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**Engagement Principles and Guidance**

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**Introduction**

This aim of this document is to provide guidance for people supporting adults with care and support needs and are looking for effective ways to support engagement with the individual.

There are many reasons as to why an adult may not engage with a service. It is important to obtain a fuller picture from the person, carer, or other professionals as to why someone is finding it difficult to engage with a service. This is to ensure steps can be taken to overcome these barriers. A person’s individual needs, including but not limited to additional learning needs, physical disabilities, sensory needs, language barriers, low levels of literacy, health issues, mental ill health, or other individual circumstances (for example low income, inability to travel to an appointment or having caring responsibilities) may make it more difficult for someone to engage with a service. Individuals who are also digitally excluded or isolated and don’t have access to or find it difficult to use the telephone or internet may also be unable to engage with services when other forms of communication are not utilised. It should be noted that some adults have faced multiple disadvantages throughout their lives, which for several reasons may also impact their engagement with services.

It is recognised that the nature of non-engagement with services is extremely complex and there may be several reasons why an individual may not engage or attend services. Looking at engagement through a trauma informed Lense can offer insight and reflection on ways of working that can better support engagement. It is incumbent on all professionals to build on strengths, be tenacious and creative, fostering relationships that better support effective engagement.

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**Principles of Engagement**

These principles have been agreed by the Newcastle Safeguarding Adults Board and should be adopted by practitioners across all agencies in Newcastle.

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| 1 | **Ask the person or other professionals working with the person what their preferred method of communication is.** |
|  | Knowing how the person prefers to be communicated with will improve the chances of them being able to engage. Consider factors including:* The person’s ability to read and write.
* Language considerations - what is the person’s first language? Is it possible to provide information in a different language or format?
* Does the person have a sensory impairment? If so, what support does the person require to help them engage? For example, this could include the use of an interpreter.
* Safety, for example, if the person is experiencing domestic abuse, is it safe to send a letter to their address?
 |
| 2 | **Recognise the extent to which a person’s vulnerability may impact on their ability to engage.** |
|  | Consider factors such as Learning Disability, substance use and capacity. Always consider what you know about a person’s vulnerability and the extent to which it may impact on the person’s ability to engage. |
| 3 | **Use the Mental Capacity Act (MCA)** |
|  | Remember to use the Mental Capacity Act to empower people to make decisions and support people who may lack thecapacity to make some decisions. Remember to consider the extent to which a person’s capacity to engage with services may have been affected by threatening, controlling or coercive behavior. |
| **4** | **Consider the persons mental capacity to engage but also the consequences of non-engagement.** |
|  | When considering a person’s capacity in relation to engagement it is important to consider whether the person understands the consequences of non-engagement. The risks might relate to areas such as the persons health, access to benefits, offers of care and support. |
| 5 | **Where possible, identify a lead professional to build up a trusting relationship with the person.** |
|  | Whilst this may not always be possible, it is helpful for the person if they have an identified lead worker. The lead worker will be in a vital position for monitoring trends of engagement, sharing information and assisting the person through service navigation. The lead professional may change depending on the circumstances of the case and the management of risk remains a shared responsibility.As part of the safeguarding adults process consideration must also be given to whether the adult may benefit from the support of an independent advocate. |
| 6 | **Don’t assume that someone else is dealing with the problem.** |
|  | When a person’s circumstances change, or concerns arise about their lack of engagement, don’t presume that other professionals are aware of what you know. Build up good relationships with professionals from other agencies and ensure that information is shared appropriately, using safeguarding procedures if required. Where a Safeguarding Adults Plan is in place, it should be clear how information will be shared between all of the agencies involved, including how concerns will be escalated if the persons lack of engagement continues to be a risk factor. |
| 7 | **Be careful what you record around engagement or lack of.** |
|  | The language used in your recording can make a big difference. Terms like “failed to attend” and “difficult to engage with” place the emphasis solely on the person, there may be external factors impacting on a person’s ability to engage.Recording of this nature can also affect the way another professional may approach the case. |
| 8 | **Remember, engagement may fluctuate** |
|  | Just because a person has not engaged with services in the past, is does not mean that this will always be the case, this time it might be different. Be tenacious with clients and always let them know that services are available should they need them. |

