Solihull Safeguarding Adults Board
Protecting Adults Together

Newsletter

December 2020 Issue 33

WELCOME to the SSAB Newsletter

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Local News

*** New Guidance and Resources ***

"Something doesn't feel right" - Guidance on Professional Curiosity and Persistence

We know that it is better to help individuals and families requiring our support as early as possible, before issues get worse. That means that all agencies and practitioners need to work together – the first step is to be professionally curious.

Professional curiosity is a recurring theme from Safeguarding Adults Reviews completed both locally in Solihull (John, Rachel, Graham, Peter and Stephen SARs) as well as regionally and nationally.

Click here for the Guidance on Professional Curiosity and Persistence

Adult Grooming – One Minute Guide

Grooming is a form of abuse that involves manipulating someone until they're isolated, dependent, and more vulnerable to exploitation.

When most people think about grooming, they think about children. But adults are vulnerable to grooming too.

Grooming can lead to many different types of harm, including modern slavery, physical, sexual and financial abuse. Learn to spot the signs of adult grooming.

Click here for the One Minute Guide on Adult Grooming

Adult Exploitation Screening Tool

This screening tool has been designed to support staff to determine whether an adult is potentially being exploited or is at risk of exploitation. It should be completed when you have concerns that an adult is at risk of exploitation, or you have spotted some signs of exploitation. Where possible, the screening tool should be completed in partnership with the adult.

This screening tool provides some examples of indicators you may see if someone is being exploited. You may not see all of them or any of them.

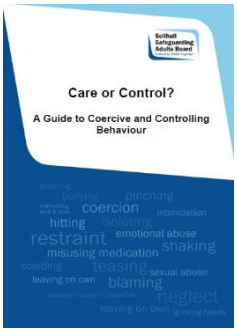
It's important to engage the adult in a dialogue around your concerns and where appropriate their family/carers.

Access the Adult Exploitation Screening Tool here

Care or Control? – A Guide to Coercive and Controlling Behaviour

SSAB have worked with Caroline Murray to develop a brief guide on 'Care v Control', which explores coercive control, how control can be mistaken for care and how professionals can support people to identify coercive & controlling relationships.

Click here to read the Care or Control? Guide



SSAB Training

The **Prevent awareness E-Learning** has recently been refreshed. This includes updates to reflect the recommendations from the Parsons Green review, updated information following the change in threat and attacks of 2017, and new case studies. Click here to access the training

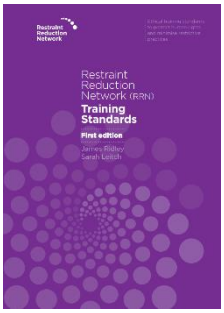
This training is for anyone who has been through the Prevent awareness eLearning or a Workshop to Raise Awareness of Prevent (WRAP), and so already has an understanding of Prevent and of their role in safeguarding vulnerable people.

The training follows on from the Prevent awareness training which introduces users to the NOTICE-CHECK-SHARE procedure for evaluating and sharing concerns relating to radicalisation.
The package shares best practice on how to articulate concerns about an individual and ensure that they are robust and considered. It is aimed at anyone who may be in a position to notice signs of vulnerability to radicalisation and aims to give them confidence in referring on for help if appropriate. It is also designed for those (for example line managers) who may receive these referrals and have to consider how to respond, whether that be establishing more context, or reaching out to partner agencies for support.

This training package is for anyone who may be asked to contribute to, sit on, or even run a Channel Panel. It is aimed at all levels, from a professional asked to input and attend for the first time, to a member of staff new to their role and organising a panel meeting. It covers both an introduction to what Channel is, how it operates in the user's region, and how to organise a Channel Panel for the first time. In response to feedback, it also covers information sharing, including how, when and with whom to share information of a Channel case.

Restraint Reduction Network (RRN) Training Standards first edition published in January 2020 for implementation from April 2020.

