Current Safeguarding Messages February 2021 Workshop

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Aims and Learning Outcomes

- This one hour Microsoft Teams workshop will focus upon the findings and research from the latest National and Local Safeguarding Adult Reviews

- Aimed at front line practitioners from statutory and non statutory safeguarding agency's. Exploring 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

Latest National Research on Safeguarding Adult Reviews

What is a Safeguarding Adult Review (SAR)?

- A Safeguarding Adults Review (SAR) is a Multi-Agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is to promote ***effective learning and improvement***, not to apportion blame

- The purpose of a SAR is to learn the lessons about how professionals and organisations work together, and to consider how the learning can be used to improve practice for others in the future

When is a SAR undertaken and by whom?

The Care Act 2014 statutory guidance says that the Safeguarding Adult Board **must** arrange a review involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

1. there is reasonable cause for concern about the SAB, ***partner agencies or other persons with relevant functions worked together to safeguard the adult; and***
2. **Either**
    a) The adult has died, and the SAB knows or suspects that the death resulted from serious abuse or neglect; OR
    b) The adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect

When is a SAR undertaken and by whom?

The Care Act 2014 statutory guidance says that the Safeguarding Adult Board **may** also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

National Analysis of SARs

An analysis of SARs completed nationally between April 2017 and March 2019 was undertaken

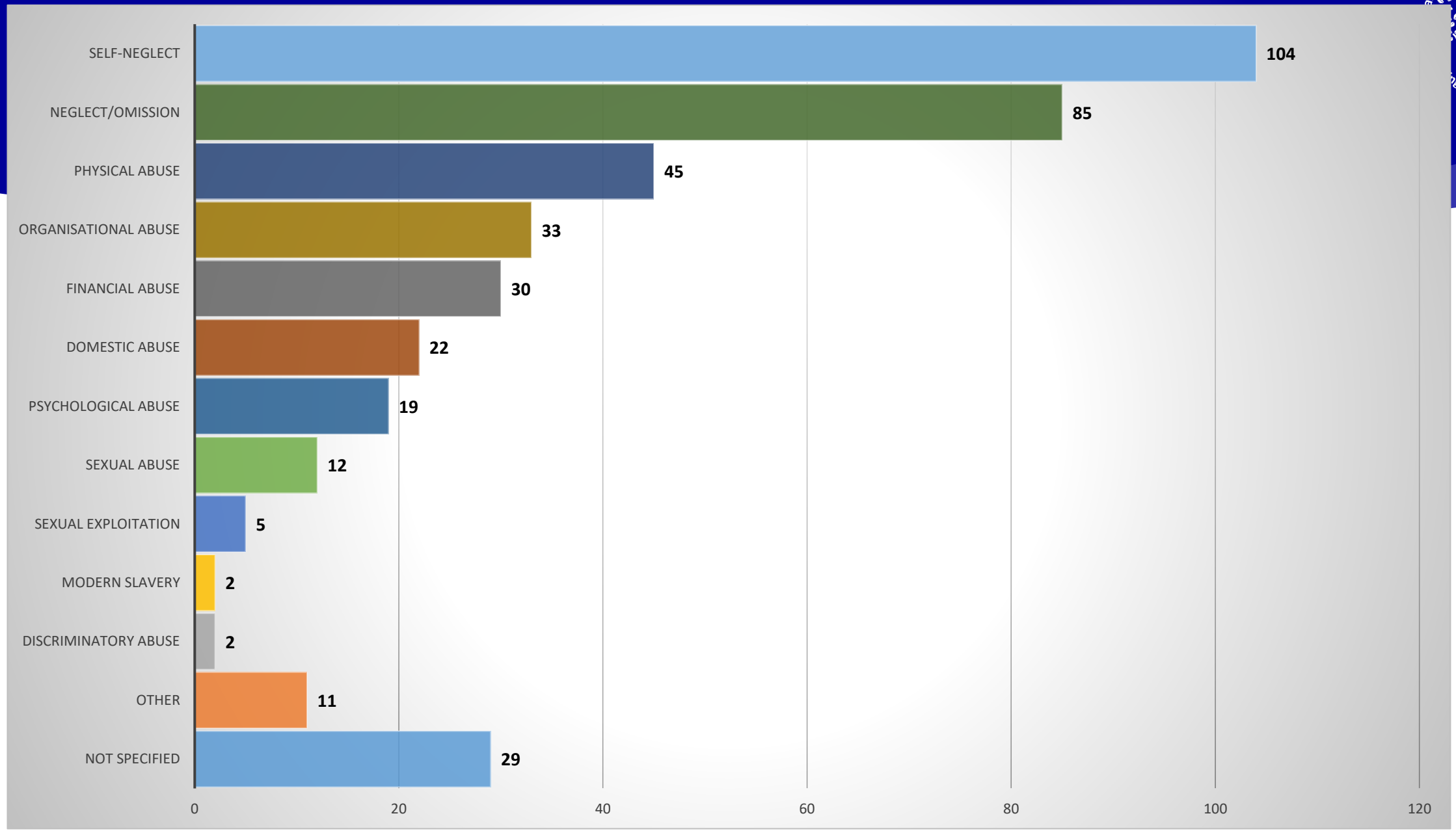
- A total of **231** SARs from **103** Safeguarding Adult Boards
- There were 263 people whose experiences were reviewed in the SARs, 81 per cent of whom had died

Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 | Local Government Association

Gender of individuals featured In SARs										
Gender	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire & Humber	All regions
Male	7	9	33	8	17	18	19	12	6	**129**
Female	10	4	28	6	23	13	10	5	10	**109**
Other / Transgender / Unknown[93]	1	1	7	4	5	1	2	2	2	**25**
Total	**18**	**14**	**68**	**18**	**45**	**32**	**31**	**19**	**18**	**263**

Age of individuals in SARs compared with age of people in section 42 enquiries				
Age	Total s42	Percentage in s42 enquiries	Total SAR	Percentage in SARs
0-17	0	0.0	1	0.5
18-64	1128	3.5	120	61.2
65-74	2270	7.0	34	17.3
75-84	7031	21.7	16	8.2
85+	21973	67.8	25	12.8

There were slightly more men than women. The average age was 55. Comparison with Section 42 data showed that the people featured in SARs were more likely to be younger and male, whereas those for whom Section 42 enquiries took place were older and female.


SELF-NEGLECT
104
NEGLECT/OMISSION
85
PHYSICAL ABUSE
45
ORGANISATIONAL ABUSE
33
FINANCIAL ABUSE
30
DOMESTIC ABUSE
22
PSYCHOLOGICAL ABUSE
19
SEXUAL ABUSE
12
SEXUAL EXPLOITATION
5
MODERN SLAVERY
2
DISCRIMINATORY ABUSE
2
OTHER
11
NOT SPECIFIED
29
0
20
40
60
80
100
120

- ‘What emerges from detailed reading of the SARs is the complex interplay between physical comorbidities and between physical and mental ill-health, and the complex medical conditions which practitioners were called upon to manage. Such complexity illustrates the necessity of bringing together a bespoke team around the person’
- ‘What also emerges from a detailed reading of the reviews is the significance of the impact of a life event, such as loss of a parent. That impact may well be hidden from view, at least initially, and highlights both the importance of time to establish a trustworthy relationship and skill in sensitively exploring emotional distress’

Recommendation Themes across 4 domains

Direct Work	Interagency Working	Organisational Features	SAB Governance
Risk Assessment	Case Coordination	Training	Learning Dissemination
Mental Capacity	Information Sharing	Commissioning	Quality Assurance
Working with Carers	Safeguarding	Quality Assurance	Training
Care/Support	Procedures	Policy/ Procedures	Self-Neglect Policy
Personalisation	Record Sharing	Records/ Recording	Other Procedures
Responding to Health			

Latest Local Safeguarding Adult Reviews

Alan

About Alan

- The background to Alan was discussed during the workshop

Themes Identified

- There was a lack of understanding about The Office of the Public Guardian and Power of Attorney.
- There was a lack of understanding of Coercion and Control in family relationships, and how the adult's mental capacity should be considered in this situation
- There was inadequate information sharing
- Policy and procedures weren't always followed
- It was hard to identify the issues; neglect, financial abuse, coercion and control
- There were challenges in dealing with the family/carers who were manipulative/aggressive/difficult

Key Learning

There needs to be:

