Safeguarding Partnership Board

Report from a Review of Safeguarding Adults Arrangements in Jersey

October 2018

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Contents

1 Executive Summary

1.1. The Independent Chair of the Safeguarding Adult Partnership Board (SAPB) commissioned an independent review of Jersey's safeguarding adult arrangements.

1.2. The objectives of the review were:

1. To understand how the multi-agency partnership is identifying and responding to safeguarding adults in Jersey
2. To understand what outcomes are being achieved for adults at risk of abuse in relation to their well-being and protection and whether responses reflect Making Safeguarding Personal[1].
3. To identify strengths and barriers to effective partnership working.

1.3 The review applied an adapted sector led improvement tool based on the Adult Safeguarding Standards 2015.[2] Information was drawn from a case file audit, interviews with adults and carers who had used services; interview with practitioners and senior managers; focus groups and consideration of policies, procedures and data.

1.4. The findings were grouped under the following inter-connected areas:

Summary of Findings:

1.5. Preventative approaches are important to address factors that may increase the person's vulnerability to abuse or neglect. However, there is a need to distinguish between this wider preventative work and incidents where abuse or neglect has occurred (or is likely to occur), that requires a response through referral to the Safeguarding Adults Team (SAT).

1.6. The review highlighted that safeguarding adults procedures were being used in the absence of alternative effective mechanisms to manage complex needs. The absence of a robust multi-agency process to manage complex cases outside of safeguarding adult criteria, resulted in:

- Failures to resolve the adult's risks and care and support needs
- High cost to services through the adult's repeat attendances, escalating needs and behaviours

[1] Making Safeguarding Personal is a personalised approach that enables safeguarding to be done with, not to, people. https://www.local.gov.uk/topics/social-care-health.../making-safeguarding-personal
[2] An improvement tool developed by developed by: Association of Chief Police Officers (ACPO); Association of Directors of Adult Social Services (ADASS); Local Government Association (LGA);

- Inappropriate use of the scarce SAT resource
- Damaged partnership relationships as individual agencies are denied support from other services

1.7. There is a need to develop a clearer strategy for responding to different levels of need that incorporates prevention and early help as well as responses through safeguarding procedures to abuse and neglect.

1.8. The current restructuring in Jersey[3] offers an opportunity to coordinate and mobilise community, voluntary, parish and State services, setting out what the 'offer' is from these agencies to work together, providing better outcomes for the adult and more effective use of combined resources.

1.9. There is evidence of the SAT endeavouring to work in line with Making Safeguarding Personal The feedback from adults who had been helped through safeguarding services, by enlarge, demonstrated they had valued the response they received. However this is largely despite the systems that the SAT operate in rather than because of them. There is a need for a wider cultural shift by all agencies to the adult's informed consent and involvement in the safeguarding response from the outset. This needs to be supported by reasonable adjustments and adequate provision of advocacy.

1.10. The data set needs to be developed to capture whether safeguarding adults is making a difference to people's lives. Currently it is weighted toward outputs, with minimal qualitative information that could then be used to inform the SAPBs strategy.

1.11. The Safeguarding Adult Partnership Board multi-agency procedures were last updated in 2016 and it is recognised are in need of updating. They currently do not provide the platform to support agencies in carrying out safeguarding adult's responses in the way that they would wish. Currently the procedures are process driven and overly focused on investigative findings as opposed to management of risk and the changes the adult may want in their life.

1.12. There was also some evidence that safeguarding responses can be episodic and disconnected from other aspects of care. Recording systems do not flag repeat referrals and build a chronology that can inform the risk assessment. There were examples of cases being closed before the efficacy of a safeguarding plan had been assurred. There were some instances of a lack of safe transitions to other services and following through on restorative care that could result in more sustainable improvement in the adult's wellbeing. This reportedly was due to a pressure in Health and Community Services (HCS) to close cases early.

1.13. The introduction of the new Care Regulations provides an opportunity to develop the interface between regulators, providers of care and the SAT. The current absence of regulation within State providers has resulted in an inequitable system for responding to safeguarding concerns. There is also an opportunity to improve data analysis and information sharing to identify emerging concerns about the quality of care in a single provider. Improved data analysis may

[3] Chief Executives Six Month Report to States Assembly https://www.gov.je/SiteCollectionDocuments/Government and administration/R Chief Executive's six-month report to States Assembly 20180709 CK.pdf

also identify themes across the sector that may indicate a need for whole pathways service improvement work.

1.14. Members of the SAPB saw partnership working as a strength in Jersey and this was apparent in the ethos of organisations and evidenced in some of the practice examples the review saw.

1.15. Building strong multi-agency relationships is fundamental to good safeguarding practice and will be even more key within an island environment. There were many very good examples of multi-agency working. However, when there are the inevitable conflicting views about a case response, custom and practice has been to involve senior managers and ministers at an early stage, rather than use the SAPB escalation process. This risks disempowering front-line managers in their role of supporting staff in constructive resolution.

1.16. There were also some organisational tensions within HCS in relation to the respective roles of the SAT and the health safeguarding adults team. HCS is an integrated service but this was not always evident in the functioning of the teams. The combined expertise of these teams has the potential to make a real difference in safeguarding adults and further work is needed to enable them to work more effectively together to make best use of their combined resource.

1.17. The partnership is considering developing a Multi-Agency Safeguarding Hub (MASH). This has the potential to strengthen multi-agency working but will need planning to ensure there is added value and to mitigate against resources being diverted from safeguarding adults into the programme of work required to improve safeguarding children.

1.18. Investing in front-line managers will help to shift the culture and create the momentum for change that has been highlighted in this review. There is also a need to develop a training strategy and to support staff in their difficult task, through supervision and peer group development.

1.19. All those who contributed to the review were hopeful that the investment into this review could lead to real change, feeling that safeguarding adults was overdue for reform.

1.20. The review comes at a time of radical change in Jersey with new legislation, restructuring of services and a new senior team. This presents an opportunity to make a significant improvement in how Jersey safeguards adults. It is hoped the recommendations from this review will aide this process.

2. Introduction

2.1. The Independent Chair of the Safeguarding Adult Partnership Board (SAPB) commissioned an independent review of Jersey's safeguarding adult arrangements. The SAPB has been operational for 5 years and the Chair felt it appropriate to seek assurance that arrangements were effective across the system.

2.2. In order to ensure objectivity, the SAPB Chair commissioned an independent consultant to lead the review. Neither the consultant or the associates carrying out the review were connected to any of the stakeholders involved.

2.3. The review was run concurrently with an aligned review of how adults with a learning disability are safeguarded. Jersey's Chief Executive Officer asked the Independent Chair of the SAPB to consider commissioning this review of learning disability which was agreed to. These two reviews worked collaboratively and combined some aspects such as case auditing.

3. Objectives for the review:

3.1 The review aims were to understand the effectiveness of Jersey's adult safeguarding arrangements:

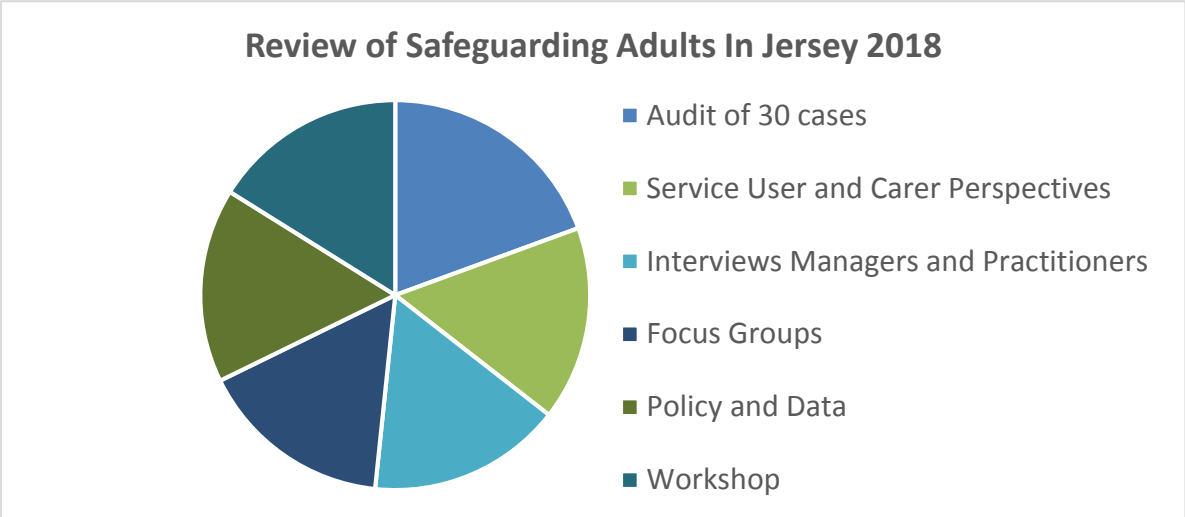
4. To understand how the multi-agency partnership is identifying and responding to safeguarding adults in Jersey
5. To understand what outcomes are being achieved for adults at risk of abuse in relation to their well-being and protection and whether responses reflect Making Safeguarding Personal[4].
6. To identify strengths and barriers to effective partnership working.

4. Scope and Methodology:

4.1. The review terms of reference focused on operational aspects of safeguarding adult practice. However, the efficacy of frontline safeguarding practice is dependent upon the strategic context in which the agencies and practitioners were operating. The review applied an adapted sector led improvement tool based on the Adult Safeguarding Standards 2015.[5]

4.2. The review drew on a range of qualitative and quantitative information to gather a rounded picture of the strengths in the system as well as areas that the partnership could develop.

[4] Making Safeguarding Personal is a personalised approach that enables safeguarding to be done with, not to, people. https://www.local.gov.uk/topics/social-care-health.../making-safeguarding-personal
[5] An improvement tool developed by developed by: Association of Chief Police Officers (ACPO); Association of Directors of Adult Social Services (ADASS); Local Government Association (LGA);



4.3. These components are detailed in appendix 1. The findings from the audits are referenced throughout this report and a chart with the audit questions and ratings red/amber/green from all 30 audited cases is embedded in appendix 2.

5. Background and Context for Safeguarding Adults in Jersey

5.1. This section provides a background of safeguarding adults in Jersey and the policy and legal context in which it operates.

5.2. In 2000, the Department of Health and Social Care published No Secrets[6] guidance as a framework for agencies in England to work together to ensure that vulnerable adults, who were at risk of abuse, received protection and support. Social Care was the lead agency for coordinating these arrangements.

5.3. In 2004, Jersey began to implement the No Secrets guidance. In 2011, as Jersey Community and Social Services became established (now Health and Community Services (HCS)), existing funding was used to set up a dedicated Safeguarding Adults Team (SAT) comprising a team manager and two full-time posts. HCS subsequently established a Single Point of Referral (SPOR) into their services that included referrals for safeguarding adults.

5.4. In 2013, the Jersey Safeguarding Adults Partnership Board (SAPB) was established and formalised the Jersey Safeguarding Adult procedures,[7] using Tri-X to produce web-enabled multi-agency procedures, alongside those for children.

[6] Department of Health (2000) No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/194272/No_secrets__guidance_on_developing_and_implementing_multi-agency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf [accessed July 2018]

7 Latest version of the Jersey Safeguarding Adult Procedures is available on the SPB website http://www.proceduresonline.com/jersey/adults/ [Accessed July 2018]

5.5. Meanwhile, in 2008, the Department of Health in England, began a review of No Secrets. This included a sector wide consultation exercise and heard from many people who had been the subject of safeguarding procedures.[8] The Mental Capacity Act (2005) in England and Wales had recently been implemented. Alongside concepts of protection, agencies were rightly focused on issues of capacity, duties to support people to make decisions for themselves and recognising rights to make decisions that others may deem to be unwise.

5.6. One of the key messages that came from the No Secrets consultation was that safeguarding adults was too process driven. People who were referred to as 'vulnerable adults' felt that rather than making their lives better, agencies protected themselves; focused on investigation and took 'protective action,' without their consent. Adults with capacity to be able to determine their own safety felt they were being treated as children. There was not due regard for their views and wishes about whether they wanted assistance and if so, in what areas.

5.7. This consultation, along with the Mental Capacity Act, created an initiative termed Making Safeguarding Personal[9] (MSP). MSP describes a shift of focus toward enablement and empowerment; the adult defining what constitutes their wellbeing; the adult's consent (where capacitous) and involvement throughout safeguarding intervention; focusing on the outcomes the adult wants rather than process. This shift in approach was set in statute through the Care Act 2014 (England and Wales) and detailed in that Code of Practice.[10]

5.8. Jersey has been supportive of adopting Making Safeguarding Personal. This requires a shift in culture and practice but also has to be supported in policy and statute. This has been challenging in Jersey for a number of reasons:

i) Jersey has not had specific statute for Safeguarding Adults thus limiting the leverage of the SAPB.

ii) Jersey has not had statute relating to capacity. The SAPB had published joint procedures on capacity in 2014[11] but has taken some time to embed in practice. Jersey now has statute regarding capacity and rights to self-determination[12] that is due to be implemented in 2018.

iii) The Independent Jersey Care Inquiry[13] into the abuse of children in Jersey concluded in 2017. Prior to the publication of the report and the need to focus on improvements in children's services the joint SPB agreed that, given the Boards capacity, for a two

[8] Department of Health (2009) *Safeguarding Adults A Consultation on the Review of the 'No Secrets' Guidance*
[9] ADASS LGA: (2013) Making Safeguarding Personal
[10] Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014*
[11] The States of Jersey, Department for Health & Social Services (2014), *Mental Capacity Policy and Procedures*, Available from: http://www.proceduresonline.com/jersey/adults/pdfs/mental_capacity_policy.pdf [Accessed: July 18]
[12] Capacity and Self-Determination (Jersey) Law 2016, Available from: https://www.jerseylaw.je/laws/enacted/Pages/L-30-2016.aspx [Accessed: July 18]
[13] https://www.gov.je/Government/Departments/HomeAffairs/RespondingtoIndependentJerseyCareInquiry/Pages/WhatistheIndependentJerseyCareInquiry.aspx [Accessed: July 18]

year period, the Board's attentions would be on multi-agency work in respect of children's services, this, as anticipated had detracted from the development of safeguarding adult policy and practice.

