Buckinghamshire Safeguarding Adults Board

Learning Summary

March 2023

Safeguarding Adults Reviews (SARs) are a statutory requirement for Safeguarding Adults Boards (SABs). Safeguarding adult practice can be improved by identifying what is helping and what is hindering safeguarding work, in order to tackle barriers to good practice and protect adults from harm.

'JULIE'

During her childhood Julie had complex physical and mental health needs and was supported by a number of agencies. At an early age she was diagnosed with a serious medical condition, which was complicated by concerns of parental neglect. Over a number of years, and up until her eighteenth birthday, Julie was supported within statutory Child Protection Plans but these were not successful in delivering her positive outcomes.

Upon transitioning to Adult Services Julie was diagnosed with autism, something that existed but was not identified in her childhood and adolescent years. Julie was being supported by a number of agencies however the efficacy of this support was compromised by the inability to identify a lead agency to develop and lead multi-agency planning.

Julie's mental wellbeing and health continued to deteriorate, and her condition became life threatening as a result of the improper use of her medication and self-neglect.

KEY LEARNING THEMES

Child Protection

The understanding of practitioners around medical neglect, multi-agency planning and lack of improvement around outcomes of Child Protection processes

Adult Safeguarding

Referral process where the are significant numbers of referrals received, and protocols for complex cases where there are vulnerable people who do not meet the Care Act criteria for care and support needs

Multi-Agency Planning & Outcomes

No clear method of identifying a lead agency to take responsibility for the development and delivery of multi-agency planning.

The apparent lack of specialist pathways and services to support people who are autistic and have complex needs.

Transition From Children's to Adult Services in Complex Cases

In complex cases a good transition from Child to Adult Services should provide the opportunity to develop multi-agency plans in advance of the eighteenth birthday and to also allow the young person to develop relationships with their new Support Workers before those from Children's Services stop working with them.

Whilst transition procedures exist for young people who are leaving care, such a process does not exist for young people in Julie's position.

RECOMMENDATIONS

A 'medical neglect' awareness training programme should be delivered to Social Workers and Managers working with the First Response Team of Children's Services. This should aim to develop a greater understanding of serious medical conditions and how this may be seen in a Child Protection context.

A protocol should be developed for the management of complicated child protection cases which considers: how adult and children's services work together; a framework to identify and measure desired outcomes; the leadership and management oversight of professionals working within complex cases. Whilst the definition of 'complicated cases' may be subjective, it is recommended that this includes cases where positive outcomes have been difficult to achieve and where they may involve a number of agencies or specialist disciplines.

A 'medical neglect' awareness training programme should be delivered to Adult Social Care Workers and Managers, who are involved in the assessment of safeguarding referrals. This should aim to develop a greater understanding of serious medical conditions and how this may be seen in an adult safeguarding context (self-neglect).

Adult Social Care should lead on the development of a partnership guidance document for strategy discussions, which should provide clear guidance on thresholds and levels of intervention. This includes the principle that any agency may request a strategy discussion and where disagreement exists on the necessity, one should be held if a professional discussion between safeguarding leads fails to resolve the difference. This guidance should be supported with the development of a quality assurance framework to ensure the consistent application of thresholds and the effective communication between agencies.

The BSAB Escalation and Resolution Procedure (dated September 2016) should be reviewed to ensure that it captures all of the learning from this Review.

The Buckinghamshire Integrated Care Board should lead in the development of local early help pathways for vulnerable adults. This should include: a method of identifying vulnerable people; a forum to discuss cases at a local level and coordinate services; a protocol to identify a lead agency in complex cases.

A multi-agency review should take place of the specialist capability in Buckinghamshire to support people who have both autism and complex needs. The review should seek to define the gaps in services, improve current services, and where necessary develop new pathways.

It is recommended that a new transition protocol is developed for young people with complex needs. This should allow the development of multi-agency planning and a lead agency to be appointed prior to the young person reaching their 18th birthday. The planning meetings should include Adult and Children's Social Care, any other agencies that are working with the young person, and should consider what early help pathways could provide ongoing support.

Who are we and what do we do?

[About the BSAB - Buckinghamshire Safeguarding Adults Board (buckssafeguarding.org.uk)]