



Keeping Adults Safe  
in Shropshire  
Board

# Annual Report

April 2015 – March 2016



# Annual Report

October 2016

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## Foreword by Ivan Powell, the Independent Chair

Welcome to the Keeping Adults Safe in Shropshire Board Annual Report and thank you for taking time to read this very important document.

The Board has an important role in keeping adults free from abuse in Shropshire. The organisations that make up the Board share responsibility for ensuring that all efforts to keep adults safe and well are effective and well-co-ordinated. It is part of the Board's job to promote greater public awareness of every individual's rights to feel safe at home and in the community.

We will work together to strengthen links with our local communities to help raise the profile of keeping adults safe. I encourage Board members to be passionate and actively engage in work that protects and promotes the well-being of some of the most vulnerable members of our community and I welcome your views and the views of people who use our services, their carers and families about how we can do this better.

### What I have enjoyed most about working in Shropshire over the last year includes:

- Board members working positively together, and there is genuine sense of collaborative working
- The pace at which partners work together to deliver significant policy development and implementation
- Seeing the important decisions being made by the Board become actual operational activity

### I am really proud of:

- The consultation and engagement event we held in November 2015 which was a big success and is a strong foundation on which to build
- The progress the board has made to meet the requirements of the Care Act
- The progress of a very diverse multi-agency workforce working hard to Making Safeguarding Personal for those adults who experience the safeguarding system

### Looking to this year I want us to:

- Continue to meet the challenges of working with our most vulnerable community members to help empower them to live safely
- Do more to engage with adults, their friends and their families to understand how we are doing
- Do more to build resilient communities which help protect those adults who live within them

I do hope you will find this report helps you to become familiar with our work.



## Who we are

We are a group of organisations who work together to make sure “Shropshire is a place where adults with care and support needs and children live a life free from abuse or neglect”. This is our vision for Shropshire.

The organisations that make up the Board are:



**Shropshire and Wrekin**  
Fire and Rescue Service



# What our Strategic Plan says we have planned to do

The Government has told us we must explain how we will make the people of Shropshire safer. This is called our Strategic Plan and it covers 2015 – 2018. In our plan we say there are some activities we need to do regularly to make the Board function and they are:

## a. Assurance and challenge

**Example** – The Board has a system for recording actions and decisions at meetings in which all members are held to account for providing evidence that actions have been completed.

**Example** – at a recent Board meeting there was a critical review of how agencies should have worked together more effectively. The degree of challenge allowed senior members of the respective organisations to understand what they needed to do differently next time.

**Example** – Shropshire Clinical Commissioning Group and Shropshire Council have undertaken an independent visit to Royal Shrewsbury Hospital designed to help the hospital understand how well the Mental Capacity Act is being used by staff in the hospital. This has been well received and will happen in other organisations this year.

## b. Ensure the effective undertaking of safeguarding enquires

(including section 42 enquires, which we have to do if a person has care and support needs and they are experiencing or are at risk of abuse)

**Example** – Shropshire Clinical Commissioning Group actively participates in the safeguarding process, and when necessary will identify key health personnel to assist or lead in enquiries. This may be by providing expertise such as in medicine management or through undertaking co-ordinated visits to care homes.

**Example** – Shropshire Council have two safeguarding practitioners who work with our Customer Services Team to help prioritise safeguarding concerns that are raised. This means we can protect people more quickly if required, and act as a source of expertise to Customer Services staff helping customers.

**Example** – West Mercia Police have named Police Officers (known as the Adults at Risk Unit) who work with the safeguarding team in Shropshire Council to deal with the highest risk and most complicated adult safeguarding cases.

Here is an example. There were two separate adults in the same town who were not capable of protecting themselves from the actions of an offender who posed as their 'friend', but ended up stealing over £100,000 from one of the gentlemen. Using their specialist skills, the team gained the trust of one of the victims of this crime.

The quality of the evidence, along with clearly demonstrating just how vulnerable one of the victims was, resulted in the offender receiving the maximum custodial sentence allowed. The positive outcome was that one of the people, who had spent 15 years living in isolation and poor living conditions, through our multi agency working processes in adult safeguarding, now has an excellent quality of life, is safe and free from abuse.

### **c. Undertaking Safeguarding Adult Reviews and changing practice as a result of what we learnt from them –**

these reviews must be undertaken by the Board if someone dies or is seriously injured because of abuse and there has been a multi-agency failure to safeguard that person. These kinds of review focus on learning in order to stop things going wrong again.

**Example** – The Board has put a robust process in place which is agreed by all members that will emphasise the learning to be implemented.

**Example** – The Board has undertaken one Safeguarding Adult Review in Shropshire that started this year about the care received by a woman in a nursing home in south Shropshire while she was there on a temporary basis. This is her story.

On 10 February 2015 Mrs V was admitted to the nursing home for respite care as it was felt her leg ulcers would improve with such a placement. During this period of respite she also developed a urinary tract infection which resulted in an extension of the respite period in order for the infection to be treated.

On the evening of 25 February 2015 it was noted that Mrs V had sustained bruising to her upper body. This bruising developed extensively over the following days to the extent that on 2 March 2015 Mrs V's daughter removed her mother from the home, so concerned was she that no account could be given as to the cause.

During the days that followed Shropshire Council commenced the safeguarding process, the home conducted an internal investigation and Mrs V's daughter informed West Mercia Police.

Sadly Mrs V passed away on 21 April 2015. The cause of death was formally recorded as community-acquired pneumonia and chronic kidney disease.

The full report has not yet been in front of the Board; however, the themes emerging from the review of the situation fall into the following headings:

- poor recording
- poor communication with Mrs V's family
- an inability to identify the cause of the bruising
- difficulty obtaining a medical opinion when there is no police investigation

The recommendations and actions taken will be reported on fully in our next annual report.

## d. Audit and performance

(including identifying trends from our communities and using our experience to constantly improve what we do)

**Example** – Shropshire Council has rewritten its client information system in order to tell us who is affected by abuse and where it is happening (please see the "What we know about safeguarding in Shropshire" section). This has helped identify the quality of care provided by care homes and domiciliary care services as a priority for this year.

**Example** – Shropshire Clinical Commissioning Group identified poor catheter care in care homes which resulted in changes to the catheter care discharge processes, which in turn involved liaison with Shrewsbury and Telford Hospitals and Shropshire Partners in Care.

**Example** – South Staffordshire and Shropshire Foundation NHS Trust volunteered to set up and chair the audit and performance sub-group of the Board. The work of this group will help the Board understand how effectively people are being kept safe from harm and abuse.

In addition to what we regularly do, to deliver our vision we have identified the following important areas to work on over the next three years:

## 1. Preventing abuse from occurring –

we need to do this for three main reasons:

- to develop a culture of caring for others
- to stop harm from happening to people and
- to minimise the impact of dealing with abuse on our services

**Example** – Shropshire Partners in Care’s core activities include training, providing good quality courses which promote high standards across the care sector. In addition, they are an umbrella body for Disclosure and Barring Service checks, which support care providers to ensure all eligible staff seeking to work in the care sector are checked in line with current statutory requirements.

**Example** – The Learning Development sub-group of The Board has written a competence framework to give guidance to service users and all organisations about the knowledge and skills they need in order to detect, manage and prevent harm and neglect.

**Example** – Shropshire Clinical Commissioning Group chairs the “Improving Clinical Input into Care Homes” group. This involves NHS providers, General Practitioners, care homes and patient representatives and seeks to identify ways to improve the effectiveness of care within care homes.

## 2. Making Safeguarding Personal and implementing personalisation –

personalisation means giving people as much control as possible over their lives. The Board needs to be confident that this practice happens in all services. The Board also needs to be confident that when a safeguarding concern has been raised, the person affected is part of all decisions that are made.

**Example** – Shropshire Council has changed its practice to ensure that the adult with care and support needs is at the centre of the safeguarding process. This is done by encouraging workers to support the adult to raise the concern themselves or if this is not possible, ensuring that the process begins with a discussion with the adult about how they want to be made safe. This will be further enhanced by collecting data showing when this happens.



**Example** – The delivery of Mental Capacity Act training to service users and their parents and carers is an important part of helping people understand the Mental Capacity Act and their rights. As result of this training, Taking Part and Shropshire Council have worked with a group of adults with care and support needs to devise cards identifying the five principles of the Mental Capacity Act. This will mean that professionals are reminded to promote choice and control for the individual about their lives.

**Mental Capacity Act 2005**

- 1, 2 & 3 are all about me
- 4 & 5 you do with me if I lack capacity.

**5 rules for supporting me**

- 1 Start by thinking I can make a decision
- 2 Do all you can to help me make a decision
- 3 You must **not** say I lack capacity just because my decision seems unwise
- 4 Use a **best interest checklist** for me if I can't make a decision
- 5 Check the decision made **does not** stop my freedom more than needed

“Capacity means I can make my own decision. I need the information in a way that I can understand. I can then decide what to do.”

**“Professionals have to use it because it's the law”**

**Example** – Shrewsbury and Telford Hospitals Trust provide training for all staff to reinforce the concept of empowering and supporting the individual to make their own choices and to make sure the individual's well-being is promoted at all times.

**3. Public and workforce awareness (please see learning and development section for more information) of their responsibility to safeguard people and report concerns if necessary –**

the public and the workforce are essential if we want to stop abuse happening in the first instance and respond effectively if it has happened. Everyone needs to understand their responsibility at all stages of the process.

**Example** – The Board organised a consultation event for service users, carers, and other stakeholders to consider what the safeguarding strategy for Shropshire should say. As a result of the event we changed the content of the strategy and came up with a new name for the Board and produced ideas for the board's logo, which were then developed by Designs in Mind; a group for people who use mental health services. In order to share messages about adult safeguarding and the work of the Board as widely as possible, a news story about this event was issued to educate the community.

**Example** – Shropshire Community Health NHS Trust have made safeguarding training essential for all of their clinical staff, with higher levels of training for specific roles including undertaking enquiries.

**Example** – South Staffordshire and Shropshire Foundation NHS Trust have produced safeguarding posters and leaflets that are available in all of their clinical areas. They provide service users and staff with local contact details for safeguarding support and advice, as well as highlighting our responsibility to keep service users safe.

#### **4. Establishing effective working relationships with other strategic partnerships –**

The Keeping Adults Safe in Shropshire Board should not work on its own. In order to be effective and achieve as wide a reach as possible, other partner organisations need to be clear about their role in safeguarding adults with care and support needs from abuse.

