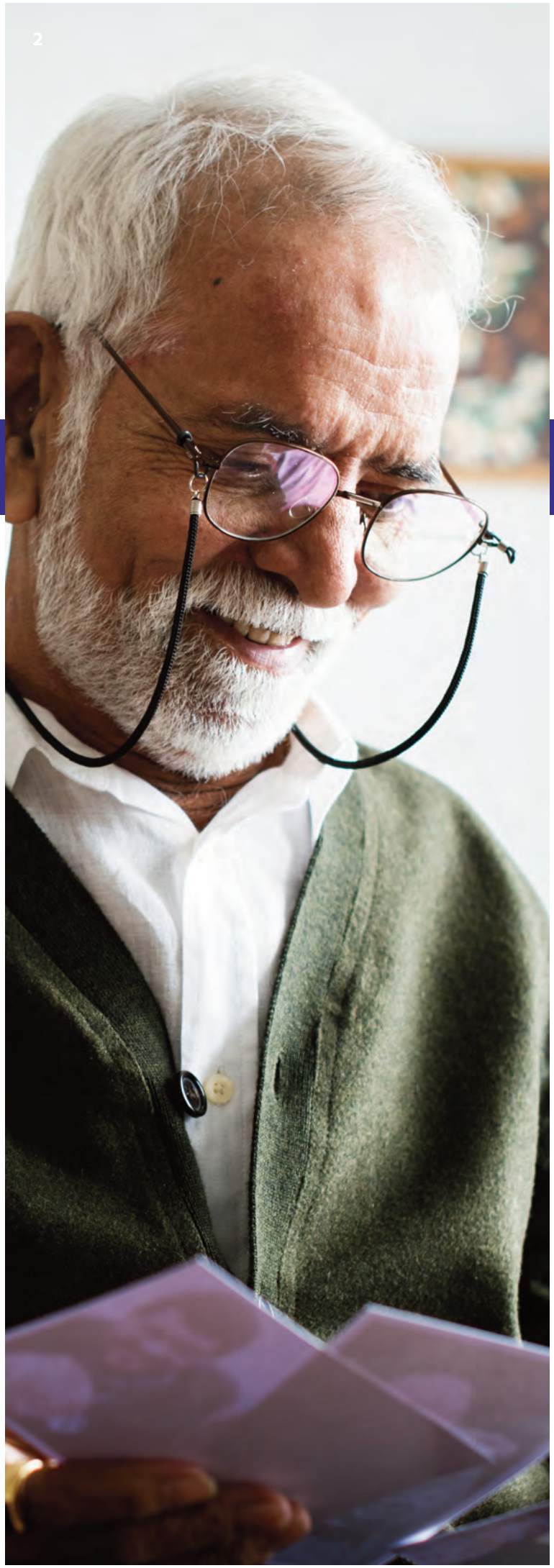
Keeping Adults Safe in Shropshire Board

Annual Report

2018 – 2019



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Foreword by Ivan Powell (Independent Chair)

Thank you for taking the time to read this annual report and your interest in safeguarding adults in Shropshire.

My role is independent of the organisations that make up the Keeping Adults Safe in Shropshire Board, and my duty as Chair is to ensure that the Board is given assurance that we are all delivering safe services, and that board members hold each other to account for this.

The report shows what the board aimed to achieve on behalf of residents of Shropshire during 2018-19.

We continue to reflect on how effective the board is, and hold structured development sessions each year to hold ourselves to account for progress and efficiency.

This report gives more detail of the two key events held this year. One jointly with Telford & Wrekin Council about self neglect and compliance with the Mental Capacity Act; the second a joint event with professionals who work with children and young people where we heard from a range of people about the challenges faced by those who experience exploitation. This latter event resulted in the adoption of a joint priority for tackling exploitation across all ages.

During the year the board also reflected on the challenges posed nationally to the adult safeguarding system in a publication called "A Patchwork of Practice". This resulted in the board having a detailed focus on Making Safeguarding Personal and the Mental Capacity Act, in particular the issue of mental capacity assessment. This report contains some more detailed information on how consistently the safeguarding process is engaging people and meeting their stated outcomes.

We have also established that there is a need locally for board members and partners to better understand the realities for frontline professionals supporting people to make their own decisions about how they choose to live, with the distinct possibility of professionals having then to continue to work with and support people who remain exposed to risk.

The board are actively engaged in the national Local Government Association and Association of Directors of Adult Social Services commissioned work on this theme, and we are developing local guidance for those professionals. In addition, a national theme which emerged from the report was the consistency with which councils are causing safeguarding enquiries to be made when concerns are raised with them. Again, the board are actively engaged in the resulting work at a national level, which will be a focus for the board during this forthcoming year.

