ASPB Workshops on the latest findings from Safeguarding Adult Reviews and Multi-agency Audit Activity 2018 - 2019

Aims and Learning Outcomes

- This two hour workshop will focus upon the findings from the latest local Safeguarding Adult Reviews and Multi-Agency Audits
- The workshop will also explore new policies and procedures and information from the safeguarding adult arena
- Aimed at front line practitioners from statutory and non statutory safeguarding agency's. We will explore how we can put the ‘learning’ back into front line practice to ensure the safety of the adult at risk, their carers and families that we work with

Safeguarding Partnership Board Structure

Adults Safeguarding Partnership Board

Under the Care Act 2014 every local authority must set up a ASPB - a multi agency strategic partnership that is responsible for monitoring safeguarding adult's at risk practice. It is a key mechanism for ensuring effective partnership working.

The objective of the Adults Safeguarding Partnership Board is to help and protect adults at risk of abuse or neglect.

The ASPB must seek to co-ordinate agencies and ensure the effectiveness of what each of its members does.

Adult Safeguarding Partnership Board

An ASPB will;

- Authorise the policy, process, strategy and guidance required to support Board priorities and effective safeguarding
- Publish a strategic plan that sets out how it will meet its main objectives
- Scrutinise, challenge and maintain an overview of adult safeguarding in Cambridgeshire and Peterborough
- Ensure that Safeguarding Adult Reviews (SARs) are undertaken in accordance with S44 of the Care Act 2014 and where necessary will oversea the SAR process.
- Assess whether partner agencies are fulfilling statutory obligations in relation to safeguarding adult's at risk
- Quality assure practice through joint audits of case files and identifying lessons to be learned
- Monitor and evaluate effectiveness of training, including multi-agency training

Cambridgeshire & Peterborough Safeguarding Adults Partnership Board

Safeguarding Adult Multi-Agency Audits

Self – Assessment Audit Tool

In line with the statutory responsibilities under the Care Act 2014, in order to assure the safeguarding adult board that; agencies are effectively safeguarding adults at risk an agency self-assessment audit tool was developed for agencies to complete. This is the first time that Cambridgeshire and Peterborough Adult Safeguarding board has undertaken a safeguarding self-assessment audit with partners.

During 2017 the statutory leads (Health, Police and the Local authority) helped develop and completed the self-assessment tool

The remaining agencies, who make up, the membership of the adults quality effectiveness group (QEG) and others were asked to complete and submit the self – assessment audit tool by the end of December 2018. Alongside this, practitioners of those agencies undertaking the self - assessment audit tool, were given the opportunity to complete an anonymous survey (Survey Monkey) to gather their views and thoughts about some of those questions contained within the self-assessment audit tool.

The Standards set out within the Tool

1. **Empowerment** – Making Safeguarding Personal – Personalisation & the presumption of person led decision and informed consent, service development includes the need to safeguard and is informed by the views of service users, carers, families and advocates
2. **Prevention** (including training and recruitment) – It is better to take action before harm occurs
3. **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented
4. **Protection** – Support and representation to those in greatest need
5. **Partnership** – local solutions through services working in their communities
6. **Accountability** –Transparency in delivering services – A clear line of accountability within the organisation for work on safeguarding and promoting welfare of adults at risk
7. **Information Sharing**

The Survey Professionals

- The practitioner's survey was initially developed as part of an overall project to ascertain what people [practitioners and the general public] knew about safeguarding adults at risk.
- Survey developed with members of the Quality Effectiveness Group and consisted of 25 questions; some of which were directly taken from the Self-Assessment Audit Tool – in order to triangulate the evidence
- The practitioner's survey was opened on July 2018 and closed at the end of February 2019 to coincide with Safeguarding awareness month, with a view to obtaining more responses. In total 406 responses were received. Of those 62% were front line practitioners,13% team managers; 1% head of service and 18% other.
- The majority of respondents to the survey, either, worked directly within adult facing services, or children and adults services, and were those practitioners for whom the survey was aimed at

Findings- Good Areas of Practice

- Escalation policy process was mentioned as part of multi-agency working
- There were illustrations of where policies had made a difference to practice and the environment for working with an adult at risk
- Reminder cards given to staff about safeguarding
- In some instances there was evidence recorded that service users were asked what they want to happen to them
- Some agencies actively audited cases to examine practice
- Safeguarding, for some agencies, was reportedly noted as being in every job description
- Some agencies evidenced that they displayed safeguarding posters with contacts written on and that they included links to the SAB website
- There was evidence that people who were assessed as adults at risk were asked to sign consent forms for sharing information, if there is a safeguarding concern

Findings - Areas to Improve On

- Both the self -assessment audit tool and the survey suggest that professionals know where to find and how to access their ***policies and procedures*** regarding safeguarding adults at risk. The survey responses showed that **86%** of professionals know how to access their policies, although **14% (47 people**) indicated that they did not. It was not clear from the evidence given from the self-assessment audit tools *whether policies and procedures are up to date*.
- The self-assessment audit tool showed that staff knew about policies and procedures relating to ***allegations made against staff****.* However, there was no evidence given to show that professionals had accessed the policies nor if there had been any referrals / reported concerns within the agency. The survey supported agencies, in that only **6%** of respondents (19 people) did not know what to do if they had a safeguarding concern about a staff member.
- Most agencies reported that they had a clear ***Whistleblowing Policy*** in place. However there was no evidence as to whether the policies had been used by staff and although **87%** of survey respondents indicated that there was a clear whistleblowing policy within their agency only **76% felt** confident to use it.

