

## WELCOME to the SSAB Newsletter

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## LOCAL NEWS

### SSAB and LSCP Launch new joint website

Solihull Safeguarding Adults Board (SSAB) and Solihull Local Safeguarding Children Partnership (LSCP) are pleased to announce that our new joint website is now live.

The new domain name for the joint website is: [www.safeguardingsolihull.org.uk](http://www.safeguardingsolihull.org.uk)

With a fresh look and feel, we hope that the new site offers a smoother, more intuitive user experience. The new site replaces the two existing SSAB and LSCP websites and brings together information about safeguarding adults and children into one central space. Work to develop the site will continue in the coming weeks.

Access to contact details for reporting abuse of adults/children remains unchanged and inter-agency adult/child protection procedures are available. If you require any information which is not immediately accessible please contact [ssab@solihull.gov.uk](mailto:ssab@solihull.gov.uk) or [lscp@solihull.gov.uk](mailto:lscp@solihull.gov.uk)

We would encourage you to take some time exploring the new site and would welcome any feedback both positive and constructive that you wish to share.

**NEW NEW NEW NEW NEW NEW NEW**

#### Safeguarding Practice with Autistic People – A Brief Guide

This guide is intended to provide professionals with an introduction to autism, and to support them in exploring how they can ensure autistic people are involved in safeguarding enquiries about them.



[Find it on our website here.](#)

#### Commissioning, Procurement and Safeguarding Framework

This guidance sets out how the commissioning, procurement and contract management processes can be utilised to strengthen the understanding and awareness of:

- Child safeguarding
- Adult safeguarding
- Domestic abuse
- Modern Slavery
- Exploitation.



It will also help commissioned services meet their responsibilities and provide reassurance that they are providing services in our Borough that are competent in recognising and responding to harm, abuse and exploitation.

[Find it on our website here.](#)

#### Deciding if you need to raise a safeguarding concern

This short guide is based on the [ADASS Framework](#) and is intended to offer support in making decisions about safeguarding concerns. It offers a framework to support practice, recording and reporting, in order to impact positively on outcomes for people and on the level of accountability for those outcomes.



[Find it on our website here.](#)

## SAFEGUARDING ADULT REVIEWS

**Joanna, Jon and Ben published by Norfolk Safeguarding Adult Board  
September 2021.**

Norfolk Safeguarding Adults Board (NSAB) has published an important Safeguarding Adults Review (SAR) into the deaths of three young adults: **Joanna**, **“Jon”** and **Ben** (all in their 30s). They had learning disabilities and had been patients at Cawston Park Hospital. They died within a 27-month period (April 2018 to July 2020).



Joanna, Jon and Ben were admitted to the hospital under sections of the Mental Health Act (1983). Joanna and Jon originated from London boroughs. Ben was from Norfolk. Their behaviour was known to challenge services and sometimes their families. Joanna and Jon had experienced several out-of-family-home placements. Ben had lived with his mother for most of his life. Their placement at the hospital resulted from personal and family crises.

The review makes 13 recommendations for critical system / strategic change. In addition it contains the following key learning for practitioners:

- **the critical role for professional curiosity and challenge**
- **the trauma of transition**
- **meaningful support for individuals with behaviours that challenge others**
- **critical responsibility for staff to advocate reporting and openness**
- **where the victim of abuse doesn't want to 'complain'**
- **the importance of meaningful occupations**
- **making sure attention is given to physical health needs**
- **mental capacity**

[Read the full report, executive summary and other supporting documents on Norfolk's website here](#)

## TRAINING

### Webinars

#### How can we support survivors by being trauma responsive?

As part of a series of webinars produced across the West Midlands region by Safeguarding Adults Boards, SSAB joined up with RSVP to learn more about supporting survivors by being trauma responsive.



This included:

- Exploring the prevalence of sexual violence, harassment and abuse
- Myths surrounding sexual violence and abuse
- Victim blaming attitudes and language
- Examining the physical and emotional impact of trauma
- Reflecting on the basic principles of 'trauma-informed' practice
- Understanding ways of supporting survivors in a trauma responsive way

[Watch the webinar here](#)

#### What do you know about the new Domestic Abuse Act 2021?

The session will be delivered by Caroline Murray Solihull's Domestic abuse coordinator with Bhavna Somia from Birmingham & Solihull Women's Aid and Lisa Thompson from RSVP.

The session will summarise the Domestic Abuse Act 2021 and consider the implications on different parts of the system and practitioners.

