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Safeguarding Adults In Torbay

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Aim of Session

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- **Torbay and Devon Safeguarding Adult Partnership**. Overview to include

✓ Role

✓ Structure

✓ Strategic Priorities.

- **Torbay Safeguarding Adults**. Overview to include

✓ Setting the scene

✓ Data Insights

✓ Learning and Improvement

Torbay and Devon Safeguarding Partnership

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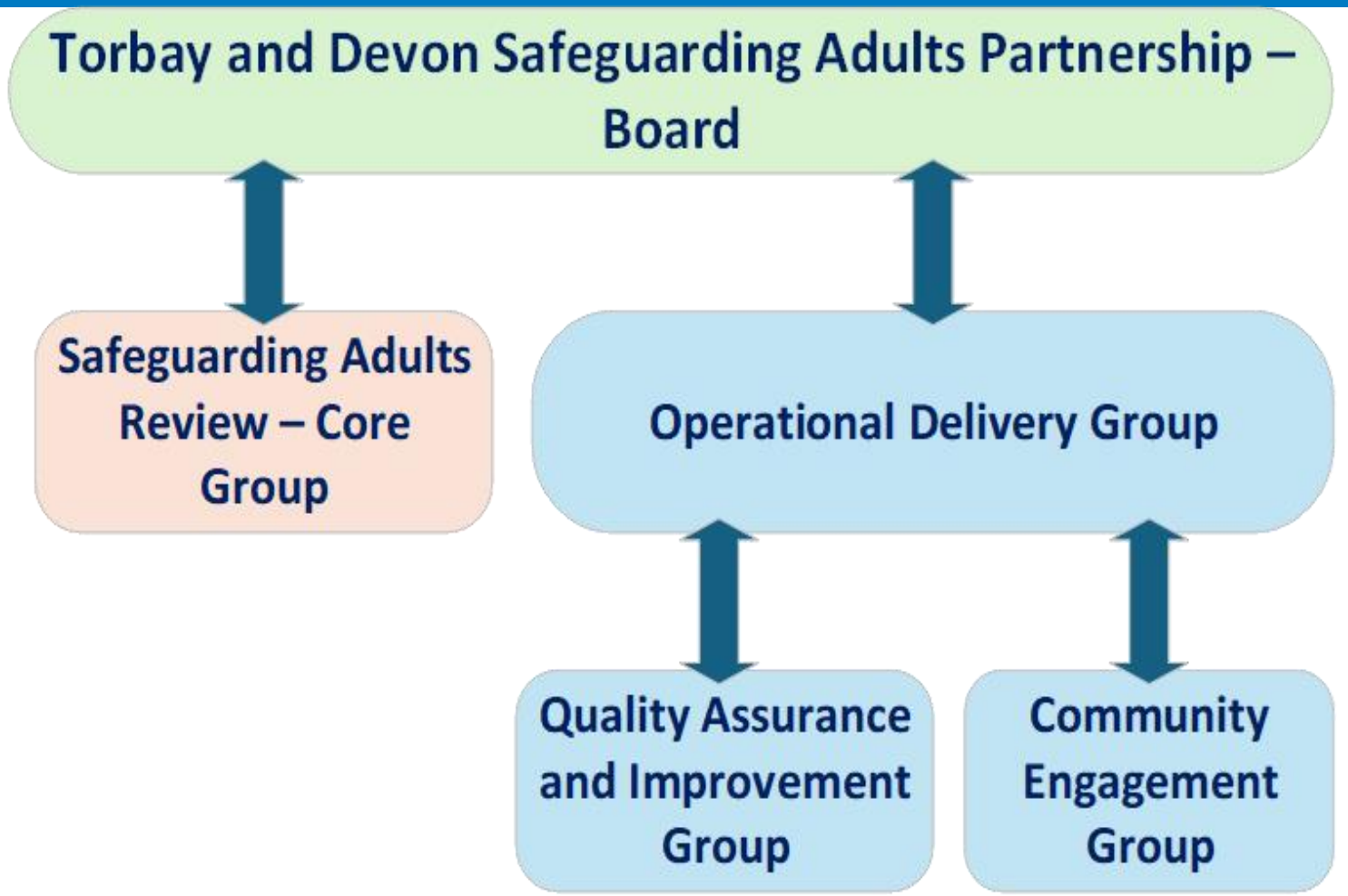
Torbay and Devon Safeguarding Adults Partnership



