Safeguarding Adult Review of Paul

Presented to the West of Berkshire Safeguarding Adults Board

On

25th June 2018

Is there evidence that practitioners are learning from messages in reviews?

What are the challenges in practice preventing application to safeguard?

Contents

1. Introduction

1.1 Following the death of Paul, West of Berkshire Safeguarding Adult's Board made the decision to commission a Safeguarding Adult Review under Section 44 of the Care Act (2014) (See Appendix 1). This was because the circumstances of the case appeared to have a wider significance for practice, in particular, how different agencies worked together in the community to support Paul and his cousin Bruce.

1.2 The Board acknowledged that some of the systemic issues present in the case had previously been identified in other SARs commissioned by the Board. The Board wanted to understand why it may be that learning does not appear to have become embedded in practice. The Review therefore also examined actions taken by organisations following previous SARS. Paul's son's agreed that this was a reasonable approach to take.

1.3 This report will be published on the Board's website in anonymised form following discussion with Paul's family. Any development of workshop based learning and subsequent rollout of learning to the workforce will be subsequently determined by the Board.

2. Summary of the case.

2.1 Details of the person subject to the Safeguarding Adult Review

Name: Paul

Date of birth: N/A Date of death: N/A

2.2 Family composition

At the time of his death, Paul lived with his cousin Bruce and had done for many years. His two sons lived locally whilst a third son lived some distance away from the area. During the period under review, Paul's son supported both Paul and Bruce and continues to support Bruce.

2.3 Timeframe

Following discussion at the SAR Panel on 8th February 2018, the period under review was agreed to be over 18 months. This gave sufficient opportunity to review the pattern of interaction of the cousins with services.

2.4 Overview of the Case

2.4.1. This section provides an overview, both of what happened and why it happened and provides some indication about the quality of the practice in this case, including where practice fell below what would be expected. Systemic issues present that were also identified in previous SARs are explored in more detail in Section 4.1.

2.4.2. Both cousin experienced difficulties with many of the practical aspects of daily living. This resulted in poor living conditions, with a high level self-neglect. Paul and Bruce's needs continued to be assessed by social care individually rather than holistically.

2.4.3. Paul had a range of physical problems and a history of anxiety but found it difficult to trust or accept support from statutory services and to build relationships with social care practitioners. Towards the end of his life, he apparently rarely left the

house. Paul was assessed by Wokingham Integrated Social Care and Health Team (WISH) and by Berkshire Healthcare Foundation Trust (BHFT) a number of times during the period under review but this never progressed as he declined services. This apparent refusal to accept support was exacerbated by the staff 'churn' in both WISH and Optalis as he was seen by a series of practitioners who never built up a relationship with him.

2.4.4. Although Bruce has not been assessed as having a global cognitive impairment consistent with a diagnosis of a learning disability, his variable scores indicate some specific areas of impairment. This includes having some deficits in some areas of daily functioning, in particular his ability to self-care and difficulties in understanding some information in relation to his everyday life. Bruce also suffers from Bi Polar Disorder. In contrast to Paul, during the period under review Bruce was regularly attending a voluntary sector drop in centre and he also volunteered regularly. In addition he was receiving a few hours support for daily living commissioned via Optalis. It was notable that, although the support was with daily tasks, the care worker only took Bruce shopping and never went inside his home which was what Bruce wanted to do. Whilst this practice gave Bruce choice and control, it was an opportunity missed. The service could have been commissioned in such a way as to allow the care worker to observe Bruce's ability to self-care and manage his home and subsequently feedback to his Care Manager in Optalis.

2.4.5. About 10 years ago, Paul moved in with his uncle and cousin. Bruce, who is a few years younger than Paul, had always lived with his father. After their uncle/father died, the cousins continued to live in home but eventually, after seven years, sold the house and had to move out. This was because their uncle/father had taken an equity release on the property, in part caused by Bruce's compulsive spending. They were assisted with the move by a voluntary housing organisation, whose worker, in contrast to those from other services, was able to build a positive relationship with Paul in order to assist with paperwork and completion of forms

2.4.6 It was following the move to a much smaller home that the cousin's close but volatile relationship became more problematic. During the period under review there was a cycle of crises where Bruce accused Paul of hitting him. These accusations seemed to be triggered by issues relating to finances and then there would be a period of calm. Bruce would often spend all his income and thereby causing friction between them as there wouldn't be sufficient funds for food and other expenses. This friction sometimes led to Bruce making multiple calls via members of the community and other services to the Police alleging violence by Paul. Safeguarding referrals were usually made by the Police and two DASH assessments were made- as standard which was positive. However, rather than progressing Section 42 enquiries, social care attempted to assess Paul for services. Paul was offered social care support but refused and this decision was accepted without consideration of the risks to both Paul and his cousin.

2.4.7 During April and May 2016 two further safeguarding alerts were raised by both the Police and Bruce's Drop In Centre due to disclosures by Bruce but only one Section 42 was raised by Wokingham Borough Council. However again the alerts did not result in any strategy discussions or enquiry made. The decision not to progress to a Section 42 is explored further in Section 4.3.

2.4.8 It was not until September 2016 that there was a joint visit by Paul and Bruce's Care Managers to their home. The only agreed action was a deep clean to address the poor state of the house. The deep clean never took place; it is unclear why although a succession of agency workers holding Paul's case, during the period under review, may have contributed to this. Later that month the counsin's GP telephoned to advise Bruce's Care Manager in Optalis that Bruce alleged Paul was hitting him. The Care Manager visited and saw the two cousins together. No safeguarding alert was raised. It is unclear if this was a safeguarding investigation but when investigating Domestic Abuse, perpetrator and victim should not be seen together. The original enquiry from May remained open but without an action plan.

2.4.9 A safeguarding audit by Wokingham Borough Council safeguarding team in late December 2016 was critical of the handling of the case and identified actions to support Paul and Bruce. In January 2017 there were discussions about the cousins '*seemingly symbiotic relationship'* between Paul's new Care Manager in WISH and Bruce's Care Manager in Optalis. A strategy meeting was held finally in March 2017 The Police declined to attend, the rationale being that there had been no recent involvement with the family. In fact call outs to the home had not been passed to and recorded by the Police Public Protection Unit.

2.4.10 Despite the identification of their complex relationship, Paul and Bruce continued to be seen by services as individuals rather than a family unit. Although Paul was at times identified as Bruce's 'carer', no carer's assessment was attempted. Bruce was never seen as Paul's carer. It was positive that an independent advocate was appointed to support Bruce and explore his ambivalence about living with or without his cousin. Paul's need for advocacy was never identified.

