

From the West of Berkshire Safeguarding Adults Board (SAB)

Thank you for taking the time to read this briefing note. It is one way by which we are supporting multi-agency professionals working with adults at risk to learn from practice. The SAB undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk.

This briefing note pulls together key messages arising from a local Safeguarding Adults Review.

We ask that you take time to reflect on these issues and consider, together with your team, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults.

The briefing note will also be disseminated to training providers to ensure the content informs safeguarding adults training.

How you can make a difference

Take some time to think about what these key messages mean for your practice:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

What is a Safeguarding Adults Review?

The Board will commission Safeguarding Adults Reviews (SARs), when:

An adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult; or

An adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

Mr I Case Review

The key messages in this briefing note reflect the findings to emerge from a recent case review of a man whose death was due to alcohol related illness.

Mr I had suffered a brain injury and had a lower leg amputation. He was prone to depression and developed an increasingly severe dependence on alcohol. He resented contact from services and was aggressive to visitors including the regular care staff who had been commissioned by the Local Authority to provide daily support and monitoring.

Mr I was assessed as having the mental capacity to make decisions about his health and welfare and had a strong and consistently expressed wish for the service providers to leave him alone. Despite efforts to engage Mr I, no active work was possible due to his use of alcohol and reluctance to engage. He died unexpectedly in June 2015 and was found in his home several days later by the police.

This case highlights some of the particular challenges that develop for professionals when the needs presented by an individual service user do not neatly meet the criteria of existing teams, which can lead to confusion and/or tensions between teams about ownership.

The case also outlines the challenges for professionals in seeking to find an appropriate response when service users are actively resistant to intervention.

The full report can be found on the Board's website:

<http://www.sabberkshirewest.co.uk/media/1202/sar-mr-i-final-report-2016v4.pdf>

Finding 1

Supervision processes did not support practitioners to work with the complexity of capacity decisions in relation to adults with addictive behaviours, with the result that assessments of capacity were made but practitioners acted as though capacity was lacking.

What was the issue?

There was a unanimous view amongst professionals that Mr I's capacity was retained in relation to key decisions about his health and welfare; however, the reality of his daily situation was that he was rarely sober enough to make informed day to day choices. There was a tendency by the Local Authority and Mental Health Trust Team to work with Mr I as if he lacked capacity and required 'best interest' decisions to be made on his behalf. This was probably because in relation to many day to day decisions, since he was not sober, Mr I did lack capacity. However, capacity assessments were not undertaken to confirm this, and consequently there were no clear best interest care plans in place to support Mr I or the care staff working with him.

What are the implications?

The Mental Capacity Act 2015 enshrines the rights of individuals to be actively supported to make their own decisions and where they lack the capacity to do so, the Act ensures that their best interests (including their wishes) govern the outcome. Getting the outcomes legally and ethically right requires a more careful assessment of capacity, not only for the significant decisions but also for the day to day decisions. It is a significant concern if practitioners and front line managers are not putting the principles of the Act into practice because they have not sufficiently teased out the complex picture of capacity, as there is a high likelihood that the rights of service users are not being respected.

These are complex legal and ethical issues and it is essential that practitioners and commissioned care staff are well supported by their managers and have clear guidance and care plans that differentiate actions required, identifying which decisions the service user has and has not got capacity to make. The assessment and management of cases of fluctuating capacity needs particular attention where there are high risks to the service user. At times the autonomy and rights of the person can seem to be in conflict with the need for services to intervene to reduce risk. Good quality staff supervision is key and members of risk advisory panels need to be willing to enter into the complex discussions required to support the proper implementation of the Mental Capacity Act.

Further reading:

[Case Study: a practical analysis of a mental capacity assessment](#)

[Mental Capacity Act Code of Practice](#)

<http://www.sabberkshirewest.co.uk/practitioners/mental-capacity-act-and-dols/>

How confident are you about managing cases where there is fluctuating capacity?

Finding 2

The tendency to assume that everyone knows about and understands policy, procedure and guidance but not to quality assure how well they actually do, resulted instead in a culture of informal agreements, misunderstandings and tensions

What was the issue?

Policies and procedures provide a structure and roadmap for practitioners to follow, in order that they understand what to do, when and how to evidence their thought processes and decision-making. None of this will work properly if busy practitioners are not supported to use policy and procedure appropriately and to understand why it is so important to do so.