The Restraint Reduction Network has worked with Health Education England to produce a set of ethical training standards that protect human rights and support the minimisation of restrictive practices. These Training Standards apply to all training that has a restrictive intervention component and will provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings. They apply across child and adult services, and to all populations, including people using services with mental health conditions, those living with dementia, people with a learning disability and autistic people.



From April 2021, CQC expect to see all services across health and social care use training in restrictive practices that is certified as complying with the Restraint Reduction Network Standards.

Commissioners are asked to share this document with services they commission who use restraint and consider how it can be referenced in future contacts.

Click here to access the training standards

Structured Partnership PowerPoint with Voice Clips

This PowerPoint with Voice clips has been developed to help organisations and individuals understand when this framework should be used to support them when working together to support individuals who have multiple needs living with high levels of risk and where services are struggling to engage with them.

West Midlands Police FIB PowerPoint

This PowerPoint has been developed with Solihull LSCP to explain when the West Midlands Police Force Intelligence Bureau (FIB) form should be used.

Making Safeguarding Personal

Understanding what constitutes a safeguarding concern and how to support effective outcomes - Suggested multi-agency framework to support practice, recording and reporting produced/published by LGA/ADASS in June 2020. Available at this link

This framework for understanding safeguarding concerns connects with one which supports making decisions on the duty to carry out safeguarding adult enquiries (LGA/ADASS, August 2019)

The framework aims to support all organisations in making appropriate referrals of concerns to adult social care consistent interpretation of Section 42 of the Care Act (2014) and the key terms used within it and consistent response by adult social care services to safeguarding concerns referred to them a shared responsibility across all organisations for addressing risks to wellbeing and safety, either as a safeguarding concern, or by jointly agreeing alternative pathways for support a shared understanding of what to report as a safeguarding concern in the Safeguarding Adults Collection (SAC).

The framework suggests that where it appears that criteria a and b of S42(1), Care Act (2014) are met and the referring worker/organisation believes that the circumstances amount to a safeguarding concern a referral is made to the local authority. The local authority will take all such referrals seriously and consider S42 (1a and b) alongside the third criteria under S42(1c) of the Care Act (2014) with the referrer as it gathers further information. Local authorities it is suggested, should not be rigid in deciding to reject all but those referrals that meet all three of the criteria in S42(1).

Strengthening the role of advocacy in Making Safeguarding Personal produced/published by LGA/ADASS in June 2020.

This briefing has been generated to support strengthening the role that advocacy (of all types) can play in safeguarding adults and specifically in making safeguarding personal.

The core messages are in five key areas relating to:

- the need for advocacy to be better understood; for advocates to be involved in appropriate and timely ways that take account of people's legal rights to advocacy and the statutory duties to refer.
- a need for increased clarity, consistency, and transparency across agencies in relation to adult safeguarding roles and responsibilities and definition of what constitutes a safeguarding concern.
- making the most of the significant contribution that advocacy can make in safeguarding people in health and social care provider settings.
- a partnership approach to governance that supports the potential role of advocacy in effective safeguarding and in making safeguarding personal.
- the part commissioners can play in supporting the advocacy contribution to effective safeguarding.

Click here to read the briefing in full

National Policies, Procedures and Guidance

Transgender Day of Remembrance was 20th November 2020

What Is It?

Transgender Day of Remembrance takes place on 20th November every year to honour the transgender and gender non-conforming people whose lives have been lost to acts of transphobic violence.

It was established in the US in 1999 by the trans advocate Gwendolyn Ann Smith as a vigil to honour Rita Hester, a trans woman stabbed to death in 1998 at the age of 34. Since 2008, an annual report has been published detailing the trans people who have been killed.

Why Do We Have It?

Trans gender and non-conforming people continue to experience unprecedented levels of violence, particularly women of colour who are disproportionately represented in annual homicide rates.

