Information Classification: PUBLIC

# Thematic Review for the Cornwall and Isles of Scilly Safeguarding Adults Board

**Chris Robson**

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## Appendices

## 1. Introduction

This, the Safeguarding Adults' Review (SAR), was initially commissioned in 2020 by the Cornwall and Isles of Scilly Safeguarding Adults Board. The Safeguarding Adults Board (SAB) commissioned a thematic review following a number of cases in which vulnerable, elderly people died or were admitted to hospital with safeguarding concerns present. Each case, whilst having its own distinct issues, exhibited themes that were similar to the others being considered. The 'starting point' for the SAB was the fact that each of the individuals had a 'non-paid' carer or lived unsupported. Several other common factors will be examined in this report.

The reviewer was provided a Terms of Reference a copy of which are attached at appendix A. Due to the unique circumstances created by the Covid 19 pandemic the review has not been able to utilise a multi-agency panel. Instead, the reviewer has held regular meetings with the SAB Board Manager and senior colleagues from the Partnership. This has provided opportunities to update on progress and seek views / information.

The process suffered unexpected and unavoidable delays because of the COVID pandemic, with agencies prioritising the immediate safeguarding threats that resulted in the unprecedented times that we all experienced. It is to the SAB's credit that they persisted with the review and saw it as an opportunity to ask for an additional case to be considered.

The SAR considers the circumstances in seven separate cases. A brief outline of each case is contained within the report for context, but the review seeks to examine the systemic issues that have impacted on individuals. This approach means that it is not possible to go into the detail of each case. The reader should note that the lack of detail does not, in any way, seek to diminish the impact of what happened to individuals, family, friends and professionals involved. The methodology seeks to capture systemic learning that can improve practice and outcomes for individuals for the future.

A hybrid approach was adopted seeking information from agencies through written reports (chronologies and individual management review reports (IMRs)), practitioner events and one-to-one interviews which explored process, policy and key practice events.

The review has examined key practice episodes across all agencies, concentrating on professional practice, multi-agency working and impact on individuals. This has afforded the review the opportunity to identify common themes, maximise reflection and learning for individual agencies and the wider partnership.

## 2. The Cases

A total of seven separate cases have been considered in this review. This section of the report gives a brief overview of all seven cases.

This Thematic Safeguarding Adult Review (SAR) has considered the circumstances of 7 individual adults who lived in Cornwall. Of course, each case was unique to the individuals' situation and what happened to them. Our sympathy goes out to the families of these 7 individuals. However, there were some similarities in the circumstances, particularly as in each case, an unpaid carer was involved in providing varying levels of support, personal care and emotional well-being support to an adult at risk.

These unpaid carers were often family members, who through their relationship and close historical proximity took on the carer's role. These carers were also in need of, or in receipt of community-based services from health and social care themselves and were, at times, diagnosed with complex mental health issues and/or learning disabilities.

In some of the cases, there appears to have been a lack of consistency in effectively assessing the individual's capacity to consent to their support, care, treatment. There was also lack of clarity in identifying when there was a need for advocacy support to ensure that the vulnerable person's voice was heard.

Potentially, this led to a lack of consistency in safe, quality services being delivered to adults at risk, as identified through their assessed needs, and their subsequent support and care plans as completed by health and social care agencies.

In some cases, this may have led to carers managing complex, risky situations on an ongoing basis, that resulted in the individual at risk becoming "invisible" and not being known to health and social care services until there was a breakdown of the situation, a crisis or a serious incident.

In acknowledging the need to ensure the well-being of all the individuals involved is maintained and supported, an assessment of the unpaid carers as potentially "an adult at risk" in their own right should be considered at an early stage. This should also consider the impact if this carers arrangement breaks down and what contingency planning would be required. We recognise the invaluable role that family carers provide to their loved ones but we also need to ensure that services support family members to provide this care in a safe way to meet the needs of the individual.

### *Issues identified in these cases*

- Unpaid carers who were reluctant to accept support from statutory agencies.
- Lack of formal intervention following multiple referrals.
- No apparent consideration of cumulative risk to the individual.
- Apparent lack of consideration as to the vulnerability / suitability of the carer.
- Disguised compliance and lack of professional challenge / curiosity resulted in avoidable risk.
- Lack of professional intervention / referral following failure to engage may have resulted in lost opportunities to safeguard.

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## 3. Analysis of the information

The information which forms the basis for this analysis is limited to referral forms and chronologies. There is, however, sufficient detail to evidence 'common themes' across the cases which provide the SAB with an opportunity to consider learning and multi-agency practice improvements.