**Understanding non-engagement with services**

**What has led to this situation?**

Seeing behaviors and engagement through a trauma lens allows us to understand potential links between current difficulties and past experiences. Re-traumatisation can occur when a current experience triggers the same, or similar, emotional, psychological and/or physiological response as an original, traumatic experience*.* Re-traumatisation may occur when professionals make decisions on a person’s behalf. Trauma responses may be triggered when practitioners do not understand how their interactions and imbalances of power remind a person of a past trauma.

When practitioners are concerned that a person is not responding to a plan, they should be asking:

* *What could be contributing to any presenting behaviours?*
* *Does this current situation have a connection to a previous, traumatic experience?*
* *What skills can I use to help this person feel safe and create connection?*
* *How can I enable this person to feel empowered and have choice in the way they are engaging with me?*
* *How can I create a relationship based on trust?*

Adopting a trauma informed approach means doing the opposite of what occurs when trauma is experienced and building a relationship based on the 5- trauma informed principles: **Safety, Collaboration, Trust, Empowerment and Choice**. (Adapted from research in practice, Embedding trauma informed practices in adult social care).

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| **Principle Description Why? How might this feel?** |
| **Safety** | People should feel and be physically, emotionally, psychologically, socially, and culturally safe. This involves cultural, sexual and gender sensitivity, an awareness of intersectionality, practitioner competence and working in a way which promotes choice and control, transparency. | Experiencing trauma fundamentally disrupts a person’s ability to feel safe at any given moment and they may be more sensitive to stress. People who identify as part of a minority group, for example LGBTQ+, may feel particularly unsafe in mainstream services. | *‘I feel safe and understood, like I can finally begin to trust people again.’* |
| **Collaboration** | Relationships should be collaborative and mutual, based on respect, trust, connection, and hope. As with strengths- based approaches, there should be aclear move away from ‘helper’ roles which reinforce helplessness or power dynamics. | The inherent power imbalance between practitioners and survivors can mirror that of abusive relationships. Having experienced powerlessness in the past can lead to ongoing feelings of disconnection, hopelessness, mistrust, and fear. | *‘We are working through this difficult stuff together’* |
| **Trust** | This involves keeping people informed of any changes, telling a person when we will be late, using simple language, being accountable and transparent in what we can and cannot do. We can demonstrate trustworthiness by being genuine, non- judgmental, compassionate, and kind inour interactions. | Trust needs to be earned. It can be difficult for those who have experienced trauma to establish trust. We cannot expect a person to automatically trust us because we are a professional. | *‘I feel valued, and I have a secure attachment to my worker.’* |

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|  **Empowerment** | Ensure people are supported to take control of their lives, so that they can make meaningful, genuine choices around their care and support. This approach promotes self-care, it is strengths based, creative, joyful and acknowledges the coping and adaptive skills survivors have developed to get to this point. | Peer support and the coproduction of services mean that mutuality, empowerment, collaboration, and fairness are part of the response to trauma.A sense of control will have been removed during the time of the abuse. Partnership working allows for control to be returned to the survivor. | *‘I am taking control of my life now; I have a deeper understanding of myself, and my past’* |
|  **Choice** | Trauma survivors may convey distress non-verbally, for instance by losing concentration. Practitioners can look for cues that the person is feeling anxious or distressed and respond to this, by asking ‘Is it ok to talk about this?’Remember that a person who appears unaffected may be in acute distress. Trauma survivors can be adept at presenting as robust and composed, which may or may not reflect what is going on internally.Consider how they will cope after the conversation. How can they be supported with this? | Survivors often find accessing trauma specific support very difficult. There needs to be the option for survivors to access trauma-specific treatment from specialist services, (if they wish to) when the time is right for them. | *‘I am an expert in my own life, and I want to choose in how I work with services’* |

# **How can trauma be disguised?**

Professionals should consider the impact of the language that is used to describe people and consider how this language can affect the interactions between the professional and the person.

