Module Code ECAY 5001
Assignment Number 1
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What do you consider to be the main benefits of and challenges for multi-agency working? Your discussion should focus on a specific sector of society and should include reference to good practice and theory.

This assignment is about the main benefits and challenges for multi-agency working within the vulnerable adults' sector. It will explain what multi agency is, and the pros and cons of it. There are two case reviews on how the lack of multi-agency working failed on both occasions, and if the professionals involved had communicated and followed the policies and acts then these incidents would never have happened. There are many policies and acts which vary in different countries such as England and Wales, and some which apply to the European Union, the most relevant ones have been explained.

Multi agency working is an effective way helping to support individuals and their families with additional needs, to improve their life outcomes and futures. Multi agency working is when two or more agencies work together to combine their knowledge, skills and expertise, with the same goal of meeting the individual's needs. ‘’It is often necessary for professionals from different disciplines to work together to get the best results’’ (Thomas et al, 2014). For multi-agency to work, the agencies involved must have a good understanding of each other's work structures and plans, they must work well as a team and have very good communication skills at all times. ‘Active listening ensures that everything a person is trying to say is fully received and understood by the listener’ (Moss, 2012) this describes perfectly the need for the listener to pay attention to what they are being told in order for them to be able to pass on the relevant information to be shared with other agencies. Multi agency work is used widely and it can involve children, adults or both. It becomes effective when it comes to protecting vulnerable adults from harm and abuse. There are many benefits to multi agency working these include, agencies using their specialised skills and strengths to their best advantage, and any support required can be easily accessed with good communication. An individual who has many different professionals involved in their lives will find it far easier and more manageable that all the professionals are aware of the individuals needs and are supporting them together, making them feel safer and more secure when it comes to future needs, appointments and goals in life. Although multi agency working should be an advantage to local authorities, it does come with its disadvantages and concerns. If the agencies involved lack communication or do not thoroughly plan properly then the service will not work as well as hoped and problems soon

occur. Ensuring all staff are trained properly is also very important, and not just trained to do their job but to work as a team too, as agreed by Zambon, ‘’The employees may not be confident and motivated enough to work in partnership (Zambon, 2010). Confidentiality can be breached if the professionals don’t communicate properly, notes and documents can be left lying around or lost if a proper document sharing system is not set up correctly and followed. Confidentiality is not absolute, and this is explained by Adams as he comments

> ‘’workers are accountable to their employers and not just to service users. In general, the appropriate response to the request: I’ll tell you a secret if you’ll promise not to tell anyone’, is along the lines of, ‘I’m prepared to listen to you. But if what you tell me involves harm to you or to another person, I may have to tell somebody’’ (Adams 1994).

Important information vulnerability and needs could be affected if they are not supported properly and important information shared correctly. This is agreed in a statement by Gilbert where he says ‘’An organisation therefore has the basic preventative responsibilities in terms of ensuring that it’s managers not only have the necessary leadership skills but are also actually using them’’ (Gilbert,2005).

Safeguarding means to protect an individual's right to live in society safely. To live safely always means to be free from abuse and neglect from other individuals. It is about individuals, groups, organisations and professionals being able to work together to stop and prevent neglect and abuse, while at the same time making sure the individual's identity and well-being is promoted. Any person whether a professional or not can and should be able to identify and report concerns of an individual who may be at risk of being vulnerable to being abused or neglected. All local authorities will have procedures and guidelines whereas to where and how these worries and concerns should be reported too. Adult safeguarding is just as important as children safeguarding, they can and are just as vulnerable as each other. There are seven main aims with regards to adult safeguarding these are, to stop abuse and neglect, prevent harm and reduce the risk of abuse and neglect, safeguard adults in a way that supports them in making choices and having control about how they want to live, promote an approach that concentrates on improving life, raise public awareness so that communities and professionals play their role in preventing identify and responding to abuse and neglect, provide information and support in accessible ways to help people understand the different types of abuse and last of all to address what caused the neglect or abuse.