2.4.11 In April 2017 Bruce again disclosed alleged abuse by Paul and a safeguarding alert was raised. There was a strategy meeting in late April which included the advocate and drop in centre staff but not Paul and Bruce. However, despite this, in early May Paul was closed to WISH as he declined assessment. The reasons for his refusal was not explored, nor were the risks to Paul identified. This was despite Paul's son raising concerns about self-neglect. Later that month, following a further allegation of abuse by Bruce against Paul, a second strategy meeting was held, without Bruce and Paul present. Bruce was invited but declined to attend.

2.4.12 Paul was discovered on the floor at home by the mobile hairdresser on 3rd June 2017, a family friend. He had apparently been there for 24 hours or more. Bruce did not/could not raise the alarm. Paul was taken to hospital where he passed away – *cause of death: pulmonary embolism.* There was an initial concern that maybe Bruce had deliberately caused harm to Paul but Police on further investigation considered there was no evidence for this.

2.4.13 Following his cousin's death Bruce was initially given some additional support but deteriorated rapidly and was arrested six times in course of a week following anti-social behaviour. He was not referred to Social Care. He was finally detained under Section 2 of the MHA in October 2017. The poor partnership response to Bruce was referred to the Community Safety Partnership who have addressed the concerns.

3. Methodology

3.1 Research Question

Following discussion, at the Meeting on 14th September 2017, the SAR Panel identified that a review of this case held the potential to shed light on particular areas of practice, including addressing the following Research Questions:

Is there evidence that practitioners are learning from messages in reviews?
What are the challenges in practice preventing application to safeguard?

Posed at the start of the process, these research questions provided a frame of reference and identify the key lines of enquiry most relevant to current practice.

3.2 Specific areas of concern for the Safeguarding Adult Review

The SAR Panel also agreed particular areas for analysis including:

- **How effective is shared accountability and quality of safeguarding within our work?** In particular, the impact of **'**Making Safeguarding Personal'

  How did the various agencies involved work together to provide support to Paul –and Bruce: how was Paul's refusal of care responded to?

- **The interface between the two companies** (WISH and Optalis) {and other agencies e.g. GP and BHFT}.

  How were Paul's own needs responded to as an individual and in regard to caring for his cousin? How was his co-dependency with his cousin managed?

- **Why doesn't learning from SARs appear to be embedded within practice?**

These areas for analysis are addressed specifically as part of the conclusion in Section 7.

3.3 Approach Followed

Following initial investigations, at their meeting held on 8th February 2018, the SAR Panel determined that a proportionate response to the case should include examination of the following:

- Issues identified from a joint chronology of events from the case.
- Issues already identified from previous SARs common to this case
- Review of actions taken by the Board and agencies following previous SARs
- Analysis of a social work staff questionnaire conducted in late 2017/early 2018 across Wokingham Borough Council, West Berkshire Borough

Council, Reading Borough Council and Mental Health Service Social Care staff

3.4 Sources of Data

The following documentation was made available to the Review:

- Recent SARs conducted by the Board
- The 2015-18 Board Strategy, 2016-17 and 2017/18 Business Plans, Action Plans and minutes of sub groups.
- Social work staff questionnaire conducted in late 2017/early 2018 across Wokingham, West Berkshire and Reading
- Supervision audits from Wokingham
- Social Care case notes from WISH and Optalis about Paul/Bruce including the Safeguarding Audit conducted by WBC
- Chronologies from agencies who were involved with Paul and Bruce during the period under review.

3.5 Agency Chronologies

Chronologies were received from:

- Berkshire Health Care Foundation Trust
- GP
- Optalis
- Drop in service
- Adult Social Care Provider
- Thames Valley Police
- Transform Housing
- Wokingham Borough Council

In addition, agencies were asked to provide a brief background of any significant events and safeguarding issues in respect of Paul and include information around wider practice at the time of the incident as well as the practice in the case. These were combined and analysed order to identify key practice issues during the period under review and to try to understand the interactions between practitioners working with Paul and Bruce.

3.6 Engagement with the family

3.6.1 While the primary purpose of a Safeguarding Adult Review is to set out how professionals and agencies worked together, it is imperative that the views of the family are included. The Lead Reviewer was able to meet with 2 of Paul's children at the start of the review and would like to thank them for their very helpful perspective

from the family's point of view on their father and cousin's relationship. They were also able to provide some historical context. In particular Paul's son was able to provide his own considered analysis of the way that agencies worked with Paul and Bruce which was extremely useful to this Review.
Because of his illness, at the time of writing (May 2018) Bruce had no involvement with this review but it is hoped that there will be an opportunity to discuss what happened from his perspective.

3.6.2 The lead reviewer will be discussing the draft report with Paul's children shortly before the Board meeting and will verbally feedback their views. They have already indicated that they would like to know about any outcome of actions identified through the SAR.

3.6.3 Bruce's family and care coordinator believe that the report should not be discussed with Bruce as he is still grieving and not completely well.

3.7 Publication

Consideration should be given by the Board with regards to the potential impact publishing may have on Paul's family.

All agencies involved should also be aware of the impact on their staff and ensure that suitable support is offered and that staff are aware in advance of the intended publishing date.

3.8 Membership of Safeguarding Adult Review Panel

- Kathy Kelly — Clinical Commissioning Group (Chair)
- Jane Fowler — Berkshire Healthcare Foundation Trust
- Elizabeth Porter — Royal Berkshire NHS Foundation Trust
- Jo Purser — Reading Borough Council
- Kathy Abbott — West Berkshire Council
- Helen Spokes — Wokingham Borough Council
- Julie Pett — Independent author/lead reviewer

3.9 Acronyms used and terminology explained

Appendix 6 provides a section on terminology to support readers who are not familiar with the processes and language of adult social care and health.

3.10 Methodological Limitations

3.10.1 In order to be 'proportionate', the commissioner elected to use a data collection exercise as the central mechanism rather than conduct a lengthier process that included more detailed individual conversations with practitioners involved in the case. Whilst this was a pragmatic approach, particularly as many of the practitioners no longer worked locally, it left some particular unique aspects of the case unexplored in depth. This was mitigated to some extent by careful analysis of chronologies and examination of case notes and incident reports produced by

individual agencies and discussion by the SAR Panel about the systemic issues identified.

