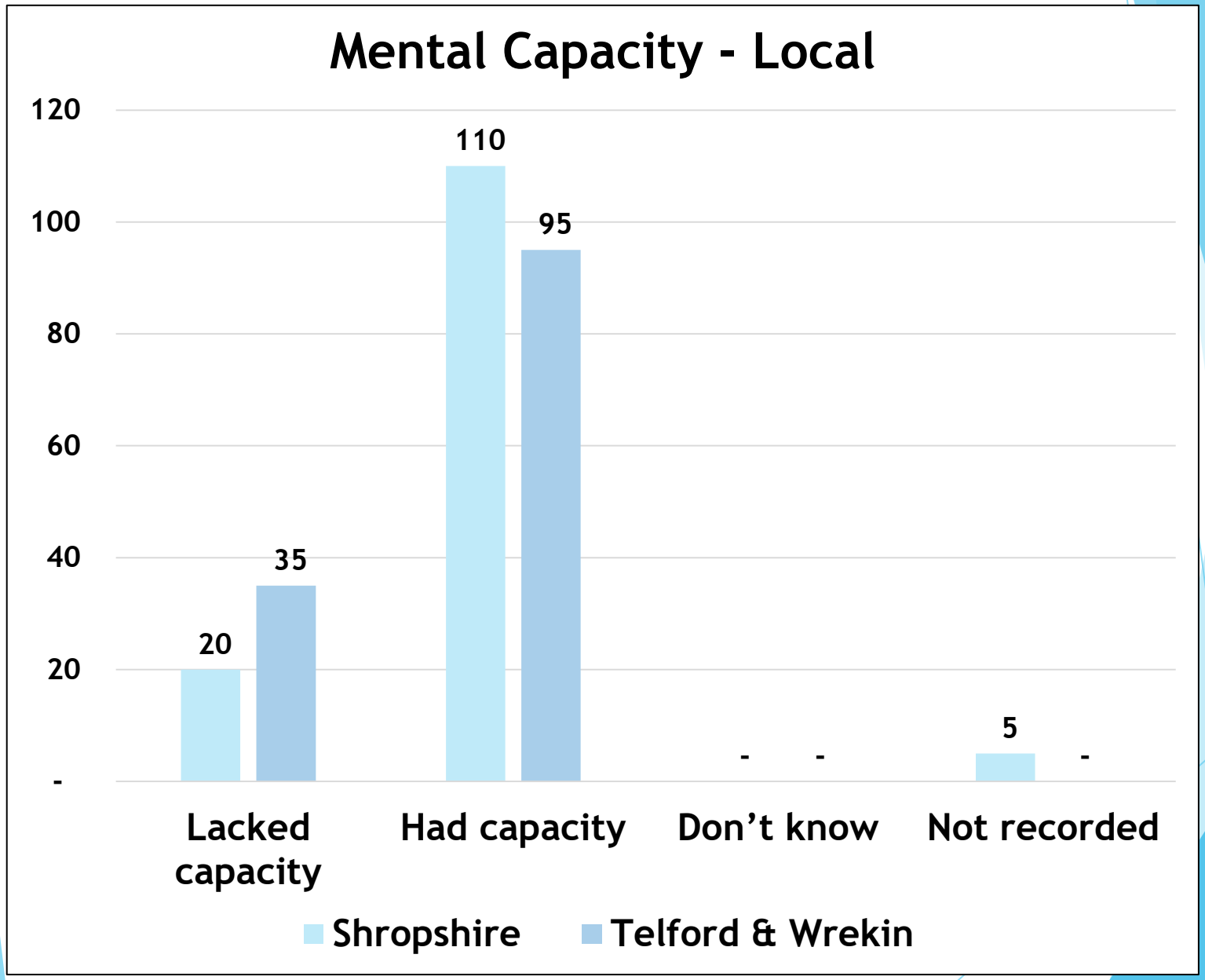
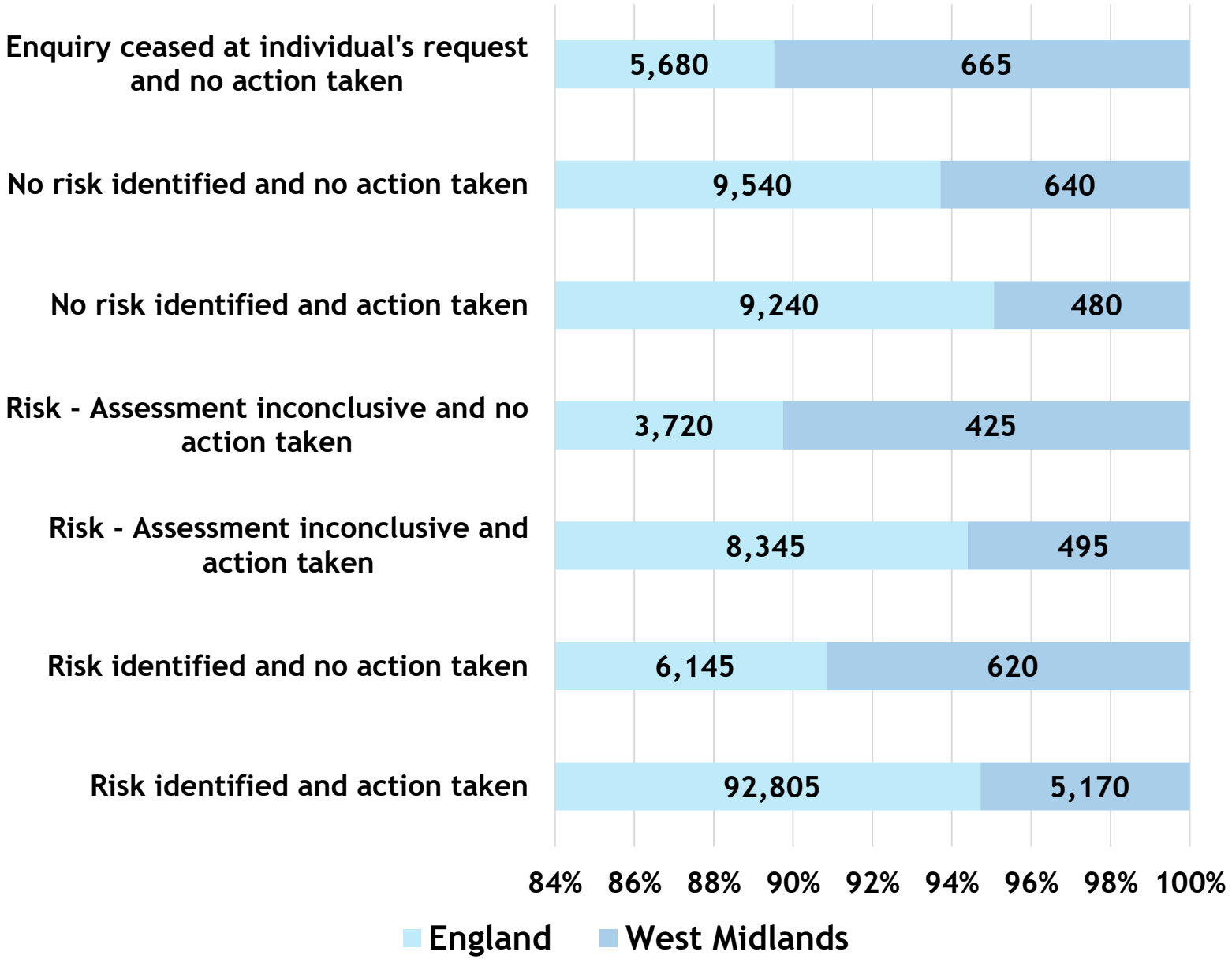


