Working effectively together to safeguard adults

LEARNING FROM REVIEWS

OPEN FORUM EVENT, NOVEMBER 2023

Being Happy
Stopping Adult Abuse Everyones Business
See it hear it report it
Feeling Safe as I want
Freedom
My control
Believed Listen to me
Outcomes
My Identity
My Choice
No Secrets
My decisions
Include me
Supported
allowed to make own decisions
Told how to do things
Told when to do things
Fitting in a box
not getting to know me
Safe guarding unit to be visible
RESPECT
Transparent
Not taken Seriously
TOLD
Frustrating
"You will do!"
"You people"
lots of moves
NOT LISTENED TO!
Impatient
TOLD
Making decisions for me
treated like a child
Swept under the carpet
Assumptions
Not prioritising adults
TOLD
Not support & protected by some services
Training
Communication
Taking risks
Making unwise decisions
Clear Information
Creative
Action Plan
Taking action
Ideas
Continuity
a contact I can talk to
EDUCATION
Honest
flexibility
open
Road to abuse
Stop adult abuse
Outcomes 1st
support
No Jargon
Blah!
blah!
blah!
Simple but cool language
Road to respect
I am the expert!
FUTURE
MY VIEWS & WISHES TAKEN & ACTED ON!
listened to & taken seriously
Informed
Not made to feel stupid!!!
Health professionals sensitive to my needs
SEE THE PERSON NOT THE DISABILITY
See Ability I can do!
PARTNERSHIP WORKING
Nothing about me without me!

MSP Principles

- Person led & outcome focused, working with – not doing to.
- Focus on the individual, their perception of what is happening, what is important to them, what needs to change – to enhance involvement, choice & control, aiming for resolution and recovery.
- Enquiry and concerned curiosity is part of MSP.
- Support to enable people to build resilience & to make meaningful changes to reduce or remove risk.
- In the context of the overarching duty to promote wellbeing, which includes protection from abuse & neglect.
- Thus:
  - What does the person want to happen? How can we work with people to make that happen? Does the person feel safer and protected? How do we know intervention has made a difference?

Direct practice – best practice

- Person-centred, relationship-based practice
- Professional curiosity (history)
- Assessment of care & support, and mental health
- Transitions – opportunities not cliff edges
- Assessment & review of risk and capacity
- Family involvement (think family)
- Availability of specialist advice
- Legal literacy
- Balancing autonomy with a duty of care

Inter-organisational environment – best practice

- Guidance on balancing autonomy with a duty of care
- Information-sharing & communication
- Working together on complex, stuck and stalled cases
- Use of multi-agency meetings and safeguarding enquiries
- Clear roles and responsibilities (lead agencies and key workers)
- Shared record-keeping

Organisational environment – best practice

- Development, dissemination & review of guidance
- Clarifying management responsibilities and oversight
- Staffing, supervision, support & training
- Recording standards
- Commissioning & contract monitoring
- Culture of openness, challenge and escalation

SAB governance – best practice

- Audit & quality assurance of what good looks like
- Multi-agency training
- Review of management of SARs
- Workplace as well as workforce development
- Continual review of outcome of recommendations
- Use of SARs to inform policy development, practice audits and training