3.10.2 The Review was commissioned in October 2017 but there were significant delays in progressing the review, caused mainly due to a number of management vacancies within key agencies. Appendix 2 shows the timetable followed.

4. Systemic Issues Identified from the Case

4.1 Issues Previously Identified in other SARs

The Board had already recognised that there were some common issues identified in previous reviews were apparent in this case. The issues discussed below were identified by the SAR Panel at their meeting on 8th February 2018 and subsequently cross referenced with previous SARs conducted by the Board. The title of the SAR which previously identified the issue is shown in brackets. More detail about previous reviews is provided in Appendix 4 and the full reviews can be found at: http://www.sabberkshirewest.co.uk/board-members/safeguarding-adults-reviews

- **Understanding of complex relationships and interdependencies (Ms F)**

Practitioners did not address the interdependencies between the cousins in their approach to working with Paul. There was little attempt to work jointly with other agencies to address joint needs. In March 2017 Bruce's care worker identified that support was needed jointly for the two cousins but this was not progressed by Optalis and in fact Paul's case was closed in May 2017 by WISH despite an open safeguarding enquiry.

- **Professional engagement focused on other individuals in the family unit (Ms F)**

Paul chose not to engage but whether this was an informed choice by Paul was never addressed. Bruce continued to disclose to practitioners about his fractious relationship with Paul through the period under review and this remained the focus of practitioner's engagement throughout the period under review.

- **The impact that an individual's presentation can have on assessments of vulnerability (Ms F, Mr X)**

Bruce appeared more open than his cousin; he was more vocal, would appear to accept interventions and engaged with services. Paul was much less willing to discuss any issues and his refusal of services was accepted at face value and his choice.

- **Assessment of individuals rather than assessment of the family (Ms F)**

Practitioners did not use a holistic approach to assessment but assessed both cousins solely as individuals even when their complex relationship was identified. The stress caused on their relationship by them living together was never assessed.

- **Identification of and addressing possible domestic abuse / coercive control. (Mrs H)**

When considering domestic abuse, Bruce and Paul were not the stereotypical couple of young husband and wife. Despite Bruce disclosing alleged domestic abuse on a number of occasions, agencies did not always consistently raise safeguarding alerts. When an enquiry did take place the practitioner did not follow domestic abuse best practice and saw Bruce and Paul together but this was never progressed as a Section 42. DASH assessments were not completed by any agency apart from the Police.

- **Management of complex cases / Risk management (Mr I)**

Bruce was deemed to have both a learning disability and subsequent mental health problems but there was not joint approach between these services either. Paul was also known to have both mental health and physical problems but again there was no management of a potentially complex case. There was no joint management of risk. No multi-agency meetings were held until March 2017. Some agencies declined to attend this meeting as a consequence of risks not being recognised.

- **Approach to case where service user is deemed to be 'Difficult to engage'(Mr I, Ms F)**

Bruce was never difficult to engage; he volunteered and attended Drop In every week. In addition his care worker met with him every week. By contrast there was no agreed approach to engaging Paul. Instead Paul's refusal of services was accepted at face value. The paucity of strategy meetings added to this as there was no shared opportunity to explore differing views or threshold of need between practitioners.

- **Lack of clear accountability for the case between teams.(Mr I)**

There was no evidence of joint working between Paul and Bruce's case workers in Social Care and little communication until January 2017 when a new worker was asked to assess Paul. Until that point there had been no joint working between Paul and Bruce's case managers. Other agencies involved with Paul and Bruce including the GP and voluntary organisations were rarely consulted. Confusion around responsibility for assessment between WISH and Optalis is discussed in Section 4.3 below.

- **Use of capacity assessments (Mr X, Mr I)**

Paul's capacity to refuse services for himself was never formally assessed but taken at face value.

- **Ability of supervision processes to support practitioners (Ms F, Mr I)**

Supervision both in one to ones and group sessions were not used to support practitioners to engage Paul or to consider why he did not wish to engage. Likewise supervision was never used as a forum to look at the cousin's relationship.

- **Periodic Cycle of intervention and engagement (Ms F, Mr I)**

Practioners intervened with the family periodically but once a particular 'crisis' ceased e.g. when Bruce wanted to move out of the shared home then changed his mind, practioners withdrew and closed the case.

4.2 Issues not previously specifically identified in other SARs

- **Long Term Impact of Bereavement**

In the SAR Ms F, the Review Team speculated that impact of the removal and subsequent adoption of her baby could be seen as a form of bereavement and that this may have contributed to her and her families' behaviours.
Both Paul and Bruce cited the inadequacy of their shared home compared to the original family home as a factor in their disputes. Paul struggled to come to terms with moving from the family home. The impact on both Paul and Bruce their uncle/father's death and subsequent the loss of their family home could similarly be seen as bereavement but the consequences were never addressed by any agency.

- **Identification of/Assessment of Carers**

Although Paul was identified by a number of agencies as Bruce's carer and carried out a number of caring activities e.g. medication management, he was never assessed as a carer and there is no evidence that he was asked if he would like an assessment. Bruce could also have been identified as a carer for Paul. He performed a number of activities e.g. shopping and cooking for Paul who did not leave the home. Although it is recorded in Bruce's annual review in 2015 that Paul identified himself and Bruce as caring for each other, Paul was never considered to be a formal carer or assessed as such and there was no consideration of either Paul or Bruce's ability to care.

4.3 Other Issues specific to the Governance Structure between Optalis and Wokingham Borough Council

4.3.1 Some additional issues were identified as specific to the governance structure between Optalis and the initial assessment service in Wokingham Borough Council (WISH) and how the safeguarding function is managed between the two organisations. These include:

- Transfer of cases between assessment and long term teams
- Responsibility for assessment particularly assessment of carers
- The lack of clear differentiation between safeguarding investigation and assessment for service

4.3.2 New Assessments are undertaken by the WISH Team within Wokingham Borough Council, and if the referred adult is already known even though the case is not currently open, they are transferred to Optalis. Following the initial assessment by WISH, if the adult is eligible for a service, they are allocated a personal budget.

Then their case is transferred to Optalis to manage. Paul's case was opened and closed a number of times for assessment during the period under review. Because Paul was never fully assessed and also refused services the case was never transferred to Optalis.

4.3.3 If someone is identified as a carer of a service user, they may be assessed by Optalis but sometimes a potential carer will be referred back to WISH for assessment; this would also apply if the customer is not in receipt of a service. This is a clear area of inconsistency in the relationship between the two services.