- better use of multi-agency meetings to share information and make effective decisions to ensure that robust protection is in place for adults at risk. These meetings should include care providers who often have a great deal of information about a case.
- a process to ensure that before a person is discharged from hospital all safeguarding concerns are addressed and appropriate referrals made, particularly if the discharge is to be during a weekend
- there should be better information sharing and each agency should be clear what their responsibilities are.
- there needs to be better knowledge of Power of Attorney rules/processes so professionals can be more confident to identify, challenge and report any potential misuse of LPA,
- Professionals need better understanding to be able to identify domestic abuse offences and what support may be available for victims of coercive control.
- Where coercive control is suspected, timely and full records must be kept, so that a pattern of behaviour can be demonstrated.
- There needs to be better understanding of how concerns of a coercive or controlling relationship can be discussed with the OPG without the Attorney being involved in a way that could increase a risk to the adult who may be in a controlling relationship.
- When faced with repeatedly aggressive and manipulative persons, professionals should be supported, and robust action taken to protect them so they can do their work safely.

Latest Local Safeguarding Adult Reviews

Peter

About Peter

- Peter was born in Poland, he was a computer engineer and had been married, but had lost contact with his wife.
- At some point, while in Poland, he acquired a brain injury
- He had no recourse to public funds
- He was homeless
- He was support by a variety of agencies
- He was alcohol dependant, and had physical and mental health needs
- He had a number of hospital presentations - 25
- Peter died after falling into the River Cam in December 2018. At the time of his death Peter was 45 years of age. The cause of death was cardiac arrest.

The Referral

- A number of agencies worked extensively to support and work with Peter, this work intensified shortly before Peter's death, as the risk of him being unable to sustain his lifestyle and the harm it was causing his health was recognised.

- In February 2019 a SAR referral was made by his the GP. The referral was made on the basis that Peter had died, was in need of care and support services and that there was learning that could be achieved from the circumstances of Peter's death.

Period of review 1st January 2018 to 24th December 2018

Themes

There was a clear pattern of repeating behaviour; Peter was unable to keep up his accommodation because of his alcohol use, despite good support being offered, so he ended up living on the streets. When his health or safety reached a critical level he would then end up in hospital, mostly because members of the public called an ambulance after seeing him either incapacitated or suffer a fall and injury

- Mental capacity
- Best interest
- What to do when individuals don’t want to engage
- Diagnosing of mental health problems
- Use of different legislation and Safeguarding procedures
- How to effectively work together when dealing with individuals who do not want the help
- How to ensure that one agency co-ordinates/leads when engaging with the individual

Key Learning

There needs to be:

- greater awareness of the long-term effect of alcohol misuse on mental capacity and the recognition of Alcohol Related Brain Damage.
- greater understanding of the duty of care under the Care Act 2014 and what is available for those persons who have no recourse to public funding.
- continued training and understanding of the Multi Agency Risk Management Guidance (MARM).
- a review of what services are available locally for street drinking people, particularly those who are resistant to change. We need to look at what good practice is recognised nationally. A multi-agency, holistic and whole system-based approach is needed - any work in this area should include input from a service user group.
- The Street Aid Scheme needs promoting and education is needed on the risks of direct street donations to the homeless. (Peter lacked motivation to stop drinking, and he received a lot of financial contributions which funded for his drinking) This work should include the views of those with lived experience.
- The Homeless Hospital Discharge Protocol needs to be reviewed and promoted to ensure consistent application.
- Work is needed between the SAB and health providers of accident and emergency services to establish whether a marker can be added to frequent vulnerable homeless hospital attenders, with a link to a lead professional.

Finally – the review recognised that a number of organisations, and individuals, worked very hard to support Peter but often Peter did not, or could not accept the support available due to his alcohol dependency.