The analysis is enhanced by the information gleaned from focus groups where the cases were used as case studies to understand, in more general terms, practitioner and manager's view of practice. This also afforded the opportunity to examine systemic issues and operational challenges faced in this field of multi-agency safeguarding.

This review would seek to highlight the apparent difficulties in General Practitioner (GP) engagement in the review process. In many of the cases reviewed there was significant contact with the individual's doctors. The review sought to engage them through inclusion in focus groups. When this was unsuccessful the reviewer drafted a short set of questions designed to illicit their views. No information was ever returned. Whilst it is accepted that this group of professionals are under extreme pressure due to the unique circumstances, we find ourselves in, the priority of seeking improvement through Safeguarding Adult Reviews is key to delivery of best practice for patients and their families. The lack of engagement by this key group is significant and may result in gaps both in terms of information received and context.

**Recommendation 1 – The SAB seek urgent reassurance from GP's that they will commit to the process of Safeguarding Adult Reviews. This should include consultation with GPs to design the best possible system for their engagement in the process.**

## 4. The Common Themes

As already stated, whilst it is acknowledged that each of these cases involved issues that were specific to the individuals involved, the review did identify a number of common themes. These themes, through their repetition, offer the greatest opportunity to consider systemic learning. The themes were highlighted through the analysis of information provided, discussed in detail at the practitioner's event, were the subject of a written document seeking the views of General Practitioners (not returned) and discussed with other interested parties on a one-to-one basis. Each will now be examined in turn:

A. *Evidence of a lack of professional challenge and / or an acceptance of disguised compliance.*

Almost all of the seven cases presented evidence of a lack of professional challenge that resulted in missed opportunities to provide support and intervention. This ranged from professionals simply accepting the accounts given by vulnerable adults and / or their carers to appearing not to question why multiple referrals were being made.

This theme was discussed at length by a multi-agency practitioner focus group. The majority of agencies represented highlighted that training that was aimed at improving professional curiosity was in place. Police colleagues highlighted training in the Domestic Abuse arena whilst health representatives spoke about 'courageous conversations' training being

provided in children's safeguarding. This discussion also highlighted the barriers, some of which are undoubtably systemic, that practitioners face when tackling difficult conversations or issues of disguised compliance.

There was a general acknowledgement that whilst practitioners were highly skilled and motivated, they were often dealing with 'clearly vulnerable but fiercely independent people'. This coupled with the continuous issue of people who have capacity but make unwise decisions is something that requires high levels of skill, knowledge and training to overcome. It is apparent that there is a lack of multi-agency training in this essential area of practice. This is particularly challenging when vulnerable adults are presenting with fluctuating levels of capacity.

It is equally clear that where practitioners are working to, or above capacity, disguised compliance or accepting poor decisions is liable to be more prevalent. Whilst it would be wrong to make a sweeping assumption that this happens in all cases (it clearly does not) the cases examined in this report give cause for concern.

**Findings**

There is a lack of multi-agency training that affords practitioners an opportunity to develop their skills in this key area. Much of the training provided is subject specific and does not provide an opportunity for broader application. This leaves practitioners vulnerable to not being in possession of all of the facts and missing opportunities to put interventions and support in place.

This lack of training offer, when combined with a lack of guidance regarding 'capacity' versus 'unwise decisions', can lead to practitioners and managers being averse to engaging individuals and carers in challenging conversations. This in turn leads to increased risk through lack of intervention.

The issue of workload carried by practitioners will undoubtedly affect their ability to recognise and challenge disguised compliance or other similar threats. It is essential that, particularly given the increased pressures associated with the current pandemic, professionals are afforded the time and opportunity to make informed decisions having had, where necessary, challenging conversations.

Challenge cannot be the sole responsibility of one agency. It is essential that everyone involved with vulnerable adults is aware of the importance such conversations have in the management of risk. From the cases reviewed there is evidence that referrals lacked evidence of such conversations making it more difficult for those who must assess risk to do so.