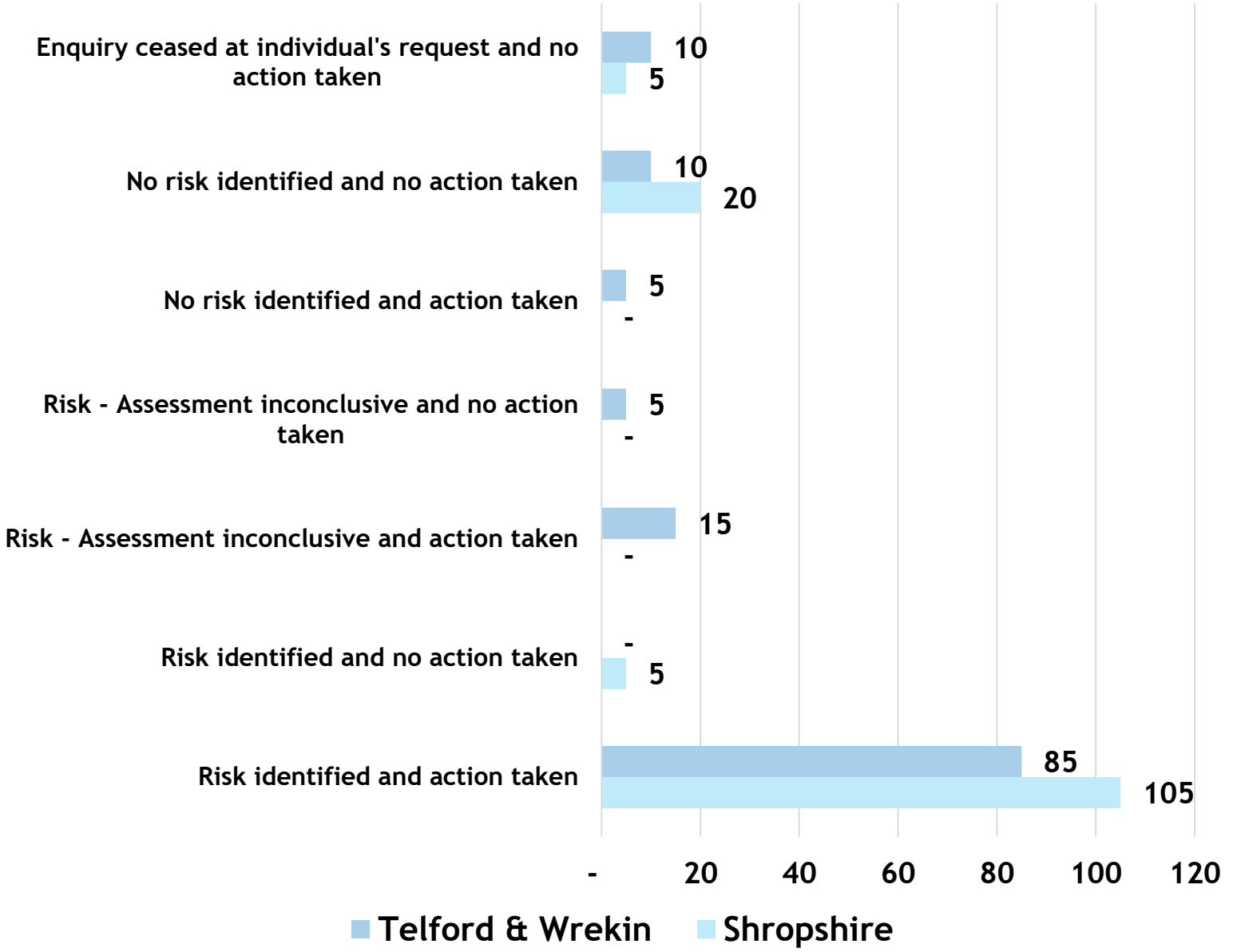
NHS Digital (2019)