Governance Structure

Our Strategic Priorities

Torbay and Devon Safeguarding Adults Partnership

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Strategic Priority 1

Seek assurance from partners in relation to practice improvements in key risk areas (e.g. MCA, self-neglect, voice of the person, audit outcomes

Strategic Priority 2

Seek assurance from partners that learning from SARs is embedded into practice

Strategic Priority 3

Improve awareness, engagement and inclusion

How the Partnership monitors and ensures delivery

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- The TDSAP Business Activity Plan monitors and reviews the development, progression and delivery of the actions that support these Strategic Priorities.
- The Operational Delivery Group holds the Business Activity Plan and reports on progress to each TDSAP Board meeting.
- We will regularly monitor and assess the safeguarding data and performance to inform future thinking and direction of travel.
- A yearly Annual Report is produced that describes the activity in relation to each priority.

Safeguarding Adult Benchmarks

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- **Empowerment:** People being supported and encouraged to make their own decisions and informed consent
- **Prevention:** It is better to take action before harm occurs.
- **Proportionality:** The least intrusive response appropriate to the risk presented.
- **Protection:** Support and representation for those in greatest need.
- **Partnership:** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability:** Transparency in safeguarding practice.

Safeguarding Culture

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Just and Learning approach – Openness, honesty and candour reporting, focus on what went wrong rather than who's to blame.

Civility Matters – Be respectful and kind. Person centred care that builds trust. Crucial for staff well-being and quality of care.

Individual choice and control – Valid consent. Apply making safeguarding personal values.

Understanding the impact of trauma on behaviour – Shame. Loss of self worth, safety, trust, danger cues. Anxiety. Disassociation.

Vicarious Trauma – Awareness to support mental well-being.

Zero tolerance of abuse – If you see something, say something.

Professional Curiosity – Avoid assumptions or accepting information at face value. Active listening, direct questions, awareness of non verbal cues, gathering a broad level of information from multiple sources.

The Safeguarding Continuum

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Safeguarding

Promoting welfare

Protection from harm

Abuse – It's a wide agenda.

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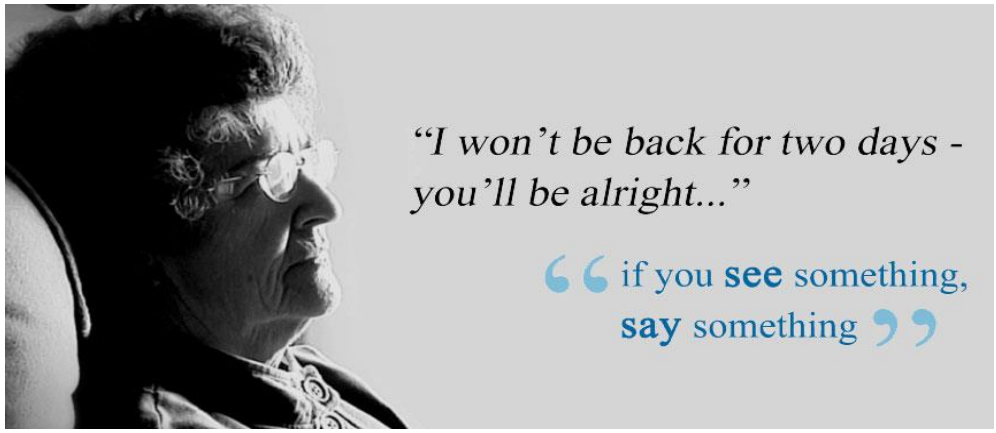
- Physical
- Restriction and restraint
- Sexual
- Emotional and Psychological
- Financial
- Modern Slavery (Exploitation - forced labour, sexual, criminal, domestic servitude)
- Discriminatory / Hate Crime
- Organisational
- Neglect / Acts of Omission
- Prevent (Radicalisation)
- Domestic Abuse
- Self Neglect