4.3.4 Wokingham Borough Council has the statutory responsibility of determining if a Part 1 Alert should progress to a Section 42 Enquiry. During the period under review, the practice followed in Optalis was that Part 1's deemed not to meet the threshold were not passed to Wokingham Borough Council but simply closed or recorded as a case note. This practice has now been rectified and all alerts are passed to Wokingham Borough Council for decision whether to close or move to a Section 42 Enquiry.

4.3.5 Safeguarding continues to have some inconsistencies however. If a service user is open to a service in WISH, Optalis (or BHFT), when a safeguarding alert is made, the Section 42 enquiry is carried out by the case worker. If the adult at risk is not known to a service then the section 42 enquiry is allocated to a worker in WISH assessment team. The safeguarding team in Wokingham Borough Council retains oversight of all safeguarding alerts and agrees when no further action is to be taken in response to an alert, and completes final sign off on all safeguarding cases.

4.3.6 This split of responsibilities between assessment, safeguarding and long-term functions is still causing some inconsistency and tension between teams around eligibility threshold, e.g. is the issue safeguarding or assessment and tensions around the double sign-off, although actions are being taken to try to resolve these care governance issues.

5. Strategic Actions Already Undertaken Following Previous SARs

5.1 Introduction

5.1.1 The Findings identified above in 4.1 are complex and the Board recognised that they should be addressed by a suite of activities. This review examined the actions taken to embed learning from SARs into the multi-of the agency safeguarding system.

5.1.2 In order to address the question why learning does not appear to be embedded in practice, the Lead Reviewer examined the Board Strategy 2015-18 and Business Plans for 2016/17 and 2017/18 together with Action Plans for some of the Board subgroups.

5.1.3 The Board has developed clear and laudable objectives and priorities which 'flow' from the systemic issues identified in SARs and discussed above in Section 4. The following is just one example of the pathway followed of Board priorities and subsequent actions:

Strategy Plan 2015-18

↓

Priority 4
‘Ensure effective learning from good and bad practice is shared in order to improve the safeguarding experience and ultimate outcomes for service users’

↓

Objective 4.2
‘Improve mechanisms to critique good and bad practice and share learning more widely’.

↓

Business Plan 2016-17

↓

Business Plan 2017-18

↓

PRIORITY 3:
3.1 The workforce has the capacity, knowledge and skills to keep people safe and improve safeguarding outcomes c. Promote good record keeping

↓

Extract from Action Plan2016-17 (Actions Completed)
• Domestic Abuse event October / November, to include presentation to raise awareness of cohesive control. • Supervision audits undertaken

- Effectiveness Subgroup to review Multi-Agency At Risk Pathway& produce guidance document to help raise awareness of opportunities for practitioners to discuss complex cases within each agency.

5.2 Actions Completed

It is notable that the Board Business Plan 2016-17 action plan is 'rag' rated green overall. (The 2017-18 Plan has not yet been rag rated). Three main types of activity were identified as worthy of comment and can be explained using the examples shown in extract from the Action Plan above:

- **One Off Actions**
- **Long Term Activity**
- **Quality Assurance**

5.3 One-off Actions

Actions in the Plans tended to be 'SMART' and as a consequence were too often 'one off' and so quantifiable and thus be easily rag rated e.g. bite sized training. Stand-alone training can kick start awareness as with the example of domestic abuse training above. However, training will not get to the 'nub' of complex issues or change practice in isolation. Rather what is required is a range of activities which then follow on and build on the original message. With this example the original training could have re-enforced, for example, by discussion of identified cases in 121 supervision, at team meetings etc. to change culture and practice. This multi-pronged approach is more difficult to rag but is likely to be more effective.

5.4 Long Term Activity

Actions rated as completed in the 2016-17 Plan also included supervision audits. The green rag rating was applied but due to a template being devised in 2016-17 rather than actual audits taking place on a regular basis. Whilst audits are a useful method of reviewing any change in practice, in practice only one organisation was able to provide supervision audits to this Review. Carried out in September 2017 and again in February 2018 by one social care organisation in West of Berkshire, these were not sufficient to prove or disprove change in practice.

5.5 Quality Assurance

5.5.1 The Effectiveness Subgroup reviewed the Multi-Agency at Risk Pathway and developed guidance document. Documents were developed and subsequently also ragged as green. However there were no actions relating to check whether the pathway was being used or how practitioners valued the guidance.

5.5.2 This review found no consistent evidence of any other form of quality assurance to identify any change in practice e.g. peer reviews or audits. The Lead Reviewer struggled to identify any feedback loops developed to assess how successful actions are.

5.5.3 In addition some sub groups were more active than others. In addition attendance at some sub group meetings was poor and this issue together with Quality Assurance is addressed in the recommendations in Section 8 below.

6. Staff Surveys

6.1 Introduction

6.1.1 The SAR Panel, used Survey Monkey to send sent out a simple questionnaire to social care and community mental health social workers across Reading, West Berkshire and Wokingham in late 2017/early 2018. The purpose of the survey was to gauge practitioners own view of their safeguarding knowledge and skills.
The lead Reviewer was able to analyse responses from Reading and Wokingham and Community Mental Health Adult Social Care Teams but unfortunately those from West Berkshire were unavailable for analysis.

6.1.2 Engagement was good which evidences in itself that practitioners are willing to reflect on their own practise. Slightly different questionnaires were sent out to front line practioners and their managers as shown below.

6.2 Analysis of Responses

6.2.1 Effective supervision had already been identified by the Board as an issue for social care staff and some changes to supervision paperwork had already been agreed to support safeguarding practice, although this review saw little evidence of change in practice and some areas of concern.

6.2.2 A total of 17 responses were received from Managers with 113 front line responses and a summary is shown at Appendix 3. There was a consistent response between managers from all agencies and likewise from staff. As the responses from the other agencies were similar it is considered unlikely that the tenor of the responses from West Berkshire would have been very different.

Question 1 How confident do you feel in leading on Adult Safeguarding Work?

Unsurprisingly, as leadership is part of the job role, Managers were much more confident about their ability to lead on safeguarding than staff. 94% of managers (all but one manager) were confident or very confident in their ability to lead on safeguarding compared to 69% of staff. In comparison with Managers, the spread of confidence levels was much wider amongst staff which is not unexpected given a greater range of skills and experience amongst staff.

Interestingly comments made were similar in both managers and staff responses and focused around lack of resources and need for more guidance. This is in conflict with their assertions that they are confident and is addressed in the recommendations.