When we use a trauma informed approach we begin to understand and accept that behavior is a form of communication. As professionals we need to be curious about the ways that individuals present, and the impact of those underlying reasons have on their current behavior. It is the role of the professional to find ways of engaging with the person, build connection and create safe.

 **Here are the 5 key behavioral reactions to trauma.**

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|  **Trauma response How it feels What individuals are coping with described How people get described** |
| **Fight** | ‘I am bigger, stronger and can win against this person. I will stand my ground and fight and not be told what to do’. | Frightened; low or no self-esteem; no reason to trust anyone; hypervigilant; fear driven; have been let down in the past; unable to emotionally regulate; unable to think through consequences of actions; struggles with learning and being curious; afraid of change; cultural differences; poor mental health; depression and anxiety. | Challenging, disruptive,non-compliant, hostile,argumentative, or aggressive. |
| **Flight** | ‘I am smaller and will not win, I can get away, so I am going to run’. | Anxiety; toxic stress; lack of trust; feeling unsafe; hyper avoidance; fear of authority; poor experiences in the past when working with practitioners; or recent staff changes. | Difficult to engage, avoidant, evasive, or did not attend. |
| **Freeze** | ‘I can’t get away and I can’t win. I will freeze because if I don’t respond they may lose interest and go away’. | Fear of relationships; does not feel safe; unable to trust; feels let down; feelings of shame and guilt. | Un-responsive, shows no emotion, or not interested. |
| **Flop** | ‘They aren’t going away, if I stay frozen it is going to hurt more so I will flop and play dead, then it will be over, and they will leave me alone’. | No childhood opportunity to develop executive functioning skills of self- regulation and organisation; poor con centration; frightened; no sense of safety; wanting to numb the pain; and is afraid of the unknown. | Need to take responsibility, in denial, not ready for therapy, unmotivated, or prioritises their own needs above everyone else. |
| **Friend** | ‘I can’t stop it, maybe if I keep them on my side and keep them happy, they won’t hurt me as much’. | Scared all the time; does not know how to identify own needs; wants to please others; deprived of affection; no ability to self-soothe or take care of own emotional distress. | Attention seeking. Not meaningfully engaging, dishonest, overly compliant, people pleaser or lack of boundaries. |
| **Do you recognise any of these behaviors in the people you work with? What other explanations might there be for their behavior?** |

# **What are the risks when we struggle to engage the individuals we are working with?**

* Professionals don’t recognise the root cause of the behavior.
* The relationship between the professional and the person may break down.
* Professionals may perceive the risk to be low level.
* It removes focus from the adult with support needs.
* Professionals can become over optimistic about progress being achieved, leading to cases being stepped down and delaying timely interventions.
* Professionals may close the case because of lack of engagement or lack of progress.

**Multi agency forums and frameworks.**

Where professionals are unable to manage risk or feel that the risk is escalating – multi agency frameworks are an excellent support mechanism for the individual and the professional. Multi agency frameworks draw together professionals and agencies to ensure all appropriate intervention or support is being undertaken, and that there is a cohesive multi-agency response to addressing concerns.

These forums and frameworks promote mutual support and the exchange of ideas between practitioners helping the sharing of expertise, knowledge and resources for good practice and increases the ability to offer services that meet the needs of those they are supporting. Safeguarding adults have several resources, training, and information available to help you to support those who have care and support needs and are suffering from abuse or neglect. [Safeguarding Adults - Newcastle Safeguarding](https://www.newcastlesafeguarding.org.uk/safeguarding-adults/)

**When and how to apply multi agency working.**

* When safeguarding adults criteria has been met, use safeguarding adults procedures to facilitate information sharing and shared risk management.
* Where safeguarding adults criteria has not been met, consider whether there are any other multi-agency frameworks which would apply e.g. MARAC for domestic abuse cases. Your organisation or locality may have their own M.D.T arrangements for discussion and escalation.
* If there are not any relevant multi-agency frameworks to use, could you arrange a multi-agency meeting with relevant partners to share information and agree a plan to manage risk.
* Also be aware of, and use, your escalation pathways. For safeguarding adults scenarios please use your Safeguarding Adult Leads/Teams and/or the Safeguarding Adults Unit for further advice and support.