**Example** – The Board has participated in a mental health workshop run by public health for all the strategic partnerships, which included people's stories about their experiences of services. The safeguarding Board has promised that mental health will be included in its business plan.

**Example** – The Board is capturing data about mental health and safeguarding issues to better understand the needs of those who have such problems, which will inform preventative work for this year.

**Example** – Shropshire Fire and Rescue Service is represented at The Hate Crime Forum, PREVENT Board, Multi-agency Risk Assessment Conference where high risk domestic abuse cases are discussed and the Multi-agency Public Protection Arrangements management meeting.

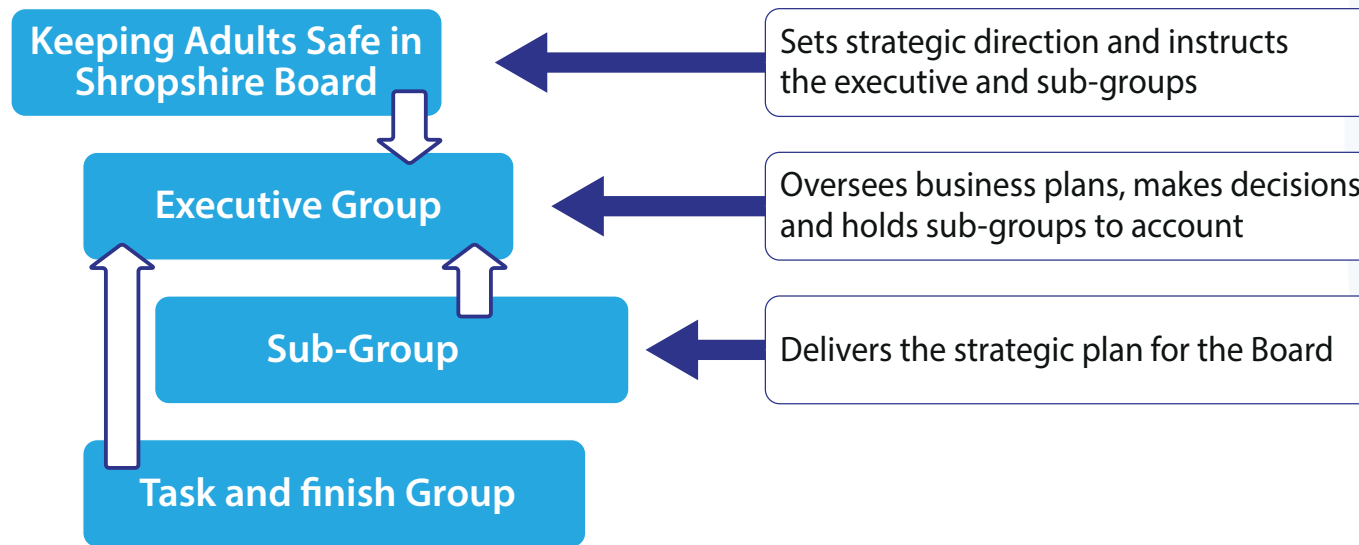
For more detailed information about the specific contribution to the Strategic Plan from the members, please see the appendix section.

## How we work as a Board

Shropshire has had an adult safeguarding board since 2000, so this work is not new to us, but the Care Act 2014 requires Shropshire Council as a local authority to establish a Safeguarding Adults Board. The Board is independent of the council and other partners.

We appointed an Independent Chair in June 2015 who reports to the chief executive of Shropshire Council. We hold a series of meetings throughout the year to make sure that our strategic plan is being put into action.

This is our Board structure and what each group does.



## Board policies and their effectiveness

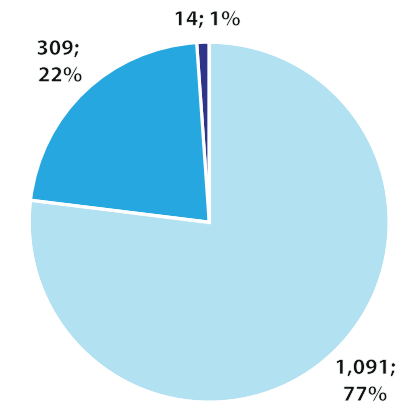
It has been a busy year for the Board as we have had to make sure our safeguarding practice has changed to fit the Care Act 2014. We have produced a number of documents to help everybody keep people safer. Our documents can be found on the adult safeguarding page of the Shropshire Council website. Our new documents are:

- **Risk assessment and risk management** – this document helps us have a balanced approach when we respond to safeguarding concerns. For example, it helps us work out if a situation could result in serious harm.
- **Safeguarding Adult Reviews process** – if someone dies or is seriously hurt because of abuse, this document helps us to understand what could have been done differently.
- **The safeguarding process in Shropshire** – this document explains when and how to raise a safeguarding concern but, more importantly, reminds people they must make someone safe as quickly as possible.
- **Self-neglect** – this offers advice to professionals if they are working with people who neglect themselves. It is a very complicated area of work but can result in people being at risk of very serious harm.

We hope you can see how much difference what is in these documents can make to people experiencing abuse or neglect in Shropshire.

# What we know about safeguarding in Shropshire

## Safeguarding concerns 2015/16



- Total no of safeguarding concerns
- No of S42 enquiries
- No of other safeguarding enquiries

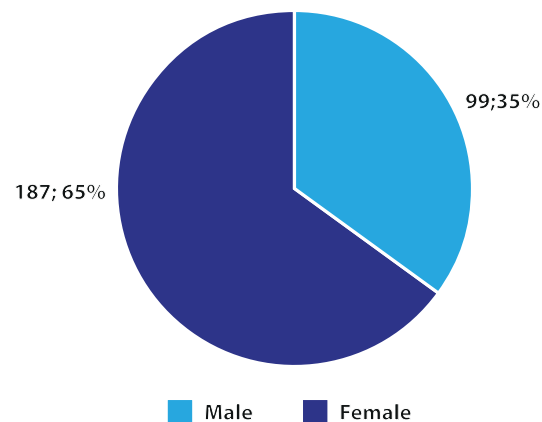
This information has been provided by Shropshire Council. The council is responsible for telling the Department of Health who is affected by abuse in its area every year.

**A total of 1,414 safeguarding concerns were recorded, which affected 1,115 people. This shows a number of people were affected by potential abuse more than once.**

**The concerns raised resulted in 323 enquiries being carried out in total.**

**Section 42 enquiries (309) were carried out when Shropshire Council had a duty to. "Other" enquiries (14) were carried out because they chose to.**

## Section 42 enquiries by gender

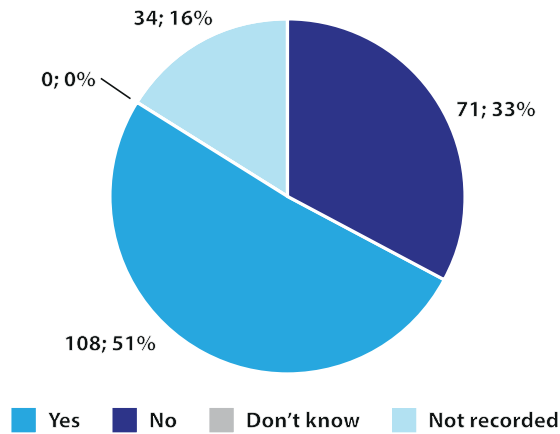


- Male
- Female

**Women are almost twice as likely as men to be affected by abuse in Shropshire.**

The Keeping Adults Safe in Shropshire Board will consider this in developing our prevention work.

### People lacking capacity in concluded section 42 enquiries



**Most people affected by abuse have capacity to make decisions about this area of their lives for themselves. This does not, however, mean people are better able to protect themselves. Fear of reprisals and feeling disempowered are key factors here.**

**Although the majority of people have capacity, there are a significant number of people experiencing abuse who lack capacity.**



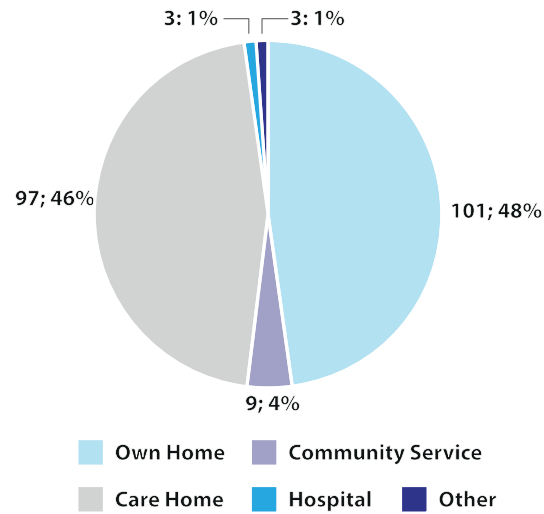
The involvement of advocates, families and friends is particularly important when people lack capacity to safeguard themselves. **This is an area that must be improved in Shropshire.** In completed section 42 enquires, only 58% of people who had “substantial difficulty” participating in the process were recorded as receiving the support of an advocate, family member or friend.

Making Safeguarding Personal is essential if we are all to help people be in control of their lives as much as possible.

When asked, people or those acting on their behalf, should say what they want to happen. **There are a significant number of “don’t knows” recorded, which is unacceptable.** It should always be obvious in an enquiry report how the person was involved and how they want to be protected. **This has been identified as an area for local performance monitoring by Shropshire Council.**



### Concluded section 42 enquiries by location of abuse



About 32% of enquiries undertaken are about neglect. It is the biggest form of abuse reported in Shropshire. Where it occurs and who is responsible is difficult to unpick.

Most abuse takes place either in the person’s own home or care homes.

Some people living at home are supported by both paid staff and family and friends, and most abuse takes place by someone known to the person.

The Care Quality Commission inspect many organisations that provide personal care and treatment. They inspect against five key lines of enquiry; caring, safe, well-led, effective and responsive. Of the care homes and domiciliary care agencies in Shropshire that have been inspected in this way, the majority of services are assessed as “good”.

**Neglect is an area of abuse that both the Keeping Adult Safe in Shropshire Safeguarding Board and Shropshire Council need to better understand, to find ways of preventing it.**

# Safeguarding Training in Shropshire

The Learning and Development sub-group is chaired by Shropshire Partners in Care. The group is responsible for agreeing the learning and development programme of the Board and understanding how well it works.