Findings

- ***Safeguarding adults at risk***.**100 %** of professionals surveyed said that if they knew an adult at risk was being abused or neglected that they would report it. **96%** said they knew what to do if they had a concern about an adult at risk and **88%** felt that they were confident that they could recognise the signs and indicators of abuse. However, **41 people (12%)** did not feel confident.
- ***Information sharing***. **85%** of respondents from the survey said they felt confident about sharing information in relation to an adult at risk when consent had been obtained. However, **70 professionals (15%)** of those surveyed stated that they were not confident about sharing information. There is still much work to do on information sharing and **working together** to safeguard adults at risk.
- ***Supervision***, although there was some inconsistency reported regarding the frequency and type of supervision available to professionals within an organisation, **95%** of respondents to the survey indicated that they did receive supervision and support within their role.
- **Safeguarding Lead**. ¾ of respondents to the survey said that they knew who the safeguarding lead was within their organisation; though **24% (81 people)** did not

Findings

- **Safeguarding Training** - questions related to training or induction, within the self-assessment audit tools, were scored a green (fully met) by agencies. However, the survey suggests that **91 people (27%)** have not accessed safeguarding adult training
- ***Voice of the adult***. This was barely mentioned nor evidenced within all of self-assessment audit tools and where it was this was in relation to providing information to the adult at risk. **As professionals we need to find out what 'the lived in experience' of the adult at risk is like either by asking them, speaking to their family/carers or making observations. This needs to be an embedded part of safeguarding practice.**
- ***Cultural competence*.** This is an area that is about the wider protected characteristics of individuals, including race, ethnicity, gender, sexual orientation, age, disability and mental health. Although diversity and equality was referred to in some self-assessment audit tools there was very little in terms of evidence about cultural competence and an understanding of what good practice looks like within this area. **Agencies need to show how staff put into practice how they work with adults at risk and their families and how they don't make assumptions and do find out about the lived experience of the adult**

The General Public Survey

The Survey

- During September 2018 until the end of February 2019 the Safeguarding Adult Board (SAB) held a survey to find out what the general public knew about safeguarding adults at risk. The survey was accessible via easy read surveys and electronic surveys (Survey Monkey) and all responses were anonymous
- In total 122 members of the public responded to the survey. The age ranges of respondents were varied with the largest group being from the 45 – 54 age category closely followed by 55- 56 age group. Most were recorded as being female (70%) and white British (73%). 15 people (18%) stated that they had a care / support need and 15 respondents identified themselves as an ‘unpaid carer’

Findings

Question : What is Safeguarding?

- 89% of respondents said that they had heard of the term safeguarding before and most (50%) had heard about safeguarding from a safeguarding training event or conference, which might suggest that these people may have been professionals working within the safeguarding arena. In the ‘other category’ an additional 33 people knew about the term safeguarding from work and 3 knew through personal experience or family.
- A number of people had heard about safeguarding through social media (6%), the media (9%) (television / radio) and websites (8%). This reflects what professionals have informed the SAB from the recent self-assessment audit tool that all agencies need to do more to promote’ what safeguarding is’ to the public

Findings

Question : Who is an Adult at Risk?

- For every category given within the survey over 60% indicated that they regarded them as being examples of adults at risk of abuse or neglect and this included; someone with a hearing impediment, someone in a wheel chair, someone being sexually or physically assaulted and someone with a broken leg. Clearly adults within these categories may have been harmed or may need support but they would *not be* readily identified by definition as an 'adult at risk'.
- For the question on '**what people would consider as adult abuse**' over 90% stated that; not providing adequate care in residential or care home, withholding someone's medication, humiliating or intimidating someone and pressurising someone into having a sexual relationship was adult abuse. This is a difficult area to understand in terms of adult abuse and further information would need to be known as to whether the brief statements were actual adult abuse cases as the adult having these things happening to them would have to be an 'adult at risk' by definition. That is not meaning to say that some of these categories are not abusive and not criminal but they are not necessarily 'adult abuse' in terms of an 'adult at risk'.

Findings

If an adult was at risk of being abused what would you do?

- From the first question in this section of 'if you had concerns that an adult was being abused or neglected would you report it, a resounding 100% of respondents to the question stated that they would. However, 29 people skipped the question.

'If you thought that an adult was at risk of abuse or neglect and you decided that you would report it, where/who would you report this to?'

- 34 people (32%) stated that they would contact either Cambridgeshire or Peterborough Adult Social Care, followed by; the Safeguarding Adults Board (17 people 18%), police (9 people 10%), a carer/support worker (7 people 8%), 5 % (5 people) would tell a general practitioner/nurse, 2% (2 people) family/friend and one person 'did not know'.20 people stated that they would tell 'other' people and this included; safeguarding leads, local authority, MASH (Multi-agency Safeguarding Hub) or a trusted person.
- These answers would seem to reflect that the sample of respondents were professionals answering the survey though it is quite worrying that the second highest group would report a safeguarding concern to the SAB.