**Top Tips to achieve change:**

* Focus on the adult with care and support needs, ensure you speak to them about their wishes and feelings in line with **Making Safeguarding Personal**.
* Consider if the views of family and carers are consistent with the those of the adult with care and support needs. Are their stories inconsistent?
* Practitioners need to ensure they are professionally curious about the person, their life experiences, and the impact it still has on them.
* Work with other professionals and identify a lead professional who holds a strong relationship with the individual.
* Effective multi-agency work needs to be coordinated, so we have all available information regarding the lived experience of the adult.
* Family or carers can easily prevent practitioners from seeing and listening to an adult with care and support needs.
* Practitioners can miss opportunities to identify risk because of stories we want to believe are true.
* Practitioners need to build cooperative relationships with people based on the **5 trauma informed principles.**
* Use regular supervision to help understand your decision making.
* **Incorporate the 6 principles of the Care Act: Empowerment; Prevention; Proportionality; Protection; Partnership; and Accountability.**

**What people with lived experience told us will help them engage:**

 Consistency of worker or lead professional.

 Not needing to repeat their story or trauma.

 Feeling understood and heard.

 Not having someone assume what is best for them without being asked or consulted.

 Being asked what their views are and being planned ‘with, and not on’.

 Having other people with lived experience involved in their care or treatment.

 ***Thank you to the Newcastle User and Carer Forum for their feedback on engagement.***

**Can we make any reasonable adjustments to make it easier for the person to engage? Simple adjustments can often make a big difference. Practical things to consider:**

Does the person prefer morning or afternoon appointments?

Would having someone attend with them make it easier for them to attend?

Does the location affect someone’s ability to engage?

Don’t assume just because the person can attend one kind of appointment that they can attend another. Different appointments can cause varying levels of worry or anxiety and stress.

Do they have any unmet needs or undiagnosed needs? Think neurodiversity, think learning needs.

Does the person have any communication needs we have not considered?

Does someone have the financial means to attend if the appointment is not close to home?

Are there any physical conditions that may make it difficult for them to attend?

If you are unsure……… Remember to ask the question.

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**What to consider when you are struggling to engage someone you are working with**

 **Strategies to consider.**

* + A multi-agency forum to build a team around the person.
	+ Be professionally curious.
	+ Build cooperative relationships.
	+ Incorporate the 5 Trauma Informed Principles into every interaction.
	+ The 6 Principles of the Care Act.
	+ Engage in regular supervision.
	+ Recognise the impact of professional optimism and unconscious bias in our decision making.
	+ Be patient, trusting and secure relationships take time to develop.
	+ Make sensitive enquiries.
	+ Have the confidence to have difficult conversations.

**Concerns Raised**

 **Always complete**

* Chronology and clear case recording which evidences defensible decision making.
* Risk Assessment. Refer to the Safeguarding Adults Risk Threshold Tool to review the individual’s risk (Appendix 1)
* Mental Capacity Assessment.

**Next Steps**

* Do not close the case because someone has withdrawn from contact or has not attended an appointment.
* Discuss with your line manager.
* Consider a carers assessment.
* Coordinate a multi-agency response, seek advice from partner agencies.
* Be accountable. Do not assume that someone else is doing something.
* Consider the self-neglect pathway.
* Seek legal advice if applicable.
	+ Does this behavior increase risk? Refer to the Safeguarding Adults Risk Threshold Tool to review the individual’s risk (Appendix 1)
	+ Consider the impact of trauma- historical, cumulative, and current.
	+ Is this behavior a trauma response?
	+ Does this person feel unsafe and unable to trust others?
	+ Mental health
	+ Mental Capacity Act
	+ Does this person have capacity, but they are still vulnerable?
	+ Could there be coercive control or exploitation?
	+ Could this person have fluctuating capacity?
	+ Is alcohol or substances impacting on their capacity?
	+ Corroborate information shared by family and carers.