The Learning and Development sub-group recognise the need to develop a positive learning culture across the wider community in Shropshire. There is a need to produce a range of learning materials that suit people’s different learning styles. This is important when promoting key messages regarding the prevention of abuse and making safeguarding personal. Everyone needs to understand their own responsibilities. These materials need to be based on the latest, nationally-agreed learning standards. These are made available to all of the partners on the Board and have been shared more widely as well. The Shropshire Partners in Care website is where you find these materials.

Publicity material is one of our priorities for the next business year. The website, once established, will be used by the sub-group to make local and national learning resources easily available to all.

## The way the sub-group works is described in this diagram.

The Learning and Development Sub-Group has good representation from statutory and non-statutory organisations. A learning and development training programme is monitored by the sub-group which promotes an approach of positive learning. This will include learning from local, regional and national Safeguarding Adults Reviews.







**Pictured left: Louise Edwards (Four Rivers Nursing Home) and Oliver Rothwell (Marches Energy Group), feeding back learners thoughts on prevention. (Safeguarding Adults Awareness Training, 26 May 2016).**

It is a priority for the group to work out the best way of gathering data about who and how many people receive safeguarding training in Shropshire and how it makes a difference. Initial conclusions from the data submitted so far suggest:

- Safeguarding and related training is accessed by a variety of face to face sessions and other methods mainly by e-Learning package.
- The majority of people accessing safeguarding-related training are paid staff or volunteers.
- All agencies regulated by the Care Quality Commission should be in a position to evidence to them as the regulator, that staff access appropriate training and professional development.
- Some organisations take a proactive approach accessing preventative training such as professional boundaries, despite such training not being mandatory.
- Data gathered tends to report on the number of learners accessing training, rather than the impact of training on practice.

As a result of the pilot exercise, the Learning and Development Sub-Group will be assessing the data submitted and commence planning for future data capture and evaluation. The Learning and Development Sub-Group will provide partner members with a further opportunity to reflect upon the strengths and weaknesses of their training delivery in order to promote more effective safeguarding practice through developing training opportunities.

## What we want to do next year

There is still a lot more work to do to make sure people can live their lives free from abuse in Shropshire, but in particular we want to:

- have adults who use care and support services and carer representatives in every group within the Board.
- finalise our performance framework and make sure the Board are holding partners to account for their work.
- finish setting up our website to promote the work of the Board and link with the public.
- develop easy to understand publicity material so everyone knows how to seek help if they can't stop abuse themselves.
- write a prevention strategy for Shropshire with other partnerships, that includes targeting women to help them safeguard themselves from abuse or neglect, neglect; in particular.

## Closing statement from Councillor Lee Chapman, Shropshire Council's Cabinet Member for Adults

The Care Act has been a catalyst for a new approach to safeguarding adults in Shropshire. Everyone working in health and social care has refocused on the most important thing and that is people being in control of their own lives. I really welcome this new emphasis.

The discussion that took place at our engagement event in November 2015 was very encouraging. It was great to see people get involved and challenge us on the work we had done so far. It is because of people's contribution that the Board has a new name and logo. I would particularly like to thank "Designs in Mind" (a group for people with mental health problems) for bringing the ideas from that day to life. I very much look forward to the next engagement event which is taking place on 25 November 2016, which will focus on Making Safeguarding Personal.

The examples from our partners show how when we work together, we can achieve change for people affected by abuse.

I am sure that we have the right organisations on the Board to continue to make a difference to people's lives. We must now focus on involving adults with care and support needs even more and try to prevent abuse from happening in the first place.

Thank you for reading our first statutory report and I look forward to working with the Board this year.

# Appendix 1

The following priorities are identified in the Keeping Adults Safe in Shropshire Board Strategic Plan. Please give specific examples of how your organisation has been working towards the Strategic Plan of the Board.

Name of Organisation:

**Shropshire Clinical Commissioning Group (CCG)**

Name and role of person completing the template:

**Paul Cooper, Safeguarding Lead - Adults**

## 1. Preventing abuse from occurring – we need to do this for three main reasons:

- to develop a culture of caring for others
- to stop harm from happening to people and
- to minimise the impact of dealing with abuse on our services

The CCG in partnership with all of the Board members has supported the work being undertaken to enhance training and development of staff to make them more aware of the role they can play in Safeguarding Adults, this emphasises the key role of prevention in ensuring that all staff adhere to their duties to challenge poor practice and champion high quality services. The Learning & Development sub group has supported the development of a learning culture through the creation of specific reflective learning logs and is working to provide a repository of high quality safeguarding learning tools to equip practitioners to recognise the role they can play in prevention.

The CCG seeks to ensure that those who provide health services on behalf of the NHS are committed to constant quality improvement and assurance measures. It oversees the Serious Incident investigation process were by providers acknowledge sub optimal care candidly, where applicable report errors or omissions to commissioners and family and patients. It then puts learning action points in place which are shared with staff members.

The CCG chairs the Improving Clinical Input Into Care Homes group. This involves NHS providers, GP representation, care homes and patient representatives and seeks to identify ways to improve the effectiveness of care within care homes. By attempting to raise the standards of care in Shropshire its remit is very much about prevent and quality improvement. It does this by identifying concerns and attempting to find solutions e.g. it has produced or disseminated best practice guidance on Hydration and nutrition, tissue viability. It has undertaken audit work regarding admissions in order to review the most effective care is being offered in order to reduce necessary admissions and prevent deterioration. This has included looking for trends in care home admissions so the Integrated Community Service Team can target support to those homes. It also undertook a piece of work in which a GP and member of the medicine management team visited the learning disability care homes in Shropshire to discuss the admissions of people with learning disabilities to hospital for physical health reasons in order to promote the best use of the patient passport and annual health checks. It has also formed a group for care home activity coordinators to share best practice.

## 2. Making Safeguarding Personal and implementing personalisation –

personalisation means giving people as much control as possible over their lives. The Keeping Adults Safe in Shropshire Board needs to be confident that this practice is embedded in all services. The Board also needs to be confident that when a safeguarding concern has been raised, the person affected is part of all decisions that are made.

The CCG has supported the wider partnership working being led by the board to ensure that Making Safeguarding Personal is embedded into Safeguarding. This includes the focus upon service user determined outcome measures are the premise from which all safeguarding work emanates. The CCG is supporting this message through the work of the Learning & Development group as it seeks to deliver this practice principle in its training. The CCG have also directly delivered training to GP and other primary care staff throughout the county and have promoted this to all GPs.

The CCG has sought assurance from the provider organisations that it commissions about training which includes Making Safeguarding Personal and its contribution to the Keeping Adults Safe in Shropshire Board. The CCG has disseminated information to all the 44 GP practices in Shropshire about Safeguarding processes including how to address service user outcomes and keep these at the heart of the process.

## 3. Public and workforce awareness of their responsibility to safeguard people and report concerns if necessary –

the public and the workforce are essential if we want to stop abuse happening in the first instance and respond effectively if it has happened. Everyone needs to understand their responsibility at all stages.

As the commissioner of NHS provider services, the CCG has a contract in place with its providers and seeks to hold them to account with regard to their delivery of training targets in support of safeguarding. It has also worked with others to ensure that there is a suite of training and learning resources that increase awareness about Safeguarding. The CCG has contributed to the launch of the safeguarding event that sought to engage stakeholders and the wider community in understanding the key messages of safeguarding and the role they can play in supporting people with care and support needs. This included consultation on the name of the board and the logo.

The Learning and Development group are also leading on devising ways to enhance the information available about safeguarding so more people are aware of how to access help and support.

#### 4. Establishing effective working relationships with other strategic partnerships –

The Shropshire Safeguarding Board should not work in isolation. In order to be effective and achieve as wide a reach as possible, other strategic partnerships need to be clear about their role in Safeguarding adults with care and support needs from abuse.

The CCG promotes partnership working within safeguarding. Its personnel either chair or co-chair the following groups; the Executive Group, the Learning & Development Sub Group; the MCA and DOLs associate sub group. The CCG are a key member of the Channel panel and works in partnership with all of the different agencies involved in this work. The CCG promotes and champions the work of the Keeping Adults Safe in Shropshire Board.

#### Our “Business as usual activity”

Shropshire recognises that safeguarding adults is not just about reacting when abuse has been identified but it is very important to prevent abuse from happening in the first instance. Safeguarding is a range of activity and the development of a culture that promotes good practice and caring within services. The person at the centre of the concern should feel safe in their homes and in their communities.

The following areas are identified as business as usual activities for the Keeping Adults Safe in Shropshire Board. They should be reflected in the structure of the Board and its business plan:

##### a. Assurance and challenge

The CCG is responsible for commissioning services from NHS Provider Trusts. This includes ensuring that the providers comply with the safeguarding requirements of the NHS Standard Contract. The NHS providers need to demonstrate that they have recognised safeguarding leads, policies and training available to staff. The NHS providers are required to provide a safeguarding dashboard on a quarterly basis demonstrating compliance. The CCG meet with the NHS providers to hold them to account accordingly.

In addition to that, NHS provider organisations have a duty of candour to report and learn from circumstances where owing to deficiencies in the care provided there have been adverse outcomes. This involves Serious Incident (SI) investigation and the creation of learning action plans. The CCG meets with Providers every three weeks to review and challenge the reporting of and learning action points from Serious Incidents.

**b. Ensure the effective undertaking of safeguarding enquires (including section 42 enquires which we have to do if a person has care and support needs, and they are experiencing or are at risk of abuse).**

The CCG adheres to the safeguarding process and when necessary will identify key health personal to assist or lead in enquiries. This may be by providing specific expertise such as in medicine management or through undertaking coordinated visits to care homes e.g. when required Complex Care Team nurses will undertake visits and or reviews along with LAocal Authority Safeguarding Practitioners regarding the implementation of Safeguarding Plans when there are concerns about a care home.

The CCG also regularly attend safeguarding planning meetings and assist in the evaluation of risk and the determination of remedial actions.

The CCG, the Local Authority and the NHS provider trusts agreed the process when the Local Authority may cause others to undertake enquiries.

**c. Undertaking safeguarding adult reviews and changing practice as a result of what we learn from them**

The CCG contributed to the implementation of the Safeguarding Adult Review process and chair the executive group which receives referrals into the process and oversees the Reviews.

