Safeguarding and self care

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BSAB Independent Chair

Webinar: house keeping

- Please put all microphones on **MUTE**
- If you would like to ask a question, please use the **CHAT** function
- **RESPECT** the stories you hear and protect the identity of adults at risk through **CONFIDENTIALITY**
- Take care of your own **WELLBEING** throughout this session

How to report concerns in Barnet

Social care direct at Barnet council are the point of first contact

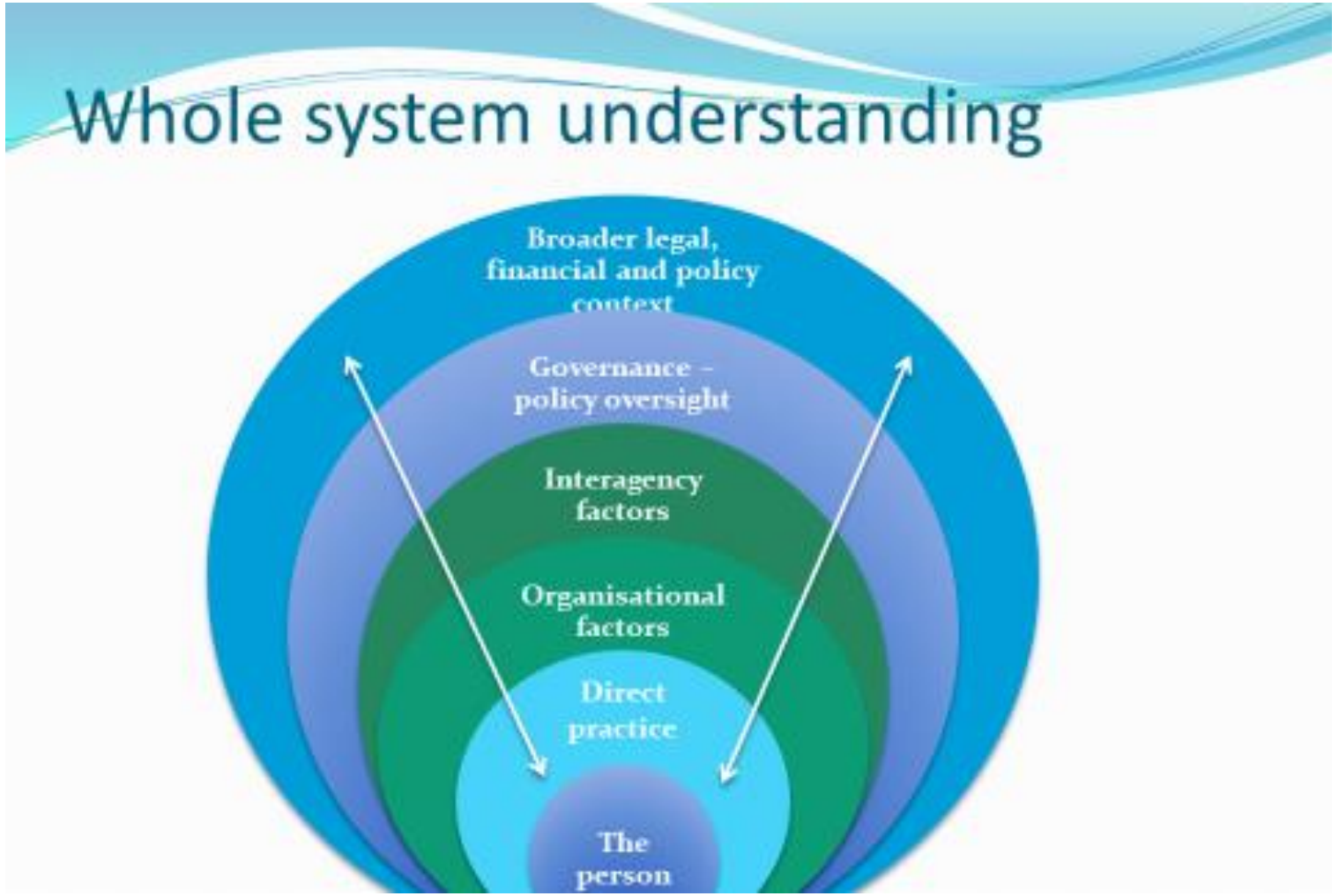
- **Tel 020 8359 5000 text (SMS) 07506 693707 email** socialcaredirect@barnet.Gov.Uk