 **Links to further reading and resources.**

* [Opening Doors-a video on trauma informed practice](https://www.canva.com/link?target=https%3A%2F%2Fwww.google.com%2Furl%3Fsa%3Dt%26rct%3Dj%26q%26esrc%3Ds%26source%3Dweb%26cd%26cad%3Drja%26uact%3D8%26ved%3D2ahUKEwiYguW03ajzAhXJi1wKHTQ0Ct8QwqsBegQICRAB%26url%3Dhttps%253A%252F%252Fvimeo.com%252F274703693%26usg%3DAOvVaw2ngAfB87nSfFSe2cdySKLo&design=DAGL30KLaaU&accessRole=editor&linkSource=document)
* [Academy for social justice-understanding the use of trauma informed practice](https://www.canva.com/link?target=https%3A%2F%2Fassets.publishing.service.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment_data%2Ffile%2F746766%2FTrauma_informed_practice_seminar_SW_8_Oct_2018_slides.pdf&design=DAGL30KLaaU&accessRole=editor&linkSource=document)
* https://www.newcastlesafeguarding.org.uk/safeguarding-adults/
* [What is Trauma-Informed Care? - Trauma-Informed Care Implementation Resource Center (chcs.org)](https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/)

**Thank you to Wigan Safeguarding Adults Board for their contribution to this guidance.** 

**Newcastle Safeguarding Adults Board Risk Threshold Tool**

**Appendix 1**

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| **Factors**  |  | **Guidance and considerations** |
| 1. **Vulnerability of the adult at risk**
 | **Less** **vulnerable** | **More** **vulnerable** | * Does the adult have needs for care and support?
* Can the adult protect themselves?
* Does the adult have the communication skills to raise an alert?
 | * Does the person lack mental capacity?
* Is the person dependent on the alleged perpetrator?
* Has the alleged victim been threatened or coerced into making decisions?
 |
|  |
| **The abusive act** | **Less serious More Serious** | Questions 2-9 relate to the abusive act and/or the alleged perpetrator. Less serious concerns are likely to be dealt with at initial enquiry stage only, whilst the more serious concerns will progress to further stages in the safeguarding adult’s process.  |
|  |
| 1. **Seriousness of Abuse**
 | Low | Significant | Critical | **Refer to the table overleaf.**  Look at the relevant categories of abuse and use your knowledge of the case and your professional judgement to gauge the seriousness of concern. |
| 1. **Patterns of abuse**
 | Isolated incident | Recent abuse in an ongoing relationship | Repeated abuse | * Most local areas have an escalation policy in place e.g. where safeguarding adults procedures will continue if there have been a repeated number of concerns in a specific time period. Please refer to local guidance.
 |
| 1. **Impact of abuse on victims**
 | No impact | Some impact but not long-lasting | Serious long-lasting impact | * Impact of abuse does not necessarily correspond to the extent of the abuse – different people will be affected in different ways. Views of the adult at risk will be important in determining the impact of the abuse.
 |
| 1. **Impact on others**
 | No one else affected | Others indirectly affected | Others directly affected | Other people may be affected by the abuse of another adult. * Are relatives or other residents/service users are distressed or affected by the abuse?
* Are other people intimidated and/or their environment affected?
 |
| 1. **Intent of alleged perpetrator**
 | Unintended/ ill-informed | Opportunistic | Deliberate/Targeted | * Is the act/omission a violent/serious unprofessional response to difficulties in caring?
* Is the act/omission planned and deliberately malicious? Is the act a breach of a professional code of conduct?