5.9. The current structure of the SAT has broadly remained unchanged since 2011. Referrals for safeguarding adults come through the SPOR. The team manager for SAT is now also responsible for managing all referrals into community services (other than mental health), through this SPOR. There are two full-time posts in the SAT but no dedicated administrative support.

5.10. The implications for practice arising from this resource and the policy context are considered further in section 5.

6. Findings from the Review

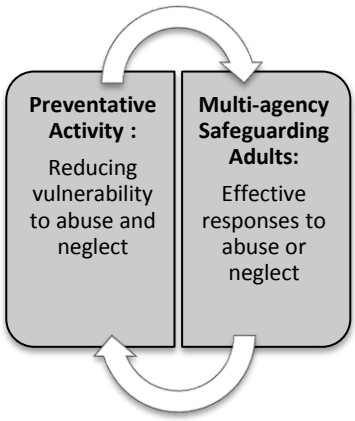
This section provides a summary of the findings that have emerged from the review, grouped under the interconnected themes:

For ease of reference, terms used to describe safeguarding activity are:

- *Safeguarding 'alert'*: the form completed by the referring body, detailing the safeguarding concern and sent into the SAT
- *Safeguarding 'referral'*: refers to a decision made to manage the alert under the multi-agency safeguarding procedures

6.1. Preventative Approaches, Wellbeing and Safeguarding Adults

6.1.1. 'Safeguarding' in its broadest sense can apply to a range of activity carried out by agencies that is designed to protect an adult's right to live in safety, free from abuse and neglect.



6.1.2. Preventative approaches are important to address factors that may increase the person's vulnerability to abuse or neglect. Factors such as poverty, homelessness, cognitive impairment, social isolation and exclusion; dependence upon others due to health or social care need - all may put a person at much greater risk of abuse or neglect. The ability of services to work together to minimise these vulnerability factors is essential to any preventative work.

6.1.3. However, there is a need to distinguish between these wider preventative measures and incidents where abuse or neglect has occurred (or is likely to occur), that requires a response through referral to the SAT.

6.1.4. As outlined in section 4, the focus of this review relates to responses under safeguarding adult procedures for adults where the following apply:[14]

1. The adult has needs for care and support *and*
2. Is experiencing, or at risk of, abuse or neglect *and*
3. As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

6.1.5. A strong and recurring theme from this review was that many of the concerns that were being labelled as safeguarding did not in-fact meet these criteria. This was demonstrated in the case file audits completed for this review:

> *'What was also clear from several cases was the misuse of the safeguarding process to attempt to 'fast-track' cases to get additional resources……. There were examples of alerts being raised that did not meet an elementary use of the criteria and which appeared to be a means of raising care and support concerns rather than safeguarding.*
>
> *In several cases, what was identified as needed was a multi-disciplinary approach to complex mental health/health needs, not a safeguarding response at all.'*
>
> *'Three alerts reviewed [people with a learning disability] were focused, on the whole, on welfare/wellbeing and could and should have been 'managed' with the person and those that know them well and not raised as safeguarding alerts.*
>
> **Review Audit Reports**

[14] Note: This is the definition referenced in the SAPB procedures and used in the Care Act 2014 statutory guidance. However, as detailed in section 5.3, the SAPB procedures also use definitions from No Secrets

6.1.6. Where cases did not meet the safeguarding adults criteria, the audits found some good practice examples of working with the adult and their carer to put in place an alternative package of support.

> *'There was some excellent individual person centred working as well as joint working with colleagues across and within health and social care to improve experiences and resolve low level welfare concerns. Discussion with the referrer for [case LD 2] and the Social Worker resulted in what was described by the referrer as proportionate response which was respectful of the potential sensitivities in relation to family dynamics and relationship with the provider. Follow on actions were agreed jointly with the referrer, family and social worker, which was viewed as appropriate and empowering by the referrer..'*
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> **Learning Disability Review Audit Report**

6.1.7. However, in some other cases where the alert had been screened out, there was not effective handover to the alternative care plan. In one audit case, the alert was closed by the SAT service with an alternative plan for a multi-disciplinary team meeting to be convened. This meeting did not happen for almost 10 months. In another case, the alert was closed before a district nurse involved with the adult could visit to clarify the position. Similarly, in one of the audits for an adult with a learning disability, there was a multi-agency meeting held and a detailed action plan developed. However, the referrer when interviewed, expressed concern about the delay in getting this follow-on support.

6.1.8. In interviews with some partners, they expressed frustrations about 'safeguarding.' However, when this was explored more fully, many of the incidents related to broader welfare concerns that were not abuse or neglect:

- Adults not receiving the level of care that another agency felt was required
- Adults who were continually presenting in crisis but not engaging with care
- Adults who did not meet criteria for lots of individual agencies but nonetheless, were highly vulnerable and/or presenting risk to others and with no coordinated care or lead agency

6.1.9. In the interviews with health partners and independent care providers, there were examples where multi-disciplinary working was described as 'business as usual' for example in hospital discharge. However, there were examples of safeguarding referrals that could have been averted, had there been the expected standards of multi-disciplinary and multi-agency working. This was reinforced by the audit findings:

> *'Many of the cases I audited were examples of reactive responses to crisis that were, in most cases, predictable and which will come back without coordinated multi-agency monitoring and management in the long-term. The lack of coordinated hospital discharges and their management into the community was also apparent. The management of service users with long-term mental health issues in the community was also an issue, compounded by the lack of a similar process to the Care Programme Approach in England and Wales.'*
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> **Review Audit Report**

6.1.10. Learning from Jersey's serious case reviews[15] has also highlighted the lack of effective multi-agency collaboration and communication that had led to safeguarding concerns.

6.1.11. An attendee at the health focus group identified the need for a clearer strategy in prevention and early help. This may include developing robust multi-agency pathways around areas where greater risks of safeguarding concerns may emerge, for example, transfers of care between care providers and hospital – an area some independent care providers were keen to develop further.

6.1.12. Any prevention and early help strategy should also consider carer inclusion and support. A carer who was interviewed for this review, emphasised the importance of this. She highlighted the valuable support she had received through St John's Ambulance service, but felt more needed to be done to help carers who are often under huge levels of physical and mental stress.

6.1.13. An area that was of particular concern to health partners, was the high incidence of self-neglect where risks may sit below the current thresholds for management under safeguarding adult procedures, i.e. where the public safety criteria was not met. There did not currently appear to be effective mechanisms for multi-agency responses.

6.1.14. Social Security also thought that there was a gap in the system below the threshold for safeguarding adult referrals and a need to develop a more cohesive preventative multi-agency response. Social Security described the extensive role they play in supporting people with high levels of vulnerability, many of whom will need a very gradual and long-term plan to support them into employment.

6.1.15. Social Security's common experience was of being left on their own to manage complex cases as the eligibility criteria for other services were not met, or the adult had declined engagement.

6.1.16. Social Security recognised that their role (being linked to benefits), can give them an advantage in engaging with a person who has declined engagement with other agencies. However, they have had limited success in convening multi-agency meetings and securing a case lead worker to work alongside them. As a consequence, Social Security have recently appointed a mental health nurse and drugs and alcohol worker. However, these roles are advisory rather than case management and Social Security remain very concerned that they may not be best qualified to respond to a person with complex needs and risks.

> *'We have to ask why is an employment advisor left holding this? If we are the only ones able to engage, we need support from other services. We need to be clearer about what our offer is…..if we're being asked to carry more we need to acknowledge and resource this '*
>
> **Social Security**

6.1.17. The review heard similar experiences from Shelter Trust. Shelter Trust felt homeless people were often excluded from services despite their vulnerable circumstances. An example was given of a person who presented significant risks to himself and to others, but who had been excluded from other services or refused to engage. The consequence for Shelter Trust was that they were left to try and manage a person with highly complex need, presenting risk to himself

[15] https://safeguarding.je/serious-case-reviews-learning-points/

and others. Attempts to gather help and advice through calling a multi-agency meeting had been unsuccessful.

> *'How can it be that a newly recruited support worker with no professional qualification is expected to respond to people who other agencies have not been able to meet needs of?'*
>
> **Shelter Trust**

6.1.18. These challenging circumstances affect staff recruitment and retention (Shelter Trust lost 55% of their staff in 2017) as well as having an adverse impact for the person. The consequence in this case was the adult ended up back in prison - a poor outcome for the adult and costly to the Jersey economy.

6.1.19. Police and probation supported this view. Jersey police referenced some earlier analysis they had commissioned in relation to high demand families. This analysis estimated the cost of policing Jersey's top five high demand families over a three-year period was approximately £775,000. A similar analysis could also be applied to adults with complex needs. When these costs are extrapolated out to Health and Social Care, Housing, Social Security and the justice system, the overall cost to the Jersey system will be substantial.

6.1.20. Of particular concern to police and probation, were adults who may present higher risk but were declining services – typically people with mental health needs and/or drug and alcohol dependence. Concern was expressed about the availability of services and cases being closed where a more tenacious and creative approach was merited.

6.1.21. The case audits reinforced this, referencing one case where a 'did not attend' response meant that someone with known mental health issues was closed, even though there was a pending safeguarding matter. There was no evidence of a risk assessment about the reason for non-attendance.

> *'We get a referral merry-go-round. The first one doesn't hit the target so it gets cranked up. We need more mature discussions to be held about meeting people's needs.'*
>
> **Probation**

6.1.22. Police acknowledged that the safeguarding adult procedures '*may be the wrong vehicle to use*' to access a coordinated, multi-agency response but this was in the absence of alternative structures.

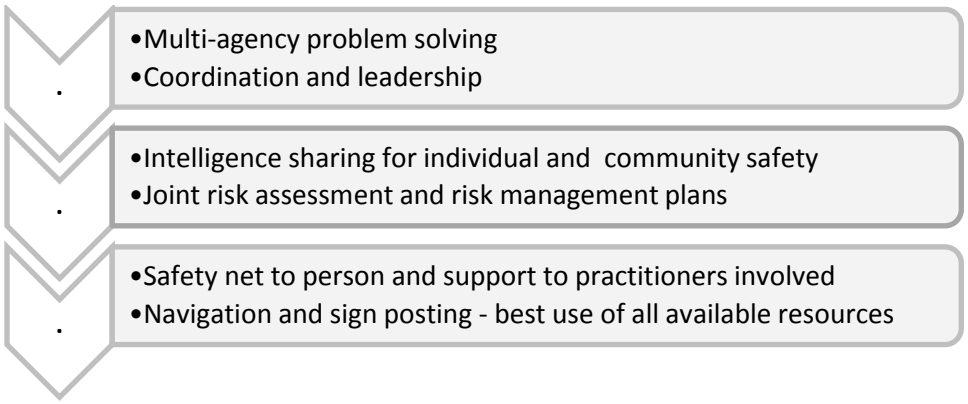
6.1.23. In 2017 police generated 714 Adult Protection Notices (APN) into the SPOR. However, the vast majority of these referrals were seeking a care and support response rather than a response from SAT. An analysis of one month in 2018, identified that out of 86 APN's into the SPOR, only 2 (2.3%) progressed under safeguarding adult procedures. Interviews with the Police Public Protection Unit confirmed that these were appropriate decisions – the unmet need was not the safeguarding response but access to wider services. The term 'Adult Protection Notice' is therefore misleading and 'Adult Welfare Notice' may be a more apt descriptor.

6.1.24 While other formal multi-agency structures such as Jersey's Multi-Agency Public Protection Arrangements (JMAPPA) and Multi Agency Risk Management Conference (MARAC) were widely viewed as operating well, their functions are also necessarily very defined. There remained a

gap in provision for multi-agency work below the thresholds of these structures that would provide effective preventative approaches.

6.1.25. The review heard that there have been recommendations to establish multi-agency complex needs meetings in the past but these had not had sufficient authority or 'buy in' by all agencies to succeed. Some agencies, such as probation, have established risk management meetings (RAMAS) for cases at one level down from Jersey Multi-Agency Public Protection Arrangements (JMAPPA). However, these are limited to probation having some involvement. Similarly, police have a 3 X 30 days process, where a person coming to the attention of police would trigger an APN. Mental health services have a Managing Organisational Risk in a Clinical Environment (MORCE)[16] to provide a multi-disciplinary risk review for people in secondary mental health services.

6.1.26. In summary, there was a resounding call for a more robust multi-agency process to coordinate and manage complex and higher risk cases outside of safeguarding adult criteria, that all agencies commit to. This could take the form of a multi-agency meeting providing the following functions.



6.1.27. A multi-agency risk meeting could bring together the various initiatives set up by single agencies, such as RAMAS and MORCE. It could also provide a vehicle for other cases such as anti-social behaviour,[17] self -neglect (below thresholds for adult safeguarding), Prevent – radicalisation cases, people with high levels of vulnerability, for example, street homelessness and high users of services with complex and/or challenging behaviours.