The learning & development group are currently undertaking a piece of work in which they are seeking to identify the best way to promote learning at a regional or national level from Safeguarding Adult Reviews. The independent chair of the Keeping Adults Safe in Shropshire Board is therefore taking this up with other counterparts regarding how best to have a system of shared learning.

**d. Audit and performance (including identifying trends from our communities and using our experience to constantly improve what we do)**

The CCG ensures that the services it commissions have an array of audit and performance measures.

The CCG has a Clinical Quality Review Meeting and a Contract Review Meeting with providers on a monthly basis. This looks at the key measures of patient care and safety and identifies actions to provide quality assurance. Some of these key measures include the Safeguarding Dashboard, Mortality Review Trends and benchmarking and the Patient Safety Thermometer which looks at rates of hospital falls, hospital acquired infections and other key measures.

## Appendix 2

The following priorities are identified in the Keeping Adults Safe in Shropshire Board Strategic Plan. Please give specific examples of how your organisation has been working towards the Strategic Plan of the Board.

Name of Organisation:

**Shropshire Fire and Rescue Service**

Name and role of person completing the template:

**Guy Williams, Group Manager Prevention**

### 1. Preventing abuse from occurring – we need to do this for three main reasons:

- to develop a culture of caring for others
- to stop harm from happening to people and
- to minimise the impact of dealing with abuse on our services

Shropshire Fire and Rescue Service has worked closely with the Board to produce a new Adult Safeguarding Order. This document was passed by the Senior Management Team in June 2016.

The document supports the Care Act 2014 and provides definitions and guidance for all members of staff. The previous Order was rendered out of date by the introduction of the Care Act 2014.

### 2. Making Safeguarding Personal and implementing personalisation –

personalisation means giving people as much control as possible over their lives. The Keeping Adults Safe in Shropshire Board needs to be confident that this practice is embedded in all services. The Board also needs to be confident that when a safeguarding concern has been raised, the person affected is part of all decisions that are made.

Shropshire Fire and Rescue Service has a cohort of Vulnerable Persons Officers who now attend Safeguarding and other related training programs supported by this board. This incorporates SPIC, Children's Safeguarding Board and some national initiatives/courses.

This group of Officers liaise with those identified as at risk and the various partner groups that might support the individual. They also advise and support Shropshire Fire and Rescue Service senior management in the process of safeguarding.

An E Learning training package is being designed in house and will be rolled out across Shropshire Fire and Rescue Service to support the new order on safeguarding.



Shropshire Fire and Rescue Service fed back to the board on a case which highlighted areas of best practice and also development. This feedback process is linked to the operational response debriefing that is carried out by Shropshire Fire and Rescue Service following emergency incidents. Feedback is also provided for non-emergency situations which are dealt with by the Vulnerable Persons Officers.

### **3. Public and workforce awareness of their responsibility to safeguard people and report concerns if necessary –**

the public and the workforce are essential if we want to stop abuse happening in the first instance and respond effectively if it has happened. Everyone needs to understand their responsibility at all stages.

The new guidance document issued by Shropshire Fire and Rescue Service clearly states;

- The responsibilities of all members of the organisation.
- The process for raising concerns.
- The definitions of what constitutes a safeguarding issue.

This document will be supported by a bespoke E-Learning training package which is currently being designed.

### **4. Establishing effective working relationships with other strategic partnerships –**

The Shropshire Safeguarding Board should not work in isolation. In order to be effective and achieve as wide a reach as possible, other strategic partnerships need to be clear about their role in Safeguarding adults with care and support needs from abuse.

To construct the new guidance document Shropshire Fire and Rescue Service liaised with this board, especially with Sarah Hollinshead-Bland. In addition to this Shropshire Fire and Rescue Service consulted various Fire and Rescue Services and West Midlands Ambulance Service.

Donna Trowsdale Development Manager at Shropshire Fire and Rescue Service supports the Learning & Development sub group. Shropshire Fire and Rescue Service links up with SPIC for training opportunities.

Shropshire Fire and Rescue Service is also represented at The Hate Crime Forum, Prevent, MARAC and MAPPA.

### **Our “Business as usual activity”**

Shropshire recognises that safeguarding adults is not just about reacting when abuse has been identified, but it is very important to prevent abuse from happening in the first instance. Safeguarding is a range of activity and the development of a culture that promotes good practice and caring within services. The person at the centre of the concern should feel safe in their homes and in their communities.

The following areas are identified as business as usual activities for the Keeping Adults Safe in Shropshire Board. They should be reflected in the structure of the Board and its business plan:

#### **a. Assurance and challenge**

Partners and Board members are invited to feedback to Shropshire Fire and Rescue Service regarding raised concerns, the methodology adopted and the appropriateness of the concern. Shropshire Fire and Rescue Service review serious case interventions and hold monthly meetings to discuss best practice within the specialist Vulnerable Persons cadre.

#### **b. Ensure the effective undertaking of safeguarding enquires (including section 42 enquires which we have to do if a person has care and support needs and they are experiencing or are at risk of abuse).**

Shropshire Fire and Rescue Service has a policy which details a clear pathway of required action for raising a concern.

**c. Undertaking safeguarding adult reviews and changing practice as a result of what we learn from them**

Shropshire Fire and Rescue Service will contribute to reviews as and when required. Best practice will be implemented.

Shropshire Fire and Rescue Service will feedback to partners on all occasions where concerns are shared.

**d. Audit and performance (including identifying trends from our communities and using our experience to constantly improve what we do)**

Shropshire Fire and Rescue Service has identified an increasing trend in Hoarding disorder. As a result a guidance document has been issued across Shropshire Fire and Rescue Service to ensure the correct identification, support and intervention for such cases.

## Appendix 3

The following priorities are identified in the Keeping Adults Safe in Shropshire Board Strategic Plan. Please give specific examples of how your organisation has been working towards the Strategic Plan of the Board.

Name of Organisation:

**Healthwatch**

Name and role of person completing the template:

**Jane Randall-Smith, Chief Officer**

### 1. Preventing abuse from occurring – we need to do this for three main reasons:

- to develop a culture of caring for others
- to stop harm from happening to people and
- to minimise the impact of dealing with abuse on our services

Healthwatch Shropshire undertakes an Enter & View programme of visits to health and social care facilities. The visit programme is intelligence led and the purpose of a visit will be determined by the intelligence available on a specific facility. If the visit team identifies other issues outside the scope of the purpose these would also be documented and any safety concerns would be raised at the time of the visit.

Recommendations are made to the provider who is invited to respond to the report and prepare an action plan.

Concerns are also shared with the Clinical Commissioning Groups, Local Authority Adult Social Care and Safeguarding.

### 2. Making Safeguarding Personal and implementing personalisation –

personalisation means giving people as much control as possible over their lives. The Keeping Adults Safe in Shropshire Board needs to be confident that this practice is embedded in all services. The Board also needs to be confident that when a safeguarding concern has been raised, the person affected is part of all decisions that are made.

Healthwatch Shropshire receives calls from members of the public about the quality of services and / or asking how to raise a safeguarding concern. Healthwatch Shropshire will discuss with the caller how to raise a concern, may contact the Safeguarding team on behalf of the caller and always asks for permission to share information.

Healthwatch Shropshire will follow up to establish what action has been taken and if there is not enough information to raise a safeguarding concern, will consider what steps it is appropriate for it to take to address the concerns raised.

### 3. Public and workforce awareness of their responsibility to safeguard people and report concerns if necessary –

the public and the workforce are essential if we want to stop abuse happening in the first instance and respond effectively if it has happened. Everyone needs to understand their responsibility at all stages.

All the Healthwatch Shropshire staff team and Enter & View Authorised Representatives have undertaken Safeguarding training so that they are prepared to deal with situations when callers contact Healthwatch Shropshire about the quality of health and social care and when undertaking an Enter & View visit. Enter & View Authorised Representatives are all DBS checked.

Healthwatch Shropshire raised concerns with Safeguarding on four separate occasions in 2015-16

### 4. Establishing effective working relationships with other strategic partnerships –

The Shropshire Safeguarding Board should not work in isolation. In order to be effective and achieve as wide a reach as possible, other strategic partnerships need to be clear about their role in Safeguarding adults with care and support needs from abuse.

Healthwatch Shropshire works in partnership with many organisations across Shropshire. It can use its networks to raise awareness of safeguarding.

Healthwatch Shropshire receives feedback on a confidential basis and the caller may not wish to disclose details which make it a challenge for the Safeguarding team to act on these concerns. Healthwatch Shropshire maintains a record but it is recommended that Safeguarding keeps a record of all its callers who raise a concern whether or not it is progressed, as it will build up a fuller picture of that provider.

### Our “Business as usual activity”

Shropshire recognises that safeguarding adults is not just about reacting when abuse has been identified, but it is very important to prevent abuse from happening in the first instance. Safeguarding is a range of activity and the development of a culture that promotes good practice and caring within services. The person at the centre of the concern should feel safe in their homes and in their communities.

The following areas are identified as business as usual activities for the Keeping Adults Safe in Shropshire Board. They should be reflected in the structure of the Board and its business plan:

**a. Assurance and challenge**

Healthwatch Shropshire undertakes Enter & View visits using the feedback it receives or by request from commissioners where concerns are raised about a provider.

**b. Ensure the effective undertaking of safeguarding enquires (including section 42 enquires which we have to do if a person has care and support needs and they are experiencing or are at risk of abuse).**

N/A for Healthwatch Shropshire .

**c. Undertaking safeguarding adult reviews and changing practice as a result of what we learn from them**

N/A

Healthwatch Shropshire makes recommendations in its Enter & View reports and invites a provider response and Action Plan. These reports are published and are also shared directly with key agencies.

In 2016-17 Healthwatch Shropshire will be reviewing progress on Action Plans to explore the impact of Enter & View.

Healthwatch Shropshire has been involved in multi-agency meetings following safeguarding concerns being raised. Healthwatch Shropshire is able to continue any intelligence it holds and may offer to undertake an Enter& View visit or participate in an engagement event.

**d. Audit and performance (including identifying trends from our communities and using our experience to constantly improve what we do)**

Healthwatch Shropshire gathers feedback from the people of Shropshire on their health and social care services and analyses it to identify trends and hot spots. The nature of a concern raised will determine the action to follow and may include a referral to safeguarding.

## Appendix 4

The following priorities are identified in the Keeping Adults Safe in Shropshire Board Strategic Plan. Please give specific examples of how your organisation has been working towards the Strategic Plan of the Board.