The 2018 Trans Report by the LGBT campaigning group Stonewall revealed that 28% of trans people had faced domestic violence from a partner in the past year, 12% had been physically attacked by colleagues or customers in the past year and 41% had experienced a hate crime or incident in the last 12 months.

According to Transrespect vs Transphobia Worldwide (TvT) a project monitoring the number of trans and gender diverse people killed globally, 331 people were killed between 1 October 2018 and 30 September 2019 because of their identity. This figure may be higher due to underreporting.

What Happens on Transgender Day of Remembrance?

Around the world, transgender people and their allies hold vigils to remember the names of those who have been killed.

Want More Information?

This video filmed by BBC News London covers Tyler's story. He struggled with his gender from an early age and came out as trans when he was 15. Click here to watch Tyler's Story

Galop support people from all LGBT+ communities who are experiencing hate crime, domestic abuse or sexual violence and has a dedicated Trans Advocacy & Community Development Service which can offer confidential advice and support by telephone, email or face-to-face.

Mermaids supports gender-diverse children and young people until their 20th birthday, as well as their families and professionals involved in their care.

Stonewall work with LGBT individuals offering them support and advice, they also work with institutions to create inclusive cultures and work to ensure LGBT equality via campaigns and lobbying government.

National Policies, Procedures and Guidance

Honour Based Abuse and Forced Marriage

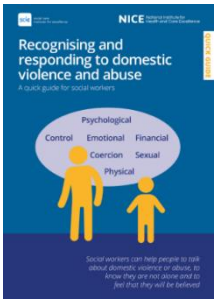
Karma Nirvana is a British human rights charity supporting victims of honour-based abuse and forced marriage. Honour crimes are not determined by age, faith, gender or sexuality, they support and work with all victims, operate a National helpline to support victims in immediate danger, and can provide training to professionals and in schools.

To raise awareness Karma Nirvana have posted these myths on their social media platforms

Instagram - @knfmhbv Facebook - KarmaNirvanaUK Twitter - @KNFMHBV

National Policies, Procedures and Guidance

Recognising and Responding to Domestic Violence and Abuse: a quick guide for social workers published by NICE/SCIE in January 2020



This quick guide offers social workers a summary of NICE guidance on the how to identify and help stop domestic violence and abuse. It includes recognising the indicators of abuse, talking to people about it and offering support and referral for protection, if needed.

It covers the key points on domestic violence and abuse and guides social workers so they can provide effective support for people who have experienced domestic abuse, as well as their children. It includes:

- Asking about domestic violence and abuse
- Responding to disclosures
- Children and young people
- Training and supervision

Dignity in Care published by SCIE in June 2020

This practical guide helps to define dignity in care, as well as how best to implement it. It is aimed at care providers, managers and staff who work with adults – especially older adults.

It defines the meaning of real everyday dignity to the lives of people receiving social care, their carers, families and friends, as well as the managers and staff who provide it. In effect, this means all of us. It also shows the links between dignity and key policy issues and relates to Care Quality Commission (CQC) regulations at each stage.

scie social care institute for excellence

Learning Disability Mortality Review (LeDeR) Programme: Action from Learning Report 2019/2020 published by The University of Bristol, NHS England and NHS Improvement on 16th July 2020.

This is the fourth report from the Learning Disability Mortality Review (LeDeR) programme. LeDeR was commissioned in 2015 with the aim of contributing to the improvement of quality of care and health outcomes for people with a learning disability.

This report includes actions taken at a national level and a number of examples of improvements in local areas from across the country. The issues around healthcare of people who need care and support, their families and carers has been further heightened in recent months by the COVID-19 pandemic. NHS England and NHS Improvement are working closely with partners to understand the impact of the pandemic on people with LD and how changes to services can be made to help ensure that health inequalities are reduced.