Findings

The Safeguarding Adults Board

- To the question ‘Have you heard of the Cambridgeshire and Peterborough Adults Safeguarding Board?’ 74% of respondents said that they had with 24 people saying that they had not and 29 people skipped the question. This could be a good indication that the general public have heard of the SAB, but this is a relatively small sample and it is not exactly clear whether a number of professionals completed this survey as well as the general public

Pre-requisite Tools for Practice

Person Centred

Professional Curiosity

Respectful Uncertainty

Beware Disguised Compliance

Think the Unthinkable!

Flexible Thinking

Professional Boundaries

Cultural Competence

'Carefrontational' Questioning

Safeguarding Adult Reviews

What is a Safeguarding Adult Review (SAR)?

The Care Act 2014 statutory guidance says that a Safeguarding Adult Board must arrange a SAR when the following criteria is met:

- When an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- If an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

ARTHUR

- Very little was known about Arthur's life until after the completion of the Safeguarding Adult Review. Arthur was 60 years old and lived alone in a first floor housing association flat. He was registered as disabled, having type 2 diabetes and a below the left knee amputation. He had limited mobility and used a wheelchair, which was stored in a hall cupboard for outside use as it was too big to use around the flat.
- Arthur was generally isolated and did not see many people apart from those agencies working with him and a friend, who was his neighbour. His neighbour characterised him as a 'cantankerous, angry, miserable and embittered bloke' but also described a mutually supportive relationship.
- Arthur's case is a complex one and involved a number of professionals working with him. He spent a number of times in hospital with regards to his amputation site becoming infected, swollen and on one occasion maggot infested. Whilst in hospital Arthur was generally compliant and his health improved and he was discharged back home.
- District Nurses the General Practitioner (GP) Ambulance practitioners Occupational Therapists Fire and Rescue Service and Housing Officers visited, were all involved within Arthurs case. Most of these professionals noticed that Arthur had been using empty milk bottles as a toilet and that the flat was scattered with belongings and furniture.

ARTHUR

- Each professional agency had various bits of information regarding Arthur's mobility, though they were often at odds to each other as to whether Arthur was mobile and able to get around and in and out of his flat.
- There were a couple of referrals to Adult Social Care, once Arthur had said yes to the professionals raising their safeguarding concerns with him, but when social care contacted him by telephone he would refuse their help. Arthur missed outpatient health appointments scheduled at the hospital and with his GP. On one occasion his case was closed by the District Nurse when he said that had managed to get out with friends and in response he was advised to see the practice nurse at his GP surgery in order to get his bandages changed.
- Arthur appeared to some professionals as being exasperated at particular services that he felt should have helped him when he first had his leg amputated and at the wheel chair service for their lack of action. To an occupational health professional he asked them to just 'give me a gun' indicating how frustrated and [maybe] distressed Arthur really was.
- Sadly, Arthur, died in 2018 and his cause of death was recorded as cardiac arrest, peripheral vascular disease, hypertension, sepsis, type two diabetes and hyperosmolar hyperglycaemic state.

Learning Points for Professionals

- Self Neglect
- Hospital Discharge
- Working Together
- Policies and Procedures
- Disguised Compliance
- Assessment – Professional Curiosity and Respectful Uncertainty
- Mental Capacity
- Recording
- Making Safeguarding Personal
- Lived Experience of the Adult – What's life like for them ?

Learning Points for Professionals

Cambridgeshire & Peterborough Safeguarding Adults Partnership Board

Self- Neglect

- All of the agencies involved with Arthur were able to identify areas of Arthur's self-neglecting behaviours, though none ascertained from Arthur when his self- neglect started nor the reasons why. Many of the Professionals within Arthur's case lacked **'professional curiosity'** as to how and why he was living the way he was. A number of agencies failed to ask Arthur about his current life situation or his past life experiences.
- No agency took the **lead to co-ordinate** assessments and planning for Arthur and no multi-agency meetings were held to discuss ways forward for working together to support Arthur. Instead agencies worked largely in isolation

Hospital Discharge

- ***When discharging patients discussions and discharge plans should consider the suitability of the accommodation and home conditions. Key agency's working with the service user should be part of the planning process. Plans should also contain a case history of previous admissions including areas of concern such as self –neglect and a discharge checklist. The checklist and discharge plans should be completed for every patient case and recorded on file.***

Working Together

Working Together

- ***Professionals when working with complex cases should have clear policies and procedures regarding agencies working together to safeguard the adult at risk. There needs to be clear communication between agencies***. In Arthur's case **Multi-agency meetings** might have overcome this and may have led to greater engagement with Arthur and better outcomes by combining assessments and planning

Disguised Compliance

Disguised Compliance

- Arthur may have been offering **disguised compliance** to some professionals for a number of reasons only known to Arthur and how he felt at the time. However, the practitioners involved in the case should have been ‘**respectfully uncertain’** and checked out with Arthur and with the other agencies what he was telling them. This may have changed initial assessments and planning by some agencies, avoided the closure of his case when he needed health provision and given a true picture of what was happening in Arthur’s life.
- For those whom he told that he could leave the flat he was never asked how he could actually physically manage to do that. A **’show me’** approach might have indicated whether or not he could execute his stated decisions.

