Working to improve practice in safeguarding adults

Examples of emerging practice

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2024/25

ADASS East of England Safeguarding Adults Network

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Foreword

We are proud of our collaborative work in the East of England and firmly believe that sharing practice examples across the region is an important part of our sector-led improvement work, giving councils and partners the opportunity to learn from each other. For the first time this year, we have brought together some practice examples to showcase different aspects of adult safeguarding work highlighting ways that organisations are working together to protect the rights of adults who have care and support needs (and because of those needs, are unable to protect themselves against abuse or neglect or the risk of it) to live in safety, free from abuse and neglect.

This is a critical area of our work, where listening to the person affected is key and approaches need to be tailored to deliver positive outcomes for the individual. Organisations need to understand the role of each partner and collaborate to achieve the best outcomes for the person/people involved, as well as promoting safeguarding adults as being everybody's responsibility.

I am delighted to share these practice examples with you and would like to thank those who have contributed. I hope that you find these examples interesting and useful. Please follow up with the named contacts if you would like further information on any of this work.

Stephen Taylor

Executive Director, Adult Social Care and Commissioning
Peterborough City Council and DASS Sponsor for the ADASS East Safeguarding Network

Cambridge and Peterborough Foundation Trust and Cambridgeshire County Council

Section 42 – allegations of inappropriate touching in a care home

Mr H advised that he had been touched inappropriately on his arm by a carer within the care home, without his consent. Mr H was supported to express his desired outcomes and preferences, and the care home and social work team made changes to the care and support plan to ensure his wishes are respected and he is protected. An internal investigation took place within the care home and was overseen by the social work team.

Mr H made an allegation of inappropriate touching on his arm while he was sleeping. He was distressed by this event and felt that the touch had been done without his consent. The aim of the intervention was to establish if abuse or neglect had occurred and to work in partnership with Mr H and the care provider to ensure his safety going forward.

Action was needed because Mr H felt violated and uncomfortable with the alleged touch. It appeared that the touch had been on his arm and possibly had occurred to get his attention. However, Mr H was distressed and felt uncomfortable being touched in this way by a male carer. Mr H had clear views on what he wanted as an outcome and so the social work team worked with him to ensure his views and wishes were central to the enquiry and outcome.

A 'Making Safeguarding Personal (MSP)' conversation was had with Mr H, and he was able to clearly express what he wanted and did not want in terms of the outcome. Mr H did not want the Police to be contacted, did not want the male carer to be involved in his support again and did not want to be touched to get his attention going forward.

The carer was initially suspended pending the enquiry. The outcome of the enquiry was that the carer had acted in accordance with accepted practice, and he returned to work. Changes to Mr H's care plan were made to support both him and carers in the future. It was agreed that when Mr H is asleep or during the night, he will be supported by carers in pairs in order to protect him and carers from future concerns. It was also agreed that the carer involved would not be involved in Mr H's support again.

Mr H was listened to throughout the enquiry and his views and feelings were validated and acted on. Mr H has confirmed that he feels safe at the care home. All parties were satisfied with the action taken and the risk of further incidents happening of this nature has been reduced.

Mr H, the social work team and the care provider were able to work together to support the enquiry and adhere to Mr H's desired outcomes. The provider led an internal enquiry and openly communicated plans for this and the outcome to Mr H and the social work team. Mr H reported feeling safe at the care home following the enquiry.

What were the outcomes?

Empowerment: Mr H's voice was supported at all stages in the safeguarding interventions. Communication with him was supported by relationship-based practice as he already had a positive and established working relationship with the social work team involved. The workers were able to actively listen to Mr H, acknowledge and understand his trauma associated with the incident and previous experiences to support their understanding of his response to the incident. Consideration of previous allegations made against staff by Mr H were acknowledged and reflected upon, and the team used supervision and peer discussions to ensure that this background knowledge enhanced their response to Mr H and his concerns.

Proportionality: The team responded quickly to the allegation and were able to offer Mr H time to discuss his concerns, wishes and outcomes in a timely way. It was agreed that the care home would complete an internal enquiry into the concern and that this was proportionate given the quality assured status of the provider and lack of concerns regarding the wider team.

The enquiry was approached with open thinking and focused on the outcomes for Mr H. Although it was established that the carer had not acted outside of accepted practice, the impact that their actions had on Mr H and the risks of this occurring again was given significant consideration. It was agreed that although the abuse/neglect was not established, Mr H had been significantly distressed and felt violated and there was a risk of this occurring again. It was recognised that learning and a change of approach was needed. An action plan was therefore implemented to reduce the risk of further incidents and Mr H's risk assessment and care and support plan within the care home was amended to reflect this. This ensured a proportionate response which focused on his individual needs and strengthened the confidence of the carers in their approach with support.

Protection: There was a focus on Mr H's wellbeing and safety throughout the enquiry. This resulted in the carer being suspended pending enquiry and then resulted in the carer not being involved in Mr H's support going forward. Mr H was able to fully participate in discussions and decisions about his safety and wellbeing and the social work team supported him to advocate his views and wishes at every stage. Whilst the outcome of the enquiry was that the carer had not acted outside of accepted practice, it was recognised that steps were needed to protect Mr H from similar incidents which could cause him further distress and the action plan supported this. Advocacy was offered but Mr H declined this, advising that he was satisfied that he had been able to express his views to social work staff. A referral to the Police for consideration was offered but Mr H declined this. There was also an awareness of a background of previous allegations and the safety of carers was considered, resulting in a plan to ensure two carers are present during interactions with Mr H at night.