- Respiratory conditions remain the most significant causes of premature mortality for people with a learning disability where deaths have been reviewed as part of the LeDeR programme.
- Sepsis was identified as the second leading cause of death for people with a learning disability whose deaths were reviewed as part of the programme.
- Of the deaths reviewed as part of the LeDeR programme in 2018, 12 people died from constipation.
- The rate of deaths from cancer for people with a learning disability (13% for men and 15% for women with a learning disability in 2019) are half that for the general population but the 2018 report showed that, for the deaths reviewed as part of the programme, gaps in services and support for accessing cancer screening may have contributed to the death of 7% of people with a learning disability.
- This report identified that a lack of understanding of epilepsy and how to support someone who also has a learning disability may have contributed to 5% of deaths.
- Whilst there are situations where do not attempt cardiopulmonary resuscitation (DNACPR) directions may be appropriate, the 2018 report raised concerns about instances in which a learning disability was cited as the reason for making a DNACPR order.

National Policies, Procedures and Guidance

It Still Happens Here: Fighting UK Slavery in the 2020s published by the Justice and Care and The Centre for Social Justice in July 2020

The report has been produced in collaboration by Justice and Care and the Centre for Social Justice and identifies the issue of modern slavery is likely to intensify in the wake of the COVID-19 pandemic and is already costing the taxpayer many billions of pounds.

Based on police evidence, they can accurately estimate there are more than 100,000 victims of modern slavery in the UK – 10 times the number previously estimated by the Government.

To deal with the problem, the report calls for more Government action on the issue, better care of victims, which they believe will help bring those responsible to justice, and for more action to hold companies to account for slavery in their supply chains. In total, sixteen key recommendations are made in the report.

Safeguarding people in 'closed' environments produced by ADASS in June 2020

Whorlton Hall & Winterbourne Hall highlighted the risks of 'closed' environments. Both institutions had passed external inspections yet shocked all who watched the expose filmed within their walls of staff treatment of learning-disabled residents.

This tool is aimed at both senior managers and front-line practitioners. It is based on a review of evidence from serious case reviews and other research about what to look out for when reviewing placements or 'closed' environments where people may be experiencing abuse.

Multiple Exclusion Homelessness - A Safeguarding Toolkit for Practitioners DRAFT from Voices Stoke on Trent in June 2020

Keele University, Kings College London and CASCAIDr the VOICES team produced this Safeguarding Toolkit for adults experiencing homelessness and exclusion – It can be used as an aid to fact finding by any practitioner working across homelessness or with adults experiencing other deep forms of exclusion where they have care and support needs and are at risk. The toolkit is not the final version yet, however we're releasing it as a working prototype for testing.

This toolkit can be downloaded via the above link and Voices would like feedback via email to: enquiries@voicesofstoke.org.uk

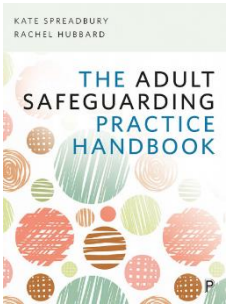
Delivering health and care for people who sleep rough: Going above and beyond published by The Kings Fund in February 2020. A full report (112 pages) and a Summary Report (8 pages) are available.

The number of people sleeping rough in England has risen substantially over the past decade. People who are homeless have some of the worst health outcomes in England and are more likely to experience and die from preventable and treatable medical conditions and to have multiple and complex health needs. Many people who sleep rough experience a combination of physical and mental ill health and drug or alcohol dependency.

Don't Pass The Parcel (County Lines awareness video)

Please look at the fantastic piece of arts and music created by Theo Thompson around raising awareness of County Lines. Theo is currently working closely with WM Police developing two new pieces of work around CE awareness that will be launched by the end of this year.

The Adult Safeguarding Practice Handbook is an essential, practical guide to best practice in adult safeguarding which supports practitioners to develop skills and knowledge.