6.1.28. This would reduce the inappropriate use of safeguarding adult procedures, leaving the SAT greater scope to provide effective responses where abuse or neglect has occurred or is at high risk of occurring.
[Recommendation 1]

[16] Jersey Adult Mental Health Service (2015) Managing Organisational Risk in a Clinical Environment

[17] An example is Camden Safety Intervention Panel https://www.londoncouncils.gov.uk/our-key-themes/crime-and-public-protection/new-asb-powers-london/lb-camden-safety-interventions. 60% of London Boroughs have now established 'Community MARACS'

6.1.29. In relation to the structure of services, HCS are planning a service re-design to have a single 'front door' for all referrals and creating four multi-disciplinary teams linked to GP clusters. This aims to improve the multi-disciplinary input and give greater access to consultation for other agencies. This may assist in connecting safeguarding work to a more holistic response to an adult's and carer's needs, an area the audit found needed strengthening.

> *'In most cases, the referrer had made sure the adult was safe, but again the actions were focused on the presenting issue and didn't show any awareness of broader issues or areas of possible concern…. Any Safeguarding Alert should lead to an assessment of the adult's care and support needs or a review of their assessment/support package to reflect the impact of the alleged abuse or neglect.'*
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> **Review Audit Report**

6.1.30. At time of the review, agencies were also planning to establish a Multi-Agency Safeguarding Hub (MASH) for adults (this is discussed further in section 5.4).

6.1.31. HCS has also drafted a safeguarding adults prevention strategy.[18] At the time of the review, this was yet to be fully consulted upon and needed wider contribution from key partners such as health. The strategy incorporates some important elements including strengthening multi-agency working, risk management, workforce development and the need to improve public awareness of safeguarding adults. However, the findings of this review indicate this strategy needs to be part of a far-reaching strategy to support adults in Jersey.

6.1.32. The review is aware of a radical re-structuring of services in Jersey.[19] In addition, there has been a review of the SAPB; review of housing provision and a planned review of mental health services.

6.1.33. It is beyond the scope of this review to consider these strategic developments in more detail. However, the plans set out in 'Team Jersey One island, One Community, One Government, One Future,'[20] offers the opportunity to operate as a whole system to develop a more cohesive approach to adults' wellbeing, including prevention and safeguarding adults.

6.1.34. Jersey also has the unique structures of the parishes and this provides opportunities for a strong, community-based welfare system. Serious Case Reviews have provided examples of the benefits of this parish system in safeguarding adults as well as examples of missed opportunities.[21] There are also some excellent community initiatives such as the postal 'call and check' service.[22]

6.1.35. In the focus group with Honorary Police and Constables, they discussed the contribution they could make in preventative, community-based support that may avert some safeguarding circumstances arising, for example, support to carers or where an adult may be isolated and have care and support needs.

[18] States of Jersey – Adult Safeguarding Prevention Strategy 2018 to 2021 (draft)
[19] Chief Executives Six Month Report to States Assembly https://www.gov.je/SiteCollectionDocuments/Government and administration/R Chief Executive's six-month report to States Assembly 20180709 CK.pdf
[20] States of Jersey (2018) Team Jersey One island, one community, one government, one future,
[21] Serious case reviews 'Mr Hunter' and 'Ms Evans' https://safeguarding.je/serious-case-reviews-learning-points/
[22] http://www.callandcheck.com/

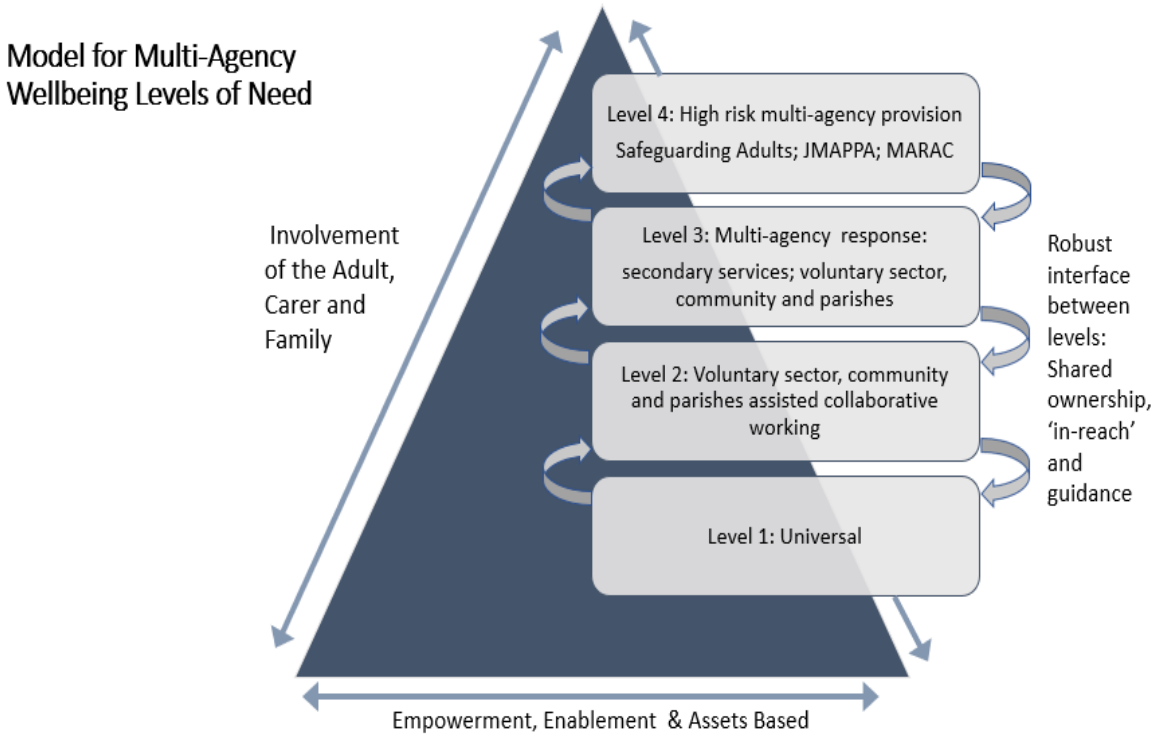
'There is a vast resource out there that is waiting to be used that's not being accessed….we had 40-50 volunteers but who then dropped out because they weren't being used.'

Honorary Police and Constables Focus Group

6.1.36. Approximately 50% of the parishes have Community Service Groups with volunteers that could offer support. The parishes had no way of connecting this resource with the people who may need it and who would consent to receiving support. Attendees were concerned that the General Regulations for Data Protection (GDPR) may add a further barrier to agencies sharing information to enable preventative work. There is a need for all agencies to ensure their understanding of the provisions and limitations under Article 6 of the GDPR to support the processing of information that may enable multi-agency working.
[Recommendation 2]

6.1.37. A whole systems approach to wellbeing, led by the SAPB, could set out what the 'offer' is from agencies; voluntary sector, communities and parishes at the different levels of need – from general preventative support through to management of high risk cases including responses to safeguarding adults. This system could also set out the multi-agency coordinated activity and the inter-face between these levels so that there are effective transitions in the step up and step down between the levels and between children and adult services - an area that the case audit findings confirmed was lacking.
[Recommendation 3]

6.1.38. The diagram below offers a representation of what this model could look like:



6.1.39. Developing such a SAPB strategy could deliver a more cohesive and sustainable approach to prevention, enabling specialist safeguarding resources to focus on providing effective responses where abuse or neglect has occurred.

6.2. Making Safeguarding Personal

6.2.1. As outlined in section 4, MSP promotes rights and inclusion and aims to deliver outcomes that the person has identified as important for their wellbeing – safety being only one factor.

6.2.2. MSP needs to apply at operational level i.e. in the response to an individual safeguarding concern. MSP also needs to apply to strategic development through participation, self-advocacy and co-production. The implementation of the Capacity and Self-determination (Jersey) Law will significantly aid a more inclusive, consent-based approach to safeguarding adults. However, it can take some time for legislation to lead to a shift in practice and culture.[23]

6.2.3. The findings from the review indicate some good practice but a need for further development in both operational and strategic practice.

> *'Whilst there was some individual good practice in attempting to focus on maintaining a person led and outcomes focused approach, this did not always live through in terms of behaviours and actions as a collective.'*
>
> **Learning Disability Review Audit Report**

6.2.4. Many of the interviews with agencies and service users referenced the SAT working to support the adult's involvement at all stages of the safeguarding pathway. However, the SAT felt the current procedures can present barriers to them practicing in a way that is compatible with MSP. They felt concerned that failing to follow procedures could leave them open to criticism. **[Recommendation 4]**

6.2.5. The review confirmed the procedures and documentation do not facilitate effective personalised, outcomes-based practice and that MSP needed to be strengthened.

6.2.6. Interviewees felt that understanding of capacity was developing but was not yet consistent. As outlined in section 5, consent is important for the adult to remain in control of decisions impacting on their lives, respecting their right to choose whether they wish support from other agencies and respecting the fact that they are adults and should decide how any intervention is managed. The audits identified that referrers in 2017, were not routinely considering whether there was informed consent to an alert being raised. In 66% of the sample, the adult was not aware of the alert being raised.

6.2.7. There will be times when an alert should justifiably be raised without consent. This may be due to the adult lacking capacity to make decisions about the relevant risk; concerns of coercion or undue influence, for example, fear of retribution; concerns that others (including children) may be at risk; public interest or where the risk to the person so severe as to affect

[23] House of Lords (2014) *Mental Capacity Act 2005: Post legislative Scrutiny Committee*, Available from: https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm [Accessed: July 2018]

their vital interests. Where consent was not given, 47% of the sample did not provide justifiable reasons to refer without consent:

> *'There was a mixture of degrees of involvement of the adult, often due to a lack of awareness on their part of the Alert.'*
>
> **Review Audit Report**

6.2.8. Neither the alert form or the screening form used at the SPOR prompted this consideration. The procedures provide limited guidance for practitioners in information sharing without consent.[24]

6.2.9. The case audits of people with a learning disability identified a good practice example where the justification for raising the alert without the adult's consent was clearly detailed in terms of acting in best interests. However, in other cases for adults with a learning disability, decisions had been made that an adult shouldn't be informed or included in safeguarding meetings but with no recorded justification or specifying a lack of capacity for the relevant decisions.

> *'The information provided at the alert stage on the whole reflected the referrer's views and perspective and showed little if any reflection of steps taken to empower the adult and consider their wishes where there was capacity……*
> *The [screened out alerts] audits lacked evidence of engaging with the person to enhance their choice and control.'*
>
> **Review Audit Report – Learning Disability Case Sampling**

6.2.10. The SAT felt that they were often in a position of back tracking and gathering this information even in circumstances where the adult was well known to the referrer:

- In 66% of audit cases, the recorded actions of the SPOC demonstrated account had been taken of equality and diversity e.g. accessibility; communication needs, familiar support, adjustment to pace and timings. This was less well evidenced in the case samples for adults with a learning disability.
- In 67% of cases that progressed as referrals, there was clear evidence of matters of capacity/acting in best interests defined from the outset with a further 27% partially evident. Again, this was less well evidenced in the case samples for adults with a learning disability.

6.2.11. Recording *consideration* of capacity and informed consent needs to be more explicit. The number of formal capacity assessments is not an effective measure as there should be a presumption of capacity. However, in cases of complexity and significant risk, it is good practice to make explicit in records:

i) If there is no evidence to suggest the person lacks capacity to make the relevant decision or,

[24] Example is Social Care Institute for Excellence: What if a person does not want you to share their information? - Adult safeguarding: sharing information https://www.scie.org.uk/care-act-2014/safeguarding-adults/sharing-information/does-not-want-to-share.asp [Accessed: August 2018]

ii) Where there is any doubt, to carry out a formal capacity assessment on each of the principle risks or,

iii) Record other factors that impair decision making i.e. coercion or undue influence

6.2.12. It is notable that the SAT do provide safeguarding protection plans in easy read formats for service users when required. One of the case audits of an adult with a learning disability gave a good example of this being used in practice. However, reasonable adjustments had not consistently been made for all relevant cases.

6.2.13. Accessible information and communication aids should be routinely used across all steps in the process to maximise involvement, choice and control.
[Recommendation 5]

6.2.14. Maximising involvement is also about considering the physical environment, for example, the location of meetings and number of attendees assists involvement. Feedback from one adult in a self-neglect case, demonstrated how intimidating the process could be:

> *'I was horrified that all these heads of department turned up for the meeting! I have never had much to do with the States before and suddenly I am sitting in front of people who are discussing my situation!....It made me feel so humiliated, if I'd known the humiliation! I've never had anything to do with the States"*
>
> **Extract: Feedback from service user in self-neglect referral**

6.2.15. The terminology and focus of the procedures are on the investigation rather than the adult. 'Outcomes' do not refer to whether the adult's life has been improved but refer to whether the allegations are 'substantiated or unsubstantiated'.

6.2.16. The minutes from one case conference was an example of the quasi-judicial process.

> '***Purpose of Meeting***
> *To review findings from the investigation, question accuracy of findings and test information provided within the investigation findings.'*
>
> **Minutes from a Case Conference**

6.2.17. This focus on whether an allegation was substantiated or not may detract attention from outcomes for the adult and evaluating whether there has been a risk reduction/stabilisation.

6.2.18. The language used can also make safeguarding an alienating and intimidating experience for all involved, including the adult and carer. Harm may be caused by a range of circumstances for example, a carer under stress; accident, misinformed care or deliberate abuse. The phrase 'perpetrator' is applied to all these circumstances. The audits found examples where the 'perpetrator' themselves had care and support needs but there was insufficient consideration of their needs. The impact of this inquisitorial approach was described well by an adult in their feedback form and by one interviewee.

> **'***The nurses were all very good and I know that no one deliberately failed me. It was unnecessary to say they had abused me or not, those words are harsh. X is a very good nurse***.'**
>
> **Adult's views: feedback form on a pressure care related safeguarding concern**

'We need to decide if this is about retribution or working to make people safer.'
Head of Care Regulations Community and Constitutional Affairs

6.2.19. This approach can lead to head on disagreements between agencies and professionals, with all energies trying to reach a consensus on the investigation outcome and who is to blame. This can constrain the safeguarding responses according to whether the allegation has been substantiated or unsubstantiated.