Outcomes - National



NHS Digital (2019)

Outcomes - Local



NHS Digital (2019)

National and Local Figures

- A discussion took place at the Forum alongside the figures to explore:
  - Why figures for raising safeguarding adults concerns nationally had increased since the introduction of the Care Act (rather than decreased as might be expected with the principles of proportionally, Making Safeguarding Personal etc.).
  - There was no consensus or single acknowledged explanation on this point, it was suggested in the room that there was greater awareness since the implementation of the Care Act, including across the general public etc. (although locally it appeared the majority of concerns were raised by workers and professionals as opposed to the general public).
  - Safeguarding Adults Concerns had decreased in Shropshire over the last two years, this was now Sarah felt increasing. Reasons for this are not fully understood at the present time.
  - The potential explanations for any variance in the data set across the two local authorities was explored, in some cases data capture may potentially explain variance.
  - Figures and the differences between those for Shropshire and Telford and Wrekin were generally explored with input from both local authorities during the forum.
  - The full NHS Digital data set may be found here

(Summarised by Karen Littleford)

Summary and Actions Resulting From The Discussion

Summary of discussion focused on raising a safeguarding adults concern:

- The discussion revealed challenges for Providers in Shropshire when working to the local safeguarding processes (i.e. not everything is going to need to be raised as a safeguarding adults concern with the local authority). The Council promotes Providers dealing with issues that have the potential to become safeguarding matters as early as possible and take action that resolves the issue and prevents further escalation. This includes being open and transparent with those involved, demonstrating candour and calls for the use of professional judgement about the need to raise a safeguarding concern externally with the local authority if the remedial actions have fully addressed the concerns. However, matters of abuse and were the risk remains; or is unquantifiable; or significant harm has occurred would be exceptions to this and are likely to need a discussion with the Council. Forum members explained the CQC, as the regulator, can offer a different interpretation about the need to raise a safeguarding concern regardless of such preventative actions.
- This reported divergent approach between the LA and the CQC could potentially impact on a providers compliance with the CQC and ultimately reflect on the 'Leadership' element of the ratings process.

Actions:

- Sarah agreed to raise the issue with the CQC at their joint Information Sharing Meeting.
- Sarah to take to the Regional Safeguarding Adults Network to raise this issue with Local Authorities across the West Midlands.

(Summarised by Karen Littleford and Paul Cooper)

Reference

- NHS Digital (2019) *Safeguarding Adults*. Leeds: NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults

ReSPECT

Marion Kelly

(Trainer and Development Officer, Shropshire Partners in Care)

Shropshire Partners in Care

MYTHS

MYTH - WE HAVE TO REPLACE ALL DNACPR'S URGENTLY

Existing DNACPR forms should be replaced with ReSPECT forms at the point of review should any change be identified

DNACPR and ReSPECT forms should be reviewed regularly and updated with any changes.

MYTH - EVERYONE NEEDS A RESPECT FORM

The form is in theory for anyone but especially those patients with complex health problems, severe frailty etc. and in the last 12 months of life.