Sadly adults continue to experience abuse or neglect. Where this happens we are determined to

learn, and improve our services and safeguarding practice across the partnership.

We still have more to do to secure the engagement and feedback from adults who have been involved in safeguarding so that we can learn from their experiences. Our Citizen's Engagement Group have been helping the board in recent years, but they have reinforced to us that effectively obtaining the experience from individual people is highly complex. However, we remain committed to this crucial piece of work.

The board also continue to hear a personal (anonymised) 'Safeguarding Story' shared by a board member to ensure that Making Safeguarding Personal remains a significant focus. In this year's annual report our case studies seek to show how complex some of the challenges adults who need our support are on a daily basis, and for our workforce who seek to support and work with them.

We also need to continue to raise the awareness of adult safeguarding with all the citizens of Shropshire, as well as our organisations, particularly if we are to support and promote the ability for people to live as independently as they can and for as long as they choose to do so.

Finally I wish to place on record my acknowledgement and thanks to all of those who work to safeguard adults in Shropshire.

Ivan Powell,
Independent Chair

Introduction

This Annual Report explains what the Keeping Adults Safe in Shropshire Board have done from April 2018 until March 2019. In the report we will look at:

- Multi-agency procedures
- Who has needed help to stay safe in Shropshire and what work has been done to help keep them safe
- What progress the board has made on its strategic priorities and plan and what board members have done in their organisation to contribute to these
- Safeguarding Adult Reviews

The report will be published on the board's website and presented to:

- The chief executive and Leader of Shropshire Council
- West Mercia Police and Crime Commissioner
- The Chief Constable of West Mercia Police
- The Accountable Officer from Shropshire Clinical Commissioning Group
- Healthwatch Shropshire
- The Chair of the Health and Wellbeing Board in Shropshire

Awareness campaign launched April 2018

What is the Keeping Adults Safe in Shropshire Board?

The Keeping Adults Safe in Shropshire Board (we will call it the board in this report) is a group of organisations who work together to help keep adults with care and support needs safe from being abused or neglected. Helping to keep someone safe means working with the person who is experiencing, or who is at risk of experiencing, abuse or neglect to help or protect them. This is called adult safeguarding.

The law says that there are some organisations who must work together to safeguard adults and children in local authority areas. In Shropshire these are:

Shropshire Council

NHS Shropshire Clinical Commissioning Group

West Mercia POLICE
SERVING - PROTECTING - MAKING THE DIFFERENCE

There are also lots of other organisations who work with adults who also contribute to the board:

Shropshire Partners in Care

Department for Work & Pensions

National Probation Service

Warwickshire & West Mercia Community Rehabilitation Company
PROBATION

NHS Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

healthwatch Shropshire

The Shrewsbury and Telford Hospital NHS
NHS Trust

VCSA Shropshire

Taking Part
Changing Times, Changing Lives

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS
NHS Foundation Trust

Shropshire Fire and Rescue Service

Shropshire Community Health NHS
NHS Trust

The board works closely with the Shropshire Safeguarding Children's Board. Both boards want Shropshire to be a place where adults with care and support needs and children live a life free from abuse or neglect.

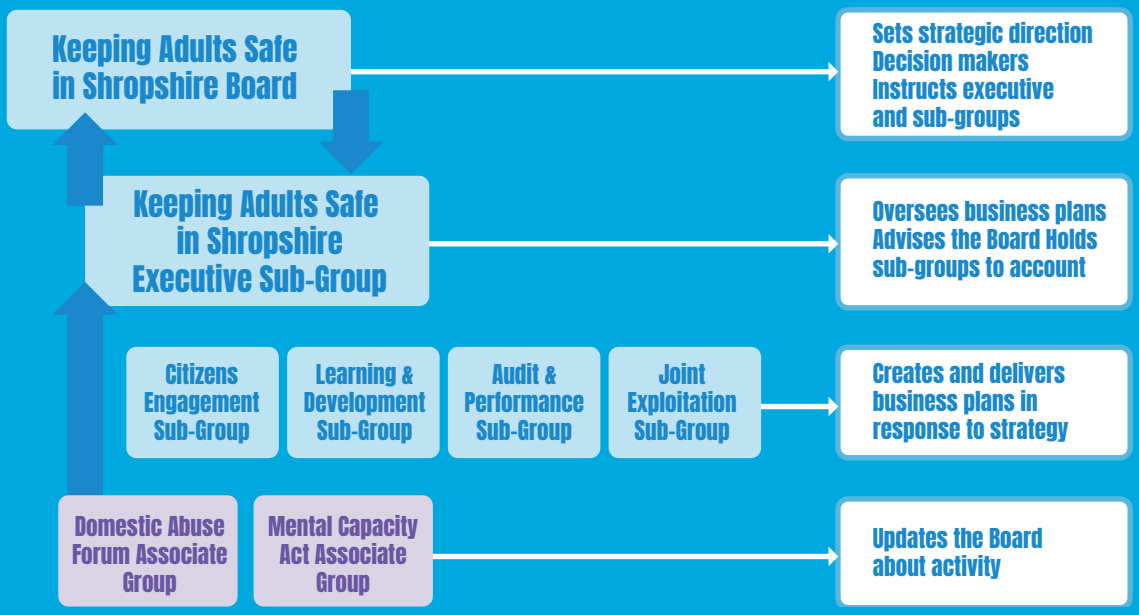
The board's job is to make sure that adults with care and support needs are safeguarded when they might be or when they are being abused or neglected and cannot protect themselves.

