Suffolk
Safeguarding Adults Board

Review of multi-agency Adult Safeguarding services in Suffolk

Briefing note for Team Meetings

SUMMARY

This briefing sets out what was learnt from a review of multi-agency adult safeguarding services in Suffolk. The review was commissioned by the Suffolk Adult Safeguarding Board, following concerns about how effectively safeguarding services to and for vulnerable adults and older people are being provided and managed.

The review focusses on how the whole system works together. It is not a review of individual cases, specific organisations or the practice of specific professionals. It identifies what needs to change to ensure that vulnerable adults and older people receive the best possible services and outcomes when in need of or the subject of safeguarding services.

FINDINGS

Much of what the review has identified was known across the system. Importantly the review found that no one is at serious risk of harm from system failure or poor practice at this point in time and overall, practice is adequate.

The review found:

- Some outstanding pieces of casework, and some good, innovative and caring practice.
- The skills of frontline staff in all agencies are recognised but are not always best utilised when considering safeguarding issues.
- Weight is not always placed equally on the frontline's understanding of how to best promote health and wellbeing for individuals and minimise the need for statutory interventions.
- Everyone who contributed cared strongly about the vulnerable adults and older people they were there to protect
- Everyone wanted to do a good job.

The review also found

- The overarching "system" (the way in which key agencies work together) is not working well and the focus is not always on the right things.
- Collective system governance arrangements are unclear, roles and responsibilities are often misunderstood,

- More recently, decisions are sometimes contested so inter-agency disputes are increasing.
- Some of the reasons for the difficulties are linked to the impact of an increasingly adversarial culture across agencies.
- Silo behaviour is the norm, the skills of respective professionals are not fully recognised or acknowledged and relationships are in some areas, strained.
- The impact is significant on senior and middle managers and it consequently also affects front line staff.

KEY LEARNING

1. No one is at risk of significant harm
2. Frontline practitioners are dedicated, hard-working and doing their best despite weaknesses in the way the system is governed, led and delivered
3. There needs to be a significant improvement in the way that Agencies work together at senior and middle management level
4. There needs to be major changes in culture and behaviour in every agency, so that everyone shares the same ethos and expectations
5. Making safeguarding personal to the people of Suffolk they are working with needs to be central to what is done and why
6. The language that senior leaders, managers and frontline staff use needs to change so that everyone understands what they mean when they are concerned about a situation or individual's safety and care. The way professionals relate to each other across agencies also needs to change and become less "silo" driven and more collaborative.
7. There need to be shared and "owned" policies, procedures, systems and frameworks for responding to concerns, that everyone uses regardless of their professional background
8. When professionals disagree there need to be shared rules for dealing with those disagreements

RECOMMENDATIONS

The review concludes that to improve practice and safeguard adults more effectively there needs to be a significant transformation programme put in place and action taken across four key areas (in order of priority)

1. Improving strategic leadership through creating a senior system leadership group and addressing the governance issues
2. Addressing the cultural, behavioural and linguistic issues through establishing a major joint workforce development and change programme
3. Addressing the systems, processes and practices gaps by developing a significant range of joint policies, processes, tools and frameworks, and agreeing, disseminating, implementing, complying with and reviewing them.

4. Addressing specific shortfalls in relation to managing disputes, learning from cases, managing allegations against professionals and developing intelligence led decision making

IMPROVING PRACTICE

There are lots of things to be done to implement the recommendations. The Safeguarding Adults Board has agreed to implement the report as has the Senior System Leadership Group.

- A group of key safeguarding leaders across the main organisations and agencies in the County are being identified to work together on the action plan from the report.
- A Transformation Programme Manager will soon be appointed to lead the work.
- The Senior System Leadership Group will lead the programme of work, and progress will be monitored by the Safeguarding Adult Board.

NEXT STEPS

- Circulate this briefing note to all members of your team
- Arrange regular discussion “slots” in team meetings to consider what **Making Safeguarding Personal** means to your team, and how it affects what you do.
- Think about the language you use as professionals when involved with a concern about an individual, how you work with other colleagues in other professionals and how you can improve it
- Consider how well your team understands how safeguarding concerns are responded to and identify what you may need to find out as a team
- Identify a member of your team as a transformation champion, so that as the transformation programme begins the Programme Manager knows who to contact