Question 2: Do you feel that your advice is understood & followed in relation to Adult Safeguarding work? (Managers)

Question 2 Do you understand the advice and guidance given by managers and are able to confidently follow it? (Staff)

This was the only question in the survey which asked something different of Managers and staff. However it was asking about the same aspect of the relationship albeit from different sides. Around three quarters of staff and managers were in agreement about advice and guidance with 74% of managers confident or very confident that staff understood them with a similar 73% of staff able to understand and follow advice. However around a quarter of managers were unsure whether their guidance was followed and a similar proportion of staff felt unable to understand and follow advice. 6% of staff were very unsure about the guidance provided which is concerning.

Managers commented that sometimes staff lacked confidence. Staff also felt recording was too complex which chimes with the managers view about staff confidence. However it was the impact of 'Making Safeguarding Personal' that stood out when it came to comments made. Managers felt some confusions with eligibility with regards to safeguarding versus the Care Act assessment existed. Staff commented that different managers gave differing advice on the need for safeguarding and eligibility for services. This is addressed in the recommendations below.

Question 3: How confident are you in knowing that a safeguarding enquiry is needed?

All managers were confident or very confident that they knew when a safeguarding enquiry was needed with 80% of staff confident or very confident. However this still leaves 20% of staff unconfident or very unconfident about when to make a referral. This implies that learning from previous SARs has not been embedded in practice. Interestingly there were no comments made by anyone regarding this question.

Question 4: What would help you to improve your Safeguarding practise?

A wide variety of interesting suggestions were given but they focused on talking to each other about practice. Managers and staff felt that processes and procedures should be easier and clearer which again suggests a lack of confidence. Both groups wanted more opportunity to discuss cases and practice for example around self-neglect and coercion and control-both issues that feature in this case. Staff also made suggestions of activities that would assist, for example discussion at Team Meetings and 'bite sized training.

Managers felt that as they no longer practice directly there was a need to discuss best practice in order to keep up to date. There was also a perception that multi-disciplinary meetings rarely occurred, again a possible impact of Making Safeguarding Personal which has been indicated in some research on the impact of the guidance.

Q**uestion 5: Is there anything else you'd like to say?**

Both Managers and staff reiterated the need for clearer and simpler processes including sign-offs and deadlines together with the need for more shared learning. The inconsistency between different Managers having different thresholds/different opinions was also raised again. The comment '*Wish Managers would respect us'*

may imply that managers don't trust staff's ability and may be another manifestation of the confidence issue. The need for continuous training about specific issues such as Domestic Abuse was also raised. Safeguarding Teams were complimented for their support of practitioners which was positive. However staff also wanted more feedback on referrals and cases from the Safeguarding Teams.

6.3 Summary of Overall Results

6.3.1 There appears to be some degree of mismatch between Staff and Managers as to how competent they felt about understanding and knowing when to raise a Safeguarding. It is interesting that despite the majority of staff and managers identifying as confident, much the greatest number of comments were about the need to have more training and joint discussions and the need to simplify processes. Both these requests are at odds with a confident and competent workforce.

6.3.2 A significant minority of staff were not confident with regard to safeguarding. They were most likely to consider the systems complex and difficult to navigate particularly threshold to eligibility. Also of concern was the staff were receiving inconsistent support and advice from different managers.
6.3.3 A number of respondents also commented that MSP was not owned by other safeguarding partners in localities which left social care teams feeling responsible and isolated.

6.3.4 The recent Thematic Reviews of SARS carried out in London (Suzy Braye and Michael Preston-Shoot July 2017) and the South West (Michael Preston-Shoot October 2017) both cite the lack of 'safeguarding literacy' that is the failure to recognise the presenting picture as one of concern. This was commonly coupled with a lack of management oversight and an absence of adequate supervision.

7. Analysis and Conclusion

'Risk is not caused by people in otherwise safe systems, Systems are not basically safe but are made safe through people's practice'.
(Dekker: The Field Guide to understanding Human Error)

7.1 Introduction

7.1.1 The West of Berkshire Safeguarding Adults Board has long recognised this premise. Consequently, the Learning Together methodology developed by the Social Care Institute for Excellence has been used to identify the gaps and weaknesses in multi-agency systems when conducting SAR's for a number of years.

7.1.2 Where the Board has not been quite as successful is in influencing the responses to those gaps and weaknesses within organisations. Whilst priorities were clearly identified, actions plans tend to default to one off actions that can easily be measured and the Board was probably too quick to sign these actions off. The Board has not held agencies to account in the longer term to ensure that there has been systemic learning. Brandon, Sidebotham et.al. (September 2011) identify this tendency in 'A study of recommendations arising from SCRs 2009-2010 '

'SCRs have become more 'specific, achievable, relevant and timely' but this has resulted in a further proliferation of tasks to be followed through. Adding new layers of prescriptive activity leaves little room for professional judgement'

7.1.3 Examples abound within Board documentation of initial good work. The example of domestic abuse training is discussed above in Section 5. But there has been no oversight of longer term activity which reinforces initial training. In the example in 5.2.2 above, supervision templates had been designed but the roll out and use of the templates have not been monitored. In addition quality assurance such as staff supervision audits were not completed consistently or analysed to provide evidence of change in practice. The issue was previously identified in SAR Mr I e.g. Finding 2:

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

7.1.4 In a safe system, the range and depth of quality assurance systems, including supervision, should be designed to pick up individual errors of judgement and challenge thinking as well. Practitioners cannot police their own biases, so need supervision and other quality assurance processes including peer audit and spot checks to bring fresh eyes and constructive challenge.

7.1.5 Essential Components of an effective Quality Assurance Framework include:

- Supervision Audits
- Case Audits
- Management Reports

The lack of robust supervision within an overall scheme for quality assurance brings professional decision making in adult safeguarding into question. Thematic file audits are necessary and when followed up can transform the quality of practice.
Often effective quality assurance is detailed in a Quality Assurance Framework which covers, amongst other things, level and types of supervision, training and audit.

7.2 How effective is shared accountability and quality of safeguarding within our work?

7.2.1 Paul demonstrates that there is some good practice in identifying abuse and neglect by agencies outside of social care. However, there is a need for improved and consistent shared accountability of safeguarding. The social care staff survey also corroborate this analysis. Staff and managers have different views of thresholds and feel that other agencies do not always consider safeguarding their responsibility.