Partnerships: The social work team were able to utilise effective working relationships with the provider (manager and care staff) in order to progress this enquiry in partnership. The care home provider is known to be a quality assured provider within the contractual arrangements of the council. The social worker worked with the care home manager to give guidance on the internal care home investigation and the team were able to implement an action plan together to support Mr H and carers going forward. The social work team were able to initiate an open discussion about risk and safety planning with the care home.

Was there any specific learning that supported success?

- Safeguarding training undertaken by the social work team and the provider/carer teams.
- Safety and safeguarding in the care home (Social Care Institute of Excellence).
- The team involved had a good understanding of the Care Act in terms of their duties and good practice.

What were the barriers to success?

- Workload pressures, the need to prioritise workload and interventions according to need and risks.

What were the conditions for success?

- Good joint working with the care provider.
- Established positive relationship with the person enabled open conversations.

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Cambridgeshire Police

Innovative use of Adult Safeguarding Board Closure Order on a domestic violence property to prevent offender from attending the location

A high-risk domestic violence offender who continually attended Ms C's address where Ms C allowed access. There were repeated offences committed against Ms C by the suspect. A Domestic Violence Protection Order had failed to stop the suspect from attending the location and assaulting Ms C.

A partial Closure Order under Section 80 of the Anti-Social Behaviour Crime and Policing Act 2013 was obtained, allowing Ms C and support agencies to access the flat, but it is a criminal offence for the suspect to enter the property. This was in place for three months.

All agencies had a discussion regarding the best course of action. When the Closure Order was discussed, it was explored if this would put Ms C at more risk. It was agreed that this was the most suitable course of action as it stopped the suspect attending the location and gave time for support agencies to engage with Ms C. No offences were committed during the time of the Closure Order.

Was there any specific learning that supported success?

This was the first time a Closure Order of this type had been used for a domestic violence location in the county. No offences occurred whilst this was in place. Support agencies had time to provide support for Ms C. Normally this legislation is used for anti-social behaviour cases, rather than domestic violence.

What were the barriers to success?

- Lack of support from Ms C, but despite this the Police were still able to proceed.

What were the conditions for success?

- Close partnership working.
- Early identification of options available.
- Support from Police legal services to try something that hadn't been tried in the past.
- Good knowledge of Closure legislation.

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Cambridgeshire and Peterborough Independent Domestic Violence Advisory Service (IDVAS)

IDVAS and partners in Cambridgeshire working together to support carers experiencing domestic abuse

The individual (Mr M) in this example had been in a domestic abuse relationship with his female partner for around ten years and the abuse was continuously getting worse. This caused a significant impact on Mr M's physical health, and he was diagnosed with angina and subsequently had three heart attacks in the space of a year. This also had an impact on his mental health and Mr M was diagnosed with severe anxiety and depression.

Mr M was also a carer for his partner, which he felt was a barrier to leaving as he felt guilty and concerned for the welfare of his partner if she was to be left at home.

Mr M suffered physical abuse, emotional and psychological abuse and coercive and controlling behaviour. He was also harassed on the phone even when he was critically ill in hospital. Mr M also felt isolated from family and friends because his partner had to go with him to see people or he was told not to stay in contact with others. Mr M lost contact with his daughter because of this. The way Mr M managed to disclose the abuse was when he was in hospital and said that he felt unable to return home.

With Mr M's consent, a referral to housing service was completed which was accepted and a homeless prevention officer was quickly assigned. The Police had a very positive experience of working with the housing officer, who understood the impact of the abuse and the urgency to find Mr M somewhere to stay. It was felt that through partnership working, Mr M got the best outcome possible.

What was the representation of the individual at the Multi-Agency Risk Assessment Conference (MARAC)?

- Mr M was reluctant to leave his partner and felt guilty. Emotional support was provided and reassurance that contact would be made with adult social care to continue to provide the care and support needed by his partner.
- Supporting housing letter sent to the local housing and liaison with the police officer involved with Mr M, so all could meet in a safe space to discuss an appropriate outcome
- Liaison with adult social care regarding concerns for Mr M's partner to ensure the appropriate support was arranged for her.
- Signposted Mr M to support services regarding his finances.

What were the outcomes?

It was a very positive outcome for Mr M:

- Placement in temporary accommodation in a one-bedroom property in a village close to his daughter to help to re-establish their relationship.
- Mr M's health improved significantly. He has had no further heart attacks, and his mental health has improved.
- Mr M no longer feels guilty about not being able to care for his partner as she is now supported by adult social care for her care and support needs.
- Bidding for a property on a Band A to achieve a forever home.

Mr M was grateful for the support from all agencies involved and never thought it was possible to be able to leave or have help to do so. There was recognition that partnership working is important.

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Essex County Council

Domestic abuse can occur in supported living placements

Two adults with care and support needs who live in the same supported living placement have been in a relationship for a few years. There have been incidents of abuse from one adult to the other, which professionals involved were labelling as 'challenging behaviour' whilst the social care team saw this as domestic abuse.

