CARE & SUPPORT ALLIANCE

Draft guidance on Safeguarding
Care and Support Alliance response

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The Care & Support Alliance (CSA)

The Care & Support Alliance was set up in July 2009. It is a consortium of over 70 organisations that represent and support older and disabled people, including disabled children, those with long-term conditions and their families, and campaigns to keep adult care funding and reform on the political agenda.

The CSA would like the safeguarding guidance to be significantly strengthened, to ensure that the ambitions in the Care Act in relation to strengthening safeguarding are fully realised.

The key changes we would like to see include:
- clear national guidance for local areas on when concerns should be reported to Adult Safeguarding
- clear national guidance on when and how information-sharing should happen
- a greater focus on prevention, including the addition of 'Staying Safe from abuse and neglect' to the eligibility criteria, to ensure people can get social care support if needed to help prevent abuse and neglect happening
- further detail on independent advocacy for safeguarding
- a specific focus on carers and safeguarding within the guidance.

This response outlines all the changes we would like to see, including those raised at the consultation meeting with the DH on 9th July as well as other key issues, which have been raised by members of the CSA.

Main response

1. Structure of the chapter

- We don't think the structure is quite right –? Some of the information does not seem to be in the right sequence? For example, MCA is mentioned early on (14.18 – 14.22) and again in the advocacy section (14.55 – 14.57). These parts need to be pulled together in a coherent way.
- We think there needs to be a section a section on 'spotting abuse - what to do, including when to refer to the LA'. This would logically come before 'making enquiries' section.

2. Make links to other areas of the guidance

- **Promoting individual wellbeing** (protection from abuse and neglect)

- **Prevention** (prevention duties: preventing people being put at risk of abuse and neglect crucial – but safeguarding, abuse or neglect are not mentioned in the chapter at the moment)
- **Information and advice** (audience: adults subject to safeguarding concerns, opportunity to provide info and advice during or following an adult safeguarding enquiry, what sort of information)
- **Assessment and eligibility** (When carrying out an assessment local authorities may identify that the person is at risk of abuse or neglect).
- **Reviews** (unplanned reviews may happen if LA receives safeguarding alert)

14.1 – change to 'arrange for an independent advocate to represent' ie delete 'where appropriate'. At the end of the paragraph, replace 'help them' with 'facilitate their involvement'.

3. Make links to other legal duties

- We think it is important that all relevant legal duties are referred to so that all agencies understand their legal obligations to protect people from abuse (ie it is not just about duties to cooperate and the LA's duty to make enquires under the Care Act).

    - Common law duty of care
    - Human Rights Act 1998
    - The role of the Office of the Public Guardian in safeguarding against financial abuse
    - Criminal offences of abuse and neglect under the Mental Health Act 1983
    - Duty to have regard to the Mental Capacity Act and DoLS Code of Practice and the ECHR.
    - CQC standards – require regulated services to have suitable arrangements in place to ensure people are safe, to prevent abuse and to respond appropriately to allegations of abuse (this outcome is intended to meet the requirement in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2009)

    Also could mention early on the 'duty to supply info' if SAB requests it (ie if you don't report risk and share info – SAB can get it from you anyway).

    Need to check all musts and shoulds and highlight.

4. Role of safeguarding

(Why do we need it when there are other channels for many things eg. complaints, police investigations, contract monitoring)

What is it, why is it valuable? (that is not really explained)

1. Prevention - community strategy – make sure people don't get put at risk of abuse in the first place eg. through information, advice, specific community initiatives, advocacy, social care support early on, good commissioning decisions (ie not sending people to places like Winterbourne View) – some of this could go in the Prevention chapter.

2. Prevention – multi-agency - information sharing early on to understand where and why people are at risk and what steps can be taken to protect people from abuse.

3. Enquiries - ensuring multi-agency work and information sharing, when abuse suspected.

4. When things go seriously wrong - SARs and lesson learning.

5. Key part is prevention

- Information and advice or advocacy won't be enough to help some people stay safe. Some people may need some social care support. We strongly believe that 'Staying Safe from abuse and neglect' should be in the eligibility criteria to ensure people can get social care support if needed to help prevent abuse and neglect happening. This would reflect what is currently in FACS criteria. It is also in line with Article 16 of the UNCRPD which makes clear there must be a focus on prevention of abuse not just reacting once concerns have materialised. (We have submitted a separate paper on supporting people to keep safe: interrelationship between assessment, eligibility and safeguarding, which looks at this issue).