The board must have a strategic and annual business plan that says what its priorities are and how it is going to achieve them. The priorities should make sure that adults with care and support needs are helped and protected. It must also write a report every year to explain what work it has done on the strategic plan.

The board has sub-groups who have work plans to deliver the board's priorities and strategic plan. The work of the board and its sub-groups is supported by a joint business unit that is shared with Shropshire Safeguarding Children's Board.

The image below is our current board structure and what each group does.

Keeping Adults Safe in Shropshire Board Structure 2018/19



Adult Safeguarding in Shropshire 2018-2019

1,895 contacts into the First Point of Contact team.

These contacts resulted in

534 safeguarding concerns (28% of contacts) being raised about 477 people.

This means some people experienced more than one type of abuse more than once in the same year.

189 safeguarding enquiries (35% of concerns) were started and 169 enquires were concluded.

16 people (9% of enquiries) started on a safeguarding plan, which means risk had not been reduced during the enquiry.

Types of abuse

38% of concluded enquires were about domestic abuse.

31% of concluded enquires were about emotional abuse.

30% of concluded enquires were about financial abuse.

The age of adults affected by abuse

48% are between the ages of 18-65.

52% are 65+.

Where does abuse happen?

68% of concluded concerns happen in people's own homes.

12% happens in residential care homes

What happens as a result of a concluded enquiry?

89% of people (or their representative) were asked what outcomes they wanted to be achieved.

89% of people who expressed an outcome, were identified as their outcomes being fully met.

70% of people's risk of abuse was either reduced or removed.

Our multi-agency procedures

We have continued to work on our multi-agency procedures. When followed, these documents help everybody keep people safe and work together. The procedures are for people and organisations from the independent, voluntary or public sector who have contact with adults with care and support needs. The board is committed to making sure its procedures are meaningful and applied across all agencies.

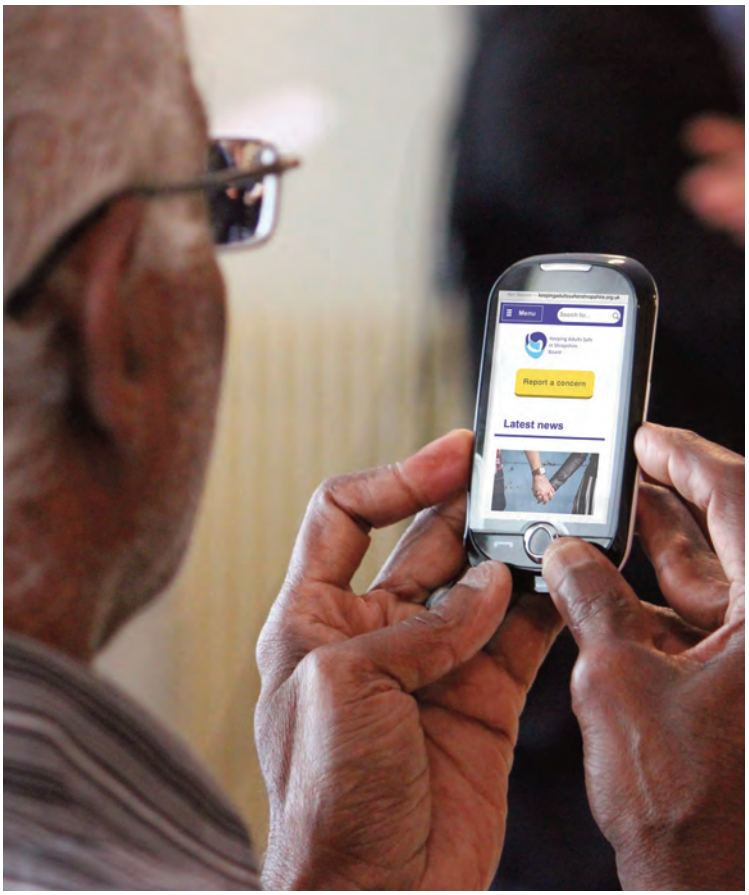
The board also ensures that it is represented on and contributes to the work of the West Midlands Regional Editorial Group, which produces the West Midlands Regional Adult Safeguarding documents.