Adult social care is one of the most important public services in Wales, it helps support adults of all ages and under all circumstances. The services help individuals to prevent and end harmful and vulnerable situations and has the vital connection to other public, private and voluntary services so important information can be passed on safely and quickly. Any adult can have access to Adult Social Care however according to The WLGA and ADSS Cymru key facts and figures show that ‘’there will be an average increase of 56% in the number of people needing adult social care by 2035’’ (WLGA, 2018), the amount of people living longer and the population increasing means that the demand for this service is increasing, again the WLGA states that ‘’an increase of 127% in the number of people aged over eighty five will be living by 2039’’ (WLGA, 2018). The local government must keep this in mind when making important decisions about the service as them decisions do not just affect the individual it effects thier family, friends, workers and the community.

The murder of Steven Hoskin was brought to light and reviewed in August 2007. Steven was murdered on 6th July 2006, his body was found at St Austell railway. During his life Steven suffered with learning disabilities, as a child at the age of twelve he left his local primary school to attend a weekly boarder special school. After leaving school Steven was admitted as an impatient to Westheath House, a National Health Service (NHS) ‘assessment and treatment’ unit for people with severe learning difficulties and mental health problems. After leaving there Steven helped on a local farm, he loved farm life, but his short attention span soon resulted in him leaving. Stevens behaviour started to deteriorate as did his relationship with his mother, he was spending all his benefit money on alcohol and things went seriously wrong. Stevens behaviour and mental state was picked up on and after being assessed he was given planned weekly visits, but this did not last as Steven decided he did not want them. Even though Steven ended the visits records after his death show that he only received eleven visits when he should have received eighteen. In the serious case review it states that Steven had made several visits to his general practitioner and to his local hospital via ambulance, as well as ringing the police on several occasions for different reasons the main one for being threatened and harmed by other individuals. Stevens body was found by the railway station and it was proven that he was forced to take paracetamol with alcohol and then forced to the railway station where he was made to hang off a wall with a thirty-meter drop. While hanging off the side his hands were stood on and his face kicked until he eventually lost his grip and fell to his death. Steven was murdered by two individuals while three others were also sentenced for being involved, the two convicted for murder were called Darren and the other was called Sarah. Darren was also

well known by the local authorities, he regularly used the NHS and ambulance service, he had had his children removed from his care and placed on the Child Protection Register. Before Darren was convicted of murder, he had previously been jailed for arson, professionals were concerned about his welfare on release due to him causing self-harm and his aggression to others. The serious case review proves that Darren had many visits and phone calls to and from police about being assaulted and threatened on many different occasions. Sarah was also well known with The Youth Offending Team and The Children's Social Care Service for her troubles. Martin was the third to be sentenced for his part in Stevens death. Martin lived at home with his parents and was employed. According to the review Martins substance misuse is likely to have a played a part in his relationship with Darren and Steven. After Stevens death a serious review was needed into the warnings and missed opportunities for interventions from professionals. The serious case review panel confirmed that with better inter-agency or multi-agency working Steven would not have suffered so much physical, financial and emotional abuse in his own home. They also said that if the many agencies involved had had better communication skills then the safeguarding of Steven from his self and others could have been prevented. Sme of the agencies and individual services did not have access to important information obtained by the other services and agencies. The amount of logged calls and visits to the hospital and police under the influence of drink and drugs, he should have had regular contact with drug and alcohol services, but he did not. Since this review the agencies involved have been told of and understand that their lack of support and communication played its part in the death of Steven.