Enquiry Plan

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- The purpose of an adult safeguarding enquiry is to investigate concerns of abuse, neglect, or self-neglect involving an adult with care and support needs, assess any risks to their safety, and determine appropriate actions to protect and support them effectively

A look at our data…

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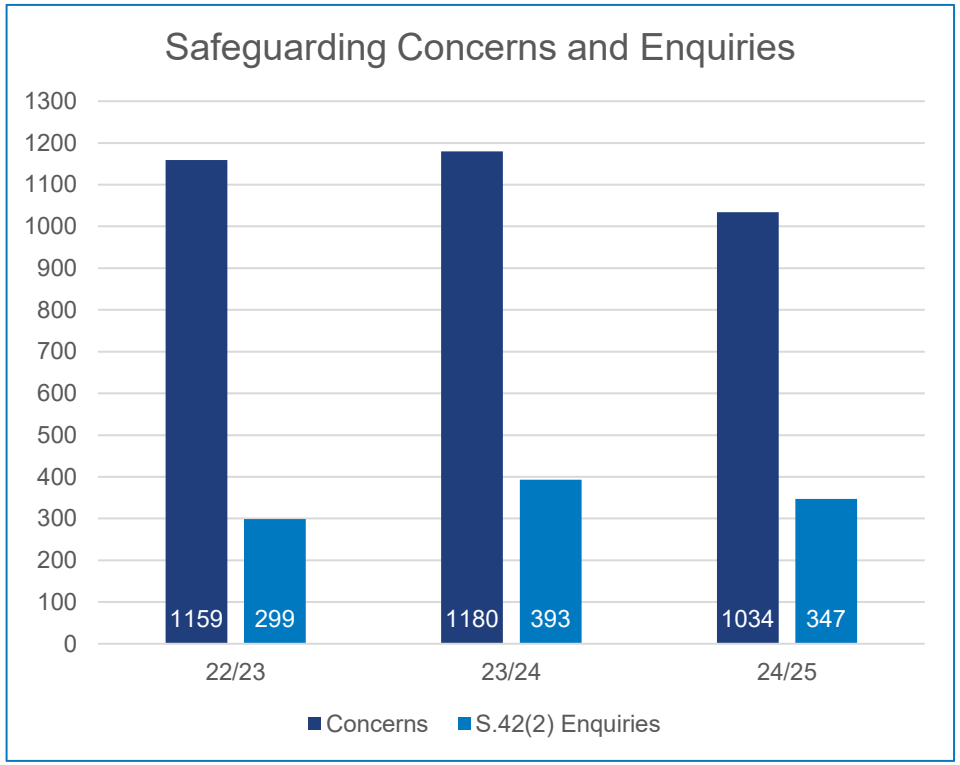