We are still reviewing our Safeguarding Adult Review policy. This is because we have agreed to come together with the Children's Board to form a Joint Case Review sub-group, so more work is required. Working jointly will give us the opportunity to:

- Strengthen our work with families.
- Work together on cross-cutting themes.
- Work better together and build our knowledge.

We have undertaken a thorough review of our self-neglect document with all partners. We are confident that we have improved what we had, and made it easier for all agencies to understand what we need them to do.

All of our multi-agency documents appear on our website: http://www.keepingadultssafeinshropshire.org.uk/multi-agency-procedures



What we have done this year

Actions for 2018-2019

Action 1. Look at ways that the Keeping Adults Safe in Shropshire Board and the Shropshire Safeguarding Children's Board can continue to improve how they work together

Our update

Organisations across both Shropshire and Telford and Wrekin came together on Thursday 14 June 2018 to mark World Elder Abuse Awareness Day. The Preventing Abuse in Shropshire and Telford & Wrekin Event was held at Oakengates Theatre, Telford and was jointly led by Keeping Adults Safe in Shropshire Board (KASiSB) and Telford & Wrekin Safeguarding Adults Board (TWSAB), with support from Shropshire Partners in Care, to promote the importance of preventing abuse of all adults with care and support needs.

Professor Michael Preston-Shoot headlined the event, presenting best evidence for working with adults who self-neglect and Mental Capacity Act compliance learning from Safeguarding Adult Reviews (SARs). Over 160 delegates attended the conference, which also included several workshops and information stands with a focus on preventing abuse and neglect. The event was part- funded by NHS England.

The resources from this event (films and presentations) can be accessed here http://www.keepingadultssafeinshropshire.org.uk/learning-resources/information-and-learning-resources/self-neglect-and-best-mental-capacity-practice/

Photo: Sam Anderson (Shropshire Safeguarding Boards Business Unit), Marion Kelly (Shropshire Partners in Care), Karen Littleford (Shropshire Partners in Care), Andrew Mason (Independent Chair, Telford and Wrekin), Emma Harding (Shropshire Safeguarding Boards Business Unit), Professor Michael Preston-Shoot, Ivan Powell (Independent Chair, Shropshire), Sarah Hollinshead-Bland (Shropshire Council), Kerry Woodhouse (Telford and Wrekin Partnerships)

In November 2018 the Keeping Adults Safe in Shropshire Board and Shropshire Safeguarding Children's Board held a joint conference on the theme of exploitation, at Shrewsbury Town Football Club. The aim of the conference was to launch our joint Boards' exploitation priority and begin to raise awareness with staff, managers and strategic leaders across organisations working with adults and children about the different types of exploitation that can take place and what can be done to safeguard people from exploitation in its various forms. The event was attended by over 250 delegates and the feedback we received was excellent.

We had a number of speakers at the event who gave us some real insight into these areas and told very moving stories about their experiences. Videos and PowerPoint presentations can be accessed to develop learning and improve practice at:

http://www.keepingadultssafeinshropshire.org.uk/learning-resources/information-and-learning-resources/exploitation/

Action 2: Write a Prevention Strategy which aims to prevent the types of abuse that we know are happening most in Shropshire

Our update

This work has not yet been completed but we consider an important part of the work we need to do. This will be an action we carry forward into the next year.

Action 3: Continue to make sure that adults who use care and support services and carer representatives are asked to be involved and heard in the work of the board

Our update

At the events that are described above, people who access support from both adult social care and children's services were involved in attending and speaking at the events. Hearing what they had to say was a very powerful way for the professionals to learn from their direct experience. Please take the time to look at the links provided above where you'll be able find more detailed information.

As a result of a Safeguarding Adult Review in another area, the Citizens Engagement Sub-Group were tasked with exploring how we could promote people's understanding of their rights in Shropshire. The group have been talking to people who use our services to see what they think. We'll tell you about our progress with this in our next Annual Report.