**This online webinar will take place on Monday 29<sup>th</sup> November 2:00pm - 4:00pm, via MS Teams.**

**To book a place please visit the [LSCP Training page](#)**

If you have any queries please contact [lscptrain@solihull.gov.uk](mailto:lscptrain@solihull.gov.uk)



#### Free, online training about women and gambling related harms

Run by GamCare, the training aims to:

- Increase awareness of gambling-related harm, including hidden harms;
- Boost confidence in having discussions about gambling with those you work with;
- Raise awareness of support and treatment available to those who are experiencing gambling-related harm;
- Increase confidence to screen, signpost and refer individuals experiencing gambling harms.



[To book a session please click here](#)

# NATIONAL SAFEGUARDING WEEK 15<sup>TH</sup> – 19<sup>TH</sup> NOVEMBER

Safeguarding Adults Week is organised by Ann Craft Trust and is a time for organisations to come together to raise awareness of important safeguarding issues. The aim is to highlight safeguarding key issues, facilitate conversations and to raise awareness of safeguarding best practice.

We hope the week will enable more organisations and individuals to feel confident in recognising signs of abuse and neglect and recording and reporting safeguarding concerns.

The theme for Safeguarding Adults Week 2021 is 'Creating Safer Cultures'. Promoting safer cultures is all about how organisations and individuals can take steps to minimise harm occurring in the first instance, whilst simultaneously ensuring correct policies and procedures are in place so that safeguarding concerns that are raised, are recognised and responded to effectively.

To find out more from Ann Craft Trust [click here](#)



**Monday 15<sup>th</sup>  
November**

**Psychological Abuse &  
Safeguarding**

**2:00pm – 3:30pm**

[Click here to book](#)

This training will consider the impact of emotional abuse on an adult's mental and physical health, barriers to seeking help and research to support practitioners consider approaches to improving mental wellbeing.

**Tuesday 16<sup>th</sup>  
November**

**The Power of Language**

**2:00pm- 4:30pm**

[Click here to book](#)

This webinar will consider the use of "strong language". An in depth consideration of the use of language in anti-oppressive practice and how it can be used to empower or disempower those we work with.

**Thursday 18<sup>th</sup>  
November**

**'Bridging the Gap' -  
Transitional Safeguarding**

**2:00pm – 4:00pm**

[Click here to book](#)

This will be led by Dez Holmes, director of Research in Practice who has been involved in the publication of 'Bridging the Gap: Transitional Safeguarding and the role of social work with adults'.

The session will cover: What is transitional safeguarding? What does this mean in practice? Embedding this approach into practice. The importance of language. It is aimed at managers, those in strategic positions & front line practitioners working with young people

**Friday 19<sup>th</sup>  
November**

**Identifying and Responding to  
Closed Cultures**

**2:00pm – 3:30pm**

[Click here to book](#)

This fascinating webinar will be led by CQC and will focus on organisational abuse in care homes and institutions, and the learning from the experiences at Whorlton Hall, Winterbourne View, Mid Staffordshire Hospital and other institutions that failed to protect those in their care.

## MAKING SAFEGUARDING PERSONAL

### How to use legal powers to safeguard highly vulnerable dependent drinkers

This guide aims to help practitioners to improve the well-being and safety of adults who are highly vulnerable, chronic, dependent drinkers. It considers the governance of the use of these legal powers and recommends using a robust management framework such as multi-agency management. It provides advice on how such frameworks can be implemented.

This guide also explains how certain 'myths' can hamper practitioners' work with highly vulnerable, chronic, dependent drinkers. In particular, it encourages practitioners to challenge the assumption that these people 'choose' or 'like' an abusive or self-neglecting lifestyle; and outlines alternative ways of thinking about the reasons for the challenges they face.



[Click here to read the document](#)

### New Shared Learning Resource

Solihull Safeguarding Adults Board, Local Safeguarding Children Partnership and Community Safety Partnership have developed a new learning resource which brings together the key themes emerging from Safeguarding Adult Reviews, Child Safeguarding Practice Reviews and Domestic Homicide Reviews.