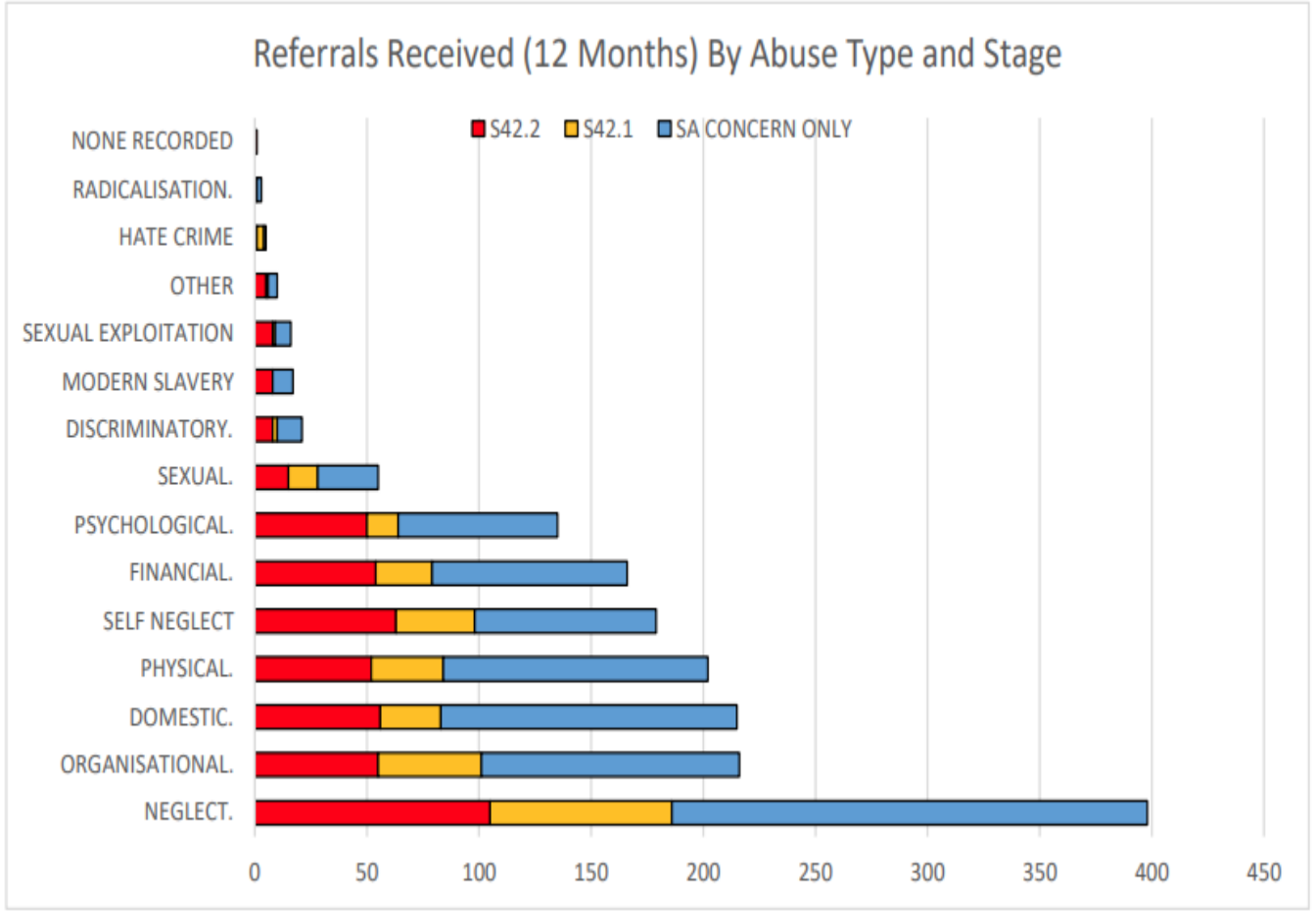

Current Trends for this year: (5-month comparator)

Concerns reported::<11.44 (533/472)

Conversion rates: +5% - 23.94%

S.42(2) Care Act enquiries: >9.7% (101/113)

Types of Abuse. Neglect still highest.

A look at our data…

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Avg. time from receipt to s.42(2) allocation.

12 days

Current number of open enquiries (including those caused out to DPT

86

Enquiries open beyond 90 days

21

she felt listened to and included through the process and added '' everything has been clearly explained''.

''everyone is doing everything they can to make him safe''.

Actions were taken to prevent it happening again.

She felt fully included and listened to, she stated '' there was genuine concern'', she also fully understood why the action was being taken adding '' absolutely'' She felt included in meetings and conversations…she felt her father was much safer

He described the actions as "swiftly dealt with, he stated, my son almost died, however, the outcome has been amazing so positive''. Outcomes were all archived with a positive response ''now in a much better home''.
He stated that he felt fully included '' absolutely brilliant, Social worker did a brilliant job'

They both felt that the case could have had a speedier intervention, the victim should have been listened to, she found the meeting intimidating and was dependent on the nurse to explain and support her.

On the radar…(apart from CQC)

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Ensure we are completing safeguarding enquiries in a timely manner. To include increased line management review and oversight of enquiries open beyond 90 days.

- Better use data within all parts of the safeguarding system to support increased awareness and scrutiny.

- Within front end re-design, identify further opportunities to streamline / redirect some contacts away from Safeguarding single point of contact.