- It is important the Safeguarding chapter flags up that it is important the SAB has a focus on prevention and what the levers are for this eg. prevention and wellbeing duties.
  (it says in **14.113** 'a key part of SAB role will be to develop preventative strategies and aiming to reduce instances of abuse and neglect in its area' – this could be added to the bullets in **14.104**).

- **See section on multi-agency working and cooperation – 14.26- 14.35.**
  This is confusing as it combines multi-agency work around prevention and multi-agency work around responding to abuse.

- It should be clear that **14.29** focuses on **prevention**. It could say that SABS should ensure there are mechanisms for multi-agency working/information sharing eg. a multi-agency safeguarding hub that does work to de-escalate risk, prevent crisis. Would be useful to explain that **what is found out should be used to inform commissioning strategy/ H&W Board plan for local area** – ie combating isolation, improving commissioning (stopping people being put at risk in inappropriate settings). It would be useful to include a case study of a hub.

14.31 – 14.35 It should be clear that these paras are about the 'multi- agency response to abuse'

6. When abuse is spotted - what action to take including referral to LA

There should be a clear section about what to do when abuse spotted, including when to refer to LA. We suggest this comes before the 'Enquiries' section.

There are some relevant bits in different places which could be grouped together in this new section:

- Some bits in Adult safeguarding procedures – 14.43-14.45
- 14.30- talks a bit about workers being vigilant and acting on concerns
- 14.138 - a section about information for staff, people who use care and support (eg. info about how to express concerns)
- 14.14 - says 'and no professional should assume that someone else will pass on info which they think may be critical to the safety and well-being of an adult risk of abuse or neglect'. 'If a professional has concerns about an adult's welfare and believes they are suffering or like to suffer abuse or neglect, then they should share the info with the local authority'.
- 14.26 – 14.35 this focuses on statutory agencies rather than providers. **Providers' responsibilities must be much clearer (this links to the need for legal duties to be spelt out).**
- Link to roles and responsibilities at the end, including para about providers of service (clear operational policies etc)

It would be good if the guidance was much clearer when referrals should be made to the LA. Threshold for referral should be clear. **14.44** says about having 'local procedures…for initially assessing abuse and deciding when intervention is appropriate'. **But local areas want help with this.**

7. Thresholds for safeguarding referrals

People need to know when to report….

- There is no mention of 'thresholds' – when a safeguarding referral should be made (just mentions in **14.44** about local procedures for initially assessing abuse and deciding when intervention is appropriate).

- Currently wide variation between different local areas and between health and social care within local areas.

- **We want national guidance on thresholds, to end postcode lottery.**

Comment on DH consultation website shows importance of consistency re: thresholds:

> 'These HSCIC statistics, whilst offering a helpful indication of the overall direction of travel with alerts and referrals, still needs to be treated with extreme caution. Until such time that we can all be satisfied that there is absolute consistency in the application of definitions and the ever growing number of threshold agreements, these figures are unsafe. I could quote many examples of how definitions of adult abuse/safeguarding vary across the country, but when some areas are defining all pressure sores as adult safeguarding alerts, and others have not conducted a single serious case review, it shows how far we have to go yet to achieve that consistency.'

- SCR on Steven Hoskin – Margaret Flynn said need for clear thresholds (a number of reports have commented on failure to refer). More recently there

have been more referrals, but still a postcode lottery – re: when to refer/ when something will be investigated.

- National guidance needed – wide variation about things like pressure sores, restraint, institutional abuse.

- Pointless trying to get national picture/ compare local areas, when thresholds are different in every area. If new legislation is to improve safeguards for vulnerable adults, we're not going to get a proper picture if each LA is uses its own criteria. Without the thresholds, it is also difficult to see how the information provided by the Safeguarding Boards can give a 'national assurance'

- Not even got an equivalent section to No Secrets **– '***what degree of abuse justifies intervention'.*

8. Information sharing

- This section should flag up the importance of information sharing for: **prevention, enquiry, SAR**

- Would be helpful to combine 'information' and 'confidentiality' sections (and link better to 'record-keeping' section. We know confidentiality is often used as a reason to withhold information. This should be made clear.