Action 4: Start to collect information from members about their work. This information is telling us how adults in Shropshire are being helped and protected.

Our update

We have done this by asking our partners to explain how they have contributed to the priorities of the Keeping Adults Safe in Shropshire Board. For this year's report, we have focussed on two of our four priorities, Prevention and Making Safeguarding Personal. We have chosen a few of our favourite examples for the report. You can read more about what other organisations said in Appendix 1.

Shropshire Council (adult social care) said:

Our social work and safeguarding teams work with many different people with different needs. They often work together. Here is an example of how we have worked with someone to improve their living situation while keeping him in control of his life:

"Self-neglect and hoarding had been present for a number of years. Previous contact with services had resulted in the client being seen as having mental capacity and thought to be making unwise lifestyle choices. However, the most recent referral was progressed to safeguarding, and a number of multi-agency meetings were held which highlighted multiple risks, not only to the individual, but also to those who lived close to him and his local community.

By working within this multi-agency forum, it was possible to identify the roles and responsibilities of each agency. We obtained a greater insight into other legal frameworks available to support the person and promote his engagement in minimising the risks, gradually addressing the longstanding issue of hoarding.

Although our work with him and our partners has not eliminated all of the risks, there has been significant progress in terms of gaining access to more areas of his home and he would now be able to leave his home more easily should an emergency arise. The person has now permitted the installation of battery-powered smoke detectors, which he had refused during previous interventions.

By working closely with housing colleagues, it has been possible to identify a housing pilot scheme which will enable the client to access more appropriate accommodation in his current locality, enabling him to remain connected to his current informal network of support, established relationships and his local church.

During this intervention, the client has consistently engaged with the practitioners and has also consented for the practitioners to liaise and engage with his informal network of support. This has enhanced his network of support and provided them with an agreed approach to notifying the practitioners should they observe a change or deterioration.

To do this work, our staff have to visit him at 9pm at night as that is the only time he will see anyone.

Shropshire Community Health NHS Trust said:

A patient was at risk of harm due to non-compliance of the family with our wound care plans. The patient was at the end of their life and did not want any disruption to her family contact, which a safeguarding plan or hospitalisation may well have had.

We were able to be flexible in our approach to wound care to prevent deterioration of the wound. In line with the patient's wishes we did not make a safeguarding referral, but after discussion and negotiation with the patient and her daughter we agreed a way in which we could manage the patient as safely as possible at home whilst retaining family contact.

Healthwatch Shropshire said:

One of the ways we can prevent abuse from occurring is through our Enter and View programme of visits to health and social care facilities. We can visit any service that is publicly funded, eg NHS providers and residential care homes for adults with learning disabilities or the elderly. Visits are led by the intelligence we receive, eg comments from the public, or information provided by partners at Shropshire Council, the NHS or the Care Quality Commission.

The aim of Enter and View visits is to speak to people using services about their experiences, the staff who work there and to make observations about the environment. By going into services, we are able to speak to some of the most vulnerable and seldom heard groups in our communities. We are not experts in health and social care but offer a lay perspective in order to represent the views of service users. The volunteers who conduct these visits always work in pairs, and have completed Safeguarding Adults Awareness Training through Shropshire Council's Joint Training, and been trained in how to raise concerns if they are concerned for the safety or welfare of the people using services. Enter and View is intended to be a constructive process and as well as identifying ways services could improve, we always try to highlight areas of good practice.

Our reports are shared with NHS England, Healthwatch England, Care Quality Commission and local commissioners. They are available to the public through local libraries and on our website: http://www.healthwatchshropshire.co.uk/what-we-do-0

Between April 2018 and March 2019 Healthwatch Shropshire visited 16 services, including two clinics at Royal Shrewsbury Hospital, eight care homes and seven GP practices.

Multi-Agency Adult Safeguarding Training

The Board's Learning and Development Sub-Group conducted a survey and gathered data about how organisations are accessing training and complying with their own training targets. The sub-group considered how well people retained and used the knowledge they had acquired after their training. This provided an opportunity for partners to reflect upon their training provision, the contribution training makes to effective safeguarding practice, and how learners can be better supported to retain their knowledge after training.

Each organisation was asked to provide a minimum of five learning reflections if they employed fewer than 150 people, and a minimum of 15 if they employed more than 150. The reflections were to be completed by learners who had undertaken Safeguarding Adults Awareness training within the year 1 April t 2018 – 31 March 2019.

In total, 103 learning reflections were received from eight organisations (this included three different teams within Shropshire Council).