**Recommendation 2 - The multi-agency training offer should be reviewed, and consideration given to the above findings. Any re-design should consider existing good practice / bespoke training used by individual agencies. It should also deal with issues of capacity and how they should impact on challenging conversations.**

**Recommendation 3 - The SAB should satisfy itself that measures are in place within agencies to ensure that case numbers and capacity are managed. It should promote a culture where professionals are supported by managers, peers and colleagues from other agencies to have sufficient time to make sound, evidence-based assessments.**

**Recommendation 4 - The SAB should consider how it can disseminate learning from this review to a wide-ranging audience of those involved in safeguarding, emphasising the need for early challenge and the positive impact this can have on**

**risk assessment and outcomes. This should include a seven-minute briefing highlighting the common themes.**

*B. Lack of consideration regarding cumulative risk*

Over half of the cases considered in this review involved multiple referrals and / or contacts with safeguarding professionals. The existence of a number of safeguarding concerns, in some cases over a protracted period of time, should raise concerns and have an impact on the assessment of risk for the individual. The cumulative effect of persistent contact with, or presentations to, safeguarding professionals should be considered as a significant safeguarding issue.

Evidence gleaned during this review has made it clear that each individual agency has policies in place to deal with this issue. Representatives talked openly about the fact that systems are in place to 'recognise multiple referrals', 'frequent callers' and 'high intensity users'. These cases were monitored or flagged and then supervision models would be implemented. The application of thresholds on an individual case basis was considered to be a risk, this is increased by practitioners having autonomy to sign off cases without supervision.

**Finding**

It is clear that despite adequate policy to deal with the issue over half of the cases considered by the review involved multiple referral / contacts. This should have raised safeguarding concerns and increased risk assessment. If policy is clear, then implementation and management oversight should be considered.

**Recommendation 5 - The SAB should seek assurance from all safeguarding partners that they have policy in place that deals with the impact of cumulative risk through multiple contacts or referrals. Consideration should be given to conducting a multi-agency audit of cases with these features to consider systemic practice or policy issues that may exist. This will afford an opportunity to test existing policy and application, learn from good practice and identify areas for improvement.**

*C. The existence of safeguarding issues 'in plain sight'*

The issue of vulnerable adults who are exhibiting behaviours or have visible signs that raise safeguarding concerns within their own communities is an ongoing issue for all SABs. In all seven cases reviewed there is strong evidence that the individuals concerned would have exhibited visible signs of neglect or distress within their local communities. Some exhibited signs of self-neglect whilst others were in situations where concerns were raised about their care. In at least one case this manifested in a carer shouting verbal abuse at her father.

The fact that more referrals were not received is perhaps not at all surprising. Neighbours, friends and other members of the community often fear making such referrals for a number of reasons. The current pandemic has highlighted further the need to engage with our communities and ask them to be our 'eyes and ears', ultimately taking responsibility for safeguarding all vulnerable people, this of course has now long been the mantra of the children's safeguarding partnerships who have used the strap line '***safeguarding is everyone's responsibility'*** for some considerable time. Greater community engagement during the pandemic has resulted in successful media campaigns such as ***'see something,***

***hear something, say something'*** ensuring that the community take responsibility for reporting concerns to professionals.

These seven cases highlight the need for a sustained campaign aimed at raising awareness and responsibility in Cornwall and the Isles of Scilly. The safeguarding issues that must have been apparent received surprisingly low attention from members of the public. Had they been reported more frequently or earlier then interventions could have taken place that would have improved the chances of better outcomes. It is recognised that any such campaign would need to address issues such as confidentiality, understanding and confidence if it was to be successful. Existing models in the children's safeguarding arena would show good practice and could be used to inform any work done.

**Finding**

It is clear from descriptions of behaviour, appearance and care given that members of the community would have been aware of safeguarding issues in each of these cases. Despite this there was not a significant number of referrals made. This indicates a gap in reporting and intelligence gathering in safeguarding cases. Increased reporting by communities would afford professionals greater opportunity to reduce risk and support vulnerable adults.

**Recommendation 6- The SAB should consider a multi-agency campaign aimed at increasing community engagement and awareness. Any such campaign would require significant research, planning and implementation. The benefits of community engagement would be significant for adult safeguarding**

*D. Unpaid carers, their suitability, assessment and support.*

In four of the seven cases reviewed the vulnerable adult lived with family members. In two of the cases, it is clear that the family member provided care, or the expectation would have been that they provided care. In two other cases family members were present in the family home.

The issue of wide-ranging acceptance that a family member will provide appropriate care for an individual is raised in this review as an area of significant concern. It is absolutely accepted that the vast majority of individuals will be cared for to the highest standards by family members who will provide care, love and support in abundance. However, this review and the papers supplied, illustrate cases where families known to services are not subjected to adequate assessment resulting in lack of support and interventions.