At each stage of the case, informal agreements were in place between teams and practice was sometimes at odds with the policies, procedures and guidance that were in place.

What are the implications?

Informal agreements are variable, open to interpretation and human bias: they are only as reliable as the person making them and the relationship at that time. A policy or guidance is a standard that provides a bench mark. Without effective compliance of guidance and policy we risk human bias and miscommunication which can lead to tension and poor relationships.

High quality procedures support good practice, providing realistic and practical guidelines that promote best practice, and clarity about how professionals work together and across agencies. However, procedures and policies are not always well understood or communicated to staff. Where there is a culture of staff not following procedure, there is a risk of confusion and tensions emerging between teams and agencies.

It is also vital that senior managers undertake quality assurance checks to see how well policies are being understood and implemented and what the practice implications are when they are not being followed. If a local policy is actively monitored, the organisation has an opportunity to make changes and staff can contribute to design of these changes to improve their working practice and service user outcomes.

Berkshire Multi-Agency Safeguarding Adults Policy and Procedures

The Berkshire Multi-Agency Safeguarding Adults Policy and Procedures were launched on 1 April 2016. They have been adopted by Bracknell, Slough, Reading, West Berkshire, Windsor & Maidenhead and Wokingham.

Our vision in Berkshire is that all agencies will work together to prevent and reduce the risk of significant harm to adults at risk of abuse or neglect, whilst supporting individuals to maintain control over their lives and make informed choices without coercion.

The purpose of the Policy and Procedures is to support staff to respond appropriately to all concerns of abuse or neglect they may encounter, providing a consistent response across the county. The Policy and Procedures will be updated regularly and practitioners are encouraged to refer to this on-line version rather than download and retain a copy.

<http://www.sabberkshirewest.co.uk/practitioners/berkshire-safeguarding-adults-policy-and-procedures/>

Finding 3

There is confusion about the meaning of the 'duty of care' that is generating risk adverse practice and preventing the voice of the service user being heard.

What was the issue?

The Duty of Care is the legal obligation to safeguard others from harm while they are in your care, using your services, or exposed to your activities.

The concept of the 'duty of care' is found in case law, generated by negligence cases that have been taken to court. The 'duty of care' is most often judged in court by how well practitioners and organisations undertake the key processes of risk assessment and risk management. Generally speaking, a finding of negligence requires evidence that risks were not properly assessed and/or proportionately managed.

However, in this case, limited understanding of the duty by practitioners appears to have resulted in a skewed, rather paternalistic interpretation of the duty, linking it particularly to the need to reduce risk and ensure the safety of service users, with little reference to protecting their rights and choices.

What are the implications?

One of the most concerning consequences of risk averse or defensive practice is that the service user is not empowered to have greater control over their lives, instead the protection of the practitioner or organisation is in effect prioritised. In recent years there has been a concerted move towards more person centred practice, which empowers the service user and places their voice and wishes at the centre of support planning. The philosophy and duties of the Mental Capacity Act 2005 and the Care Act 2014 have placed an increased emphasis on the need for the service user's voice to be heard. While huge efforts have been made across the sector to move practice and systems closer towards the goal of meaningful empowerment, the barriers to this are sometimes subtle yet can have a huge impact on decision making.

Sound professional decision-making requires individual workers to make choices and to understand not only the rationale for their decisions but also the more subtle influences that are at work. This kind of reflective practice is not always easy to achieve in the midst of the busy workplace. It is essential that opportunities are found and supported to enable practitioners and managers to actively reflect on their practice and decisions, and identify the powerful influences that can push them unconsciously towards risk adverse practice. It is vital that practitioners' understanding of their 'duty of care' is a broad and empowering one, which supports sound risk management work.

Further reading:

Care Act Factsheets <https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets>

"It is important that the 'duty of care' is interpreted in a more empowering way, with clearer reference to the legal framework of the Mental Capacity Act 2005 and our responsibility to hear the wishes of the service user.

When staff do not have a broad understanding of the meaning of the 'duty of care' there is a danger that it is a piece of common law which can generate and /or be used to defend risk averse practice which impacts negatively on the rights and empowerment of service users."

Is the voice of the service user appropriately prioritised within your risk assessment processes?