

Quality Training and Development in the Health and Social Care Sector

Re: Responses to No Secrets Consultation by Making Connections (IOW) Ltd.

We are a small firm of social care trainers and consultants specialising in Safeguarding Adults' training.

In the course of a year, we come into contact with as many as 4,000 - 4,500 practitioners and managers in the context of Safeguarding Adults' Training.

Jane Hughes, Company Director, is an experienced practitioner, social work practice teacher and trainer, and also sits on her local Safeguarding Adults' Board.

Louise Lamb, Company Director, also a qualified social worker, was employed for 8 years as an adult protection co-ordinator for a large local authority before joining Making Connections.

Both have developed a particular expertise in safeguarding and have worked for and with a number of local authorities in the South East delivering safeguarding training at all levels and with all agencies.

What follows is our response to 'Safeguarding Adults: A consultation on the review of the No Secrets Guidance' based on our experience of delivering training to practitioners and managers within health, social services, police and the independent sector.

We welcome the review of the Guidance and have recognised the need to re-examine the context of the Guidance in the light of policy and legislative developments. We particularly welcome the recognition that safeguarding is everyone's business and we believe that No Secrets needs updating and refreshing to reflect this.

As trainers and consultants in this area we would like to see national occupational, competency based training standards at all levels:

- Pre-qualifying
- Qualifying
- Post qualifying

We were interested to read the document, *Healthier, Fairer and Safer Communities - Connecting People to Prevent Violence Towards a Framework for Violence and Abuse Prevention* Draft 20th November 2008 which seems to reflect some important and common themes in relation to prevention and strategic responses to the issue, which we would endorse. We feel that any new guidance should reflect the wider citizenship and community agendas in order to ensure successful implementation and, more importantly, strategic ownership across statutory agencies.

The document does not specifically address the issues of Disability Hate Crime and abuse in Institutions however, which we feel are vitally important in any consideration of issues of abuse and which should not be overlooked or marginalised.

Specific responses to Consultation Questions are as follows:

1. Leadership

As suggested above, the new arrangements for the Local Strategic Partnerships and the NI's mean that the accountability for Safeguarding could/should logically rest with LSP's, having accountability and governance arrangements with the powers to compel partners to address issues of violence and abuse locally.

Violence and abuse affects everyone and must involve cross- sector working:

- The Health Sector – including hospitals, public health, Community health, mental health and all front line health professionals
- Those working with young people, including Children's Centres, education, youth services, the Youth Justice Board and those working with vulnerable groups of young people who are at risk of violence and abuse as adults
- The Criminal Justice Sector – probation, prisons, CPS and CJB

- Communities and Local Authorities – including Local Strategic Partnerships, Planning Departments, Environmental Health and Crime and Disorder Partnerships.

Each sector has its own contribution to make and each sector can make a difference both individually and collectively. Cross-sector working requires a shared understanding about information sharing in terms of current legislation e.g. Data Protection Act, Crime & Disorder Act, but we feel that **additional legislation** is required to place a **duty** on all organisations to share information when there are concerns about violence and abuse.

Local Safeguarding Boards could form the tip of the 'chain of command' in respect of Safeguarding Adults who may be at risk of abuse, with the necessary accountability and responsibility for local outcomes.

Currently 'leadership' is in the hands of those within organisations who often have a safeguarding role alongside a number of other responsibilities. There are few dedicated posts and those organisations that do this, do so within existing resources. In our work we note that raising and maintaining the profile and good practice of safeguarding work sits in the hands of just a few local champions who are always at risk of marginalisation and 'burnout' as their work is not seen as mainstream within their organisations. This risk is increased as a result of no ring fenced monies to support this agenda. Safeguarding co-ordinators often have little or no authority or powers, and little or no specific budgets to implement and mainstream this work within partner agencies.

More clarity is needed in terms of the role of social services (No Secrets Section 3) as our experience shows that ownership and responsibility by other agencies is patchy and that the role of social services is often misunderstood by staff within and outside the agency.

No Secrets always envisaged that the NHS would work actively within the inter-agency framework and undertake investigations; this has not universally been the case.

We would recommend that in respect of only individual adults whose *independence, wellbeing and choices* are being significantly affected as a result of the risks of violence and abuse, that the NHS and Social Services are the agencies jointly responsible for the co-ordination of any assessment and responses under safeguarding adults' procedures in accordance section 47 (1) (a) of the NHS and Community Care Act. For those who do not fall within these criteria the responsibility of other agencies should be made clear.

We are pleased to see the steps for change laid out in Lord Darzi's report '*High Quality Care for All*' and the commitment given by the DH to fund these changes and we would want to see that safeguarding patients from abuse and neglect is given equally high priority.