In terms of summarising four key points from training accessed, it was reassuring to see the highest reference was made to key learning objectives from training. The workforce cited the following areas as those to be most aware of:

- the categories of abuse
- reporting arrangements
- the safeguarding principles.

Any opportunity to review and recap learning post-course is to be welcomed. Through this survey it was apparent that the majority of respondents (73%) had some opportunity to do this prompted by their organisation. 27% of respondents were not supported by their organisation to carry out activity in order to retain their knowledge, which is an area of development for the board to consider.

The work concludes with a range of recommendations for partners to consider including:

- Organisations should consider supporting staff to access information related to the subject before they attend training (flipped learning) to prepare them for their learning experience.
- Organisations should consider offering a range of opportunities via supervision, team events and further reflection activity for learners to consolidate and synthesise their learning post-training.
- Organisations should consider releasing staff to attend face to face training or accessing elearning, but also time to carry out post-course (self-directed) learning.

Safeguarding Adult Reviews

There are some circumstances when the board must carry out a review of how everyone worked together with an adult with care and support needs in their area. This is so that everyone can learn from what happened and improve how they work in the future. This process is called a Safeguarding Adult Review. A Safeguarding Adult Review must be carried out:

- If there is a reasonable cause for concern about the board, members of it or other people who worked together to safeguarding an adult with care and support needs

and

- An adult with care and support needs dies and the board knows or suspects that their death resulted from abuse or neglect;

or

- An adult with care and supports needs is still alive, and the board knows or suspects that the adult has experienced, and was seriously injured because of, serious abuse or neglect.

Mr E

We have now completed our Safeguarding Adult Review that we told you about last year.

Mr E's house, along with several other properties in his village, flooded in 2016. When the Fire Service responded to the flood they found that Mr E was neglecting himself by hoarding items in his house which made his home an unsafe place for him to live. He was taken to hospital because there was no other suitable accommodation available at that time. The findings and recommendations of the review have been presented to the board. We will publish the recommendations in full next year.

We also try and learn from Safeguarding Adult Reviews that have happened elsewhere in the country. One of the reasons we asked Professor Michael Preston Shoot to be the key speaker at our event was because he published an important review of learning from 27 Safeguarding Adult Reviews that took place in London. This has helped us focus upon the importance of self neglect and the Mental Capacity Act. Our website also has information on Safeguarding Adult Reviews.

What we want to do next year

We reviewed our priority areas of work for 2019-2022. In addition to our business as usual activity, to deliver our vision we have identified the following priority areas to work on over the next three years:

1. **Preventing abuse and building the resilience of individual and communities –** we need to do this for the following reasons:

   - to develop a community culture of caring and protecting others
   - to help people to become able to protect themselves
   - to stop harm from happening to people in the first instance; and where harm from abuse is occurring, to minimise the impact of that harm.

   We will know we are successful when we have:

   - increased the proportion of safeguarding concerns going to enquiry
   - increased the number of targeted Fire Service, Health and wellbeing checks
   - reduced the number of repeat adult safeguarding concerns within the last 12 months where the source of risk and type of abuse are the same
   - increased the number of organisations signing up as a Safe Place.

   We will monitor our success measures through:

   - regular reporting of the performance framework to the board
   - the implementation plan that sits under our Prevention of Abuse Strategy.

2. **Making Safeguarding Personal –** "Hearing the voice of the person" - the board needs to be confident that when a safeguarding concern has been raised, the person affected is part of and aware of all decisions that are made, even when action is being taken that the person is not happy with as a result of a Safeguarding Enquiry.

   We will know we are successful when we have:

   - an increasing number of people (and / or their representatives) who have been asked about the outcomes they want to achieve
   - an increasing number of people (and / or their representatives) who had their outcomes partially or fully achieved
   - we have an increasing number of people (and / or their representatives) who report positively about their experience of being involved in the safeguarding process.

We will monitor our success measures through:

- our annual reporting to the Department of Health through the national reporting mechanism the Safeguarding Adult Collection
- assessing feedback through a user survey
- monitoring how often we report back to the adult and the person raising the concern.

3. **Reducing the number of inappropriate safeguarding concerns referred by adult social care and health professionals (including volunteers)** This is essential to enable everyone to understand their responsibility for keeping people safe at all stages. Additionally, inappropriate referrals create risk in the 'system'. They still need a response, which can cause delay in reacting to those situations that require intervention to help stop abuse happening or being ongoing.