Some cases did show that carers are provided with support, specifically in terms of respite care. That said, there was little evidence of engagement with the voluntary sector. Carer's representatives who took part in the review spoke of the need for support for family members who often face considerable emotional, physical and financial strain. Such support would normally follow assessment from professionals. The review found little evidence of coaching or monitoring of carers in the cases it considered. Again, it is the view of the review that such assistance would be given post assessment.

The way in which we define carers and quantify hours of care required to reach set criteria brings with it some difficulties. In many cases family members will not classify or label themselves as carers. They will not receive allowances, support, or assessment for the role they are playing. The impact of this can, as evidenced in some of the cases reviewed, have serious consequences for vulnerable adults. Practitioners were keen to emphasise that this lack of assessment can have a negative impact on those in the caring role often leaving

them in situations that have major influences on outcomes for their own lives.

What is clear is that when safeguarding concerns are raised it is essential that consideration is given to carers, whatever their status or relationship to the adult, being assessed. The need for assessment of family members can be lost because of issues raised in theme one '*professional challenge and disguised compliance'.* This review acknowledges the complex nature of trying to assess if a relative is suitable to care for an individual, particularly in circumstances where vulnerable adults maintain that the care, they are being provided with is adequate. Professionals drew a comparison to assessments carried out in children's safeguarding where evidence would point to a more robust application of carers' assessments.

The complexity of the issue is increased when professionals consider legislation and guidance on the subject. There is a careful balance that needs to be managed when professionals consider the six principals of the Care Act. Each one of these principals, when considered in isolation, could lead to professionals taking opposing courses of action. However, in the cases reviewed, a holistic approach that empowered individuals whilst considering the other five principals may have led to different plans, interventions and support being put in place. The Care Act, Article 8 HRA and Mental Capacity Act also need to be considered. One of the cases reviewed (RW) highlighted the conflicts that can occur when managing individuals who insist that their care is being adequately provided. Safeguarding professionals are often called upon to make judgements in situations where vulnerable adults, who have capacity, appear to be making poor decisions. The Mental Capacity Act Codes of Practice deals with this as one of its key principles '*a person is not to be treated as unable to make a decision merely because he makes an unwise decision'*. It is therefore of paramount importance that where safeguarding issues exist carers, whatever their relationship, are assessed regarding suitability and support. Such assessments would result in greater recognition of risk, prevention of escalation through support and better outcomes for all the individuals concerned.

The scope of this review was limited to seven cases and there is no evidence to support any supposition that this is an endemic issue for Cornwall and the Isles of Scilly. That said, it is imperative that the SAB assures itself that this is in fact the case.

**Findings**

There is evidence that conflict between aspects of the Care Act can result in carers not always being adequately assessed. This may be more prevalent in circumstances where family members are the main carers for individuals. It is imperative that this hypothesis is tested by the SAB and action taken if it is found to be the case.

**Recommendation 7 - The SAB seek assurance from all partners that they take steps to assess or contribute to the assessment of all carers where safeguarding concerns are apparent.**

**Recommendation 8 - The SAB should seek assurance that agencies have clear policy and practice guidance in place to guide practitioners when dealing with such assessments. They should ensure that this policy is widely understood and offers support to staff who are dealing with these circumstances.**

**Recommendation 9 - The SAB commissions an audit of existing adult safeguarding cases where carers are relatives or unpaid. This audit should examine if individuals are being subjected to a formal assessment. If not, what rationale is provided and**

**what support is being offered by the Partnership to inform the decision made. This will inform the SAB regarding the extent of this issue and if further action is required.**

*E - Agencies were working in silo.*

Throughout the cases there was evidence of agencies working in silo with little evidence of a multi-agency approach. It was difficult, from the papers provided, to see a systemic approach to address the presenting concerns. Agencies often took responsibility for safeguarding issues that fell in their own areas of expertise but did not promote a holistic approach, identifying and utilising partner agencies to protect vulnerable adults.

Perhaps the clearest example of this is that of presentations made to GPs and other community health care providers. In over half of the cases examined there was evidence of frequent contact with community health care professionals. In all cases the individuals were treated for their illnesses but other than referrals to ASC there was little evidence of other agency support being considered.

Whilst it is clear that agencies provide professional care to individuals who present to them the lack of partnership consultation, information exchange and interventions is of concern. Little evidence of multi-agency planning meetings, exchange of ideas or identification of support outside of statutory agencies was evident. Only one of the seven cases involved the vulnerable adult being supported by the voluntary sector. It is of note that in this case it was the voluntary sector who alerted statutory agencies to a number of safeguarding concerns. The overriding view gleaned from the information presented was that as soon as an agency had dealt with the issue with which they were presented they simply withdrew from the safeguarding process.

