SSAB NEWSLETTER

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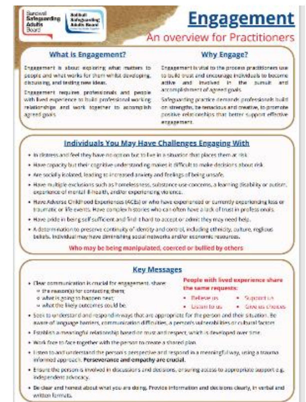
LOCAL NEWS

Engagement – Overview for Practitioners

Have you seen our brief guide to engagement?

It's on our website here and provides useful information on what engagement is, why it is important, and gives some tips and advice on how to engage with people you might have challenges engaging with, or who might be reluctant to talk to professionals.

The short guide also includes links to other useful resources to support with practice.



Sandwell Safeguarding Adults Board

Solihull Safeguarding Adults Board

Engagement

An overview for Practitioners

What is Engagement?

Engagement is about exploring what matters to people and what works for them whilst developing, discussing, and testing new ideas.

Engagement requires professionals and people with lived experience to build professional working relationships and work together to accomplish agreed goals.

Why Engage?

Engagement is vital to the process practitioners use to build trust and encourage individuals to become active and involved in the pursuit and accomplishment of agreed goals.

Safeguarding practice demands professionals build on strengths, be tenacious and creative, to promote positive relationships that better support effective engagement.

Individuals You May Have Challenges Engaging With

- In distress and feel they have no option but to live in a situation that places them at risk.
- Have capacity but their cognitive understanding makes it difficult to make decisions about risk.
- Are socially isolated, leading to increased anxiety and feelings of being unsafe.
- Have multiple exclusions such as homelessness, substance use concerns, a learning disability or autism, experience of mental ill-health, and/or experiencing violence.
- Have Adverse Childhood Experiences (ACEs) or who have experienced or currently experiencing loss or traumatic or life events. Have complex histories who can often have a lack of trust in professionals.
- Have pride in being self sufficient and find it hard to accept or admit they may need help.
- A determination to preserve continuity of identity and control, including ethnicity, culture, religious beliefs. Individual may have diminishing social networks and/or economic resources.

Who may be being manipulated, coerced or bullied by others

Key Messages

- Clear communication is crucial for engagement, share:
  - the reason(s) for contacting them;
  - what is going to happen next;
  - what the likely outcomes could be.

People with lived experience share the same requests:

- Believe us
- Support us
- Listen to us
- Give us choices

- Seek to understand and respond in ways that are appropriate for the person and their situation. Be aware of language barriers, communication difficulties, a person's vulnerabilities or cultural factors.
- Establish a meaningful relationship based on trust and respect, which is developed over time.
- Work face to face together with the person to create a shared plan.
- Listen to and understand the person's perspective and respond in a meaningful way, using a trauma informed approach. **Perseverance and empathy are crucial.**
- Ensure the person is involved in discussions and decisions, ensuring access to appropriate support e.g. independent advocacy.
- Be clear and honest about what you are doing. Provide information and decisions clearly, in verbal and written formats.

Self-Neglect Awareness Raising Video for the Public

This fantastic short video developed by Sandwell Safeguarding Adults Board helps to explain what self-neglect is to the public, who may be unfamiliar with the term.

Please share this video to enable understanding as well as to support a conversation about self-neglect. The last page of the video includes contact details for support in each area in the West Midlands including Solihull.

Self-Neglect film - YouTube

NATIONAL NEWS

Learning from Safeguarding Adult Reviews

The Care Act 2014 requires Safeguarding Adult Boards to arrange Safeguarding Adult Reviews (previously known as Serious Case Reviews) if there are concerns that partner agencies could have worked more effectively to protect an adult with care and support needs from serious harm or abuse, whether the adult has died or not.