MYTH - ANY REGISTERED NURSE OR DOCTOR CAN COMPLETE THE FORM

- **Anyone qualified to explain the persons condition, progression and treatment options**

- **The form can be completed by any health and care professional competent to do so and ideally trained in "important conversations" but needs to be endorsed by the senior responsible clinician.**

MYTH - CARE HOME NURSES CAN SIGN OFF A RESPECT FORM

Care homes staff are able to complete the form but it must be signed off by the senior medical professional in charge of the persons care

MYTH - THERE IS NO NEED TO RECORD A ASSESSMENT OF CAPACITY

Ticking the box and saying the person is unable to contribute to the decisions being made is not sufficient

Box 6 of the form asks - Who was involved in the decision and where the record of the discussions can be found (i.e. how do you evidence that those assessments and discussions have taken place)

MYTH - RESPECT CAN BE USED JUST FOR DNACPR

- **It has been agreed locally that in *exceptional rare circumstances* just the DNACPR section of the form could be completed**
- **Be aware that whilst DNACPR is a clinical decision; the Tracey ruling makes it very clear that this cannot be done in isolation from the patient or the patients family.**
- **Tracey Ruling - https://www.resus.org.uk/media/statements/tracey-v-cuh-and-secretary-of-state-for-health/**

BACKGROUND TO RESPECT TRACEY RULING (DNAR)

As a result of the court case between Tracey and Cambridge University Hospital NHS Foundation trust:

You must :

- Discuss with patient
- Make a decision that is in the patients best interests
- Discuss with Relatives (if the person lacks capacity)
- If no relatives appoint an IMCA
- Record the discussion- including efforts that have been made to discuss that have been declined
- Consider offering the patient the option to seek a second opinion about their condition

MYTH - FAMILIES CAN DECIDED WHAT TREATMENT THE PERSON DOES OR DOES NOT HAVE

Where the person does ***not have capacity*** to take part in the making of the recommendations, and if there is ***no legal proxy*** to represent the person the **clinical team must consult family or friends about a person's situation and *previously expressed views or wishes***, in order to make recommendations that are in that person's best interests (in England & Wales) or for their benefit.

However, the responsibility for making those recommendations rests with the ***senior responsible clinician***. The family should not be given the impression that they are being asked to make them.
https://www.resus.org.uk/respect/faqs/

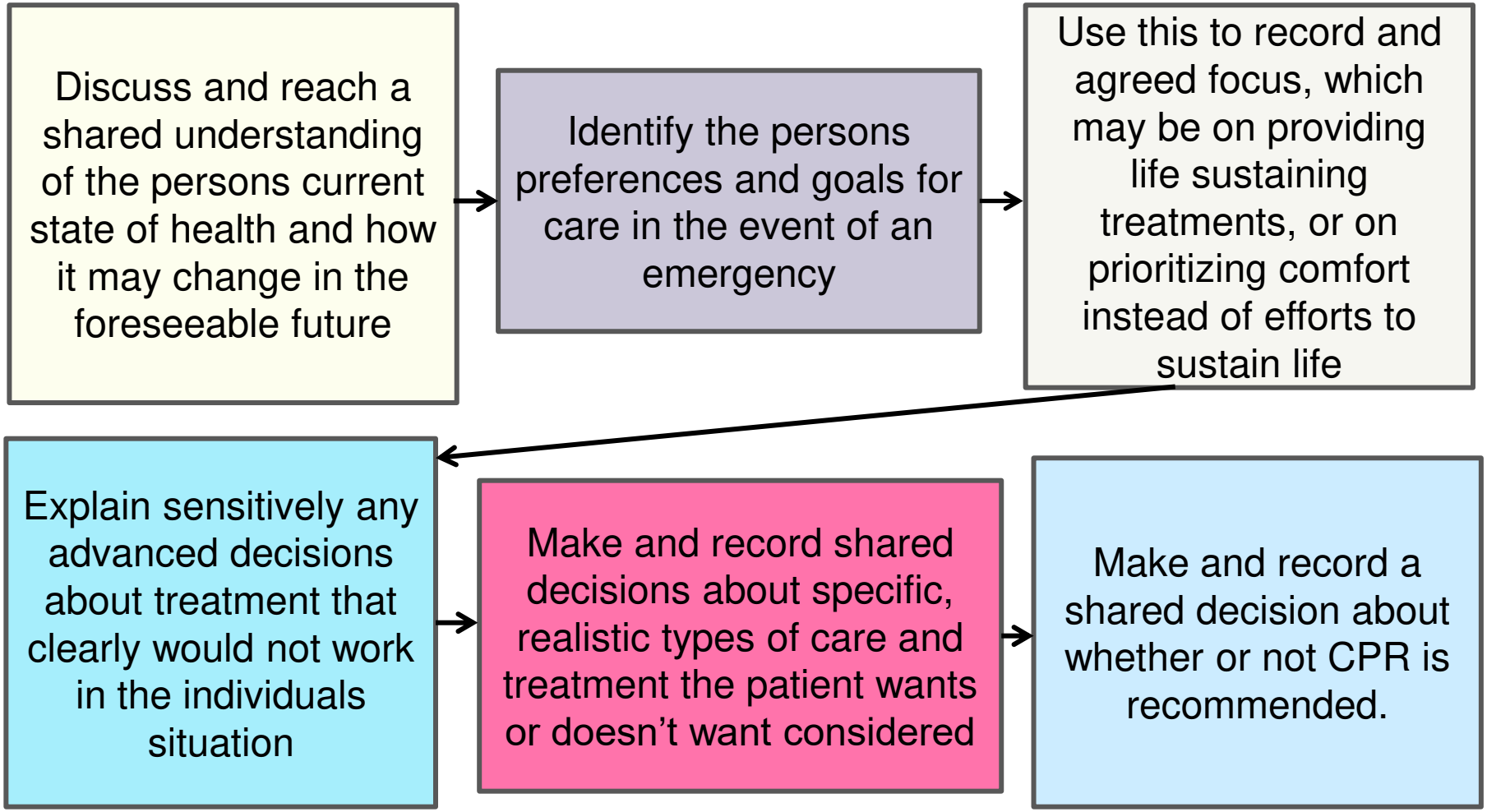
MYTH - THE CONTENT OF FORMS CANNOT BE CHALLENGED