Two adults who have care and support needs live in the same supported living placement and have been in a relationship for a couple of years. This is the first serious relationship both adults have been in. Both have reported to be happy in their relationship and until the safeguarding concern was received, there were no concerns about their relationship.

Both adults have learning disabilities; one person has mobility issues and is a wheelchair user and the other person can move independently. Additionally, the parents of one of those involved were unaware of the relationship as the person was concerned they would try to end it.

One of the individuals had been told that due to problems with their eyes, they were going to need an operation. This heightened anxiety for the couple. There were two incidents in less than 24 hours: One was where staff were attending to care and support, which was refused. This resulted in one of the couple pushing the other to the floor and a drink being spilt. The other incident was in relation to a television remote control not working and calling for help, but the person being agitated.

The issue was supporting staff to understand that these incidents were considered to be domestic abuse, due to the nature of the relationship between the adults, and how they could be managed.

Both individuals were supported to help them understand the concerns being expressed and why they were being investigated under a safeguarding enquiry. The desired outcomes were established and included the desire to be safe and not be hurt anymore, and to tell the parents about the relationship.

A meeting was set up with the provider to agree the following actions:

- Risk assessment to be put in place for staff.
- Positive Behaviour Support (PBS) training for staff to be arranged.
- Technology Enabled Care (TEC) referral to be made for adults.
- Referral to Learning Disability Health Service for relationship work.
- Conversations to be held with all parents to alert them to the relationship and recent incidents.

This led to the following outcomes:

- Parents were informed of the relationship and the incidents as requested by the individuals and they took it well and were able to support.
- The provider managed to consult their PBS worker and put in place a robust risk assessment as well as ensuring all staff completed PBS training.
- A referral was made to TEC and buzzers were given to both adults. This was for them to use when they were in each other's rooms and away from staff. If either were feeling anxious, angry, or concerned then they were able to alert staff who could go and check on them.
- A referral was made to Learning Disability Health Service for both adults. At first the referral was not accepted for one individual but subsequently accepted and offered support with a learning disability community nurse for positive relationship work.

The professional network pulled together to address the issue promptly and minimised the risk of it happening again. The meeting was held two days after finding out about the incident and actions were agreed as to how best to proceed and protect both adults from further incidents occurring. There were visits to both adults and joint visits with the TEC team to discuss possible options for TEC.

Was there any specific learning that supported success?

- Staff to complete PBS training.
- Domestic abuse development session shared with the team and presented by a student social worker.

What were the barriers to success?

- Learning Disability Health Service not recognising the domestic abuse initially.
- Staff not being PBS trained and not having experience of supporting someone within a domestically abusive relationship.

What were the conditions for success?

- Staff attending PBS training and completing the risk assessment
- Learning Disability Health Service recognising both individuals were experiencing domestic abuse within the relationship.

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Essex County Council

Safeguarding Adults and Communities

To understand the thematical trends for safeguarding that were being received into the local authority. To understand the diverse needs within the community and what protective factors can be built and sustained.

Essex County Council has developed locality teams across the county to support community and asset-based services that strive to meet adult and carers' needs within the community. This enables social care staff to understand the uniqueness within each community.

The team has worked incredibly hard to ensure this vision is achieved and in doing so, they have been able to integrate into some of the most closed communities known because of their levels of deprivation, poverty, and poor health. For example, a retirement village that the team worked with is a perfect example of successful safeguarding work.

Whilst this is one site, it is split into two parts. On one part of the site there are small static caravans. There used to be over four hundred static homes, but the whole site is in the process of redevelopment, so all adults at the retirement village have been given a Section 21 notice and slowly the adults are moving off the site.

The site is completely deprived and most of the static homes are uninhabitable to the most extreme level. In 2022/23, several safeguarding concerns were received into the local authority regarding self-neglect. The local authority acted and started the Section 42 process, and what came to light was shocking and incredibly sad to witness.

Three cases stand out because when these adults were visited, their home conditions were so appalling that urgent actions were required.

Ms B, who was elderly, frail and blind, was taken to a care home. Her home was so bad there were rats but due to sensory needs Ms B was unable to protect herself and would scream out for help. It was her screams that prompted a neighbour to call for help. Ms B is now thriving and after many months of work has moved from the care home into sheltered living with a package of care in place.

Mr F was living in equally poor conditions, such that the security said that each time they visited him, they were worried that he may have passed away. Mr F had reduced mobility, was severely depressed, alcohol dependent and making regular comments that he wanted to end his life.

Initially Mr F did not want to engage. He was embarrassed, and his emotions showed this, however, after three visits in one week, social care managed to support him to move out of the static home and into an interim placement whilst the static home was cleared and made habitable.

In order to get Mr F out of the static home, as much rubbish as possible had to be moved so the ambulance stretcher could get in. Mr F has since returned to the static home with a small package of care and is on the waiting list for a permanent move to more suitable accommodation and support with housing is being continued. Mr F no longer drinks alcohol, is back in contact with family and has a fresh outlook on life. Visits are undertaken regularly to say hello.

After meeting these two individuals, there were concerns that there were others not receiving the care and support they needed with poor living conditions. The team decided that they needed to be proactive and build links and relationships so that they could understand the community better.