David SAR – Coventry published November 2023

David was 55 years of age at the time of his death. He lived in a one-bedroom rented flat and had done so for some time. David was a drug user and was very open about the use of heroin and other controlled drugs. David had for some months lived in one room in his flat and had not moved from the sofa. When he was admitted to hospital in July 2021 his home conditions were very poor and it was apparent that he had neglected his health and personal care for some time. David was in receipt of low-level package of support, to maximise his independence, but also to ensure that his basic care needs were met. Three weeks after being admitted to hospital David died. HM Coroner held an inquest in January 2022. HM Coroner recorded a narrative verdict stating that David died 'due to multifactorial causes which included the deceased drug addiction and self-neglect, agencies involved in his care not escalating issues regarding his living conditions.'

Coventry SAB - David Safeguarding Adult Review (November 2023)

Gillian SAR – Hampshire published August 2023
Gillian lived at home with her daughter Natasha who has Alzheimer's dementia and her son Richard who appeared to be their main carer. The family had been largely 'under the radar' in relation to services, although there were periodic visits by the primary care nurses or the GP. No significant concerns had been raised by the primary care team about the family's ability to cope and no care package or service provision was in place at the time of this incident. Gillian was understood by family members to be very controlling (description by her son Richard) and had always been the 'boss' of the family even before her husband had died.

In September 2021, Gillian was admitted to hospital from home, having been found in a state of severe neglect by her neighbours who had been contacted by Natasha. Richard had gone away on holiday. Neighbours found Gillian in a bed which was heavily soiled with faeces and urine and the room was full of flies with sheets on the bed and no clean clothing visible. There was no food in the fridge. Unfortunately, Gillian died in hospital in early October 2021.

Hampshire SAB - Gillian Safeguarding Adult Review (September 2023)

Online Safety Act Received Royal Assent

The new Online Safety Act has just received Royal Assent and seeks to make social media companies keep the internet safe for children and give adults more choice over what they see online. To read more about what the Act means for online safety click this link Children and adults to be safer online as world leading bill becomes law and to read the response from the Domestic Abuse Commissioner click this link Domestic Abuse Commissioner welcomes online safety act receiving royal assent.

Most of the new rules will come into force in late 2024, however, the government has commenced key provisions early to establish Ofcom as the online safety regulator and allow them to begin key preparatory work such as consulting as quickly as possible to implement protections for the country. Ofcom will then take a phased approach to bringing the Online Safety Act into force, prioritising enforcing rules against the most harmful content as soon as possible.

New National Campaign: No Blame. No Shame

The National Trading Standards Scams Team are proud to launch their new **'No Blame. No Shame.'** campaign. This campaign is following the Coercive Control in Fraud, Scams and Financial Abuse: Learning from Domestic Abuse research report which launched earlier this year.

The team have produced a video to explain what coercive control is and how it is used in fraud, scams and financial abuse setting, and to raise awareness which can be found here:

Discharging People Who Are at Risk of or Experiencing Homelessness (January 2024)

This guidance was published 26th January 24 by Department for Levelling Up, Housing and Communities and Department for Health and Social Care.

Department of Health & Social Care

Department for Levelling Up, Housing & Communities

This guidance is for staff in care transfer hubs and others involved in planning discharge of patients (including NHS, local authority, housing and other partners). It builds on the Home First: Discharge to Assess and homelessness guidance produced by the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS).

It includes examples of best practice, including step by step guides and example pathways, which can be adapted to suit local practices, for discharging patients:

- at risk of or experiencing homelessness
- with safeguarding concerns
- with no recourse to public funds (NRPF)

Find the guidance at this link: Discharging people at risk of or experiencing homelessness guidance

Working Together to Safeguard Children (2023) Statutory Guidance (December 2023)

This has involved a substantial rewrite to the prior 2018 statutory guidance, following consultation from June 2023 to September 2023 with the government response to the consultation published the same day as Working Together.

Impetus for the review was the government's plan to re-set children's social care following the National child safeguarding practice review into the murders of Arthur Labinjo-Hughes and Star Hobson.