6.2.20. SAPB may wish to consider adapting 'Signs of Safety[25]' to safeguarding adults. The evidence in safeguarding children is that use of Signs of Safety has improved how professionals work together and with the family. There is greater emphasis on assets and a focus on solutions toward future safety rather than on blame. Application of this methodology in safeguarding adults could help shift from the current investigative approach to a more balanced framework that will:

i) Focus on the adult's wellbeing and their outcomes
ii) Explore the wider context of the presenting concern
iii) Help agencies involved to be collaborative and solutions focused
iv) Effectively manage risks

6.2.21. Any necessary response to address the source of harm, for example, police investigation, disciplinary measures, regulatory action or Health and Safety Executive, becomes a separate but aligned process and governed according to those guidelines. Where the person causing harm has themselves got care and support needs, for example, a carer or fellow resident, Signs of Safety could also be used in the response to their needs.
[Recommendation 4]

6.2.22. In general, the audit and interviews found that the SAT did endeavour to identify outcomes the adult wanted from the procedures although this was not consistently identified at point of referral.

- In 50% of the audit sample, the adult's view and outcomes they wanted to achieve had been gathered at point of alert

[25] Signs of Safety is a strengths-based, safety-organised approach used in Safeguarding Children https://www.signsofsafety.net/signs-of-safety/ [Accessed August 2018]

- In 67% of the audit sample that had been managed under procedures, there was strong recorded evidence the adult or their carer/representative was fully involved in the development of the safeguarding plan and supported to identify their (or their representatives) desired outcomes. In a further 20%, there was partial evidence.

6.2.23. This was less evident in the eight audit samples of adults with a learning disability. In 75% of cases, the recording that the individuals desired outcomes from the safeguarding process had been considered, was weak.

6.2.24. There was a theme from this review that safeguarding interventions were fragmented and disconnected from ongoing care. There was a lack of safe transfers of care – closures before a safeguarding plan was assessed as being effective or failure/delay in follow up care by other services. This limited the effectiveness of intervention and risked recurrence

> '*It is therefore important that cases are kept open to safeguarding long enough to be able to monitor the achievement or not of the desired outcomes and to ensure their continued appropriateness. The speed at which most cases were closed to the procedures, for operational reasons, mitigated against this happening. What also didn't happen was any requirement for the transfer of outcomes from the safeguarding procedures to the care management procedures; this, obviously, is linked to the apparent lack of long-term care management processes within Jersey*.'
>
> **Review Audit Report**

6.2.25. There were also examples that demonstrated the limited availability of restorative care that was required following an incident of abuse. One example is below:

> 'However, in case LD19 there would appear to be worrying gaps in the opportunity to get psychological intervention to assess the psychological need and trauma following being involved in an allegation of sexual abuse…. Access to psychology is still outstanding at the time of the audit review.
>
> This individual LD 19 has been linked to other abuse cases and used to be independent and a very able person, they are now non- verbal at times, struggling with communication and having health investigations for dementia and other tests for neurological causes. However, from questioning, the auditor could find no evidence that the person has ever had any assessment for trauma or offered specialist therapeutic intervention, ….. It was concerning that there might be potential diagnostic overshadowing the behaviour and professionals missing an opportunity to assess this individual for trauma which is known to manifest itself in a variety of physical, emotional and psychological ways.'
>
> **Learning Disability Review Audit Report**

6.2.26. This reinforces the recommendations made in section 6.1. to establish more effective integration and step-up/step-down from the safeguarding adult procedures, connecting safeguarding much more robustly into wider care and support.
[Recommendation 6]

6.2.27. The prescribed timeframes within the procedures, (for example 4 hours response times and 28 days to conclude investigations) can also restrict the ability to work with the pace of the adult and to be creative in the best way of implementing the protection plan toward the adult's outcomes. This is particularly important in working with self-neglect and has been raised in a

serious case review.[26] Timeframes should be aspirational rather than performance indicators, with the proviso that not meeting them has to be justified in terms of the adult's outcomes or service deficiencies.
[Recommendation 4]

6.2.28. This difficulty in embedding MSP is not unique. The Making Safeguarding Personal Temperature Check[27] highlighted challenges that some Safeguarding Adult Boards in England had in assuring MSP was in place.[28]

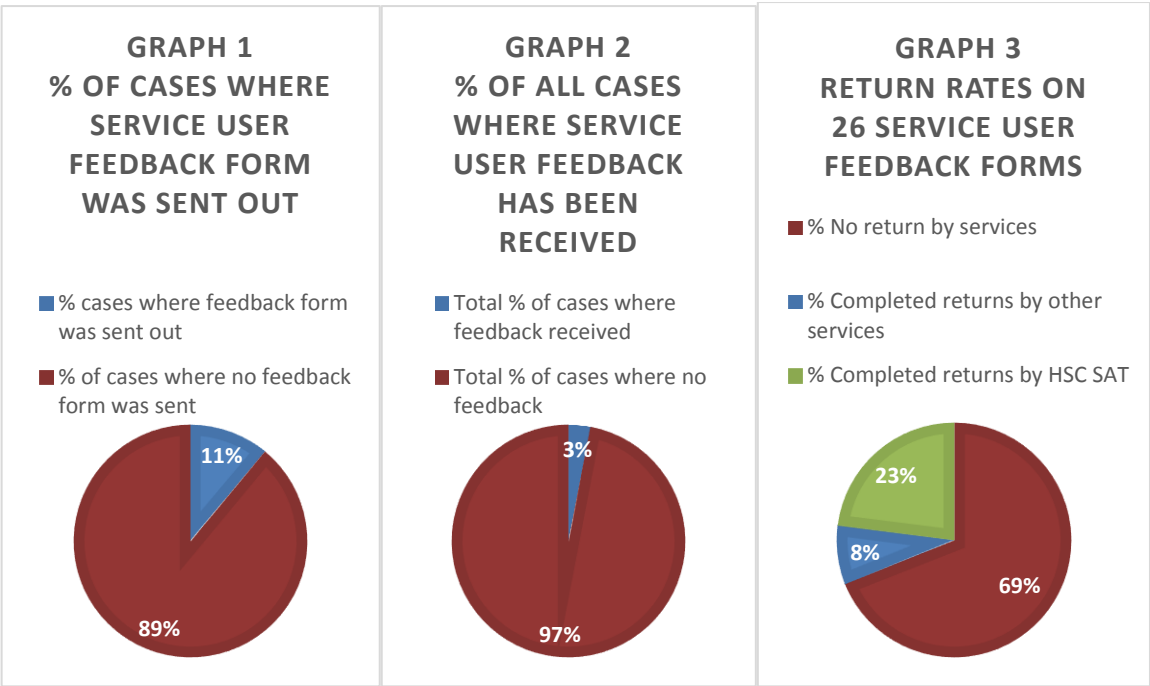
6.2.29. The audit samples found very limited evidence of feedback from adults who had used safeguarding adult services. In only 7% of cases from sample group two (cases managed through safeguarding procedures) was the adult/carer/representative offered the opportunity to give their views regarding their experience of the safeguarding process.

6.2.30. The SAT has developed 'guided questionnaires' for adult to give feedback on their safeguarding intervention. These forms are well designed, covering many aspects of MSP. The intention is where ever possible, for the adult's key worker from the relevant service to facilitate this so to provide objectivity. This was good practice. There is also a feedback form for adults who have been referred through the multi-agency self-neglect procedures.

6.2.31. The use of the feedback form has been very limited. In 2017, there were 239 referrals that were managed under safeguarding procedures.

- Feedback forms were sent out to adults for 11% (26) of all cases
- Feedback was received from 3% (8) of the 239 cases
- Completion rate on the 26 cases that were sent out was 31% (8 cases)

[26] Mr Hunter Overview Serious Case Review Report (2018) https://safeguarding.je/wp-content/uploads/2018/04/Mr-Hunter-Overview-Report-FINAL-PUBLISHED.pdf
[27] ADASS (2016) Making Safeguarding Personal Temperature Check https://www.adass.org.uk/media/5461/making-safeguarding-personal-temperature-check-2016.pdf
[28] SCIE (2017) Learning from SARs: A Report for the London Safeguarding Adults Board https://www.scie-socialcareonline.org.uk/learning-from-sars-a-report-for-the-london-safeguarding-adults-board/r/a110f00000NeKhVAAV



6.2.32. The detail behind the low feedback rate of 3% needs to be better understood. The reasons given for not sending out a feedback form in 89% of cases were in part justifiable for example, when the adult did not wish to engage with the process or had died. Cognitive impairment was also cited as a reason. This *may* for some make it impracticable to receive feedback.

6.2.33. However, there is a need to develop accessible information to maximise the potential for the adult to be able to provide feedback.

6.2.34. A further reason given was that the adult was not aware of the safeguarding intervention or that the case involved institutional abuse. This raises further questions about why the adult would not be aware of a safeguarding referral about them and the need to understand this data better. This further exemplifies the need for additional steps for inclusion and a cultural shift toward enablement and empowerment.

6.2.35. Where a request was made for other services to help facilitate a response, there was only an 11% return rate (2 responses, 8% of all completed returns). There was no information about whether this was because the adult had declined to complete the form, or that the service had simply ignored the request to gather feedback. As a consequence, the SAT has reverted to gathering all feedback themselves. This reinforces the need for improved use of data i.e. the development of an MSP dashboard, combining a mix of quantitative and qualitative measures (discussed further in section 6.3). This will enable the SAPB to support the SAT in their work and, if necessary, hold specific services to account for their contribution in MSP. **[Recommendation 7]**

6.2.36. For the eight responses that were received during 2017, six adults had used the questionnaire. For the six, the majority did feel involved and listened to although 50% did not feel the intervention made their situation better. These results are collated below along with some extracts from commentary.

Collated Questionnaire Responses from Six Service Users 2017	% Responses			
	Yes	No	Partly	No response
I had the information I needed; in the way that I needed it	100%			
Professionals helped me to plan ahead and manage the risks that were important to me	83%	17%		
People and services understood me- recognised and respected what I could do and what I needed help with	83%	17%		
The people I wanted were involved	83%	17%		
I had good quality care –I felt safe and in control	67%	17%	17%	
When things started to go wrong, people around me noticed and acted early	83%	17%		
People noticed and acted	83%			17%
People asked what I wanted to happened and worked together with me to get it	83%			17%
The people I wanted were involved	67%	17%		17%
I got the help I need by those in the best place to give it	67%	17%		17%
The help I received made my situation better	33%	50%		17%
People will learn from my experience and use it to help others	33%	17%	33%	17%
I understand the reasons when decisions were made I didn't agree with	50%	17%	17%	17%

Extracts from Commentary

'I feel that this is the first time that I have felt listened to by those around me. I have had problems with my family not understanding me and treating me badly. [Safeguarding Practitioner and own Social Worker] have both helped me get my voice heard.'

'I am very well thank you and happy with how social workers have worked with me. I have no complaint about [safeguarding practitioner] input in my case. He has included me in meetings and has been seen to see me many times. However, I did not want this process to be started and I am unhappy that I now cannot live in my home.'

'I felt that the process was ok, however I didn't like that I had to say that the people who cared for me had abused me or not. I felt that the issue (of my grade 4 pressure sore) could have been handled in a different way.'

'Everyone in health and social service was very good. You were good, your report was good and [Safeguarding Practitioner and own Social Worker] were very good. However, I cannot understand why the meeting did not feel that abuse happened. I was very disappointed. I don't feel that it was fair. I feel glad it's over... The meeting outcome wasn't what I wanted.'

6.2.37. The two additional responses were from the self-neglect questionnaire. These demonstrated the challenges in working with people who are resistive to intervention but nonetheless, highlighted how the SAT endeavoured to work in a respectful way, maximising control. This is demonstrated in the extract below:

Q. Did the people involved in the self-neglect process recognise and respect your strengths and what you needed help with?
'Not really - you asked me about my life which was appreciated, you saw me as more than the issue in hand- we spoke on the stairs, you were very good, it's not your fault you're a social worker..'

Q. Were you asked who you wanted to be involved?
'Yes and I am very grateful to this. My minister and my friends were welcomed to the meetings, it made the process easier.'

Extract: Feedback from service users in self-neglect referrals

6.2.38. This positive, person centred practice was also borne out in one-to-one interviews the reviewer carried out with adults and carers. Some examples are below.

6.2.39. Adult 1 had had a referral made due to self-neglect –hoarding behaviours associated with mental health needs. She felt the public needed to know more about safeguarding and particularly, what value the service could add as well as what the limitations were. However, she felt strongly that she was treated with respect, by the safeguarding practitioner and the fire safety officer:

'I was afraid people would come and take things away I didn't want them to. They listened and were respectful. I didn't see the risks like the fire service did but they didn't push me. It was a good thing they got involved – they've put back the trust.'

Extract: Interview with Adult 1

6.2.40. Adult 1 was also a positive example of restorative care that had been put in place. A psychologist and a support worker had been involved for some months, gently engaging at Adult 1's pace.

6.2.41. For Adult 2, she had burns caused by omissions of care in a care setting. Adult 2 had not been aware that an alert had been made about her. However, she was very positive about how she had been involved, was happy with the protection plan and kept informed. Adult 2 viewed the intervention very positively, feeling it gave her redress to the poor care she had received. Her sister and main carer was also interviewed and highly commended the response she had received.

'Vulnerable people are often silent as they're scared to rock the boat in case there is come back. Social services and the safeguarding put power back in the hands of the individual'

Extract: Interview with Adult 2

'I thought the way the meeting was conducted was absolutely brilliant. They couldn't have been nicer.. so much so that it gave me the ability to speak and feel I had something to say. She gave me ample time and kept on checking if I had anything to add….. The involvement of safeguarding made

a big difference. It would have been very traumatic to deal direct with the care agency. It was all very well handled- compassionate and the right contact.'