- The information section says 'in the past, there have been instances where the withholding of info has prevented organisations being fully able to understand what went wrong'. This section also needs to flag up how '**lack of information sharing** between agencies about risks etc. **has led to things going wrong**'. And the SAB needs to ensure there are mechanisms in place to enable effective information sharing (eg hubs), ensuring there is a mechanism for CQC and Safeguarding Adults to share info, spot patterns etc.

- Highlight **legal levers to ensure info-sharing happens:**
    - Duty to supply information if requested by the SAB is key. (ie if information not shared then SAB can demand it). It needs to be clearer that this duty to supply information applies to the enquiry stage as well as Serious Adult Reviews
    - Duty to cooperate
    - MCA Code chapter on best interests decision-making about info sharing when someone lacks capacity (chapter 16). Case law: court has stressed importance of councils (who argue a person lacks capacity to agree to his papers being seen by a third party) undertaking a proper best interests assessments on this (R(S) v Plymouth City Council (2002) EWCA Civ 388).

- **It would be helpful if this section gave clear guidance in respect to information sharing. It doesn't explain 'how' information sharing will happen**. This is something local areas struggle with and it would be good to have clear guidance on. Tricky issues include things like information sharing around staff conduct and allegations that may not be proven. There needs to be clearer guidance around how to balance confidentiality, legal rights, data

protection, public interest. What happens if people refuse to share information etc.

9. Advocacy

The part of the chapter that relates to advocates lacks detail. It may well fit better with chapter 7 on Independent Advocacy.

See further comments from Phillippa (Voiceability)

10. Mental Capacity Act

- 14.55 – 14.56 need to be clear that when a person lacks capacity a 'best interests' decision must be made – refer to MCA code best interests checklist Also, in relation to information sharing, refer to chapter 16 in the MCA code about info sharing.

See further comments from Phillippa (Voiceability)

11. Support following a safeguarding enquiry

- **14.68** sets out that one outcome following such an enquiry might be a safeguarding plan. This must set out a range of things, including: "the provision of any support, treatment or therapy including advocacy". The paragraph would be stronger if it read: "the provision of any support, treatment or therapy including advocacy, **which is necessary to help assure their safety in future".**

- It would also be useful to **clarify here that the intention is that this should be provided regardless of eligibility**. If that is not the intention it needs to be clear under what duty support, treatment or therapy including advocacy would be provided.

12. Carers

- We are concerned that the current wording does not make it clear enough that **local authorities have safeguarding duties towards carers too**.

- Carers are not vulnerable per se as a result of being a carer. However, there are instances where the person they are caring for has violent, extreme or controlling behaviour which puts the carer at risk of harm. This may be intentional or can be unintentional due to the condition of the cared for person e.g. dementia or learning disability. Carers may also be at risk of physical harm such as a back injury and their mental health (and risk of serious self-harm) can also be put at risk due to the stresses of caring and/or discriminatory abuse relating to the cared for person.

- The choice of case studies in the draft guidance creates a further risk that carers will only be viewed as potential perpetrators of abuse rather than as people with support needs who may need help themselves to reduce risks to their own physical or emotional wellbeing.

- The families of those receiving care services have a vital part to play in detecting and preventing abuse. It is vital that where these concerns are raised, they are listened to. This is an important issue to emphasise particularly in light of recommendations from the Francis Report and following Winterbourne View where the repeated concerns of carers were ignored.

- ADASS recently produced a guide on carers and safeguarding http://static.carers.org/files/carers-and-safeguarding-document-june-2011-5730.pdf It would be very helpful if the guidance referenced this guide.

13. Other issues

- **14.4 –** In order to achieve these aims…Insert bullet point: **'To provide accessible information, and support if necessary to understand it, on how to raise a concern about the safety or wellbeing of an adult, awareness of different types of abuse and how to stay safe (ref to 3.47 and 3.48)**

- **14.7 –** Types of abuse. It is confusing having intent/ response straight after the types of abuse eg. it immediately talks about pressure/ stress on carers after intentional abuse and neglect and it almost reads as if it can be justified in these situations. Needs a new section about intent/response.

