West of Berkshire Safeguarding Adults Board

Briefing no. 2 - September 2016

Welcome to the second edition of the West of Berkshire Safeguarding Adults Board briefing.

The West of Berkshire Safeguarding Adults Board meets four times a year and discusses how agencies should work together to keep adults at risk of abuse or neglect safe in Reading, West Berkshire and Wokingham.

Among the topics discussed at our September Board meeting were: findings from Wokingham Borough Council's peer review which focused on safeguarding, care governance and commissioning; an update on safeguarding within Mental Health inpatient services; actions that are being taken to manage the high numbers of DoLS applications; and streamlining of the Board's governance processes to avoid duplication of functions. We discussed the **Induction Pack** for new Board Members, the Board's Annual Report which will be published in November, and the **Guide for people on how to reduce the risk of skin breakdown.** An important function of the SAB is to ensure partner organisations work together and we explored our processes to support joint communication in the event of a significant safeguarding incident.

DO YOU RECEIVE FEEDBACK FOLLOWING AUDITS OF SAFEGUARDING CASE FILES?

Quality Assurance in Safeguarding

We have developed documents and processes to help agencies identify how well they are doing to safeguard people and where they need to improve, such as a Quality Assurance Framework, Self-Audit Tool and a set of Key Performance Indicators. Organisations regularly undertake audits of case files and in August colleagues met to undertake a peer audit of a sample of case files. An action plan has been agreed to develop areas that needed improving. MORE BELOW…

Berkshire Multi-Agency Safeguarding Policy and Procedures Following a consultation period the **Policy and Procedures** have been revised. The on-line version is available on the Board's website and should be referred to regularly. The purpose is to support staff to respond appropriately to all concerns of abuse or neglect they may encounter.

Need help with acronyms?
This Glossary might help.

Service user involvement and feedback

A priority action for the next three months is to improve the way we involve service users and gain feedback. It is essential that we know how people experience the safeguarding process and whether their desired outcomes are met, and we plan to work with service user groups and local organisations to make sure we all improve in this important area.

DO YOU GAIN FEEDBACK FROM INDIVIDUALS WHO HAVE BEEN THROUGH A SAFEGUARDING ENQUIRY?

Survey

You are invited to complete a short survey that will help us understand how we can improve the way we communicate and raise awareness of the Board's work and of local safeguarding processes. Please take five minutes to complete this survey. Closing date is 31st Oct. https://www.surveymonkey.co.uk/r/SABWestofBerkshire2016

FIND OUT MORE…..The Board's website contains information for the public, practitioners and Board members and is regularly updated: http://www.sabberkshirewest.co.uk/

Contact Natalie.Madden@reading.gov.uk to be added to the distribution list for these briefings.

Safeguarding Adults Reviews

Safeguarding Adult Reviews (SARs) are about learning lessons for the future so that all organisations can improve their practice. A SAR is undertaken when there is concern about how agencies worked together to safeguard an adult and the adult has died or experienced serious abuse or neglect. The process is overseen by the SAR Panel which meets regularly to consider cases put forward by agencies. Last year, we commissioned two Safeguarding Adults Reviews and the reports were finalised this summer. One report cannot be published as the case is the focus of criminal proceedings, but the report into the case of Mr I can be found on the Board's website **here.** An action plan has been developed to ensure learning from these cases is embedded. The main findings are that:

- Assumptions that people with dementia do not have mental capacity prevented assessments from being carried out, resulting in **the voice of the adult** not being heard.
- The **Mental Capacity Act 2005** is not fully understood or applied in practice as a safeguard for people who may lack capacity.
- Assumptions are made that **private care arrangements** will be appropriately caring.
- Lack of (or late) response to actions resulted in **incomplete understanding of risks**.
- **Workflow processes** were automated at the expense of professional discussion, resulting in assumptions being wrongly made about appropriate service provision.
- **Supervision processes** did not support practitioners to work with the complexity of capacity decisions in relation to adults with addictive behaviours.
- Assumptions that everyone understands **policy, procedure and guidance** without quality assuring how well they actually do, resulted in a culture of informal agreements, misunderstandings and tensions.
- Confusion about the meaning of **'duty of care'** generated risk-averse practice and prevented the voice of the service user being heard.