Practitioners from across all agencies spoke about a lack of consistency of approach within the adult safeguarding arena. They believed the Partnership dealt well with crisis work but were clear that other cases were not always subjected to equal multi-agency measures. Concerns regarding referral pathways and simply 'not knowing who to speak to' were also raised.

Those who attended the focus group raised the apparent disparity between children and adult safeguarding. They spoke about the difference in terms of contact between agencies and well-established multi-agency referral pathways. *'Will we ever reach equitable status with children's safeguarding?'* Whilst this is an understandable comparison to make it could also be used by the SAB to emphasise the benefits of working in partnership. Many safeguarding principals are transferable between children and adult work, it therefore follows that some of the good practice could be adapted to improve outcomes for vulnerable adults.

**Finding**

There is evidence that agencies worked in silo in many of the cases reviewed. This review does not make any adverse comments regarding the level of service provided to individuals who presented with specific issues or complaints. It is however apparent that little action followed to galvanise a multi-agency plan to deal with underlying, long-term issues. This appears to be primarily due to a lack of knowledge regarding referral options, pathways and individual points of contact. This lack of multi-agency planning, and intervention limits options open to professionals and risks less well-informed judgements being made regarding individual's circumstances. This in turn impacts on risk and can adversely affect outcomes.

**Recommendation 10 - The SAB consider forming a multi-agency task and finish group to examine how greater multi-agency work can be promoted across the Partnership. This should examine short, medium and long-term goals that will improve practice. Easily achieved changes such as published points of contact, referral pathways and a directory of non-statutory partners who can add value should be prioritised. Long term strategies for improvement including policy, practice guidance and training would follow.**

## 5. Conclusion

It is important that the reader of this review recognises the limitations placed on a reviewer to acknowledge the impact the circumstances described will have had on individuals, families, friends and practitioners. A thematic review cannot deal adequately with each individual case and therefore this report seeks to identify and examine common systemic issues that arise out of these cases. It is clear from the information provided that each case will have caused sadness and impacted on those involved. The reviewer hopes that this report and the improvements it seeks to make to multi-agency safeguarding will have a positive impact on all concerned.

The review was commissioned to examine seven cases. A number of common themes have been identified and recommendations made to the SAB. These recommendations are made to improve practice, disseminate learning and seek assurance about existing guidance and policy.

It is abundantly clear that Cornwall and the Isles of Scilly have some exceptional individuals involved in adult safeguarding. The review was given clear examples of existing policy, practice guidance and training that should impact on many of the themes that exist. The challenge therefore is to examine why this has not been the case when dealing with these seven vulnerable people. The themes are such that it is highly likely they will reach beyond these seven cases. It is imperative that the SAB provides appropriate scrutiny and support to improve practice across all agencies and in turn improve outcomes.

**Appendix A – Terms of Reference**

# Thematic – Safeguarding Adults Review (SAR) Terms of Reference:

## Background:

It has been considered that although these SAR and LFE (Learning from Experience) cases are unique to individuals' circumstances and outcomes there is in each case an unpaid carer involved that provided varying levels of support, personal care and emotional well- being support to an Adult at risk.

These carers were often family members who through their relationship and close historical proximity took on the carer's role, they were also in need or receipt of community-based services from health and social care themselves and were at times diagnosed with complex mental health issues and/or learning disabilities.

This potentially led to a lack of consistency in safe quality service delivery to adults at risk in-line with the assessments support and care plans completed by health and social care agencies. This in some cases may have led to carers managing situations on an ongoing basis resulting in individuals becoming "invisible" and not being know to health and social care services until there was a breakdown of this situation or a serious incident.

Although there is acknowledgement of the need to ensure that the well-being of all individuals involved is maintained, there also seems to be a lack of consistency in identifying these carers as adults at risk themselves and the consideration of the impact if this carers arrangement breaks down and contingency planning.

## The Safeguarding Adults Review:

This Safeguarding Adult Review is needed to establish what lessons can be learned from how agencies worked individually and together to safeguard and protect carers and adults at risk.

The purpose of the SAR is **not** to hold any individual or organisation to account and other processes exist for that purpose. The focus of the review is to identify any lessons to be learnt from the case and apply those lessons to future cases.