- **14.9** – we would like this to be re-ordered if possible so that examples of relatives and friends are not first.

- **14.10** – (insert: as well as looking at single incidents), professionals and others should look beyond single incidents to identify patterns of harm.

- **14.11** – more detail needed on patterns of abuse so it has same detail as No Secrets eg. useful detail on institutional abuse and unacceptable 'treatments' or programmes (this detail would help people spot abuse).

- **14.16 –** insert more guidance on how to identify financial abuse and what steps should be taken. Applying to the CoP for the appointment of a Deputy for property and affairs if there is concern that a person may lack capacity and may be being financially abused by others. **Insert steps LAs should take** in such circumstances – ie **referring the matter to the Office of the Public Guardian.** Include ref to MCA Code of Practice and OPG for further guidance.

- **14.34** – Remove 'it is not useful…'. Instead put 'Commissioners of care or other professionals **should not** attempt to improve services by using safeguarding procedures as a threat to intimidate providers.'
- Also add in: **'Commissioners of care or other professionals should not use safeguarding procedures as a threat to intimidate families.'** (note: having clear thresholds set at the national level should help stop this happening as it will be clear what is a safeguarding concern and what isn't).

- Insert new bullet between **14.37 and 14.38** – '**local procedures should ensure that safeguarding enquiries take place in an appropriate timeframe'** (we

know that safeguarding enquiries can go on for months leaving individuals, families, staff, providers in limbo – having to chase for updates).

- **14.42** – social workers, police and other professionals and staff involved in enquiries and SARs must have understanding and skills needed for particular cases, or bring expertise in. For example, cases involving people with complex health, communication or behaviour needs, sensory needs need experts involved who really understand the complexity of a person's needs to ensure there is a thorough investigation and a proportionate response.

- **14.50** – it says police must have considerable skill in investigating and interviewing people with a range of disabilities and communication issues if early involvement is to prevent the adult being interviewed unnecessarily on subsequent occasions. Also insert: We know that **too often evidence** from victims and witnesses with a learning disability is **discounted (see CPS research[1]). It is crucial reasonable adjustments are made and appropriate support given, so people can get equal access to justice**.

- **14.53 –** when an enquiry should take place. The guidance should reflect that LAs safeguarding obligations derived from common law duty of care and their obligation under s6 of the HRA to act compatibly with human rights as well as the Care Act.

- **14.114** – strategic plan must also be a document that 'can be read and understood by anyone'. Must be accessible formats. (it says the annual report must be).

- **14.121 –** after list of individuals/ organisations who SAB must send a copy of its report to, add a sentence: **'they should each demonstrate they have considered it, for example with a written statement or comment.'**

- **14.140** – Information should explain clearly what abuse is and also how to express concern or make a complaint. Also needs to flag up right to an independent advocate during safeguarding enquiries in certain circumstances.

- **14.168** – a further bullet should be included about **listening to the views of relatives.**

- **14.165 - Training–** training is a continuing responsibility.. can it refer to need for supervision, reflective practice. (Perhaps along the lines of the MCA section pg 197 14.19 – regular face-to-face supervision from skilled managers is essential to enable staff to work competently with difficult and sensitive situations.)

14. Case studies

Some comments:

Pg 194 – A family mediation approach – if this isn't safeguarding what is – it appears that it is not taking serious abuse seriously.

[1] http://www.cps.gov.uk/publications/docs/mhld_cps_research.pdf

Pg 196 – Listening to the adults views
They should have involved the person from the start.

Pg 197 – Need a good example here of when you report/ decision-making about whether you report. Case study should take you through process.

Pg 201 – This should more clearly be an example illustrating a case where both the adult with care needs and the carer are the subject of safeguarding concerns. The end of the case study seems unrealistic and is not a helpful example.
Pg 205 – Should have involved an advocate?

Pg 207 – Needs more detail – eg. Susan and her mum had a good relationship and it was out of character for Susan to attack her mum…

Pg 210 – Advocacy one – says advocate was involved mainly to talk through his concerns (not actually role of an advocate?)

Some CSA members are sending in potential case studies separately.