- Pilot / implement new TDSAP multi-agency risk management meeting processes (MARMM)

Learning from Safeguarding Adult Reviews

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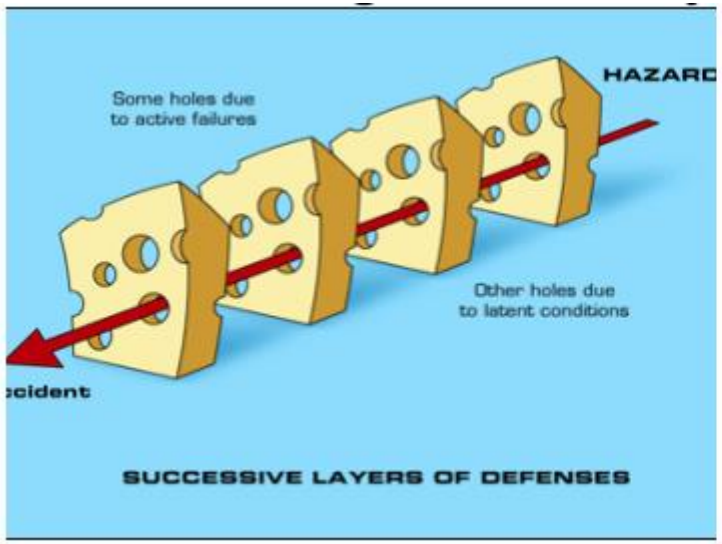
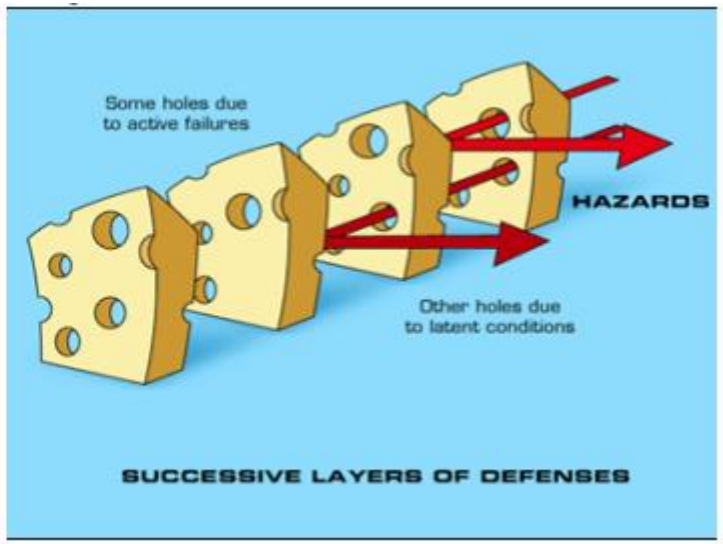
➢ Unique and complex pattern of shortcomings

- Learning rarely confined to poor practice
- Weaknesses in all layers of the system
- Taken together they add up to a ‘fault line’





Safeguarding Adult Reviews - 2nd National Analysis

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[Briefing for elected members: Second national analysis of Safeguarding Adult Reviews | Local Government Association]

Role

As a lead member or in a scrutiny role, it is good practice to seek assurance from partners that they are meeting their statutory responsibilities in adult safeguarding. It is important to check that the Safeguarding Adults Board is seeking assurance on safeguarding practice and on the robustness of services, and that partnership worki is improving as a result of learning from Safeguarding Adults Reviews

Learning and Applying Lessons

Elected members must have oversight of how Safeguarding Adults Review findings are disseminated and the lessons learned, both in their own locality and elsewhere. It is important that Safeguarding Adults Boards build on the learning from reviews completed previously, both locally and nationally. Rather than starting again each time, newly commissioned reviews should question where change recommended in previous reviews has still not been achieved.

Governance and Quality Markers

Elected members must seek assurance from their SAB that it has appropriate mechanisms to achieve robust governance, including compliance with the SAR quality markers…..seek assurance also from the SAB that learning from SARs is cascaded, recommendations are actioned, and service improvements are carried out, with evidence of impact on adult safeguarding practice.

Practice

Lead members and members in a scrutiny role must check that their Safeguarding Adults Board is cascading SAR learning on safeguarding practice to all partners through dissemination of briefings, and that evidence of its desired impact on practice is available. When carrying out casework, members can scrutinise whether safeguarding practice is good practice.