**\*The act/omission doesn’t have to be intentional to meet safeguarding criteria**  |
| 1. **Illegality of actions**
 | Bad practice - not illegal | Criminal act | Serious criminal act | Seek advice from the Police if you are unsure if a crime has been committed. * Is the act/omission poor or bad practice (but not illegal) or is it clearly a crime?
 |
| 1. **Risk of repeated abuse on victim**
 | Unlikely to recur | Possible to recur | Likely to recur | * Is the abuse less likely to recur with significant changes e.g. training, supervision, respite, support or very likely even if changes are made and/or more support provided?
 |
| 1. **Risk of repeated abuse on others**
 | Others not at risk | Possibly at risk | Others at serious risk | Are others (adults and/or children) at risk of being abused: * Very unlikely?
* Less likely if significant changes are made?
* This perpetrator/setting represents a threat to other vulnerable adults or children.
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| **Types of abuse and seriousness** | **Concerns may be notified to the Local Authority but these are likely to be managed at Initial Enquiry stage only. Professional judgement or concerns of repeated low level harm will progress to further stages in the safeguarding adults process.** | **Concerns of a significant or critical nature should be referred to the local authority (with consent of the alleged victim where this is relevant and appropriate to do so). They will receive additional scrutiny, and progress further, under safeguarding adults procedures. Where a criminal offence is alleged to have been committed, the Police will be contacted. Other emergency services should be contacted as required.** |
|  | **Low**  |  **Significant or critical** |
| **Physical**  | * Staff error causing no/little harm e.g. friction mark on skin due to ill-fitting hoist sling.
* Minor events that still meet criteria for ‘incident reporting’ accidents.

**Medication*** Adult does not receive prescribed medication (missed/wrong dose) on one occasion – no harm occurs.
 | * Isolated incident involving service on service user.
* Inexplicable marking found on one occasion.
* Minor event where users lack capacity.