A series of *quick guides* have been produced on the following cross cutting themes:

- Coercive Control
- Information Sharing
- Voice of the Person
- Complex Needs
- Professional Curiosity
- Who is Around the Person
- Cross Boundary Issues
- Risk Assessment

[Find the joint learning resource here](#)



## National Policies, Procedures and Guidance

[Social Care Responses to Self-Neglect Among Older People](#) published by NIHR Policy Research Unit in Health and Social Care Workforce July 2021



This is a review of the English-language research literature (published 2015-20), which focuses on Adult Social Care responses to self-neglect among older people. It also examines the law and policy context in England provided by the Care Act 2014 and the Mental Capacity Act 2005.

The review found little evidence (of any kind) from England specifically focusing on older people in the field of self-neglect, two studies within the time-frame are referred to. The importance of relationship building and effective multi-agency working were the primary themes identified by the review of the literature.

### [New Mental Capacity Act Guidance 2020](#)

The National Centre for Post-Qualifying Social Work and Professional Practice has produced a series of brief guides to help all health and social care professionals.

The guides include:

- Guidance on the use of the Mental Capacity Act for decisions regarding clinical treatment and care: An introduction
- The Liberty Protection Safeguards
- The Mental Capacity Act requirements when an individual lacks the mental capacity to consent to treatment and care
- The Mental Capacity Act requirements for clinical decisions regarding treatment and care
- Advance Care Planning.



[Liberty Protection Safeguards factsheets](#) published by the Government were updated on 11 June 2021



The factsheets available include:

- Liberty Protection Safeguards: what they are
- Liberty Protection Safeguards: overview of the process
- Liberty Protection Safeguards: settings and Responsible Bodies
- Liberty Protection Safeguards: criteria for authorisation
- Liberty Protection Safeguards: the appropriate person and independent mental capacity advocates
- Liberty Protection Safeguards: the approved mental capacity professional role
- Liberty Protection Safeguards: deprivation of liberty and authorisation of steps necessary for life-sustaining treatment or vital acts (section 4b)
- Liberty Protection Safeguards: authorisations, renewals and reviews
- Liberty Protection Safeguards: the right to challenge an authorisation in court

[LeDeR 2020 Annual Report](#) published by the University of Bristol on 10th June 2021 (Caution 156 pages)

[Easy to Read version](#)



**Learning Disabilities Mortality Review  
(LeDeR) Programme**

This report focuses on findings from completed reviews of the deaths of people with learning disabilities that occurred in the calendar years 2018, 2019 and 2020, identifying any trends that have occurred over time.

A total of 9,110 deaths of people with learning disabilities (622 deaths of children; 8,488 deaths of adults) occurring between 1st Jan 2018 and 31st December 2020 were notified to the LeDeR programme.

- A large majority of adults with learning disabilities were of white British ethnicity, fewer than 5% of adults whose deaths were reported to LeDeR were of Asian/Asian British ethnicity.
- Almost half (46%) of adults had 7 to 10 long-term health conditions when they died.
- Almost a quarter of adults (24%) were usually prescribed an antipsychotic medication.
- People aged 18-24 years, or those with mild learning disabilities were less likely to have received an annual health check in the year prior to their death.
- In 2020, the condition-specific leading cause of death in people with learning disabilities from age 35 and over for males, and age 20 and over in females was COVID-19. The peak month for deaths from COVID-19 was April 2020, when 59% of all deaths were from COVID-19.
- The majority of children and adults with learning disabilities (60%) died in hospital.
- Of those who died between 2018 and 2020 - 26 had their liberty restricted by the criminal justice system at the time of their death.
- The proportion of adults with a DNACPR decision at the time of their death was 71% in 2018, 70% in 2019 and 73% in 2020.

[A Review into Domestic Homicide and Safeguarding Adults  
Reviews relating to Victims with Additional Vulnerabilities](#)

published by Shaping our Lives 2021



This report was commissioned by Shaping Our Lives to explore recurring recommendations from Domestic Homicide Reviews and Safeguarding Adults Reviews across the Eastern Region where the victim had an additional vulnerability.

The report is based on 14 DHRs and 6 SARs.

The recommendations from the DHRs and SARs analysed were generally repetitive throughout the research. Information sharing was identified 12 times, risk assessments 12 times, training for professionals 11 times, GP issues 6 times, carer support 7 times, and public awareness raising 4 times.

[The hidden victims Report on Hestia's super super-complaint on the police](#) published by the Government in May 2021

The findings of this report include:

- The police approach to modern slavery has improved.
- The numbers of crimes recorded, and referrals made under the NRM, have increased year on year.
- Some victims are still treated poorly and don't get a good service.
- Low rates of prosecution that allow offenders to continue to exploit vulnerable people significantly harm the public interest.