2. Prevention

We feel that prevention should rest in the hands of all agencies at all 3 levels, primary, secondary and tertiary levels as outlined in **No Secrets** and in *Healthier, Fairer and Safer Communities - Connecting People to Prevent Violence Towards a Framework for Violence and Abuse Prevention* Draft 20th November 2008 and that the Standards set out in '*Safeguarding Adults ADSS 2005*' could provide a useful self audit/regulatory tool in ensuring that prevention is built into commissioning and contractual arrangements for health and social care. Public education and awareness raising and mandatory training in all sectors should form part of a universal preventative approach. But most importantly people's right to control who and what they commission in the way of social care services should be at the forefront of a preventative approach. Standard 11 of '*Safeguarding Adults ADSS*' is important in terms of building in the involvement of people who use or may be in need of services, into the training, membership, strategic planning, monitoring and implementation of safeguarding policy and practice.

In respect of health and social care the local LINKS should be expected to play a key role in influencing the way in which health and social care services are run and delivered in relation to safeguarding adults in receipt of or in need of community care services.

3. Outcomes

See 1 above, We would like to see an outcome framework for all partners with the addition of measures which specifically captures the person's view of the success of any safeguarding intervention. This could be regularly audited, monitored and evaluated by independent advocacy/representative groups at local (through LINKS) and national levels (through the work of the CQC). Our experience is that practitioners and managers rarely know what the outcomes are of any safeguarding response in terms of what it means for the person.

4. Managing Risks and 5. Managing Choice*

(*we feel this is unfortunate phrase and reinforces the idea that 'we' retain the power over people's choice and decision making and that the work of the DH *'Independence Choice and Risk' May 2007* reinforces the concepts of *'supported decision making'* which may be a more appropriate phrase)

People managing their own personal budget and the service provided are probably the most powerful preventative measure against abuse. However, we do recognise that for some people, this is more difficult and checks and safeguards will need to be introduced in some situations where there is or may be an identified risk. This should be done with the person, taking account of their view and the views of others close to them and on an individual by individual basis. This will require a person-centred, skilled and sensitive approach by care managers and social workers and the provision of wider community interventions to both individuals and groups to equip and enable people to have more control over their own lives through stronger development of the 3rd sector to promote and deliver a range of prevention and protection interventions.

We believe that there needs to be a coherent advocacy framework to enable vulnerable adults to make choices. Advocacy Schemes and Keep Safe Schemes are scattered throughout the country, existing services are stretched and they are not equally available to all vulnerable adults.

6 Health Services and Safeguarding

In our safeguarding adults' training with managers and practitioners in health and social care one of the biggest challenges identified is the role of health in safeguarding adults from abuse, which is well reflected in the consultation review document. Despite the '12 reasons why the NHS **should** be interested in safeguarding' this is rarely the case.

Safeguarding must be integrated within existing governance arrangements within health and that training must acknowledge and work with the very different culture that exists in health.

We do think there is a need for additional specific guidance for healthcare professionals and in particular GP's who can often be the first professional to become aware of violence and abuse. Safeguarding adults should be mandatory training for all healthcare staff according to their levels of responsibility and accountability.

Within adult mental health there are barriers similar to those within the NHS in general, but additional factors which mental health practitioners raise are around working with risk and how in adult mental health this seems to much more embedded in practice and in multi-agency working. Within integrated MH Teams there are specific issues around the interface between the safeguarding adults' inter-agency framework CPA and MAPPA's and MARAC's and we feel that there is a need for some more guidance in this area, in particular with the links with CPA and domestic abuse responses.

A mandatory shared responsibility for the co-ordination of safeguarding responses between the NHS and Social Services may help with joint ownership rather than as it stands at the moment the NHS seeing it as a social services responsibility.

7. Safeguarding, Housing and Community Empowerment

See comment above in relation to the DH paper *Healthier, Fairer and Safer Communities*. Housing providers are well placed to prevent, identify and act on abuse, yet are rarely directly represented at a senior level at Safeguarding Boards or are fully aware of the important role they and their staff play in relation to Safeguarding Adults.

Training for all housing staff and supporting people providers should be mandatory at both awareness levels and at more specialist levels for key housing staff. They have a key role in prevention and as members of Local Strategic Partnerships should be actively involved in developing a range of strategies for example, provision of advice and information about Keep Safe initiatives to enable their tenants and residents keep themselves safe in their own homes.