**Medication*** Recurring missed medication or administration errors that cause no harm.
 | * Inexplicable marking or lesions, cuts, or grip marks on a number of occasions.
* Accumulations of minor incidents.
* Recurring missed medication or errors that affect more than one adult and/or result in harm.
* Deliberate maladministration of medications.
 | * Covert administration without proper medical authorisation.
* Inappropriate restraint.
* Withholding of food, drinks or aids to independence.
* Inexplicable fractures/injuries.
* Assault.
 | * Grievous bodily harm/assault with a weapon leading to irreversible damage or death.
* Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death.
 |
| **Sexual (including sexual exploitation)** | * Isolated incident of teasing or low-level unwanted sexualised attention (verbal or touching) directed at one adult by another whether capacity exists.
 | * Minimal verbal sexualised teasing or banter.
 | * Recurring sexualised touching or isolated or recurring masturbation without consent.
* Voyeurism without consent
* Being subject to indecent exposure.
* Grooming including via the internet and social media.
 | * Attempted penetration by any means (whether it occurs within a relationship) without consent.
* Being made to look at pornographic material against will/where consent cannot be given.
 | * Sex in a relationship characterised by authority inequality or exploitation e.g. receiving something in return for carrying out a sexual act.
* Sex without consent (rape).
 |
| **Psychological/Emotional** | * Isolated incident where adult is spoken to in a rude or inappropriate way – respect is undermined but no/little distress caused.
 | * Occasional taunts or verbal outburst.
* Withholding of information to disempower.
 | * Treatment that undermines dignity and esteem.
* Denying or failing to recognise adult’s choice or opinion.
 | * Humiliation.
* Emotional blackmail e.g. threats or abandonment/harm.
* Frequent and frightening verbal outbursts or harassment.
 | * Denial of basic human rights/civil liberties, over-riding advance directive.
* Prolonged intimidation.
* Vicious/personalised verbal attacks.
 |
|  | **Low**  |  **Significant or critical** |
| **Financial**  | * Staff personally benefit from users funds e.g. accrue ‘reward’ points on their own store loyalty cards when shopping.
* Money not recorded safely and properly.
 | * Adult not routinely involved in decisions about how their money is spent or kept safe – capacity in this respect is not properly considered.
* Non-payment of care fees not impacting on care.
 | * Adult’s monies kept in a joint bank account – unclear arrangements for equitable sharing of interest.
* Adult denied access to his/her own funds or possessions.
 | * Misuse/misappropriation of property or possessions of benefits by a person in a position of trust or control.
* Personal finance removed from adult’s control.
* Ongoing non-payment of care fees putting a person’s care at risk.
 | * Fraud/exploitation relating to benefits, income, property or will.
* Theft.
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| **Neglect**  | * Isolated missed home care visit where no harm occurs.
* Adult is not assisted with a meal/drink on one occasion and no harm occurs.
* Adult not bathed as often as would like – possible complaint.
 | * Inadequacies in care provision that lead to discomfort or inconvenience- no harm occurs e.g. being left wet occasionally.
* Not having access to aids to independence.
 | * Recurrent missed home care visits where risk of harm escalates, or one miss where harm occurs.
* Hospital discharge without adequate planning and harm occurs.
 | * Ongoing lack of care to the extent that health and wellbeing deteriorate significantly e.g. pressure wounds, dehydration, malnutrition, loss of independence/confidence.
 | * Failure to arrange access to lifesaving services or medical care.
* Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk.
 |
| **Self-Neglect** | * Incontinence leading to health concerns.
 | * Isolated/ occasional reports about unkempt personal appearance or property which is out of character or unusual for the person.
 | * Multiple reports of concerns from multiple agencies
* Behaviour which poses a fire risk to self and others
* Poor management of finances leading to risks to health, wellbeing or property
 | * Ongoing lack of care or behaviour to the extent that health and wellbeing deteriorate significantly e.g. pressure sores, wounds, dehydration, malnutrition
 | * Failure to seek lifesaving services or medical care where required.
* Life in danger if intervention is not made in order to protect the individual.
 |
| **Organisational****(anyone or combination of the other forms of abuse)**  | * Lack of stimulation/ opportunities for people to engage in social and leisure activities.
* Service users not given sufficient voice or involve in the running of the service
 | * Denial of individuality and opportunities for service user to make informed choice and take responsible risks.
* Care-planning documentation not person-centred
 | * Rigid/inflexible routines
* Service user’s dignity is undermined e.g. lack of privacy during support with intimate care needs, sharing under-clothing
 | * Bad/poor practice not being reported and going unchecked.
* Unsafe and unhygienic living environments
 | * Staff misusing their position of power over service users.
* Over-medication and/or inappropriate restraint used to manage behaviour.
* Widespread consistent ill-treatment
 |
|  | **Low**  |  **Significant or critical** |
| **Discriminatory**  | * Isolated incident of teasing motivated by prejudicial attitudes towards an adult’s individual differences
 | * Isolated incident of care planning that fails to address an adult’s specific diversity associated needs for a short period.
* Occasional taunts
 | * Inequitable access to service provision as a result of a diversity issue.
* Recurring failure to meet specific care/support needs associated with diversity.
 | * Being refused access to essential services.
* Denial of civil liberties e.g. voting, making a complaint.
* Humiliation or threats on a regular basis, recurring taunts.
 | * Hate crime resulting in injury/emergency medical treatment/fear for life.
* Hate crime resulting in serious injury or attempted murder/honour-based violence.
 |
| **Modern Slavery** | All concerns about modern slavery are deemed to be of a significant/critical level.  | * Limited freedom of movement.
* Being forced to work for little or no payment.
* Limited or no access to medical and dental care.
* No access to appropriate benefits.
 | * Limited access to food or shelter.
* Be regularly moved (trafficked) to avoid detection.
* Removal of passport or ID documents.
 | * Sexual exploitation.
* Starvation.
* Organ harvesting.
* No control over movement / imprisonment.
* Forced marriage.
 |
| **Domestic Abuse** (Consult Domestic Violence and Abuse Flowchart) | * Isolated incident of abusive nature
 | * Occasional taunts or verbal outbursts
 | * Inexplicable marking or lesions, cuts, or grip marks on a number of occasions
* Alleged perpetrator exhibits controlling behaviour.
* Limited access to medical and dental care
 | * Accumulations of minor incidents
* Frequent verbal/physical outbursts
* No access/control over finances
* Stalking
* Relationship characterised by imbalance of power
 | * Threats to kill, attempts to strangle choke or suffocate.
* Sex without consent (rape).
* Forced marriage.
* Female Genital Mutilation (FGM).
* Honour based violence.
 |
| **The CAADA DASH Risk Assessment Checklist should be used to determine the level of risk in domestic abuse cases and a referral made into MARAC where appropriate** |

**Further guidance on using the safeguarding adults risk threshold tool.**

**Purpose**

The safeguarding adults risk threshold tool has been developed to assist practitioners in assessing the seriousness and level of risk associated with a safeguarding adults concern. It is primarily for use by Safeguarding Adults Managers, in the Local Authority, to assist with their decision-making at the point of receiving a safeguarding adults concern; however, others may find it helpful to refer to this tool when responding to a concern of abuse or neglect. The aim is to ensure that everyone understands the threshold consideration. The tool is not intended to replace professional judgement.

