Adult G Action Plan

Newcastle Safeguarding Adults Board

September 2017

This plan takes each of the recommendations made within the report and explains the actions taken by the Newcastle Safeguarding Adults Board (NSAB) to ensure that each learning point is addressed.

Recommendation		What the NSAB has done
1	It is recommended that the Newcastle Safeguarding Adults Board examine again the transition process to ensure as smooth and integrated a process as possible. In particular, whenever possible the family of the vulnerable person should be informed and consulted about the care of their family member notwithstanding legal requirements and the 'Adult' status of the subject.	The Newcastle Safeguarding Adults Board and the Newcastle Safeguarding Childrens Board have launched a joint transition protocol. The multi-agency protocol explains to staff members from all agencies, what should happen when a child is subject to safeguarding children's procedures and is approaching their 18th birthday. A key element of the plan involves a worker from Adult Social Care being invited to meetings as part of the safeguarding children's process to ensure that a plan is in place for when the young person turns 18. In March 2016 Newcastle City Council invited the Local Government Association to undertake an independent "Peer Review" of the transitional arrangements in place in Newcastle. In particular, the review looked at the arrangements in place for transition between Childrens Social Care and Adult Social Care. The review concluded that "transition for children with disabilities into adult social care in Newcastle is good." Safeguarding training provided to staff continues to promote the importance of effective transition.
2	It is recommended that the Newcastle Safeguarding Adults Board examine the realities of partnership working with particular emphasis on transition between Children's and Adults' services, joint decision making, the inclusion of all relevant agencies such as housing, the consideration of legal options and most importantly the inclusion of the family in all decisions if possible. These issues may be addressed by training or the refreshing of guidelines.	The Newcastle Safeguarding Adults Board have revised and re-launched a Best practice Guide for Chairs of Safeguarding Adults Meetings. This resource guides managers through the process of a safeguarding adult's enquiry and ensures that all of the relevant agencies are invited to engage in the multi-agency process. The guidance was launched with staff members via a series of bespoke sessions delivered to managers between September and November 2016.

3	It is recommended that the Newcastle Safeguarding Adults Board examine the management of Safeguarding Alerts to ensure that the cumulative effect of a number of alerts is seen as an escalation of risk to be separately considered as such.	The Newcastle Safeguarding Adults Board have in place a threshold tool and risk escalation policy to monitor the cumulative effect of concerns and ensure cases are escalated where appropriate. This tool and the associated policy ensure that when 4 concerns have been raised about an individual within a certain timeframe, the case is automatically escalated to the next stage of a safeguarding adult's enquiry regardless of the assessed level of risk. The purpose of these mechanisms is to ensure that the appropriate level of multi-agency enquiries and risk assessments are made, where numerous concerns have been raised in relation to the same individual. Newcastle City Council have re-designed the safeguarding adults recording process to ensure that the threshold guidance is embedded within the Stage One safeguarding adults form.
4	It is recommended that the Newcastle Safeguarding Adults Board consider the application and legal requirements of the Mental Capacity Act. It is a powerful piece of legislation placing responsibility on all agencies but it is complex and requires detailed knowledge. To facilitate this, it is further recommended that a Mental Capacity Act "Champion" is appointed in all statutory agencies so as to ensure a high degree of familiarity and compliance.	The Newcastle Safeguarding Adults Board offers a free and comprehensive training programme in relation to the Mental Capacity Act. Courses on offer range from Basic Awareness courses to sessions which specifically focus on the skills required when undertaking Mental Capacity Act assessments. The training is open to all staff members and volunteers working within Newcastle. All statutory Health and Social Care organisations working in Newcastle have in place Mental Capacity Act Leads who work together and within their own organisations to promote awareness of the Mental Capacity Act and provide case advice in relation to complex cases.
5	It is recommended that the Newcastle Safeguarding Adults Board address partner agencies response to clients who regularly do not attend appointments. While it is costly and frustrating and often leads to a cessation of service, in the case of Adult G it was symptomatic of his disability. Agencies and the partnership should consider non-attendance on a case by case basis and jointly agree actions to respond to this issue.	In February 2017, the NSAB Improving Practice Committee sought assurances from partner agencies about the measures in place to monitor concerns and assess risk in relation to clients who regularly do not attend appointments or engage with services. Further work in this area has been identified as part of the committees work plan for 2017-2018 with the intention to produce a set of best practice standards or guidance notes for professionals working with clients who are not engaging with services.
6	Newcastle Safeguarding Adults Board has a well-developed	The NSAB Learning and Development Committee (a sub-committee of the NSAB) have designed a case study

	training programme which has been regularly updated and widely attended. Most of the staff who worked with Adult G had attended training specifically addressing disability hate crime yet some did not recognise it when they met it in reality. It is recommended that training is once again refreshed, using experience of this case as a case study.	based on the case of Lee Irving which will feature in multi-agency safeguarding adults training. The key purpose of the case study is to provide professionals with the opportunity to reflect on the case and consider how the learning can be applied to practice. The multi-agency training programme coordinated by the NSAB is free of charge and available to all organisations working or volunteering in Newcastle. Individual agencies have also arranged specific Learning from Practice Sessions focussing on learning from Lee's case.
7	Latterly the only way to track Adult G's chaotic lifestyle was via social media, as he regularly used Facebook and other sites to communicate with associates and family. While children's services regularly use social media to communicate with clients, this is less common in agencies who deliver services to adults . It is recommended that consideration be given to improving agencies familiarity and use of social media so as to improve service delivery.	Nationally, the use of social media to engage with clients is a new and emerging theme for agencies represented on Safeguarding Adults Boards. Different agencies and professional bodies will have differing guidance for staff on the ways in which social media can be used to improve engagement with client groups. In Newcastle, the Improving Practice Committee has been tasked with identifying national best practice standards for the use of social media in a safeguarding adult's context. Findings from this work stream will then inform guidance issued by the board and through the multi-agency training programme.
8	As part of this review agencies submitted detailed Single Agency Reviews including recommendations for improving their own service. These recommendations were of a high standard and should be implemented by the relevant agencies.	As the Safeguarding Adults Review (SAR) has progressed each of the agencies represented on the NSAB have been progressing their own internal action plans. These action plans contain learning identified via the internal reviews conducted at the beginning of the SAR process. In October 2016 the NSAB SAR Committee (a sub-committee of the NSAB) met to give consideration to these action plans and received assurances from each partner agency that progress had been made in relation to each of the learning points identified.