8. Access to the Criminal Justice System

Much work has been done in the past 10 years to improve access to the CJS, however this has yet to translate into practice. We regularly train police officers and have co-delivered training to interviewing and investigating officers on '*Achieving Best Evidence*'. However, this training is still not mandatory, is not universally JOINT with social services and disability awareness remains patchy among police, CPS and the Judiciary. Special measures under the Youth Justice and Criminal Evidence Act are too often overlooked or not applied early enough to secure best evidence from an older person or someone with a disability.

Existing legislation under section 17 of the Crime and Disorder Act 1998 allows for the passing of information between agencies to prevent crime, and should be more widely understood and utilised.

The Disability Equality Duty Schemes and their implementation within each agency should be independently audited on a regular basis. Alternative and third party reporting systems should supplement existing reporting mechanisms and there are a number of good practice models available to call upon (e.g. Visual Evidence for Victims - Birmingham Victim Support, True Vision etc.).

The development of the Public Protection Units has been welcomed and practitioners and managers have been very positive about the improved working relationships with the Police, however this has highlighted a marked difference in response between those in the PPU's and those in the rest of the local police force. The PPU's do not deal with all crimes against vulnerable adults, and do not have the capacity to do so, but we feel that it is inevitable that the number of reported crimes against vulnerable adults will continue to grow as the 'veil of abuse' of vulnerable adults is lifted. We would recommend that ACPO consider the resource implications within the PPU's and consider the need for more robust training programme for **all** officers to include, disability awareness, the nature and extent of crimes against vulnerable adults, mental capacity and understanding of how and when the use of 'Special Measures' may be appropriate.

9. Guidance and Legislation

We would recommend that the guidance in the ADSS document *Safeguarding Adults 2005* is reviewed with a view to it becoming a set of national mandatory standards. Currently each local authority has procedures which are all slightly different both in terms of:

- Definitions
- The involvement of the person/advocate/family carers
- The involvement of provider services
- The involvement of CSCI (despite the CSCI protocol varies between the CSCI regions)
- Terminology used to describe the process
- Timescales
- Thresholds for intervention

- Roles and responsibilities of social services and health staff within the process

This lack of consistency is very confusing to people who use services, responses vary between authorities which does not help with the implementation of the ADSS inter-authority protocol.

We do feel that Safeguarding Adult's Boards should be placed on a statutory footing with a duty to co-operate, however if this is formally proposed, the need for this should be evidenced by the successful outcomes from Safeguarding Children's Boards around the country.

In respect of powers of entry, removal orders and powers to remove an adult, we feel strongly that this is unnecessary for the following reasons:

- a) In respect of people who retain capacity to make a decision to remain in an abusive situation, action of this nature could directly contravene the person's human and civil rights
- b) The implementation of any such legislation would depend on a skilled, experienced and knowledgeable workforce within the existing co-hort of social workers and care managers. Every day, we meet social care practitioners who are struggling with the existing legislative framework, without support, detailed legal training, skilled supervision or confident management in this area. Without considerable investment in social work the risk of mis-applying a piece of legislation of this kind would be high both for vulnerable adults and for local authorities.
- c) As the CSCI Safeguarding Inspections recently reported, we have a considerable existing legislative framework which is under used and often misunderstood.
- d) In our work with practitioners we have found that people are still demonstrating a lack of awareness of the Mental Capacity Act and its implications for safeguarding adults. This piece of legislation could and should be more widely used to empower and protect adults at risk of abuse. The IMCA service has yet to develop fully and the Court of Protection has yet to fully develop its role in relation to welfare decision making in respect of adults who lack capacity and the High Courts in respect of vulnerable adults with capacity.

e) Any new powers in respect of entry and removal should be with the Police and not Social Services.

We would recommend a mandatory framework to enable all local statutory partners to create pooled funds specifically for safeguarding adults as can be found in section 10 of the Children Act. A formal agreement to commit funding and resources towards agreed shared outcomes which would provide greater scope for safer commissioning, integration; close partnership working, inter-agency governance arrangements; and the opportunity to consider redeploying and re-investing resources around prevention. Such an agreement would also strengthen the commitments of all partners and the ability of the LSP via the Local Safeguarding Adults Boards to ensure more effective local delivery and outcomes to meet identified needs of the local population, e.g. access to advocacy, support to survivors of abuse, keep safe training, etc.

Money is a vital resource and its effective use is essential to the delivery of quality services. But the introduction of No Secrets in 2000 came with no ring fenced money for implementation. Despite increased commitment from many safeguarding partners, organisational boundaries, competing priorities and budgetary constraints have sometimes been cited as a reason to obstruct attempts to improve safeguarding adults' responses.

We would recommend a requirement to establish and operate a national common data base, as our experience has shown us that local authorities operate different paper or electronic systems and collate slightly different data. Also that data on outcomes is generally poor and not always used to inform consultations, commissioning, practice and service delivery across the sectors and is rarely drawn from the experiences of people at the centre of the concern.