- **They can - if anyone is unhappy with the quality or clarity of the information on the form they should ask:**
  - Either the person who completed it or another medical professional (GP) to review it and if necessary redo the form.
- **If you need to use the NHS to NHS Concern Reporting Form to address the completion of ReSPECT Forms they can be downloaded here**
  - Please provide as much detail as possible to enable to issues to be addressed.

MYTH - RESPECT IS JUST ANOTHER FORM THAT NEEDS FILLING IN

This is about peoples dignity and involves having a conversation! In some situations this conversation may take place over some time, for instance over several weeks.

THE RESPECT CONVERSATION



WHAT IS THE REGULATOR (CQC) LOOKING FOR

Points considered will be:

- A documented, planned process of care that all staff are aware of
- Evidence of respect for the provisions of the Mental Capacity Act 2005
- Evidence of discussion that reflects respect for good direct communication with patients and relatives
- Clear documentation within the health record of any discussion as well as a completed form/record that the individual carries or has access to

https://www.resus.org.uk/respect/faqs/

ADDITIONAL RESOURCES

Websites:

National Resuscitation Council website – includes online training on ReSPECT www.resus.org.uk/respect;

Worcester Hospital website – very useful short training videos https://www.hacw.nhs.uk/respect/

Top tips for DNACPR https://www.macmillan.org.uk/_images/ten-tips-dnacpr_tcm9-300186.pdf

Top tips for advanced care planning https://www.macmillan.org.uk/_images/ten-tips-advance-care-planning_tcm9-300169.pdf

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life

www.compassionindying.org.uk

www.dyingmatters.org

www.severnhospice.org.uk

www.rcgp.org.uk/daffodilstandards

www.goldstandardsframework.org.uk

Findings of the DNACPR Nursing Home Audit in Shropshire

16th January 2020

Paul Cooper, Head of Safeguarding Adults, Shropshire CCG
paulcooper2@nhs.net

Resuscitation Council Guidance to ALL Healthcare Providers

- Effective recording of decisions about CPR in a form that is recognised and accepted by all those involved in the care of the patient
- Effective communication with and explanation of decisions about CPR to the patient, or clear documentation of reasons why that was impossible or inappropriate
- Effective communication with and explanation of decisions about CPR to the patient's family, friends, other carers or other representatives, or clear documentation of reasons why that was impossible or inappropriate
- Effective communication of decisions about CPR among all healthcare workers and organisations involved with the care of the patient.

The Importance of (DN)CPR

- CPR can be a life-sustaining intervention
- A decision not to resuscitate may be in the best interests of the patient
- Futile CPR attempts may affect dignity and cause distress
- CPR may contravene a persons expressed wishes

Three Determining Factors for DNACPR

- When a patient with capacity refuses CPR or a patient without capacity has recorded their refusal of CPR in advance

- When CPR is judged very unlikely to be effective because the patient is dying from an irreversible condition

- When the potential burdens of CPR outweigh the potential benefits

(British Medical Journal, 2017)

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

DNACPRadult.1(2015)

Name _____

Address _____

Date of birth _____

NHS number _____

Date of DNACPR decision:

/ /

DO NOT PHOTOCOPY

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. All other appropriate treatment and care will be provided.

1 Does the patient have capacity to make and communicate decisions about CPR? YES / NO

If "YES" go to box 2

If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition? YES / NO

If "YES" go to box 6

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? YES / NO

If "YES" they must be consulted.

All other decisions must be made in the patient's best interests and comply with current law.