The third individual, Ms P, had a safeguarding raised for self-neglect and Section 42 enquiry started. Ms P was elderly, frail, depressed and had anxiety. She was very withdrawn from everyone and all services. Again, her living conditions were extremely poor, and she had skin conditions which impacted on daily life due to pain and discomfort. Ms P was unable to maintain her personal care due to inadequate facilities.

Ms P was supported to move into sheltered housing and a small package of care implemented. Several months later, the skin condition that she had suffered with has completely gone; this was simply because Ms P had washing facilities to keep the home clean.

These are examples of providing simple life necessities.

Since this time, the owners of the site have been contacted and concerns have been raised to demonstrate the risks. Initially the site manager was reluctant to engage with safeguarding processes due to a misunderstanding of who and what social care are and do, but after a while relationships grew, and the site owners recognised adult social care could be an asset.

The team have developed and delivered various presentations to the site staff which includes what is adult social care and what it can offer, what a safeguarding concern is and when safeguarding concerns should be raised.

The difference this has made has been incredible. Reception staff and security now contact social care directly if they have any concerns about adults living on the site, and from this social care have met over fifty adults to provide advice and information about support. Social Services now has its own caravan on the site offered by the owner to provide weekly drop-ins. This supports the Council's preventative agenda and provides early information and advice before a crisis occurs.

During the drop-in sessions, a member of staff will stay in the caravan for anyone that wants to drop in while two or three staff members walk around the site and check in on the adults who have known risk factors. Each time the staff visit, they speak with new adults and carers and have around ten adults that are always checked on each time social care visit due to ongoing concerns.

There is a restaurant on site which residents can attend. Social care is based in the restaurant one Wednesday a month and again drop in sessions are offered. This has become more popular over recent months and adults are waiting to ask for information and advice.

The Alzheimer's Society have delivered a session to residents as well, and this was again very successful with some adults asking if their loved ones can be put forward for further contact. This had led to earlier dementia diagnosis.

There is still work to be achieved, but the team are trying to reach out to people earlier to provide information and advice which can prevent things deteriorating for them.

There has been feedback from the Primary Care Network and from a carer which positively supports the work:

'This year has been a pleasure working with you and the team. I'm finding the barrier between health and social care to be a lot less frustrating now we are able to contact each other without having to do direct referrals all the time can just send an email or give a call to obtain more information. I think the joint visits are going really well and it's good for us to be able to update SystmOne notes for doctors so they can see any interaction with the patient. As you are aware SystmOne does not tell us if someone has a care package unless we ask you.' (Primary Care Network)

'Since your team have been coming to our meetings, the help given to many people has been invaluable. Your team have helped so many people, they were lost when they came into our meeting. They came in crying and go out smiling. Once I introduced them to the social care team, I knew that the care needed would come, that includes myself. I don't know if I could have coped without the help.' (Carer)

What were the barriers to success?

- Initial engagement from adults on the site. It was clear that for many adults and families they were embarrassed about their situation, and this hindered their engagement.
- Initial engagement from staff on the site. The staff on the site, including the security, are an important asset as they know these adults and see them daily, so building a relationship with the staff that enabled them to communicate with social care workers provided a massive step forward.
- Social care reputation was a barrier because adults within these types of community have more often than not had previous bad experiences with social care, so the team has worked really hard to change people's opinions and views about social care.
- Services working in isolation from one another and a culture of blame or hand offs.

What were the conditions for success?

- **Consistency –** for some adults it took longer for them to engage but the team kept turning up, kept checking in and maintained presence within that community. Now the team offer familiar faces, relationships continue to build, and conversations have become organic and authentic,
- **A human approach –** some adults on the site were living in conditions that most people would be unable to comprehend. It was so important for the team to recognise the impact of each adult's situation, to listen to them with compassion and to be a friendly face in the most difficult of circumstances.
- **Community connections –** the adults on the site have diverse needs and health determinants, often underpinned by frailty, older age, and poverty. Building a person-centred, holistic and partnership approach to the adult being supported was therefore key to building relationships.
- When social care drop-ins are held every month, health colleagues from the Primary Care Networks attend to support with any health-related queries (e.g. blood pressure checks, medication reviews, GP follow-ups).
- Support from housing and benefits services to support people out of poverty and into suitable accommodation. Support to people facing eviction to create pragmatic and achievable solutions.
- Offered support by Carers First, who have a clear focus about the site and the support they can offer.
- Alzheimer's Society sessions for adults and carers living with dementia.
- Developed strong links with the local supermarket bus, which is stocked with fresh food at really low prices and arranged for the bus to go onto the site regularly.

A range of services are now in one place which are having many benefits and reducing the need for crisis support.

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Luton Borough Council

Safeguarding high risk and complex vulnerable adults

Development and implementation of the Luton Critical Adult Safeguarding Partnership Arrangements (CASPA) to provide multi-agency interventions in the high-risk adult vulnerability cases across Luton, coordinated through a monthly multi-agency panel meeting.