Aims of the guidance are:

- Strengthening multi agency working
- Bringing in a child centred approach within whole family focus
- Strong and consistent child protection processes

Find out more here: Working together to safeguard children 2023: summary of changes (publishing.service.gov.uk)

Prevent Resources

The Home Office has developed some useful resources to promote Prevent awareness. This short video explains what Prevent is and what to do if you have concerns someone has been radicalised.

Watch here - [Prevent Duty Animation - YouTube]

Please also use this link which will take you to a leaflet on our website to be shared with the public: [Prevent Leaflet (safeguardingsolihull.org.uk)]

EQUALITY, DIVERSITY & INCLUSION

New Videos on Rough Sleeping

Ellie Atkins, who runs the Adult Social Care - Complex Needs Service in Manchester, has developed a series of videos which aim to change people's thinking and actions about rough sleeping. These focus on a client called Beryl and look at the steps taken to address her needs and include an episode on executive functioning.

Ellie is sharing these videos to help people understand, commission, plan and deliver the ways of working required to prevent and address complex needs.

Click the links below to learn more:

- Ellie Atkins: Episode 1 What you need to know, to end rough sleeping - YouTube
- Ellie Atkins: Episode 2 - Why You Need to Know About Executive Functioning - YouTube
- Ellie Atkins: Episode 3 What We Need to Do to End Rough Sleeping - YouTube

LEARNING AND DEVELOPMENT

SSAB Training (February – March)

Course: Cultural Competency
Date/Time: Monday 26th February - 10:30am to 3:30pm
Trainer: Anita Eader, Bexley Safeguarding Adults Board
Delivery: Face-to-Face at Sans Souci, 196 Tanworth Ln, Shirley, Solihull, B90 4DD.
Book your place: Cultural Competency Registration, Mon 26 Feb 2024 at 10:30 | Eventbrite

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Course: Working with People that Self-Neglect
Date/Time: Tuesday 5th March - 10:00am to 1:00pm
Trainer: David Gell
Delivery: Online, via Zoom
Book your place: Working with People that Self-Neglect Registration, Tue 5 Mar 2024 at 10:00 | Eventbrite

Orange Button Scheme – Training Dates

People who are having thoughts of suicide or who are worried about a friend or family member can ask Orange Button wearers in their community for information and support. The orange button is worn by people in Solihull and Birmingham who have undergone specialised suicide prevention training, and while they are not able to counsel people, they can provide comprehensive signposting to relevant services.

Click here to find out more about the Orange Button Community scheme

If you would like to become an Orange Button holder, you will need to complete, or have already completed; at least three hours of quality assured mental health or suicide prevention training. This is to ensure you are equipped with the skills to listen and signpost people.

No previous training
If you have no previous training and would like to become an Orange Button holder, you will need to register for Orange Button training. It is FREE online training from 9:30am to 1:00pm.

There are currently 2 dates available to book

- Wednesday 10th April 2024 – 9:30am to 1:00pm - Eventbrite
- Wednesday 17th April 2024 – 9:30am to 1:00pm - Eventbrite

Click here to see when more dates become available

Previous mental health or suicide prevention training
If you have previously completed 3 hours of quality assured mental health or suicide prevention training and would like to become an Orange Button holder please complete this registration form

MAKING SAFEGUARDING PERSONAL

MSP Audit

In November the Performance Quality and Audit Sub-Committee completed an audit of safeguarding enquiries, where the person has a diagnosis of dementia to see if Making Safeguarding Personal (MSP) was captured.

The audit showed that practitioners were positively engaging with the person, or their family. There was effective recording in the safeguarding forms and the Mental Capacity Assessments were thorough and evidenced the individual was involved.

The Audit report shares some ‘Best practice prompts’ for practitioners which are detailed below.