Go to box 2

2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:

3 Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:

4 Summary of communication with patient's relatives or friends:

5 Names of members of multidisciplinary team contributing to this decision:

6 Healthcare professional recording this DNACPR decision:

Name _____ Position _____

Signature _____ Date _____ Time _____

7 Review and endorsement by most senior health professional:

Signature _____ Name _____ Date _____

Review date (if appropriate):

Signature _____ Name _____ Date _____

Signature _____ Name _____ Date _____

Purpose of the DNACPR Form

- DNACPR forms revised in 2014
- Ambition to create universal high standards
- To provide a consistent approach to recording DNACPR
- Demonstrate and promote effective consultation
- Ensure decisions are effectively communicated to all involved in the care of patients who are affected by these decisions

Difficulties with DNACPR Process

- Shortcomings in considering, discussing and implementing
- Futile CPR owing to frailty and comorbidities a major concern for patients
- Some clinicians reluctant to initiate discussion of the topic
- Legal requirement to consult not always understood
- Erroneous conflation of DNACPR decisions with other end of life care practices leading to a reduction in some treatments

Purpose of the Audit

- Evaluate how well the medical staff **with** care home staff assistance complete the DNACPR form as an indicator of the quality of decision-making around whether to resuscitate

- Evaluation of the role care home staff can constructively play in the process

- Highlight recurrent themes where documentation is not completed or completed in full

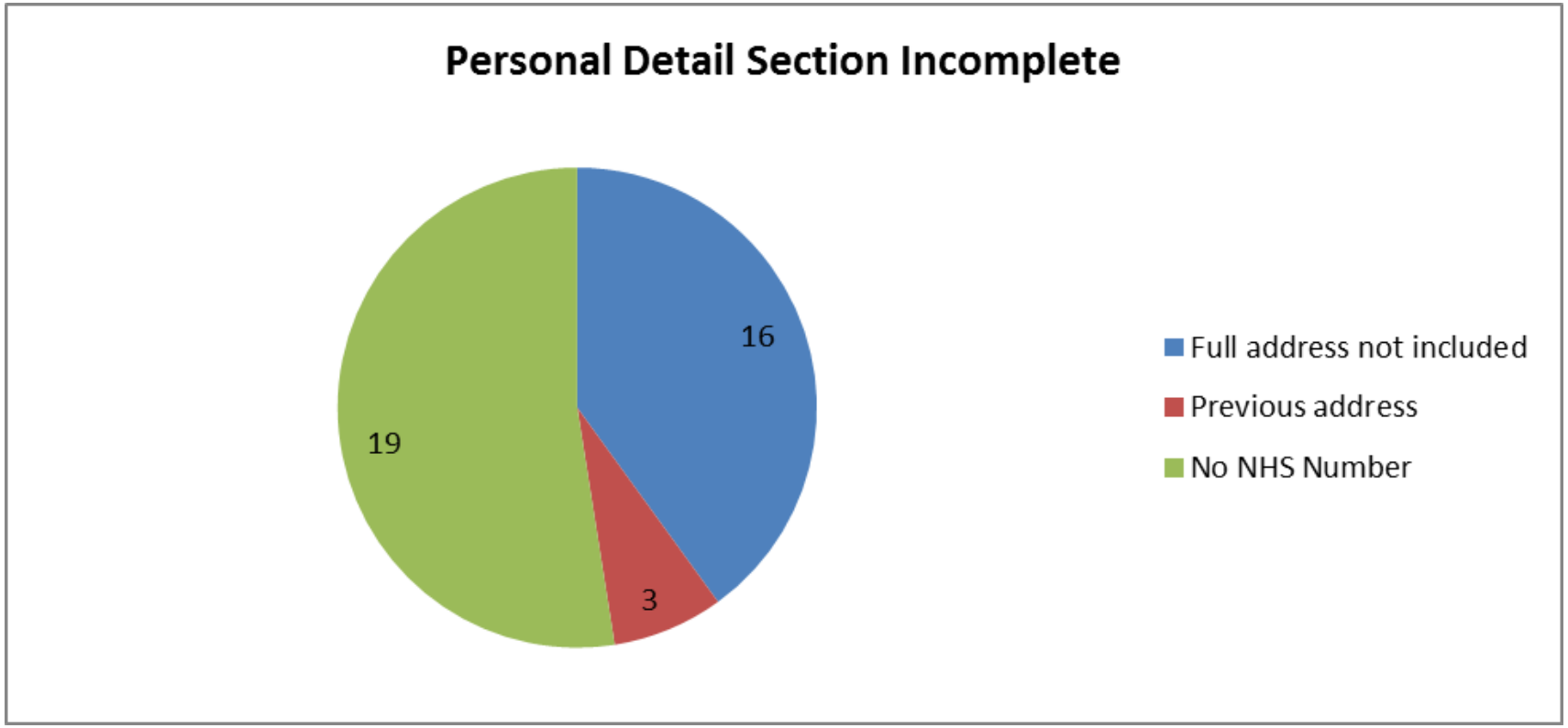
- Provide learning outcomes for staff involved in the decision for DNACPR process

Method & Results

- All 36 NH in Shropshire asked to randomly audit 10 DNACPR forms
- 29 responded (85% - 2 NH were excluded)
- 270 DNACPR forms were audited

Number of Nursing Homes Audited	Total Number of Beds	Number of Residents in the homes	Number of Residents with a DNACPR in Place	% of Residents with a DNACPR in Place
27	1602	1321	951	72%

19 out of 27 Care Homes had Incomplete Personal Details



Question 1
Does the patient have capacity to make and communicate decisions about CPR?