A clear threshold and process, together with a common understanding across local partnerships and agencies will improve consistency. A number of reasons are provided to support the need for a threshold tool. These include:

* A benchmark to assess the level of vulnerability of an individual.
* A measure of consistency.
* Managing the demand of low, significant, and critical level concerns.

**Consistency**

There is a need for a consistent approach to safeguarding adults. Appropriate thresholds are seen as a good way to achieve this. The safeguarding adults risk threshold is clearly explained in the multi-agency procedures and in learning and development opportunities. Practitioners are encouraged to use their professional judgement and to consider each case on an individual basis. Additional processes may need to be considered for some sections of the community who are harder to reach.

**The Care Act**

The Care Act statutory guidance states that:

“Local Authorities must make enquiries, or cause others to do so, if they reasonably suspect an adult:

* Has needs for care and support (whether or not the local authority is meeting any of those needs) and;
* Is experiencing, or at risk of, abuse and neglect; and
* 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.”

There is no longer a “significant harm” threshold for action under safeguarding adults’ procedures. However, any actions taken must be proportionate to the level of presenting risk or harm and be driven by the desired outcomes of the adult or their representative. Referring agencies need to use their professional judgement, consider the views of the adult at risk and where appropriate, seek consent for sharing information on a multi-agency basis.

If a decision is made **not** to refer to the Local Authority, the individual agency must make a record of the concern and any action taken. Concerns should be recorded in such a way that repeated, low level harm incidents are easily identified and subsequently referred. Not referring under safeguarding adults procedures, does not negate the need to report internally or to regulators/commissioners as appropriate.

Where a concern is referred on a multi-agency basis, a Local Authority Safeguarding Adults Manager will then use the risk threshold tool to determine whether safeguarding adults procedures will continue beyond the Initial Enquiry stage.

The following diagram highlights the different stages of a Safeguarding Adults (Section 42) Enquiry:

**Critical harm/ complex case**

**Significant harm**

**Low level harm**

* Person-led
* Outcome-focused
* Proportionate
* Consistent
* Resource efficient
* Publicly accountable
* Robustly risk managed.

**Managing the different levels of harm**

To manage the large volume of concerns which come under safeguarding adults’ policy and procedures, there is a need to differentiate between those concerns relating to low level harm/risk and those that are more serious. Whilst it is likely that concerns relating to low level harm/risk will not progress beyond an Initial Enquiry Stage, the concern will be recorded by the Local Authority and proportionate action taken to manage the risks that have been identified. This may include: provision of information or advice; referral to another agency or professional; assessment of care and support needs. The sharing of low-level concerns helps the Local Authority to understand any emerging patterns or trends that may need to be taken into consideration when deciding whether safeguarding adults procedures need to continue.

**Using the safeguarding adults risk threshold tool**

The safeguarding adults risk threshold tool has been designed to consider both the vulnerability of the adult at risk, the seriousness of the abuse that is occurring, the impact of the abuse and the risk of it recurring.

Regular, low-level concerns can amount to a far higher level of concern which then requires more in-depth investigation or assessment under safeguarding adults procedures. Each local area has an escalation policy in place to aid professional judgement in these circumstances. This means that a specified number of safeguarding adults concerns reported to the Local Authority in a specified timeframe will result in further action under safeguarding adults procedures. Please refer to each area’s policy and procedure.

The tool is not designed in way in which further actions are determined by achieving a score or a specified number of ticks. It is there to provide guidance and key considerations for practitioners who are assessing and managing risk.