7.2.2 In 2016 ADASS published Making Safeguarding Personal: Temperature Check, the results of a survey covering 76% of all English Local Authorities. There was no particular focus on how the adoption of MSP had impacted on the use of multi-agency strategy meetings, however the following comments from respondents highlight the issue:

'The number of formal meetings has significantly reduced as a result of MSP.'

The Board may have a view on whether this is also true in West of Berkshire but the impact of the lack of strategy meetings manifest itself in the Paul case.

7.3 The interface between the two companies (WISH and Optalis) {and other agencies e.g. GP and BHFT}.

7.3.1 Whilst Bruce was well supported individually from a range of agencies outside of social care, there was never a joint consideration of the two cousins' needs during assessments and safeguarding investigation. For example in March 2016 there were multiple safeguarding referrals by Police and other agencies but a Section 42 enquiry was never raised. Instead attempts were made to assess Paul as an individual. When he refused services the case was closed.

7.3.2 Following a safeguarding allegation in May 2016 and a subsequent Section 42 enquiry, there were no actions agreed but the case remained open until a safeguarding audit in December 2016. Paul was then allocated a new worker, and finally two meetings were held with Paul and Bruce's workers both present. These were not Section 42 enquiries however. The Police declined to attend as they incorrectly believed that there had been no recent Police involvement. However, the case continued to drift with no resolution over a number of months, due in part to the uncertainty as to which social care agency was leading.

7.3.3 In Wokingham, care governance for safeguarding may not be as systematic as it could be. In this case it was not until a safeguarding audit that case drift was picked up. Effective triage of safeguarding alerts has already been recognised as an issue by Wokingham Borough Council and there have been some attempts to address the confusion between assessment and safeguarding beyond the 10% audit required by the Board. It is too early to say whether this has been effective.

7.4 Why doesn't learning from SARs appear to be embedded within practice?

7.4.1 Complex systems involve non-linear dynamics. How things develop may often be unpredictable and unintended consequences should be expected although they rarely are. Therefore directing and achieving change is challenging. Strategic leaders need constant feedback loops in order to ascertain how things are actually playing out on the ground. Yet disconnects between strategic and operational levels occur all too easily.

7.4.2 Focus on core current guidance and good practice principles at strategic level, is not always evident on the ground. This leaves the quality of service that people locally receive may be down to luck and the individual practitioners they encounter. It also made it less likely that partner agencies act to help and protect all adults in its area who are unable to protect themselves because of their care and support needs. This was evident that Paul received an inconsistent service from practitioners who did not take his complex needs into account or consult each other often enough. Instead of identifying possible risk factors, practitioners considered Paul as able to make decisions about his own care.

7.4.3 In 2016 ADASS published Making Safeguarding Personal: Temperature Check, the results of a survey covering 76% of all English Local Authorities. The following comment is relevant here:

'However a warning was sounded by a couple of respondents that some staff had misunderstood the concept and closed cases …. failing to take into account the wider implications of coercion, for others at similar risk and the public duty to protect people.'

8. Recommendations

8.1 Leadership

8.1.1 For practitioners, professional decision making is often fraught and challenging, involving as it does a question of weighing in the balance the relationship between a person's autonomy and a professionals' duty of care. The current national system balances more in favour of the former, with the Making Safeguarding Personal agenda making it less likely that practitioners understand that they are expected to consider critically and question respectfully a person's choices and the risks inherent in them. Without overt leadership and consistent strategic direction about priorities, it is hard for practitioners to actively consider for example domestic abuse in non-stereotypical cases.

8.1.2 It is recommended that the Board should consider how it can become more adept at not only identifying systemic issues but in articulating them to practioners and how it may hold agencies to account by showing subsequent changing practice.

8.2 Review of Board Sub Groups

8.2.1 Part of the role of the West of Berkshire Safeguarding Board is to collectively hold local agencies to account for their actions including active membership of Board Sub Groups. It was evident from the review of sub groups undertaken that some were more effective than others in carrying out their activities. Some had much more robust action plans than others although most continued with 'SMART' actions rather than a recognition that a range of longer term activities were necessary in order to change systems and evidence that change.

8.2.2 The most effective subgroups are because of the personality and drive of the Chairs of those groups rather than because of active membership. This links directly to the leadership issues discussed in Section 7.1. The Board has already tasked itself to review and refresh its Strategic Plan for 2018-19.

8.2.3 It is recommended that a review of sub group roles, activities and actions be undertaken as part of the Refresh of the Strategic Plan.

8.3 Review and Development of Quality Assurance Framework

8.3.1 The Board has clearly given much thought to the complex world of safeguarding and has provided clear and unambiguous direction to organisations

and practioners about what constitutes a safe system. However the Board and partner agencies need to constantly monitor how the system is developing.

8.3.2 Without actual work within organisations and the accumulation of empirical evidence that changes have made the system safer there is no sustainability. This review has exposed the opposing demands and resource limitations that determine and constrain practitioners and managers ability to create safety.

8.3.3 All systems need appropriate and proportionate quality assurance processes to act as a systematic process of checking to see whether a service meets needs and to prevent mistakes occurring. Effective Quality Assurance includes a variety of processes which combine to measure the quality of the multi-agency safeguarding system. The Board should consider what a safe quality assurance system should look like in West of Berkshire and review the current Framework.

8.3.4 It is recommended that the Board consider how it is able to directly influence activities and responses contributing to systems development. This should include review of the Quality Assurance Framework.

8.4 Supervision Audits

8.4.1 The Board has previously agreed that effective supervision is key to safe practice. Good supervision can take a variety of forms dependant on the nature of the organisation practioners work in as well as their role.

8.4.2 Safe supervision impacts on the risks to service users. Supervision as an issue is not unique to West of Berkshire, for example, the recent review of SARS in London (Learning from SARS: A Report for the London Safeguarding Board by Suzi Braye and Michael Preston-Shoot July 2017) found that in ten of the 27 Reviews, supervision focused on service provision rather than reaching any understanding of the situation observed. '*Supervision for staff focuses primarily on case management rather than reflective practice'*.

8.4.3 Supervision audits can be used as a method of checking supervisory practice and the Board has already developed a template for audits.

8.4.4 It is recommended that Supervision Audits are carried out across social care agencies in West of Berkshire and the results reported back to the Board regularly for further consideration.