Extract: Interview with Carer of Adult 2

6.2.42. Adults interviewed also commented very positively on involvement by other services. Adult 3 was a woman who had been sexually and financially exploited. She clearly valued the support by police and victim support

'They believed me and gave me confidence. They were very supportive. They basically said if you are going to report it, we will be there for you…I now know that services had been having meetings about me in the background. I didn't know anything about it at the time. It makes me feel like a worthy person that people were that concerned about me … that was nice.
I didn't feel able to tell people [about taking illicit drugs] because I wasn't sure how far it would go…not like at the Doctor when they keep things confidential, I was not sure how much they would hold my confidence and I was worried.'

Extract: Interview with Adult 3

6.2.43. For Adult 4, he had consented to an alert being raised – this related to his self-neglect arising from depression and some concerns about potential financial abuse by a relative. The alert had been raised by Jersey Employment Trust but was screened out from safeguarding with an alternative support plan to be provided by his support worker from Jersey Employment Trust and a social worker. Adult 4 also highly commended the support he received.

'They were excellent- I went to a place I wouldn't have thought I could come back from [workers from JET and the social worker] Thank God for them- I was desperate, if you can take me from that and sort me out……well, they did it.'

Extract: Interview with Adult 4

6.2.44. However, Adult 4 was also a further example of limited restorative care. The Occupational Therapist who was working with Adult 4, was concerned that delay in accessing counselling may jeopardise his full recovery. The OT felt this was symptomatic of the fragmented, short-term care provided in Jersey that prevented sustained change.

6.2.45. For Adult 5, the referral related to concerns about harm from her family. Records demonstrated some good evidence of MSP: identifying what relationship Adult 5 wanted to have with her family, providing options that included referral to police and through Independent Domestic Violence Advisors (IDVA) and arranging support for future contacts.

6.2.46. Adult 5 also had no knowledge of safeguarding prior to her incident so would not have been able to self-refer. She felt her high functioning autism meant she could make some but not all decisions. Adult 5 highlighted the importance of advocacy.

'The box says this but we should think about stretching the box…. It needs to be ok to continue voicing stuff and to be believed. Jersey needs something more tailored…..

I have a phobia of meetings….no right to advocacy – you are up a gum tree. No-one to fight your corner. I use support staff as my advocacy but I shouldn't need to.'

Extract: Interview with Adult 5

6.2.47. Advocacy[29] provides an essential mechanism to enable adults' involvement where that adult may have difficulty in being involved.

6.2.48. The Safeguarding Adult procedures reference '*All adults at risk have the right to support throughout any safeguarding process, including an advocacy worker or representative of their choice'* However, in practice this has not been available to all who needed it.

6.2.49. This was highlighted in one of the audit cases for an adult with learning disability where the adult had been subject of an assault by another adult with learning disabilities. The referrer felt the adult's needs were getting lost and needed advocacy to have their voice heard. It was not available.

6.2.50. The right to advocacy has been introduced under the new Mental Health (Jersey) Law and the Capacity and Self Determination (Jersey) Act. The previous contract for advocacy was extended to October 2018. This contract is limited to people in receipt of secondary mental health services. There is no specific provision for safeguarding adults.

6.2.51. People with a learning disability in Jersey may access advocacy from a worker who is employed part time and funded through Mencap. It is understood this advocate is not trained in non-instructed advocacy i.e. where the adult is unable to give clear instruction to their advocate so the advocate acts in the adult's best interests, upholding their rights and ensuring a person-centred response.

6.2.52. The mental health advocate has historically supported some people in the safeguarding response. However, at time of the review, there had been no referrals made to the advocate in the previous nine months.

6.2.53. The reviewer was informed that the commissioning specification for advocacy is being revised and the new specification will include advocacy provision for safeguarding in addition to rights to advocacy contained in the new statutes.

6.2.54. There is limited data reported on the use of advocacy. The current dashboard asks *'Was the client at risk lacking capacity? If so was there advocate, family or friend support?'* However, this does not give a breakdown of information on the use of advocacy or unmet need.

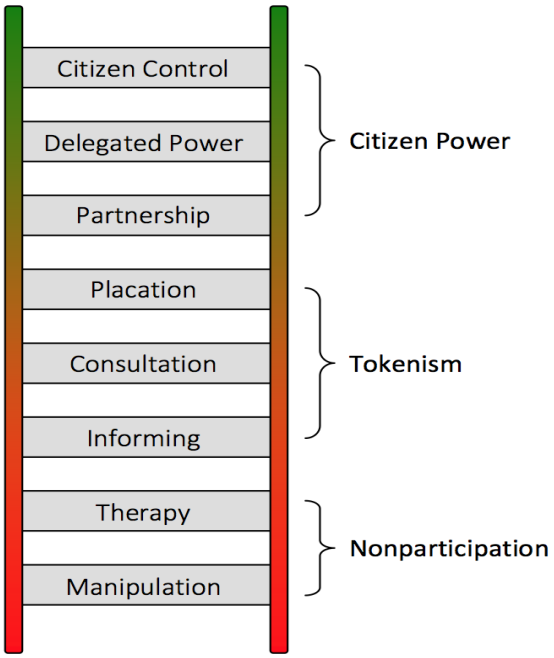
6.2.55. The use of advocacy should not be confined to a person lacking capacity but for any circumstances where the adult may have substantial difficulty in being involved in the safeguarding process and where there is no other person able or appropriate, to represent them. The commissioned service will need to be able to provide instructed and uninstructed advocacy across different presenting needs. The absence of referrals to the current mental health advocacy provider suggests a need to prompt consideration within the documentation and through training, along with collating data on referrals and unmet need. **[Recommendation 8]**

[29] The term 'advocacy' as referenced in this review relates to support provided to adults with care and support needs to help them express their views and wishes and exercise their rights

6.2.56. The advocate's view was that Jersey citizens are not knowledgeable about safeguarding services and would not know how to self-refer. The advocate could not recall seeing any publicity in areas such as mental health inpatient units where people may be more vulnerable to safeguarding concerns. This general lack of public awareness was echoed by different agencies, frontline practitioners, Honorary Police, Constables and was borne out by the reviewer's interviews with service users. This need for public awareness is within the SAPB draft prevention strategy.
[Recommendation 9]

6.2.57. The review for people with a learning disability also highlighted significant limitations in self-advocacy. There appeared to have been very limited engagement with user groups on development plans and strategies. One carer who was interviewed was keen to be able to contribute and felt carers and service users needed to have greater involvement in policy development. This may reflect a need to develop co-production and inclusion within strategic safeguarding adults work, for example, through establishing an expert reference group for the SAPB.

6.2.58. The SAPB may find the application of 'the ladder of participation'[30] a useful aide to benchmark the application of MSP in both operational and strategic safeguarding and to use this to develop an improvement plan.
[Recommendation 10]



Arnstein's Ladder of Citizen Participation

6.2.59. Bringing momentum to the cultural shift toward MSP will require significant resource. This coincides with implementation of the Capacity and Self-Determination (Jersey) Law, which is also likely to take considerable effort to embed in practice.

[30] Arnstein Sherry 'A Ladder of Citizen Participation' Journal of the American Institute of Planners Vol 35 1969 pp216 - 224

6.2.60. The SAPB may wish to consider resourcing a dedicated post to provide leadership to this work. This post could provide leadership in MSP at both operational levels, for example, seeking feedback from adults; developing MSP guidance and procedures; training. The post could also lead the strategic MSP agenda, for example, establishing self-advocacy and expert reference groups; setting processes for consultation and co-production; using service user data analysis to inform service development.
[Recommendation 11]

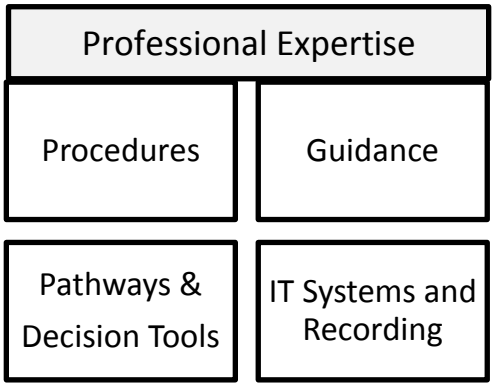
6.3. Systems, Processes and Accountability

6.3.1. This section will consider

- Systems and processes that support safeguarding
- Assurance – data that informs the SAPB
- Regulation and interface with safeguarding adults

• Systems and processes that support safeguarding

6.3.2. Systems and processes provide the framework to deliver effective safeguarding practice.



6.3.3. The case auditors found some examples of excellent practice, both on an individual level and between agencies. However, their view was this was despite the systems surrounding them not because of them. This view was supported by interviews with practitioners.

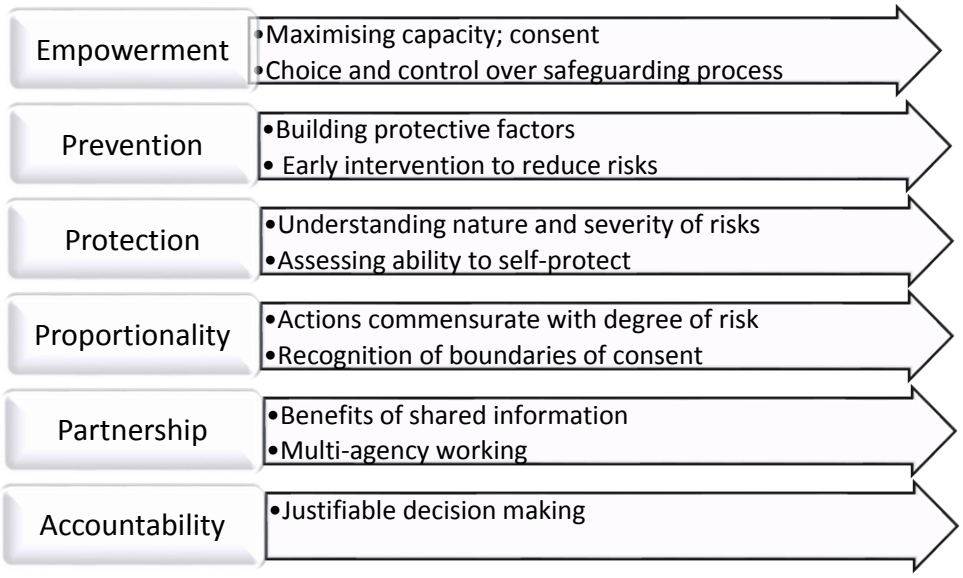
6.3.4. This review is aware that the SAPB has had very reduced staffing levels for some time and this has negatively impacted on the improvement work carried out through the SAPB sub groups.

6.3.5. As identified in section 6.1 and 6.2, the pathways into safeguarding or alternate support generally need to be better understood so that the limited resource can be used most effectively and with clear step-up/step-down to wider care and support.

6.3.6. There is threshold guidance[31] in place which is useful to define safeguarding criteria, though also needs to reference the need for alternative support where criteria are not met. The guidance also requires refresh to reflect applying MSP, linking to guidance about sharing

[31] Safeguarding Adults Partnership Board Safeguarding Adults Threshold Guidance 2015

information without consent[32] and weighing the Safeguarding Adult Principles in decision making surrounding the alert and progressing as a referral through the procedures:



6.3.7. The definitions for 'adults at risk' are confusing within the procedures - at one point referencing the Care Act 2014 (England and Wales) definition (section 2.2.1), but then referencing the No Secrets definition (section 2.2.3).

6.3.8. There was wide spread agreement by all interviewed that the safeguarding adult procedures required revision. The current procedures have not been updated since 2016 due to capacity in the SAPB team, although the procedures reference that an update was due in May 2017. **[Recommendation 4]**

6.3.9. When first established, safeguarding adult procedures may have needed to be highly prescriptive in order to establish the multi-agency response with steps in the process and timescales for meeting those steps. However, the procedures have not moved with time. As discussed in section 5, this very much reflects the journey that many Safeguarding Adult Boards have been on subsequent to the review of No Secrets and implementation of mental capacity legislation.

6.3.10. As one SAPB member put it '*We need to be clear about what we are trying to achieve*.'

6.3.11. Rigid timescales can stifle professional judgement around effective risk management, particularly when a limited resource is trying to stay on top of the referral rate. Findings from the audit work raised questions of whether this may be compromising the quality of some of the response.

[32] Social Care Institute for Excellence: What if a person does not want you to share their information? - Adult safeguarding: sharing information https://www.scie.org.uk/care-act-2014/safeguarding-adults/sharing-information/does-not-want-to-share.asp [Accessed: August 2018]

6.3.12. The audit found that the strategy discussion was almost always timely (93%). However, very few of the referrals sampled progressed to a case conference, most being closed once a strategy had been agreed to manage the presenting issue/s.

6.3.13. While early closure may be a proportionate response for many cases, as identified above, some cases were closed before assuring the safeguarding plan had been effective. Staff interviewed from HCS, recognised the value of engaging the adult in work that will bring more sustainable improvement in their lives and reduce likelihood of re-referral. However, a recurring message from HCS staff was that they were under pressure to close cases.

6.3.14. Risks associated with this practice are increased as there is also no automatic system to flag previous safeguarding alerts. A robust risk assessment must take account of historic concerns, whether risks are escalating and whether previous safeguarding interventions had worked. Good risk assessment needs to draw on this chronology rather than manage individual incidents in an episodic way.