Policies and Procedures

Policy and Procedures

- ***Professionals should be aware of their agencies policies and procedures and know where to find them and how to access them. Practitioners should adhere to multi-agency policy and procedures for supporting people who self- neglect and for working with people who display hoarding behaviours***. In Arthur's case, for some agencies the risk assessment indicator tool in the policy was not used when it would have indicated that a section 42 enquiry was appropriate and there was no consideration of whether his behaviour and lifestyle amounted to hoarding.
- ***Professionals should be aware of multi-agency policies on hoarding and self-neglect and follow procedures when this becomes a safeguarding concern. Agencies should consider a multi-agency approach as part of a safeguarding enquiry. (working together / multi-agency safeguarding meetings).***
- ***When there are repeated patterns of self- neglect and increased difficulties with everyday living or an escalation of risks; safeguarding referrals/meetings should be considered.***

Assessment

- ***When completing assessments professionals should include an analysis of the person's history (service provision and life experience) that may include patterns, risks and resilient factors to inform the assessment and plan of support for the individual. Holistic assessments should involve other agencies, extended family and friends and the person involved.***
- In Arthur's case, there was limited evidence of risk assessments being completed nor of evidentially supportive risk assessment tools, for assessing self-neglect, being used. ***Professionals should be aware of risk assessment indicator tools available within agency practice and when to use them to support their assessments.***
- ***Within assessments 'mental health' should be considered as well as 'physical health'***. There were no assessments of Arthur's mental health despite one reference to "significant mental health problems" by one professional and another noting a history of low mood and depression.
- ***Assessments are most effective when completed face to face and in the individual's home environment so that a full picture can be seen of where and how they are living, what care and support needs they may have and what their reactions and expressed feelings are (non-verbal communication).***
- ***Assessments should be timely***, in Arthur's case some assessments took a significant time to start and be completed which lead to delays of care and support with Arthur having to chase his own referrals.

Mental Capacity

Cambridgeshire & Peterborough Safeguarding Adults Partnership Board

Mental Capacity

- Arthur's mental capacity was never formally assessed; even though his behaviour and circumstances could have been considered reason enough (sepsis, infections and not coping) to question his decisional capacity. There was a lack of recognition that Arthur was unable to carry out his own good intentions at times which could have led to consideration of his executive capacity.
- ***Some agencies may not have a statutory duty to undertake mental capacity assessments, as in Arthur's case. However, they may be the best placed agency to do so by virtue of their knowledge of the person and of the question to be decided as to whether an individual does indeed have the mental capacity to take a specific decision at a specific time.***
- ***Professionals should use mental capacity assessments tools and be clear in their analysis and recording what elements of mental capacity are being assessed.***

Recording

- ***Professionals should keep clear and accurate records of the individual concerned including visits, telephone calls, meetings, assessments and referrals. Records need to be: clear, concise, void of agency jargon, up to date and have management oversight.***

- In Arthur's case some agency records were incomplete or unclear. Records of referrals were missing and no indication of when and if visits took place. Multi-agency meetings were not recorded and case files did not contain senior management oversight. On some files, the incorrect details for Arthur had been recorded which lead him missing out on health provision and it was not clear, from the records, what advice had been given to Arthur by various professionals

Making Safeguarding Personal

Building relationships. There was little evidence that anyone sought to understand Arthur's life history or the rationale behind any of Arthur's decisions, for example no one asked why, at times he refused help, failed to respond to telephone calls or letters and missed medical appointments. The intention, by practitioners, may have been to respect Arthur's choices and to promote his independence but this approach underplayed the apparent health risks.

Professionals should consider how to mitigate the risks arising from an individual declining services and failing to keep appointments. Agencies must consider why someone may not be responding, and consider using a different approach to engage with the service user.

Practitioners should always communicate with the adult at risk and ascertain their thoughts, feelings and wishes; though at the same time professionals should find out the reasons why services are being declined and weigh up what the risks of significant harm are for that individual if services are not implemented or are withdrawn

Friends and Family – The lived Experience of the Adult

Friends and Family. In Arthur's case his neighbour played a big part, calling the ambulance for him, tidying and decluttering his flat and speaking to professionals. However, the neighbour was not recognised as a carer nor asked about Arthur's past life nor his current life experiences.

In order to ascertain the lived experience of the adult at risk professionals need to communicate with friends, family and carers to find out the wider history and life of the individual. Working alongside significant others helps to safeguard the adult at risk.

Self-Neglect Resource Pack

- Leaflets and Posters
- Multi-Agency Policies and Procedures
- Protocol for dealing with Hoarding Behaviours
- Guidance for health and care professionals
- Presentations
- Resources from SCIE

SCOPE OF THIS CHAPTER

This document used should be used alongside the Multi-Agency Adult Safeguarding Procedures

This procedure will work alongside the Cambridgeshire and Peterborough Multi-Agency Protocol for Working with people with Hoarding Behaviours

Download the following Self-Neglect Resource Pack to guide and support you when working with people who self-neglect.

