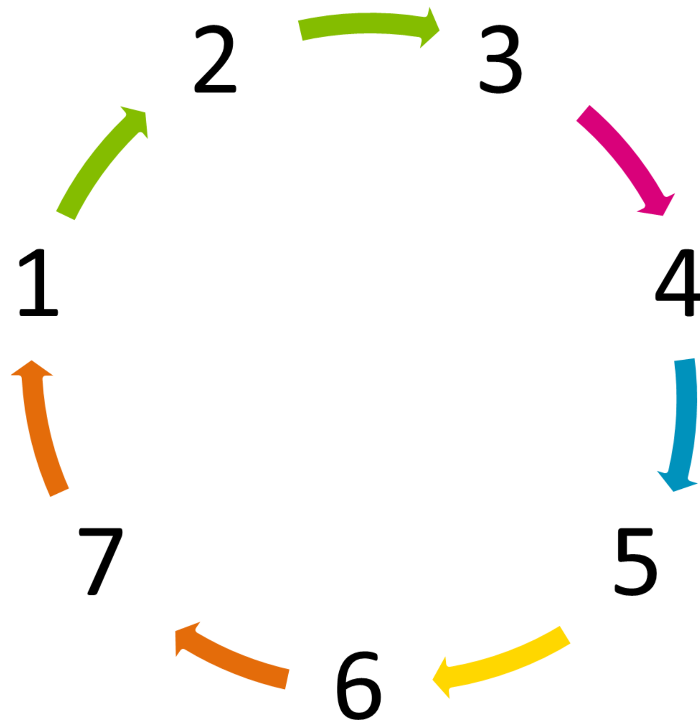

7 Minute Briefing: Colin

Safeguarding Adult Review (SAR): Colin

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Methodology

The Adult's Independent Chair is consulted on the methodology utilised in any given SAR and mandates the approach.

The WSAB used a 'Systems Learning' approach in the review of Colin. This is a model that was introduced by the Social Care Institute for Excellence following the Munro Review of Child Protection published in 2011. This approach sets out to study the whole system and look closely at what influenced professional practice. It does this by taking account of the many factors that interact and influence individual worker's practice in a more in-depth way. The process seeks to be a collaborative process with professionals being actively involved in the review from the outset. The approach promotes reflective thinking as a system to identify the causal factors that influenced practice for which improvements can be made upon.

Background

Colin is an elderly man who was admitted to hospital in a poor state of health due to his care and support needs not being met by his informal carer (his son) following a failure of services to respond to concerns or to assess Colin's (and his son's) needs.

The main themes within the case are:

- Self-Neglect / Neglect and Acts of Omission
- Informal Carer
- Pressure Ulcers

The main learning themes from the review are captured within Key Lines of Enquiry and in this case include:

1. Social Care Assessment
2. Informal Carer Support
3. Significant Life Event
4. Professional Curiosity

Learning points were identified through the case review, highlighting areas of learning and improvement.

1. Social Care Assessment

GMFRS raised a safeguarding concern via eyes and ears to MASH following a home risk assessment on Colin's property in reference to self-neglect and hoarding and the consequential fire risk / evacuation of the property. MASH conducted a home visit and a subsequent referral to Adult Social Care was made for contact and assessment. There was an apparent delay of 2-months before a Social Care Officer was allocated to the case, which was then closed due to lack of contact with Colin, and as such Colin did not receive a Social Care Assessment for his Care and Support needs.

Initial triage of the MASH referral did not identify the associated risk relating to self-neglect and as the self-neglect pathway was not in place at the time of the referral, the referral was considered through a supported self-assessment pathway opposed to a safeguarding Section 42 pathway.

The self-neglect pathway provides an earlier opportunity for identifying risks across a multi-agency information sharing process, and puts in place a multi-disciplinary approach to those risks via a Section 42 process. This includes considering risks relating to non-engagement / capacity / social care assessment, and others.