Wider Organisational / Interagency

These factors compromise the effectiveness of safeguarding, but they also have a direct influence on how practitioners in any one agency approach their work. It is good practice to check that such factors are given due attention in the implementation of recommendations from Safeguarding Adults Reviews….and evidence how partners have implemented recommendations, and whether changes have been embedded and achieved desired results.

Wider Implications

Lead members and members in a scrutiny role can ask: do our local Safeguarding Adults Reviews provide learning about national policy, economic or legal frameworks that should be raised at a national level? The National Network for Safeguarding Adults Board Chairs has an agreed escalation protocol with the Department of Health and Social Care, enabling matters of national importance to be raised. It is good practice for members to consider how they can support the SAB to place a stronger focus on the impact of the national context on local safeguarding practice.

SAR Learning Example – Self Neglect

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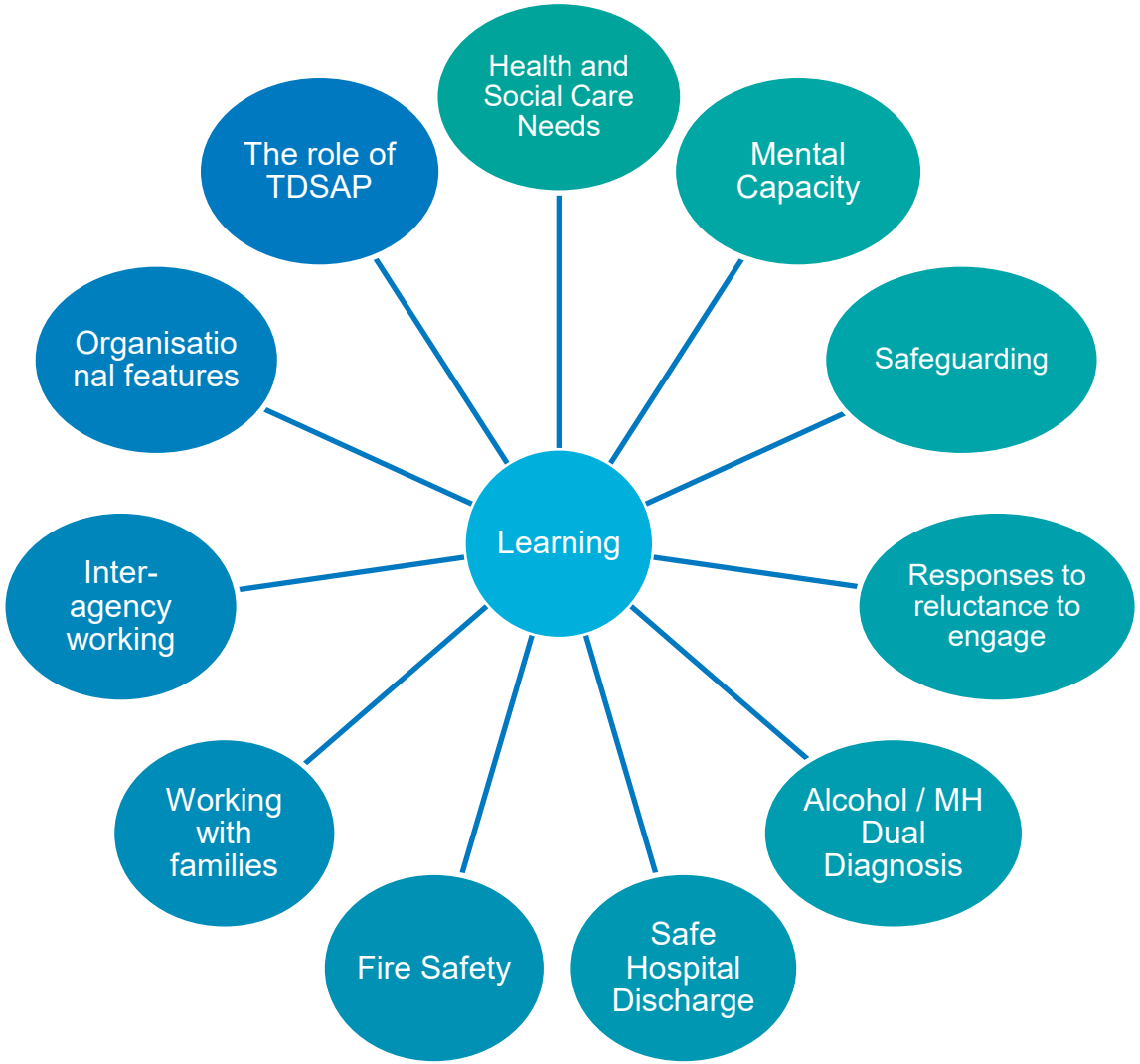
Thematic Safeguarding Adults Review - Self Neglect