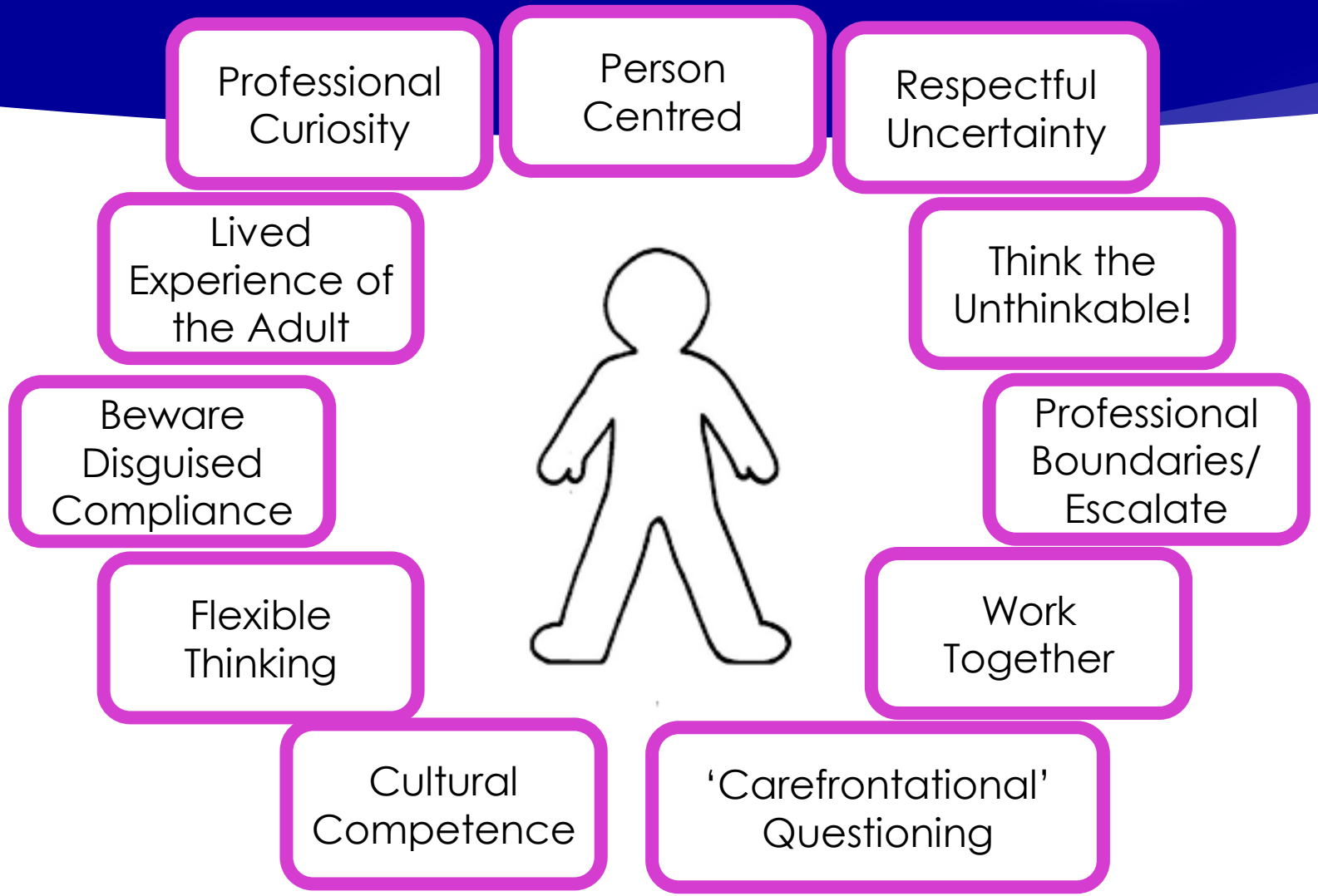
Cambridgeshire Street Aid Scheme

- Cambridge Street Aid helps people on the streets to turn a corner. We do this by raising a fund from which people who are, or have been, on the streets can apply for a grant to help them get off, and stay off, the streets.
- http://cambscf.org.uk/cambridge-street-aid.html

Safer off the Streets Peterborough

- All the partners in Safer off the Streets believe that everyone has the right to a home, to have hope and to feel part of a community, that's why charities and organisations across the city have joined up to create a network or support to help people who are sleeping rough, but also to look at ways to prevent and support people so they don't end up on the streets in the first place.
- https://www.saferoffthestreets.co.uk/