Police community safety unit in an **emergency 999**

- **Tel 020 8200 1212 email** sxmailbox-tib@met.Pnn.Police.Uk
- What happens after you report abuse: https://www.Barnet.Gov.Uk/sites/default/files/assets/citizenportal/documents/adultsocialcare/whathappensafteryoureportabusebookletmay12.Pdf
- Your concern should always be taken seriously and acknowledged. Usually the adult at risk will be consulted and you should always be told if the concern will be investigated.
- If you hadn't had this it is ok to ask again!

The role of BSAB

- BSAB is a partnership, it includes the local authority, clinical commissioning group, police, fire service, housing, health and social care providers and voluntary organisations. The board provides partner agencies opportunities to review practice, provide positive cross-agency challenges to enable accountability and strengthen the culture of continuous improvement.
- Our priorities this year are:
  - To establish that safeguarding practice reflects ‘MSP’ principles, meaning that adults at risk and people important to them are involved in decisions about how best to protect them from harm
  - Adults at risk are heard and their experiences shape continuous improvement
  - That we advance equality of opportunity, including ensuring access to justice for adults at risk
- S44 Care Act: statutory function to review cases where an adult with care and support needs dies or suffered serious harm as a result of abuse or neglect and there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult.



Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection, 17 (1), 3-18.

Learning Lessons From Safeguarding Adult Reviews

Remember social work professional standards require that you are able to undertake assessments of risk, need and capacity and respond appropriately [1.3] make and receive referrals appropriately [4.7] recognise signs of harm and respond appropriately [1.5] recognise power dynamics in relationships [2.9] share information responsibly [7].

Findings from the National Analysis of SARs (2020) reinforced findings from other reviews- identifying common pitfalls linked to poor record keeping:

- Direct practice with adults at risk was impaired because of poor recording, insufficient understanding of the person's history or capacity to understand risk/ protect themselves from harm- all of which undermined effective risk management. Often in safeguarding situations an initial hypothesis is formulated on the basis of incomplete information and is accepted too quickly. Practitioners become committed to this hypothesis and do not seek out information that may disconfirm or refute it. This is linked to '**unconscious bias**'.
- The analysis found inter-agency practice all too often flawed as information taken at initial enquiry wasn't adequately recorded, facts are not checked, frequent failures to feedback the outcome to the referrer or coordinate and share information with other professionals or carers supporting the adult reduces opportunities for 'fact checking' and shared risk management.
- Attention is focused on the most visible or pressing problems; case history and less "obvious" details are insufficiently explored. Insufficient weight is given to information from family, friends and neighbours or insufficient attention is paid to what children or adults at risk say, how they look and how they behave. This can result in '**professional optimism**'.

We saw these issues in the SAR in rapid time and thematic review published by BSAB this year.

For your own piece of mind, make sure you carefully review case history. Remember Care and Support guidance requires we seek input from experts if it is an area outside our knowledge/ experience so be aware of local policy and processes and what they say about access to expert support. Remember too the legal powers (s6-7 Care Act) to request assistance and **record** when these are used. Escalate concerns if you don't get responses needed from partners. At every level, partners are committed to protecting adults at risk!

Common pitfalls linked to poor use of supervision or escalation processes

Crucial to effective safeguarding practice is the organisational support around the team providing direct work, but too frequently practitioners report within SARs insufficient support/supervision to enable them to work effectively with service users who are uncooperative**,** ambivalent, confrontational, avoidant or aggressive. There are policies (e.g. BSAB self-neglect policy) and courses available to develop these skills, but remember also to speak to your line manager, Designated Safeguarding Leads/ Champions and legal departments for ongoing support.