6.3.15. This combination of early closure and a lack of systems to flag repeat referrals is concerning. At best, this is likely to be a false economy (leading to repeat referrals) and at worse, may miss crucial information that could make the difference in high risk cases.
[Recommendation 12]

6.3.16. HCS and specifically the SAT, should review their systems to enable chronologies to be readily available to aide decision making and risk assessments in the safeguarding response. A recommendation has already been referenced in 6.2. regarding the need for effective integration and step-up/step-down from the safeguarding adult procedures.
[Recommendation 6]

6.3.17. The audit also cited examples of safeguarding plans speedily put in place but where the quality of the analysis was not always sound and risk assessments not always completed. A theme arising from the audits was the need to look beyond the presenting issue, show professional curiosity and consider the underlying factors rather than just the presenting picture. This included thinking beyond the needs of the adult, considering safeguarding children and the needs of the person causing harm where they also had care and support needs. This was not always evident from the recorded information.

6.3.18. The case audits noted that the supporting documentation and decision tools that were used in 2017, did not always direct good practice by referring agencies. The audit found that in general, there was a lack of lateral checks. The SAPB should facilitate routine multi-agency qualitative sampling of safeguarding alerts and responses to assure the quality of risk assessments, safeguarding protection plans and step-down care.
[Recommendation 13]

6.3.19. The documentation should enable assessment of safeguarding concerns as part of a wider assessment of the adult's care and support needs – collating information from referrers (where available), the adult's circumstances; existing support systems, current and historic health and social care involvement.

6.3.20. Many of these forms were revised in March 2018. It is positive to note that the supporting documentation is improved but it remains constrained by the procedures. As the procedures are revised, the supporting documentation, decision making tools and process maps will all need reviewed and refreshed to reinforce the new procedures.
[Recommendation 4]

6.3.21. In relation to availability of specific subject matter guidance, the review is aware of work underway to provide guidance on areas such as financial exploitation and falls management. There are however gaps in guidance for areas that have emerged as concerns in recent years. Examples are Prevent anti-terrorism agenda and Modern Slavery.

6.3.22. Interviewees agreed that the transient population and agricultural economy in Jersey, may make some people highly vulnerable to Modern Slavery. Police do have a clear route for responses to Modern Slavery but there is a lack of multi-agency policy and guidance and HCS practitioners are unclear about their role as first responder through the National Referral Mechanism.[33]

6.3.23. There is also no policy for managing allegations against persons in a position of trust, i.e. anyone working in either a paid or unpaid capacity, with adults who have care and support needs.[34] An allegations management policy is in place for safeguarding children and there is work underway to extend this to adults. The new Regulations of Care,[35] due to be phased in in 2018, set out standards expected by the employing body but there remains a gap in defining how and when concerns should be shared with other key individuals such as the HCS SAT and regulators. This procedure will need to apply principles of proportionality and accountability relevant to protecting the well-being of adults at risk. This is considered further in section 6.3.50 below on regulation.

6.3.24. Management of pressure care and interface with safeguarding adults is a further area that would benefit from update. Pressure damage is a common reason for referral and requires skilled clinical knowledge to establish if it was avoidable or may indicate neglectful care.

6.3.25. The Department of Health issued guidance in January 2018 on safeguarding and management of pressure care.[36] This has been widely consulted on by clinical experts and specialists in safeguarding adults. It provides for robust and proportionate decision making about whether a referral should be made through safeguarding procedures.

6.3.26. In one of the cases reviewed, it was clear that the pressure damage was not caused through neglectful care. The adult (who was interviewed as part of the review) was able to give a clear

[33] The National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support. https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slavery-england-and-wales
[34] Jersey does have a policy in place for person's in positions of trust for Safeguarding Children
[35] Regulations of Care (Standards and Requirements) (Jersey) Regulations 201-
[36] Department of Health (2018) Safeguarding Adults Protocol Pressure Ulcers and the interface with a Safeguarding Enquiry https://www.gov.uk/government/publications/pressure-ulcers-safeguarding-adults-protocol [Accessed August 2018]

account of her informed choice not to follow the treatment advice and the records indicated all reasonable steps had been taken to try and prevent the ulceration. However, the process to establish this was overcomplicated and disproportionate given the information that was known at point of referral. There was an extremely detailed and thorough nurse investigator report and several safeguarding meetings involving many professionals and the adult. This was not the best use of resources.

6.3.27. The Department of Health guidance was not available at the time of this referral. The HCS SAT has been accessing clinical opinion regarding whether pressure damage may be due to neglect. At the time of the review, practitioners were aware of the Department of Health guidance and it is understood there were plans to adopt it in Jersey.

6.3.28. There is a need to review the policy and procedures and incorporate guidance on these specific subject matters.
[Recommendation 4]

6.3.29. The review also heard of some positive work to align responses to safeguarding adults and domestic abuse. The IDVA reported that until a year ago, IDVAs had not received any referrals from the SAT. The IDVA and SAT have worked together to develop a pathway. An interview carried out by this review with one adult (Adult 4) was a good example of safeguarding now using the expertise of IDVAs.

- Assurance: Data that informs the SAPB

6.3.30 The SAPB has a dashboard for safeguarding adults. The dashboard provides some useful information but is weighted toward activity and demographic information. The review was informed that there are no Jersey wide unified categories for recording data on ethnicity and consequently the data is not reliable.

6.3.31. There is limited qualitative information, other than the limited number of service user feedback returns (as referenced on 6.2.). The review was informed that there has been limited multi-agency qualitative audit carried out to date and that this is a priority area for the SAPB.

6.3.32. Interviewees were generally of the view that the partnership needed to make better use of data as part of the wider cycle of continual development and informing the SAPB's priorities.

6.3.33. Outcomes based accountability (OBA) offers a simple but effective performance framework that moves the emphasis of information from outputs to outcomes – answering the '*so what*?' question.

Outcome	Safeguarding Adults in Jersey
Indicators	Measures that quantify the achievement of that outcome
Performance Measure	A measure of how multi-agency safeguarding is working – based on a matrix that draws out questions:

	Quantity	Quality
Effort	How Much Did We Do?	How well did we do it?
Effect	What difference did we make? (numbers)	What difference did we make? (% population or individual experiences risk reduction and enhanced wellbeing)

6.3.34. Currently, data is weighted toward the effort/quantity dimension - '*how much did we do*.'

6.3.35. The data that *is* available indicates safeguarding adults activity in Jersey is broadly in line with statistics from England (239 enquiries per 100,000 population). [37]

6.3.36. In 2017 there were 389 'alerts' in Jersey. This is 0.36% of the population. Of this number 239 met criteria and were managed as referrals under the procedures (0.22% of the population). This equate to a 61% conversion rate.

6.3.37. However, there is a need to ensure a single operating procedure that defines what is being counted as a safeguarding referral managed under procedures. The review learned that where an alert meets criteria but is managed through a different resource than the SAT, (such as the adult's social worker), this is not being recorded as a safeguarding referral. This skews data and also does not build up a chronology of the safeguarding concerns for that adult. **[Recommendation 13]**

6.3.38. The SAPB annual report for 2017 notes the highest referrers were hospital, social work services and residential services. Neglect was most prevalent form of abuse. Main support reason was a learning disability.

6.3.39. In comparing this data to England, it indicates Jersey is not an outlier. Nonetheless, it should lead to further enquiry to understand the context behind these figures. The review of safeguarding people with a learning disability has provided the opportunity for further qualitative enquiry.

6.3.40. A dashboard based on an OBA model, would combine qualitative and quantitative data with audit work and user feedback to understand what difference safeguarding arrangements are making. This in turn would inform the SAPB's strategy and programme of work.

[37] Safeguarding Adults, annual report: England 2015-16, experimental statistics. NB The term 'Enquiries' is broadly the same as 'Referrals' in Jersey's procedures

6.3.41. The reviewer was informed OBA is already used in other aspects of the HCS and some staff are trained in the methodology so could offer leadership in this.
[Recommendation 13]

6.3.42. The current data set is also very focused on the SAT activity. This is understandable in that they are the lead agency for safeguarding adults. However, there is very limited data from other parts of the partnership.

6.3.43. Some partners, such as social security and probation held data on referrals and outcomes. Police also had information about the number of APN's made– however, as discussed in section 6.1, these do not distinguish between referral for broader welfare needs as opposed to making a safeguarding referral and again, this data is about activity. There was limited data provided to the SAPB that could lead to more qualitative enquiry, for example, prosecutions arising from safeguarding interventions or patterns of repeat APN's.

6.3.44. The review heard that the health safeguarding adults team are just beginning to develop data that helps them to assure that health practitioners are identifying and referring appropriately. Until recently, they had limited information to help them assure clinical governance responsibilities for safeguarding adults as set out in Department of Health guidance.[38] There had also not been routine reporting of safeguarding assurance regarding health care, to the senior executive team through the Chief Nurse.

6.3.45. At time of the review, the health safeguarding team was in the early stages of collating safeguarding data as part of wider incident reporting through Datix. Datix is a patient safety system, widely used in the health services to record incidents. It enables governance of all clinical incidents, as well as drawing off themes and trends. In relation to safeguarding, Datix would enable the health safeguarding team to check all reported incidents in case a safeguarding referral has not been made where one was warranted.

6.3.46. Use of Datix to record safeguarding alerts made by health staffs, will also flag areas of the service with high or low referral rates and identify emerging patterns relating to quality of care, as part of preventative safeguarding work. Consequently, the Chief Nurse raised the need to know about any safeguarding alert where there were concerns about health care, as part of her professional governance role.

6.3.47. The Named Nurse reported struggling to obtain copies of safeguarding alerts made by health staff. As well as restricting good clinical governance, this will limit their ability to redress many of the concerns arising at point of raising an alert that have been highlighted within this review for example:

i) Criteria and thresholds for safeguarding procedures are met
ii) Immediate care and safety needs have been addressed and alternative pathways of care considered

[38] Department of Health (2011) Safeguarding Adults: The role of health services https://www.gov.uk/government/publications/safeguarding-adults-the-role-of-health-services [Accessed August 2018]

iii) The adult has been consulted, consent gained (or justification for acting without consent)and recorded

iv) Reasonable lateral checks made and background information provided

This would be consistent with the roles and responsibilities expected of the Named and Designated Professionals for Safeguarding Adults, as set on in the recently published inter-collegiate guidance.[39]

6.3.48. In interviews with the health safeguarding adults team and SAT, it was agreed it would be helpful for periodic joint review of relevant incidents recorded on Datix. This could reinforce a clear benchmark of thresholds for raising alerts and address any concerns that incidents are inappropriately 'screened out' or managed outside of procedures. This could be part of a work to improve integrated working between these two teams, discussed further in section 5.4. below.
[Recommendation 19]

6.3.49. The review also understood that there is limited data available to identify recurring concerns across all providers of health and social care and to draw off themes of concern that are commonly occurring across providers. This data is important to flag potential deficits in the system and to generate any required improvements in pathways of care, for example, if safeguarding concerns are arising due to poor communication of care needs at point of transfer.
[Recommendation 15]

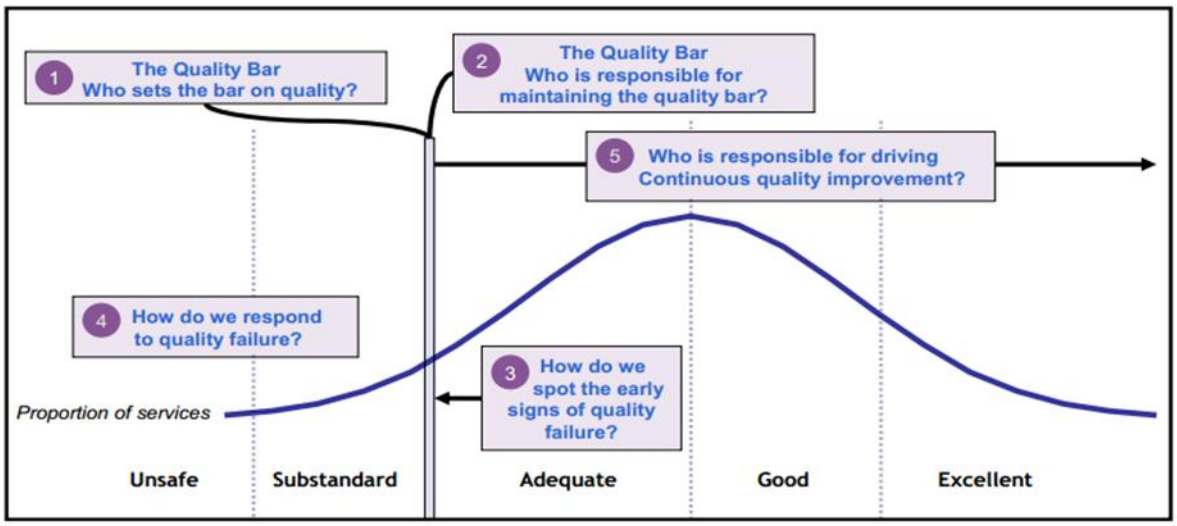
6.3.50. It is understood that work is already underway within the SAPB to revise the data set for 2019. It is hoped that the findings from this review will be helpful to this process.

- Regulation and Interface with Safeguarding Adults

6.3.51. There can be substantial grey areas in establishing when sub-optimal care should be defined as abuse or neglect meeting thresholds for safeguarding adults. As outlined in section 6.1, the audits identified variable interpretation of this threshold.

6.3.52. A diagram by Sir Bruce Keogh,[40] considers the quality of care as a continuum and asks questions about responsibilities for sustaining standards and responding to sub-standard and unsafe care.