The Winterbourne Case is about a hospital based in South Gloucestershire for individuals with autism and learning disabilities, it was owned by company called Castlebeck. The NHS paid Castlebeck money to look after people, who's behaviour sometimes made their families and some professionals have cause for concern. The hospital was made up of twenty-four beds and was used to assess and treat individuals so that they could manage and cope with ordinary lives while living in their own homes. The serious case review was put into place by Safeguarding Adults Board, which is made up of the local council, the NHS, the police force, the quality are commission and other organisations. The case review states that patients at the hospital had been hurt by themselves or by staff members and had to seek medical treatment in accident and emergency. The local police had been called on numerous occasions due to patients being hurt or running away. When patients were notifying family members and managers about the abuse, they were not believed, and the incidents were not looked into. A

nurse called Terry Bryan had informed managers of the abuse and when nothing was done about it, he wrote to the care quality commissioner and the BBC, who made a television programme about it. It was soon known that Castlebeck had rules, but they were not followed, lack of training to staff and managers meant their jobs were not done properly. Incidents of abuse were not reported to patient families or the local safeguarding service. The fact that none of the incidents were reported meant nobody knew so nothing could be done about it until Mr Bryan made the correct professionals aware. The lack of communication between the police, the quality care commission and the NHS organizations meant that patients were mistreated and had they had regular meetings the problems would have been picked up a lot sooner. The home was closed to prevent further patients being harmed, it was then found that patients with learning difficulties and autism should remain in their homes and community where they know and feel safe. Any incidents or complaints should be taken seriously, and the patients should be given the option to speak to a professional who doesn't work at the hospital and NHS organisations should always be informed. The serious case review will have shown the certain professionals involved where they went wrong and how to prevent it happening again in the future.

All professionals in multi-agency working should follow legislations, policies and laws to ensure they are treating people correctly. Some of the policies and Acts to follow when dealing with vulnerable adults are mentioned and explained here. In safe hands 2000 is about Implementing Adult Protection Procedures in Wales. This legislation was put in place in 2000 it ensures all local authorities in Wales have a duty to carry out protection procedures in their areas for all adults at risk. It was put in place to help prevent, identify and respond to abuse of any adults at risk of harm or neglect. Adult-Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from abuse 2010 was put into place to ensure all individuals have the right to be fully involved when it comes to decisions being made about their health, safety, welfare and protection process. The only time an individual can be exempt from this is when they do not have the mental capacity to make such important decisions themselves. Deprivation of Liberty Standards is another legislation mended to The Mental Capacity Act 2005 to help protect the rights of individuals in care homes in hospital It allows the individual to be deprived of their liberty, so in order to keep them safe and free from harm thier consent to their care and treatment is out of thier hands due to their lack of capacity. Restraints and restrictions can be used if it is in the individual's best interests, but all information should be logged and reported to managers or whoever is in charge. The Care Standards Act 2000 provides a minimum standard below which no company, hospital or any their provider may

work under. It ensures the protection and safeguarding of all their residents or clients. It means that all standards are achievable and enforceable to ensure that the residents health, wellbeing and quality of life are manageable. The Safeguarding of Vulnerable Groups Act (2006) was put in place to prevent unsuitable individuals working with children and vulnerable adults by providing a vetting and barring scheme for all people who are applying to work in this type of industry. Another important act is The Data Protection Act (2018), this act is an act that controls how your personal information is being used and held by companies, businesses, organisations and the government. There are data protection principles to be followed such as the data should be used fairly, lawfully and transparently and used in a way that is adequate and relevant and is not kept for longer than is necessary. You as an individual have the entitlement to find out what information organisations store about us. Lastly the Social Serices and Wellbeing Act (Wales) Act 2014 is a Welsh law that helps you to live the life you choose and stay independent for as long as possible with aims to make your care and support personal to your individual needs. This Act would not apply to the Winterbourne Case as it was in South Gloucestershire.

To conclude this assignment, we have the understanding that multi agency is a very important role for professionals to share, if used properly it is a huge benefit to the individual and the professionals. All professionals should be trained appropriately, and information received should be used and shared wisely with other professionals to benefit each other's roles. However, multi-agency does not always go to plan as the two serious case reviews show, these reviews should have taught certain professionals and organisations where they went wrong and how-to improve their communication and roles in the future. The policies, laws and acts are put in place to protect everybody, from the patient to the carer to the family and close friends. These policies and laws are achievable and should always be followed, to ensure the individual is free from harm, abuse and neglect. With more acts, policies and legislations being passed all the time, harm, abuse nd neglect should in theory soon come to an end for everybody.

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