8.5 Practice Workshop

8.5.1 Following a Safeguarding Adults Review, the Board, has in the past, used a primarily *workshop based* approach for enabling the learning to be delivered direct to the front line workforce around a case. It should continue to do so as this approach enables a practical and meaningful engagement of key front line staff and managers in the development of actions to mitigate the issues identified in this case. However, increasing general awareness of an issue such as using workshops may be a good first step but it is no reason to suppose that a change will become embedded in a system and further actions are required if agencies are to become learning

organisations. Part of the development of such a workshop should include opportunities for social care practitioners themselves to embed learning in practice

8.5.2 It is recommended that a workshop based approach be used as <u>the first step</u> in learning for front line social care practitioners about this case.

8.6 Safeguarding Support for Social Care Managers

8.6.1 Supervision can take a variety of forms. Supervision may include informal or ad hoc case discussion, one-to-one clinical reflection on cases, group supervision, observation of practice, or direct instruction of activity. (Bishop (2007), NMC (2016). These processes are designed to bring check and challenge to the sense making of people directly involved in the case, in order to identify and minimise their inevitable biases.

8.6.2 It was a clear concern both by managers themselves and by staff that Managers did not always give effective support to their Teams. There are many reasons for this including time and resource implications. In the staff survey, Managers themselves identified a need for a forum for discussion about current good practice as it may have been some time since they were directly involved in case management.

8.6.3 ***It is recommended that a Safeguarding forum be developed for social care managers.***

8.6 Summary of Recommendations

It is recommended that:

- The Board should consider how it can become more adept at not only identifying systemic issues but in articulating them to practioners and how it may hold agencies to account by showing subsequent changing practice.

- A review of sub group roles, activities and actions be undertaken as part of the Refresh of the Strategic Plan.

- The Board consider how it is able to directly influence activities and responses contributing to systems development. This should include review of the Quality Assurance Framework

- Supervision Audits are carried out across social care agencies in West of Berkshire and the results reported back to the Board regularly for further consideration.

- A workshop based approach be used as the first step in learning for front line social care practitioners about this case.

- A Safeguarding forum be developed for social care managers

Appendix 1:

Care Act 2014

The Care Act 2014 requires a Safeguarding Adults Board (SAB) to undertake a Safeguarding Adult Review (SAR) if:

- ‘A*n adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) has died,*

  And

- T*here is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult.’*

The Care Act also states that: ‘*each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:*

- *Identifying the lessons to be learnt from the adult’s case,*

  And

- *Applying those lessons to future cases.’*

The Care and Support Statutory Guidance [14:138] DoH, October 2014, sets out the following principles which should be applied by SABs and their partner organisations to all reviews:

- *‘There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice,*

- *The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined,*

- *Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed,*

- *Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith,*

- *Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.’*

Appendix 2

Timetable for Paul Safeguarding Adult Review

Action	Lead	Date
Letter to key agencies to request chronologies	Board Manager	November 2017
Discussion with the family	Lead Reviewer	16/11/17
Scoping Meeting to agree Panel members, terms of reference, methodology etc.	SAR Panel chair /Lead Reviewer	18/01/18
Completion date for combined chronologies	Board Manager	25/1/18
1st Panel Meeting and Lead Reviewer briefing to agree ToR, Review the combined chronologies, Review questionnaires results.	SAR Panel	8/02/18
Family informed of SAR process	SAR Panel chair	March 2018
Analysis of questionnaires, supervision audits and previous SAR Findings. Production of draft Report	Lead Reviewer	March 2018
2nd Panel meeting to discuss draft of the report and draft SAR Findings.	SAR Panel	25/04/18
Any amendments made to final draft following Panel meeting. There will not be a formal lengthy SAR report although there needs to be an exec summary for publication in order to meet SAB's obligations	Lead Reviewer	April 2018
Final report and recommendations circulated to SAR Panel members.	Lead Reviewer	04/05/18
Meeting with family to discuss outcomes and learning	Lead Reviewer	20/06/18
Safeguarding Adults Board meets to consider final report.	Board Manager	25/06/18
SAR Panel / Effectiveness Subgroup determines multi-agency action plan from the SAR recommendations	Board Manger	31/10/18
Final report and summary of learning published.	Board Manager	TBC

Appendix 3

Summary of Safeguarding Questionnaire Responses

Summary of Manager's Responses

Q 1	**How Confident do you feel in leading on Adult Safeguarding Work**											
	Very Unconfident				**Unconfident**		**Confident**		**Very Confident**			
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**No of Responses**
Wokingham								3	1	2	1	7
Reading				1				1	4	1	1	8
BHFT								1			1	2
Total				1				5	5	3	3	17
%				6 %				29 %	29 %	18 %	18 %	*
Comments	Not sufficient resources, more guidance required											

Q 2	**Do you feel that your advice is understood & followed in relation to Adult Safeguarding work?**											
	Very Unconfident				**Unconfident**		**Confident**		**Very Confident**			
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**No of Responses**
Wokingham								2	4	1		7
Reading			1			2	1	2	1	1		8
BHFT								1	1			2
Total			1			2	1	5	6	2		17
% of Total			6%			12%	6%	29%	35%	12%		*
Comments	Some Issues re conflict re eligibility re Care Act vs Safeguarding											

	eligibility, some staff lack confidence

Q 3	**How confident are you in knowing that a safeguarding enquiry is needed?**											
	Very Unconfident				**Unconfident**		**Confident**		**Very Confident**			
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**No of Responses**
Wokingham								1	1	4	1	7
Reading							2		3	2	1	8
BHFT											2	2
Total							2	1	4	6	4	17
%							12%	6%	24%	35%	24%	*
Comments	Threshold tool, practice											

Q 4	**What would help you to improve your Safeguarding practise?**
Comments	**Managers don't often carry out safeguarding practise unlike ATMs so discussions about practical applications** More about self-neglect Easier and clearer processes Clearer process for MAPPA/MARAC **Common procedures between health and social care**

Q 5	**Is there anything else you'd like to say?**
Comments	**Easier and clearer processes** More shared learning

- Note % rounded to nearest whole number so will not always total 100%

Summary of Staff Responses

Q 1	**How Confident do you feel in leading on Adult Safeguarding Work**											
	Very Unconfident				**Unconfident**		**Confident**		**Very Confident**			
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**No of Responses**
Wokingham		2	1	4		4	13	3	14	14	5	61
Reading		2		2	2	3	5	9	12	7	3	44
BHFT						2	2	1	1	1	1	8
Total		4	1	6	2	9	20	13	27	22	9	113
%		4%	1%	5%	2%	8%	18%	12%	24%	19%	8%	*
Comments	Not sufficient resources, more guidance required, Domestic Violence more difficult											