Pre-requisite Tools for Practice



SAR Audit Activity

Background

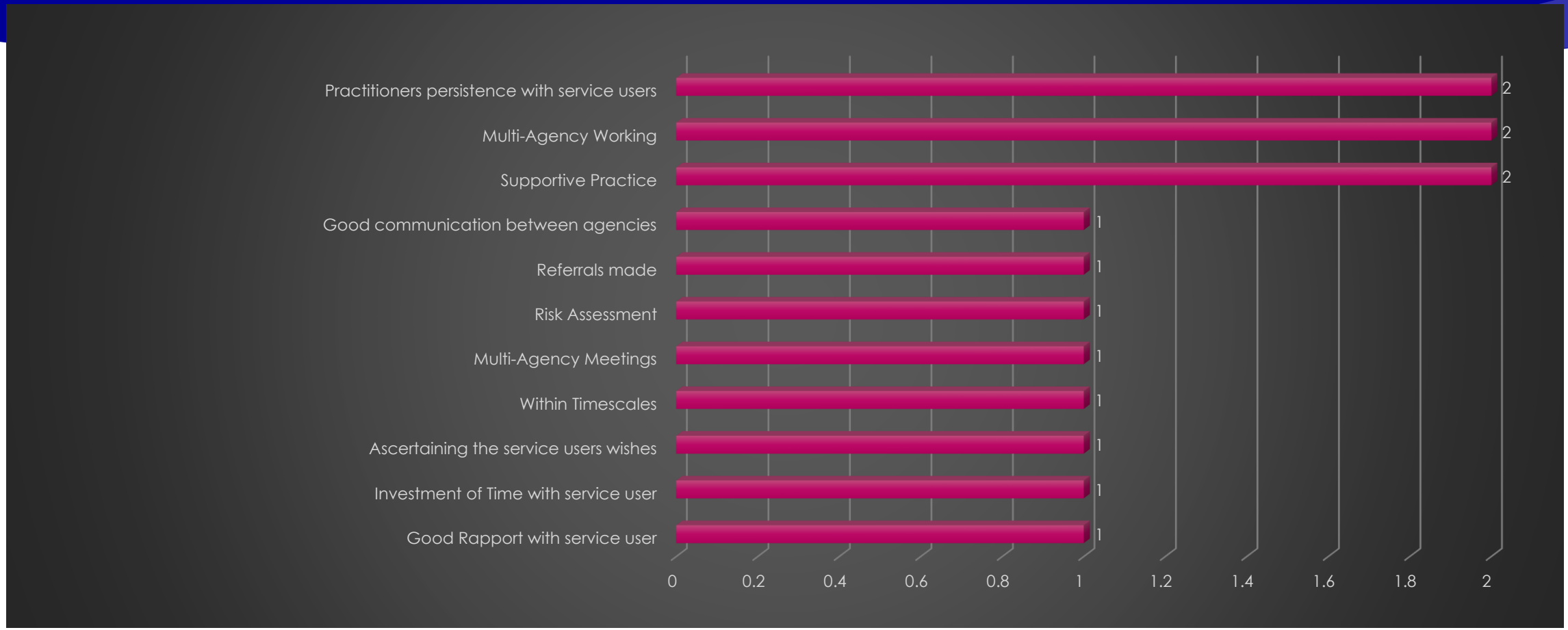
- The initial Thematic Report (January 2020) looked at all SARs undertaken from 2011 – 2018 across Peterborough and Cambridgeshire. A request from the SAR subgroup was for a smaller audit of SARs to be undertaken from after the Care Act 2014's implementation 2015 until 2019. Specifically at a time when reports may have been written differently to include both good and poor areas of professional practice to learn from
- ***Thematic Review*** was undertaken of the Professional Themes found within Safeguarding Adult Reviews (SARs) and SAR Action Plans from 2015 - 2019
- In total both boards undertook 3 Safeguarding Adult Reviews and a Safeguarding Adult (SA) Briefing during the period 2015 to 2019

Good Practice

Good Areas of Professional Practice

- Within three of the reports there was a small section, ranging from a paragraph to a page that focused on ‘good practice’. Even though in some of the reports the terms of reference included the requirement for good practice to be highlighted there was very little mention of it.
- This omission could be due to the fact that there were few illustrations of positive practice identified within the cases. However, it is or more likely that the analysis and style of writing adopted by the author has a predominant focus on ‘poor practice’, that both SARS and Serious Case Reviews (Children’s reviews) have historically tended to follow.

