**Report to NE Lincolnshire Safeguarding Adults Board**

**Seminars on Decision-Making**

**Introduction**

Following a presentation on the law relating to decision-making, mental capacity assessments, and the findings from safeguarding adult reviews on working with people who might be taking decisions that other people would regard as unwise, participants were asked to consider two case studies. These case studies were drawn from two safeguarding adult reviews. Participants were asked to consider their risk assessment of each case and their expectations of how practitioners would approach their work with each case. They were then asked to consider what might happen in their locality if such a case arose there and to identify their assessment of the strengths and vulnerabilities in adult safeguarding arrangements in NE Lincolnshire.

**Risk assessment**

The quality of risk assessments emerges as a significant concern from thematic analyses of safeguarding adult reviews (Braye and Preston-Shoot, 2017; Preston-Shoot, 2017). Seminar participants were clearly able to identify risks in the two cases. The risks identified that related to direct practice with the individual included social isolation, self-neglect, infection, mental health deterioration, malnourishment, loss and bereavements, fragmented care and carer breakdown, and the robustness of mental capacity and other assessments. Seminar participants also considered risks associated with vulnerability from being targeted for exploitation and individual disengagement from services and support being offered. In both cases the family history could prove significant and carers’ assessments should not be overlooked.

The risks identified that related to single and multi-agency working with the individuals in the case studies included practitioners and organisations working separately and along parallel lines, and superficial consideration of assessments. Risks here included a failure to involve all the agencies that might have a contribution to make, including housing associations and third sector organisations, and not exploring the many reasons that may lie behind a person’s decision-making and rejection of assessment/interventions. Hospital discharge could often prove a key transition point at which multi-agency and multi-professional collaboration was crucial.

**Expectations**

Seminar participants identified clear expectations for practice. In line with Making Safeguarding Personal, participants wanted to know about individual wishes and feelings, and were aware that advocacy might be necessary to enable people to participate in care and support planning and in adult safeguarding. Thus, it was recognised to be important to consider a person’s history and to express professional curiosity about their choices and behaviours. The six principles (DH, 2017) were also sometimes in evidence in participants’ responses to the case studies, especially empowerment and protection.

In terms of single agency contributions, there were references to social care, nutrition, fire service and occupational therapy assessment and, in understanding self-neglect, whether the individuals in the case studies were unable and/or unwilling to address apparent risks. Assessment again emerges in reflections as to whether individuals were exercising choice in how they were living or were vulnerable to exploitation by others and/or at risk because of historical experiences. There were occasional references to possible interventions, for example counselling to address underlying mental health and psychosocial issues, such as loss and bereavement.

In terms of multi-agency practice, participants were clear about the importance of updated and robust mental capacity assessments, including evidence of executive functioning (any disjunction between what an individual says and does), use and weigh discussions and where necessary best interest deliberations and consideration of applications to the Court of Protection or the High Court. The importance was also emphasised of case conferences, safeguarding referrals and the appointment of a lead agency and a key worker to coordinate information-sharing and risk management, as opposed to factors being treated in isolation.

**Strengths and vulnerabilities**

Seminar participants were then asked to consider strengths and vulnerabilities in single and multi-agency adult safeguarding systems in NE Lincolnshire.

In terms of strengths, there were references to good working relationships across public, private and third sector organisations, strong links within and between multi-disciplinary teams and the availability of specialist advice (on mental capacity and deprivation of liberty safeguards for instance) and multi-agency meetings. However, it was stated that good processes are often reliant on individual staff members and their relationships with others; these can break down when those staff members leave. There is a need to formalise processes so that this doesn’t happen.

There were also references to robust policies and procedures and the availability of training. There were individual comments about receiving feedback regarding safeguarding referrals and about the quality of assessment of mental health and mental capacity.

Shared record systems were stated to be an advantage. Although not all providers use the same system, many apparently do. Mechanisms are needed to ensure that those agencies that do not participate in the shared record system do not miss out on vital information. There was recognition of considerable attention having been given to raising awareness about financial abuse but less on other types of abuse. Similar investment in raising awareness about other forms of abuse and neglect may be necessary.

Multi-agency case file audits might provide further evidence of strengths in adult safeguarding practice, using a template that identifies the core components of good practice. Rochdale Safeguarding Adults Board has published such templates, for example for the audit of self-neglect practice.

In terms of vulnerabilities, those identified by seminar participants can be divided into three areas – direct practice, single agency practice and multi-agency working together.

*Direct practice*

Making Safeguarding Personal may be misunderstood in that the individual is not asked questions or challenged respectfully about their situation and apparent choices. Sometimes apparent lifestyle choice might be accepted too readily. However, practice could also veer in the opposite direction, being overly paternalistic and not allowing individuals to make ‘unwise decisions’ when that might be appropriate. As in many other respects, supervision is an important safeguard here.

On mental capacity there was a view that practitioners are not yet confident with the ‘basics’, namely assessing and recording capacity, on which so many further considerations hinge. This might mean that practice proceeds on the basis of presumed mental capacity without appropriate assessment and challenge. Concern was expressed about the quality of mental capacity assessments and understanding of the legal requirements in this field of practice.

On risk assessment, a view was expressed that templates would be useful as guidance on areas to consider. There is no shared approach to or template for risk assessment, or to risk mitigation planning – everyone does it differently. Templates should not constrain the use of professional curiosity, however. Some self-neglect and hoarding procedures, published by Safeguarding Adults Boards, contain risk assessment templates (Norfolk, Solihull and Kent and Medway are examples). Similarly, these procedures often outline when multi-agency risk management meetings should be convened and when adult safeguarding referrals are appropriate. Concerns were expressed about the quality and recording of risk assessments.