The areas that this review will address are set out below. With regards to lessons learned, the review will set these out very clearly as a summary and set of recommendations which will be produced at the end of this review. It is expected that these recommendations and learning points will be taken forward and regularly monitored.

This SAR review follows the process and principles as set-out in **SAR Quality Markers** that are intended to support commissioners and lead reviewers to commission and conduct high quality reviews. Covering the whole process, they

provide a consistent and robust approach to SARs. The Quality Markers are based predominantly on established principles of effective reviews / investigation as well as experience, expertise, and ethical considerations.

**This review seeks to:**

- Establish whether there is learning from these cases circumstances which will include considering the way professionals from across the range of services worked together to identify the importance of a carer's role, their level of input, how sustainable this resource was and what support/assessment/treatment each carer needed from the multi-agency teams involved.
- Establish based on the evidence available if there could have been possible better outcomes for individuals if support to carers was improved by all agencies that were involved.
- Consider these situations against current legislation and support available to carers from commissioned services and charitable organisations/volunteers.
- Review the effectiveness of the relevant agencies policies and procedures with particular regard to identifying, assessing and supporting carers well-being and needs when supporting an adult at risk.
- What training, coaching mentoring and monitoring checks carers need to receive to function effectively.
- Were GP appointments missed, was the person disengaged with health professionals and what actions were taken by the practice when this was noted, what impact did this have on the individual and the outcome.
- Make findings and recommendations under the 6 key principles of the care act

**Appendix B Recommendation grid**

| Recommendation | Lead Agency | Action | Outcome |
|---|---|---|---|
| **Recommendation 1** –<br><br>The SAB seek urgent reassurance from GP's that they will commit to the process of Safeguarding Adult Reviews. This should include consultation with GPs to design the best possible system for their engagement in the process. | CCG | | |
| **Recommendation 2 –**<br><br>The multi-agency training offer should be reviewed, and consideration given to the above findings. Any re-design should consider existing good practice / bespoke training used by individual agencies. It should also deal with issues of capacity and how they should impact on challenging conversations. | SAB Training Lead | | |
| **Recommendation 3 –**<br><br>The SAB should satisfy itself that measures are in place within agencies to ensure that case numbers and capacity are managed. It should promote a culture where professionals are supported by managers, peers and colleagues from other agencies to have sufficient time to make sound, evidence-based assessments. | All | | |
| **Recommendation 4 –**<br><br>The SAB should consider how it can disseminate learning from this review to a wide-ranging audience of those involved in safeguarding, emphasising the need for early challenge and the positive impact this can have on risk assessment | SAB Training Lead / Board Manager | | |

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| and outcomes. This should include a seven-minute briefing highlighting the common themes. | | | |
| **Recommendation 5 –**<br><br>The SAB should seek assurance from all safeguarding partners that they have policy in place that deals with the impact of cumulative risk through multiple contacts or referrals. Consideration should be given to conducting a multi-agency audit of cases with these features to consider systemic practice or policy issues that may exist. This will afford an opportunity to test existing policy and application, learn from good practice and identify areas for improvement. | All | | |
| **Recommendation 6-**<br><br>The SAB should consider a multi-agency campaign aimed at increasing community engagement and awareness. Any such campaign would require significant research, planning and implementation. The benefits of community engagement would be significant for adult safeguarding. | SAB | | |
| **Recommendation 7 –**<br><br>The SAB seek assurance from all partners that they take steps to assess or contribute to the assessment of all carers where safeguarding concerns are apparent. | Adult Social Care | | |
| **Recommendation 8 –**<br><br>The SAB should seek assurance that agencies have clear policy and practice guidance in place to guide practitioners when dealing with such assessments. They should ensure that this policy is widely understood and offers support to staff who are dealing with these circumstances. | Adult Social Care | | |

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| **Recommendation 9 –**<br><br>The SAB commissions an audit of existing adult safeguarding cases where carers are relatives or unpaid. This audit should examine if individuals are being subjected to a formal assessment. If not, what rationale is provided and what support is being offered by the Partnership to inform the decision made. This will inform the SAB regarding the extent of this issue and if further action is required. | SAB | | |
| **Recommendation 10 -**<br><br>The SAB consider forming a multi-agency task and finish group to examine how greater multi-agency work can be promoted across the Partnership. This should examine short, medium and long-term goal that will improve practice. Easily achieved changes such as published points of contact, referral pathways and a directory of non-statutory partners who can add value should be prioritised. Long term strategies for improvement including policy, practice guidance and training would follow. | All | | |