Expressing concerned curiosity: findings from SARs

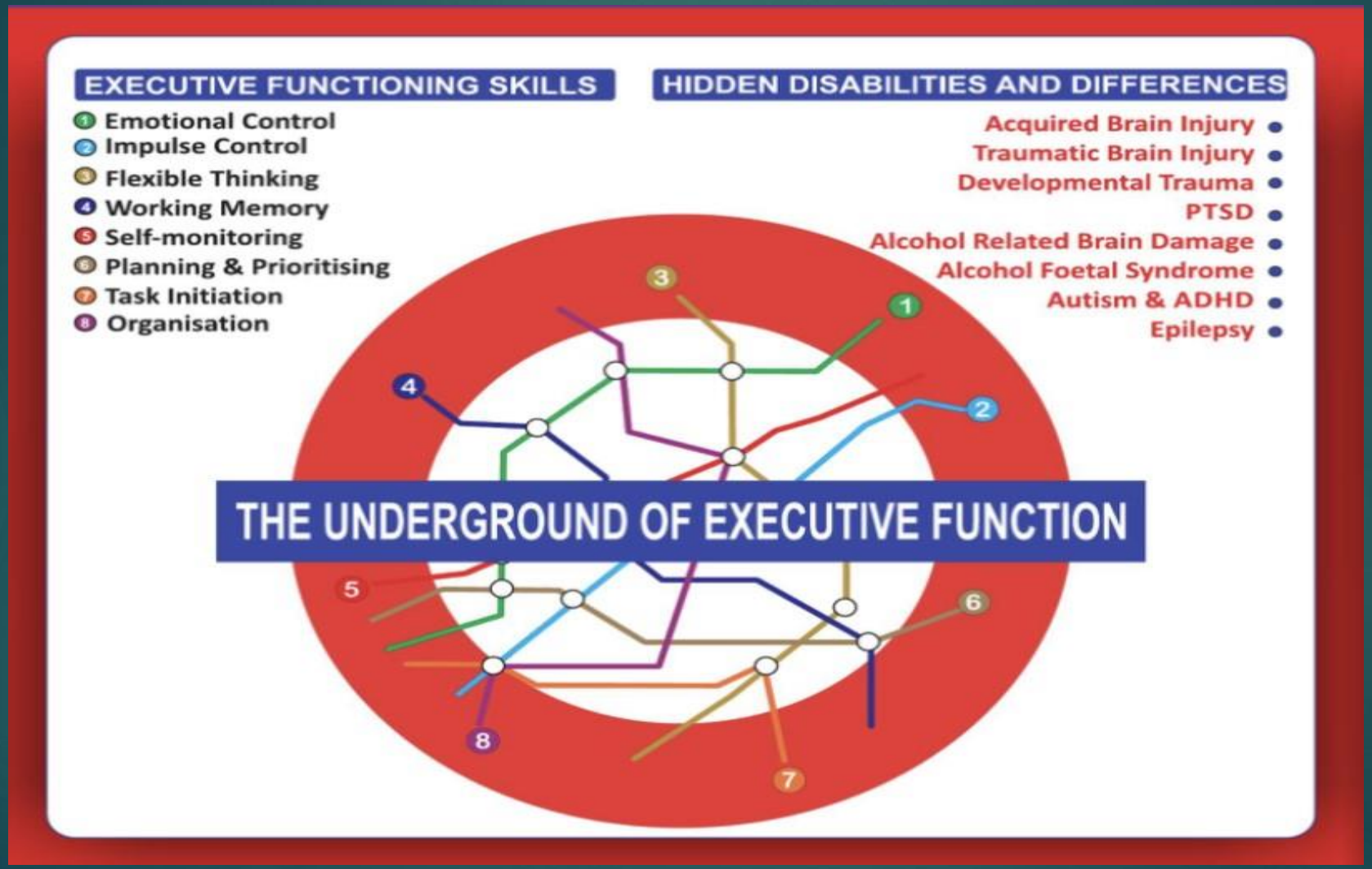
- An important skill in gaining an understanding of the individual and the significance of their history
- Practitioners accept accounts at face value, which minimised abuse/neglect or failed to recognise trauma
- Self-neglect, for example alcohol-dependence and/or refusal of services, not explored
- Shortcomings in curiosity in risk assessment, carer needs, family dynamics, rapidly escalating health needs, repeated A&E attendance, dropping out of sight

- "Care-frontational questions"
- "Look for the not so obvious"
- Omission of "the mundane and the obvious."

Why is curiosity in the too difficult box?

- Lack of time, pressure of workloads, and priority given to short-term involvement over relationship-based practice?
- Fear of reaction – even hostility and anger?
- Concerns about causing offence?
- Concerns about lack of cultural awareness?
- Perceived lack of skill – uncertainty about how to question?
- Myths about making safeguarding personal?
- Impact of rule of optimism/
- Prioritising autonomy and self-determination, the right to private and family life?
- Myth of lifestyle choice?

Executive Function



“They don’t engage”

- Who is really not engaging here? Has our service erected barriers to engagement? Do we place ourselves in their position and see the world from that vantage point?
- Is a person really unwilling to engage and/or unable to engage (see SAR Andy, Salford Safeguarding Adults Board)
- Do we consider what might be the emotional barriers to seeking care and support? What might we learn if we reflect on occasions when we might have sought help but something stopped us?
- Why should patients and service users immediately trust us? Building confidence can take time. How can we make every contact count?