   We will know we are successful when we have:

   - reduced the number of contacts to Shropshire Council's First Point of Contact team that do not result in Safeguarding Concerns being recorded.
   - reduced the number of Safeguarding Concerns raised where abuse is no longer happening
   - we have increased the proportion of Safeguarding Concerns that progress to enquiry.

   We will monitor our success measures through:

   - the reports that are produced from Shropshire Council's client database Liquidlogic
   - reporting on safeguarding activity through the board's Annual Report

4. **Increasing community awareness of adult safeguarding –** this is essential to enable everyone (including individuals using our services and Shropshire citizens) to understand their responsibility for keeping people safe at all stages.

   We will know we are successful when we have:

   - Increased the number of Safeguarding Concerns raised by individuals using our services
   - Increased the number of Safeguarding Concerns raised by family and friends of the individuals using our services
   - Increased the number of Safeguarding Concerns raised by the public.

   We will monitor our success measures through:

   - the reports that are produced from Shropshire Council's client database Liquidlogic
   - reporting on safeguarding activity through the board's Annual Report

5. **Understanding exploitation –** the board is keen to understand the emerging issue of exploitation, in particular how it impacts on adults with care and support needs. It is a complex issue that makes us rethink our approach to how we understand financial and sexual abuse,and modern slavery.

   We will know we are successful when we:

   - can separate the different types of exploitation and report on them
   - can understand the information held by the Community Safeguarding Partnership about the prevalence of exploitation in the wider Shropshire community.

   We will monitor our success measures through:

   - the reports that are produced from Shropshire Council's client database Liquidlogic
   - reporting on exploitation activity through the board's joint exploitation sub-group

Closing Statement from Shropshire Council's Cabinet member

I hope you've enjoyed reading about the progress we have made this year. As you can see, all of our partners have been working hard to keep people at the centre of everything they do.

All of our board meetings start with a hearing a person's story. This helps to remind us why we are at the meeting, and why we need to do what we can to help people keep themselves safe from abuse. It is particularly important for us to explain to you the experiences of people who are affected by abuse. I'm sorry to say it does happen in Shropshire, but we should never get used to it or accept it as something that happens here.

Please make sure you play your part in keeping people safe from neglect and abuse and help us to stop it.

Thank you.

Councillor Lee Chapman,
then Cabinet member for
adult social care, health
and social housing

Appendix 1:

More contributions from partners about our priorities of prevention and Making Safeguarding Personal

Shropshire Clinical Commissioning Group said:

We have worked with NHS Trusts to review cases that come into safeguarding to see if they can learn lessons to stop these types of matters happening again. The hospital realised that there was an issue with people accessing medication after discharge, so provided advice to the ward in question about how they needed to help organise the community ordering of insulin to ensure people were safe and had access to their medication. They also put up a notice up to remind staff of what to do with the aim of preventing a similar incident in the future

We help the NHS Trusts in Shropshire to get better at finding out about when people develop pressure ulcers in their care, and what they need to do for that person to help them recovery and to learn from the incident, by using the Pressure Ulcers Protocol and the interface with a safeguarding enquiry to see if the matter also needs to come into safeguarding.

The CCG has also been offering safeguarding training to GP practices, and are providing advice to GPs if they need further information about what they need to do to help work with other partners to safeguard people. This has identified self neglect as a significant concern and so more work is being done in 2019-20 to improve the understanding of how different agencies can work together when there are concerns about self neglect.

Shropshire Council (housing services) said:

We have taken part in a number of multi-agency audits this year working with colleagues to better understand cases and what could be done to improve things for the individuals.

Housing are a primary member of the hoarding forum, leading on cases where necessary and supporting colleagues with challenging decision-making by providing evidence and practical examples.

Housing have been heavily involved with local meetings and research undertaken on cuckooing and County Lines. We have worked hard with local housing providers and the police to ensure people remain safe and to move people who are at risk urgently. Our temporary accommodation team work closely with all those we house to monitor who is having access to properties and that we ensure, to the best of our ability, the safety and security of the vulnerable people we are working with.

Shropshire Council (regulatory services) said:

MATES (Multi-Agency Targeted Enforcement Strategy) is leading the way in the disruption and enforcement to address modern slavery and exploitation which can be hidden within some businesses and cultures. The Strategy seeks to protect the vulnerable and offer protection and reassurance to the public by tackling criminality and non-compliance with regulatory legislation.

Some people are using multiple identities supported by false documents and fraudulently-obtained genuine documents. The response therefore requires greater inter-agency co-operation. Some people are being placed into Houses of Multiple Occupancy and being forced to work in businesses for little or no money. We attend regular meetings with key partners to review intelligence and plan operations. MATES meetings have identified and then carried out multi agency visits to premises including:

- Carwashes
- Nail bars
- Suspected brothels
- Agricultural premises employing migrant workers.