Case File Audit ....CONTINUED

The case file audit revealed good examples of **partnership working**, with agencies across sectors making safeguarding referrals, signposting and being involved in safeguarding enquiries. **Individual record keeping** was highlighted as an area of concern consistently across the three localities, in particular the recording of mental capacity and use of advocates. Record Keeping Skills training is available and managers should consider prioritising this essential skill for staff development. Overall, **categories of abuse** were well recorded, but in **high risk cases** it appeared that professionals struggled to accurately define the abuse. In practice this made it difficult for professionals to recognise and uphold the principles of Making Safeguarding Personal and provide clear protection outcomes. The findings show that **Empowerment** is also an area that requires improvement.

Empowerment

Empowerment and choice are at the core of good safeguarding policy and practice; this means working to enable adults at risk to recognise and protect themselves from abuse. It means taking a risk enabling approach within services and ensuring that people have genuine choice. It also means a person centered approach which achieves the outcomes that people want.

What Empowerment might look like from the perspective of the adult at risk: I am consulted about the outcomes I want from the safeguarding process and these directly inform what happens.

What Empowerment might mean for agencies: We give individuals relevant information about recognising abuse and the choices available to them to ensure their safety. We give them clear information about how to report abuse and crime, and any necessary support in doing so. We consult them before we take any action. Where someone lacks capacity to make a decision, we always act in his or her best interests.

Mental Capacity Act

The Mental Capacity Act (MCA) 2005 came into force in April 2007 to empower and protect people who do not have the ability to make their own decisions, especially about things like finance, social care, medical treatment and living arrangements.

Having mental capacity means being able to understand and retain information and to make a decision based on that information. Someone might not have capacity because they have, for example, a learning disability, dementia, a mental health problem, a brain injury or a stroke.

The MCA aims to ensure that people who lack capacity to make decisions by themselves get the support they need to be as involved as possible in decisions about their lives. It also outlines how an assessment of mental capacity should be made.

Mental Capacity Act 2005

An Easy Read Guide

There are five principles at the heart of the Mental Capacity Act which should be used to underpin all actions and decisions taken in relation to those who lack capacity:

Principle 1: A presumption of capacity. Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.

Principle 2: Individuals being supported to make their own decisions. Make every effort to encourage and support people to make the decision for themselves.

Principle 3: Unwise decisions. People have the right to make what others might regard as an unwise or eccentric decision.

Principle 4: Best interests. If a person has been assessed as lacking capacity, any action taken or decision made for that person must be made in his or her best interests.

Principle 5: Less restrictive option. *C*onsider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action.

Deprivation of Liberty Safeguards (DoLS)

When someone lacks mental capacity to consent to care or treatment, it is sometimes necessary to deprive them of their liberty in their best interests, to protect them from harm. **DoLS** are intended to protect people who lack mental capacity from being detained unless it is in their best interests and there is no other less restrictive alternative. Each area has a DoLS Coordinator who can be contacted if you are concerned someone is being deprived of their liberty without proper authorisation:

Reading 0118 9373747
West Berkshire 01635 519056
Wokingham 0118 9746850

Annual Joint Children's and Adults' Safeguarding Conference

Safeguarding children and adults with disabilities was the theme of this year's joint safeguarding conference, held at Easthampstead Park on Friday 23 September. Over 130 practitioners from a wide range of service areas attended and once again enjoyed networking and hearing from national and local speakers. Presentations will be posted in the **Workforce Development** section of the Board's website soon.

SAVE THE DATE FOR NEXT YEAR'S CONFERENCE: 22 SEPT 2017