Contents [hide]

http://www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/selfneglect/

Clutter Image Rating Scale

https://hoardingdisordersuk.org/wp-content/uploads/2014/01/clutter-image-ratings.pdf

Pressure Ulcer Guidance

This guidance is intended to inform staff who are concerned that a pressure ulcer (or other forms of skin damage) may have arisen as a result of poor practice, neglect, acts of omission or deliberate harm, and therefore have to decide whether to raise a safeguarding alert in line with the local multi agency Safeguarding policy and procedures.

Cambridgeshire and Peterborough Safeguarding Adults Boards

Practice Guidance on Pressure Ulcers

1. **What is the purpose of this guidance**

This guidance is intended to inform staff who are concerned that a pressure ulcer (or other forms of skin damage) may have arisen as a result of poor practice, neglect, acts of omission or deliberate harm, and therefore have to decide whether to raise a safeguarding alert in line with the local multi agency Safeguarding policy and procedures.

The guidance outlines basic information about the prevention and development of pressure ulcers and when these should be considered as a safeguarding concern. This does not replace individual organisations' pressure ulcer guidance but provides advice on when pressure ulcers should be referred under the adult safeguarding procedures.

It provides guidance to staff in the Cambridgeshire and Peterborough Safeguarding Adults Boards locality:

- Adult Social Care Staff
- Domiciliary Care Staff in relation to referring a pressure ulcer under adult safeguarding procedures and the management of pressure ulcers.
- Staff working in residential and nursing homes
- NHS providers including, community nursing and hospital staff

The guidance could also be of interest to those who want to learn more about pressure ulcers.

2. **What is a pressure ulcer and how is it caused?**

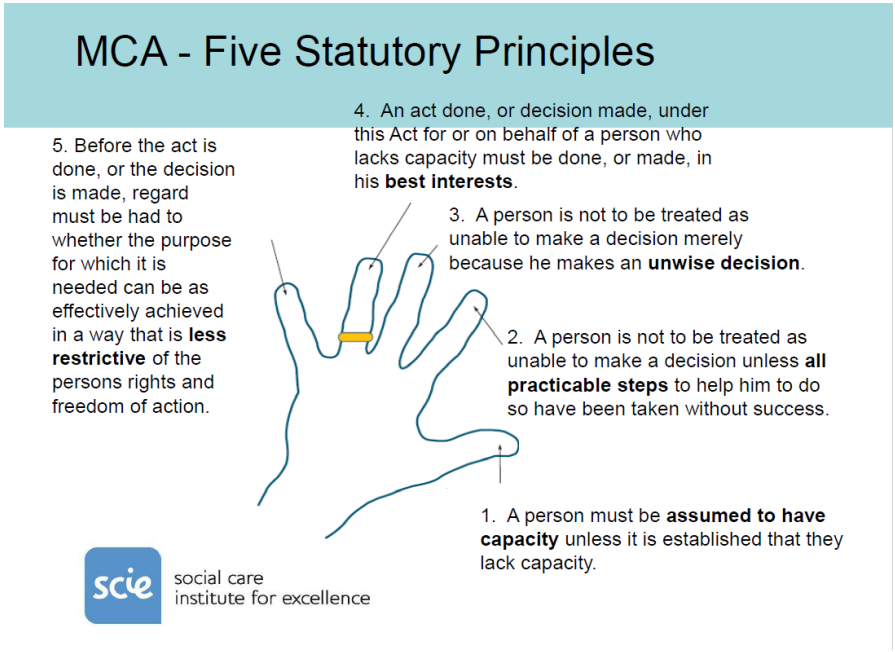
A pressure ulcer is a localised injury to the skin and / or underlying tissue usually over a bony prominence. This can be the result of

http://www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/pressure_ulcers/

Mental Capacity Act (2005)

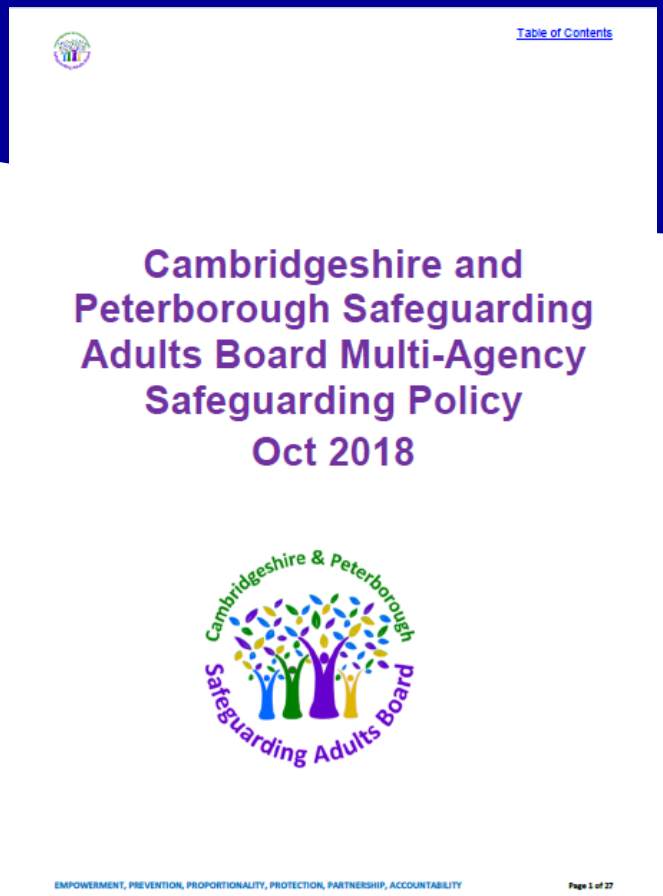
SCIE's MCA directoy:
https://www.scie.org.uk/mca-directory/