We have already identified a family with children living in a summer house in the garden of a takeaway restaurant. Housing Notices were served to stop the use of this inadequate accommodation.

Robert Jones and Agnes Hunt (RJAH) Orthopaedic NHS Foundation Trust said:

RJAH has continued to undertake work regarding the culture of the organisation and ensuring that staff are encouraged to speak up about issues relating to each other's behaviour, and anything affecting the safety of our patients. As part of our culture and leadership programme called "Make The Difference", we conducted a piece of work to define exactly what our Trust values (professional, caring, friendly, excellence and respect) mean and identify behaviours linked to all of them. We called these signature behaviours. They are important because they are all about how we work and interact with each other, and care for our patients.

Caring for patients remains a key focus within our organisation and this is reflected in the training for all staff in relation to preventing harm from happening, starting from staff induction.

We continue to monitor and improve our Harm-Free Care processes, considerably reducing harm to patients in the areas of pressure ulcers and falls.

West Mercia Police said:

'Professional curiosity' and 'looking beyond the obvious' are an embedded part of force practice. Staff are briefed to look beyond what is initially presented at incidents to identify vulnerability and take positive action. This case study relates to an older victim in a care home in Shropshire.

"A referral had initially been made to the Care Quality Commission by an individual wishing to remain anonymous. The concern was about members of staff working at the care home who allegedly put ketchup all over a person who was blind and a wheelchair user, thinking it was funny, and took photographs.

Another incident was mentioned involving the same carers. On this occasion someone fell out of bed sounding her alarm. Nobody came, and the person was found lying in a pool of blood. Both carers were outside having a cigarette. Although they did eventually respond, the anonymous staff member said the accident book was not a true reflection of what happened. The manager of the care home was aware, but appeared to have done little about the situation other than tell staff to delete the photographs.

Shropshire Council agreed a Section 42 safeguarding enquiry would commence, but as there were criminal allegations the police would lead. A statement was taken from the witness and a multi-agency meeting was arranged to decide on the best way forward for all agencies.

We worked with a member of the safeguarding team to obtain the relevant information from the care home. The home owners arranged for staff to come in and cover those arrested.

Following a proportionate investigation, a decision was made not to prosecute the suspects. Safeguarding and the Care Quality Commission remained heavily involved. The manager and the two carers were dismissed from the care home and referred to the Disclosure and Barring Service for a barring decision."

Shropshire Partners in Care said:

SPiC provides a number of opportunities to engage with members and partners in terms of raising awareness of organisational and individual's roles in safeguarding adults, and in particular the principle of accountability. In order to achieve this the workforce has access to a range of training, support and signposting to ensure there are opportunities to develop good practice across the sector. A workforce which views safeguarding as everybody's business is better placed to seek support, engage with partners, challenge practice and prevent abuse from happening in the first place. A total of 1,275 learners attended safeguarding-related training delivered by Shropshire Partners in Care as follows:

- The Safeguarding Adults Lead for Shropshire Partners in Care delivered 82 Safeguarding Adults Awareness sessions. A total of 1,130 learners accessed these sessions delivered through Shropshire Council's Joint Training or Shropshire Partners in Care.
- Three Safeguarding for Provider Managers sessions were delivered to a total of 43 learners through Shropshire Council's Joint Training in partnership with Shropshire Partners in Care.
- Two Safeguarding Adults Enquiry Training courses were delivered to a total of 34 learners through Shropshire Council's Joint Training in partnership with Shropshire Partners in Care.
- Four Day Five Care Certificate courses were delivered covering safeguarding adults and children to a total of 68 learners through Shropshire Council'sShropshire Council in partnership with Shropshire Partners in Care. (Joint Training delivered an additional session to a single agency with 9 learners attending).

Taking Part said:

As an advocacy service we often advocate for clients when, unfortunately, they have been subject to abuse. We then work with them in a very sensitive manner using MSP approaches, putting them at the centre of all conversations.

Where a client discloses information which gives advocates for concern, then we explore this information again using MSP approaches and work with the client to report it to the relevant bodies with their approval and consent.

In our prevention work, we provide in-hours training for our Experts by Experience, and we also work closely with Joint Training to co-develop and co-deliver training to clients on safeguarding and reporting abuse.

We have been a partner agency in the co-production of the My Enquiry and Safety Plan cards.

Keeping Adults Safe
in Shropshire
Board

Annual Report

2018 – 2019