We would recommend that Serious Case Reviews are put on a statutory footing, similar to part 8 enquiries under the Children Act and that pooled budgets are available to resource these. Although many LA's have protocols for serious case reviews there are variations in the guidance, practice, learning and funding of such enquiries.

We would recommend additional guidance and standards for each safeguarding partner alongside nationally agreed inter-agency procedures.

10. Definitions

We believe that safeguarding adults from violence and abuse needs to be seen as a social responsibility, and as a systemic issue – and the actions, processes, behaviours and cultures of all partners involved need to reflect this and should be embedded in all aspects of practice, processes and systems.

Protecting adults from abuse is a specific aspect of safeguarding work, and should be clearly defined within national standards and local Policies, practice and processes to enable an inter-agency response to protect the person and promote their rights and choices. In respect of terminology, safeguarding adults work describes the broader preventative agenda and adult protection work the specific work involving assessments, investigations and protection planning.

We prefer the term *'adult at risk of abuse'* rather than 'vulnerable adult' and would endorse the view that the term vulnerable adult is patronising and disempowering and that whilst we continue to talk about vulnerable adults as an homogenous group we will continue to marginalise responses and see people as different.

We would like to see definitions that help the person and professionals make shared decisions about who needs a signposting response and who needs a response in line with inter-agency procedures, which should not just be defined by a person's label or characteristics, but by a person's experiences, context and setting in which the abuse has taken place.

We would welcome further definitions of 'adults who may be in need of a community care service' and have found the guidance in *'Safeguarding Adults' ADSS 2005* helpful in terms of the risks to an adult's *'independence, wellbeing and choice'* is impaired by the risk of violence and abuse and that they are *'unable to protect*

themselves from significant harm'. We welcome the review of **FACS** as our experiences have shown considerable variation in understanding, application and transparent use of this national criterion.

We recommend that the review of fair access to care must take into account the safeguarding issues more explicitly. Alongside this there should be a common approach to risk among all parties concerned in delivering health and social care, which will promote the sharing of responsibility for risk in a transparent and constructive way and could be used to compliment the risk processes used in MAPPA's and MARAC's.

We need a definition that helps communities understand what is meant by violence and abuse and understand who has responsibilities to prevent and protect those adults at risk. We also need additional definitions that help each organisation understand their own statutory duties and powers in respect of those adults at risk. We would endorse the review of social care legislation currently underway which may help to address these issues.

Abuse is abuse, whether perpetrated by people known to the person or strangers, each situation requires a personalised response. Anyone can experience abuse which can impact significantly upon their independence, wellbeing and choice and for some people they find themselves unable to protect themselves and as such may be in need of a community care service.

The No Secrets definitions can be interpreted as abuse occurring in a relationship context, and therefore the definition can be seen as excluding 'adults at risk' who are victims of violence and abuse by strangers.

The definition should start from a fully inclusive standpoint and then be further informed by an initial assessment of need and risk to determine the impact or likely impact of the abuse on the person's/or others in terms of their independence wellbeing and choice. Such individuals should be afforded greater protection from the additional inter-agency safeguarding framework.

Such a wide and inclusive definition would place a duty on **all** statutory partners to provide at minimum, advice, information and signposting to uphold people's human and civil rights and only use inter-agency safeguarding responses for those in need of such a response. We believe that **all** statutory agencies should be empowered to act.

There are considerable pressures for social services' staff at all levels with the changes needed to respond to the modernising agenda, the personalisation agenda, '*Valuing People Now*', etc. Alongside this is an increase in safeguarding referrals, (which we believe does not reflect the actual scale of the safeguarding work that is going on, but not being recorded as such) let alone the unreported cases of abuse. We work with managers and practitioners many of whom are already overstretched in terms of workload, who recognise that safeguarding is core business but so is personalisation, section 47 assessments, mental health act assessments, carers assessments, campus closures and many other high priority and high risk work often being undertaken by unqualified care managers. **We believe that safeguarding adults should be integral to each of these initiatives and explicitly recognised as such but too often is perceived as separate and additional.**

We would support a view that is shared by many frontline staff that aspects of this work requires trained, experienced and skilled practitioners with appropriate levels of authority and accountability, who are afforded the dedicated time, resources and supervision to enable them to provide a quality service and who have the additional protection of their professional bodies.

If in the new guidance the NHS and Social Services have a lead role in co-ordinating responses to those adults in receipt of or in need of a community care service under inter-agency procedures, then they will in our view, need additional human resources to do this work effectively.

Making Connections (Isle of Wight) Ltd.