- Practitioners to consider professional curiosity when discussions about decision making are undertaken with the person, to fully understand the situation and the reasons given for decisions when there is fluctuating capacity.
- Practitioners to consider challenging responses when discussions about decision making are undertaken with representatives.
- Practitioners to focus on investigating all areas of risk, although it can be complex when multiple risks are identified.
- To explore less restrictive options to ensure decisions and actions are proportionate.
- To ensure referrals to partners are completed in a timely manner.
- Professionals to ensure they are openly exploring all options, for the decisions required and not influencing the progress of the case to suit a particular outcome.

Look out for the Learning Briefing which is coming soon!

BOARD & SUB-COMMITTEE NEWS

The Board's priorities for 2023-24 are:

1. **To improve our understanding of who Solihull's communities are and use this to improve the accessibility and quality of safeguarding information as well as service development.**
2. **To understand from Solihull's communities and those with lived experience of safeguarding, what they need from an effective safeguarding response and act on this.**
3. **A robust response to financial abuse.**

Safeguarding Adults Board Meeting

At our meeting on 7th December 2023 we received an update from West Midlands Police following their recent HMIC inspection, they also gave an update on the implementation of Right Care Right Person, we received an update from Birmingham Solihull Mental Health Foundation Trust following their CQC inspection, we reviewed the Board's progress against its 3 priority areas and received an update on the findings from recent audits. We also received the action plan from probation following their inspection and an update on exploitation reduction progress which is overseen by the Exploitation Reduction Delivery Group.

Our next meeting is 7th March 2024

Safeguarding Adults Review Sub-Committee

At our meeting on 7th November 2023 we looked at regional SAR data and how Solihull compares, we looked at a thematic review of SARs involving mental capacity and what learning we could take from this, we received a route cause analysis report from one of our partners including the learning identified, we also looked at 2 SARs from other areas Eileen and Joshua and considered local learning in terms of equality and diversity as well as safeguarding practice.

Our next meeting is 6th February 2024

Engagement & Prevention Sub-Committee

At our meeting on 23rd January 2024 we reviewed the feedback from the key safeguarding questions which were shared with the public. The group agreed some actions following this feedback. We considered the Hoarding guide and discussed what partners were hearing from the community. We reviewed the findings from the cultural competence survey and shared the training being run to support practitioners.

Our next meeting is 30th April 2024

Performance, Quality & Audit Sub-Committee

At our meeting on 25th January 2024 the group received the data from the safeguarding performance dashboard and discussed changes to consider incorporating. The group received a summary of the dip sample audit report on Making Safeguarding Personal where the person has a diagnosis of dementia. We reviewed the audit schedule and discussed plans for the existing audits and new areas for the 2024 schedule. The group had a discussion about Hate Crime in relation to the action on the subcommittee's workplan and what can be done to raise the profile.

Our next meeting is 25th April 2024

Policies & Procedures Sub-Committee

At our meeting on 9th January 2024 we received an update on the review of Solihull's Exploitation Reduction Procedures, we considered guidance to support staff in identifying and supporting people affected by gambling, we identified 4 pieces of local practice requiring review and agreed plans for this amd we received an update on the review of the West Midlands Adult Safeguarding Procedures which should conclude by March 24.

Our next meeting is 9th April 2024

Learning & Improvement Sub-Committee

At our meeting on 11th January 2024 we discussed topics for the 2024 training offer, we reviewed the findings from the cultural competence survey and the key safeguarding questions which were shared with the public. The group received a summary of the dip sample audit report on Making Safeguarding Personal where the person has a diagnosis of dementia.

Our next meeting is 18th April 2024

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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 --- Click here to view the Procedures

To Report Abuse

Tel: **0121 704 8007** (Office Hours)
Tel: **0121 605 6060** (Out of Hours)
Tel: **101** – Police (Call **999** in an emergency)

Safeguarding Referral Form

Public - Find the details on our website
Professionals - Click here to make a referral to SMBC Adult Social Care