Name of Organisation:  
**West Mercia Police**

Name and role of person completing the template:  
**Jason Wells, Detective Superintendent, Warwickshire and West Mercia Police**

### 1. Preventing abuse from occurring – we need to do this for three main reasons:

- to develop a culture of caring for others
- to stop harm from happening to people and
- to minimise the impact of dealing with abuse on our services

Within the Strategic Alliance between West Mercia Police and Warwickshire Police, (The Alliance) there is a shared vision of 'protecting people from harm', which focuses our activity on areas of business which will include the delivery of the Adult Safeguarding Board priorities as set out in the strategic plan.

Preventing abuse from occurring is obviously a very important area for the police. Criminal investigations involving crimes against adults with care and support needs are intrinsic to the prevention of on going, or further abuse. From a Shropshire perspective, one such case involved the specialist police, Adults at Risk Unit. It was a complicated theft and fraud investigation in the Market Drayton area, and involved two elderly, disabled gentlemen who lived in different areas of the town. Both gentlemen were incapable of protecting themselves from the actions of the female offender due to their vulnerabilities.

The specialist team were able to obtain evidence that clearly demonstrated that she had stolen over £100,000 off one of the gentleman. The offender received the maximum custodial sentence permitted. However, the true positive outcome was that for one of these frail, disabled gentlemen, who had been spent 15 years living in isolation and dreadful living conditions, through our multi agency working processes in adult safeguarding, he now has an excellent quality of life, he is happy, safe and free from abuse which epitomises the Warwickshire Police and West Mercia Police commitment to 'protecting people from harm' and preventing abuse.

## 2. Making Safeguarding Personal and implementing personalisation –

personalisation means giving people as much control as possible over their lives. The Keeping Adults Safe in Shropshire Board needs to be confident that this practice is embedded in all services. The Board also needs to be confident that when a safeguarding concern has been raised, the person affected is part of all decisions that are made.

What does MSP mean for the police?

It means:

- Victim centred safeguarding approach working with the relevant partner agencies within the confines of legislation.
- Engaging with the adult in a meaningful way, listening to the adult and protecting from harm from self or others.

We deliver this by utilising the following framework. We:

- Investigate possible crimes.
- Conduct joint investigations with partners.
- Gather best evidence to maximise prospects for prosecuting offenders.
- Achieve (with partners) best protection and support for the person suffering abuse / neglect.

In Shropshire we have also have the addition of the Adults at Risk Unit, this specialized units primary function is to work with other statutory and voluntary agencies to manage risk, investigate and prosecute offences, and safeguard and protect adults with care and support needs from the risk of significant harm or exploitation. This team actively engages with and utilises the premise of MSP, in that their actions are based upon 'supported decision making for the individual'. Through every step of any engagement, the person or person's family, are involved in the process.

One example of MSP involved a lady with extensive learning difficulties who had been subjected to a serious sexual assault. Her main carer was her mother and from the start of the process, right through to the end, when the officer wanted to update her and to see how she was, all meetings were carried out in a coffee shop as this was where the lady and her mother felt the most comfortable and at ease.



### 3. Public and workforce awareness of their responsibility to safeguard people and report concerns if necessary –

the public and the workforce are essential if we want to stop abuse happening in the first instance and respond effectively if it has happened. Everyone needs to understand their responsibility at all stages.

Raising awareness of the adult safeguarding process, not only with police officers but in our communities is vital in the holistic approach of prevention of abuse to adults with care and support needs. With the aim of raising that awareness, there is a commitment to review and develop both working practices and training across the organisation. Since July 2015, the Alliance has used the '13 Strands of Public Protection' training as provided by the National College of Policing. We recognise that this training is generic in relation to 'vulnerability' per se, and not specific to adults with care and support needs however, The Alliance is actively developing courses for all established front line officers and staff to look at 'professional curiosity', 'vulnerability' and adult safeguarding more specifically.

We also strive to improve our engagement with both service providers and our adults with care and support needs in the community. Through working in unison with partner agencies, there have been many positive outcomes for our adults with care and support needs and this will go from strength to strength with increased and specific 'adults with care and support needs' training, thus dissemination of that knowledge into our communities.

### 4. Establishing effective working relationships with other strategic partnerships –

The Shropshire Safeguarding Board should not work in isolation. In order to be effective and achieve as wide a reach as possible, other strategic partnerships need to be clear about their role in Safeguarding adults with care and support needs from abuse.

In line with The Alliance values to 'work in partnership to provide the best service we can', we now have a combination of Multi Agency Safeguarding Hub (MASH) or Harm Assessment Units (HAU) serving Herefordshire, Shropshire, Telford, Warwickshire and Worcestershire. In Shropshire, the HAU provides a single point of contact for statutory safeguarding activity however, we are moving forward to the HAU being far more engaged with the adult safeguarding process, this is a matter of capacity and adequate training. We hope to achieve the same involvement and engagement within the HAU with our partner agencies that we currently have in relation to Child and Domestic Abuse safeguarding processes.

## Our “Business as usual activity”

Shropshire recognises that safeguarding adults is not just about reacting when abuse has been identified but it is very important to prevent abuse from happening in the first instance. Safeguarding is a range of activity and the development of a culture that promotes good practice and caring within services. The person at the centre of the concern should feel safe in their homes and in their communities.

The following areas are identified as business as usual activities for the Keeping Adults Safe in Shropshire Board. They should be reflected in the structure of the Board and its business plan:

### a. Assurance and challenge

The Alliance document, ‘Looking to 2020’ sets out the vision for the future of policing, and highlights that ‘Protecting people from harm’ is at the core of everything we do. The overriding ambition over the next five years is to become ‘great’ at protecting the most vulnerable from harm. With that in mind, a pilot for generic ‘Vulnerability’ training has taken place in the Telford policing area, consisting of both e-learning and work with an external drama group. This pilot has been evaluated by Worcester University, and as a result a larger pilot is due to take place with the long term aim of rolling the training out across the entire Alliance. This will mean that for all areas, including Shropshire, non specialist departments and officers will be provided with training on a variety of aspects of vulnerability. This will include adults with care and support needs specifically and thus, target the adult safeguarding process.

To facilitate continued joint working, the Alliance has developed a new shared vision and set of values. These provide a unified purpose for the two organisations and a clear direction to our workforce and our stakeholders as to how the forces will operate.

Vision - Protecting people from harm

Values - We will:

- Take pride in our professionalism and standards of behaviour
- Listen and engage
- Use professional judgement and be courageous in making decisions
- Seek out better ways of working

- Lead with confidence and do the right thing
- Work in partnership to provide the best service we can

Our vision and values form the basis of the Alliance's organisational culture - a set of shared attitudes, goals, practices and aspirations. In Shropshire we will continue to protect our adults with care and support needs from abuse or the risk of abuse through improved and increased training to all officers and staff, and through our very strong ethos and commitment to multiagency working. Inherently incorporated throughout that whole process, will be our policy of robustly challenging and changing our working practices as part of on going learning processes.

### **b. Ensure the effective undertaking of safeguarding enquires (including section 42 enquires which we have to do if a person has care and support needs, and they are experiencing or are at risk of abuse).**

The Alliance has exceptional working relationships with its partner agencies in Adult Safeguarding in Shropshire. Having such strong symbiotic associations allows us to effectively undertake enquires so that we can achieve constructive action, prevention of abuse and most importantly, positive outcomes for our adults with care and support needs. In Shropshire, we also have the specialist Adults at Risk Unit. They have forged strong, working relationships with agencies, in particular Shropshire Council Adult Safeguarding, and this has been instrumental in effective safeguarding enquiries or indeed, criminal investigations.

One such example of this effective working relationship involved a concern regarding financial abuse. The adult at risk was an elderly lady with a diagnosis of dementia and she had been admitted to a care home by her son. Initially the lady herself was capable of signing her own cheques for payment as she was a 'self funding' client. However, after a short period of time, the lady's capabilities diminished and financial responsibility was passed to her son.

The son failed to continue with payments and after a few months a substantial fee for his mothers care remained unpaid. Following enquiries made at the care home and after extensive consultation with the Shropshire Council Adult Safeguarding Team, detectives from the Adult at Risk Unit instigated an investigation into financial abuse. It was quickly identified that the ladies accounts were being defrauded of large amounts of funds, whilst the fees for her care remained unpaid. Investigations revealed that the money had been withdrawn by the son to support his own lifestyle. He was later charged with a number of offences under the Theft Act. The Shropshire Safeguarding Team ensured that the lady's care home placement continued unaffected and funded.

### **c. Undertaking safeguarding adult reviews and changing practice as a result of what we learn from them**

The Alliance has always embraced the ‘transparent approach’ when dealing with policies or practices that if had been different, then an enquiry or investigation may have been focused in a different direction or a more timely manner. Similarly, if actual organisational errors have been identified in an adult with care and support needs investigation, then we are very much part of, and embrace the Safeguarding Adult Review process (SAR).

One such case involving the multi agency Safeguarding Adult Review process was the investigation into a lady who had received significant and substantial bruising. Through the review process, it was identified that all agencies were required to instigate changes to areas of their practice. One area of improvement identified across all agencies, was the need for more frequent and thorough communication between organisations. From the Alliance perspective, once a criminal enquiry has been finalised then that information must be relayed to fellow agencies allowing them to undertake actions from their organisational perspective.

A dedicated Detective Inspector for Strategic Safeguarding is responsible for thematic reviews of SCR learning across the Alliance to ensure service delivery takes into account the lessons to be learnt and ensure that any action plans are seen through to conclusion. In effect, all points of learning and changes to practice are disseminated through the Alliance thus, learning as a whole from the SAR process.

### **d. Audit and performance (including identifying trends from our communities and using our experience to constantly improve what we do)**

Warwickshire and West Mercia Police were inspected by the HMIC who produced the PEEL: Police Effectiveness 2015 (Vulnerability) reports dated December 2015. The summary of findings highlighted that both Warwickshire Police and West Mercia Police generally provided a good service in identifying vulnerable victims and responded appropriately with its partners, and the public could be confident that many victims felt supported. There were however, areas identified for improvement. It was recommended that the forces should improve their response to vulnerable victims by reviewing the behaviour of staff towards vulnerability and evaluating the effectiveness of its training, learning and development. It also recommended that the forces should improve compliance under the Code of Practice for Victims of Crime, specifically in relation to the use of special measures.