Making a difference:

> There is now a self-neglect toolkit available for Adult Social Care practitioners to support the challenges of managing and escalating risk related to self-neglect, including perceived non-engagement

> The Self-Neglect Delivery Group to develop and implement a Performance and Quality Assurance Framework to demonstrate effectiveness in identifying and managing non-engagement, using trauma informed practice to identify the cause of non-engagement (for example, physical issues)

> There is a practice guidance tool to aid practitioners in a trauma informed response to perceived non-engagement which will be shared across the partnership via the Learning and Quality Assurance Subgroup Delivery Plan

> The Self-Neglect Delivery Group have ascertained a baseline for self-neglect via self-reported awareness and understanding so that a subsequent improvement plan can be developed and implemented, alongside the delivery of WSAB Self-Neglect Lunch and Learn Sessions; awareness and understanding levels to be reassessed following the delivery of improvement plans

> System links between safeguarding in the place (i.e. MASH and Complex Dependency Team) and Section 42 Safeguarding are being developed in order to improve wider system oversight and clarity

of process regarding escalating safeguarding concerns and information sharing via risk management processes

> Practice standards under the Safe, Effective Practice Transformation Programme across Adult's Community Services will provide clarity of expectations of local practice, highlighting expectations for face-to-face contact on initial assessment, and end-to-end process expectations including:

Quality of referral

Allocation of Social Worker / Social Care Officer in relation to complex and self-neglect cases

Threshold for closure

Oversight of closure from Advanced Practitioners

2. Informal Carers

- **There was an assumption that Colin's care and support needs were being met**: Colin disclosed that his son was his carer on contact with MASH.

- There was an assumption that Colin's son was able to provide suitable care and support to his father: **Carer assessments should be completed as standard, and support offered via referral to the Carers Centre.**

Making a difference:

> Monitoring of carer assessments offered and completed, and referrals to the carers centre is being developed into the WSAB Quality Assurance Framework for the partnership for oversight and assurance

> The conversation offering a carers assessment should promote the importance of it as a supportive tool

> Ensure there is signposting information available for carers who are not engaged with the carers centre, so they know where to seek help if needed

> Review of the Adult Social Care Carers Strategy to consider themes raised in Safeguarding Adults Reviews

> WSAB Business Unit and GMMH Carers Lead to discuss the themes raised in Safeguarding Adults Reviews in relation to mental health to connect to Carers Strategy

3. Significant Life Event

Colin's history was not considered as part of his presentation of self-neglect. His physical health deterioration in his ability to use his legs was not considered in relation to the impact on his ability to care for himself or in his ability to have contact with professionals.

Making a difference:

> Primary assessors to complete holistic assessment of need, considering an individual's history. This will feature as a practice standard within the Positive, Safe, Effective Practice Workstream and be subject to related Quality Assurance Frameworks

4. Professional Curiosity

There was a lack of professional curiosity highlighted at the following key points in the case:

- The extent of the care and support provided by an informal carer
- The support needs of an informal carer
- Considerations to barriers for contact, or lack of; considering face to face contact and outreach
- Consideration to the history of an individual and the impact this has on current presentation / root cause

Good practice was identified in GMFRS's practice to follow up on their contact to Eyes and Ears and in Age Well's persistence to make contact with Colin and his family.

Making a difference:

> Professional Curiosity training to be completed as CPD and refreshed every 2-years, monitored by WSAB Training Competency Framework

> Monitoring of S.42 feedback to referrers at point of closure has been put in place within the WSAB Quality Assurance Framework to ensure there is communication between organisations in relation to safeguarding concerns

Practitioner questions to consider

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1. ***Does the organisation have a process to follow up on onward referrals?***
2. ***Do we consider GDPR as a guide to sharing information, rather than a barrier?***
3. ***Are we aware of apprehension within our service around sharing information and how to appease this in relation to safeguarding concerns?***
4. ***What is our services ability to respond to out of hours concerns in a robust way?***
5. ***How well do we understand or enquire how our service users came to be in their presenting circumstance?***
6. ***How do we make sure our service users and their support networks are aware of the support available to them even when they report to be coping / managing?***
7. ***What is our services ability to understand potential risk in order to work towards addressing "unknowns" in a case?***
8. ***Where best practice is identified, how do we ensure that this can be replicated service wide?***

Want to learn more?

Wigan and Leigh Carers Centre:

Wigan and Leigh Carers Centre (wlcccarers.com)

Self-Neglect Toolkit:

Wigan policy and procedure (wigansafeguardingadults.org)

Trauma Informed Response Guidance to Perceived Non-Engagement:

Understanding non engagement with services (wigansafeguardingadults.org)

S42 Safeguarding Training which covers data sharing guidance:

WSAB Training Brochure 2021 (wigan.gov.uk)

Professional Curiosity Training:

WSAB Training Brochure 2021 (wigan.gov.uk)

WSAB Training:

WSAB Training Brochure 2021 (wigan.gov.uk)