These are some the challenges the council was facing:

- Increased number of Safeguarding Adults Reviews (SARs)where common themes identified in the review showed poor multi-agency working and silo working between agencies in complex cases with high risk.
- Evidence that agencies were all working hard in their organisations to address issues but there was insufficient multi-agency multi-disciplinary assessment, planning, and intervention in these cases.
- Evidence that Luton was seeing an increase in the number of high-risk complex cases with adults presenting with multiple vulnerabilities and services not being able to engage them long enough for successful interventions and improved outcomes to take place.
- A previous Pan Bedfordshire intervention through a Vulnerable Adult Risk Assessment Conference (VARAC) had been coordinated by the Police and had focused on reduction of crime through early intervention, reduction of harm through early intervention, safeguarding and maintaining public confidence through a coordinated approach. VARAC had been stood down following a policing review of the approach and funding had been withdrawn for the coordination and management function of VARAC.

Following the removal of VARAC across Bedfordshire, Luton Safeguarding Adults Board (SAB) did not have a procedure or process to coordinate and manage risk for cases that often challenge the existing safeguarding protocols and where there is a high degree of multiple need such as:

- dual diagnosis
- risk of offending/reoffending
- poor mental health
- poor self-care
- vulnerable housing or unstable tenancy
- social exclusion and problems with accessing support
- health issues that are often poorly managed
- victimisation by others
- anti-social behaviour
- inability to protect themselves from danger and harm
- unhelpful thinking and behaviours
- poor engagement with and by services.

In order to tackle this problem and ensure a high-risk and complex procedure and pathway was being delivered by multi-agencies with SAB oversight, a proposal was brought to Luton SAB to develop and implement a Luton place-based pathway to address the above issues in a multi-agency coordinated way. A further aim was to shift the focus from the previous police-led focus to providing person-centred approaches to these cases.

The objective was to:

- strengthen collaborative working within the safeguarding partnership
- provide a high-level platform for risk assessment, risk planning and risk management
- bring ownership and oversight of high-risk complex cases to the safeguarding partnership and reduce silo working
- enable partner agencies to share information in order to risk assess individuals appropriately.

Luton SAB developed and implemented the Critical Adult Safeguarding Partnership Arrangements (CASPA). CASPA seeks to facilitate multi-agency interventions for Luton-based adults with complex needs who are assessed as a critical safeguarding risk.

The aim of the procedure and pathway was to decrease risk and increase positive outcomes through:

- effective community and monitoring arrangements
- forming contingency plans to address possible or known risks
- identifying and implementing strategies that manage escalating scenarios
- identify previous and ongoing interventions to reduce service demand
- support services to hear the voice of the adult at risk and provide person-centred care while managing risk
- progress reporting and regular review built into the pathway
- revised care plans with contingency arrangements
- multi-agency risk assessment and planning.

Commissioners, people who access care and support and providers worked together on the following areas:

- Development of a CASPA strategic board and panel to include terms of reference for the groups, information sharing protocol and agreements about minute taking and record keeping for the panel.
- Each partner appointed a single point of contact (SPoC) who were fully signed up to the procedure and pathway and aligned to working together to ensure the processes of the agreement were fully adhered to.
- The CASPA panel needed to be coordinated and managed and to ensure plans and outcomes were tracked and monitored; this required the appointment of a CASPA coordinator and administrative staff.

- The panel receive referrals from all agencies within the safeguarding partnership arrangements via the CASPA referral form. They identify a cohort of the most vulnerable adults in Luton who are appropriate for this pathway and take these individuals into the panel for multi-agency agreement of plans and outcomes.
- There is a monthly cases discussion meeting, where new referrals are attended to and a summary/update of existing cases within CASPA are discussed.
- There are then smaller, regular, and intense multi-disciplinary team meetings and discussions relevant to specific cases. These are triggered by the coordinator who is responsible for follow-up on actions and progressing agreed plans. The coordinator keeps a log of all actions and will escalate to lead agencies were required.
- The cases do not leave the CASPA caseload until high-level risk has been reduced and it is safe for one agency to continue with ongoing case management.
- The CASPA pathway will not manage more than 15 cases at any given time. This includes new referrals and cases already accepted into the pathway.

What was the impact?

- Provided effective multi-agency interventions.
- Enabled partner agencies to share information in order to risk assess individuals appropriately.
- Served as an escalation process and specialised support for complex cases involving high levels of risk and multiple intersecting vulnerabilities that demanded a specialised approach.
- Increased multi-agency participation and reduced silo working.
- Provided some stories of difference to share – outcomes from agencies working collaboratively together.

Ms A – Victim of sexual exploitation

Problem: Agencies were not in agreement as to which one of them should take responsibility to protect and provide support for Ms A.

Background: Ms A had experienced 10 years' involvement in sexual exploitation, trauma from having lost six children into care and being moved from man to man within the circle of exploitation. Ms A was heavily using drugs and alcohol to cope. Ms A was rescued by the Police following a police drugs raid operation. She then became homeless and at risk of rough sleeping. Ms A wanted to go back to her exploiters as that is all she had known for years and saw them as family. The police provided short-term hotel accommodation whilst other assessments were requested. Mental Health Services declined to assess Ms A as substances were still being used and they believed that her mental health issues were likely to be drug and alcohol induced. Mental Health Services advised drug and alcohol treatment.