Includes:
Links to government documents
Resources for public and professionals
Assessment tools and guidance
Best interest decision making tools and guidance
Webinar recordings



Cambridgeshire & Peterborough Safeguarding Adults Partnership Board

Policies and Procedures



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EMPOWERMENT, PREVENTION, PROPORTIONALITY, PROTECTION, PARTNERSHIP, ACCOUNTABILITY

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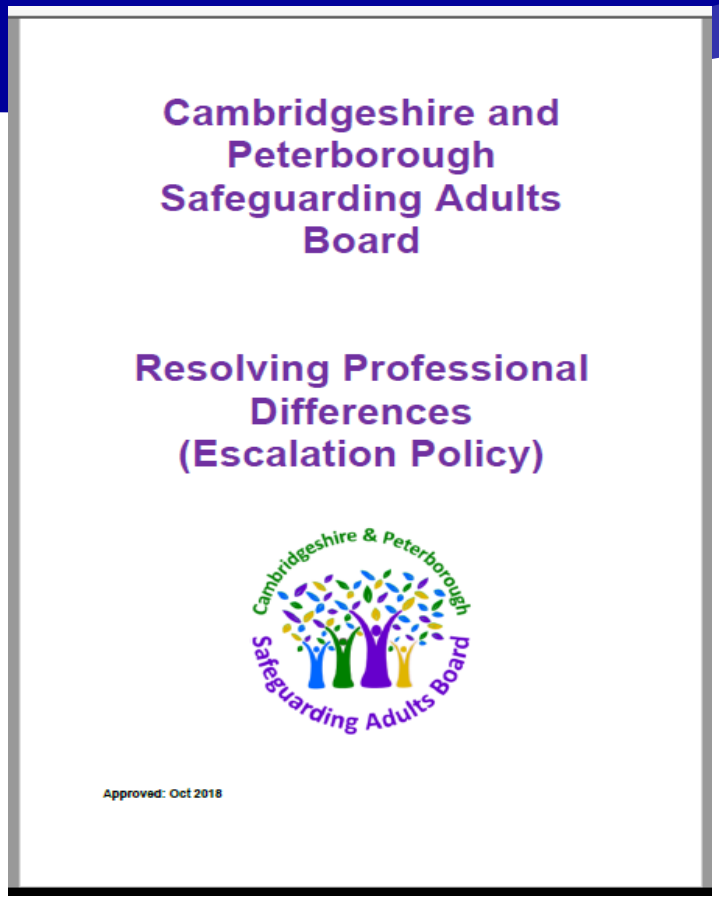
Includes:

- Background
- Definitions of Abuse, Neglect and Safeguarding Criteria
- Mental Capacity
- Advocacy
- Agency Roles and Responsibilities
- Serious Incidents in the NHS
- Multi-Agency Public Protection Arrangements
- People who are responsible for employing their own carers
- Useful websites and publications

Resolving Professional Differences

www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/adultescalation/



Cambridgeshire and Peterborough Safeguarding Adults Board

Resolving Professional Differences (Escalation Policy)

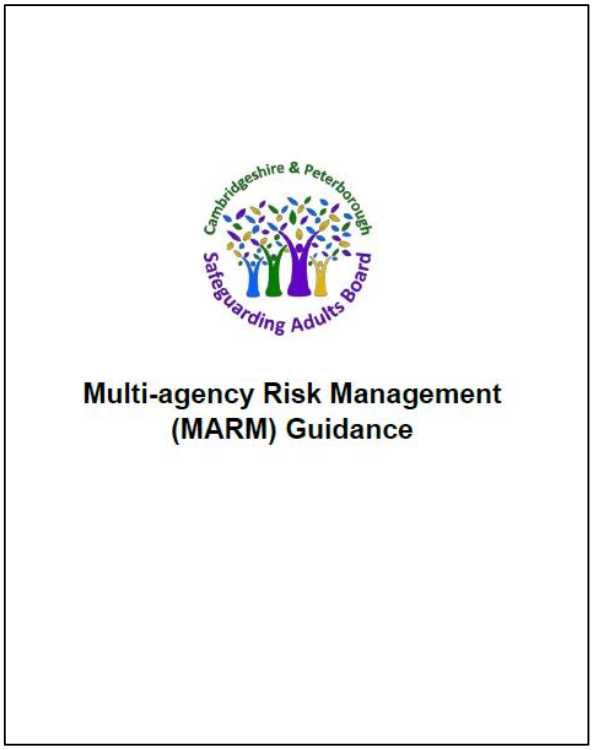
Approved: Oct 2018

Multi-Agency Risk Management

The Multi-Agency Risk Management Guidance document sets out a co-ordinated, multi-agency response designed to protect adults deemed most at risk to ensure that any significant issues raised are appropriately addressed.