Another common pitfall occurs if, during the initial assessment/enquiry process, professionals do not clearly check that others have understood their communication. There is an assumption that information shared is information understood. This can be amplified if there is overreliance on IT systems across multi-agency practice. Do not assume case information recorded on one system is accessible, ensure care or treatment providers, other professionals and familial carers understand what is expected to reduce risk and what they should do if risk remains. This should be recorded in the care or protection plan!

We know that all too often case responsibility is diluted in the context of multi-agency working, impacting both on referrals and response. Too often adults at risk involved in SARs were signposted to other agencies, with no follow up and insufficient checks to ensure those agencies could meet the needs/ risks identified. A key theme in the 2020 SAR analysis was lack of management oversight of key decisions [7.3.4] *'Only by using an approach of active leadership, supported by internal audit and responsive escalation routes, can an organisation ensure the needs of adults at risk can be responded to with timely approaches consistent with agreed polices and procedures.'*

So how to avoid these…

- Identify your duty to assess and eligibility criteria- This is the parameter of your **duty of care**. Consider wider legal duties owed by relevant partners and request cooperation, chasing if necessary. Escalate and report if there are needs beyond which you can meet- so gaps are met and wider needs form part of the JSNA!
- Go through the eligibility outcomes, within the the child/adult and their carer/family. Provide guides beforehand, so they know what to address. Focus on their strengths, empowering them to reduce risk, prevent harm and achieve the outcomes that matter to them.
- Record any inabilities, applying the regulations-based approach to what *constitutes* inability, following the guidance eg that prompting is assistance.
- Decide objectively in your professional capacity, but having paid a lot of attention to the views of the child/ adult at risk what their perception is of the risk and impact. Consider risk- how high is it and how likely is it to arise.
- In NHSCHC and Care Act needs assessments you must be blinkered to informal carer's input. So if they say, 'Well there would be an impact, but there isn't because my brother….etc', then they are still able to be found to be unable, so assess the impact that they describe C/WOULD arise without the informal input. But remember, families/ friends often offer protective value- this must be taken into account in line with article 8 ECHR duties.

Care Act: Procedural requirements for record keeping

Consultation: The adult, any carer and anyone LA or adult thinks appropriate must be consulted as part of the assessment or care planning process. Please record who was consulted, their views and how this impacted on the assessment of risks/ needs. Record also their views on willingness/ ability for involvement in care or protection plans.

Written reasons for decisions: LA must provide a written record of the assessment (s.13) and, if eligible, the care plan (s24) to the adult to whom assessment relates, any carer and any person the adult requests is informed. S.24(1) requires LA to prepare a care plan or give written reasons for not meeting needs and advice on preventing needs (s.24).

Decision making: If the adult has eligible needs, s.13 requires the LA to specify how it'll meet those needs, ascertain if the adult wants LA to meet needs, determine whether some of those may be services for which the LA makes a charge (where that is the case, the LA must carry out a financial assessment) and establish whether the person meets the ordinary residence requirement, though decisions re ordinary residence should not lead to a delay in meeting eligible needs.

Discussion

- How frequently do you discuss policy developments in team meetings, is time taken to explain how they relate to supporting you to make the right decision in difficult cases?
- What are the expectations for recording within your local policy and professional standards?
- What mechanisms do you have to get support if risk remains despite protective interventions?
- Are you more confident now to build in time to your workload to ensure effective use of records, or utilise supervision and the policy framework to develop your skills and protect your own wellbeing?

Further reading

- 'Safeguarding Adults under the Care Act 2014', Jessica Kingsley Publishers, 2017
- https://www.local.gov.uk/sites/default/files/documents/25.130%20Making%20Decisions%20on%20the%20duty_06%20WEB.pdf: LGA and ADASS guidance on decision making re s42 enquiries
- https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice: MCA Code of Practice
- https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance: Care Act statutory guidance
- https://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-safeguarding-practice-questions/: SCIE guidance and https://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-suspected-at-risk-of-neglect-abuse/ on gaining access to an adult at risk
- http://www.cps.gov.uk/legal/p_to_r/prosecuting_crimes_against_older_people/#mental: Guidance on prosecuting crimes against adults at risk