SAR Learning Example – Self Neglect

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Practice Briefings

- Learning themes
- Executive Function

System

- Self Neglect Task and Finish Group
- New self neglect and hoarding guidance
- New Multi-Agency Risk Management meeting protocols (MARMM)
- Pilot MARMM
- MARMM Implementation Group
- Self Neglect Conference – what more do we need to do / understand? – e.g. non-compliance with health recommendations
- Further practice briefings
- Utilise existing learning in response to new SAR referrals
- TDSAP strategic priority within business plan

Local

- Briefings disseminated
- Safeguarding Adult Improvement Group (operational sense check / reflective practice opportunities
- Local legal ASC legal service briefing on Executive Function
- Changes in front end practice responses – improved welfare check opportunities.
- Learning embedded into core mandatory safeguarding training
- Learning embedded into core mandatory Mental Capacity Act training
- Trauma informed approaches enhanced within standard training
- Bespoke in depth trauma informed practice offer to teams
- Active contributions from front line practitioners in self neglect learning conference.

Recent Audit / Peer Review Outcomes

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Ongoing:
Management sign off all s.42 enquiries. Oversight and assurance that LA safeguarding duty has been met. Ongoing oversight and data analysis by SA Lead Practitioner. Data analysis and review within TDSAP arrangements. Safeguarding Adult Improvement Group. Quality Assurance Panel.

2023 - Partners in Care Programme Advisor (check and challenge approach):
MDT approach strong. SA awareness across system is strong. Strong MA frameworks. Positive feedback re. Quality Checker system. Utilise data to describe person's journey. Greater visibility of Out of area placements.

2023 Independent Review into Large Scale Enquiry:
Positive feedback on timely MDT responses to safeguard people. Identify initial risk assessment tool to collate risk and use with partners.

Recent Audit / Peer Review Outcomes

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2023: SPOC Audit:

Identified some inconsistency in decision making. Peer support workshops in response. Ongoing enhanced peer support. Revised Operational Guidance. Professional Practice Supervision to Lead

2024: LGA Independent Peer Review:

Positive feedback re. MDT input, SAB visibility and feedback about Making Safeguarding Personal, strong quality checks for safeguarding and enquiry processes, strong learning culture. Primary recommendations linked to TDSAP – clear plan for delivery and that learning is evidenced, closer relationships with children's board around transitions, monitoring of experiences of homelessness via the TDSAP to support improvements.

2025: Care Health Improvement Advisor Independent Review:

Check awareness of TDSAP. Ensure making safeguarding personal strengths are articulated. Sense check feedback rationale on Care Act duty decision making processes.

Closing Summary

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- The Torbay and Devon Safeguarding Adult Partnership oversees our local safeguarding arrangements. Elected members have an important role in supporting the TDSAP to deliver its overall functions.

- Overall, safeguarding should be an approach that underpins all the work we do, regardless of whether **formal powers under section 42 of the Care Act 2014** are used or not. It is about supporting people to make informed choices about risk and live lives free from unnecessary harm and abuse.

- Our just and learning culture is essential to avoid a closed safeguarding culture. Raising concerns early is essential along with ensuring we have effective systems and processes to respond to concerns of abuse of neglect.

Over to you

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Thank you for listening

Any questions and reflective feedback

Further Reading:

Safeguarding roles and responsibilities: Safeguarding is everybody's business

ADASS Councillors Briefing Safeguarding Adults