[39] Royal College Nursing: Adult Safeguarding: Roles and Competencies for Health Care Staff (August 2018) https://www.rcn.org.uk/professional-development/publications/pub-007069
[40] National Commissioning Board: The NHS Commissioning Board's role in maintaining quality; Sir Bruce Keogh 2012



6.3.53. This concept can also be applied to safeguarding work within care settings, considering roles and responsibilities for providers, regulators and the SAT:

- Preventative work: Setting and sustaining acceptable standards of care:
- Proactive work: Supporting improvements, sharing information; identifying and tackling emerging concerns and themes to avert risks of abuse and neglect.
- Responsive work: Collaborative and assertive approaches to managing safeguarding concerns arising from substandard or unsafe care

6.3.54. Providers of health and social care should have internal governance processes to assure the quality of care. An example is in HCS, the Chief Nurse informed the review of developing a new nursing accreditation and assessment assurance framework, with standards that mirror the Care Quality Commission core standards using key lines of enquiry. The Designated Nurse was also working to develop a joint governance group as part of her assurance role.

6.3.55. However, at time of the review, there was no independent regulation of State providers of health or social care. The regulator's role was limited in statute to some independent providers of health and social care.

6.3.56. There was a consistent view from those interviewed, that this had led to an inequitable process. The independent care providers focus group, expressed strong views of a power in-balance – their view that the level of scrutiny of care within their independent provision was not mirrored in State funded provision.

6.3.57. Some attendees were also highly critical of how the safeguarding procedures and thresholds were applied. Their view was that a different yard stick was applied to them than would be used in the hospital. They were also critical of the quality of responses, delays in responding to alerts and occasions when they were not made party to safeguarding plans even where they may know the adult best.

6.3.58. Independent care providers also shared frustrations in having no 'right to reply' where allegations and findings of 'abuse substantiated' were found – in one example given, this was even in the face of contrary findings by the regulator. They had not used the SAPB escalation

procedure and felt their only redress is through the complaints procedure which there was no confidence in. As outlined in section 6.2, this can lead to an alienating and conflictual experience.
[Recommendation 15]

6.3.58. The interviews with HCS managers discussed situations where the safeguarding investigation relates to a social care provider that is managed by the same manager who is responsible for the SAT. This will present challenges in objectivity and reinforces perceptions of conflicts of interest and inequitable treatment.

6.3.59. The manager emphasised that great care is taken to ensure a robust safeguarding investigation is carried out. Nonetheless, there is a need to ensure objectivity and the appearance of objectivity, 'clear blue water,' particularly when the nature of the safeguarding incident may be serious. There has not been any formalised way of managing this, for example, establishing reciprocal arrangements with peer services on other islands.

6.3.60. Similarly, within State funded health care, health practitioners from the service are routinely involved in investigating safeguarding concerns relating to their care provision. This may well be appropriate given the clinical expertise required and the standards of clinical governance in place. However, their needs to be a proportionate and equitable process for determining when any provider (State or independent), should be actively involved in safeguarding incidents arising from their care. This needs to weigh factors such as:

- severity or recurring nature of the safeguarding concern
- the ability of the provider to be objective
- whether the provider has the skills required to carry out enquiry
- degree of confidence in the provider to be open and transparent etc.

[Recommendation 15]

6.3.61. The review heard that the ethos of regulation is for support and improvement. The SAT and health safeguarding team, could contribute to this proactive and preventative approach through sharing information about emerging concerns and/or trends and pressures across the system.

6.3.62. The review understands that currently, there are no formal information sharing meetings in place between regulators and SAT. As noted earlier in this report, there is no policy for managing allegations against people in a position of trust and the SAT does not collate data about emerging themes and trends.
[Recommendation 4, 15]

6.3.63. At the Independent Care Providers focus group, there was discussion about ways to generate a more proactive and constructive relationship between safeguarding and providers. Independent Care Providers were supportive of a forum to provide support and improvement across the sector, for example sharing best practice; inviting expert speakers, developing care pathways and opening up communication with SAT – an area that some providers felt was significantly lacking.
[Recommendation 16]

6.3.64. Jersey has recently carried out significant work to establish a new, comprehensive and independent regulatory framework. The regulation of care,[41] sets standards and requirements for all providers of health and social care services from the large State General Hospital through to an individual Personal Assistant. The regulations are due to be implemented in 2018 but through a phased roll out to different types of providers.

6.3.65. This new regulatory system will have a positive impact on safeguarding adults within all care environments. The gives the opportunity to use this new system to strengthen how providers, regulators and HCS work together to safeguard adults from preventative/pro-active approaches, through to responses where there are concerns about abuse or neglect. **[Recommendation 15]**

6.4 Partnerships and Culture

6.4.1. Many people interviewed for this review identified partnership working as a strength in Jersey, both in relation to safeguarding and in the other aligned partnership arrangements such as JMAPPA and MARAC and the joint management of the IDVA service.

6.4.2. SAPB members highlighted the commitment by all to '*getting safeguarding right.'* This commitment was demonstrated in the contribution by the SAPB to this review. There was a generalised view of effective partnership working at operational level as well as strategic levels.

6.4.3. The review noted many positive contributions and initiatives made by partner agencies and practitioners who were working together toward a shared goal. It was common to hear SAPB commenting positively about other partners and there was respect for the collective knowledge within the SAPB.

> *'SPB is a good place…someone will know how to get the job done.''*
>
> **SAPB Member**

6.4.4. Some practitioners and their line managers felt there was a need to strengthen the connection between the strategic work of the SAPB and frontline practice. This would attune the SAPB to pressures on the ground and improve understanding of how its work is influencing practice. **[Recommendation 17]**

6.4.5. One example given was a view that the increase in serious case reviews (SCRs) has increased anxiety for staff and resulted in 'back covering' responses that can undermine relationships between partners.

6.4.6. SCRs by definition focus on when things have gone significantly wrong (although should also highlight good practice). This should lead to constructive learning but can have a dispiriting effect on the partnership.

[41] Regulation of Care (Standards and Requirements) (Jersey) Regulations 201-

It is necessary to carry out SCRs, but equal attention should be paid to randomised multi-agency audit, and to cases that exemplify effective practice and collaborative partnership working i.e. an appreciative enquiry approach. This celebrates and extends good practice and may also help strengthen the connection between the SAPB and front-line practice. This would assist in building a balanced assurance framework as outlined in section 6.3. **[Recommendation 13]**

6.4.7. There were many examples of effective partnership working in operational practice. The audit interviews found in general that referring bodies felt their contributions were respected and considered. 67% felt very satisfied, 25% were mainly satisfied and 8% viewed the respect and consideration given to their contribution was poor.

6.4.8. There were variable views on how clear and reasoned decision making was in relation to individual audit cases. (50% viewed this very highly, 33% moderate and 17% felt decision making was poor) This perhaps reflects the diverse nature of referrals and that decisions can be difficult and at times contentious.

6.4.9. Police commented that the response of the SAT was invariably measured and acknowledged the validity of referring professionals. However, an interview from another agency felt it was difficult to have their perspective heard and a further interviewee commented on how a case of self-neglect had caused them to lose sleep and they had had to push for action. This case may reinforce the challenges of responses to self-neglect where the public interest threshold is not deemed to be met and further reinforces the need to establish a more comprehensive multi-agency approach below the thresholds of safeguarding.

6.4.10. Tensions within any safeguarding partnership can be common. Sometimes frustrations can arise as partners are constrained by resources or the statute and guidelines governing their work. An example may be frustrations in progressing prosecutions due to limitations in Jersey of having special measures for vulnerable witnesses and 'Achieving Best Evidence' arrangements being limited to people with mental health needs.

6.4.11. As identified, tensions commonly arise where partners are critical of thresholds and access to services. A healthy and secure partnership should encourage debate and respectful challenge as this is likely to generate the best quality of decision making and focus on collective solutions.

6.4.12. The SAPB has had escalation procedures in place for many years. However, interviewees consistently confirmed that these procedures were very rarely used. There appeared to be negative connotations associated with using the escalation process – being seen as too formal and risking damaging relationships.

6.4.13. The review heard an alternative practice has emerged.

'It's an Island thing of copying everyone into emails.'

'Things go from ground level to stratospheric,'

Interviews with HCS Practitioners

6.4.14. There seemed to be a practice of involving senior managers and ministers without working through due steps of trying to resolve matters through line managers who should be better appraised of the full circumstances.

6.4.15. This approach is likely to be more difficult to de-escalate and risks feeding myths and beliefs, potentially acting on anecdotal information without all parties having all the necessary facts. Such practices are likely to be more damaging to the partnership and discourage the good practice of questioning decisions and offering alternative views. Furthermore, this may undermine and de-skill line managers.

6.4.16. The review is aware that learning from a recent children's SCR also highlighted the lack of a positive culture for professional challenge and use of escalation or resolution processes. An action from this review is to develop a framework for use in children and adults' safeguarding, that will encourage professional challenge and constructive escalation. However, for any framework to be successful, SAPB members will need to commit to shifting the culture away from the current custom and practice and empower practitioners and their line managers to resolve disagreements.
[Recommendation 18]

6.4.17. Interviewees discussed effective joint working between SAT and health practitioners, drawing on their clinical skills in the safeguarding investigation and protection plan. This was supported by evidence from the case audits.

6.4.18. Despite this positive working in frontline practice, the review found organisational tensions between health and adult social care in relation to the respective roles of the SAT and the health safeguarding adults team. HCS is an integrated service but this was not always evident in the functioning of the teams.

6.4.19. Managers and practitioners of the SAT expressed concern that the health safeguarding adult team had confused the referral pathway for safeguarding adults, undermining the lead role of the SAT. Examples were given of other disciplines sending alerts to the health safeguarding team, creating risks in the timely response to the adult.

6.4.20. The Named and Designated Nurses from the health safeguarding adult team acknowledged that historically, there had been confused communications and pathways and they are working to redress this. They described their role as providing leadership, challenge and assurance across health services, supporting health practitioners to identify safeguarding concerns and to follow the safeguarding adults procedures. However, the review heard there remained misinterpretation of their role by different HCS services.

6.4.21. The health safeguarding team can make a valuable contribution in addressing some of the problems outlined in this report – raising the quality of information in alerts by health colleagues; guiding health practitioners in applying the criteria; assuring openness and transparency. This team also provides additional resource and clinical expertise to support the

SAT in managing safeguarding responses. These responsibilities are now set out in the recently published inter-collegiate document.[42]

6.4.22. It is therefore unfortunate that the current tensions and misunderstandings seem to be getting in the way of these two teams making best use of their combined limited resources toward their shared goal of improving safeguarding adults.

6.4.23. It would be beneficial for the SAT and health safeguarding adults team and their respective line managers to have a facilitated session to help them work through respective roles and responsibilities, dispel myths and establish more constructive partnership working so that best use can be made of scarce resources.
[Recommendation 19]

6.4.24. The partnership also has a Multi-Agency Safeguarding Hub (MASH) for children and is considering extending this to safeguarding adults. Co-locating agencies has the potential to strengthen multi-agency safeguarding and potentially help resolve some of the current tensions between the SAT and health safeguarding adults team:

- Provide more robust risk assessment through bringing together information held by different partners
- Strengthen risk management through accessing the professional expertise of different disciplines
- Build relationships and mutual respect between professional groups
- Potential to strengthen connection across safeguarding children and safeguarding adults, for example, in relation to domestic abuse

6.4.25. The MASH also provides a clear single point of access for public and agencies. Some members of the Honorary Police were not clear about the current referral routes and, as noted some alerts have been sent to the health safeguarding adults team rather than the SAT.

6.4.26. The prospect of a MASH was broadly welcomed by those interviewed. However, there were concerns that the improvement agenda required in children's services (arising from the Jersey Care Inquiry and recent Ofsted inspection) may detract resources and attention away from safeguarding adults.

6.4.27. There are different models used by safeguarding boards in how a MASH may operate and which functions of the safeguarding process it will manage e.g. information gathering; triage; initial assessments. There is a need for careful planning in order to ensure the MASH does add value to safeguarding adults – defining roles and responsibilities; investing in team building and a shared culture; developing the necessary protocols and systems that will support joint working.
[Recommendation 20]

6.5. Leadership and Workforce

[42] Royal College Nursing: Adult Safeguarding: Roles and Competencies for Health Care Staff (August 2018) https://www.rcn.org.uk/professional-development/publications/pub-007069

6.5.1. At the time of the review, there was a radical restructuring of services underway. Some interviewees commented on the destabilising effect this had had in being able to get consistency of approach to sustain improvement work in safeguarding adults.

6.5.2. There was also a view of needing to build leadership from within Jersey. Some interviewees commented on the risks of practice becoming insular and the need to look outside Jersey to keep abreast of new developments and best practice. This was reflected in some of the findings from the review, noted in section 6.2. and 6.3. However, the review also recognised the unique opportunities Jersey has and, as one senior manager pointed out:

> *'You have to understand Jersey culture – you can't just 'drag and drop' from England.'*
> **SAPB Member**

6.5.3. There were many examples of strong leadership across individual agencies at SAPB level – the welfare-based ethos of the States of Jersey police was a good example and was consistently commented on. As noted, there is strong commitment by senior managers across agencies to safeguard adults.

6.5.4. Creating the momentum for change and shifting culture toward MSP, may require investment in safeguarding adults leadership at front-line management level. This could generate a self-supporting group across partner agencies with a shared vision and common purpose to take forward the recommendations from this review and influence change in practice. **[Recommendation 21]**

6.5.5. There had been mixed experiences of training and development. For most agencies, safeguarding adults training was a set requirement. Agencies interviewed, such as the police, probation, social security and Shelter Trust, had used their specialist safeguarding leads and the SAPB's pool of trainers to roll out training across the workforce. Health colleagues recognised their previous training had not delivered to the standard needed and were developing a new training programme set at different levels and made bespoke for the care setting/professional discipline. This will be linked to a competence passport and should be part of approved SAPB training.