In a clear reference to legal and research literacy, practitioners and decision makers are not always aware of the intervention options open to them; it would be useful to have a list of powers/ menu of options when deciding how to respond to a person’s situation. References to legal powers and duties, and to research evidence about interventions, could be included in policies and procedures, covered in training seminars and circulated in briefing notes. A particularly challenging area, that might be worthy of particular focus, is the interface between mental capacity and mental health law.

Concerns were also expressed about waiting times for assessments and the quality of referrals into adult safeguarding. Clarity about procedures, including identification of safeguarding leads in different agencies, might assist here, as might training and supervision of practice.

*Single agency practice*

Organisational boundaries can prove problematic, with individuals passed between agencies or becoming someone nobody owns as distinct from safeguarding being everyone’s business.

A disconnection was reported between managers and front line staff. It was expressed that managers are often more confident that staff are aware of processes and that they are being followed than is actually the case. For example, mental capacity assessments are not happening or are not being recorded as often as they should be.

Practitioners are not convinced that organisational structures support ‘good delivery’ or that processes support development of the ‘right culture.’ Put another way, training does not always inform/ amend practice. This may be explained by a failure to consider workplace development (changes to organisational culture and working procedures) following workforce development (training), with the outcome that those who have experienced the training find themselves unable to implement what has been learned (Braye, Orr and Preston-Shoot, 2013).

Practitioners and decision makers need support to understand the legislative options available to them – current understanding is low. Also important is access to specialists – “if we’re stuck, who should we ask for help?”

There is no common approach to recording with regard to adults at risk.

It was recognised that much turns on the quality of professional supervision. In this context there was a view that there is a lack of assurance that this is currently good enough to support practitioners to navigate difficult situations. A question then followed, namely how better supervision be commissioned? Supervision was sensed to be patchy across health and social care. As one comment identified, supervision needs to ask: ‘what would good look like in this situation / what should good have looked like in this situation?’

*Multi-agency working together*

Practitioners are not clear when to instigate a safeguarding referral, proposing a section 42 enquiry, as opposed to a multi-agency meeting, and where they might find guidance on this. There is confusion about when to use which pathway. Alongside this, some participants felt that multi-disciplinary meetings should take place earlier and include discussion of whether a safeguarding referral should be made. Some staff who attended the seminar did not appear aware of the criteria for a safeguarding referral that might lead to a section 42 enquiry. It was also felt that practitioners needed clarity regarding when they can make a referral, hold a meeting, seek information and/ or share information about a person without that individual’s consent. Further guidance, training and supervision in this area could be considered. There is a link here to enabling staff to develop their legal, safeguarding and practice literacy. The availability of guidance about when to use different pathways for notifying concerns and managing risks could be reviewed.

Another challenge that was emphasised surrounded organisational boundaries acting as a barrier for the person to access support; sometimes individuals can fall through the ‘gaps’ between services. Best practice emphasises that a bespoke team should be created around the person, drawing on a variety of inputs as fits the emergent understanding of the case. However, sometimes it appears that no one wants to take responsibility and the person experiences a ‘revolving door’ in and out of various services.

In the event that practitioners are not able to secure appropriate cooperation from others, they are not aware of an escalation procedure. There is an escalation policy but no one seemed to know about it. Thus, a question for the Safeguarding Adults Board is the degree to which available policies and procedures are embedded in practice.

**Safeguarding Adults Board – next steps**

Comment was made concerning not losing momentum created by the seminar day, linking what had been learned with other strands of work, for instance on vulnerability and promoting independence. Boards often focus on raising awareness and comments were offered about needing to raise awareness amongst the public and different sections of the workforce on notifying safeguarding concerns and on what constitutes good, defensible decision-making.

Boards often focus too on developing policies, procedures and/or protocols. Comments were offered in the seminar about the need to be clearer about lead agency and key worker requirements, to ensure that someone accepts overall responsibility for specific cases. Comments were also offered about the need for further work on expanding existing mechanisms for promoting supportive challenge, for prompt reporting of concerns about individuals and for sharing concerns about providers. It was suggested that the referral form for reporting safeguarding concerns is too long and off-putting. This might be looked at.

A key function of Safeguarding Adults Boards is to seek reassurance. One tricky area facing single and multi-agency systems relates to case closures. To what extent do managers oversee such decision-making and ensure that closure is appropriate in the circumstances of the individual case? Another challenging area is securing multi-agency engagement in meetings, when called by a single agency, to ensure all available information is shared and risk management plans instituted. The Board might want to review how agencies are interpreting the duty to cooperate that resides in the Care Act 2014.

The Board’s partner agencies all operate within a context of on-going financial austerity, impacting on access to and the capacity of services. The Board might want to consider how this context has impacted on commissioning and service provision, and what safeguards are in place to ensure lawful and safe practice.

Frontline staff are an untapped resource in respect of these next steps. They are often best placed to inform strategic and operational managers where the challenges and vulnerabilities are, based on their lived experience of work. Annual development days that involve practitioners, managers and Board members comprise one way of collecting evidence about how well adult safeguarding systems are performing. Learning and service development seminars are also useful, taking the findings of a safeguarding adult review and exploring how agencies locally would respond to such a case.

**References**

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Preston-Shoot, M. (2017) *What Difference Does Legislation Make? Adult safeguarding through the Lens of Serious Case Reviews and Safeguarding Adult Reviews. A Report for South West Region Safeguarding Adults Boards*. Bristol: South West ADASS.

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