The Local Authority Adult Social Care assessed Ms A and advised that there were no care and support needs according to the Care Act guidance and no functional disabilities were apparent. Ms A was said to be capacitated when not under the influence and able to meet her own daily living needs. Adult Social Care advised that Ms A needed housing and access to drug and alcohol services. However, housing services were adamant that she would not be able to hold a tenancy, and they believed she could not manage to live independently without support. Ms A was therefore not given mainstream housing. The drug and alcohol services were expecting Ms A to come to their service and engage with a detox and rehab plan. However, she was not ready to engage with anyone and just wanted to go back to family and her old life.

Outcome: CASPA took responsibility to bring all partners together, appoint a lead agency and effectively completed risk assessment and risk planning with all agencies. A temporary placement with low-level support was arranged for a short period for Ms A, with a view to stabilising the situation before formal assessment for long-term support. As part of ongoing assessments, a couple of weeks later further assessments took place whilst Ms A was in temporary arrangements to ensure the level of risk to her was understood. Mental capacity and mental health needs were also understood clearly, and partners were able to implement plans. The multi-disciplinary teamwork was carried out under the auspices of CASPA. Ms A started to make progress towards the planned outcomes within this setting in a short period of time.

With improvements being made to Ms A's mental capacity due to support for drug and alcohol use, underlying mental health needs became more apparent. She was supported into a low supported housing scheme with a care package that addresses trauma and supported to engage with both mental health and drug and alcohol services at the same time. Ms A received counselling to understand her experiences of sexual exploitation and received support to engage with a police investigation into the abuse that she had suffered. Ms A was able to achieve stability in her life for the first time in over ten years and remains in current accommodation.

Was there any specific learning that supported success?

- The role of the previous VARAC had been subject to a formal evaluation in 2020 which provided evidence of the strengths of the approach and some recommendations for improving the process. This was fed into the consideration of what would work well in the Luton place-based model.
- The learning from SARs was a key factor where there were concerns with gaps in practice particularly around silo working and agencies working individually on complex cases without thinking about formalising multi-agency support and the types of referrals that could potentially help support these individuals.
- Multi-disciplinary teams (MDT) – where these were adopted, they were not comprehensive and sometimes were MDTs of one or two agencies so that other key agencies who had information to support planning and intervention were left out.
- There was evidence of duplication of work and interventions due to lack of collaboration and start again approaches.

What were the barriers to success?

- Funding for the procedure – agencies were not ready to spend money on additional arrangements.
- Agencies were slow to realise the benefits of this high-risk platform – it took longer than anticipated to get all agencies to engage effectively, especially after the stand down by the Police of the previous Pan Bedfordshire arrangements.
- The need to create new information sharing arrangements for some agencies following the stand down from VARAC with the Police and National Probation Service.
- Some agencies were initially uncomfortable with the increased scrutiny that the multi-agency platform brings in practice and this took a while to work through.

What were the conditions for success?

- A shared desire to decrease risk and increase positive outcomes and willingness from across the partnership to contribute resources and personnel to the process.
- A supportive SAB with a robust and creative approach – focused on learning and collaborative working.
- Strategic leaders from across the partnership supporting the initiative with both time resource and creative ideas.
- Funding was diverted from another project to kick start the project, allowing time to work on long-term funding solutions.

Further information:

- https://panbedfordshiresabs.trixonline.co.uk/resources/contacts-and-practice-resources
- https://trixcms.trixonline.co.uk/api/assets/panbedfordshiresabs/ef3aad7f-d82b-49f4-8fc4-ec9135b4dc6e/pathway-caspa-april-2024.pdf

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Milton Keynes City Council

Cultural humility in safeguarding

The interface between culture in safeguarding and making safeguarding personal in practice. Can a lack of cultural humility be a cause of safeguarding?

An older adult (Ms S) was receiving care at home from a care agency. Ms S was of Sikh faith. Ms S's two adult sons advocated on her behalf, as she was found to lack capacity to make decisions about how her care needs were being met. Ms S's sons found it quite difficult to have discussions about their mother's personal care.

The sons raised a safeguarding concern against the care agency for neglect and omission and verbal abuse. There were ongoing tensions between the family and care agency. The safeguarding allegations were around communication and understanding with the care workers regarding their mum's specific care requirements and this was leading to a high risk of the package of care breaking down, as it had in the past.

The specifics of the allegations were in areas such as not using specific prescribed soap (causing skin rashes and skin integrity breakdown), lack of awareness regarding appropriate clothing for different body parts and misunderstanding of general hygiene practices, all causing Ms S distress. There were instances of Ms S becoming angry with carers and alleged incidents of verbal abuse by carers towards her.

A Section 42 process was started. The allocated social worker identified the cultural and spiritual requirements in connection with care and the support provision. The social worker listened and heard Ms S and her family, finding out from them their point of view and how they felt. It was decided by all parties that the care agency would change and a plan to 'get it right' with the new care agency would be implemented. An interpreter was also used to support communication with Ms S and her family. The care agency was changed, and the cultural and spiritual nuances of the care and support outlined.

Working with the new provider has ensured they understand these cultural and spiritual nuances, including the importance of family visits, emotional support, social interaction and maintaining these important relationships. Safeguarding has now closed, and the care package is going well with no further safeguarding concerns.

Was there any specific learning that supported success?

This case was brought to the safeguarding forum, which is a panel of (usually) the Head of Safeguarding, the Service Manager for Safeguarding, and the Principal Social Worker (PSW). The safeguarding forum is provided fortnightly to social workers holding Section 42s over 28 days.