Details regarding Capacity Assessments	
Number of people with capacity determined prior to completion of DNACPR	**Number of people where capacity was not determined prior to completion of DNACPR**
246 (91%)	26 (9%)

Question 2

Summary of the main clinical problems and reason why CPR would be inappropriate, unsuccessful or not in the patient's best interest.

Summary of clinical problems	
Number of NH reporting all DNACPR forms had a summary of main clinical problems	**Number of NH reporting at least one DNACPR form did not have a summary of main clinical problems**
21 (78%)	6 (22%)

Reason why CPR would be inappropriate	
Number of NH reporting reason why CPR would be inappropriate	**Number of NH reporting at least one form did not have the reason why CPR would be inappropriate**
15 (55%)	12 (45%)

Question 3

Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why.

Communication with the Resident	
Number of homes where discussion had taken place with all residents	**Number of homes where discussion was not documented on all forms**
12 (44%)	13 (48%)

Question 4
Summary of communication with patient's relatives or friends.

Communication with Relatives	
Number of homes where communication had taken place with relatives on all forms	**Number of homes where communication with relatives had not been recorded on all forms**
11 (41%)	16 (59%)

Question 5
Names of members of multidisciplinary team contributing to this decision.

Multidisciplinary team involvement	
Number of homes where the MDT were involved in the decision	**Number of homes were the MDT had not been involved in the decision**
13 (48%)	14(52%)

Question 6
Healthcare professional recording this DNACPR decision.

Healthcare professional recording the DNACPR decision completing their details in this section	
Number of nursing homes were the healthcare professional recording the decision had completed this section in all cases	**Number of nursing homes were the healthcare professional recording the decision had not completed this section in all cases**
21	6

Findings

- 72% completion rate ~ evidence of complex care with high levels of acuity
- Process requires high levels of coordination between GP, care staff, person and family
- Evidence of elements of good practice suggests CH vital to best outcomes e.g. consultation/engagement, advanced care planning

Findings Continued

- Documentation critical to ensuring purposeful and lawful DNACPRs ~ key areas
- Capacity
- Consultation
- Clinical reasons

Future Steps

- ReSPECT came into being on the 01.11.2019
  - See July 2019 Safeguarding Adults Forum ReSPECT PowerPoint Presentation here

- See Severn Hospice website for ReSPECT resources here
- Empathise on dialogue/consultation
- Discussions about end of life care
- Care Home's **vita**l to improved end of life care planning

(Resuscitation Council (UK), 2019)

References

- British Medical Journal (2017) *Resuscitation policy should focus on the patient, not the decision.* Published 28 February. London: BMJ. 2017https://www.bmj.com/content/356/bmj.j813

- Resuscitation Council (UK) (2019) https://www.resus.org.uk/respect/

Consultation

Providers views on *Provider Record for Alternative Actions to Raising a Safeguarding Concern*

Emma Harding

Safeguarding Partnership Development Officer (Adults Lead),
Shropshire Safeguarding Partnership Business Unit

Consultation

- Providers fed back on their thoughts and changes they would find helpful.
- Telford and Wrekin Providers can also use this form for record keeping purposes.
- The purpose of the form is within the document but it will be clarified in the revised version.
- When relaunched the *Provider Record for Alternative Actions to Raising a Safeguarding Concern* will feature as a stand alone document that is easier to use rather than having to extract it as an appendix from the *Keeping Adults Safe in Shropshire Network Guidance; the Safeguarding Process in Shropshire* document accessible here

Signposting - CPD Opportunities, Open Access Journal Articles and Events

Karen Littleford

Safeguarding Adults Lead, Shropshire Partners in Care

Shropshire Partners in Care

pixabay

The Psychology of Hate

Thursday, 23 January, 7pm, University Centre Shrewsbury, Guildhall, Frankwell Quay, Shrewsbury, SY3 8HQ (Free Event)

Distinguished Emeritus Professor of Social Psychology Rupert Brown of the University of Sussex will discuss "The Psychology of Hate." Prof Brown is a co-founder of the Sussex Hate Crime Project which investigated the indirect effects of hate crimes over five years and in 20 studies with 4000 participants. The project examined the thoughts, emotions and behaviours of members of the affected community. By understanding the types of emotions that hate incidents typically give rise to, and how each of these emotions predict certain behavioural and attitudinal responses, the project has important implications for the ways in which policy makers and the community respond to hate crime.