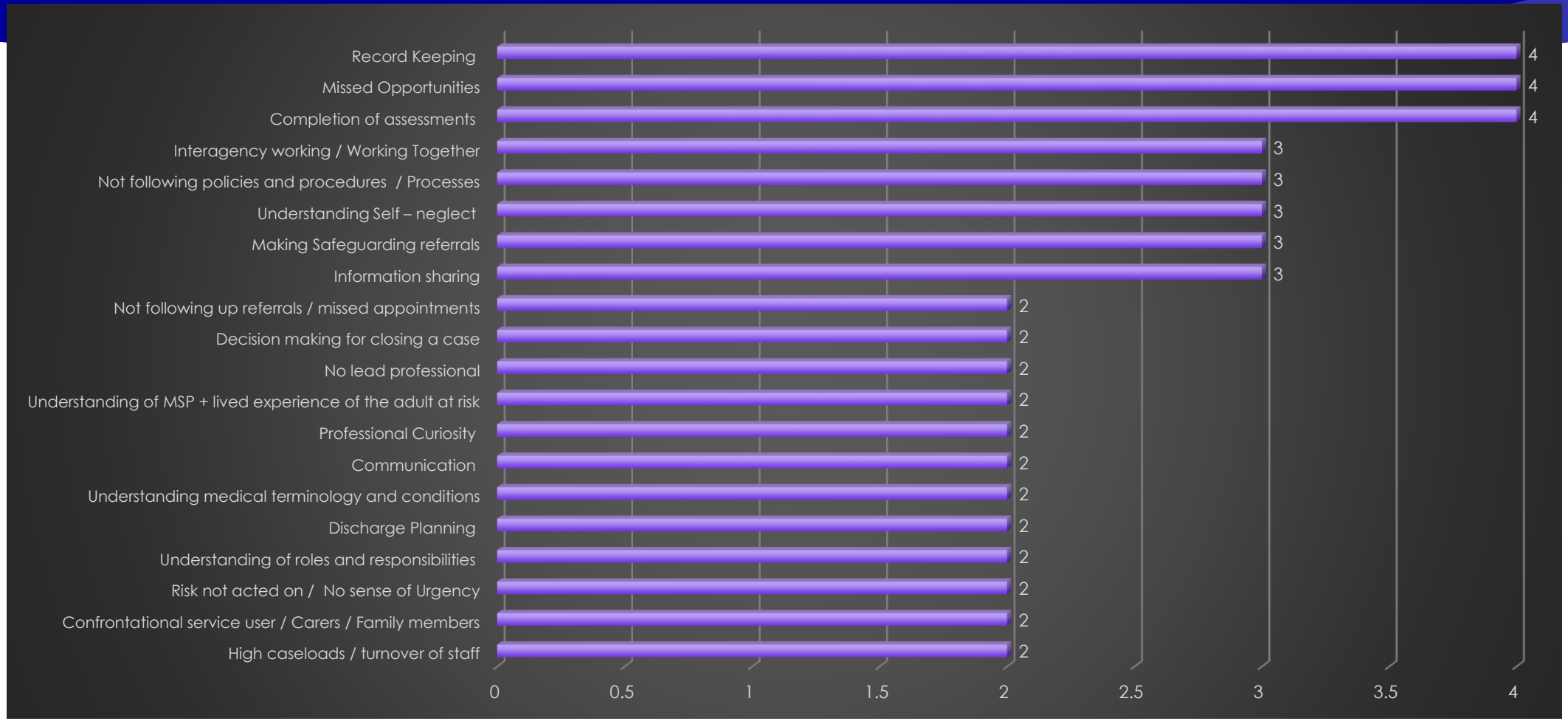
Good Practice



Areas for Improvement

- As with the thematic review of SARs in January 2020, professional's **recording** and assessments featured in every review (100%) of this sample. The phrase '**missed opportunities**' was also recorded in 100 % of these cases. Missed opportunities are individual to each case and were often situations that the report authors felt could and should have been acted upon by professionals.
- A similar finding to the thematic review report in January was that in 75% of this sample failed to **share information** and to **make safeguarding referrals**, did not follow **policies and procedures** nor **work together** to safeguard the adult at risk.
- A different feature, as compared to the initial thematic review report, was the practitioners understanding of **self-neglect.** This anomaly is due to the small sample size and that the majority of cases selected had adults at risk that experienced self-neglect. For these cases professionals failed to identify self-neglect and to use the risk assessment tools available for assessments and to support referrals.
- The professional theme of practitioners ascertaining the **lived experience of the adult**, finding out what life is like for the adult at risk featured within 50% of SARs, which is higher than the findings within the thematic review (2020). The disparity is possibly due to this being a smaller more select sample it is important to note that it is **'good practice**' that professionals actively seek the lived experience of the adult at risk in order to inform their assessments, planning and the support that can be offered to safeguard them