This guidance must only be used where the adult:

- has the mental capacity to understand the risks posed to them,
- they continue to place themselves at risk of serious harm or death, and
- refuse or are unable to engage with necessary care and support services



PROCEDURE FOR MANAGING ALLEGATIONS AGAINST PEOPLE IN POSITIONS OF TRUST (PIPOT)

Available here: http://www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/pipot/

Six Step Process

This process should not be followed where an identified adult coming under safeguarding is at risk. A Safeguarding Adults Referral Form must be used.

STEP ONE: The Referral

The Referrer should:

- Confirm all details of the allegation in the full awareness that they will be contacted to clarify and confirm information as required;
- Inform the "person in a position of trust" that a referral to the MASH is to be made, and encourage them to share the information with their employer;

STEP TWO: Decision making

On receipt of a completed Referral Form the MASH Social Worker will report details to the MASH Manager. The MASH Manager will review the details and as applicable:

- Close the referral to the local authority confirming all required actions have been taken; **OR**
- Allocate the case to a MASH Social Worker; **OR**
- If the allegation relates to a person in the employment (paid or unpaid) of the local authority, escalate the referral to the Head of Safeguarding for decision making.

STEP THREE: Contact with the referrer

The MASH Social Worker will;

- Contact the referrer (this includes members of the public where allegations are raised via the Contact Centre) to clarify and confirm the details of the allegation
- Confirm that the person in a position of trust has been informed about the referral.
- As applicable, inform the referrer that the referral will not be accepted without confirmation that the person in a position of trust is aware.

STEP FOUR: Contact with the person in a position of trust

The MASH Social Worker will contact the person in a position of trust to:

- Establish if the nature of the concerns indicate a potential risk to adults at risk (in line with the definition given in Section 1 of this document)
- Encourage the person to share the allegations with their employer if they have not already done so.
- Inform the person that the MASH will be contacting their employer, within 24 hours, if the allegations indicate reasonable cause to suspect potential risk to adults at risk

STEP FIVE: Information sharing

The MASH Social Worker will clearly record all decision making considerations in relation to the nature of the allegation, the further actions to be taken by the local authority **OR** the decision that the referral should be closed to the local authority at this point. This may include referral to Childrens Services or other relevant agencies as applicable.

Information sharing decisions must be:

- Justifiable;
- Proportionate to the potential or actual harm to adults or children at risk
- In line with all applicable legislation and regulation

STEP SIX: Contact with the employer & case closure

In cases where the allegations indicate reasonable cause to suspect potential risk to adults at risk the MASH Social Worker will contact the Employer within 24 hours to confirm with them that:

- They are aware of the allegation.
- They have completed or are in the process of completing a Risk Assessment.


Cambridgeshire & Peterborough
Safeguarding Adults Partnership Board

Resources

Slides for Professionals

Professional Briefings

Safeguarding Adults Partnership Board Practitioner Briefing

Safeguarding Adult Review - Arthur

What is a Safeguarding Adult Review (SAR)?

The Care Act 2014 statutory guidance says that a Safeguarding Adult Board must arrange a SAR when the following criteria is met:

- When an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- If an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

This SAR was undertaken on a male who we shall call Arthur, to respect his anonymity. The SAR was initiated whilst Arthur was alive and it was reported that he neglected his own health and wellbeing, and appeared to have hoarding behaviours. The referral, for a SAR, concluded that Arthur was a "vulnerable adult" with limited mobility, who had suffered significant harm due to potential neglect to his wounds.

In the case of Arthur all agencies were required to provide Independent Management Reviews (IMRs) and a chronology of their involvement with Arthur. In addition, a practitioner's event took place which explored key episodes and events within the timeframe being reviewed by the SAR enabling professionals to talk through their experiences in a safe and learning environment.

Changes since the SAR for Arthur

- During early 2019 Multi-Agency Risk Management (MARM) Guidance was developed and launched within workshops across the region. 137 professionals attended the workshops. The **Multi Agency Risk Management Guidance** sets out a co-ordinated, multi-agency response designed to protect adults deemed most at risk to ensure that any significant issues raised are appropriately addressed. It seeks to provide frontline professionals with a framework to facilitate effective working with adults who are at risk; where that risk may lead to significant harm or death and the risks are not effectively managed via other processes or interventions.
- Workers are encouraged to have regular meetings or 'huddles' regarding cases where there are safeguarding concerns to look at risks and how to work effectively together with the adult at risk.
- Self- Neglect and Hoarding multi-agency training has been developed and designed and is available through the Safeguarding Boards Training Brochure. Lived Experience of the Adult at Risk workshops were cascaded across the region earlier this year. 71 professionals from a variety of agencies attended. Arthur's case study was used as an exercise for ascertaining what the safeguarding issues were, what the roles of responsibilities of professionals should be and how agencies could work together to

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Safeguarding Adults Partnership Board Practitioner Briefing

Briefing Number 2: Safeguarding Adult Practitioner Themes and Lessons

The Cambridgeshire and Peterborough Safeguarding Adult Board (CPSAB) has undertaken a number of Safeguarding Adult Reviews (SARs) and a recent multi-agency audit. From the audit and the SARs reoccurring practitioner themes when working with adults at risk and their families were found. These themes have also been identified within national SARs as lessons for agencies to learn and to put into practice:

Voice of the Adult at Risk: Ensuring that the adult's voice is not just listened too but is actively heard. It is a phrase used to describe the real involvement and experiences of the adult at risk– not just what they tell us but 'What is life like for them?' – What do they understand / **Wish** could be different/ Why do or don't they want help?