The Alliance has sought to address the PEEL recommendations across both police areas and is therefore promoting a more consistent approach by staff in relation to the understanding and the management of the adult safeguarding process. We are also improving the manner in which we identify and record concerns surrounding adults with care and support needs.

An example of this in practice can be evidenced by the specialist police Adults at Risk Unit in Shropshire. Through its audit and monitoring processes, the unit identified an increase in significant and complex fraud offences against adults with care and support needs. As a consequence of this identification, the unit enlisted the help of the specialist Economic Crime Unit to improve the understanding and therefore obtain best evidence when dealing with complex fraud investigations.

## Appendix 5

The following priorities are identified in the Keeping Adults Safe in Shropshire Board Strategic Plan. Please give specific examples of how your organisation has been working towards the Strategic Plan of the Board.

Name of Organisation:

**Shrewsbury and Telford Hospitals (SATH)**

Name and role of person completing the template:

**Helen Hampson, Adult Safeguarding Lead**

### 1. Preventing abuse from occurring – we need to do this for three main reasons:

- to develop a culture of caring for others
- to stop harm from happening to people and
- to minimise the impact of dealing with abuse on our services

Throughout the safeguarding training at SATH staff are reminded that safeguarding is not just part of their professional duties, but also as members of their own community. Staff are encouraged to act on and report actual or suspected abuse, including anti – social behaviour and hate crime.

### 2. Making Safeguarding Personal and implementing personalisation –

personalisation means giving people as much control as possible over their lives. The Keeping Adults Safe in Shropshire Board needs to be confident that this practice is embedded in all services. The Board also needs to be confident that when a safeguarding concern has been raised, the person affected is part of all decisions that are made.

With the introduction of the Care Act 2014 we acknowledge that the emphasis is now on Making Safeguarding Personal. Training provided on site for all members of staff reinforces the concept of empowering and supporting the individual to make their own choices and that the individual's wellbeing is promoted at all times. If the individual has been assessed as being unable to make decisions for themselves we ensure that the individual is fully supported with the appropriate advocacy service. We maintain a safeguarding database for all safeguarding concerns made and can be used for audit and evidence information gathering.

### 3. Public and workforce awareness of their responsibility to safeguard people and report concerns if necessary –

the public and the workforce are essential if we want to stop abuse happening in the first instance and respond effectively if it has happened. Everyone needs to understand their responsibility at all stages.

Adult safeguarding training provides staff with an awareness of what abuse is, types of abuse, which includes examples and indicators, how to recognise abuse and the process on how to report actual or suspected abuse or neglect, also informing staff of the variances in the reporting procedure for the different local authorities. Ensuring staff receive feedback once a referral has been made if possible from the local authorities.

### 4. Establishing effective working relationships with other strategic partnerships –

The Shropshire Safeguarding Board should not work in isolation. In order to be effective and achieve as wide a reach as possible, other strategic partnerships need to be clear about their role in Safeguarding adults with care and support needs from abuse.

We work together with our colleagues and partners in the community to develop an effective safeguarding plan if required. This includes sharing information with due regard to confidentiality and information sharing protocols.

We complete our own internal investigations and as part of a multi – agency enquiry, reporting back to the relevant agencies and individual.

As a Trust, the Director of Nursing and Quality and Associate Director of Patient Safety are core members of the Safeguarding Adults Boards, whilst the Safeguarding team attend the subgroups for both Shropshire and Telford and Wrekin.

The safeguarding team within the Trust consists of;

Named Nurse for safeguarding children and younger people (Lead for Domestic Abuse)

Safeguarding Midwife

Adult Safeguarding Lead

Safeguarding Support Nurse for both children and adults including domestic abuse

## Our “Business as usual activity”

Shropshire recognises that safeguarding adults is not just about reacting when abuse has been identified, but it is very important to prevent abuse from happening in the first instance. Safeguarding is a range of activity and the development of a culture that promotes good practice and caring within services. The person at the centre of the concern should feel safe in their homes and in their communities.

The following areas are identified as business as usual activities for the Keeping Adults Safe in Shropshire Board. They should be reflected in the structure of the Board and its business plan:

### a. Assurance and challenge

Safeguarding training is mandatory for all patient handlers within SaTH. It is also introduced at induction for all new members of staff. We continue to emphasise to all our staff that we all have a responsibility in recognising potential abuse or actual abuse and then taking the necessary actions to prevent further harm.

Safeguarding training is mandatory for all patient handlers within SaTH. It is also introduced at induction for all new members of staff. We continue to emphasise to all our staff that we all have a responsibility in recognising potential abuse or actual abuse and then taking the necessary actions to prevent further harm.

Staff are also made aware of the implementation of Making Safeguarding Personal and this is an on-going process throughout our training. This includes promoting the individual's wellbeing at all times.

### b. Ensure the effective undertaking of safeguarding enquires (including section 42 enquires which we have to do if a person has care and support needs and they are experiencing or are at risk of abuse).

SaTH safeguarding team complete full internal investigations in a timely manner and continue to have a close liaison with relevant external agencies.

Information is shared within the Trust and actions taken from any learning points.



**c. Undertaking safeguarding adult reviews and changing practice as a result of what we learn from them**

SaTH contribute to safeguarding adult reviews as required and share learning points and any agreed actions.

**d. Audit and performance (including identifying trends from our communities and using our experience to constantly improve what we do)**

A safeguarding database is maintained within the Trust and information can be gained for audit purpose and for also recognising any trends internally and externally.

## Appendix 6

The following priorities are identified in the Keeping Adults Safe in Shropshire Board Strategic Plan. Please give specific examples of how your organisation has been working towards the Strategic Plan of the Board.

Name of Organisation:

**Shropshire Community Health NHS Trust**

Name and role of person completing the template:

**Andrew Thomas, Head of Nursing and Quality (Adults),  
Quality and Compliance Lead, Adult Safeguarding (Shropshire)**

### 1. Preventing abuse from occurring – we need to do this for three main reasons:

- to develop a culture of caring for others
- to stop harm from happening to people and
- to minimise the impact of dealing with abuse on our services

Values into action, internal assessment of the CQC KLOE domains and action plans drawn up.

### 2. Making Safeguarding Personal and implementing personalisation –

personalisation means giving people as much control as possible over their lives. The Keeping Adults Safe in Shropshire Board needs to be confident that this practice is embedded in all services. The Board also needs to be confident that when a safeguarding concern has been raised, the person affected is part of all decisions that are made.

Safeguarding training is mandatory for all clinical staff. Any referrals are alerted to the SCHAT safeguarding leads and support to ensure the adult is involved in decision making as much as possible. Currently an MCA audit is taking place and one aspect of the audit is the 5 principles of the MCA. The findings will be presented to relevant quality forums and a learning action plan made to ensure learning is shared and lessons learned are actioned.

### 3. Public and workforce awareness of their responsibility to safeguard people and report concerns if necessary –

the public and the workforce are essential if we want to stop abuse happening in the first instance and respond effectively if it has happened. Everyone needs to understand their responsibility at all stages.

Safeguarding training is mandatory for all clinical staff with higher levels of training for specific roles. Safeguarding and safeguarding being everyone's business has been the focus at the community Trust Leadership Group in June 2016.

### 4. Establishing effective working relationships with other strategic partnerships –

The Shropshire Safeguarding Board should not work in isolation. In order to be effective and achieve as wide a reach as possible, other strategic partnerships need to be clear about their role in Safeguarding adults with care and support needs from abuse.

SCHT works closely with the CCG and local authority, and engages in regular safeguarding and MCA meetings with these parties and other local health providers.

### Our "Business as usual activity"

Shropshire recognises that safeguarding adults is not just about reacting when abuse has been identified but it is very important to prevent abuse from happening in the first instance. Safeguarding is a range of activity and the development of a culture that promotes good practice and caring within services. The person at the centre of the concern should feel safe in their homes and in their communities.

The following areas are identified as business as usual activities for the Keeping Adults Safe in Shropshire Board. They should be reflected in the structure of the Board and its business plan:

**a. Assurance and challenge**

Keeping adults safe is a standing agenda item on adults quality and safety meetings and is also reported at executive level at Quality and safety committee. Included is any safeguarding incidents, reports, MCA and DOLS issues. All safeguarding incidents are seen by the SCHAT safeguarding leads and challenges made to referrers. Safeguarding level 1 is mandatory for all clinical staff, and higher levels for those in specific roles.

**b. Ensure the effective undertaking of safeguarding enquires (including section 42 enquires which we have to do if a person has care and support needs and they are experiencing or are at risk of abuse).**

SCHAT has been caused to undertake Section 42 enquiries relevant to our Trust and to our areas of expertise, e.g. diabetes care, Tissue Viability and elderly inpatient care. Lessons learned and actions from these enquiries are taken forward via Quality and Safety meetings.

**c. Undertaking safeguarding adult reviews and changing practice as a result of what we learn from them**

N/A

**d. Audit and performance (including identifying trends from our communities and using our experience to constantly improve what we do)**

An audit is underway exploring the embedding of MCA and DOLS into practice within the community trust. All incidents and section 42 outcomes are explored for learning opportunities and learning is shared throughout the Trust.

## Appendix 7

The following priorities are identified in the Keeping Adults Safe in Shropshire Board Strategic Plan. Please give specific examples of how your organisation has been working towards the Strategic Plan of the Board.

Name of Organisation:

**Shropshire Council**

Name and role of person completing the template:

**Andy Begley, Director Adult Social Care**

### 1. Preventing abuse from occurring – we need to do this for three main reasons:

- to develop a culture of caring for others
- to stop harm from happening to people and
- to minimise the impact of dealing with abuse on our services

The Community Mental Health team share an office with health staff and have joint weekly team meetings in order to share information quickly. Risk assessments are completed with all relevant people within three meetings.

The work of the Deprivation of Liberty Safeguards team focusses on reducing restrictions in any care and support plan and assessing the person's best interests. Their wishes, feelings, beliefs and values are central to this process. Best Interest Assessors have attended training on talking to people who have complex needs and also on Autism this year which has helped them develop a more person centred approach to assessment work. The work with care homes to identify and reduce restrictions contributes to a culture of caring.