The report recommends that the Home Office, chief constables, the Independent Anti-Slavery Commissioner, victims' commissioners and the Crown Prosecution Service (CPS) work together to better understand victims' experiences and what improvements they need to make.

[Interim report: Inspection into how effectively the police engage with women and girls](#) published by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services 7<sup>th</sup> July 2021.



In March 2021, the Home Secretary commissioned Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) to inspect the effectiveness of police engagement with women and girls.

The interim report recommends:

- There should be an immediate and unequivocal commitment that the response to VAWG offences is an absolute priority for government, policing, the criminal justice system, and public-sector partnerships. This needs to be supported at a minimum by a relentless focus on these crimes; mandated responsibilities; and sufficient funding so that all partner agencies can work effectively as part of a whole-system approach to reduce and prevent the harms these offences are causing.
- The relentless pursuit and disruption of adult perpetrators should be a national priority for the police, and their capability and capacity to do this should be enhanced.
- Structures and funding should be put in place to make sure victims receive tailored and consistent support.

## BOARD AND SUB-COMMITTEE NEWS

### Safeguarding Adults Board Meeting

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

- **Exploitation and Transitions**
- **Safeguarding Adult Reviews and**
- **Strengthening the links to CSP, LSCP and H&WBB**

At the Board meeting on the 2<sup>nd</sup> September 2021 we received a presentation from West Midlands Fire Service on their Serious Incident Review process, we also heard from Healthwatch about the key points from their annual report. We received an update on Covid-19 and the local impact and we reviewed the progress made on the Stephen SAR Action Plan and agreed this is complete. The next stage will be to review the impact of action plan which will be undertaken via an audit next year.

**Next Board meeting is 9<sup>th</sup> December 2021**

#### Engagement & Prevention Sub-Committee

At our meeting on 21<sup>st</sup> October we received an update on work with self funders being undertaken by SMBC's Engagement Officer, we also received an update on Hate Crime Awareness Week activity from the police. We agreed to review and refresh our "Involvement and engagement approach and plan for safeguarding adults in Solihull" and we will also look to review our suite of Safeguarding Information Leaflets in the new year. Finally we received some data from the Performance and Audit Subcommittee which suggests that older adults aged 85+ are over represented in safeguarding concerns, we agreed to look at this in more detail at our next meeting and to set some actions.

**Next meeting is Thursday 20<sup>th</sup> January 2022**

#### Performance & Audit Sub-Committee

At our meeting on 19<sup>th</sup> October we reviewed the performance dashboard and had a discussion about refining this for future meetings. We reviewed the National and Local Safeguarding Adults Collection data and discussed work that has been undertaken to assure ourselves locally that we have good quality data. We also agreed to make a request to the Engagement and Prevention Subcommittee that they do some work on raising awareness of safeguarding and support available for adults over the age of 85years, as there are a high number of safeguarding concerns received for this age group.

**Next meeting is Tuesday 18<sup>th</sup> January 2022**

#### Policies & Procedures Sub-Committee

At our meeting on 12<sup>th</sup> October we received updates on progress with developing guidance on when a fall is a safeguarding concern and guidance around choking, both are progressing well. We agreed to produce a local briefing on managing racial abuse towards staff from people who lack capacity following an effective piece of work that was published on this in Norfolk. We also agreed to review and update the SSAB Code which sets out best practice minimum standards that anyone who is experiencing Solihull's Safeguarding Adults Procedures can expect.

**Next meeting is Wednesday 19<sup>th</sup> January 2022**

#### Learning & Improvement Sub-Committee

At our meeting on 7<sup>th</sup> October we received an update on the work of the Exploitation Reduction Delivery Group from Rachael Eaves. We also discussed a recent SAR published in Sandwell called "Anne" on the subject of self neglect and agreed some local actions to support our approach to this area of safeguarding. We also discussed a SAR from Norfolk about 3 individuals "Joanna, Jon and Ben" and discussed its implications for Solihull. We considered some new practice guidance on the use of legal powers in safeguarding published by Alcohol Change UK and agreed to explore the option of training on this topic.

**Next meeting is Thursday 27<sup>th</sup> January 2022**

## 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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### **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](http://www.ssab.org.uk)**

**SSAB TRAINING INFORMATION/BOOKINGS - [ssab@solihull.gov.uk](mailto:ssab@solihull.gov.uk)**

**Professionals - [Click here to report adult abuse](#)**