One of the areas of focus for this case was consideration of making safeguarding personal (MSP) in practice and that MSP is more than just asking people what they want to happen or who they want to be involved.

The Council has been considering how MSP means thinking about the whole person as a starting point, considering how their culture and identity should be front and central, in order to begin to understand how to make safeguarding personal for them as an individual.

The social worker shared that impact of attending the forum: "... helped me to see clearly, set out what the issue was and problem-solved ideas and where I was going with the case and structure and process of safeguarding."

Considering the principles of MSP and strengths-based practice ensured the right questions were asked from the outset. The adult's care plan reflected this as the plan was preventative, allowing understanding before disagreements escalated and led to a crisis of another breakdown of care.

Since carers now understand the need and have the right information to follow, there have been no further issues. It was important to start the learning from who the person was and what was important to them as opposed to starting with the consideration of how a care and support need would be met, which would have completely changed the outcome for the person. It would also have been likely that the safeguarding concern wouldn't have been raised.

More broadly, it has also led the Council to consider when a failure to meet cultural needs becomes a safeguarding issue.

What were the barriers to success?

- Not understanding that Ms S's needs should be considered within a cultural and spiritual context of what was important for her.
- By not understanding the above, the provision of care/care plan was not being delivered in a bespoke way to Ms S.
- History of several care agencies and several safeguarding concerns being raised was a barrier as there was a lack of trust between care agencies and Ms S's family.
- Language, as English was not Ms S's first language.

What were the conditions for success?

- The social worker identifying the barriers and the need to address cultural and spiritual areas of the adult's life, as being valuable and important to Ms S.
- Implementation of MSP in practice, so not merely asking what was important to Ms S and/or what she wanted to happen, but rather understanding holistically the central and important part of Ms S's culture and spirituality.
- Focus in practice on what the current main issues/concerns were to improve the situation.
- Language interpreter was arranged so nuances of language and culture could be considered in practice.

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Norfolk County Council

Locality Safeguarding Adults Partnership (LSAPs)

Norfolk has five LSAPs across the county, to deliver key safeguarding adults objectives at a local level from the Norfolk Safeguarding Adults Board (NSAB), and to provide a local view to support effective development of the NSAB plan. Representatives come from a wide range of organisations in each local area.

The LSAPs have been in place for many years, each one meeting up to five times a year but with no regular direction from the NSAB due to limited resources. This meant each group was relatively independent and without a clear or shared focus, making it harder to make effective use of local knowledge and expertise to inform or deliver strategic safeguarding plans.

When the deputy manager post was created for the NSAB they were asked to directly support the LSAPs, to strengthen the links between strategic and operational levels and more effectively co-ordinate the work of the groups. They spoke to the existing chairs, the people attending the groups and board members to understand the needs at different levels. The deputy manager now co-ordinates topics for each round of individual meetings, which more directly link with the strategic priorities and work of the board. One of the key priorities is prevention, in this context linked to early recognition and support of adults at risk and effective local multi-agency approaches to achieve this.

The deputy manager delivers updates on the NSAB and other safeguarding work/information to groups and then feeds back from the groups directly to the board as well as other subgroups and forums. NSAB actively promotes the partnerships across the county, to increase membership and engagement, for example, via a monthly newsletter.

Members are regularly invited to give feedback on the meetings and topics, etc., so that approaches can be adapted according to need and to try and find engaging ways of making the meetings interesting as well as informative (e.g. using video clips, animations, new articles, word clouds). The deputy manager links with the coordinator of the parallel Locality Safeguarding Children Groups to work together on topics or themes where possible.

Examples of topics covered to date:

- Professional curiosity
- Domestic abuse and older adults
- Carers and safeguarding
- Safeguarding as prevention
- Self-neglect and neglect
- Financial and economic abuse.

The discussions held and information shared improves wider understanding, recognition and responses to abuse or neglect in the local areas. The deputy manager also arranges regular webinars for all the groups (and wider colleagues) to attend, rather than guest speakers coming to each local meeting. This enables the meetings to be more focused on solutions rather than just absorbing information.

Membership (those who contribute to the ongoing development of the LSAPs over time) includes adult social care, community health, local councils, libraries, acute hospital trusts, mental health, charitable and voluntary organisations, trading standards, probation, police, and care providers.

NSAB surveys the group each year. Here are some comments on what people get out of being involved in the LSAPs:

- Partnership – 'getting to know different agencies and their views on safeguarding' (Police)
- Networking – 'learning from others and obtaining up-to-date information on risks in Norfolk at that time' (Adult Social Care)
- Working on particular issues – 'developing approaches and practice' (District Council)
- Understanding together – 'working together to support safeguarding improvements' (District Council)
- Networking – 'providing information, brainstorming, learning from other, professional curiosity' (voluntary sector).

What were the barriers to success?

- People's time and ability to commit to meetings on a regular basis.
- Attendees from agencies outside of social care often felt they didn't have the skills to chair the groups, or the more specialised safeguarding knowledge they felt might be needed for the role.
- Because the invite is very generalised, there is a wide spectrum of roles and organisations in each group. With a varied baseline knowledge, some people felt the subject matter can be too obvious, while others felt it was over their head.
- High turnover, intermittent attendance and continued system pressures all contribute to the need to repeat information or topics to ensure embedding of learning or information.