6.5.6. The SAT team has been providing training to specific groups. Some attendees at the Honorary Police and Constable focus group commented very positively about the training they had received although many others had not accessed it or known about it. Due to the high turn-over of Honorary Police, they requested an annual training session so that they could maintain a high level of expertise within each parish.

6.5.7. Members of the SAT team felt training should be a priority. They had been providing training although this should be delivered through the SAPB. Members of the SAT team also commented on the need for their own professional development as lead professionals in safeguarding adult's work. They identified a need to develop a training plan that was linked to Jersey priorities and UK developments.

6.5.8. For some interviewees it appeared they were not clear about what training should be provided by the SAPB and what remained the responsibility of the partner agency, quality

assured through the SAPB. It is understood that the entire budget for the children's and adult's Safeguarding Partnership Board was just over £7,000, but following the Care Inquiry, has increased. The SAPB has delivered foundation training and commissioned a training agency to deliver training at levels 3 and 4. However, the training offer is necessarily limited by resource and dependent on a pool of trainers drawn from partner agencies.

6.5.9. At time of the review, there had been recent multi-agency training on capacity, in preparation for the implementation of the new legislation. This was commented on very positively and hopefully will help to build competence required for practice.

6.5.10. There are plans to develop an Adult Safeguarding Capability Framework. This work should note the findings from this review and set out competency requirements against different levels and an annual training programme linked to the SAPB priorities. The Adult Safeguarding Capability Framework will also need to determine governance and quality assurance of any training that is not directly delivered through the SAPB.
[Recommendation 22]

6.5.11. Supervision and peer development will support the application of training to practice and also support practitioners in what can be very difficult and emotionally challenging working environment.

6.5.12. The review heard HCS practitioners' call for time to have supervision, reflection and development although there is a SPAB supervision policy. The Designated Nurse is aiming to establish a peer supervision group for health practitioners which is a positive initiative for that sector. Interviews arising from the case audits identified that there had been limited opportunity for reflection and de-briefing

> *'The team have been dealing with a number of sexual abuse cases and yet have had no time for reflection either as individuals or as a multi-agency approach and therefore no learning from situations taking place to support protective measures for staff nor findings being used to improve upon practice or commend good practice.'*
>
> **Learning Disability Review Audit Report**

6.5.13. Developing opportunities for supervision, reflection and peer development, will support resilience of practitioners and extend practice. Linking to peer-groups for Safeguarding leads in England may also help keep abreast of national developments and sharing best practice.
[Recommendation 23]

7. Conclusion

7.1. This review set out to understand:

1. How the multi-agency partnership is identifying and responding to safeguarding adults in Jersey
2. What outcomes are being achieved for adults at risk of abuse in relation to their well-being and protection and whether responses reflect Making Safeguarding Personal.
3. The strengths and barriers to effective partnership working.

7.2. The review has identified some examples of good practice and strong collaborative multi-agency working. The review heard directly from some adults and carers about the difference this had made to their lives.

7.3. The review has also identified where multi-agency practice needs to be improved and how practitioners should be supported better by the systems that surround them.

7.4. Some interviews highlighted that historically, reviews have been held but then had not led to change. However, all those who contributed to the review were hopeful that the investment into this review and the learning disability safeguarding review, could lead to real change, feeling that safeguarding adults was overdue for reform.

7.5. The review comes at a time of radical change in Jersey with new legislation, restructuring of services and a new senior team. This presents an opportunity to make a significant improvement in how Jersey safeguards adults. It is hoped the recommendations from this review will aide this process.

8. Recommendations

Recommendation	
Prevention	
1.	**Partner Agencies:** Establish a multi-agency panel to coordinate care for higher risk cases that do not meet safeguarding adult criteria
2.	**SAPB:** Update briefings and guidance on information sharing in line with the GDPR, so that agencies have a common understanding of the provisions and limitations of sharing information, including circumstances where information can be shared without consent.
3.	**SAPB:** Develop a strategy around levels of need, setting out how agencies should work together in relation to prevention; early help and responses to higher levels of risk and need. The strategy should: I. Create a cohesive response that coordinates State; Voluntary Sector, Parish and Community II. Communicate what each agency's 'offer' is for different levels of need. III. Incorporate the draft safeguarding adults prevention strategy into this wider strategy IV. Establish robust interface between different levels of need including in-reach from safeguarding specialists and step down from safeguarding plans V. Define the role and remit of the Safeguarding Adults Team

Making Safeguarding Personal	
4.	**SAPB:** Revise procedures, decision tools and supporting guidance: i) To better reflect Making Safeguarding Personal. ii) To provide specific subject guidance including modern slavery and allegations against people in positions of trust and pressure care. iii) Consider using an adapted form of Signs of Safety approach in adult safeguarding
5.	**SAPB:** Develop accessible information for use in each part of the safeguarding adult pathway.
6.	**HCS:** Review and revise the safeguarding pathway within Health and Community Services to ensure: ○ Clear responsibilities for reviewing the efficacy of the safeguarding protection plans ○ Effective 'step-down' and safe transfer from the safeguarding intervention to any continued support ○ Provision of restorative care, (including recording and using data on unmet need where this is not available).
7.	**HCS:** Develop systems for feedback from adults and carers as routine, record reasons for exceptions.
8.	**HCS:** Advocacy: Ensure advocacy for safeguarding adults is contained in the new service specification and assurance to SAPB that the need for advocacy is being identified and accessed
9.	**SAPB:** Lead a public awareness campaign to inform and empower public; carers and adult who may need safeguarding, including what they should expect from the process.
10.	**SAPB:** Set a development plan for adult and carer involvement in the strategic work of the SAPB.
11.	**SAPB:** Appoint a dedicated resource to lead the Making Safeguarding Personal improvement agenda at operational and strategic levels, including implementation of the Capacity and Self-determination (Jersey) Law into safeguarding practice.
Systems, Processes and Accountability	

12.	**HCS:** Develop mechanism to flag repeat alerts
13.	**SAPB:** Assurance Dashboard i) Develop a model for Outcomes Based Accountability to strengthen the SAPB assurance dashboard and balance across qualitative and quantitative information ii) Establish routine, multi-agency qualitative sampling of safeguarding alerts and responses to assure the quality of risk assessments, safeguarding protection plans and step-up/step-down care. iii) Develop the multi-agency data set, strengthening MSP and clarifying a single operating procedure to define what is being counted as a safeguarding activity. iv) Develop assurance mechanisms to develop a culture of appreciative enquiry to draw out and extend positive examples of multi-agency working.
14.	**HCS:** Resource dedicated administrative support for the SAT to release resources of the safeguarding practitioners, improve administrative support for individual cases and to provide business management information e.g. data analysis.
15.	**Care Regulator and HCS:** Develop working arrangements between the regulator and SAT for roles and responsibilities under the new regulations, (where necessary, supported by a memorandum of understanding and protocols) setting out roles and collaboration in: • Preventative work: continuous improvements in care provision • Proactive work: information sharing meetings; systems to identify emerging concerns and recurring themes; redressing systems and care pathways • Responsive work: Clarity of roles; equitable inclusion and involvement of providers; 'right to reply'; managing allegations against people in position of trust
16.	**HCS; Care Regulator; Care Providers:** Engage Independent Care Providers in developing a forum e.g. showcase best care; practice development; joint work on pathways of care etc
Partnerships and Culture	
17.	**SAPB:** Review and develop the connection between the SAPB with frontline practice, so SAPB directly informs practice and practice directly informs the work of the SAPB
18.	**Safeguarding Children and Adults Partnership Board:**

	Progress the development of the escalation/resolution toolkit for use in adult and children's safeguarding work. SAPB members to demonstrate leadership in behavioural change, supporting practitioner's and their direct line manager, to make constructive challenge and reach resolution, calling on senior managers and ministers by exception.
19.	**HCS:** Provide a facilitated workshop between SAT and the health safeguarding team to define roles and responsibilities and maximise collaboration toward their shared objectives.
20.	**Partner Agencies:** Consider learning from this review in the development plans for the MASH: • Define the added value and how this will be measured • Define roles and responsibilities • Invest in team building and a shared culture/values • Develop the necessary MASH protocols and systems that will support joint working.
Leadership and Workforce	
21.	**SAPB:** Invest in a leadership programme for front-line managers to take forward the improvement programme arising from this review and support change in culture and practice ○
22.	**SAPB:** Develop the safeguarding adult capability framework. ○ Use learning from this review to inform development of the framework ○ Connect to an annual training programme linked to the SAPB priorities ○ Set out core offer by the SAPB and requirements for partner agencies' provision and quality assurance of training not directly delivered through the SAPB training pool
23.	**SAPB and Individual Partner Agencies:** Develop opportunities for supervision and peer group learning to build on good practice and support emotional resilience.

Sylvia Manson

Date: October 2018

Sylman Consulting

Appendix 1: Review Components

1. Case Sampling

Reviewing 30 randomly selected cases from 2017. This is approximately 10% of cases referred to safeguarding adult social care in 2017. Cases were selected by the review team to be representative of presenting need, gender, age, and referring agency. The review also identified cases that had been re-referred within a one-year period.

The audit sample included 8 cases relating to adults with a learning disability. These cases were audited by the independent specialists from the learning disabilities review team.

Of the sample group of 30:

i) **Sample group 1:** 50% of cases (15) were screened out from requiring a response under multi-agency safeguarding procedures. Of this sample group:
   - For 8 cases, the reviewers made further enquiry as to whether the alternative plan was acted upon.
   - 4 cases included interviews with the referrer and the ASC safeguarding practitioner.

ii) **Sample group 2**: 50% of cases (15) had been managed under safeguarding adult procedures. Of this sample group:
   - 8 cases included interviews with the referrer and the ASC safeguarding practitioner.

A narrative report arising from the 8 cases relating to adults with a learning disability is available from the SAPB. A separate narrative report relating to the remaining 22 cases of adults with other care and support needs is also available through the SAPB.

The RAG chart summarising the results is embedded in appendix 2

2. Service User and Carer Views

The review sought views of service users and carers in line with Making Safeguarding Personal

i) One to one interviews with five service users and a carer
ii) Interview with advocacy provider
iii) Analysis of service user data and satisfaction questionnaire returns for 2017
iv) Questionnaires to service users and carers

3. Systems and Processes

i) Review of agency and inter-agency related safeguarding adult policy, procedures and protocols
ii) Review of partner agency and SAPB quality and performance reports and data sets related to safeguarding adults
iii) Review of decision tools and guidance that supports safeguarding practice
iv) Review of recommendations arising from adult serious case review since 2015

4. **Semi-structured interviews:**

Interviews with senior managers and practitioners from key partner agencies and other stakeholders:

- **SAPB** Independent Chair and SAPB Business Manager

- **Police**: i) Representatives from senior management team ii) Interview with officers from the Public Protection Unit
- **HCS** Interim Director Community and Adult Services
- **HCS Health** i) HSS Chief Nurse, Health and Social Services ii) Named and Designated Nurse
- **HCS Community and Social Services** i) Director of Operations Community and Social Services and Director of Adult Social Services ii) Senior Managers Community and Social Services iii) Safeguarding adult practitioners and team manager
- **Probation:** Assistant Chief Probation Officer
- **Social Security**: Operations Director and Head of Occupational Support
- **Shelter Trust**: Manager of Shelter Trust
- **Head of Care Regulations**, Community and Constitutional Affairs

5. Focus Groups with Stakeholders

Focus groups:

1. Parish Officers and Honorary Police
2. Independent Providers of Social Care
3. Health managers and practitioners

6. Facilitated Workshop with Partner Agencies

Workshop with SPAB partner agencies and front-line managers involved in safeguarding adult services.

Appendix 2: Collated results from the audits and audit interviews

Audit results RAG chart - final anon 1

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About the reviewers

This review was led by Sylvia Manson, of Sylman Consulting. Sylvia is a mental health social worker by background and has many years' experience in Health and Social Care senior management and commissioning. Sylvia worked for the Department of Health, developing safeguarding adults policy and guidance including the Safeguarding Adult Principles, now incorporated into the Care Act statutory guidance. Sylvia was also a Department of Health regional lead for the Mental Capacity Act 2005 and Mental Health Act 2007.

Sylvia now works for the Mental Health Tribunal along with independent consultancy focused on partnership development, service improvement and statutory learning reviews. Prior to this review, Sylvia had carried out two Serious Case Reviews in Jersey.

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Case Audit Team

The audit of cases was carried out by

- Pete Morgan – 22 cases for adults with range of care and support needs.

Pete is a registered Social Worker and was the Head of Service – Safeguarding Adults for Birmingham Adults and Community Services. He has chaired two Safeguarding Adults Boards and was a member of the DH's Safeguarding Adults Stakeholders Group relating to the Care Act 2014. Pete holds an MA in Safeguarding Adults: Law, Policy and Practice and lectures at the University of Warwick. He has authored Safeguarding Adult and Domestic Homicide Reviews.

- Judy Thorley and Jackie Lawley – 8 cases relating to adults with a learning disability.

Judi has over 30 years' experience working in the NHS. A Learning Disability and General Nurse by background, Judi has worked in a range of services in senior leadership and clinician roles within Learning Disability, Acute services, Education and commissioning. Judi has worked in a regional strategic role as lead for learning disability health and safeguarding adults and carried out a range of independent consultant work encompassing service review, review of arrangements for adult safeguarding, SAR and development and delivery of leadership development programmes.

Jackie has worked with people with a learning disability for 34 years as a nurse; nurse practitioner; a senior manager in NHS provider health care and Strategic Joint Commissioner of health and social care and as a Group Development Director for a National Independent support provider. Jackie has more recently in the past 10 years been a freelance consultant in Health & Social Care securing contracts to carry out roles of commissioning and leadership roles to support service capacity, national closure programmes and to implement service transformation /redesign.