Q 2	**Do you understand the advice and guidance given by managers and are able to confidently follow it?**											
	Very Unconfident				**Unconfident**		**Confident**		**Very Confident**			
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**No of Responses**
Wokingham	1	2	1		5	12	4	9	10	16	1	61
Reading		2				4	2	4	18	7	7	44
BHFT					1	2	1	1		1	1	7
Total	1	4	1		6	18	7	14	28	24	9	112
%	1%	4%	1%		5%	16%	6%	13%	25%	21%	8%	

Comments	Not always consistent advice, recording complex

Q 3	**How confident are you in knowing that a safeguarding enquiry is needed?**											
	Very Unconfident				**Unconfident**		**Confident**		**Very Confident**			
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**No of Responses**
Wokingham			1	4	3	4	8	11	19	9	2	61
Reading				2	2	3	2	7	16	6	6	44
BHFT					1	2	1			3		7
Total			1	6	6	9	11	18	35	18	8	112
%			1%	5%	5%	8%	10%	16%	31%	16%	7%	*
Comments												

Q 4	**What would help you to improve your Safeguarding practise?**
Comments	**Easier and clearer processes** **Clarity about processes/procedures** **Discussion with others:** at team meetings, case studies, shadowing, continuous training **Specific training** e.g. on coercion & control

Q 5	**Is there anything else you'd like to say?**
Comments	**Different Managers have different thresholds/different opinions** Wish Managers would respect us

	Sign off process not helpful; too long/complex, deadlines too short **Feedback on cases**

Appendix 4

Relevant Reviews and SARs Completed By West of Berkshire Safeguarding Adults Board

X

Reported to the Board in January 2017

X appeared have some degree of Learning Disability and lived a chaotic lifestyle. He had Warnings on PNC for mental disorder, self-harm, weapons and drugs. He had 17 convictions and two cautions between 1985 and 2015 for offences including criminal damage, theft and related offences, drugs and firearms. A Criminal Behavioural Order was applied for in relation to Anti-Social Behaviour (March 2015).

X attempted suicide in April 2015 by jumping out of a window and received serious injuries, including injury to his brain. A referral was made to the Community Mental Health Team and he spent two months in hospital. He was made subject to Section 136 after a disturbance in a chemist and taken to Prospect Park Hospital. A further referral was made to CMHT.

Issues identified of relevance to Paul:

- There were complex relationships, interdependencies and possible domestic abuse / coercive control between X and his two cousins.
- Management of complex cases / Risk management
- Supervision processes are not supporting practitioners to work with the complexity of capacity decisions
- Approach to case where service user is deemed to be ‘Difficult to engage’

Mr I

Reported to the Board in July 2016

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 the services and was aggressive to visitors including the regular care staff. The Police were often used to check on Mr I’s welfare. He died unexpectedly in June 2015 and was found in his home several days later by the police.

Issues identified of relevance to Paul:

- Lack of clear accountability for the case between teams.
- Approach to case where service user is deemed to be ‘Difficult to engage’
- Management of complex cases / Risk management
- Needs presented by an individual service user do not neatly meet the criteria of existing teams

- Supervision processes are not supporting practitioners to work with the complexity of capacity decisions

Ms F

Reported to the Board in July 2014

Ms F was a 22 year woman who died of sepsis in May 2013. Her baby had been removed and consequently adopted in October 2011. With the exception of her GP, her case was not open to any service until just before her death, when she was referred to Adult Social Care by the Police. Other members of the household were well known to many services in Reading including the Learning Disability Service, Antisocial Behaviour and the Police, both as victims and perpetrators.

Issues identified of relevance to Paul:

- Needs presented by an individual service user do not neatly meet the criteria of existing teams
- Strong interdependency between members of the family went unrecognised
- Impact of assessment of individuals rather than assessment of the family
- Periodic Cycle of intervention and engagement
- Professional engagement focused on other individuals in the family unit
- The impact that an individual's presentation can have on assessments of vulnerability

Appendix 5

Glossary and explanation of terms

Term	Explanation
ADASS	Association of Directors of Adult Social Care
ASC	Adult Social Care
BHFT	Berkshire Healthcare NHS Foundation Trust provides community based physical and mental health services in Berkshire.
Care Act 2015	The Care Act 2014, which came into effect from 1st April 2015 reformed social care and support. The aim was to put people and their carers in control of their own care and support.
CSP	Community Safety Partnership is "An alliance of organisations which generate strategies and policies, implement actions and interventions concerning crime and disorder within their partnership area".(A guide for Police and Crime commissioners)
DASH	DASH stands for domestic abuse, stalking and harassment. When someone is experiencing domestic abuse, completion of a DASH is an assessment of the risks in the form of a checklist used by a variety of agencies.
GP	General Practioner
IMCA	Independent Mental Capacity Advocate-an independent person who supports a service user to voice their own decisions when they lack capacity to do so.
Making Safeguarding Personal (MSP)	An Adult Social Care sector led initiative, developed following safeguarding principles set out in the Care Act 2014 in order to enable safeguarding to be done with, not to, people, and to move away from a process of 'investigation' and 'conclusion ' towards one which enables all concerned to know what difference has been made.
Mental Health Act Section 136	The police can use Section 136 when they think someone has a mental illness and needs care or control. They are able to take someone to a place of safety using this section of the Mental Health Act.
Mental Health Act Section 2	Section 2 provides for someone to be detained in hospital under a legal framework for assessment and treatment of their mental disorder.
Mental Health Act Section 3	Section 3 is a "treatment order" that allows for detention for treatment in the hospital. The person must be suffering from mental disorder and also that there is risk to their health, safety of the

	service user or risk to others. which warrants their care and treatment in hospital
MCA	Mental Capacity Act, 2005 provides the statutory duty of agencies to formally assess capacity whenever there is a concern that a person may lack the mental capacity to make decisions regarding their care and treatment arrangements.
Optalis	Optalis is Wokingham Borough Council's trading arm which provides longer term support for older people and people with a disability in Wokingham.
RAG	Stands for Red Amber Green: The traffic light is a simple method of assessing progress of an action plan.
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
Section 42	An **enquiry** is any action that is taken (or instigated) by a local authority, under **Section 42** of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.
SMART Actions	The acronym **SMART** is used often to define **goal** setting: S - specific, M - measurable, A-achievable, R-realistic, T-timely.
SW	Social Worker
WISH	Wokingham Integrated Social Care and Health Team is part of Wokingham Borough Council and provides initial assessment of the needs of older people and people with a disability in Wokingham