What were the conditions for success?

- Dedicated time/resources – NSAB deputy manager coordinating and directly supporting every meeting alongside the individual group chairs.
- Involving the groups in choosing topics for discussion and providing a range of materials and different formats to engage as wide an audience as possible.
- Offering written information and face-to-face sessions for chairs/prospective chairs to build confidence.
- Offering biannual in-person county sessions to provide a mix of virtual (local) and face-to-face (county) meetings, which improves the practical and social networking element whilst still appreciating that virtual sessions are less time consuming for many.
- Keeping it local – sessions feel more relevant to members and enable local relationships to build.

Further information:

- Locality Safeguarding Adult Partnerships (LSAPs) | Norfolk Safeguarding Adults Board

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Norfolk County Council

Insights into Section 42 enquiries and feedback from adults

Norfolk County Council have implemented a process for gathering feedback from adults, or their advocates, who have experienced a safeguarding enquiry, and are using this to learn and inform future practice and interventions.

Norfolk County Council had an intention to gather feedback directly from people who have experienced a Section 42 enquiry for a long time as they wanted to find out more about people's experience of going through an enquiry. In particular, the Council wanted to know what people think they are doing well, where there is room for improvement, whether people felt involved in their enquiry, and how they felt about the outcome. The Council also wanted to understand what makes people feel safe, as they wanted to be able to use feedback to guide practice and preventative safeguarding.

The Council think they know what the issues and problems are, but this does not necessarily align to what those experiencing the services think are the issues or problems. The Council felt it was only by taking to people that further learning would emerge. Social workers talk to people at the end of an enquiry about how they feel about the outcome and whether they feel safer, but the Council wanted to ask some more general questions about the person's experiences and to be able to use these to inform service development.

The Council gathers feedback from people who receive services, but no feedback had been sought more generally from people who had had an enquiry. This was due in part to various assumptions, for example, people don't want to revisit the abuse they've experienced or to risk being retraumatised by discussing their enquiry. The Council wanted to test out these assumptions and find ways in which to engage people in a supportive way, giving them the space they needed to reflect on their own experiences.

With no additional resource available, the project needed to operate using existing staff within the safeguarding service. A small project team was set up, led by the head of service, and including the safeguarding team managers, the deputy board manager, complex review manager and assistant practitioner. The team began by thinking about what they wanted to achieve from the project and what information would help them to develop their safeguarding service. Given that prevention is a priority area, the team wanted to focus on asking people what makes them feel safe as a key question.

A process for selecting people who might be appropriate to contact was developed. Part of this process includes reviewing the electronic record and consulting with the allocated social care practitioner to establish if there are any issues such as complex family dynamics or the risk of traumatisation that would bring too much risk for the individual. The assistant practitioner makes telephone contact with the person or their representative to ask if they would be willing to talk to the Council and whether a telephone conversation would be possible, or a face-to-face meeting needed. The person is sent a letter of introduction and a date/time for the call. The assistant practitioner completes a proforma following each call and records the findings in the person's own words if possible.

The complex review manager is sent all the completed proformas and records key information on a spreadsheet, periodically reviewing the data, picking out themes and presenting findings. The team have established the importance of human elements of feeling safe and have been able to share this with the department to emphasise the importance of preventative safeguarding approaches by connecting people to family or community networks.

Was there any specific learning that supported success?

- A respondent commented that having his dog and mobile phone helped him feel safer. This reflects the reality of how a mixture of practical and emotional reassurance helps people to feel safe.
- Another respondent said he was happy with the end result and that he finds it very helpful meeting up and talking to people (this was following community connections as part of the safety plan to reduce loneliness and isolation). This illustrates the importance of in-person contact and the opportunity for discussion rather than just being asked or told something by email.
- A respondent said they were very happy with the support provided and believes they wouldn't be here if it wasn't for the lady at the chemist and adult social services.
- Another respondent said they felt that the social worker really helped them, and he couldn't see how the support could have done more to keep him safe.
- A respondent said they had a lot of visits from professionals to make sure they were safe, and the support was appreciated.
- The Council also received some comments that people hadn't received feedback at the end of the enquiry. The team managers were able to check the records in relation to feedback. It was noted that frequently, it had been recorded that people had been given feedback but either hadn't recognised it as such or had forgotten. This has prompted the Council to review the feedback process so practitioners give feedback in writing where this is the preferred method, rather than assuming that being talked through the enquiry outcomes would be preferable.

These are small examples from a project managed at small scale, but they illustrate some of the incremental changes that can be made by gathering feedback independently from the enquiry.

What were the barriers to success?

- Resource to review records to check for suitable cases.
- Resource to carry out the interviews.
- Resource to analyse the data.
- The Council has found it constraining to find people to approach due to the distressing nature of many safeguarding enquiries and the suitability of making calls to the person. As the project progresses, the team is cautiously expanding the range of people they are including within the boundaries of the project.

What were the conditions for success?

- A small team of determined, passionate and committed people who were willing to work together and fit this into their already busy jobs.
- An assistant practitioner with the willingness to step outside their comfort zone and carry out the interviews.
- Senior management willingness to allow the team to try something different.

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directors of
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adult social services
eastern region
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www.adass.org.uk/community/eastern-region