Lifestyle choice or lack of capacity to act? Kirklees SAB Adult N (2022)

- Adult N died in his flat, aged 41. Cause of death was acute fatty and chronic alcoholism. Adult N had a history of homelessness, self-neglect and substance (alcohol) abuse.
- During this time he had experienced periods of homelessness, living in a car, in woodland or occasionally hotels. Often he was found living in insanitary conditions, self-neglecting, unresponsive and intoxicated.
- There were assumptions about lifestyle choice and insufficient curiosity about the background and his lived experience.
- There were no multi-agency risk management meetings despite a repeating pattern of attendances at A&E and concerns expressed by paramedics and the police. There was no lead agency or key worker appointed.
- Services did not work together, for example in-reach and outreach mental health and substance misuse agencies

MS: City of London & Hackney SAB (2021)

- MS died, aged 63. Cause of death was acute myocardial infarction, coronary artery atherosclerosis and aspiration pneumonia. He died at a bus stop where he had been living and sleeping for several weeks.
- MS was Turkish (Kurdish ethnicity) with limited understanding of English and a history of homelessness, self-neglect and substance abuse. He had returned to the bus stop where he eventually died at the end of May 2019, having spent the previous five months in a nursing home. When that placement came to an end he was offered a hotel room but declined. He is reported as having said that "something brings [me] back to the bus stop."
- There were discussions on whether and how to use anti-social behaviour powers, and mental capacity and mental health legislation, in order to safeguard his health and wellbeing, and to address expressed concerns from local residents. No effective means of resolving the situation was found before he died. No multi-agency risk management meetings.

Learning from Reviews (1)

- The need to improve
  - Safeguarding and legal literacy
  - Integrated whole system working and cross-border/cross-agency communication
  - Recognition and assessment of care and support needs
- The need to clarify
  - Pathways into safeguarding
  - The role of different multi-agency panels
- The need to assess
  - The likelihood and significance of risks
  - Executive functioning after prolonged substance misuse
  - The impact of trauma and adverse experiences

Learning from Reviews (2)

- The need for creativity
  - Thinking collectively about ways forward
  - Avoidance of case dumping
  - Inter-agency mechanisms for responding to stuck and stalled cases
- The importance of wrap-around support
  - Not just for service users but also for staff; the work is challenging
  - The importance of time, relationships and being "held"
- The importance of candour and challenge
  - The importance of escalation of concerns
  - Ensuring all voices are listened to and included in multi-agency meetings

Learning from Reviews (3)

- SAR Jessica (Blackpool SAB)
  - Lack of cross-border communication and information-sharing; lack of multi-agency risk management meetings; shortcomings in communication between children's social care and adult social care.
  - Loss of Jessica's voice and failure to make safeguarding personal for her; missed opportunities to refer concerns; acceptance of family explanations at face value; undue reliance on family to keep appointments.
  - Misunderstanding of MCA 2005 and delays in Care Act assessments; lack of challenge when denied entry.
- SAR P1 (Sheffield SAB)
  - Not seen in person for several months; face to face appointments missed by the family; lack of exploration when he was removed from day centre/college; no engagement with annual health checks and poor response when "not brought".
  - Over-reliance on information from parents.
- SAR GB (Bradford SAB)
  - Some good individual and inter-agency practice
  - GB's voice not heard and reliance on his mother; assumptions about (lack of) capacity; missed opportunities to share information

Important Final Word – Helen's Message

- "What hope do I have to ever recover or feel better when this keeps happening? I encourage anyone who truly cares to come and spend a day with me to see what it's like to be helpless, when days feel like weeks, weeks feel like months." (reported in a Luton SAB SAR).

- Children's Social Care did exhibit a "think family" approach and sought to involve other agencies as part of the work to support Helen and her family network with her disabled son. However, this attempt to secure a "think family" approach did not materialise. There were delays in assessments and service provision, and a failure to involve all the family when they were providing support.

Discussion

- What barriers are there to adopting a "team around me" approach?
- What are the enablers that promote effective "multi-agency" practice?
- What changes in systems, policy or practice could help to promote a "whole system, wrap-around health, housing and social care" approach?
- What specific recommendations would you make?
  - In relation to your own practice?
  - In relation to your own organisation?
  - In relation to interagency working?

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