Public Protection have led on the following cases to prevent or stop abuse:

- Working with scam victims subject to financial abuse to stop further money being sent and to stop unwanted mailing/direct marketing being received. The victims are often older and socially isolated.
- Helping people who hoard a lot of things in their home, who are living in unsafe and unhygienic housing conditions, to improve their housing conditions and connect them with support providers enabling them to remain living in their home.
- Resolving neighbour disputes and anti-social behaviour which cause harm to people with care needs
- Involving people to help them change their behaviours which are putting them at risk of eviction and enable them to access the support they require to remain living in their own home.

- Successful use of consumer protection legislation (including the Fraud Act 2006 and associated legislation) to tackle financial abuse from doorstep crime by 'rogue traders' through a range of approaches from advice to prosecution. When undertaking investigations financial reimbursement and compensation is sought for victims through informal negotiation with offenders undertaken by officers and formal compensation applications through the Courts.
- Significant work has been undertaken to revise the Shropshire Council's Hackney Carriage and Private Hire Licensing Policy and the Gambling Act Policy to specifically address safeguarding and the changes that have been made to licensing application processes and supporting enforcement in relation to licensing conditions and the law. Private Hire Operators are required to have a suitably trained Designated Person with specific responsibility for safeguarding.

A Principal Social Worker has been identified. The Care Act requires the Local Authority to have a Principle Social Worker to make sure that the quality and consistency of social work practice is high, to promote Making Safeguarding Personal and being confident that this is happening. The current Principle Social Worker is an active member of the Learning and Development sub-group of the Board.

The Principle Social Worker works with the Safeguarding Lead to maintain standards of social work in the Safeguarding Team.

## 2. Making Safeguarding Personal and implementing personalisation –

personalisation means giving people as much control as possible over their lives. The Keeping Adults Safe in Shropshire Board needs to be confident that this practice is embedded in all services. The Board also needs to be confident that when a safeguarding concern has been raised, the person affected is part of all decisions that are made.

Shropshire Council has changed its practice to ensure that the adult with care and support needs is at the centre of the safeguarding process. This is done by encouraging workers to support the adult to raise the concern themselves or if this is not possible, ensuring that the process begins with a discussion with the adult about how they want to be made safe. This will be further enhanced by collecting data showing when this happens.

The delivery of Mental Capacity Act training to service users and their parents and carers is an important part of helping people understand the Mental Capacity Act and their rights. As result of this training, Taking Part and Shropshire Council and has worked with a group of adults with care and support needs to devise cards identifying the five principles of the Mental Capacity Act. This will mean that professionals are reminded to promote choice and control for the individual about their lives.

In Mental Health, a discussion with the individual takes place before any further action in most cases as part of the risk assessment. The wishes and needs of the individual are taken into account when making any decisions.

The Deprivation of Liberty Safeguards team work only with people who lack capacity to make care and support decisions. A significant part of their assessment is to determine the person's views and to explore whether and to what extent their wishes can be followed. In some cases this year people have been found to actually have capacity once assessed and this has resulted in the care home only being able to impose restrictions which the person agrees to.

The team have ensured people are informed of their rights and we have received a number of appeals to the Court of Protection which is a positive application of their human rights.

A new process for checking through the case files has been developed to make sure that they are checked regularly with the social worker as part of their supervision with their manager

Housing Services ensure that all safeguarding referrals, wherever possible, are discussed with the client and / or family members before a referral is made. Housing Services also check to make sure there are no risks to individuals who are housed in temporary accommodation as well as those that present as homeless due to threats and abuse. We work alongside other agencies to ensure we take into account a person's individual situation and consider their wishes before taking any action.

### **3. Public and workforce awareness of their responsibility to safeguard people and report concerns if necessary –**

the public and the workforce are essential if we want to stop abuse happening in the first instance and respond effectively if it has happened. Everyone needs to understand their responsibility at all stages.

All Mental Health staff have to attend the safeguarding training and updates and this is monitored by management and staff. Safeguarding is a regular agenda item at the Team Meetings.

The Public Protection team now have links with the Anti-Social Behaviour team to support the sharing of information between agencies and to make sure we can quickly respond to safeguard people.

A programme of safeguarding awareness training is in place for new and existing taxi and private hire drivers.

Housing Services has made sure that all front line staff are booked onto Adult Safeguarding and Mental Capacity Act training.

#### 4. Establishing effective working relationships with other strategic partnerships –

The Shropshire Safeguarding Board should not work in isolation. In order to be effective and achieve as wide a reach as possible, other strategic partnerships need to be clear about their role in Safeguarding adults with care and support needs from abuse.

The Community Mental Health team work with other agencies as part of a partnership agreement such as will housing and public protection.

The Mental Capacity Act Manager has supported work with people who use services to put together information to help others who find themselves in the same situation. They have also made a film. The training officer has delivered Mental Capacity Act training to people who use services and to young people and their parents and carers at transition.

The Mental Capacity Act Manager has continued to be part of the multi-agency Mental Capacity Act group working with the Clinical Commissioning Group, the local acute hospitals and Robert Jones and Agnes Hunt Hospital/ There have been visits to the hospital wards to see how they use their training in their day to day work. This also helps us to decide how we will training people in the future.

Senior managers from Housing Services attend the Keeping Adults Safe in Shropshire Board including all sub-groups. Housing Services are aware of the importance of partnership working and this is key to our day to day work.

#### Our “Business as usual activity”

Shropshire recognises that safeguarding adults is not just about reacting when abuse has been identified but it is very important to prevent abuse from happening in the first instance. Safeguarding is a range of activity and the development of a culture that promotes good practice and caring within services. The person at the centre of the concern should feel safe in their homes and in their communities.

The following areas are identified as business as usual activities for the Keeping Adults Safe in Shropshire Board. They should be reflected in the structure of the Board and its business plan:



### a. Assurance and challenge

Social Care staff are challenged by their line managers in supervision when case files are checked.

Best Interest Assessors continue to ensure they meet Shropshire's expected compliance of having Adult Safeguarding training and have worked alongside one or more cases which has been to the Court of Protection due to concerns of abuse and resulting in a deprivation of liberty issue.

All housing staff are held to account for providing evidence that actions have been completed. Regular reviews of cases ensure that Housing Services are aware of what they may need to do differently next time.

The Adult Safeguarding Team are regularly involved in challenging the practice of all working with people who need care and support. This helps individuals to be more in control of their lives and the decisions they need to make.

### b. Ensure the effective undertaking of safeguarding enquires (including section 42 enquires which we have to do if a person has care and support needs and they are experiencing or are at risk of abuse).

Shropshire Council have put two Safeguarding practitioners in the Contact centre to help prioritise safeguarding concerns that are raised, this means we can protect people more quickly if required and act as a source of expertise to the contact centre staff.

All Mental Health social workers are attending Section 42 enquiry training.

Housing Services have a named manager who attends the Keeping Adults Safe in Shropshire Board. Housing actively participates in the safeguarding process and if necessary, will lead in enquiries or provide specific expertise.

**c. Undertaking safeguarding adult reviews and changing practice as a result of what we learn from them**

See annual report.

**d. Audit and performance (including identifying trends from our communities and using our experience to constantly improve what we do)**

Shropshire Council has rewritten its client information system in order to tell us who is affected by abuse and where it is happening (please see the “What we know about Safeguarding in Shropshire” section). This has helped identify the quality of care provided by care homes and domiciliary care services as a priority for next year.

Housing Services are developing a new data management system which uses innovative dashboards and scoreboards. This will be used to provide real time data on all Housing issues and will ultimately lead to predictive analytics.

There has been an internal audit of adult safeguarding practice that has identified some changes in practice that need to be made including the need to take action to reduce the number of open adult safeguarding referrals and in particular clear the referrals from previous financial years. This has resulted in the review and closure of approximately 600 cases. The Adult Safeguarding Team continue to report their progress on other recommendations to Internal Audit. This also demonstrates internal assurance and challenge.

## Appendix 8

The following priorities are identified in the Keeping Adults Safe in Shropshire Board Strategic Plan. Please give specific examples of how your organisation has been working towards the Strategic Plan of the Board.

Name of Organisation:

**Shropshire Partners in Care**

Name and role of person completing the template:

**Karen Littleford, Adult Safeguarding Training & Development Officer**

### 1. Preventing abuse from occurring – we need to do this for three main reasons:

- to develop a culture of caring for others
- to stop harm from happening to people and
- to minimise the impact of dealing with abuse on our services

SPiC's Core Activities include training, providing affordable and good quality courses which promote high standards across the care sector. In addition, SPiC is an umbrella body for DBS checks which supports Care Providers to ensure all eligible staff seeking to work in the care sector are checked in line with current statutory requirements. The Care Workforce Development Partnership and SPiC address workforce development needs, identifying and promoting the importance of and investment in the development of staff and opportunities within the care sector.

In terms of raising the profile of adult safeguarding to prevent abuse SPiC commemorates World Elder Abuse Awareness Day each year. In 2016, SPiC (AnnsCroft Office) has signed up to the Safe Places scheme to support adults who need a place of safety in the community. As part of its commitment to preventing abuse or neglect SPiC has asked all SPiC members who have not already done so, to also sign up to the scheme.

Shropshire Partners in Care works to the key principles of adult safeguarding as outlined in the Care and support statutory guidance. Clear messages are given to providers via training and guidance concerning prevention and the need to stop harm from happening in the first instance.

As well as the existing training and Development Posts and associated courses SPiC has been providing falls prevention and management training. In 2016 a new joint Falls Prevention Project Lead Post in partnership with Shropshire CCG, Shropshire Council and SPiC became operational.

A range of the training, information and advice functions of SPiC contribute to the prevention agenda in addition to partnership working arrangements. Safeguarding Adults Awareness sessions require learners to consider their own and organisational roles in preventing abuse and neglect as well as responding and reporting.

## 2. Making Safeguarding Personal and implementing personalisation –

personalisation means giving people as much control as possible over their lives. The Keeping Adults Safe in Shropshire Board needs to be confident that this practice is embedded in all services. The Board also needs to be confident that when a safeguarding concern has been raised, the person affected is part of all decisions that are made.

SPiC's Fundamental Principles include working in a way that safeguards the human rights of all those who may need, use or work in care services and supports its members to deliver services that place people's rights at the centre of their decision making.

Making Safeguarding Personal (MSP) is embedded in the Business Plan of the KASiSB Learning and Development Sub Group chaired by SPiC. All safeguarding related training courses have been developed to ensure MSP is seen as a role for all organisations in Shropshire. Key messages include starting with the adult and ensuring they are fully involved in decision making about being safe.