Professional Curiosity: is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. In other words: ***ask questions*** about 'What is life like for the adult at risk living at home / in a care setting?' 'What is it like for the family?' etc.

Make observations about the home/ setting environment- how does the adult at risk react to their family and to workers/staff? If the service user has walking aids / other aids are these easily available for them to access and if not why not?

If an adult at risk has a medical condition – what does this mean for them in their daily lives, ask them? If it's a medical condition that you know nothing about or would like to know more about then ask the professionals who do (i.e. medical professionals).

Respectful Uncertainty: Meaning that Professionals must remain ***sceptical*** of the explanations, justifications or excuses they may hear. In other words professionals should not take what families/professionals and the adult at risk tell us at face value – they should 'check out' with other agencies / sources of information what is being said.

Cultural Competence: is a term used to describe a set of skills, values, behaviours and principals that enable professionals to work effectively with service users who have one or more of the protected characteristics, as defined by the Equality Act 2010. Illustrations of these include disability; ethnicity or race; gender; gender identity; religion and belief; sexual identity/orientation and mental health.

Professionals need to be culturally competent and ***should not make assumptions*** about an adult at risk nor their family and as part of 'Informed practice' should be confident to ask about what their life experiences are in order to meet their needs and to provide the best service.

Think The Unthinkable: is a phrase that has been used in Children's Serious Case Reviews where professionals did not think that serious harm could ever be inflicted on a child by their parents. Professionals sometimes need to think about the worst case scenario and that family members might be harming children / adults at risk.

For working with an adult at risk think about the negatives and the risks, within their environment, as well as the protective factors...have a balanced approach to thinking about what might be happening in terms of safeguarding and potential abuse.

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Safeguarding Adults Partnership Board Practitioner Briefing

Briefing Number 1: Self-Assessment Audit Tool

Self- Assessment Audit Tool – What is it?

In line with the statutory responsibilities under the Care Act 2014, in order to assure the safeguarding adult board that; agencies are effectively safeguarding adults at risk an agency self-assessment audit tool was developed for agencies to complete.

During 2017 the self- assessment audit tool was developed and in 2018 was piloted with the three statutory partners of the board which included: Peterborough city council local authority, Cambridgeshire county council local authority, Cambridgeshire constabulary and the clinical commissioning group.

The remaining agencies, who make up, the membership of the adults quality effectiveness group (QEG) and others were asked to complete and submit the self – assessment audit tool by the end of December 2018. Alongside this, practitioners of those agencies undertaking the self - assessment audit tool, were given the opportunity to complete an anonymous survey (Survey Monkey) to gather their views and thoughts about some of those questions contained within the self-assessment audit tool. In total 406 professionals completed the survey.

What did we find out?

Good areas of practice identified within the self-assessment audit tool:-

- Escalation policy process was mentioned as part of multi-agency working
- There were illustrations of where policies had made a difference to practice and the environment for working with an adult at risk
- Reminder cards given to staff about safeguarding
- In some instances there was evidence recorded that service users were asked what they want to happen to them
- Some agencies actively audited cases to examine practice
- Safeguarding, for some agencies, was reportedly noted as being in every job description
- Some agencies evidenced that they displayed safeguarding posters with contacts written on and that they included links to the SAB website
- There was evidence that people who were assessed as adults at risk were asked to sign consent forms for sharing information, if there is a safeguarding concern

Areas to Improve on

Both the self -assessment audit tool and the survey suggest that professionals know where to find and how to access their ***policies and procedures*** regarding safeguarding adults at risk. The survey responses showed that 86% of professionals know how to access their policies, although 14% (47 people) indicated that they did not. It was not clear from the evidence given from the self-assessment audit tools whether policies and procedures are up to date.

The self-assessment audit tool showed that staff knew about policies and procedures relating to ***allegations made against staff***. However, there was no evidence given to show that professionals had accessed the policies nor if there had been any referrals / reported concerns within the agency. The survey supported agencies, in that only 6% of respondents (19 people) did not know what to do if they had a safeguarding concern about a staff member.

Most agencies reported that they had a clear ***Whistleblowing Policy*** in place. However there was no evidence as to whether the policies had been used by staff and although 87% of survey respondents indicated that there was a clear whistleblowing policy within their agency only 76% felt confident to use it.

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SAB Multi-Agency Training

You can find out more about the training the SAB has on offer here: http://www.safeguardingcambspeterborough.org.uk/availabletraining/

Our website is now in 104 languages

- www.safeguardingcambspeterborough.org.uk/
- Just click on the translate button
- Lots of information, leaflets and guidance for professionals and parents/ carers and young people