Further details can be found here:
https://www.ucshrewsbury.ac.uk/events/psychology-hate?list=987

Shropshire Partners in Care

Sex, Mental Capacity- Rights and Risks

Shropshire Council presents a one day conference

Theatre Severn
Shrewsbury
March 2nd 2020
9.15 to 4.15
Cost: £55 including lunch
Booking line : 01743 281281

Speakers include

- **Neil Allen**
- **Professor Claire de Than**
- **Dr Brad English**
- **Supported Loving**
- **Alzheimer's Society**

Image Grace Currie

On Line Learning - Safeguarding Adults: Level 3 Training

Learn how to ensure the successful safeguarding of adults with this training course from Health Education England.

Level: 3

Starts: 27 Jan 2020

Duration: 3 weeks

Weekly study: 1 hour

Cost: FREE

https://www.futurelearn.com/courses/level-3-safeguarding-adults?fbclid=IwAR3gStL0s4iIslIvHFCJE96ucBBuFf78ZOb0lZGYmaqmbpk5eKzh_2wNRBg

Shropshire Partners in Care

Open Access Journal Articles

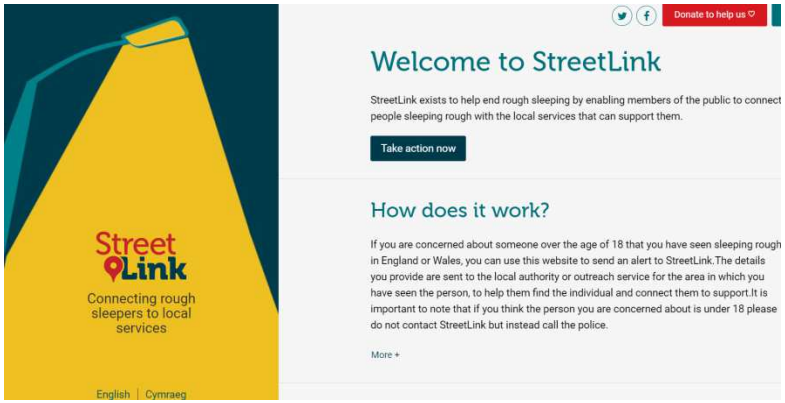
- Cornes, M. Ornelas, B., Bennett, B., Meakin, A., Mason, K. Fuller, J. and Manthorpe, J. (2019) *Increasing access to Care Act 2014 assessments and personal budgets among people with experiences of homelessness and multiple exclusion: a theoretically informed case study.* Journal of HOUSING, CARE AND SUPPORT, VOL. 21 NO. 1 2018, pp. 1-12. https://www.emerald.com/insight/content/doi/10.1108/HCS-09-2017-0022/full/pdf?title=increasing-access-to-care-act-2014-assessments-and-personal-budgets-among-people-with-experiences-of-homelessness-and-multiple-exclusion-a-theoretically-informed-case-study

- De Oliveira, B. (2018*) On the news today: challenging homelessness through participatory action research*. Journal of HOUSING, CARE AND SUPPORT, VOL. 21 NO. 1 2018, pp. 13-25. https://www.emerald.com/insight/content/doi/10.1108/HCS-01-2018-0002/full/pdf?title=on-the-news-today-challenging-homelessness-through-participatory-action-research

- Bramley, S. , Norrie. C. and Manthorpe, J. (2018) *Gambling-related harms and homelessness: findings from a scoping review*. Journal of HOUSING, CARE AND SUPPORT, VOL. 21 NO. 1 2018, pp. 26-39. https://www.emerald.com/insight/content/doi/10.1108/HCS-02-2018-0003/full/pdf?title=gambling-related-harms-and-homelessness-findings-from-a-scoping-review

Reporting Rough Sleepers to The Local Authority

If you are a member of the public or a local service and wish to make the Local Authority aware of a rough sleeper, please check out Street Link and Appendix A opposite



Appendix A – How to Report a Rough Sleeper:

If you are a member of the public or a local service and wish to make the Local Authority and services aware of a rough sleeper, please find the process below:

Rough Sleeper seen by member of public/Local business

↓

Member of public uses Streetlink to make referral

→ **How does Streetlink work?**

StreetLink exists to help end rough sleeping by enabling members of the public to connect people sleeping rough with the local services that can support them.

If you are concerned about someone sleeping rough in England or Wales, you can use this website (www.streetlink.org.uk) to send an alert to StreetLink. The details you provide are sent to the Local Authority or outreach service for the area in which you have seen the person, to help them find the individual and connect them to support

↓

Streetlink referral is received by:
Local Authority (Shropshire Councils Housing Options Team - 03456 789 005 / housingoptions@shropshire.gov.uk)
and The Shrewsbury Ark – 01743 363 305)

↓

Outreach Service acts on referral to identify and support the person to link in with services, working to end rough sleeping and find accommodation. The Outreach will feed into the Rough Sleeper Task Force meetings to ensure a multi-agency response to meet the needs of rough sleepers

Health and Wellbeing Board Shropshire (2020) Provision for Rough Sleepers in Shropshire.

New Film from Shropshire Community Health NHS Trust

Watch ‘What Does a Dignity Champion Do?’ Documentary on YouTube here - [Dignity Video]