Available from Policy Press here

Board and Sub-Committee News

Safeguarding Adults Board Meeting

The Board's **priorities for 2020-21** are:

- **Financial Abuse**
- **Exploitation & Transitions**

At the Board meeting on the 3rd September 2020 we received an update on how the recommendations from the Rachel SAR are progressing and a report from SMBC actions taken during the early impact of Covid-19. West Midlands Police gave an update on the action plan to address the recommendations from report - "The poor relation: The police and Crown Prosecution Service's response to crimes against older people". BSOL CCG shared with us the NHSE Host Commissioner Guidance Quality oversight of CCG-commissioned inpatient care for people with a learning disability, autism or both guidance and explained how it was being implemented in Solihull. We received a presentation on the LeDeR Programme: Action from Learning Report 2019/20 which reports nationally Respiratory Conditions remain the most significant causes of premature mortality for people with a LD. Other conditions or areas of concern identified that contribute to the premature mortality for people with a LD include Sepsis, Constipation, Cancer, Epilepsy and Do Not Attempt Cardiopulmonary Resuscitation.

On 18th November 2020 we held a joint event with Solihull Local Safeguarding Childrens Partnership and the Community Safety Partnership. The Event was an opportunity to focus on the progress against each of the Board's priorities and reflect on initial responses to the Covid-19 Pandemic. These insights were used to determine whether there were any areas of business we needed to give more focus to. Insights also informed initial planning on how priorities for the three boards for 21/22 would be set, with improved collaboration and co-ordination across the three boards. **Next Board meeting is 3rd December 2020.**

Engagement & Prevention Sub-Committee

At our meeting on 15th October we received an update from SMBC Public Health on the work they are doing in relation to Social Isolation and Loneliness and Suicide Prevention. Trading Standards attended to offer advice on how to deal with aggressive doorstep sellers and Victim Support attended to give us an update on their Hate Crime Project. **Next Engagement & Prevention Sub-Committee meeting Thursday 28th January 2021.**

Performance & Audit Sub-Committee

At our meeting on 20th October a significant increase in requests for support from services around Domestic Abuse was noted. New data re. NRM referrals was also included in the dashboard following a request from the P&A chair for data from partners in relation to exploitation. The group received a presentation from BSMHFT on adherence to Safeguarding Policy which was felt to be useful and supported other members to think about audits in their own organisations. **Next Performance & Audit Sub-Committee meeting is Tuesday 26th January 2021.**

Policies & Procedures Sub-Committee

At our meeting on 6th October 2020 we discussed the LGA - Understanding what constitutes a safeguarding concern & how to support effective outcomes – suggested multi-agency framework to support practice, recording and reporting, OMG on Information Sharing and two PowerPoint presentations that have been developed to support the implementation of the Structured Partnership Approach and explain the West Midlands Police FIB Form. **Next Policies & Procedures Sub-Committee meeting is Tuesday 19th January 2021.**

Learning & Improvement Sub-Committee

At our meeting on 8th October, the group were asked to share with their organisations "Learning from Paul SAR" presentation and practice briefing, a presentation about the Structured Partnership guidance and Professional Curiosity Guidance and feedback any comments. "Tyrone" SAR was discussed and the group were encouraged to share the 7 minute briefing produced by Lewisham Council within their organisations. The group agreed to share learning and best practice in terms of virtual training with one another as this continues to be the main method of delivering training currently. **Next Learning & Improvement Sub-Committee meeting is Thursday 14th January 2021.**

West Midlands Adult Safeguarding Policy & Procedures

Adult Safeguarding: Multi-Agency Policy and Procedures for the protection of adults with care and support needs in the West Midlands

The Procedures can be viewed HERE

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SSAB TRAINING INFORMATION - ssab@solihull.gov.uk

To report adult abuse

Tel: 0121 704 8007 (office Hours)
0121 605 6060 (out of hours)
101 – Police

On-Line Referral Form
Public - SSAB WEBSITE: www.ssab.org.uk
SSAB TRAINING INFORMATION/BOOKINGS - ssab@solihull.gov.uk

Professionals - Click here to report adult abuse