Areas For Improvement



‘SO WHAT’ has happened since the SARs? (in this sample)

- Task and finish set up to focus on some of the findings within the SARs and these included groups on; Discharge and Planning and Pressure Ulcers.
- **Multi-Agency Risk Management** Tool (MARM) was developed and launched within workshops during 2019
- Multi-agency policies and procedures have reviewed and developed situated on the safeguarding adult partnership board’s website
  - Escalation policy (Resolving Professional Differences)
  - Practice guidance on Pressure Ulcers
  - Protocol for working with people with hoarding behaviours
  - Risk management guidance
  - Policy and procedures to support those people who self-neglect
  - Mental Capacity Act guidance

‘SO WHAT’ continued ….

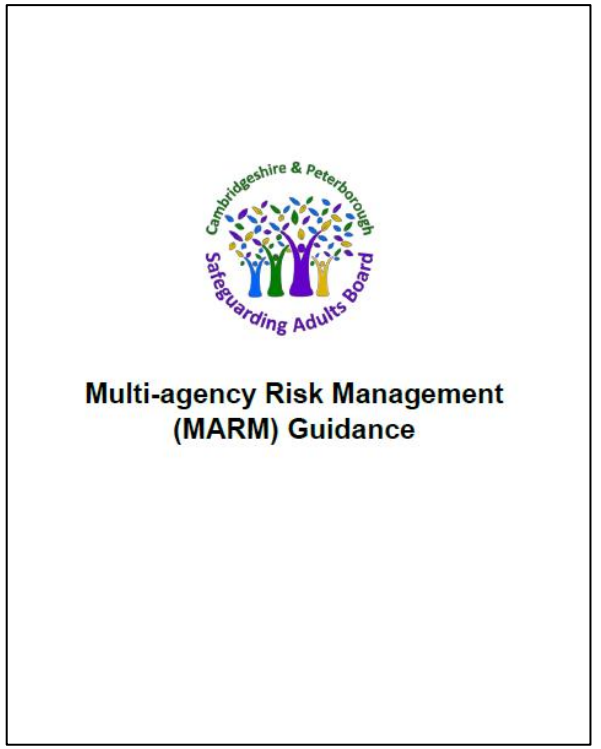
- Within the action plans were a number of actions undertaken by single agencies as a result of the SAR and recommendations
- Since the reviews, the safeguarding partnership board has integrated a multi-agency **training programme** including :Self-neglect and Hoarding / Mental Capacity Act /Having complex conversations (being professionally curious) renamed ‘Strategies for affecting positive change’ /Working Together /Understanding roles and responsibilities/ Parental mental health
- Termly Workshops / Virtual Workshops / SWAYs/ Briefings
- ‘**lived experience of the adult**’ took place during 2019 . Practitioner **guidance** on the lived experience of the adult was launched during August 2019 within the latest virtual learning lessons workshops.

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



Training

Virtual Briefings and Training

User-Led resources on a variety of topics, including:

- Safeguarding Adults
- Safeguarding Children
- Online Abuse
- Domestic Abuse

(Virtual) Training Currently on Offer

Safeguarding Children

- Current Children's Safeguarding Messages: **February 2021 Workshop**
- Graded Care Profile
- Working with Child Sexual Abuse
- An Introduction to Child Criminal Exploitation
- Introduction to Child Neglect
- The Sexual Assault Referral Centre and Supporting Victims of Child Sexual Abuse
- Fabricated & Induced Illness (FII)
- Sexually Harmful Behaviour (SHB)

Safeguarding Children and Adults

- An Introduction to Domestic Abuse

Safeguarding Adults

- Current Adult's Safeguarding Messages: **February 2021 Workshop**
- Hoarding & Safeguarding Adults at Risk
- Self-Neglect & Safeguarding Adults at Risk
- Making Safeguarding Personal

Slides for Professionals

https://safeguardingcambspeterborough.org.uk/adults-board/resources-for-practitioners/

Professional Briefings

https://safeguardingcambspeterborough.org.uk/adults-board/resources-for-practitioners/

7 Minute Briefings

[Resources for Practitioners | Cambridgeshire and Peterborough Safeguarding Partnership Board (safeguardingcambspeterborough.org.uk)](#)

Bottom of the page – also what is a SAR 7 minute briefing

http://www.safeguardingcambspeterborough.org.uk