## 3. Public and workforce awareness of their responsibility to safeguard people and report concerns if necessary –

the public and the workforce are essential if we want to stop abuse happening in the first instance and respond effectively if it has happened. Everyone needs to understand their responsibility at all stages.

SPiC delivers and facilitates access to a range of training courses supporting the development of skills, knowledge and competence around adult safeguarding. Many of these courses are delivered in partnership with Joint Training, Shropshire Council. All safeguarding training has a focus on the prevention of abuse and neglect as well as responding and reporting. In addition to adult safeguarding training, a wide range of training is delivered or commissioned by SPiC contributing to the development of good practice and a competent workforce.

SPiC activity around adult safeguarding reinforces the safeguarding principle of accountability; this includes clear messages via advice and training regarding challenging practice where needed and intervening to stop abuse or neglect.

The SPiC website has a range of publically accessible information and SPiC receives calls from members of the public who require support and signposting. The Adult Safeguarding Training and Development Officer engages with community groups to raise awareness of safeguarding including The Women's Institute and Volunteers.

SPiC utilises its weekly e-newsletter and website to update members on current issues and developments in the sector. SPiC contributes to national and local consultations, representing the independent care sector and challenging views and concerns from the sector to other organisations, including; local authorities, CQC, MP's and the Clinical Commissioning Group (CCG). Members of the SPiC team participate in working groups, the KASiSB and various sub groups of the KASiSB. SPiC chairs the KASiSB Learning and Development Group. This interaction enables SPiC members to engage with the strategic processes around safeguarding and this was evident at the inaugural KASiSB event.

#### **4. Establishing effective working relationships with other strategic partnerships –**

The Shropshire Safeguarding Board should not work in isolation. In order to be effective and achieve as wide a reach as possible, other strategic partnerships need to be clear about their role in Safeguarding adults with care and support needs from abuse.

SPiC continues to develop positive working relationships with partners in Health, Local Authorities and other statutory agencies. This enables SPiC to share information with members and others to prevent abuse and neglect and reinforce the provider's role in safeguarding adults.

In Shropshire, SPiC sits on the KASiSB, KASiSB Executive Board and the KASiSB Audit and Performance Sub Group. In addition, SPiC chairs the KASiSB Learning and Development Sub Group.

The SPiC Care Awards 2016 celebrated the provision of good quality care in Shropshire and Telford & Wrekin. Attended by SPiC members, partner organisations and hosted by Vicky Archer (Radio Shropshire) with Kelda Wood (GB Paracanoe athlete) giving an inspiring pre- awards talk. The ten 2016 categories included the following Awards Health & Wellbeing, Healthy Eating, Supporting End of Life Care, Supporting/engaging with your local community and Supporting out of hours discharge.

### **Our “Business as usual activity”**

Shropshire recognises that safeguarding adults is not just about reacting when abuse has been identified but it is very important to prevent abuse from happening in the first instance. Safeguarding is a range of activity and the development of a culture that promotes good practice and caring within services. The person at the centre of the concern should feel safe in their homes and in their communities.

The following areas are identified as business as usual activities for the Keeping Adults Safe in Shropshire Board. They should be reflected in the structure of the Board and its business plan:

#### **a. Assurance and challenge**

–

#### **b. Ensure the effective undertaking of safeguarding enquires (including section 42 enquires which we have to do if a person has care and support needs and they are experiencing or are at risk of abuse).**

–

#### **c. Undertaking safeguarding adult reviews and changing practice as a result of what we learn from them**

–

#### **d. Audit and performance (including identifying trends from our communities and using our experience to constantly improve what we do)**

–

## Appendix 9

The following priorities are identified in the Keeping Adults Safe in Shropshire Board Strategic Plan. Please give specific examples of how your organisation has been working towards the Strategic Plan of the Board.

Name of Organisation:

**South Staffordshire & Shropshire Healthcare NHS Foundation Trust**

Name and role of person completing the template:

**Sharon Conlon, Safeguarding Lead Adults and Children**

### 1. Preventing abuse from occurring – we need to do this for three main reasons:

- to develop a culture of caring for others
  - to stop harm from happening to people and
  - to minimise the impact of dealing with abuse on our services
- 
- Over 80% of our staff have been trained in adult safeguarding . This training includes recognition and awareness of abusive practices, by ensuring that our staff are aware of what actions/omissions constitute abuse we are able to foster a culture of prevention.
  - As a mental health and learning disability NHS Trust promoting and supporting service users to develop resilience and build on strengths is the underpinning philosophy of how we work with adults with care and support needs.

### 2. Making Safeguarding Personal and implementing personalisation –

personalisation means giving people as much control as possible over their lives. The Keeping Adults Safe in Shropshire Board needs to be confident that this practice is embedded in all services. The Board also needs to be confident that when a safeguarding concern has been raised, the person affected is part of all decisions that are made.

- During 2015/16 SSSFT have completed a safeguarding audit , this audit identified that in 58% of adult safeguarding referrals the wishes and feelings of the adult at risk were captured at the point of referral

Making Safeguarding Personal is acknowledged as a priority and is included in SSSFT safeguarding strategy for 2016/17

### 3. Public and workforce awareness of their responsibility to safeguard people and report concerns if necessary –

the public and the workforce are essential if we want to stop abuse happening in the first instance and respond effectively if it has happened. Everyone needs to understand their responsibility at all stages.

- During 2015/16 SSSFT has developed a safeguarding website, this holds information for services users, carers and staff on all aspects of safeguarding.
- The safeguarding team produce a quarterly learning the lessons bullet which provides a synopsis of safeguarding reviews and shares local and national learning.
- A safeguarding update is a feature in SSSFT monthly staff newsletter keeping frontline staff up to date on changes in practice and safeguarding priorities.
- Changes in safeguarding policy and practice as well as news items are added to the trusts discussion forum which enables frontline staff to express their thoughts ideas and opinions in relation to safeguarding themes topics. This is an interactive forum where the exchange of views and opinions can be seen by all staff and all staff can contribute.
- SSSFT have produced bespoke safeguarding posters and leaflets that are available in all of our clinical areas, they provide service users and staff with local contact details for safeguarding support and advice as well as highlighting our staffs responsibility to keep service users safe.

### 4. Establishing effective working relationships with other strategic partnerships –

The Shropshire Safeguarding Board should not work in isolation. In order to be effective and achieve as wide a reach as possible, other strategic partnerships need to be clear about their role in Safeguarding adults with care and support needs from abuse.

We will work in partnership to ensure effective safeguarding

Protecting people from the risk of abuse and neglect is not something that any individual or organisation can achieve on their own – safeguarding is about working in partnership with other agencies so that together we can identify risks, share information and do whatever we can to reduce the risk of harm to vulnerable people” ( SCIE 2015).



Partnership working is core business within SSSFT and safeguarding is an example of how the organisation implements its values. SSSFT is an active member of six safeguarding boards:

- Staffordshire Safeguarding Children Board
- Staffordshire and Stoke on Trent Safeguarding Adult Board
- Shropshire Safeguarding Children Board
- Keeping Adults Safe in Shropshire Board
- Telford and Wrekin Safeguarding Children Board
- Telford and Wrekin Safeguarding Adult Board

### **Our “Business as usual activity”**

Shropshire recognises that safeguarding adults is not just about reacting when abuse has been identified but it is very important to prevent abuse from happening in the first instance. Safeguarding is a range of activity and the development of a culture that promotes good practice and caring within services. The person at the centre of the concern should feel safe in their homes and in their communities.

The following areas are identified as business as usual activities for the Keeping Adults Safe in Shropshire Board. They should be reflected in the structure of the Board and its business plan:

#### **a. Assurance and challenge**

South Staffordshire and Shropshire Foundation Trust (SSSFT) is a NHS Foundation Trust that provides Mental Health and Learning Disability services within Shropshire. Our services are regulated by the Care Quality Commission and commissioned by the local CCG. As an NHS provider organisation SSSFT is required to demonstrate compliance with local and national safeguarding policies and procedures. This is done via a quarterly safeguarding reporting procedure as well as annual completion of the Department of Health Safeguarding Adults Self-assessment tool. The Trust is also required to demonstrate compliance with regulation 13 of the Care Quality Commissions fundamental standards during our recent CQC inspection SSSFT was graded as a good in this area. SSSFT has a safeguarding lead who is directly accountable to the executive lead for safeguarding. The Trust completes a safeguarding annual report which is available via the trusts website and shared with our partners and our commissioners.

**b. Ensure the effective undertaking of safeguarding enquires (including section 42 enquires which we have to do if a person has care and support needs and they are experiencing or are at risk of abuse).**

SSSFT have effective systems in place to capture safeguarding activity from across the organisation. This is monitored via the safeguarding team and performance is reported on a quarterly basis. There is a system in place for responding to section 42 enquires which is managed centrally by the safeguarding team. SSSFT also has various other processes in place to ensure that we can learn from adverse incidents and prevent risks to our service users. These include a complaints process, Patient advice and Liaison (PALS), Serious Incident investigations and local learning reviews.

**c. Undertaking safeguarding adult reviews and changing practice as a result of what we learn from them**

SSSFT contribute to the Safeguarding adult Review process and translate any learning via our quarterly learning the lessons bulletin. SSSFT covers 6 safeguarding boards and therefore our experience of learning from the multi-agency review process is well established.

**d. Audit and performance (including identifying trends from our communities and using our experience to constantly improve what we do)**

SSSFT has a safeguarding audit cycle which enables the team to identify key aspects of safeguarding practice to audit. Making safeguarding Personal is one of the aspects that SSSFT will be focusing on during 2016/17 to ensure that people who use our services are central to safeguarding practice.

Safeguarding performance reports are produced by the safeguarding team for each of our directorates as well as for our commissioners and quality governance committee.



Keeping Adults Safe  
in Shropshire  
Board

# Annual Report

April 2015 – March 2016

## Contacts

You can report safeguarding concerns by phone or online.  
Please contact Shropshire Council's First Point of Contact on 0345 678 9021  
or visit [www.shropshire.gov.uk/report](http://www.shropshire.gov.uk/report)  
If you feel you require first-time help, support or advice about social care,  
contact Shropshire Council First Point of Contact on 0345 678 9044

Other organisations you may wish to contact for more information and  
advice include

Care Quality Commission 03000 616161 <http://www.cqc.org.uk>

Action on Elder Abuse 080 8808 8141 <http://elderabuse.org.uk/>